# The ‘new humanitarian aid landscape’

## Case study: MSF interaction with non-traditional and emerging aid actors in northern Mali 2012-13

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# Introduction

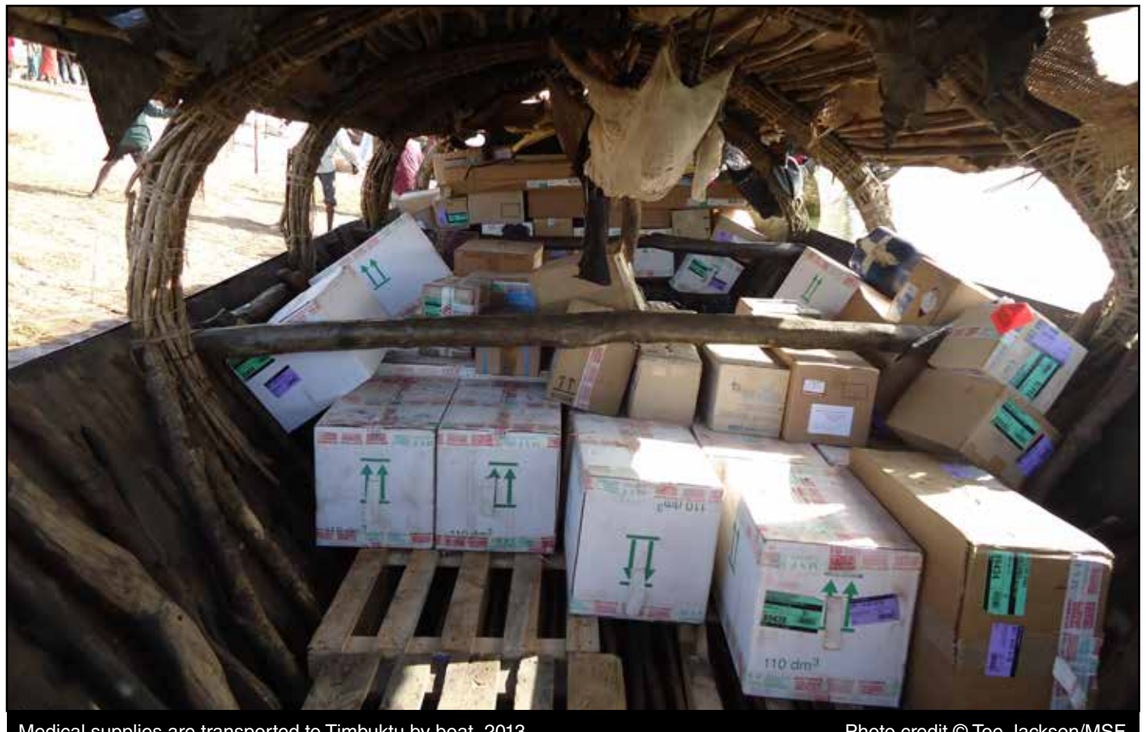
Humanitarian crises around the globe continue over the years to attract a growing number of aid actors with varying capacity. They are also increasingly of diverse origins. As MSF finds itself working alongside with these new actors - particularly in some of the most difficult contexts where more established aid actors are increasingly absent - it constantly has to decide what level of interaction and engagement the organisation ought to have with these actors. Whilst relationships and positioning towards the traditional aid system and MSF have been clearly developed and purposely limited over the years, this is not so clear for these emerging, new aid actors. This study is aimed to expose some of the field realities and dynamics, which can contribute to the development of a MSF strategy and positioning towards these new aid actors,

Mali was selected as a case study due to the context in which the conflict took place: the north of the country was under the control of armed groups with a strong anti-western rhetoric, and a history of kidnap of western aid workers. In this environment, it was very difficult for the traditional aid agencies to respond to the crisis, so a likely environment for non-traditional aid actors to operate.

Based on a review of the literature and a field study in two of the three northern regions of Mali during which semi-structured interviews were conducted with a variety of key informants, this paper attempts to shade light, on the one hand, to the changing landscape of aid actors in Mali with a special attention to the "new" actors; and, on the other hand, to MSF's relationships (or lack of thereof) with these actors and the factors that shape these relationships.

This paper does not attempt to provide an exhaustive mapping and analysis of who those new actors in Mali are. Rather, its focus is on the interaction between MSF and those with a medical and operational field presence in project locations of MSF in northern Mali during the period January 2012 to September 2013. As such, it gives an MSF-centred perspective in terms of interaction, domain of activity and geographical scope - it does not include Kidal region for instance.

The first section of this paper provides a brief description of these new actors and the context in which they filled the institutional void induced by the retreat of State authority. The second section puts into perspective their role, on one hand, with that of the established aid system and, on the other hand, with regards to the dynamics of centre-periphery relations in Mali and their translation in the field of health care delivery. The paper concludes with a description of MSF relations with these new aid actors and a discussion of the factors that influence MSF's posture towards these actors.



Medical supplies are transported to Timbuktu by boat, 2013 Photo credit © Toe Jackson/MSF



# A profound transformation of the nature and landscape of aid in Mali

Following the re-emergence of a rebellion in 2012 – the fifth since the country gained its independence – and a military coup in Bamako, Mali has been beset by what many consider to be the worst crisis in Mali's history. In January 2013, Mali's former colonial power, France, launched a military intervention aided by African troops to put an end to the rule of armed opposition groups in northern Mali who had driven away the Tuareg separatists and threatened to extend their territorial gains. Six months later, pressed by international actors to unlock over four billions dollars in promised funds for this highly aid dependent country, a presidential election was conducted and a new president was sworn in September 2013.

The crisis has resulted in a number of important consequences for aid work. In a country where aid actors had been engaged in development work for most of the past 40 years besides intermittent crises due to environmental and socio-political factors, events in 2012 completely transformed the nature and landscape of aid work beyond a mere adaptation to changing needs.

The crisis has put a new emphasis on the role of local actors while the specific security situation has forced the traditional aid actors to impose severe limitations to the presence of its mainly Western (white) expatriates since 2010. It has also brought in new actors such as Red Crescent societies and "non-traditional" humanitarian donors like the OIC and African Union although in limited number. Some of them had to face severe criticisms and saw their motives questioned.

The crisis has also reinforced the presence of the Western dominated international aid system despite debates about the negative impact of aid dependency in a country where the majority of the population is poor and health indicators are abnormally alarming for a country that had been stable until 2011 and a major recipient of development aid. The subordination of aid to political and security objectives may risk causing further harm in this fragile security, economic and social environment.

The crisis has also been a transformative experience for many in the north who took the lead in organising the continuity of the provision of essential services and the distribution of aid. At a time when state public agents start regaining their vacated positions, the Malian State intention to reinstate its authority in the region is confronted to the mutual resentment and mistrust that the crisis stoked between populations in the north and in the south.

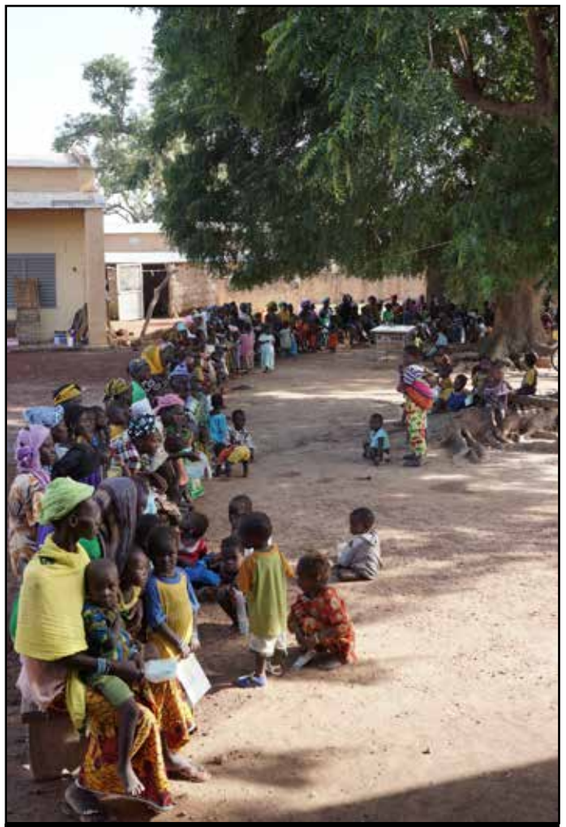
Mothers wait with their children for consultations at an MSF clinic in Konseguela, 2014 Photo credit © Aurelie Baumel/MSF

# An institutional vacuum filled by a collection of mainly non-state actors

Under harsh conditions in these Sahelian and Saharan areas of northern Mali, some 311,000 Internally Displaced People (IDPs) have fled within the country and 170,000 refugees have sought shelter in neighbouring countries, mainly in Mauritania, Burkina Faso and Niger[1]. Among those who fled were employees involved in the provision of public services, the great majority originating far from the northern regions where they were employed. It resulted in the complete disruption of these services, among which, essential health care. The situation was compounded by the ransacking and looting of many health facilities at the onset of the crisis.

