Approved minutes OCA-Council Meeting
Tuesday June 29, 2010 10h30 – 16h00
Amsterdam Office MSF-H, meeting room “Afghanistan”

Present: Pim de Graaf (chair), Wilna van Aartsen, Paul Foreman, Simon Burling (till 16h00), Tankred Stöbe, Katja Kusche, Joni Guptill, Bruce Lampard, Justin Fryer, Hans van de Weerd (as of 14h00), Michel Farkas (as of 11h00), Leslie Shanks (as of 10h45), Arjan Hehenkamp (as of 10h45) and Thijs van Buuren (for Integrity of Missions topic only)
Minutes: Margreet Kamp

Agenda

Planning of the day and Approval of minutes
2b) Strategic Plan Review (Review IC decision and explore impact on OCA)
2c) Governance of OCA during SP period
3) MT update
4) Operational red flags
5) Reporting OCA Medical Committee
6) Forward planning of the OCA-Council meetings and AOB

Planning of the day and Approval of Minutes

The chair opens the meeting and the agenda is stipulated un-amended.

The draft notes of the OCA-C TC about Governance on March 3, 2010, are approved without further textual edits.

The draft Minutes of the OCA-C F2F meeting in London on March 26, 2010, are approved with the following amendments:
- On page 2/OCA-Council Treasurer – in practice (+ on page 10/Action & Decision List): ‘MSF-Canada (Bruce/Joni) will set up TCs between Justin and Canadian Treasurer and Board members’ should read ‘MSF-Canada (Joni/Bruce) will set up a meeting between Justin and the Canadian treasurer’
- On page 2/OCA-MT Review: the first paragraph should read: ‘In the past a survey was conducted among OCA-MT, OCA-Council and OCA Platforms. A follow-up of the platform’s (director’s) level to assess its working relationship with the MT was planned. Therefore the platforms are included in the recent survey, but unfortunately the buy-in from the selected Platform members was small (4 out of 6 responded)’.
- On page 5/Financial Overview: the sentence ‘would the Council prefer it to go to the general (free) reserves or to the ‘earmarked’ (restricted) reserves?’ should be deleted.

The draft Minutes of the OCA-C F2F meeting in London on March 26, 2010, are approved without further textual edits. Some pending actions from the ‘Plan of Action for the implementation of OCA MoU & ToRs’ are repeated below on page 8/Action list.

The draft Minutes of the OCA-C TC about SP Review on April 15, 2010, are approved without further textual edits.

The draft Minutes of the OCA-C TC about AP indicators/MT Review/Confidentiality clause on June 15, 2010, are approved without further textual edits. Pending actions are to be included in the wish-list for AP 2011, on the agenda for the September meeting. Paul and Wilna volunteer to
discuss with Hans and Michel the set of indicators (excl. medical indicators) for AP 2011, between now and end of September (keeping in mind that the OCA-Council should avoid asking for too detailed indicators, i.e. micro-management).

### 2b) Strategic Plan Review – IC decisions and impact on OCA

- In future the executive cannot stand for Board membership/cannot vote.
- Fully elected IB (5 sections were in favour) was rejected.
- IGA (and not IB) should be responsible for (non-) establishment of New Entities and Operational Directorates (ODs). (IGA has to 'approve' instead of 'endorse', as it was formulated in the proposal).
Composition IB: 5 OC / OD representatives, the International President and 6 further elected members (positions for which any Association member can stand); if executive, they have to leave their executive position. IB members may be remunerated may be remunerated for up to 50% of a full time salary; the president however can be compensated for full-time work.
- Criteria for members joining the IGA apply to new and existing entities. New entities should at least have 50 members, strive for majority being medical, and 30% needs to have int. field experience. Implies further harmonization of membership criteria.
- Number of ODs remains flexible.
- FADs: only one Board member per OC will take part in a FAD => within OCA we have to coordinate this. All sections have 11 Board members, so 44 in total, which is more than the number of OCA FADs. One section should coordinate the visits of the OCA Board members: Germany will do so.
- ICB should revisit question of joint coordination mechanism. (Note that MSF-UK abstained, because they feel it is not an associative matter). A cost-risk-benefit analysis takes however several years.
- For Iraq the Executive came up with OCP taking the lead in representation; IC not satisfied, tasked ICB with monitoring. OCA-Council will ask OCA-MT how they assess the current set-up with regards to coordination and security. An eventual Council decision (as stated in March, OCA-Council might advice withdrawal of OCA when MT gives red flag) will be taken afterwards (during VC on July 15th).
- The Int. Governance WG is dissolved, ICB takes over. Tasks are divided as follows: Follow-up Governance in general, lead by Abiy - President MSF-Switzerland Development Movement-wide Vision, lead by Pim - President MSF-Holland Development International Association (AIM), lead by Matthew - President MSF-USA Follow-up Executive Reform, lead by Marie-Pierre – President MSF-France

### 2c) SP Review - Governance of OCA during SP period

The Council members are asked whether they see the current OCA structure fit to continue with for the next Strategic Plan.

