Board Report 2020

Vereniging Artsen zonder Grenzen

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Opening letter

Dear donors, supporters, volunteers, and employees of MSF Holland and OCA,

With this report, we present what we were able to do with the resources you trusted us with in 2020. We want to tell you in all transparency where we worked, what we were able to achieve, what hurdles we faced, and how we spent the funds you entrusted to us.

The core of our work is assisting people in crisis; whether human made or natural disasters. No matter where people live in the world, they need healthcare: children will be born and children will get sick, people will become infected with diseases such as measles, TB, HIV or, more recently, the coronavirus causing COVID-19. People will need mental health support, help with treatment for chronic diseases such as diabetes, people will need palliative care, and much more.

People forced to flee – be it from war, persecution, hunger, or the impact of environmental change -will need a safe place, water, sanitation and dignity. People on the move will need treatment when they are wounded or ill. Nobody asks to be in a crisis, and crisis takes many forms; but the need for people in crisis to have medical aid is universal.

MSF strives to provide that medical aid, and to help amplify the voices of people in crisis. Although, unfortunately, there are more needs than we can respond to, thanks to the generosity of our supporters, mostly private donors, we can make a significant contribution and are able to work in many complex and highly insecure settings.

In 2020, COVID-19, was added to the mix. A crisis in and of itself; it also compounded existing crises around the world. We adapted our ways of working to the pandemic. We created guidelines applicable to the settings we work and made changes to our operational model to manage challenges brought by lack of options for transport and supply. Our focus was to keep providing the aid that any person needs in a crisis. At times, this was extremely difficult. We are proud of our staff worldwide, who continued to carry out their work, often in very insecure settings.

2020 brought challenges to the implementation of our medical humanitarian programmes in a context of increased insecurity. On May 12th 2020, at the Dasht-e-Barchi maternity hospital in Kabul supported by Operational Centre Paris, 25 people lost their lives in a brutal attack. 16 mothers in labour, five of whom were about to deliver their babies, were murdered one after another, room after room. Nine other people were killed, including Maryam, one of our colleagues who worked as a midwife; and two children, aged 7 and 8, who had come to the maternity hospital for vaccinations. Four other MSF colleagues were also injured. The attack led to the withdrawal from the area.

We also experienced three separate incidents of abductions of MSF staff in South Kivu, Democratic Republic of Congo. Thankfully, all staff were returned unharmed. However, the frequency of the attacks and level of impunity – and lack of minimum guarantees for the safety of our staff, led us to take the extremely painful decision to close two of our long-standing projects in the region. Although we handed over the project to the Ministry of Health and continue to seek ways to support, it is devastating to know that our withdrawal will have significant impact on a particularly vulnerable, conflict-affected population.

Despite these challenges, there is also much to celebrate. In 2017, the first patient was enrolled into MSF's clinical trial testing a shorter regimen for multidrug-resistant tuberculosis (MDR-TB), a disease which leads to many deaths worldwide. Current treatment is long, only cures three out of every five patients, and often still includes painful injections and drugs that cause toxic side effects including deafness, despite changes in WHO guidance.

The TB-PRACTECAL trial, as it was called, tested a combination of new drugs. In early 2021, the trial could stop enrolling patients early after its independent data safety and monitoring board indicated that the new treatment being studied is superior to current care, and more patient data was extremely unlikely to change the trial's outcome. We are very pleased with this outcome. The findings could transform the way we treat patients with drug-resistant forms of TB worldwide, who have been neglected for too long.

In 2020, we were also confronted with some difficult truths: racial inequities and racism at individual and systemic levels are not only a problem in wider society, but also part of our organisation. We recognised through many discussions and reflections that systemic inequities and biases on race, geographic origin, gender, sexual orientation and identity, age, physical ability, religious orientation and other forms of discrimination exist in MSF. This has led to unequal opportunities within the organisation, particularly for locally hired colleagues or colleagues originating from low and middle-income countries. MSF has always worked with large groups of locally recruited staff, no matter where we were in the world. However, for too long it has been staff coming from our (traditional) donor countries who were sent to be their supervisors, and to oversee country head offices. Growth opportunities and remuneration for locally hired and international staff are still not equal; decision-making power is still concentrated in Europe, in the founding countries of MSF.

As individuals, we are asking uncomfortable questions of ourselves. As an organisation, we are now openly debating racism, and obstacles to fully achieving diversity, equity and inclusion. We are educating and reforming ourselves, as individuals, as MSF Holland, MSF OCA and the whole global MSF Movement. It is sometimes a painful process, as we are forced to confront our hidden biases and privilege. It is necessary. We will come out stronger.

MSF will continue to provide essential care to those in crisis, regardless of race, gender, religion, ethnicity, sexuality, or age. We will continue to advocate that every person must first and foremost be recognised as a human being. That everyone, no matter who they are, deserves respect, dignity, and agency. We will continue to counter narratives that dehumanise people who need to flee, and against the criminalisation of attempts to provide them with lifesaving humanitarian aid.
With your support, we can continue with our work, our efforts to aid those who need help in their times of crisis. We could not do this without you. We thank you for your commitment. We hope to continue our journey together with you in the coming years.

Marit van Lenthe
President MSF Holland
Chair of the OCA Council

Introduction

This report is the Board Report and Accountability Statement of Artsen zonder Grenzen/Médecins Sans Frontières (MSF), the Netherlands (MSF-Holland), published on www.artsenzondergrenzen.nl, together with the financial statements of the MSF-Holland Association[1].

This Board Report and Accountability Statement considers the most important matters that occurred in 2020 – in relation to the ways in which we:

- Adapted and responded to the COVID-19 pandemic – in our projects, and in the Amsterdam office;
- Implemented our medical humanitarian programmes in a context of increased insecurity and efforts to undermine independent humanitarian action;
- Carried out our social mission – in our projects, in the Netherlands and worldwide;
- Were confronted with the need to better acknowledge and tackle institutional racism and discrimination; and to accelerate our efforts to increase diversity, equity and inclusion.

1 https://www.artsenzondergrenzen.nl/over-ons/jaarverslag-en-jaarrekening/
2 The South Asia Regional Association comprises Afghanistan, Bangladesh, Sri Lanka, India, Nepal, Pakistan and Myanmar
3 Some MSF sections have opened branch offices to further extend support work. Currently there are 23 sections and 17 branch offices around the world. In public representations, the MSF movement chooses not to distinguish between the work of the separate entities to strengthen our collective voice and influence.

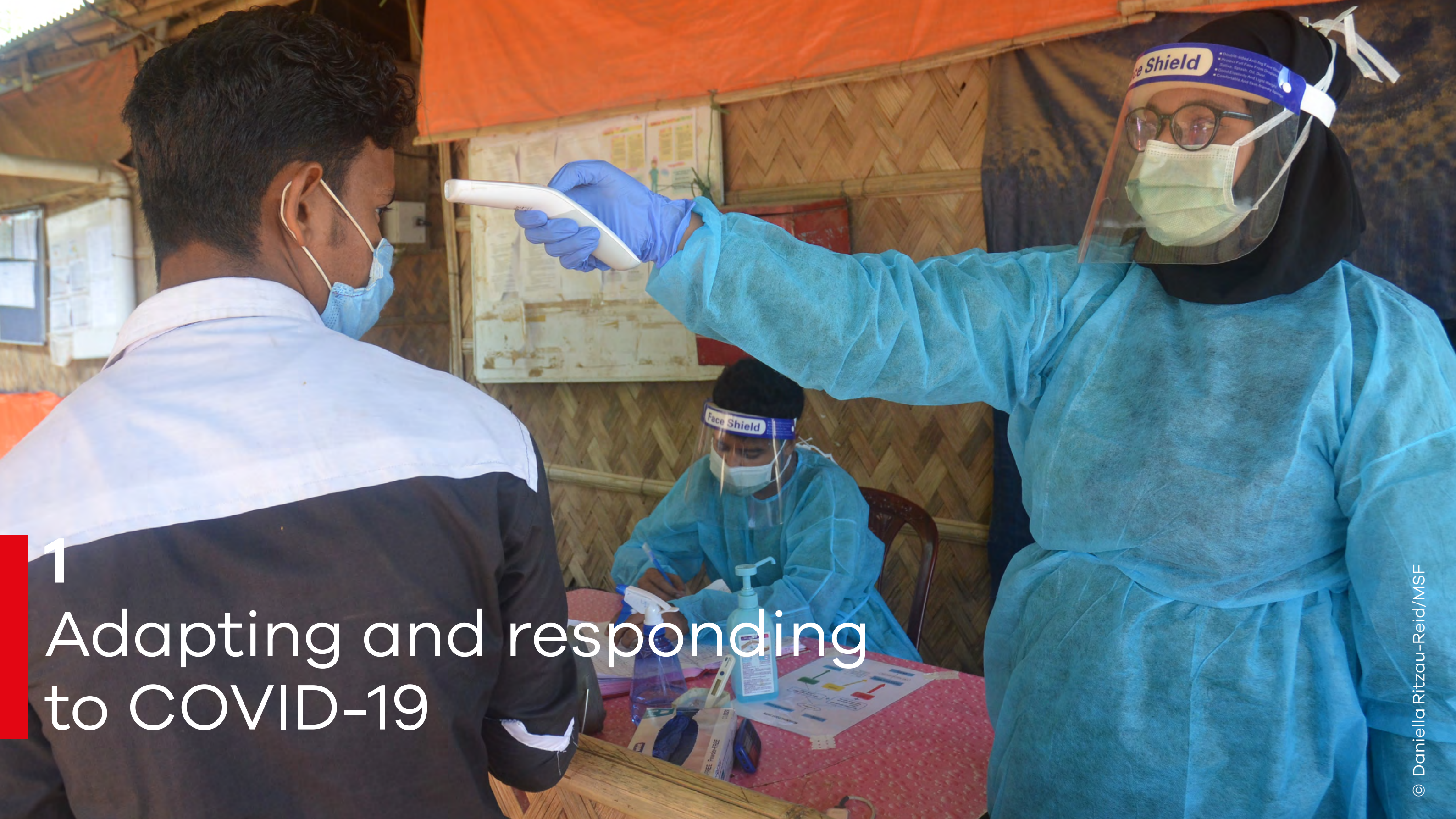
▲ Dr. Nisha Mohan is explaining the safety protocols at the COVID-19 treatment centre in Bihar, India.

Who we are: MSF-Holland, OCA, and the MSF movement
The international MSF movement comprises 25 associations around the world. Each is an independent legal entity registered in the country in which it operates and each is linked to one of five of the operational centres (OCs) responsible for the delivery of MSF's medical humanitarian work.

MSF-Holland is the legal entity which hosts the *Operational Centre Amsterdam* (OCA) partnership. The OCA partnership is composed of MSF-Canada, MSF-Germany, MSF-Holland, MSF-South Asia Regional Association[2], MSF-Sweden, and MSF-UK. OCA's medical humanitarian operations fall under the responsibility of the Board of the MSF-Holland Association (the Board). The Board delegates oversight of OCA's operations and activities to the OCA-Council, made up of representatives of the Boards of the different OCA partners, including MSF-Holland.

MSF-Holland is also a 'section' – an office which supports operations; mainly through recruitment, fundraising, advocacy and awareness-raising – that is governed by an independent association.

In this report you will see the different uses of the terms MSF-Holland, OCA and the MSF movement, as well as to specific project locations, branch offices and sections[3]. The report highlights both OCA's medical humanitarian operations and global advocacy and communications efforts; and reviews 2020 from the perspective of MSF-Holland as a section, including updates related to the office in Amsterdam and highlights of our advocacy, communications and fundraising work in the Netherlands.



1
Adapting and responding to COVID-19

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Despite our long history of managing disease outbreaks and health crises, COVID-19 brought new challenges and tough choices. Transport networks were severely disrupted as borders closed, and national lockdowns and movement restrictions were introduced. Shortages of essential medical supplies, including protective equipment, tested our logistics and supply systems, our staffing models and our financial resource management.

MSF, along with the rest of the world, adapted. We focused on maintaining essential medical and humanitarian operations; and responding to COVID-19 where it was needed, while prioritising the safety of our staff and patients.

From the beginning of the pandemic, we had four operational priorities, to:

1. Keep all staff as safe as possible and support them;
2. Maintain our medical humanitarian activities (as far as was feasible, in a responsible manner) while:
    a. Engaging with the communities we work with on the best strategies to adapt our medical humanitarian activities to prevent the spread of COVID-19, including health education;
    b. Developing COVID-19 specific treatment programmes for vulnerable communities;
3. Address challenges in movement of staff;
4. Address our supply issues.

Concurrent with our operational priorities, we advocated for equal access to protection and treatment for vulnerable and marginalised groups.

▲ MSF staff screen patients for respiratory symptoms and fever at the entrance to Goyalmara mother and child hospital in Cox's Bazar, Bangladesh.

1.1 Keeping our staff safe

In 2020, we employed 10,536 full-time staff (2019: 10,466 full-time staff) working in 115 emergency aid projects in 31 countries (2019: 111 projects in 31 countries) and at the head office in Amsterdam, and in other support offices. At a time of great uncertainty, our staff faced significant pressure - wherever they were in the world. We set up psychosocial and mental health support for both international and locally hired staff across our projects, as well as for our Amsterdam-based staff. These included a 24/7 phone and messaging line, as well as individual and group counselling. All international staff had a personal health briefing including a screening for COVID-19 risk factors, before being matched to different countries. We ensured regular check-ins with people in quarantine, or unable to travel because of lockdown measures, as well as with people who were ill. Despite severe disruptions and pressure on the international medical evacuation system, we found creative solutions to repatriate medically vulnerable international staff.

We reached out to people in leadership positions, who, while caring for others, might neglect to care for themselves. We organised webinars with tips on working from home and held regular information sessions. In Amsterdam, with the majority of staff at home, we sent office equipment such as chairs and computer screens to people's homes and sent weekly emails with office updates and news about COVID-19 and rules in the Netherlands. We conducted two wellbeing surveys in the Amsterdam office (in April and July) to understand how staff were coping with the pandemic, what their needs were and how we could support them. In the surveys, though staff indicated to be relatively comfortable with working from home, feeling disconnected was by far the biggest challenge people faced, followed by lack of appropriate workspace. We acted upon this through, amongst other things, increasing virtual social events.

1.2 Maintaining our medical humanitarian activities

From the beginning, we were concerned about 'knock-on' effects of COVID-19. We knew from experience, how the indirect impacts of outbreaks, such as interruptions to routine vaccinations, can be devastating. This is all the more so for health systems weakened by conflict and environmental change, and for people living in precarious conditions, such as in refugee camps. Alongside responses to the pandemic, we made every effort to keep essential services running, including opening new projects to address indirect impacts.

Adapted models of support, guidance and medical care
We refocused our attention to get operational, medical, and logistics COVID-19 guidelines and protocols to projects: we organised and moderated around 36 webinars with more than 800 participants. We developed specific COVID-19 guidance across every aspect of our medical humanitarian operations, from remote support for patients, to online mental health consultations; to installing water points in refugee camps; to identifying medically vulnerable patients. We integrated medical and personal protective equipment (PPE) guidance from the World Health Organisation (WHO) in our own guidelines. Within our clinical trials, such as TB PRACTECAL (see Section 4.2), working closely with investigators on the ground, we adapted research methods to ensure they were compliant with local measures and sought new ways to support patients, such as through video consultations. We found new approaches to support medical activities remotely, such as hosting webinars to train health workers on how to safely conduct mass drug administrations, or logistics teams on how they could continue to build hospitals. We developed online training sessions on critical incident response, providing remote support with security advice and coaching.

These adapted models of support were made possible by our Information and Communications Technology (ICT) efforts, which were almost entirely focused on adapting to COVID-19.

We were concerned that women and girls would be disproportionately impacted by the indirect effects of the COVID-19. We adapted our models of care for Sexual and Reproductive Health (SRH) activities including antenatal and postnatal care, safe abortion and contraceptive care. As OCA we led the development of MSF-wide programmatic guidance for reproductive health and sexual violence services during the pandemic.