This institutional void was filled in by a number of Malian and international actors, most of which were non-state. The governance of health care delivery in northern Mali during 2012 and until recently was fragmented and largely dominated by locals although health care providers such as MSF were generally given a large autonomy in running main health facilities such as hospitals.

Those actors can be divided between *new aid actors* - those who did not have an operation field presence prior to the crisis - and *old aid actors* - those from the more established and 'embedded' aid system. Both groups include Malian and international actors and are described below.



Mothers queue with their children for preventive antimalarial treatment in Koutiala, 2012 Photo credit © Simon Rolin/MSF

# Outside the established aid system: Who was on the ground?

## *Malians' Mobilisation Across the Country and abroad Triggers Concrete Aid Initiatives*

Crisis has put a new emphasis on the role of local actors while the specific security situation has forced traditional aid actors to impose severe limitations to the presence of its mainly Western (white) expatriates. Local actors – composed of new actors and those from the established aid system - have played an essential role in the direct provision of aid but also in coordinating the response of aid actors including that of internationals.

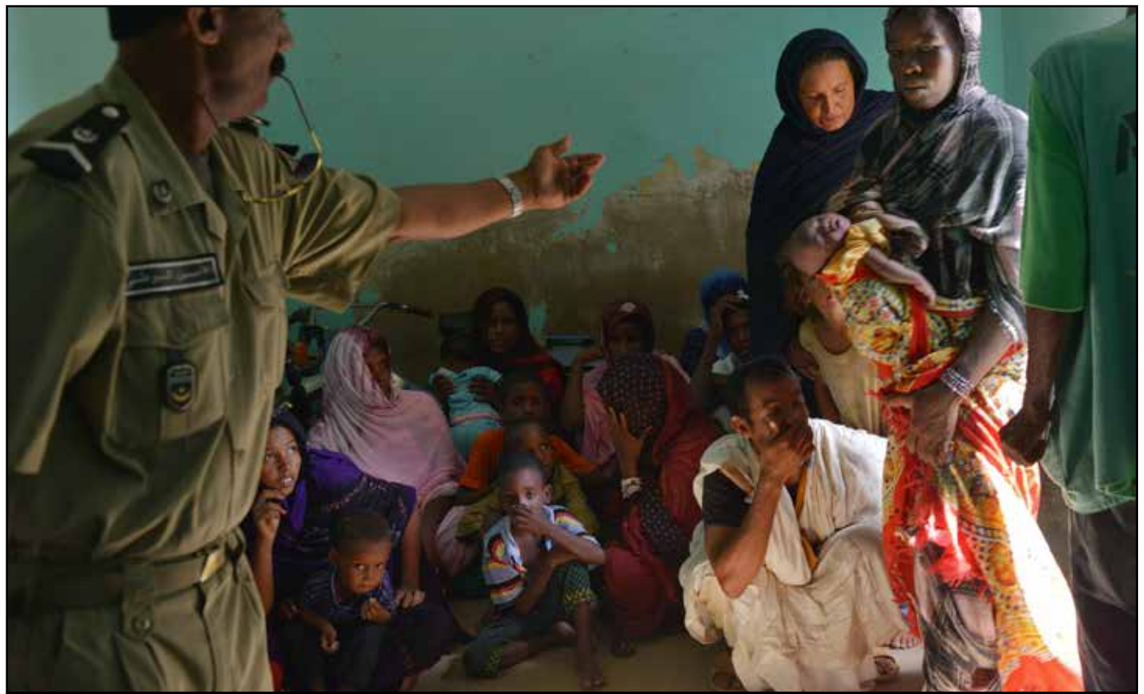
Many of these new initiatives find their origin in civilian networks that existed before the crisis erupted. Their contributions to the aid effort have varied from punctual interventions such as food distributions to more complex operations such as the management of a hospital. Their sustained calls and direct efforts to cater for the population needs have arguably also contributed to opening access for others aid actors although this would be difficult to measure.

For instance, Cri du Coeur - "A Cry of the Heart", an initiative born during the crisis – are largely considered to have been the first to organise humanitarian convoys to the north. The medical personnel in Gao and Timbuktu hospitals declared that the first medical donations were provided by Cri du Coeur.

The crisis saw also the mobilisation of Malians leaving outside the northern regions where they originate from including the Malian Diaspora who have been active in the collection and donation of financial resources and drugs. The "Northern Citizens' Collective", known by its French acronym COREN - Collectif des Ressortissants du Nord – has facilitated the transport and the reception of IDPs and have also sent medical personnel[2] to staff some health facilities. Although COREN did not exist as such prior to the onset of the crisis, a number of associations regrouping northerners leaving outside their region of origin were already established.

The Malian High Islamic Council known by its French acronym HCIM played a substantial role at the initial





Mauritanian officials register refugees who fled violence in Timbuktu, 2012 Photo credit © Lynsey Addario/VII

stage of the crisis in terms of mediation with armed groups to ensure the delivery of humanitarian assistance by aid actors. It has also collected money for the victims of the crisis and organised some distributions of aid assistance. It has also served as a mediator[3] between the Malian state and the armed groups.

The College of Physicians has also been active during the crisis. It has been posting for short missions medical personnel in public health facilities in northern Mali with the financial support of the World Health Organisation (WHO).

Action Humanitaire Gao (AHG)[4] – was created in April 2012 only few days after the fall of Gao. It took responsibility for the management of Gao hospital after many of its personnel vacated their positions. Headed by the then president of Gao young doctors' association, volunteers teamed up with the remaining hospital staff – contracted and civil servants - and started by putting the ransacked health facility in order. After a sensitisation campaign in the city, they succeeded in collecting some of the stolen material and equipment. The first services to reopen were the emergency surgery, paediatrics, obstetrics and gynaecology, laboratory and pharmacy units. With the income generated by the fees paid by patients – except for the indigents who were exempted – and the support of the International Committee of the Red Cross, Action Contre la Faim, the Qatari Red Crescent Society (QRCS) and a punctual donation by MSF, the full recovery of the hospital activities took place two months later.

The absence of the State and many of its agents was mainly compensated by a multitude of local initiatives.

## *Regional, Islamic and Red Crescent aid stay out of the system*

The crisis in Mali has also brought in new actors such as Red Crescent societies and 'non- traditional' humanitarian donors like the Organisation of Islamic Cooperation (OIC) and the African Union (AU) in limited numbers though and in limited areas, mainly in Gao. This modest presence was in contrast with expectations following the massive deployment of non-western aid groups in Somalia, which was thought to represent a new pattern in terms of involvement of donors and aid organisations originating from the Muslim and Arab world in aid operations[5].

In contrast, in Mali these non-western aid groups weighed their efforts against those of the traditional – western - aid system and decided on a more limited presence. As a result their intervention in Mali has not been up to the OIC's expectations expressed in 2008[6] in Dakar. During a visit to Bamako in 2012, a delegation of the OIC expressed disappointment with the meagre representation of Muslim-based organisations in the humanitarian effort[7]. This was also deplored among some representatives of Muslim organisations in Mali[8]. In the end, the financial contribution to humanitarian assistance provided by the OIC for Mali has been marginal.

To their credit though, the Algerian and Qatari Red Crescent Societies have been among the rare international actors who have been able to respond directly to medical needs in northern Mali during the crisis when the region was no longer under government control. In comparison,

most of the Western INGOs arrived once the area had been retaken by government forces supported by French military, and the humanitarian jargon shifted to the 'recovery' phase.

According to local accounts, the Algerian Red Crescent Society remained in Gao where they had arrived with supplies at the end of the first half of 2012 for less than 48 hours after being ordered by armed groups to leave. The Qatari Red Crescent Society (QRCS)'s intervention in Gao – the only city in Northern Mali where the QRCS has operated - has been surrounded by suspicion in the press[9]. It has been accused of supporting the armed groups that threatened Mali's sovereignty. Among aid actors from the established aid system, they have also been criticised for what is considered a lack of transparency. They intervened outside the agreed principles by the Red Cross and Red Crescent Movement meant to regulate the presence and actions of individual members when they operate in the same country (The French and Algerian Red Cross/Red Crescent also refused to sign up to the required agreements with the International Committee of the Red Cross (ICRC)). The context of "Qatar bashing"[10] as the French press termed it due to repeated public denunciations in France concerning allegations regarding Qatar's involvement with armed militants across North Africa and the Middle East, did not help[11]. In this context, privileged contacts with armed groups and a cross-border operation from Niger to northern Mali did not help the QRCS build trust as MSF has experienced elsewhere. Last, the ban on Western expatriates in Northern Mali during the crisis meant that the vast majority of foreign actors from the established aid system had to rely on second hand information.

