Emergency response to Typhoon Haiyan

Intersectional review

EVALUATION REPORT

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Executive summary

The Intersectoral Philippines MSF Typhoon Haiyan Emergency Response review was requested by the Executive Committee of MSF. It was designed to examine the operational choices of each Operational Centre, the perceived cost disparity, the role of the MSF regional offices in the emergency and the external perception regarding MSF’s added value in the response. The review took place during August and November 2014.

Overall the response by MSF to Typhoon Haiyan was well perceived by all involved – with good geographical coverage, including a focus on the more rural and isolated communities, pertinent activities and services, a timely response compared to other actors, excellent coordination and information sharing with the authorities and other actors and good communication relating to the different exit strategies.

The response was timely compared to other actors, but the first MSF consultations were only done six days after the emergency and MSF’s surgical services commenced only after two weeks. MSF missed the opportunity to send small regional teams prior to the emergency which could potentially have saved a day or two but this is not definite. The focus on rural and isolated communities, such as the islands, was an important strategy with high impact. In pure time terms relating to the treatment of the injured following a natural disaster, it can be said that MSF was late in some locations.

The very low surgical activities done by OCB and OCBA raised the question of pertinence of the decision to send and setup an OT, especially as they were not functioning until two weeks after the typhoon. This indicates that MSF’s medical role in such a natural disaster (in a country where MSF is not present) will not be the immediate care of the wounded, but is more orientated towards the re-establishing of health care services that have been interrupted because of the disaster.

The presence of five OCs allowed for a good geographical coverage which was appreciated by the authorities and it allowed for a good contextual understanding and provision of a wide range of assistance. The fact that all OCs were present was not seen as a negative but many of those interviewed in hindsight thought three sections would have been sufficient.

There was a cost disparity regarding the different operational choices and strategies which resulted in a wide difference between budgets. This disparity between the sections can be explained, based firstly on their different policies towards natural disaster responses and by the location of each OC which was a major factor in subsequent operational choices and the strategies of each OC. Because of their policy commitments, OCP and OCB were the first to decide to send teams and intervened in the areas with the biggest needs. In addition, it must be remembered that both OCP and OCB continued to provide services in 2014, whereas OCA, OCBA and OCG all took the decision to wind down their activities in December and exit in January 2014.

The MSF response was perceived as having had an added value and played an important role in the overall response, especially regarding the input provided by MSF as part of the foreign medical teams. In addition, the strategy of MSF-OCB was particularly highlighted as an example by the authorities and UN agencies, especially WHO and UNOCHA which addressed the short and mid-term needs required by the communities and authorities.

The main obstacle remains the difficulty of access in natural disasters. From an MSF perspective the issue of supply remains a constraint, even though this doesn’t seem to be the case for OCB. How many resources are allocated towards managing supply in an emergency is still an issue for some OCs. Initially insufficient resources were provided to manage the supply chain in Cebu and solutions to share roles and responsibilities between OC teams were ad hoc and not pre-defined. There is no agreed strategy or structure in place prior to an emergency on how to collaborate and
share responsibilities and resources and prevent competition between supply teams during an emergency.

The role of the regional offices, especially Hong Kong, was very useful regarding the provision of human resources; particularly experienced by Philippine staff. However, there were missed opportunities to send teams prior to the typhoon making landfall. However, whether this would have made an impact is debatable, but the opportunity was there.
Emergency response to Typhoon Haiyan, intersectional review, Nov 2014

Abbreviations

ANC  antenatal clinic
ASEAN Association of Southeast Asian Nations
CS  Caesarean section
DART Disaster Assistance Response Team
DoH Department of Health
ER emergency room
ERSU Emergency Response Support Unit
FMT Foreign Medical Team
ICRC International Committee of the Red Cross
IDP internally displaced camp
IPD inpatient department
MSF Médecins Sans Frontières
NFI non-food item
NGO non-governmental organisation
OC Operational Centre
OCA Operational Centre Amsterdam
OCB Operational Centre Brussels
OCBA Operational Centre Barcelona and Athens
OCG Operational Centre Geneva
OCP Operational Centre Paris
OCs Operational Centres
OPD outpatients department
OPS Operational Support Unit
OT operating theatre
PDU Programme Development Unit
PNC postnatal clinic
RHR Regional Humanitarian Representative
RHU Regional Health Units
UNOCHA United Nations Office for the Coordination of Humanitarian Affairs
WHO World Health Organisation
1 Introduction

1.1 Background

Typhoon Haiyan, known locally as Typhoon Yolanda, hit the central Philippines region of Eastern Visayas on 8 November 2013. It was classified as a category 5 tropical storm and is unofficially the strongest recorded storm to make landfall. At its peak, the winds were recorded up to 280 km/h. The eye of the storm made landfall in Guiuan, Eastern Samar province of Leyte province. As the storm weakened, it made five additional landfalls in the Philippines.