We developed a COVID-19 specific assessment for our healthcare facilities. Ninety-four per cent of our inpatient facilities teams completed the questionnaire and responded to offers of follow up from infection prevention and control (IPC) advisors. The biggest needs identified were for improved cleaning and disinfection procedures; personal protective equipment (PPE) and hand hygiene gels; as well as trainings on implementation and best practice. IPC advisors focused on finding solutions and mentored project staff, helping people to understand and apply evolving COVID-19 guidance and advice, navigate supply challenges, and identify and address unsafe practices.

Of course, many projects were impacted. For example, treatment programmes and research for neglected tropical diseases (NTDs) such as kala azar, cutaneous leishmaniasis and snakebites were delayed or put on hold. This included a clinical trial to evaluate new snakebite treatments. In Nigeria, we had to defer planned reconstructive surgery for noma patients[4].

1.3 COVID-19 responses

In 2020, we opened 11 new COVID-19 specific projects, and adapted all our projects to respond to the impact of the pandemic[5].

We increased IPC measures and adapted models of care across our projects. We conducted trainings for healthcare staff; set up triage and patient flow systems and renovated and built COVID-19 isolation and treatment facilities. In Venezuela, we supported medical clinics in camps for returning migrant workers, in South Sudan we supported the Ministry of Health to conduct laboratory testing for COVID-19, in Afghanistan, Bangladesh, Iraq, Jordan, Syria, Venezuela and Yemen we set up and/or supported dedicated COVID-19 treatment facilities.

We worked closely with vulnerable communities, helping them to protect themselves through measures such as: improving access to water and hygiene, mass distributions of soap, masks and protective equipment, and through education and health promotion, including working with communities to build trust and overcome rumours and misinformation.

To better understand the pandemic's impact in our project locations, we conducted community-led assessments in more than ten projects. A multidisciplinary team including epidemiologists, anthropologists, humanitarian affairs officers, and health promoters, developed a qualitative research protocol and conducted interviews with community leaders and members. In the interviews we asked about people's perceptions of COVID-19 – seeking to understand which preventative measures would be most supported by their community. Each site conducted one to four rounds of conversations at different stages of the pandemic. Site teams tailored the topic guides and tools to explore a range of issues including perspectives on health, COVID-19 disease, and prevention and control measures. The results helped us to better align our interventions with people's needs. For example, in Nigeria, we increased the number of handwashing points, showers and latrines for displaced people in response to community requests. The same the community told us that temporary separation of families to 'shield' elderly members would not be acceptable for them and we respected this in our prevention planning.

4 For more information on these neglected diseases and our work see https://www.msf.org/neglected-diseases

5 For more information on the response across the MSF movement, see our global accountability reports, available at: www.msf.org/msf-and-coronavirus-covid-19-june-august-2020

A snapshot of some COVID-19 activities in our projects in 2020 - *(some activities have now closed or been adapted).*

In **South Sudan**, we provided technical support to the Ministry of Health, including with laboratory testing for COVID-19, installing water points across the capital Juba, and ran testing in our projects across the country including in the Bentiu Protection of Civilians camp, which is home to, at times, more than 120,000 internally displaced people. We treated the first confirmed COVID-19 case in Bentiu, in our facility inside the camp in May.

In **Venezuela**, together with our colleagues in Operational Centre Barcelona, we set up a COVID-19 centre inside a major hospital in the capital city, Caracas. The centre had 22 beds, including 16 inpatient beds and six intensive care beds. We operated three ambulances and rehabilitated five public ambulances to support the transport of patients between hospitals and testing centres. We provided financial support to help hospital employees continue their work and screened around 3,500 people for COVID-19.

In northeast **Syria**, around 700,000 displaced people are almost entirely dependent on humanitarian assistance; we supported the only dedicated COVID-19 hospital of the region, helped renovate a 48-bed isolation ward and provided region-wide training. In Al Hol camp, where more than 65,000 people (mostly women and children) are held, our teams identified 1,900 people living with non-communicable diseases such as diabetes, or heart conditions, and provided them with medicines, soap and other essential items.

In **Jordan**, we opened a 30-bed COVID-19 testing and treatment centre inside Zaatari camp, the largest refugee camp in the country, hosting around 76,000 Syrian refugees. Run in collaboration with the Ministry of Health, local authorities, UNHCR and others, the centre provides medical care to people with mild or moderate COVID-19 symptoms, with critical patients referred to Ministry of Health hospitals.

In **Bangladesh**, early predictions of the impact of COVID-19 on the nearly 900,000 Rohingya refugees living in refugee camps in Cox's Bazar district, were catastrophic. We built isolation wards and dedicated treatment centres, and together with other MSF operational centres, reached more than 130,000 families with door-to-door health promotion activities. Fortunately, although the first COVID-19 cases among the refugee population were confirmed in mid-May, case numbers have remained relatively low. However, we have observed serious secondary impacts of the sustained reduction in access to healthcare and preventative and community-based healthcare and social protection.

In **Malaysia**, in our projects working with Rohingya refugees, we provided health education and mental health support and donated food to vulnerable families. We carried out a survey with the community about their needs. Based on their advice we collaborated with R-vision, an online Rohingya-language media network, to make health education videos, on COVID-19 prevention, and mental health support. The videos reached tens of thousands of people in Malaysia, as well as in Myanmar and Bangladesh. We also advocated against measures requiring public health facilities to report irregular migrants, including refugees and asylum seekers.

In Central Asia, in **Uzbekistan**, **Tajikistan** and **Belarus** we developed tailored health promotion materials and campaigns on COVID-19 prevention and awareness for tuberculosis (TB) patients, supported national ministries of health with care for patients co-infected with COVID-19 and TB, donated PPE and helped establish triage protocols and patient flow systems in hospitals. In **Russia**, we donated PPE and food parcels as part of our TB outreach work and converted a TB dispensary to a COVID-19 testing site.

Response in Europe
Given the unprecedented toll the pandemic took across Europe, MSF colleagues in different European countries, including Belgium, Italy, France, Spain and Switzerland supported the treatment of COVID-19 patients in hospitals and health centres; supported shielding and isolation capacities in nursing care homes, and worked with vulnerable groups such as migrants, refugees, the homeless and prisoners.

In the Netherlands, we advised medical facilities on means to help keep their staff psychologically healthy. Drawing on our operational experience, our activities included: individual and group psychosocial support and coaching for medical staff working in intensive care units and COVID-19 wards, as well as guidance to managers responsible for implementing staff health measures. We also connected experienced MSF staff to medical facilities and nursing homes and provided technical advice to a migrant reception centre on IPC and person-flow measures.

OCA's partner sections also supported responses at home. MSF-UK partnered with a major hospital to care for homeless people in London, converting a hotel into a COVID-19 care facility; and provided support to St. John ambulance. MSF-Germany supported health education and mental health support in response to a COVID-19 outbreak in a refugee reception centre. Our work in the Netherlands, and across Europe, shows how our knowledge and experience in medical emergencies and outbreak response, can also be of great value in high-resource settings, with advanced healthcare systems.

1.4 Addressing challenges and issues in movement of supply and staff

1.4.1 Supply issues

From March, we faced major challenges in procuring, supplying and shipping essential supplies, including masks, gowns and gloves as well as medicines and medical equipment. Global production, supply chains and distribution systems were disrupted on an unprecedented scale. Several countries, including EU member states, started to restrict exports of PPE. In the Netherlands, we re-established relationships with Dutch government bodies, who provided significant support to enable us to carry out our lifesaving operations. In mid-March, thanks to MSF advocacy, the EU added waivers for essential medical goods and humanitarian aid shipments to its export restrictions.

At the MSF-movement level we created an international procurement taskforce to coordinate our efforts. Through this we collaborated to monitor project requests and stock levels; evaluate procurement opportunities and source essential items. Highlights included multiple charter flights, such as those organised through the UN and EU[6], to deliver essential medical equipment and staff to projects in Central African Republic (CAR), Democratic Republic of Congo (DRC), Nigeria, Syria and Yemen. For example, in Syria, after several weeks of negotiating and planning, we were able to fly 46 tonnes of medical supplies and 15 staff into Erbil (Iraq), who then reached Syria by truck.

Within MSF-Holland and OCA, we established a multi-department supply support cell to address critical shortages in stock. With critical delays in our Amsterdam procurement, in combination with COVID-19 restrictions, we experienced further difficulties that threatened our ability to continue with our operations. The supply support cell focused on ensuring support to our programmes most affected by shortages. Pharmacists worked particularly hard to explore local-purchase options, while finding a balance with adhering to our procurement policy.

1.4.2 Staff movements

Meanwhile, as international travel came to a near-standstill, we faced significant challenges in moving staff. In several countries we had to mitigate large-scale staff shortages, including in countries with substantial need such as Bangladesh, Nigeria, and Yemen. In Bangladesh, for example, around one third of MSF's international staff were outside the country and unable to return when borders closed. In addition, 71 of our Bangladeshi clinical staff left to join a government recruitment drive for nurses and doctors, and many international staff with heightened vulnerability to COVID-19 were repatriated. We also faced shortages as previously eligible health professionals were considered high risk for COVID-19;

6 Through the European Commission Humanitarian Aid Office (ECHO)

some others stayed in their home countries to support national responses

We strived to find solutions to get international staff into project locations where they were most needed, while maintaining duty-of-care – including repatriating those who were medically vulnerable. Some international staff extended the length of their assignments to support gaps. We secured places on humanitarian charter flights. We sought support from customs and immigration departments in the Netherlands, who were very helpful in facilitating transit through Amsterdam of colleagues flying to projects, despite the restrictions. We also successfully negotiated to get staff into project locations by having them join the outbound portions of repatriation flights, organised by different government agencies. Many staff started assignments remotely, while waiting for opportunities to travel.

In 2020:
- Average international staff assignment duration increased, from 7.1 to 9.7 months;
- 860 international staff departed on assignment, including pre-pandemic (in 2019, the total number was 1306).

We also took steps to move more locally hired staff into more senior roles, previously held by international staff.

Future approaches
Despite the challenges, we did not have to permanently close any of projects because of COVID-19. The adapted models we developed also provide a foundation for improved support for existing and future projects. Though these changes were borne from COVID-19, they have evolved into an opportunity: in adapting our ways of working to become more localised, moving events and trainings to an online environment (rather than flying staff to training centres), we found that our organisation and information became more equitably accessible to all staff. Many of these shifts in models of working had been long-awaited. This will be elaborated on in Section 5.

The impact of climate change and environmental degradation on health is an area of strategic focus for us. The negative health consequences of the climate crisis disproportionately affect people living in precarious situations. We expect our work to include more climate change disaster interventions in the future, for example in flood-prone areas and responding to climate refugees. At the same time, we must take our share of responsibility to reduce our carbon footprint. Though some strategy and policy discussions had already moved online towards achieving this, such as the financial coordinator annual meetings in 2019, COVID-19 also helped to reduce our carbon footprint. This was mainly due to the aforementioned transition of events and trainings to an online environment. In addition, we made efforts to minimise our carbon footprint by closing floors of our Amsterdam office that were not in use because of the reduced staff presence.

1.5 COVID-19 advocacy and communications

Témoignage (witnessing) is a core MSF principle – one that goes hand-in-hand with our medical operations. As COVID-19 took hold we sought to better understand and address the impact of the pandemic on the communities we seek to assist. As well as our work in the Netherlands (see Section 9), we advocated alongside our patients and the communities we seek to serve at local, national, regional and global levels. We coached and supported our project-based advocacy and communications teams, for example to: adapt witnessing and monitoring tools to document impacts of COVID-19; and support content gathering through online trainings with professional videographers and photographers.

Knock-on effects
A priority was to draw attention to the need to be aware of, and mitigate, the knock-on effects of COVID-19. We highlighted and advocated for equitable access to services for vulnerable groups across the world. For example, we highlighted the importance of tackling a measles epidemic in Central African Republic (CAR), Chad and Democratic Republic of Congo (DRC), and published articles on the impact of COVID-19 and TB patients. In Bangladesh, we showed how COVID-19 related restrictions has increased stress on Rohingya refugee communities, with particularly damaging impacts on their mental health and coping mechanisms. In Syria we highlighted impacts of increased restrictions and forced closures of healthcare facilities as COVID-19 infection rates soared amongst health staff. In January

2021, we released the first part of a multimedia series bringing together stories from patients, staff and affected communities about their experiences of the knock-on impacts, from CAR to France to Venezuela[7].

Global solidarity needed, the call for fair and equitable division of resources

Together with the MSF Access Campaign[8], we consistently called for global solidarity in a global crisis, focused on ensuring enhanced production and equitable access to COVID-19 treatments or vaccines. We have brought global attention to attempts to profiteer from the pandemic, and supported calls to suspend and override patents and other intellectual property. We have backed landmark waivers to ensure no patents on COVID-19 related medical products, and the call for fair and equitable vaccine distribution, the right vaccines, at the right time at the right price.

Pandemic used as excuse to control movement of migrants and refugees

We witnessed the increase of restrictive measures and marginalisation of vulnerable communities, as a result of COVID-19. Among them are the world's almost 80 million forcibly displaced people – refugees, asylum seekers, internally displaced people (IDPs) and migrants. We saw discriminatory and disproportionate actions by governments, including European member states, calling for an end to civilian search-and-rescue, or closing their ports to people. The use of the pandemic to enforce containment policies, coupled with ongoing measures preventing humanitarian work at sea, led to the end of our search-and-rescue partnership with SOS-MEDITERRANEE.[9] We returned to sea in August (see Section 2.1), publishing a briefing paper on the impact of COVID-19 on search and rescue efforts.[10] We advocated with governments not to use COVID-19 as an excuse to enforce further restrictive migration control policies and evade international obligations towards refugees, asylum seekers and migrants. In Malaysia, we offered to further support the government in COVID-19 management, including for new arrivals into the country after the authorities refused entry to a boat of Rohingya refugees[11], citing COVID-19 concerns. We urged that COVID-19 should not come at the expense of humanitarian obligations and advocated against immigration raids at COVID-19 testing centres.

Going forward

In 2021 the world remains in the grip of COVID-19. In many countries an initial emergency response has turned into a sustained effort to contain recurring waves of infection and the development of new strains, putting relentless pressure on healthcare systems, economies, and social life. Safe and effective vaccines now exist, but for the vast majority of people they are not yet available – and may not be for a long time. Often, the people who fall through the cracks in the system when it comes to preventive measures and access to healthcare, are the same people who will again fall through the cracks for vaccination. We will support our projects to identify and advocate on behalf of these groups, in the different places where we work.

We remain committed to addressing the direct and indirect impacts of COVID-19, through our humanitarian and medical operations and through our témoignage. As MSF we know how outbreaks of infectious disease do not affect everyone equally, but now we see this on a global scale. Among those disproportionately affected are neglected and marginalised groups: people we seek to assist wherever we are in the world. We will continue to amplify the voices of these communities and provide them with all possible medical care.

7 https://www.msf.org/covid19-knockoneffect

8 https://msfaccess.org/

9 https://www.msf.org/eu-states-use-covid-19-shirk-search-and-rescue-obligations

10 https://www.msf.org/msf-returns-mediterranean-search-and-rescue-operations-sea-watch

11 https://www.msf.org/msf-ready-support-malaysia-safe-disembarkation-people-sea

2 Our medical humanitarian work in 2020 (non-COVID-19)

© Valérie Batselaere/MSF

In 2020, we implemented 115 projects in 31 countries, of which:
93 were already running at the start of 2020;
27 were opened, of which 11 were new COVID-19 specific intervention projects;
37 were responding to acute emergencies (including ongoing projects;
24 projects were closed;
12 projects were opened and closed within the year 2020.

In numbers, OCA medical figures 2020
2,629,534 outpatient consultations
148,923 inpatient admissions*
829,046 patients treated for malaria
49,974 patients treated for malnutrition
2,468 patients treated for cholera or acute watery diarrhoea
13,722 major surgeries conducted
79,846 babies delivered
35,530 people given psychosocial care support
157,905 measles vaccinations administered**
616 new multidrug-resistant TB patients started on treatment
9,537 COVID-19 cases registered
56,886,549 litres of clean water provided

* excludes inpatient therapeutic feeding centres and neonatology

**(as part of both routine vaccination programmes and outbreak response)

▲ Surgeons Edwin Kosgei and Zacarias Asuncion perform a caesarian section to remove the patient's baby who died in utero before term. Agok, South Sudan.