At the onset of the French military intervention in January 2013, the QRCS stopped operating in Gao. It now provides support to Malian refugees in Mauritania and Niger.

While the reasons as to why aid efforts originating from Muslim and Arab countries have not been up to their own expectations would require a thorough investigation, the following reasons are given here as tentative explanations: a commitment to respecting Malian sovereignty and hence difficulties in intervening in areas where State authority is totally absent; the political cost on the world scene of being associated with Islamist armed groups against the backdrop of international critics towards the interventionism of some countries in the north African and Middle East revolutions; hostility in some segments of the Malian population[12] towards the OIC that they suspect of having a hidden agenda and who is seen as representing the political interests of States with too many diverging views to be effective[13]; a lack of operational capacity in this insecure context and a state-centric aid culture of cooperation that rarely encourage by-passing State institutions; and last, a lack of trust in Malian institutions due to their reputation for being corrupt[14].

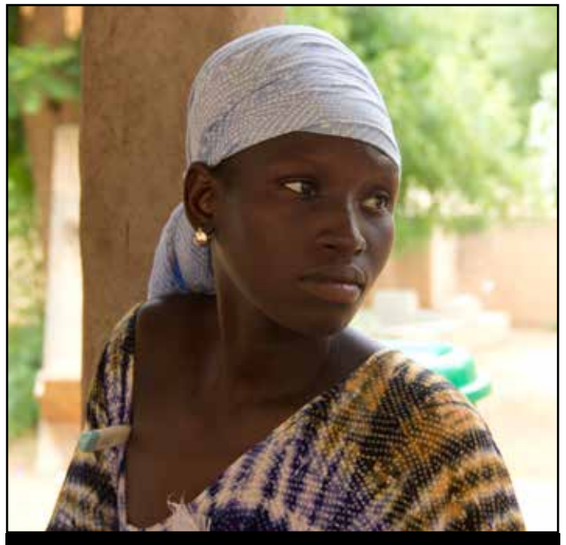
For their part, besides military involvement, aid from countries in the region not channelled through Malian authorities has been minimal. The African Union pledged 50 million dollars in humanitarian funding in January 2013. This study has not found any initiatives directly funded by the AU in the visited locations. Direct aid from countries in the region took mainly the form of what the military calls Quick-Impact Projects (QIPs) as part of their "Hearts and Minds" campaign.

This trend of armed forces involved in aid activities is being reinforced by the UN peace keeping operation (MINUSMA) which has funds for such activities. The MINUSMA relief activities are coordinated with the established aid system through the UN coordination system ('clusters')

The establishment of UN peacekeeping operation in Mali appears to have side-lined the Economic Community of West African States (ECOWAS), the regional interstate cooperation organisation. Indeed, the UN Security Council choice against an African led military force and the dynamics of "neo-trusteeship" that followed the French military intervention have taken their toll on a more assertive Africa and regional cooperation, including in the humanitarian field.

So-called "non-traditional" actors choose to operate outside the aid system, not in the least because of a deep mistrust of the United Nations. Yet, little evidence of OIC or AU funded aid activities were found on the ground in this field study.

Algerian and Qatar Red Crescents, although quickly on the ground in Gao, both have suffered distrust fostered by suspicions about the reasons of their presence. These suspicions have also been a major factor in preventing partnerships between the QRCS and the established aid system.



A patient waits to be seen at Douentza health centre, 2013
Photo credit © Verhenne Leen/MSF



# Aid in Mali: Limitations and influences on centre-periphery relations

## *The limitations of existing aid structures*

### Local aid groups face financial and capacity challenges

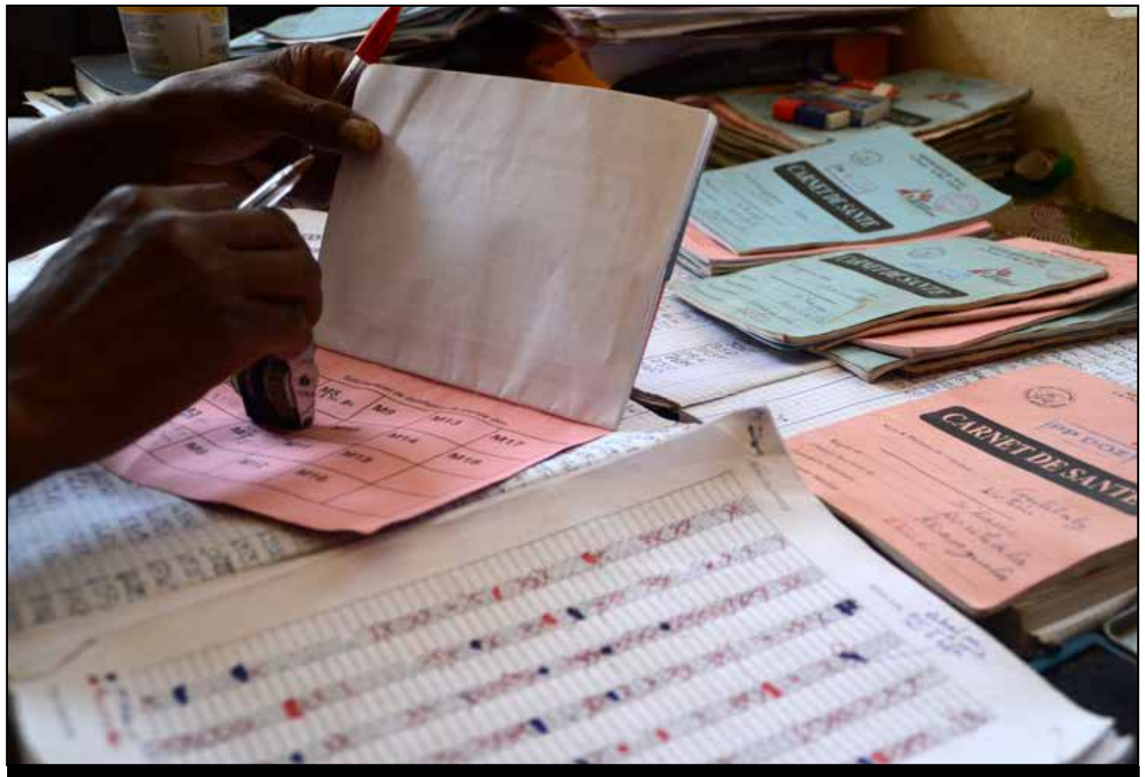
Malian NGOs, the Malian Red Cross Society and the ASACOs ("Association de Santé Communautaire" in French) constitute a sub-group of the "established" aid system.

The Malian NGO sector is large and diverse, from single to multi-mandate NGOs. Its three decade existence is linked to several historical factors. In the 1980s and 1990s, the liberalisation of political and associative life in Mali and, on the other hand, the liberalisation of the Malian economy has both been major drivers of the LNGO sector. Envisaged as a link between the base and the government, the development of civil society organisations as been part of the democratisation process in Mali. The Malian NGO sector also received strong international support. The arrival of INGOs in the 1970s and 1980s including MSF due to droughts in Mali contributed to the creation of LNGOs[15] and continues to this date. For instance, in the health sector, employees from MSF and MdM have established their own NGOs in the 2000s.

Their area of operation is often local although many LNGOs extend their activities throughout the country. Many do not have a representation in Bamako which has been a severe handicap during the crisis as LNGOs are heavily dependent on external financial support.

Their capacity in the health sector during the crisis has been limited to information gathering, sensitisation, prevention and malnutrition with the notable exception of AHG that managed Gao hospital. Like their international sisters, shifting to an emergency mode in a radically changed environment has proven difficult. Many were no longer active during the crisis and others were funded or worked in partnership with international actors (UN, INGOs) to deliver aid the latter being unable to operate directly due to security management related constraints. LNGO are part of the cluster system, at least meetings are opened to them and they have taken part to the UN Consolidated Appeal Process (CAP) – a collective funding appeal.

Neutrality has also been an issue for some. As part of the




Health staff fill in children's medical records in Konseguela health centre
Photo credit © Aurelie Baumel/MSF

political culture in which the emergence of LNGOs took place, many LNGOs have expressed views that would constitute a breach of neutrality for purely humanitarian actors. Malian Civil Society platforms have expressed public views and opinions on the military coup, the nature of the conflict in North Mali and its resolution.

