

# MSF OCA Strategic Plan 2026-2031



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← March 2023, Bulengo, Democratic Republic of Congo (DRC) – Originally from Rugari, Josée Ciza Sebakara used to work in the field of gender-based violence. For the past year, she has been living alone with her six children in Kanyaruchinya. When the MSF teams came to set up the vaccination site, Josée went to meet them to share her motivation to participate in this campaign. Her role is to sensitize parents about the importance of vaccination. "My greatest pride in this work is to be useful to the population. We have fled our homes, and once here, children who are not vaccinated are in danger. This vaccination campaign is essential." ©Michel Lunanga/MSF

Médecins Sans Frontières (MSF) is composed of 27 associations around the world. Each of these associations is an independent legal entity registered in the country where it operates. Most MSF associations are linked to an Operational Centre (OC) or Operational Directorate (OD) that is responsible for carrying out MSF's medical humanitarian operations.

This is the Strategic Plan for MSF Operational Centre Amsterdam (OCA). The OCA Partnership includes MSF Canada, MSF Germany, MSF South Asia, MSF Sweden, MSF The Netherlands, and MSF United Kingdom. The OCA partners, their associations, boards and executives collectively and individually share the responsibility for the successes, failures and risks of the OCA and the achievement of this Strategic Plan.

# Foreword

**The start of this Strategic Plan 2026-2031 occurs at a momentous time, with the world as we know it undergoing rapid changes. Repercussions are expected across the strategic period, exacerbating medical humanitarian crises and adding pressure on the work we do. In such times, our choices are more critical than ever.**

Over the course of the last Strategic Plan (2020-2025), enabled by over 10,000 staff around the world, OCA conducted nearly 16 million outpatient consultations, provided care to over 1.2 million hospitalised patients and 116,000 malnourished children, and rescued more than 13,700 people at sea. OCA also provided safe abortion care to over 47,800 women and girls, supported the delivery of 525,000 babies, and cared for over 106,000 sexual and gender-based violence survivors. We have borne witness to the circumstances that led to people seeking care, whether from violence, armed conflict, or discriminatory and exclusionary policies, advocating for change. And this is just a snapshot of the work undertaken over the last six years which has laid the foundations for the coming period.

With steering from the OCA Council, the current plan has been developed over more than a year and included hundreds of staff from all corners of the organisation, as well as a review of the perspectives of the people we assist. There are consequently many voices represented here, from the aspirational to the concrete, and through this engagement we have clarified and converged on a vision of our work for the coming six years.

Our success depends on doing many different things well: some ambitions push us into new territory while others focus on improving our foundations. The pages that follow describe our global programme, not the choices we make in every project. This Strategic Plan will be underpinned by more specific strategies, including from our country programmes, and will be translated into annual plans and inform resource allocation.

**We reaffirm who we are as a medical humanitarian organisation grounded in the experiences of the people we assist, ensuring responsiveness and adaptability as emergencies develop and crises evolve. Obvious in ways, this remains a radical choice as norms degrade, violence increases and international solidarity is challenged.**

We are putting at the forefront the need for responsiveness, to adapt, be agile and pivot if needed, in order to deliver the form of healthcare that is most needed in any given context. However, our experience and the changing medical humanitarian landscape tell us that we can anticipate the greatest needs in some key medical areas, and these are captured in this plan. It is in these areas that we intend to most improve over the next six years, to enhance care and catalyse change. Other priorities will help us to extend our reach and effectiveness. And despite the hostile landscape, we will maintain our outspokenness, bearing witness and advocating for change that meets the essential needs of people in medical humanitarian crises.

Finally, this plan captures strategic enabling functions that we believe will be vital in the coming years and that need to be as responsive and adapted as our programmes while working to ensure longer-term resilience. We have integrated our ambitions with the collective priorities of the MSF Movement's Strategic Planning, Accountability and Resource Cycle.

Six years is a long strategic cycle and not everything here is set in stone: a monitoring framework is annexed to this plan and can be adapted as needed. Yet this is the groundwork for the years ahead, focused on providing quality healthcare, provoking change and galvanising international solidarity to improve the lives of people in medical humanitarian crises.

**None of this is possible without people who are willing to care about and for those in crisis, whether through their work or other forms of support. To those people, both inside and outside of MSF: thank you.**

December 2025

# MSF OCA Strategic Plan 2026-2031

<p><b>Purpose</b></p>	<p>Médecins Sans Frontières works to save lives and alleviate suffering, providing healthcare and bearing witness in situations of violence. We stand in solidarity with people in medical humanitarian crises whose rights have been denied.</p>												
<p><b>Ambition</b></p>	<p>OCA is highly responsive, adapting as crises evolve to deliver safe and effective person-centered healthcare, speaking out and driving change to meet people’s needs. As a diverse and engaged global community, we foster agility and a culture that respects people’s dignity and agency, united in a shared sense of humanity.</p>												
<p><b>Global Objectives</b></p>	<p>Agile programming and emergency response      Strengthening our medical impact      Bearing witness, speaking out and advocating for change</p>												
<p><b>Sub-objectives</b></p> <p>Enhance Care and Catalyse Change</p> <p>Extend Our Reach and Effectiveness</p>	<table border="0"> <tr> <td data-bbox="612 1406 746 1435">Nutrition</td> <td data-bbox="826 1397 1094 1449">Sexual and reproductive health and rights</td> <td data-bbox="1150 1397 1382 1449">Vaccine-preventable diseases</td> </tr> <tr> <td data-bbox="612 1491 746 1543">HIV, TB and malaria</td> <td data-bbox="815 1491 1106 1543">Water, sanitation, hygiene and vector control</td> <td data-bbox="1129 1491 1401 1543">Antimicrobial resistance and neglected diseases</td> </tr> <tr> <td data-bbox="608 1621 751 1673">Humanitarian access</td> <td data-bbox="890 1621 1031 1673">Safety and security</td> <td data-bbox="1193 1621 1337 1673">Partnerships and alliances</td> </tr> <tr> <td data-bbox="619 1715 740 1767">Climate adaptation</td> <td data-bbox="858 1715 1062 1767">Safe and effective clinical care</td> <td data-bbox="1182 1715 1348 1767">Research and innovation</td> </tr> </table>	Nutrition	Sexual and reproductive health and rights	Vaccine-preventable diseases	HIV, TB and malaria	Water, sanitation, hygiene and vector control	Antimicrobial resistance and neglected diseases	Humanitarian access	Safety and security	Partnerships and alliances	Climate adaptation	Safe and effective clinical care	Research and innovation
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<p><b>Strategic Enablers</b></p>	<p>People and Culture   Safeguarding   Organisational Integrity</p> <p>Data and Technology   Supply and Logistics   Mobilising Support</p> <p>OCA Partnership and MSF Movement</p>												

# Who we are

**Médecins Sans Frontières** works to save lives and alleviate suffering, providing healthcare and bearing witness in situations of violence. We stand in solidarity with people in medical humanitarian crises whose rights have been denied, upholding the principle of humanity in the midst of conflict and with people who are excluded, targeted, persecuted, or experience discrimination. When access to healthcare is denied, we persist.

Grounded in the perspectives of the people we assist, we strive to be present to respond to emergencies and deliver safe, effective and dignified person-centred healthcare, adapting our programmes in conjunction with local communities to ensure the greatest positive impact on evolving needs. Centring the voices of people affected by medical humanitarian crises to challenge the injustices that cause their suffering, we bear witness, speak out and advocate for political and social change that meets their essential health needs.

We learn from our experiences, from what we do well and what we get wrong, accountable to the people we assist and the communities in which we live and work, our supporters and each other. As a diverse and engaged global community, we are mindful of power imbalances and inequity. We foster agility while working to achieve longer-term resilience and effectiveness. We respect the dignity and agency of people in medical humanitarian crises, united in our shared sense of humanity.

## Our principles, values and ethics

Our principles and values help to establish MSF's identity and distinguish our work from political, military, religious, commercial and other actors. Each of the concepts below has its own history, overlaps with ideas drawn from other ethical codes and approaches, and can contribute to critical reflection on the best way to provide medical humanitarian assistance.