MSF-Germany has discussed this topic during their Board retreat. Re. the *associative* level they concluded that they wish to maintain the current OCA-Council structure with 2 reps per section plus the additional Treasurer. Re. the *executive* level they feel that OCA and MSF-Holland need to be separated out more, i.e. the OCA-MT chair should be independent and fully dedicated to chairing the OCA-MT (not to be combined with a GD position, also for workload reasons). They proposed the following MT composition:

- 1 Chair + the 3 Directors, being DirMed + DirOps + DirRes (Chair independent from sections; GDs should form separate platform) [BUT: also opposition against creating more FTEs/posts]
- 4 GDs + DirMed + DirOps + Chair (=DirRes) [Chair would be independent from sections without creating additional FTE]
In general the German Board considers the OCA a transitional structure, meaning that they are open to changes and ambitions.

The MSF-Holland Board wants to be more ambitious: apart from looking at the structure they want to make a step further. Re. the associative they are satisfied with the Council structure, having 2 reps from MSF-Holland fully mandated. However the Dutch Board wants to be consulted on certain matters, such as the SP review, and there the double reporting problem appears. Next they consider the accountability of the Council ambiguous and therefore suggest exploring the establishment of 1 OCA association. OCA could be governed by the Council, composed of members from the OCA Association. The current legal status of the MSF-Holland Board could be used as a vehicle to create an OCA Association. Also they intend to include MSF East Africa in the governance of OCA and search for an appropriate way to do that, and to explore how best to engage with MSF India. The MSF-Holland Board rationally accepted the mandate of the OCA-Council, but in reality it is not always applied. They wish to make a clear spit between home society and operations, and maybe reduce the number of Board members.

Re. the executive governance of OCA the Dutch Board has asked the MT for proposals for a different management, disentangling MSF-Holland and OCA responsibilities. Also the availability and predictability of (human) resources has to improve, the 70-30% allocation of funds of partner sections should be re-discussed and an agreement on the use of reserves should be reached at Council level.

In general the MSF-Holland Board would like the OCA to be a catalyst for change in the light of the IGR, on three of its main objectives: inclusiveness, reduction of complexity of the organisation and of inefficiencies.

Formal reflection from the MSF-Canada Board: they feel multiple commitments, as they are committed to continue with OCA, but also want to stay loyal to secondary partners and the int. movement. If there is a redistribution of funds (RSA), MSF-Canada might alter their financial contribution division. They consider OCA and MSF-Holland too much intertwined, esp. in the role of DirRes, and are open to add another layer/independent person (outside of the managerial line) that could be the link between Associative and Executive. Anyhow the structural change should allow for more visionary and strategic discussions at executive level. The Canadian Board supports crosspollination with other sections.

The Board of MSF-UK generally felt that the OCA within it structure should be left intact, allowing organic growth or adaptation. In the UK office there’s no real sense of OCA engagement or involvement (more MSF International), however the platforms are in place and are functioning and appreciated, so the integration of the Manson Unit is no longer an issue. Re. the executive structure there are no objections against a GD4 platform in combination with current OCA-MT structure. If the model has growth potential, it should be outward looking. MSF-UK remain committed to Belgium for 30%.

MT/DirOps: re the associative structure Arjan supports openness to new entities (East Africa) in OCA, reaching out for other OCs and sections, resulting in a more a dynamic Association. He is in favour of creating of an OCA Association with elected OCA-Council. Re. the executive structure Arjan brings forward some negative elements of having an independent OCA-MT chair: it would imply a break in the operational line (independent OCA-MT chair – GD – DirOps) and adding other layers. Re. the executive structure Arjan thinks that –for the moment- no radical changes should be made; the request for a more elaborate vision and strategy has always been requested, regardless of any structure. He struggles with the model of co-management: the combination of day-to-day-management with vision and strategy comes at a cost (GDs of PS struggle with responsibility and decision-making). Still for now he sees the necessity of the OCA engagement: it has positive effects towards operational projects (although it could be more efficient).

