



OCB EBOLA REVIEW

Part 4: Advocacy & Communication

[February 2016]

This publication was produced as part of a broader review of OCBs response to the Ebola emergency. It was independently prepared by **Michel Peremans**.

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CONTENTS

ACRONYMS3

EXECUTIVE SUMMARY4

 RECOMMENDATIONS 4

BACKGROUND.....7

 INTRODUCTION..... 7

EVALUATION METHODS & LIMITATIONS9

FINDINGS 10

 ANALYSIS, REFLECTION & STRATEGY 10

 MOBILISATION 15

 LOBBYING & PUBLIC COMMUNICATIONS..... 18

 LOCAL LOBBYING & PUBLIC COMMUNICATIONS..... 33

CONCLUSIONS..... 39

RECOMMENDATIONS & LESSONS LEARNED 43

ANNEXES..... 45

 ANNEX I: TERMS OF REFERENCE..... 45

 ANNEX II: LIST OF INTERVIEWEES 45

 ANNEX III: INFORMATION SOURCES 47

Front Cover Photo by Morgana Wingard

“Jackson Niamah, Liberian physicians’ assistant at MSF’s Ebola Management Centre in Monrovia addresses UN Security Council members in New York who later unanimously vote through an emergency resolution on the Ebola outbreak.”

ACRONYMS

AFRO	WHO Regional Office for Africa
ALIMA	The Alliance for International Medical Action
AU	African Union
CDC	Centre for Disease Control and Prevention
DFID	Department for International Development (UK)
ERF	WHO Emergency Response Framework
EU	European Union
ExCom	Executive Committee
GERC	Global Ebola Response Coalition
HAT	Humanitarian Advocacy Team
HART	Humanitarian Advocacy and Representation Team
HIT	Humanitarian Innovation Team
HQ	Headquarter
IB	International Board
ICRC	International Committee of the Red Cross
IFRC	International Federation of the Red Cross and Red Crescent
IMC	International Medical Corps
MSF	Médecins Sans Frontières
NATO	North Atlantic Treaty Organisation
NERC	National Ebola Response Centre
OCs	Operational Centre's
OCA	Operational Centre Amsterdam
OCB	Operational Centre Brussels
OCBA	Operational Centre Barcelona
OCG	Operational Centre Geneva
OCP	Operational Centre Paris
OCHA	Office for the Coordination of Humanitarian Affairs
PHEIC	Public Health Emergency of International Concern
R&D	Research and Design
RIOD	MSF Directors of Operations Platform
UK	United Kingdom
UN	United Nations
UNICEF	United Nations Children's Fund
UNMEER	UN Mission for Ebola Emergency Response
US	United States
USAID	United States Agency for International Development
VHF	Viral Haemorrhagic Fever
WHO	World Health Organisation

EXECUTIVE SUMMARY

It is beyond doubt that the Ebola response is one of the most significant milestones in the history of MSF OCB and, by extension, the whole of MSF. Reviewing the MSF response to the epidemic – including the communications and advocacy activities carried out – is therefore highly important.

As well as consulting press releases, statements, Q&As, briefing papers and minutes of meetings, more than a hundred interviews were conducted for this review with MSF OCB field and HQ staff, MSF staff from other operational centres and offices, and also with representatives from governments, international institutions, NGOs and the media.

This review looks at the period between March 2014 and March 2015, and distinguishes three key phases during this timeframe:

- Phase 1: Sounding the alarm (from March 2014 to August/September 2014)
- Phase 2: Scaling up (from August/September 2014 to the end of 2014)
- Phase 3: Not over (from January 2015 to the end of March 2015)

Ebola had a significant impact on MSF in terms of advocacy and communication, catapulting the organisation unexpectedly into an expert and advisory role. MSF was an information provider and advisor, influencing public opinion, institutions and organisations.

Despite efforts in public communication and lobbying the international community, it was only in the first half of September that the world started to engage with the Ebola crisis. This review identifies a list of important barriers to the advocacy efforts. For many journalists and institutional bodies, the warnings did not stand out in comparison to other MSF press releases and warnings.

The final wake-up call was a result of better coordination of all the MSF advocacy and communication regarding the outbreak. A big game changer was the infection of international staff, which created huge media pressure that MSF communication departments managed very well. MSF's public messaging also built up over a period of months.

Interventions at the United Nations (UN) General Assembly (including a call to deploy civilian and military biohazard assets) and at the UN Security Council were particularly powerful and triggered a response. Equally significant were the transnational threat when the outbreak spread to Nigeria, Mali and Senegal; the declaration of a Public Health Emergency of International Concern by the WHO (August 8); and the open letter from Liberian president Ellen Johnson Sirleaf asking for help. Any one of these individual actions might not have led to a meaningful international intervention, but together they served to raise awareness and prompt significant action.

Mobilisation of resources was slow and difficult within the MSF movement. Before the creation of the specific MSF Ebola Task Force in August 2014, there was no systematic advocacy analysis and therefore a lack of a clear strategy.

The epidemic gave MSF unprecedented access to the highest levels of governments, international institutions and scientific communities. This served to underline the importance of identifying and developing such relationships, in order to better understand how they function and to allow MSF to target them at the right level and the right time.

One important lesson learned from the Ebola response is that in such an emergency the challenge is to maintain sufficient space for reflection due to the overwhelming management of the operation. It is critical to bring in extra capacity to work alongside emergency operations on an overall advocacy strategy for both lobbying and public communication.

WHO was reluctant to interact with MSF at a high level. MSF's critique of WHO resulted in lack of trust from their side. MSF's interaction with institutional bodies was mainly handled by the Ebola specialist, but on reflection engagement from a more senior representative at an earlier stage may have been helpful. Engaging with regional health actors or AFRO was not seen as a priority by MSF.

Many rumours, misunderstandings and false information were circulating and seriously hampered the containment of the disease. As well as a focus on international media in the field, public messages from MSF mainly targeted the international media. Some of these messages conflicted with local needs, creating tensions with national authorities and confusion within communities. A focus on the gravity and fatality of Ebola served to keep local people away from medical centres rather than encouraging them to seek help.

Best practice examples in Liberia and Guinea demonstrate the immediate and striking impact of good local communication, and helped staff to avoid stigma. These examples also show the importance of using local mass communication tools to support health promotion.

The Ebola experience highlights the need to put in place resources to document and analyse changes in the context in the field and at HQ. Before the specific inter-sectional MSF Ebola Task Force was set up in September there was insufficient advocacy analysis and the strategy was not clear enough for the communication teams.

The notable issue in this Ebola response was the difficulty of putting messages across in a way that were understood as intended, internally and externally, as well as nationally and internationally. There was a clear need to target messages better according to different situations and audiences.

The Ebola outbreak has clearly emphasised the difficulty, vulnerability and sensitivity of MSF's internal communications. Examples of this are the difficulties in mobilising internal action; the often unbending deliberation; the painful open letter and – at times – the lack of useful and up to date information flowing between the field and HQ, and between MSF and other organisations.

The outbreak also demonstrated that medical advocacy is a field that urgently needs to be developed and that local communication and advocacy must be prioritised. The review highlights the need to put resources in place to document and analyse context changes and experience in the field.

The Ebola emergency response has massively elevated the prominence of MSF as a global health actor, both in terms of public awareness and perception, and financially in terms of fundraising. Where press officers usually fight for media coverage, in the Ebola emergency requests had to be turned down. MSF was upfront in the news for weeks and months, which resulted in an increased profile.

A number of lessons on communications and advocacy have been identified and are described at the end of the report. The main recommendations of this review are:

1. **Develop and maintain a better network** with, and a better understanding of, the functioning of governments and institutional bodies, including at higher levels, and deploying MSF offices and other MSF entities to lobby in a timelier manner.
2. **Have sufficient numbers of on-going dedicated staff for communications and advocacy**, both in the field and at HQ, from the beginning of a response.
3. **Define the profiles, roles and expectations of health promotion and field communications staff**; develop local communications tools and strategies; and document good practices in different emergency situations.
4. **Develop MSF's international capacity for medical advocacy.**

5. **Integrate a 'skilled analyst' in the set-up for large-scale emergencies.** This will allow more, better and earlier context analysis and identification of potential allies and influencers, including 'unknown and unusual' actors (e.g. African platforms and the Elders). It should also consider the timely involvement of high level MSF representatives, where necessary.
6. **Develop a more efficient advocacy and communications set-up in the field,** including the development of an intersectional pool of trained field communications staff¹ and develop some standard templates for field analysis, e.g. a template for actor mapping and a local advocacy strategy.
7. **Explicitly follow and respect Chatham House rules** in order for MSF to be trusted and accepted in bilateral talks with global and state actors.
8. **Increase attention to and investment in staff and strategies to reach out to non-western media** (China, Russia, the Arabic world etc.) in emergencies with a large global media reach.

¹ An International Field Communications Officer pool, managed by MSF UK on behalf of the movement, has been launched at the beginning of 2016. This is the first such international pool and is an important step, primarily in terms of improving field communications capacity. The Heads of HR and Communications will work closely with the International Communications Coordinator to ensure its success and the pool will be evaluated by the IDRH six months after its launch.

BACKGROUND

The MSF Operational Centre Brussels (OCB) response to the Ebola outbreak in Western Africa has undoubtedly been complex and challenging. Questions have arisen over whether the choices made were timely and right. This is why the OCB management has commissioned an extensive multi-sectorial review of the intervention.

The review looks at the time period from the 1st March 2014 to 31st March 2015. It identifies key learning areas based on examples of good and bad practice as well as making recommendations for possible future best practices which can potentially improve guidelines, departmental strategies and learning for future similar interventions.

A summary report that highlights main findings from the nine reviews is available.

INTRODUCTION

I've never experienced, in seven years at MSF, such a crisis where a complete HQ is overwhelmed; 'avec le nez dans le guidon'² — and it's just too easy to say that more could have been done. We were dealing, mostly alone, with one of the biggest things we had over the last 10 years. (MSF International Office)

It is beyond doubt that the Ebola response is one of the most significant milestones in the history of MSF OCB and, by extension, of the whole of MSF.

Unfortunately, there is no simple and watertight answer to the question: could MSF's communications and advocacy have been better? It is likely that there was another way, but one cannot be sure if the result would have been better. Nevertheless, there are lessons to learn for future emergencies.

This Critical Review on Communications and Advocacy deployed during the Ebola response looks into the period between March 2014 and March 2015. For the purpose of the review and based on the questions outlined in the terms of reference, we have picked out four major themes:

- Mobilisation
- Analysis, reflection and strategy
- International Lobbying & Public Communications
- Local Lobbying & Local Communications

Three phases have also been chosen as a 'rogue' file within in each theme. However, these are not necessarily aligned with other interpretations of the Ebola Operational Response phases:

- Phase 1: Sounding the alarm (from March 2014 to August/September 2014)
- Phase 2: Scaling up (from August/September 2014 to the end of 2014)
- Phase 3: Not over (from January 2015 to the end of March 2015)

Firstly, the review investigates the **mobilisation** issue, both internal and external. The second chapter reviews findings on **analysis, reflection and strategy**; in particular the issues of the *Task Force* and *Quarantine* are put under the spotlight. Thirdly **lobbying and public communications** are reviewed. In this chapter the review enlarges on the MSF interventions at the *UN General Assembly* and the *UN Security Council*, the *infected staff* and the *One Year report*. The final chapter of the review dwells on

² French expression. Translation: with your nose on the handlebars

local lobbying and communications, taking a closer look at each project country (Guinea, Sierra Leone and Liberia) in each phase.

Because advocacy and communications were ‘intersectional’ all the way through, and this was in contrast to other disciplines, we also look at the intersectional dynamics of the messaging and of communications and advocacy activities.

Finally, there are the lessons learned and the conclusions of this review, followed by the recommendations. Ultimately the review identified several issues on which the organisation needs to reflect.

For the purpose of clarity, key terms regularly used in this report are defined here to ensure shared understanding of their intended meaning.

- **Advocacy:** The act of pleading or arguing in favor of something, such as a cause, idea, or policy. Within MSF advocacy stems from what MSF witnesses in its projects. This can be done through inter alia lobbying (e.g. bilateral meetings) and public communications.
- **Lobbying:** The act of attempting to influence decisions (e.g. bilateral meetings) of any other actor, not only a government
- **Campaign:** A series of different tools put in place (public, private) in favor of a change.
- The terms **local communications** and **local lobbying** are commonly used in MSF to refer to communications and lobbying strategies and activities conducted in the country where the humanitarian emergency is occurring.

Many external interviewees noted that MSF is far too critical about itself, but that doing a critical review is strong proof of the organisation’s maturity. It should be emphasised that nearly all interviewees (internal and external) stressed that MSF did a fantastic job. This must be kept in mind when reading this review; it is the start and the end point of each reflection on the Ebola response. All comments and critiques in this review need to be understood within these parameters.

A review process inevitably focuses on things that did not work well or could be improved. However, the evaluator would sincerely like to acknowledge the huge amount of work, the important achievements and deep commitment of the MSF teams in the field as well as at Headquarters and in other MSF offices.