Our principles begin to frame our strategic decision-making and we must be aware of when they are in tension. As we strive to apply and communicate them, the consequences of our decisions must also be weighed. The **fundamental principles** inspire us to act, while the **operational principles** serve as practical guides.

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## Our fundamental principles

### Humanity

**We endeavour to save life, alleviate suffering and uphold dignity.** How we do this matters, reflecting the inherent dignity in all human life. Operationalising the principle of humanity leads to the development of MSF's other principles and values and is consistent with a person-centred approach.

### Impartiality

**We seek to provide assistance to people in medical humanitarian crises according to their needs alone.** We do not discriminate based on age, race, ethnicity, nationality, sex, sexual orientation, gender identity, class, political opinion or creed. We ensure the integrity of our work by providing assistance that is without bias and reaches people in proportion to their needs.

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## Our operational principles

### Neutrality

**We seek open and transparent dialogue with all parties** that enables us to focus on people in need of assistance and ensures trust and respect for our programmes. We do not take sides with any belligerent in a conflict. Neutrality does not imply silence, and our public positions are informed by what we witness in the places we work. We recognise that our positions are perceived differently by different stakeholders and may incur risks for both the organisation and individual staff that must be considered.

### Independence

**We are independent in our actions and decision-making** and avoid subordination to political, economic, military or other agendas. Yet we are part of a complex ecosystem and cooperate with other stakeholders, recognising the interdependence of our efforts to expand access to healthcare. Independence supports impartiality and neutrality, and MSF's financial and operational independence are critical for the quality of our humanitarian operations. This helps to make it possible for us to be where others are not.

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## Our values

While our principles and values both alert us to the importance of our actions, our values contribute to further shaping our distinct organisational identity and interactions, and should be embedded across all we do and how we work.

### Solidarity and Proximity

**We stand with people in medical humanitarian crises, providing support and assistance to those in need.**

We strive to be physically present where our medical humanitarian activities take place. Through this persistence, we forge a collective resilience that supports creativity to adapt to what is needed. Such engagement enables the best possible healthcare and fosters trust and compassion, encouraging people to care for themselves and others.

### Respect and Dignity

**We respect the dignity of all people at all times, honouring each person's experiences.** We respect the autonomy and agency of those who seek care with MSF. This reflects our person-centred approach and focus on quality of care, which supports the preferences of individuals and their community regarding health and wellbeing. We are diverse, inclusive and sensitive to differences, welcoming many perspectives to inform our work. We listen to each other and challenge the status quo in ways that respect our professional and social contexts. We cultivate connections and understanding to empower personal and organisational growth.

### Accountability and Integrity

**We are accountable to the people we assist and the communities in which we live and work, our supporters and each other** in varied ways. Our actions are guided by our principles and values and we address situations in conflict with them. Transparency and honesty about our choices and their impact promote trust, and our values are practised by each individual, each team, and MSF as a whole in our day-to-day conduct. We optimise and protect our resources to sustain our ability to deliver on our commitments. We learn from our experiences, from what we do well and what we get wrong. Being accountable and practising integrity ensures that we are aligned with our associative nature and consistent in our words and actions.

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## Medical ethics

We uphold the principles of medical ethics, including beneficence (to do good), non-maleficence (to do no harm), autonomy (to respect an individual's informed choices) and justice (to distribute health resources fairly). The principles of medical ethics do not provide easy solutions to complex problems, yet they support individual and programmatic decision-making across the diversity of contexts in which MSF works.

# The medical humanitarian landscape

**We are living through a period of upheaval, shifting social and political power structures, an unravelling of norms, deepening inequity, fragmentation, widespread conflict and unrest, attempts to normalise atrocity, and climate injustice. The scale and complexity of medical humanitarian needs will increase in the years ahead while the capacity of other impartial actors to respond, particularly in a timely manner, will diminish.**

The era in which medical humanitarian action may have held a privileged space is passing. International multilateral systems are fragmenting and being reshaped by shifting alliances, the rise of regional blocks, and more transactional relations. Respect for international humanitarian law is largely absent and commitments to human rights law, including those on sexuality and reproductive health, are being rolled back as authoritarian and illiberal actors fuel discontent, division and xenophobia. This leads to dehumanising attacks on different population groups and rights-based values. The turbulence is reflected in the global economy, which remains unstable due to shifting economic policies, inflationary pressures and debt, adding to unrest. The landscape is transformed by the pace of technological change, with access to online space ever more part of people's lives. The ways in which we communicate evolve, and access to information improves while mis- and disinformation contribute to the polarised context, shaping discourse, diluting trust and fomenting violence.

This is the most conflict-affected period since World War II, characterised by catastrophic violence and the targeting of critical infrastructure, including healthcare personnel and medical facilities. Alongside new confrontations on a massive scale, many protracted crises where MSF has worked for years grind on. Counter-terrorism policies can criminalise entire populations in need of assistance (and at times those who try to provide it). Warfare is also changing, with new threats linked to the use of artificial intelligence and autonomous weapons, while other threats believed to be contained, such as nuclear weapons and landmines, are again ascendant. As conflicts increase, so does conflict-related displacement, multiplying tensions and straining people's access to basic services. Climate change and environmental degradation amplify risks, disrupting lives and accelerating crises, with people in the places where MSF has programming disproportionately affected.

Combined with demographic patterns such as mass migration and urbanisation, we see a changing disease burden. This includes: increasing antimicrobial resistance and chronic diseases globally; lack of access to sexual and reproductive health services; a regression in tuberculosis and HIV prevention, diagnosis, treatment and care; and increased risks related to fragile food and water systems, zoonoses, vector-borne diseases, and mental health. While non-communicable diseases represent the fastest-

growing burden of diseases worldwide, communicable diseases, often vaccine-preventable, are the main source of morbidity for people living in poverty. People with little access to care will likely suffer the worst consequences of these trends.

In parallel, the humanitarian sector and global health ecosystem face deep uncertainty. Traditional global stakeholders have retreated to focus on security issues, re-directing funds to defence and trying to contain migration. In their absence, new stakeholders arrive with different incentives to work in medical humanitarian contexts. Decades of progress in infectious disease control and vaccination, previously supported by large-scale funds, are in danger of being wiped out. At national levels, healthcare systems have been strengthened; however, the global health workforce remains under strain, hindering quality care. Many countries with critically low healthcare worker density include areas with active conflict where MSF works. Finally, the humanitarian sector too appears increasingly fragile, its legitimacy questioned with important calls for greater accountability and the localisation and decolonisation of aid.

MSF is a part of this landscape and the dynamics we witness externally are also active inside the organisation. As a large and independent organisation, supported by millions of private supporters from around the world, we are somewhat uniquely placed in the sector. With this comes a responsibility to ensure that our choices are adapted to the consequences of global dynamics as they are felt by people at the local level. We expect a more hostile operating environment, yet opportunities abound to build on a history of international solidarity with people in medical humanitarian crises as we look to its future.

# What we do

**Given the medical humanitarian landscape and our finite organisational resources, we make choices regarding how we respond in a crisis based on the vulnerability of a population, the context in which a crisis occurs, and the significance of the unmet health needs.** We act when there is a deterioration of the medical humanitarian situation. A rapid and effective response to emergencies is core to who we are. At the same time, we are committed to people in protracted crises and in fragile and collapsing health systems. We act in solidarity with people in medical humanitarian crises, outraged by injustice, violence, and health inequities. We act with people who are excluded, targeted, persecuted, or experience discrimination.

