OCB Gathering - MSFB General Assembly

November 2020

Moral Report

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Dear friends and members,

Once again, this was a special year not only for our movement, but also for all the people we fight for on a daily basis. The year was marked by an unpredictable event of indescribable magnitude – a global epidemic that has already caused almost 50M cases, 1M deaths spread worldwide: COVID-19. No one saw it coming, including MSF. It is without doubt too early to draw final conclusions from our interventions because it is ongoing. It would be a serious mistake to think that this pandemic is behind us. However, we can highlight what OCB has achieved so far and reflect on the failures and successes of our strategies. Internal reflections and debates were undertaken at several levels, with reviews and evaluations of the interventions documented. We must continue to do this.

The response strategy was put forward at the beginning of the year during the response to this epidemic in China and Hong Kong: the shipment of equipment, its societal impact, assessing our added value in this type of context, sending not only material to Wuhang/Hubei Hospitals but also a health education and community engagement project for at-risk groups such as the elderly. People in these countries whose institutional bodies often have larger and far better response capacities than in other countries has led us to understand the extent of the problem. This intervention was followed by one in Italy, mainly in the north of the country. This taught us the immense complexity of this disease, not only at the medical-scientific level, but also in the reorganization of care and patient flow within structures and the importance of measures to prevent and control within-hospital infections. Working in European hospital intensive care units will remain a unique experience. Although we might think that our added value is minimal in this sector within European countries, it has given us a whole new series of questions and reflections on what can be achieved in such an environment.

With the contribution of several documents, reflections and opinions, OCB has positioned itself on a multitude of intervention lines ranging from commitment within communities to more specific intervention within specialized hospital units. In Belgium, intervention in nursing homes was one of the key building blocks of this intervention. It was a new and unknown environment for MSF, yet a humanitarian intervention above all with special proximity not only to the residents but also to the staff of the nursing homes. Several lobbying and testimonial actions were launched to ensure that this situation does not happen again in the future. This intervention in NH in Europe had a cascade effect in the movement and interventions in nursing homes followed in the United States, and Ecuador. The opening of a large COVID Centre in central Brussels to take in charge patients forgotten

in the response, migrants and the homeless, has also been a success not only in working with other partners, but above all in giving help to people who, as usual, are not taken into account by the state system. This type of structure has also brought to light for those who do not want to face the reality, the needs of these vulnerable people. In the United States, after too-long internal hesitations, it was decided to embark on an intervention within nursing homes in Michigan and Texas that enabled completing other lines of intervention already undertaken. With the epidemic hitting indigenous peoples hard in Brazil, we have had to expand our intervention not only in this country, as large as a continent, but also in other countries of South America. Other interventions specifically dedicated to this pandemic within our missions and projects have emerged in Yemen, Guinea, Lebanon, Iraq, South Africa, Congo, Bangladesh and beyond. We must salute the adaptability of field staff in facing this new situation in their daily lives.

As in other recent examples of our operational history, teams have often had to work without adequate tools. There was little scientific knowledge available at the beginning of our interventions, a lack of diagnostic tools, no specific treatments, and no vaccines. We should congratulate all involved at OCB for their inventiveness and implementation of innovative strategies and tools. There were, for example, the use of digital health promotion tools, reflection on Step-Down units to release ICU beds faster, implementation of adapted and innovative protocols in the face of a shortage of protective equipment and disinfectants, efficient washing units of protective equipment, sterilization with UV, etc., etc. In addition to constraints specifically related to taking care of our beneficiaries, we must remember the immensity of other constraints that we have had to endure. The sending of staff and equipment is an example, and the field had to adapt and remain flexible. We had to deal with the human resources available on site, given the stoppage of air traffic. We were blocked from sending equipment and MSF-Supply had to adapt. I would like to say thanks for this work that is essential for maintaining our operations and for the high level of supply center professionalism. Risk-taking has once again been an important element in the reorientation of our supply center in the face of this pandemic. Purchases of equipment essential to our operations have been hindered by market demand. In addition, we have had to suspend various training courses and new approaches will have to be put in place to overcome the constraints associated with this pandemic. While we had accepted a limited and reduced budget for emergencies in 2020 because of financial constraints (we on the Board of Directors must also learn from this), we were able to overcome constraints by our willingness to act, respond massively to needs wherever they were, and to let our public know, who once again responded. More than 30M has been spent around the world to deal with this epidemic. We have seen that humanitarian action undertaken with proactive communication and fundraising activity is once again the guarantee of success and remains firmly rooted in OCB's DNA. One does not go without the other. Other OCs have had other approaches and it is imperative to talk about them. While OCB has highlighted the need to act in the face of the immensity of the needs related to this epidemic (the Duty to care) and