2.1 Medical humanitarian operations in 2020

In addition to the COVID-19 project information provided in Section 1, below is a snapshot of our operations, to illustrate some key moments in 2020. Please note that each text focuses on a specific project (or two) in different countries and should not be seen as a comprehensive overview of our activities in those locations.

Syria
Following the tumultuous end to 2019, when extreme volatility led us to withdraw international staff and close most of our projects, while supporting Syrian staff remotely[12] we re-established our presence in northeast Syria delivering medical care to displaced and conflict-affected people. Despite ongoing conflict, MSF continued to provide support to displaced people and supported the local health authorities with their COVID-19 response (see Section 1.3). We also reopened our medical clinics in Al Hol camp, which continues to be a site of humanitarian need with harsh conditions and limited access to essential services for the mostly women and children living there.

Yemen
In late 2019, we launched new medical activities in Marib governorate, where nearly 2.7 million people are gathered in displaced persons camps. Formerly a safe haven, in 2020, Marib became a major battleground in the long-running conflict. We provided primary healthcare to vulnerable people in the area, while also responding to COVID-19 in Sanaa, the capital city. In Taiz governorate in the southwest, active frontlines and restricted movements over many years, have increased the vulnerability of patients on all sides. We continued to provide healthcare on both sides of the frontline.

Belarus
In Belarus, large-scale political demonstrations faced a violent response from the government. When the first of an ongoing series of protests started in May, our project team adapted programming to ensure we were prepared to respond to any emerging medical needs. Our assessment found gaps in mental health services, and through collaboration with the Ministry of Health, we have provided training on psychological first-aid and first-aid response, donated essential medicines and first aid kits to hospitals, and supported the rollout of the WHO's "mental health GAP initiative" which aims to increase services for mental, neurological and substance use disorders, particularly in low- and middle-income countries.

Nagorno-Karabakh
Nagorno-Karabakh is a self-proclaimed republic, internationally recognised as belonging to Azerbaijan but home to many ethnic Armenians. In September, conflict over the disputed territory was re-ignited for the first time in more than a decade. We sent a rapid assessment team to negotiate access, identify humanitarian and medical needs and prepare to respond to acute gaps. Despite the intense fighting, we did not find acute gaps or major unmet needs, although we did provide some short-term support to one of the hospitals. In addition, we identified some gaps in mental health support, which were supported by our colleagues in MSF Operational Centre Paris.

Democratic Republic of Congo
Security in the eastern Democratic Republic of Congo (DRC), an area that has been affected by conflict for decades, has deteriorated in recent years. In 2020, we were targeted multiple times, including the kidnapping of eight staff in three separate incidents. Although we are deeply relieved that all staff were released physically unharmed, there were long-term consequences. The frequency and severity of the incidents forced us to re-examine our exposure to risk, and ultimately to take the very difficult decision to end two projects, in Baraka and Kimbi[13]. Doing so was particularly painful as we have a long history in eastern DRC and were keenly aware of what an important lifeline our healthcare services provided. In 2021, we will explore alternative ways to assist them. Doing so, however, requires that we can guarantee minimum standards of safety for our staff.

Nigeria
Last year we reported that our programming in Nigeria would be re-orienting in 2021, to be able to increase our support to people affected by violence. While most international attention remains focused on the northeast[14], recent years have seen increasing violence in the northwest and the middle belt states – leading to mass displacement and insecurity. In addition, the Nigerian economy has been hard hit by COVID-19 and

12 www.msf.org/northeast-syria-msf-forced-evacuate-staff-due-extreme-volatility-region
13 https://www.msf.org/msf-forced-pull-out-eastern-drc-territory-following-violent-attacks
14 Our colleagues from other MSF operational centres are active in the northeast

increasing numbers of people have struggled to access basic necessities, including enough food. In 2020, we continued to support displaced communities in Zamfara (northwest) and Benue (middle belt) states, including with primary healthcare, building shelters as well as with COVID-19 health promotion, the distribution of hygiene kits and installation of water points. In 2021, the Benue project will transition to focus on the provision of sexual and reproductive healthcare services.

Central African Republic
Thousands of people have been killed or wounded and millions displaced during years of largely neglected conflict in Central African Republic (CAR). In 2020, we continued to provide primary healthcare and sexual and reproductive healthcare. In March and April, we conducted a mortality survey in Ouaka prefecture in central CAR. The results showed a high crude mortality rate, of 1.34 deaths per 10,000 people per day; far exceeding the emergency threshold of 1 death/10,000/day. It is also higher than other recent estimates for Ouaka, and approximately four times the UN's nationwide estimate of 0.34 deaths/10,000/day, across CAR.[15]. In August, we overcame COVID-19 related challenges to carry out a mass drug administration (MDA) for malaria in Bossangoa. The administration took place in three cycles, with 4-5-week intervals, starting in August and ending in November. It reached 46,000 children under 15 years-of-age, with drugs to help interrupt transmission and reduce incidence and death. As 2020 drew to a close, we saw renewed violence around national elections. We treated wounded patients arriving at our hospitals and set up emergency referrals between hospitals in and around the areas of Bambari and Bossangoa. Tragically, an MSF staff member was killed in an attack on a bus, as he travelled home from work.

Tigray crisis: Ethiopia
On 4 November, Ethiopia's Prime Minister ordered military action against the Tigray People's Liberation Front (TPLF), following an attack on an Ethiopian military base. This led to heavy fighting close to our project in Abdurafi near the Tigray border, which is usually focused on treating kala azar and snakebites. On 5 November, our team started supporting the Ministry of Health-run health centre in Midre Genet. In one week, we treated 265 casualties, including severely wounded patients. As the conflict escalated we deployed an emergency team to the Tigray region to try to negotiate access into the closed-off area. The UN estimates that 2.3 million people inside Tigray, are in need of assistance. In December, our emergency team was finally granted limited access, and we witnessed massive unmet needs – malnutrition was a major concern. With most areas out of reach, we were particularly worried about the hundreds of thousands of people cut off from any assistance.

Tigray crisis: Sudan
An estimated 50,000 people fled Tigray into Sudan, where after a 12-year absence MSF-Holland had returned in 2020. On 16 November we arrived in Hamdayet, where thousands of people were crossing the river that separates Ethiopia from Sudan. As a first response, we set up a clinic at the border crossing point, provided clean water and screened people's nutrition status. The clinic carried out around 300 consultations a day, the majority for respiratory infections, malaria or diarrhoea. At the same time, we started to support refugee camps where in these first weeks there was massive overcrowding, shortages of water, food and shelter, and poor sanitary conditions. Responding to conflict-affected and displaced communities in Ethiopia and Sudan will continue to be a priority in 2021.

South Sudan
In South Sudan, repeated cycles of intercommunal fighting in Jonglei state, sometimes lasting many months, intensified throughout 2020. In March, we received 68 wounded patients in 12 hours in our clinic in Pieri. Tragically, in May, we lost one of our staff, who was killed as he fled fighting – two more staff members were injured. In the summer as violence again erupted and we treated more than 100 people in one week – evacuating dozens of patients to our hospital in Bentiu for urgent surgery. Floods have displaced hundreds of thousands of people and left many more without reliable access to food or clean water.

Search and rescue
In 2020, we continued our efforts to assist people at risk of drowning in the central Mediterranean Sea. However, as efforts to criminalise civilian search-and-rescue continued, we faced countless obstacles. One particularly unfortunate consequence was the end of our partnership with SOS MEDITERANEE (see Section 1.5). In August, we entered a temporary partnership with the NGO Sea-Watch. In our first, and only, rotation we assisted 354 people in a series of rescues and transfers, having to wait 11 days for a port of safety. Upon arrival in Italy, the Sea-Watch 4 was detained – the fifth NGO search and rescue vessel in five months (it was released following a successful appeal by Sea-Watch in February 2021 as an administrative court ruled that its detainment was unlawful). In 2020, at least 983 people lost their lives in the central Mediterranean and nearly 12,000 were intercepted at sea and returned to Libya.

15 The UN estimate is a projection of reported data, while ours was designed to measure the CMR based on a door-to-door survey of all, not only selected, households, across the prefecture. Our study design included questions carefully constructed to reduce bias (mortality-targeted short questionnaire, recall period to identify seasonal variations). We believe the true mortality in the region has been underestimated.

2.2 Our medical approach

2.2.1 Person-centred care & primary healthcare

We strive to provide the best possible care for the people we assist, wherever they are. Doing this requires us to continuously learn, adapt and improve. In 2020, alongside our work responding to COVID-19, we focused on further developing and implementing inclusive strategies to deliver quality person-centred care (PCC).

The idea behind person-centred care (PCC) is that healthcare services are attuned to the needs, values and preferences of individuals and communities. In taking a PCC approach, we strive to implement an inclusive approach that ensures that the people and communities we assist are active participants in their healthcare choices. Integrating PCC into all our medical activities is a strategic objective, and in June we recruited a Health Programming Advisor dedicated to developing our PCC strategy. This focuses on building skills and systems to help embed a PCC lens into all aspects of our health activities, including mapping existing initiatives within MSF to pool PCC programming efforts where possible, such as in COVID-19 responses. In 2021, we will further develop our PCC strategy, with adapted PCC models being introduced in projects in Chad, Malaysia, Myanmar, Sierra Leone, Syria, and Yemen.

Ensuring high-quality primary healthcare[16] (PHC) is a strategic ambition closely linked to PCC. Everyday, we see the critical role PHC can play in reducing the burden of disease and avoiding unnecessary deaths. We have provided PHC in our projects since we were founded; today it is a mainstay of our programming. As we continuously seek to improve our medical care, it is critical that we assess our PHC programming and work with communities to understand whether our approach still aligns to their needs. Through this we aim to better equip our project teams to address the complex and varied primary health needs of different communities. In 2020, we identified Jebel Marra, Sudan as a pilot site for the implementation of a project focused on ensuring high quality, context-adapted and person-centred approaches to our PHC programming. In 2021, we will evaluate the project to better understand which components positively or negatively influenced the delivery of PHC. The findings will contribute to our efforts to develop contextually adapted, inclusive, person-centred PHC across our projects.

16 Primary healthcare (PHC) is the first level of contact, outside of emergency care, that individuals, their families and communities have with health systems. It encompasses health promotion, preventive, curative and rehabilitative services, with comprehensive approaches to address individuals and communities' physical and mental health needs.

2.3 Medical research

Carrying out research of our medical work, including topics that are often neglected in academic research and public health policy, is an increasingly important part of our work. All operational research protocols are reviewed by an ethics review board (ERB)[17]. In 2020, the ERB reviewed 29 OCA protocols – eight related to COVID-19 and classed as urgent, required expedited review an overview of our medical research can be found in table 1.

Table 1: Medical research

Publications	In 2020, we had 43 papers published across 28 peer-reviewed journals, including The Lancet Infectious Diseases, The Lancet Global Health, British Medical Journal (BMJ), Journal of American Medical Association, (JAMA), Vaccine, Conflict and Health, PLOS NTDs, Water Research.
Conferences	European Scientific Conference on Applied Infectious Disease Epidemiology ESCAIDE 2020 WHO Technical Meeting on Antimicrobial Stewardship, 2020 International AIDS Conference 2020
MSF Scientific Days	MSF Scientific Days presents innovation and research from our global programmes. The 'conference without borders' brings together researchers, practitioners, academics and patient representatives from across the world. In 2020, MSF Scientific Days were fully virtual (instead of being held in the UK), with connected regional events in Asia, southern Africa, and Latin America. Four OCA abstracts were selected for presentation at Scientific Days 2020. One, on screening for sleeping sickness, was presented live from the project, in the DRC[18]. We have submitted 15 research abstracts to Scientific Days 2021.
Research Impact	

- Improved detection and treatment algorithms in MSF kala azar programmes across east Africa
- Sodium stibogluconate plus paromomycin combination therapy replaced sodium stibogluconate monotherapy for post-kala azar dermal leishmaniasis, based on evidence from an MSF retrospective cohort study in South Sudan, that showed combination therapy to result in more favourable outcomes, lower costs, and shorter treatment duration than monotherapy[19]
- Development of a new severity scoring system to predict death in kala azar patients, based on evidence from a retrospective cohort study, Ethiopia[20]

17 The MSF-ERB comprises a diverse group of professionals from across the world, with an understanding of humanitarian and NGO realities. The members of the Board do not have a working relationship with MSF to avoid conflict of interest and ensure independence. For more information, see: https://www.msf.org/msf-ethics-review-Board

18 https://f1000research.com/videos/9-932

19 https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0163047

20 https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0178996

2.3.1 Environmental health

From sourcing and delivering clean drinking water, to constructing latrines, to hygiene promotion and appropriate medical waste disposal, environmental health is core to emergency response. In addition to meeting basic survival needs, our water and sanitation activities are essential to prevent and control water-borne diseases, such as cholera.

Over many years, we have built significant expertise in this area, through our responses in some of the world's most complex emergency settings. In 2020, in addition to our work supporting COVID-19 responses, we continued to contribute to research and policy and to invest in innovation, training and tools. Much of this work was carried out in collaboration with other NGOs and academic institutes. An overview can be found in table 2. This included continued work to develop a faecal sludge management plant for the world's biggest refugee camp in Bangladesh, in collaboration with IHE Delft Institute and Oxfam; and supporting the development of training content for the Graduate Professional Diploma Programme for Humanitarian WASH, at IHE Delft, in collaboration with the WASH cluster consortium. In addition, we published research and piloted innovative tools, developed in partnership (outlined under 'research impact' below).

Table 2: Environmental health research and impact

Publications	Loonen, J.A.C.M., Dery, D.B., Musaka, B.Z. et al. (2020) Identification of main malaria vectors and their insecticide resistance profile in internally displaced and indigenous communities in Eastern Democratic Republic of the Congo (DRC). Malar J 19, 425 [21]. Ali, S. I., Ali, S. S., & Fesselet, J. F. (2021). Evidence-based chlorination targets for household water safety in humanitarian settings: Recommendations from a multi-site study in refugee camps in South Sudan, Jordan, and Rwanda. Water Research, 189, 116642. [22]
Conferences	Water and Health Conference 2020, University of North Carolina, USA Oral presentation: Safe Water Optimization Tool: Water Quality Data Analytics for Ensuring Household Water Safety in Refugee Camps and Other Humanitarian Settings

Research impact

- Piloted the Safe Water Optimization Tool (SWOT) developed in collaboration with York University, in camp settings in Bangladesh and Nigeria. The SWOT helps responders to measure optimal water chlorination levels in different settings[23]. Following a successful pilot, we have expanded its use in Nigeria, and are preparing to use it in Syria and Sudan in 2021.
- Piloted the digital Drillers' Toolbox, to support groundwater development for field workers, consisting of a smartphone app and online dashboard, developed in collaboration with the PRACTICA Foundation and Groundwater Relief.[24]

Medical entomology, in collaboration Wageningen University
- Developed a tool for indoor residual spraying of health structures, to prevent the spread of malaria through mosquitoes; and a tool for insecticide and mosquito net monitoring, using power BI;
- Piloted a test to detect antibodies in mosquitoes fed on human blood.

Impact on policy
- The WHO updated its recommendations for the containment and disinfection of human excreta in cholera treatment centres, based on an MSF study comparing the efficacy of chlorine-based approaches (at different concentrations) and one hydrated lime-based approach [25].

21 https://doi.org/10.1186/s12936-020-03497-x

22 https://doi.org/10.1016/j.watres.2020.116642

23 In addition, 50 external organisations have registered interest in using the SWOT on the website. For more information visit: https://www.safeh2o.app/

24 The Digital Toolbox is available for download on PRACTICA's website: https://www.practica.org/digital-tools-for-groundwater-development/

25 https://www.mdpi.com/2073-4441/11/2/188/htm

2.4 Medical incidents

Reporting medical incidents is a patient safety priority for MSF. Reporting on medical incidents enhances transparency and helps us improve our medical practices. In 2020, fifteen of our projects identified and reported at least one medical incident. In total, 61 incidents were reported, a number more or less consistent with previous years. Nearly half of the patients affected by medical incidents were children, from newborns to 14-years-old.

Of the reported incidents in 2020, 62 per cent were of a serious incident, in which there was a harmful event to a patient or death (and the incident was believed to have contributed directly or indirectly). This reflects historic reporting practices. However, underreporting of all, including less severe, medical incidents remains an issue. Targets for 2021 are that 100 per cent of our projects submit at least one incident report. Ongoing awareness building and staff education activities will continue in 2021.