**Grounded in the experiences of people affected by medical humanitarian crises, we work to save lives and alleviate suffering,** providing a broad range of services, bearing witness and speaking out to advocate for political and social change that meets people's essential health needs. We acknowledge the intersectionality of violence, inequalities and social injustice and the consequences for access to preventive and curative healthcare. We respond in the following medical humanitarian contexts:

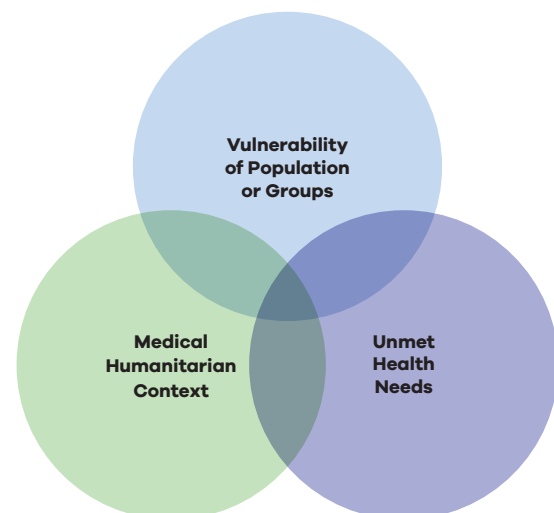
- **Armed conflict or instability** that directly or indirectly affects populations, responding to trauma caused by direct violence and needs arising from the disruption of health systems and forced displacement.
- **Emergency medical crises** with high unmet medical needs caused by outbreaks or nutritional crises.
- **Systemic medical crises** where critical gaps in healthcare are caused by an overall ineffective health system or due to lack of care for certain pathologies.
- **Social violence and healthcare exclusion,** including that of population groups affected by targeted violence and persecution, those with unmet medical humanitarian needs in restricted environments and prisons, people on the move, and deliberate or customary neglect that results in exclusion.
- **Natural and environmental disasters** where populations have urgent unmet medical humanitarian needs.

Our choices are informed by: the scale and/or severity of unmet medical humanitarian needs; the presence of populations with compounded vulnerabilities; the likelihood that a situation will rapidly deteriorate without prompt response; the feasibility of launching meaningful programmes in light of our ability to gain access, bear witness, manage security risks, and deploy resources and people; and the lack of other actors.

## Our programme portfolio

**We aim to respond to a diverse range of crises and needs worldwide.** This approach builds our capacities and ensures that our responses include a balance of established and innovative activities, large and small projects, short- and long-term commitments, and direct care and other operational modalities such as partnerships.

For the majority of our operations, we prioritise medical humanitarian contexts where substantial and immediate unmet health needs intersect with the vulnerability of a population or group, notably those with significant or compounded vulnerabilities. For a limited number of projects, we respond based on specific medical humanitarian change agendas and our decisions may not include the same intersection of priorities. In these projects, we allocate resources in support of multi-year commitments.



## Closing projects or country programmes

We recognise that a population's needs do not disappear the moment an acute crisis ends. Where unmet health needs remain and where the response by national authorities and other stakeholders remains insufficient, our commitment to a population often requires us to maintain our operations. However, when resources are needed more urgently elsewhere, we may need to reduce activities, close projects or exit countries even when ongoing medical humanitarian needs remain. In such circumstances, we ensure that our exit is governed by careful decision-making and we focus on an adequate handover or closure.

# Agile programming and emergency response

**We respond in medical humanitarian crises with agility and by adapting our programming as needs evolve, anticipating changes in contexts and pivoting to emergencies whenever necessary.** In the changing medical humanitarian landscape, we are strongly positioned for emergency response and to sustain longer-term programmes that address critical needs. This requires constant attention, expertise and decision-making capacity at all levels, monitoring for emerging crises, assessing risk, and maintaining our capacity to respond. **We foster critical and creative thinking in all our programming,** reflecting on our actions and analysing their impact on the people we assist, re-examining our priorities and assumptions as we navigate dilemmas.

**For this, we remain grounded in the perspectives of patients and communities in the places we work and aim to ensure that our programmes are designed in conjunction with the people that we assist.** From timely assessments through to project closures, we listen with intent and strive to understand the intersecting factors that drive vulnerability and exclusion from healthcare, seeking opportunities to systematically integrate community feedback into our programming. Mitigating safeguarding risks remains a conscious priority in our decision-making from the onset of a crisis and throughout the programme cycle. **We coordinate with actors who offer specific services that we do not,** aiming to alleviate the risks of violence, exclusion, targeting, persecution and discrimination and achieve better outcomes for the populations and patients we assist. Within OCA, we establish clear roles and responsibilities related to

protection in order to contribute to more coherent and accountable practices.

**We ensure emergency preparedness at all levels of the organisation.** Our country programmes anticipate and are ready to respond to acute emergencies. We invest in our capacity to respond to crises in countries or regions where we are not present through strategic positioning, engagement, networking and access negotiations, including exploring novel levers for access. **And we reduce activities as emergencies subside,** transitioning into longer-term programmes or closing them in order to reallocate resources to other crises. In such cases, we work proactively with local communities and other stakeholders on exit strategies, ensuring that our departure is carefully governed, including with a focus on an adequate handover whenever possible.

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## Extending our reach and effectiveness

### Humanitarian access

**We strive to overcome the political, social, legal, administrative, security and physical barriers that prevent people from meaningfully and effectively accessing impartial medical humanitarian assistance.**

We invest in innovative, adaptive and multidisciplinary approaches, grounded in community participation and acceptance, while ensuring accountability for our choices and decisions. While our ability to secure and sustain access is intrinsically linked to the quality and relevance of the medical humanitarian healthcare we provide, which shapes our legitimacy and the trust that communities and stakeholders place in us, it is not enough in the current landscape. We therefore:

- **Enhance people's access to healthcare in medical humanitarian crises by consistently identifying and addressing barriers they face,** including those internal to MSF and in the external environment. This includes a particular focus on marginalised, criminalised and excluded groups to ensure services, health workers and supplies are accessible and adapted to people's complex and diverse needs so they can receive timely and appropriate care.
- **Invest in engagement strategies that pre-empt, navigate and denounce policies and practices that intentionally obstruct aid delivery and access to healthcare** for people in medical humanitarian crises. For this, we will enhance our humanitarian negotiations, networking and diplomacy at local, national and regional levels, and engage in public and bilateral advocacy and speaking out.
- **Pre-empt and address legal, bureaucratic and administrative complexities and impediments that hinder aid delivery.** Facing an increased regulatory environment, we create opportunities, taking informed decisions in relation to risk in service of people in medical humanitarian crises and avoiding harm to patients and staff.
- **Capitalise on our financial and operational independence and seek partnerships and alliances with local and community-led health and humanitarian actors** to enhance access to impartial assistance for the people we jointly assist.

→ August 24, 2023, Central Mediterranean – The MSF team aboard the Geo Barents successfully conducted two rescue operations in the Libyan Search and Rescue region. A total of 168 women, men and children were rescued from two different overcrowded rubber boats. Over 65% of the survivors consisted of unaccompanied minors who were traveling without their parents or guardians. Following the successful rescue, the Italian authorities issued instructions for us to proceed to Brindisi in order to disembark the 168 survivors who were on board.  
©Stefan Pejovic/MSF



## Safety and security

**We reinforce our security management to facilitate programme implementation in complex environments and to ensure a safe environment for MSF staff, patients and assets.** Providing humanitarian assistance, especially in conflict zones, involves risk. While we strive to manage risks, we cannot eliminate them entirely. The success of our work often depends on our ability to navigate these risks in insecure environments. In order to ensure the continued strength of our security management in the delivery of medical humanitarian assistance, we:

- **Build an operational culture in which security management is integrated in all phases of our work.** This ensures that staff, patient safety, and partners are considered throughout our activities, including adapting our approach to ensure preparedness for and management of specific differentiated risks; e.g. due to sexual orientation, gender identity, ethnicity or other specific groups.
- **Make concerted efforts to ensure that all staff are aware of the differentiated risks associated with their roles.** All staff take an active role in security management and the sharing of information is an active two-way process, enabling informed decisions related to risk.
- **Review and update project and country-level security approaches to ensure that we are upholding our standards of security management.** We adapt quickly to emerging threats, such as online and digital criminal threats, through timely analysis. We ensure that gender mainstreaming is integrated into our security management.
- **Seek to mitigate the impact of the most serious security incidents** via the active development and maintenance of a relevant, proportional incident response capacity at country and organisational level.
- **Continuously learn from our experiences in security management** across the breadth of MSF programmes globally and intersectionally, strengthening transparency, learning and capitalisation in collaboration with the Intersectional Security Agreement (ISA) and the Security Incident and Memory Management (SIMM) project.