The typhoon was followed by a storm surge of between 4 and 6 metres with Leyte and Samar islands being the worst affected. In Tacloban, Leyte province, the airport terminal building was destroyed by a 5.2 metres wave. The resulting damage from the Typhoon affected an estimated 11.5 million people with 6300 being reported killed and 544 606 displaced. The number of deaths was low considering the intensity of the typhoon, which was in a large part due to the 1215 evacuation centres and the pre-warnings provided.

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1 China Meteorological Administration
2 UNOCHA map
3 National Disaster Risk Reduction and Management Council (NDRRMC)
4 BBC News Website 14-11-14
All five MSF Operational Centres (OCs) intervened in the subsequent emergency with four OCs supporting projects in Eastern Visayas (Tacloban city, Guiuan,Ormoc, Burauen and surrounding areas) and one OC in Western Visayas (Carles and Estancia). Within the different MSF responses there was a significant difference of both scale of activities and subsequent cost of the interventions.

The MSF Executive Committee (ExCom) requested an operational critical review of the MSF Typhoon Haiyan emergency from an operational and a fundraising perspective (not part of this review). This critical review will analyse the operational strategies used by each OC as well as the role of the MSF regional capacity (Hong Kong, Japan and Australia) and their added value in the response.

1.2 Scope

The operational critical review's main focus is on the first weeks of the emergency but it also provides an overview of the six-month period from November 2013 to April 2014.5

This review is not fully exhaustive but aims to provide the main elements in terms of timeliness, relevance, (regional) support, differences around operational choices and lessons learnt from the response.6

1.3 Methodology

Both a qualitative and quantitative methodology were used during the review. To define the process, main questions and persons relevant for each issue to interview, an evaluation design matrix was created. Following this data collection included:

- Interviews of key actors in the response (all e-desks and identified team members, Operational Directors, regional offices)
- Review of key documents e.g. correspondence, action plans, project committees, sitreps, assessments, reports
- Global review of medical and operational data: no in-depth analysis of outcomes
- Interview of key external national and international actors during a twelve-day field visit
- Review of previous research including aid system analysis

1.4 Limitations

The main limitation was linked to the availability of key persons. This was due to the heavy volume of work experienced during the time of the evaluation because of MSF’s involvement in other emergencies such as Ebola. It must be noted here that this impact was reduced by the willingness of people to make themselves available even if it was not convenient.

The second limitation was the amount of documents and data available, which were poorly organised in most cases.

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5 See 5.1 Terms of reference
6 See 5.1 Terms of reference
2 Findings

While this is an operational critical review, the findings do not only focus on what can potentially be discussed, learnt from or improved in terms of the different operational responses but also highlight the positive aspects of the emergency response. The review does not evaluate in detail the operational outcomes but looks at them from a global perspective in the context of the situation at the time.

2.1 Anticipation and preparedness

2.1.1 Natural disaster policy

All the MSF Operational Centres (OCs) have a policy or strategy towards responding to natural disasters though not all are formalised in a document or have been updated recently. These policies have fluctuated over the years and are dependent on the context: regional or international at the time of the natural disaster. There are some questions regarding the validity or benefit of responding to natural disasters, especially in countries where MSF is not present already, e.g. the MSF-OCA policy states that there is

“... Little added value to intervene in natural disasters in countries where MSF (OCA) is not present. This is questioned when the scale of the emergency exceeds expectations (CNN emergencies) and in those cases, OCA will evaluate a response”.

For MSF-OCB as well as for MSF-OCP, natural disasters are a reason for intervention, especially for large scale natural disasters (like Typhoon Haiyan) when it is clear that normal coping mechanisms of the countries will be overwhelmed. OCB over other OC’s has developed a clear strategy when responding to natural disasters which involves switching from an initial emergency medical focus to relief (in this case shelter focused) and then to recovery which can include a mid-term medical structure solution. While for OCP there is a clear focus on the added value of a medical response by MSF which needs to be emphasised.

Another important point to emphasise regarding the OCB approach is the need to quickly incorporate the second phase "recovery" into the action plan. In case of Typhoon Haiyan, a mid-term exit solution was also included. The OCBA approach has evolved over time. Whereas emphasis has been put on prepositioning of stocks some years ago, especially in South America, two years ago it was realised that this approach has been neither efficient nor cost-effective, and was therefore changed. OCBA as well as OCG consider that a response to natural disasters remains part of their operational portfolio.

