ARTSEN ZONDER GRENZEN

Accountability Statement 2015

Accountability statement

▲ Medical Doctor Erna Rijnierse and one of the people rescued at sea. Meditarranean near Italy, May 2015.

This accountability statement by the Board looks at the most important matters in relation to

- the supervision, management, and implementation of policy (governance);
- the effectiveness and efficiency of achieving the MSF objectives, risk management, and internal monitoring;
- informing stakeholders;

and the extent to which these matters affect the realisation of the objectives of the MSF-Holland Association .

This accountability statement should be read as an integral part of the entire Annual Report of the Board and Management Team (MT) and alongside the Financial Statements of the MSF-Holland Association.[1]

The Board reflects on a year in where the entire organisation is going through a period of unexpected growth and our medical emergency work in contexts of armed conflict expanded. During the year, unfortunately, on several occasions we faced direct attacks on our medical facilities, violating our medical humanitarian mission.

[1] The entire project activities referred to in this Annual Report is coordinated by the Operational Centre Amsterdam (MSF OCA) group under the responsibility of the Board of the MSF-Holland Association. The MSF OCA group is the operational partnership in which in particular MSF-Holland, MSF-Germany and MSF-UK cooperate to realise our medical humanitarian mission.

In October 2015, the MSF trauma hospital in Kunduz, Afghanistan, was bombed by the US Airforce, 42 people, 24 patients and 14 MSF staff died and the hospital was destroyed. Between early October and January 2016 three medical facilities supported by MSF were hit in air raids carried out under the responsibility of the Saudi-Arabian led coalition. Of all these facilities in both Afghanistan and Yemen the coordinates of the facilities were known to all parties. All attacks were dismissed as 'human error'. After a disappointing response to our call for independent investigations into these attacks, MSF has collectively engaged in a process of addressing the issue of full accountability regarding violations of humanitarian principles and the threats to our access to the most vulnerable populations.

Also in Leer, South Sudan and in Kobanî, Northern Syria, our medical facilities were attacked and destroyed by warring parties. We have regularly been faced with attacks on our medical facilities in civil wars, especially in the past years. The fact that states that are signatories to the elementary war treaties are clearly involved in the attacks is of great concern to us. Our concern is aggravated by the fact that calls for investigations into these attacks are systematically ignored. We will therefore continue to call for respect for these rules and increased accountability for states.

Despite the growing insecurity and different operational challenges we expanded our operations in the Middle East, responding to the increasing humanitarian needs created by the ongoing armed conflicts in Syria and Yemen. In Turkey, Iraq, Jordan and Syria we are engaged in a wide variety of activities ranging from surgical support to out-patient care, emergency room support, vaccination, non-communicable diseases, mental health, water & sanitation, and the distribution of non-food items. In Yemen we are supporting hospitals in the south of the country on both sides of the frontline in Taiz, Qataba, and Ad Dhale'e, primarily with maternity services and emergency room support.

In March 2015, we entered into a partnership with MOAS[2] for providing medical care on their rescue operations on the Mediterranean Sea and in line with our strategic ambition to engage more with 'people on the move'. Advocacy communications were a main component of this operation that ended in September. Working in a partnership and exploring a new area of operations, rescue and providing medical care at sea proved to be challenging and controversial to many people: our aid was deemed by some – including donors and journalists – as too political. It is at the core of our humanitarian mission to assist people in danger and it did enable us to give a face to people drowning on the shores of Europe and gave us a prominent place in the public discussion around the issue of (forced) migration.

As in 2014 the humanitarian circumstances in South Sudan remained very tenuous. Following continuous fighting and violence against civilians in southern Unity State, a large part of the population fled to Bentiu where we responded to the sudden influx with increased hospital capacity, the establishment of health posts and increased surveillance. Besides addressing hepatitis-E and malnutrition, we responded to a large outbreak of malaria, treating approximately 67,000 patients during the year.

On a more positive note, early in the year our engagement in Sierra Leone in the Ebola response could be downsized as the number of admissions in our Ebola treatment centres dropped considerably. We are committed to stay in Sierra Leone focussing on post-Ebola gaps in the medical care in the country especially maternal health needs, and remain vigilant to possible new Ebola cases occurring. The Board is content with the extensive reflection process on our Ebola intervention that was organized in 2015, the results of which are further elaborated on page 7 below.

In Ethiopia we were granted permission to assist the Eritrean refugees in the Tigray region in two refugee camps while we also expanded our medical aid to people in the Gambela region fleeing the violence in South Sudan. We provided basic health care in hospitals and health posts, and provided water and sanitation activities. In Myanmar we regained access to Rakhine and restarted reproductive health and HIV-related activities for the Rohingya population as well as expanding our work on HIV and tuberculosis treatment in Shan State and Kachin State. Although the size of our operations in Rakhine is still incomparable to what it was before the violence broke out in the region in 2012 or even to what it was before we were expelled from the region in early 2014, the Board believes that with all its operational dilemmas and compromises our presence In Rakhine remains enormously relevant. In 2016 management shall engage in an extensive review of our presence in Rakhine over the period 2006-2015. This review will encompass the choices made by MSF about how best to assist the Rohingya population and our public positioning to this end.

[2] Migrant Offshore Aid Station. www.moas.eu MOAS is a Malta-based registered foundation dedicated to preventing loss of life to refugees and migrants in distress at sea.