They role is likely to become more prominent as attention appears to shift to "recovery" and development work. Some fear that should the security situation deteriorate, they risk being associated to the stabilisation agenda, and become vulnerable for violence from armed opposition groups.

The ASACO are community health associations in charge of managing community health centres based on cost recovery[16]. They were established two decades ago in the backdrop of limited State resources. They enter into agreement with the State and follow national regulations. Like the public health institutions, among the ASACOs that were still functional before the crisis erupted, some have remained active thanks to external supports. Now that a relative calm has returned, many want to revert to a recovery of the costs of services prompting in some instances an end to the cooperation with MSF who maintains a free health care policy.

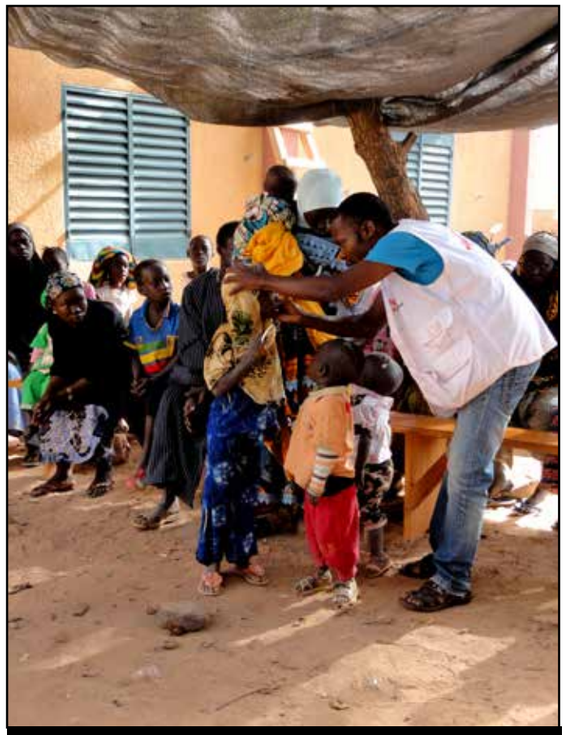
Mali offers a good illustration of the fact that the strength of a national Red Cross or Red Crescent society is often a function of the wealth of the country. The MRCS has little capacity in the provision of health services and has focused instead on the distribution of food, water and other humanitarian activities. However, the crisis has brought in many actors from the Red Cross and Red Crescent movement and its capacity in health is being built. The Malian Red Cross Society (MRCS) had been active in northern Mali well before the crisis erupted.

The Malian aid system, although well established, was not able to cope with the rapid change of environment, because of an external funding dependency, a focus on development and a lack of capacity to work outside of their usual area of intervention.

## International aid machine: reinforcement and alignment with security and political objectives

While new aid actors have been criticised for their lack neutrality, the international aid system did not fare any better. In comparison to the new aid actors, what characterises the international aid system is its large number of, its diversity, its emphasis on a hierarchical structure dominated by the UN agencies and donor governments; its large funds; the extensive resources it dedicates to coordination; and its degree of integration to foreign political and security objectives.

The crisis has not only led to the mobilisation of new actors, it has also triggered the deployment of all possible crisis response tools at the disposal of the "international



MSF provides medical care in Mopti to people displaced due to regional insecurity Photo credit © Gonzalo Wancha/Filmalia

community" including its humanitarian wing. Meant to cooperate in order to reach their claimed ultimate objective in Mali – a "stabilisation" [17] of the country - the number of international actors in Mali has grown significantly.

After, Sierra Leone[18], Liberia and Cote d'Ivoire, MINUSMA is the fourth DPKO mission in West Africa in two decades. On 25 April 2013, the UN Security Council established[19] UN Multidimensional Integrated Stabilization Mission in Mali, known by its French acronym MINUSMA. Its civilian and military components are tasked with an impressive "to do list": the stabilisation of key population centres; the reestablishment of the Malian State authority in the north of the country; the support to the political dialogue and electoral process; the protection of civilians; the promotion and protection of human rights; the support for humanitarian assistance, cultural preservation and national and international justice. Some consider that the United Nations response to the crisis in Mali has been to put the country under trusteeship[20] with two immediately visible results, the presence of foreign forces under a UN Security Council mandate and the reinforcement of the international aid presence.

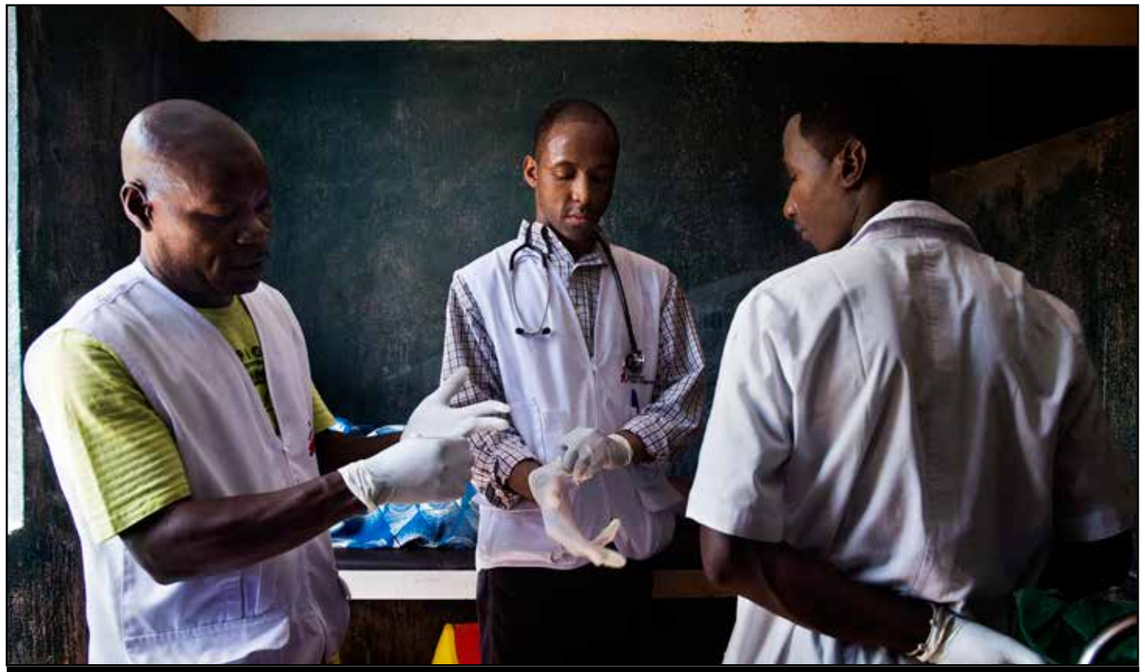
Humanitarian assistance in Mali – an in other countries where such integrated model is implemented - is subordinated and in support[21] of the United Nations political and security objectives. These efforts towards a coherent and integrated response risk compromising the ability to negotiate access to certain areas[22] and hence hinder humanitarian assistance.

Various paradigms and agendas - development, humanitarian assistance, state building, refugee and migration management and counterterrorism - have conflicting objectives. This reflects in the climate of rivalry and distrust among the various actors – including within the same families of organisation such as the UN or European Union. Each of these actors has its own institutional understanding of the crisis and, therefore, of what the response should be. There are tensions between the MINUSMA and almost all UN agencies. In particular, the peace keeping forces and its 'Quick Impact Projects' (QIPs) are considered to be a potential danger by aid actors threatening both, the physical security of the aid community who risks being associated with the military force and, potentially, that of civilians which runs at cross-purposes with the civilian protection mandate that was given to the MINUSMA. Among aid actors, it is not rare to even contest the need for such number of troops in Mali.

More detrimental for the aid sector and its chances of being successful in bringing relief and a better future to Malian, the rivalry between the humanitarian and the development agencies. Development actors did not feel comfortable with the landing of the humanitarian aid machine in Mali and some have questioned the need for their presence. For their part, many foreign humanitarian aid workers feel that decades of development actors' work in Mali have failed to produce the expected results. Instead, some believe that these efforts have even contributed to some extent to the crisis by feeding a corrupt system while turning a blind eye to signs of failure[23]. Many also feel that the presence of humanitarian aid organisations will be short-lived as funding dries up and development will be the principal aid tool of the international aid donors, hence giving an opportunity to development actors to return to a situation of "business as usual". Already, project proposals submitted by humanitarian aid actors must have a "resilience" component, which represents a pure long term development objective..

