World Humanitarian Summit
Europe and Others Group consultation

Submission from Médecins du Monde: Transformation through Innovation

Médecins du Monde is an international network which delivers over 300 projects in more than 70 countries through 3,000 volunteers.

Our vision is of a world in which vulnerable people affected by war, natural disasters, disease, hunger, poverty or exclusion get the healthcare they need regardless of income or status. Through our health programmes and advocacy we work to ensure excluded and vulnerable people overcome barriers to healthcare.

Success in Innovation

Innovation in a humanitarian setting sits across a spectrum of activities – it is not only limited to technology, but also includes looking at developing new approaches, embracing new ways of working, using tried and tested methodologies in new contexts, or combining approaches in different ways to create synergies and efficiencies.

There is already innovation taking place across the sector, largely driven by some of the major funders as well as by smaller groups like the Humanitarian Innovation Fund. Médecins du Monde as a network has significant experience of incremental innovation including testing new approaches, scaling up programmes that work, and advocating for changes to practice. An example of this incremental innovation can be seen in our harm reduction work in Tanzania – taking a tried and tested approach and applying it somewhere new (see annex).

It is important to reflect on the purpose of innovation within humanitarian settings. We strongly believe that the primary purpose of innovation should be to improve the resilience and long term sustainability of local communities, thereby reducing the need for a humanitarian crisis response – rather than simply innovating for improvements within humanitarian responsiveness (although this of course also has a role).

As such, success in innovation should be defined by the generation of ideas and approaches which improve the ability of national and local governments and local communities to respond to disasters. This understanding of the role of innovation has implications for how we measure its impact and success.

Innovative approaches should be developed alongside local communities, using participatory approaches outside of emergency events to ensure consent and full agreement and participation of affected communities. Placing population needs and the community at the center of projects, co-designed by communities and/or local operators, is a key factor in ensuring the success of innovation – alongside ongoing reflection, evaluation and redesign where necessary. Once methods and approaches to improve health care have been proven to be successful, these should be then scaled up and incorporated into the national health system – this scaling up is critical for the long term successes of innovations. Outside organisations have a role to play in advocating for this scaling up,
but should withdraw from actual operations if approaches are to be fully integrated into state systems and communities are to be empowered to develop solutions to problems they face. This innovation cycle, from needs to empowerment, via facts based advocacy and successful projects, can lead to the transformation of communities.

**Challenges to innovation**

Innovation, beyond incremental changes, within the humanitarian system is difficult for a number of reasons:

- **Professional knowledge and experience**
  Innovation as a process, and the dynamics of that process, are often not well understood within the humanitarian community because the institutional knowledge and experience of the profession tends not to be ‘design-centred’. This issue of professional skills is an important practical and conceptual barrier to innovation and can be perceived as one of the greatest differences between the social enterprise/start-up sector and the more traditional NGO world.

- **Funding:**
  Traditional funding structures for humanitarian work are extremely intolerant to failure, placing financial burdens on providers and jeopardising future income streams. For innovative approaches to be developed, funders need to be willing to accept a certain level of risk and be willing to accept failure. Failure can itself be valuable if learning is taken and disseminated for future activities. Traditional methods of funding also exclude those outside the humanitarian system – arguably those who are most able to develop innovations are actors ‘outside’ of the system.

  Furthermore, the investment structure of the humanitarian system does not currently allow for access to capital gains for investors, although innovative forms of funding such as social impact bonds may change this in the future. It is therefore important to understand how we can change the structure of our funding to incorporate instruments and initiatives that reward investment in innovation, learning from initiatives such as ‘The Grand Challenge’.

- **Opportunities to test:**
  Testing innovations is difficult – the ideal setting is within emergencies, but rarely do organisations have the capacity or resources during these highly stressful environments to properly and thoroughly pilot an innovation. Testing and designing outside of emergencies is of limited use as it does not take place within a real life disaster scenario, and in addition securing funding for work outside of emergency settings is limited. It’s not clear what the solution to this might be.