In April, Nepal was hit by two large earthquakes to which we responded in an intervention which lasted 2.5 months. We focused on assistance to people in remote areas; distributing shelter kits by helicopter to remote villages, providing basic health care, mental health support and installing emergency water installations. Unfortunately, on June 2, a chartered helicopter returning from an outreach mission crashed in a fatal accident. We are very sad with the loss of 3 of our staff who died in the crash.

Our increased operations in contexts of armed conflict, the biomedical safety aspects of working with diseases such as Ebola but also the accident in Nepal, have caused the Board to carefully reflect on its obligations of duty of care for both our staff and patients. Security and safety of staff is being actively monitored and reported on with the aim to improve our policies and systems where required. The care for staff health will be consolidated and reside under the HR Department as a new Staff Health unit, bringing together medical and psychosocial expertise as well as HR expertise. This will enable us to better assess the effectiveness and relevance of existing policies, guidelines and activities whilst the number of expats passing through our system continues to increase significantly. Whereas this to-be-established Staff Health unit will provide better communication, coordination and systemization of services to expat staff, the need to improve our care for national staff is recognized too. Not only should they be equally included in data collection and analysis, but policies pertaining to national staff should be made situation-specific and psychosocial care should extend its services to national staff.

2015 was again a year in which we could count on the tremendous support of our donors in the Netherlands, Germany, the United Kingdom and all the other countries where MSF is raising funds. We are especially grateful for the overwhelming support from the public and our donors all over the world after the tragic accident in Nepal and after the attack on our hospital in Kunduz. This support enables us to persevere in our work and to structurally expand our emergency aid projects and take initiatives to improve our emergency medical aid. The Board remains actively committed to this during the next few years.

Governance

The Board of the MSF-Holland Association has delegated the day-to-day management of operations and the supporting office to the General Director and the four members of the Management Team appointed by the General Director. The General Directors of MSF-Germany and MSF-UK actively work together with the Management Team in the daily and operational management of the emergency aid projects. The Board retains full responsibility for this work.

The principles of governance that apply to the MSF-Holland Association are detailed in three documents: the Articles of Association, the By-laws, and the Management Statute. In addition, the cooperation agreement with MSF OCA describes the operational management powers delegated to MSF OCA and its supervisory body, 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 that they are actually applied in practice. The Board has monitored this throughout the year with the help of the committees established by the Board and in regular consultations with the General Director and the Controller appointed by the Board.

2015-2019 Strategic Plan

In 2015 management kick-started the implementation of the Strategic Plan 2015-2019 which we adopted in December 2014. The Strategic Plan forms the basic guideline for our medical, operational and organisational ambitions between 2015 and 2019. On the basis of our vision, values, and principles, and following on from an extensive analysis of humanitarian aid in the world, we have formulated six overarching objectives that we will be seeking to attain in this period. As well as these objectives, we want to focus attention on diversity and further globalisation in our organisation.

Main Strategic Plan objectives

Our most important objectives laid down in the MSF OCA Strategic Plan are:

- Improvement in our access to populations in need and acceptance by authorities and populations in our operational contexts;
- A continuing improvement in the delivery of our medical programmes; in particular we aim to achieve medical programmes that are more effective and more accessible to patients and communities, as well as more responsive to their needs;
- Improvement in the acute emergency response, and assistance of refugee populations, provided by both MSF OCA and the wider humanitarian system;

- Recruitment and retention of sufficient numbers of qualified, appropriately supported and well equipped staff;
- An improved support model that offers appropriate, timely services and enables our staff to be field- and needs-driven;
- A decisive contribution to a financially sound and accountable MSF movement, which remains operationally strong and diverse;
- An increasingly diverse, international and inclusive MSF OCA, enhancing our relevance in a changing global context.

Main Strategic Plan achievements

The implementation of the Strategic Plan started in 2015. Main outcome of our strategic plan goals in 2015 translated into the growth of our medical operations activities. A significant achievement has been to maintain our access in Yemen, expanding our medical activity whilst many other humanitarian organizations withdrew their staff and suspended their operations. The growth, relevance and impact of our operations for Syrians improved significantly and our emergency project in Iraq developed in a full-fledged mission in response to its growing humanitarian crisis. Despite this, our ability to access and assist civilians inside Syria remained frustratingly limited and faced set-backs such as destruction of our newly built hospital in Kobanî and border restrictions by the Turkish authorities. Overall, whilst MSF continues to invest in its capability to negotiate and maintain access, this remains our biggest struggle and challenge. The bombings of and attacks on our health care facilities demonstrate that we cannot take this challenge for granted even when we have been able to secure our presence.

Our medical services continued to grow in volume, diversity and complexity, in response to a wide variety of contexts and needs in which MSF performs today. Running tertiary chirurgical facilities, treatment programmes for extremely resistant tuberculosis as well as primary health care centres, MSF has a unique range of medical activity in some very different health care contexts and systems. This presents some hefty challenges which our medical strategy is set to tackle, preserving the capacity and expertise we require for more basic programmes whilst building future capability. None of this will be easy. Medical activities at this scale and complexity are bound to challenge any private organization. But our strategy allows us to structure and plan, with clear deliverables, these challenges. And, in this sense, the strategy is already helping the organization to have an impact on needs today, whilst building our capacity to continue to do so in future. In 2015 we adopted a new approach to monitor the implementation of our medical goals that, besides looking at progress on the objectives, is expected to provide more insight on the performance and quality of our medical projects.