Many reported incidents occurred in inpatient paediatrics (22%), maternity (19%), or surgical services (19%). The most frequent underlying causes were improper clinical decision-making (39%), incomplete, missing, or inappropriate documentation (26%), inadequate monitoring (20%), and treatment errors (19%).

3 Logistics

3.1 Supply

In addition to the challenges presented by COVID-19, our projects also faced acute supply issues because of a backlog dating back to 2019, outlined in last year's report[26] . Our programmes experienced several shortages of critical stock, exacerbated by COVID-19. Overall, the impact of the supply problems we faced in OCA in late 2019 and well into 2020, included programmatic disruptions and impacts on our ability to deliver care. We failed in our obligations to supply our projects adequately. Consequences included: increased referrals for lab tests we would normally conduct inside our own facilities; a delayed measles vaccination campaign; stricter treatment protocols due to limited availability of snakebite antivenom; reduced testing and treatment for malaria; threats of interruption for antiretroviral treatment for HIV patients; and delays in starting new activities. Projects that faced shortages, such as those in DRC North Kivu, Nigeria, and South Sudan, worked hard to procure essential drugs and items locally, or to borrow them (for example, from other MSF entities or WHO). For some countries such as Yemen and CAR, we were able to find alternative supply lines with other MSF supply centres.

In 2020, after months of planning and preparation, we switched to a new logistics service provider (LSP) identified in 2019. Although in the long-term the move will enhance our ability to meet our operational goals, the transition and implementation in June 2020 brought additional challenges. These had the unfortunate consequence of adding to our supply backlog. As we moved our warehouse, significant weaknesses, built over many years, in systems management and processes of our former LSP, as well as our internal processes became apparent. As a result, in 2020, we had to write-off stock, as a one-off, worth an estimated €1.2 million that cannot be reclaimed. The full transition to the new LSP was completed in January 2021. With this move and additional mitigation measures now in place, we anticipate that our supply chain will be fully recovered by mid-2021.

In the second half of 2020, we carried out an internal audit of our supply issues, encountered in the second half of 2019 and continuing into 2020. The objective was to identify the root causes of problems in supply which impact our work. The report was completed at the end of the year. This is further elaborated on in Section 10. Once

26 https://www.artsenzondergrenzen.nl/over-ons/jaarverslag-en-jaarrekening/

▲ MSF staff checking the loading of the medical supplies at Maastricht Airport, The Netherlands.

we have be able to restore the normal operations we expect more comprehensive investments in systems, procedure, and staff capacity, to be necessary.

Construction
In addition to COVID-19 specific support activities, we continued building work on a multidrug resistant-TB hospital in Kandahar, Afghanistan. When complete, the hospital will have 24 isolation rooms with their own bathrooms and eight consulting rooms, and will include facilities from a laboratory to logistical offices. The centre has its own decentralised waste water treatment system and will be powered with 175 kWp hybrid solar system. It is the largest construction project we have undertaken in two years, in a country affected by ongoing conflict and insecurity. Although progress was slowed – by transport-related supply difficulties, on top of already tight security measures; as well as additional COVID-19 measures such as physical distancing and temperature checks – we made good progress and expect to complete construction by the end of April 2021.

Advanced security and safety management
We also substantially developed and improved operational advice and organisational competencies in applied security and safety management (ASSM). The objective of this work is to promote a security culture that can enhance our operational reach, increase communities' access to healthcare, and allow for high quality medical humanitarian programmes.

In 2020, we:

- Developed a new fire safety policy for healthcare facilities;
- Developed a new risk analysis tool and checklist for air operations;
- Updated our standard operating procedures for site and movement security;
- Enhanced our field digital security policy.

In addition to our work on ASSM, we continued to develop essential guidance and tools linked to safety and security, including updating our guidelines for closing projects, and evacuation procedures.

4.1 Humanitarian affairs, advocacy and communications

Igniting change and enabling action through our témoignage, our reporting on what we witness is core to our social mission and our operations. We draw attention to crises and abuses, based on our medical humanitarian action, and advocate for changes to policy. In 2020, in addition to, and often linked to, our COVID-19 advocacy and communications (see Section 1.5), we continued to expose and counter discourse and policies that may result in dehumanising people. We did this at project, country, regional and global levels, often working together with other MSF operational centres and sections, and in collaboration with like-minded organisations.

Countering discriminatory policies
We sought to counter discourses which criminalise people and those who seek to assist them, and to influence policies that undermine humanitarian action. In the Netherlands, together with like-minded organisations we took action to oppose a draft annex to a law that criminalises humanitarian action. For more on this, see Section 9. We advocated for the rights and dignity of people on the move, people in containment and systematically excluded groups, based on our proximity to them. This included drawing attention to plight of people held in Al Hol camp in northeast Syria; or in detention in Libya; or trapped in Bangladesh. We highlighted the consequences of ongoing violence in South Sudan, and published a report detailing a neglected healthcare crisis in Afghanistan.

We found creative ways to draw attention to neglected crises, such as collaboration with a celebrated artist for a 'rotoscope' animation, Give Me Hope, first released in March[27]. The award-winning animation seeks to evoke the experience of Rohingya refugees and help viewers grasp the human cost of their displacement.

Search and rescue
In addition to highlighting the instrumentalisation of COVID-19 measures to block search-and-rescue efforts (see Section 1.5), we continued to advocate for the needs and basic rights of people on the move attempting to cross the Central Mediterranean Sea. In collaboration with key MSF sections and representatives, we brought our messages forward in European capitals at EU level and with relevant international actors. We produced impactful communications, including a video of a rescued man, Souleman, delivering his personal message to Europe[28]. We commissioned an internal review of our experience with search-and-rescue in the five-year period between 2015 and 2020. The report reviewed the

27 https://msf.org.uk/video/give-me-hope-rohingya-crisis
28 https://msf.org.uk/video/search-rescue-message-to-europe

▲ Midwife Marina takes the temperature of people on deck of the Sea-Watch 4.

impact of the dramatically changed political context – including increasing hostility towards search-and-rescue activities – on our operations and advocacy, taking stock of our operational impact and analysing the current context. The report's recommendations are helping to guide our next steps in saving lives at sea and exposing the consequences of deadly migration policies and harmful state practices.

Understanding and responding to mis- and disinformation
The COVID pandemic has fuelled an 'infodemic' of mis- and disinformation. Health misinformation poses a significant risk to people's trust in MSF's medical activities, and to their health-seeking behaviour. States and interest groups are increasingly using disinformation to push their narrative and discredit those who challenge them. In 2020, OCA launched an initiative to better monitor and understand the impact of, and our responses to, mis- and disinformation in MSF projects, across the movement.

A tool and methodology to gather, verify and analyse rumours and misinformation at field level is being piloted in Tajikistan and Somalia at the end of 2020, with plans for further roll out in 2021. Resources to facilitate the management of disinformation have been created, including a logbook, workflow and threat assessment, and training and simulation exercises for MSF staff worldwide. Together with other NGOs, academics and researchers we are increasing our engagement strategy with big tech, such as Facebook who play an instrumental role in the spread of mis- and disinformation. In 2021, we will continue with this work and further build and integrate knowledge and understanding within MSF.

Going forward
In 2021, our ongoing advocacy and communications efforts will include continuing to counter criminalisation discourses and advocating for independent humanitarian action. In May, as UN Security Council Resolution 2286 (drafted with MSF and ICRC support) which condemns attacks on medical facilities and staff in conflict zones, turns five, we will host a series of debates and public communications on the impact we see of continued failures to protect humanitarian and medical workers in conflict. We will mark the 10-year anniversary of the Syrian conflict, including the hundreds of hospitals that have been bombed. As South Sudan turns 10, we will release a report detailing the medical humanitarian consequences of pervasive violence over the last decade.

4.2 Medical innovation and health policy

Neglected tropical diseases (NTDs)
We have been providing medical care for patients with neglected tropical diseases (NTDs) for more than 30 years. Our focus is on patients with "difficult-to-treat" diseases who are, as a result, often the most neglected. We link our patient care with operational research and advocacy, to identify new treatments and diagnostic tools and support efforts to reduce the incidence of NTDs. As outlined in Section 1, in 2020 many of our treatment and research activities were impacted by COVID-19. We invested in strategies for future work such as the integration of a simplified algorithm for the diagnosis and treatment of sleeping sickness, in our projects in endemic areas.

In January 2021, we published our report Overcoming Neglect[29], which provides an overview of our 30-year history treating NTDs, and advocates for action on NTDs. We had deferred publication to coincide with the launch of the new WHO NTD Roadmap 2021-2030 – which had been delayed by COVID-19; and updated its content to reflect the threat of COVID-19 on progress towards the control and elimination of NTDs. In 2021, we will also develop clinical diagnostic algorithms for integrated management of persistent fever syndromes, new treatments for visceral and cutaneous leishmaniasis and snakebites, and a new diagnostic tool for brucellosis.

Noma
Noma is a disease that mostly affects children living in poverty[30]. Without treatment, up to 90 per cent of people affected die in the first two weeks of infection. Survivors are left with severe facial disfigurements that make it hard to eat, speak, see or breathe. Noma is so neglected that it is not even recognised as an NTD by the WHO. Together with partners we are advocating to change this, including through carrying out research and organising events. In 2018, in collaboration with production company Inediz, we produced an award-winning documentary about noma survivors in Nigeria. In 2020, a new short-

29 https://www.msf.org/overcoming-neglect-report-ntds
30 For more information visit noma.msf.org

form version of the film was shortlisted at the WHO inaugural Health for All festival. In 2021, we will increase research on models of care and prevention for noma while continuing to advocate. This includes organising, together with the International Society for NTDs, a global virtual conference for the NTD community hosted in February 2021. The conference brought together nearly 1,000 participants from 94 countries.

TB-PRACTECAL trial

Tuberculosis (TB) is the world's deadliest infectious disease, claiming 1.4 million lives in 2019. Drug-resistant TB (DR-TB) occurs when the bacteria that cause TB do not respond to standard treatment. There are many forms of DR-TB, including multidrug-resistant TB (MDR-TB) which is resistant to the two most powerful first-line treatments. Until recently, treatment options for people with DR-TB took up to two years, included up to 14,600 pills and painful daily injections, often with side effects such as deafness and psychosis. Made possible by the Netherlands Postcode Lottery, TB-PRACTECAL is one of the most ambitious medical trials we have ever implemented. Its aim is to identify short, effective and tolerable treatments for MDR-TB patients. The trial started in 2017, and has sites in Uzbekistan, Belarus and South Africa, where trial participants are recruited at TB clinics, (where we provide free treatment for all patients, whether they join the trial or not).

Despite the challenges presented by COVID-19, we were able to avoid a prolonged disruption in all trial sites. While assuring staff safety, patient care and the integrity of the data, we successfully completed Stage 1 in 2020[31]. In this stage, trial participants were given a six-month course of one of three new combinations or new and/or repurposed TB medications, or the standard longer treatment. All three drug combinations proved to be safe and effective. One combination – of the antibiotics bedaquiline, pretomanid, linezolid, and moxifloxacin – looks particularly promising and we are taking it forward to Stage 2, where we will compare its effectiveness to the standard treatment and assess whether it's easier to adhere to.

During the development of this report, in March 2021, the trial's independent data safety and monitoring board indicated that the regimen being studied is superior to current care, and more patient data was extremely unlikely to change the outcome[32]. As a result, the trial was able to stop enrolling new patients. MSF is preparing a dataset to share with the WHO as soon as possible; with full results to be submitted to a peer reviewed journal later in 2021. TB-PRACTECAL will be the first ever multi-country, randomised, controlled clinical trial to report on the efficacy and safety of a six-month, all oral regimen for MDR-TB. If we are able to identify a safe and effective regimen we will drive change in WHO and national guidelines and advocate for all MDR-TB patients (MSF patients or not) to be treated with short all-oral regimens.

Antimicrobial resistance

Antimicrobial resistance (AMR), the development of resistance to antimicrobial drugs, is an increasing global health priority. Without action AMR risks undoing many of the advances on healthcare made in the last few decades, as common infections become harder, or even impossible, to treat. Our AMR approach aims to meet our patients' needs by addressing the underlying causes of resistance, while advocating for changes to national and global policies – to ensure stewardship[33] to promote responsible use, and sustainable access to lifesaving antibiotics for those who need them. In our projects, we are prioritising understanding and addressing AMR in our surgical and burns patients; patients with compromised immune systems, such as people with HIV and TB; children and malnourished patients.

In 2020, we worked together with the MSF Academy for Healthcare, a training programme for health workers in our projects worldwide[34] to conduct a feasibility study for a mentoring project for project staff. The focus is on building knowledge and expertise, particularly on best practice for IPC and antibiotic stewardship in hospital settings. The feasibility study was completed in September, leading to a successful submission for funding for the project, which was granted at the end of the year. The virtual course is designed to be flexible to different learning needs in diverse hospital settings, accounting for variations in e.g., IT facilities.

A significant challenge in tackling AMR is lack of data; in particular, in low- and middle-income settings. To support efforts to build a global evidence base, our hospital in Bentiu, South Sudan took part in the Global Point Prevalence Survey (GPPS)[35]. The GPPS surveys hospitals around the world over set time periods. Its aim

31 The project's three main sub-studies which are researching pharmacokinetics and pharmacodynamics; quality of life and patient-reported outcomes and assessing costs to patients and providers) were also implemented across 85 per cent of target sites.

32 MSF Press Release, 24 March,2021 Drug-resistant TB clinical trial ends enrolment early after positive initial data https://www.msf.org/drug-resistant-tuberculosis-trial-ends-enrolment-after-positive-initial-data

33 Antimicrobial stewardship refers to interventions designed to promote the optimal use of antibiotic treatments, including drug choice, dosing, route, and treatment duration.

34 https://www.msf.org/academy

35 https://www.global-pps.com/

is to provide quantifiable measures to support comparisons of the quantity and quality of antimicrobial prescribing and resistance in hospitalised adults, children and babies, including newborns. We plan to repeat the survey in Bentiu in 2021 and for additional projects to take part.

Sexual reproductive health and safe abortion care
In 2020, we completed the fourth and final year of our safe abortion taskforce. In this time we developed significant knowledge and tools, and our focus now is on integrating this into our regular programming. In addition to leading on internal guidance for sexual reproductive health (SRH) and sexual violence services during COVID-19 (see Section 1.2), we finalised a new strategy for the provision of SRH services. The strategy aims to reduce maternal mortality through holistic and person-centred approaches to SRH. This includes continued support for, and expansion of equitable access to, safe abortion care and contraceptive services. In addition, we developed strategies to improve and increase SRH programming tailored to the needs of different at-risk groups, such as adolescents. We will continue to prioritise and expand our safe abortion care into our SRH services in 2021 and beyond, as well as to improve inclusive access to care for survivors of sexual violence.

Nursing
COVID-19 underscored the importance of the nursing workforce, globally and in MSF. Our nurses are at forefront of our efforts to deliver compassionate care for our patients, wherever they are. We are committed to develop nurse leadership and improve the safety and quality of nursing care in our projects, through investing in professional development of nursing staff.

As well as the support we provided to our nurses for COVID-19 responses, we published a nursing training manual and carried out extensive training programmes for operating theatre nurses. We saw growth in nursing leadership at all levels of MSF, essential to ensure the voices of these essential workers are heard. In South Sudan, in 2020, we saw that we had more than doubled the percentage of qualified nurses in our projects, since 2017 (from 17 to 36 per cent). This includes increased opportunities for locally recruited staff, with five nurse activity managers and one head nurse locally recruited in 2020. MSF nurses also contributed to publications by the International Council of Nursing and WHO, further amplifying the knowledge and experience of our nurses worldwide.

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5 Diversity, equity and inclusion

Diversity efforts within MSF are focused on ensuring fair representation of the rich mix of differences within individuals in the organisation, across ethnicity, race, age, gender, experiences, sexual orientation across our governance and management.

Equity is about assuring fair treatment, access, opportunity, and advancement for all, while striving to identify and eliminate barriers that have prevented full participation for some groups, including within our procedures, processes, and distribution of resources.