- **The cost of failure:**
  The humanitarian system has historically been extremely conservative and suspicious of change – although this is an interesting contradiction as innovation could be seen to reflect the pioneering spirit of humanitarian action. However, there is a perspective that because the role of the humanitarian system is essentially to save lives, failure could cost lives, and therefore there is a resistance to testing. However where current approaches are not efficient, one could argue that by not innovating we are costing lives and that we therefore have a responsibility to critically evaluate our practices and seek to improve these.
• **The monopoly of large organisations:**
  Within the humanitarian sector there is a monopoly of large organisations who have a lock on much of the funding, leading to an environment in which smaller organisations are crowded out. These larger organisations tend to have less innovation, perhaps due to a lack of any real competition. This monopoly also means that there is a limited pool of smaller humanitarian actors, and true innovation needs an outside perspective and a range of opinions in order to effectively challenge the status quo.

• **A lack of an evidence base and poor information sharing:**
  A lack of a robust and comprehensive evidence base within the humanitarian sphere means that there is a gap in knowledge about what methods are successful in what situations, making it difficult to innovate in an informed environment. It is critical that any innovations be rigorously tested and evaluated as this will help us to understand why unsuccessful approaches have failed, as well which elements have been successful and how these can be replicated and scaled up. It is extremely difficult, within emergency situations to gather high quality research data. There are however increasing collaboration between academics and humanitarians which could begin to address this.

  The increased sharing of information about projects could become a requirement of donors – alongside a simple, shared way of measuring impact. This will support the movement towards innovation and the undirected emergence of new forms of mobilization, horizontally and spontaneously. Such patterns have already been noted in communities when they themselves work to reproduce successful projects.

• **Relations with the local community:**
  Our experience tells us that many local communities are fatigued by the humanitarian system – confused by the plethora of organisations and the unfamiliar language and structures imposed in crisis situations. We know that this can, on occasion, lead to community leaders simply saying what they think humanitarian actors wish to hear so as to receive the help they need. This needs to change so that a meaningful dialogue can be achieved – for example the problems that local communities are facing need to be expressed in their terms, as described and articulated by them - so that they can clearly and honestly discuss their concerns and their perspectives on what needs to change. Humanitarian actors then need to listen - to be more responsive to the concerns of communities, reacting to feedback and making changes as required – this will not only serve to improve responses and generate effective innovations that truly serve the needs of the local community, but also relations with the local community.

• **Scaling for success**
  The scaling up of effective innovations is critical for their longer term success. Historically, however, this has been problematic - although it isn’t always clear why this is. There is a critical role here for national and local governments – taking ideas to scale and implementing – and more work should be done to better understand the barriers to scaling and how these can be overcome.

**The role of the private sector in innovation**

The private sector has an increasing role within the humanitarian sphere – both in terms of a partner to existing actors and as an actor in their own right. It would be fair to say that there is a significant amount of concern and nervousness regarding their role and this needs to be carefully managed.
As a partner to existing actors, the approach and culture of the private sector arguably has something to add to the humanitarian sector and provides an opportunity for new perspectives and the sharing of best practice to ultimately improve efficiencies and effectiveness. For example, the private sector has traditionally been the home of innovation and arguably there are lessons to be learnt – both in terms of how they innovate and the types of solutions they develop. They also have a potential role in funding new innovations. However, one challenge for increasing the involvement of the private sector in co-designing innovations within the humanitarian sector is the ability to attract and reward private sector experimentation in order to spur meaningful innovation dynamics. However, any openness to partnership and collaboration on the part of existing actors is at odds with deep concerns and suspicions of the private sector playing an independent role within the humanitarian sphere. This stems from a concern about their lack of commitment to traditional humanitarian principles, and the profit-driven culture of the private sector which could place human rights and lives at a lower priority than reporting to shareholders. We strongly believe that any independent involvement needs to be overseen with particular attention and restrictions should be placed on their possible roles and involvement in order to protect extremely vulnerable populations from actors who may not be prioritising their welfare.

There is, perhaps, a possible role for existing humanitarian actors have a supervisory and consultancy role for private sector companies in ensuring that the private sector fully understand and incorporate humanitarian principles into their work, and this should be explored further.