MSF maintains its emergency responsiveness in a wide variety of contexts. In accordance with our strategic objectives, we now offer Water and Sanitation as a first and even a stand-alone response in acute situations, absent capacity or willingness of other humanitarian organizations. Whilst 2014 was dominated by response to a single outbreak, 2015 was characterized by successful emergency response to conflicts, in Yemen, South Sudan and towards refugees. Notably, we engaged in sea-rescue operations, due to increased numbers of asylum-seekers coming across the Mediterranean as their only route of flight to safety and towards a future. The so-called 'European migrant crisis' being a relatively minor reflection of the global crisis of forced displaced, MSF will further expand its response to the plight of refugees, providing assistance where needed most and taking a stand for the right to flight.

The results achieved on the basis of our ambitions regarding our model for support and the international cooperation are reflected upon in the paragraphs below.

International cooperation

In 2015 a new agreement on the sharing of financial resources between the MSF sections was concluded. In the Memorandum of Understanding, which is the third consecutive agreement, comprehensive agreements have been made on the strategic financial planning of income, the bandwidths for operational expenditure as well as the expenditure regarding fundraising, administration and programme support and the main policies that should be governing the financial management of the MSF sections as well as the financial management between them. As a result of the agreement, in 2015 the reserves policy framework has been further agreed. An important element of the reserves policy framework is the expansion of a commonly agreed risk management framework that was led by MSF OCA. At the end of 2015, almost all MSF sections made good progress regarding applying the risk management framework. The intended development of a framework for investment has been delayed into 2016.

An important decision in the resource sharing agreement is that a significant amount of around € 237.5 million of the reserves held between the MSF sections is designated to invest in what is now internally called 'transformational investments capacity', creating an opportunity for triggering changes that would radically improve the organization's ability to address key external and internal challenges. Four main areas of investment have been identified: investing in people, operational 'enablers', to close operational gaps in the delivery of our emergency aid and medical research & development. The MSF-Holland Board and the MSF OCA Council actively support and drive the initiative.

Organisational developments, policies and procedures

The Board and the management realise that the organisation is growing faster than its processes and systems will be able to support and that investing in effectiveness and expertise to sustain optimal support to operations is a continuous endeavour for the year to come. This was already recognised in the Strategic Plan and has become more imminent after the operational growth realised in 2014 and 2015.

Given the importance of good HR processes, adjustments to the structural changes we are undertaking at the head office, were pursued with some urgency in 2015. As a concrete measure we separated the Training Unit from the HR department and gave it the mandate of a separate Learning & Development Department. This will enable the team to move away from operational tasks only, i.e. the provision of training, to a more strategic approach towards learning interventions based on a demonstrated need. In line with this, full priority was given to free up expert capacity via the establishment of a trainers pool, enabling the internal team to develop a programme for management development and leadership for the entire organisation. This is a Strategic Plan priority, and an enabler of many other strategic objectives in the field of people management. Other structural changes were realized already in 2014 but following an evaluation in 2015, it was concluded that they did not achieve the envisaged results. Therefore, further structural adjustments are expected to take place in 2016.

In 2015, the main focus of the HR department remained successfully delivering the field postings and supporting operations, both having seen – again – a significant increase. In the area of recruitment, efforts were made to improve intersectional collaboration within the MSF OCA partnership, each section focusing on the strengths of its respective labour markets. New measures were put in place to recruit candidates for key positions in hospital management as our more complex medical projects require specific competencies. The recruitment function at MSF-Holland will be strengthened in 2016. Investments are to be made in pro-active recruitment, regarding the fields of expertise in which the Dutch labour market excels in terms of quality and availability.

We stepped up investments in leadership, improving working processes and in the area of IT. This has resulted in demonstrable improvements in IT support to field and head office workers. The team's project portfolio is larger than before, and their success rates equally high. The systems supporting our fundraising processes were successfully migrated to our external data centre. We prepared and tested the centralization of our head office end-user support, currently residing with 3 departments, and the first phase of the project which aims to replace our current ERP backbone systems was successfully completed. The team's IT vision and strategy was approved, which built upon guiding principles, clear goals and KPIs, which will enhance the organisation's performance through technology and innovation.

The logistics department delivered a revised strategy based on the MSF OCA Strategic Plan, and started projects to improve local purchasing, importation, forecasting, and warehouse management capabilities.

In the context of international MSF collaboration, further work was carried out on the new system for improving the integration of the financial and logistical administration of our projects. The financial-logistics system was launched in our projects in Bangladesh in August 2015 and is expected to be available in at least 11 of our project countries by the end of 2016.

The above developments, strategic priorities and necessary organisational changes have led to the start of a significant number of improvement projects in 2015. The Program Management Office was created as a department to help build our project management capability in our support departments, to assist management to make the right decisions regarding our total portfolio of projects and to run a number of transformational projects. Management already prioritized a number of larger projects, and will need to continue to prioritize improvement projects of all sorts, in order to help the support departments to keep up with the regular, but growing, support demands from operations.

Planning and control

In accordance with the regulations of MSF, the Board approved the 2015 Annual Plan. The Board considered the Annual Plan to be in line with MSF OCA's 2015-2019 Strategic Plan, approved in December 2014. Although much of the planning and control cycle is covered by the responsibility shared with the MSF OCA Council, the Board is regularly informed on the objectives, programmes and activities included in the Annual Plan. MSF has a planning and control cycle with three main reporting stages: the Annual Plan (in the autumn), the adjustment of the Annual Plan (in the spring) and the fulfilment of the Annual Plan after twelve months. In view of the growth of our operations and the programme support management is adjusting the planning and control cycle reporting to ensure we retain the right levels of delegation and accountability. The reporting contains concise management information on the projects, medical quality and the amount of aid provided, as well as the income (fundraising) and expenditure (HRM, financing, purchasing). Investing in improving reporting and management information is a priority in the following years.