Inclusion is about each person feeling valued and connected, their inherent worth is recognised and that they are safe to express themselves.[36]

Alongside COVID-19, another major global event in 2020 had a particular and important effect on MSF. The surge of the Black Lives Matter movement – in response to the police killing of an unarmed Black man, George Floyd, in the US – was also a catalyst for much-needed scrutiny within MSF.

As a global movement, MSF has long strived to promote the principles that underlie Diversity, Equity, and Inclusion (DEI). In the 2006 La Mancha Agreement[37], MSF recognised "the urgent need to address any issues of discrimination within MSF that are undermining our ability to realise our full operational and associative potential." The statement echoed earlier declarations that defined the evolution and principles of MSF[38]. It was amplified in calls over the years, including a significant movement-wide push in 2018.

Inequalities within MSF

Founded in Europe in the 1970s, MSF practices and structures are not immune from the influence of the continent's colonising past. In 2020, most of MSF's movement-wide operations continued to be run by five operational centres, headquartered in Western Europe[39]. There is often significant disparity in the status, salaries, and opportunities for locally hired staff compared with international staff. Despite locally hired staff having

36 https://msf-transformation.org/news/moving-towards-diversity-equity-and-inclusion/
37 http://associativehistory.msf.org/la-mancha-agreement
38 http://associativehistory.msf.org/chantilly-principles
39 Although some operational desks are decentralised outside of Europe (e.g., in Amman, Delhi, and Nairobi), these remain supervised by European headquarters. In 2019, the West and Central Africa Association (WaCA), the only non-European MSF section responsible for operational delivery, was established in Dakar, Senegal.

▲ Nurse Rebecca Alethéia provides training to the staff of the regional hospital in Tefé, Brazil, explaining the correct use of personal protective equipment.

greater experience and seniority in projects, for too long the default has been that they are supervised by international staff. Inequalities are also perpetuated by lack of diversity and representation in governance and leadership positions.

In 2017 and 2018 these issues came to the fore, with calls for change across several MSF movement-wide events. As a result, we created dedicated projects to tackle discrimination and support MSF's DEI ambitions, and to challenge the concentration of power in Europe. These are reflected in the 2020-2023 strategic plans of different MSF operational centres, including commitments by OCA towards greater diversity among senior managers and leaders, to be more representative of our overall global workforce, and to address inequities in personal and professional development by recognising blind spots and systematically tackling biases and structural barriers. However, progress has not been fast enough, or gone deep enough.

The events of 2020
In 2020, the renewed critical analysis within MSF included an open letter signed by more than 1,000 MSF staff across the world, highlighting institutional racism and calling for major change. Internal and external scrutiny of the issues included formal and informal discussions on different channels, as well as media reports and interviews with former and current MSF staff.

In response, the MSF Core Executive Committee of general directors from MSF operational centres, including MSF-Holland, released a public statement committing to radical action to address racism[40]. At the same time, MSF boards across the movement released individual antiracism statements, including commitments to hold the executive accountable. In a letter to all staff the OCA Management Team acknowledged the existence of institutional racism and discrimination and reaffirmed its commitment to tackling it[41]. The statement's pledges include commitments to redistribute decision-making power and address policies and procedures that perpetuate racism and other forms of discrimination. The MSF-Holland Board also released a statement, with a particular focus on action, to ensure that representation and governance of the Association is as diverse as the membership.

In August, we hired a DEI officer and formed a coordination group to support implementation of the commitments made. We are developing a multiyear roadmap to structure our antiracism work, with plans, for example, to ensure equitable and non-discriminatory recruitment processes. We expect the roadmap to be completed in mid-2021. We have invested in education and training, bringing external professional expertise to run a series of antiracism workshops, which continue into 2021. These sessions are an essential first step to help shift individual mindsets and collective culture and be open to, and ready for, change. Through the workshops we are learning to recognise and acknowledge our inherent biases and explore the resources needed to promote inclusiveness and equity.

Ongoing DEI projects
Despite some COVID-19 delays, in 2020 our People Respect and Value project[42] saw 14 'bottom-up' (i.e., reflecting voices at project level) initiatives started, eight from OCA projects; carried out project-level workshops in India, Kenya, Malaysia, Myanmar, Pakistan and Uzbekistan; as well as trainings for the MSF Executive; created a DEI toolkit and supported different projects and offices strategic approaches on DEI.

In 2020 we also updated our Code of Conduct (CoC), which is closely related to our DEI ambitions. We continued to focus on promoting responsible behaviour standards and fostering a safe and respectful working environment for all staff, across our prevention and awareness-raising work with employees. Within OCA, we saw a rise of official complaints related to discrimination (10 in 2020, compared to just one in 2019). While these are of concern, we believe the increased number reflects better reporting, and as such trust in the complaints system. Nonetheless, we still have a long way to go, and actual numbers may be higher still.

To help measure staff satisfaction about our DEI efforts, we included questions on this in the employee engagement survey carried out in 2020 (in the Amsterdam office, with plans to implement it across programmes and offices by 2023). The results will help to enhance and adapt the planning of DEI activities going forward. Our aggregate score was 6.1 (out of 10), indicating that we have much work to do, particularly in relation to areas in which we scored badly, such as equitable and fair opportunities for all.

40 https://www.msf.org/msf-management-statement-racism-and-discrimination
41 https://msf.org.uk/letter-msf-operational-centre-amsterdam-management-team-concerning-institutional-racism
42 In 2018, together with other MSF offices we initiated and sponsored a programme called "People, Respect and Value". The project's objectives include to identify and address the structural barriers to inclusion, at all levels that lead to injustice in our efforts to be an aspirational inclusive, fair and diverse organisation. www.msf-transformation.org/news/people-respect-and-value-phase-2-diversity-equity-inclusion/

Going forward

As MSF-Holland and OCA, we are committed to making the necessary change to tackle institutional racism. We know this journey may be uncomfortable, painful at times, as we learn to recognise and confront our own biases. We also know that it is fundamental.

In many areas, we are seeing progress. At the MSF movement level, nearly 50 per cent of all project coordination positions are held by international staff, who originate from the Global South, a near-doubling since 2009. We have also, expedited by COVID-19, taken further steps to dismantle policies which can be discriminatory. For example, increasing the removal of barriers for locally hired staff to enter leadership positions, and moving events and trainings online has made them more accessible to all staff. Although we are pleased with these outcomes, we recognise that it should not have taken the pandemic to initiate them, and that there is much work to do.

We will continue to prioritise the work of the DEI programme to ensure tangible change, complementing and supporting similar activities across multiple MSF governance bodies. We also commit to revisit and review our structures of power and privilege, currently still concentrated in Europe. In the year MSF turns 50, we do this as part of global efforts at the MSF movement level, towards to "Becoming the MSF We Want to Be." Through this we strive to be a better MSF in the future – one that truly reflects our rich diversity.

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6 Staff

6.1 Human resources and learning & development

In human resources (HR) and learning and development (L&D), in addition to COVID-19-related efforts, in 2020 we continued to work on essential projects. This includes updating our policies and procedures, in line with legal requirements; and completing the stabilisation of the new HR information technology system, implemented in 2018 and 2019.

Human resources

In the Amsterdam office, our HR activities included re-establishing the FuWa (Functiewaardering) Committee in February 2020. The FuWa reviews and scores new or updated job descriptions. We also adapted all policies to ensure compliance with the new Balanced Labour Market Act (Wet Arbeidsmarkt in Balans), implemented on 1 January 2020.

At project level, the complete roll out of our new performance management framework tool was delayed by COVID-19. We were able to fully implement the tool in Ethiopia and Malaysia (which had received it 2019); to introduce and fully implement it in India and to introduce it in Iraq and Yemen. We also trained more than 50 'performance management champions' in 16 countries. As we continue to develop performance management frameworks for the Amsterdam office, we are likely to draw on learnings from the rollout of the project-based framework.

Learning & development

Until March, we had planned 20 trainings for 290 participants (152 international staff and 138 locally hired staff). As the pandemic took over, we re-focused activities, as described in Section 1.1. At the same time, we expanded our mentoring and coaching programme to include eight more job profiles, giving more people in project positions the chance to benefit. In 2020, requests for individual coaching nearly doubled – from 31 in 2019, to 58 in 2020. We have also seen a steady increase of L&D support positions at project level. In 2020, we had 25 L&D project positions, an increase of 25 per cent from 2019. Most of these (23) are held by locally hired staff; and seventeen countries now have an L&D strategy in place. Developing our leaders is a strategic priority, and we carried out an assessment of our People Management and Leadership course to identify and improve upon weaker areas. A series of recommendations will be implemented in 2021.

Employee engagement

In the last quarter of 2020, we launched an employee engagement survey in our Amsterdam office (with plans to roll it out to all OCA programmes and offices by 2023). The survey's objective is to measure staff engagement and satisfaction and use the findings as a basis to build our strategy to improve job satisfaction, increase staff motivation and create a more inclusive culture.

In Amsterdam, the average employee engagement score was 6.9 (out of 10), based on an 89 per cent response rate. We shared the top-line results with the entire Amsterdam office. We then set up workshops and information sessions for managers, including senior managers, to help them understand the results, and start to build action plans, at office, departmental and team levels. We are focusing on areas we did not score well in, such as staff perception around organisational fit, recognition, reward, and opportunities for growth. We will measure our progress on an annual basis. In 2021, we will start the next phase of the project, rolling it out in partner offices and programme countries.

Responsible behaviour unit
We continued to focus on promoting responsible behaviour standards and fostering a safe and respectful working environment across our prevention and awareness-raising work with employees.

In 2020, the most commonly reported issues were abuse of power, discrimination and psychological harassment. We received a total of 104 cases from both offices and projects. 86 were requests for advice for cases managed at project level, with the support from the Responsible Behaviour Unit (RBU) in Amsterdam, and 18 were directly managed by the RBU. This is a significant increase from 2019, when we received 53 cases overall, of which 17 were directly managed by the RBU, and the rest were requests for advice from our projects. The increase in requests for advice is a positive indication of growing cooperation between the Amsterdam office and projects. It supports our efforts to identify and address potential code of conduct violation – including in the early stages. However, we still have low visibility on cases involving patients, or others in the local community, in project sites.

In 2020, we improved our responsible behaviour approaches and tools through active collaboration with other MSF offices, to ensure consistency in how we manage cases and in shared definitions and understandings of irresponsible behaviour, such as discrimination or sexual harassment. We contributed to a booklet on behaviour that serves as a common tool and guidance for staff across the MSF movement.

We also adapted key components of our prevention programming to online platforms. This included the responsible behaviour component of departure briefings, trainings for managers in the field (Sierra Leone and Uzbekistan), and trainings for a group of confidantes (confidential counsellors) based in the Amsterdam office. In addition, the RBU conducted monthly webinars on case management and provided training material to projects, as well as collaborated with L&D to produce an e-learning module on sexual harassment to be rolled out in 2021. As mentioned in Section 5, we updated our Code of Conduct, with a particular focus on addressing gaps in our framework for responsible behaviour.

Staff health
COVID-19 impacted on much of our routine support to staff health – such as in-person briefings and debriefings and project visits. We updated or created new policies and guidelines to support staff health – such as the occupational health screening and vaccination guidelines. We promoted and implemented psychological support to help office-based employees cope with the impact of the pandemic (see Section 1.1). We finalised a research project on how staff stay healthy in our projects, and are preparing several publications based on its results. We are also developing a screening tool to support monitoring of (international) staff health before and after assignment. At the same time, we expanded our support for decentralised psychosocial services for locally recruited staff in Afghanistan, India, Belarus, Tajikistan, Russia and Uzbekistan, Pakistan, and across the Middle East.

Our office
A highlight of 2019 was the return to our renovated Amsterdam office. However, from March 2020, there was little opportunity to enjoy it. We drastically cut the number of employees from around 250 to a maximum of 30 people a day. All-staff meetings were moved to virtual environments, thanks to our IT team. The Amsterdam office worked hard to ensure the wellbeing of staff, focused on keeping employees connected and being as flexible as possible to support individuals needs.

In 2020, we:
- Managed office attendance through a rota system;
- Adapted office catering and cleaning, including the installation of several hygiene points;
- Adapted the office to ensure 1.5 metre distance kept at all times by blocking desks, applying a routing system, and adapting meeting rooms;
- Closed off unused office floors to minimise our carbon footprint;
- Provided hardware, such as chairs and computer screens, to support staff working from home;
- Organised webinars with tips on working from home, and office updates, as well as online yoga and cooking classes, and much more.

6.2 Staff safety and security

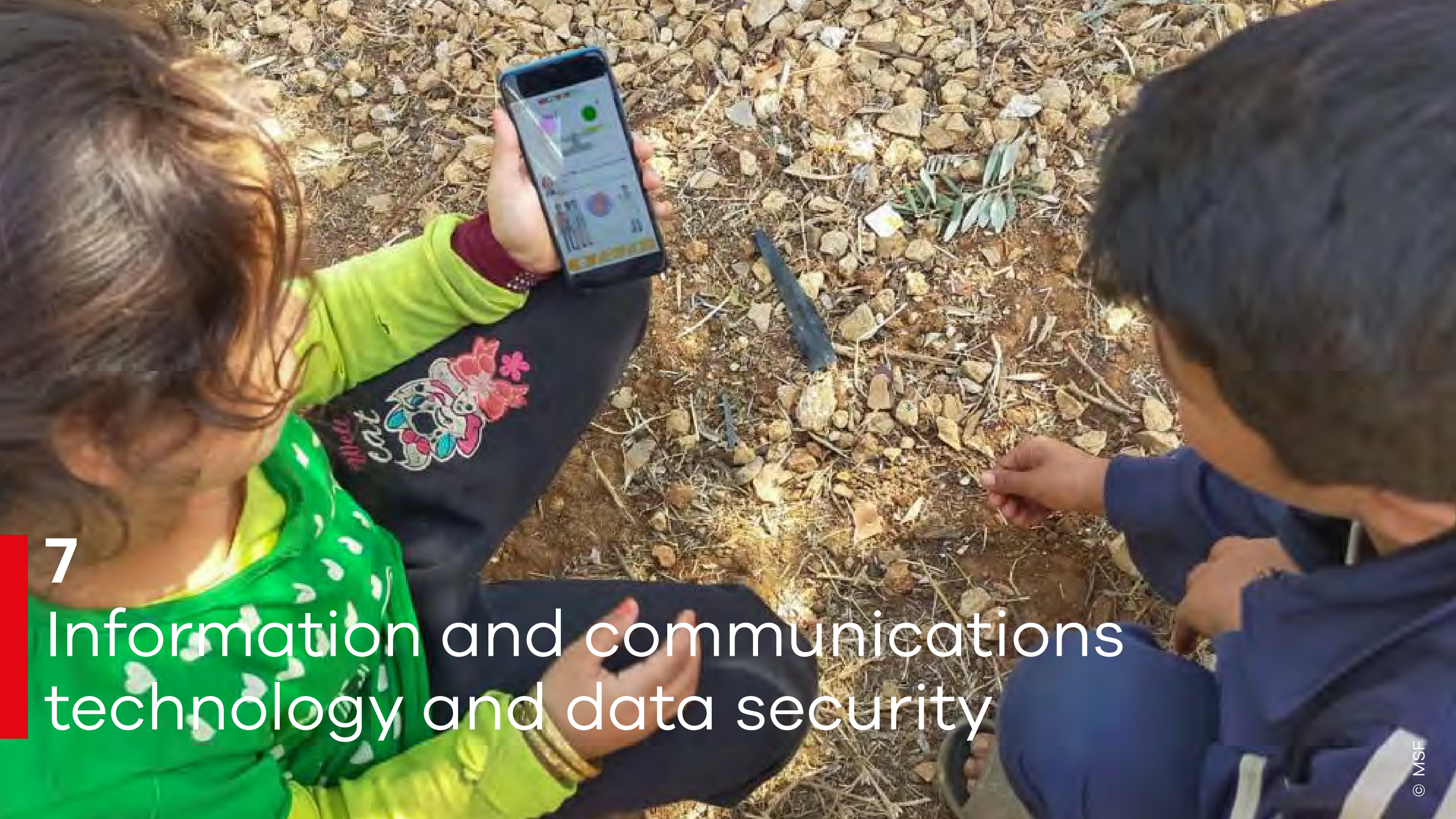
In 2020, we recorded 197 security incidents, compared with 248 in 2019. The reduced number is likely a consequence of COVID-19 related changes, in particular reduced movements. However, the number of severe incidents increased – from seven in 2019, to 12 in 2020. Five were in South Kivu, DRC, including three separate incidents of kidnapping which affected eight staff in total. Thankfully all incidents were resolved without injury or death to staff, but their frequency and severity led us to take the painful decision to close two projects and rethink our approach in the region.

Tragically, we lost staff members 2020, to COVID-19 and to violence. In South Sudan a staff member was killed and two more severely injured in intercommunal violence[43]. A staff member was killed when the bus he was travelling in was attacked in CAR[44]. One staff member died in Afghanistan from COVID-19 infection.

In 2020, we recorded 30 car accidents - four more than in 2019. All were minor and did not result in serious physical harm. Eighteen staff members were detained or arrested over the year. Several of these incidents related to zealous implementation of COVID-19 restrictions. As outlined in Section 1.2, we shifted our security training plans and support to staff to virtual environments. We also strengthened our Amsterdam-based crisis response capacity, increasing the number of trained staff for crisis management response.

We developed a security assessment tool, to be piloted in a few projects in 2021, before wider rollout. We continued to work with other MSF operational centres on plans to improve the movement-wide security database, which is being updated in 2021. The revised system will help improve analysis of security and safety incidents we encounter across the world. In doing so it will help enhance our ability to prevent incidents.

43 https://www.msf.org/renewed-violence-south-sudan-kills-msf-staff-member
44 https://www.msf.org/shooting-incident-near-bambari-car-kills-people-including-msf-staff



7
Information and communications technology and data security

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In 2020, our information and communications technology (ICT) efforts were almost entirely focused on adapting to COVID-19. We focused on ensuring ICT could support the new reality of almost 100 per cent work-from-home set ups. Investments over recent years, such as moving all our files to the 'cloud' remote network and transitioning to Microsoft Sharepoint and Dynamics Enterprise Resource Planning (ERP) systems, paid off. We were able to achieve a smooth transition for users and maintain a solid internal control environment. Stabilisation and further improvements of our ERP software continued throughout 2020. We dedicated time to user training for new video conferencing tools and ensured everyone had the right equipment at home.

We continued work on information management and security. We focused on educating end users about 'General Data Protection Regulation' (GDPR) and cybersecurity. We designated October as 'cybersecurity month', and held quizzes and information sessions. In addition, together with other MSF offices, we began a two-year programme of work to enhance the maturity of our IT security and control environment. We collaborated with MSF offices across the world on security and licensing issues, through a shared IT services centre. Located in the Czech Republic, the centre pools and mutualises 'shared' IT services and resources across the MSF movement, helping us align approaches and save costs.

We also overcame COVID-19 challenges to roll out cyberkits; installing 10 kits in different locations and implementing end-user training. Cyberkits contain hardware and software to improve IT infrastructure, security and connectivity in low-resource settings. This in turn helps improve performance of different tools and applications and enables improved monitoring and support set-ups for projects, including upscaling of ICT infrastructure. In 2021, we will continue to roll out cyberkits in different projects.

Health information system and eHealth

The health information system (HIS) upgrade project to develop and implement a new system for routine medical data across our programmes, was completed in April. We then created an 'eHealth and health information team' to support the integration and management of eHealth solutions (including HIS) across our programmes. As several planned project visits to implement HIS had to be cancelled because of COVID-19, we adapted the implementation strategy to a virtual format. This successful project strengthened teamwork and collaboration efforts between the Amsterdam office and project teams. With most projects now using the new HIS, in 2021 we will focus on improving user experience, with enhanced functionality. In addition, we will develop a new application for case monitoring and follow up of patients receiving care for TB, kala azar, as well as non-communicable diseases, such as diabetes. In our eHealth work we continued supporting project teams using mobile data collection tools such as KoBo Toolbox (an open-source tool designed for humanitarian settings) for survey activities and to set up dashboards for early warning surveillance.

▲ Children using the COVID-19 quiz challenge app. Lebanon.

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8 Programme finance

In 2020, we were able to adapt to remote management of most finance activities. We limited our office presence to the minimum required for essential services, such as processing of paper-based inheritance and legacy files.

The onset of the pandemic coincided with preparation of the 2019 Annual Financial Statements. At the time, there was great uncertainty about the potential financial impact of COVID-19 on the global economy, and our donors' ability to maintain their support. This was compounded by concerns about the resources that may be required for projects to be able respond to COVID-19. In this situation, the Management Team required assurance that our robust financial position could be sustained. Therefore, we developed a dashboard with regular and frequent updates on our income, costs and cash position, to support any needed response to unforeseen events. To safeguard continuity of our projects, we developed an in-depth contingency plan detailing how we would respond to differing levels of reduction in donor income. We also carried out a financial "stress test" showing we could remain a "going concern" even with a 50 per cent drop in donor income.

Thankfully, we did not need to take these measures. At the end of 2020, MSF-Holland closed the year in a stronger financial position than in 2019. This was a result of an exceptional fundraising performance across the MSF movement, and the overwhelming generosity of our donors. We have embedded the contingency plan and management dashboard into our financial management procedures, ensuring we continue to be able to respond quickly to changes in our financial position.

The entire MSF movement faced the same financial management challenges. Therefore, we worked together with colleagues across the movement on a unified assessment of the potential impact of COVID-19. This included reviewing income and expenditure and developing alternative scenarios to assist financial planning. We provided financial insights of income and cost developments and reserve levels, to MSF leadership at all levels. This was to be able to advise against financial decisions which could adversely affect our projects and programme support activities. We also advised internal OCA COVID-19 committees and provided COVID-19 financial reporting to the MSF international office to support movement-wide reporting and analysis.

With MS Dynamics and Office 365 implemented in 2019, we focused our attention on ensuring the systems' stability in their first full year of operation and identifying incremental improvements. Together with other MSF offices, we worked on a project for advanced user training for an integrated ERP system in our projects. This was particularly helpful at a time when travel was restricted, limiting project visits for financial advisers, as it allowed us to carry out internal control and budget verification and reporting remotely. We also began the

▲ The physiotherapy rehabilitation room in Tabarre trauma hospital, Haiti.

implementation of a new budget tool for real time access to cost information, in our projects

We adapted financial processes and procedures to accommodate changes to our travel and logistics service providers. We began a project to improve the recording of liabilities and commitments, to give better insights into commitment and future expenses. This project will continue in 2021. For more details on the financial impact of COVID-19 activities on MSF-Holland, please refer to the Financial Statements of 2020[45].

45 https://www.artsenzondergrenzen.nl/over-ons/jaarverslag-en-jaarrekening/

9 In the Netherlands

In this extraordinary year, which impacted on every level of society, we as MSF-Holland, better-known in the Netherlands as Artsen zonder Grenzen, adapted, reprioritised and accelerated our communications, advocacy and fundraising efforts. We achieved great success in many areas, thanks to the heart-warming engagement and generosity of our supporters and the Dutch public.

9.1 Fundraising and income

At the end of the year, our income from Dutch support was 2 per cent above our initial projections for 2020. Mainly thanks to gifts from our private donors, who have loyally supported us, we brought in income of €1.18 million above our target. This is an exceptional result particularly as income from regular donations (monthly direct debits) was €700,000 lower than initially projected.

Adapted strategies

Lockdown measures meant we had to put face-to-face fundraising activities – such as knocking on doors or starting conversations in the street – on hold. The temporary suspension of these activities led to a lower number of new regular donations than predicted for 2020, while cancellations of regular donations continued (as in other year). The impact was in part mitigated, by our adapted fundraising strategies. For example, we switched from face-to-face activities to phone and mobile fundraising. We also launched a COVID-19 campaign, including offline activities such as posters and mail-outs, and launched a popular podcast and online quiz. At Christmas, we broadened our traditional campaign. Over the year, these adapted strategies brought in 3000 new supporters, and we saw a 200 per cent growth in the number of people donating to us for the first time.

Impact on regular and institutional donations

In 2021 we will continue to build on the knowledge we have gained and to engage supporters and raise funds with these adapted models, while seeking new opportunities. Nonetheless, we expect a continued loss of regular donations to negatively impact our income in the years to come. The economic uncertainty brought about by COVID-19 has also impacted on donations from companies, foundations and major donors; in particular for highly affected sectors, such as travel and hospitality. Building new relations with companies, foundations and major donors was also more difficult in 2020. In general, organisations were less willing to engage with new organisations.

▲ Abri as part of the COVID-19 campaign.

Huge support from the Netherlands' National Postcode Lottery
The Netherlands' National Postcode Lottery is MSF's largest donor worldwide. Our longstanding relationship with the Lottery is very valuable to us, both financially and in highlighting the work and dedication of our staff worldwide. In 2020, the Lottery not only continued its annual regular donation of €13.5 million, but also announced an additional donation of €4 million for our PRACTECAL trial for improved MDR-TB treatments (see Section 4.2), which we will receive in 2021. The Lottery also supported our participation in national TV shows, such as 'Koffietijd' and the '5 Uur Show' – reaching large audiences and potential new donors.

Awareness and image
MSF is the third most recognised charity in the Netherlands; in a 2020 survey, 19 per cent of people asked to name charities, mentioned MSF, unprompted. Thanks to awareness raising and targeted campaigns we saw particular growth in awareness of our work among 28-39-year-olds, in 2020. This is an important group for us, and this engagement is very positive. As for the image of our organisation, we are perceived as a distinct, trustworthy organisation, which sticks to its core principles.

9.2 Advocacy and communications

In 2020, in addition to advocacy with the Dutch government to support humanitarian exemptions on restrictions for the export of essential supplies, we joined MSF movement-wide efforts, to advocate for a fair and equitable distribution of the COVID-19 vaccine. This entailed meetings with the Dutch Ministry of Foreign Affairs and the exchange of information with the Ministry of Health. We also engaged publicly on the subject, for example by co-organising an election debate on access to medicines (including access to the COVID-19 vaccine) and by contributing to articles on journalistic platforms such as De Correspondent's Q&A on vaccine production. We highlighted our COVID-19 interventions, in Europe and across the world and drew attention to the indirect impact of the pandemic. In early 2020, Facebook verified MSF accounts, including the MSF-Holland Facebook page, as a reliable source of information on COVID-19. As a result, we saw a 300 per cent increase in the visibility of our COVID-19-related information.

We drew attention to neglected crises such as Ebola in DRC, measles and violence in CAR, the Tigray crisis, Bangladesh, Syria and Yemen. At the same time, we continued to voice our opposition to the impacts of EU migration policies. We highlighted the effects of the pandemic on migrants and refugees on the Greek islands, as well as the fire that destroyed Moria camp, leaving 12,000 people homeless. Our supporters joined 450 organisations and members of European Parliament in a petition calling on the EU to urgently evacuate Moria and for humane migration policies. We will continue to speak out on the issue of migration, as we did with our strong opposition to a motion in the European Parliament criminalising NGO search-and-rescue operations; and through our participation in an Expert Meeting, on the EU Migration Pact, in the Dutch Senate in March 2021.

Together with the Netherlands Red Cross and the Dutch Relief Alliance we advocated against the NGO criminalisation bill, (see Section 4.1), with Dutch Senate members. Senate approval is the last stage before the law is passed in the Netherlands. We met with Senate members to explain the dangers the bill poses, including severe restrictions on independent humanitarian action, neutrality and impartiality. We are also concerned that if passed it will open the door for future politicians to revise policies to be even more restrictive; and risks creating a domino-effect with other EU member states. The Senate postponed the final vote and we remain in negotiations with the Ministry of Justice.

10 Safeguarding systems

© Adrienne Surprenant / Collectif ITEM

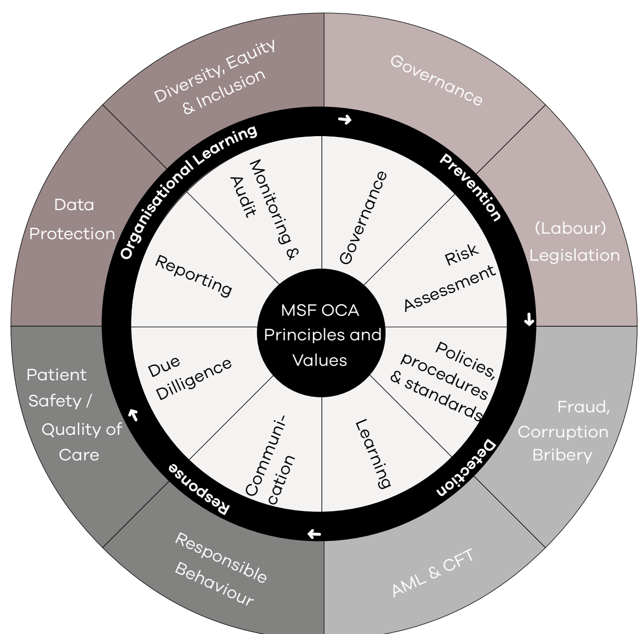
Risk

Our biggest risks are associated with contexts characterised by quick onset and unpredictable deterioration of the security situation. We are also exposed to operational risks associated with needing to comply with programme country legislation. The future development and impact on our activities can be extremely difficult to predict and is subject to frequent change.

To fulfil our strategic ambition to maintain the highest standards of integrity we are implementing a 'Compliance and Ethics Framework' supported by an appropriate oversight mechanism. This is to fulfil our responsibility to the people we assist and their communities, our supporters, and our staff. Both the framework and oversight mechanism will enable us to better organise the complex elements outlined above, to ensure high and consistent standards of integrity and ethical conduct in accordance with regulatory and compliance obligations. Those obligations may derive from the countries in which we provide medical, humanitarian care or from the countries in which we are headquartered, as well as from internal standards and regulations. The framework allows us to take a systematic approach to different initiatives to provide a comprehensive and integrated system of compliance and ethics management within OCA.

With the development of the Compliance and Ethics Framework and our ambition to move towards integrated compliance, ethics and risk management, we have strengthened our annual risk management cycle. Based on the risk assessment, management has identified eight priority work streams as shown in figure 1, the key deliverables in relation to these are outlined in the 2021 Annual Plan.

Figure 1: Compliance and ethics framework



▲ France walks out of the MSF's SICA hospital after completing her inpatient treatment. She got wounded when a stray bullet hit her. Bangui, Central African Republic.