to monitor the evolution of the epidemic and intervene where we are needed, no matter where, other OCs have highlighted the desire to work on a more Duty of Care framework, one not excluding the other, of course! A debate on the importance to be given to these two orientations and therefore of this dilemma should give us several reflections for our future. However, the OCB has also made progress in this area to limit the risk inherent to our humanitarian work for our own staff. This will be partially addressed during our debate today, but it was imperative to take place at the level of the movement. This need for action will continue to be at the forefront of our operational approach, especially when it comes to emergencies and epidemics. While all of this can be seen as sometimes insurmountable constraints, we are not able to mention here the whole range of opportunities for which an in-depth debate is needed not only in the context of our Operations on COVID, but also on other projects that are close to our hearts. Whether it is about recentralization with the problem of sending people abroad, the inclusive and equitable participation of all our members in the debates with digital tools, a reduction of costs in online training events or remote associative debates, let us also look at the glass half full.

While this pandemic has been a major part of our attention since the beginning of 2020, it would not be fair not to mention other emergency interventions as well as a whole series of interventions related to extremely varied health and humanitarian issues. Indeed, the operational portfolio remains very diverse and the desire since the beginning of this pandemic has been above all to maintain these operations. In most cases, we succeeded, but it was not simple. I would like to take this opportunity to thank one person in particular. It is not common to cite a specific person in a moral report, but I must do so. By mentioning the list of emergencies, by thinking back to our past emergencies, be it the earthquakes in Armenia and Haiti, the Tsunami, the measles, meningitis and other epidemics, the Ebola intervention in West Africa, and now COVID, Marie-Christine has always been there, combining humanity and professionalism. Marie-Christine, you are the symbolic figure of the OCB emergency pool. It wasn't easy every day, we had some tough times together, but you always kept that desire to put response to the emergency as the operational spearhead. After so many years, you are now passing the torch, but know that this torch will remain the same as your values: interventionism, humanism and adaptability. Thank you, Marie, for all you have brought us. I am sure that we will meet you here and there in our corridors... because your experience is second to none.

In Burundi, our humanitarian action has focused on the curative aspect in the management of cholera cases while our fight against malaria focuses on the preventive aspect with the continuity of intra-home spraying in several provinces. This shows once again that these different levels of action can have specific added value even when done separately, as in every year when we have organized major measles vaccination campaigns. We must never forget the importance of this prevention activity and especially for this disease whose virulence and contagiousness are responsible for hundreds of thousands of deaths annually. We have been able to vaccinate in Guinea, the Democratic Republic of Congo, the Central

African Republic, and Nigeria, and these are just examples. More than 200,000 children have benefited, and vaccination remains an important activity in our programmes with nearly 900,000 children vaccinated throughout 2019. While our legitimacy of action in the response to Ebola epidemics has taken a hit for multiple reasons that are not all negative (multiplication of actors, state accountability), we are still demonstrating our added value in the response to fight against this virus in the Mabalako Region of the DRC. It is imperative that we keep this area of intervention as one of our leading examples of emergency intervention, given the investment that has been made for many years, even though we must increasingly accept the expertise and involvement of other players in research and treatment of filovirus disease.

The response to victims of violence and conflict also remains one of our main activities. Before we begin to mention a whole series of activities that have arisen in recent months, I cannot fail to have a thought for the victims of the unspeakable attack on the Dar-e-Bashi hospital in Afghanistan. Patients were executed. One of MSF's midwives was killed in the attack. While risk-taking is an integral part of our humanitarian work, voices have been raised among our Parisian colleagues on MSF's ability to manage these constraints. Of course, Afghanistan remains a country where the safety of our patients and staff is being undermined. Preventive and corrective measures had been put in place long before this unprecedented event. Finding the right balance between saving lives and preserving them must be part of our daily discussions. These are obviously extremely difficult choices and there is very little room for finding ideal solutions. Missions in Iraq, Syria, Idlib, Yemen are also extremely sensitive. Specific, tailored solutions must be continually re-discussed and re-evaluated. A few years ago, the OCB Board of Directors called for greater investment at the Sahel level, so executive management set up significant interventions in Mali, Nigeria, and Cameroon. Following the announcement of extremist factions, radical groups targeting Humanitarian Organizations as potential targets, we must rethink our operations in the region. Specific measures have been taken on the ground, and an analysis group has been set up. The OCB Board of Directors participates in the group because there are several questions, be it the profile of our members active in the region or security constraints specifically related to this context. Some will say that we talk less about it, but the Syrian context and support for hospitals remains a major concern in our operations, and our difficulties in sending people and equipment are unfortunately the same as in previous years. We also had to strengthen the emergency preparedness plan for violence in all projects and missions such as In Iraq, in Guinea following the elections, in Haiti where we had to reopen the care units within the Tabarre hospital in collaboration with OCP following the increase of urban violence in Port-au-Prince. These examples are not isolated and other missions are doing the same. The new reconstructive surgery project in Palestine is another example of the vast needs faced by victims of conflict. The OCB Board of Directors follows this very closely with a specific committee dedicated solely to the management of security that continues to bring a mirror and reflection effect. The implementation of the new

security management policy will certainly improve difficult decision-making and the overall and holistic management of security within our missions.

Reproductive and women's health remain one of the pillars of our interventions. We see that sexual violence has not disappeared from our environment, that voluntary termination of pregnancies and unaccompanied dystocical births are still unfortunately a reality that lead to an unacceptable increase in maternal mortality. In Khost, Afghanistan, we have reached an incredible 130,000 births since the beginning of our intervention, what would have happened to these women if this hospital had not been born? The number of admissions of people who are victims of sexual violence at the Masisi hospital in the DRC has not decreased, and the lack of actors in the region or the resumption by the health authorities is a real operational constraint. The question of maintaining this specific supply of care if we should leave, coupled with the continuity of demand remains a real problem. This is an example and other projects in this area within our operations can also be cited in South Africa, Lesbos or elsewhere. In Egypt, we had the opportunity to transfer some lines of activity to local partners. Other projects have been opened such as in Bolivia where maternity support has emerged. A referral system for pregnant women has been set up in Cameroon, Nigeria and Iraq where we have increased our care activities related to this issue. A project specifically related to cervical cancer in Zimbabwe and Mozambique retains its added value. The implementation of activities related to the voluntary termination of pregnancies remain essential and continue to remain an important part of reproductive health projects when compared with other operational centers (exercise of little interest if any)

Children under the age of 5 retain a special place in our projects, whether at the hospital level as in Kenema, Sierra Leone where the different units are full and continue to play a key role in reducing infant mortality. A specific approach more adapted to neonatology has also emerged in a whole range of projects, mainly within our different maternity units and in neonatology units.

We will of course continue to be involved in the fight against specific infectious diseases. In addition to malaria, AIDS and tuberculosis remain two of our operational choices. While significant progress continues to be made on specific strategies in southern Africa on AIDS and in KwaZulu-Natal in particular, the drastic reduction in international funding in the fight against AIDS is having a negative impact on the accessibility of testing and a range of treatment regimens for this Region. A major effort to integrate the activities related to this disease has paid off, whether in DRC or Bangui in the Central African Republic, but this cannot mask the important need still strongly present on the African continent for the specific mortality associated with this disease. It has been noticed in Kinshasa and of course in southern Africa: continuity of care and the care of the patients at the advanced stage must be continued within our social mission. While greater investment in the prevention of mother-to-child transmission and increased attention to advanced patients, integrating the

provision of care into horizontal care access projects will remain one of the priorities in the field of HIV for the future. While tuberculosis is the leading cause of death from infectious disease, it is worth noting the significant efforts that have taken place this year both in terms of pediatric care, often neglected in previous years, and in the response to the problem of multi-resistance from which significant results have emerged in Ukraine and South Africa. Also, in Baghdad which, after a rather slow start, is showing interest in both the use of adapted diagnostics and a therapeutic approach based on Delanamid/Bedaquiline. It is also worth noting the special attention that has been given to the overall problem of antibiotic resistance and the major advances in the implementation of infection prevention and control within our health facilities, even though episodes of nosocomial infections are unfortunately still present now. This is a sign that our work in this area must be maintained. I would be remiss if I did not mention also the work dedicated to the fight against Lassa fever and hepatitis C, two pathologies in which problems related to access to diagnosis and treatment are still unfortunately very present.

While the world is concerned about the COVID pandemic, the migration problem and the scandalous absence of government authorities to provide structural solutions only make the situation worse. In Europe, whether in Bosnia or Serbia, the situation of these people in transit is only getting worse, and the Lesbos camp in Greece has been ransacked and set on fire. Despite numerous calls for better reception and management of the health needs of these populations, a comprehensive response has still not been heard. Of course, while, some of MSF's activities such as the first emergency psychological contribution in Italy, the primary health care activities in Lesbos, support in the care of torture victims in Egypt, and a flexible and adapted approach in Brazil and South-East Asia are real examples of success, it is clear that our lobbying and witnessing leverage has few satisfactory answers, at this time. Some innovative approaches are even denied us such as telemedicine in Nauru in the Pacific. Nevertheless, let us not lose our courage and keep this theme at the top of our list of priorities, we are talking about human dignity here!