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**Annex: Case Study - Harm reduction in Tanzania**

**Background**

Whilst the prevalence of HIV in Tanzania is declining, there is emerging evidence that a concentrated epidemic has developed among people who inject drugs (PWID). Urban poverty is also driving drug use, increasing the risks of disease transmission and challenging the sustainability of national prevention efforts. People who use drugs (PWUD) are extremely vulnerable, and Dar es Salaam in particular is facing the highest concentration of drug users and the second highest HIV incidence in the country. Drug use is highly stigmatised by the general community and healthcare workers, further marginalising people with dependency problems. Furthermore, this group is often denied access to basic health services.

**About the project**

Following a successful pilot, which an external evaluation commended for ‘[adopting] a truly harm reduction approach – not abstinence focused nor judgemental of drug use [which is] rare in Tanzania’, this two year harm reduction programme was established in Dar es Salaam to support PWUD to access HIV prevention, treatment and care services.

The programme, part funded by the Elton John Aids Foundation, includes the direct provision of harm reduction services and technical assistance to local stakeholders to run nine new drop in centres for PWUD. The drop in centres, six of which have already opened, have increased the number of needle syringe exchange services, improved access to and use of condoms and to HIV testing and treatment. The programme is also training a range of stakeholders including medical staff and police officers in harm reduction in Dar and other regions, as well as wider advocacy to bring national HIV/AIDS protocols in line with international standards and to develop adequate municipal implementation plans.

*The impacts of the project*

From February – July 2014;
• Over 7,500 PWUD have been reached - almost four fifths of the year one target.
• Over 1,000 PWUD have been tested for HIV – almost three quarters of the year one target.
• Training and awareness-raising sessions have been provided to 3,241 stakeholders (including medical staff, police officers and NGOs).

There has been very high demand for the training of employees. This is particularly important as there is a high level of stigma attached to both HIV and drug use. Prior to the awareness-raising sessions, we faced the issue of the police confiscating the clean needles that we were providing, putting drug users at higher risk. The joint advocacy to promote harm reduction programming, sustainable funding and PWUD rights has also shown some progress with the recognition of an urgent need for a Needle Exchange Programme in Tanzania and well as the need for increased support from councillors and mayors.

**Participation and feedback from beneficiaries**

The project primary beneficiaries have had a key role in designing and implementing the programme and have always been part of the outreach workers’ team. We have also provided peer educator training to beneficiaries and 45 have successfully gone on to become peer educator volunteers, with a further seven who have become part of our paid staff team undertaking roles including outreach workers, trainers and HIV testing counsellors. Peer educators also attend the six-monthly review meetings, along with other partners.

**Prospects for future harm reduction in Tanzania**

Before Doctors of the World (DOTW) started the programme, there were no harm reduction services available in Tanzania and the programme is seen as truly innovative. A key achievement to date is raising awareness that harm reduction services work in attracting PWUD to services that improve their health and their position in society, strongly reducing marginalisation. This message is gaining ground across the country. Municipal and national authorities, both in health and law enforcement sectors (and in other sectors, such as development & education) have seen and understood the contribution of our harm reduction approach to reducing HIV in the country and to helping re-integrate marginalised youth into mainstream society.

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**Rehema is 46 and lives in Dar es Salaam. She didn’t finish primary school. In 2007 her boyfriend was selling heroin and asking her to test the quality. She had been using for years when she met DOTW. After testing positive for HIV, she decided to educate herself on it and is now aware of safe injection, HIV, Hepatitis, and STIs. She attended an Income Generating training course and got involved with the HIV+ self-support group as secretary. In July 2014 she participated in a training session on HIV testing & counselling together with another beneficiary of the program, following which they became the first employed HIV counsellors from the PWUD community. Rehema’s life has changed drastically. She has quit drugs and is no longer a sex worker. She explains how her health is much stronger but says “The virus is still hiding. I have changed physically of course, but I know that I shouldn’t stop taking my ARV. I can forget to eat ugali [a staple food] one day, but I won’t forget my treatment!” Continuous treatment whilst in a stable job will allow her to initiate one of her dreams - a business with her sister. She also hopes to continue studying until she achieves a diploma in HIV counselling.**