We manage risk with an emphasis on ensuring minimal risks to staff, patients and the communities we assist, to safeguard their wellbeing, our reputation, and to ensure our solvency. Our organisation's support infrastructure is designed to be able to quickly respond to changing circumstances, and emerging risks and opportunities; thus, risk mitigation is central. We continue working on creating an open culture in which risks can be discussed. In our approach to risk, management teams in our headquarters and programmes play an important role. In our work, security, health and safety, and behavioural risk management require and receive specific attention. See table 3 for more information. Specifically, financial risk exposure may arise from tax and regulatory legislations

Table 3: Risk appetite

Risk category		Risk acceptance level					Description
		Averse	Minimal	Cautious	Open	Hungry	
Str Postco- ronaposts.com ategy							OCA strives to achieve its objectives, to fulfil its ambition to play a leading role in delivering medical-humanitarian aid and to invest in the capacities to support that ambition. A fair part of our operations are unpredictable and require a dynamic approach. In order to respond to significant emergencies, we might accept to take strategic risks including possibly stretching available resources if it benefits the population in danger.
Program Implemetation	Medical humanitarian action						First and foremost, our purpose is to start up and/or continue emergency aid operations. Populations in situations that are life threatening or of dire needs would drive us to accept more risks in our interventions and in our strive for meaningful access.
	Supply chain						We ensure employing a responsive and adaptable supply chain, maintain product quality standards and continuity of supply services and of operations. We therefore maintain comprehensive supply policies and procedures.
	Safety and security						Although we accept the need to work in contexts of acute crisis or conflict, we will nevertheless do everything reasonably practicable to reduce significant risks to our employees, our patients and the populations we assist. We apply strict rules and regulations in order to minimise safety and security risks for our staff and beneficiaries. We take minimal risks in regard to safety and have cautious approach towards security risks if we assess there is a high benefit for our patients.
Medical care							We minimize risk (especially clinical risk) and maintain high standards of medical care. We realise that in acute emergency response operations we may accept a higher level of risk. We emphasize the importance of creating a culture of learning from error and disclosing incidents.
Reputation							We maintain a solid reputation for living up to our core principles (neutrality, independence and impartiality), for transparency and for accountability towards our donors and beneficiaries. This translates in an open model of associative governance and an insistence on modest levels of compensation for all employees. Our communications are accurate and based on our own observations and experience while we maintain a relatively open approach towards communication risks and the potential reputational impact if it concerns the plight of the people we assist
Finance	Income						Our emergency aid operations are principally funded by private donations. While we are cautious to accept funding that can be perceived to be at tension with our independence, we will maximise diversification of funding sources.
	Financial position and solvency						We maintain a solid financial position in order to guarantee our emergency response capacity and ensure independent access to populations in distress and the achievement of our objectives. We are risk-averse in our financial and investment policies.
	Foreign exchange						Working worldwide in unstable environments and having a diverse but predictable flow of income, we incur minimal foreign exchange risk, in spite of the unstable environments in which we work, as we have an inbuilt hedge resulting from the diversity of currencies in which we receive income and make expenditures.
Legal and compliance	In countries of operation						We comply as much as possible with applicable laws and regulations. In our programmes, we accept a cautious level of risk towards local (tax) laws and regulations. We may accept to be non-compliant, as we place greater priority on our patients and staff. This is particularly the case when compliance may restrict our ability to assist population in distress.
	In countries of management						In countries where we have our head offices we comply to the regulatory frameworks. As in OCA we have our head offices in various countries, we align our compliance policies. We are risk averse in respect to financial compliance; we follow rules and regulations adhering to governance codes, charity regulations, Good Distribution Practices and when preparing our financial statements and management reports.
Integrity	Behaviour						We are strongly committed to prevent, detect, manage and follow-up on all aspect inappropriate behaviour in the workplace, towards patients and vulnerable populations whilst managing the cultural change to achieve it.
	Fraud and corruption						We have an averse tolerance for internal fraud and corruption as we do not accept our staff engaging in any form of corruption in relation to their work and our operations. Due to the context of our operations, we acknowledge that circumstances may arise taking precedence over other considerations and justify greater flexibility in our position. Whilst we do not support it, we have operations in environments with a reasonable acceptance of external corruption.
	Data security						We are vigilant to the protection and security of data and with a specific emphasisi on the personal data of patients, donors and staff.
Organisation and work culture							We strive for a diverse and inclusive organisation and work culture, in part by ensuring an international workforce, while realizing that difference can be challenging. Diversity means openness to people with different perspectives and differing expectations. Becoming a truly global organisation is key to our development and growth.

that, in an unstable environment are subject to different interpretation and frequent change. This is captured in our risk appetite towards legislation and compliance in the countries where we work. In our programmes, we accept a minimal-to-cautious level of risk toward local (tax) law and regulations. Where management has assessed it as probable that a position on the interpretation of relevant legislation cannot be upheld, an appropriate provision has been included in the financial statements.

In 2020, we made significant progress in our internal control and continuous assessment with regard to compliance with laws and regulations in our programmes, and the mitigation of associated risks. The comprehensive framework, developed in 2019, for capturing and monitoring laws and regulations that apply specifically to project staff was fully implemented in 2020. Further, internal control maturity ambition levels were articulated for our approach to fraud, bribery and corruption that translates into a two-year programme of work in 2021 and 2022. The Management Team also reviewed the central risk inventory. Identification of risks with potential consequences for achieving our goals, are mainly those directly linked to implementing our social mission, their likelihood of occurrence, and calculations of financial consequences.

The top five risks, and their development during the year, are shown in table 4:

Table 4: Main organisational risks

Risk	Trend	Main mitigation measures	Impact
Operations: Interruption of the supply chain.	↗	• Increased local purchase; • Increased direct delivery; • Continue organisational and management capacity for supply support; • Monitoring and forecasting of metrics used.	*High* The risk could lead to interruption of our health care services.
Operations: Serious adverse (security) event affects staff and/or patients under our care.	→	• Continue and reinforce safety and security policies and measures including applied security network; • Security and crisis management training; • Staff induction and awareness; • Regular security assessments and monitoring by Field Security Advisor.	*Medium-High* The risk could lead to severe interruption of our health care services.
Reputation and Integrity: Inappropriate behaviour of humanitarian worker of an NGO, UN or MSF staff proper.	↗	• Implement improved Code of Conduct; • Continue Responsible Behaviour Unit and prompt investigation and response of incidents; • Confidantes/Persons of Trust installed in all (programme) locations.	*Medium-High* The incidents could negatively affect MSF reputation, including beneficiary trust and donor recognition and income.
Integrity – data security Threats to the confidentiality, integrity, or availability of MSF networks, systems or data caused by cyberattacks or lack of appropriate security controls and infrastructure measures.	→	• Continue and reinforce security measures; • Continue and strengthen MSF Shared Services security policies and implementation to improve security visibility and risk intelligence; • Increased awareness of staff for security and privacy.	*Medium* The incidents could lead to loss/theft of data, higher costs and reputational damage.
Legal and Compliance: Non-compliance with regulations, including – but not limited to – privacy regulation and inability to efficiently adapt to new regulatory decisions in the EU and/or programme countries	↙	• Strengthen the effectiveness of the Ethics & Compliance Framework and the compliance organisation by integrating Compliance staff pool, proactive internal compliance investigations, improving, and maintaining robust internal controls.	*Medium* The risk could affect operations (access), higher costs and reputational damage.
Organisation and work culture Inability to attract and retain the right staff and ensure cohesion in the management to ensure an agile organisation and engagement of staff to meet our ambitions.	→	• Regular employee engagement surveys; • Development and implementation of staffing strategy; • Implementation of Diversity, Equity and Inclusion strategy; • Reinforcing Leadership and People Management training; • Increased internal communication.	*Medium* The risk could affect operations effectiveness and efficiency; result in higher costs and reputational damage.
Organisation and work culture Inability to keep pace with the level of growth and complexity in operations and lack of capacity for required change in the organisation.	→	• Investment / project portfolio planning; • Implement improved planning & control cycle including subsidiarity and joint implementation responsibility for partners; • Increased internal communication.	*Medium* The risk could affect operations effectiveness efficiency; result in higher costs and reputational damage.

The Board also paid special attention to reputational risks (e.g., related to our image as described in Section 9), and calculated the financial buffer required to absorb these risks and integrated this into our reserves policy. This has enabled us to redesign our risk management policy to be able to better respond to these risks.

Evaluations
Official evaluations were completed in 2020 included; an evaluation of a critical security incident (a kidnapping) in South Kivu, DRC (see Section 6.2). We also completed a year-long study[46] of how the organisation engages with ministries of health, our principal collaborators in nearly all programmes. The report included an analysis of the project typology data, country strategies and project proposals; interviews with key informants from MSF, ministries of health and other health actors; and visits to four 'case study' countries (CAR, Myanmar, Sierra Leone and South Sudan). Finally, we commissioned an internal review of our experience with search-and-rescue operations between 2015 and 2020. The report reviewed the impact of the dramatically changed political context – including ever-increasing hostility towards search-and-rescue activities – on our work, took stock of our operational impact and provided analysis of the current context. The report's recommendations are helping to guide our migration and search-and rescue operational plans, in 2021 and beyond

Internal audit
In 2020, we conducted three internal audits and reviews.

In January, we carried out an extensive internal audit in Bentiu, South Sudan, focused on overall compliance of the South Sudan programme and the supply chain. The audit was combined with a first pilot internal audit of the clinical governance framework – the first time an internal audit extended to medical activities. The pilot delivered a successful audit and learning on approach, procedures and expectations for audits. For supply and compliance the audit extended to Juba (the South Sudan capital), and to Nairobi and Lokichoggio in Kenya, from where we manage supply. Overall, the audit established that the programme is well in control and well managed.

We also reviewed our data analytics set-up. For this we engaged external expertise to apply the framework provided by the 'data management body of knowledge'. We started to systematically build our data and analytics functions four years ago, which established good results. The review showed that, overall, good strategic guidance is provided but we need to take steps to ensure more articulate leadership on data analytics; better coordination and alignment across departments; and improvements are needed in our data security policy and standards, following the growth in demand for data analytics. In 2021, we will address most of the recommendations.

In autumn 2020, we carried out an in-depth internal audit review into our persistent supply chain issues, - including significant events and decision making processes, root causes of issues and management responses. At the end of 2019, we noted a serious deterioration of the time to needed to deliver supplies, immediately following our transition to a new ERP-system. The review showed that supply performance has been slowly declining since 2016 and further deteriorating as the size and complexity of the supply chain increased. The review makes significant recommendations on the need to further develop and invest in management, personnel, process and technology. Management is confident that with the changeover to a new LSP and the ERP-system stabilising there is solid basis to improve supply chain performance by the second quarter of 2021. We will also dedicate additional capacity and assure Board supervision to support and monitor needed improvements.

Additional internal auditing plans were hampered by COVID-19 travel restrictions. Therefore we redirected some planned workflows to complete the Internal Audit Handbook and self-assessment of the maturity of the internal audit function. These projects aim to improve internal function in the organisation. The General Director and Audit & Risk Committee discussed all reports and followed-up on findings and recommendations. Patterns of reoccurring findings are incorporated in the planning and control cycle and discussed at different management levels. The Board and the Audit & Risk Committee are regularly informed on progress. The internal audit reports are shared with the external auditor. It remains a priority to safeguard awareness of the importance of compliance and supporting processes in difficult operational situations.

External audit
PricewaterhouseCoopers Accountants N.V. has been our auditor since 2012. In 2020, PwC advised management to determine the ambition level for the internal control environment that fits the size and the complexity of the organisation and its operational environment. Over the year, management addressed the definition of the ambition levels and systematically followed-up on the interim management letter findings. After completion of the 2020 statutory audit we will tender for audit services for the years 2021-2024.

46 Lone Ranger No Longer: MSF's engagement with ministries of health, November 2020
https://reliefweb.int/report/world/lone-ranger-no-longer-msf-s-engagement-ministries-health

Protecting our brand

It is important to ensure the integrity of the Artsen zonder Grenzen name and logo to reduce the risk of dilution of these trademarks; to avoid confusion in fundraising and operational activities; and to manage reputational risk. In 2020, we reached an agreement on name change or cancellation of registration of two cases (in 2019, we had six cases). The Board engaged Simmons&Simmons LLP who supported us on a pro bono basis to follow-up on new and existing trademark infringements. In 2020, we registered the established names 'Actie zonder Grenzen' and 'Baby zonder Grenzen' – which we use for fundraising and awareness raising – as trademarks.

11 Association and governance

11.1 MSF-Holland Board and Association

On 31 December 2020, the Board of the MSF-Holland Association consisted of 10 members, as shown in table 5. Board members are elected by our Association from the membership. In addition, the Board may "co-opt" (appoint) up to three members, from within or outside MSF who offer specific expertise or experience to support its activities. In February 2020, the Board co-opted Santhosh Kumar SS, Vice-President of the MSF South Asian Regional Association (SARA) Board, as a member of the MSF-Holland Board. This annual co-optation also supports the governance of the SARA.

Board elections were held at the statutory General Assembly, on 13 June 2020. Tessa Thiadens was re-elected as a Board member, and Els Niehaus was elected as Board member, both for a term of three years. Peter Draaisma's term as a co-opted member ended in June. We express our gratitude to Peter for his valuable input, in particular his support in strengthening the Board's oversight of management, his contribution to the Audit & Risk Committee, and his healthy external perspective on MSF.

Marit van Lenthe served as the President of the Board throughout 2020. In September, the Board re-elected her to serve as President for 2021. All Board members provided full disclosure of their professional activities, their ancillary activities and other interests in accordance with Article 5 of the Association's By-laws. The Board has determined that there were no direct or indirect conflicts of interest, for any member.

▲ People collect water in the village of Hadaelga, near Chercher, in Ethiopia.

Table 5: MSF-Holland Board composition

(Re) Appointed	Name (term of membership) Positions/other memberships	Term runs until	Secondary activities
2019 (1 Jan)	**Marit van Lenthe** (first term) President Chair of the OCA Council Member of the International Board	2021	
2018	**Annemarie Duijnstee** (first term) Vice-President Chair of the MSF-H Remuneration Committee Member of the OCA Duty of Care Committee	2021	Head of HR Department, Leiden University
2018	**Unni Karunakara** (second term) Member of the MSF-SARA Board Member of the OCA Medical Committee (from September 2020 until June 2021)	2021	Assistant Clinical Professor, School of Public Health, Yale University; Member, Selection Committee, MSF Transformational Investment Capacity); Member, Steering Committee, MSF Access Campaign; Member, Advisory Board, Prasanna School of Public Health, Manipal University
2018	**Michel Farkas** (first term) Treasurer Chair of the Audit and Risk Committee Member of the MSF-H Remuneration Committee	2021	Chief Operations Officer (COO), Hivos
2020	**Tessa Thiadens** (second term) Chair of the MSF-H Association Committee IGA Representative	2023	Resident for the specialisation General Practice/ Family Medicine, SBOH Stichting Beroepsopleiding Huisartsen
2017	**Peter Draaisma** (first term, co-opted member) Member of the Audit and Risk Committee	Term ended, June 2020	External Member, Audit Committee of the Ministry of Economic Affairs and Climate Policy of The Netherlands; Chairman of the Supervisory Board, Rotterdam-Rijndam Child Protection Agency; Member of the Board, Rotterdam Foundation Supporting Child Protection; Chairman of the Board, Foundation 'Preservation of the Monument Holy Family Church'; Honorary Ambassador, Mind Management System Organization; Member, Sourcing Committee of the Audit Institution Rotterdam (till 27.11.2018); Board member, Stichting Pathan (Until end July 2019); Chairman of the Committee Topcure and Research of the Ministry of Health, Welfare and Sport of the Netherlands
2019	**Leonoor Cornelissen** (first term) IGA Representative Member of the OCA Association Committee Member of the MSF-H Association Commit-tee (from September 2020)	2022	Migration and Displacement Senior Policy Advisor, Ministry of Foreign Affairs; Language Buddy, Stichting Nieuw Thuis Rotterdam; Advisor, United World College

(Re) Appointed	Name (term of membership) Positions/other memberships	Term runs until	Secondary activities
2019	**Hans Stolk** (first term) Member of the Remuneration Committee	2022	Manager Polikliniek Amersfoort, Sinai Centre
2019	**Riekje Elema** (first term) Member of the OCA Council (until September 2020) Member of the Medical Committee (until September 2020)	2022	Projectmanager/coach Verpleegkundige Topzorg, Universitair Medisch Centrum Groningen, Cater for Health (ZZP); Onderzoeker Ondervoeding Ouderen, Universitair Medisch Centrum Groningen, Cater for Health (ZZP)
2020 (1 Feb)	**Santhosh Kumar SS** (first term, co-opted member) Vice President of MSF-SARA Board	2021	Deputy Superintendent of Trivandrum Medical College
2020 (13 Jun)	**Els Niehaus** (first term) Member of the Audit & Risk Committee (from September 2020)	2023	Director of Dow Jones

Board remuneration and expenses

Apart from the President, Board members are not remunerated. However, they are eligible to receive a "volunteer payment"; of a maximum of €1,000 a year – to cover costs such as travel and printing. In 2020, all ten Board members exercised this option. In 2020 total volunteer payments to Board members, excluding the President, were €8,000 (2019: €7,000). No volunteer allowances were made following the end of term of any Board member and no loans, guarantees or advance payments were provided to any Board member.

The MSF-Holland By-laws, in conjunction with the Remuneration Policy, specify the framework for remuneration of the President. The President may receive partial remuneration for time exclusively spent on Board responsibilities and the MSF movement. The President's remuneration can be found in the 'Policy on the Remuneration of the MSF-Holland Board' and is in accordance with the principles approved by the General Assembly . Its key stipulations are:

- The President may be compensated for lost income if tasks for the Board take up substantial amounts of time that s/he could otherwise have used to earn income;
- The President can claim remuneration to a maximum of 20-hours-a-week;
- The President's hourly fee is based on the salary grid that applies to the Management Team.

In 2020, we compensated the President, Marit van Lenthe, the sum of €85,906 (2019: €63,778, reflecting an increase in FTE from 0.57 to 0.75). The President received this remuneration for her combined efforts as President of the MSF-Holland Board, Chair of the OCA Council and member of the MSF International Board.