The years 2019 and 2020 have also been marked by an awareness of the significant constraints we have suffered in recent years in the rehabilitation/construction of hospital structures. A brake has been put in the creation of new large-scale hospital projects. This does not mean that we will stop working in hospitals, but it highlights our desire to find more appropriate interventions in order to reduce the often too-long time in the implementation of operational activities, and to target more precisely and specifically hospital activities of choice.

In line with the motion on our desire to reduce our negative impact on the environment and the climate, a specific action plan has been proposed by some fifteen members with the help of operations and medical directors. The action plan is ambitious and several axes of practical intervention are proposed. It is also worth noting the various initiatives of the

environmental health unit within the medical department. All this shows a clear willingness of OCB to move forward on these issues and to become more eco-responsible.

I would like to highlight a positive internal dynamic within the different departments of OCB (medical, logistics, HR, etc.) on a community work approach. Combining the different expertise present in the various OCB executive offices and people in the field, this dynamic approach provides support adapted to different contexts and in different fields. This is one of the examples of our desire, at the OCB Board, to move towards a more inclusive and participatory management of the organization following our validation of these principles during our January Board session. By gradually moving away from an overly standardized non-specific approach and involving the responsibility of all of our members, we arrive at better appropriation of technical support and respond in a more adapted way to the different questions that our members active in the field are asking. Working with digital tools (constraints partially related to the pandemic) can only facilitate this. I would like to thank the logistics department that initiated this, and the other departments that have followed this approach by adapting this initiative to their areas of expertise. When we were recruiting our DG, a project that was focused on greater field responsibilities and decision-making closer to needs convinced us. Several discussions, a vision, a team recruitment effort in this direction, and an implementation plan have been carried out. Several advances have since emerged, in South Africa and reflections are starting as well in other contexts. We have made progress in this strategic axis and the COVID pandemic reinforces us in this idea, given our difficulties in sending people and equipment. Monitoring will continue to be carried out on this initiative by the OCB Board of Directors. The medical academy project retains its full meaning in these difficult times on sending people on the field, it is imperative to continue to strengthen the professional skills and competences of our staff in the field. Although the Covid pandemic has had a significant negative impact on a whole series of projects and initiatives mainly on face-to-face training, the ambitions on the constant improvement of the quality of care remain unchanged as shown by the various works and approaches carried out by the Medical Department following the debates of last year. But we are still far from being satisfied with this situation and we must always remain attentive to it! I would also like to thank the various actions realized at field level to give greater attention to the elderly, as requested in the motion on the vulnerability of this population. Intervening in nursing homes during the COVID pandemic is one example.

Although working collaboratively between missions, projects and the various operational centers have improved in recent years, we must admit there are still few things to be achieved and not only on the supply chain, often mentioned. It is worth noting a series of achievements: the work of interaction in Haiti with OCP on the transfer and resumption of activities within the Tabarre hospital following the increase in the urban violence, joint reproductive health activities in Iraq, the division of tasks between sections in Yemen (although the beginning was not easy, it should be noted), our project in Cameroon with our Swiss colleagues, and of course the sharing of information on security management through

our missions, even if we are not always aligned in the security contextual analysis, as in Afghanistan, for example. But we must remain critical on this domain regarding the internal barriers that prevent us from improving on this collaborative work. An example comes to my mind: What will happen to the intersectional model in Afghanistan if OCP's decision to withdraw from the intersectional coordination model comes into practice?

