

MSF EMERGENCY RESPONSE TO CYCLONE IDAI IN MOZAMBIQUE

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

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ACRONYMS

AECID	Agencia Española de Cooperación Internacional al Desarrollo
COSACA	Consortium Oxfam, Save the Children, Care
CTC	Cholera Treatment Centre
CTU	Cholera Treatment Unit
EMT	Emergency Medical Team
FreLimo	Frente de Libertação de Moçambique
GoM	Government of Mozambique
HIV	Human Immunodeficiency Virus
HP	Health Promotion
HR	Human Resources
IFRC	International Federation of the Red Cross
INGC	Instituto Nacional de Gestão de Calamidades (National Disasters Management Institute)
IO	International Order
IOM	International Office of Migration
MDM	Movimento Democrático de Moçambique
MISAU	Ministerio Saude MoH
MoH	Ministry of Health
NFI	Non-Food Item
OC	Operational Center
OCA	Operational Center Amsterdam
OCB	Operational Center Brussels
OCBA	Operational Center Barcelona
OCG	Operational Center Geneva
OCHA	Office for the Coordination of Humanitarian Affairs
OCP	Operational Center Paris
OCV	Oral Cholera Vaccine
ORS	Oral Rehydration Salts
Renamo	Resistência Nacional Moçambicana
RIOD	Reunion International Operational Directors
RSA	Resource Sharing Agreement
TB	Tuberculosis
UN	United Nations
UNICEF	United Nations International Children's Emergency Fund
Watsan	Water and Sanitation
WCO	WHO Country Office
WHO	World Health Organization

EXECUTIVE SUMMARY

This evaluation analyses the emergency intervention of MSF in Mozambique in March-May 2019. The 5 OCs intervened, responding to a cyclone and a subsequent cholera outbreak. The overall operation resulted in treating 3,800 cholera patients, delivering 12,000 consultations, supplying 6,000m³ of water and distributing NFI to 23,000 families. It cost 9,3M€ and included 208 international positions. The objective of the evaluation is to provide an independent assessment of the intervention, to draw lessons, and offer recommendations for inter-OC management of future natural disasters.

METHODOLOGY

The evaluation, commissioned by the RIOD, was conducted over a 10-weeks period by two external consultants. It is based on interviews with 70 people, document review and field visit. The results were analysed according to the following evaluation criteria: relevance, appropriateness, effectiveness, efficiency and coordination. Some limitations affected the evaluation, specifically the unavailability of focal points & key informants; the limited time between the field visit and RIOD presentation; and the lack of and difficulty to obtain documents.

BACKGROUND

On March 15, 2019 the Tropical Cyclone Idai hit Beira in Sofala Province affecting 1,85 million people. The government declaration of a national emergency and appeal for international support activated a strong response by the international community: UN Level 3 emergency, 200+ agencies, 386M\$ budget requested. A cholera outbreak was declared on March 27. A few weeks later another cyclone, Kenneth, made landfall in Cabo Delgado province already affected by a low-intensity conflict. At time, OCB and OCG were present in Mozambique with a joint coordination, HIV/TB projects in Beira and Maputo and a recent primary health care/watsan project in Cabo Delgado.

FINDINGS

WHAT IS THE SPACE FOR MSF IN NATURAL DISASTERS?

As one of the world's most vulnerable countries with regards to natural disasters, Mozambique has developed an effective emergency response system. In Idai crisis, limited medical needs, strong national and international response capacity raises questions about the operational space for MSF. MSF intervention became more relevant with the cholera outbreak, managing 57% of overall patients. With climate change and suggested increased frequency of natural catastrophes, as well as a growing number of actors with improved capacities, MSF needs more than ever to reflect how it can intervene in such contexts. To find its space, MSF must be reactive, bear in mind its expertise and conduct thorough analysis of both needs and competing responses.

AN APPROPRIATE INTERVENTION

The emergency response to both cyclone and cholera outbreak was appropriate. Confronted with fewer needs than expected MSF re-oriented its activities to pre-emergency needs, making use of the important on-site resources. Idai intervention was the opportunity to develop innovative approaches as the Aquaforce 15000 water treatment station and the systematic use of GIS mapping.

REACTIVITY UNDER QUESTION

While it was known days ahead that a major storm was about to hit Mozambique MSF did little to anticipate, highlighting here a limited emergency preparedness by the regular missions and OCB E-cell. As a result, MSF arrived and deployed later than some other agencies, when some priority activities had already been assigned.

A FEW TOO MANY

The request by OCB for support turned into the intervention of the 5 OCs without a proper coordination: OCBA and OCP decided to intervene unilaterally; and OCA switched from supporting OCG with extra HR to a separate intervention. This resulted in the redistribution of the operational space, overlaps and challenging internal and external coordination. Besides needs, operational ambitions and internal pressures have come into play in the decision to intervene for some OCs. Nevertheless, the presence of 5 OCs gave rise to several conclusive mutualization initiatives (such as a common supply dispatch in Maputo).

RESOURCES: FROM A “NO-REGRETS” APPROACH TO A DEBATABLE ACCOUNTABILITY

The main expenditures of the 9,3M€ budget were supply (45% budget) and international HR (18% budget). While taking the risk to “overshoot” is expected in responding to natural disasters, in Idai response MSF could have taken decisions less blindly. Poor initial needs assessments and limited consideration of other actors led to an incomplete analysis of the situation and, in turn, to an oversized intervention. The lack of internal coordination regarding the supply also particularly impacted the operations’ efficiency (43% of the international orders ended up in donations).

This substantial use of resources was made possible in an environment where “money shouldn’t be a blocking factor” is the motto. It was also favoured by its financial independence, discharging MSF to link inputs to outcomes, analyse and challenge results. Finally, it was the result of internal mechanisms such as the RSA system and the social mission ratio that indirectly don’t support accountability among decision-makers. This is particularly problematic in MSF current financial situation.

INTERVENTION IN CABO DELGADO, CYCLONE KENNETH

While it looked like a “classic” MSF context (conflict, neglected population, IDPs and limited number of actors) the response by MSF was minimal (prioritizing easily accessible areas, delays, etc.). The reasons for this reduced response were in part the same as for the international community: tiredness of the E-teams after Idai, reluctance to deal with

insecurity and lack of funds. But MSF internal dynamics and individual OC approach also came into play.

CONCLUSION

While MSF response to the cholera outbreak was relevant, appropriate and effective, the response to the cyclone is more questionable. Considering the limited needs and the massive national and international response there was little space for MSF. This space was further reduced as MSF arrived and deployed later than some other actors, as a result from insufficient preparedness and reactivity.

The intervention of 5 OCs was unnecessary. Although it gave rise to some positive mutualisation efforts, it was the main reason for a clearly oversized intervention. Another reason for the over-resourcing was a weak analysis of the situation; needs, priorities and competing responses. This was facilitated by internal mechanisms that don't encourage efficiency and accountability among the decision-makers.

Idai intervention highlights the need for MSF to adapt its way of intervening in natural disasters, to better coordinate and to become more accountable as a movement.

RECOMMENDATIONS

Details in main body of the report

Area 1: Strengthen emergency preparedness

Area 2: Reinforce needs assessment capacity

Area 3: Improve inter-OC coordination

Area 4: Question the role of MSF in natural disasters

Area 5: Foster further accountability

INTRODUCTION

This summative evaluation, commissioned by the RIOD, analyses the emergency intervention of MSF in Mozambique in March-May 2019. The 5 operational centres intervened, responding first to the cyclone Idai and then to a subsequent cholera outbreak. The overall operation resulted in treating 3,800 cholera patients, delivering 12,000 consultations supplying 6,000m³ of water and distributing NFI to 23,000 families. It cost 9,3M€ and included 208 international positions.

The objective of the evaluation is to provide an independent assessment of the intervention. While reviewing the relevance, appropriateness, effectiveness, efficiency and coordination of the intervention – within the larger scope of the international response – the assessment gives rise to discussions regarding the space for MSF in natural disasters, emergency preparedness, internal coordination as well as accountability.

The evaluation intends specifically to support the RIOD drawing lessons and developing recommendations for inter-OC management of future natural disasters.

METHODOLOGY

According to the terms of reference (Annex I) the evaluation's purpose was to:

“Support the RIOD to decide if there is an argument to look at how each OC manage comparable events in the future and potentially make decisions towards change in both practice and policy.”

“Learn about the different perspectives, approaches, and understandings, which could help to define future inter-OC approaches to natural disasters to enhance effective & efficient responses.”

The evaluation was conducted over a 10-weeks period by two external consultants with MSF experience. The decision to evaluate Idai response was initiated by OCB with support from the RIOD with a strong interest by OCB/OCG regular missions in Mozambique. The ToRs were drafted by Stockholm Evaluation Unit with inputs from all OCS and shared with the 5 directors of operations.

The inception phase allowed to clarify the expectations from each OC and specify the evaluation's scope, in particular the extend of the inclusion of the response to cyclone Kenneth.

SOURCES INFORMATION

Document review: Review of the information available concerning MSF response and general humanitarian needs and response (See. Annex III. Information sources):

MSF internal documents: needs assessments, final intervention reports, end of mission reports, sitrep, budget, donations, organigrams, etc.

Other actors' documents: Mozambique Humanitarian Response Plan, ALNAP briefings, MoH reports, etc.

Interviews: Semi-structured individual interviews with 70 persons involved in MSF response in the field or the headquarters (E-cells, E-teams, Reg. missions, Reg. cells, DirOps, etc.), external actors (WHO, IFRC, etc.) and authorities (MoH). Most interviews were held via videoconference; some were done in person (See. Annex II. List of interviewees). Most interviews for OCP were done in the frame of the RIDER Critical Review by OCP consultant; notes of the interviews were used as secondary data.

Field visit (5 days): Maputo OCB & OCG regular missions', authorities, external actors

TOPICS ANALYSED IN-DEPTH

- Initial needs assessments: medical/non-medical needs, cholera outbreak epidemiology, MoH/other actors' presence and capacity, etc.
- Definition of the intervention: strategy, objectives, choice of activities and resources
- Reactivity: emergency preparedness, timeline of teams' deployment, reception of international orders, etc.
- Results: number of patients treated in CTU, number of consultations in mobile clinics, percentage of referrals, water distributed, NFI distribution, etc.
- External coordination with authorities and external actors
- Intersection coordination, especially in the decision to intervene, and mutualization

EVALUATION CRITERIA

The results were analysed and interpreted according to the following evaluation criteria:

- Relevance in view of the context and needs
- Appropriateness of strategy and activities
- Effectiveness
- Efficiency
- Coordination

LIMITATIONS

This evaluation faced some limitations:

- Unavailability of focal points & key informants
- Limited time between the field visit and RIOD presentation;
- Lack of documents (e.g. no written initial assessments) and difficulty to obtain others

BACKGROUND

CONTEXT

OVERVIEW OF THE CRISIS

For the first time in history two strong tropical cyclones made landfall in Mozambique in the same season.