2.1.2 Contacts and knowledge

MSF has had operations in the Philippines in the past, the most recent being the OCP response to a number of small scale emergencies following natural disasters between 2011 and 2013. However, only a few networks or contacts were still available from these interventions, except for those established by the Emergency Response Support Unit, Hong Kong (ERSU) and the deputy e-desk of OCP based in Tokyo and Australia during the previous two years. This approach was also supported by the MSF International Regional Humanitarian Representative (RHR), who had also visited the authorities and developed relationships as part of the RHR mandate.
### 2.2 Operational choices

Table 1: MSF Typhoon Haiyan timeline of key decisions and activities

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* OCB initially identified a private hospital which was able to perform surgery before the decision was taken for OCB to provide surgical services
** No figures for OCP treating patients between 13/11 and 16/11
*** OCA did not support a hospital
**** OCG supported an existing hospital structure

7 Assessment reports, chronogram of activities and OC sitreps
2.2.1 Decision to go

While some discussions took place in the emergency desks in both Paris and Brussels as well as in the emergency support positions in Tokyo and Hong Kong, no OC took a decision regarding the deployment of teams to the Philippines prior to the typhoon hitting the country. The typhoon made landfall on 8 November and both OCB and OCP decided to send emergency teams including personnel from the region on the 9th. MSF-OCA, OCG and OCBA, following short discussions with OCB and OCP, took the decision to go on 10 November. The different emergency teams arrived in the Philippines between the 10th (OCB and OCP) and the 12th (OCA, OCBA and OCG).

2.2.2 Internal MSF pressure

During the interview phase it was stated at both headquarters and field level that internal MSF pressure was felt especially by communication and fundraising teams. This was particularly relevant for partner sections. However, it must be made clear that this did not directly influence operational choices or decisions. It did create pressure and the question was raised whether the projects could do more and if needs had been properly assessed. Some emergency teams were regularly updated regarding fundraising and they were made aware of the fact that emergency finance was not an issue.

2.2.3 Choice of operational locations

The decision where each OC would intervene was made according to the arrival date in the country of each OC and their operational strategies. OCP who had chosen to send an inflatable hospital with surgery capacity established activities in Tacloban City where the reference medical structures were badly affected. The other OCs focused on the more remote areas affected by the emergency. MSF OCB quickly decided to assess Eastern Samar, where little information was available and typhoon Haiyan had made landfall. OCA assessed Ormoc in Western Leyte where the UN were not present yet. OCBA assessed the area south Leyte in Burauen while OCG decided to follow the direction of the typhoon and assessed Roxas Island in Western Visayas. MSF was able to put some areas such as Leyte and Ormoc on the map for other organisations. Some areas which were not so affected were ignored by most actors.

The area around Cebu was also assessed in the initial stages but other organisations were present. The relationships between the different emergency coordinators also played a part as they knew each other.
2.2.3.1 OCP choices

In Tacloban City, a large urban hub with more than 250,000 inhabitants, medical needs seemed to be more pre-eminent. Prior to the typhoon, Tacloban City was the health care hub with a 350-bed tertiary government referral medical centre for the region as well as the 25-bed Tacloban City Hospital which served approx. 200,000 inhabitants of the city. There were five other big private hospitals serving Leyte and nearby provinces. Almost all of these health structures were destroyed or partially damaged when the super typhoon hit the city, disrupting the health services of the city in particular and that of the region in general.

OCP also intervened in Palo, Tanauan and Tolosa, in the coastal areas south of Tacloban with a population of around 70,000 inhabitants. All the towns’ health services halted after the typhoon as their health facilities were destroyed or damaged and rendered non-functional. The Leyte Provincial Hospital in Palo, which was catering for the whole province of Leyte, was destroyed and became non-functional. There was no transportation or if there was, then it was very expensive for the people to look for alternative health structures.

2.2.3.2 OCB choices

OCB assessed the area of Eastern Samar, specifically Guiuan city, by air. There the typhoon made landfall and little information was initially available. Although the area was heavily affected, the initial surge of relief efforts rather focused on the area of Tacloban city and the surrounding area and most aid actors did not extend their scope of activities until later on. Traditionally a somewhat neglected area, the population of Guiuan is poorer than most other areas affected by the typhoon, leading to the assumption that buildings and structures would have been heavily damaged. The target population of 100,000 is rather big and widespread and the area includes islands difficult to access off the peninsula where Guiuan city is located. A majority of the medical structures in the
Guiuan Inter-local Health Zone, comprising five different municipalities, were left damaged and unusable. Obtaining access to potential victims of the disaster on the islands represented a major logistical challenge.

2.2.3.3 OCA choices

OCA assessment focused on Northern Leyte (on the path of the typhoon) and conducted several assessments in Ormoc/Santa Fe with a population 250,000 and surroundings; the area was 90% damaged but not devastated. All barangays (villages) in the area were affected. There were 16 evacuations centres in the district. The more remote villages were not receiving aid even though some other organisations came in, e.g. Mercy Malaysia (OPD in hospital), Canadian Red Cross (IPD), Catholic Relief Services, Care (food distribution) but all located predominantly in Ormoc town.