The UN Cluster approach provides the coordination platform that regroups the largest number of foreign and Malian aid actors. This platform is an essential component of the integrated approach which was introduced as part of the 2005 UN reform of the humanitarian system. Though this approach in Mali is new, it bears already several shortcomings that had already been identified in a 2010 global evaluation[24] of the Cluster Approach commissioned by the Inter-Agency Standing Committee (IASC). The authors noted that "Coordination and links between the cluster approach and existing coordination and response mechanisms is weak", "The cluster approach can threaten humanitarian principles." and "…clusters are often process- rather than action oriented". In a country where so many international and Malian aid actors have been present

Nomads have built temporary homes on the road from Bara to Ansongo in Gao region Photo credit © Miguel Cuenca/MSF



An MSF team prepares to see a patient in Konne health centre in Mopti region, 2013 Photo credit © Paulo Marchetti

for decades, with a presence regulated by the state and coordination mechanisms already in place, the arrival of a parallel system - even if important efforts have been made to have the platform as inclusive as possible - with a lot more resources was not without consequences. Many feel that the Cluster system unnecessarily duplicates existing coordination mechanisms. With a level of humanitarian activities still far from the hopes raised by billions of dollars promised in aid, this feeling is reinforced by the little visible difference for Malian lives this system appears to have made. With its multi-prong strategy, the integrated approach is process-oriented and generates a time-consuming production of multiple strategic documents, tools and reports that require the involvement of all actors, from the military to the civilian. By contrast, during the crisis, local communities organised fairly efficient coordination systems with much less means and with a very action oriented agenda.

With such distrust and rivalry among actors who are urged to integrate their efforts, one is left wondering whether aid may risk causing more harm than good in this fragile ethnic and social fabric. In case it causes more harm, will it be depicted again as a success story - as it had been until 2011[25] - to facilitate the illusion of organisational success through the construction of an alternative reality[26]?

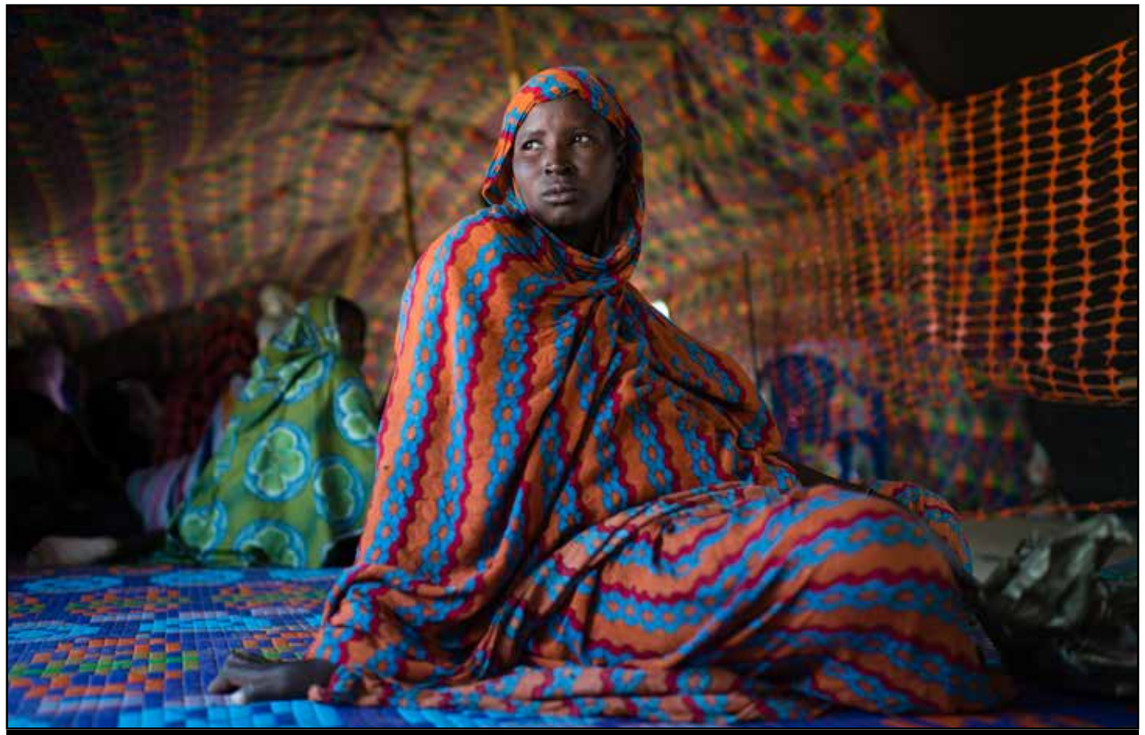
The arrival of the international crisis machine carries significant risks for aid delivery in northern Mali. It has already side lined existing coordination mechanisms and, with its stated intent to co-opt aid work into broader political and security objectives, it risks harming the independence and impartiality of the humanitarian action.

### *Health services and the remaking of centre-periphery relations*

The crisis of 2012 has also been a transformative experience[27] for many in northern Mali who took the lead in organising the continuity of the provision of essential services and the distribution of aid while under the rule of a completely new authority that had little experience administrating territories and populations. At a time when state public agents start regaining their vacated positions, the Malian State intention to restore its authority in the region is confronted to the mutual resentment and mistrust that the crisis stoked between populations in the south and in the north and among communities in the northern regions. With the return of the State authority, those who had come to fill in the institutional void during the absence of the State, such as MSF[28], have now to redefine their role and navigate the tensions that arise at times in this process that some do not want to see ending with a simple return to the status quo ante.

The degree of organisation of communities in the management of essential services varied from one location to another and was a function of a lot of factors, including socio-economic factors[29]. Crisis committees were established in the Timbuktu and Gao regions and played a primary role as interlocutors with the armed groups and in the coordination of aid activities. Some of these crisis committees – called differently from one region to another – were also directly involved in the management of health facilities as in Gao where the "Cadre de Concertation" – the crisis committee in Gao took the name "consultation framework". As mentioned





A Malian refugee waits in the triage tent of MSF's hospital in Mbera camp, Mauritania, 2013 Photo credit © Nyani Quarmyne

earlier, many initiatives that were launched during the crisis find their roots in forms of organisations for collective action or the defence of common interests that predate the crisis. In Gao, the crisis committee was composed of members who have been mobilised since 2008 as representatives of the sedentary populations in the region and, shortly before the crisis erupted, decided to manage their own fate when they realised that the State's authority was weakening.

Health services have not been immune to tensions that the crisis has generated between the centre and the periphery. Each has grievances against the other. These tensions play out at times in the return of the governmental health authorities.

Resentment towards the Malian authorities can be felt among some of the health professionals who did not flee and continued providing much needed help. Some in the regional health authority have put their lives in danger by maintaining quietly their line of communication with Bamako. They feel that their efforts have not been appreciated by the Malian administration[30]. Instead, they feel stigmatised by those who left and who accused them of having sided with the enemy[31].

Some even feel that armed groups had more consideration for their work. In comparison to other essential services, health seems to have benefited from a particular attention on the part of the armed groups. Some recall also that fuel and other imported basic commodities were cheaper at the time.

They also question the capacity of the State to support the Malian health sector. For instance, the regulation ordering the free delivery of health care in the affected regions was not accompanied with alternative state funding to compensate for the losses. In addition, some have found job opportunities in health facilities during the crisis or received a top up to their salary by international aid organisations including MSF and fear with the return of State authority that they will lose these benefits[32].

While in most places we can note a slow, progressive and uncontested return of State agents to their previously vacated position, State authority is being challenged in Gao. AHG has refused to return the management of the hospital to the Malian health authorities until their grievances are addressed. Some of the current hospital staff were not previously employed in this structure and risk losing their jobs and want the State to employ them or find compensation. Some in AHG regret what they feel is a greater consideration on the part of the State for those who fled than for those who stayed behind and helped.

Many in northern Mali do not want to come back to the previous situation where Bamako would exercise its relation of authority through what they consider corrupt state agents[33] sent by the central authority.

The absence of the State and its agents for almost a year has created in some instances a new reality in health services. This is making a return to the past model difficult.

# Pragmatism and a singular focus limit MSF relations with other aid actors

## *MSF and local new actors*

MSF has collaborated with few Malian new aid actors and, to rare exceptions, relations have been deemed by both parties good and mutually supportive.

Besides aid actors coordination meetings, MSF has had limited contacts with LNGOs besides the notable exception of 'Action Humanitaire Gao' (AHG). MSF initial talks with AHG in April 2012 around a formal collaboration to operate the Gao hospital were deemed positive. However, they did not lead to a formal agreement as the Gao crisis committee decided instead to accept ICRC's offer that manifested its interest for supporting the hospital around the same period. Few months later, MSF started activities in the Gao region which involved the referral of MSF patients to the AHG run Gao hospital. This collaboration continues to this date and both parties are satisfied with their collaboration.

