

OCB EBOLA REVIEW

Part 8: Governance

[December 2015]

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

DISCLAIMER

The author's views expressed in this publication do not necessarily reflect the views of **Médecins sans Frontières** or the **Stockholm Evaluation Unit**.

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ACRONYMS

ALIMA	Alliance for International Medical Action
CDC	Center for Disease Control and Prevention
Co-Dir	Committee of Directors (OCB)
ETC	Ebola Treatment Centre
EXCOM	Executive Committee of General Directors (of MSF)
HART	Humanitarian Advocacy and Representation Team
IB	International Board (of MSF)
IMC	International Medical Corps
INGO	International Non-Governmental Organisation
IO	International Office
LuxOR	Luxembourg operational research (MSF)
MSF	Médecins Sans Frontières
OC	Operational Centre
OCB	Operational Centre Brussels
OCG	Operational Centre Geneva
RIOD	MSF Directors of Operations Platform
WHO	World Health Organisation

EXECUTIVE SUMMARY

The OCB Ebola Critical Review covers the intervention of MSF OCB and focuses on the period between March 2014 and March 2015, when the main impacts and constraints were felt. There was an overwhelming recognition that the role played by MSF OCB in the overall response went beyond what is normally expected and the findings related to the individual sectors implied by the intervention can be found within the individual or summary reports.

The findings of this governance review relate to the governance role, both internal and operational, of OCB. Other governance factors relating to MSF as a whole and to the role of the different platforms - including the shared intersectional Task Force - will be dealt with in a separate governance review commissioned by the MSF International Board.

The Ebola outbreak occurred during a very difficult period for MSF OCB. During March and mid-May 2014, the organisation had been dealing with the kidnapping of some of its staff members in Syria as well as emergencies in the Central African Republic and the Republic of South Sudan. This caused a certain emotional fatigue which, combined with the summer holiday period, resulted in a lack of senior and middle management representation within the office. These gaps and lack of management representation have been identified as one of the reasons behind the delay in reflection on external advocacy strategies to other actors, as well as a more systematic mobilisation of resources within MSF itself, i.e. the emphasis at the highest levels of the organisation to mobilise.

The main operational finding relates to the timing of the decision to transfer management from the emergency unit to a Task Force setup. In hindsight the deployment was delayed by one to two months and impacted on the response during the peak of the outbreak in August 2014. The setup was impacted by gaps in senior and middle-management during the summer as well as the limited availability in number of Ebola experts within the organisation and high demand for their services. Within the Task Force and Emergency Unit there was insufficient reinforcement of the key management positions and of some support functions. This was also a factor at department level, where certain positions were not sufficiently divested from their day to day responsibilities in support of the Task Force.

The governance structure of the Task Force was streamlined and centralised by choice, which had both positive and negative impacts. While it allowed for fast complex decision making, it limited the amount of organised strategic reflection space.

At a national Task Force coordination level, OCB played an important role in the three affected countries but, in Sierra Leone, this stopped when OCB handed over its projects. The support and coordination provided by OCB to other organisations was commended by most of them and played a crucial role in their operational reactivity.

The main **recommendations** of the governance review reflect the above findings and the need to:

- ⇒ Provide a sufficiently robust investment in human resources support:
 - a. Provide coordination management support positions.
 - b. Separate the functions of emergency unit/Task Force support positions from the day to day responsibilities.
 - c. Ensure sufficient resources allocated to the Task Force setup, especially relating to advocacy and communications, medical/epidemiologist and briefing/debriefing positions.
 - d. Invest/expand the formal liaison capacity within OCB or HART (IO).
- ⇒ Ensure adequate reflection moments during a long emergency whether at an operational

strategic or response governance level. This should include the timing and criteria for mobilising a Task Force.

- ⇒ Be a catalyst for change: organise a roundtable with key actors from the humanitarian emergency sector to discuss future response capacity and availability of resources.

BACKGROUND

OCB's response to the Ebola outbreak in Western Africa has undoubtedly been complex and challenging. Questions have come up also 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 make 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 9 reviews is available.

INTRODUCTION

The Ebola outbreak in West Africa was unprecedented in its sheer size and scale. By unhappy chance the outbreak occurred close to the confluence of the borders between Guinea, Sierra Leone and Liberia, where movement of people between countries is regular and often not controlled.

On March 21, 2014 the Ebola outbreak in Guinea was laboratory confirmed and MSF quickly dispatched experienced teams from Geneva and Brussels to set up Case Management Facilities and start outbreak control measures. An MSF team in Sierra Leone with Ebola experience was directed across the border into Guinea and began setting up isolation facilities in Guéckédou near the epicentre of the outbreak as well as implementing outbreak control measures in the affected area.

By late July, the epidemic had spread to major cities in Guinea, Liberia and Sierra Leone and the situation was described as out of control. It became the first large outbreak of Ebola in urban settings. At the beginning of October 2015, World Health Organisation (WHO) reported more than 28000 cases and 11 000 deaths¹. With the rapid rise in cases and the lack of other humanitarian actors, MSF was stretched to the limit. Because of the high risk associated with responding to Ebola and the previous outbreaks being quite small in comparison, very few humanitarian actors had the experience or capacity to respond. In August, during the peak of the outbreak, MSF increased its on ground capacity by five times.

The international community, including the WHO, was slow to respond and reluctant to accept the scale and severity of the Ebola outbreak. Affected governments did not want to spread panic among their populations. For the MSF's response, this resulted in very limited access to important data and also little opportunity to engage the population in controlling the disease with safe practices, awareness raising and setting up networks of alerts. Soon the epidemic had become the largest Ebola outbreak in history. Finally by late 2014, the outbreak showed signs of slowing.

The OCB management commissioned an extensive multi-sectorial critical review of its Ebola intervention. Sub-reviews covered medico-operational issues, human resource management, water and sanitation, supply, logistics, communications and advocacy as well as governance. A review of treatment centre design and construction was included but steered by the operational centre Amsterdam. Two archivists have supported the use of an information system (Knowliah) for quick and easy access to relevant documents and information.

The review is focused on the appropriateness of the chosen strategies and an analysis of the effectiveness of the intervention. It identified key learning areas based on examples of good and bad

¹ Ebola Situation Report - 7 October 2015- WHO

practice and made recommendations for possible future best practices. The time period reviewed starts from the 1st March 2014 to 31st March 2015.

The full ToRs are available online from: <http://evaluation.msf.org/ocb-ebola-critical-review-work-page-1>

EVALUATION METHODS & LIMITATIONS

The information and data collection consisted of a series of interviews with key individuals, feedback from the other sectors of the critical review, document research through the Knowliah information project and a feedback session on the preliminary findings. Due to the planned MSF International Board (IB) Governance Review, the scope of the OCB governance review was reduced to accommodate the above and focuses on the following:

1. Role of the Emergency Unit and OCB Task Force
2. What role did the governance platforms in OCB play in the response?
3. What coordination role did OCB assume and how was it perceived by other actors?

An additional limitation was the time available due to additional responsibilities as Review Team Leader.

Sourcing information during interviews relied on anecdotal accounts of events and people's ability to recall events that in some cases occurred more than a year ago. It was also not possible to interview everyone involved with the response.

During the document review of OCB Ebola information stored electronically, many records had no dates and the authors were not clear, making it difficult to attribute to a specific time or event.

Interviews in the field were mainly conducted with staff currently working with MSF, or staff willing to come and give time for the OCB review.

FINDINGS

The following findings should be viewed in the context of the very positive feedback regarding the MSF OCB led intervention. The governance review of the OCB led response has been undertaken while considering the following aspects:

- What could have been done better; would OCB make the same decisions again?
- What choices were available and were there alternatives?
- What limited the OCB decision making?
- What role did OCB assume and how will it impact on future decision making?

The complexity of the outbreak (which spread across three countries and touched major urban locations) and the numerous resource challenges (including a lack of Ebola experts) impacted on the governance of OCB's emergency intervention. The lack of experienced human resources played a major role in the decision making process and strategy implementation. This cannot be undervalued when reflecting on the findings outlined below. OCB was fortunate to have several experts in-house, who were stretched between providing inputs on strategy, supporting field operations, providing advice and support to other organisations and playing a reference role. At some stages they were also simultaneously engaged non-Ebola activities or operational management.

EMERGENCY UNIT COORDINATION

OCB and OCG were the first MSF sections to react to the outbreak, initiating an emergency response led by the Emergency Unit in Brussels. The usual process of managing an Ebola emergency through the Emergency Unit was implemented at the start of the outbreak. At the time there were other emergencies ongoing which included Syria, Central African Republic and the Republic of South Sudan, which also required attention and impacted upon the available resources within the Emergency Unit. It was recognised during the interview process² that the transition/decision to move from an Emergency Unit managed response to a designated Task Force management should have been taken earlier. Ideally, the Task Force should have been implemented during June and July 2014. The moment the outbreak reached Sierra Leone has been identified as an opportunistic trigger that should have prompted the switch to a Task Force setup. There are, however, mitigating circumstances in that the outbreak slowed in May giving the impression it was finally coming under control. Unfortunately this did not happen and the number of cases increased again in June/July before exploding in August. In addition to this, there was an issue with the availability of experienced resources to manage such a setup.

During the period March to end of July 2014, when the Task Force was established, some missed opportunities have been identified. While there are several examples of meetings where strategy was discussed and shared within OCB and with other MSF key people, the inter-emergency desk teleconferences did not take place systematically during the first months of the response. In addition the response lacked a crisis info position to collect and share information. This is likely to have contributed to the perception of some that OCB was not open to outside input.

TASK FORCE SETUP

In OCB, the Task Force model is a recognised solution when a focused and self-contained team is required to manage a crisis or operational response. There are no fixed guidelines or structure so that

² Interview OCB Operational staff

each situation requires an organic adaptation to the problem/issue at hand. The timing of the decision to setup the Task Force, i.e. mid-summer, meant that there were limited resources in the headquarters to support the Task Force, especially at senior and middle management. The result being that the support departments were not sufficiently involved in the discussions on the Task Force establishment. This resulted in insufficient involvement at senior/middle management level in defining how each department linked to and supported the Task Force. It is recognised that the flexibility and commitment shown by the teams in the different departments was exemplary.

The decision to switch to a Task Force was taken on July 29th 2014, but then it took six weeks to be fully established and staffed, which occurred at the same time as a significant increase in the number of cases in the three affected countries. The Task Force was limited in size by choice and was composed of an operation manager assisted by advisers (medical, water and sanitation, supply, human resources, finance and communications). On specific issues, the Task Force team was supported by several people based in different departments of OCB headquarters.

While covering the majority of functions, in the first weeks of its existence the Task Force lacked; sufficient medical support, i.e. epidemiologist (joined in October), medical focal point, sufficient advocacy and human resource positions. The operational briefing and debriefing of staff going to and coming from the field was often performed by returned field staff on the 21-day standby in Brussels and therefore changed frequently. The result being that there was no systematic collection of feedback which could be effectively shared with the operational management.

As identified earlier, the Ebola intervention increased the pressure on a very small number of individuals with sufficient Ebola knowledge. One of the roles of the Task Force was to provide technical support, advice or information sharing, not only from within MSF but also to other organisations, such as the Center for Disease Control and Prevention (CDC), ALIMA and Samaritan's Purse. This role of technical referent was on top of the ongoing operational support provided to the MSF field teams.

The Task Force later played an international role in providing backup to all MSF operations initiated by other Operational Centres (OCs). OCB was leading as "expert", with a joint biosecurity team visiting all MSF projects in Guinea, Liberia and Sierra Leone on a regular basis to ensure consistency in biosecurity³. An "on-call line" was setup for all staff at risk of an exposure incident. This contributed to reassure other OCs in terms of biosecurity related issues.

In December, the intersectional Task Force was gradually wound down with the operational capacity of the other OC's increasing. The MSF Emergency Units agreed that each was able to be responsible for their own operations and they no longer needed to be directed by OCB but would use the OCB Task Force coordinator for support upon request⁴. A limited number of positions: coordination of biosafety and investigation, communication and advocacy continued to provide support to all OC's. According to other sections, the Task Force collaboration and work on these issues produced good results (less discussions/conflicts than in other emergencies). Having the Task Force supporting all OCs improved collaboration between them, even if it was also felt that the Task Force was not open enough to discussions and exchanges. There was frustration expressed at time by the some OCs of the lack of debate and especially the difficulty to consider in September-October alternative strategies than the one considered by OCB based principally on setting up Ebola Treatment Centres. This will be explored in a later chapter.

The role and functioning of the intersectional Task Force will be reviewed separately in a review requested by the MSF IB⁵ and therefore not covered here.

³ Refer to OCB Ebola Critical Review; Water and Sanitation Report

⁴ Final minutes RIOD meeting-18th - 19th December 2014

⁵ IB Terms of Reference: Governance

TASK FORCE COORDINATION

The management structure of the Task Force coordination was streamlined and centralised, which resulted in huge pressure on a very small number of positions. This was a specific structural choice with both positive and negative sides. On the positive side, it made decision-making more efficient and allowed for multiple decisions to be taken in a short space of time. On what concerns the negative side, it did not allow for a more open and inclusive management approach and most likely led to some feeling excluded or that the management process was being too protective. One of the reasons provided for the chosen approach was to protect the small number of experts and avoid spending too much time in meetings where their input would be required.

The trust that existed at the time between key individuals within OCB was a major factor in allowing the space and flexibility to manage the response. This cannot be overlooked, especially considering the gaps within the office during the summer at very difficult moments of the response, which will be covered in a following chapter.

While emphasis was placed on reinforcing support positions within the Task Force - such as supply, logistics and medical - no additional positions were opened to relieve the pressure on the Task Force coordinator or the operational director. Considering the length of the response, there were limited opportunities for the emergency unit and Task Force coordinators to undertake field visits due to the workload. While some visits did occur or were supplemented by input from other operational support visits, it would in hindsight have been beneficial to create space and possibilities for more visits.

STRATEGY REFLECTION

One of the criticisms voiced on the OCB response coordination was the lack of availability for reflection on the strategy. The Task Force dealt with an enormous amount of complex issues and had to answer quickly and effectively to critical emergency requests, such as staff member infections. The day-to-day involvement in the response did not leave much space for reflection on larger strategic issues. During interviews both with field staff and other OCBs, there were regrets that discussion on alternative strategies or modus operandi was limited.

The lack of support to the coordination positions and the small number of experts meant that the opportunity for reflection was even more limited. This was particularly highlighted through the communication and advocacy component of this review⁶, which identified insufficient coordination between operational objectives and advocacy strategy. Through planned or *ad hoc* strategic reflection moments, a more streamlined approach could have been possible. From the medical perspective, it was felt that there was little space for exploring or pushing the boundaries within the accepted Ebola response strategy. Again, though planned or *ad hoc* reflection moments, the implemented strategy could have been questioned, examined and adapted with the participation of relevant key persons (whether from within OCB, MSF or other organisations). This last point is disputed as other organisations were contacting OCB for strategic advice.

At the end of the summer, the RIOD discussed the installation of a “comité des sages”, a group of senior people of the operational centres reflecting on critical topics such as quarantine and home-based care, as well as advising on designing medical and advocacy strategies for the Task Force. This was considered, but attempts, with the support of OCB, to establish a committee came to nothing.

⁶ SEU OCB Ebola Critical Review; Communications and Advocacy Report Dec. 2015

In November 2014, a quick review⁷ was undertaken by the MSF International Secretary, which interviewed 10 key persons within MSF and which was presented to the RIOD and IB. The quick review identified the need for the Task Force coordinator and operational director to have additional support and recommended the development of an operational strategy paper which would have been shared within MSF sections. The review, while commending the work of both the Emergency Unit Coordinator and Task Force Coordinator, noted that the "MSF beast was heavier to manage than other operations".

REGIONAL COORDINATION

There was no regional coordination as such to avoid an additional decision-making layer that would have slowed down the information sharing and decision-making process. A number of field staff highlighted that it would have been useful to have a better information sharing system between the Guinea, Liberia and Sierra Leone, as well as a sharing mechanism for technical support.

NATIONAL COORDINATION

The role of national coordination within an Ebola response is very important and it is crucial for an MSF response to be a part of the coordination structure. *"MSF should participate from the first day to the last"*⁸. At a country level, MSF played a key role in coordination activities, even if sometimes it was perceived as too rigid or too dogmatic, i.e. limited willingness to accept ideas from non-Ebola experts or to experiment with activities considered outside the normal Ebola response modalities. It was identified that better communication and coordination between OCB, potential partners and national authorities was required at different stages of the intervention. Within this response the lack of an effective participation of WHO in the central coordination of the response put a greater responsibility and pressure on MSF to take the role of coordinator, which under normal circumstances would not be its responsibility. When the situation in Sierra Leone and Liberia deteriorated, this exacerbated the human resource crisis and stretched MSF to its limits.

The positioning of MSF towards the national coordination systems was different in the three countries.

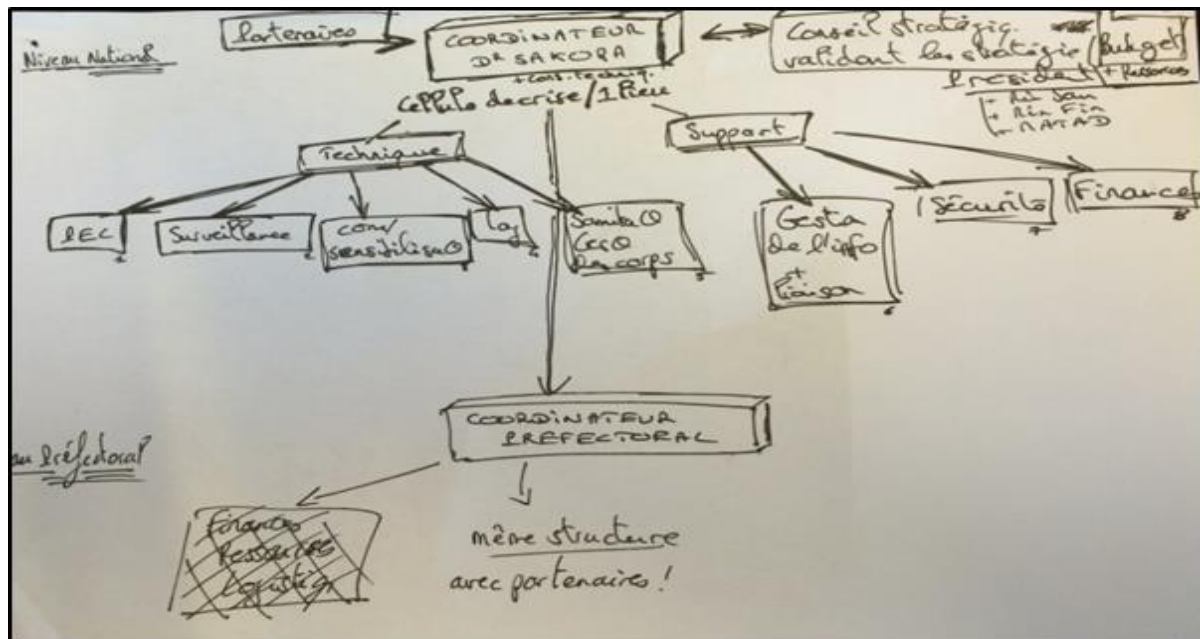
In **Guinea**, OCB played a key role in the technical support to health authorities, which became a unique model for other players on many different fronts and sectors of the Ebola response⁹. OCB was the motor and catalyst for the creation of strategic coordination mechanisms for the response in Guinea.

⁷ Powerpoint presentation to the ExCom and IB: Ebola intersectional collaboration – Final quick review; Jerome Oberreit, November 2014

⁸ Interview OCB Taskforce

⁹ Visit report - Guinea Ebola Emergency project Tom Decroo LuxOR, MSF – Luxembourg, Brussels Operational Centre

Picture 1. Coordination structure and organigram created by MSF OCB and the health authorities in Guinea at the beginning of the epidemic



The heavy involvement of OCB in the response coordination was a difficult role to manage especially for the Emergency Coordinators, splitting their time between the national Task Force liaison and the MSF emergency programme coordination. The reality for those involved, in the absence of the WHO coordinating the response, alternatives were limited. As advocacy was not having the required results and actors were not coming on-board to manage the response centrally, there was few other options for MSF. This dual role which was required did impact on the OCB operational response and was often played by one position. The lack of experienced liaison positions definitively impacted on this support role.

In **Liberia**, with the lack of WHO capacity and the state of urgency from early April up to October, MSF was initially heavily involved in the design and coordination of the overall response. OCB initially added dedicated resources to perform the liaison role which became less pre-eminent with the arrival of other actors. Due to the lack of leadership from WHO, OCB's role was mostly directed to provide advice on the design of the response. MSF was also very present in many coordination and technical meetings at national, county and local levels. As more donors and actors (NGOs and UN) arrived in Liberia in October/November, the challenges of coordination became even more acute, with numerous coordination meetings being simultaneously organised each a day and the lack of coordinated response and even competition for operational space among different NGOs and partners. As in all the countries, by December MSF started to withdraw from some of the coordination mechanisms for fear that its presence would or could stop the participation of others.

In **Sierra Leone** MSF was also present in the national coordination of the response and in technical meetings. Like in Liberia, when more actors came on the ground, the role of MSF at the coordination table became less central. Although OCB was respected for extraordinary input in the response and its willingness to speak out on behalf of affected people, questions were raised by a number of interlocutors during the review team's field mission regarding the official OCB position on a number of issues. In particular, an episode mentioned by a number of interlocutors was the criticism voiced by an MSF OCB staff member during a meeting at the National Centre in Freetown regarding the national

government's decision to institute mass quarantine regulations¹⁰. The MSF staff member was asked to stop attending the meetings and was replaced by another representative. For some this was incident was seen to have soured relations and coordination with the national Task Force¹¹. This incident occurred during the handover of the OCB projects to OCA, and may have together with the departure of OCB from Sierra Leone contributed to the participation in the coordination effectively stopping. This was later seen as a negative fact and a missed opportunity. It also goes against the usual Ebola response strategy, requiring MSF to be part of the coordination from the first to the last day of the response.

While much was done with regards to participating within the coordination of the response in the three countries, the role is quite specific. It is not an *"MSF T-shirt and jeans"* position and requires a certain experience, knowledge and liaison skills which are not always readily available within MSF. The HART, based and coordinated by the IO, while possibly the perfect body to play this operational role, does not have the necessary capacity or function. A similar role was undertaken by the HART position based in Asia during the Philippines typhoon response in 2013 and it was very effective and appreciated. This concerned, however, only one country for a short period of time, not three countries over 18 months.

OTHER INTERNATIONAL ACTORS

The general perception of OCB by external actors, as experienced during the Dakar workshop and interview process, has been overwhelmingly positive. As other actors and institutions participated to the Ebola response, additional support and input/advice was requested from MSF. Through its activities and expertise, OCB was looked at by external organisations as the technical reference for the Ebola response. When considering the scale of the intervention, this added another layer of responsibility, coordination and workload on top of what was already a difficult situation. It should also be noted that the role of technical reference implied several different layers and not all the technical requests were obvious. With the guidelines not always providing the relevant answers and the operational challenges causing new and sometimes unexpected consequences, all who played a technical role should be commended.

Training was a major activity and MSF was involved in the formation of other organisations' staff both in Europe and in the field. In ELWA 3, International Medical Corps (IMC) staff were trained and supported to allow them to begin their own medical operations. A knock-on effect of this was that IMC subsequently established their own training programme and trained other organisations, which helped speed up the ability of other actors, as for example the International Rescue Committee (IRC), to respond.

MSF's intervention in Foya, which included the setting up of an ETC, outreach and health promotion activities, was a good example of collaboration between MSF OCB, MSF OCG, the INGO Samaritan's Purse and the Liberian Ministry of Health (MoH). Although two of the staff members of Samaritan's Purse became infected leading to the interruption of its operations, this intervention model demonstrated the value of collaboration between MSF, another NGO and MoH staff to be able to implement the overall Ebola intervention strategy. Even given the difficulties encountered by Samaritan's Purse in Liberia, this intervention is generally regarded as an outstanding success by MoH, Samaritan's Purse and others.

From September 2014, OCB ran training of staff from other organisations and of seconded government staff. For figures and data related to this activity, please refer to the Human Resources component of

¹⁰Interview with EOC National Operations Coordinator

¹¹ Interview with Deputy Chief Medical Officer

this review¹². This activity was highly praised by all interlocutors from these organizations the review members were able to discuss with. The majority of training was carried out in Europe. In Liberia, the MoH requested OCB to carry out a more comprehensive training of its staff. This was however refused¹³ due to the lack of availability of personnel to undertake the support. Training of MoH staff was then conducted by WHO without the participation of OCB.

In terms of relations with WHO, despite the history of common work on the Ebola response and despite MSF's calls, there were difficulties in getting them on-board at the right level. There was even a partial denial from WHO on the severity of the crisis. Later on, collaboration took place at field level -with more or less success depending on people on the ground - and at Geneva level with the involvement of MSF's IO.

OCB GOVERNANCE

The Ebola outbreak occurred during a very difficult period for MSF OCB. During the first months of the outbreak, March to Mid-May, the Syrian kidnapping of MSF staff was very intensive and a major focus of the organisation. Following the release of the last staff members this did not signal the end of the crisis and additional follow up activities were required to close the crisis team. The whole episode absorbed the focus of the senior management representatives of the organisation, including the General Director and President. As a result, it has been stated, that following Syria, there was a certain emotional fatigue and combined with the summer holiday period, there was a lack of senior and middle management representation within the office.

The situation has been described as a 'frog in boiling water', i.e. when you realise the scale and size of the situation it is already too late. During the summer, until the end of August, there was a lack of representation at the Committee of Directors (Co-Dir) of OCB, in part due to Syria but also, both the communication and human resource departments were transitioning between directors. While the gaps were covered, it was not the perfect scenario. The Co-Dir was effectively bypassed because of a lack of a functioning platform. This does not mean however that the consequence of this was negative in relation to operational support. In the opinion of some operations staff, this allowed for quicker decision-making, emphasised the trust and respect the different positions had for each other and placed an extra responsibility on the support department teams to fill the gaps, which they did.

Whether these gaps and lack of management representation impacted on the delay in reflection on mobilising other MSF sections or advocacy strategies to other actors is difficult to ascertain. There was representation to the RIOD platform as well as teleconferences from Liberia during this period as well as other initiatives. With the full management being present from late August and early September, there was additional support available and discussions on strategy.

OCB and MSF Belgium boards

During the outbreak, at several stages, briefings and updates were provided. The first time this occurred was in May 2014 where the issues regarding biosecurity and risk for staff were discussed extensively. As with the Co-Dir, the Syria kidnapping had an impact. In July, briefings provided by the Emergency Unit

¹² SEU OCB Ebola Critical Review; Human Resource, Training, Briefing and Debriefing and Duty of Care report December 2015

¹³ Interview with Head of case management pillar, IMS, Liberia

highlighted that the situation with Ebola was worse than previously thought and more resources were needed.

Missed opportunities were identified between the Co-Dir and IB in sharing information/requests for assistance. The OCB president represented OCB at the IB in relation to Ebola. Ebola was discussed at this level but not in-depth. The role of the IB and other MSF governance platforms will be covered in the IB requested governance review¹⁴.

The release of the internal MSF letter, which criticised aspects of OCB's response and was also published externally, had serious implications for cooperation between individuals and offices of or related to MSF. It soured the atmosphere and effectively ended much collaboration. The full IB rejected the letter, including the three members that signed it. The process and impact should be covered in more detail by the IB governance review. Suffice to say that, from an OCB perspective, it had an operational impact not only in sharing of information and openness but, more importantly, on the moral and team spirit of the field missions.

OCB DG9

The DG9 is the platform composed by general directors of the nine OCB partner sections. It was questioned whether the members of this platform could or should have provided additional support during the summer months of 2014, when gaps in the senior management of OCB were evident. There is no formal agreement to use members of the DG9 platform in this manner and, while there could have been possibilities, few of the members have sufficient operational experience, therefore lacking operational credibility.

Departments

It is clear that the support departments played a crucial role in supporting the Ebola response with many of the staff undertaking field visits and missions. However, as highlighted earlier, the gaps during the summer months did impact at times on the implementation of the different strategies, most notably on the aspect of reinforcing the departments sufficiently to ensure key individuals were able to separate their normal ongoing work portfolio from that of full-time satellite/support positions for the Task Force. As a consequence, many positions were overloaded and other operational needs could not be satisfied. The office administration was very flexible and supportive of the Task Force needs -such as extending/stopping contracts - and this was highly appreciated.

It is important to note here also that while many support staff filled gaps in the field, they seldom could take a break after a field mission and slotted straight back into their normal office functions. This issue is expanded upon more in the Human Resources section of the MSF Ebola Review. Suffice to say that during the peak of the outbreak, the work of the headquarters staff cannot be commended highly enough. The logistics department asked other sections to second logistics staff to work within the OCB logistics support department, but this did not materialise. The OCB office was central in supporting the response, whether through the lobbying of Brussels Airlines, the Belgian government, by ensuring a flow of information to the general public, organising medivacs and staff health support, to name but a few.

¹⁴ MSF IB Ebola Governance Review; Terms of Reference Nov 2015

CONCLUSIONS

EMERGENCY UNIT AND TASK FORCE

There was a significant pressure on both the emergency unit and Task Force because of the limited number of Ebola experts available to provide support and advice amid the numerous requests that were received on top of the already high operational workload. During an extended emergency, there is a need to reinforce coordination positions managing the response. This is crucial to ensure that focus can be put on the bigger picture and not the administrative or basic implementation issues.

While there are mitigating factors as explained in the findings, in large scale emergencies the use of a Task Force should be part of the planning from the beginning and it should be constantly evaluated to avoid any delays in implementation. It is unclear whether it is feasible or not to establish thresholds or criteria automatically triggering the implementation of a Task Force setup in an emergency such as this Ebola outbreak.

HUMAN RESOURCES

Any Task Force should be adequately staffed from the outset. The lack of availability of key management positions during the summer played a part in the Task Force setup. Sufficient medical, communications/advocacy and briefing/debriefing are key to success.

It is important to ensure adequate investment in human resources capacity to allow for a clear focus on the tasks ahead and to separate daily ongoing tasks from Task Force/emergency unit support, especially at a departmental level. The request made by logistics to other sections to second staff to support the response should be acceptable within MSF.

Secondly, it is necessary to reinforce the management positions with support roles where daily tasks and responsibilities can be delegated. The failure to do so can be seen as having impacted on certain aspects of the intervention.

REFLECTION

It is important in an extended emergency to ensure moments of reflection, whether on strategy, setup, resource requirements or advocacy and communications. In the case of this emergency, many decisions were taken quickly due to necessity, often life-saving, especially during the period of August to October many informally in "*corridor conversations*". While this has its positive aspects, it does not provide to the space for challenging/discussing strategies, which an organisation such as MSF often requires. While the need for reflection when there is a limited availability of experienced actors is a recognised conundrum, the importance of reflection should not be underestimated. Not all reflections require Ebola experience. More could have been done to challenge the existing strategy, especially in what is possible within the accepted response model.

Reflection should not be done to tick a box but only when required to step back and look at the bigger picture.

NATIONAL TASK FORCES

OCB position within national coordination and its support to the national Task Forces was well appreciated but, at times, it lacked the necessary resources and skills to adequately fulfil this function/role. There must be a clear understanding by all, of the importance to be present in the national Task Force from the first to the last day of the response. In the absence of other actors, OCB needs to ensure its continued participation, which should be as interim and back-up, not as a permanent replacement of others. The question of whether OCB should have coordination responsibility over other organisations or not is still to be debated. While MSF does not have this mandate, when it becomes by default a technical referent and response leader, this may be unavoidable.

INTERNAL GOVERNANCE

The situation during the summer of 2014 could have been described as the “*perfect storm*”. The consequences of the kidnappings in Syria, the change of both human resources and communications directors, and the simple fact that it was summer, did impact on the global strategy. Opportunities to ensure external coherence in the mobilisation of the response within MSF and in the external advocacy strategy were missed. The normal reflection and discussion at a senior level did not take place as often as would normally have been the case in a major crisis until after August. In future crises this aspect should be re-emphasised.

EXTERNAL ORGANISATIONS

The response, role and implemented activities towards other organisations was highly appreciated and instrumental in ensuring that other actors had the basic capacity to intervene.

Regarding the ongoing consultation and discussion on the WHO reform, for MSF legitimacy to be critical in the future, it is important that MSF takes part to the process. At present, MSF has participated in different discussions on the WHO reform, particularly through panel discussions focusing on what WHO needs to do to be prepared for the next epidemic.

MSF will need to think about its role and its responsibilities for the future. The leadership in Ebola created unseen expectations towards MSF. MSF can use this position, if desired, to be a catalyst for change, especially within the emergency humanitarian aid sector. Following the critic in the “*Where is everyone*” and the report “*Pushed to the Limit and Beyond - A year into the largest ever Ebola outbreak*” reports, and now with the aftermath of the Ebola response, MSF has a unique opportunity to open up dialogue with key actors to better understand the humanitarian aid emergency infrastructure and their priorities for the future.

RECOMMENDATIONS

The following recommendations are limited to the top three which are defined as the most important:

- ⇒ Provide a sufficiently robust investment in human resources support:
 - a. Provide coordination management support positions.
 - b. Separate the functions of emergency unit/Task Force support positions from the day to day responsibilities.
 - c. Ensure sufficient resources allocated to the Task Force setup, especially relating to advocacy and communications, medical/epidemiologist and briefing/debriefing positions.
 - d. Invest/expand the formal liaison capacity within OCB or HART (IO).
- ⇒ Ensure adequate reflection moments during a long emergency whether at an operational strategic or response governance level. This should include the timing and criteria for mobilising a Task Force.
- ⇒ Be a catalyst for change: organise a roundtable with key actors from the humanitarian emergency sector to discuss future response capacity and availability of resources.

Additional recommendations

- ⇒ Better organisation of vacation planning at middle and senior management level during key moments of the year like summer vacations.

ANNEXES

ANNEX I: TERMS OF REFERENCE

<http://cdn.evaluation.msf.org/sites/evaluation/files/attachments/governance.pdf>

ANNEX II: LIST OF INTERVIEWEES

Many additional persons gave information through other parts of the OCB Critical Review which was used to feed the governance information collection process. Therefore the list below is not exhaustive.

[First name Last name, Title]	[Function]
Brice De Le Vingne	OCB Operational Director
Rosa Crestani	Task Force Coordinator
Marie-Christine Ferir	OCB Emergency Unit Coordinator
Dr Bertrand Draguez	OCB Medical Director
Stephan Goetghebuer	OCB Deputy General Director
Renzo Fricke	Cell 1 Coordinator
Dr Jean-Clement Cabrol	OCG Operational Director
Meinie Nicolai	OCB President
Francesco Checchi	Save The Children UK
Henry Gray	Task Force Coordinator
Megan Coffee	IRC
R. Cummings	Save the Children
Stuart T. Nichol	Chief, Viral Special Pathogens Branch, CDC

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