FINAL DRAFT

HAITI EARTHQUAKE RESPONSE
INTER-SECTIONAL REVIEW

EXECUTIVE REPORT

SYNTHESIS OF SIX SPECIFIC REVIEWS

REVIEW PERIOD: FROM 12TH OF JANUARY TO 12TH OF APRIL 2010

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ACKNOWLEDGEMENTS

This review could start only four months after this catastrophic earthquake in Haiti. Therefore it does not reflect enough the harsh reality of the first days, weeks and months of this emergency, but at least must acknowledge that the scale of suffering has been (and still is) immense and that the circumstances of this intervention have been (and still are) extreme.

The Haitian people have had to endure so much suffering caused by this destructive Earthquake. We remain moved by the deeply touching stories from patients and their families: revealing their trauma, their despair for the losses of their loved ones, their struggle for survival, and their fear and anxiety about the future. We are also impressed by the stories of the relentless care, initiative and zeal of MSF staff and their collaborators.

Unfortunately most of the affected Haitian population continue to live in the very precarious conditions of the overcrowded displaced people camps; now also affected by a deadly and quickly expanding cholera outbreak.

Throughout this review process, we have been impressed by the commitment and efforts many in MSF made to facilitate this process, access to data, answer to our many questions etc. The level of openness and willingness to share was encouraging.

A review process inevitably focuses on things that did not work well or could be improved. However, the evaluation team would like to deeply acknowledge the important achievements and strong commitment of the MSF teams in Haiti as well as in the respective Head Quarters.

The Evaluation team consisted of:

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Sabine Kampmüller	Process facilitation, Executive report
Ewald Stals	Team leader

Short C.V.s can be found in Annex 1.

LIST OF ABBREVIATIONS

Comms:	Communication
DG or GD:	Director General
DirOP:	Operation Director
DirFin:	Platform of six Finance Directors (5 OCs + USA) + International Finance Coord.
DirFund:	Director of Fundraising
EF or ERF:	Emergency Fund or Emergency Relief Fund
EFM:	Emergency Fundraising Mechanism
EF or ERF:	Emergency fund or Emergency Relief Fund
E-desk:	Emergency Desk
EPI:	Expanded Programme of Immunization
E-Prep:	Emergency Preparedness
EQ:	Earthquake
ESC:	European Supply Centre
EXCOM:	Platform composed of the GDs of the five operational centres + ISG General
EXDIR:	Platform composed of all General Directors + International Secretary General
Expat:	Expatriate
Fin:	Finance
FR:	Fundraising
FR 19:	All Heads or Directors of Fundraising
GIS:	Geographical Information System
HIV:	Human Immunodeficiency Virus
HoFR:	Head of Fundraising
HoM:	Head of Mission
HR:	Human Resources
HQ:	Headquarters
ICB:	International Council Board
IDP:	Internally Displaced People
ISG:	International Secretary General
Log:	Logistics
LogCo:	Logistics Coordinator
Med:	Medical
Minustah:	United Nations Stabilization Mission in Haiti
MoH:	Ministry of Health
MSF:	Médecins Sans Frontières
MSPP:	Ministère de la Santé Publique et de la Population
NFI:	Non Food Item
OC:	Operational Centre
OCA:	Operational Centre Amsterdam
OCB:	Operational Centre Brussels
OCBA:	Operational Centre Barcelona-Athens
OCG:	Operational Centre Geneva
OCP:	Operational Centre Paris
OPD:	Outpatient Department
OT:	Operation Theatre
PAHO:	Pan American Health Organization
PAP:	Port-au-Prince
PROMESS:	Programme de Medicaments Essentiels
RIOD:	Platform of the five Directors of Operations + Intn. Policy Advocacy Coordinator
SGBV:	Sexual and Gender Based Violence
TB:	Tuberculosis
UN:	United Nations
UNICEF:	United Nations Children´s Fund
WatSan:	Water and Sanitation

EXECUTIVE SUMMARY

Following the devastating earthquake in Haiti in January 2010, MSF's Committee of Executive Directors decided to conduct a global review of MSF's response to the disaster. This exercise covered the interventions of the five operational centres and consisted of six specific reviews looking at the different axes of the response: global/operational, medical/surgical, logistic/supply, communication, human resources and fund raising. An intended inter-sectional finance review and/or audit did not take place. Evaluators consider this the biggest limitation of this review exercise.

The scale and speed of MSFs emergency operations in Haiti were impressive. In the first three months after the disaster MSF teams carried out more than 165,000 consultations, performed 5,707 surgical interventions in 16 operating theatres, had a 1,237 bed capacity, and distributed 85,603 NFI kits and 28,642 shelters. To achieve this MSF spend about 41 million euro, send 1,800 tons of material by air and sea, and contracted more then 800 international and over 3,000 national staff for going to Haiti. MSF became one of the biggest emergency health actors and contributed significantly to the survival and recovery of thousands of Haitians.

The interviews with patients showed a high level of satisfaction with the quality of MSF's care. Patients regret the lack of attention to their spiritual needs during long hospital stays. And community members are desperate about the uncovered needs on shelter, water and sanitation and also the rising problems of violence months after the disaster.

Initial operational choices were in line with medical emergency needs; the focus on surgery, post operative care and mental health very relevant. Many other needs were addressed late or insufficiently: medical and non-medical assistance to displaced and homeless, set up of medical and paediatric hospitalisation, treatment of chronic diseases, care for victims of violence.

Surgery was implemented at large scale with high output and with evidence of sufficient quality despite the many challenges. Surgical expertise was missing in defining the intervention strategies. The decision of two OCs to get involved in advanced orthopaedic care including internal fixation was not an optimal use of organisational resources and capacities.

Operational choices became less coherent over time, when individual OCs decided on their strategies for the mid and longer term. In the beginning of February a proposal was made for an inter-sectional assessment and context analysis, but turned down.

Reviewing the immediate emergency phase, two issues deserve particular attention to obtain the greatest impact for the benefit of the population: i) the **absence of Emergency preparedness for a major disaster** event though MSF was prepared "by chance" through the existing surgical programs, and ii) **MSFs capacity to respond to mass casualties**, including expertise on triage, stabilisation, end of life care and a global surgical strategy.

Overall a framework for needs assessment and inter-sectional planning were missing; coordination between OCs was weak. A global medical strategy could have enabled the movement to respond (earlier) to different priorities in different phases or at least prepare activities for a later phase.

In the overwhelming context of Haiti the **individual OCs reached their operational limits** and as a result activities were delayed or not developed at all. Challenges like the response to massive shelter needs, which were insurmountable for individual OCs could have been better addressed with a common strategy.

Obtaining data on the various areas of intervention has been very difficult and partly impossible as different definitions and data collection systems are used by the OCs. The fact that MSF can not produce a conclusive set of data from all five OCs poses concerns in terms of accountability.

The Santo Domingo hub was quickly set up as in inter-sectional base for transit of human resources and supplies as well as local purchase. It provides an **innovative example of successful and efficient collaboration**. More generally collaboration between OCs was limited to information sharing, with no actual strategic discussions and planning taking place.

Several of the MSF technical working groups discussed the Haiti intervention, some of same **proactively made proposals to address the challenges** in the Haiti context and ensure better support to the field. International working groups have an important potential to inform operational decisions and to ensure experiences are documented and lessons learned. They need to be given the capacity authority to realise this.

Advocacy needs were repeatedly identified in Haiti, but complicated decision making processes prevented MSF from analysing, articulating and agreeing on strong messages based on what the field was witnessing.

Engagement and interaction with other stakeholders was limited during the Haiti intervention. MSF – being a main health actor in Haiti – did not use its weight much to influence decisions on health policy and action. MSFs standpoint on the cluster system was unclear and participation not part of a conscious and coordinated strategy to push the MSF agenda.

There are **many questions on the efficient use of the organisations resources** in the inter-sectional set-up chosen in Haiti. Five coordination offices in the capital, all with individual support from their head quarters, carrying out similar administrative and support activities. Overall the organisation has a significant scope to increase efficiency.

The institutional knowledge of the Haiti intervention is spread out over a large number of people, many staff emphasised that they were learning an incredible lot. At the same time they wondered why previous lessons were not more realised in this emergency. There is a need for improved retention and dissemination of experiences.

Recommendations include the empowerment of international platforms and technical working groups, a focus on organisational learning and more engagement with national and international actors. A global strategy for intervention as a movement is needed in major emergencies and the use of organisational resources and expertise must be optimised and accounted for. Investment in an inter-section response capacity for major disasters is recommended.

1 INTRODUCTION

As 2010 began, Haiti was finally making some progress: the economy was growing, the government on its feet, crime figures decreasing and there was more optimism than at any point in the last two decades. Then, in the span of a few seconds, everything fell apart. The 7.0 magnitude earthquake that hit Haiti on January 12th created one of the worst natural disasters in recent memory. According to the Haitian government 222,570 people are thought to have died, 300,572 were injured, more than one million lost their homes and two million people were in need of food aid.[1] For the country's people as well as its government, the earthquake has been an epic tragedy, setting back years of painstaking development efforts. For the humanitarian aid system the magnitude, geographical location and operational consequences of the Haiti earthquake presented new challenges in an already struggling sector.

It was the first time in recent history that a capital city was virtually wiped out in a natural disaster and it was the first time that in a matter of seconds three MSF OCs[2] (OCA, OCB, OCP) became victim and responder. MSF teams were assisting wounded within minutes after the disaster. Many national staff were missing, some lost everything they owned and all had to deal with loss of loved ones. In total twelve Haitian MSF staff members died in the earthquake. One of the OCA expat houses collapsed completely, leaving an expat trapped in the rubble for 24 hrs. All MSF structures – except the Martissant emergency facility - were severely damaged, some with some patients and staff members trapped inside.

MSF has succeeded to respond rapidly with emergency teams to the needs of thousands of wounded and traumatised. The scale and scope of health care services and the level of specialised medical and surgical care provided was impressive.

Within days the organization mobilised enormously its worldwide capacity and resources: the funds, supplies and human resources for what turned out to be one of the biggest interventions in its history. MSF was one of the most important emergency actors in the health sector and the most important provider of emergency surgical care.

The enormous consequences of the Haiti earthquake and subsequent scale of MSFs response has prompted the ExCom to request an inter-sectional review. This exercise, involving all five Operational Centres, is the first of its kind. It consists of six specific separate reviews covering the following areas: Global/Operational, Medical/Surgery, Logistics/ Supply, Communication, Human Recourses and Fundraising. This executive report summarises the global issues emerging.

An intended inter-sectional Finance review and/or an inter-sectional audit did not take place.

This report provides answers the questions raised in the global Terms of Reference (see Annex 3). The main part consists of summaries of each of the specific reviews, which is then followed by overall conclusions and recommendations. A synthesis of all the specific recommendations made is provided in Annex 4).

[1] These numbers are estimations and are not backed up by a reliable count. Some commentators accuse the Haitian government of inflating the total numbers of dead and wounded. It is safe to say however, that while the exact figures will never be known, the effects of the earthquake were devastating.
[2] MSF has been present in Haiti since 1991.

1.1 PROCESS & METHODOLOGY

Based on the Global Terms of Reference issued by the ExCom, Terms of Reference for the six specific reviews were drafted by the International office coordinators and agreed upon in the respective platforms.

Each Review process was led by at least one evaluator; the complete process facilitated by the Vienna Evaluation Unit. Regular skype conferences took place between the evaluators in addition to physical meetings (e.g. for joint analysis) in order to foster coherence and limit overlaps. Tukul workspace was used to share documents and serves as an archive of all reviewed and working documents.

One focal point[3] in each OC facilitated access to key documents, selection of interview partners, etc.

Review	**Steered by (ToR and Follow up)**	**Evaluators**	**Field visit**
Global	Jean Clément Cabrol	Paula Frankema	Yes
		Ewald Stals*	No
		Roger Teck	Yes
Log/supply	Jerome Michon	Francis (Pako) Coteur	Yes
		Laura Kopczak	No
Comms	Erwin Vantland	Amaia Esp	No
Med/Surg	Pedro Pablo Palma / Jean Clément Cabrol	Roger Teck	Yes
		Johan von Schreeb	No
		Luis Encinas	Yes
HR	Gabriela Breebart	Juli Niebuhr	No
FR	Jordi Passola	Karine Klein	No

**also served as a Team leader in support of Jean Clément Cabrol*

The specific methodology applied for each of the reviews is described in detail in the respective reports.

Overall there was a mix between quantitative and qualitative methods. The core methodology for each of the reviews consisted of extensive document review, observations and semi structured interviews, face to face as well as by telephone. Interviews were carried out with senior operations and support staff in the European offices of the five Operational Centres and the International Office and discussions with national and international staff in Haiti (and Europe); also with key players in the Haitian health sector and emergency responders after the earthquake. A full list of interviewees can be found in annex 2; Terms of Reference in Annex 3.

Interviews (82) and Focus Group discussions (N= 352) were conducted with patients and community representatives in Haiti.

[3] Focal points were for OCA: Vincent Hoedt, OCB: Anneli Erikson / Marie-Christine Ferir, OCBA: Bernard Lapeyere, OCG: Sabine Kampmüller / Laurent Ligozat, OCP: Laurent Suri (Paris Desk Urgence)

A web based questionnaire was sent by e-mail to all international MSF staff (N= 965) who worked in Haiti during the first three months after the earthquake (response rate was 46 %). In addition the request to respond to the survey was sent to 22 MSF project addresses in Haiti, requesting national staff to reply.

In addition to the specific reviews one international pharmacist visit to Haiti took place with a special objective to review pharmacy management during the emergency.

1.2 THE MSF RESPONSE

In the first days the immediate and highest priority for MSF was to receive the afflux of wounded people, organise triage, stabilise and refer for immediate lifesaving surgery or provide end of life care. The number of wounded was overwhelming at all the different MSF sites. Although a lot of the MSF infrastructure was damaged or destroyed the organisation was still well positioned for immediate response with surgical expertise, trained staff, some stocks and material. Many of the national staff had experience in earlier natural disaster response and situations with influx of wounded, although those disasters were of course incomparable in scale and damages.

The MSF logistic teams mobilised very quickly to set up temporary infrastructure, repair and expand existing infrastructure. For weeks there were regular aftershocks (with a particular powerful one on the 20th). Even where hospitals had withstood the earthquake, the Haitian staff and patients understandably refused to stay in concrete structures out of fear for more damage by the aftershocks. Consequently initial operations in tented structures, albeit not clinically ideal, were in fact the only option for immediate treatment of victims.

“Emergency hospitals” gradually expanded or opened up services for medical and paediatric inpatient care, as earthquake related trauma patients decreased.

The MSF teams had to set up specific postoperative care structures under heavy time pressure in the face of the enormous caseload of surgical patients. Finally this resulted in an overestimation of the postoperative care needs.

Physiotherapy services, including prosthesis preparation and training were integrated in all postoperative care and rehabilitation centres, either directly by MSF staff or through collaboration with other actors (in particular Handicap International).

As part of the usual MSF earthquake response, a team of the MSF facilitated Renal Disaster Relief Task Force managed to restart in less than one week after the earthquake kidney dialysis in the University Hospital to treat crush syndrome patients with acute kidney injury (as well as patients with pre-existing chronic kidney disease).

From the start of the emergency response all OCs mobilized or reinforced existing mental health care teams. These teams had to focus first on the national staff, among whom many had lost their home, belongings and even family members but continued to work despite anxiety about their situation and the uncertainties of the future.
Soon mental health care consultations were targeting (mainly mutilated) patients and their family members in the postoperative care services. As of early February mental health care activities expanded to outpatient services and later into several communities of displaced and neighbouring communities. Psychiatric care was organized at the OCP St. Louis hospital and the attached OPD (Delmas 30) for all those patients requiring psychiatric care and who could be referred from other MSF services or other actors.

As of the end of January, MSF teams set up outpatient department (OPD) services linked to or integrated within the emergency hospitals and postoperative care centres, except for the OPDs of the hospitals of Choscal and Jacmel which remained under the management of the MSPP with the assistance of other actors. Soon afterwards, MSF set up also fixed or mobile OPD services in several IDP camps or supported existing clinics inside and outside PAP.

MSFs involvement in non-medical assistance started late, because of expected mobilization by other actors and supply delays but also because of concerns for possible insecurity provoked by distributions. Distribution of tents, shelter materials and non food items started in late February.

Working in the urban setting of Port au Prince proved to be challenging for all OCs. While giving assistance to large groups of displaced populations is of course not new to MSF, the organization has less experience with working in urban contexts. The target population was spread out in groups of varying sizes, landownership totally unclear, standard MSF materials showed their limitations (i.e. size ad quality of the tents not appropriate for urban use and for use during several months). Although it took some time, teams developed innovative approaches for distribution of NFIs in this setting.

Table 1: MSF emergency medical/surgical activities; *January 12th – April 30th, 2010*

First line emergency and outpatient services	Consultations	123,108
	Dressings	34,044
	Antenatal care consultations	8,353
	Victims of sexual violence	**38 (?)**
	Total	**165,543**
Surgery	Major surgical interventions	**5, 707**
Inpatient care	Admissions for Surgery	1,243
	Maternity	3,425
	Medical	1,982
	Paediatrics	1,132
	Total	**7,782**
Mental Health	Individual consultations	**14,765**
	Group sessions	**4,310**
Water distribution and sanitation	Treated water distributed (litres)	**50,917,000**
	Latrines built	**534**
	Showers built	**302**
Distribution of shelter materials and non-food items	Shelters	**28,642**
	Rolls of plastic sheeting	**2,792**
	NFI kits	**85,603**
Hospital infrastructure	Rehabilitation	**10**
	New constructions	**4**

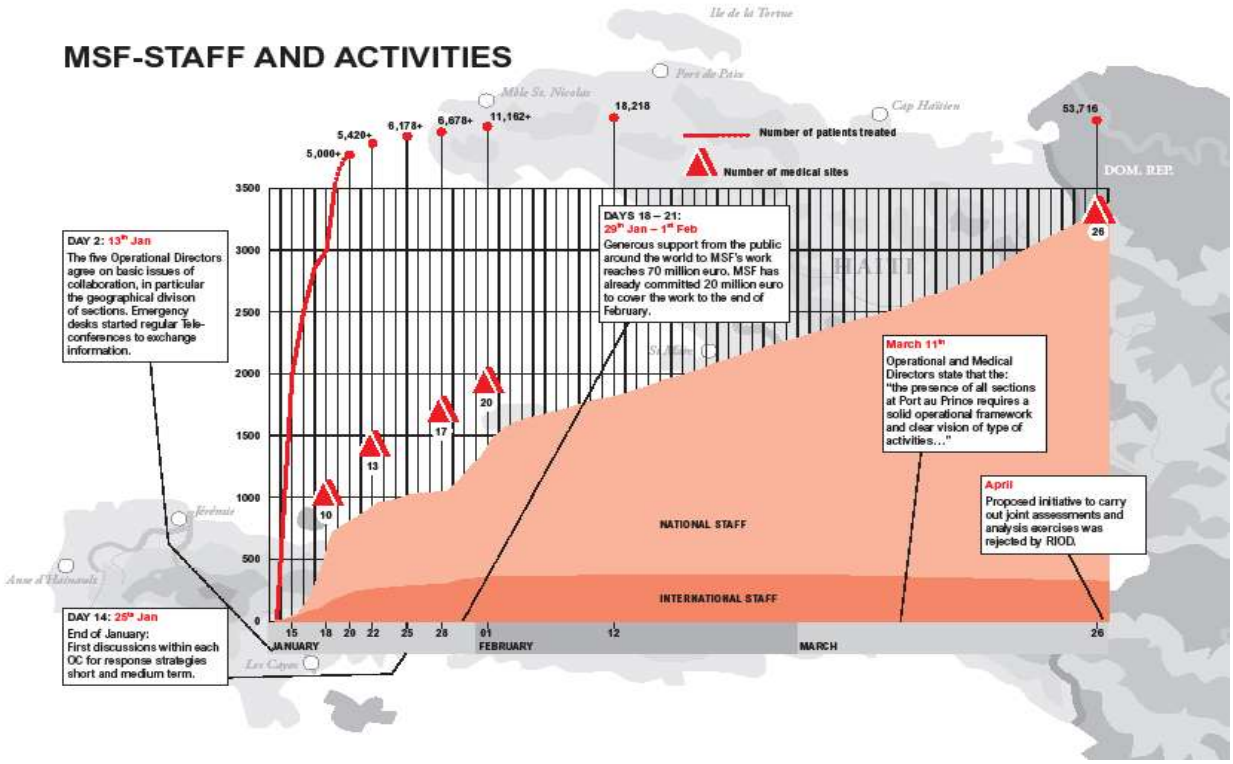
Source: compiled data from emergency desks of all OCs;
data on major surgery are from the Epicentre data analysis on surgery.

The following graph shows the key MSF output (number of patients treated, number of medical sites)[4] and the number of national and international staff in the first few weeks. Boxes indicate key decisions in the movement.

The timeline on the following page summarises key events in the same period of time.

[4] Data are taken from the Crisis updates; inconsistencies with data from other sources are due to data collection problems elaborated later in this report.

Figure 1: MSF-staff and activities between January 12th and beginning of April



Source: Haiti Crisis Info

Next page:

Figure 2: Timeline of events between January 12th and beginning of April

TIMELINE HAITI INTERVENTION
12th January 2010 – 12th April 2010

DAY 1: 12th JAN 7.0 quake strikes 15 km SW of PaP 17.00 pm Haiti time ▶ 17.30 Haiti time: first telephone contacts between HoMs and their emergency desks. ▶ Within minutes, injured people start arriving at MSF's sites. Emergency first aid given all evening and night. ▶ All of the MSF's existing three medical facilities in the capital have been partially damaged. ▶ Start of assessments and search for sites/structures that could be used for surgical interventions **DAY 2: 13th JAN** Martissant evacuated – patients in tents. 300 new cases treated for trauma, fractures and burns. ▶ Pacot also deals with 300, La Trinite with over 400 patients. ▶ Petionville admin offices become tent clinic with 200 treated. Others at Solidarite. ▶ Choscal hospital identified as possible site for setting up of surgical activities ▶ OCBA cargo charter arriving from Panama **DAY 3: 14th JAN** First expats start arriving from North America and Europe to support teams already present ▶ Struggle to get medical materials and staff into Haiti. Only one MSF flight with 25 tons able to land so far (from Panama) ▶ Last staff rescued from collapsed Trinite hospital. **DAY 4: 15th JAN** Choscal Hospital, starts as new MSF treatment centre with 300 transferred from Martissant. ▶ 1,500 patients seen so far in all MSF locations. ▶ Race against time with infected wounds needing care and surgery. ▶ Charters leaving Europe but blockages at PaP airport. Only 9 new staff have been able to get in. ▶ Food shortages are arising. **DAY 5 : 16th JAN** Choscal Hospital starts surgery ▶ 2,000 patients treated so far in all locations. ▶ Two cargo planes arrive in PaP with 85 tons of supplies and half an inflatable hospital. **DAY 6: 17th JAN** Cargo flights landing in Santo Domingo and transport by road to Port au Prince. ▶ Trinite Hospital has two operating theatres, one in a container. Choscal also has two working around the clock. ▶ Carrefour hospital opens and treats 500 patients in first day. ▶ Assessment missions outside of the city to Leogane and by helicopter to Jacmel find many injured and untreated people. ▶ Mental health activities start (small scale) ▶ Needs are far from being covered! The most severe cases can hardly be taken care of due to lack of structures offering good surgical conditions. ▶ Haiti is still experiencing aftershocks. **DAY 7: 18th JAN** 3,000 people treated by this stage, with 400 surgical cases. ▶ Major concerns about medical supplies running out and cargo flights not getting in to PaP. ▶ First explo in Jacmel. ▶ Concerns persist across all offices that the provision of emergency, life-saving medical care continues to face delays. ▶ People are starting to die of sepsis from infections that go untreated. **DAY 8: 19th JAN** Another new hospital opens at Chancerelle focussed on trauma and obstetric care. ▶ Dialysis for kidney consequences of crush injuries starts. ▶ Supply problems mount. Surgeon Paul McMaster says "One day we ran out of an anaesthetic, the next it was plaster of Paris and today we have no crepe bandages." ▶ The remaining parts of the inflatable hospital reach PaP by road from the Dominican Republic. ▶ Violence is on the rise in town due to the frustration of people who have received very little assistance after almost one week. ▶ The decision-making process at the airport remains a mystery and a problem. **DAY 9: 20th JAN** 6.1 strength aftershock terrifies patients in the wards and most have to be taken outside ▶ MSF surgical teams averaging 130 operations per day. ▶ Start of assembling St Louis inflatable hospital. ▶ Leogane temporary hospital structure opens. There are now 8 operating theatres. ▶ Psychological support started for amputees and their relatives. ▶ 7 cargo flights landed in PaP total tonnage 190 ▶ Concerns about conduct of US military, militarization of aid process. **DAY 10: 21st JAN** Carrefour and Pacot buildings no longer safe after the tremor. ▶ Mobile clinics begin in PaP and outside in Grand Goave and Dufourt. ▶ Surgery starts in Leogane town. ▶ Pacot (OCP): Building is at risk of collapsing, so the team is organising the transfer of the patients to another site. **DAY 11: 22nd JAN** MSF has treated 5,400 patients since the earthquake. ▶ Choscal hospital is operating on over 30 per day and sees a growth in gunshot and machete wounds. ▶ The mobile clinics find large numbers of people with untreated injuries and conditions who have not been able to find medical care. ▶ MSF confirm with great regret that 4 Haitian staff died. 4 more who worked for MSF until recently also lost their lives and 6 staff are still missing. **DAY 12: 23rd JAN** Bicentenaire post operative facility opens, along with another in a kindergarden. Huge needs for post operative care and for treatment of people with infections or complications from initial injuries. ▶ Distribution of family kits of blankets, soap and cooking utensils starts in Jacmel. ▶ Greenpeace boat "Esperanza" docks in PaP and unloads more of these supplies for MSF. **DAY 14: 25th JAN** The inflatable hospital in St Louis opens; space for 200 patients and two operating theatres. ▶ 260 new staff now and 6,200 patients treated. ▶ 18 MSF psychiatrists and psychologists are providing support to patients and to medical staff who worked through the quake. ▶ Household essentials distributed in Grand Goave and Leogane towns. **DAY 15: 26th JAN** New phase of surgery underway shifting from life- to limb-saving operations. ▶ 54 dialysis procedures have been carried out. ▶ "New Carrefour Hospital" opens in a school next to the original building, which is now unsafe. ▶ Supplementary feeding for children begins via mobile clinics in the Carrefour area. **DAY 16: 27th JAN** Tent clinic in Carrefour Feuille camp for 9,000 people. ▶ Supplies flown to PaP and Dominican Republic reach 650 tons. **DAY 17: 28th JAN** Village Grace Clinic opens in converted church amongst 15,000 displaced people. ▶ Water trucking and bladders to camps near MSF facilities in Chancerelle, Carrefour and "Mickey". ▶ Bicentenaire post operative and emergency care centre starts in former private clinic. **DAYS 18/21: 29th JAN – 1st FEB** Lycee site opens for post operative care, minor surgery. ▶ In many of MSF's clinics, 20% of the consultations are for mental health issues. **DAYS 22/24: 2nd – 4th FEB** By now, MSF is improving access to water and sanitation for around 40,000 people. ▶ Chancerelle hospital has an average of 12 births a day, 40% of them Caesarean. ▶ Post operative tent "village" at Delmas 30 takes first 30 patients. **DAY 25/32: 5th – 12th FEB** MSF hospital beds in Haiti reach 740. ▶ Total tonnage to date: 1400 tonnes ▶ Delmas 33 site for turnkey gyn/obs hospital OCA identified ▶ Post operative facilities in Promesse open and Bicentenaire completes 50 bed extension. **MONTH 2: 13th FEB – 12th MARCH MID FEB** Delmas 24 OPD opens **06th MARCH** 2 expats kidnapped for 6 days Gyn-obs hospital OCA ordered (early March) **MONTH 3: 13th MARCH – 12th APRIL 2010 30 MARCH** press release "access to free health care" **31st MARCH** Donor conference New York **EARLY APRIL** Tabarre post-op OCP opens

2 MAIN FINDINGS FROM SIX SPECIFIC REVIEWS

This chapter provides main findings from each of the specific reviews. More detailed reports are available for each of the reviews (except the operational one, which was done in close exchange with and fed into the other reviews). The chapter starts with the main feedback provided by patients and community members during interviews and focus group discussions (2.1.) and a summary of a web based survey conducted among MSF staff (2.2.).

2.1 AFFECTED PEOPLES PERCEPTION ABOUT THE MSF RESPONSE

A qualitative assessment was conducted among patients and community representatives. It aimed to obtain their perception about the MSF intervention and the health services delivered to them. The following is a summary of the main findings:

The interviews affirmed a high level of satisfaction among patients with the quality of MSF's care, which was also greatly appreciated by the community as a whole. With only one exception, all patients reported free access to care in MSF facilities.

"God saved my soul and MSF saved my body" (Woman, 19 years)

Of the 82 patients interviewed, 23 patients had undergone amputations. All of these patients said they had been fully informed about the procedure and had given their verbal consent. Although there are no comprehensive accountability measures – such as a patient charter or written procedures – in place, the system of patients being given information and giving their consent verbally seems to be functioning well.

"They asked me and they give me the medical reasons (for amputation). I did not sign anything, but I agreed with this issue!" (Woman, 32 years)

One example of MSFs action stands out for being culturally adjusted and received disproportionate and positive attention by interviewees. This was in Jacmel IDPs camp, where latrines and showers were not only gender-split, but also painted in local colours and with Haitian naïf art (from a local painter).

"If I have to thank for something very important it's the drawings of the toilets. It's a place where we go several time per day. To see a smile painting help us!" (Teenager, 15 years, Jacmel)

Many patients expressed a deep regret that, during their long hospital stay, there had been no space for or response to their spiritual needs. Religion is of the utmost importance for almost all Haitians, and would therefore have been a key mechanism for coping with grief, loss and trauma. The dilemma for an outside organisation like MSF of whether to facilitate or allow religious practices (of which they understand little) in their structures is apparent. It is certainly an issue that should be considered in the future.

In addition to their spiritual needs, there were frequent mentions of the unfulfilled need for occupation and education within hospitals. Although patients commented positively on the psychological support provided by MSF, they still longed for diversion during their hospital stay.

"… I'm very satisfied on the medical care. My only wish would be to know where my son disappeared... Before the earthquake, I was used to go every Sunday to the religious office, maybe he (the pastor) knows something about him; maybe I can talk to him…" (Woman, 37 years, Sarthe)

One of the main points raised by patients was their uncertainty as to how to live their lives in current conditions – which remain desperate – given their physical disabilities resulting from earthquake-related injuries. MSF has invested little in medico-social support or even in facilitation of assistance through other organisations during the Haiti emergency response.

"..now that I have to quit the hospital, and I have no idea where to go. The fact that I'm condemned to stay in a wheelchair gives me a lot of fear. Where will I go? I would like to listen other people in the same case" (Woman, 42 years)

The stigma that comes with disability was a major problem for many of the patients interviewed. One patient spoke of the "dishonour" he suffered when he was given a knee prosthesis with a "white" skin tone, which shows how even apparently minor issues can have major implications for individuals. It is important that MSF continues to work on socio-cultural aspects around stigma in order to adjust the assistance it offers and reduce the burden of suffering.

"I lost my two legs, one immediately, the other one week after. The worst came after, the day they promised my artificial knee: I discovered that the colour was white – the same than the Canadian doctor who promised me and gave me hope. I did not pay attention at this time, happy to move myself. When I went out, everybody looked at me, and my white artificial legs, and I felt dishonoured. Today I have some black socks in order to hide them "(Young man, 23 years)

"I have nightmares seeing people throwing stones and hating me. I need to pass the rest of my live in a wheelchair, what do you think how will my life look like? I'm 22 years. I had a job, a family, friends, and a boyfriend. Today I lost all, not because they died, but because the ignore me. I'm feeling guilty. Why did I survive?" (Woman, 22 years, Sarthe)

Although this review did not intend to look into needs, the most frequently mentioned point during focus group discussions was about people's dire living conditions, in particular the low quality of shelters and sanitation facilities. Strong criticisms were voiced by all groups, although these were not specifically addressed to MSF. The insufficient number of latrines and the lack of access to safe water was a key issue. In three of the six IDP camps visited, the water and sanitation problems were particularly critical.

"My house was completely destroyed. We (family of four) received a big tent, blankets, hygiene and kitchen tools, and even some food. We were very happy. Today, it is more than 7 months that the earthquake happened. The tents are not good enough, some places it's already broken, and we fear for the hurricane period. If you have time, I invite you to come and sleep inside. You will see." (Man, 34 years – IDP's camp)

People also talked spontaneously about increasing levels of violence in the camps. Poor living conditions are plainly exacerbating the problem.

"My 13 years old daughter came to me and guilty said that she was pregnant. This is not the only one. Rape and violence are more and more common in this camp. I heard all these weeks of such incidents. It's true that hospitals are free, but we would like to have more medical capacities in the camps" (Man, 45 years)

The findings point to the need for a more systematic use of qualitative methods involving target communities as an operational tool in project planning and evaluation (not least as an accountability measure). The use of a patient charta could regulate the way information is given and patients' consent is sought. More attention to socio-cultural and spiritual needs is also recommended in order to better adjust MSF's response to local conditions.

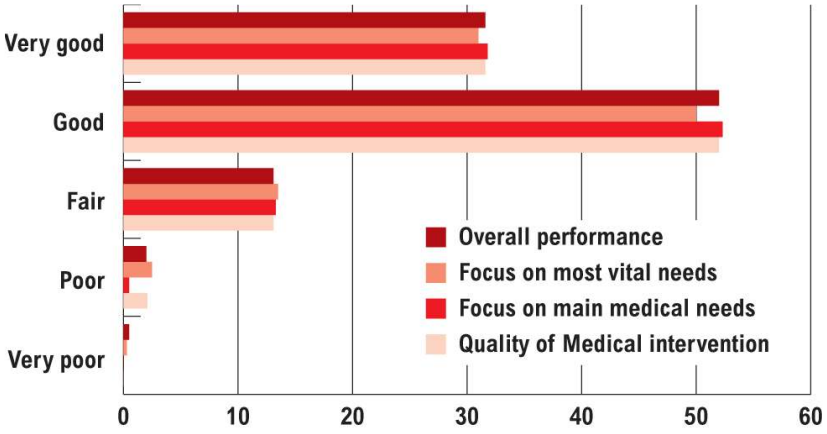
2.2 SUMMARY OF RESULTS FROM WEB-BASED QUESTIONNAIRE

A web based questionnaire was sent to MSF staff who worked in Haiti during the first three months after the earthquake; 428 international and 14 national staff responded (total N= 442; response rate of 46 % for international staff).

The main comments made in the survey very much confirm the main findings of the overall review: i) the impressive MSF response, yet ii) the lack of coordination within MSF, but also with actor actors, especially the Ministry of health iii) the failure to address public health needs, and develop a common strategy as MSF movement, vi) missed opportunities in terms of lobbying and advocacy, v) key lessons from previous disasters were not applied enough and lessons from this intervention must be taken for the future.

84% of respondents rate the overall performance of MSF's post earthquake work in Haiti as good or very good, and think that MSF focused its activities on the most vital needs (81 %) as well as the main medical needs (84 %) of the population.

Figure 3: Rating of MSFs performance and Focus on Needs (in %)



"The medical response has been excellent; however the answer to food/NFI etc was too late, too small and too slow."

Many comments are made regarding the fact that MSF failed to respond meaningfully to basic needs including shelter and WatSan and have an "impact on Public health". Respondents thought MSF should have done much more in primary health care, NFI and WatSan.

Only one third of respondents rated inter-sectional collaboration as good or very good. Inter-section collaboration and related concerns for inefficiency and waste of resources was the issue most often raised in comments. The big exception was the Santo Domingo hub, which received very positive feedback.

„Inter-sectional coordination was excellent on the day by day problem solving level in the field. Extremely weak at operational level"

„I often felt though all sections use the name MSF we were each in our parallel universe, wanting to promote our own activities…"

More detailed responses are integrated in the Medical Review.

2.3 OPERATIONAL REVIEW: CRITICAL REFLECTION ON MAIN ISSUES

The operational review was done in close exchange with and fed into the other reviews. Therefore no separate report is available, except a narrative on background and history of MSF in Haiti.

The summary below focuses on the operational challenges experienced as a movement. It identifies critical key aspects of the operational response, with the objective to feed the reflection and improve future response. The fact that the MSF intervention in Haiti is considered an impressive operational achievement should be recalled at all times.

In the first three months after the disaster MSF teams carried out more than 165,000 consultations, performed 5,707 surgical interventions in 16 operating theatres, had a 1,237 bed capacity, and distributed 85,603 NFI kits and 28,642 shelters. To achieve this MSF spend about 41 million euro, send 1800 tons of material by air and sea, and contracted more then 800 international and over 3000 national staff for going to Haiti. MSF turned out to be one of the biggest emergency health actors in Haiti and contributed significantly to the survival and recovery of thousands of Haitians.

Operational choices – appropriate at first, debatable at last

"We did a lot, yet I am frustrated, because I realise we should have done a lot more." (E-desk)

The scale of the disaster and the number of wounded justified mobilising all the movements' operational capacity and therefore the presence of five OCs. Nevertheless the fact that all OCs went for similar activities can be questioned and so also the fact that MSF was little prepared for a major disaster.

The RIOD decided a geographical distribution and "umbrella" functioning for incoming OCs within half a day. This was a pre-existing agreement for emergency setting and did not go beyond any other common agreed approach for big disasters. Major commitments for mid- and longer term investment, e.g. hospital construction were made without any inter-sectional exchange. To evaluators knowledge there was no analysis of needs or consideration of alternative choices that took place between OCs.

Assessment, Analysis and strategic planning: problems flagged, but not tackled

"We missed the big picture; we do this all the time." (Humanitarian affairs advisor)
"We were too busy to think." (E-desk)

As the teams were busy trying to overcome the day to day challenges of a large emergency operation, there was not enough time for thorough context analysis, continuous mapping of other actors (both in terms of medical facilities and services provided as well as analysis of their strategies and intentions) This problem was flagged at different levels and in different platforms but no joint action was taken. Although OCs did receive support from their HQs in terms of context analysis and strategic planning, this was done on an ad hoc OC by OC basis and shared only retroactively.

The EXCOM meeting of the 4th of February was a key moment, where an attempt was made to switch to a collective responsibility for MSFs role in Haiti, overcoming institutional and OC logic. An international assessment and context analyses was proposed, but the RIOD rejected the proposal for an early joint review of strategies (or real time evaluation) in

April. OCs felt they knew what to do, or did not see an added value of a joint exercise. A reduced version of such an analysis was conducted by three OCs only in September.

Work done, but not accounted for

The Haiti intervention is considered a big success. However, it is impossible to have an informed objective opinion on how big this success was and whether the intervention could have been more efficient. Within the movement there are no uniform data collection systems. Financial budgeting and registration for example is done according to geographical location by some and by type of activity or period of time by others. This makes compilation of total figures an almost impossible task. Though the International office made efforts to compile data for the accountability reports, this is extremely difficult. The interpretations of definitions vary, resulting in unreliable reports and operational projections. The only exception to this are inter-sectional bodies, such as the air cell (for flight data), or for Haiti the Santo Domingo Hub.

The differences in definitions and systems used by the five OCs also made MSF decide against an inter-sectional audit. Considering that MSF as a movement received close to 103 Million Euro and spent 41,5 Million Euro only in the first 3,5 months, this should be considered a concern in terms of accountability of the movement to its donors.

Inter-sectional collaboration: personal initiatives more than a systematic approach

"The scale of the emergency was so big that we should have questioned the sovereignty of the sections." (Operational Director)

In the first weeks after the earthquake, collaboration in terms of inter-sectional sharing of material and human resources was fairly good. In particular OCB made a big effort supporting other OCs. Awaiting arrival of their medical supplies, the medical teams of OCG and OCBA worked a lot in the structures of the other OCs, mainly in those of OCA and OCB. The HoMs and Medical coordinators had almost daily meetings with good information sharing. A few weeks into the intervention the OCs kept their cards much closer to their chest.

Actual strategic discussions and planning was very limited. For example this resulted in a situation where two HoMs went to the MoH to discuss the same plan at the same time or one OCs assessment team leaving the hotel 30 minutes early to have a head start on the assessment team of another OC that was planning to go to the same area.

The “Santo Domingo hub” was quickly set up as an inter-sectional base for transit of human resources and supplies as well as local purchase. Another common approach was taken with the inter-sectional warehouse in Port au Prince. Both initiatives were possible because of individual’s willingness and the availability of experienced people and they profited from the vacuum in terms of inter-sectional structures. These approaches allowed mutualisation of resources and expertise and an exceptionally easy account for freight.

Operational limits - defined by the limits of each OC

"We could do no more, this was our limit." (E-desk)

In the context of overwhelming needs in Haiti, OCs reached their operational limits and as a result some activities started up late or were only developed to certain extend.
The operational limits of MSF were defined by the limits of OCs, and also by the absence of real preparedness. Potentially the whole could be much more than just the sum of its parts.

Evaluators believe that the challenges like the response to massive shelter needs, which were insurmountable for one OC, could have been better addressed had there been a common and timely strategy.

Efficiency: much room to improve

"If we want to do more with the money we get for such emergencies, we should invest in supply, HR, E-Prep." (Deputy Operational Director)

There are many questions on the efficient use of the organisations resources in the inter-sectional set-up chosen in Haiti when it comes to support and administrative tasks. Five coordination offices in the capital, all with individual support from their head quarters, carrying out similar administrative and support activities. When it comes to tasks such as: writing security plans, gathering context information, mapping of other actors, writing sitreps and job profiles, finding accommodation, representation etc, there certainly was duplication, if not quintuplication, but certainly lack of coordination.

Resulting, for example, in five different salary scales for national staff, five expatriate administrators going to the same lawyer for the same advice on national staff contracts or five base logs inspecting and rejecting the same 'for rent' houses. High resolution satellite images were received by one OC but were not shared and further used for GIS applications.

Technical Working Groups: a stronger role in emergencies

Several of the International working-groups discussed the Haiti intervention and issues of thematic concern to them during phone or physical meetings. Some of them came out with pro-active actions/positioning to ensure a better support: e.g. the HIV/Aids and the laboratory working group. The mental health working group successfully pushed for applying the lessons learned in previous natural disaster responses. Other opportunities were missed: exchange on distribution or post-earthquake construction strategies, use of surgical data collection, etc. The working groups clearly have a role to play in emergencies: in preparedness (with policies and tools), informing and supporting response as well as documenting and re-applying the lessons learned.

Advocacy: some successes, but many stumbling blocks

"Too many messages and too many decisions makers result in no message at all." (Deputy Operational Director)

Although several possible issues were identified, internal stumbling blocks prevented MSF from fully accomplishing a key element of its work and kept communication in the press and in possible lobby forums limited to operational MSF updates. Identified advocacy issues included shelter, protection of IDPs, access to (free) healthcare, health policies and the role/plans of the Haitian government, donor commitments and the role of the military in the humanitarian aid operations.

The most important stumbling block was the current structure of layers and platforms within MSF and their decision making processes. While decision making within an OC can be swift, internationally decision making is a painfully slow process watering down messages. Expert advisors from HQ who visit the field usually have a one-OC mandate only. Apart from the internal limitations there was also lack of dialogue with local leaders and other in-country stakeholders (pre- and post earthquake).

The exception in the first week was the successful public lobbying to raise awareness of the need to change priorities in landing rights at the airport in order to improve access for humanitarian flights. The donor conference in New York was an example of a missed opportunity to convey a strong message on access to free health care. The release was preceded by time consuming discussions, lacking analysis and ended up as a very watered-down message. In a less public manner MSF did raise important issues in different platforms. For example: After the earthquake the Haitian government announced that health care should be free for a period of three months. In the health cluster and other forums MSF actively lobbied for an extension of the period of access to free health care, which was finally agreed upon. MSF also raised serious concerns regarding the presence of armed military in hospital facilities. MSF succeeded to draw attention to this, despite many mainly US organisations being appreciative and accepting military protection of their relief convoys.

Coordination: Confusing independence and splendid isolation?

"We created an island and then enlarged it a bit in the second phase. More was not possible." (E-desk)

Engagement and coordination with others was limited during the Haiti intervention. The impression is that MSF was isolating itself and stayed increasingly outside the debate around humanitarian issues in Haiti.

There are few examples of MSFs cooperation with other actors: Handicap International proved to be a valuable partner in post-op ambulatory and rehabilitation services for OCA, OCB and OCBA. While Handicap International was embedded with OCB in the initial phase, OCP had its own in house physiotherapy expertise. In Leogane, OCG chose to cooperate with the Johanniter Order for patient rehabilitation. Under the umbrella of OCB and as part of a lasting cooperation a team of Belgian nephrologists set up dialysis services in the General Hospital of Port au Prince. After some discussion there was cooperation with different military structures for the referral of patients (i.e. to the US navy hospital ship) and at the Port au Prince Airport there was no other option than to work with the US military when discharging charters with MSF cargo. Apart from these initiatives or obligations and the assistance of the Greenpeace ship for transport of cargo, no other active cooperation was sought with actors outside MSF.

There is a general sense that MSF teams were to optimistic regarding other actors commitments. This particularly goes for promises on WatSan activities and distribution of shelter in the IDP camps, where after weeks priority needs were still unaddressed.

MSF participation in the health cluster and its sub clusters was based on availability and personal initiative within the different OCs. By coincidence one Head of mission took on the responsibility and presented MSF well in cluster coordination meetings. MSF standpoint on the cluster system is not clear to many within and outside of the organisation. Participation in cluster meetings is not part of a conscious coordinated strategy to push the MSF agenda (or not) but rather used for ad hoc information gathering.

Without exception external actors interviewed in Haiti admired the achievements of MSF but accused the organisation of having a superior attitude and remarked that, while it is easy to be independent when operating in a bubble, this becomes much harder when trying to understand and communicate with authorities, target populations, local initiatives and other actors. Or, as one external interviewee put it: “MSF is confusing independence and splendid isolation”. Other actors in the Haiti earthquake response regard MSF with a

mixture of admiration (“MSFs capacity and speed of mobilisation is incredible”), jealousy (“not sure what you are doing but you must be doing something cause I see MSF cars everywhere”) and confusion (“so who is in charge with all those MSFs”).

Security: good exchange on information, but rules differ

"To manage security was beyond the capacity of the teams." (E-Pool member)

Before the earthquake the MSF OCs had their security rules in place. Directly after the earthquake a major revision of the security plans was not seen as a priority and in the first two weeks the rules were fairly relaxed. Changes in the security plans were limited to safety precautions in case of aftershocks. For the NFI distributions specific security concerns were raised and they were appropriately addressed by the Logistical Coordinators and those responsible for the distribution activities that came up with very innovative ways of distribution of NFIs in urban settings. Exchange between the HoMs and LogCo’s of security related information was very good. However security rules differed between OCs, and shared communication means, i.e. common radio frequencies were not considered.

There was a critical security incident in early March involving two expats of OCG who were kidnapped for six days. This incident had significant operational consequences for all MSF OCs. After the critical incident each OC implemented much more stringent security plans. This not only had an effect on the operational space of the MSF teams (i.e. because of reduced outreach activities in the IDP camps) the new security rules also reduced proximity to the Haitian population making understanding of the context more difficult. The planned reflection exercise after the incident never took place and therefore no lessons were shared in the movement.

Learning an incredible lot - or not?

"Most questions asked now were answered five years ago." (General Director)

Many expats who worked in Haiti during the first three months were proud of what MSF was doing and mentioned that they had learned an incredible lot which would be very useful for future missions. At the same time, however, some faced the same practical problems as they did in earlier, similar missions and wondered what happens with information given during debriefings and in their end of mission reports.

The institutional knowledge of the Haiti intervention is spread out over a large number of people with different perspectives. Working in the urban setting of a capital city proved to be difficult for all OCs. While giving assistance to large groups of displaced populations is of course not new to MSF, the organisation has less experience with the particular challenges of working in a potentially violent urban context with more than 1100 IDP settlements with varying numbers. There are many experiences and lessons to capture and document for the future.

2.4 MEDICAL REVIEW

MSF has provided **an impressive medical emergency response** to earthquake survivors. MSF has been (and still is) a major actor in the health sector response to this catastrophe, as secondary health care provider as well as through its large involvement in primary health care delivery for displaced and surrounding communities.

Table 2: Top 10 findings from the Medical Review

Positive	To be improved
❶ **Relevant focus** on **surgery, postoperative care and mental health** based on critical needs and capacity. ❷ **Scale and performance** of **key interventions**: secondary level surgery and postoperative care, emergency mental health care and primary health care. ❸ Timely introduction of **disease surveillance** ❹ Application of the **lessons learned** from previous earthquake interventions. ❺ **Proactivity** in respective areas of intervention: timely integration of emergency obstetric care and surgery; central blood bank; prevention of tetanus; immediate mobilization of kidney dialysis intervention; innovative use of point-of-care biochemistry test; anticipation of treatment for HIV/TB and chronic diseases, etc.	❻ **Inter-section capacity** for **assessment** and **monitoring of evolving needs and assistance** at health facility as well as community level ❼ Well-timed, informed and proactive **inter-section strategic analysis and decision-making** according to evolving needs and assistance. ❽ **Strategy on mass casualty, assessment of surgical needs** and surgical strategy setting towards a coherent and optimized emergency response. ❾ **Uniform data collection** with use of key indicators on outcome and quality. ❿ **Coherence in implementation** of respective areas of intervention: use of community based surveys and surveillance; internal fixation orthopaedic surgery; access to treatment (continuation) for HIV/TB and chronic non communicable diseases; use of required diagnostic imaging; mass vaccination, etc.

Operational priorities were initially driven by the huge numbers of critically injured and deeply traumatised, operational choices have afterwards **adapted rather in reaction** to demand than according to strategic analysis of needs and mobilisation of assistance.

Inter-section key strategic decisions were taken quickly at the start of the intervention aiming at maximising coverage and optimising resources through geographical repartition and some degree of operational complementarity. However **no inter-section strategic analysis and review of medical operational priorities** took place. Early decisions of OCs on planning for mid-term commitment secondary health care level were influenced mainly by pre-earthquake analysis and priorities as well as institutional interests.

The **focus on surgery, postoperative care and mental health care was very relevant**. However the need for all five OCs to choose the same focus and the late and limited involvement other activities can be questioned: Medical and non-medical assistance to the homeless and displaced was basic; set-up of medical and paediatric hospitalisation care delayed; and follow-up on treatment continuation of people with HIV and/or TB and chronic non communicable diseases insufficient.

MSF in Haiti had agreed on the set-up of a common inter-section E-PREP plan, which was however not yet formalized and implemented; it was also not up to the level of a major disaster.

Rapid site assessments happened quickly and introduction of **disease sentinel surveillance** – through Epicentre - was timely. This set-up contributed significantly to the design and weekly data collection of the national sentinel surveillance system. **More comprehensive inter-section assessment** and monitoring of needs and actors **was missing**, yet would have provided as from the early days of the emergency a "helicopter view" of the needs. Moreover lack of community based surveys and surveillance prevented from a closer view on priority needs at the community level.

Surgery was implemented at large scale with high output and with **evidence of sufficient quality** despite the many challenges. Focus was on trauma and second/third level orthopaedic surgery followed by reconstructive surgery yet with adequate space for emergency gynaeco-obstetric surgery. Although a common data collection system was introduced, teams did hardly any data collection in the first weeks. Some OCs delayed in introducing it and the collected data remained limited to OT based output without data on patient outcome. Inter-OC coordination and framework for needs assessment, planning and improving inter-section complementarity was missing. The role of advanced orthopaedic surgery involving internal fixation remains controversial requiring the inter-OC Surgical Working Group to clarify on role and practice of this level of orthopaedic surgery in resource scarce settings.

The kidney dialysis intervention, facilitated through OCB, was implemented quickly but faced many challenges and **had relatively limited coverage and output**. There should have been more investment in early detection and triage (through point-of-care biochemical tests) of crush syndrome patients for conservative management or kidney dialysis.

Physiotherapy was successfully integrated at all levels; either directly implemented by MSF (OCP) or through effective collaboration with other agencies. Data are missing on outcome and quality. Use of white prostheses enhances stigmatisation in dark skinned population.

Emergency mental health services got implemented timely and at large scale with coherent prioritisation of beneficiaries and use of approaches. Available quantitative data show high level of output but do not enable to evaluate individual patient outcome and programme performance (outcome and quality). Mental health services should have extended quicker to community level and be articulated more with social and spiritual support services and initiatives. Psychiatric care could have been more decentralised and levels adapted according to context and local capacity.

Very little output on detection and care of victims of SGBV is reported, despite the anticipated increase of sexual violence. Most MSF services have been little involved in offering access to care.

Tetanus vaccination and anti-tetanus serum was anticipated and introduced quickly for all injured victims. **MSF did not get involved in vaccination campaigns** coordinated by MSPP/PAHO/ UNICEF mainly because the corresponding vaccination strategy was considered unrealistic. Though this it was a conscious decision, it remains controversial given the very high vulnerability of the large homeless and displaced population settlements for outbreaks, such as diphtheria and especially measles. Moreover no efforts were pursued for introducing new vaccines (pentavalent vaccine in EPI services and 10-valent pneumococcal vaccination for high risk groups).

Referral was complicated by the lack of overview teams had on available health care services of MSF and other actors. Transfer of patients requires vehicles adapted for ambulance use. There was an unfounded reluctance at coordination level to refer patients

to military health care providers (e.g. US Boat), despite the clear benefits for the respective patients.

Medical supply and pharmacy management benefited from effective (but informal) inter-section initiatives (Santo Domingo transit centre and the PAP "Inter-Stock"). Inter-section collaboration and supplies through the PAHO/MSPP managed PROMESS have helped out for critical shortages. OCs missed experienced international pharmacists, medical stocks have remained too long in inadequate storage conditions and consumption monitoring and coordination of orders was poorly done. Donations were sometimes inappropriate, non-standard and without evaluation/validation by OC pharmacists.

Surgical activities required important investment and rapid mobilisation of diagnostic imaging equipment. Yet there have been important delays and difficulties with mobilisation and installation of diagnostic imaging equipment. Respective inter-OC initiatives, as proposed by Working Group, have not received much support from OCs. Preference ought to be given to mobile equipment and experts need to accompany diagnostic imaging equipment to ensure proper installation and training. MSF needs to agree on use of OT-based C-arm radioscopy in support of orthopaedic surgery.

Emergency laboratory services focussed on access to safe blood and were well-conceived using rapid diagnostic and point-of-care tests complemented by "strategic" collaboration with external reference laboratories. The central inter-section blood bank in the first week was an effective temporary solution. The innovative use of a point-of-care dry chemistry device was very effective especially for the kidney dialysis intervention.

Data collection and analysis has been far below the level required for an emergency intervention of this scale and intensity. Except for specific areas such as HIV/AIDS, TB, nutrition, outbreak, and now also surgery; MSF lacks the use of a uniform data collection system, key for comprehensive overviews, strategic analysis, operational priority setting, operations based external communication, lobbying and advocacy. Each area needs to define a few indicators monitoring quality of services, besides the use of patient based databases and qualitative research methods.

Recommendations are made for setting up capacities – in support but outside the operational line – for assessment and monitoring as well as strategic operational analysis in major emergencies, including mass casualties. The use of a uniform data collection system and the attention to socio-cultural and religious needs are recommended.

A series of recommendations are made on how to improve emergency surgical care, mass casualties; among them the need to address "strategic" E-PREP plans and stock, internationalisation of guidelines and protocols, development of an MSF disaster surgery course, centralisation of MSF advanced third level care, assignment of focal coordination and medical managerial positions.

More specific recommendations are made for improving triage, for an upgrade of capacity to run emergency services, decentralising psychiatric care, flexible OPD service set-up and others.

2.5 LOGISTIC REVIEW

Logistic was under enormous pressure to facilitate the emergency response with the difficult conditions on ground. Two of the three hospitals where MSF was working before were destroyed or seriously damaged. Therefore medical teams worked wherever they were and logistic teams at this stage had to ensure basic aseptic conditions. Various interesting technical approaches have been chosen to ensure the quick availability of operation theatres (OT) with proper aseptic conditions.

Table 3: Top 10 findings on Logistics during the Haiti emergency

Positive	To be improved
❶ Sending experienced logistic staff from HQ on the first teams increased effectiveness ❷ Good technical solutions for mobile surgical set-ups (surgical containers, inflatable hospital) ❸ Quick provision of water to health facilities and surrounding population ❹ Innovative strategies for distribution in urban areas ❺ Inter-sectional supply bodies contributed to better effectiveness of the supply pipeline (Santo Domingo Hub and Interstock warehouse in Port au Prince)	❻ Lost opportunities to share work on pre-fabricated container hospitals ❼ Insufficient expertise in building stability posed security risk ❽ Lack of pro-active support from international working groups ❾ Supply is loosely managed and viewed as a service – a proportion of the high transport costs could have been avoided. ❿ Little preparedness towards inter-sectional coordination of supply – roles of the OCs and the ESCs are not agreed upon.

The **dense urban context posed technical difficulties** and partly explained the late start of the MSF WatSan activities in the camps surrounding the medical structures. Ensuring hygienic latrines availability in these conditions obliged the teams to apply very innovative technical approaches to overcome the difficulties.

A majority of the **tents distributed** by MSF in the dense urban neighbourhood were of poor quality. Teams managed to distribute the material in difficult security context by employing various innovative methodologies (early morning distribution, moving distribution points, community approaches, etc.) and broadly employing GIS tools. There has been productive exchange of information on distributions methodology in the beginning of the intervention but a lack on sharing the experience later. Even though a guideline on NFI distributions exists (MSFB 2009), the majority of the interviewed people did not know about it.

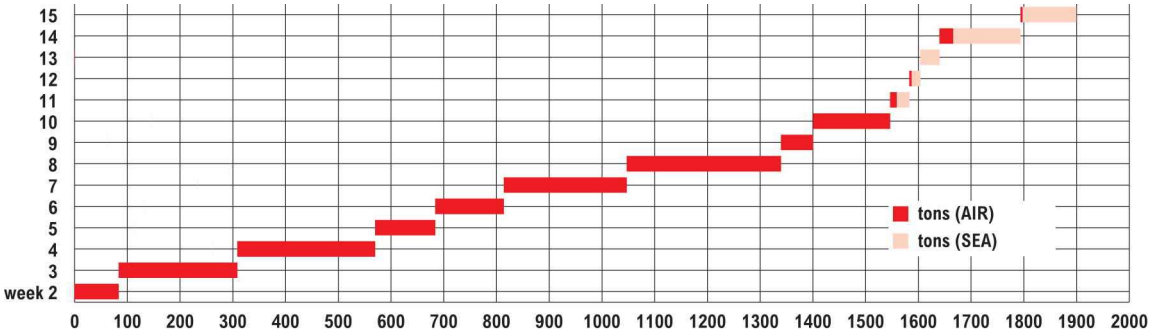
Non-sanitary **buildings have been transformed into field hospitals** with surgical wards and mobile surgical units have been deployed, from special surgical containers to inflatable tents. There is an opportunity now to transform these experiences into a practical guideline to help for further interventions. The different mobile surgical solutions and the expensive prefabricated hospital projects (the so called “container hospitals”) launched by three OCs in emergency mode require reflection and evaluation.

The deployment of **expert staff from logistic departments** in the very beginning of the intervention has increased the effectiveness of the response and the quality of the set-up. However, the organization's technical support and operational deployment would gain quality if these departments, their supply units and the different technical international work-groups would have had their **support role in emergencies** better defined before hand.

Some of the logistic / technical experts sent to the field were not used in function of their particular competences and could not dedicate their time to their domain of expertise, while these competences sometimes were lacking in other OCs at the same time (construction, telecommunication). Seen on an inter-sectional view, the use of these resources could have been better coordinated in order to improve quality of interventions.

The scope of the Haiti intervention is well reflected in amount of supplies that went into it; with a total of about **1800 tons of cargo** passing through the Santo Domingo during the first three months, this has been a major supply mission.

Figure 4: International Transit, cumulative weight and air/sea trend over first 15 weeks



An **effective inter-OC regional pipeline** was set-up in the first phase of the emergency. It was composed of an international freight transit and purchase hub in Santo Domingo and an inter-sectional reception centre and warehouse in Port-au-Prince. International Supply Facilitators have been placed without a formal frame in order to assume non-official activity coordination. This was a successful working solution; however MSF clearly took a risk of supply pipeline failure by not being able to structurally deploy inter-sectional supply teams.

The huge supply efforts to Haiti had an effect on the supply lead time to regular missions and other emergencies supply provisioned by MSF Supply. The **supply response was especially costly** because Haiti is located far from where the organization holds its stocks (Europe) and from the factories where shelter material was produced (Asia), but also because there was **no regional supply strategy** defined for shelter material.

Haiti intervention showed that the ability of OCs and ESCs to work together to implement complex supply solutions (complexity of the material and of the overall supply chain from producer to the field) is becoming increasingly important. Yet, supply is loosely managed and viewed as a service in MSF. The organization would improve effectiveness by giving more importance to its supply management and by ensuring effective supply cross-sectional coordination in order to gather strategic information, make analyse of the technical context and make proposals to the operations in order to discharge supply activities from the already heavy workload of the operational teams on the field.

Recommendations include a cross-sectional vision or strategic logistic platform for emergencies, drawing lessons from the rich experience in the urban and surgical context (pre-fabricated container hospitals, distribution strategies, etc.) and draft working documents (e.g. for assessing the stability of buildings). A shift in the organisations approach to supply is recommended going towards regional supply, inter-sectional supply platform and preparedness and end-to-end supply concept.

2.6 HUMAN RESOURCE MANAGEMENT REVIEW

International recruitment for Haiti Emergency was **extremely successful** thanks to the commitment of hundreds of expats available at short notice and the hard work of HR teams in OCs and recruiting partner sections. The visibility of MSF in this "Medical' emergency with big media coverage is expected to have a positive long term effect on recruitment.

Table 4: Top 10 findings on Human Resource Management

Positive	To be improved
❶ Quick deployment of international emergency staff ❷ Long term partnerships for recruitment established with medical institutions ❸ Most field positions filled in the first 3 months ❹ Close involvement of partner sections in Haiti time zone allowed for 18h + support / day ❺ Successful inter-section staff management at Santo Domingo Hub	❻ Human Resources (HR "budgeting") to be systematically considered in operational planning ❼ Extra HR management capacity for emergencies on HQ and Field level ❽ High turn over of expatriates ❾ Coherence in National staff management ❿ Steering of HR issues on international level

Very quick deployment of international emergency staff was managed by all OCs despite the chaos on the ground. First emergency response teams – including many HQ staff - arrived within 48 hours after the EQ. In the first three months most positions could be covered. International staff came back exhausted and shaken by the overwhelming level of destruction and needs but also satisfied by the medical work they were able to do with MSF.

Close involvement of partner sections in the Haiti time zone allowed for at least **18 hours of support per day**, which was very much appreciated by the affected teams in the field where the need for HR support was overwhelming in the first months of the emergency.

The high turnover of expats was one of the main points of criticism stated by beneficiaries, national staff and expats. The average lengths of stay was 55 days in the first 3 months (data from four Ocs); ranging from 42 days for OCP and OCG to 55 days for OCBA and 81 days for OCA. For coordinating positions this had massive implications on institutional memory, community relations, capacity for mid term/ long term strategic planning and management of staff. International agreements are necessary to avoid disruptive competition between OCs.

Expectation Management and preparation of staff was neglected. It was especially needed for specialists from external institutions, but also all MSF volunteers, to avoid problems in the field. Some sections still managed to offer basic preparation through short modules, others unfortunately decided to skip all.

The need for extra HR capacity at HQ was underestimated by all OCs; workload increased up to 50 % in the first three months. Burn outs, sick leaves, admin backlogs and reduced support to other missions were costly consequences of a strict adherence to the FTE freeze.

MSFs management set up in the field was not appropriate for this big emergency. More experienced HR coordinators (good experience in OCP) at an early stage could have

prevented many problems and ensured better HR strategic planning and handling of international and national staff. Generally a Middle management layer is felt to be missing.

The different HR procedures of five OCs today cause problems for recruiting sections (who contributed significantly to emergency HR): different qualifications for equal positions, different intake forms for e.g. surgeons, etc. There are no joint tools to allow basic inter-sectional cooperation. Joint positions would have been possible and useful with regards to sharing expertise, context analysis, mapping, looking at referral options, national rules and regulations, import licences, etc.

Little initiative for coordination and steering was taken by the **international HR platform**, which could have helped to possibly solve problems jointly rather than on each individual OCs level, e.g. the massive effects on HR in other missions, etc.

Operational plans did not consider the limitations of Human Resources. Long term consequences were only discussed after a desperate letter was sent by the HR coordinators in May.

"... Operations departments and the missions in the field need to realize that the pools are empty and more gaps are unavoidable …. We need to plan better and anticipate interventions, define limits, in order not to destabilize regular projects and keep capacity of response for emergencies."

MSF hired thousands of national staff in the first three months of the earthquake. With little HRM capacity at field level, poor technical support from HQs, and significant differences in contracts and salaries between OCs, their management remained weak. In meetings with the MOH, MSFs reliability as a medical employer has already been questioned.

> A particular challenge was the fact that almost all staff were victims themselves. Though MSF provided support to them (psycho social care, NFI, self help groups), some felt that too much was expected from them given the circumstances. Some OCs took a flexible approach and offered national staff part time work or put staff who were badly affected by the earthquake on standby.
>
> For senior national staff, who played a crucial role in the emergency response in Haiti, one observation was that they were little involved in strategic planning or communication about Haiti.

Psycho social care offered to MSF staff in and after Haiti was very different from one OC to another. The system has large holes and many did not have a chance for a psycho social debriefing. There is no clear international agreement on the basic level of psycho-social support for employees in the organization. Psychosocial care was also provided in the Santo Domingo Hub, which was a much appreciated inter-OC initiative.

In the first month hardly **any first missioners were sent**, with the exception of some specialist profiles. After that each OC tried to increase number of first missioners. Some HR Departments felt that with better HR structures in place in the field MSF could have absorbed more first missioners to learn the emergency work.

Recommendations are defined to review MSF management set up for big emergencies, to put HR E-Prep plans and protocols in place, to standardize HR tools for the movement, to try joint recruitment initiatives, to draw lessons from the Santo Domingo example with regards to inter-sectional cooperation and Psycho Social Care and to systematically consider HR in operational planning.

2.7 COMMUNICATIONS REVIEW

There is a general agreement across sections and departments on the good quality of the communications activities during the emergency in Haiti.

Table 5: Top 10 findings on Communication in the Haiti emergency

Positive	To be improved
❶ First-time two-base crises Info ensured media updates and monitoring around the clock ❷ Timely communication with first public update after 6h and immediate deployment of Communication staff with operational teams ❸ First-time Media briefings via teleconference reached over 150 journalists per briefing ❹ Field Communications Coordinator is a key position and crucial interface with HoMs ❺ Social networks like twitter and facebook open new windows of opportunity for communication and lobbying	❻ Lack of analysis and inter-sectional strategy inhibited public positioning and advocacy ❼ Too many people involved in defining communication contents resulted in watered down messages ❽ Lack of standardises data collection system for all OCs makes public accountability difficult ❾ Some MSF servers collapsed as a result of massive online traffic ❿ Communication work with local media was not systematic and delayed.

The **reactivity and responsiveness of MSF teams** after the earthquake made the organisation a media reference on medical and humanitarian issues. While this translated in an overwhelming media pressure and presence, MSF was also well positioned to exert leverage through the media on key decision-makers/ stakeholders i.e. US government, UN, and funding needs were met without virtually any pro-active efforts.

Communications teams faced **important logistic and communication constrains** that made work very difficult. However, it was MSF's internal idiosyncrasies that posed the biggest challenges. Either because MSF missed the operational opportunity or because OCs didn't agree on the analysis of the data collected, the organization lacked strategic analysis on medical and humanitarian issues and it was difficult to build any strong public positioning. At the same time, the complex decision-making process – with too many people involved in it – ended up watering-down messages or killing initiatives. Too many people are involved (HoMs, Desks, DirOps, GDs…) in decision making and just one person can block it. When no agreement has been reached, declarations of top MSF people (President, DG) have been a pragmatic, though not efficient, way to break the deadlock (i.e. poor living conditions of homeless Haitians; lack of effective relief aid).

For this review the already internationally agreed "**Checklist of Communications Roles and Responsibilities in an Emergency"** (Dec. 2008) was used as a reference. Some of its recommendations were implemented in Haiti, others need reinforcement. Some lessons learned during this intervention need to be included in order to update the Checklist.

The **first-time set-up of a two-base Crisis Info** (in London and New York) proofed a successful structure in terms of managing the overwhelming media pressure.

It took several days to define and use effective communication tools, e.g. the structure for the Crisis Info document. Simplification of the public information system (media focal

points), the use of media request templates and a centralized e-mail in the field can improve the management of media requests.

During the first phase of the emergency, MSF delivered very simple messages, focusing on MSF's operations in the field. In the second phase, the organization was unable to articulate and agree on stronger messages based on what field teams were witnessing. Many consider MSF's communications activities were focused on the promotion and protection of the organization, but little was done on public positioning. There is general consensus that **MSF has not been able to go into a proper analysis and to have voice on more strategic issues.** This results in a considerable amount of frustration.

There is an agreed schedule for publishing operational and financial information after one, two, three, six and twelve months. The one, two and three-month after reports lack transparent financial information linked to operations as well as operational intentions. This is negative for "accountability" purposes given the unprecedented amount of money collected from private funds.

MSF's websites experienced massive traffic: on key days the number of visits doubled up to ten-folded usual traffic. As result, some servers even collapsed. Websites proved to be a primary source of information for the general public. They are also an important fundraising tool, collecting an extraordinary amount of online revenues but also allowing MSF to explain issues related to fundraising, such as earmarked or non-earmarked donations, emergency fund, etc.

Personal blogs were widely appreciated by lay (non-MSF) readers and were reproduced by main national outlets, while others have not used them to cultivate media alleging difficulties to maintain editorial control and to focus the content on patients. Reuter's blog by Felix Salmon served to learn in real time the degree of public acceptance of certain decisions, such as the non-earmarked funds. In addition, it worked as a "live" opinion-maker by positively talking about this decision.

MSF's followers in Facebook and Twitter increased substantially during the emergency in Haiti (e.g. Facebook followers grew from 60.000 to 278.550 in the USA).

> *"It is no longer about pulling audiences to your website, but rather pushing out content to the spaces where people are congregating". (One Director of Communications)*

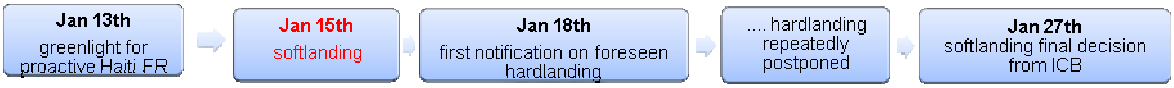
Twitter turned out – in an unprecedented way – to benefit MSF's operationality in overcoming bureaucratic barriers in an amazingly easy way. With the use of Twitter pressure was put on the US Air Forces, now a twit away, to allow MSF planes landing in PaP. The risk on the other hand is that news e.g. on kidnapping of two MSF expat nurses in early March were leaked via social networks.

Recommendations include the standardisation of Crises Info documents and media request procedures, and the importance of local media work and contacts with bloggers of influential media. Communication E-kits should be set up and experiences with Media-Teleconferences be documented.

2.8 FUNDRAISING REVIEW

The Haiti earthquake – together with the Tsunami – is the crisis that has generated the strongest financial support to MSF from the general public ever. The estimated earmarked funds to be received for Haiti are above 100 million euro (M€), notwithstanding the additional 27 M€ estimated through the Emergency fund. Haiti crisis was clearly a "CNN emergency" and the pre-existing Emergency Fundraising Mechanism (EFM) created in 2001 and adjusted in 2009, was activated for the second time in MSF history.

The decisions taken along the EFM process by the ExCom and ISG were as follows, with the intervention of the International Council board (ICB) for the ultimate decision:



This Haiti fundraising strategy[5] was variably translated in FR appeals and plans, leading to differences between sections and within sections.

Though the figures aggregated from all sections are not fully consistent, here is a rough estimate based on fundraisers figures provided at the end of April (on money received):

	Haiti earmarked funds (includes admin & HQ costs)	+ 101.5 M€6
+	Emergency Funds	+ 27.5 M€
+	Incremental un-earmarked income	+ 52.8 M€
-	Budgeted revenue of cancelled appeals	- 1 M€ (rough est.)
-	Loss due to cannibalization	- 1.5 M€ (rough est.)
=	Haiti impact on FR income	= 179.3 M€

More in-depth:

- 95% of the total funds received are coming from Western countries (50% from Europe and 45% from North America= USA + Canada)
- 69% of earmarked funds are coming from individuals
- 89% of the income comes from "spontaneous"[7] gifts versus 11% from prompted gifts, for the total earmarked + EF. Even though soft landing has curbed prompted gifts by stopping proactive fundraising, spontaneous would probably have remained preponderant.
- There were 5 times more new donors over the same period of time (January to end of April) in 2010 than in 2009 and the number of new donors acquired these first four months of 2010 (more than 900,000 new donors) is 30% higher than the number of new donors for the whole of 2009!
- Rise in MSF awareness, not yet quantifiable, is also expected due to the massive media coverage.

[5] **Soft landing** = no more proactive earmarked FR and trying to redirect the incoming gifts to Emergency Funds or unrestricted funds, but still accepting earmarked donations that could not be redirected + reactive communication on FR position - **Hard landing** = no more acceptance of earmarked gifts (in a proactive mode and even in a reactive mode) + possible proactive communication on FR decision.

6 EFM figures collected by IFC Djamila were 91 M€ at end of April (effect of timing difference and admin costs)

[7] Prompted income corresponds to the gifts, which can be directly attributed to FR appeals. Some "un-traceable" ones may fall into the spontaneous category. Hence, spontaneous gifts could be indirectly triggered by all kinds of MSF fundraising and communication activities.

ANALYSIS

Haiti fundraising strategy has globally worked well: surely no damage yet some disadvantages! The decision making process was complex with the interaction of numerous stakeholders and "challengeable" decision making parameters. The review of MSF FR performance during Haiti raises key points on respect of decisions and missed opportunities. On very rough projections, HoFR estimate that a "no landing" strategy could have enabled MSF to raise an additional 45 M€. With such figures and 2011 operational budget still to be covered, some people point out that the no landing approach would not have generated over-funding. Finally, Fundraisers consider accountability on Haiti to be of utmost importance to keep the trust and support of donors

Table 6: Top 10 findings on the Fund Raising management during the Haiti emergency

	Positive	To be improved
FR decision and strategy	❶ 2010 OPs expenses covered with no over funding over a two-year time frame	❻ Questionable decision-making parameters (due to soft landing, earmarked funds might not cover 2011 OPs needs)
Governance	❷ Swift and good running of EFM	❼ Voice of the field came too late ❽ Information and coordination gaps
Implementation of decisions	❸ No bad feelings from donors and humanitarian actors (reactive mode rather than proactive communication on FR)	❾ No consistency between sections and often within sections... partly due to the absence of a decision enforcement mechanism
Results (end of April 2010)	❹ About 180 million Euros of total income estimated (earmarked>100M€ + Emergency Fund + un-earmarked incremental) ❺ 900,000 new donors (USA>1/3rd)	❿ Aggregation of inconsistent figures

Strategic challenges ahead

What could be the most relevant FR strategy or strategies for the future, considering over- or under-funding risks, public perception, transparency, consistency and accountability issues? The choice lays between an earmarked strategy, more or less differentiated between sections/entities, a less earmarked strategy in favour of an EF or a non-earmarked one.

DIRFUND FEEDBACK

On 14th and 15th of September 2010, the DirFund platform went through the recommendations proposed here and issued a revised list, with some rephrasing, also asking to more explicitly define soft landing and hard landing. In addition, the DirFund will give its feedback to the ExDir on the potential ways forward (strategic choices) further to FR19+ meeting planned for spring 2011.

3 CONCLUSIONS

The scale and speed of MSFs emergency operations in Haiti were impressive. Despite the organisation being affected itself, MSFs teams delivered life-saving assistance to the people affected by the earthquake from the first hour. The ability to quickly mobilise resources, in- country presence of staff and supplies, 'can do' attitude, experience, solid reputation and operational reflexes made MSF one of the most important providers of emergency medical aid in the aftermath of the earthquake in Haiti. Communications managed an overwhelming media pressure that resulted in a massive amount of private funds. Appropriate expertise and medical supplies allowed the immediate and impressive setting up and scaling up of emergency operations.

The presence of three OCs in the country with surgical capacities and despite little preparedness was a chance to respond quickly and has facilitated the MSF model of response: reactivity. Without the surgical programs being in place, the MSFs response would have looked very different, would have been much delayed and certainly less efficient. This brings back an unresolved issue in MSF: the **movement's position in Natural disaster response**, which would have to include issues of engagement with international actors, (regional) supply, Human Resources, etc.

Initial choices, mainly surgical activities were in line with emergency needs, but responses to many other needs remained delayed or unaddressed. **Operational choices became less coherent over time,** when individual OCs decided on their strategies for the mid and longer term. MSF teams concentrated on activities in and around existing health facilities, rather than being guided by a conscious strategy that may have allowed a broader public health approach. The impression is that decisions against more and earlier involvement in the camps, and against a response to overwhelming shelter needs were made by default rather than based on analysis and agreement. Comprehensive, inter-sectional assessment, strategic analysis and monitoring of needs could have enabled MSF to move to more strategic and more complementary programs in Haiti.

MSF certainly had an important impact in Haiti. However evaluators believe MSF could have even achieved more, if it pulled together forces and capacities to obtain and address the "bigger picture" in a timely manner.

The fact that **MSF can not produce a conclusive set of overall data from all five OCs presents concerns in terms of accountability and transparency**. It impacts negatively on MSFs ability to define strategies and conduct operations, but also on the quality of communication, fundraising and advocacy. There is an evident need for organisational-wide clarification and agreement on a common language and improved exchange of this information.

Processes to take key decisions for the MSF movement today take too long and lack joint analysis of context and problems. This applies for the projection of operational expenses, operational choices (as a movement), advocacy messages, etc. While individual OCs can be flexible when faced with operational challenges this is not the case for the movement. Looking at the example of the projection of financial needs, these are calculated by summing up individualistic needs of each OC. There is no calculation for the movement as a whole and what the movement could do with the amount of money possibly raised (shelter is an example of it).

Fund Raising is today the only area where mechanisms are defined to arrive rapidly to a common decision. If there are still difficulties associated to this well defined process, it is

where Fund Raising decisions need to be informed by strategic (operational) analysis or where communication with donors should benefit from (reliable) output data. Unfortunately other strategic resources (Human Resources, Supply, etc.) are not addressed with the same interest and effort. Particularly the disregard of Human Resources in operational planning has shown to have negative consequences of for MSF missions elsewhere.

The "Santo Domingo hub" provides an innovative example of inter-sectional collaboration that is unanimously appreciated. Apart from this, the current set up raises major concerns in terms of the optimal use of organisational resources and credibility vis a vis national and international stakeholders. For administration and support services there often is duplication, if not quintuplication, but certainly a gross lack of coordination. The potential to increase efficiency through an economy of scale is enormous. Today - due to differences between OCs in definitions and accounting systems - detailed accounting for and a joint audit of MSF expenditures is not possible.

Many look at the inter-sectional platforms for leadership; interestingly enough often different platforms then the one they are part of. The platforms however, do not have the mandate or the tools to exercise this leadership. International platforms and working groups have an important potential to inform operational decisions, in particular to analyse and foresee problems and provide respective solutions. In the current organisational set up they are not given the authority to realise this potential.

In view of the extensive operations in Haiti and its 19 years history in the country, **MSF could and should have been a credible authority speaking out** on the humanitarian situation and the medical needs of the population. This did not happen much due to the complicated internal processes, the absence of common analysis and strategies and the lack of commitment to speak with a common voice.

MSF – being a main health actor in Haiti – **did not use its weight** much to influence decisions or health policies, nor did it take a position in the reconstruction of the health system. Inter-action with others was generally poor and consequently quite some opportunities for collaboration or influence missed.

All the specific reviews point to new challenges in the Haiti intervention, many related to the difficulties in the urban settings. There is a need for **improved retention and dissemination of the MSF experiences** and the implementation of lessons learned from earlier interventions.

Reviewing the immediate emergency phase two issues deserve particular attention to obtain a greatest impact for the population: i) **Emergency preparedness for a major disaster**, considering that MSF in Haiti was only prepared "by chance" through the existing surgical programs, and ii) **the need for a global strategy of the movement** in every major emergency to anticipate, prepare and implement the most relevant action.

There is a clear need for MSF to position itself and invest in both areas. The Haiti experience provides practical lessons on how to do this.

4 RECOMMENDATIONS

Every specific review report contains a number of recommendations; below are main recommendations to be addressed by the ExCom/ExDir, the Operational and Medical Directors as well as the International Council.

Though these recommendations are made in light of the Haiti experience, they are obviously applicable to other scenarios of intervention. Some of them may already have been made in past emergencies.

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1 There is a vast amount of experience and expertise available within the organisation. This can be better utilised for operations, if MSF agrees to:

⇒ **Strengthen technical working groups**

1.1 Clarify mandates of technical working groups, and include proactive advise to operations on policies and tools in emergencies

1.2 Technical working groups to play a key role in learning, documenting, and using lessons from emergencies.

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2 The knowledge gained from complex interventions like Haiti today is spread out over a large number of individuals, who often do not stay within the organisation. MSF can improve the institutional knowledge and the quality of its response, if it chooses to:

⇒ **Focus on organisational learning**

2.1 Capture the various new and past experiences made in the Haiti intervention, conduct further research and build specific expertise where needed

- (Logistic) inflatable OT and hospital, surgi-tainer semi-permanent structures, container- and modular hospital infrastructures
- Tents / shelter, distribution strategies, etc.
- High tech surgical equipment, standard medical supply order for surgical interventions

2.2 Systematically provide for reflection and documentation of the lessons learned during major emergencies and ensure re-dissemination and implementation of previous lessons (internal and external) in the set up of emergency interventions

2.3 Proactively disseminate all existing key reference documents, position papers, policies, guidelines and any other tools to facilitate timely operational decision making and to avoid reinventing the wheel during emergencies.

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3 As a main health care provider (in Haiti and elsewhere) MSF can use its weight (financial, operational) much better to influence local policies for the benefit of the

people. MSF can improve the complementarities of its programs, the organisations perception and can gain acceptance for its work if operational staff are ready to:

⇒ **Engage with national and international actors,** in particular interact with the aid system

3.1 Interact in with main health care and humanitarian actors

3.2 Review the level of MSFs participation in cluster coordination – depending on the context – consider to go beyond "observer status" and use capacity to lobby

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4 The Haiti experience demonstrates the potential for improvement that MSF has if it prepares for, acts and reflects on major emergencies as a movement rather than a set of competing OCs. The understanding of context and needs can be more complete, overlaps be avoided, synergies increased, if operational directors

⇒ **Define a global strategy of intervention as a movement in major emergencies**

4.1 Use an Inter-section capacity for assessment and / or for "country based" analysis and strategic review for developing operational strategies, identifying advocacy needs and feeding MSFs public communication

- Responsibilities may include context analysis, networking and representation and continuous mapping of medical structures and referral possibilities

4.2 Identify jointly main MSF messages for Lobbying and Advocacy

- Streamline decision-making processes around Emergency communication

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5 MSF has a significant scope to increase its impact and improve its efficiency. Much better use can be made of existing resources and expertise and accountability can be enhanced if decision makers are ready to:

⇒ **Optimise and account for the use of organisational resources and expertise**

5.1 Mutualise regional or country-level support services, including technical expertise (e.g. x-ray specialist, construction - stability expert, etc) and field advisors.

- This may include context analysis and reflection, security, communication networks, legal advise, representation, epicentre support, national staff management, networking, administration, etc.
- Promote the further use of international supply facilitator positions

5.2 Harmonize data management between Operational Centres to ensure the coherence and consistency of the information managed internally and externally.

- Define type & indicators and implement a common medical data collection system
- Harmonize and define resources related data management, i.e. HR, Fin, FR

5.3 Define a MSF movement supply strategy across OCs and ESCs for major emergencies

- Strengthen the international supply platform by defining its role in emergencies
- Establish end-to-end supply concept, organization and process
- Define a regional supply strategy including preparedness

5.4 Decide on common definitions and policies for Fund Raising
- Fundraisers and DirFins to propose a common definition of earmarked funds, Soft landing, Hard landing and Emergency Fund
- Define and accountability plan for every big emergency (what, how, resources)

5.5 Revise the Emergency Fundraising Mechanism
- Reinforce coordination and clarify governance, enhance Field perspective,
- Review the decisional parameters
- Ensure implementation of decisions

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6 Much better impact in responses to major (natural) disasters can be achieved if action is taken on movement and not only on individual sections level. If MSF desires to make such real impact, decision makers need to:

⇒ **Invest in an inter-section response capacity (for Natural Disasters)**

6.1 Define a common framework for intervention strategies, including preparedness, regional supply structures, training and coordination

5 ANNEXES

1 ANNEX : SHORT C.V.S OF EVALUATORS

Francis Coteur joined MSF in 1999 as a Logistician. He was Field Coordinator, Logistic and Emergency coordinator and Head of Mission and worked as Logistic officer in Barcelona and Brussels. He holds a degree in Industrial Engineering, Electro Mechanics.

Luis Encinas Pedrayes is Operations Coordinator, MSF Belgium and has been working with the organization since 1994. He started as a field nurse in Haiti, and worked there later as emergency/ medical coordinator. He holds a Master Degree in Public Health and is a registered Nurse graduate with various specializations, including Tropical Medicine, Paediatrics and Neonatology.

Amaia Esparza has worked for MSF since 1997 as Head of the Communications Unit in Barcelona, Regional Information Officer (RIO) in Bogotá (Colombia), Head of Mission in Uganda and conducted evaluations for MSF. She holds a Masters degree in International Law and International Relations. At present, she is the Advocacy and Communications Advisor for MSF-OCBA in Zimbabwe.

Paula A.W. Frankema has worked with MSF for 14 years in several countries, including Haiti, twice as a head of Mission. She has been Head of Operations for War Child and worked as a consultant for PAHO/WHO and as a Financial Manager for Newfield Partners Ltd. in Haiti. She holds a Diploma in Finance and Business Studies and an MSc in Development Practices.

Karine Klein joined MSF in 2004 as Head of Fundraising for Switzerland. In 2008/2009, she worked as a consultant for MSF-Japan and as Head of Fundraising ad interim for MSF-Italy. Previously and for over sixteen years, she had worked in the private sector in marketing and communication. She graduated from a French Business School. She is now a free-lance consultant.

Laura Angela Rock Kopczak is a researcher, educator and consultant specializing in Supply Chain Management. Her current focus is on humanitarian and global health supply chains. She has worked with organizations such as IFRC, Save the Children, MSF Spain, UNHCR, UNICEF, the UN WASH cluster, and Fritz Institute. Dr. Kopczak has an MBA from Columbia Business School and a PhD in Industrial Engineering and Engineering Management from Stanford University.

Juli Niebuhr has been working for MSF since 2002 in positions within the organization. She has been a project coordinator and Deputy Head of Mission in Myanmar. She worked in Burma and was head of human resources in Berlin. She holds an advanced degree in political science.

Roger Teck is a Belgian medical doctor with postgraduate training in tropical medicine and public health. Since 1986 he has been working with MSF mainly in sub-Saharan Africa, in Peru and has coordinated as of 2002 HIV/TB programmes in Malawi and Cameroon. He participated in strategic support, training and explo (Swaziland) work on HIV/AIDS and has been Director of Operations for MSF OCBA. At present he does short term assignments for MSF.

Johan von Schreeb is Co-founder of the Swedish Section of MSF and has been working with the organization on and off since 1993. He currently researches as a Health Emergency Analyst at the Division of International Health, Karolinska institute and still practices as a surgeon. He holds a PhD in Medical Science, a Diploma in Tropical Medicine, and is Specialist of General Surgery.

Sabine Kampmüller is the head of the Vienna Evaluation Unit; she has worked for MSF since 1996 as a nurse and project manager. Between 2001 and 2005 she was head of the Human Resource Department in Vienna. She holds a Masters degree in International Health (MIH) and is a lecturer for Public Health and Qualitative Research.

Ewald Stals works as a consultant for humanitarian organizations, and has worked with MSF from 1997 to 2007. He was head of mission, emergency coordinator and head of Operations in Berlin. He holds a degree in Biochemistry, as well as American History, English and American Literature.

2 ANNEX: LIST OF INTERVIEWEES

A
Alberti Kate
Algue Gala
Amehane Virginie
Amorena Xavier
Asztabski Voitek

B
Baajens Ramon
Bachy Sylviane
Badinier Arnaud
Barbieux Marie-Aude
Barra Fabienne
Barthaud Katia
Benoit Avril
Bernart Francis
Berret Martine
Berson Bruno
Beytout Coline
Blansjaar Martijn
Boelens Boelie
Boivin Eric
Bonneau Freddy
Bossant Frank
Bossenbroek Daphne
Boucher Thierry
Bouhabib Hocine
Boulet Pierre
Bourdais Eric
Bouriachi Oifa
Bradol Jean-Hervé
Breebaart Gabriella
Briade Claude
Broughton Martyn
Brown Vincent
Burns John

C
Cabello Angel
Cabrera Paul
Cachet Philippe
Capochici Isabelle
Captier Christian
Castell Jean Luc
Caushaj Ilir
Cecchini Sergio
Celipha Edner
Chaillet Pascale
Chan Gloria
Chanet Nicolas
Chedorge Delphine
Christiansen Grete-Liese
Ciglenecki Iza
Codina Jaume
Coeur Carole
Collin Philippe
Coloni Francesca
Colpaert Marianne
Cone Jason
Cooney Lauren
Cordaro Jean Marc
Cortes Eduardo
Cosack Cara
Crawford Liz
Crestani Rosa
Cyr Mario

D
Damascene Raymond
De Jong Kaz
De Laval Fabienne
De Los Santos Guillermo
De Metz Nicolas
Dedieu Laurent
Defilipi Loris
Delamotte Nadine
Delouche Bruno
Derdeirian Katharine
Desbareau Pierre Boulet
Di Vecchis Caio Mario
Diaz Francisco
Diplo Yann
Djumageldyev Begench
Doerner Frank
Dohn Maria
Dominicus Jaap
Draguez Bertrand
Dridi Naoufel
Drogoul Frederique
Dubois Marc
Dumain Francois
Durand Thierry
Durosier Annecy

E
Eloi Franck
Encinas Luis
Ericksson Anneli
Erneau Mondesir

F
Falero Fernanda
Felleisen Elke
Ferir Marie-Christine
Fesselet Jean Francois
Flevaud Laurence
Fournier Christophe
Fricke Renzo

G
Galey Dominique
Garat Virginie
Garbusinski Yannick
Gazet Anabelle
Gazi Harris
Gelin Gideon
Ghesquier Regis
Gignoux Etienne
Goedhart Menno
Goetghebeur Stephan
Griffioen Johan

H
Hehenkamp Arjan
Henrys Daniel
Hereu Jean
Hilares Doris Arit
Hoedt Vincent
Hug Alois

I
Iscla Marta

J
Jacobs Jean-Marc
Jancsy Irene
Jawor Paul
Joachim Caroline
Jochum Bruno

K
Kavouris Liz
Kleijer Karlina
Kliffen James
Koelewijn Bert
Kourniotti Maria

L
La Motte Pierre-Paul
Lagerholm Frida
Landemann Audrey
Lapeyre Bernard
Laumont Barbara
Le Coconnier Marie-Laure
Lefebre Alain
Leglise Jerome
Ligozat Laurent
List Liz
Lopez Francesco
Lozano Olivier

M
Madsen Laura
Maes Peter
Malaval Fabien
Manfredi Stefano
Markandya Polly
Massart Jo
Massis Gerald
Masters Pete
Meinhard Monika
Mekaoui Helmi
Mellado Angel
Michels Suzanne
Mili Djamila
Moens Alex
Mora Lara
Moriana Silvia
Mossenta Marc
Muehlebach Jean Luc
Muloni Veronique

N
Neerkorn Jessica
Nichols James
Nijhuis Mirjam
Noyer Emanuel

O
Oberreit Jerome
Obert Remi
Ossig Frauke
Ouannes Eric

P
Padberg Rob J.
Palma Pedro Pablo
Paschos Nondas
Pasquale Beatrice
Passola Jordi
Pele Patrice
Pereiro Ramon
Peremans Michel
Perez Monica
Perroud Gilles
Pettersson Johan
Phlips Stefaan
Piferrer Raimon
Pillot Anne
Pineda Anna
Pitaldi Giovanni
Pletinckx Jean
Ploeckinger Andreas
Pompetti Fabio
Ponthieu Aurelie
Pots Olaf
Powels Simona
Prager Harold
Prat Olga
Prima Philippe

Q
Queyras Guillaume

R
Rammeloo Frank
Rebeyrol Sandra
Remy Julie
Ribant Pascal
Ribeiro Filipe
Rieux Claire
Rivoire Maud
Rodrigue Marie-Noelle
Ronsse Axelle
Rosa Valentina
Roumat Sandra
Roy Sebastien

S
Sabard Laurent
Sanchez Frederic
Sanchez Gabriel
Sarrias Enric
Sauveur Laurent
Sayyad Khalil
Schaefer Jean Eric
Schiavetti Benedetta
Servranckx Francois
Sexton Mary
Shakal Marc
Shanks Leslie
Shiess Irene
Soler Ignasi
Sommarstrom Sally
Songco Nestley
Sonukuy Jerome
Soro Jean
Souquet Jerome
Spencer Sebastian
Sprunken Paul
Stokes Christopher
Surenat Claude
Sury Laurent
Swarthout Todd

T
Terzian Mégo
Tich Yohan
Tierney Jennifer
Tisch Joaquim
Torgeson Kris
Trigales Patricia
Tronc Emmanuel
Tubau Joan

V
Vallat Frédéric
Van Alphen Dana
Van de Weerd Hans
Van der Kroft Jackie
Van der Woude Jaap
Van Dillen Hans
Van Zuylen Pamela
Van't Land Erwin
Vannier William
Vasset Brigitte
Veldman Gerda
Verelst Ilse
Vermeerch Audrey
Victoria Julio
Virgo Vincent

W
Wagner Pierre
Wassington Danny
Whelan Heather
Whitfield Ben
Wilbert Jacqueline
Wolf Irene
Wolswijk Nico

Z
Zaat Roel
Zabalgogeazkoa Aitor
Zannini Stefano

Terms of Reference for
Inter-section Review on HAITI

Subject / Mission:	MSF response to earthquake in Haiti
Commissioned by:	Jean-Clément Cabrol on behalf of ExDir, RIOD, and DirMed
Starting Date:.....	April 2010
Duration:.....	+/- 4 months
ToR elaborated by:.....	Sabine Kampmüller, Jean-Clément Cabrol,
Validation……..	Excom

CONTEXT

The Haiti earthquake on 12th January 2010 was an unprecedented disaster, leaving more than 200 000 people dead, an estimated 300 000 injured in an already desperately poor country. The number of displaced is estimated to be close to a million. With the epicentre close to Port au Prince, the capital was paralysed.

MSF has been present in Haiti since 19 years and three OCs (OCP, OCB and OCA) were present in the country when the earthquake occurred. All missions included surgical programs; other activities provided for patients physical rehabilitation, assistance to victims of sexual violence as well as emergency obstetric care etc. From the first day after the earthquake MSF teams have provided medical treatment to people. All five OCs engaged immediately in emergency response, launching collectively one of the biggest interventions in MSFs history.

One month after the onset of the earthquake MSF had extended operations to 20 sites, providing amongst many other, 11 operational theatres and 740 bed capacity.
Since the onset, more than 18 000 patients have been treated; among them 1986 have undergone surgery. A total of 1450 national and 375 international staff work throughout the different project. 1 400 tonnes of Cargo have been supplied to the MSF Haiti mission.

The international response, media coverage and solidarity have been enormous, putting a particular challenge on coordination within MSF and beyond.

Due to these realities, The ExCom sees the pertinence to run an operational review, exploring different questions through an analysis of MSF operational role/responsibilities and the interest to produce an external report for accountability and transparency purposes.

OVERALL OBJECTIVE and PURPOSE of this review:

The objectives of this review are to:

a) Analyse the **effectiveness** of the MSF response, incl. reactivity / timeliness, overall output, medical quality, etc.

b) Evaluate the **appropriateness (pertinence)** of operational choices in what concerns priority needs of the population

c) Review **efficiency** by comparing MSFs input, i.e. deployment, resources (HR, funds) vs. the overall output, looking specifically at cost of opportunity related to different challenges and operational choices

These three criteria will provide the framework for reviewing all the key issues stated below.

The purpose of this review is twofold:

i) Accountability: to give account externally, to donors and the public, on the MSFs response, its scope, achievements and shortcomings (reflecting MSFs role as an emergency actor)
ii) Learning: to learn from this unique experience in order to improve MSFs future responses to earthquakes and other disasters

The evaluation will cover the initial 3 months of the intervention, starting January 12, 2010 (ending April 30th)

Due to the large scope of this review and the time constraints, this review will be covered through a general evaluation and different specific evaluations at field and HQ levels, steered by the respective platform. Some OC will perform their own evaluations like OCBA about their Panama decentralised unit effectiveness or OCB about "timing" deployment. A consolidation of these different evaluations will be realised in a second step.

KEY ISSUES

Global evaluation (Part 1)

a. Strategic operational choices:[8]
- Appropriateness of choices on main activities (medical, surgical, relief, shelter, WatSan, prevention, surveillance…) in the given context & needs, considering also role of other actors – *to be linked with main outcomes.*
- Appropriateness of the decision regarding the activities which were NOT developed in the given context & needs, others actors
- Appropriateness of advocacy (messages)
- Evolution of projects and activities
- Reactivity / Timeliness

b. Inter-section collaboration:
- Decision / distribution of activities, locations, resources (HR, Fund, supply…)
- Strengths / Weaknesses of collaboration in the current set up
- Complementarities/redundancies, coherence/lack there of amongst OCs at both field and HQ level
- Coherence and Efficiency of HR set up

Logistic and supply (Part 2):
- Availability of material and supply
- Appropriateness of logistic means
- Appropriateness of the supply supports (HQ and field)
- Pre-intervention plans, checklists, organigrams, etc. Field and HQ/Supply centres levels.

Communication (Part 3)
- Timeliness of Info-sharing in the movement
- Coherence of MSF positioning, Clarity of messages
- Appropriateness of communication mechanisms
- In country communication efforts. Perception, acceptability of the organization, work with local media and authorities.
- Lost opportunities

Medical/Surgical Quality (Part 4)
- Adherence / Divergence from MSF standards
- Analysis of concerns on quality (scope of problems, reasons, etc.)
- Analysis of the post operative care quality
- Appropriateness of structures
- Transfer from / to other actors and related observations

[8] The 10 priorities "standard / model as a basis.

Finance and Fund-raising (Part 5)

- Overall cost, costs related to different challenges and operational choices
- Decision making and implementation of FR strategy
- Pertinence of the FR strategy
- Review of the EFM

Emergency preparedness is a cross-cutting issue for all parts of the evaluation.

The criteria defined in the evaluation objectives (effectiveness, appropriateness, efficiency, timing) will be applied across the following key issues for the review:

KEY QUESTIONS FOR THE GLOBAL EVALUATION (PART 1)

1. How did MSF respond to the consequences of the earthquake in Haiti? How relevant was the choice of projects considering the existing needs?

   What alternative choices could have been done (in the view of OP managers, field staff, other actors and beneficiaries?)

2. How did projects evolve? How were activities developing with the changing situation (context, actors) and needs?

3. What were the pros and cons of the MSF set up (with 5 sections deployed)??
   How coherent and complementary was the overall set up?
   What were the messages given by MSF?

4. How were resources allocated globally? (HR, available supply, etc.) → link to financial review
   What was the impact of the massive engagement in Haiti on other missions (e.g. for HR)

5. How coherent and efficient was the HR set up of the 5 sections?
   a. How did the exchange on HR work?
   b. How was the national staff managed?

6. How timely / reactive was MSF in the Haiti emergency? What was hindering / enabling reativity?

7. What are the overall achievements of the MSF intervention? How effective and efficient was it? What were factors hindering / enabling effectiveness and efficiency?

8. MSF positioning: Did the MSF deployment contribute to an independent approach in this environment? What were the messages towards the different actors (advocacy, lobby)?

EXPECTED RESULTS

From the global review team:

- o External report: It has to clearly describe the choices done by MSF according to the populations and contexts with the positive and negatives outcomes.

From the teams of specific evaluations, general evaluation:

- o General / Internal report and specific reports on Logistic/Supply, Medical/Surgical quality, Finance/ Fund Raising
  - Including an executive summary synthesising main findings, conclusions and recommendations
  - Recommendations have to be specific to each area of responsibility (Ops including. medical /emergency desks, Log, Fin, HR) and must include E-prep and E-coordination
  - Recommendations for the OC concerning responds capacity and set-up
  - Recommendations concerning relations with the others actors

From the Deputy IS (JCC):
- The consolidation through analysis of the of different evaluations will link the the main outcomes and recommendations to challenge the MSF approaches and the aid system

On request (from all):
- Presentations at RIOD, DirMed, ExCom and IC, E-desk, DirLog

EXPECTED LIMITATIONS

It is expected that:
- No detailed conclusions on efficiency can be drawn considering the uniqueness of this disaster (impossible to compare to "similar" situations or responses).
- It may take a long time until financial reports are available, which could delay the evaluation → may be planned as a later phase of the eval process
- Real impact measurement (in the sense of reduced morbidity, mortality, suffering, resuming basic dignity) of this intervention is considered very difficult, therefore it is proposed to focus on effectiveness, i.e. overall output, outcomes, and/or perceived appropriateness by beneficiaries, etc.

PRACTICAL IMPLEMENTATION OF THE EVALUATION

Roles & responsibilities in this evaluation will be allocated as follows:

Jean-Clement Cabrol / IO is responsible for the evaluation and is the link to the commissioning bodies (ExComm, RIOD). All key decisions in the evaluation are to be taken with him (choice of evaluators, overall evaluation plan, communication to stakeholders, etc.). Throughout the evaluation he will be informed and will communicate about all steps and progress; he will revise and comment drafts before shared further. He is charge of dissemination and follows up of evaluation findings.

Sabine Kampmüller / Vienna unit: will facilitate the evaluation process: propose ToR and coordinate detailed ToR / sector, propose evaluators, design detailed work plan (Evaluation phases), supervise Eval team(s), manage the process (briefing, trips) and ensure completion of report.

OC referent: will support the process, take in charge parts of the evaluation, i.e. supervise one of the teams and/or be focal point for some of the sections.

- OCG: Sabine Kampmüller
- OCA: To be defined
- OCP: Vincent Brown, to be confirmed
- OCB: Anneli Erikson, to be confirmed
- OCBA: Bernard Lapeyre

ExCom: To support the overall process
ExCom, RIOD, DirMed, others platforms: after validation to support implementations of the recommendations.