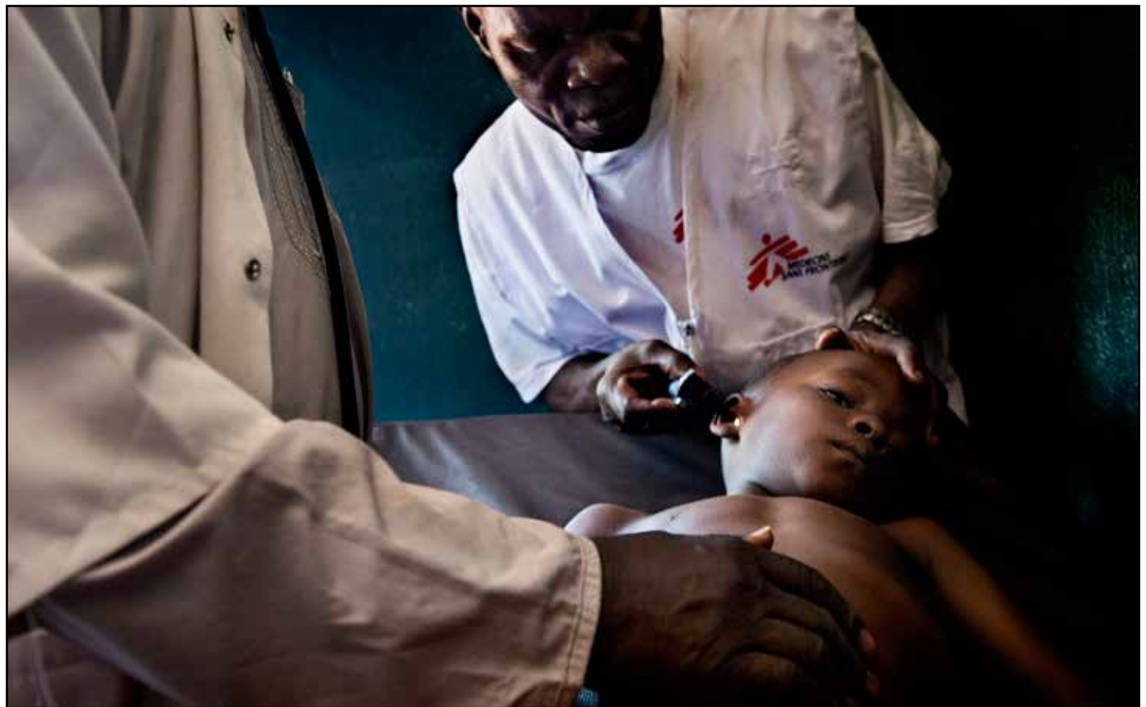
To rare exceptions, initial contacts with new aid actors were maintained only when there was:

1) direct and immediate operational benefit or requirement

2) a continuity of action on the part of these actors.

This meant that actors who were involved in punctual interventions - such as COREN, the Diaspora and Cri du Coeur with the exception of the humanitarian missions organised by the College of Physicians – were rarely met again.

Relations with the College of Physicians have been tense at the initial stage of what it is more akin to cohabitation than a partnership. The College of Physician has sent Medical personnel to public health facilities in all three northern regions including in those supported by MSF. MSF felt that this presence was intrusive and had doubts the relevance of such punctual interventions[34] in State owned health facilities run by MSF. There were also issues around adherence to humanitarian principles due to their lack of preparation at the early stage of their initiative in this radically new environment. For their part, regional health officials felt that although these punctual missions did not significantly improve the situation, it helped relieving some of the pressure in some medical services. These volunteers were sent with no means and were therefore dependent on MSF when in an MSF supported structure. MSF felt also uncomfortable with their proximity to WHO - the UN health agency – and the external communication around the project. Achievements tended to be magnified and the paternity of certain activities was obscured.



An MSF team treats a child in Konna health centre in Mopti region, 2013 Photo credit © Paulo Marchetti



On their side, the College of Physicians felt that they were rejected by MSF and other foreign organisations due to what they considered an atmosphere of competition among aid actors that they did not expect. The use of MSF' own medical protocols that differed at times from those of Malian health authorities was a source of concern for them in terms of liability They also deplored the absence of MSF's support to certain activities such as orthodontia and elective surgery. MSF's inflexibility with these issues reinforced the feeling of some that MSF behaved as if public health structures were its kingdom.

Eventually, the relation improved with time as the two actors got to know each other better and initial problems of preparation were progressively solved.

## *MSF, the OIC, the Red Crescent Societies and regional organisations*

MSF had even more limited contacts in the field with the non-traditional international aid actors.

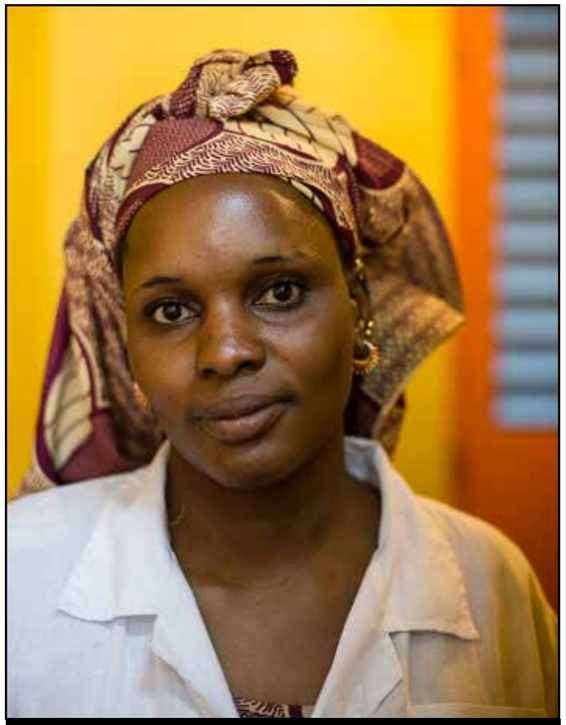
The QRCS and MSF were present at the same time in Gao only from September 2012 when MSF established itself in Gao until January 2013 when the QRCS left Gao. During this period, contacts have been almost non-existent even though the QRCS supported AHG and had an office within Gao hospital premises. On two occasions MSF did not move forward with plans to support a reference health centre (CSREF) in the Gao region because it was told indirectly that the QRCS had already made some commitments towards these health facilities. However, MSF never checked the information directly with the QRCS neither did it enquire about detailed plans and timeframes. Instead, the information was taken for granted and even came as a relief to some in MSF who did not feel comfortable working in Bourem because of insecurity in addition to capacity constraints.

In contrast, in neighbouring Niger, less than 100 KM from Gao, in early October 2013, MSF completed a handover of its medical activities in a Malian refugee camp in Niger to the same QRCS who had been a regular partner of MSF in the refugee project.

## *What made MSF so reluctant to engage?*

Several factors have influenced MSF's posture towards its engagement with new aid actors. In addition to some specific circumstances, MSF's model of intervention for emergencies, its opportunistic approach to partnerships and its focus on neutrality have all contributed to limited interaction and cooperation with both, old and new aid actors.

Opportunities to interact have been limited due to a number of specific circumstances. First of all, new aid actors were few in number or lacked medical capacity. Physical presence has also been an issue. Some had an intermittent presence in the field and others operated from neighbouring countries.



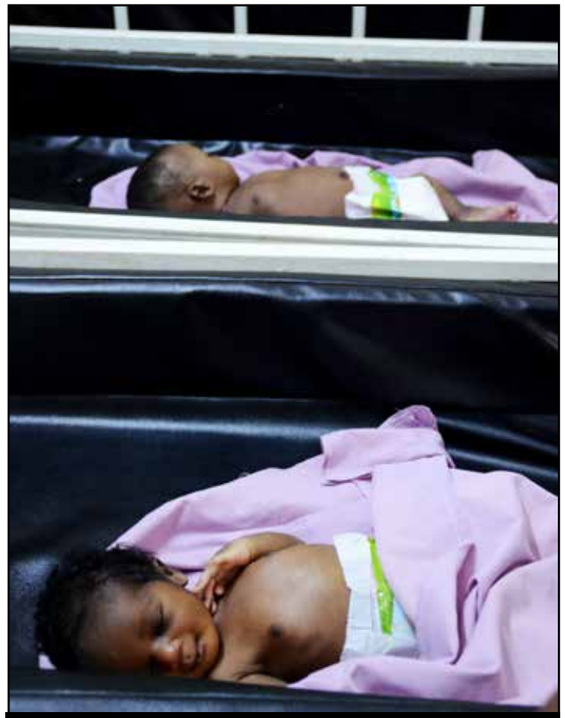
Issata Ouedraogo is an obstetric nurse in Timbuktu reference hospital Photo credit © Trevor Snapp

The presence of community based actors that had the necessary authority to act as a regulating body enabled an exchange of essential information – such as an intent to start a new project hence avoiding duplication – that reduced the need for direct and multiple interaction.