MT/DirMed: Leslie is not sure if the OCA has produced what we were hoping: financial stability hasn’t changed by establishing the OCA, and she only heard the UK saying they feel closer and
more focussed on Ops. Leslie agrees with Arjan about the difficulties of co-management: the 4 GDs on the OCA-MT need quality and F2F time together to create a vision, but workload, time difference and geographic distance make this difficult. It becomes a trade off between co-managing ops and performing ‘weaker’ on vision and strategy.

MT/DirRes: Michel feels too much focus on strategy (requested at GD level, MT level and Council level). He doesn’t believe the OCA-MT should be composed of fewer people, and disagrees that the DirRes is being absorbed by administrative matters only.

Tankred summarizes the feedback on the OCA Governance:

- The current OCA-Council structure is seen as appropriate, but with the following considerations:
  - openness to include other partners;
  - clarification multiple commitments of sections to OCs (primary and secondary partners);
  - strengthening accountability of the Council;
  - diminishing duplication.

- It seems that there is a more urgent need for changing the MT structure; a feasible change could entail:
  - disentangling the DirMed and DirOps from MSF-Holland;
  - strengthening engagement of GDs;
  - clarifying role of DirRes;
  - further developing the OCA platforms;
  - enlightening the scope of the function OCA-MT chair and MSF-Holland GD.

The OCA-MT is asked to create a document with the main obstacles from the current OCA structure and also indicate which suggestions for change are supported or not.

3) MT update

Update on progress of new Risk Management Assessment (AON) (lead: Michel)

The risk assessment development was taken to a higher level, moving away from the departmental approach, widening the involvement via including Heads of Mission & Medical Coordinators.

62 Risks were identified, varying from ‘ability to adapt to external changes’ to ‘accepting money from a non-reliable donor’. From the four components of the value chain, the FR component will be addressed in a later stage, together with other sections (depending on whether they already did assessments). Timescale: Agree approach & obtain approval in June; Offline preparation & scheduling in August; Facilitate workshops (Medical and Ops Dept with AON, and OCA-MT with AON) in September; Analysis & reporting in October; Implementation of risk improvement actions in Q4 2010; and Updated & detailed risk profile in Q1 2011. The Risk profile is to be annually reviewed; a new assessment is only required in case of big changes.

It is agreed that the management and mitigation of risks should be reported to OCA-Council (AON Risk Profile), as well as reporting on incidents (Security Incident Register), via the BodEx.
Annual Plan Process 2011 \textit{(lead: Michel)}

The OCA-Council approves the proposed content of AP 2011, the proposed time lines AP 2011 and the priority to OCA planning above sectional planning.

4) Operational red flags

\textbf{Integrity of Missions (lead: Thijs)}

In the AP 2010 integrity (in the field) is an important topic, triggered by \textit{2009 events}:

- Corruption /tax fraud challenges in DRC (Goma), manageability of the mission – internal audit
- Russia supply - internal audit
- Nairobi Supply fraud – KPMG Forensic audit
- Whistleblower procedure – internal audit investigation

The integrity issue also involves identity and security risks, and therefore the OCA-MT thought it relevant to inform the OCA-Council.

\textbf{Integrity has many aspects}; we should not only look at (short term) financial loss and our procurement cycle, but also:

- Scrutinise reporting (medical protocol adherence, pharmacy distribution and consumption)
- Competence of staff, staff adhering to procedures (and why not: Not willing/knowing/Enabled?)
- Tone at the top
- Creating awareness and having transparent discussion are a start
- Look into more tight management control mechanisms (next to relying on cultural and personnel controls)
- Support field; hands on control function

Paul agrees that we have to address corruption, but a zero tolerance will mean not being present in certain countries. He wonders how to communicate this (certain level of acceptability of corruption/bribes) in the "tone at the top"? =>Thijs: we used to not act upon signals of corruption, but we can reverse this and show that we will take measurements.

\textbf{HRM Constraints (lead: Hans & Michel)}

Hans introduces this topic by explaining that the situation is worrisome: the Haiti drain, together with (rather) empty pools of volunteers, is creating a lot of tension in the HR Dept.