Finally, when reading this review, it is important to keep in mind the point in time at which this unprecedented epidemic broke out. At the time MSF was also confronted with the abduction of its staff in Syria. In the same period other humanitarian issues requested attention and resources, for example the conflicts in South Sudan, CAR, Ukraine, Gaza, Ukraine and Myanmar. At the peak of the outbreak it was holiday season in Europe, and it was an electoral period in the Ebola affected countries. Into this came Ebola.

EVALUATION METHODS & LIMITATIONS

Press releases, statements, Q&A's, briefing papers and minutes of meetings were consulted for this review. Internal MSF interviews took place with staff that had been deployed in the field at the relevant time; and with office staff in the five operational centres (the International Office, the Access Campaign and MSF Germany, UK, US and South Africa). Furthermore, people outside the organisation were interviewed: international institutions, governments, non-governmental organisations (NGOs), international media and national media from the three affected countries. In total more than a hundred interviews took place (face to face or via Skype).

The majority of interviews were audio-recorded (with the consent of interviewees), and verbatim transcripts produced on which the analysis was based.

Some of the findings obtained through two intersectional MSF communications surveys are integrated in this review (a survey with MSF web/photo/AV and a survey addressed to MSF press officers).

For the Advocacy and Communication Review the TOR can be represented by six main questions:

- Was the communications and advocacy set-up efficient and effective enough to meet the evolving demands (Headquarter (HQ) and field level)?
- How effective was the proposition and validation process for communications messages?
- Was there space for OC's contribution? Were the messages understood?
- How did MSF interact with external actors (institutions, media, other NGOs) and what was their perception of MSF?
- What impact did its role as the main/only reliable source for Ebola information/advice have on MSF?
- How was this information dissemination inside MSF?
- Were there advocacy and communications strategies? What was the impact?

In the Ebola response there was a large amount of activity in terms of communications and advocacy. Unfortunately, not all events and activities can be covered in this review. Some important and very interesting communications and advocacy topics were considered beyond the scope of this review, *inter alia* the trials for a treatment, the infection of Dr Kahn in Sierra Leone, and the withdrawal of Samaritan's Purse in Liberia.

FINDINGS

ANALYSIS, REFLECTION & STRATEGY

The response of MSF OCB is beyond any doubt widely recognised and appreciated. However, there are also mixed feelings about the strong sense of ownership that accompanied the responsibilities that were taken, including within advocacy and communications.

On the one hand, many interviewees in MSF praised MSF OCB's availability and support, and later on of the MSF Ebola Task Force. On the other hand, the leadership is criticised for not having been receptive enough to others' perspectives. Many felt that criticism was not appreciated or even received with hostility; that there was only one point of view and no opportunity to influence, contribute, and discuss positioning, messaging, or advocacy and communications strategies. Conversely the response team stresses that it was frustrating being in an overwhelming situation, confronted daily with discussions and a multitude of questions.

Within the movement there was a lack of knowledge about Ebola, which made the interaction frustrating for both OCB and the rest of the movement. Those who did have the knowledge and expertise – the people in OCB (and later in the Task Force) were extremely overworked.

Phase 1: Sounding the Alarm

It is evident that the growing epidemic and the constantly evolving situation were overwhelming. There was little time to develop and put on paper a consistent advocacy or communications strategy before September 2014. Instead it was figured out along the way, making it reactive, constantly adjusted, and trailing the evolving epidemic. Despite this, critical messages were still put across. But the overall consequence was the lack of a strategy to share with other MSF entities.

Furthermore, according to key members of OCB management, having dedicated advocacy support was not seen as a real added value at the time and was consequently not available. In an emergency, dedicated advocacy analysis or humanitarian diplomacy are not usually central to the operational response. Essentially, the evaluator understands that advocacy is seen as a general support function rather than a central operational pillar, reflected in the working set-up at the outset.

The communications teams involved in emergency operations were asked to give support in the development of advocacy messages. At the beginning of August, communications were also asked to write an advocacy strategy. It was only then that it became clear that dedicated support was needed. When the intersectional Task Force was put in place in September, dedicated advocacy was included.

Before the creation of the Task Force, there was no evidence of a strong and systematic advocacy analysis of what was happening, to identify who should be influenced, which meetings should be attended or which briefing papers should be produced. That said, lobbying and public communications had been taking place since the beginning of the response (see further: Lobbying and Public Communications).

One example is that MSF was reportedly unaware of the health emergency mechanism: a crisis is only an international concern and declared as a Public Health Emergency of International Concern (PHEIC) if there is a threat to other countries³. Although this was arguably already the case when the virus crossed

³ It was not until late June after the GOARN meeting that WHO escalated to its highest level of operational emergency, level 3. They did not escalate Ebola to the international threat level, a Public Health Emergency of International Concern under the International Health Regulations, until August 8th. There was little political will or capacity to move up to the PHEIC for fear of economic and political concerns (<http://bigstory.ap.org/article/2489c78bff86463589b41f3faaea5ab2/emails-un-health-agency-resisted-declaring-ebola-emergency>). The affected countries did not want the outbreak's danger known to avoid

the border of Guinea in April and certainly by the second wave in June, MSF did not use the argument as a call to action directly to the World Health Organization (WHO) or others to put pressure on WHO.

Some key stakeholders and experts interviewed thought MSF should have considered rolling out a coordinated and widespread international advocacy campaign with a clear strategy, targeted requests and coherent messages, focusing on the press, civil society, high profile events, high level meetings with heads of governments and international institutions. However, both internal and external mobilisation efforts in this regard were problematic.

Phase 2: Scale Up!

The second phase covers the period from approximately mid-September 2014 until the end of 2014.

The world was awoken by a conjunction of different events (see Phase 1) but the international community's response was not according to the speed and the magnitude of the outbreak. In this second phase MSF's main objective was to lobby and communicate for more capacity⁴: scale up!

Task Force

The intersectional Ebola Task Force started in August and was fully established at the beginning of September, including a focal point for communications and one for advocacy, both directly reporting to the Operational Director. Having focal points coordinating, communicating clearly and ensuring an information flow was much appreciated, according to the informants interviewed. A large majority of the members were from OCB, operating in a similar way to the emergency desk with a strong focus on operations. Nearly all non-OCB MSF interviewees regretted that advocacy and communications were not more intersectional⁵ and that there was little space to consider alternative approaches.

The workload in the Task Force was very high and underestimated, including for the communications and advocacy focal points, according to the vast majority of MSF OCB and other interviewees. One of the problems identified was the amount of information and, as a consequence, the need for better information management. The communications focal point had assistance via a relay outside the Task Force, but it is clear that there was a need for more support, which appeared equally difficult to obtain from other MSF sections. Due to the pressure there was also a high turnover of communications staff in the Task Force⁶, which caused some loss of information.

The communications focal point was also coordinating the Ebola communications platform, a weekly teleconference to share information. This was attended by communications staff of the different Operational Centres, the Access Campaign and the International Office. This platform was perceived as generally very positive, but also struggled with high turnover and was criticised for being 'OCB-centric'.

The advocacy focal point was in regular contact with members of the Humanitarian Advocacy and Representation Team (HART) unit and MSF offices, to consult and respond to questions. Overall the

alienating investors, closing borders, e.t.c. MSF called for outside help but did not sufficiently understand the inner working of WHO to push for the PHEIC earlier, nor pushed WHO to declare a level 3 emergency by end March, or certainly by June when it was clear the outbreak was out of control. .

⁴ See press releases and statements in that period.

⁵ Other MSF sections were asked to provide human resources, e.g. to be the communications focal point in the Task Force in Brussels but none materialised, apart from ad hoc cover by distance during the Christmas period. The reasons are unclear.

⁶ From September to January there were three different main communications focal points in the Task Force (1 during September to November, then 1 in December, then January through 2015) and the Christmas period was covered by multiple people.

support, availability and information provision from the advocacy focal point were very much appreciated.

There is general agreement across sections and departments that full time advocacy resource in the Task Force improved the analysis and the strategising. However, a Task Force that dealt with both the enormous daily management challenges of the response and the analysis and strategy was seen by many as a problem. In fact, some argue it would have been more appropriate to set up a dedicated crisis management team for strategic reflection, as is usually done in response to a kidnapping, believing that a situation like Ebola constitutes a crisis rather than an emergency.

At the end of summer 2014, the MSF Directors of Operations Platform (RIOD) discussed installing a “*reflection committee*”, a group of senior people from the operational centres reflecting on critical topics like quarantine and home-based care, and designing medical and advocacy strategies for the Task Force. However, this was never put in place, for which contradictory reasons are provided. According to OCB interviewees someone in the movement should have implemented it, whilst others reported that Brussels was not interested in setting it up.

There were a few meetings to discuss positioning and strategy among the OCB Operational Director, the Task Force leader and the communications and advocacy focal points. Messages were discussed at the Task Force but also between OCB and Operational Centre Geneva (OCG) Operational Directors and the International President.

The advocacy focal point was invited during this second phase to one intersectional desk meeting to discuss positioning, advocacy and messaging, and the Operational Director was regularly in contact with the head of the HART unit to prepare the weekly Global Ebola Response Coalition (GERC) meeting.

According to nearly all interviewees involved in the Task Force, documentation of what was happening in the field was at times too slow and not strong or continuous enough. This was partly because the situation evolved rapidly and the liaisons on the ground were few and overloaded. Consequently there were some disagreements, as the field felt Task Force analysis did not always reflect the reality of what was happening on the ground and struggled to adapt or nuance the messaging.

Messaging

Overall the emergency was seen as one big outbreak in one region rather than the reality, which was three separate outbreaks in three different countries. Strong analysis came out of Liberia which resulted in a strong focus on the needs identified in that country, but the analysis was generalised for the whole affected region. The call for more bed capacity was specific for Liberia, but the needs in Guinea and Sierra Leone were less visible. Also, at that time it was not clear how the outbreak would evolve. In order to be prepared for the worst case scenario the objective was to scale up. Nevertheless, more targeted messages adapted to each context could have been developed. However, the Task Force did not want to divert the message from the main objective: the lack of capacity.

Although in November there were different problems in the three affected countries, MSF’s main message remained constant: *‘more beds and boots’*. In Sierra Leone they needed to scale up because in Freetown and in the west of the country there were no beds. In the other two countries the pressures were different. In Guinea there were not enough French speaking organisations on the ground and in Liberia there were enough beds but not enough flexibility in covering the other pillars of Ebola response.

For many interviewees the messaging was too oriented towards isolation. The regular advocacy updates included other messages than about the one about scaling up, but those other messages were apparently not read or understood. Instead, many used the crisis information as guidance because it was written in a more comprehensive way and easier to understand.

It was only after the field visit of the International President and the Operational Director in November 2014 that the messaging was adjusted. On December 2 MSF released a press statement and a briefing note pointing out ‘a double failure’: the international community’s deployment response not only took too long, but it was also neither flexible nor adapted to the new situation.

In short, although there were other messages, as well as a shift at the beginning of December, this second phase was mainly dominated by a call to scale up.

Several interviewees remarked that MSF should have talked earlier about the absence of Research and Development (R&D), and the lack of tools and available therapeutics. But the analysis of OCB was that pushing harder and earlier for a vaccine would distract governments from the task at hand which was basically to scale up the response.

Quarantine

It is clear that MSF OCB held strong opinions against quarantine. Where other Operational Centre’s (OCs) were concerned, opinions differed. MSF could not agree on a common clear message and this resulted in an ongoing discussion and pushing back from messages on quarantine in briefing papers, hand-outs, Q&As etc. To develop a solid position on quarantine the MSF Operational Centre Paris (OCP) Director of Communications went to Sierra Leone in August. This, however, did not result in any actionable outcome.

Furthermore, the reactive lines provided by the Task Force were not used by all MSF spokespeople. Some felt too uncomfortable with the message, and watered it down. Certain operational centres on the ground also did not respond to the request of the Task Force to disseminate documentation because in their opinion it was wrong.

“In MSF anybody can speak to the media. You can’t control the whole movement to stick to a message. People had different opinions. It was very frustrating”. (OCB Management)

There was never a public statement on quarantine, but at a later stage a few reactive lines were defined. Journalists and external interlocutors interviewed for this review almost unanimously say they did not understand MSF’s arguments around quarantine.

There is very little literature or knowledge about quarantine and containment of people and its impact in an Ebola outbreak. Field teams were extremely busy with the response and were unable to provide the necessary information and concrete examples to develop a rational position. The definition of quarantine is also unclear: it can be about isolating a family and also about police at the border, making it difficult to reach a consensus. A majority of the interviewees from within MSF felt that OCB was not open enough in dialogue about quarantine.

In Sierra Leone quarantine was a significant issue and in the opinion of other NGOs on the ground a missed opportunity to undertake joint work and communication.

“Nobody was really calling out the government of Sierra Leone, despite MSF having a massive voice. Everyone was listening to MSF and something stronger from MSF on quarantine would have hit the spot”. (an international humanitarian agency)

Phase 3: Not over

The third phase covers the period from January 2015 to the end of March 2015.

At the beginning of January, the Task Force coordinator's field visit served as the basis for a briefing paper that updated the remaining gaps and needs for each affected country. In short, during this phase there was not one big call, like 'Scale up' in the previous phase, but several smaller messages, adopted to the situation in the different countries. For representatives and communications staff of several MSF offices the messaging felt somewhat diluted and confusing: there were more and more diversified messages from more operational centres. Nevertheless, there was a recurring overall message in this third phase that stressed the need to continue the efforts: "the outbreak is not over!" In order to end the outbreak, MSF considered it paramount to keep people focused on Ebola until the very end, independently of their levels of exhaustion. Besides this, there was also a focus on access to healthcare and on medical trials.