2.2.3.4 OCG choices

OCG focused their attention on the west on the Island of Roxas in Western Visayas. When evaluating the situation, OCG teams noted that the Philippines’ government and population were organised and prepared for these kind of situations and had good coping mechanisms. Food distribution was organised, medical staff existed in the majority of the health clinics and hospitals as well as a good provision of drugs and vaccines. Many humanitarian actors were on the ground, more or less experienced, with the risk of overlapping in the assistance to the population. Twenty-four organisations were seen on the ground in the capital of Capiz province in Roxas, including all the major UN actors, and the Canadian Armed Forces had their Disaster Assistance Response Team (DART) deployed in Roxas with 250 military staff, including 40 medical staff. Therefore, OCG decided to focus their intervention on the more remote areas, especially on islands along the east coast of Panay with medical consultations, emergency rehabilitation of clinics, distribution of non-food items and sanitation in villages.

2.2.3.5 OCBA choices

OCBA did several assessments in southern Leyte province before reaching Burauen district. The level of destruction observed convinced the teams to intervene. Before the typhoon, Burauen District Hospital had a 75-bed capacity and was providing all the basic services, including surgery. The typhoon affected 75% of the hospital structure making it unusable. All consultations and admission of patients were done in the emergency room, lab services were interrupted, and there was no electricity. The hospital was overcrowded. The hospital director was one of five doctors usually present. Most of the health structures visited during the assessments had suffered at least partial damage and were suffering ruptures in drug supplies. A significant part of the residential areas assessed by OCBA teams were totally or partially damaged.

2.2.4 Type of operations

The scope of activities was similar amongst the different MSF OCs but with a different emphasis put on the stages of the emergency. The first stage is primarily emergency medical action, followed by the second stage of relief and recovery and the third stage of rehabilitation. The response activities were partly based on each OC’s strategy but were influenced by assessments of the different locations (areas differently affected, presence of other actors).

OCP mainly focused on a medical intervention strategy. The decision to send the inflatable hospital was taken at the same time as the decision to intervene. It was set up in Tacloban city in the
grounds of Bethany private hospital (OPD, IPD, surgery, maternity, and neonatology). A tent hospital was also set up in the town of Tanauan, further south of Tacloban City, a coastal town also severely impacted by the typhoon (OPD, IPD, maternity). Mobile clinics took place in Tacloban surroundings for the first few weeks. An NFI distribution took place in the area of Tanauan.

**OCB** took a wider approach in the area of Guiuan, an area hit hard by the typhoon. Medical activities were quickly established under tents in the previous hospital grounds as well as in the different RHU (regional health units) of the provincial zone. In addition, a programme of water and sanitation, shelter and NFI distribution activities were undertaken covering the area around Guiuan and the adjacent islands. OCB also distributed “context-developed” reconstruction kits to be shared by two families each and in a third stage (2014) built a semi-permanent modular hospital (achieved end of June 2014) to replace the hospital of Guiuan, which was destroyed during the typhoon.

**OCA** mainly focused on responding to needs predominantly through mobile clinics with a few fixed clinic locations, distributing NFIs for people in evacuation centres and providing water and sanitation for towns and villages away from the main access roads. Minor rehabilitation of the hospital was provided in order for it to quickly become operational. After the initial assessments, the most heavily affected areas needed assistance beyond medical action. Although not initially planned, NFI kits for reconstruction were then distributed in Santa Fe municipality. It was quickly decided that the intervention would be short and within three weeks a decision was taken to close down the response and leave in January 2014.

**OCBA** provided medical and logistical support to the health facilities in the area including Burauen District Hospital in order to restore their services as soon as possible. OCBA also provided medical support to clinics in the area and carried out shelter and NFI distributions as well as water trucking.

**OCG** teams provided medical services through mobile clinics, support to the District Hospital of Balasan (referrals), rehabilitation of medical facilities, distribution of NFI as well as water and sanitation in the most remote villages. A blanket food distribution was undertaken by OCG beginning of December for 10 000 households. A specific intervention took place to establish an IDP camp when an oil spill affected a township in Estancia of Roxas Island as a consequence of the typhoon.

### 2.2.5 Coordination/liaison

There was no common coordination structure in place so collaboration between OCs took place either through regular coordination meetings or bilaterally on an ad hoc basis. For the logistics and supply hub in Cebu, after a few days, a sharing of responsibilities and roles were developed to help avoid duplication.

Overall, according to the teams of the different OCs, the intersectional coordination worked well which was said in part due to the personal relationship between the different coordination positions. What was important was the decision, taken in the first days following the typhoon, to have a centralised liaison post in Manila for representation and advocacy. This was highly appreciated by all, both internally and externally to MSF. This allowed a good flow of information between national and international bodies coordinating the emergency response and MSF teams on the ground, which resulted in a better understanding of who was doing what, when and with which outcomes. MSF was seen as one of the top five organisations or agencies in terms of sharing information with the authorities.