On March 15 2019 the Tropical Cyclone Idai hit Mozambique port City of Beira in Sofala Province and the surrounding areas, flooding and destroying 90% of the city (500,000 inhabitants): more than 240,000 houses, infrastructure and hundreds of thousands of hectares of crops were destroyed, more than 400,000 people were displaced, 1,600 injured and 600 died. Idai had already entered Mozambique and Malawi as a tropical depression, causing floods and triggering fears that dams will break. Overall an estimated 1,85 million people were affected by what has been described as the biggest natural disaster in the region in history. The damages were mostly caused by the floods brought in by torrential rains rather than the wind. In terms of public health, access to water and sanitation was compromised. The cyclone caused major damage to the health sector infrastructure, with at a total of 94 health centres destroyed or damaged, including equipment, medicine and medical supplies.

On 25 April, 6 weeks after Idai, a second cyclone, Kenneth made landfall in Cabo Delgado province, flattening entire communities on its path and leading to an additional 374,000 people in need of urgent assistance, 3,000 displaced, 91 injured and 45 deaths. Although the cyclone's impact was less severe than Idai (no floods and less populated area), it hit a population already affected by a low-intensity conflict¹.

A cholera outbreak was declared on March 27 in Sofala Province with the first suspected cases in Nhamatanda district on March 17 and in Beira district on March 21. A total of 6,768 suspect cases and 8 deaths were reported (case fatality 0.1%) with Beira as the most affected district with 4,654 cases and 4 deaths. The outbreak was cut early mostly thanks to a successful cholera vaccination campaign lead by the MoH, reaching more than 800,000 people, 98% of the targeted population.

Following the cyclone, malaria cases increased in the affected provinces with an accumulative 83,138 reported cases. The GoM organized a large vector control plan (mosquito net distribution, indoor spraying, etc.).

The disaster jeopardized access to care for people living with HIV in a country where the prevalence is among the highest; in Sofala Province, at least one in six adults are HIV positive.

¹ See Political context, p. 10

Adding to months of drought, both cyclones exacerbated an already serious food insecurity and malnutrition situation in the country.

INTERNATIONAL HUMANITARIAN RESPONSE

On March 12, the government of Mozambique (GoM) declared national emergency and appealed for international support. The UN declared a Level 3 emergency activating a strong response by the international community. The response was led and coordinated by the GoM at national and provincial level through the National Institute of Disaster Management (INGC) supported by the Humanitarian Country Team and the cluster system.

The international response was massive: deployment of militaries (India, South Africa, Brazil, etc.) especially for the search and rescue activities; more than 200 agencies for a total budget of 386M\$ requested (282M\$ for Idai and 104M\$ for Kenneth)². 14 Emergency Management Teams (EMT), including 4 with hospitals level 2, were deployed following the GoM request in Beira, Buzi, Dondo, Nhamatanda districts. According to the interviews the response main shortcoming was the neglect of rural areas (focus on central areas); the main gaps were in shelter needs.

POLITICAL CONTEXT

The cyclones struck in a pre-electoral context (national elections in October 2019). This meant additional pressure for the government (led by FRELIMO party) to demonstrate its capacity to respond in Sofala Province, an opposition (RENAMO party) stronghold and in Beira city managed by a third party (MDM).

Cabo Delgado Province was already affected by a low intensity conflict. Islamic extremists (a group known as Ahlu Sunnah Wa-Jamâ) have been launching violent attacks on civilians since October 2017, resulting in 2,000 people displaced, nearly 300 killed, and 60,000 affected by violence and insecurity. The root motivations of these attacks are complex and involve poverty, unemployment, and the recent discoveries of gas³ and oil deposits besides other natural resources (rubies, gold, timber, ivory). These riches are exploited by foreign companies and do not benefit the local populations, breeding the ground for radicalization. With its porous border, the area is also the theatre of criminal activities and traffics. The response to the attacks involves brutal retaliation by the army and human rights abuses by the government which, given the economical stakes, has obviously not interest in lending visibility to the situation.

EXISTING MSF PROJECTS

At the time of the disaster OCB and OCG were already present in Mozambique with:

² 2018-2019 Humanitarian Response Plan Mozambique, Aug 2019. Idai response was funded at 34% and Kenneth at 10%.

³ World third largest gas reserve

- Joint coordination in Maputo with all positions mutualized except the HoM and MedCos
- HIV/TB project in Beira city since 2014(OCB)
- HIV/TB project in Maputo (OCG)
- Primary health care/watsan project in Cabo Delgado since February 2019 (OCB/OCG)

MSF EMERGENCY INTERVENTION

GLOBAL INTERVENTION

Following Idai, MSF launched an emergency response in Mozambique that lasted from March 19⁴ until June 2⁵ 2019 (see Annex V Timeline of intervention). The intervention included responding to the cyclone and to the subsequent cholera outbreak throughout the following main activities:

Table 1. Main activities and results, global MSF intervention

	Activity	Results
Cyclone response	Mobile clinics	11,858 consultations in 25 locations
	Health rehabilitation structure	18 Health centres
	NFI distribution	22,925 households
	Mental health	Capacity building
Cholera response	CTC	3 CTCs & 6 CTUs/ 300 beds / 3,824 patients
	ORPs	17 ORPs / 1,910 patients
	OCV	Log support to MoH
	Watsan	Supply 6,095m3 water 243 water systems repaired

The overall operations cost 9,311,061€ and included 208 international positions.

⁴ Arrival of OCB E-team in Beira

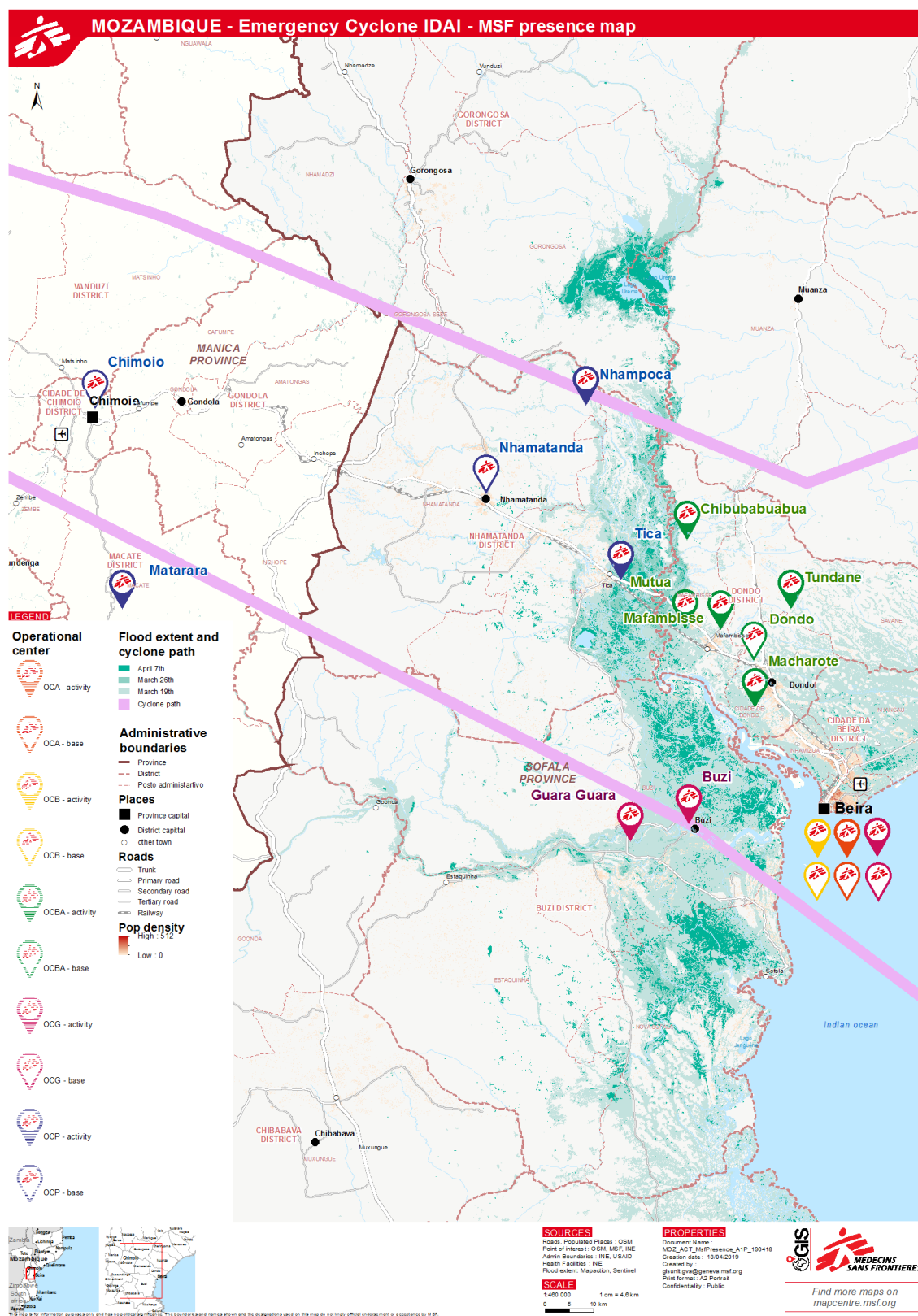
⁵ End of OCBA intervention

INTERVENTION BY OC

Table 2. Main activities, results, and resources, intervention by OC

		OCB	OCG	OCBA	OCP	OCA
Cyclone response	HC rehab	10 HC	2 HC	3 HC	3 HC	
	Mobile clinics (consultations)	2,315	2,464	5,152	1,927	
	Malnutrition					
	Malaria					
	Health promotion					
	Mental Health					
	NFI distribution (households)		1,632	7,123		14,170
Cholera response	CTC (beds, patients)	130-2,485	92-639	58-504	20-196	
	ORP (consultations)	1,266		229		415
	OCV campaign					
	Ambulance system					
	Water (supplied m3)	837	4,550		672	
	Water systems repaired					243
Budget (in 1,000€)		4,184	1,773	1,473	1,173	0,706
International positions		80	38	36	29	25

Figure 1. Map of intervention



FINDINGS

WHAT IS THE SPACE FOR MSF IN NATURAL DISASTERS?

SPACE FOR MSF IN IDAI RESPONSE

Mozambique is classified as one of the world's most vulnerable countries with regards to natural disasters and the effects of climate change⁶. It suffers regularly from major floods and cyclones⁷, causing widespread destruction of homes, infrastructure and crops and displacing hundreds of thousands. The country is also affected by recurrent droughts.

Since 1999, the national emergency response system is lead and coordinated by the INGC (National Disasters Management Institute). The specialized emergency management agency has effectively contributed to Idai response with strengthened operational capacities and innovations (e.g. drone mapping enabling rapid assessment and targeting of affected areas.) Since 2007, it is supported by the humanitarian consortium COSACA composed by Oxfam, Save the Children and Care.

OCB/OCG regular missions in Mozambique, well aware of the system, acknowledge its response capacity. For this reason, they have chosen to focus the E-prep strategy on supporting the MoH responding to outbreaks (mainly cholera) and small displacement of populations where they saw MSF had an added value.

Besides MSF intervention, the global response to Idai was strong.

The reactivity and effectiveness of the GoM response, both at national and local level, was impressive with the following achievements:

- Pre-positioning trauma kits before cyclone;
- Reopening health structures;
- Organizing medical services in IDP camps & reallocating health staff;
- Leading OCV campaign (vaccines ordered preventively on March 20) targeting 885,000 people, with a 98% coverage;
- Fixing Beira city water system in 10 days;
- Implementing a massive vector control plan against malaria (indoor spraying, larvicide and mosquito net distribution).

⁶ In 2018 INFORM Index, Mozambique scores 6.7 in lack of coping capacity, 6,8 in vulnerability and 5,3 in hazard and exposure indicators <https://drmkc.jrc.ec.europa.eu/inform-index/Countries/Country-Profile-Map>

⁷ In 2000, MSF intervened in Maputo and Gaza provinces; in 2001 in Manica, Tete, Zambezia and Sofala provinces; in 2007ⁱⁿ Zambezia and Tete provinces; in 2013 in Gaza province.

The GoM response was recognized by MSF teams who were also surprised, having underestimated its capacity.

Responding to the GoM appeal, the mobilization from the international community was massive with a budget of 96M\$ (34% of 282M\$ appeal) and a plethora of actors, some of them arriving earlier and deployed faster than MSF⁸.

The space for MSF was limited in the response to the cyclone. Experienced rescue teams carried out the search and rescue of the thousands of people stranded on roofs and in trees⁹. The MoH dealt with the surgical management of the 1,600 wounded in Beira General Hospital¹⁰ with the support of EMTs with level 2 field hospitals. The MoH organized medical services in the IDPs settlements and re-dispatched HR from other provinces. Drugs and medical material were available. The added value of MSF intervention through mobile clinics, health centres rehabilitation and NFI distribution was questionable especially in Beira as there was already a concentration of other actors involved in similar activities. Because of the presence of other medical actors, some OCs had to revise their initial plans of providing secondary health care to avoid overlapping¹¹. There was also not such a need for MSF in the malaria outbreak prevention as the GoM implemented, quickly and with success, a large malaria vector control plan¹².

MSF field teams themselves realized that the limited medical needs, the strong national response capacity as well as the growing presence of international actors lead to question the space for MSF in such context¹³.

MSF found its space and added value with an effective involvement in the cholera outbreak – as envisioned by the regular missions in their E-prep strategy – as fewer actors had the experience and skills in dealing with cholera. MSF role was especially key in the case management – dealing with 57% of the patients – while its participation in the OCV vaccination campaign was not as important as expected¹⁴.

Given the high HIV prevalence in the country and the nature of MSF regular programs, MSF also found its space in supporting and restoring the access to treatment for HIV patients. This rare co-incidence of HIV and natural disaster opens a field that could be further explored by MSF.

⁸ See Reactivity under question, p. 15

⁹ It should be noted that this activity, although not related to MSF mandate or competency, was considered by OCB E-team and that resources were deployed.

¹⁰ The hospital rehabilitation was handled by the Italian Cooperation

¹¹ OCP and OCBA both discovered that other actors had been assigned to hospitals they had planned to manage. See p. 22

¹² OCB had thought of intervening, sending its headquarters malaria and vector control referents

¹³ This question is also part of OCP RIDER Critical review Initial Question ‘Emergency intervention in Mozambique: Internal decision making mechanisms and effects on operations’: “This also brought questions on whether an intervention from OCP was needed and how it unfolded considering our organizational structure for this type of natural hazard response”.

¹⁴ See Incomplete picture p. 21

SPACE FOR MSF IN NATURAL DISASTERS IN GENERAL

All MSF operational centres – E-cell and Operations directors – acknowledge that MSF added value is limited in a natural disaster, especially cyclone/floods, and that to have an impact MSF needs to intervene from the very beginning.

This is particularly true given the increasing number of actors in natural disasters and their improved capacities. In the last 20 years a number of major natural disasters¹⁵ have triggered large-scale humanitarian action and the multiplication of actors¹⁶. Following Haiti earthquake in 2010, the critical attention given to natural disasters' response lead to improvements. The Emergency Medical Teams (EMT)¹⁷, in particular, became more reactive and effective as the WHO developed principles, criteria and standards around the system.

Unlike earthquakes, cyclones and floods/flash floods cause little severe wounded. In this type of crisis, the humanitarian priorities are first and foremost non-medical (shelter, basic relief items access to water). Medical needs are not about life saving but about supporting the restoration of routine health services and surveillance.

With the climate change and increased frequency of natural catastrophes, MSF needs more than ever to reflect how it can intervene in such contexts, given the limited medical needs and increased presence, capacity and reactivity of other actors.

For its action to be relevant in natural disasters, MSF must be reactive but not only¹⁸. In order to find its place and make the best use of its added value, MSF needs to bear in mind its scope of activity and expertise while conducting fine analysis of both needs and competing responses from all actors, especially the government. It should not a priori be assumed that the government is dysfunctional. MSF should learn to adapt its way of working in countries with stronger governments, well-structured administration and, in the case of Mozambique proven record of managing similar events.

Finally, the scale of the disaster as the main criterion for MSF intervention¹⁹ could be debated as it potentially poses a dilemma: while triggering the deployment of other actors it also reduces the space – and possibly the need – for MSF presence.

¹⁵ 2000 Mozambique floods, 2005 Pakistan earthquake, 2004 tsunami, 2010 Haiti earthquake

¹⁶ The most noticeable and recent trend in the deployment of EMTs is the rapid increase in the number of teams arriving to assist in the aftermath of heavily publicized disasters". The Regulation and Management of International Emergency Medical Teams, WHO & IFRC, 2017. 180 agencies intervened in Indonesia following the 2004 tsunami; 400 agencies provided health care in 2010 Haiti earthquake response; 150 EMTs in 2015 Nepal earthquake response.

¹⁷ www.who.int/hac/techguidance/preparedness/emergency_medical_teams/en/
<https://extranet.who.int/emt/>

¹⁸ See Reactivity under question, p. 15

¹⁹ Each OC has a different operational policies regarding natural disasters (cf. strategic plans): OCB intervenes by default; OCBA, OCG and OCP intervene depending of the specific situation and OCA doesn't intervene in principle unless it occurs in a country where MSF is present, or is of such a scale and intensity.

AN APPROPRIATE INTERVENTION

On the first days the emergency teams struggled with identifying priorities. As a result, OCB strategy was originally unclear: objectives not explicitly defined; strategy changing constantly.

Following this initial phase, the strategy was refined, and the emergency response turned out appropriate. MSF activities related to the cyclone finally focused on supporting the MoH on primary health care provision (mobile clinics, malnutrition and malaria); rehabilitating health centres and distributing NFI. MSF adapted fast to the cholera outbreak and its strategy was also appropriate with case management (ORP & CTC), support to the OCV campaign and community approach (watsan & HP). The cholera response was effective with MSF managing 57% of all reported cases.

Confronted with needs less important than expected – especially as the cholera outbreak was quickly under control – MSF choose to make use of its important on-site resources (HR, supply) and to re-orient them to activities related to pre-emergency needs. OCG watsan intervention in Buzi was mostly related to a problematic anterior to the cyclone²⁰, making use of the equipment available. OCP mainly engaged in supporting the access to malaria treatment (test & treat) and malnutrition screening. While still focusing on the cyclone/cholera needs – although needs seemingly less urgent – OCA took the opportunity to develop its know-how in watsan – working with the city authority on rehabilitation of the water network – to include an anthropological approach and implement door-to-door NFI distribution.

Idai intervention was an opportunity to develop innovative approaches. For the first time MSF deployed a massive water treatment station (Aquaforce 15000) in Beira and Nhamatanda. In addition to a further shift from more basic to high-technical watsan, what is perhaps most noteworthy is the fact that it was a partnered solution with the French foundation Veolia. The systematic use of GIS maps was also pointed out as very beneficial by the teams, allowing focusing the operations (targeted surveillance, watsan and NFI) and affecting effectiveness.

REACTIVITY UNDER QUESTION

LACK OF PREPAREDNESS

On March 9, the national meteorological authorities from Mozambique issued an alert that the tropical depression that formed off the coast of Mozambique on March 4 – and had already affected 850,000 people and caused 60 deaths in Malawi and Mozambique – was evolving into a cyclone category 1 called Idai²¹. On March 11, Idai turned into a cyclone category 3; it was then expected to make landfall near Beira on March 14 or 15, and to have a high humanitarian impact based on the maximum sustained wind speed, exposed population and vulnerability²².

²⁰ The water network had been salty for 10 years

²¹ Flash update, UN Resident Coordinator for Mozambique, 10 March 2019

²² OCHA Cyclone Idai Snapshot, 12 March 2019

While it was known days ahead that a major storm was about to hit Mozambique, MSF did little to prepare. OCB regular mission evacuated its international team from Beira. Days ahead OCB E-cell started monitoring the cyclone's evolution but without taking any preventive measure, for example leaving a satellite phone with the national staff in Beira or pre-deploying an E-team on the ground. As a comparison, the MoH and WHO prepositioned material (ex: trauma kits) in Beira and the IFRC envisioned various scenarios of impact and corresponding responses.

As OCB E-cell took on the management of the emergency, the E-prep stock list from Mozambique was not available with the regular cell; and upon arriving in the country the E-team realized the E-prep – already expected to be insufficient, as not made for this size of crisis – was also not updated and incomplete. OCB/OCG regular missions acknowledged the emergency preparedness had “not been a priority”.

LATER THAN OTHERS

Without adequate preparedness MSF had to catch up to launch the operations.

On March 19, the first E-team from OCB arrived in Beira²³, 4 days after the cyclone and 2 days after the first humanitarian actors (UN agencies, ICRC, Save the Children, Concern, etc.). As there were still no flights Maputo-Beira, OCB refused the opportunity (invoking MSF principles) to use the helicopters from the South African military to reach Beira and carry out the first aerial assessments. The fact that, in contrast, OCP sent the Aquaforce through the French army plane, raises a debate on MSF principles' interpretation, especially on the relation with the army in a context (natural disaster) where there is likely no political implication.

OCB received its first international order on March 25 (D+10); the in-country E-prep took 10 days to reach Beira as it was sent by boat. While waiting for its own supplies, MSF had to use drugs and material (Ringer lactate, ORS, anti-malaria, etc.) from the MoH, IFRC and WHO; this not only at the start, but also later on for OCP who only received its international order on April 11 (D+27).

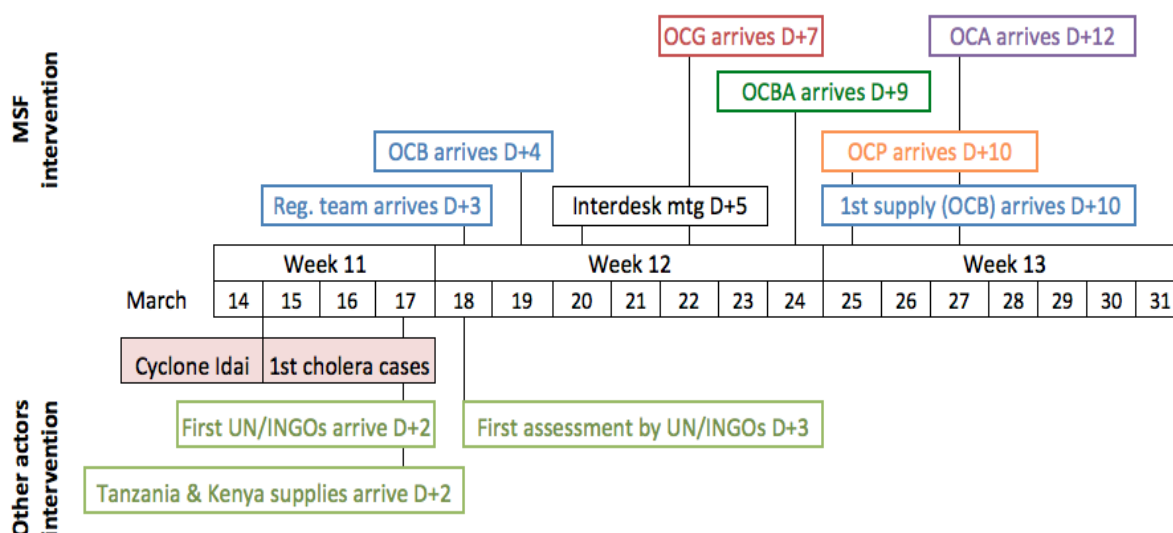
It is also worth noting that the first interdesk meeting was only organized 5 days after the cyclone had hit.

MSF late arrival and deployment meant that cards had already been dealt; hospitals had been assigned to EMTs and priority activities, such as medical consultations in IDP camps or water distribution, had been allocated to more reactive NGOs. Besides the idea that MSF needs to be present early to have an added value in a natural disaster, the fact that other actors can assume a similar role raises once more the question on the relevance for MSF intervention in such context²⁴.

²³ Following the visit from OCB regular MedCo in Beira on March 18

²⁴ See Space for MSF in natural disasters in general, p. 14

Figure 2. Comparative timeline of intervention



A FEW TOO MANY

LIMITED INTERNAL COORDINATION

As Idai was about to strike, OCB and OCG agreed that OCB would respond first given its project in Beira. On March 18, following the first assessment from the regular MedCo, OCB requested OCG to send a team to focus on the areas outside Beira. The 5 OCs were in contact but the first interdesk meeting only happened on March 20. In the meantime, as there was still no clear picture of the needs²⁵, both OCBA and OCP informed OCB they had decided to intervene unilaterally²⁶, apparently not aware of each other's intentions. On March 20, OCA contacted OCG to offer HR support²⁷ for the cholera response. What had initially started as an interesting and rational approach – embedding HR in an existing team – soon switched to a separate intervention including a large team²⁸. It is worth noting that, without any written account, each OC has a different version of this sequence of decisions to intervene: OCBA/OCP/OCA understood they were called in while OCB/OCG indicated the others came in on their own initiative, and that since the beginning it was clear for them that 4 OCs were already too much.

As a result, the OCs already on the ground had to share the operational space with the OCs arriving. The initial plan was for OCB and OCG to work in Sofala Province, OCBA in Zambezia province and OCP in Manica province. But as OCBA was refused access to Zambezia; as they were little needs in Manica; and as cholera cases were appearing in

²⁵ Email from March 18 from OCB E-cell manager describing the general situation without giving indications of specific medical needs requiring MSF intervention.

²⁶ OCBA informed OCB deputy cell manger and the HoM. OCP informed OCB cell manager.

²⁷ Email from March 20 from OCA E-cell manager to OCG E-cell manager: “we would potentially have a watsan team (international staff) who speak Portuguese and have Mozambique experience”

²⁸ Partial coordination team (E-coordo, MedCo, LogCo & Wash Co) and a project team of 18 people

Beira the areas were reallocated, and the 5 OCs ended up all developing activities in Sofala province (see below Areas of intervention).

Figure 3. Distribution of the areas of intervention following the arrival of additional OCs

	2 OC	4 OC	5 OC
Beira city	OCB	OCB OCG	OCB OCG OCA
Buzi	OCG	OCG	OCG
Dondo		OCBA	OCBA
Nhamatanda		OCP	OCP

The redefinition of the areas of intervention, due to the arrival of additional OCs, as decided at HQ level, had several impacts. It complicated OCG start of intervention. The E-team felt they had to give up areas and continue assessments. The few days of gap between the first assessments by OCB/OCG in Dondo and Nhamatanda and the deployment of OCBA/OCP created a window of opportunity allowing the arrival of other actors. In Beira, OCB and OCA teams occasionally overlapped in their health promotion and watsan activities. The coordination between the 5 OCs was challenging both for external actors and MSF itself. Last but not least, the deployment of 5 OCs was the main reason for a globally over-resourced intervention²⁹.

OPERATIONAL AMBITIONS VERSUS NEEDS

Without a clear picture of the needs and ongoing response, the decision to deploy by the additional OCs seems to have been based on elements other than solely humanitarian needs. Indeed, strategic priorities and operational ambitions also have come into play.

OCBA decision to intervene was openly based on its focus on protracted conflicts³⁰. Indeed, OCBA responded to Idai (in Sofala Province) having in mind the ongoing conflict in Cabo Delgado Province. The E-cell had been following the situation for over a year. An exploratory mission to the area had even been planned before cyclone Kenneth hit. This interest explains OCBA's strong pressure to intervene in the region after the cyclone,

²⁹ See Resources, p. 18

³⁰ As stated in OCBA Strategic Plan 2014-2017 extended until 2019 "Our main focus will be on (...) the needs^[1] of the victims of protracted conflicts^[1] and we choose to priorities those crises where MSF is irreplaceable". "Bulk of portfolio dedicated to protracted conflicts, acute conflicts and emergency response"

especially in the most conflict-affected areas. This is all the more confirmed, as OCBA is planning to open a project in Cabo Delgado, following the departure of OCG.

OCA, initially choosing not to go in following the cyclone and floods, finally decided to intervene in Mozambique for the cholera outbreak, without discussing with the 4 other OCs, already present. As part of its public health approach and with watsan being a strategic priority³¹, OCA decided to focus its intervention on watsan as a standalone activity³².

PRESSURE TO BE PRESENT IN EMERGENCIES

Another decision factor was some internal pressure to intervene. This was expressed only by some OCs and for each it manifested differently.

As a “CNN emergency” – rarely occurring and attracting a lot of public attention – Idai represented an opportunity for communication and fundraising. Like other emergencies – as Nepal or Bangladesh recently – some OCs faced a lot of pressure to intervene and to deploy significant resources. The pressure also came from the partner sections as their existence depends partly on their fundraising capacity. MSF South Africa and MSF Brazil were particularly interested considering their relationship with Mozambique (regional dynamics for the former and Portuguese-speaking for the latter).

Lastly, some key informants raised the upcoming renewal of MSF Resource Sharing Agreement (RSA) and the need to keep the same budget share as an underlying pressure to intervene and spend important resources, as also pointed out in the Resources discussion³³.

POSITIVE MUTUALIZATION

The presence of 5 OCs gave rise to several mutualization initiatives. Each of the 5 emergency responses benefited from the administrative and logistic support from OCB/OCG regular missions in Maputo (visas, local purchase, bank account, etc.). Several intersectional positions were created and valued by the teams (liaison, supply, epidemiologist, GIS and flightCo) and some services were shared (in particular the supply dispatch and customs clearance in Maputo).

RESOURCES: FROM A “NO-REGRETS” APPROACH TO A DEBATABLE ACCOUNTABILITY

BUDGET

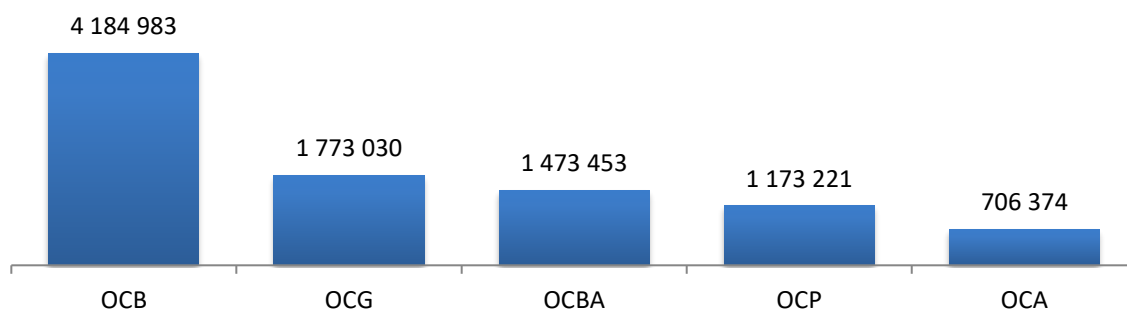
MSF spent 9,3M€ within 2 months to treat 3,800 cholera patients, provide 12,000 consultations and supply 6,000m³ of water among other achievements.

³¹ OCA Strategic Plan 2015-2019 « Integrate Watsan activities into the initial response phase as a standard part of our emergency response.» « We will invest in our water and sanitation and our outbreak response capacity

³² As already done in Bangladesh and Uganda

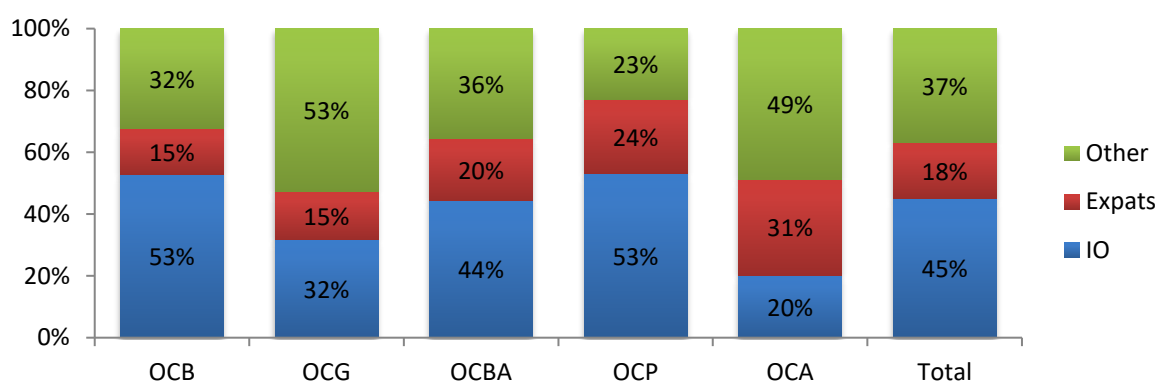
³³ See below

Graph 1. Budgets for Idai & Kenneth intervention, by OC (in €)



The main expenditures have been in international HR and international supply.

Graph 2. Proportion of international HR & international orders in budget, by OC

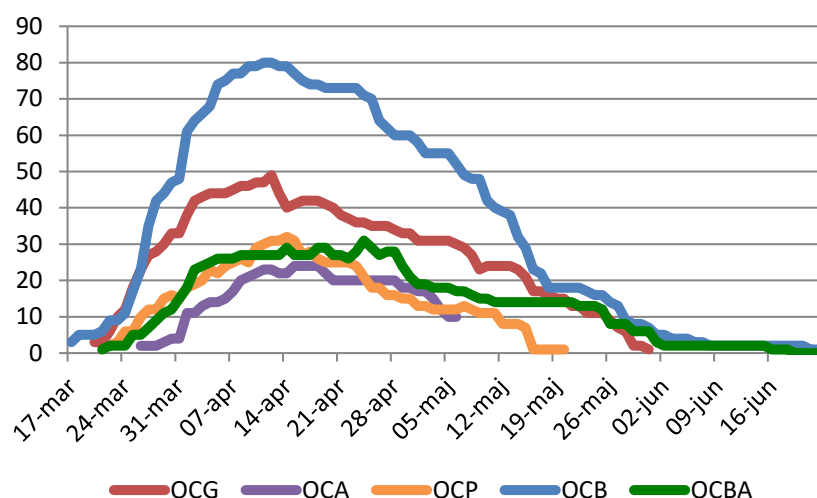


INTERNATIONAL HR

International HR amounted for a total of 1,7M€, representing 18% of the budget (Graph 2). MSF response reached a peak of 208 international positions – from 25 for OCA to 80 for OCB.

The decision to send an important number of expats was taken early, while the needs' situation and the strategy were still unclear. For example, OCP E-cell sent 28 expats despite the field's request for more time to explore the needs. Some argued it was an interesting training ground to send expats: "easy" emergency without security issues. For OCB it was the field, supported by the E-cell who requested the numerous HR. The scale up was massive from March 25 (Graph 3).

Graph 3. Field presence of international HR by OC, March 17-June 22, 2019



NB: Data based on different sources (OCB/OCG: contract dates. OCBA/OCP/OCA: field presence) as the expat follow up tools differs according to the OC

Upon realizing that the needs were less than expected – when the cholera cases started decreasing and when MSF realized its role in the vaccination campaign would not be as expected³⁴ – MSF tried to adapt the HR set up (Graph 3)³⁵. Besides early returns, some expats were reallocated to other activities as the needs and strategy evolved³⁶.

Despite the efforts to adapt HR to decreasing needs, the overstaffing was obvious for a few weeks as recognized by many expatriates, expressing significant frustration in front of limited needs and waste of resources (OCB, OCG, OCP). This overstaffing impacted both the intervention's effectiveness with challenges in team management and communication³⁷, and efficiency, creating additional needs (cars, translation, etc.). This also generates an impact on staff's retention that should not be ignored.

INTERNATIONAL ORDERS

Supply was the main expenditure with a total amount of 4,2M€ of international orders, 45% of the budget (Graph 4).

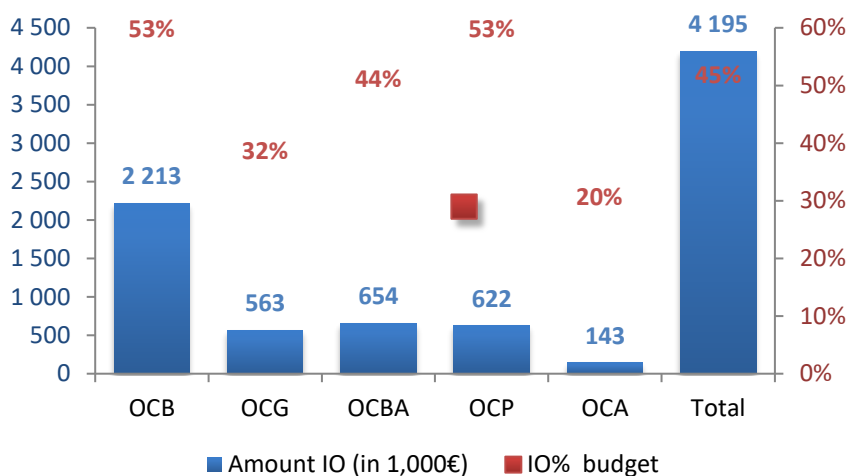
³⁴ See Incomplete picture, p. 21

³⁵ OCG and OCB initiated the team's reduction mid April. According to OCB E-coordo the adaptation could have been stronger but there was a feeling of "missing something" that lead to keeping some extra HR to conduct assessments.

³⁶ OCBA assigned nurses initially supposed to be involved in the OCV campaign to CTUs, OPR, HC assessments and community HP to have an overview of the project and build capacity for future cholera outbreaks. OCB also sent its extra HR on assessments.

³⁷ As expressed in interviews as well as some reports. For ex: "Quite a bit of frustration and stress was generated because the average team member had no idea what they were doing and why" OCB final report

Graph 4. International orders cost (including freight): amount (in €) and budget percentage, by OC



“NO-REGRETS” APPROACH

Taking the risk to “overshoot” is expected in responding to emergencies, especially to natural disasters. As developed by the World Health Organization in its “no-regrets” policy³⁸, to react as fast and effective as possible, it is better to “*err on the side of over-resourcing the critical functions rather than risk failure by under-resourcing.*”³⁹

In addition to the eagerness to act fast, the E-cells were also encouraged to send important supply immediately as, with the declaration of national emergency, the government of Mozambique had removed the usual administrative constraints regarding importations⁴⁰, opening a window of opportunity as pointed out by the regular Mozambique coordination. OCBA especially, chastened by its experience in Bangladesh, didn’t want to risk having importations blocked once more.

INCOMPLETE PICTURE

Limited information

In Idai, the definition of the response was made almost blindly, with very little and fragmented information reaching the decision makers (hospitals have been destroyed, large areas are flooded, etc.). Even though more information was available, it was not collected nor analysed: without any written account of the initial needs assessments⁴¹,

³⁸ WHO Emergency Response Framework 2013: “At the onset of all emergencies, WHO ensures that predictable levels of staff and funds are made available to the WCO, even if it is later realized that less is required, with full support from the Organization and without blame or regret. This policy affirms that it is better to err on the side of over-resourcing the critical functions rather than risk failure by under-resourcing.”

³⁹ But for the WHO this “no-regrets” concept is used within a wider framework including results-based approach, learning and accountability. See WHO Accountability Framework March 2015.

⁴⁰ In Mozambique, the validation of orders and customs procedure can take up to 7 months.

⁴¹ There is no written account of the assessments carried out by OCB in Beira and Dondo.

the interviews convey an impression of being overwhelmed and having difficulty to identify priorities for the explo team.

Likewise, the cholera response was based on partial information. The 5 OCs prepared their intervention⁴² based on incomplete information. The analysis, as provided by OCB, was based on daily admissions of 3 HC leaving out the general cholera epidemiological trends in Mozambique (endemicity, attack rates, low mortality, etc.), the recent history of cholera in the area⁴³ or the fact that the population was used to cholera. The bigger picture was only put together with the arrival of the intersectional epidemiologist. While some of this information was available with the regular missions it was not passed on the E-teams⁴⁴.

Limited consideration of others

The oversizing of the intervention was also the result of a limited consideration of other actors' presence and capacity.

Despite the regular missions' recommendations, it seems some E-coordinators were unwilling to listen to and coordinate with the MoH, not considering its sovereignty and authority⁴⁵. This attitude manifested especially around MSF participation in the OCV vaccination campaign⁴⁶ and in OCB management of Mar Azul CTC⁴⁷. Both situations led not only to calling in important resources that turned out to be not used, but also to generate tensions with the MoH⁴⁸. This leadership from the authorities was known and expected by the regular missions and the E-cell, as experienced once more in the last OCV vaccination campaign in Tete Province in 2017⁴⁹.

These difficulties to take into account the capability of others also apply to other humanitarian actors. The frequent reference to the "humanitarian circus" sidestepped a

⁴² Scenario: 3% attack rate in a city of 500,000 people=> 600 beds capacity

⁴³ Outbreaks in Sofala Province in 1998, 2003, 2006, 2010 and 2014-2015

⁴⁴ This information gap is explained by a lack of capitalization: with regular missions relying on individual memory rather than writing it down; because the regular mission didn't think of sharing it while the E-team didn't ask for it.

⁴⁵ This was reported in several interviews as well as some reports: "It was clear the difficulty of emergency teams (...) to deal with a humanitarian response in an African country with an structured State and strong government that had some capacity to respond" (OCBA final report); "lack of ability to deal with the government when it got more controlling" (MSF Intersectional liaison officer EoM report).

⁴⁶ OCB, OCBA and OCG somehow understood – or decided – that MSF would play an important role in the planning and implementation of the OCV vaccination campaign. Based on this assumption, almost 20 international staffs including HQ referents were sent to Mozambique to be part of the campaign. But soon it became clear that the campaign would in fact be lead by the MoH with the support of the WHO, not needing or at least not wanting MSF to be involved besides logistics support (cars, fuel, etc.).

⁴⁷ The provincial MoH had offered OCB to rehabilitate Mar Azul, Beira's official CTC, but it seems that OCB understood it would also open and manage the CTC independently, which the authorities would never accept. 6 days only after its opening, the CTC was closed by the MoH who wanted to regroup all cholera cases in Beira in one CTC (Macurungo CTC).

⁴⁸ OCB & OCG E-coords were expelled from the meeting on the OCV campaign by the vice director of public health

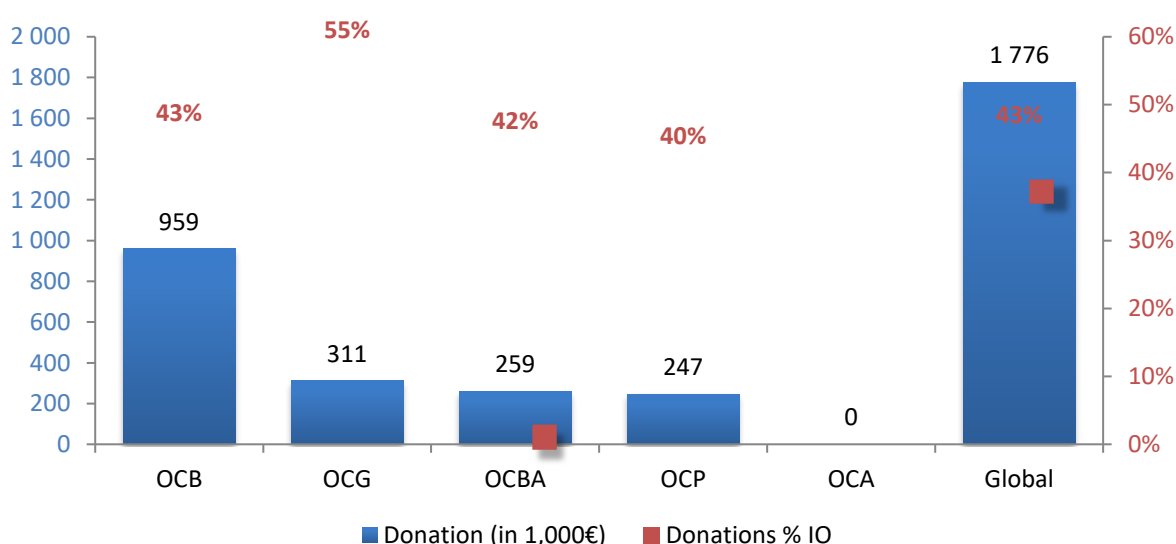
⁴⁹ Cholera Report, An MSF analysis on the joint response in Maputo, Nampula & Tete Province, MSF, June 2017. Report on implementation of the 1st round of OCV in Tete Province, Misau/MoH, June 2017

critical analysis of the said “circus”⁵⁰. MSF traditional reluctance to coordinate with the system, using its principles as an argument, has in this case prevented MSF from being part of the initial discussions and agreements between the MoH and international actors regarding allocation of areas of intervention. OCP made an international order for a hospital where the IFRC had already been assigned (Nhamatanda). OCBA also found the AECI (Spanish cooperation) affected to Dondo hospital where they had planned to manage.

These examples show that with a greater coordination MSF could have taken decisions – involving a lot of resources, “overshooting” – less blindly. For example, MSF could have avoided bringing in almost 20 international staffs for the OCV campaign if it had considered the MoH decision, experience and capacity. This raises the need for MSF to (re)think its relation to others.

This blindness also concerns the other OCs. As already touched on in the previous discussion⁵¹ MSF OCs sometimes neglected considering the other OCs. The lack of coordination in placing the international orders impacted particularly the intervention’s efficiency. OCB and OCG allocated important resources (IO) on the initial basis of being the only 2 OCs responding. OCBA, OCP and OCA then placed their IOs without visibility on each other’s orders and stocks. This lack of visibility was again experienced in the management of stocks as the OCs continued to order or purchase locally items that were available in other OCs’ warehouse, missing mutualization opportunities. What is explained not only by a lack of harmonized tools but also by a protective management of stocks is particularly disturbing when it ends up in 1,8M€ of donations, 43% of the IO cost (including its transport; Graph 5) and 19% of the budget. The fact that, 6 months later, these donations are still to be organized, adds another question regarding their use.

Graph 5. Donations: amount (in €) & percentage of international orders by OC



⁵⁰ There is very little mention of other actors (« who does what where ») in MSF documents

⁵¹ See A few too many, p. 17

“MONEY SHOULDN’T BE A BLOCKING FACTOR”

In addition to the initial decision to send large resources, regardless of other actors and OCs plans, the teams on the ground also mentioned a general mind-set of “money shouldn’t be a blocking factor”. This outlook contributed to create an environment encouraging irrational spending (ex: renting 40 cars on the first week before setting the operational strategy), not looking for cheaper solutions (ex: transporting cars instead of drivers, renting warehouses without quotations, etc.). Some international staff were shocked by this attitude (*“the tap is open”*) whether in their own OC or in other OC. Some were also under the impression that money needed to be spent regardless of needs, feeding rumours regarding the upcoming renewal of the RSA.

ACCOUNTABILITY AT STAKE

The above-mentioned points are indicative of MSF particular way of functioning and are specifically favoured by its independence. It is in the name of independence that MSF maintains limited relationships with other aid actors, leading in the case of Idai to an overshooting based on an incomplete analysis. But MSF principle of independence also affects its efficiency in another way. Not being accountable to donors on the use of funds, MSF is exempted from a reporting system linking inputs to outcomes, system that encourages awareness and responsibility among decision-makers. MSF reporting format – focused on the activities achieved and not on the results – also makes it difficult to assess the effectiveness. More generally, the lack of analysis and questioning of achievements⁵² points towards a disregard concerning effectiveness as well as efficiency, and lead to question how much the notion of accountability present in the decision-making is and in the implementation.

In Mozambique, this lack of awareness led to wasting almost 20% of MSF global budget of the intervention. The fact this issue was not pointed-out as a main concern is all the more worrying and leads to question responsibility.

Another element of MSF system that should be looked into is how the existing RSA system – that could be interpreted as “the more you spend the more you get” – and the social mission ratio⁵³ contribute to an irrational resourcing and distorted decision-making, sometimes leading to overspending. By considering any “program” expense as contributing to improving the social mission ratio – regardless of the effectiveness of this expense – the social mission ratio can in fact prove to be ambiguous, even counterproductive. MSF ends up making operational choices that, as in this case, are not helping to drive emergencies efficiently and facing similar unhealthy side effects as the NGOs depending on public institutional funds.

The irrational use of resources – and the internal mechanisms leading to it – is particularly problematic given MSF current financial situation, as it impacts other

⁵² None of the sitreps (ongoing analysis) or final reports (retrospective analysis) question for example 8 patients/day in an ORP, keeping a CTC with 3 patients for days, or donating 50% of the international orders.

⁵³ The “London ratio” is currently of 82% (MSF international report activity 2018)

operations, starting with Kenneth response that was cut short – too early according to some – because of budget limitations.

INTERVENTION IN CABO DELGADO, CYCLONE KENNETH

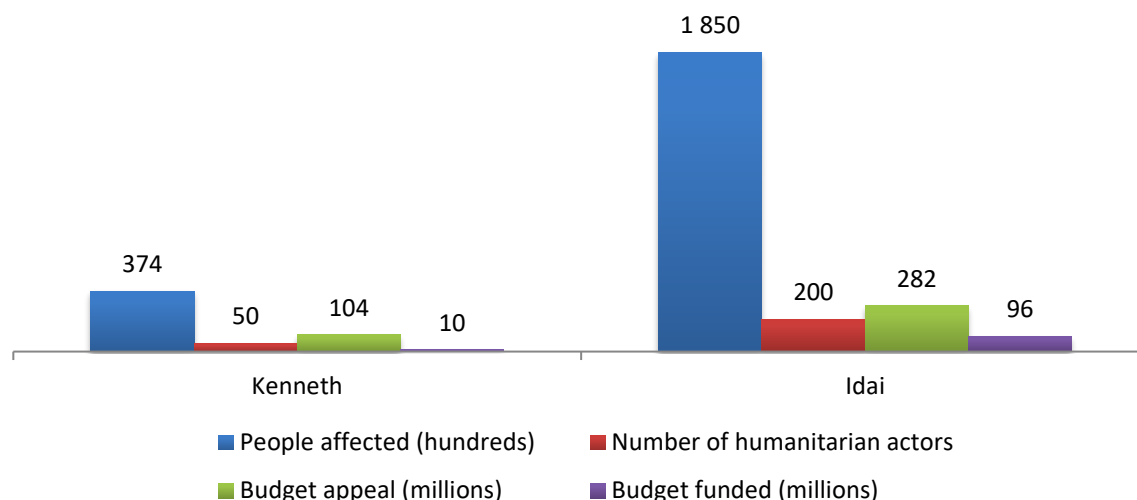
Tropical Cyclone Kenneth stroke Mozambique on April 25, 6 weeks following Idai. Although the cyclone's impact was less severe than Idai (no floods and less populated area), it hit a population already affected by poverty, violence and insecurity⁵⁴. In February, 2 months prior to the cyclone and after months of negotiating access, OCB/OCG had launched a primary health care/watsan project in Cabo Delgado province.

Compared to Idai, in addition to lower needs⁵⁵, the international humanitarian reaction also turned out to be different in Cabo Delgado. While Idai led to what can be seen as an overreaction by the international community, the response to Kenneth was clearly an “under-reaction”. The government was not willing to lend visibility to the situation, given the conflict and economic stakes. Fewer actors answered the call given the complex and insecure context (regular violent attacks); difficulties to fund the response given the Islamic radicals presence (as well as more expensive operations given the access constraints); and tiredness following weeks of involvement in Sofala.

⁵⁴ See Background, p. 9

⁵⁵ 1,85 million people affected 1,600 injured and 600 deaths with Idai and 374,000 affected, 91 injured and 45 deaths with Kenneth

Graph 6. International response to TC Kenneth and Idai



3 OCs intervened: OCB and OCG who were already present in the area and OCBA that had been interested in the context for some time; OCP and OCA assumed needs were covered. While it looked like a “classic” MSF context – conflict, neglected population, IDPs and limited number of actors (lacking financial independence and not used to work in conflict areas), the response by MSF was minimal. As the rest of the international response, MSF intervention proved to be uneven compared to Idai. Kenneth was managed with remainders from Idai (HR, supply). OCB and OCG prioritized easily accessible areas (Ibo Island, Macomia) against areas more affected by both the cyclone and the conflict such as Mucojo. While 5 OCs were present in the country, the response in the most affected areas was late⁵⁶. The response also stopped early because of budget limitations for the OCs willing to stay.

The reasons for this reduced response were partly the same as for the rest of the international community: tiredness of the E-teams after Idai, reluctance to deal with insecurity and lack of funds. But the key element that also came to play was MSF internal dynamics: difficulty of collaboration between regular and emergency teams; competition between the E-teams, etc. The fact that MSF did not approach Kenneth emergency as a movement but as separate entities with different ambitions and different limitations – willingness to intervene or not, financial resources, etc.⁵⁷ – hindered a comprehensive vision and lead to a reduced intervention.

⁵⁶ For example, MSF only intervened in Naunde 3 weeks after the cyclone (where no other had intervened yet).