30 years of medical activities in Mali have provided MSF with a strong social capital[35]. This does not necessarily encourage the development of new relationships. Indeed, a large number of[36] Malian health professionals and aid actors have interacted at some stage with MSF.

MSF does not consider that it has a role to play in development as reflected in its operational model. It is a humanitarian medical organisation that engages in direct medical action with a focus on crisis situations. This shapes its culture, including the way it interacts with other actors. Due to its attention on emergencies, the organisation does not project itself on the long-term and its structure is vertical as to facilitate decision-making. Its expatriate-led model is seen at times as paternalistic[37].

Although interviewees acknowledge that MSF model is efficient for dealing with emergencies, they often lamented the lost opportunity to build Malian capacities during MSF's presence through, for instance, a partnership with a LNGO. In addition, MSF's insistence on a free health care model for its interventions is seen as unsustainable and potentially as undermining the Malian cost-recovery model.



Children in Koutiala receive free-of-charge care from MSF & local health authorities Photo credit © Aurelie Baumel/MSF

MSF enters in new relationships with certain operational goals in mind. Its approach to partnerships is purely opportunistic. In general, MSF seeks partnerships as an exit strategy, as an advocacy strategy when it is looking for leverage to obtain changes in policy (for instance by advocating for free health care) or for complementing its own activities with services it cannot or does not provide.

In some contexts where MSF had difficulties accessing its target population, partnerships with entities that had more privileged access provided the mean to circumvent that problem. For instance, and in contrast with the Malian experience, in Iraq MSF partnered with the country Medical Union in 2006 - two years after it had left the country - to regain access at a time when it was particularly difficult to operate in the country. But the need was not felt in northern Mali. Indeed, after an initial period of negotiation, MSF was granted access and was one of the rare foreign direct implementer of humanitarian activities. Therefore, MSF had little operational incentives to push for a closer collaboration with other actors.

Instead, MSF put its emphasis on preserving a distinct working space in order to maintain its access to civilians in Mali. The organisation maintained throughout the crisis a close relationship with Malian health authorities in Bamako, including with hospital officials who took refuge in the capital city. Yet, the organisation has made important efforts to avoid, on one hand, getting embroiled in centre-periphery power relations and, on the other hand, being perceived as colluding with Western interventionism, or the Islamist armed groups. These efforts have also implied a reluctance to consider cooperation with other aid actors.

Having managed to stay without interruption during the rule of three successive authorities, MSF is largely seen as neutral and impartial in northern Mali. However, despite these efforts, some in the south, especially in the capital Bamako, question MSF's neutrality and impartiality. For instance, not taking a public position on the territorial integrity and sovereignty of Mali was instead interpreted by some as a sign of support for the rebels. In addition, some are unaware that the single most important MSF project is located in the south of Mali, in Koutiala, and believe instead that for years MSF has been operational only in northern Mali hence raising suspicions that the organisation has a hidden agenda. Many also pointed to the potential unintended consequences of MSF free health care model when it exits. A return to a cost recovery system may stoke anger against the government and hence further undermine State authority.

There is a fine line between the autonomy that MSF aspires to and isolation. During its three-decade presence in Mali, what is today considered at times as an isolationist posture on the part of MSF in Mali has not always been the norm. To preserve its independence and neutrality, MSF has chosen to maintain a certain distance from the aid system in Mali and has built a tight distinction between humanitarian aid and development[38]. For instance, the president of the Civil Society National Council in Mali remembers that MSF had been an active contributor to the structuring of the NGO sector in Mali when in 1983 the first NGO coordination platform in Malian was established - known by its French acronym **CCA-ONG** (Comité de Coordination des Actions des ONG au Mali). As for MSF's stance on development, among those who did not vacate their positions during the crisis were locally trained nurses in the Gao nursing school initiated in the 1990s with the support of MSF for the specific purpose of serving the health needs in Mali's three northern regions.



# Endnotes

1 OCHA humanitarian situation report September 2013, available at: https://mali.humanitarianresponse.info/fr/system/files/documents/files/BIH_9octobre_publication.pdf ; Accessed September 2013.

2 Interview with health official in Timbuktu.

3 *A Tale of Two Islamisms*; New York Times, January 25, 2013; available at: http://latitude.blogs.nytimes.com/2013/01/25/another-kind-of-islamism-gains-ground-in-southern-mali/?_r=0 ; accessed September 2013.

4 Its name was given to reflect the diversity of its membership made-up of not only medical but also socio-sanitary staff.

5 Organisation of Islamic Cooperation, December 08, 2011; *The OIC's Humanitarian Activities in Somalia*; available at: http://www.oicun.org/65/20111208035901128.html ; accessed September 2013

And

*Arab and Muslim Aid and the West: Two China Elephants*; Integrated Regional Information Networks; October 19, 2011; Available at: http://www.irinnews.org/report/94010/analysis-arab-and-muslim-aid-and-the-west-two-china-elephants ; accessed September 2013

6 *OIC and Islamic NGOs Pledge Support for Humanitarian Work*; Integrated Regional Information Networks, March 13, 2008; Available at http://www.irinnews.org/report/77268/global-oic-and-islamic-ngos-pledge-support-for-humanitarian-work ; accessed September 2013;

7 Interview with a person familiar with the topic; Bamako; September 2013,.

8 Interview Bamako, September 2013:
*« I wrote to all partners to tell them that Islamic aid is not matching up Western aid. Our intervention has been limited. »*

9 *Is Qatar fuelling the crisis in north Mali?*; France 24, January 23, 2013; Available at http://www.france24.com/en/20130121-qatar-mali-france-ansar-dine-mnla-al-qaeda-sunni-islam-doha; accessed September 2013;

10 *François Hollande veut désamorcer les polémiques avec Doha*; Le Monde, June 22, 2013 ; Available at http://www.lemonde.fr/international/article/2013/06/22/m-hollande-veut-normaliser-la-relation-avec-doha_3434763_3210.html ; accessed September 2013;

11 The controversy in Mali regarding Qatar's role in the rebellion started with an article in June 2012 in French weekly Le Canard Enchainé.

12 Interviews Mali, September 2013.

13 *Syria, Mali expose divisions within Muslim world*; Associated Press, February 6, 2013; available at: http://news.yahoo.com/syria-mali-expose-divisions-within-muslim-world-151259603.html; Accessed September 2013.

14 Mali is ranked at 105 out of 174 countries in Transparency International's Corruption Perceptions Index; available at: http://www.transparency.org/cpi2012/results; accessed September 2013

15 For instance, the NGO Association Malienne pour la Survie au Sahel (AMSS) in Timbuktu originates from employees who decided in 1992 to create their own NGO after the departure of the Quackers. Interview with a member of AMSS in Timbuktu, September 2013.

16 On consequences of user fees in Mali see: MSF, April 2008; *No Cash no Care - How User Fees Endanger Health*

17 The Overseas Development Institute, one of the leading think-tank on development and humanitarian action defines stabilisation as:
*Yet if stabilisation is understood to mean a combination of military, humanitarian, political and economic instruments to bring 'stability' to areas affected by armed conflict and complex emergencies, it can be seen to have a far broader transformative, geographical and historical scope. (…) With security and stability as the primary objective, development and humanitarian activities are seen as a means to achieve these goals and ultimately to legitimise the host state and an internationally-sponsored political settlement.*
*Stabilisation is thus "about powerful states seeking to forge, secure or support a particular "stable" political order", in line with their particular strategic objectives".*
Overseas Development Institute, May 2010; *States of Fragility - Stabilisation and Its Implications for Humanitarian Action*

18 For an instance of the negative impact on civilians of the integration of humanitarian action into broader political and security objectives see the case of Sierra Leone in 1997-2000 in Henry Dunant Centre for Humanitarian Dialogue, 2003; *Politics and Humanitarianism. Coherence in Crisis*

19 UN Security Council Resolution 2100; available at: http://www.un.org/en/peacekeeping/missions/minusma/documents/mali%20_2100_E_.pdf ; accessed September 2013.

20 *Malian Envoy Calls for Calm over Election Deal*; Agence France Presse, June 20, 2013;

21 Roland Marchal describes the instrumental role of aid below:
*The aim would be to secure the main urban centres in northern Mali, rebuild local administrative capabilities, and flood these areas with humanitarian aid in order to address the current food security fragility and strengthen the "hearts and minds" campaign.*
Roland Marchal; Is a Military Intervention in Mali Unavoidable?; Norwegian Peace building Resource Centre, October 2012

22 Derderian et al, May 29 2013; *Losing Principles in the Search for Coherence? A Field Based Viewpoint on the EU and Humanitarian Aid*; available at: http://sites.tufts.edu/jha/archives/2010 ; accessed September 2013.