During this phase many external interviewees felt that MSF disappeared from the public stage. The majority of them could not remember what MSF's messaging was at this time. Indeed, the number of Ebola cases decreased; there were more agencies involved in the emergency; the quality of care improved; and the media interest reduced heavily. Other international actors voiced their feeling that MSF began to recede into the background, both publicly and in decision-making meetings, as soon as the international community engaged in the response.⁷

"A WHO guy basically said: As soon as the international community was mobilised, MSF faded away, including from coordination meetings, not just in terms of your public profile around it, but also your presence in the forums where decisions were being made". (MSF General Director)

At this stage of the outbreak the strategy was no longer to have constant global coverage and huge media 'blasts' on MSF and Ebola. Rather the focus was now on long-form pieces with investigative journalists and documentary film crews, as well as trying to 'right some of the wrongs' of the internal open letter (see below), for example writing an external piece about patient care⁸.

On the lobbying front, 'fading away' may have been the case in Sierra Leone but in the two other affected countries representation and lobbying efforts continued⁹.

At this point the intersectional Task Force was dismantled¹⁰. The usual MSF operational set-up resumed, with five operational centres, with the exception of the communications and advocacy focal points who remained intersectional

The decision to end the intersectional Task Force was also influenced by an 'internal open letter', according to several of the OCB management team. This 'internal open letter', written by a number of high level MSF representatives, including presidents and International Board members, contained a very sharp and polemic critique of the Ebola response in terms of its balance between individual patient care and outbreak control. The content of this letter, the dissemination to List Press without any instruction, and the decision taken to leak it to the press¹¹, had a hugely negative impact, creating an environment of hostility and a lot of distrust between sections. It reduced the willingness to consult and resulted in significant polarisation.

⁷ We come back to this in the chapter on 'Lobbying and Public Communication'.

⁸ Interview with senior OCB communication manager.

⁹ We come back to this in the chapter on 'Lobbying and Public Communication'.

¹⁰ In December the decision was taken to dismantle the intersectional Task Force and to stop the Task Force leadership function. Only advocacy, communications and supply remained intersectional. See: Minutes Intersectional teleconference 18/12/14.

¹¹ MSF OCB received a request for interview by a Radio France International journalist that referred to an internal open letter circulating in MSF. A few weeks later the full letter was published by Liberation

MOBILISATION

One of the big challenges of the Ebola response was the mobilisation of response capacity, both internally in the MSF movement and externally through other agencies.

MSF OCB took the lead in the response: OCB was on the ground fast, and Ebola experts were moved in from Sierra Leone. However, MSF OCG and MSF Operational Centre Barcelona (OCBA) also provided Viral Haemorrhagic Fever (VHF) experts and later on Operational Centre Amsterdam (OCA) and OCP also provided human resources. Furthermore, MSF OCBA took the lead outside West Africa and intervened in Senegal, Nigeria and Mali.

For the majority of the interviewees the final wake-up call was a result of coordinating all the advocacy and communications regarding the outbreak. A big game changer was the infection of returning international aid workers. Fear struck the world, creating a media avalanche in all the MSF home society offices, particularly in France and the US.

MSF's public messaging built up over a period of several months, with the interventions at the UN General Assembly (including the call to deploy civilian and military biohazard assets¹²) and the UN Security Council, in particular triggering a big response.

Also significant in awakening the world's attention were the transnational threat when the outbreak spread to Nigeria, Mali and Senegal; the declaration of a Public Health Emergency of International Concern by the WHO (8 August); and the open letter from Liberian president Ellen Johnson Sirleaf asking for help¹³. The latter was especially important in mobilising the American and German authorities.

Internal mobilisation

The full magnitude of this epidemic was not clear at the start, and other emergency interventions were ongoing. It was only in June, when the situation started to get out of control that the rest of MSF started to mobilise. Before this point there had been no strong appeal from MSF OCB to push other MSF sections and entities to get involved. Talking points were not shared with the MSF movement and the MSF advocacy network was not explicitly requested to focus on Ebola and reach out. In consequence it was difficult to share responsibilities and understanding about messaging. Key MSF informants point to a hesitancy towards 'sounding too alarmist'. Instead it was decided to deflect media attention towards less covered crises such as Central African Republic and South Sudan.

A critical point in MSF's mobilisation appears to have been at the first RIOD meeting focussed on Ebola during the OCB Operational Director's debriefing on his visit to Monrovia in June. At this meeting OCB called for more sections to get involved; prompted by the scale of the emergency. In July the first RIOD discussion took place on advocacy and messaging around Ebola. The perception in other OCs was that OCB was keeping much of the responsibility to itself, rather than sharing it with others in the movement. Many interviewees felt that OCB did not really take the discussions into consideration.

"OCB was distributing too many responsibilities on to itself rather than pushing others. This may have been at some point why OCB was finally pushing others. They were doing too much".

(MSF General Director)

However, given the situation, MSF OCB felt that it was in the position with the most knowledge, and therefore responsibility, and so was justified in adopting such an approach.

¹² A regular revision of the status of the (evolving) situation with the military was necessary but did not happen.

¹³ MSF strongly influenced the Liberian president to write this open letter to the US. Also Guinea and Sierra Leone were pushed to engage with the international community, but with less obvious results.

Human resources for advocacy and communications

Both OCB and OCG had difficulties in finding staff to cover or replace positions in their offices, such as the replacement of the communication and advocacy focal points in the Task Force. In addition, the turnover of communication staff was high in other operational centres. Despite the massive media pressure only a few offices put additional resources in place.

Finding field staff was even more difficult, especially for a longer period. MSF communications has no pool, unlike other departments. They usually look to recruit from MSF communications departments which creates gaps elsewhere, leading to those staff only being released for short assignments. There was also a lack of experienced additional resources, and the support for field communication positions was at times less than ideal. The communications staff and advocacy liaisons deployed in the field were working in emergency mode, just like everyone else. Communications in the field during this emergency was a 24-hour job: journalists call from all over the world and need immediate responses. The classical set-up put in place was clearly not sufficient to cope with these demands.

Barriers to mobilisation

Most interviewees agree that MSF did what it had to do by sounding the alarm, but the world did not (re)act and important international actors did not take their responsibility. However, many also express that with hindsight MSF could have done things differently, or done more to raise the alarm. Below is a list of internal barriers identified by interviewees¹⁴:

Critique of WHO

The limited and late action of WHO and their disclaimer are seen by most interviewees as key. According to half of the external interviewees and a minority of MSF interviewees, MSF's public critique on WHO was counterproductive. The way MSF expressed the critique irritated the organisation and slowed down its response. However, it must be noted that MSF did not issue a single press release that publicly denounced WHO.

Internal mobilisation

Because MSF OCB (and OCG) had experience of Ebola and were on the ground first, other MSF Sections have stated that they assumed the two OCs would manage it on their own. That is also how MSF OCB presented the situation, according to many interviewees.

Analysis and strategy

The majority of internal (non-OCB) stakeholders, as well as the vast majority of external stakeholders have intimated that an insufficient analysis and understanding of national and international bodies and their regulations, a poor mapping of influences and power, and a poor network at the higher levels of institutions were significant barriers towards internal mobilisation. This led to an inconsistent advocacy strategy, missed opportunities, a delay in lobbying and a reactive communications strategy.

¹⁴ In the following chapters we come back to the raised barriers expressed by the stakeholder interviewees.

Messaging

In the opinion of most external interviewees, and over half of MSF interviewees, the calls and requests issued by MSF were often too vague and poorly targeted. This reportedly created confusion and tensions, made it difficult for stakeholders to react as expected, and in consequence hampered the response.

Directive approach

One barrier identified within MSF is the strong sense of ownership by OCB. There is a strong feeling that there was too little discussion about the public messaging and also on the calls and requests to other agencies and governments¹⁵.

Data

Actionable data was identified as an important element that could have helped to strengthen the appeal for a response to the emergency. Consistently, according to internal and external interviewees, there was a lack of the proof required to build the case. Ultimately, better quality and use of data was identified as something that would have helped prompt the international aid community into acting earlier.

MSF's reputation

Several key high level external interviewees (institutions, other NGOs and media) indicated that MSF's reputation was one reason why the alarm bells it was sounding were not heeded. The important characteristics of this reputation were summarised as follows:

- MSF would manage the job on its own, like it had done with previous outbreaks.
- MSF is not perceived as a team player, which led to others being reluctant to collaborate.
- Public communication was seen as an extension of the 'Where is Everyone?' report (July 2014).
- The perception was that MSF was merely raising its profile: some even thought that the Ebola alarm was part of a fundraising campaign.
- Because MSF (too) often sounds the alarm, many external agencies could not see any difference from other 'alarmist calls' (e.g. press releases).
- The nature of contact with the media: press releases were not followed up effectively and journalists not sufficiently approached directly.
- MSF is perceived as 'an outsider' to the system (activists versus humanitarian establishment). At higher levels there was a discomfort about and fear of interacting with MSF.

¹⁵ This view recurred in 44 of the 58 non-OCB MSF interviews.

LOBBYING & PUBLIC COMMUNICATION

Phase 1: Sounding the alarm

From March 2014 MSF raised the alarm and tried to mobilise the national and international community. This advocacy was undertaken through, and in parallel with, public communications.

Public communications in the early phase

In the first months of the epidemic MSF communications were constantly adapting talking points and developing reactive lines. As a consequence a mid or long term strategy was never put together.

On 22 March, after the Guinean Ministry of Health officially declared an Ebola outbreak, MSF launched a first press release confirming the epidemic and providing information on its response. Based on experience from previous outbreaks (that Ebola might cause panic) and to avoid tensions with the authorities, MSF was very careful in its first public communications. Nine days later, on 31 March, due to the geographic spread of the cases, MSF publically declared the outbreak as ‘unprecedented’.

The first press release confirming the outbreak and the “*unprecedented*” statement encountered resistance, not only from WHO but also from MSF communications teams. Raising the alarm on Ebola was seen by the majority of informants as too ‘alarmist’. The fear was that it would feed sensationalism and create unmanageable media pressure. MSF OCB communications staff had to convince some of their colleagues of the sense of this approach.

From March to September 2014 MSF was increasingly sounding the alarm both behind the scenes (see below) and in public, in parallel with the evolution of the outbreak. The pinnacle of this activity was the speech of MSF’s international president at the UN General Assembly (2 September) followed by the testimony via videoconference of the Liberian MSF team leader – Jackson K.P. Naimah – at the UN Security Council (18 September).

There was a sliding scale in the communications in this first phase: from “*unprecedented*” to “*out of control*” to “*we can’t cope, we need others on board*”, peaking after summer with a call for civilian and military support. Until all the other MSF sections got involved there was no formal validation process for messaging within the OCs. Although there was some consultation between the operational directors of OCB and OCG, OCB usually went ahead anyway. Some of the messages also happened “spontaneously” in interviews (such as “*unprecedented*” and “*out of control*”).

Between “*unprecedented*” in March and “*out of control*” in June there were a lot of different variations on the same message. With “*unprecedented*” MSF set the stage and despite different ways of qualifying the situation the messaging became somehow ‘anchored’ or static. Moreover, the majority of informants felt a lack of clarity in terms of MSF’s assessment of the situation.

After a drop in Ebola cases in May, the alarm was raised again in June. There was total disagreement with the field about whether to speak out more loudly and in a more accusatory¹⁶ tone. Amidst this disagreement the Operational Director stated in an interview that the situation was “*out of control*”. Although the statement received worldwide attention, it still did not lead to action by the international community.

The “*out of control*” message was repeated until mid-August in MSFs public communications. In mid-August the communication became much stronger, describing the escalated situation in Liberia and explaining the human consequences of the uncontrolled situation.

¹⁶ Both the Emergency Coordinator and the OCB Operational Director talked about the disagreement they had with each other at that time about communicating publically in a stronger and more accusatory way.

Despite public communications efforts resulting in massive media attention in August and lobbying the international community, it was only in the first half of September that the international community finally woke up fully and started to mobilise.

Nearly all press officers in the offices report that they are overall very positive about the level of information they received, especially at the beginning and at the height of the outbreak. Communications staff in the field were considered very helpful.

UN General Assembly & UN Security Council

The UN General Assembly

MSF international president Dr Joanne Liu's speech on 2 September 2014 to the UN General Assembly was seen within MSF, and by many in the outside world, as not only historical but also a game changer. According to the collected data and the vast majority of the informants, communications around the UN speech worked very well. In the days leading up to the speech there was a build-up in the media and on social media, which was seen as a success.

Calling on the UN member states to deploy civilian and military biohazard assets was considered a last resort, with the hope that this would bring the necessary logistical means and knowledge. It is generally recognised that the call produced a significant shock – it is unusual for MSF to call for military intervention. However, the impact of the call was not at the scale MSF expected. No military biohazard teams were deployed¹⁷ and it took a long time before the military logistical response materialised. OCB retrospectively acknowledged that the decision to call publicly for military assistance was not thoroughly assessed, but it is clear that the level of desperation at this point was acute – to the point where radical measures were deemed appropriate.

As a result, the Ebola coordination teams in the French, British and American governments felt they could have been consulted on or informed about the call in advance. It gave them the impression that MSF clearly lacked an understanding of the military capacity and how governments function in general.

"It was too vague. When you ask for something, you need to know what you need. A military asset is everything and the military need a clear mission. Nobody understood what MSF was talking about. It was confusing and not specific enough".

(Ministry of Foreign Affairs of a Western state)

Also, when questioned about the call MSF press officers in different offices were not consistent in their understanding of the issue. They had difficulties in getting anyone to define exactly what MSF was asking for, or to give clarity. In the following weeks and months, the situation evolved constantly and the needs were ever changing. MSF failed to adapt its request to this evolution, and to the velocity of the virus. When the military response came it was slow, late and often working with inaccurate information.

The UN Security Council

There is broad consensus that the testimony via videoconference of Liberian MSF team leader Jackson K.P. Naimah at the UN Security Council on 18 September was unique and very powerful.

"We are failing the sick because there is not enough help on the ground".

(Jackson K.P. Naimah, MSF team leader)

The declaration of Ebola as a threat to international peace and security by the UN Security Council triggered international support¹⁸. Countries like the US could not intervene officially out of respect of the sovereignty of the affected countries. However, appealing to the UN Security Council also meant that MSF put itself in the realm of security and thus the logic of 'forced control', something MSF was uncomfortable with¹⁹.

Lobbying

“We ran it old-style ourselves with – later on – good support from the International Office. But we weren’t well organised. It was ad hoc lobbying, without a real strategy and a real objective”.

(MSF OCB Management)

In this first phase MSF clearly chose, above all, the media as the instrument to sound the alarm. Yet MSF was also doing advocacy behind the scenes. This advocacy was particularly carried out by operations staff, which were already busy with the operational management and response.

In these first six months the OCB advocacy units; Humanitarian Innovation Team (HIT) and Humanitarian Advocacy Team (HAT), were not significantly involved. In OCB these units’ function is not to support daily operations and they were not asked to take this on.

Before the summer of 2014 the only advocacy resource in Brussels that was involved in the emergency was the HART unit’s European Union’s (EU) advocacy liaison officer. He gave important support in identifying key contacts and representing MSF at the EU and the North Atlantic Treaty Organisation (NATO), organising meetings, drafting letters, etc.

Before June Ebola was one of many topics that the HART unit was dealing with simultaneously. From June onwards the unit became very active in representing MSF at bilateral meetings (WHO, GERC, Centre for Disease Control and Prevention (CDC), UN, and EU, but also the International Federation of the Red Cross and Red Crescent (IFRC) and International Committee of the Red Cross (ICRC), and international NGOs represented in Geneva, Brussels and London) but overall they had little input in analysis and development of messages. According to the HART unit, field visits by HART members might have helped to gather more material to develop strategic pieces for advocacy work. However, to avoid further pressure on the field staff the team did not push for it. Moreover, the HART unit does not usually deal with major health issues, and is therefore inexperienced in medical advocacy. Nevertheless, the HART unit presented and shared medical messages with key stakeholders. Other MSF bodies specialised in this field (and in health issues) such as the Access Campaign, were also not mobilised, thus making medical advocacy on Ebola non-existent.

Engagement with other organisations

It was only in the second half of 2014 that MSF engaged more with WHO at the highest levels²⁰. There is no record of OCB addressing individual states, or even organisations that could have had an impact on the WHO and individual states. Despite having offices all over the world, MSF did not target top-level health officials or health ministers that were part of the WHO executive board.

MSF did not seek joint advocacy efforts with other NGOs to push, for example, governments and WHO to action. It is likely this would have not been an easy task in any event because, as stated earlier, there was an assumption that MSF would get the job done on its own. This assumption was strengthened by WHO statements that MSF was dramatising the situation and that Ebola would soon be under control. Moreover, in the early months MSF’s discourse in bilateral coordination meetings was at times

¹⁷ The majority of the military effort deployed in October and November was limited to support, coordination and logistics for the international aid organisations and local authorities. Although the military set up ETUs for healthcare workers in the capitals of Guinea, Sierra Leone and Liberia, the appeal for deployment of biohazard teams to the wider community was not met.

¹⁸ See section ‘Analysis, reflection and strategy’

¹⁹ MSF insisted that the military should not be used for quarantine, containment or crowd control measures. MSF feared that the call would be misconstrued or internationally twisted into a call for armed stabilisation (see one year report ‘Pushed to the Limit and Beyond’).

²⁰ The WHO Ebola response organigram was not established and clear until September 2014.

ambiguous, stressing on one side the seriousness of the situation but, on the other, discouraging other actors from joining the intervention.

Until the end of June, MSF's position in external meetings was to share information about Ebola rather than directly advocate for greater engagement. This reinforced the impression by many key informants that MSF would manage by itself.

"On the one hand we were sounding the alarm but on the other hand we were saying to other NGOs: "Let the professionals do the job" and "Be careful, don't come into Ebola, we know how to deal with that". That was the double discourse at the very beginning, until June-July". (MSF International Office)

Later, the "out of control" call was perceived as a significant shift by most informants. MSF asking for help was almost unheard of and this was for many organisations the beginning of the trigger that finally brought them on board.

Data

According to OCB emergency managers it was difficult to send internal reports at first, because of a lack of clean data. As far as they were concerned, not a lot of analysis was needed: they felt the situation was clearly dramatic enough to respond.

In the first months the United States Agency for International Development (USAID) reports claimed not to have known how many cases there were (surveillance data), although the CDC, who were present on the ground, leads on disease outbreaks for the United States (US), and conceivably had the data available as well. WHO was not providing information. According to the United Kingdom (UK) and US governmental Ebola cells, MSF did not have that kind of data either.

According to the UK, US and Germany, hard facts and data showing what was happening would probably have strengthened MSF's plea for help earlier. However, OCB deemed it sufficient to have shared the number of confirmed cases in March and April, and that showing the already considerable spread of the outbreak (five different locations at the time) was enough of a reason for other agencies to mobilise.

WHO

MSF had regular interactions at the technical level (specialists) of WHO. However engagement with the higher levels came at a later stage. In April there was a meeting with Director-General Margaret Chan. Ebola, however, was only one of many topics on the agenda and, according to MSF, WHO did not seem very concerned. It was only at the end of July that the first significant high level meeting on Ebola with WHO took place between Joanne Liu and Margaret Chan.

Within WHO²¹ there was also a reluctance to interact at a higher level. People were nervous about institutional relationships with MSF due to the way the NGO had been addressing the UN agency on Ebola, both publicly and in the field. As recently as August 2014 there were questions about whether to have formal bilateral relations with MSF due to lack of trust.

According to interviewees in OCG, MSF proposed pushing other agencies and to engage more with WHO on several occasions. OCB was reluctant however as it did not see pushing others and engaging more with WHO as the role of MSF, and was sceptical that others were capable of managing Ebola. In July MSF was invited by WHO to brief the country representatives at the UN and the ambassadors of the affected countries. OCB did not send anybody²² to the briefing, but an OCG representative attended.

²¹ In contrast to WHO informants interviewed for this review MSF representatives did not note a major reluctance from the highest levels at WHO to enter into discussions with MSF.

²² It is not clear if MSF OCB did not want to or was unable to send anybody to this meeting (conflicting information).

Although WHO AFRO is the representative for WHO in the African countries, MSF did not fully engage with them. Although there was contact in the field, a visit to the WHO Regional Office for Africa (AFRO) headquarters in Congo Brazzaville to discuss Ebola never took place.

The African Union and other African platforms

It was recognised by nearly all MSF informants that engaging with the African Union (AU) or other African organisations like Mano River was not seen as a priority.

Although some African organisations are key players the understanding was that they were out of MSF's scope. Within MSF there were also only a few people who had experience with Ebola, and these people could not be sent because they were busy with the response.

Governments and donors

The lobbying of individual states by national MSF offices started at the end of July. MSF general directors were asked to organise meetings with their governments and put MSF's demands on the table. MSF sections worldwide carried the same advocacy messages targeting their governments.

The majority of informants who represented MSF in meetings think that there should have been more tailored messaging – for example to the UK on Sierra Leone, the US on Liberia and to France on Guinea.

When donors engage, they are able to push organisations to do more, because most organisations depend on their money. However, in this instance, donors were not directly targeted by MSF.

Not all MSF offices conducted intensive advocacy with their governments. The two main reasons given for this were: 1) there was, on principal, a reluctance to engage with government bodies; 2) they did not agree with all the messages and Brussels did not allow an adjustment of them.

The response to the Ebola outbreak implied an unusual dynamic for MSF in the later stages, in which the organisation found itself working alongside other humanitarian agencies and governments, giving them training and acting as consultants for them. While on the one hand this strengthened relationships between MSF and other organisations, on the other hand different governmental and non-governmental bodies unanimously agreed that MSF's demands were not concrete or specific enough, which created confusion and did not lead to the expected response. MSF representatives shared this view and felt uncomfortable about explaining more precisely what MSF wanted.

Infected staff

The return of infected international staff to their home countries struck the world with fear and created an unforeseen media avalanche in all the MSF home society offices, particularly in France and the US.

In April two members of MSF's locally hired staff were contaminated with the Ebola virus in Guinea. Over the following months more Guinean staff became infected. MSF did not want to cover the cases up but at the same time, did not want to discourage aid workers to come and help.

Reactive lines were developed, explaining how the staff got infected and that – in accordance with MSF health policy – patients were being treated close to their families. MSF press officers felt uncomfortable with and worried about the unspoken question: *why were local staff with Ebola not evacuated?*

At the end of July an American doctor working for Samaritan's Purse tested positive for Ebola. His evacuation back to the US for medical care provoked a serious increase in media attention, especially in the US.

The first MSF international staff diagnosed with Ebola was a French nurse in Liberia in mid-September. The plan was to bring her swiftly and quietly to France. Although the news leaked and the media were alerted, the field team succeeded in getting her discreetly on to a plane. MSF OCP communications were in charge of protecting the nurse's identity and managed to reduce media attention, though some publications mentioned her identity. Anticipating the high number of media requests, and harnessing an opportunity to advocate publically for a more efficient evacuation system, MSF organised a press conference in Paris.

Overall, media representatives are positive about how MSF communicated regarding infected international staff in France and later in the US. Nevertheless, press officers did not feel prepared for explaining the difference in how MSF treats local and international staff. But surprisingly, this question was rarely asked. Furthermore, some journalists in the US had trouble reaching anyone at MSF to confirm the guidelines for returning staff: what they were supposed to do in terms of staying near hospitals or whether they were supposed to quarantine themselves or not.

In October the return of two American MSF staff, a doctor who subsequently developed symptoms and a nurse who was wrongly feared to be infected with Ebola, sparked paranoia in the US. This was an institutional communications crisis for MSF US, with a Crisis Management Team set up. The issue of the isolation measures taken in the US was very clearly opposed by OCB, whose position was 'no quarantine'.

Phase 2: Scale up!

Lobbying

MSF met, lobbied and briefed hundreds of governments, institutions and NGOs. This was considered very useful for a better understanding of the needs outside MSF (government's etc.). Many MSF offices reached out, with MSF US, MSF UK and MSF Germany in particular playing a significant role. The overall aim was to get external agencies on the ground more quickly. Lobbying for medical evacuations of expatriate staff was another key outcome that was ultimately successful. For many MSF offices the lobbying work around Ebola was an opportunity to get access to their governments at high levels, which they had rarely had before.

There was strong interaction with CDC, IFRC, International Medical Corps (IMC), the Alliance for International Medical Action (ALIMA) and others. And from September onwards there was a direct relationship with some key staff in WHO.

The vast majority of the external interlocutors point out that on the one hand MSF was not clear enough what it wanted to happen, and on the other hand government and NGO informants expressed their regret that MSF seemed unwilling to develop meaningful partnerships. MSF attended countless Ebola meetings but did not partner with others in joint advocacy work. MSF's Ebola response team deemed it sufficient to have shared information and documents, believing its role was not to say what others needed to do, or to formalise collaborations with institutional bodies²³.

MSF was seen by the vast majority of external stakeholders (especially other NGOs and in MSF offices (apart from OCB) as too focused on increasing bed capacity. At one stage ICRC said they were keen to organise food and waste disposal for the centres and ready to contribute to revamping the health system by supporting other hospitals. However their efforts fell very short of what was needed according to a key MSF informant.

They did almost nothing: food for 200 patients + participate in waste management meeting with one watsan on ground? When we have a dozen? They promise to remove the waste and it's still there. Officially I phoned them twice in August and September and they clearly told me that they will not intervene because too busy with other emergency and because IFRC was in charge of this one! They never support other hospitals! They never sent a team with some capacity! (Key MSF informant)

According to the Department for International Development (DFID) there was negligible interaction with MSF in London. Although there were some "good" high-level meetings pointing out the important issues and encouraging other NGOs to step up, it was felt the meetings were not very useful after that. DFID regrets that – at that point – it was advocacy people providing messaging, when what they needed was technical medical advocacy people to help them in thinking through their strategy about how to support a medical humanitarian response.