⁵⁷ OCG regular mission wanted to intervene but did not have the budget for it. OCG E-cell was not interested in another operation following Idai. OCB E-team was not willing to get involved in security management. OCBA really wanted to intervene but lacked funds and had to cut short the intervention.

CONCLUSIONS

While MSF response to the cholera outbreak was relevant, appropriate and effective, the response to the cyclone is more questionable. Considering the affected populations' needs – limited – and the national and international reaction – massive and effective – there was little space for MSF. This space was even further reduced as MSF arrived and deployed later than some other actors, as a result from insufficient preparedness and reactivity.

The intervention of 5 OCs was unnecessary. Although it gave rise to some interesting mutualization efforts, it was the main reason for a clearly oversized intervention. Another reason for the over-resourcing was a weak analysis of the situation – needs, priorities and competing responses. This was facilitated by internal mechanisms that doesn't encourage efficiency and accountability among the decision-makers.

Idai intervention highlights the need for MSF to adapt its way of intervening in natural disasters, to better coordinate and to become more accountable as a movement.

RECOMMENDATIONS

- ⇒ **AREA 1: STRENGTHEN EMERGENCY PREPAREDNESS**
- ⇒ **AREA 2: REINFORCE NEEDS ASSESSMENT CAPACITY**
- ⇒ **AREA 3: IMPROVE INTER-OC COORDINATION**
- ⇒ **AREA 4: QUESTION THE ROLE OF MSF IN NATURAL DISASTERS**
- ⇒ **AREA 5: FOSTER FURTHER ACCOUNTABILITY**

The recommendations identify five key areas for improvements based on the evaluation findings. Some recommendations are quite specific and concrete although implementation may need to be adapted to each OC. Some others, on the other hand are broader and concern strategic and institutional elements that will need to be discussed further to identify actionable recommendations.

RECOMMENDATION AREA 1: STRENGTHEN EMERGENCY PREPAREDNESS

Strengthen emergency preparedness in regular missions

Although it seems basic, the findings of the evaluation suggest there is still room for improvement at this level. Suggested areas of improvement are as follows;

→ **MONITOR EMERGENCIES IN THE COUNTRY & CAPITALIZE INFORMATION ON**

- History of emergencies: magnitude, impact, location, epidemiological trends, etc.
- History of emergency response by the government (national, local level) & other humanitarian actors
- Liaise with authorities on emergency response system and epidemiological surveillance

→ **REINFORCE E-PREP PLAN USING SYSTEMATIC & SIMPLE TOOLS INCLUDING:**

- Mapping of the main risks & scenarios
- Response capacity of government & other humanitarian actors present in the country
- Strategy
- List of HR with emergency experience
- Transport & supply options
- Updated stocks

→ **DEVELOP IN MISSION SUSTAINABLE EMERGENCY MANAGEMENT EXPERIENCE**

- Build a pool of key national staff with emergency experience

- Send key national staff on secondment in emergencies (related to the mission's main risks) as part of their career development
- Organize local E-prep trainings

Reinforce exchanges between regular cells and E-cell

Again, quite obvious but the findings of the evaluation suggest there is still room for improvement at this level. Suggested areas of improvement are as follows;

→ **ENSURE TRANSMISSION OF KNOWLEDGE BETWEEN REGULAR MISSIONS/CELLS AND THE E-CELL(S)**

- Develop a system of information sharing from regular missions/cells to E-cell so that it is available in case of an emergency requiring the E-cell intervention
- Ensure this information is shared with other OCs in case of an inter-OC intervention

→ **CONSIDER ORGANIZING REGULAR AND SYSTEMATIC SUPPORT FROM E-CELL TO REGULAR CELLS ON E-PREP**

- Share standards tools
- E-cell to participate in workshops/ad-hoc local trainings especially with key national staffs
- Explore the existing lessons learned exercises (OCG review on the Support Emergency Preparedness Service; OCB Emergency preparedness review)
- Explore regional opportunities

→ **MONITOR AND MAP THE MAIN REGIONAL RISKS (SURVEILLANCE OF OUTBREAKS)**

→ **ANALYSE REGIONAL LOGISTIC OPTIONS**

- Supply
- Transport
- Importation facilities

→ **MAKE USE OF REGIONAL HR EXPERTISE**

- Establish and maintain an updated list of regional staff with emergency experience ("Red organigram") in MSF South Africa and regional missions
- Make this information available to each OCs when intervening in the region

RECOMMENDATION 2: REINFORCE NEEDS ASSESSMENT CAPACITY

Again, it might seem fundamental, but the evaluation pointed out important gaps at this level. Suggested areas of improvement are as follows:

→ **ENSURE THE USE OF TOOLS TO QUICKLY GET A GLOBAL UNDERSTANDING OF THE CRISIS AND IDENTIFY PRIORITIES**

- These tools should be standard, concise and user-friendly (ex: MSF guidelines, check lists)
- Ideally these tools could be applied by all OCs (harmonized tools)

→ **ENSURE COORDINATORS FROM THE E-POOL ARE APPROPRIATELY TRAINED ON NEEDS ASSESSMENT**

- Through existing trainings (PSP, RépEpi, regional E-prep trainings)

→ **DEEPEN MSF GENERAL UNDERSTANDING OF THE EVOLVING HUMANITARIAN CONTEXT (ACTORS – E.G. EMTS, COORDINATION MECHANISMS, ETC.) FOR BOTH HQ AND FIELD TEAMS HELPING TO SOFTEN MSF CULTURE OF “SEPARATION”**

- Trainings (ex: OCP FOOT training)
- Workshops and discussions during coordinators’ week

→ **CONSIDER NEEDS ASSESSMENTS AS A KEY STEP, ESPECIALLY IN COMPLEX CONTEXTS**

- Invest resources and time in quality needs assessments including in emergencies
- If necessary, dedicate specific HR for needs assessment separately from the intervention

RECOMMENDATION 3: IMPROVE INTER-OC COORDINATION

This point should be further developed by MSF operational directions.

In future multi-section emergency responses

→ **DEPLOY ASAP INTER-OC POSITIONS THAT HAVE PROVEN ADDED VALUE**

- Liaison (especially in this context with many actors)
- Epidemiologist

→ **MUTUALIZE ASSESSMENTS BETWEEN OCS**

- Avoid duplicating assessments in the same locations, having one OC carry out assessment in a specific area for all OCs. In addition to improving efficiency it also encourages effectiveness
- Share information from previous assessments (ex: create an online platform)

→ **IMPROVE MUTUALIZATION OF SUPPLY**

- Find systems to enhance visibility on existing orders & stocks between OCs
- Consider making inter-OC international orders

- Organize mutualized inter-OC dispatch of supply in the country/emergency site

→ **DEVELOP OPERATIONAL GOVERNANCE**

In a situation where several OCs want to intervene

- MSF should be able to come up with clear and concrete decisions as a collective, and stick to these decisions, or review them together
- Any initiative from an OC should be made known to the others (transparency)

RECOMMENDATION 4: QUESTION THE ROLE OF MSF IN NATURAL DISASTERS

This point should be further developed by MSF operational directions.

→ **REFLECT ON MSF ROLE IN NATURAL DISASTERS BASED ON THE LESSONS LEARNED FROM IDAI AS WELL AS PAST INTERVENTIONS (USING FOR EXAMPLE OCA REVIEW OF NATURAL DISASTERS INTERVENTIONS)**

- What is MSF added value in natural disasters?
- In which type of natural disasters MSF has a stronger added value (large scale, neglected, conflict, specific vulnerable populations, etc.)?

→ **ADAPT FUTURE INTERVENTIONS MAKING THE BEST USE OF ITS ADDED VALUE**

→ **DEVELOP FURTHER THE INTEGRATION OF HIV/TB TREATMENT IN EMERGENCIES**

RECOMMENDATION 5: FOSTER FURTHER ACCOUNTABILITY

This point should be further developed by MSF operational and general directions.

It is essential for MSF to reflect on the ways to improve accountability at all levels.

→ **SET TOOLS TO ENCOURAGE ANALYSIS OF ACTIVITY AND RATIONAL DECISION-MAKING**

- Develop a reporting system that enable
 - Focusing on achievements and challenging results (effectiveness)
 - Connecting inputs with outcomes (efficiency)

→ **QUESTION MSF INTERNAL MECHANISMS INDIRECTLY NOT SUPPORTIVE TO A RATIONAL USE OF RESOURCES**

ANNEXES

ANNEX I: TERMS OF REFERENCE

Subject/Mission	MSF emergency response to cyclone IDAI in Mozambique
Commissioner	OCB's Director of Operations (on behalf of the RIOD)
Evaluation Focal Point	Anja Wolz (Coordinator, OCB Emergency Pool)
Consultation group	Head of Emergency Desks, OCG/OCB Regular desk managers, HoM/Emco's who were on the ground during response
Starting Date	15 August
Duration	6 weeks

MEDICAL HUMANITARIAN CONTEXT

Cyclone Idai made landfall on the evening of 15 March 2019 in the port city of Beira (500'000 inhabitants) located in Sofala Province of Central Mozambique. The cyclone wreaked havoc on Beira and surrounding areas resulting in loss of communication, important damage and destruction to shelter and settlements, health and WASH facilities and standing crops, as well as to communication infrastructures. Roads were blocked and the Beira airport was closed for two months. More than six-hundred people lost their lives and 1'600 resulted injured.

The cyclone's path led to destruction in Chinde District located in Zambézia, Manica and Inhambane provinces. While crossing, the tail of cyclone Idai has also left widespread destructions in Zimbabwe. MSF Operational Centres Brussels and Geneva (OCB and OCG respectively) were running projects in Beira city (Sofala province) at the time of the disaster.

REASON FOR EVALUATION / RATIONALE

Beyond being just a reflection on the pertinence of MSF's response, the evaluation should improve the understanding of how the different OCs determined their relevance for their interventions. The evaluation should look not only into the assessed needs and strategic priorities but also the analysis of existing capacity and explore how these factors may have fed into strategic choices in terms of target population, locations, objectives, and stemming activities. It should consider each OC's respective effectiveness and efficiencies in terms of their defined objectives and at the global level in relation to needs and to other actors' response capacity. The evaluation should identify key opportunities and constraints in relation to both MSF but also in the context of the response.

OVERALL OBJECTIVE AND PURPOSE

The findings from this evaluation are primarily intended to be used by the RIOD to decide if there is an argument to look at how they manage comparable events in the future and potentially make decisions

towards change in both practice and policy. For each OC it will be an opportunity to learn about the different perspectives, approaches, and understandings which could help to define future inter-OC approaches to natural disasters to enhance effective and efficient responses.

SPECIFIC OBJECTIVES

How relevant was MSF's intervention when considering the affected population's needs and the operational priorities of the different OCs?

- Was the decision to intervene coherent with the strategic priorities/operational policies of the respective OCs?
- Were appropriate needs assessments/exploratory assessments carried out by all OCs?
- How was the capacity of other organizations, government bodies and other MSF sections taken into consideration by each OC?
- Were intervention choices appropriately prioritized to meet the most urgent needs first?

How appropriate were MSF strategic choices given the presence of other actors and OCs?

- To what extent did MSF achieve complementarity in terms of resources and/or activities?
- Did the operational choices reflect a reasonable balance between capacities and needs in each area of intervention?
- Were appropriate and timely adaptations collectively made in response to changes in the environment?
- Did we make the right choices to support fundraising initiatives?

How effective was the MSF response in terms of reaching the objectives of the respective OCs and globally?

- Were all OCs able to respond in a timely manner and what were the reasons for this?
- Were all OCs able to achieve their expected coverage and what were the reasons for this?
- Were there any gaps in coverage when considering the needs and the capacity of other organizations/government actors?
- Were all OCs able to meet their objectives and to what extent?
- What obstacles were inherent in the context and was MSF able to overcome them?
- What opportunities were inherent in the context and was MSF able to exploit them?
- What internal constraints can be identified in MSF and how did they affect the OCs effectiveness?
- What opportunities exist within MSF and was MSF able to capitalize on them?

How efficient was MSF's use of resources considering the presence of multiple OCs?

- What positive example can be identified of ‘mutualization’ of resources between OCs?
- Are there any areas where the opportunity to ‘mutualize’ resources was missed and for what reasons?
- To what extent did ‘mutualization’ help or hinder the effectiveness and/or efficiency of the OCs interventions?
- To what extent was there a need for deployment of 5 OCs?

How well did MSF coordinate with other actors and internally?

- Are there examples of ‘good practice’ in terms of MSF coordination between OCs both at field level and HQ and within OCs between regular desks / coordination & projects and emergency desks / coordination & teams?
- Are there examples of ‘good practice’ in terms of MSF OCs coordination with both governmental and non-governmental organizations and agencies?
- What gaps in coordination can be identified both within MSF and between MSF and other government and non-government actors?

EXPECTED RESULTS

Report of maximum 20 pages (without counting executive summary or annexes) including executive summary, timeline of key decision making/events, findings and recommendations.

Please note that the draft report will be presented by the evaluation consultant to Head of Emergency desks and RIOD before finalization and the final report will be shared widely both internally and externally.

TOOLS AND METHODOLOGY PROPOSED

- Mixed method using qualitative and quantitative data from routine program information and secondary data collection.
- Review of documents (End of Mission Reports, Situational Reports, intersection TCF).
- The consultant is expected to carry key informant interviews with:
 - Members of the coordination teams in Mozambique;
 - HQ staff in Brussels, Geneva, Barcelona, Paris and Amsterdam;
 - Key field staff from all OCs, HQ/Key staff including at least those who were responsible for [SEP] program strategy, supply/stock management, overall management;
 - Interviews with key communications managers in HQ and in the field;
 - Interviews with key Directors of Communications and Directors of Fundraising from Brazil, Southern Africa, HK, USA, Germany, and the International Fundraising Coordinator.

DISSEMINATION STATUS OF THE EVALUATIONS

This report will be shared on the MSF evaluation website and Facebook page, therefore available to the general public.[SEP]The evaluation team is not expected to put forward recommendations that are immediately actionable within the MSF context but is

expected to put forward options based on the findings that can be considered by the RIOD as part of a consultative process.

PRACTICAL IMPLEMENTATION OF THE EVALUATION

Number of evaluators	1 or 2
Timing of the evaluation	August-September
Required amount of time (Days)	
• For preparation (Days)	4
• For field visits (Days)	4
• For interviews (Days)	8
• For writing up report (Days)	5
• For presentation of results (Days)	1
Total time required (Days)	22

ANNEX II: LIST OF INTERVIEWEES

First name, Last name	Function, Organisation
Maria Eugenia Serbassi	E-team MedCo, OCA
Robert Onus	E-team coordo, OCA
François Quik	E-team watsan, OCA
Habtamu Mehari	E-team log, OCA
Martine Flokstra	E-team coordo, OCA
Karline Kleijer	E-cell manager, OCA
Marcel Langenbach	Operational Director, OCA
Gert Verdonck	E-team coordo, OCB
Aurélié Maréchal	E-team log, OCB
Jérémy Guérin	E-team watsan, OCB
Anja Wolz	E-team coordo, OCB
Gilles Van Cutsem	E-team MedCo, OCB & SAMU
Eric Goemare	E-team MedCo, OCB & SAMU
Isabelle Greneron	E-team MedCo, OCB
Patrick Montaner	E-cell supply, OCB
Lily Caldwell	E-cell HRO, OCB
Marie Christine Ferir	E-cell manager, OCB
Silvia Pineda	Epidemiologist, OCB
Vitoria Ramos	Inter-OC liaison, OCB
Carina Perotti	Reg. mission MedCo, OCB
Caroline Rosa	Reg. mission HoM, OCB
Christoph Jankhofer	Reg. mission LogCo, OCB/G
Kristel Eerdeken	Reg. Cell RP, OCB
Marc Biot	Operational Director, OCB
Radoslav Antonov	E-team HRCo, OCG
Philippe Courtiau	E-team coordo, OCG
Yaya Ba	Inter-OC supply Maputo & E-cell supply, OCG
Korina Vaiou	E-team HRCo & E-cell HRO, OCG
Cécile Barrier	E-cell fin, OCG
Johan Duhamel	Watsan referent, OCG
Iain Thompson	Security manager, OCG
Alan Gonzalez	Reg. Cell ARP, OCG
Lucas Molino	Reg. mission HoM/Medco (former), OCG
Carlota Silvia	Reg. mission HoM, OCG
Hugues Robert	E-cell manager, OCG
Llanos Ortiz	E-cell deputy manager, OCBA
Esperanza Santos	E-team coordo, OCBA
Katharina Lange	E-team HRCo, OCBA
Jairo Gonzalez	E-team coordo, OCBA
Roberto Penin	E-cell fin, OCBA
Olimpia de la Rosa	E-cell med, OCBA
Katy Brown	E-cell med, OCBA
Gabriel Sanchez	E-cell manager, OCBA
Rebecca Virseda	E-cell supply, OCBA

Thierry Huaume*	E-team coordo, OCP
Gilles Lepelissier*	E-team log, OCP
Roland Fourcaud	E-team PC, OCP
Mayouri Savant*	E-team FiRHCo, OCP
Marc Gillemmer*	E-team FinCo, OCP
Marine Henrio*	E-team HRCO, OCP
Corinne Torre*	E-team coordo, OCP
Ana Leticia Nery*	E-team MedCo, OCP
Gwenola Séroux	E-cell manager, OCP
Eric Pfeiffer*	E-cell log, OCP
Caroline Dulinge*	E-cell HRO, OCP
Aline Serin*	E-cell fin, OCP
Ghassan Abou Chaar	E-cell deputy manager, OCP
Isabelle Defourny	Operational Director, OCP
Guilhem Molinie	DG, MSF SA
Olga Pratt	International Fundraising Director
Ussene Isse	National director, National direction of Medical Assistance, MOH
Saozinha Augustin	Deputy Director, Planning & Coordination department, MOH
Lorna Gujral	Head of Epidemiology department, MOH
Sergio Seni	Deputy Director, Center of drugs and medical equipment, MOH
Cristina Gutiérrez Hernández	Head Office Humanitarian Aid, AECID
Francisco Monteiro	National Coordinator Shelter Cluster; IFRC
Magnus Murray	Coordinator Shelter Cluster Beira/Pemba, IOM
Shirley Patterson	Technical officer Health Operations, WHO
David Wightwick	Deputy Incident Manager Beira, WHO
Anne Fortin	Team leader, HSS health technologies and innovations, WHO

* Names followed by an asterisk were interviewed in the frame of OCP RIDER Critical Review by OCP consultant. Notes of the interviews were used as secondary data.

ANNEX III: INFORMATION SOURCES

MSF DOCUMENTS

1. Needs assessment and exploratory mission reports
2. Proposals
3. Situation reports (sitreps)
4. Intersectional weekly reports
5. Intervention final reports
6. End of Mission reports
7. Handover reports
8. Visit reports
9. Epidemiological data
10. Activity Medical data
11. OCBs operational policies & strategic orientations
12. Budgets
13. Organigrams
14. HR matrix & follow-up
15. E-preparedness: strategy, stocks
16. E-mails
17. Minutes of interdesk meetings
18. Maps
19. OCB & OCG regular mission: country paper, Cabo Delgado CoPro, etc.
20. Idai, Some lessons learned for future E-pool intervention, SAMU
21. OCP RIDER Critical review, initial question, Aug 2019
22. Cholera Report, MSF analysis on joint response in Maputo, Nampula & Tete Province, MSF, June 2017
23. MSF Mozambique 30 years report, May 2015

EXTERNAL DOCUMENTATION OF THE GLOBAL EMERGENCY RESPONSE

24. Report implementation, 1st round of OCV in Tete Province, Misau/MoH, June 2017
25. Regulation/Management of International Emergency Med Teams, WHO/IFRC, 2017
26. Flash update, UN Resident Coordinator for Mozambique, 10 March 2019
27. OCHA Cyclone Idai Snapshot, 12 March 2019
28. Humanitarian response Plan 2018-2019 March 2019
29. Humanitarian response Plan 2018-2019 May 2019
30. Humanitarian response Plan 2018-2019 August 2019
31. Mozambique Tropical Cyclone Idai, Briefing note, Acaps 15 March 2019
32. Mozambique Tropical Cyclone Idai, Briefing note Update I, Acaps 19 March 2019
33. Mozambique Tropical Cyclone Idai, Briefing note Update II, Acaps 27 March 2019
34. Mozambique Tropical Cyclone Kenneth, Briefing note, Acaps 29 April 2019
35. Multi-sectoral rapid assessment post cyclone Idai, 14 Districts in Sofala and Manica Provinces, Mozambique 1-17 April 2019, INGC, OCHA, IFRC, Acaps
36. Misau/MoH Health & nutrition Post Disaster Needs Assessment Idai 9 May 2019
37. Mozambique government Post Disaster Needs Assessment Idai
38. Financial Tracking System of Mozambique Humanitarian Response Plan 2019
<https://fts.unocha.org/appeals/761/summary>

39. <https://www.unocha.org/southern-and-eastern-africa-rosea/cyclones-idai-and-kenneth>
40. <https://reliefweb.int/country/moz>
41. <https://www.humanitarianresponse.info/en/operations/mozambique/infographic/mozambique-responding-organisations-presence-27-may-2019>

ANNEX IV: TIMELINE