Programme evaluations and reflection

Every year, a number of programmes are carefully selected for evaluation. In 2015 we engaged in an extensive internal reflection on the Ebola intervention in Sierra Leone focussing on 2014. Following the tragic helicopter accident in Nepal management reviewed the flight operating procedures and operator contracting procedures.

Reflection on our Ebola intervention

The internal reflection report for MSF OCAs Ebola intervention in Sierra Leone showed that, overall, there has been good support and understanding for the medical operational choices made at key decision moments. It was correct for MSF OCA to select both the reduction in transmission of the virus and the provision of individual patient care as equal objectives for our response; however the implementation of our outreach strategy was not consistent across the sites. The intentionally short contracts and the subsequent high staff turnover were identified as the cause of many of our programmatic problems. It created a huge workload at our HR department, made improving clinical care in the Ebola Management Centres (EMC) difficult and proved to be the causal link to most management problems. This had a hugely negative impact on the work, affecting especially our national staff.

The Ebola task force we set up in the head office functioned well throughout our response, in spite of new roles and new lines of communications that were necessary. Overall, the taskforce was effective in minimizing the impact upon other missions and facilitated the changes required throughout MSF OCA. We have learnt that we can scale up quickly and effectively. This was achieved through the acceptance and active support of the management, the allocation of extra resources (such as staff for fast-track recruitment and posting and the staff health unit) and was made possible by clear choices regarding executing or postponing other projects. Biosafety was an important element in the Ebola intervention. It was one of our biggest successes. However, the biosafety protocols combined with the high patient numbers had a negative impact on the level of care we were able to provide in the EMC. However, adapting our biosafety protocols sooner in response to changes in the development of the epidemic and the increase in our knowledge and the growth in our experience would have improved our intervention. This would have made it easier for staff to find the correct balance between biosafety and patient care in both the EMC and outreach.

A main question for the Board has been whether we have been doing enough in terms of duty of care towards our staff. The answer is a resounding yes. When compared with our non-Ebola missions, the Ebola mission provided higher quality of living conditions and achieved a higher score for good collaboration between international and national staff. Despite inexperienced staff fulfilling coordination positions, the quality of management they provided in the Ebola intervention was perceived as better than in our non-Ebola missions. The HQ team provided outstanding quality in terms of briefings, guidance and training. All our international staff felt 100% prepared for their missions. All of the staff who became sick during the 21-day monitoring period found the guidance provided to them useful.

Flight operations procedures

Separate from the formal investigations around the helicopter accident by the competent authorities in Nepal, and in line with standard practice after occurrence of a serious safety or security incident, MSF OCA has reviewed the circumstances surrounding the air operations in Nepal. The purpose of a broader review was to identify any lessons learnt and possible implications for policy and procedures. In this way MSF commits to continually improving the overall management of risk and safety and security of the organisation's staff and beneficiaries.

From the review a number follow-up actions are being taken up by the management. A key recommendation is that here is a need to clarify roles and responsibilities between MSF and air operators/service providers for different types of engagement. This translates, amongst other things, in defining a risk matrix for air operations which should give insight into the specific risk associated with the type of air operations involved and the basic mitigation measures that should be put in place, improving contracts with air operators and improving standard operating procedures for flight operations (e.g. including obtaining hazard reporting) .

Evaluation 2013 Strategy Water, hygiene and sanitation

Our strategy for meeting the Water, Hygiene and Sanitation (WHS) needs in large scale emergencies was developed 2013. The objective of the evaluation was to assess the extent to which the renewed investment has since contributed to a sufficient response or whether MSF OCA should engage in large-scale emergencies in a more assertive manner. This evaluation is to be viewed in relation to the 'Where is everyone' report that was published by MSF OCA in 2014 .The evaluation focused on our interventions in South Sudan in Jamam, 2012, Bentiu in 2014, CAR/Bossangoa and Bangui in 2014 and Ethiopia/ Gambela in 2014. The evaluated period was the first 3 months of the actual commencement of interventions.

MSF OCA typically would like to take on the responsibility of WHS in the first 3 month of an emergency after which activities ideally should be handed over to other actors. A key recommendation of the evaluation is that a clearer more timely handover strategy should be developed to improve

the communication with other actors and with donors. This should provide an outline regarding what is expected from other actors in terms of taking over facilities, possibly combined with pre-emptive agreements with major WHS actors.

The evaluation is generally positive on the contents of the delivered WHS facilities although there is a clear recommendation to identify appropriate solutions to ensure proper drainage at water distribution points and showers in difficult settings (black cotton soil for example). Another key recommendation is made on the finding that data collection has been difficult as in different emergency setting accounting for WHS activities follows different operations logics and is not easily identified as WHS expenditure. Management will follow-up on these recommendations.

Strengthening reflection and analysis
Current external developments in humanitarian action are leading to major questions concerning access to populations and respect of humanitarian principles. The Board wishes to strengthen its reflection and analysis capacity with regards to humanitarian principles and action, in particular regarding the protection of the medical mission and regarding migrants and refugees. It is intended to develop a capacity that conducts and commissions studies of humanitarian predicaments and their challenges for MSF's response. This capacity should support the Board's supervising role and providing strategic guidance to the executive.

Internal and external audits

Internal audit
MSF employs two full-time auditors who report to the Controller. The Controller reports directly to the Audit Committee of the Board, the MSF OCA Council, and the General Director. The Board has monitored the progress of the 2015 Audit Plan and the resulting management actions and has approved the Audit Plan for 2016. The audits are planned and conducted based on a systematic risk assessment. In 2015 a start was made with a more specific audit scope in consultation with the Head of Mission of the mission which will be audited. The approach will be further tested in 2016. Six internal field project audits have been scheduled for 2016. An additional two audits of head office processes are planned.