At a headquarters level, apart from the initial contact between individual emergency desks and initial e-desk teleconferences coordinated by the international office there was no structured coordination in place. Information was shared between the desks on an adhoc basis. There is
currently no mechanism in place to coordinate in an emergency regarding areas of intervention, sharing of positions or information. At present this works on an adhoc basis.

2.2.6 Mapping of activities

It needs to be noted that the pre-typhoon health status of the population was relatively good and that the health system was well organised and functioning.

2.2.6.1 Foreign Medical Teams

In order to understand how MSF was represented amongst the international aid community in terms of medical aid, we used data provided by the new system of Foreign Medical Teams (FMT). The concept of FMTs was developed following the Haiti earthquake by the WHO. It consists of setting up standards and an accreditation system for medical teams. The Philippines response was the first emergency where the FMT registration system was put in place. For the Department of Health (DoH) supported by the WHO, it was a good tool to classify teams arriving in the field. Upon arrival in Cebu at the ‘one-stop shop’ medical teams were classified and their details put online.

The classification of type I, type II and type III corresponds to primary, secondary and tertiary health care. The majority of teams were classified as Type I. There were only eleven registered type II FMTs and only two type III FMTs. MSF-OCP was classified as a Type III and the other OCs were classified as Type II. Being registered as an FMT meant that MSF had to report to the DoH and WHO. Not all teams registered or provided information on the type of activities they provided and for how long.

Table 2: Aggregated services delivered by reporting registered-FMTs

<table>
<thead>
<tr>
<th>FMT Type</th>
<th>Total registered</th>
<th>Total teams reporting</th>
<th>Total consultations</th>
<th>Total admissions</th>
<th>Total deliveries</th>
<th>Total</th>
<th>Total major surgeries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type 1</td>
<td>Fixed</td>
<td>57</td>
<td>36</td>
<td>82 850</td>
<td>341</td>
<td>73</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Mobile</td>
<td>12</td>
<td>8</td>
<td>22 892</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>69</td>
<td>44</td>
<td>105 742</td>
<td>341</td>
<td>73</td>
<td>2</td>
</tr>
<tr>
<td>Type 2</td>
<td>11</td>
<td>9</td>
<td>41 822</td>
<td>2 247</td>
<td>538</td>
<td>47</td>
<td>490</td>
</tr>
<tr>
<td>Type 3</td>
<td>China-M</td>
<td>1</td>
<td>1</td>
<td>46 035</td>
<td>591</td>
<td>651</td>
<td>412</td>
</tr>
<tr>
<td></td>
<td>MSF-France</td>
<td>1</td>
<td>1</td>
<td>46 083</td>
<td>639</td>
<td>655</td>
<td>452</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>2</td>
<td>2</td>
<td>46 083</td>
<td>639</td>
<td>655</td>
<td>452</td>
</tr>
<tr>
<td>Specialised</td>
<td>1</td>
<td>0</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Total</td>
<td>83</td>
<td>55</td>
<td>193 647</td>
<td>3227</td>
<td>1266</td>
<td>121</td>
<td>949</td>
</tr>
</tbody>
</table>

The data reported through the FMT/DOH register cover a larger period than the data that have been used in table 3 below. When comparing the different data, it can be shown that MSF provided more than 30% of consultations, hospitalisations and deliveries provided by all the registered FMTs. The data also show the essential role MSF played in terms of surgical cases, mainly through the OCP hospital in Tacloban. MSF provided 3 out of 11 type II FMTs as well as one of the two type III structures. It must be noted here that the China-M hospital ship was only present for two weeks,

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8 WHO FMT report
which again emphasises the role of the OCP inflatable hospital. Regarding the fixed and mobile clinics, the number of clinics provided by MSF was not available but it was reported as a considerable percentage of the overall figure.

While the FMTs played a key role, it is important to remember that the first response was provided by national medical teams and the DoH, who conducted the emergency response. It was not possible at the time of the evaluation to receive the DoH medical data to compare the input of the FMTs versus that of the existing health system.

2.2.6.2 Medical activities

Table 3 below presents the data on medical activities per OC for the period from week 46, three days after the typhoon, until the end of 2013.

<table>
<thead>
<tr>
<th>MEDICAL ACTIVITIES</th>
<th>OCA</th>
<th>OCBA</th>
<th>OCB</th>
<th>OCG</th>
<th>OCP</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>OPD consultations</td>
<td>5263</td>
<td>22 926</td>
<td>10 021</td>
<td>12 675</td>
<td>14 277</td>
<td>65 162</td>
</tr>
<tr>
<td>Dressings*</td>
<td>473</td>
<td>1584</td>
<td>2503</td>
<td>436</td>
<td>2346</td>
<td>4996</td>
</tr>
<tr>
<td>IPD** nr of admissions</td>
<td>0</td>
<td>357</td>
<td>498</td>
<td>0</td>
<td>535</td>
<td>1390</td>
</tr>
<tr>
<td>OT activity</td>
<td>0</td>
<td>45</td>
<td>27</td>
<td>0</td>
<td>266</td>
<td>338</td>
</tr>
<tr>
<td>Caesarean Sections</td>
<td>0</td>
<td>1</td>
<td>9</td>
<td>0</td>
<td>24</td>
<td>34</td>
</tr>
<tr>
<td>Deliveries</td>
<td>0</td>
<td>92</td>
<td>108</td>
<td>0</td>
<td>160</td>
<td>360</td>
</tr>
</tbody>
</table>

*Includes wounds
**Includes maternal and neonatal admissions

OCP maintained its medical focus during the intervention and most of their activities were medical and hospital-centred. In Tacloban, OCP decided to establish its inflatable hospital (55-bed) in the compound of Bethany Hospital with an emergency room, IPD, OPD, maternity, neonatal unit and operating theatre. The hospital was also equipped with a portable X-ray machine, ultrasound and a basic laboratory with blood transfusion capacity. Other activities included mental health, ante-/postnatal care, family planning and medical outreach programmes. Bethany Hospital was chosen because it was the only place with enough space to erect the inflatable hospital. No ground belonging to the DoH was available. Part of the activities were established inside the surviving hospital structure, specifically surgery and laboratory, which allowed to send part of the inflatable hospital to Tanauan. Several other actors intervened in Tacloban, especially those who arrived very early (Australian Aid hospital-military).

OCP decided to establish a 25-bed tent hospital in Tanauan with maternity, ER and IPD. An OPD was opened both in Tanauan and Tolosa. Mobile medical teams were also formed to go to the different barangays. Progressively, several other health actors also came and provided health care services for the population.

OCB’s emergency response targeted the Guiuan Inter-Local Health Zone (Guiuan, Mercedes, Salcedo, Mac Arthur and Hernani). The Abrigo Memorial Hospital was the main district hospital in Guiuan. Before the typhoon, it was a level 1 hospital with a capacity of 50 beds including a delivery

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9 OC weekly sitreps and end of intervention reports
room, X-ray machine, laboratory and operating theatre, which was mainly designated for Caesarean Sections (CS) and emergency surgeries. The hospital was significantly damaged by the typhoon, which is why MSF provided a tented hospital.

The IPD activities started in week 47 with a capacity of 30 beds and increased to 60 beds by week 49. The tented hospital was comprised of a maternity ward, adult ward, paediatric ward, an emergency and a delivery room. The OT was put in place only on the 4th of December because prior to this there was an agreement to use an existing private hospital with surgery capacity. The Guiuan RHU structure (not in the hospital) was partially destroyed due to the typhoon. A tent was provided for the OPD consultations and activities started in week 46. The RHU provided OPD activities as well as minor surgery and dressings. All deliveries, ANC and PNC consultations were referred to the temporary tented hospital. The OPD was also attached to a dispensary. The outreach medical activities started in week 48 on the mainland and islands for the five municipalities served by the Abrigo district hospital. Mainland outreach activities were stopped in week 50 as there were different actors providing health services.

OCA’s medical intervention was implemented through mobile clinics and support to two fixed clinics, with the prioritisation on the main affected areas and most vulnerable population, including active facilitation of referrals to secondary care. The initial outline of the programme planned for a 50% medical intervention, but within one to two weeks the teams on the ground came to the conclusion that health needs were not very high; in general, systems were in place but temporarily not functioning since one week due to the typhoon. There were no needs identified which needed to be addressed urgently. The total number of patients treated was lower than expected at the beginning. This was mainly due to the fact that other medical actors became active in the area and sometimes overlapped with MSF services.

OCBAs intervention consisted of support to the health facilities by providing human resources (HR), drugs and medical material and ensuring essential water/hygiene/sanitation requirements. In the hospital, MSF cleaned parts of the building that could be used and installed tents to perform the following services: ER, IPD, maternity, minor surgery (in the bubble OT that was set up in week 50). A referral system through ambulance services was organised to Tacloban. OCB also provided outreach activities in RHUs in the district. Mental health support was given within the IPD as well as community-based.

OCG decided to provide support to mobile clinics in six municipalities and to the District Hospital of Balasan, which MSF used to refer all the patients from its mobile clinics. OCG also provided support in terms of drugs, HR, training for medical DoH staff on specific topics (in coordination with local and Provincial Health Authorities) and rehabilitation of the hospital due to the damages caused by the typhoon.

2.2.6.3 Consultations

The main reasons for consultations were wounds, URTI and diarrhoea. The demand for these type of services is usually higher in the days following such disasters. Therefore, we looked at the weekly data to see how appropriate the response was.

In graph 1 a delay can be seen. A low number of consultations was done by MSF in the first week after the typhoon (week 46), the peak is situated in the second week with the number of consultations slowly decreasing afterwards. This can be explained by the late arrival of teams and supply on the ground.

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10 Does need matter? Needs assessments and decision-making among major humanitarian health agencies; Martin Gerdin, Patrice Chataigner, Leonie Tax, Anne Kubai, and Johan von Schreeb
In the report of the intervention OCA\textsuperscript{11} stated the following:

"Ensure that right from the start of the intervention expats travelling to the field carry basic medical supplies with them to enable them to start activities, even if international cargo is delayed. Basic Units of the IEHK and first aid kits in the backpack version are suitable."

For OCP, the focus was on setting up the hospital and a few medical activities were done prior to this.

Graph 1: Total cumulative number of consultations for all OCs per week\textsuperscript{12}

Graph 2 shows that OCBA’s level of activities in terms of consultations was high, but the data recorded concerns the activities run in the structures supported by MSF but not necessarily performed by MSF staff. Whereas the data of the other OCs represent activities directly carried out by MSF medical teams. The graph also shows a significant decrease of activities after the third week, except for OCP. In Tacloban, many foreign teams (especially military) intervened early and left quickly. The high level of consultations maintained by OCP up to the end of the year can be explained by OCP absorbing the capacity provided by these organisations.

\textsuperscript{11} OCA Typhoon Haiyan Report
\textsuperscript{12} OC weekly sitreps
Emergency response to Typhoon Haiyan, intersectional review, Nov 2014

Graph 2: OPD consultations during the first seven weeks\(^{13}\)

*The first consultations took place during week 46, which began on 11 November, three days after Typhoon Haiyan made landfall.

**Data are the total number of consultations of each OC from all locations combined.

***OCBA supported health structures, whereas OCA and OCG conducted mobile clinics, and OCB and OCP provided services mainly through existing or temporary MSF structures.

2.2.6.4 Surgery

In terms of surgery, table 3\(^{14}\) shows that the number of surgical interventions, apart from OCP, was relatively low considering the time frame. OCP ran surgery inside the inflatable hospital, which was used as a referral centre for the region; OCB also set up an OT under inflatable tents and OCBA trialled the bubble OT.

2.2.6.5 Mental health activities

The needs for mental health were expected given the characteristics of this natural disaster and previous experience, especially considering the following aspects:

- high number of dead people
- numerous survivors seeing family members drowning at their side and not being able to save them (feelings of guilt, especially in children)
- numerous people having lost everything (homes, properties, means of living) and therefore being at risk for depression

\(^{13}\) OC weekly medical and general sitreps
\(^{14}\) See page 13
However, the medical teams noted that strong resilience and coping mechanisms existed and were, amongst others, linked to strong family ties and community solidarity, religious spirit and the habit of frequent adverse natural disasters, even if expressing sadness and psychic distress is not really tolerated in this cultural context. Prior to the typhoon, mental health services in the region were very scarce. This justifies MSF’s mental health intervention. Furthermore, after the end of the MSF intervention, medical authorities decided to continue developing mental health services.

Mental health has been integrated by all OCs and the different interventions focused on various target groups such as children, vulnerable populations but also medical staff. Especially for health staff the DoH identified the need for mental health support after the disaster in order to foster their coping mechanisms. They were identified as a neglected group.

Table 4: Mental health activities during the first seven weeks

<table>
<thead>
<tr>
<th>MENTAL HEALTH ACTIVITIES</th>
<th>OCA</th>
<th>OCBA</th>
<th>OCB**</th>
<th>OCG</th>
<th>OCP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group sessions</td>
<td>54</td>
<td>74</td>
<td>196</td>
<td>29</td>
<td>132</td>
</tr>
<tr>
<td>Nr of participants in group discussions</td>
<td>1630</td>
<td>769</td>
<td>4606</td>
<td>2906</td>
<td>2515</td>
</tr>
<tr>
<td>Individual consultations</td>
<td>401</td>
<td>48</td>
<td>80</td>
<td>374</td>
<td>404</td>
</tr>
<tr>
<td>Psycho-educational sessions</td>
<td>164</td>
<td>117</td>
<td>125</td>
<td>*0</td>
<td>*0</td>
</tr>
<tr>
<td>Nr of participants in psycho-educational sessions</td>
<td>4186</td>
<td>9406</td>
<td>3852</td>
<td>*0</td>
<td>*0</td>
</tr>
</tbody>
</table>

*No data currently available for the number of participants of each group session
**Until end of February 2014

Some OCs raised concerns regarding the lack of inclusion of treatment for psychiatric conditions in the emergency intervention. In such disasters, psychiatric services often become non-operational, as was the case in Tacloban. However, sometimes patients already are on anti-psychotic medication or present with severe symptoms following the disaster. In such cases patients need psychotropic drugs and psychological care and, as in other chronic diseases, continuity in their treatment.