\textbf{Overall Field Staffing} \textit{N.B. Reliability data to be confirmed at 8M}

- International staff postings 17 \% higher (342 postings in 4M \rightarrow Haiti effect)
- Increase in E-postings: 36 \% (4M) (18 \% 2009, 12 \% 2008)
- Increase in number of national staff to 6443 (5152 in 2009, 6189 in 2008, 5556 in 2007)
HRM – Main international staff ratios
 Preventable early returns 4% (still decreasing)
 AMD for regular 7.9 months (vs 7.7 in 2009, 7.4 in 2008)
 Gap ratio 4.1 % (ranging 3.4% - 4.8 %)
 First departures 24 % (83) of which 18 % RFD
 Experienced field staff 76 % (of which 18% > 36 months OCA experience

HRM – some additional indicators
 Overall Planning RFD 20 % (only 15 % realized in 4M). Effect additional FD placements?
 Overall Planning (Para-)Med 50 % (only 47 % realized 4M). Boost re-medicalization.
 Medical Doctors 19 % EoY planned (17 % realized in 4M) – boost necessary?
 French Speaking FM Expats 56 % (target 70 %) – actions?
 Chantilly Ratio 1.5 (increase due to increase Operational volume)

Main expat HR issues
• Follow up needed on Workshop March (Re-medicalization; Key show stopper prevention; Diversification and flexibility)
• Continuation of projects 2009 (French speaking expats; Additional placement FDs – recruitment efforts?; National staff de-prioritized (March)
• Increased management and process/output monitoring (Agreements Codays; Management and steering HR team OCA)

Internal Bureaucracy: skipped (no agreed MT analysis yet on structural nature of problem)

Intersectional dynamics (lead: Hans)
The implement of the Inter-OC agreement has started and, although it’s going well in the area of synergies, we also are dealing with some tensions, e.g. 1) Decentralisation to the Field: the pace varies per OC (OCG and OCBa nervous about having to merge), and 2) Deployment of Ops Capacity: OCP sometimes dissonant; according to Hans the strategy should be to find a base to keep them on board.
The OCA-MT as a whole is a strong supporter of the process.

Access and Security (lead: Arjan)
Points of analysis
• Operational volume effect (cf. Chad, Somalia, Sudan)
• Modus operandi effect (cf. remote management with +/-)
• Trend continues/increases (cf. strong states, HIC)
  ➔ Necessitates a strategic operational response

Policy/practical implications
• A policy/practice of negotiated access/autonomy
• A policy/practice of continuous critical dialogue
• A policy/practice of continuity of our senior staff
• A practice of medical anchor projects

Q&A:
• Does ‘negotiated access’ also apply to advocacy? =>Besides security it also applies to our autonomy within highly controlled systems. At the moment we are very haphazard in our
dialogues with interlocutors. This practise implies having to compromise sometimes, and areas of compromise might indeed include confidentiality clauses.

- Practical implications need to be consistent across the movement, how do you see this? => Analysis is accepted across the movement, but maybe in 20% of the contexts it is not applied in the same way by all sections.
- Change in HR hiring, what do you foresee as timeline? => It will have a practical effect, but probably less strategic HR implications. E.g. differential contracts and investment in training can be options.
- I miss improvement of our own capacity to know how we are perceived in the field. => The perception study confirmed what we already know, agreed that we need to invest in this. There will be quick perception studies on the back of the Swiss study.
- Have we looked at role of senior National Staff to help ensuring continuity? => Continuation of operational and medical staff is important. Also the interaction that NS can have towards international staff is important.

**Afghanistan appropriation (lead: Arjan)**

At RIOD and OCP level there’s the desire to continue with the current set-up, meaning one section in the lead and commitment of all sections to provide the resources as they can. Several alternatives, such as ‘adoption of projects by other sections’ and ‘model of OCB as lead section’ were being discussed, but the preference is to continue the way it is now.

**Q&A:**

- Pim recalls a remark of Michiel Hofman that only 5 out of the 20 expats are not on contract with OCB, and wonders if sections really provide enough resources? And –thinking further ahead– should we accept this appropriation, anticipating on future situations where maybe OCA is the lead section and will (vainly) call for HR support? => Arjan noticed high quality staff in Afghanistan (in comparison to Pakistan) and ensures that Afghanistan is given equal priority as any other mission. He acknowledges that the appropriation will mean in reality that privileged responsibility brings along extra pressure on resources.
- Are HR constraints taking into consideration for the SP? => Our starting point is the needs, but of course in the next phase, when we’ll have to look at the feasibility, this will come in the picture.

**Iraq (lead: Arjan)**

MSF is struggling to adapt the Ops Med strategy to the context: there are still 5 OCs present, although some cooperation in terms of security, networking and communications has been achieved. As OCA we do not believe that it is necessary to have 5 line managements in Iraq, we proposed 3 OCs (in line of the inter-OC agreement). We do not exclude removing ourselves (having our project run by other OC, or remotely managed) but, for as long as we have projects running, we will not actively promote this. We however should be bold enough to be self-critical! The ExCom will be reporting to the IC December meeting about the 6 pilot countries for the Inter-OC agreement, and we proposed Iraq being one. Arjan cannot say much about the medical impact and security situation in Iraq, because the strategy is just in place and more time is needed to see how this will work in reality. A discussion arises about how to continue (or discontinue) in Iraq, and the timelines. Arjan concludes by pointing out that these types of discussions at RIOD and ExCom level already point at a behavioural change.