23 The parallel with criticisms towards counter-terrorism efforts in Mali is striking. According to some, the U.S. counter-terrorism approach has failed and is in need of a complete overhaul. See for instance:
Moss Todd, October 5, 20112, Lesson from Mali's Debacle: Time to Rethink Counterterrorism Cooperation
http://international.cgdev.org/blog/lesson-mali%E2%80%99s-debacle-time-rethink-counterterrorism-cooperation; accessed September 2013

24 Inter-Agency Standing Committee, April 2010; *Cluster Approach - Evaluation 2 Synthesis Report*; available at http://www.gppi.net/fileadmin/gppi/GPPi-URD_Cluster_II_Evaluation_SYNTHESIS_REPORT_e.pdf ; accessed September 2013.

25 Report of an event organised by the Overseas Development Institute on February 11, 2013 titled *Conflict and intervention in Mali: the humanitarian consequences*; available at: http://www.odi.org.uk/events/3125-mali-humanitarian-conflict-counter-terrorism-sahel; accessed September 2013.

26 Walkup Mark, January 1994; *the organizational culture of UNHCR: the myths of humanitarianism and the dysfunction of benevolence.*

27 Young doctors in Bamako who originate from the north: *"Public services have never been so destabilised. The State was absent for more than one year. This is unprecedented. Young doctors originating from the region have stayed without getting paid and volunteers have joined also. Mentalities have extremely changed."*



28 A regional health representative in the north : *"In such a crisis situation, MSF has MSF has replaced the State. This has enabled State's agents to continue working. MSF has compensated for the State in these matters."*

29 A doctor in Gao : «*Gao was well organised in comparison to Timbuktu. I think this is because people in Gao are more educated, Gao counts more managers while in Timbuktu there are less intellectual and wise people."*

30 A doctor in Timbuktu: *"Those who stayed have not been thanked, nor encouraged."*

31 A similar feeling was expressed by the Gao crisis committee : « *Maintenant nous sommes en porte à faux avec l'autorité qui nous accuse d'avoir collaboré avec le MUJAO.* »

32 Health official in Timbuktu : *"The problem is with the state agents whom you have given incentives to. They think that these advantages will disappear. For this reason they do not appreciate the return of their colleagues. They were not informed that these conditions were defined by the State with MSF."*

33 Some academics have alerted that a reinforcement of state authority in the north could unintentionally reinforce the capacity of criminal networks. See for instance Scheele Judith ; Trafic ou commerce ? Des échanges économiques au Sahara contemporain ; in Sciences po CERI ; *Le Sahel dans la crise malienne Dossier coordonné par Roland Marchal* ; July 2013

34 It is worth mentioning that this opinion is reminiscent of the dispute within MSF that led to the birth of Doctors of the World: MSF Timeline available at: http://www.doctorswithoutborders.org/aboutus/timeline.cfm ; accessed September 2013.
*1979: Competing Visions Lead to a Split at MSF Led by Dr. Claude Malhuret and Dr. Francis Charhon, MSF moves beyond its modus operandi of sending isolated doctors to crisis zones in favour of creating a more structured organization that can provide quality medical services in crises. Co-founder Dr. Bernard Kouchner leaves in protest and later founds Médecins du Monde/Doctors of the World.*

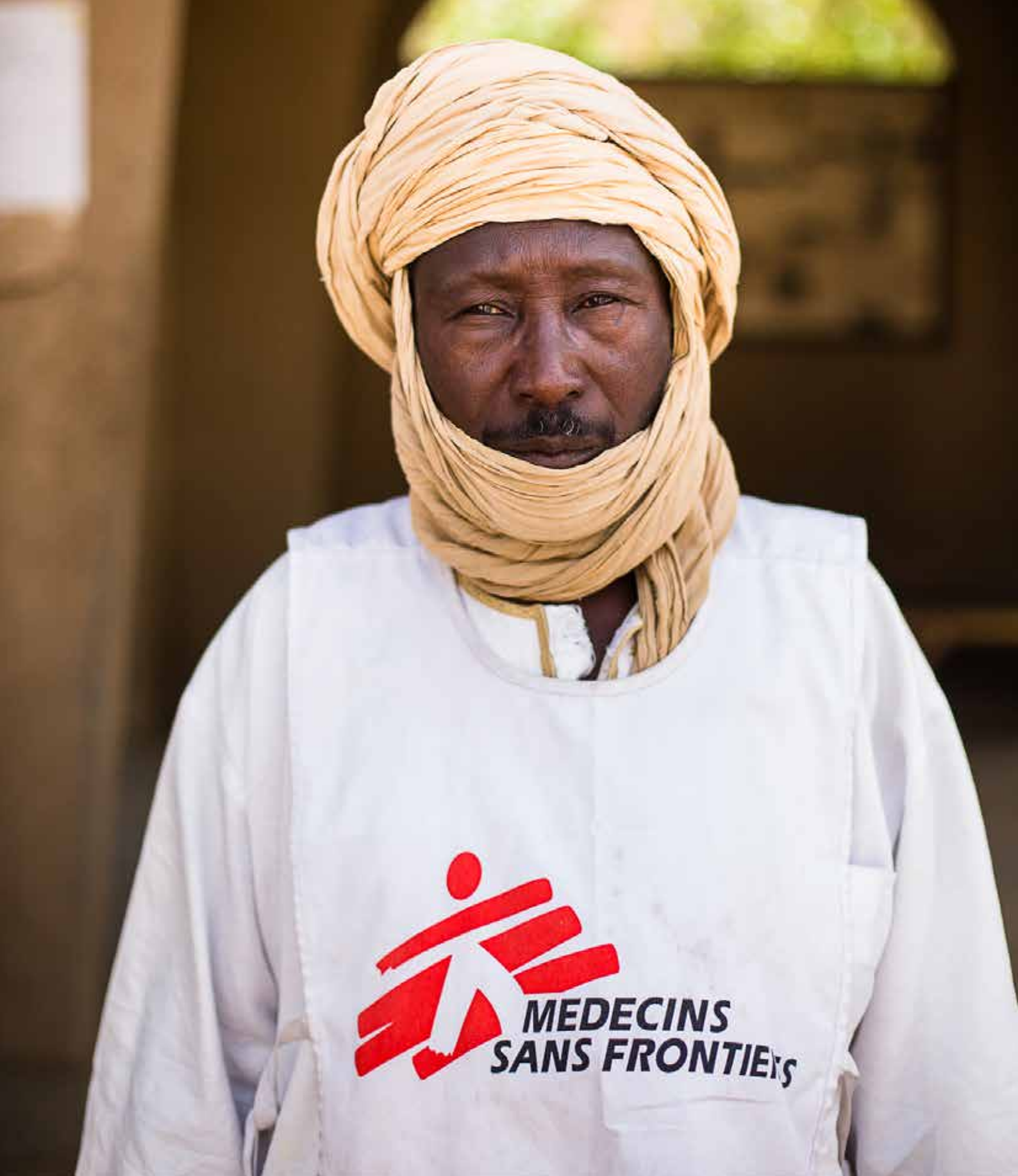
35 Bourdieu and Wacquant, *An Invitation to Reflexive Sociology*, 1992, p. 119 and Bourdieu Pierre, 1986; *The forms of capital,* in Richardson (ed.) *Handbook of Theory and Research for the Sociology of Education*; p248

36 Interview with one of the initiators of the College of Physicians medical programme in northern Mali : « *I worked with MSF before 2006 in the obstetrics and gynaecologic training in in the north programme as part of the fight against infant mortality. MSF was leading. It was a very good project.* »

Interview with a health official in Mopti : "*The real parternship is with MSF and MdM. The ideal for us was that others could intervene where we (State agents) could not. This is not the first time I worked with MSF. It was already the case in 2007. In 2011, I called MSF for the cholera outbreak. In 2012, I called MSF again. Personnaly, I have appreciated. It has allowed the continuation of the package of activities in Douentza referral health center.".*

37 During in interview in Bamako, a representative of a Malian civil society platform expressed a similar opinion: *"MSF is not very open to locals. Locals can act as a link for MSF. It can also reduce costs and increase impact. This is a very French culture. The Americans, British and Dutch do not operate the same way, the work in partnership. The French are very paternalistic. This attitude must be abandoned."*

38 Jean-Hervé Bradol, 2011; *Caring for Health* in MSF, 2011; *Humanitarian negotiations revealed.*




MSF guards wear bibs with the MSF logo as a security measure at Timbuktu reference hospital

Photo credit © Trevor Snapp

MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS