



OCB EBOLA REVIEW

Part 3: Human Resource Management

[December 2015]

This publication was produced as part of a broader review on OCB's response to the Ebola emergency. It was independently prepared by **Pierre Beurrier, Gillian Dacey and Virginie Gentien Adams**.

DISCLAIMER

The authors' 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

CV	Curriculum Vitae
EBC	Espace Bruno Corbe
E-pool	Emergency Pool
ETC	Ebola Treatment Centre
FHF	Filovirus Haemorrhagic Fever
HoM	Head of Mission
HP	Health Promotion
HQ	Headquarters
HR	Human Resources
IPC	Infection, Prevention and Control
MedCo	Medical Coordinator
MoH	Ministry of Health
NGO	Non-Governmental Organisation
OC	Operational Centre
OCA	Operational Centre Amsterdam
OCB	Operational Centre Brussels
OCBA	Operational Centre Barcelona
OCG	Operational Centre Geneva
OCP	Operational Centre Paris
PPE	Personal Protective Equipment
R&R	Rest and Relaxation
RITE	Rapid isolation and treatment of Ebola
SHU	Staff Health Unit
SITREPS	Situation Reports
TF	Task Force
USB	Universal Serial Bus
VHF	Viral Haemorrhagic Fever
VIP	Very Important Person

EXECUTIVE SUMMARY

People are at the heart of operations in every organisation, and the case of MSF Operational Centre Brussels' (OCB) response to the Ebola epidemic in West Africa during 2014/15 was no exception. Demands were placed on staff; not only on those managing the response in Brussels, but also on the international staff deployed in the field, and most significantly, on national staff in the affected countries – Sierra Leone, Liberia and Guinea.

The four key areas covered in this report are i) mobilisation of staff, ii) duty of care for staff, iii) training, and iv) briefing and debriefing. The review covers the period from 1 March 2014 to 31 March 2015.

An outstanding mobilisation of human resources

A total of 689 international staff from over 70 countries and more than 4,000 national staff worked on 20 projects during the OCB Ebola response. There were 949 international staff departures of an average length of 36 days. Intense media attention on the Ebola crisis, MSF's response, and a strong dynamic in MSF's social networks, helped mobilise many staff who had previously worked with MSF. A maximum duration of six weeks in the field was designed to minimise risks due to exhaustion and diminishing attention. However, there seems to have been a tendency to compensate for this time limit by working long hours with few breaks.

National staff acquired experience about the Ebola response on a large scale, because they worked in projects for longer periods of time. However, investment in increasing their capacity or promoting them to positions with more responsibility came late and were limited.

Health and safety well managed, but not the same for all

The staff health unit played a key role in ensuring staff safety and support, with the development and implementation of policies such as pre-departure briefings, compulsory malaria prophylaxis and a no-touch policy in the field. There were a number of work-related incidents. In total, there were 28 Ebola cases and 14 deaths among staff. Of the 28 cases, three were international staff, all of whom survived. Each exposure incident was systematically investigated, and in most of these the source of the contamination was believed to have been outside the MSF working environment – though in many cases this remained unconfirmed.

While access to general healthcare during the Ebola outbreak was of the utmost importance for national staff and their families, often the implementation of this was delayed. Partly this was due to the workload of the medical coordinators whose responsibility this was. A major limitation of the non-regular "daily worker" and sub-contracted staff contracts was their lack of access to MSF healthcare and the additional loss of income in case of illness, which was an unrecognised risk.

There is a striking disparity between the safety principles and employment policies, including breaks, for international staff and national staff. This issue deserves debate.

Most stressful mission ever

The most significant stress factors for staff were the fear of infection of oneself, one's colleagues or one's families; stigmatisation; the unavoidable exposure to death and suffering; and the difficult working conditions. Stigma was an issue for all staff, resulting in isolation from family and friends, and bringing the risk of aggression towards national staff. However, there was very positive feedback from both national and international staff regarding the quality of the teamwork and the support received from headquarters.

Staff health clinics proved to be key to reducing mental stress and as a motivating factor for the early reporting of symptoms.

Most Extensive knowledge transfer in MSF's history

MSF became the "go-to" organisation for information and advice which resulted in, what one MSF staff called, the "most extensive knowledge transfer exercise in MSF's history". Training formed a key part of the OCB response to Ebola, with staff safety at the core of the programme. There was a significant sharing of Ebola-specific information, as well as mentoring and advising other INGOs and members of the international community throughout the course of the epidemic.

An "*Ebola first responder training*" was launched in Brussels which ran from August 2014 to February 2015, while similar trainings with other organisations were initiated in the field. The decision to also hold it in Brussels and open it to other actors was key in this response. It enabled the scale-up of the response, both within OCB and MSF as a whole, as well as facilitating the deployment of other humanitarian actors. Due to delays caused by unsuccessful attempts at delegation and collaboration, this training in Brussels did not start until September, when the outbreak was already out of control.

The content of training delivered to national staff in the field was reliant on the experience and knowledge of international staff. With the constant turnover of staff in the field, and little understanding of the specific requirements for adult learning, this resulted in poor consistency in training and how procedures were interpreted. One attempt to address this was the production and dissemination of online training videos.

Briefing and Debriefing: opportunities to inform and be informed

Pre-deployment briefings were provided to international staff prior to departure, generally at the OCB office in Brussels. These formed a core part of MSF's response to Ebola, both in operations and also as part of staff welfare. In all stages of emergency response, there is a requirement to receive accurate information from the field to enable effective crisis management. The Task Force was hindered by the variability in the sitreps, reporting and briefing from the field. Instead it relied on debriefs from returning international staff for current operational information on field operations. There was a series of three debriefings for returning staff, and it was particularly important for international staff experiences and views to be heard on return.

Lessons learned and recommendations

The lessons learned on the different areas of Human Resource (HR) management are thoroughly documented in this report. Recommendations are addressed to the HR department, the training unit and OCB management. HR specific recommendations address the definition of policies for national staff

in emergencies, a minimum package of regulations for subcontracted staff, maintaining return talks, models for HR administration that are adjustable and replicable to different emergency situations, and better HR data analysis.

Recommendations on training point to the need to align policies for international and national staff; to include cultural awareness and communication; to invest in 'training of trainers' and to ensure appropriate adult teaching methods are applied.

General recommendations for OCB management are to develop tools and processes to share innovations and manage incidents; to have a transparent investigation process in cases of staff contamination and to include HR data more in decision making and planning.

BACKGROUND

OCB's response to the Ebola outbreak in Western Africa has undoubtedly been complex and challenging. Questions have also come up about whether the choices made were timely and right. This is why OCB management has commissioned an extensive multi-sectorial review of the intervention.

The review looks at the time period from 1 March 2014 to 31 March 2015. It identifies key learning areas based on examples of good and bad practice and makes 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

Within the HR function, training, briefing, debriefing and the duty of care formed a key part of the MSF OCB response to Ebola, with staff safety at the core of the training practice. This Ebola epidemic was unique in many ways and the requirement to train large numbers of personnel in the field meant that training was needed for people with no previous Ebola experience over a short period of time.

MSF found itself in a unique position at the start of the epidemic, as a leader in Ebola knowledge and field operations. It became the 'go-to' organisation for information and advice. The MSF response to the Ebola epidemic resulted in the most "extensive mobilisation of people", both national and international staff, and the "most extensive knowledge transfer exercise in MSF's history" (MSF Ebola report, 2015).

This review of resources mobilisation, training, briefing and debriefing, and the duty of care for OCB from March 2014 to March 2015 covers a number of key areas that were identified as part of the HR terms of reference:

- Appraise the HR strategy and governance process
- Identify the processes and challenges around implementation of the 1st Responder Training
- Identify the training programmes available for national staff
- Review the resourcing of training, and any constraints and difficulties encountered
- Develop processes for the identification of training needs and requirements
- Review the safety measures implemented to protect staff
- Review the prevention and management of stress specific to an Ebola mission, including mental health support and addressing the issue of stigma.

The terms of reference outlined by MSF OCB for this component of the review are in Annex 1.0. This report contains four sections – mobilisation of resources, duty of care, training, and briefing and debriefing.

EVALUATION METHODS & LIMITATIONS

METHODOLOGY

The methodology for the HR components of the review used several techniques to source information. Initially a document review was conducted using the MSF Knowliah database to search relevant OCB documents and emails for information created during the response to Ebola. Files containing personally identifiable information were removed and not used for the review. HR databases were accessed for statistics regarding staff deployments and training.

Interviews, both individual and group discussions, formed a key method of collecting data from staff working on the Ebola response. Interviews were conducted with national staff in Guinea, Liberia and Sierra Leone who worked in a variety of roles. International OCB staff were also interviewed who had been involved, working either in-country or at OCB offices in Brussels. A number of people who worked with external organisations or other MSF operational centres (OCs) were also interviewed. In total, approximately 60 people were interviewed. The lists of interviewees are in Annex 2.0.

A web-based survey was sent out to OCB staff who had worked either in training at OCB EBC, at the OCB HQ, or in the field and who had attended the EBC training as either participants or trainers. The general survey was sent out to all OCB staff who went on an Ebola mission. A further training-only survey was sent to all trainers and participants of the OCB 1st Responder training (external to OCB). There were 250 respondents to this survey.

LIMITATIONS

Sourcing information during interviews relied on anecdotal accounts of events and people's ability to recall events that in some cases occurred over a year previously. It was 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 unclear, making it difficult to attribute them to a specific time or event.

In some situations the language barrier was a challenge. One of this report's authors does not speak French, so the investigation in Guinea was carried out by the other HR team members. Key French documents were translated using Google Translate where possible and clarified with a review member.

Interviews in the field were mainly conducted with staff currently still working with MSF.

Due to time constraints, priority was placed on interviewing staff who were in direct contact with patients. As a result, house and office staff were not interviewed.

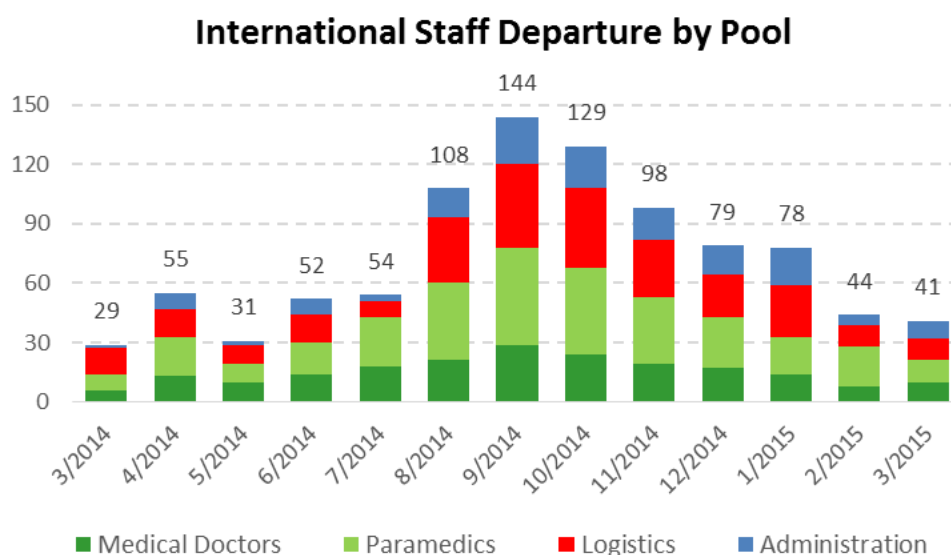
FINDINGS

MOBILISATION OF HR RESOURCES

The Ebola response is the most important mission ever conducted by OCB in terms of volume of mobilised staff from a national and international perspective, illustrated by the following figures:

- 689 international staff from over 70 countries
- 949 international staff departures (260 staff went on more than one mission)
- 56% of departures were medical or paramedical staff
- 134 international staff (full time equivalent) and more than 4,000 national staff mobilised on 20 projects globally
- Average mission duration of 36 days

Figure 1: International Staff Departure



This exceptional mobilisation was further complicated by the many factors that had to be considered in order to ensure the safety of personnel.

Initially, OCB gave priority of departure to international staff with Ebola experience. Due to the scale of the response, experienced MSF volunteers without specific Ebola background were also recruited from the beginning to complete the teams. Although OCB stuck broadly to the principle of “no first MSF mission”, some exceptions were made in order to scale up, especially in August. This equated to around 8% of staff on a “first (MSF) mission” being sent to an Ebola project in the field.

A very specific staff health policy (see Part 2 of this report) was implemented for the Ebola response, including a maximum length of field stay (six weeks), a 21 day follow-up after return, the organisation of Schengen visas for all international staff whose residence was not near to a reference hospital, etc. MSF chose to ensure safety and professionalism by deploying the most experienced staff to conduct this operation. This was the focus of the HR strategy signed off by the Task Force, and was also the main reason for the limitation of the HR capacity.

Restricting deployment to only the most experienced staff had limitations. The policy of "experienced staff/short mission" resulted in depletion of the HR pool. To counter this, there were repeated calls for the mobilisation of (former) international staff, first by pool managers from all sections, then by the directors of OCB, and finally by MSF's International President. The high levels of media interest in the Ebola crisis, MSF's response, and a strong dynamic in MSF's social networks, reinforced those calls.

International staff who had been on several missions (some up to nine) express "pride" in having participated in this operation, but they also admit that the experience was "intense" and "difficult". While they have "learnt a lot", some consider that this mission was their most "dangerous," and they knew that they often "exceeded their limit".

The following two chapters address important observations with regard to the HR mobilisation: the priorities of HR management during Ebola (departures, training and duty of care); and the unprecedented mobilisation capacity, marked by great flexibility of resources and innovations.

HR Priorities

During the Ebola response, responsibility for decision-making was at first shared between the director of operations and the head of the emergency unit. From August 2014 the head of the Task Force took over responsibility.

The operational decision-makers, despite repeated requests by the HR director for a wider remit, wanted HR to focus on three main priorities: 1) the departures, 2) the training and 3) the health of international staff.

The OCB HR director, reinforced by most of the HR management team, believed that a wider investment of the HR function was necessary within the Task Force. However, the HR representative in the Task Force focused on very defined issues of matching, contracting and the field team composition, without the capacity for more strategic issues such as the anticipation of HR policies for national staff, who formed over 97% of the work force.

The proposal to send volunteers on short-term contracts (36 days on average) attracted and enabled the involvement of many volunteers, some of whose previous experience with MSF was not recent. With restricted HR capacity within the Task Force and the short duration of international staff missions, the consequences for HR's ability to support staff were important in the following ways:

1. Supervision of and collaboration with national staff was more difficult
2. The number of briefings and debriefings, conducted in the HQ, was very high, with more than 10 briefings and debriefings per day between August and December 2014. This meant an immense workload for the Task Force, and the flow of information and lessons learnt coming from debriefings could not be comprehensively absorbed by the emergency unit or the Task Force.
3. Short-term international staff postings in the field, compounded with lack of capacity in the Task Force, led to HR issues for national staff, mainly concerning contracts and salaries. In some cases, this led to competition with other organisations for national staff.
4. Finally, HR data could not be compared to the medical, operational or financial data, because the structure of the different analytical functions did not match.

HR Flexibility and Innovation

While OCB had the lead on the Ebola response, it also received the support of all MSF sections in terms of HR mobilisation. The dynamic situation meant it was difficult to precisely project HR needs. It was common for international staff to be briefed to go to one place and end up in another.

As stated by the operational management team, during the Ebola response all other MSF programmes maintained their activities with fewer resources and support. With a very high level of unfilled positions (6.9%), the mobility policy was a concrete solution to decrease the pressure on HR. More than 55 people relocated from their current mission to the Ebola response.

International positions were replaced by national staff where their experience and qualifications were sufficient, or where they could be reinforced through coaching and training.

The next chapter on duty of care explains in more detail some of the initiatives and innovations that have contributed positively to HR management.

In Liberia, instead of waiting for a recruitment request for national positions to be made, an early and anticipatory recruitment system was established by simplifying the process to three steps:

- Step 1: the selection of candidates by sector, through the use of Curriculum Vitae (CVs) and recommendation letters.
- Step 2: training and briefing candidates on MSF's activities and Ebola.
- Step 3: contracting the candidate needed for the implementation of activities.

One particular element that helped to improve HR support in the Ebola response were the many field visits that improved coordination and helped the Task Force to identify areas for improvement.

Conclusions on mobilisation of HR

This unique mobilisation of international staff within OCB has undoubtedly created an "Ebola generation". Many staff built up very specific experience and were proud to work with OCB on this mission. Without maintaining this high level of HR resource mobilisation and capacity over a prolonged period of time, the achievements would not have been accomplished. During the response, personnel showed incredible flexibility and went beyond reasonable limits expected of them.

The global HR contribution, despite fluctuations in the dynamics of the emergency, underestimated the importance of national staff who formed 97% of the work force as well as their right to equal support. Without the commitment and input from national staff, nothing could have been achieved.

Continuous improvement needs to exist in MSF over the long term by establishing guidelines that are reviewed regularly, by training and information transfers, and, over the short term, through field visits. It is not possible to identify one system for improving HR practices that allows players to offer real-time improvements to share beyond their unit, project or domain.

There is no formal communication channel within OCB to centralise alerts. There is no regular and official platform responsible for dealing with recurring HR managerial incidents, but it is important to have this in place for the efficiency of the response.

It is not realistic to ask the people who have to react quickly to a situation to also take the necessary time to define the best strategy. Yet this was the case during the Ebola response.

Recommendations on mobilisation of HR

1. **Merge data analysis systems for both international and national staff** in order to consider these two groups as complementary, and use the same analytical structure as finance and other departments, especially at project level.
2. **Develop and implement new models for HR administration** that cover regional, multi-sectorial and multi-actor issues that are adjustable and replicable in different situations, including contracts, staff compensation, and insurance benefits.
3. **Develop tools and processes to share innovations and manage incidents**, including a capacity to filter the most important and the most urgent information.
4. Operations department to include HR data and prospective analysis to form part of decision making and the planning process.

DUTY OF CARE

As an employer, MSF has a duty of care to its employees, meaning that MSF should take all steps reasonably possible to ensure their health, safety and well-being. MSF OCB is signatory to the document MSF Social Employer¹, which includes the following:

- Responsibility: a socially responsible organisation which places people at the centre of concern.
- Health and safety: MSF continually develops and reviews adequate health and safety policies to protect staff working in the field and on its premises.
- Minimising risks: MSF has an obligation to minimise the risks for its staff.
- Fairness: equity in terms of balanced treatment for all HR matters.
- As a responsible employer, MSF provides its employees with the opportunity to evolve and progress in a professional capacity.

Staff Health Management

The MSF OCB Staff Health Unit (SHU) was created at the end of 2011 and it played a key role in the Ebola response. In May 2014, the SHU had finalised the safety procedures to put in place for international staff. The Lassa fever guideline was adapted for the Ebola response, and the following measures were implemented:

- Pre-departure health briefings (initially done by SHU, then delegated to HR)
- Compulsory malaria prophylaxis and immunisation
- Request of a Schengen visa for all non-European international staff
- Identification of referral hospitals for international staff returning home, in case of fever or Ebola symptoms
- Systematic return talk: meeting with a psychologist at the end of the mission (this used to be optional). Health debriefing and 21-day follow-up, with one contact person available (by phone) 24 hours a day in case of symptoms
- Coordination of staff health policies with other OCBs

¹ Internal document: MSF as a responsible employer, February 2009

Two other complementary measures were implemented by the OCB Operation coordinators, following their previous Ebola experiences:

- No-touch policy in the mission
- Duration of mission: six weeks maximum

There was extremely positive feedback from HQ and international staff on the quality and relevance of the work achieved. Some figures from the survey illustrate the importance of the SHU's role:

- 86% of survey respondents had a health briefing and 83% had a health debriefing. SHU staff believe that of those who did not receive debriefings, a considerable number were HQ employees.
- 15% of the respondents said that the 21-day follow-up was a high or very high source of stress, with 21% reporting that fever in the 21 days was highly stressful. However, interviews showed that people felt well supported by the SHU team when they returned.
- Out of those who said they had a return talk, 45% were men and 55% were women. 82% said that psychological support was an effective way to prevent and deal with stress. In the interviews, people responded positively to the fact that the return talk was "normalised". This resulted in staff feeling more comfortable about going on an Ebola mission. For HQ staff, MSF recruited a psychologist, who in one year, saw 145 people, including 26 people who came back from an Ebola mission. This position is said to have changed the culture, and people seemed less hesitant to visit the psychologist.

Staff health policies: need for consistency and health tensions

In the first months of the outbreak, SHU staff struggled to receive accurate and timely HR information to plan and organise their work. There were not enough HR staff within the emergency cell nor in the Task Force to provide the necessary information.

The aim of staff health policies was to be consistent between the different OCs and partner sections, and OCB's SHU took the lead. The SHU manager spent a lot of time advocating to ensure that all international staff had the same access to care in case of Ebola infection within HQ, other OCs or sections. Staff health procedures sometimes led to tensions with operations when they slowed down departures, for instance if immunisation needed to be completed or a Schengen visa application was being processed. SHU wrote a clear and specific document in September 2014 to clarify all the points of their policy on HR management. The need for collaboration and support between SHU and HR were considered key points to ensure consistency of MSF's HR rules.

The 21-day follow-up for all international staff demanded time and qualified personnel. Both MSF OCG and OCBA had a staff health unit before the Ebola outbreak started, and an Ebola-specific Focal Point was set up in April 2014. An appointment for OCA and OCP was implemented at a later stage and subsequently released the pressure on OCB, allowing better communication in countries for the international staff.

Occasionally, the strict and clear rules led to tensions with staff. For instance, the restriction on staying beyond six weeks sometimes prevented a proper handover or meant a missed opportunity to reinforce an inexperienced team and train it for a few days, to avoid mistakes and staff infection.

Medical evacuations

International staff were told that medical evacuation could not be guaranteed. Following the first international staff infection, legal procedures were included. From October 2014, international staff had to sign a form acknowledging their understanding of the risks involved in the Ebola mission. The two medical evacuations that had to be carried out were a real challenge in terms of finding a plane with a crew and getting the authorisation to fly. This was only possible through the networks of trust that MSF could inspire in partners. The input of the SHU was essential, with one staff member in charge of evacuations 24 hours a day. Altogether there were only three people in OCB with the knowledge of procedure and the contacts who were able to organise a medical evacuation. Transport challenges surrounding medical evacuations are described in more detail in the logistics report of this Ebola review.

Staff safety

From the beginning of the outbreak, staff safety was MSF's highest priority. In both interviews and the survey there was a strong recognition from staff that MSF did everything possible to protect them. The overall feedback from all national staff in the three affected countries was extremely positive – people felt as safe as it was possible to feel in an Ebola context.

“MSF [had] all the gadgets to protect us”. “Safety is very high for MSF. We were highly protected. Every morning, there was sensitisation”. “When I come to work, I am safe. In the village I was less safe”
National staff members

Staff appreciated the quality of training and the constant reminders of safety rules. However, people in every country were very scared when they first started work in an Ebola Treatment Centre (ETC). The fact that MSF international staff were there, sharing the same work, helped national staff to trust the equipment and procedures and to feel safe.

“I am a human, like you, and since you are working here with no infection, the same will happen [for me]”
National staff hygienist, talking to an international staff logistician who was recruiting him

“I was scared. But I am working what they tell me, wash my hands, no-touch policy. I checked my fever every day. MSF was taking care”
National staff member

“I said to my family, ‘White people are coming from other countries. They sacrifice their lives. I need to help them. I will follow the doctor’s advice and will stay safe’”
Sierra Leone watchman

“The disease, it scares me, but to work dressed like you, that does not scare me”
Hygienist in Sierra Leone being asked if he would accept to work with dead bodies by his international staff supervisor

For both national and international staff, the higher-risk locations were in the communities and in triage at the ETC. Regarding staff who got infected during the Ebola response, the most probable explanation for at least six of them (five national, and one international staff), according to the investigation reports, was that they became infected at the triage location.

“There is more risk in the community. In the ETC, you can control everything. People follow rules. In the community, it is different”
National staff member

Training was a key component of ensuring safety, and the fear around Ebola made people extremely attentive (see Training, page 28). During the training, staff were reassured that very strict measures had been put in place. According to the online survey, 94% of the international staff felt safe to work in an ETC after the two-day pre-departure training.

Some international staff felt that the lack of experienced international staff, and sometimes shortage of staff, put pressure on the work and critically compromised safety (especially in Liberia in August/September, and in Kenema and Bo in Sierra Leone).

Staff working in Liberia in August and September felt overwhelmed, and some were scared, as safety rules could not be applied.

“At the peak of the epidemic in September, the road to go to the house was used by staff, patients (and) patients’ families. The first pre-triage was a high-risk place, with no hygienists, distance of security not respected, and staff using their own clothes. There was no staff clinic yet, and the MedCo was having consultations of sick staff in the MSF office, which was in the same compound as the living area. One staff turned (out) to be Ebola positive”

International staff member in Liberia

There were clearly breaches in the MSF safety protocols in Liberia during these months, resulting in real danger for staff, including office staff. Subsequent HQ field visits and biosafety monitoring were very important to help staff identify the risks taken and put safety measures back in place. Field staff greatly appreciated the participative and non-judgmental approach of these visits.

In Kenema, Sierra Leone, **where** MSF worked to support Ministry of Health (MoH) workers. Both national and international MSF staff who were involved felt that the proper safety measures were not in place and that the collaboration posed a real risk. More than 50 MoH staff died in Kenema.

Field incidents

At HQ level, a team of Ebola experts were on call 24/7 to assess the risk factors around any incident in the field, and to support the responsible field-staff member to take the appropriate decision and reduce their stress. The exact number of such calls is not available and the incidents have not all been reported. However, the work was important, with an estimate of more than five calls a day for the Ebola emergency coordinator up to December. After December, the number decreased to an estimated five calls per week.

The online survey indicates that 26% of respondents had high levels of stress following personal incidents. 23.5% reported that they witnessed needle stick injury. Personal incidents include:

- Rupture of gloves:- rarely: 30%, sometimes: 8%
- Rupture of PPE:- rarely: 12%, sometimes: 2%
- Vomit on the lips:- 5%

Although there was a clear system in place to report incident cases, 8% did not report risky events they personally experienced.

Field staff were generally impressed with HQ’s level of commitment and availability to provide support, and with the efficiency of action in case swift evacuation was needed.

Ebola safety management procedures implemented

- Strict no touch policy for international staff, and compulsory in the workplace for all staff.
- Availability of protection equipment.
- Training, coaching and constant reminders of safety rules were the key points.
- Outreach: procedures were checked and adapted (see WatSan report). The teams were increased in order to reduce the workload of each staff member. Inexperienced staff had to work in the ETC first to understand all the security measures before working in the community.
- Triage: better design and organisation of the triage area; new procedures implemented and applied in all ETCs.
- 24-hour availability of an Ebola expert from HQ to contact in case of any incidents, to assess risk and to take appropriate decisions.
- Biosecurity visit: from October, each ETC received one visit every three weeks by experienced MSF staff to check all safety procedures. This was highly appreciated, prevented “awareness fatigue” and helped to maintain a high prioritisation of safety rules.
- Helicopter (from September) for internal evacuation of staff.

Healthcare for MSF national staff

From the beginning, access to healthcare for all staff was a high priority for MSF, as it could not rely on any other medical structure. However, it took some time to establish separate care.

In Guinea, staff had access to the regular programme staff health clinics. In Liberia and Sierra Leone, a staff health clinic opened as soon as possible and until then the Medical Coordinator (MedCo) was in charge of staff health. Based on the analysis of the case investigation report, the role of staff health in early detection and adequate reaction was not always satisfactory. In some places, the protocol in place was to call the MedCo for any national staff fever symptoms. In practice, this meant a heavy workload for the MedCo. The level of delegation varied, depending on the availability of experienced staff. To this day, MSF Ebola experts find it difficult to design clear protocols for staff health in an Ebola context.

One of the major risk factors was staff infection. Too many staff worked while suffering from symptoms. One of the factors contributing to this was the reluctance to be isolated and treated in the ETC with other patients, as was initially the case. Subsequently, a VIP tent was set up for staff and their families to provide a separate and private space. Referral structures were identified in order to offer high-quality care for staff. In Liberia, the American hospital agreed to treat all staff working on Ebola, and became an MSF staff referral hospital in November 2014. In interviews, international staff stated that they felt uncomfortable with the fact that MSF did not evacuate national colleagues infected with Ebola to countries that could have offered better care. No national staff expressed the view that they would have liked MSF to evacuate them. The disparity in access to healthcare for staff potentially infected with Ebola became less of an issue when the quality of care available in-country improved.

Procedure following staff infection

Despite all the measures taken to prevent staff infection, there were 28 Ebola cases and 14 deaths among staff. Of these, three were international staff, who all survived.

Following each infection, one experienced MSF staff member would conduct an investigation and send the report to the Task Force coordinator. Six reports were done by the Task Force coordinator herself. The process or policy for the management of these reports was not entirely clear. Remaining questions relate to who should take care of the archiving and how information about staff infection should be

communicated. An initiative from the SHU coordinator to define a policy of communication, never moved ahead.

Reports concerning four national staff in Sierra Leone, one in Liberia, and the two international staff conclude that the source of contamination was probably work. Others state that the source of the contamination could not be identified. For cases where contamination in the workplace was deemed unlikely, the explanations for such analysis is missing. At least four staff had close family members who were Ebola-positive. This is a strong risk factor, but there is no specific information on the level of personal contact. The investigation for one international staff member showed no identified breaking of safety measures and no contact in the non-work environment. This clearly highlighted that even with strict respect for safety measures, working with Ebola patients was a risk of infection. The standard communication to staff was that most cases were non-work related. However, the evaluators found no clear and systematic analysis of the reports to support this statement. In interviews, some international staff expressed concern about the lack of feedback and doubts that contamination at the workplace could really be excluded. It was felt that there was a need to communicate clearly about these staff infections.

“The same sentence was given every time: ‘MSF is making an investigation. The most likely source of contamination is outside the ETC’. We never received any news about the investigation. I would have liked to”

International staff member in Liberia

Compensation for the bereaved families was based on the likely source of infection identified in the incident reports: six months’ salary if the infection was considered not in the workplace; 24 months if it was assumed to be a work-related infection. From January 2015, the latter was raised to 48 months of compensation.

Stress factors

a) Survey results

According to the online survey, 35% of respondents experienced the Ebola mission as highly or very highly stressful. Moreover, all staff who were interviewed and had worked at the peak (August to October) of the epidemic stated that it was the most stressful mission they have ever worked in.

In the following figures, the percentages for the high or very high stress factors are presented:

Figure 2: Percentages for stress factors

Too much work	32%
Had to refuse patients	38%
Level of care for patients was too low	45%
Staff infection	33%
Staff deaths	33%
Team dynamic	20%
Living conditions	10%
No-touch policy	10%
21-day follow-up	15%
Fever during 21-day follow-up	21%

The SHU wrote a report in August 2014, pointing out the most stressful factors for the international staff, which were helplessness, powerlessness, sadness, frustration with the limited care available, and intensive work. Following this report, the length of international staff contracts was reduced from two months to six weeks.

b) Fear of infection

For nearly all national staff, especially the first staff members working in a new ETC, the initial work was very stressful, although they felt safe with the MSF equipment.

“At first, you must have fear. At the end of the training, Ebola was too new. The fear was high. The first week, I had [a] headache and vomiting. It took me one week to feel okay”

Staff member in Liberia

c) Infection of colleagues

Many national staff worked for months and witnessed the infection and sometimes death of one of their MSF colleagues. This was a very high stress factor. Some had been in contact with an Ebola-infected colleague up to four times, and were taking very strict measures at home to protect their families. Some staff resigned following staff infection or deaths.

“We were travelling in the same bus [with one staff who later died of Ebola]. It was high risk. Most people were traumatised. Some even resigned. We had to talk with the staff. Some, we convinced to stay”

Medical team supervisor in Sierra Leone

International staff were less directly exposed to the infection of a colleague, as their contracts were shorter. When the first international staff member was contaminated, it was a shock for many and a higher risk was felt. Infection was beginning to touch everybody. That created high levels of stress: one international staff member asked to return and four were sent home on the recommendation of the investigator.

d) No touch policy

The purpose of the no touch policy was to protect people, prevent disease contamination, and limit

the stress in case colleagues became infected. However, 50% of the survey respondents reported it as an important stress factor and 14% as a high stress factor. It was especially difficult for international staff who were deprived of physical touch during their mission. National staff did not follow a no touch policy at home. However, several reported applying it with their families when they were under a 21 day follow up after the contamination of one of their colleagues. This measure proved to be very reassuring when a staff member became positive, as people felt they had some control over the transmission route and knew they were probably safe. Consistency of this policy was not perfect, especially with staff appointed on the regular non-Ebola project in Guinea but overall, it provided safety and a feeling of control.

e) Stigmatisation

According to the survey, 14% of respondents experienced stigma as a high to very high stress factor. Some international staff were apprehensive about their return, knowing there would be rejection from family members and friends. Some people could not spend Christmas with their family, some had to wait for 21 days to see friends or close family members. To deal with this issue, the SHU designed the "Welcome back" flyer in November 2014. Although it came relatively late, it was very well received and helped staff and their families. However, some staff had to remain in Brussels during the 21 days rather than return home, because fear at home was too great.

"I was stigmatised on returning to South Africa by friends and work colleagues. It changed my work and friendship dynamics permanently. This was more stressful than being in the field"
Survey comment

Staff began to worry at the HQ as well. A meeting was organised to inform all staff in the Brussels office and provide an opportunity to ask questions. This was well received and helped to reassure people.

For national staff, stigma was a very important stress factor at the beginning of the Ebola epidemic in their respective countries. National staff had to deal with the stress of Ebola, the fear of their family being contaminated, and the everyday stigmatisation from their communities. Many examples were collected during the field visit, where national staff explained how this was a very difficult time for them. These stories were similar in the three countries, and seem to have affected most of the national staff.

"Our landlords kicked us away" "I could not sleep with my wife for two months". "My sister took my children away. I could not touch them for six months. I was only allowed to see them from far. I would give the money. My sister was telling them that if I would touch them, they would die". "I was unhappy. In the community, people drive you out of the house. My child was chased away. They called my child 'Ebola child'". "My parents still do not know I am working in an ETC [one year later]"

National staff

Some people would work challenging days in the ETC, and once home pretend to have been visiting friends. Others adopted a very strict ritual to ensure their family was safe from contamination:

*"I would come home, leave my shoes outside, remove my clothes and put them in a bag. Then I have a wash. And only then I touch my children. I am the only one who would wash my clothes".
"I have bought cheap shirts. When I come back home, I burn it. I take a new one each day"*
National staff

The situation improved over time, but during the peak of the epidemic, staff endured this for weeks. The 2008 MSF Ebola guidelines give the following recommendation: “For national staff special attention has to be given to the way that their families are responding to the intervention. If they are facing rejection, MSF should assist families to understand and cope with this”.

Some innovative initiatives were carried out: in Liberia, national counsellors identified stigma at an early stage as an important stress factor for staff. They implemented stigma workshops: up to 10 staff invited one member of their family and one member of their community. There was a group meeting, with a visit to the ETC, where the nature of the work and the safety measures were explained. This improved the situation. In Donka, one counsellor tried to implement similar workshops, but with little success. There was possibly not enough staff and support and promote the activity. There was also a stronger rejection from the Guinean community, who were very scared of approaching an ETC.

Access to mental health support and exchanges on this specific topic were sometimes facilitated, and there were initiatives that worked with local radio. However, these did not happen in a systematic way, and it appears that no overall communication strategy was developed.

f) Security incidents

In all three countries there were rumours about staff working with international agencies, and specifically about medical staff working for NGOs in an ETC. Outreach teams disinfecting houses were accused of spraying the Ebola virus. Rumours were monitored by health promoters in order to understand how MSF staff were perceived, and what the allegations were. Distrust seemed to be most serious in Guinea, where in one incident eight members of a team trying to raise awareness about Ebola were killed². The report of security incidents in Guinea with the list of villages to avoid following tensions and aggressive behaviour towards aid agencies shows the seriousness of the situation.³

There were stories of MSF staff working in these communities who had to abruptly leave due to tensions and increasing aggressiveness. Some people feared for their lives.

“À Conakry, j’ai été attaqué là-bas un jour. Ils allaient me tuer...Ils ont confondu avec la Croix Rouge. On m’a attaqué, avec Dr C. Les vitres étaient cassées, le toit était cassé. Ils nous poursuivaient même dans les quartiers. Les loubards qui étaient à pied dans les quartiers, ils avaient des bâtons, des cailloux en main. Ils allaient me tuer, c’est Dieu qui m’a sauvé. J’ai eu peur même ce jour-là”

(National staff driver)

“I was attacked in Conakry one day. I thought they would kill me ... They confused me with the Red Cross. They attacked me alongside Dr. C. The windows were broken, the roof was broken. They even followed us into neighbourhoods. The thugs who were walking around the neighbourhoods, they had sticks, stones in their hands. They were going to kill me, but God saved me. I was very afraid that day.”

² <http://www.bbc.com/news/world-africa-29256443>

³ Extract from the incident reports: 26/O06 “Incident sérieux avec chauffeur commissions suivi des contacts: lynchage évité de peu. Gens attendent cachés avec machette et gourdin, attaque au son du clocher”. “Serious incident with service driver follow-up of contacts. Attack only just avoided. People waiting with machetes and club, attack when the church bell rang”. “Guette apens sur voiture OMS avec staff MSF, bâton et machette, menace, pas de blessé”. “Ambush on WHO car with MSF staff inside, stick and machete; threat, no one wounded”.

d) Patients' death and suffering

Experienced international staff who worked during the peak of the epidemic all stated that Ebola was a unique mission, due to the overwhelming confrontation with death. There was also an issue around levels of care: in the survey, 45% of respondents reported that they felt the level of care was too low. In Monrovia in August and September 2014, only the very worst affected patients could be admitted, and the mortality rate was very high. Many were refused entry and as a result were dying at the entrance to the ETC.

"[The] end of August was the worst. We saw people dying in chairs, in front of the gate. Families were begging us to take their patient. Sick people were begging: 'Please, take me in, isolate me'. We all had grey faces ... in the ETC, the patients were too many. We were not enough, not even to give them water. It was slippery, disgusting, blood on the floor, on the walls" (International HR staff member in Liberia) "It is difficult: you enter, you see people dying people crying, asking for help, hopelessly. We did our very best. You want to do your best"

(Hygienist in Sierra Leone)

"The first week, it was difficult. I had never transported dead bodies before. I was towing dead bodies, sometimes 10, sometimes 15. It was trauma. I came home, and I thought all the time of dead bodies. I did not sleep well. Then it got better after the first week"

(Driver)

"To see someone in a body bag is very difficult. Especially once, there was a body bag for a pregnant woman. In our tradition, there is ceremony. In our culture, you take the baby out, and put the baby next to her mum. If not done, it will affect another pregnant woman... This woman in the body bag, you come home, you think, you think, you never come to conclusion"

(ETC nurse in Sierra Leone)

As previously mentioned, access to psychological support was not available everywhere. There were not enough international psychologists to cover all the positions. In Liberia, psychological support began in August 2014, while in Guinea it was only available from December 2014. Staff expressed a lot of positive feedback and appreciation for the psychological support.

"I felt better, it helped to empty my head. If you have too much in your head, you make mistake(s) for you or for others"

(Medical staff member)

In most interviews, people were asked if they were currently suffering from mental health problems from their experience in Ebola. The following statement is representative of the vast majority of feedback:

"I am fine. It was hard, but I am proud I did it"

(National staff member)

Some survivors were recruited to work as staff for MSF. They had often lost family members and were exposed to high levels of stigmatisation. Some worked as health promoters to talk to the communities. Others worked in the high-risk zone in the ETC, sometimes with Ebola positive children. For those working in ETC, although it provided them with purposeful work, it was also a source of additional trauma.

"It was easier for me to work with kids. Kids were afraid of PPE. I got attached to some of the children. Some died. That was another trauma. I am still grieving. I am grieving for my family and

also for some patients, and some kids. I have flashbacks of families and work. There were patients I became friends with. There was a baby of one year and six months. He died”

(National staff member who worked with children in the ETC)

e) Working conditions

Working whilst wearing Personal Protective Equipment (PPE) was one of the big physical stressors for Ebola workers. There were many testimonies regarding how tiring PPE was.

Complaint	% reporting “sometimes”	% reporting “frequently”
Sweating	14	74
Difficulty seeing	51	35
Difficulty breathing	31	14
Headache	22	2

The conditions could be particularly physically challenging during the rainy season. Staff sometimes had to carry patients on a stretcher over long distances, up to 2 km.

Workload

The project workload was certainly very heavy at times. National staff hours were monitored and shifts were implemented. The number of hours was kept below the legal requirement but was still high: 40 or 45 hours per week. A rest and relaxation (R & R) policy was not implemented. Staff were asked to take holidays when the work load decreased. International staff were protected by the six-week maximum period.

HQ staff were overworked for months. Many recognised that they were exhausted and burnt out, and that they did not ask for or receive support on time. There was a need for SHU and/or the HR Director and/or senior managers to recognise the extra workload, and to organise extra support to cover the crisis period. The level of responsibility was very high.

Measures put in place

- Monitoring of time in PPE (marking time of arrival on the PPE), limiting time inside (maximum one hour). In practice, the survey indicates that 48% of respondents stayed inside between one and two hours, and 9% over two hours.
- The number of rounds per day per staff was limited to two per day in some centres. However, this norm was sometimes considered a rule which did not take into account specific contexts, such as level of heat. The survey indicates that the number of rounds was often higher: 24.4% went three times a day, and 6% more than three.
- Limitation of working hours for national staff (less than the national regulation requirement).

Turnover and modification of protocols

The high turnover of international staff led to some changes in protocols, which created tensions and inconsistency in safety measures.

“One new expat comes. I went in the high risk zone to work. I start and she tells me: ‘it is not right.’ I said: ‘that was my briefing. I do what I know. Only after, when we go out, you train me and we can change’. She was not happy. But I knew it was not safe to change while I was in the high risk; I had to do what I was taught”

(Hygienist in Sierra Leone)

Contracts

For the national staff, work insecurity was a high stress factor. Ebola was unpredictable. Some of the projections that were made were incorrect, and the number of staff was large. Many had very short contracts.

There were four different levels/types of contracts:

1. MSF contract, with access to healthcare for families and compensation in case of deaths
2. MSF Regular Daily Workers, with similar benefits to MSF contracted staff, except for access to healthcare for their family (Liberia)
3. Daily worker, who could only go to staff clinics for emergency care
4. Subcontracted staff, who could go to staff clinic in case of a work accident.

In Liberia, many staff worked as daily workers up to November (some for three months). They received the same benefits as contracted staff, except that their families did not have access to healthcare. At first, MSF did not have the option of providing healthcare for all. Priority was given to Ebola. There was an issue surrounding the closure of ELWA3, as some national staff received a work certificate which did not include their time as daily workers for the first critical months. This was a serious issue and deeply angered some of them.

In Guinea, staff who worked as daily workers were interviewed and reported that they only had access to healthcare when they obtained their contract. Some staff worked as daily workers for months and on an occasional basis. They were very aware of the risk they were taking in an Ebola mission and were hoping to receive healthcare for themselves and their families. For example, one driver who was attacked in Conakry had been a daily worker for months, and he was very concerned about what would have happened to his family if he had died.

The worst situation was for subcontracted staff, who were often working in construction or as drivers. Almost none of them had access to healthcare or paid sick leave, and were often on a very low salary. They had few or no days off and no overtime expenses. In the context of Ebola, this raises safety issues. For example, MSF staff were supposed to report any symptoms and to be paid if they were sick, in order to facilitate sickness reporting and prevent contaminating colleagues. Subcontracted staff were poorly paid, and could not afford to take time off work. In Liberia, one subcontracted staff member transported his Ebola-positive wife in the car he used the following day for MSF staff. He was later infected and they both died. Today, there is still no written policy in OCB that sets out a minimum standard from the employer of subcontracted staff, and which focuses both on safety and ethical levels as a socially responsible employer.

Access to food and drink

In Liberia, national staff often complained of working while hungry. Sometimes, there was no time to get undressed and leave the ETC to get food. The work was physically exhausting, and among survey respondents, 18% reported that they sometimes felt dizzy in the PPE. National staff were sometimes

living very far from the centre and woke up at 5 am to start working at 8 am. Hunger became an issue for some staff, with potential safety impacts on attention during work in the High Risk zone.

“First, they gave juice. But after, only water. There was no food. The morning shift was difficult. You come a long way and it was stressful not to eat”

(ETC staff member)

“There was no food during the night. If you sleep, they take picture. There was no coffee, no tea, but sometimes, we saw the international staff with a cup”

(Staff in member Liberia)

National staff recognition

a) Opportunity to evolve professionally

There was extremely positive feedback from both national and international staff regarding the quality of the teamwork, developing skills and obtaining more responsibilities, especially with the initial teams. But in many international staff interviews, people stated that the national staff were undervalued or undertrained, and not given enough responsibilities. In other words, MSF as an organisation could have done more for national staff. People regretted that the priority in the emergency response had not focused enough on staff training and promotion. That feeling was shared by many national staff:

“It is very easy for an international staff to become an experienced Ebola staff, but not so for a national staff.” “After 3 months of Ebola work, an international staff is considered as expert’. We have been working for one year!” “I received supervisors with no experience. MSF trains me but does not have the courage to give me the responsibility. In the absence of the expat, I am the one doing the job. I do this job by interim, but I am not really listened to. Good enough to do the job, but with no recognition for it”

(National staff members)

The fast turnover and staff movements made it difficult to follow national staff and develop a career strategy. People were also aware that staff were not always given enough consideration and national staff gave many examples of lack of consultation. This was often related to specific international staff personalities with individual visions of teamwork and sharing with national staff counterparts. National medical staff would arrive in the ETC where new treatment protocols or a new team organisation were imposed without consultation. One international staff member left and appointed a national staff member as their replacement. The remainder of the team agreed, but the national staff member was not invited to the coordination meetings.

b) Staff-friendly workplace

With the high turnover, the national staff had to adjust to many different personalities. Decisions about their everyday lives were sometimes taken without any consultation or understanding of staff needs, with no consistency over time and countries, e.g. food or no food in the centre, access to soft drinks, tea for national staff only at night, etc.

In the first ETC designs, places to pray, rest, and safely park staff motorbikes were often not considered in planning. Adjustments were needed to make the workplace more staff-friendly.

c) Recognising the good work done together

Overall, both international and national staff were very proud to work for MSF and to have contributed to the fight against Ebola.

“It was nice to work for MSF. It was my dream to work for MSF. MSF did well for my country. MSF did well for me; by employing me”

(Driver in Sierra Leone)

“I have done a good job. I fought Ebola and Ebola gets to the end. I win the battle”. “We did our best. People worked their socks off. We could not have done more”

(Staff members)

The well-communicated support of MSF teams from all over the world helped people feel part of a big solidarity movement. People rejoiced together when patients were cured.

“When we discharged a patient, we would dance; all the expats would dance”

(Hygienist, Liberia)

The famous survivors’ hand banner is now located in OCB’s entry hall. However, there were missed opportunities to recognise the work done in an official way upon the closure of centres. In Liberia, some staff were unhappy with the way ELWA3 was closed. They felt it lacked a proper closure, with a celebration and an official recognition of their work.

“There was no appreciation. They did not even say it.”

(Group of nurses, Liberia)

The downsizing of staff before the closure of centres was difficult; people were sometimes given less than a week’s notice that their contract would be terminated. MSF provided some support in certain places to help people find new jobs including help with CVs and staff recommendations. In Guinea, some people were happy because they received training attendance certificates, but many made the request to have an official paper from MSF to legitimise the training they had received.

Conclusions on duty of care

The main challenge for MSF was to be able to provide care to patients and keep staff safe. The relatively low number of staff contamination points to the effectiveness of the bio-security measures adopted. All the staff interviewed praised the commitment and competence of MSF in protecting them. In particular the 24 hour availability of HQ experts in case of any health related incident was highly appreciated. Interviewed staff were proud to have been able to fight Ebola, and there was a strong feeling of communion in the midst of the crisis.

The establishment of the OCB health unit for international staff two years before this outbreak proved a major advantage. The unit took the lead in defining a staff health policy and it successfully implemented health and safety measures before, during and after the Ebola missions. OCB monitored the health issues of international staff from sections which did not have a staff health Unit (OCP, OCA), until they appointed a Focal Point. In the next outbreak such positions need to be in place from the start.

Health management of national staff remained under the responsibility of medical coordinators. Given their already high workload it is no surprise that the development of staff clinics in the field were delayed. Detection of Ebola positive staff was critically important, and the staff health clinic played a key role, but in a few documented cases it missed out on early detection. In general access to health care during this Ebola outbreak was of utmost importance for national staff and their families. This is where a major limitation of the 'daily worker' and sub contracted staff contracts became apparent. Limited access to MSF health care and the additional loss of income in case of illness was not only a major stress for them, but also a risk for their employer.

The main stress factor reported by staff in the Ebola response was the experience of seeing their colleagues becoming contaminated, infected or dying. Efforts were made to analyse and document each staff contamination incident, but lack of time meant it was not possible to document them all. These investigations relied mainly on a few experts already under severe work pressure. However, identifying the cause of infection remained difficult. Here several roles of the MSF teams overlapped: MSF was the employer, investigated the incidents and decided on the compensation to be made. Involvement from HQ, including the legal unit, was felt to be missing.

All staff felt that the training and safety measures provided by MSF reduced their fears and enabled them to work. Stigma was an issue for all staff, with severe consequences of isolation from family and friends, and social exclusion. Targeted workshops in the communities proved successful in Liberia, but few other actions were implemented to prevent and deal with this important stress factor for staff. Specific local contexts and politics led to physical aggression in Guinea for NGO staff working on Ebola, including MSF staff.

Short term contracts for international staff were designed to decrease the risk of fatigue or loss of attention over time. However, people tended to work long hours with very few breaks during this limited time to "compensate" for the short contract. There is a striking disparity between this safety principle for international staff, and the lack of particular employment regulations or extra breaks for national staff. This issue deserves debate.

National staff acquired experience on the Ebola response on a large scale because of their longer presence in the projects. However investment in increasing their capacity or promoting them to positions with more responsibility came late and was limited.

Issues concerning the working conditions in ETCs and access to food and drink seemed of minor importance, but posed significant practical problems and needs to be considered for future epidemics.

Lessons identified on duty of care

- ⇒ In a huge and complex emergency response **the support capacity for HR issues** at HQ level quickly becomes insufficient. The extra workload needs to be analysed at an early stage and positions adjusted in order to allow appropriate support and prevent exhaustion.
- ⇒ Staff health policies can conflict with operational priorities for quick departures. In order for the policies to be broadly accepted and respected they need to be part of overall human resources regulations with full support of the Director of Human resources.
- ⇒ Up to date information on staff movements, and especially return timings, is essential to smoothly organise the follow up of international staff. There needs to be good organisation and communication between travel administration, staff health unit and other concerned staff.
- ⇒ **24 hour availability for staff health issues** is essential in a situation with critical health risks for staff. Teams should take turns being on call because it is important to avoid placing the burden on a few individuals.
- ⇒ **Knowledge around the medical evacuation process** was held within a very small group of internal experts with an already high work load. In such a situation, sharing knowledge with additional staff will increase the specific expertise and ease the pressure on the key experts.
- ⇒ **Staff health clinics** proved to be key for reduction of mental stress and as a motivating factor for early reporting of symptoms. In an outbreak of a highly infectious and life-threatening disease, MSF staff and their families need to have access to care, and it needs to be part of any treatment facility planning from the start.
- ⇒ **Appropriate working conditions** are essential for all staff in an already very stressful environment. Different work standards between national and international staff are not justified. This needs to be adapted to the context and include, for example rest areas and prayer places.
- ⇒ When working with a highly contagious disease, **stigma can be a major issue** for national staff and their families. Staff in Guinea faced serious security incidents due to community rejection of Ebola workers. MSF has opportunities to address this through a better understanding of local context (anthropological assessments), the provision of information and strong communication in the affected communities. Stigma workshops are one way to address them. A comprehensive communication strategy in line with health promoters is another.
- ⇒ **National staff training and capacity building** makes a huge difference in creating an appropriate workforce and utilising national staff experience. A policy needs to be in place from the beginning of the crisis and resources allocated for it. Work and training certificates have a high value for national staff in many countries and should therefore be systematically planned and include periods where people were employed as (regular) daily workers.

Recommendations on duty of care

5. **Define policies for national staff in emergencies** and allocate resources for implementation.
 - These should include staff health, psychosocial support, training, capacity building, staff friendly working environment, and prevention of stigma.
 - Eliminating differences between international and national staff should be a main consideration, for example in the provision of psychological and/ or psychosocial support for all staff.
6. Design a **minimum standard HR policy for employers of subcontracted** staff, and to include paid sick leave, access to staff health clinic and training where appropriate.
7. **Implement a return talk policy for use in all crises** for international staff, and maintain the specific counselling support created for HQ staff.
8. **Design a clear and transparent investigation process** for cases of staff contamination agreed with the SHU and the Legal Unit, which includes centralising and analysing all relevant information.

TRAINING

Training Strategy

Evolution of training strategy during the response

The MSF 2008 Ebola / VHF Guidelines highlight the identification and training of staff as one of the top ten priorities at the start of an Ebola intervention. The guidelines state that ‘training of staff is a top priority’ and that briefing and general training about safety procedures needs to be given and repeated regularly (MSF, 2008).

In March 2014, the initial strategy for training by the Emergency pool (E-Pool) was to train staff in the field as is usual for an outbreak, with mentoring occurring in the first week, mixing experienced and non-experienced staff. In the early stages of the outbreak, there were sufficient staff for this training plan to be effective.

In April, the issue of wider staff training was raised – should Ebola training be delivered in Brussels? However it was decided that at this point, training would continue in-country as the preferred option.

As Ebola was increasing in geographical spread in May, but not by large case numbers, it was decided that further action was required for training, particularly as other international actors were not joining the response. The overall Ebola response management was transferred from OCG to OCB at the end of March 2014, and during May the OCB E-pool decided to delegate the development of an Ebola 1st Responder training course to OCG for delivery in-country. There was no coordination or collaboration between OCB and OCG about developing the training, or knowledge in OCB that the training had been delegated. This delegated task was not documented.

As part of the wider global call for assistance to the Ebola response from MSF on 21 June, the statement included a request for “...qualified medical staff to be deployed, for training to be organised...” (MSF, 2015). In June, Ebola training of large numbers of staff within MSF was not being undertaken, resulting in a backlog of people to train.

There was a delay in receiving the training material from OCG, and when it did arrive at the end of July, it did not meet the expectations of OCB Ebola referents. On 7 August 2014 the E-pool requested that the OCB training unit develop a two-day pre-deployment training course for MSF staff with no Ebola experience (MSF, 2014) with a focus on case management.

The statement to the OCB Board on 20 September 2014, highlighted that MSF were too late in all training initiatives, and that a global strategy was not put in place early enough. The strategy normally adopted for small outbreaks was not working in a large outbreak.

The MSF 2008 Ebola guidelines state that "measures to prevent disease and filovirus haemorrhagic fever (FHF) are the same for national staff as for international staff". Whilst national staff were not necessarily out of the scope of training as part of this Ebola response, there was no specific request from the Task Force to the OCB training unit to include them.

In Sierra Leone there was no country-wide MSF Ebola training strategy or programme in place as the main focus was on ETC operations. It was felt by some national staff that their training needed to be maximised, with regular standard training manuals, protocols, and include topics such as outreach and psychosocial support.

Identification of training requirements

The aim of the OCB two-day *First responder training* course was "to ensure that all trained staff had sufficient knowledge of the disease and its transmission routes to adopt a safe behaviour and work efficiently in a Case Management Centre" (Bachy, 2015), with a focus on first-time Ebola staff in the ETC. The identification of training needs and requirements was based on the MSF 2008 Ebola guidelines and personal experience from previous Ebola outbreaks.

The Ebola training programme that OCG developed was sent to OCB at the end of July in the form of a three-day draft course in French. The OCB training unit adapted it, reducing the length to two days and translating it into English. The decision was made that the course would be two days in length as three was deemed too long and two days was considered sufficient for focussing on work inside an ETC. During this period of amendment and development, time was lost and some duplication of resources occurred.

The opportunity to include outreach in the training, and the importance of health promotion early on was not identified. RITE training (rapid isolation and treatment of Ebola) was developed in Liberia to be used by rapid response teams, and began early 2015. Specific outreach training was not developed by OCB until the beginning of February 2015.

Governance and consistency of training

In an OCB Task Force training discussion on 18 August, it was recognised that as MSF was the only organisation with operational Ebola knowledge, it had a duty to disseminate this to other organisations (Crestani, 2014). In August 2014 the process for external organisations wanting MSF information on how to respond to Ebola was to attend a briefing at OCB, then have the opportunity to send staff on the *First responder course*, followed by access ('copy/paste') to MSF operational Ebola documents. In this process of knowledge transfer, MSF shared knowledge with external organisations, but were not responsible for subsequent actions by those organisations.

The OCB Task Force decided which external organisations would be able to attend the *First responder course* and have access to the documents. OCB did not want to train people from organisations who were not committed or had no capacity to open an ETC, and they needed to "evaluate how well an

individual or organisation was trained enough to work in Ebola or develop a proper response” (Crestani, 2014). The aim was to only support committed organisations.

There was a significant sharing of Ebola-specific information, mentoring and advising other international community and NGOs over the course of the epidemic. This training of external actors was unusual for MSF. There were high levels of pressure on MSF in the field to provide ongoing mentoring to staff from other organisations, which was generally refused (MSF, 2014). One external organisation described MSF as quick to share knowledge, and as a result was able to influence the way their organisation responded.

Interviews with HQ staff revealed that there was weak organisational governance, consistency and control of the Ebola training developed and delivered by MSF OCB, particularly for training delivered in-country. Once national staff members had received their initial training on PPE usage, further training was role-specific. National staff interviewed reported that when new groups of international staff arrived, there was frequently a change in ETC procedures in which they were trained, and that this appeared to depend on the experience and views of international staff. Some national staff found it hard to transition from one way of working to another as there were frequent new procedures, and they reported that this was frustrating and stressful.

Development and review

Course content

The *First responder course* content was based around the six pillars on request of the Task Force, and focused primarily on medical, watsan and infection, prevention and control (IPC) topics. The course content was decided by OCB Ebola referents based on the MSF 2008 guidelines, as well as personal experiences from previous Ebola outbreaks and feedback from those recently returned from the field in this current epidemic.

Findings from trainers who responded to the survey show that the majority felt the topics included in the course were sufficient, but more time could have been spent on disease management and watsan issues.

As well as the OCB *First responder course*, other Ebola training courses were also developed, or being developed as the epidemic progressed, which focused on specific aspects of the response. Development of an outreach training course began in January 2015, and was delivered in March 2015, with the aim and general objectives provided by the OCB Task Force, and in response to ongoing evaluation of training needs. This outreach course was part of a planned second level of training for Ebola staff moving from ETC to outreach operations (Bachy, 2015).

To support the 1st Responder training, a series of five one-day modules were planned for use and access via the internet (Bachy, 2015). The topics included were:

- Epidemiology
- Mental health support
- Health promotion
- Water and sanitation in outreach
- Support to normal health structures

These were designed to cover topics not included in detail in the 1st Responder training. Three modules had been ‘crash-tested’ and were available on-line – epidemiology, mental health support, and health promotion. The remaining two were not complete by 31 March 2015 (Bachy, 2015).

Use of guidelines and other reference material

As well as the MSF 2008 Ebola guidelines that formed the basis for development of the *First responder course*, there was also use of information from previous Marburg outbreaks. For some specialist areas no guidelines were available, and in these situations the personal experience of Ebola referents, other specialists and returning international staff was used to supplement the gap in knowledge. For development of the OCB outreach training there were no guidelines or protocols available, which was the biggest challenge in developing this course.

Utilisation of feedback and evaluation

Use of feedback and evaluation following delivery of training courses forms an important part of the course development process. Standard feedback processes such as evaluation forms at the close of training courses were partly utilised during the 1st Responder training. There was little documented feedback from the *First responder course* until the end of 2014 when a one-page evaluation sheet was given to participants. From the replies received, some adjustments were made to the course (Bachy, 2015). The *First responder course* evolved following feedback from returnees from the field, but this updated information was not always passed on to external actors.

There was no capacity in the *First responder course* to include topics such as epidemiology, leadership (e.g. HoM coordination), or outreach. In a report to the OCB Board on 20 September 2014, it was noted that the two-day pre-deployment course was not able to cater to all MSF needs, and did not have the right focus for coordinators, other than giving them a global understanding of the challenges.

Early on in the crisis, some staff returning from the field with direct experience of Ebola operations assisted in facilitation of the 1st Responder training and feedback on actual operations in ETCs. Whilst it may have been beneficial for course participants to talk to a returnee, often the returnee only had one viewpoint which needed to be balanced out.

Survey findings from the 1st Responder participants regarding topics to include in future Ebola training, show that cultural aspects and crisis management were most frequently mentioned. Understanding the cultural context was also a theme that was highlighted in many of the interviews with national staff. For example, Sierra Leone supervisors observed shortcomings in the cultural awareness of international staff and recommended that they needed to know more about the culture of the country.

Implementation and delivery

Delivery and facilitation

The OCB *First responder course* made use of a variety of teaching methodologies, including theory and practical sessions, case studies, and group work. Feedback from participants shows that 56% felt the course was about right when describing the course length and speed of delivery. Some facilitators felt pushed to use staff returning from the field to facilitate sessions, but reported finding it hard to ask returnees to deliver them, particularly as the mission was very emotional and psychologically demanding.

Delivery of training sessions for national staff by international staff appeared to utilise a variety of different teaching methodologies, predominantly focused on verbal group practical teaching sessions, but also including some briefings and mentoring. There was a mixed response to these techniques by

national staff, with some reporting long hours spent training. Some received two days of training, but others had a series of short training sessions. Some national staff reported the training was disjointed as people were busy, and training was provided in response to demand. Some national staff were taught for two hours standing out in the open in the heat. One international referent reported that national staff training was 'a wilderness'.

One of the challenges reported from ELWA3 was that some national staff admitted they struggled to understand the training and the way it was conducted. It took them time to grasp concepts and did not report that they were having difficulties. Similarly, in Sierra Leone national staff reported that it was not easy to teach people who are tired.

The majority of national staff interviewed reported that they were also involved in the training of international staff, predominantly in refresher training for PPE dressing and undressing. National staff reported that they enjoyed training MSF international staff as well as those who visited from external organisations. As one international doctor recalled, you learn a lot from national staff if you have an open mind and are friendly.

Refresher training was conducted in all ETCs, and was ongoing throughout the response. This was generally positively received by national staff, including receiving updates at the end of shifts in handover sessions. Case updates also helped with learning. Refresher training in ETCs increased in frequency as the epidemic progressed and case numbers reduced. This was partly to keep people's motivation up, but also to fill in time between cases.

Training materials

Participants attending the 1st Responder training at Espace Bruno Corbe (EBC) in Brussels received course material, including powerpoint presentations and documentation on a USB. Of the OCB staff who attended the 1st Responder training and responded to the survey, 82% reported receiving a copy, and 74% of these referred to it during deployment.

There was also a series of eight online training video clips produced by OCB and uploaded for open external viewing from 29 September 2014. Topics covered by these clips were:

- PPE dressing
- PPE undressing
- Blood drawing
- Dead body disinfection
- Vomit disinfection
- Equipment decontamination
- Ambulance decontamination
- Discharge procedure

These were viewed 12,545 times between being uploaded and 8 March 2015 (Bachy, 2015). The video clips were not downloadable, and had no sound to enable any organisation to use the clips. Not enabling the videos to be downloaded meant that MSF retained ownership of material, and stopped the content being altered.

Of the non-OCB participants and trainers who responded to the on-line survey, 80% viewed the videos and found them useful, although this is likely to be skewed as it includes the training staff. However, of the OCB survey respondents who deployed, 67% of staff were either not aware of the videos, or did not view them. National staff reported not knowing about the videos or being able to access them.

As part of their training, national staff reported receiving handouts covering some of the training topics, but this was not consistent. The different staff groups that were interviewed all reported receiving course material, but the only consistency was PPE dressing and undressing protocols. For example, health promoters in Liberia received sufficient information, but supervisors in Sierra Leone only received information on pain management, whilst the remaining information was held in the ETC. Some national staff groups reported taking training

material home and using it to educate families and their communities. This was particularly the case for health promoters and community-based workers.

In August, in Liberia, there was no prepared Ebola training material available for national staff in the field. At this stage, national staff were only given a handout of the PPE dressing and undressing procedures, and it was reported that delivery of the two-hour training sessions at ELWA3 in August required more resources. However, generally in the ETCs, a variety of training material and information was reportedly available for reference. For example, the PPE dressing and undressing procedures were placed on the walls for everyone to read.

Resources

First responder course

All OCB Ebola *First responder courses* were delivered at the OCB training site at Espace Bruno Corbe (EBC) in Brussels. At the end of June 2014 EBC staff started designing a simulated ETC for training using a Rubhall tent previously designated for warehousing. There was no area set up as a triage point, but patient flow through the structure was in place.

The site needed several adaptations to prepare it for delivering the Ebola training which had specific technical requirements, including upgrading water, power and heating supplies. Some operational challenges encountered by the EBC team included having to winterise the facilities for cold weather (not a requirement in the field), and to adapt the toilet facilities to cope with the increase in people on site.

The site was designed using personal knowledge from previous Ebola outbreaks, and EBC staff managed to source and borrow items to reduce costs such as fencing and matting from a neighbouring music festival. During delivery of the courses PPE was recycled to keep costs down and so as not to place a burden on stocks needed in the field. This involved washing and disinfecting all items including the suits, hoods, and disposable face masks after each course.

Field-based training

Findings from the survey for OCB international staff (88% based in Guinea, 90% for those based in Liberia, and 86% for those in Sierra Leone) who delivered training in the three countries shows that they felt they had sufficient resources to deliver the training they were tasked with.

Figure 3: After training I felt safe to work in an ETC



A recurring theme in feedback from national staff interviews indicates that on completion of Ebola training, OCB did not issue national staff with a training attendance certificate. Other organisations trained by MSF and other MSF OCs were reported to be given certificates or, in one case, T-shirts, to acknowledge attendance.

Trainers

The OCB *First responder course* required a significant number of staff with different areas and levels of expertise to facilitate the training programme, with between 11 and 17 staff needed per course. All were required to have some Ebola experience, with at least three staff needing to be experts (Bachy, 2015). The 1st Responder training report also highlighted a challenge for staffing – as the facilitators needed to be experienced, they were also required in the field, meaning that turnover of staff on the course was high. In all, 70 facilitators were used across the 21 courses delivered at EBC in Brussels.

A ‘train the trainer’ system was not used for the OCB Ebola training because it was decided that each facilitator needed to be a specialist. However, a lesson was identified from OCA training, namely that placing limits on the number and level of experienced staff can impact the ability to expand and take on new activities. Other external organisations were able to train and work with staff who had no previous Ebola experience (OCA, 2014).

This placed a high demand on Ebola trainers delivering training, responding to information requests and working in the field. Lessons identified from the internal OCB training review of the *First responder course* was that Ebola experts needed to give the first training to test the course material, but then hand over to other people to deliver. In addition, training of field trainers should be considered a priority (Bachy, 2015). Field staff also

highlighted that appropriately trained trainers are required in the field as the training role is one that is difficult to improvise (MSF Guinea, 2014).

Safety

Impact of training on staff safety

OCB staff who completed the *First responder course* before deploying to the field reported that the training had an impact on their safety, helped to reduce fear, and led them to feel safe working in an ETC. Of the OCB *First responder course* participants, more than 75% reported that the training resulted in them feeling safe to operate in an ETC (see Figure 3).

However, it was noted that international staff became less afraid as time went on, particularly if they arrived in the field when there were fewer cases which led them to believe that the situation was not as severe as described.

Both international and national staff reported during interviews that the training they received from MSF had a significant and positive impact on their safety, especially PPE training, and that they felt safe to operate in an ETC and in the community. National staff mentioned that initially they felt fearful of Ebola and unsure of the work, but found the training reduced their fear and increased their feeling of safety.

For international staff who deployed in the early phases of the epidemic before August and the start of the 1st Responder training, PPE and safety training was taught in the field. International staff who deployed at this time noted that to have worn the PPE at least once before going would have been useful, and as safety was a big concern, it should be emphasised before deployment, including the rules for working in an ETC.

According to reports from national staff, there was no training as part of ETC operations that covered the procedures for rescuing people from high risk areas in response to incidents such as staff collapse in full PPE. This was added in November and December 2014.

Informing National Staff safety

Feedback from national staff on the importance and value of PPE training was overwhelmingly supportive and positive about the usefulness and benefits of training, in particular PPE and handwashing training.

Staff felt that safety was the basis of the training. WatSan staff in Bo reported that triage was the most difficult area to work in, because it was the place with the greatest unknowns, and that they needed to be careful, to know the routines. The phrase used by the Bo WatSans was visible in many places in the ETC as a safety reminder - "slow, slow = safe, safe".

One concern expressed in interviews and field reports was that the variations in training provided to national staff in the field in some cases led to inappropriate use of PPE, such as including variation in dressing, and high consumption of PPE items, particularly gloves (WHS Manager, 2014). The MSF Ebola Guidelines (2008) clearly state that once an undressing method has been implemented, it should not be changed during the outbreak to avoid confusion.

National staff reported that benefits from their PPE training meant they were able to go home and spread the message about Ebola by teaching their family, friends and community how to stay safe and about the precautions to take.

Conclusions on training

Training is one of the top 10 priorities outlined in the 2008 Guidelines to be undertaken at the start of an Ebola intervention, and although a short-term training plan was implemented, a longer-term strategy was initially neglected. As a result, the training process became reactive rather than proactive, and initially there was no future projection of training requirements. Even when MSF was calling globally for resources in June, it was not doing enough of its own training.

Initially, the training plan was to follow the standard MSF field training process, but when OCB took on the overall Ebola crisis management process from OCG, responsibility for training was given back to OCG. At this point the OCB E-pool lost sight of training development.

This can be attributed to several causes. Firstly, because training was outsourced to another OC, it was being developed remotely from the operations and coordination centre (Task Force). The second reason focuses on Task Force operations, and the fact that many of the initial actions, delegated tasks and decisions in the Task Force were not documented. Having specific training and/or HR representative in the Task Force may have helped. In order to manage the workload, including the secretariat and administrative support in the Task Force would also have assisted with documenting decisions and tasking.

The decision-making process for transfer of Ebola knowledge to other organisations was made by the Task Force. The perception formed by external organisations that MSF questioned their aims, humanitarianism and intentions before sharing material might not have been viewed positively, particularly as MSF was requesting assistance from external actors.

A global view of national staff training requirements was missing across all countries and ETCs. There were different approaches to training and no single policy that governed the OCB national staff training programme. The content of training delivered to national staff was reliant on the experience and knowledge of international staff. The constant turnover of staff in the field resulted in poor consistency in training and interpretation of procedures, as well as confusion for national staff.

Three operational topics were pointed out as missing in the Ebola training:

1. The awareness of cultural differences, an understanding of national staff and the host country, and communicating across cultural boundaries (strongly missing).
2. Specific preparation for crisis management and leadership.
3. Training and implementation of emergency rescue procedures for incidents in high risk areas.

Basic safety training must form part of the initial training. It also needs to include the actions staff must take if they are affected by or have to respond to an emergency in the high-risk zone that results in emergency decontamination of staff.

The 12,500 viewings of the online training video clips during a period of six months illustrates their importance. More emphasis should be put on standardised resources, especially for use in the field, and to remind international staff to use them for training. Use of the videos in the field was limited as the files could not be downloaded, and internet access was not always reliable. It would have been beneficial to add the videos to the course material on the USB.

Improving the understanding of teaching methodologies and providing international staff trainers with an understanding of adult learning methods would enable successful training across the variety of situations encountered in the field, in particular working with national staff. Designing a system to develop the training skills of national staff to deliver or assist in delivering training would also be beneficial.

The OCB *First responder course* was well implemented and effective at short notice. The resourcefulness of EBC staff helped make this possible through borrowing items and re-using items normally considered disposable. However, investment in resources, both general and course-specific would be beneficial at EBC, for example, ensuring adequate water and power supplies.

Ebola course-specific items such as disposable face masks should be disposed of after each course and not re-used, to ensure a hygienic environment. To assist with clinical and safety training, use of an IV training arm would enable participants to practice IV cannulation while wearing PPE, and using fake blood would help with managing actual blood spills.

In order to recognise the training that national staff have completed, training attendance certificates could be issued. It is important for national staff to receive certificates recognising their achievements, which can assist with future work prospects.

The self-imposed constraints by OCB on trainer requirements meant there was a limited number of trainers for the *First responder course*, increasing the pressure and workload on a small group of staff with Ebola experience. Trainer development could be done using a principle similar to that in the field, for example pairing a referent trainer to work alongside one with less specialist Ebola knowledge. This concept can be applied to any type of specialist training.

A train-the-trainer concept could also have been used in-country to reduce pressure on ETC staff, utilising both international and national staff, which would also result in greater consistency. Engaging national staff and enabling them to train others empowers them to provide skills and knowledge for their own communities. In the area of training, OCB could enable national staff to do more.

Feedback from staff highlights the positive effect that training – in particular PPE dressing and undressing – had on their safety in the field during the Ebola epidemic. Consistency of PPE training and PPE use by staff in the field is vital, and the impact of fear on people's actions should not be underestimated. Fear, or a belief that the PPE is of inferior quality, can result in people making unapproved changes to PPE, such as adding extra layers of gloves, or adding tape at points they believe are vulnerable.

Clear communication to staff of any changes to PPE brand (including colour, style, material) needs to be undertaken to dispel any fears or misguided beliefs regarding quality or suitability. This should be communicated at all shift briefings, via printed material such as pictures, or through demonstration. These communications must be targeted to all staff to ensure consistency in training, use and understanding of safety equipment.

Lessons identified on training

- ⇒ That OCB (MSF) should enable the active transfer of knowledge in crises where it has a technical lead and requests mobilisation of other organisations.
- ⇒ That OCB should consider developing the use of video or on-line based training material, particularly for training on technical procedures, to ensure broad access to the information and to maintain a consistent message.
- ⇒ That OCB should invest in training facilities and resources at EBC, including improvements to water and electricity supplies.
- ⇒ That OCB should review the roles within the Task Force to include a secretariat support function that facilitates documentation of tasks, as well as other specialist functions when required, such as training, to enable a wider understanding of operational requirements.
- ⇒ That OCB consider all training courses should routinely include:
 - aspects of cultural awareness and communication
 - emergency rescue and evacuation procedures for staff working in hazardous areas
- ⇒ That OCB should review the process for the implementation and communication of PPE and other safety protocols in the field to ensure they are adhered to without approved changes or adaptations.
- ⇒ That OCB should incorporate training and knowledge transfer earlier into general operational and crisis response planning, and to include a policy for transfer of knowledge sharing for external organisations to use across all types of emergency situations.
- ⇒ That OCB considers developing a trainer policy to enable non-Ebola (or other area) specialists to deliver training and to utilise national staff skills.
- ⇒ That OCB implements a regular system for course evaluation and review, particularly from the field.

Recommendations on training

9. **Review training strategy and align it for national staff alongside that for international staff.**
 - Consider that all training courses should routinely include:
 - aspects of cultural awareness and communication
 - emergency rescue and evacuation procedures for working in hazardous areas
 - Invest in 'training of trainers' for potential international staff trainers to ensure adult teaching methods are understood and specific to national staff.
10. **Issue training attendance certificates to national staff** for attending Ebola training.

BRIEFING AND DEBRIEFING

The MSF 2008 Ebola guidelines state that as staff safety is a top priority, “briefing... about the disease... and about safety procedures needs to be given and repeated regularly”. Briefings and debriefings formed a core part of MSF’s Ebola response, both in operations and as part of staff welfare. More detailed findings regarding health briefing and psychosocial debriefing are part of the Duty of Care section of this report.

Definitions

Briefing is defined as either pre-deployment briefings or technical briefings undertaken during operations.

A briefing is a process of disseminating information prior to undertaking a task or activity. It is not a training session. Examples of technical briefings include, but are not limited to, a shift handover, staff meeting, or an update of operational information. They are generally given verbally.

Debriefing is defined as either post-deployment debriefings or technical debriefings undertaken during operations.

A debriefing is a process of review and/or reflection after undertaking a task or activity. It is not an investigation. Examples of technical debriefings include, but are not limited to, end-of shift handover, debriefing after serious incidents, or to review a task outcome. They are generally given verbally.

Briefing

Pre-deployment briefings were provided to international staff prior to departure, generally at the OCB office in Brussels. Respondents to the survey indicated that 83% received briefings, 63% received country-specific briefings, and 5% reported receiving no briefings. Of those who received pre-deployment briefings, 53% said that the briefings answered their concerns, 68% that the briefings provided relevant information, and two-thirds of respondents felt they could ask questions during the briefing sessions.

The pre-deployment briefings were constantly demanding and repetitive for those delivering them. They were considered important, however, especially for an Ebola response and to emphasise the importance of personal safety. The briefings lasted two hours and focused on the general Ebola context as well as Ebola-specific issues to be aware of in the field. Staff reported that continually repeating the same message daily for two months was a challenge and very intense, but worth taking the time to deliver.

In the field, international staff received a briefing on arrival which included the rules, non-negotiables, and roles. A variety of operational briefings also formed part of ETC operations, including daily morning briefings where updates were given, any rumours were dispelled and correct information was given.

National staff reported that they had the opportunity to participate in the various briefings that took place at the ETC, and that the shift handover briefings were particularly beneficial. In these briefings national staff reported that they were able to ask questions, that they learnt about specific case details and could discuss patient care. The shift change briefings were considered very important in the ‘confirmed’ areas of the ETC.

Briefings also formed an important information communication function in the Task Force, most often in the form of situation reports (sitreps) from the field. There were variations in reporting from the field to the Task Force as no standard briefing structure was used. Initially, written sitreps and updates from the field were sporadic, and most of the briefings were received by phone and email. Internally, the Task Force held two briefings a week at OCB to disseminate information amongst OCB staff.

The fact that many of these initial briefings and sitreps were received verbally and not recorded, caused an increased workload in the Task Force when staff were required to make a record of the verbal updates. In some cases information received by phone in the Task Force was not written down. The Task Force faced challenges in the early response stages to ensure that staff in the field wrote a sitrep and sent it to the Task Force, thus increasing the difficulty of sharing information.

Debriefing

Post-deployment debriefings were offered to international staff on return from the field, with the majority of staff attending the OCB office. There was a series of debriefings for returning staff, which sometimes took place on the day of their return from the field. From the survey, 80% of respondents reported receiving a debriefing from the SHU, 55% reported having a debriefing with their pool manager, 72% received a psychological debrief, and 61% had an operational debrief. A small number (6%) reported not receiving any debriefing session, a figure similar to the proportion who also reported not receiving a briefing.

The Task Force reported that it was important to debrief all returnees, to gather recent information from the field and to adapt Task Force actions according to the information received. HQ staff reported that it was important for international staff experiences and views to be heard on return and that it was beneficial to listen, as returnees needed to talk and be listened to, especially after an Ebola mission. Some staff reported that it was difficult to debrief colleagues whom they knew.

International staff interviewed reported feeling happy with the debriefings on return, particularly the psychological debriefing sessions, that they felt taken care of, and they could talk openly.

Debriefing or post-incident reviews at ETCs were often conducted following operational incidents. National staff reported that they received debriefing following critical incidents which acted as a learning point, and that it was possible to discuss issues in staff meetings. After serious incidents involving staff, such as infections, there were extra group debriefings. In the case of national staff infection, the cause was explained.

However, in the case of international staff infection, national staff were excluded from being debriefed and informed of the cause. Not being part of the discussions increased their fear about what was being hidden. Similar issues were reported in Sierra Leone when staff felt they were not given enough information in post-incident debriefing sessions. However, in the same ETC, WatSan staff reported that they were well debriefed and informed following incidents.

All national staff interviewed reported that they had access to psychological support as part of the debriefing process, and that it was beneficial. They highlighted the opportunity to talk and be listened to for psychological support and debriefing, both individually and in groups.

Conclusions on briefing and debriefing

The briefing process used for the Ebola response was an opportunity to give reassurance to people and highlight key points to stay safe in the field. Whilst a high number of staff reported receiving a briefing, only about half of these felt that the briefing answered their concerns.

The main challenge reported by staff delivering the briefings was to remember the content, and the repetitive nature highlighted the importance of needing to use a structured briefing system. Reviewing the content of briefings and obtaining feedback from staff about the usefulness of briefings would help to ensure that content is relevant and responds to staff concerns.

The positive reports received from national staff indicate that the shift handover briefings in the ETC formed a very important role in the transfer of information not only about daily ETC routine, but also relevant patient care details. It also afforded the opportunity for people to learn and to ask questions. These effective briefing sessions should continue to form a core part of daily operations.

At all stages of emergency response, there is a requirement to receive accurate information from the field to enable effective crisis management. The Task Force was hindered by the variability in the sitreps, reporting and briefing from the field. Formalising this process with standard briefing and reporting structures in the field and Task Force – not just for Ebola, but all emergencies – would enable more effective and accurate information management.

On return from the field, international staff were required to attend up to three debriefing sessions at OCB, often in one day. As this occurred immediately after leaving the field, it gave little time for staff to process what they had seen and experienced. Whilst the requirement for debriefing may be particularly important following an Ebola mission, consideration could be given to delaying some of the debriefing to allow processing of the mission.

At times the Task Force relied on obtaining current operational information from field operations through debriefing of returning international staff. For the latest operational information, the Task Force should be gathering information on a daily basis from briefings sent from the field, not routinely using returnees. Challenges experienced in receiving briefings from the field, as previously highlighted, may be placing pressure on returning staff to provide operational information which should come from daily briefings.

A regular, structured and consistent approach is needed for the process of debriefing in the field, particularly following a serious or critical incident. It is also important to treat all staff groups equally by providing both national and international staff with the necessary post-incident information. The differences that occurred in post-incident debriefing within ETCs suggest that further training is required for staff in the technique of operational incident debriefing.

Lessons identified on briefing and debriefing

- ⇒ That OCB should review the process for operational incident debriefing in the field, including providing additional training for international staff in conducting effective debriefing sessions.
- ⇒ That OCB E-Pool should consider including a secretariat role in the Task Force to assist with administrative tasks to ensure that all activity, tasking, and information to and from the Task Force is documented. This will allow for a clear operational picture from the field to be regularly updated and maintained.
- ⇒ That OCB SHU and E-pool should review the pre-deployment briefing process to ensure that it delivers the required information for staff.
- ⇒ That OCB reviews the process of debriefing international staff on return from deployment, including the timing and number of debrief sessions.

ANNEXES

ANNEX I: TERMS OF REFERENCE

<http://evaluation.msf.org/ocb-ebola-critical-review-work-page-1>

ANNEX II: LIST OF INTERVIEWEES

For all HR components of the review

[Surname, First Name]	[Function]
Adamson Brett	Medical Focal Point, ELWA, OCB
Bachy Catherine	Ebola training referent, OCB
Bedock Gérard	Coach, training Unit, OCG
Cabrol Jean-Clément	Director of Operations, OCG
Caluwaerts An	Health and IPC referent, OCB
Ciglnecki Iza	Medical Referent, Medical Department, OCG
Cornelis Muriel	Human Resources Director
Crestani Rosa	Emergency coordinator / Task Force coordinator, OCB
Dafour Sébastien	Head of HR Specialist unit, OCG
De Cleckr Hilde	Emergency Medical coordinator, MIO VHF, OCB
De La Tour Roberto	Laboratory expert, Medical Department, OCG
De Lamotte Nadine	Recruitment and Development coordinator
De Leval Fabienne	HR Learning and Development Unit Coordinator, OCB
De Le Vingne Brice	Director of Operations, OCB
Delahaie Agnès	FAU & SHU Coordinator, OCB
Didri Naoufel	Polyvalent logistician, Logistic Department, OCG
Dorion Claire	Watsan, Logistic Department, OCG
Draguez Bertrand	Medical department director, OCB
Ferir Marie-Christine	Emergency coordinator OCB
Folkesson Elin	Project Medical Referent
Forget Marc	Emergency Coordinator, Guinea
Fraser Emma	Human Resources Support, OCB
Goublomme Stéphanie	HR Referent, Task Force Ebola, OCB
Grumit Lainie	HR Referent, Emergency Desk, OCG
Isaacs Ken	Samaritan's Purse, USA
Jamiru Bernard	HR Coordinator Assistant, Sierra Leone
Janssen Bart	Director of Operations, OCB
Jemmy Jean-Paul	Medical coordinator of operations, OCB
Joachim Caroline	Mental Health Referent / SMS, OCB
Job Dorian	Deputy Head of Programs, Emergency Desk, OCG
Jochum Bruno	General Director, OCG

Juvyns Catherine	Project Medical Reference,
Lecanu Sophie	HR Referent, Task Force Ebola, OCB
Levistre Violaine	Human Resource, OCB
Loop Benoit	Field HR Coordinator, OCB
Moret André	Logistic Coordinator, OCB
Mortier Delphine	EBC manager, Brussels, OCB
Oraegebu Anthony	International Staff doctor, Sierra Leone
Ozaltin Basak	Logistic Coordinator, OCB
Perivier Isabelle	Training unit, OCG
Petrucci Roberta	Medical Operation Support (MOSU), OCG
Pontiac Nicolas	HR Coordinator, OCB & Bioforce
Robert Hugues	Head of Emergency Desk, OCG
Roux Alex	Head of HR operation, OCG
Roy Sébastien	HR Director, OCB
Saive Françoise	Staff Health Unit manager / SMS, OCB
Severy Nathalie	Mental Health Referent, OCB
Sterck Ester	Medical referent, OCG
Tampellini Livia	Medical doctor, field, OCB
Thorel Aude	Deputy HR Director, OCG
Torborg Bridget	HR Administrator Manager, Liberia
Tyre Patrick	Medical Coordinator Assistant, Sierra Leone
Verhoustraeten François	Coach at Training Unit, OCG
Verschauer Jesse	Health Promoter Supervisor, OCB
Vogt Florian	International Staff epidemiologist, Liberia
Waterho Claire	HR Coordinator
GROUP INTERVIEWS – Training	
Sierra Leone MSF National Staff	Nurse Aides
	Nurses
	Clinical Supervisors
	Counsellors
	Health Promoters
	Watsans
Sierra Leone IFRC National Staff	Nurse, Logistics, watsan, IPC
Liberia MSF National Staff	Watsan trainer
	Nurse Aides
	Nurses
	Physicians assistants / supervisors
	Health Promoters
	Community Health Workers
	Watsans

ANNEX III: INFORMATION SOURCES

Field visits and interview locations:

Brussels – EBC training facility, OCB HQ (June – Sept 2015)

Liberia – Monrovia, ELWA3 ETC, MSF Clinic (14 - 21 Aug 2015)

Sierra Leone – Bo, Bo ETC at Bandajuma, Kenema, Freetown (21 – 30 Aug 2015)

ANNEX IV: REFERENCES AND BIBLIOGRAPHY

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Survey:

Live from 4 to 20 September 2015

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