The OCA-Council agrees with the approach of entering the negotiating process, but wishes reporting from the OCA-MT by the end of September, to ensure that the process is not stalling. The OCA-Council supports the IC decision and moreover supports the expressed openness to being self-critical about OCA presence in Iraq.
Legal challenges regarding medical malpractices *(lead: Hans & Leslie)*  
This session was for information to the OCA-Council. Because of the sensitivity of the subject, no minutes were taken.

Darfur review *(lead: Hans)*  
The review holds an analysis, critical conclusions (e.g. insufficient support and advice of HQ, insufficient understanding of contexts) and recommendations. The OCA-MT (reluctantly) adopted the review and agrees with the recommendations. Maybe more of these independent reviews are useful, but then real time.

Preview 4M *(lead: Michel)*  

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The free reserves are put into the operational reserves, and the MT would like to leave it there (for Haiti response in 2011, + new proposals operational projects). The OCA-Council was asked to brainstorm on allocation of reserves, outside of operational line.

### 5) Reporting OCA Medical Committee *(lead: Bruce)*

The minutes of last week’s HIV/AIDS discussion (incl. ‘Paris statement document’) will be available soon. The OCA MedCom was asked to comment on the IC resolution, but since it was overtaken by the Paris statement, the ctee did not express any concerns.

The OCA MedCom became a bit more reactive in looking at medical priorities and strategies for the SP: no recommendations yet, because of late circulation of relevant documents and lack of background info from PHD (i.e. why the specific priorities were chosen and why others were not included). In general the OCA MedCom is looking for a bit more contextual info from Leslie, before being able to put forward recommendations to the Council.

Update agenda F2F meeting OCA MedCom in London on July 3rd; during the open session the SP (HOPS) will be discussed, including Nigeria lead intervention and Q/A with Leslie. For the closed session the following topics are listed on the agenda: In-depth Review of Medical Priorities, incl. preliminary discussion of creating strategic, annual medical indicators (for 2011 AP); Best Practices – where are we: participation, governance versus executive balance, topic holders, reflection on MedCom structure (TCs, FTFs, numbers, etc.); and Approval of ToR, incl. MedCom Goals for 2010/11 and Election of Chair. Participation: besides the 6 MedCom members Corien Swaan, Harry van Schooten (MSF-Holland) and Kate Alberti (MSF-Canada) have indicated to attend.

### 6) Forward planning of the OCA-Council meetings and AOB

The next meeting (VC/TC) is scheduled for July 15th. on the agenda will be 4M (2 hrs) and HOPS (2 hrs). However, before being able to approve the general direction of the HOPS, the OCA-Council wants to have more contextual info, a review of the current SP and more items added (e.g. Advocacy and Coms). The OCA MedCom will be asked for advice.
Add on Pim for last agreements, discussions topics (Governance, Access and Security policy, planning of meetings, etc) decided upon after 17h20

*The Chair closes the meeting at ??*

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**Action & Decision List**

- **Paul and Wilna**: to discuss with Hans and Michel the set of indicators (excl. medical indicators) for AP 2011, between now and end of September.
- **OCA-MT**: to create a document with the main obstacles from the current OCA structure and also indicate which suggestions for change are supported or not; by end of August.
- **OCA-Council**: to brainstorm on allocation of reserves, outside of operational line.
- **OCA-Council**: to provide wish-list AP 2011 to the OCA-MT by September 15th.

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*From 'Plan of Action for the implementation of OCA MoU & ToRs'*:

- **Pim**: to channel into the SP discussion that a mechanisms will be established that will facilitate the coordination of activities that fall both within the scope of the OCA and within the scope of home society.
- **Pim**: to communicate OCA dispute resolution to Unni Karunakara (after June IC meeting).
- **Justin**: to follow-up on the creation of a reserve policy (centralised vs decentralised reserves).

Other open topics from the ‘Plan of Action’, such as ‘Job descriptions for MT members’, ‘Evaluation of OCA operations’ ‘Make the sponsoring of Finance, HRM and FR platform work’ and ‘Develop ToR for each platform’ will be dealt with in combination with MT review, or will be part of the OCA SP Review.