MSF messaging was focused on treatment, and was seen as potentially obstructing others from scaling up around the other five pillars. Oxfam, for example, wanted to engage in important activities such as community outreach, tracing and sensitisation. DFID, however, picking up on MSF messaging, which was dominating the narrative on Ebola, initially put all its funding into treatment. Despite Oxfam's request for help in persuading the British government of the importance of other intervention components, MSF's messaging remained unaltered.

German government

MSF invested significantly in reaching out to 'important governments'. One example is the lobbying efforts²⁴ conducted by representatives of MSF OCB and MSF Germany towards the German authorities. From June onwards the German authorities were lobbied, but with very limited success until September. For the German authorities the data before September was not clear enough, and as such was unconvincing. The German authorities were also dealing with Ukraine, Gaza and with ISIS. The turning point in Germany was the open letter written by Liberian president Ellen Johnson Sirleaf. In the meantime, MSF increased pressure on all ministries and the chancellery in Berlin, resulting, by the end of September, in a massive response, including direct contact with Angela Merkel. MSF became, because of its expertise, *the* authority for the German authorities and the most important source of information. The shaping of the German crisis management set-up was also influenced by MSF. The organisation provided a crucial reality check. At one stage MSF was even offered permanent

²³ WHO requested MSF to sign a MOU for Ebola emergency response. MSF did not sign.

²⁴ MSF had weekly, sometimes daily (high level) meetings with the German authorities briefing them, demanding things and making clear things were happening too slowly.

representation in the German Ebola Crisis Cell, but a member of staff with the right profile could not be found.

“You know, without MSF I would not had known the dimension of this whole thing. Our reaction would have been even slower. Maybe we would not have had medivac planes. We wouldn’t have spent so much money on NGOs.”
(German Ebola Crisis Cell)

The different German ministries made many promises regarding their plans, but it was not until November/December that their first actions became visible in West Africa. This included the availability of an evacuation plane. By the end of December, the German government had established an Ebola clinic in Monrovia with the German Red Cross, which by then was no longer needed.

According to MSF Germany the information flow from the Task Force had some room for improvement and it was not necessarily kept in the loop when there was new information, specifically in the first couple of months up until September. It would also have been better to have more support in terms of what the German government (and other NGOs) should do. MSF representatives were confronted with the criticism that their requests were not concrete enough, and they were unable to formulate a clear response to questions such as: *How much and which type of capacity is needed in which location? How many tents? What flight capacity is needed?* MSF Germany had to refer directly to MSF Brussels to answer these questions, and in the process MSF Germany lost its overview of the discussions. Information regarding the actual German response on the ground came too late for MSF Berlin to really keep the pressure up on German institutions.

Public communications

From September, media attention was constantly increasing, generating a massive volume of press requests. This resulted in huge pressure on MSF press officers who were constantly asking for information on a wide range of aspects of the Ebola intervention. The Task Force tried to answer them and produced a significant number of reactive lines.

From September, fundraising on Ebola was allowed, and with more communication staff on the ground in November and December there was a significant increase in human interest stories giving more voice to beneficiaries (‘survivors’) and local staff.

Ebola was still not discussed in-depth at the meetings of the Directors of Communication of the five operational centres. What discussion there was focused on a sharing of information rather than on steering communications. The Ebola communications focal point reported weekly to the teleconferences of the Operational Communication Coordinators, but even here there was a lack of focus on strategy at a macro level.²⁵

Phase 3: Not over

The third phase covers the period from January 2015 to the end of March 2015.

Lobbying

The briefing paper updating the remaining gaps and needs per affected country (see previous chapter) was meant for advocacy behind the scenes. Despite this, and the fact that many in MSF found the paper too long and not user-friendly, it was used in several bilateral meetings. Agreed intersectional messages on (for example) weak contact tracing and weak surveillance, were provided to the MSF network as

²⁵ According to the majority of participants, in both the meetings mentioned there was no discussion or reflection on the strategy. The focus was on updates of status and activities.

talking points and updates. However, with five operational centres now involved, many MSF offices felt that they were receiving mixed messages.

MSF also missed some opportunities, such as being unprepared for the WHO executive board in January 2015, and it did not have the necessary information on Sierra Leone for a report for the EU conference.

Interaction with other actors

Contrary to how MSF was perceived in general, most external interlocutors talked about good collaboration, and they experienced MSF as very open minded and helpful during Ebola. However, institutional bodies in particular found collaboration difficult at times due to MSF's lack of understanding, or willingness to understand, the functioning and sensitivities of the institutional bodies.

One example was MSF going public on issues (or talking to a higher level) without informing the involved agencies in advance. One example was calling publically for military assets before informing USAID or DFID, who had the lead on Ebola response in their countries. Another was addressing complaints to the United Nations Children's Fund (UNICEF) HQ about the quality of its activities without talking first to field staff. The noise that MSF made publically caused irritation; it was perceived as arrogant and sometimes aggressive.

A recurring remark in interviews was the poor network before Ebola and the irregular and unreliable participation at coordination meetings. According to MSF representatives these meetings were often uninteresting and time consuming. Some staff interviewed also stated that they were reluctant in principle to engage with official bodies.

A changing narrative

From a quick analysis of MSF public communications the foremost focus was on the deteriorating situation in the countries affected by Ebola. But the lens was also directed at the great work MSF was doing. While for a period of months, public communication was predominantly advocacy driven, portraits of aid workers, awards and other 'good news' gained more and more space in MSF's communication activities. Clearly, this was requested by the media, but MSF could have refused to be profiled as heroes. On the contrary, MSF was in fact strengthening the heroic narrative itself, including solidarity actions for frontline staff on the MSF websites. Moreover, according to key MSF communications and operational interviewees (particularly OCB MSF informants) the tone and messages were not perceived as 'humanitarian' enough: too distant and too cold-blooded. Clearly, a medical-scientific expert discourse dominated the message, especially at the beginning, where there was less attention on the distress of the population and relatively little empathy with the patients and their families.

New markets and "difficult countries"

Ebola was prominent in the news the world over. However, opportunities to increase MSF's visibility and credence in new markets and 'difficult' countries – such as Russia, Iran, the Middle East, the BRIC countries – were not always exploited. The 'One Year' report, for example, was not translated into Arabic. Despite the lack of a specific strategy or plan, there were some isolated initiatives such as some blogs in Arabic.

Pushed to the Limit and Beyond, A year into the largest ever Ebola outbreak

For the one-year anniversary of the Ebola outbreak MSF wanted to communicate, advocate and document the events of the previous year for the organisation's institutional memory. Time was short and a lighter version than planned was made. During the report's preparation there was much discussion about the challenges and how to be transparent about them.

The report received good media coverage, although a quarter of the international journalists interviewed for this review were slightly disappointed because they had expected it to be more political or contain new information. The report also received some strong internal criticism as a missed opportunity to provide a sober look at what MSF had done as opposed to focusing on what others did wrong. Because of this, some MSF offices did not use the report. Overall, internal and external interviewees felt its tone was too congratulatory and too self-aggrandising. That said, the vast majority of MSF offices disseminated the report to the press and used it in their bilateral meetings.

WHO seemingly found the report traumatic, as it criticised them for being too late and not having done enough, which was picked up by the media. However, MSF representatives received positive feedback on the report. WHO insiders told MSF that the criticism was helpful because MSF was saying what they couldn't and in the GERC discussion on the report 'the humility' of MSF was highlighted. That said, WHO informants for this review also expressed their view that the report was in no way helpful and some facts not well balanced, especially as it drew on individual opinions rather than the organisation's position.

"It was not until that report came that anything really public that MSF put out was considered a problem for us. But it was never the WHO position that they had overstated the size and the severity of the outbreak. That was an individual's opinion and they knew that. Another thing that I found very upsetting was the characterisation of WHO only declaring the outbreak on March 23 as if it had been going on for four months and we had done nothing of worth. In fact, it was MSF that investigated the outbreak first and we missed it". (WHO)

There was no reference in this report (and specifically in the critique of WHO) to the WHO emergency response framework (ERF)²⁶, which could have usefully highlighted the difference between what WHO said it did on paper and the reality of the Ebola response, using concrete examples.

MSF visibility

Media interest was huge. According to all MSF communications departments the organisation was dealing with an unprecedented volume of media inquiries. One spokesperson in OCB HQ testifies that he did an average of six interviews a day during a period of four to five months. Unfortunately, this review can't provide exact numbers on how many interviews in total were conducted because overall statistics are not available.

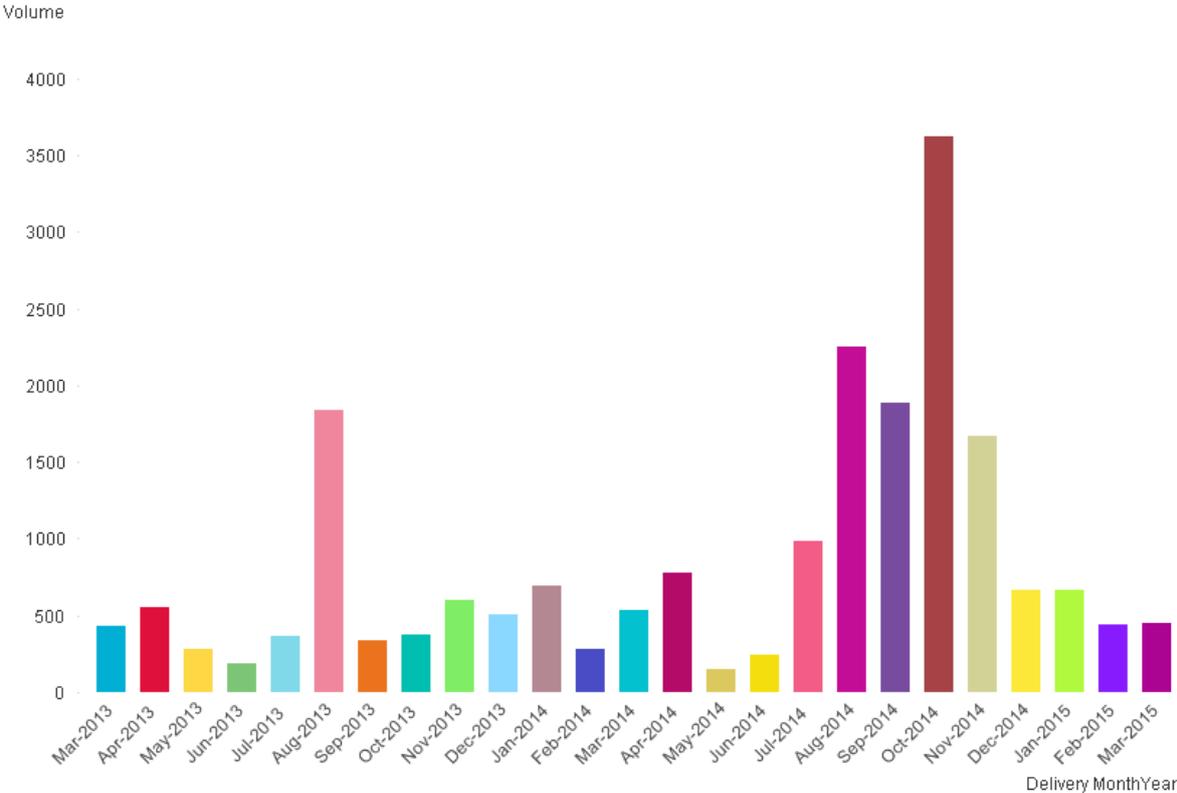
Media coverage

It is incontestable that media coverage was massive. In the UK there was a sharp increase in coverage from July to November with the biggest peak in October (see chart below). Compared to 2013 media coverage doubled in July 2014. In September and October 2014 there was eight times more coverage

²⁶ <http://www.who.int/hac/about/erf/en/> the purpose of the Emergency Response Framework (ERF) is to clarify WHO's roles and responsibilities and to provide a common approach for its work in emergencies. Ultimately, the ERF requires WHO to act with urgency and predictability to best serve and be accountable to populations affected by emergencies.

than in the previous year. A deeper analysis of how much of each month's coverage is down to Ebola is not possible because the volumes were too great to score at points.

Figure 1: Coverage volumes MSF UK



For US media coverage it is hard to determine the accuracy of the 2013 figure because in 2014 MSF US updated its reporting tools. However, it is clear that Ebola greatly impacted the amount of coverage MSF received in the US in comparison to 2013. October 2014 saw MSF US's highest level of visibility. October was when the two US expats returned home. Furthermore, Ebola accounted for almost 85% of the coverage MSF received in the US news media between March 2014 and March 2015. The coverage MSF received continued to increase on an even more impressive scale in 2015 partly due to Ebola, but also due to coverage of the crisis in the Mediterranean as well as coverage of the attack on the MSF hospital in Kunduz (in October 2015).

Figure 2: US News Media Coverage 2013, 2014, 2015

	Number of stories
2013	6,470
2014	49,913
2015 (excluding December)	83,094

In South Africa the numbers reveal an increased MSF presence in the traditional media (print, radio and TV) with spikes in March/April, and again in June/July but with massive coverage from August to

November 2014. For example, in September 2014 MSF was nearly four times more in the South African press (878 hits) than in 2013 (221 hits) and in October almost six times more (1,099 vs 187 hits). Compared with 2013, coverage of MSF tripled in 2014: from 1,832 up to 5,748 items²⁷.

MSF Online & Social Media

Visitor statistics on MSF websites point clearly to a very significant global increase. According to key MSF communications informants the Ebola page became an important resource for journalists and the public during the crisis.

Take MSF Brazil for example. In 2014, 34% of all visits to its website visited the Ebola static page. In January its Ebola information page had 241 views and by October this was over 1,000,000. In Portuguese, MSF Brazil is the number one page result on Google when you search simply for 'Ebola'.

The MSF UK site had 428,391 page views for content with 'Ebola' in the URL in the one-year period under examination. Some 213,835 of these were on the msf.org.uk/ebola page, which the MSF UK team ran as a Wikipedia style page using small snippets of information, multimedia and social media content to update regularly. This page massively outperformed all other MSF Ebola content in the UK. The next most popular piece of content was <http://www.msf.org.uk//article/ebola-my-last-day-isolation-zone> with 37,777 page views.

Ebola content was also popular in Sweden. From February until 21 December the MSF website lakareutangranser.se had in total 169,214 page views (articles, static pages, blog entries, etc.), of which 142,566 had 'Ebola' in the URL.

In South Africa the number of total page views almost doubled compared with 2013. Also interesting is the increase of unique visitors. Between March and December 2013 the MSF SA website had about 6,000 unique visitors and in the same period in 2014 this number increased to more than 74,000 unique visitors, equating to an increase of more than 1,200 % in one year. The biggest peak was here was also in October 2014, when the MSF website had 27,692 unique visitors: a huge increase compared with October 2013 when it was 7,542 visitors.

According to MSF specialists the blogs were by far and away the best content MSF produced during Ebola. The MSF Ebola blog has had over 100,000 views to date on blogs.msf.org

"We had to follow the most intense rhythm of communication I've ever seen in MSF, and we started to integrate more visual and pedagogical tools such as ThingLink, which has very good results among our digital audience (even the media relayed these infographics)" (MSF webmaster)

MSF Facebook pages also saw very high growth. For example, in South Africa the number of Facebook friends grew from 13,269 at the end of 2013 to 46,505 at the end of 2014: an increase of more than 350 %. According to MSF South Africa informants there was also a high level of engagement on Ebola. For them it was striking that many people shared content, added comments and liked posts on Facebook.

²⁷ See chart 'MSF SA Media monitoring 2009-2015' in Annexes

Figure 3: Social Media Growth during Ebola Outbreak

		Facebook	Twitter	Total
2013	January	9119	5509	14628
	February	9543	5862	15405
	March	10017	6302	16319
	April	10353	6766	17119
	May	10553	7162	17715
	June	10717	7443	18160
	July	11066	7841	18907
	August	11341	8194	19535
	September	11684	8537	20221
	October	12039	8896	20935
	November	12873	9199	22072
	December	13269	9479	22748
			Facebook	Twitter
2014	January	13972	9862	23834
	February	14676	10182	24858
	March	16581	10579	27160
	April	25023	11003	36026
	May	26666	11473	38139
	June	28299	11891	40190
	July	30363	12490	42853
	August	32862	13070	45932
	September	34940	13660	48600
	October	43716	14290	58006
	November	45823	14835	60658
	December	46505	15295	61800
2015		Facebook	Twitter	Total
	January	58524	15755	74279
	February	59270	16420	75690
	March	59304	16973	76277
	April	60961	17782	78743
	May	63720	18612	82332
	June	65351	19591	84942
	July	66652	20764	87416

	August	68550	21317	89867
	September	70334	21352	91686
	October	75817	21434	97251

The Ebola response also boosted MSF Twitter accounts to unprecedented heights.

MSF video production

There is general satisfaction on the quality and the quantity of the videos produced by MSF OCB on Ebola. On the video database one can find fifteen B-rolls produced for news wires, seven web clips for social media and (mainly) MSF websites, one ThingLink and one DataViz. Although there are no exact numbers on the use of the B-roll one can say that the material was used by a large number of international media organisations such as the BBC, CNN, Al Jazeera, AFP, Euronews, Vice News and others.

Furthermore, MSF OCB produced eight training videos, two health promotion videos, one in-house documentary (Affliction) and facilitated three external documentaries. One example of a video that worked very well on YouTube was 'Ebola – A Race against Time' (July 2014): <https://www.youtube.com/watch?v=F5nkkEwPaEA> In the UK this video had more than 18,000 views, in the US almost 5,000 views and in France almost 3,000 views. The most popular Ebola video on YouTube was 'The Boy who Tricked Ebola' (September 2014) with in total almost 145,000 views by the end of 2015: https://www.youtube.com/watch?v=9OQXZWz15_A

LOCAL LOBBYING & PUBLIC COMMUNICATIONS

It is clear that resources were stretched in terms of appropriate advocacy and communications human resources. Maintaining a high standard of advocacy and communications across the projects was therefore difficult. In general, advocacy and communications was deemed to be stronger in the locations where the most experienced and skilled staff were assigned, for example during the disease's peak in Monrovia. Whilst at other points, across all locations, the advocacy appears to have been weakened by a strain on human resources that resulting in weaker analysis and networking, and ultimately a lower level of investment in communicating the reality, gaps, challenges and concerns the organisation faced.

Reporting from the field was not consistently strong. This has been explained by the fact MSF teams were overwhelmed by the response and did not have time to gather information, observe and put it down on paper. Therefore key information from the field was missing, which would have made the messages stronger. Examples of this include the fact that there were no reports from the field flagging up the early dissatisfaction with WHO country reps in the affected nations, and the fact that there were never any notes from WHO-AFRO meetings. Furthermore, and according to key informants of the Task Force, MSF could not get clear answers to who was doing what in each of the countries in a standardised format.

A recurrent comment from staff working in the field was the lack of a regional response and the lack of interaction between the three affected countries. In effect, MSF's response was different in each country.

Another recurrent observation is the lack of communication and collaboration around advocacy activities. There was a clear need for a structure that brought together the voices of the people working in the affected countries, so they could effectively communicate their experiences and impressions. Such a strategy would have given useful material to feed the advocacy strategy.

During 2014 MSF did not launch as many official press releases designed to galvanise attention as one might expect. The organisation instead relied on interviews and short quotes to get their messages across.

Phase 1: Sounding the Alarm

MSF deployed communications resources on the ground from the very beginning. In week one a communications field officer was sent to Guinea and a second person followed very quickly. It was the classic setup: one staff member dealing with international media and the other focusing on national media. As media attention increased, more press officers were sent to the field. Later (for many too late) field communications managers were deployed to coordinate the fieldwork and relay information to HQ. But the search for available communications resources became more and more difficult as resources were severely stretched.

"At one point I sent desperately an email to List Press, asking for a press officer to come to Guinea. It was in July and I received around hundred "I'm out of the office" answers. I got one positive answer, and one saying, "If you don't find anybody else, I'll try to make myself available".

(MSF Field Emergency Coordinator)

The increasing number of international media on the ground demanded all the attention – to the cost of local and regional media. International media are often prioritised by press officers because the outcome is more visible in their home countries²⁸. According to many key communications and

²⁸ A vast majority of MSF communication informants, including field press officers, indicated this was one of the reasons why international media was prioritised.

operational informants in this review, local media are often considered as somewhat deontological, biased and instrumentalised by the authorities. On top of that, the major operational objective for many press officers sent to the field, was to sound the alarm internationally. In fact, several field press officers were requested by HQ to treat the international media as the top priority²⁹. Later on MSF deployed more press officers dedicated to local media, which played a very important role in the response (allowing them to track rumours, address communities' concerns and questions, and achieve transparency), but still not enough to meet the vast needs. Even with this additional resource it was challenging – especially for inexperienced staff – to prioritise local media over the international press.

“It’s very difficult for someone who doesn’t have a lot of experience to refuse BBC or CNN, instead of local radio. Many think that it’s more important to respond to an international radio than to a local radio. I hope that lessons will be learned to have someone specifically for that, and to have objectives of collecting the rumours, following the rumours, answering all the questions, being transparent”.

(MSF field press officer)

Rumours, misunderstandings and false information were circulating, seriously hampering MSF’s intervention, which had serious consequences for containment of the disease itself. As well as a focus on international media in the field, the public messages were also predominately targeted at the international media. Some of these messages conflicted with local needs, creating tensions with national authorities and confusion within the communities (e.g. stressing the gravity and fatality of Ebola did not encourage people to go to the centres – on the contrary, it led to them staying away).

Communications that targeted the local population, countering the many rumours and myths, telling people how to prevent infection and explaining what happened in the centres, was poor. According to local journalists, national MSF field staff and some key MSF expat communication staff, the few specific messages engaging with the local communities were often too complicated, too technical and not in the appropriate language.

At the very end of August OCB hired a local member of staff in Liberia to focus on local media. In Guinea local communications staff were only hired in March 2015 and in Sierra Leone it never happened at all. In this first phase there is an overall recognition that there was no strategy to communicate to the local media and the local population. As with communications, no additional and dedicated advocacy resources were deployed in this first phase. According to the vast majority of the interviewees, lobbying and representation support was needed and more reaching out could have been done. It has to be said the field teams were overwhelmed with the operational response and that there was little time left over for lobbying.

There seems to have been reluctance by some field staff to engage at regional or country level with the coordination platforms. Only in Guinea was there consistent interaction. In Liberia MSF began by interacting, but it evolved almost into a refusal to play a role or to influence the strategies of the authorities. This was definitely the case in Sierra Leone.

Guinea

In April the first press officer dedicated to local media arrived in Conakry. It quickly became apparent that the local media had very little knowledge about Ebola and did not engage in proper sensitisation, instead mainly contributing to spreading and feeding rumours about the virus.

MSF started to engage with local media in Conakry and Guéckédou, and to attend and take an active role in the NGO communications platform. MSF helped with the development of a strategy and messages for communities. But staff turnover was high and attention often diverted to international media and MSF websites. It is recognised by the vast majority of the informants that if there was any

²⁹ Source: deployed field press officers

attention given to local communication, it was the result of personal initiatives rather than of a real strategy.

Liberia

From the very beginning there was much confusion and misinformation about the disease and the response, such as conflicting information about what to do to avoid contamination. There were also striking myths about what was happening in the treatment centres. People had heard that although there was no treatment, patients in Ebola centres were given pills that – rumour had it – were used to kill them. MSF organised a local press conference to address these myths and rumours. However, this only happened at the beginning of September, after a local press officer was hired. The press conference was attended by a large number of local media and the coverage was huge.

Sierra Leone

It is generally recognised that MSF did not have a good relationship with the authorities in Freetown before the outbreak. Furthermore, MSF had no projects in Freetown, and was only working in the provinces. In Sierra Leone the majority of bilateral relations were at district level. At the central level MSF was less active and from June onwards MSF only attended a few Ebola meetings in Freetown. However, MSF had a strong relationship with the president of Sierra Leone.

Phase 2: Scale Up!

In all affected countries it was clear that the international response needed to be monitored and analysed. By mid-September a liaison officer position was created to do this in Liberia, Guinea and Sierra Leone. Both Head of Missions of the regular/existing projects fulfilled this role.

Normally it is the Office for the Coordination of Humanitarian Affairs (OCHA) that brings together the humanitarian actors to ensure a coherent response in emergencies. But in this instance OCHA could not deploy because it had too many other crises to deal with. Because coordination of the health emergency by WHO was seen as very poor, the UN Security Council created the UN Mission for Ebola Emergency Response (UNMEER). However there was a lot of confusion on what UNMEER was supposed to do³⁰.

When UNMEER started its work, it took some time before it could find its own place and role within the already existing coordination mechanisms. MSF, which was already interacting with these platforms, did not fully understand their structures, compositions and roles, mainly because no proper research or analysis had been conducted on them. This was also true in regards to UNMEER. MSF got in touch with UNMEER on several occasions, but did not make significant efforts to engage with its HQ in Accra³¹. In-country there was some interaction, in particular in Liberia. In Sierra Leone a different model was in place. There, the National Ebola Response Centre (NERC) coordinated all agencies and activities, including UNMEER. MSF did engage with NERC³² until MSF OCA took over the projects.

³⁰ UNMEER was created to coordinate the UN agencies and not the response to the intervention (a fact most high-level MSFers did not realize until mid 2015). At the beginning MSF believed that UNMEER was replacing OCHA. In humanitarian emergencies, OCHA usually coordinates the different actors, but because it was working in too many other crises, UNMEER was specifically started for Ebola.

³¹ UNMEER was based in Ghana where MSF had no representation.

³² MSF was only welcome as an observer at the NERC briefings in the afternoons but not at the NERC coordination meetings in the mornings where decisions were taken. Clearly, this reduced the possible 'influence' of MSF.

Guinea

In Guinea, MSF was the only aid organisation to treat patients until the end of November, while in Liberia and Sierra Leone other organisations took responsibility earlier. MSF was very active in reaching out in Guinea, resulting in a strong relationship with the Guinean government (e.g. MSF helped with the reorganisation of the government's task force). MSF worked also very closely with the French ambassador to push France to participate in the response. Furthermore, training was provided to French NGOs and assets from the French government (mainly the army).

According to most of the deployed MSF field staff, the organisation failed to make much distinction between the three countries in their public communications³³. Perceiving the affected countries to be one region was challenged by the field team in Guinea. It also created tensions with the Guinean government, the Ministry of Health and the president. Asking for more beds and more boots did not apply at the same level in Guinea as in Liberia. Despite many discussions about having more messages customised to the reality of the situation in Guinea, only a few adjustments were made in the messaging.

It was not until the end of November that a Guinean staff member was hired to work on local communications. Strategies were developed and there was also a good collaboration with health promotion.

Liberia

A Liberian press officer was hired to focus on the local media at the end of August. Before that, international press releases were sent to the local media without any adaptation. In October the press officer finalised the first local communications strategy, including an anti-stigma campaign that was fully rolled out in November. MSF was providing health messages in radio talk shows, articles in local newspapers, etc. The local communication officer was working closely with the health promotion team and according to everyone involved this was a success.

Up to mid-September MSF Head of Missions were very engaged with the national Task Force, helping to guide the response and to raise the alarm. When finally other organisations stepped in, and the number of meetings increased, the first liaison officer was on the ground (from September 20th) and took over the representation activities.

In October, Liberia was at the epicentre of the outbreak and the situation was evolving by the day. By the beginning of November, the messaging was no longer reflecting the reality on the ground. The field wanted to communicate a different message, pushing for a more agile response instead of calling for more capacity. They wanted attention to the other pillars of the response but messaging lagged behind and became obsolete.

There was a big time lag between the decision by other agencies to build centres and their finalisation. By the time the centres were built, there was a reduced need for them, but even then MSF did not advocate for an adaptation of the response to the changed dynamic of the outbreak.

"In November the situation was probably not sufficiently differentiated in our communication. They pushed to adapt the message saying "Hey, don't continue those initial plans. Adapt your response". In Brussels we were just simply lacking that information and we didn't want to discourage what was going to be delivered". (MSF Task Force)

This definitely created a delay in the messaging, but in the end the Task Force did adjust the message. However, when a press release did go out, it was not pushed as efficiently at an international level as it could have been, according to the field team and communication staff at HQ.

³³ There were some country-specific messages in the talking points and the advocacy documents but very few in external documents and interviews.

Sierra Leone

Sierra Leone was the most complicated of the affected countries, both politically and epidemiologically. MSF was trying to influence the government, working with the Ministry of Health and pushing WHO.

MSF had a reasonably close relationship with DFID, having regular high level meetings and sharing information, which was very much appreciated by DFID. According to DFID these meetings were really useful in helping them to understand what they should be doing on the ground, in terms of trying to influence strategy. However, DFID regrets that MSF did not actively engage with them, or tell them precisely what the needs were. DFID felt that MSF was trying to get them to do something but, they were not clear about what MSF wanted them to do. DFID would have preferred, for example, to join up and have a common planning.

Relations with USAID were good, but tense with UNICEF. However, UNICEF was a main actor in Sierra Leone, bringing in supplies for Ebola and suits to support the Ministry of Health. The Task Force was (internally) very critical of UNICEF's strategy, which, even if considered justifiable, was not productive.

“There was a very aggressive stance against UNICEF. At times I really had to push back on what I considered UNICEF-bashing, not because I didn't think the criticism was justified, but bashing like that was not going to help.” (MSF Field Coordinator)

Later on in the crisis, three MSF sections in Sierra Leone became operational, but the lead section did not run operations in the capital, which made representation more difficult. Finding a liaison officer for Sierra Leone was also challenging, and there was a high turnover which – according to the key informants of the Task Force – resulted in poor outcomes. There seem to have been few efforts by MSF to build or maintain high-level contacts with for example the NERC, WHO or the IFRC.

Phase 3: Not Over

Guinea

In mid-December there was a big change of strategy in terms of advocacy and how to deal with other organisations. Previously MSF had been one of the pillars of the national coordination meetings, very collaborative and trusted, trying to influence the authorities' decisions. The new approach was based on criticism rather than encouragement to do better and trying to find solutions. For example, community resistance was a major burden to surveillance, case investigation and contact tracing. Part of this criticism involved recognising that there had been too much focus on treatment, neglecting the prevention aspect. UNICEF was targeted because it was deemed to be in charge but not properly implementing community health promotion and engagement.

Liberia

According to external stakeholders and several MSF field staff, MSF was very present in Liberia, very well listened to and very well respected until a new Emergency coordinator came. At this point the level of engagement reduced. According to the Task Force MSF was clearly against community care centres and refused to set them up because it was not feasible and unethical. For external stakeholders this position was perceived as stubborn, and they felt that MSF refused to enter into discussion about the community care centres. Operationally MSF was focusing and fighting for the rapid response team and against quarantine.

Sierra Leone

For a long time, there was either no liaison staff, or none that were engaged on the ground. From December MSF was no longer invited to the coordination meetings, and only able to observe the afternoon NERC briefings. Having a liaison officer in Freetown from January did not increase MSF's representation. There was no advocacy strategy because no one would work on one. According to a vast majority of the MSF informants, and also in the opinion of external actors, MSF's advocacy was not strong in Sierra Leone in this third phase. MSF disappeared, as it were, from the scene.

Local communication and health promotion

In OCB HQ there seems to be no real tradition of collaboration between communications and health promotion. However, at field level this collaboration exists de facto (e.g. vaccination campaigns) and the two are considerably interlinked. In cases where there was no health promoter in the field, the teams often expected communications to take on the role of sensitisation. However, exchange of good practices between Guinea, Liberia and Sierra Leone was lacking, as confirmed by all related informant interviews.

Nearly all informants who were in the field certify that there was some confusion about the role of communications and that of health promotion on the ground. In some projects there was the expectation that communications staff would give their support but this was not always possible because of the already high workload. On the other hand, not all health promotion and communications staff were keen to collaborate.

Other actors

The diaspora communities of Liberia, Guinea and Sierra Leone received little consideration. According to diaspora and MSF informants there are numerous Liberians, Guineans and Sierra Leoneans living abroad who were keen to lend a hand or to give an insight into the culture of the affected countries.

Finally, MSF focused in the affected countries only on the officials, choosing not to interact (enough) with the so-called soft power within communities who have a lot of influence, such as traditional healers and elders.

CONCLUSIONS

Only the future will tell whether the Ebola response has – or will – effectively changed MSF. However, Ebola definitely had a significant impact on MSF in terms of advocacy and communications. The organisation was catapulted into an expert and advisory role that had not been expected. The world was interested in what MSF had to say. MSF was an information provider and an advisor, influencing public opinion, institutions and organisations.

Need for analysis, reflection and strategy

An important lesson learned from the Ebola response is that in such an emergency the challenge is to maintain sufficient space for reflection despite the overwhelming management of the operation. A better capacity to reflect and inform strategies with a general overview (a ‘helicopter view’) must be considered for the next large scale emergency. Similarly, more capacity is needed for dedicated analysis and to work alongside emergency operations on a roadmap towards expected change, i.e. an overall advocacy strategy for both lobbying and public communications.

A better analysis and understanding of the functioning of national and international bodies, their sensitivities and their regulations (e.g. knowing about the international health emergency mechanism) could have accelerated the take up of MSF’s message. In particular, targeting WHO at the right level earlier or using influential states or institutions as door openers might have helped a faster advocacy impact. In the Ebola outbreak MSF could also have identified and tried to get support from “*unusual suspects*” who have a tremendous influence on public opinion but with whom MSF rarely engages with, e.g. the Pope, the Elders, and international Imams.

MSF was quite alone in its appeal for action. To increase pressure, the organisation could have looked at partnerships; at building a sense of anger and dismay in order to mobilise civil society; and at making more use of the returning field workers to inform their home societies. In short, MSF could have made more use of its humanitarian power and set up a coordinated campaign to achieve the necessary changes.

Very notable in this Ebola response was the difficulty of putting messages across so that they were understood as intended, both internally and externally as well as nationally and internationally. This requires a basic knowledge of the recipients and their realities.

Persistent advocacy towards the three affected countries, pushing them to mobilise other states did not happen enough, and when it did take place, it was too late. More advocacy, and earlier, would probably have been more efficient and effective because states are more likely to intervene if they receive a request from the country in need itself. Another option would have been to regularly consult between the three countries and the Task Force, working together on an overall communications and advocacy strategy, developing nuanced messages according to the different situations.

Lobbying and public communication

The Ebola emergency response has massively elevated the prominence of MSF as a global health actor both in terms of public awareness and perception and in terms of fundraising. Where press officers usually fight for media coverage, requests had to be turned down and all MSF media related records were broken. MSF was – for weeks and months – upfront in the news, resulting in an increased profiling.

Despite public communication efforts and lobbying the international community, it was only in the first half of September that finally the world started to engage. For many journalists, but also for institutional bodies, the warnings did not stand out in comparison to other MSF press releases and issues.

The public messaging of MSF built up over a period of months. In particular the interventions at the UN General Assembly and the UN Security Council, and the lobbying efforts, triggered a response, but it was not big enough to be the only game changer. The final wake-up call was a result of coalescence of different elements. Another big game changer was the infection of the returning international aid workers. One without the other would not have led to a meaningful international intervention.

For almost the first time an MSF international president was prominently at the fore-front of the organisation. In this crisis, as rarely before, the role of the international president became visible to the world.

It is a new and interesting fact that MSF succeeded in having huge coverage by using interviews and short quotes to deliver its messages, rather than relying solely on official press releases.

A new level of trust

The epidemic dramatically increased the credibility of the organisation and gave MSF, as one of the Ebola specialist actors, unprecedented access to the highest levels of governments, international institutions and scientific communities. This intervention has been a medium through which to build more trust at a very high level. The question to answer now is whether – and how – MSF wants to proactively make use of these open doors.

MSF's experience during the Ebola response demonstrated the necessity of prospectively investing in representation and networking. A lot of interaction with institutional bodies (such as WHO) was kept for too long to a very narrow technical level of Ebola specialists. In this outbreak it was necessary to go way beyond the technical people. Therefore, even if there are strong feelings about WHO's engagement with the crisis, it is important to have a good understanding about how WHO works, people's roles within the organisation, and where the power lies. It was only in the second half of 2014 that MSF engaged more at the highest levels³⁴. In addition to this, MSF's critique towards WHO would have been more credible if it was informed by (or based on) better knowledge of WHO, PHEIC and the WHO Emergency Response Framework (ERF).

Barriers for mobilisation

Although some 'barriers for mobilisation' flagged by stakeholders are only based on perception and not always according to reality, they are often interesting and possibly indicative. It must also be said that some identified barriers might be given by certain internal or external actors to mask their own late response and thus might be used as an excuse for not acting earlier. However, this cannot be a reason for the organisation to wipe those barriers from the table. Therefore, the validity of certain claims remains significant.

Medical advocacy: a field to be developed

A lack of medical advocacy resources and medical leadership in the movement became apparent during this crisis. The latter can partly be explained by the fact that the international medical secretary position was not filled. Governmental bodies expressed in the interviews that they needed medical people to provide messages rather than advocacy people. The outbreak demonstrated that medical advocacy is a field that urgently needs to be developed.

³⁴ It should be noted that the WHO Ebola response organogram was not established and clear until September 2014.

Difficult internal communications

The Ebola outbreak has clearly emphasised the difficulty, vulnerability and sensitivity of MSF's internal communications. Examples of this are the difficulties in mobilising internal action; the often unbending deliberation; the painful open letter and – at times – the lack of useful and up to date information flowing between the field and HQ, and between MSF and other organisations.

The internal open letter caused high levels of distrust, and the impact on MSF's functioning cannot be ignored. MSF became very internally focused, which had an impact on the work, particularly on reflection and messaging. It was detrimental to MSF's external public persona.

Striking impact of local communication

It is striking that MSF did not give more attention to local communications, because the lessons learned from previous Ebola or cholera outbreaks (as for example Haiti in 2010) are well documented.

Due to an issue of resource constraints, and assuming that other actors would take care of the sensitisation, MSF did not see local communications as a priority, instead focussing on increasing treatment capacity. Because sensitisation was not happening as supposed, the result was a false understanding of Ebola and a poor acceptance of the medical response. It took a while before MSF started to invest in local communications.

Good practice examples in Liberia and Guinea demonstrate the immediate and striking impact of local communications in general, and even stigma prevention for staff. The experience also shows the importance of local communications being sufficiently integrated with health promotion. Local mass communications tools are an efficient support for health promotion.

There seems to have been appropriate set up and concepts for local communications at the field level in some instances, but it is not necessarily reflected in the departments at headquarters. This is an issue that needs to be addressed. There is no doubt that stronger local communications would have helped to counter the many rumours, misunderstandings and false information that were circulating. Good practices and successful strategies need to be documented, shared and applied.

Importance of lobbying on the ground

The Ebola response highlighted the importance of deploying field liaison officers for lobbying and representation, from an early point in an emergency. There is also a need to document and analyse context changes and experience in the field: the necessary resources need to be in place. Input from the field increased when dedicated liaison officers were deployed. More experienced advocacy and communications staff in the field to relay the issues directly from the field would have maximised MSF's voice and positioning.

Input from the diaspora could have been helpful in gaining a better understanding of the local situation and culture. Moreover, the diaspora could have been a very useful human resource to deploy on the ground, and in support of the Task Force. MSF also underused local capacity in the affected countries.

Discussing MSF's future role

One can seriously question whether MSF's increased credibility and popularity, and especially its role as an influencer, will be maintained, and whether it will change the organisation. Even more importantly, will MSF be able to capitalise on the positive impact of its Ebola intervention? Maintaining access to the highest levels in other agencies for instance, will be a big challenge.

MSF will need to think about its future role and responsibilities. The organisation's leadership in Ebola created unforeseen expectations towards it. Today, for example, MSF is approached for advice, or even its political endorsement, on everything that has to do with the global health system, such as the reform of WHO.

Currently there is a certain ambiguity within MSF and amongst external actors in regards to MSF's role in the global health field. Will MSF continue to act as the 'Rebel without a Cause' of the medical humanitarian world, or should the organisation develop as a more established interlocutor contributing to the debates about the global health system and being part of coalitions in emergencies? It is most certainly food for thought for the next general assemblies of MSF worldwide.

RECOMMENDATIONS & LESSONS LEARNED

LESSONS LEARNED

Advocacy needs in (large scale) emergencies can only be appropriately covered if **sufficient advocacy and communications resources** based on longer term assignments are available early on, both at HQ and field levels. In the field capacity it is particularly key to have capacity for **analysis and documentation** that will feed the Task Force.

Where community fears of a disease are high, and acceptance of an intervention is at stake, there must be dedicated (local) staff for **local communications** from the very beginning of a response. A proper analysis of the cultural understanding, needs and dynamics must take place and strategies be developed accordingly and in good interaction with health promotion.

For the most important messages, the **gravity of an emergency must be stressed** more clearly to the press. This will require a more individual approach towards journalists/editors, better follow up of press releases, the differentiation of press releases and organising simultaneous press conferences in key media.

Within the **MSF movement, more reflection at a macro level, strategic direction and leadership** from the Directors of Communications platform and the Operational Communications Coordinators will add value and increase movement-wide support. A **better use of internal advocacy resources** is an option to increase capacity.

Good information management (cf. note taker in a Crisis Management Team) is essential to maintain coherence, allow smooth hand over and document the choices made.

The development of effective and appropriate advocacy messages **requires a global strategy with targeted messages** for each context and for specific audiences that can run in parallel to each other, e.g. individual states, local population.

Engaging with the media in a different way when an emergency of such gravity occurs is key, and will **increase effectiveness**.

TO REFLECT ON

Reflect on solutions to improve communication and advocacy in emergencies:

- ⇒ After a while in any emergency, field staff begin to find that conducting media interviews is a burden that distracts them from their actual work. Furthermore, the questions and answers can become very repetitive as there is nothing new to say. Assigning one designated spokesperson on a crisis to conduct all the interviews (as opposed to a number of spokespeople), so that others can spend less time on media activities, could be considered.
- ⇒ Consider the option of including a dedicated crisis management team in the setup of a large scale emergency intervention (based on common practice in abduction situations) to improve strategic reflection.
- ⇒ The necessity for different MSF offices and field staff to stick to the set communication lines versus a freedom to divert from them.
- ⇒ The option to have, for example, two communication people in the task force: one who maintains an overview and develops messaging, and one for daily media management OR one on the international side (HQ focal point) and one dedicated to the field (strategic support).

- ⇒ In an ideal world MSF only sends experienced communication staff to the field, but to counter the tendency for junior press officers to focus on the international press:
- The option to assign senior communications staff for local media and junior staff for international media.
 - The option to assign the senior communication staff to manage the messaging for international and local media and interaction with HQ while the junior press officer facilitates all the media visits and helps design the local media strategy with input from the senior communication staff and the health promotion team.

RECOMMENDATIONS

1. Develop and maintain a better network with, and a better understanding of, the functioning of governments and institutional bodies, including at higher levels, and deploying MSF offices and other MSF entities to lobby more frequently and in a timely manner.
2. Define the profiles, roles and expectations of health promotion and field communication staff; develop local communication tools and strategies; and document good practices in different emergency situations.
3. Develop MSF's international capacity for medical advocacy
4. Integrate a 'skilled analyst' in the set-up for large scale emergencies. This will allow more, better and earlier context analysis and identification of potential allies and influencers, including 'unknown and unusual' actors (e.g. African platforms and the Elders). It should also consider the timely involvement of high level MSF representatives where necessary.
5. Develop a more efficient advocacy and communications set up in the field, including the development of an intersectional pool of trained field communications staff³⁵ and develop some standard templates for field analysis, e.g. a template for actor mapping and a local advocacy strategy.
6. Explicitly follow and respect Chatham House rules in order for MSF to be trusted and accepted in bilateral talks with global and state actors.
7. Increase attention to and investment in staff and strategies to reach out to non-western media (China, Russia, the Arabic world etc.) in emergencies with a large global media reach.

³⁵ An International Field Communications Officer pool, managed by MSF UK on behalf of the movement, is about to be launched in the beginning of 2016. This is the first international pool and is an important step, primarily in terms of improving field communication capacity. The Heads of HR and Communications will work closely with the International Communications Coordinator to ensure its success and the pool will be evaluated by the IDRH six months after its launch.

ANNEXES

ANNEX I: TERMS OF REFERENCE

http://cdn.evaluation.msf.org/sites/evaluation/files/attachments/communications_and_advocacy.pdf

ANNEX II: LIST OF INTERVIEWEES

MSF INFORMANTS

ORGANISATION	NAME	POSITION AT THE TIME
MSF Access Campaign	Katy Athersuch	Field Communications Manager in Liberia
MSF Access Campaign	Manica Balasegaram	Executive Director
MSF Access Campaign	Philipp Frisch	Coordinator Germany
MSF Access Campaign	Joanna Keenen	Field Communications manager (Liberia) Press Officer
MSF International Office	Julie Damond	Regional Information Officer West Africa
MSF International Office	Kate De Rivero	International Communications Coordinator
MSF International Office	Fabien Dubuet	Representative to the United Nations (HART unit)
MSF International Office	Joanne Liu	President
MSF International Office	Jerome Oberreit	Secretary General
MSF International Office	Eduard Rodier	Representative to the EU (HART unit)
MSF International Office	Emmanuel Tronc	Humanitarian Advocacy & Representation Coordinator (HART unit)
MSF Germany	Tankred Stoebe	President
MSF Germany	Florian Wesphal	General Director
MSF OCA	Gina Bark	Humanitarian Affairs Advisor
MSF OCA	Katrien Coppens	Deputy General Director
MSF OCA	Hernan Del Valle	Head of Advocacy & Operational Communications
MSF OCA	Arjan Hehenkamp	General Director
MSF OCA	Nicole Johnston	Operational Communication Coordinator
MSF OCA	Marcel Langenbach	Operational Director
MSF OCA	Karline Kleijer	Emergency Desk (in charge of Ebola) Field Emergency Coordinator
MSF OCA	Mireille Koeleman	Press Officer MSF Holland
MSF OCA	Ronald Kremer	Field Medical Emergency Manager Field Medical Coordinator
MSF OCA	Caitlin Ryan	Field Communication Officer (Liberia) Communication Advisor
MSF OCBA	Raquel Ayora	Operational Director
MSF OCBA	Teresa de San Cristobal	Emergency Desk Coordinator
MSF OCBA	Louis Encinas	Field Emergency Coordinator Liberia Special advisor for support to non affected countries in preparing for Ebola
MSF OCBA	Amaia Esparza	Director of Communications
MSF OCB	Halimatou Amadou	Communications Advisor
MSF OCB	Rosa Crestani	Task Force Coordinator
MSF OCB	Brice de le Vingne	Operational Director Head of intersectional Ebola TF
MSF OCB	Bertrand Draguez	Director of the Medical Department
MSF OCB	François Dumont	Operational Communications Coordinator
MSF OCB	Marie-Christine Féris	Emergency Desk Coordinator

MSF OCB	Seco Gerard	Advocacy Focal Point intersectional TF
MSF OCB	Stephan Goetghebuer	Deputy General Director
MSF OCB	Jean-Marc Jacobs	Communication Focal Point intersectional TF
MSF OCB	Bart Janssens	Operational Director
MSF OCB	Helène Lorinquer	Director of Communications & Fundraising Special Advisor to the DG
MSF OCB	Adolphus Mawalo	Local Field Communication Officer Journalist local media & RFI
MSF OCB	Heather Pagano	Field Communication Manager Liberia Communication Focal Point intersectional TF
MSF OCB	Marc Poncin	Field Emergency Coordinator (Guinea)
MSF OCB	Sergio Ceccini	Director of Communications & Fundraising
MSF OCB	Christopher Stokes	General Director
MSF OCB	Kris Torgeson	Field Liaison Officer (Advocacy) Liberia
MSF OCG	Louise Annaud	Field Local Communications Officer
MSF OCG	Jean-Clement Cabrol	Operational Director
MSF OCG	Bruno Jochum	General Director
MSF OCG	Aurelie Lachant	Operational Communications Coordinator Communications Advisor
MSG OCG	Mariano Lugli	Field Coordinator Guinea Deputy Operational Director
MSF OCG	Sally Mc Millan	Communications Advisor
MSF OCG	Monica Rull	Medical Advocacy Advisor Field Coordinator in Sierra Leone
MSF OCG	Yasmin Rabayan	Communications Advisor
MSF OCG	Hugues Robert	Emergency Desk Manager
MSF OCG	Micaela Serrafini	Director of the Medical Department
MSF OCP	Andrea Bussotti	Medical Communication Officer
MSF OCP	Samuel Hanryon	Media Relations Coordinator
MSF OCP	Benoit Leduc	Deputy General Director
MSF OCP	Yann Libessart	Field Communication Manager (Liberia) Regional Information Officer West Africa
MSF OCP	Claire Magone	Director of Communications
MSF OCP	Mego Terzian	President
MSF OCP	Brigitte Vasset	Deputy Director of the Medical Department
MSF South Africa	Daniel Berman	General Director
MSF South Africa	Borrie Lagrange	Director of Communications
MSF South Africa	Sharon Ekambaram	Head of Program Unit Field Liaison Officer (advocacy) Sierra Leone
MSF South Africa	Jens Pedersen	Medical Focal Point (Liberia) Humanitarian Advisor
MSF United Kingdom	Vickie Hawkins	General Director
MSF United Kingdom	Andre Heller Perache	Head of Programmes Field Liaison Officer (Advocacy) Sierra Leone
MSF United Kingdom	Sophie-Jane Madden	Press Officer
MSF United Kingdom	Polly Markandya	Head of Communications
MSF United States	Jason Cone	Director of Communications
MSF United States	Sophie Delaunay	Executive Director
MSF United States	Michael Goldfarb	Media Relations Manager
MSF United States	Sandra Murillo	Medical Communications Officer
MSF United States	Andres Romero	Operational Advocacy Advisor
MSF United States	Tim Shenk	Press Officer Field Communications Manager (Liberia)

INSTITUTIONS & NGO INFORMANTS

ORGANISATION	NAME	POSITION AT THE TIME
Chatham House	David Heymann	Head and Senior Fellow, Centre on Global Health
Council on Foreign Relations	Laurie Garrett	Senior Fellow Global Health
DFID	Clea Kahn	Humanitarian Advisor
French Ministry of Foreign Affairs	Mathilde de Calan	Advisor French Ebola Task Force
French Ministry of Foreign Affairs	Christine Fages	Head of the French Ebola Task Force
French Ministry of Foreign Affairs	Clément Taron-Brocard	Advisor French Ebola Task Force
German Ministry of Foreign Affairs	Walter Lindner	Head of the German Ebola Crisis Cell
ICRC	Pascal Hundt	Head of the Assistance Division
ICRC	Eric Marclay	Head of Operations
IFRC	Amanda McClelland	Senior Officer Emergency Health
London School of Hygiene & Tropical Medicine	Peter Piot	Director and Professor of Global Health
OCHA	Quintin Tayfun Levet	Team Leader West Africa & Sahel
Oxfam UK	Debbie Hiller	Humanitarian Policy Advisor
Save the Children International	Michael von Bertele	Humanitarian Director
Sierra Leone diaspora	Yvonne Aki Sawyerr	
South African Ministry of Health	Precious Matsoso	Director General at the Department of Health
South African National Institute for Communicable Diseases (NICD)	Lucille Blumberg	Head of the Epidemiology Division
UNICEF	Barbara Bentein	Head of Ebola Cell
UNICEF	Carole Vignaud	Humanitarian Field Support Emergency Programmes
UNMEER	Béatrice Godefroid	UNMEER Team Leader Ebola Monitoring MSF Consultancy for MSF- RIOD: Ebola Setup
USAID - OFDA	Sonia Walia	Public Health and Nutrition Advisor
WHO	Richard Brennan	Director, Emergency Risk Management and Humanitarian Response
WHO	Margaret Harris	Communications Officer
WHO – GERC (Global Ebola Response Coalition)	David Nabarro	Head of GERC - UN Special Envoy on Ebola
Worldbank	Shunsuke Mabuchi	Senior Health Specialist

MEDIA INFORMANTS

Agence France Press (AFP), Associated Press (AP), BBC TV, El Mundo, El Pais, Le Monde, Libération, National Public Radio (NPR), New York Times, Radio France International (RFI), Internews Guinea, Radio Lynx, Reuters, Sociedad Española de Radiodifusión (SER), The Guardian, The Wall Street Journal.

ANNEX III: INFORMATION SOURCES

Available on request.

Stockholm Evaluation Unit
Médecins Sans Frontières
<http://evaluation.msf.org>