A reflection on the roles and responsibilities between operational centers and with the entities of the movement is necessary in order to have a clear framework when the decision is made to intervene in a region where there is an executive or associative entity (and not only) . Recent examples, only to mention them, such as the violent protests in Hong Kong, the intervention in nursing homes in the United States, the beginning of the COVID intervention in Brazil, have shown a need for clarification on who decides what so that the beneficiaries of our intervention do not pay a heavy price due to our internal bureaucracy. While an associative and executive framework has been launched at the international level, leaving the opportunity for the various associations to launch operational initiatives related to COVID, it is clear that there is still a long way to go to clarify all the issues. We notice that there may be differences of opinion whether or not to intervene. While operational centres have been given an operational mandate, it is often necessary to discuss and reach an agreement (formal or informal) with the entities of the movement. This does not cause any problems in itself, if it is done in a suitable timeframe. Sometimes it takes time, time taken at the expense of patients if this procedure is done in an emergency, and often frustrations arise. This dilemma is not new, but it is high time that we work together (at the OCB level) to define a clear framework on this. So we are committed to achieving that in the coming year, and we encourage the movement to do the same. A document called ‘a networked OC” has been approved at the Board level to guide us in the future. Recently, there has been a problem with our fundraising policy at the international level. Should we or should we not accept funds from an institution that has assets in the construction of drones active in the war in Somalia? While most of the movement's stakeholders agree that this policy needs to be reviewed, I would like to point out a trend that is increasingly present in the current movement: prioritizing these policies at the expense of implementation and management of our operations. This trend must be reversed in the future at the risk of the movement becoming more focused on internal bureaucracy rather than on our operations and the patients we have chosen to care for. As the movement undertakes a range of action guidance both in terms of vision for our association and on our funding, I would like to point out where we are going. After the International Board drafted a document out of our desire for change entitled "call for change", several initiatives followed. Between exchanges and discussions, and writing of other documents, we finally come to the end of what I would call the exercise of appropriation, of including what we want to become within the movement. After the writing of the 5 strategic plans of the OCs and a finding of sharing of the situation, guidance will be proposed at this year's IGA, as well as more precise and detailed lines of work. A repetitive cycle of reflection, every 4 years, is proposed with all members,

headquarters and field, in order to move concretely towards the axes of change proposed by members. Despite the fact that this could be seen as merely a desire for discussion and not implementation, I would like to recall the appropriation of WACA, the entire movement's ownership of the need for change to address institutional discrimination/racism and these advances, a better inclusiveness of gender, ethnicity, decision-sharing between field and headquarters, between sections and OCs within our organization. All this is already a change! It is in this sense that I would like to congratulate the Congolese initiative to become a full-fledged association within the movement, and I welcome this! Of course, there is still a long way to go, as the debates and the willingness of our members to see concrete actions rather than a semantic debate on the issue of discrimination and institutional racism show. Indeed, in recent years, various motions or reflections have been discussed at different sessions both at the executive level and at meetings of the various boards of directors at all levels. At the IGA in 2017 when a motion proposed by MSF-USA citing institutional racism was not addressed, a societal movement arose in the United States fighting the inequalities suffered by the African-American population. This led to a series of heated debates within our organization. While for some the semantics of words prevailed over the concept of change, voices rose to address the real problem that exists within our movement. Everyone agrees at the moment that the debate is no longer enough, but that real change is needed in order to advance our organization towards greater diversity, towards greater sharing of decision-making power in a whole range of areas. OCB has therefore decided to set up an anti-racist working group to identify the internal barriers of our organization, to review all of our internal policies in our various departments in order to properly address this issue, and to take a step forward in the coming months. We will be assisted in this by Professor Margo Okazawa Rey who will support us in this exercise. A review of the situation and specific discussions will be organized tomorrow to inform all members of OCB on the status of the situation and to take into account the various suggestions that might result.

Several other follow-up committees were established this year on the OCB Board of Directors. A committee dedicated solely to internal and external audits has been set up to give greater visibility to these audits, to monitor them, and to define an annual audit plan. An HR committee has been set up in order to be able to better guarantee follow-up of this area and no longer focus solely on behavioural issues (GAREC). Although the Board of Directors will of course ensure proper functioning and continue to analyze the trends of the GAREC (an adaptation of the ToR has been carried out), the HR committee will allow the Board of Directors to have an overview in the field of human resources. The HR committee is committed to ensure the HR management as a global work force, while admitting that this concept encounters several challenges and constraints during its implementation. We will specifically monitor the progress of the working group on the issue of institutional racism and we are also committed to providing guidance on this problem by sharing it with all of our members. We were able, within the OCB Board, to count on the presence of a field representative, Joël whom I thank, following the motion to have a better participation of the

field staff in our executive and associative platforms, and we will continue in this meaning the years to come; Let us not forget neither the implementation of the financial envelope dedicated to field initiatives and its associative nature.

We cannot forget that yesterday was the official anniversary of the 40th anniversary of the creation of MSF Belgium. Normally, a big party at the Gathering OCB with all our members would have been organized, but the health situation prevents us from doing so. This is only partly postponed because we all feel the need to see one another, to discuss one-on-one with each other, to exchange our opinions and our reflections by highlighting our associative identity, which is also being hindered by this pandemic.

I would also like to honor all those people who have recently left us who have made our association what it is today. Obviously, Marleen comes to mind, she who has been so active at the executive and associative level in a whole range of fields of interventions but it is above all her personality, her energy, her empathy, her listening and her generosity that will remain an example for us! I think of you today especially, Marleen, for tomorrow it will be your values that will continue with us.

I wish everyone good discussions and debates.

Bertrand