## Partnerships and alliances

**We collaborate purposefully, from local to global levels, to improve health outcomes, strengthen protection and reduce harm.** Partnerships have different rationales from contributing to humanitarian access and the protection of people with compounded vulnerabilities to expanding access to care or sustaining healthcare after MSF leaves. These partnerships take many forms including operational co-management, technical collaboration, donations, joint advocacy and campaigning. And we partner with a variety of actors including Ministries of Health, community-based and women-led groups, human rights organisations, patient groups, first-responder networks, academia, and both national and international NGOs. We therefore:

- **Seek partnerships, expanding the reach and impact of medical humanitarian assistance,** seeking alignment on principles and values and based on shared ambitions and complementary expertise. We pursue new and innovative context-specific partnerships to improve medical humanitarian response, for example in emergencies, in support of our medical priorities, and to speak out.
- **Continuously improve our partnerships through practice and learning.** We are conscious of potential risks in partnering and of risks that could be transferred to people we aim to assist and our partners and mitigate against them including by proactively discussing security concerns and communicating our safeguarding standards and ways of working, monitoring our collaborations as they progress.

# Strengthening our medical impact

We will continue to provide primary and secondary healthcare services as well as implement community-based and facility-based approaches to strengthen the overall continuum of care for patients. We prioritise responsiveness and adaptiveness to be able to deliver the healthcare that is most needed. Our experience and the medical humanitarian landscape indicate that we can have the greatest impact in a few key medical areas, and it is in these that we intend to most improve over this strategic period.

## Enhancing care and catalysing change

### Nutrition

**We take a comprehensive and integrated approach to our programming in nutrition**, understanding that an effective nutritional response takes place across a continuum of care, from community to primary care and secondary levels. Our approach recognises the deterioration of key drivers such as climate stresses, conflict and displacement, and humanitarian funding. We therefore anticipate that gaps in food security and resulting nutritional crises will require us to improve and broaden the way in which we approach nutritional responses.

**We work to understand the pre-existing capacity to respond to nutritional crises in institutions and communities** for our programmes in locations where food insecurity and/or malnutrition are of concern. **We integrate pregnant and breastfeeding women and girls as well as at-risk children with moderate-acute malnutrition (MAM)** in our ambulatory feeding centres, alongside severe-acute malnourished children and infants. **We ensure that severely ill hospitalised patients receive nutritional support** appropriate to their needs.

### Sexual and reproductive health and rights

**We integrate care across our programming that helps to meet sexual and reproductive health needs at the community and facility levels and throughout people's lives. We use a rights-based approach** informed by intersectionality, which includes treating women, girls and gender-diverse people with respect and recognising their autonomy to decide if, when, and how many children to have, ensuring access to safe perinatal care and childbirth, and access to safe contraception and abortion services. **We ensure that the integration of sexual and reproductive health and rights (SRHR) into our response is considered from the outset of an emergency**, including in response to conflict, outbreaks and displacement. We use our work as a catalyst to advocate for SRHR of individuals regardless of sex or gender identity.

**We implement a core package of SRH services<sup>1</sup>** in all relevant projects, adapted to the local context, including but not limited to:

- Provision of both community and facility-based antenatal, obstetric, postnatal and newborn care.

- Integration of the care of women and children as a tandem beyond the neonatal stage, offering joint simultaneous services where possible, thereby increasing access to both groups.
- Ensuring access to safe abortion, contraception and women's healthcare, particularly in fragile and conflict-affected settings where the rollback of rights is most severe.
- Ensuring that the physical and psychological consequences of sexual violence are reduced through the provision of medical and mental health and psychosocial care, and protection where relevant.

**We recognise that people's needs differ throughout their lives**, and will include adolescent-friendly care, self-managed care, and, where possible, gynaecological care that restores dignity; e.g. the management of incontinence.

### Vaccine-preventable diseases

**We reaffirm our commitment to the prevention and treatment of vaccine-preventable diseases by integrating vaccination into primary care programming and improving outbreak response.** Given the toxic combination of reduced funding for both surveillance and vaccination, routine immunisation disruptions, and misinformation that results in vaccine hesitancy, there is an increased risk of outbreaks caused by vaccine-preventable diseases.

**We strengthen routine immunisation** in conflict-affected, remote and other fragile settings, as well as in underserved communities. **We implement multi-antigen catch-up campaigns** where routine immunisation programmes are failing.

**We ensure access to adequate vaccine supply** chains in a timely manner. Where we cannot vaccinate or provide supply directly, we advocate for others to fill that role.

**We increase outbreak preparedness and timely response capacity for vaccine-preventable diseases. We advance equity and access through context-specific, data-driven microplanning** by making use of existing data to strengthen and support integrated mobile and outreach activities in hard-to-reach areas for zero-dose and under-immunised children.

**We identify key vaccine-preventable diseases and contexts** where there is an evidence gap regarding the epidemiological burden, and contribute to global understanding of infectious disease trends in humanitarian settings with a view to guiding vaccine implementation.

### **HIV, tuberculosis and malaria**

**We focus our work in HIV, tuberculosis and malaria on supporting patients and populations with compounded vulnerabilities**, and by using our voice to push for improved access to new and better-adapted medical products and service delivery models. Advocacy and research will be integral to our activities, with the goal of leveraging our expertise and amplifying our experiences to have impact beyond our own programmes.

**For HIV, we focus our clinical care on children and populations that are frequently excluded from care.** We invest in HIV prevention among populations at the highest risk of acquiring HIV infection, including key population groups, adolescent girls and young women, and advocate for expanded, affordable access to long-acting injectable pre-exposure prophylaxis (PrEP). **We ensure that we do not miss opportunities to prevent HIV transmission within our integrated projects**, including integrating prevention of mother-to-child transmission into all relevant programme settings and offering PrEP to all patients seeking treatment for sexually transmitted infections. In high-burden settings, our first instinct is not to cover gaps but rather to work with local and national health systems in simplifying models of care delivery, as well as to support national programmes in adapting to new funding realities by improving their readiness, stock management and logistical capabilities.

**For TB, we focus on prevention, diagnosis and treatment of childhood TB in all our non-vertical programmes.** We continue our efforts to ensure and advocate for global access to BPaLMii and other simplified and effective regimens for the treatment of all resistant forms of TB. In selected regions or programmes, we work at the intersection of national programmatic support, research and care for patients with advanced TB resistance.

**For malaria, we focus on prevention and treatment in children, pregnant women, and displaced populations.** We choose context-appropriate combinations of preventive measures, including for vector control, population-specific chemoprophylaxis, mass drug administration and vaccination. Understanding that deaths due to severe malaria are often driven by late presentation and poor access to care, we increase community-based recognition of malaria, facilitate referrals and, where appropriate, integrate community-based pre-referral treatment.

### **Water, sanitation, hygiene and vector control**

**We remain committed to impactful water, sanitation, hygiene and vector control activities in precarious settings.** Integration of these activities has long been a part of our work. Climate change will affect water scarcity, flood patterns and the burden of vector-borne diseases in the coming years, and the potential retreat of other global

health actors from this space may compound the resulting adverse consequences.

**We provide safe water, sanitation solutions, and perform vector control** in emergencies and outbreaks. Where gaps persist, we use epidemiological data and testimonies to speak out and advocate for others to step in. **We improve the quality and quantity of water provided and management of waste** within inpatient and outpatient OCA-supported health facilities. **We support innovation and work in partnerships for the provision of public health engineering solutions** at the community level.

### **Antimicrobial resistance**

**We seek recognisable improvement in the standard of care for antimicrobial resistance (AMR)** within MSF projects and beyond. AMR risks making common infections difficult or even impossible to treat, exacerbated within low-resource settings by lack of access to appropriate diagnostic tools and treatment. While we improve the quality of AMR programming within our projects, we strive to fill the gaps in knowledge and practice in AMR for wider humanitarian and resource-limited settings.

**Within our projects, we work to reduce the burden of AMR and prevent AMR-associated deaths and morbidity** by implementing systematic AMR-risk identification and mitigation. Building on previous AMR strategies, we focus our efforts to address AMR through a context-adapted trans-disciplinary and integrated approach to prevent, identify and respond to AMR.<sup>3</sup> **We support the co-development of integrated context-specific prevention activities** in priority sites<sup>4</sup> across four multi-disciplinary axes: infection prevention and control (IPC); person-centred care; access to antibiotics and antimicrobial stewardship (AMS); and access to diagnostics.

**We expand operational access to diagnostic microbiology and near-point-of-care testing** by ensuring that projects better incorporate the needs of priority populations through innovation and improved implementation. **We improve our primary healthcare services through access to antibiotics and AMS initiatives**, acknowledging the need to address rational use of antibiotics via context-adapted social and behavioural change strategies.

**We inform normative guidelines and changes in practice**, establishing a research and advocacy hub and spoke model platform in Patna, India, with the expertise and capacity to implement transformative and cross-disciplinary research. **We mobilise local, national and global health actors**, together with the wider MSF Movement, to improve global policies and guidelines to meet the needs of humanitarian settings and marginalised groups, and include humanitarian contexts in global analyses and action.

### **Neglected tropical and re-emerging diseases**

**We develop, maintain and evolve a set of activities centred around specific Neglected Tropical Diseases that improve patient care, leveraging our research to advance our advocacy and communications goals.** Neglected Tropical

Diseases affect over a billion people and reflect historical and ongoing inequities, disproportionately impacting neglected patients and populations, including those affected by conflict, climate change, gender inequality and social exclusion.

**We also focus our change agenda on diseases that are likely present but under-recognised or re-emerging in our programmes and where we can affect change either by direct care, research or advocacy.** For dengue, a climate-sensitive infectious disease, we build on our expertise in vector control and prevention while exploring novel diagnostics, novel therapeutics, vaccination, innovative vector-based strategies, and comprehensive facility-based outbreak management. For female genital schistosomiasis, we document the burden of disease and integrate screening and treatment as appropriate in our programmes.

**Our engagement builds on our strengths in noma, leishmaniasis and snakebite as we integrate new models of care for early detection, prevention, and to improve access in our programmes while we influence global policy.** By the end of this strategic period, we expect to be less engaged in global advocacy around noma. We work with national and international actors on leishmaniasis (visceral and cutaneous) to simplify diagnostic and therapeutic procedures and algorithms and for uptake of new approaches, advocating for supporters to invest in control programming in endemic countries. We refine our leishmaniasis outbreak prediction, preparedness and response. We reinforce the existing infrastructure of our projects that care for snakebite to contribute to research and innovation for medical and behavioural responses that lessen the burden of snakebite for populations we assist.

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## Extending our reach and effectiveness

### Safe and effective clinical care

**Providing safe and effective healthcare is the foundation of our medical programming.** Across all our projects, we strive to continuously improve the quality of our services, adapt our programming to reduce the adverse effects of climate change on population health, and leverage research and innovation as powerful tools to improve our impact. **We aim to deliver safe and effective person-centred care in all contexts.** An effective response embraces a holistic and multidisciplinary approach and champions continuous learning, ensuring that healthcare is equitable, timely, responsive, and tailored to the diversity of needs in medical humanitarian crises. We therefore:

- **Tailor our approaches to meet the specific needs of women and children** as the majority of MSF patients. **We operationalise a shared understanding of quality of care that is the responsibility of all staff (medical and non-medical)** to integrate a sustainable approach to quality in all our programming.
- **Implement an adapted clinical governance framework** across all levels of the organisation and ensure standardised, simplified quality-of-care monitoring and data-driven improvements.
- **Ensure collaborative engagement with communities,** including marginalised groups, throughout the project cycle to ensure that services are responsive, inclusive and tailored to community needs.

### Climate adaptation

**We recognise that climate change inequitably impacts people in need of medical humanitarian assistance, and integrate climate adaptation strategies throughout our programmes.** The impacts include injury and death, heat stress, respiratory disease, water- and vector-borne disease, malnutrition, mental health issues, and social impacts such as the loss of livelihoods, migration, violence and conflict. Women and children are often disproportionately affected. We therefore:

- **Systematically integrate climate risks in project planning,** ensuring anticipation, early action and long-term planning against locally identified climate threats.
- **Use climate and weather forecasting and monitoring platforms and tools to act earlier** and reduce health impacts from climate-related health crises and disasters.
- **Operationalise climate impact assessments and forecasting models,** nutrition security and water scarcity studies, flood risk and environmental health risk mapping to improve our responses.
- **Develop capacity to identify, anticipate and respond adequately to climate-sensitive diseases.**

### Research and innovation

**Research and innovation are integral to MSF's work and drive improvements in medical care.** MSF is uniquely positioned to carry out impactful research and innovation projects in many settings where we work. We must therefore ensure a robust framework for decision-making about our research and innovation investments, embedding and aligning them with our advocacy objectives. For this, we:

- **Curate a portfolio of research and innovation activities that are driven by a desire to improve the health and wellbeing of the patients and populations we intend to serve.** We are intentional about the research projects we choose to undertake, ensuring medical and operational alignment and promoting collective ownership of research with patients, communities and partners.
- **Maximise our impact** by focusing our research, innovation and advocacy on the medico-operational themes prioritised in this Strategic Plan, routinely integrating advocacy and communication strategies.
- **Strengthen and expand our efforts to ensure access to products for healthcare,** focusing on women, children and adolescents. This work will identify and tackle barriers faced by both patients and project teams, mobilising the required resources towards these ambitions.

→ June 2025, Cox's Bazaar, Bangladesh – The "Taro Leaf project" as a metaphor for the Rohingya experience. In June 2025, Rohingya photojournalist Zia Sahat Hero and MSF Australia photographer Victor Caringal produced a series of photographs to show how the Rohingya have adapted to daily life in the Kutapalong refugee camps near Cox's Bazaar, Bangladesh. ©MSF



# Bearing witness, speaking out and advocating for change

**Standing with people affected by medical humanitarian crises, we confront those who perpetrate harm**, centring the voices and agency of the people we aim to assist and informed by our operational experience. As humanitarian and health-related norms erode, access to care is weaponised and people are deliberately stripped of their rights and dignity, we bear witness, speak out and advocate for political and social change that meets their essential health needs. Témoignage is not only a tool for change: it is an act of solidarity, an assertion of humanity, and a refusal to be silent in the face of violence and injustice. We consult with the people we assist about bearing witness and to inform our positioning, deliberately joining or building alliances on specific time-bound initiatives. We are outspoken and at times prescriptive in our efforts to:

- **Denounce and challenge the catastrophic violence, neglect, and injustice** that endangers or directly harms people in conflict and other medical humanitarian emergencies. We specifically call out:
  - the impact of crises on people with compounded vulnerabilities, including those who are criminalised;
  - deliberate attacks on patients, healthcare workers and facilities;
  - the politicisation and securitisation of aid;
  - the spread of mis- and disinformation that fuels mistrust and exclusion;
  - the failure to uphold international legal norms and protections; and
  - the drivers of vulnerability, including climate-related crises that exacerbate health inequities.
- **Defend and expand access to medical humanitarian assistance, calling attention to emergency and other unmet, neglected needs.** We advocate for the political, legal, and security conditions necessary for people to access healthcare safely, as well as for the required funding. We resist and expose policies and practices that block, restrict, or criminalise access to impartial aid, and we engage in negotiation and diplomacy, from local to global levels.
- **Advance sexual and reproductive health and rights (SRHR).** Progress in sexual and reproductive health (SRH) requires us to confront barriers to achieving SRHR that are embedded in regressive and discriminatory laws, policies and practices. We speak out against political and legal restrictions that reduce access to critical reproductive healthcare services and support for patients and create a difficult environment for care providers, which heightens the risk of unintended pregnancies, unplanned births, unsafe abortions, preventable infections and morbidities, and increased maternal, neonatal and child mortality and morbidity. We defend the right of individuals to safe, respectful and comprehensive sexual and reproductive health services, especially in crisis settings. This includes people's right to make decisions about their own sexual and reproductive wellbeing, while respecting the rights of others.
- **Drive political action on antimicrobial resistance (AMR) in humanitarian settings.** We push for global and national commitments on AMR to translate into practical action in humanitarian settings: ensuring access to essential and novel antimicrobials, strengthening infection prevention and microbiology, and removing barriers to timely, appropriate care. AMR risks making common infections difficult or even impossible to treat, threatening to reverse decades of medical progress. Within low-resource settings, these scenarios are exacerbated by lack of access to appropriate diagnostic tools and treatment.
- **Elevate attention to neglected tropical and re-emerging diseases.** We call on governments, donors and industry to prioritise sustained investment in the prevention, diagnosis and treatment of select neglected diseases. Our focus will include dengue and female genital schistosomiasis, alongside continued work on noma, leishmaniasis and snakebite.

# How we work

Our organisation needs to be responsive to the needs of our medical humanitarian operations, anticipating support needs and working with agility, able to pivot when required to enable a response to emergencies. Our enabling functions are vital for our future effectiveness and resilience and must be developed over the longer term. For this strategic period, we focus on People and Culture, Safeguarding, Organisational Integrity, Supply and Logistics, Data and Technology, OCA Partnership and MSF Movement, and Mobilising Support.

## People and Culture

**We have a diverse and engaged global workforce united by a shared sense of humanity.** People are at the heart of MSF. Our principles and values are practised in how we lead, interact, decide and collaborate. We develop people and culture strategies for all staff, regardless of contract type or location, ensuring consistency and inclusivity while actively addressing their distinct needs and challenges.

### Our workforce

**We build a global workforce that is resilient and has the competence, experience and attributes to deliver safe, effective and person-centred care** in every context.

A workforce that works with creativity and agility and can pivot to respond rapidly and effectively to acute emergencies as needed. We identify and capitalise on our existing capabilities, skills and potential, and enhance forecasting to ensure we meet the evolving needs of our operations. A specific focus will be on securing a highly reactive surge capacity for emergency response and key roles.

### Retaining high performers, advancing women at all levels and ensuring succession for crucial positions

are all essential parts of our enhanced workforce strategies. We remove structural and systemic barriers to development, retention and progression, most notably for locally hired staff. This includes deepening our understanding of systemic inequalities, their intersectionality and how they impact our workforce, and implementing strategies to address these for under-represented groups within OCA, such as women of colour.

### Our people

**We embed safe and equitable recruitment practices across the organisation.** A specific focus will be on gender balance, safeguarding and exploring opportunities for mutualisation. High-quality onboarding programmes specifically designed for our country programmes are essential to set new colleagues up for success, given special attention to cultural competence, safety and security, and safeguarding. By offering development and learning

opportunities, we improve performance and contribute to the success of our operations. Frontline clinical staff, particularly nurses, will have the theoretical, clinical and managerial skills to provide quality care; we will maximise hands-on training opportunities to support this

### Our culture

**We foster a workplace culture that is informed by our values,** a transparent and learning culture in which staff are safe to learn from each other, from what we do well and what we get wrong, committed to safe, effective and person-centred care and working collaboratively, seeing our roles within an interdependent system. We foster a culture in which we openly debate yet still make decisions, acknowledging each other's expertise and experience and moving forward together, preserving what is good and changing what no longer serves us. We are committed to identifying and addressing systemic barriers that hinder inclusion and belonging.

### Our leadership

**We support our leaders and people managers at all levels to lead their teams with clarity, empathy and cultural competence, modelling our values and safeguarding standards.** We support managers, coordinators and team leads across OCA to succeed by enhancing people management capabilities, offering timely and effective support and feedback, as well as opportunities to enhance their leadership skills. A solid performance management methodology and implementation is essential to make sure that staff receive constructive feedback so they can learn and grow.

→ August 2023, Bulengo, Democratic Republic of Congo (DRC) – In the camps of Bulengo and Lushagala, MSF teams installed two clinics named Tumaini (“Hope” in Swahili) to provide free and confidential medical and psychological support to women. Women of all ages came to the clinic, survivors of sexual violence but also to access family planning, seek psychological advice or treat sexually transmitted diseases.  
©Alexandre Marcou



## **I Safeguarding**

**We build an environment free from abuse and embed safeguarding in every aspect of our work. We prevent, report, detect, and respond to harm and misconduct caused directly or indirectly by MSF** in country programmes and OCA section and regional offices. We know that our proximity to people experiencing vulnerability and crisis creates opportunities for abuse that some will look to exploit, and we must consistently safeguard against this. Mitigating safeguarding risks is a conscious priority in our operational decision-making, from the onset of an emergency and across the programme cycle.

### **Prevention**

**We discuss safeguarding standards and the rights described in our Patient Charter with staff, patients, communities and partners.** We are committed to hiring individuals who display awareness of our values in their everyday actions, via safe recruitment processes that clearly outline our behavioural expectations and safeguarding duties, regardless of contractual status or time of day. All country programmes and OCA offices will undertake the Safeguarding Self-Assessment to determine risk levels and develop context-specific safeguarding action plans. We onboard, train and support staff to effectively deliver on these plans, with a focus on those in frequent contact with people in medical humanitarian crisis. As we reinforce our capacity to work in partnership, we consistently apply safeguarding standards when we select and monitor our collaborations.

### **Reporting**

**We work with communities to design appropriate and effective reporting and feedback mechanisms, fostering an environment in which people feel able to signal any safeguarding concerns.** We improve our support for complainants and survivors following safeguarding incidents, offering clarity on our actions and follow-up. We will roll out an interoperable reporting platform to ensure easier access to our reporting mechanisms throughout our country programmes and offices. We strengthen the ‘duty to report’ in our Code of Conduct to continuously encourage all staff to speak up about inappropriate behaviour.

### **Detection**

**We are proactive in identifying situations in which abuse may arise.** Experience has taught us that our reporting channels are only effective when people are willing to use them, and that many cases remain unreported. In situations of heightened risk or vulnerability, we seek out patterns of abuse that expose weaknesses in our safeguarding approach. We work with partners and train and enable staff to signal situations that carry elevated risk of misconduct or abuse, so we can mitigate and respond accordingly.

### **Response**

**We sustain trust in our organisation by responding to complaints from staff, patients, partners and communities in a timely and person-centred manner.** Every alert is considered, and each violation receives a proportionate response. Drawing lessons from security incident management, we share trends and lessons inside OCA as well as between ODs. We collaborate on common definitions and policies, creating collective investigative capacity and sharing information on staff who have been found in severe breach of our Code of Conduct. **For staff whose physical or mental wellbeing is affected in the course of their duties with MSF, we establish a clear, effective, equitable and consistent framework on Duty of Care.** At times, our support will go beyond our obligations as an employer, as an expression of solidarity with our colleagues.

# Organisational Integrity

**Our workplace culture and our systems of governance, finance and control aim to consistently produce ethical, transparent and accurate outcomes aligned with our principles and purpose.** Organisational integrity allows us to meet varied stakeholder expectations, building trust with patients, staff, partners and donors. Organisational integrity includes the frameworks and day-to-day conduct and behaviour that enable responsible choices in complex environments.

## Decision-making and risk ownership

**Our decisions are informed by integrated risk management practices** so that authority and accountability can be effectively distributed throughout the organisation. We build capability to ensure that the right information and expertise is available at the level where a decision should be taken. This allows decision-making and risk ownership to go hand in hand, empowering staff to act while ensuring visibility and accountability at the right levels. **We make clear our risk appetite so that decision-makers can act accordingly and in line with our principles and values.** We strive for compliance, taking informed decisions in relation to risk in service of people in medical humanitarian crises and avoiding harm to patients and staff, documenting our decisions and their rationale.