ANNEX 4: Recommendations from the specific reviews

MEDICAL RECOMMENDATIONS – 1. General

Page	Key stakeholder	Recommendation	Addressed to
61		Set up immediately an intersection capacity for assessment and monitoring	DirOp
61		Ensure capacity for assessment of surgical needs and surgical strategy setting for a coherent and optimized response	DirOp
61		Assure intersection strategic analysis and operational priority setting	DirOp
61		Use a uniform data collection system, linked to International Typology, including key indicators on outcome and quality	DirMed / DirOp
61		Increase attention to socio-cultural and spiritual needs and provide locally adjusted responses to such needs	Ops
2.	**Surgery and Postoperative Care**		
61		Include capacity for initial response to emergency surgical needs in "strategic" EPREP plans and stocks	DirMed / DirOp
61		Internationalise guidelines and protocols regarding surgery, OT management and wound dressing	DirMed / SurgWG
61		Agree on indications and preconditions for internal fixation orthopaedic surgery in emergency conditions thereby using among others analysis of patient outcome of the Hospital St. Louis internal fixation orthopaedic surgery	DirMed / SurgWG
61		Stick to one single data collection system to evaluate output and patient outcome	DirMed / SurgWG
61		Develop an MSF Disaster Surgery Course incl. assessment, surgical principles, protocols, guidelines and data collection	DirMed
61		Wherever several MSF sections are providing surgical care, MSF advanced third level care services, such as care for severe burn injuries and internal fixation orthopaedic surgery should be centralised.	DirMed
61		Deploy a surgical coordinator in any large surgical program	Ops/HR
3.	**Other Intervention Areas**		
62		Capitalise on previous experiences and assign emergency services coordinators for improving triage in emergencies	DirOp / E-desk
62		Upgrade capacity for running emergency services and intensive care units in emergency conditions	DirOp / E-desk
62		Plan for communication and adequate capacity for early detection and triage for victims with crush syndrome for either conservative fluid management or kidney haemodialysis.	DirMed
62		Decentralise psychiatric care in large scale emergency mental health programs through guidelines and involvement of medical doctors and nurses in the use of psycho-pharmaca.	E-desk
62		Include chronic disease (HIV/TB, non-communicable) kits within EPREP stocks and/or the first emergency medical orders	E-desk
62		Apply flexibility in the set-up of OPD services in response to gaps in treatment for chronic diseases	E-desk
62		Test the feasibility of critical medical equipment to be hand-carried by medical teams.	E-desk
62		Assign focal coordination and medical managerial positions and big/complex interventions	DirMed / HR
62		Capitalise on the experiences with the various approaches for temporary and mid-term modular health care structures.	DirMed / DirLog
62		Strengthen medical supply and pharmacy management in line with the recommendations in the pharmacy review.	DirMed / DirOp

ANNEX 4: Recommendations from the specific reviews

RECOMMENDATIONS[9] FROM THE LOGISTIC & SUPPLY REVIEW : LOGISTICS

Page	Key stakeholder	Recommendation	Addressed to
1. WATER AND SANITATION ACTIVITIES			
9	WatSanExperts, IntWorkingGroup	Water and sanitation experts need to share the lessons learned during this intervention in their international work-group and make sure the experiences from this urban context are capitalized and used for the future intervention.	Log Dir
9		If MSF want to provoke an impact on the sanitation condition of its beneficiaries, it should adopt a stronger position in the United Nation's WASH cluster.	Riod
2. RELIEF DISTRIBUTION			
11		The organization needs to decide whether it wants to be an effective shelter actor in urban context and give it self the means to properly address this needs.	Riod
11		The international work-group referent for the NFI distributions should ensure the knowledge of the distributions activities in urban context acquired in Haiti is capitalized and available for the future emergencies.	Log Dir
11		Make sure the MSF logistic teams have access and are trained to use a GoogleEarth-like GIS system to be used in other non-mediatic and less well internet-covered urban contexts in the future.	Log Dir
3. LOG SUPPORT TO SURGICAL ACTIVITIES			
12		The international construction work-group should capitalize the experience of the mobile OT structures used during this emergency and make a mapping of the different solutions to be applied in function of the context (consider transportability, sterility conditions, simplicity of set-up and cost).	Log Dir
13		Construction and surgical international work-groups need to develop a practical guideline to help team to establish surgical units in emergencies.	Log Dir
13		The organization should make an in depth assessment of the prefabricated “container” hospitals projects it has started:	ExCom
4. LOGISTIC DEPLOYMENT AND SUPPORT			
15		Define logistical department's role and procedure in relation with emergency response in terms of HR deployment and support mechanisms to the field in order to systematically reinforce e-cell.	Log Dir
15		Define the role of the different international working-groups in the context of major emergencies in order to be more effective and use more confidently complex technology used today	Log Dir
15		Document the evaluation process of the stability of buildings in earthquake context.	Log Dir
15		Consider the punctual gathering of a cross-sectional “vision” or “strategic” logistic platform when major emergency occur.	Excom + ???

[9] For more elaboration, details and background to Recommendatios please see the specific reports.

ANNEX 4: Recommendations from the specific reviews

SUPPLY

Page	Key stakeholder	Recommendation	Addressed to
1. EUROPEAN SUPPLY CENTRES			
8*		Establish emergency coordinator position at each supply centre	Supply Centres
8*		Implement procurement best practices to reduce procurement risk and replenishment risk during (emergency) scale-up	Supply Centres
8*		Set up capacity for establishing and running ongoing end-to-end supply (see rec. to Excom.)	Supply Centres
8*		Address staffing as a key issue for high impact emergencies (at supply center and sending people to the field).	Supply Centres
8*		Designate one ESC as the lead on sourcing, procurement, mobilization and delivery of shelter/NFIs.	Supply Centres
8*		Acknowledge the potential inclusion of shelter/NFIs in high impact emergencies ; Include options for using a dual pipeline	OCs
9*		Each OC should formalize and manage its relationship with the supply centre(s) through an SLA and monitoring of key performance indicators.	ExCom/Riod
9*		Establish end-to-end supply concept, organization and process.	ExCom/Riod
10*		Define an MSF movement supply strategy across OCs and ESCs to position MSF to be effective and efficient in supply	ExCom/Riod
10*		Strategically implement information systems to support end-to-end supply and the multiple supply centre structure.	ExCom/Riod
10*		Address staffing as a key issue for high impact emergencies (at supply centre and sending people to the field).	ExCom/Riod
10*		Invest in ERP and information systems strategy for the supply centres and MSF movement and making the right decisions.	International Council
2. REGIONAL PIPELINE SETUP			
21		The international supply working group needs to ensure that the experience and knowledge from the inter-sectional regional supply pipeline is documented, capitalized and transformed into usable documents for further use.	Log Dir
21		The organization needs to re-think its approach towards its management of Supply in emergencies in order to pass from a re-activity to a pro-activity mode by being able to promptly set-up efficient and reliable regional inter-sectional pipelines for future emergencies. Therefore, MSF should10: ⇨ Reinforce supply bodies within each section. ⇨ Strengthen the international supply platform by defining its role in emergencies. ⇨ Re-install the international Supply coordinator position at the International office. ⇨ Make an inter-sectional supply emergency preparedness plan.	Excom
21		Ensure the further use of international supply facilitator positions, clarifying their responsibilities and support resources.	Riod

ANNEX 4: Recommendations from the specific reviews

RECOMMENDATIONS ON HUMAN RESOURCE MANAGEMENT

Page	Key stakeholder	Recommendation	Addressed to
1.	**Develop HR Emergency preparedness**		
		Define lines of communication, task division, responsibilities (OCs, Partner sections, HR departments, E-desks, field, etc)	
		Increase HR management capacity in HQ in early stage of emergency	
		Strengthen HR management set up in the field for big emergencies with regards to absorption of first departures, national staff management, job descriptions, capacity to analyse HR needs and strategic planning	
		Strengthen technical support role of HR departments (for the field)	
		Provide capacities for technical and legal advise, considering inter-sectional options	
		Develop standards tools and protocols (generic job profiles for natural disaster, attention to expat health, etc.)	
2.	**Revise Steering of International HR issues**		
		Implement joint international HR vision (endorsed in November 2009)	
		Define steering role of international HR platform in emergencies	
		Pilot joint recruitment initiatives to address prevailing HR problems, e.g. high turnover, coherence in qualifications, etc.	
		Harmonise National Staff Management	
		Learn from positive inter-sectional initiative in Santo Domingo	
3.	**Improve psycho-social support**		
		Agree on common minimum standards fro psycho-social care (in emergencies)	
		Improve coverage of psycho-social care for emergency staff	
		Use Haiti experience to evaluate the state of psycho-social care offered across MSF	
4.	**Ensure that HR planning becomes a self-evident part of operational planning**		
		Consider «HR budgeting » systematically in operational planning	

ANNEX 4: Recommendations from the specific reviews

RECOMMENDATIONS ON COMMUNICATION

Page	Key stakeholder	Recommendation	Addressed to
1. COMMUNICATION STRUCTURE			
33		Define work tasks and responsibilities for two-base Crisis Info.	
33		Define a standardized format for Crisis Info document.	
33		Introduce a standardized media request template and a specific e-mail account to handle media requests.	
33		Include Bloggers of influential media in communications' contact lists.	
33		Include local media in MSF's communications' priorities.	
33		Improve coordination among web sites as advised in the 2008's Checklist document.	
2. COMMUNICATIONS HUMAN RESOURCES			
34		Prepare a pool of emergency press officers who can leave for the field asap and within a week or two	
34		Train press officers in a more strategic fashion to increase the number of experienced press officers.	
34		Ensure good briefings and hand-over to minimize the impact of high rotation of press officers (each 2 to 3 weeks).	
34		Consider deploying a stable press officer around the second to third month after the emergency started.	
34		Deploy a spokesperson to do the media rounds on the ground during the first two to three weeks of the emergency.	
3. COMMUNICATIONS TECHNICAL MEANS			
34		Set-up a "Communications E-kit" with all basic connection materials for emergencies (Iridium, handsets, blackberries…).	
34		Implement a single field e-mail account for emergency press officers, in order to centralize all communication	
35		Implement a centralized information management system in the field to be shared by all press officers.	
35		Develop instructions on "How to host a media teleconference".	
35		Develop Blogging and Twitter guidelines.	
35		Upgrade servers' capacity to face increasing demands for online operational information.	
4. RECOMMENDATION FOR THE ORGANIZATION IN GENERAL			
35		Deploy a senior communications person (Field Comms Coordinator) on the ground to support HoMs	
35		Reduce the number of people involved in the definition of public positioning messages.	
35		Streamline decision-making processes: Define communications' red lines and delegate responsibility to lead communications issues to one Operational Centre.	
35		Accountability reports must include financial figures linked to Operational activities.	

ANNEX 4: Recommendations from the specific reviews

RECOMMENDATIONS ON FUND RAISING

Page	Key stakeholder	Recommendation	Addressed to
1. GOVERNANCE		**Reinforce coordination: enhance field perspective + create an ad hoc temporary committee**	
37	ExCom	Enhance field perspective during EFM process (OPs to decide on best solutions)	ExCom + ISG + Dirop ExDir
32	ExCom	Create a special and temporary ad hoc committee for coordinated recommendation in major emergencies	ExCom with ISG ExDir
32	ExDir	Clarify the role of existing platforms, during emergencies, to maintain their high involvement	ExDir with ISG
31	ExDir	Clarify governance for the redefinition of IO keys. Who recommends? Who decides?	ExDir with ISG
43	ExDir	Validate the set-up for implementation and enforcement of decisions to be addressed in the EFM	ExDir with ISG
37	ExCom	EFM should designate a focal point for exceptions in the implementation. Arbitrate, record and share info	ExCom with ISG ExDir
	ExCom	Rely on someone or on platforms to translate general decisions in precise implementation guidelines	
33	ExCom	At EFM level, adapt to the split of ICFC position in ICC and IFRC positions	ExDir with ISG
2. DECISION MAKING		**Review the decisional parameters and integrate the different realities and perspectives (field, home societies)**	
		First assess the specific situations	
31	ExCom	For EFM, define objective criteria to determine which are the situations requiring special consideration	ExCom with ISG ExDir
37	ExCom	Have a more systematic review of the three possible situations regarding specificities in home societies.	ExCom with ISG
34	FR & FinDir Int'l	FinDir with HoFR to work out global statistics models to be able to better project CNN emergency income	FinDir + DirFund + IFRC + IFC
35	Riod	Rely on a more strategic inter-sectional vision/analysis in the process of estimating emergency expenses	DirOps, E-desks?
-	ExCom	Decide on the share of OPs expenses to be covered by Private FR	
31	ExCom	Decide on what are the applicable IO keys, “normal” or reviewed according to the specific contexts	ExCom with ISG
34	FinDir Int'l	During EFM, cap to be set by FinDir and ExCom, not by FR and for hard landing only	FinDir+ ExCom + ISG
3.COMMUNICATION		**Better (wider, quicker, more systematic) information and coordination**	
31	ExCom	Communicate swiftly to HoFR and FinDir what are the applicable IO keys	ExCom with ISG
31	IFRC	During EFM, ensure coordination between HoFR and ExCom to manage the FR requests related to “specificities” and communicate on decisions taken	
32	ExCom	Feedback on the recommendations made by the platforms	ExCom with ISG
4. IMPLEMENTATION		**Ensure good synchronization of FR decision communication with actions and monitor**	DirFund/DirCom IFRC, ICC, ISG, ExCom

ANNEX 4: Recommendations from the specific reviews

Page	Key stakeholder	Recommendation	Addressed to
5. DEFINITIONS AND PRINCIPLES		**Earmarked funds**	
17	FR & FinDir Int'l	Have a common definition for earmarked funds	FinDir + DirFund + IFRC + IFC ExDir
18	FinDir Int'l	On HQ & admin costs, have a common policy for earmarked funds but also for emergency funds?	FinDir + IFC ExDir
18	FR & FinDir Int'l	Define what the international Emergency Fund is, if it is to become an international concept	FinDir + DirFund + Riod + IFRC + IFC + ExDir
50	FR & FinDir & Com Int'l	Be accountable on all the Haiti earmarked money collected (incl the amounts dedicated to admin costs)	FinDir + DirFund + Com + IFRC + IFC+ ICC ISG?
50	FR & FinDir & Com Int'l	Broaden the scope of accountability taking into consideration the FR requirements	FinDir + DirFund + Com + IFRC + IFC+ ICC
50	FR Int'l	On top of national obligations to use local figures on MSF response, sections should use international data.	
50	ExDir	Devote enough resources to work on accountability	
50	FR & COMMS INT'L	To work on accountability guidelines and report and to optimize “reporting” skills of fundraisers (training), reactivate the Com&Fund accountability working group (and why not include DirFin?	DirFund/DirCom IFRC, ICC ToR of working group
6. OPTIMIZATION OF FR PLANS		**Improve e-prep**	
15	FR & Comms Int'l	FR and Comms to work out emergency plan with new media networks	DirFund/DirCom IFRC, ICC
41	FR & Comms Int'l	Include FR needs in the briefing of at least one field Comms officer (common e-prep plan)	DirFund/DirCom IFRC, ICC
5	FR local	Develop e-prep in terms of technical organization to manage at best the flow of calls/web visitors/on-line givers and payment entry, and plan possible back-up or extra-support solutions	HoFR
15	FR Int'l	Share best practices during next Int’l FR meeting, with a particular focus on new channels, new concepts	DirFund + IFRC Agenda FR 19 meeting
18	FR Int'l	Evaluate the impact of the spike in emergency giving to Haiti for MSF in long term reviewing donor trends	IFRC with HoFR Agenda FR 19 meeting
15	FR local	Assess radio opportunity for emergency appeals	HoFR