In 2015, a total of six internal audits were carried out of our activities in Central African Republic, Gambela project in Ethiopia, Jordan, South Sudan and Turkey (North Syria activities) and Haiti. At the head office in Amsterdam the reliability of reporting indicators around recruitment processes was audited revealing weaknesses in the primary registration and reporting errors.

The quality of the corrective actions based on the recommendations from the internal audits are periodically assessed by the management team. In general, the findings are followed up properly in all of the project countries. In addition to the specific findings, the audits focused mainly on those issues that affected several project countries. Examples include the continued need to adhere to local taxation and employment laws and to improve stock management. The findings, reports and the follow-up of the recommendations in the internal audits are reported to the Audit Committee and discussed in its meetings.

The internal audit in Gambela, Ethiopia was based on a draft fraud incident report but not designed as a forensic investigation. The internal audit revealed omissions in past contract management and the procedures around payments to daily workers working in the refugee camp setting. The complicated internal management structure of having a parallel emergency support intervention within an existing mission added to weakness in the internal control mechanism in the project.

The internal audit in Turkey had a specific focus on the complicated operations compliance requirements that impact all programme support departments and that require different levels of adherence to standard procedures and documentation. As a result mission specific policies have been drafted.

In 2015, the most common findings were listed and discussed with the different management levels. The Board and the Audit Committee are regularly informed on progress made with regard to the most common findings.

External audit
In their report the independent external auditors (PricewaterhouseCoopers Accountants N.V.) highlight the ambitious operations growth the organisation is going through. In relation to the growth a key recommendation from the auditors is to reinforce the quality of our project budgeting and control capacity and to ensure our internal control procedures remain in line with our growth. Management recognises that due to the changing scope of programmes, such as the increased investment in medical facilities, follow-up actions are necessary. In addition the external auditors emphasize the importance of obtaining and maintaining knowledge of local tax legislation and registration requirements, this is also recognised by the management. As a mitigation measure we have invested in legal capacity at the head office in support of our operations.

Risk management and integrity policy

The integrity of our projects and the prevention of fraud and corruption remain high on our agenda. All our relevant policy documents and an accessible summary of these were issued to all our employees in the first quarter of 2015 (in English and French).

No significant cases of fraud were reported in 2015. Proceedings are still ongoing in our project in Katanga, in the Democratic Republic of Congo, where we detected fraud during an internal audit in 2013.

The management of our risks and continuously improving this activity is one of the most important priorities of the Board. A risk inventory is maintained throughout the organisation, involving employees and the middle management. The risk assessment involves the identification of risks with potential consequences for achieving our goals, including the quantification of the financial consequences and likelihood of the risks actually occurring. The Board is also paying particularly close attention to risks that could undermine MSF's reputation, and therefore the trust of our donors. On the basis of the risk analysis, we calculated the financial buffer required to absorb these risks and integrated this into our reserves policy. This has enabled us to efficiently redesign our risk management policy so that we can respond to these risks more adequately. The Board recognises that risks are inherent to our work and is working on creating an open culture in which risks can be discussed.

Horizontal supervision and covenant

In 2009, we made a covenant with the Dutch Tax Administration regulating the fiscal relationship between the two parties and including agreements on supervision, specific procedures and the open exchange of relevant information. This covenant remains extremely relevant. In 2015 no significant issues needed to be discussed with the Dutch tax administration. For 2016 management has identified the complete and correct application of VAT rules as issue for follow-up. This is mostly the result of the growth in variety of financial transactions for goods and services with foreign parties.

MSF-India

The Indian branch of MSF-Holland was set up in January 2013 at the request of MSF International. The aim of setting up a branch in India is to strengthen MSF's presence in India and the region. MSF-India has much to offer the international network of Médecins Sans Frontières, including building up a structural relationship with the strongly developing Indian society and the wider region, raising funds, and recruiting employees. India is also of great importance for medical research, medical innovation and the production of the so-called generic drugs that are often used by MSF. We started fundraising activities on a small scale in India in May 2013 and are gradually expanding the investment in fundraising. A net total of € 1.95 million was invested in MSF-India in 2015. This investment is being monitored using internal control procedures.

MSF-Holland has a formal stake of 80% in the future share capital of MSF-India. The remaining 20% is in the hands of the British section of MSF. The fact that MSF-Holland has a majority interest, which is regarded by the Indian government as a major foreign interest, led to increasing difficulties in the development of the Indian office in 2014. The free import and export of funds is not possible, for example. In 2015, the Board has therefore decided to reduce its formal stake to 1% starting the Indian fiscal year 2016. The remaining shares will be transferred to Indian residents who are affiliated to MSF. This will be done alongside a package of measures that will guarantee effective monitoring by the Board.

Communication and advocacy

In 2015, MSF-Holland kept up the high pace and large scale of communications set in 2014, both to our donors and in relation to (press) publications in external media – radio, television, newspapers, magazines, and medical journals. While the unprecedented Ebola epidemic resulted in unprecedented news coverage in 2014, 2015 saw several major crises causing headlines. As of April, we reported actively to media and donors on the natural disaster in Nepal and our aid. At that point, we had also garnered headlines for our announcement that we would commence search and rescue operations in the Mediterranean Sea. Our aid to refugees at sea, as well as the migration issue at large, stayed in the news throughout 2015.