Board meetings
The Board met 13 times in 2020. Table 6 outlines the dates and attendance record of these meetings. From March, all meetings – except for July and September – were held online.

Table 6: Board meetings and attendance

Board meeting dates, 2020	Attendance record
18 January	6/9
14 February	6/9
13 March	9/10
30 March	7/10
9 April	7/10
24 April	8/10
16 May	10/10
3 July	7/10
25 & 26 September	10/10
17 October	9/10
4 December	9/10
14 December	7/10

In 2020, recurring agenda items, included:

- Discussions with the Management Team about risks and mitigation policies, the approval of the Annual Plan and the Mid-year Review, and the development of the MSF-H Strategic Plan. The Board was also closely involved with the roll out of the employee engagement survey carried out with Amsterdam-based staff in autumn 2020;
- The road to section-hood for MSF-SARA. In 2020, we reconfirmed our partnership with MSF-SARA in a 'Letter of Agreement'. Our common ambition is for MSF-SARA to become an MSF section in 2021 and to further develop as a strong member of the OCA partnership and the MSF movement;
- Preparation for the MSF-Holland General Assembly and the MSF-International General Assembly (IGA). Because of the pandemic, the Board spent a lot of time transforming the General Assembly from an in-person gathering to a fully virtual event. The Board also prepared and mandated its representatives to discuss, decide and vote on its behalf at the IGA; As there were elections for the International Board (IB) of MSF, the MSF-Holland Board interviewed candidates and held discussions to inform their voting. The Board voted for three quality candidates from the Global South, also in an attempt to contribute to greater diversity within the IB. One of these candidates was selected. Moreover, the Board had lengthy discussions on its own representation at the IGA, given the imbalance between representation from the Global North and the Global South. The Board intended to 'give away' one seat to a representative of the MSF movement wide association, but unfortunately the statutes did not allow for this. The Board did approve a motion tabled by MSF-Canada at the IGA to revise the international governance structure in an attempt to contribute to more diversity in the IB and IGA;
- Updates from different Board committees, to facilitate well informed decision making on issues related to finance and risk, remuneration and the MSF-Holland Association;
- Discussions with the Management Team about the relationship and division of tasks between the Board and the Management Team.

The Board also reflected upon and discussed three recurring themes, related to global events of 2020:

- From March, the implications of COVID-19 on MSF-Holland, our staff, patients and their communities. The Board discussed possible risks related to staff health and wellbeing, income, supply and the ability to continue operations. The Board also explored options of mobilising Association members to support Netherlands-based operations, if needed.
- In May, the Black Lives Matter movement sparked reflection and intense debate across the MSF movement about racism, discrimination and inequality. The Board worked to educate itself and held in-depth discussions with its members to share observations and contributions during Association events. In December, the Board released a statement committing to rectify and dismantle institutional injustice and inequity in our movement and our social mission; pledging to reflect on needed changes to make representation and governance of the Association as diverse as its membership;
- In 2021, MSF will turn 50. Within our Board, and the wider movement, we are reflecting on the question of 'What is the MSF we want to be?' The Board also discussed this question with a focus on MSF-Holland and its position in the Netherlands.

The Board and the executive
In each of its regular meetings, the Board had an exchange with the Executive about current issues and potential risks in MSF-Holland. In addition, the President had regular meetings with the General Director and the (interim) Deputy Director. These meetings concerned ongoing organisational matters that did not require the involvement of the full Board. Martje van Nes fulfilled the role of interim Deputy Director in 2020. The Board would like to express its gratitude to Martje for her great work carrying out this task for almost a year, including through the onset of the pandemic. The Board welcomes Judith Sargentini into the role of Deputy Director from January 2021.

The Board also took a new look at the phases of change of MSF-Holland, with the General Director, Nelke Manders. These consultations carried into 2021, and from 1 March 2021 the Board and Nelke Manders took the decision to go separate ways. The Board is grateful for Nelke's essential contribution to the future of MSF-Holland and OCA. The Director of Operations, Oliver Behn, has been acting General Director since December 2020 and will continue in this position until the recruitment for a new General Director is completed.

Consultations with the Works Council
The Board and the Works Council (WoC) met twice in 2020: on 28 February and 24 November. In these meetings, the Board and the WoC discussed the wellbeing of staff, the engagement survey, the culture in the Amsterdam office and the WoC's advisory role to the Executive. In the November meeting, the Board also discussed how it could continue to support the WoC in 2021 and what topics to focus on.

Self-evaluation
The Board carries out a self-evaluation together with the Executive, every year at its annual retreat. The purpose is both to identify areas of improvement, and to give the Executive an opportunity to express its wishes and recommendations for the functioning of the Board. The Board and Executive received a questionnaire before the start of the retreat to evaluate the Board in its role as employer, supervisor and sparring partner during the joint session with the Executive.

The main findings of the 2020 evaluation were, that:
- The Board functions well as a team. Members have a high level of expertise and good knowledge of internal and external developments that are relevant to MSF-Holland. In addition, meetings are well-structured sufficient space is given to the voicing of different opinions.
- The Board should invest more in building high-level networks in the Netherlands. This is in line with the 2019 evaluation which found the Board should give more priority to advocacy and the organisation's position in the Netherlands. The Board also decided to invest in achieving mutual understanding of roles and responsibilities between the Board and the Executive.

In addition, the Board started the 'governance with impact' initiative during this retreat. The goal of this joint session is to improve collaboration between the MSF-Holland Board and Executive through increased understanding of our governance model, our shared task and prioritisation of high-impact issues for immediate resolution. The 'governance with impact' initiative continues in 2021.

Supervision
Sound governance is key to the values and culture of MSF-Holland. The principles of governance that apply to the MSF-Holland Association are detailed in three main documents: the Statutes of Association, the By-laws, and the Management Statute. The Association plays a governance role in the wider MSF movement, by means of its direct participation in the IGA in accordance with the MSF International Statutes. In addition, the Memorandum of Understanding with MSF-OCA describes the operational management functions and oversight responsibilities that MSF-Holland shares with its partners within MSF-OCA and the MSF-OCA Council. The principles agreed upon and set out in these documents reflect the principles of good governance to which the organisation subscribes. The Board is responsible for ensuring that these principles are relevant and applied in practice. The Board continued to monitor these questions throughout the year with the help of its committees, and in regular consultation with the General Director, the interim Deputy Director and the Controller appointed by the Board. MSF-Holland and MSF-OCA partners are represented on the International Board of MSF, by the MSF-OCA Council Chair in accordance with the MSF International Statutes.

The OCA Council
The OCA Council is a non-statutory body which oversees the implementation of OCA's social mission. As of 31 December 2020, the OCA Council comprised of 11 members – two from each of the Boards of MSF-Holland, MSF Germany, MSF-UK and MSF-South Asia and one from the Boards of MSF-Canada and MSF-Sweden. MSF-Holland is represented by the President and one other elected Board member. In addition, the MSF-Holland Treasurer, (Chair of the Audit & Risk Committee), and the Chair of the Medical Committee also sit on the OCA Council.

Statutory committees
MSF-Holland has three statutory committees: The Medical Committee, the Audit & Risk Committee (ARC) and the Remuneration Committee. The Medical Committee and the ARC are primarily OCA committees. The Board also has an Association Committee to ensure a vibrant and active MSF-Holland Association; and a Board member sits on the OCA Duty of Care Committee.

Medical Committee
The Medical Committee advises the OCA Council on medical policy and strategy and approves the accountability framework for implementation of medical programmes. The Medical Committee currently consists of five representatives from the OCA partnership – from MSF-Holland, Germany, UK, SARA and Sweden. The OCA Medical Director has a standing invitation to the meetings. In 2020 the Medical Committee met five times, mostly by videoconference, on: 17 February, 16 April, 6 July, 29 October and 7 December. In February 2020 Rob Verrecchia was appointed as the new Medical Committee Chair to replace Andre Griekspoor, who had finished his term. In November 2020, Rameez Akhtar was appointed as the new representative of SARA.

Audit & Risk Committee
On 31 December 2020, the Audit & Risk Committee (ARC) consisted of five members: the treasurers of MSF-Holland, MSF Germany, MSF UK and MSF Canada and one MSF-H Board member: Peter Draaisma (until June) and Els Niehaus (from September). Damien Regent was replaced by Derek Morgan as MSF-UK treasurer/ARC member. The treasurer of MSF-Holland, Michel Farkas, is also the chair of the Audit & Risk Committee and has a seat on the OCA Council in this capacity. The General Director, the Controller and the Chair of the OCA Council have a standing invite to ARC meetings. In 2020, the ARC met 9 times, mostly by videoconference, on: 12 February, 31 March, 14 April, 8 May, 15 May, 7 July, 29 September, 27 October and 8 December. The ARC and the MSF-Holland treasurer advised the Board on matters of finance, risk management, governance and internal control. In 2020, the Committee mostly advised the Board on: the 2019 Financial Statements and Auditors' Report; the budget for 2020 and 2021 and the interim auditor's management letter. In the second quarter of 2020, the Committee has been quite involved in the assessment and advice on the going concern assumption following the COVID-19 pandemic, the forward cash flow planning and stress testing as well as the endorsement of the contingency plan as established by management.

Following the auditors' recommendations in their 2019 report, the ARC monitored the definition and implementation of internal control maturity ambition levels by management in the areas of IT-controls, staff employment and taxation compliance in the programme countries, fraud, bribery and corruption and inventory and supply chain. Especially the supply challenges the organisation experienced were regularly attended to in the ARC.

Remuneration Committee
On 31 December 2020, the Remuneration Committee consisted of three members: Annemarie Duijnstee, Hans Stolk and Michel Farkas. The Staff Director and the Controller have a standing invitation to the Remuneration Committee. The Committee advises the Board on the remuneration and grading framework for MSF-Holland, and the specific remuneration policy for members of the Management Team and the Board. In 2020, the Remuneration Committee met, mostly by videoconference, on: 5 February, 21 April, 13 May and 6 October. Amongst other topics, the salary benchmark, exit arrangements and contract extensions of MT members and review of the function grid were discussed in these meetings.

Duty of Care Committee
On 31 December 2020, the Duty of Care Committee consisted of consisted of three members: Javid Abdelmoneim (President, MSF-UK), Dal Babu (Trustee, MSF-UK) and Annemarie Duijnstee. The OCA MT Chair has a standing invitation to the Duty of Care Committee. The Duty of Care Committee supports the OCA Council to monitor and oversee the OCA Integrity Framework and OCA Safety and Security Framework, ensuring that there is an effective culture of accountability on integrity, behaviour, health and safety and professional conduct. In 2020, the Duty of Care Committee met, by videoconference, on: 9 July and 27 November. In the meetings, it discussed the functioning of the Responsible Behaviour Unit, staff health, the design and implementation planning of the Compliance and Ethics framework and the evaluation of critical incidents.

11.2 Association and governance

The Artsen zonder Grenzen/Médecins Sans Frontières Holland Association grew from 1,020 members in December 2019, to 1,149 members in December 2020.

Association Committee
The Association Committee consisting of members of the Board, the Association Engagement Officer and a delegation of members, is responsible for organising events that engage and encourage association members to actively participate in the development of our social mission.

General Assembly
The annual General Assembly (GA) of the MSF-Holland Association is the biggest associative event of the year. In June 2020, we hosted the first fully virtual GA. There were 174 unique views to the livestream, with more than 150 members casting their ballots using the online eVoting system. The Board presented the 2019 Accountability and Financial Statements, which were approved with 83.3 per cent of the votes. The Board also asked the members to adopt the OCA Strategic Plan 2020-2023, which it was with 90.8 per cent of the votes. The membership also elected Els Niehaus (first term) and Tessa Thiadens (second term) to the two open Board vacancies.

For the first time, the Association organised a series of events in the lead-up to the GA. In these separate online events, members could learn more about the highlights of the past year, MSF's COVID-19 strategy and strategic plans for the coming years. Members were given an opportunity to ask questions about the Annual and Financial Report and the Strategic Plan before the official start of the Assembly. In the first event of the series, the OCA MT Chair and the OCA Medical Director shared their reflections on the OCA Strategic Plan 2020–2023. In the second session, the interim Delegate Director for MSF-Holland and the Head of Finance helped members understand the Annual and Financial report. In the third and final event, colleagues from operations, humanitarian affairs and operational communications and the MSF Access Campaign gave their reflections on MSF's response to COVID-19. Each event had over 130 unique views.

Association events
Outside of the GA, the Association team organised several other member events throughout the year (all online from March onwards). To support members through COVID-19, the Association team organised a series of 'virtual coffee mornings' – informal meetings in which members had the opportunity to meet and share their experiences of the pandemic.

Members gathered for numerous discussions and debates, including on the future of MSF, institutional racism and representation, including a screening of the documentary 'Stop Filming Us.' The discussions on institutional racism, were organised in response to the internal debate on discrimination within MSF. The Association hosted a series of four events over a week, with the aim to educate, including through acknowledgement MSF's systemic racism, reflect on MSF's position and voice in the context of Black Lives Matter and commit to reform.

On 12 September, we hosted the first fully virtual edition the OCA Café, with live translation into English, French and Arabic. A total of 331 people registered for the event and the live presentations had 286 unique views, including 82 French speaking and 23 Arabic-speaking participants. Upon registration, participants represented 30 different countries, and MSF projects in Afghanistan, Bangladesh, Chad, Ethiopia, and Iraq joined via the livestream. Discussions centred around two main themes: 'COVID-19 Cracks: A discussion of the fault lines exposed by the pandemic' and 'Becoming the Antiracist MSF we want to be'. Between sessions attendees were given opportunity to connect to members of the OCA Council and the Management Team.

External events
MSF speakers, and the organisations we partnered with, adapted to hosting events, lectures and presentations online. We did this throughout the Netherlands, participating in debates and presenting on topics such as criminalisation of aid, and search-and-rescue. These events helped to raise awareness and broaden our target audience. In mid-March a team explored how MSF could help respond to the impact of COVID-19 in the Netherlands. Our focus was on supporting vulnerable groups, such as asylum seekers, migrants and the homeless.

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Conclusions and account

In the opinion of the Board, the 2020 Annual Report provides a fair reflection of the programmes, activities, and results achieved in 2020 in relation to the 2020 Annual Plan, the long-term strategic objectives, and to what was approved by the Board during the course of the year.

The Board is confident that the programmes, activities, and results achieved in 2020 have contributed to achieving the social mission goals of the Association as laid down in the statutes: 'to organise the provision of actual medical help to people in disaster areas and crisis anywhere in the world, in accordance with the principles expressed in the MSF Charter. Based on its medical work, the association endeavours to be an effective advocate for the population it assists'.

All members of the Board accept responsibility for the Financial Statements and the Annual Report. The Board accepts responsibility for the internal control system established and maintained by the Management Team, which is designed to provide reasonable assurance of the integrity and reliability of the organisation's financial reporting and to assist in the achievement of the organisation's objectives. MSF-Holland maintains an internal audit function that supports in the review of the internal control and risk management systems. Internal Audit reports are issued to the Audit Committee of the Board and contribute to the Board's opinion on the design and operational effectiveness of the internal control and risk management systems. The Board is of the opinion that the internal control and risk management systems provide reasonable assurance that the Financial Statements for year ending 31 December 2020 do not contain errors of material significance. Accordingly, the Board considers, to the best of our knowledge, that the Financial Statements and Report drawn up by the Management Team for the year ending on 31 December 2020 fairly reflect the financial position and transactions of the MSF-Holland Association.

On behalf of the Board and the OCA Council, we would like to thank every MSF employee and volunteer, our donors and our supporters for their determined dedication in realising our humanitarian medical objectives under the extraordinary circumstances of the global spread of COVID-19.

Amsterdam, 18 May 2021

On behalf of the Board,
Marit van Lenthe, President

▲ Veronique Ziboski (Ministry of Health staff) administers Vitamin A to an infant about to be vaccinated. Besson, Central African Republic.

Colophon

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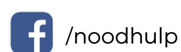
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Cover photo: Badro Noor Mohammad is being treated for drug resistant Tuberculosis along with her 7 year old daughter Zainabo at MSF's treatment centre in Kandahar, Afghanistan.
Photo: © Laura Mc Andrew/MSF