## Accountability and organisational learning

**We remain accountable to the people we assist and the communities in which we live and work, our supporters and each other.** Accountability helps to drive continuous improvement, and an openness to grow and change. **We will build our reporting systems so that data cascades easily**

between layers of the organisation, supporting planning, performance monitoring and shared understanding. We learn from what we do well and what we get wrong, and this informs decision-making. This approach ensures that our organisational integrity is measurable and actionable, reinforcing trust through a commitment to evidence-based improvement.

## Environmental, social and governance responsibility

**We embed environmental, social and governance frameworks in our day-to-day operations,** increasing coherence and visibility that our stakeholders can rely on. We will continue to progress on our efforts to halve our environmental footprint as compared to 2019 levels through targeted solutions in energy, supply chain, air travel, fleet management and waste, guided by the OCA Environmental Impact Roadmap, aligned with movement-wide commitments. Alongside our environmental targets, we strive to ensure employees' health, safety and security, and to foster a diverse, equitable and inclusive workplace. We govern according to our principles and values, striving for clear, collective and just lines of accountability.

# Supply and Logistics

**We ensure a fit-for-purpose and resilient supply chain organisation as well as operational and technical logistics support, enabling our response to emergencies, evolving operational needs and long-term programme delivery.** We advance OCA's supply chain network, integrated at global level with the wider MSF supply system, to ensure timely delivery of quality critical products, operational continuity and adaptability in complex environments. In logistics, we balance robust systems with adaptable technical capacities across diverse domains to meet evolving operational and quality requirements.

## Our supply chain

**We integrate our supply chain organisation and our supply footprint to leverage our networks for greater effectiveness and efficiency, developing partnerships and conducting regular reviews of our physical footprint.** We will place special emphasis on strengthening our regional supply hubs in the Kenya Office and with MSF South Asia as part of the International Supply Transformation Roadmap, deepening collaboration with other MSF regional entities and enhancing partnerships across our outsourced supply activities.

**We develop and execute sourcing strategies for reliable access to critical, quality-assured product groups,** enhancing preparedness and resilience to manage and mitigate market disruptions, guided by an ethically responsible procurement framework. We will diversify global procurement through regional and local sourcing that meets OCA quality standards, reduces lead times and costs, and strengthens procurement capabilities in country programmes.

**We accelerate supply chain digital transformation to achieve end-to-end supply chain visibility and data-driven decision-making.** This includes building an integrated digital ecosystem and improving data quality, transparency and accessibility across the supply chain. **We will establish a global inventory framework that ensures stock availability at the right place, time and quantity.** We maintain strategy alignment and visibility across European Supply Centres and regional and emergency preparedness stocks, ensuring timely access to critical supplies.

**We implement a transport strategy that ensures full visibility and optimisation of the movement of all goods across our supply chains, while striving to reduce costs and minimise our carbon footprint.** This includes a focus on inbound and outbound transport efficiency, visibility and cost management at the level of the European Supply Centres, and tailored approaches for emergency transport needs at a global level.

### **Operational and technical logistics**

**We will strengthen our independent logistics capabilities, including air transport operations,** and reinforce applied security and safety measures to meet growing operational demands, enable effective, interoperable and efficient operations, and expand our responsiveness and operational reach. **We enhance Movement-wide support for technical domains** through partnerships and by sharing expertise between ODs, with a focus on biomedical equipment services and enhanced Geographic Information System (GIS) capabilities. This includes engaging with external partners and utilising outsourced expertise when required.

**We ensure safe, functional and effective built environments for patients, their communities, and MSF teams through person-centred, operationally relevant technical support solutions.** This includes technical solutions that can be quickly deployed during emergencies.

## **I Data and Technology**

**We will transform how data and digital tools support our medical humanitarian operations to enhance decision-making, fuel innovation, enable our ability to work collectively, and optimise resources.** In a rapidly evolving technological landscape, we recognise both the opportunities and risks that come with digital transformation. **We democratise access to data and technology across our programmes, ensuring that all teams, regardless of location or context, can benefit from the tools and information they need.** By fostering interoperability and mutualisation across the MSF Movement, we are more able to join forces and collaborate, remaining adaptable to local contexts through a coordinated, governed approach.

### **Establish our digital foundation and build strategic value**

**We will ensure a secure, sustainable and scalable digital environment that integrates systems and data and can act upon technological advancements. A digital environment that supports our activities in a responsive and resilient manner** wherever we operate. This foundation is built with information security and data privacy by design, guided by ethical, sustainable practices, and is ready to mount an incident response in the event of critical cyber-attacks. Platform and architectural decisions are shaped by operational realities and made in close collaboration with users and stakeholders to ensure usability, consistency and future readiness.

**We will build on this foundation** modernising our application and infrastructure portfolio, transforming data into a strategic and governed asset, and forging partnerships that amplify our digital capabilities while preserving independence. We harness artificial intelligence and emerging technologies to amplify our impact, enhancing decision-making and operational efficiency. These efforts are underpinned by standardised data management structures and clear, accessible policies

that enable safe, effective and accountable use of digital systems across the organisation.

### **Make technology work for our staff and patients**

**Our people-centric approach empowers the OCA workforce through digital systems. We promote inclusivity in how our technology is designed and deployed,** working to reduce bias and tailor our systems to serve the diverse needs of our staff. Through thoughtful design and ongoing user engagement, we keep our digital solutions adaptable and relevant as our operating environment evolves.

**We build on our technical strengths to integrate these capabilities into digital- and data-literacy programmes, enabling staff to use and shape the tools we rely on.** We invest in building confidence and competence across the workforce, ensuring that technology is not only accessible but meaningful in daily practice. We build trust with our staff, patients and the communities in which we work by clearly communicating how data is used and protected. By aligning technology with our principles and values, we ensure it amplifies – but does not replace – human judgement and compassion.

# OCA Partnership and MSF Movement

**We create and seize opportunities to shift power, furthering MSF's international identity, to deepen the interdependence of the OCA Partnership and the interoperability of the MSF Movement.** The OCA Partnership is built on cooperation, commitment and shared ownership.<sup>5</sup> Our integrated executive and associative governance enables collective responsibility and accountability for the implementation of this Strategic Plan. We prioritise the sustained delivery of medical humanitarian operations in decisions on our future.

## Association and governance

**We navigate our internal and external environment collectively, building on our strengths and diverse membership.**

We nurture a vibrant associative life in the OCA Partnership and in the places we work, and sustain our commitment to the Associative Life in the Field programme, supporting debates and ensuring that people are welcomed, and Association members' contributions and exchange help to drive our work.

**We govern according to our principles and values, striving for clear, collective and just lines of accountability to our partner boards and OCA associative community.**

MSF associates to act, and that action is typically organised by sections. In OCA, sections come together in a true partnership governed through the OCA Council, where voices are heard equitably. Our governance includes timely review of the founding documents of the OCA Partnership. We are open to new partnerships and models of working that provide opportunities for OCA to further shift power and adapt to MSF Movement-wide evolutions.

## Strengthening our executive management

**We continue to refine and strengthen our executive management platforms to ensure co-ownership of our work, sharing responsibility, accountability and participation in the implementation of our medical humanitarian operations.** Leadership on topics elaborated in this Strategic Plan comes from across our executive partnership. We value the diversity that this brings to our leadership and consistently strive for that to be representative and inclusive.

## Developing our functional domains

**We capitalise on our multicentric model to diversify and develop our functional domains, building on the strengths of the four existing executive partners** to meaningfully contribute to the implementation of our medical humanitarian operations. This brings benefits for our operations as well as for OCA as an organisation as we gain advantages from each of our executive partners and maintain an interdependent partnership.

- We aim for a coherent geographic distribution of functions and teams, building critical mass in existing executive partner offices and creating opportunities to mutualise functions.
- We prioritise the further development of medical

operational capability in South Asia, establishing an Operational Support Team and medical expertise in line with our medical priorities.

**We develop our partnerships and capacities in the Middle East and North Africa (MENA) and Eastern Africa region,** enhancing our networks, humanitarian access and emergency response.

- The MENA Office will work with other ODs to create a single integrated MSF support office. Our activities will continue to serve all ODs throughout the region and globally, and maintain a focus on recruitment and career management (enhancing our French, English and Arabic capacity); the mental health of our staff in the region; and communications towards Arabic-speaking audiences. We explore ways to further integrate these functions across the region, linking with offices in Lebanon and Dubai.
- The Kenya Office (KO) will develop its supply, logistics and IT capability. The KO follows the International Supply Transformation Roadmap, integrating its supply activities with European Supply Centres as part of the broader development of the OCA global supply network. Additionally, the KO will serve as a key location for technical logistics and biomedical support, as well as data and automation capabilities. We will be complementary to and not duplicate any services that MSF Eastern Africa provides.

## Collaborating across the MSF Movement

**While we focus on the OCA partnership, we also partner with other MSF entities to implement our medical humanitarian operations and support MSF's organisational evolution.** These collaborations should be reciprocal, such that each MSF entity extends the role it plays in supporting medical humanitarian operations.

**Our plans support MSF's organisational evolution** and new ODs, ensuring that they can develop while MSF as a whole sustains and ultimately grows its global volume of operations. **We accompany MSF South Asia's intentions to lead an OD** emerging from the South Asia region, working as part of an innovative OD partnership that pairs existing MSF strengths with new capabilities. OCA benefits from this partnership, enriching our practices with new thinking and ways of working, while MSF South Asia benefits from established systems and processes.

**We commit to the MSF Movement’s Strategic Planning Accountability and Resource Cycle (SPARC) common priorities and accountability mechanisms – collectively agreed rather than centrally driven – and respect the autonomy of each Section and OD** (and their accountability to their respective governing bodies and associations) to implement the common priorities in the most effective way given the specificities of their context.

**We establish interoperability as a criterion in decision-making processes for new initiatives and projects and shift support capacity out of OCA towards mutualised structures** (shared services) where this brings a collective gain for the MSF Movement or the OCA Partnership. Our executive and associative bodies work to optimise resources dedicated to support structures (protecting fundraising investments), and maximise the percentage of our income dedicated to country programmes, respecting programme and social mission ratios.<sup>6</sup>

## **■ Mobilising Support**

**Mobilising support is a shared collective responsibility between the fundraising teams of the MSF Movement and the ODs** working together as a ‘one MSF’ Movement and requiring a conducive fundraising and philanthropic culture. Our independence of action is dependent on the financial support of millions of people worldwide. We want people to be inspired to support us financially, as well as by mobilising and speaking out with us or choosing to work or volunteer with us.

### **Working with restricted gifts**

**We identify thematic activities and projects suitable for dedicated support**, and systematically define the financial support necessary for those plans to succeed. This requires teams from across the MSF Movement to work together. We align our efforts across the organisation to mobilise support through shared understanding of current and future operational plans, ambitions and effectiveness. As an OD, we commit to find ways to expose the realities and complexities of our work to the parts of the MSF Movement that are proactively involved in mobilising support.

### **Fostering innovation**

**We encourage an opportunity-driven mindset and an appetite for innovation**, working with fundraisers as they develop creative initiatives to engage new and more diverse groups of supporters. Potential for income growth lies, among others, in high-value giving and emergency fundraising. Opportunities also arise through new avenues of partnerships that can bring operational benefits or in-kind support.

### **Campaigning for change**

**We support the efforts of all MSF sections to mobilise supporters and work in alliances** to denounce and challenge the forces that endanger people in medical humanitarian crises, defending and expanding access to impartial medical humanitarian care, calling attention to emergency and other unmet and neglected needs, and advancing sexual and reproductive health and rights. In the context of the erosion of longstanding norms and the fragmentation of international multilateral systems, generating public pressure in response to medical humanitarian crises in order to provoke political and social change becomes an increasingly important undertaking.

→ July 2024, Tashkent, Uzbekistan – Dr. Sevara Abidova from Uzbekistan’s Republican AIDS Centre is conducting a rapid tests for HIV, Hepatitis C, and sexually transmitted diseases. The tests are performed in a mobile lab traveling within and around Tashkent, operated by the Republican AIDS Centre and MSF. ©Natalia Chekotun/MSF



# Glossary and Endnotes

## *Compounded vulnerability*

Building on the definition of vulnerability, which describes an individual's susceptibility to harm in relation to their capacity to adapt, compounded vulnerability highlights a systemic interdependency and intersection of factors over time and across different contexts. Compounded vulnerability may involve a multitude of stressors, including lack of access to food and healthcare, poverty, violence, political instability, disease and exposure to natural hazards. Individual and community perceptions are also relevant. For MSF, the concept of compounded vulnerability touches on populations that may be excluded, targeted, persecuted, criminalised, or experience discrimination, and for whom access to healthcare is especially challenging. This includes people on the move or in restricted contexts, such as detention centres, and people affected by targeted violence and persecution due, for example, to age, race, religion, ethnicity, sex, sexual orientation, gender identity, or disability.

## *Intersectionality*

Intersectionality is a framework for understanding how different forms of inequality, discrimination and social exclusion intersect and interact to create unique experiences for groups and individuals. This concept draws attention to the specific experiences and needs of those affected by two or more forms of discrimination, which may not be fully understood in isolation from one another. In humanitarian contexts, intersectional analysis provides a more accurate and complete picture of the lives and experiences of people affected by crisis, including the complex barriers they face in accessing humanitarian aid, the multiple forms of violence and exclusion they are exposed to, and the network of resources they might be able to draw upon during emergencies. For MSF, intersectional analysis can help to understand who may be excluded from our programmes and how to adapt our response to reach highly marginalised groups and respond to their specific needs.

## *Protection*

Protection within the humanitarian sector relates to efforts to uphold the rights, safety, dignity and wellbeing of people affected by crises. It involves preventing or alleviating risks of violence, coercion, neglect and deprivation, and ensuring that affected populations can exercise their rights in line with international law, including international humanitarian and human rights law. For MSF, protection includes: ensuring patients can access care safely and with dignity; medical, legal and psychosocial care in response to violence, abuse, discrimination or neglect; and bearing witness and speaking out when systemic threats endanger health and survival.

## *Safeguarding*

Safeguarding refers to the comprehensive set of measures implemented by MSF to prevent, detect and respond to harm and abuse caused directly or indirectly by MSF, or by the actions or inaction of MSF and its staff towards individuals who come into contact with the organisation and its staff, including but not limited to patients, caretakers, communities, MSF staff, partners, and associated personnel.

- 1 This core package of SRH activities is taken from 'Sexual and Reproductive Health Core package of activities In MSF projects', International Working Group on Sexual and Reproductive Health, Version 2 (February 2009).
- 2 BPaLM is a six-month TB treatment regime that includes bedaquiline, pretomanid, linezolid and moxifloxacin.
- 3 Prevention is for all infectious diseases: bacterial (inclusive of TB), viral, fungal and protozoal (focus on malaria).
- 4 These are agreed intersectionally to include neonatal intensive care, inpatient therapeutic feeding centres, advanced HIV care, countries with high rates of MDR infection, reconstructive surgery and intensive care. Note that competing priorities and operational constraints will be weighed; e.g. in places where we might support on antimicrobial stewardship and infection prevention and control but where diagnostic microbiology may not be manageable at the project level.
- 5 The Operational Centre Amsterdam (OCA) Partnership currently includes MSF Canada, MSF Germany, MSF South Asia, MSF Sweden, MSF The Netherlands, and MSF United Kingdom. The OCA partners, their associations, boards and executives collectively and individually share the responsibility for the success, failures and risks of the OCA and the achievement of its objectives. The OCA Management Team is comprised of the General Directors of MSF Germany, South Asia, The Netherlands, and United Kingdom. OCA also has offices in Jordan (MENA Office) and Kenya (Kenya Office).
- 6 Note that the SPARC process may result in updated financial steering indicators which may replace these ratios.

## **OCA Partnership**

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