This was spurred on by our advocacy efforts concerning the migration issue. All through 2015, we (also in cooperation with other organizations) have pleaded for safe, legal passage for these refugees.

In October our trauma hospital in Kunduz, Afghanistan, was hit by a dreadful airstrike. The nature of the incident, an attack by US forces and the subsequent dismissal of the attack as 'human error', generated many (in-depth) articles and stories, as well as a proactive lobby campaign by MSF in which we called on the general public to sign our petition demanding an independent investigation into the attack. We also called on the Dutch government to support our demand. Disappointingly, they replied that they had faith in current investigations by the parties involved.

We have at various moments continued to raise awareness for the need for rapid independent humanitarian assistance both in anticipation of the World Humanitarian summit and as a follow up to the "Where is Everyone?" report.

Of course, we also kept calling for attention to the many other humanitarian crises in which MSF OCA works, both through participation in and organizing briefings at the Ministry of Foreign Affairs regarding several key contexts. This was combined with continuous communications efforts and through publicity campaigns aimed at the general public through our own channels.

This included calling attention to issues of access to affordable medicine for people with HIV and TB. Together with the AIDS Foundation, MSF launched a petition that called upon the Dutch Minister for Foreign Trade and Development Cooperation to press for fair prices and better access to HIV medicine. With KNCV TB Fund, MSF called upon the same Minister to help improve diagnostics and treatment methods for people with multi-resistant TB.

In our campaigns to the public, most primarily intended to raise awareness about our work and the challenges faced by our patients, we focus on telling the stories of our patients through the eyes of our aid workers in countries like South Sudan, Democratic Republic of Congo, Central African Republic, and Syria/Jordan. To reach as many people as possible, we used different channels to disseminate these stories: traditional media like television, magazines, and newspapers, and 'new' media like our website, social media, and external websites, where we published our branded content in the hope of reaching people who, generally speaking, otherwise would not likely see our stories.

Our rapport with (traditional and commercial) media outlets remains strong. They are generally very supportive of our organization, and frequently offer us extra exposure or special tariffs. Similarly, our (steadily growing number of) followers on our social media channels show great support, as well high engagement to our posted content. Many Dutch signatures on our Kunduz and medicine petitions were generated by requests on Twitter (over 5,000 followers) and Facebook (over 70,000 followers). In 2015, we started experimenting with other social media channels such as Instagram.

In all our communication, we remain committed to bringing the reality of the field to the general public and engaging a broad audience with MSF's work. We continue to be successful in doing so: among the public, we have a spontaneous name awareness of up to 23% (as researched by market research organization GfK). Finding out and learning how to be relevant for younger (and future) generations remains one of our major challenges. The media landscape and the way people process information is changing rapidly. To stay visible and relevant, we will need to change the way we share our stories.
When reporting to individual donors in the Netherlands, MSF-Holland adheres to principles and guidelines set out by the CBF and the Dutch charity branch organisation Goede Doelen Nederland. The CBF seal of approval was again granted for a three-year period and is valid until July 1, 2017. There are no outstanding issues with regard to the CBF seal of approval. A new validation system for charities in the Netherlands is currently being developed. The Board is following discussions on the new validation system with interest.

The Association

The Association had 695 members as of 31 December 2015 (2014: 656 members). Of the 695 members, 432 live in the Netherlands and 263 live abroad.

There is an ad hoc Association Affairs Committee to which the tasks and responsibilities pertaining to the promotion of an active and vital association are delegated. On 31 December 2015, the Association Affairs Committee consisted of two Board members, Josine Blanksma and Annemarie ter Veen, two co-opted Association members, Michiel van Tongeren and Corinne Grant, and an Association Affairs staff member.

General Assembly

On 30 May 2015, the Board accounted for its policies to the General Assembly. The meeting was attended by 113 members A large number of members attended the meeting online, via a livestream. Altogether, 241 members voted to adopt the 2014 Financial Statements, and for the election of new Board members and various Board and Association member motions regarding the acceptance of institutional funding and regarding pushing the boundaries of MSF OCA's engagement in non-communicable diseases. The Board further informed the members about its' actions taken in returning to Rakhine, Myanmar. A lively debate was held with the members about the dilemma of decreasing interest rates for MSF-Holland's reserves and the risk of investing compared to maintaining the capital on bank accounts. This provided further input for the development of an investment policy.

Several current humanitarian medical crises constituted the main topics debated at General Assembly: balancing care of our patients & safety of our staff in the fight against Ebola, migrant issues around the Mediterrean Sea, dilemmas of speaking out regarding the oppression of the Rohingya population in East-Asia and working in highly insecure contexts like Syria and Somalia. Members discussed specifically if and to which extent we could/ should compromise on MSF's principles (independence, neutrality and impartiality, medical ethics and respect for human rights), acknowledging that these principles are not a goal in itself but guide us in the work we do.

Debate meetings
In September 2015, a lively and successful 'OCA Cafe' was held for the third time. The MSF OCA Council informally accounted for its monitoring activities and policies to the members of the partner sections of MSF OCA, including the Netherlands, Germany, the United Kingdom, as well as to the members of the MSF organizations in Canada, South-East Asia, East Africa, and Sweden, with which MSF OCA has a more close co-operation. Information was provided about MSF OCA's medical operational policies and debates were held about the themes People on the Move or People in Flight?, MSFs positioning on the refugee crisis, Hepatitis C, Should MSF treat or not? and IS, to negotiate or not to negotiate?

The Association organised 8 debates and information evenings for the members on, among other things: Reflection on Srebrenica, MDRTB, Protection of Civilians, Ebola & the quality of care and the Associative roadmap (on growth strategies).

Other activities of the Association
An important activity of the Association is the organisation of the speakers' pool. Returning MSF OCA field employees are invited to give talks at schools, universities, social organisations, etc. regarding their experiences in the field and about MSF's work. 220 of such presentations were given in 2015 (2014: 190).

The Association is also closely involved with the organisation of the Psycho-Social Network, which provides support by volunteers to field staff on their return home. Alongside the professional debriefing and supervision, returned staffs are also offered peer interviews or other means of support should they require them.

Composition of the Board

On 31 December 2015, the Board consisted of 10 Board members (2014: 10). The members of the MSF-Holland Association vote for the Board members from among their number. The 2015 Board elections were held during the statutory General Assembly of 30 May. Additionally, the Board has the option of appointing three members who have specific expertise or experience in order to enable it to perform its duties effectively. The composition of the Board is as follows:

Appointed or reappointed in	Name Function (duration of membership)	Termination from	Functions
2015	Wilna van Aartsen (third term) President – member of the MSF OCA Council, member of the Board consultation body; member of the MSF OCA Audit Committee	2018	No other functions in addition to Presidency
2013	Joost van der Meer (first term) Vice-President – member of the MSF OCA Council, member of the Board consultation body	2016	Public Health and Humanitarian Aid Consultant at Phesta; member of the 'TB in Prisons' working group of the International Union against Tuberculosis and Lung Diseases (IUATLD); treasurer of Nedwork Broodfonds; Chairman of the Board of the Aids Foundation East-West (AFEW) Ukraine; Chairman of NVTG Public Health working group
2014	Joke Bakker-Jansen (second term, co-opted member) Treasurer – member of the Board consultation body; non-voting member of the MSF OCA Council; Chairman of MSF OCA Audit Committee, Chairman of Remuneration Committee	2017	Chief Financial & Risk De Goudse NV Director - Goudse Levensverzekeringen NV - Goudse Schadeverzekeringen NV - Goudse Verzekeringen Services BV - Automatiseringsmaatschappij Gouda BV - Goudse Assurantiedesk BV - Goudse Beleggings-en Financieringsmaatschappij BV - Collectie Stationsplein BV - Assurantie Maatschappij Hollandia Anno 1924 NV Member of the Netherlands Institute of Chartered Accountants ('Nederlandse Beroepsorganisatie Accountants', NBA); member of the Professional Risk Managers' International Association (PRMIA)
2013	André Griekspoor (first term) Member of the MSF OCA Medical Committee	2016	Employed with the World Health Organization (WHO); member of the Active Learning Network on Accountability and Performance of the Overseas Development Institute (ODI)
2013	Annemarie ter Veen (first term) Member of the Remuneration Committee; member of the Association Affairs Committee	2016	Senior Advisor with the Royal Tropical Institute (KIT) Amsterdam; lecturer at the London School of Hygiene and Tropical Medicine; member of the Afghanistan National Public Health Organisation
2014	Joe Belliveau (first term)	2017	Programme Director Humanitarian Access & Negotiations at Conflict Dynamics International
2014	Josine Blanksma (first term)	2017	Trainee general practitioner; International Healthcare and Tropical Medicine doctor
2014	Gert van Essen (first term, co-opted member) Member of the MSF OCA Audit Committee	2017	Supervisor: - Stichting IJsselland Ziekenhuis - Stichting Zorgsaam Terneuzen - Rode Kruis Ziekenhuis BV - Bright HR Strategy consultants; NVZD assessor; Director Ndola Holding BV
2015	Jacques de Milliano (first term)	2018	General practitioner
2015	Unni Karunakara	2018	Senior Fellow, Jackson Institute for Global Affairs, Yale University; Assistant Professor, Mailman School of Public Health, Columbia; University Director of Drugs for Neglected Diseases Initiative (DNDi) India

Two Board members, Nonhlanhla Dube and Peter Giesen, stepped down in 2015 upon reaching the maximum permitted period of office. Wilna van Aartsen has been re-elected by the General Assembly for a third term of three years.

All Board members provided full disclosure of their professional activities, their ancillary activities and other interests in accordance with Article 5 of the By-laws. The Board has determined that there is no direct or indirect conflict of interest.

Evaluation of the Board
An evaluation of the Board is held every year, in which the Board evaluates its performance in relation to processes, content, meeting style, and its relationship with the management team. The evaluation held in September 2015 led to a better understanding of the strengths and challenges of the Board as a whole and focus on pro-active agenda setting and scanning the way ahead with the agenda setting for the Strategic Plan implementation 2015-2019, identification of ownership and the division of subject areas among the various Board members.

Remuneration and Board expenses

With the exception of the President, no Board members are remunerated for the work they do for the Board of MSF. The Board members are reimbursed the costs they incur for travel, printing, telephone calls, etc. Board members may receive a volunteer payment of no more than € 1,000 per year. Nine Board members exercised this option in 2015.

The MSF-Holland Articles of Association specifically determine the remuneration of the President. The President may receive partial remuneration exclusively for the time he/she spends on Board responsibilities for the international MSF network. It has been agreed with the CBF that '… the remuneration, or partial remuneration, of the President may be granted exclusively for activities and agreements within the international network of Médecins Sans Frontières and in his/her capacity as a member of the various executive bodies within the network'.

The President's remuneration is detailed in the 'Policy on the Remuneration of the MSF-Holland Board' and is in accordance with the principles approved by the General Assembly.

- The President can claim remuneration for a maximum of 20 hours per week;
- The hourly fee is based on the salaries of the Management Team;
- The President's other income is taken into account when determining his/her remuneration.

In 2015, MSF-Holland paid the President, Wilna van Aartsen, the sum of € 15,000 (2014: € 15,000). In accordance with the approved policy, this amounts to an hourly rate of € 47.24, up to a maximum of € 1,250 per month. It was determined in 2015 that this is realistic remuneration for the extraordinary workload related to her international Board responsibilities. In 2015, volunteer payments to Board members amounted to € 7,000 (2014: € 5,500).

Board meetings

The Board met five times in 2015: on 23/24 January, 10/11 April, 19/20 June, 25/26 September, and 27/28 November. Telephone meetings were held on 21 May, 8 July, 14 October, 9 December and 21 December.

The MSF OCA Council met five times: on 13/14 February, 17/18 April, 10/11 July, 16/17 October and 11/12 December.

It is estimated that the Board members spend an average of one day a week on their Board responsibilities. There are large differences in the time spent by the various members on their Board responsibilities, depending on their membership in Board committees and the MSF OCA Council.

Consultations with the Management Team
A permanent delegation of the Board holds consultations at fixed times with the Management Team and the Controller concerning ongoing organisational matters that do not or do not fully require the involvement of the Board, the progress with regard to matters previously discussed, and the preparations for plenary Board meetings. There were three such meetings in 2015 (on 3 March, 3 November and 15 December).

Supervision

MSF-Holland has three statutory committees: the Medical Committee, the Audit Committee and the Remuneration Committee.

Medical Committee
The Medical Committee consists of four members. The partner organisations in the Netherlands, Germany, the UK and Canada each have a representative on the committee. The Chairman of the OCA Council and the medical director also take part in the meetings. The Medical Committee is chaired by André Griekspoor.

The Medical Committee advises in first instance the MSF OCA Council and indirectly the Board of MSF-Holland on medical policy and approves the framework for providing

accountability for the execution of the scheduled medical programmes. The Medical Committee met five times in 2015 (in person or per teleconference): 7 April, 7 May, 7 July, 28 September and 8 December. Specific topics discussed in the Medical Committee were amongst others Ebola treatment protocol and lessons learned, paediatric guidelines and medical data collection, and the desired strategy on treating non-communicable diseases. As a standard agenda item the Medical Committee monitors the progress and development of the medical goals and associated projects as intended in the Strategic Plan and the quality of care towards our patients.

Audit Committee
The Audit Committee consists of six members: the treasurers of MSF-Holland, MSF-Germany, MSF-UK and MSF-Canada, the President of the Board and a Board member of MSF-Holland. The Chairman of the OCA Council, the Controller and the General Director of MSF-Holland take part in the Audit Committee meetings. The treasurer of MSF-Holland, Joke Bakker-Jansen, is the chairman of this committee.

The Audit Committee advises both the MSF OCA Council and the Board of MSF-Holland on matters of finance, risk management, governance and internal control. In 2015, the Audit Committee met on 7 January, 30 March, 13 April, 6 July, 12 October and 7 December. In 2015, the committee advised the Board primarily on the 2014 Financial Statements, the 2016 budget, the MSF-International led Resources Sharing Agreement, the interim financial reports, and the findings of internal audits that were carried out by the Control Unit both in the field and at the head office. The development of an investment policy, started in 2014 under the supervision of the Audit Committee, has been put on hold awaiting further guidance of MSF-International to ensure full alignment between all MSF-sections. The committee also consulted the independent external accountant, PricewaterhouseCoopers accountants N.V., on its findings in relation to the finances and internal controls.

Remuneration Committee
The Remuneration Committee consists of three Board members and is chaired by Joke Bakker-Jansen. The meetings of the committee are also attended by the head of the HR department and the Controller. The Remuneration Committee advises the Board on the framework of the remuneration policy for MSF and the specific remuneration policy for the members of the Management Team and the Board members. The Remuneration Committee has not met in 2015 as there were no appointments or remuneration issues for advice to the Board.

Consultations with the Works Council
The Board and the Works Council have not met in 2015 as for simply practical reasons agendas could not be aligned.

Meeting with heads of departments and operational managers
The MSF regulations provide for an annual consultation meeting between a Board delegation with the departmental heads, with the Controller, and with the operational managers. This specific consultation meeting did not take place in 2015. However, there was regular bilateral contact between the President and the Controller, and between the President of the Board and a number of departmental heads and operational managers. Furthermore, on a regular basis the Board invited heads of department for a consultative session in its meetings.

Accountability

In the opinion of the Board, the 2015 Annual Report provides a fair reflection of the programmes, activities, and a result achieved in 2015 in relation to the agreed 2015 Annual Plan, the long-term strategic objectives, and to what was approved by the Board during the course of the year. The Financial Statements drawn up by the Management Team for the year ending on 31 December 2015 fairly reflects the financial position and transactions of the Association MSF-Holland. The Board is confident that in this Annual Report and the present accountability statement the application of the three main principles of good governance related to oversight, policy and communication with all stakeholders of the organisation is well explained. By signing Appendix 12 of the CBF, the members of the Supervisory Board and the Board state their individual approval of these three principles of good governance for good causes.

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.

On behalf of the Board and the OCA Council, we would like to thank every MSF employee and volunteers for their relentless efforts for and dedication to realising our medical and humanitarian objectives all over the world in 2015.

Amsterdam, 8 April 2016
On behalf of the Board

Wilna van Aartsen, President