2.2.6.6 Water and sanitation activities

All sections conducted water and sanitation activities in health structures and ensured provision of water to hospitals and RHRs, which they were either supporting or running directly. All OC’s, except OCP, also performed water and sanitation activities for the general population focusing either on most populated areas or on more remote areas. The range of activities covered water trucking, water provision by bladders, chlorination, well cleanings, provision of hand pumps and provision of latrines. In table 5, the provision of water provided has been represented by cubic metres rather than number of beneficiaries as there was insufficient data available from enough OCs.

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Table 5: Water and sanitation activities

<table>
<thead>
<tr>
<th>WATSAN ACTIVITIES</th>
<th>OCA</th>
<th>OCBA</th>
<th>OCB</th>
<th>OCG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Water trucking/bucket chlorination: pop assisted</td>
<td>32 967</td>
<td>8165</td>
<td>23 345</td>
<td>**</td>
</tr>
<tr>
<td>Total m3 treated water provided</td>
<td>3710</td>
<td>993</td>
<td>4103</td>
<td>**</td>
</tr>
<tr>
<td>Target population Aqua tab/chlorine donation</td>
<td>28 200</td>
<td>2996</td>
<td>**</td>
<td>**</td>
</tr>
<tr>
<td>Aqua tab/chlorine donation in m3 of potable water supply</td>
<td>35 071</td>
<td>0</td>
<td>**</td>
<td>12 000</td>
</tr>
<tr>
<td>Well cleaning</td>
<td>0</td>
<td>0</td>
<td>62</td>
<td>37</td>
</tr>
</tbody>
</table>

*OCP provided Watsan support to their health facilities but there is no information available regarding community activities

**No data currently available for activities provided

Both OCA and OCB ran the most comprehensive intervention in terms of water and sanitation. The one difference being that OCB supported the re-establishment of the water system in Guiuan which was 90% destroyed by the typhoon. In addition a well cleaning campaign was conducted in Guiuan town and outreach locations.

2.2.6.7 NFI, shelter, food distributions

Table 6: Non-food item and shelter distribution

<table>
<thead>
<tr>
<th>NFI/shelter distribution</th>
<th>OCA</th>
<th>OCBA</th>
<th>OCB</th>
<th>OCG</th>
<th>OCP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hygiene kits</td>
<td>1093</td>
<td>12 115</td>
<td>2896</td>
<td>452</td>
<td>3000</td>
</tr>
<tr>
<td>NFI kits</td>
<td>2009</td>
<td>3819</td>
<td>3238</td>
<td>10 256</td>
<td>3000</td>
</tr>
<tr>
<td>Jerry cans</td>
<td>14 811</td>
<td>1215</td>
<td>960</td>
<td>6000</td>
<td></td>
</tr>
<tr>
<td>Blankets</td>
<td>6874</td>
<td>3760</td>
<td>1604</td>
<td>21 850</td>
<td></td>
</tr>
<tr>
<td>Tents</td>
<td>3846</td>
<td>2956</td>
<td>1529</td>
<td>1500</td>
<td></td>
</tr>
<tr>
<td>Tarpaulins</td>
<td>9855</td>
<td>2280</td>
<td>1874</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shelter reconstruction kit</td>
<td>4820</td>
<td>1250</td>
<td>2000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Cannot be compared like for like as the distributions did not consist of the same items

**Non-food items**: All OCs distributed NFls on various scales, targeting the most affected and isolated populations. However, items distributed and the composition of the various kits differed greatly between OCs.

**Shelter**: In anticipation of incoming typhoons, the Philippines authorities encourage the population to move or to take shelter in evacuation shelters, generally schools or public buildings not specifically constructed for this purpose. During typhoon Haiyan, some evacuation centres were damaged themselves, and in some areas (coastal areas, islands), the level of individual houses destroyed were impressive.

In the first stage, tents and tarpaulins were distributed by all OCs except OCA, using either individual household or communal approach. In the second stage, some OCs decided to distribute

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17 Weekly sitreps and end of intervention reports
reconstruction kits to support families that had lost their homes. These distributions were targeted towards the more remote populations most of the time. Three OCs distributed shelter kits, but their compositions were different. Whereas OCA’s and OCBA’s shelter kits were mainly consisting of tools, OCB decided to propose a full kit comprising of plywood, corrugated roofing and marine proof wooden beams, in order to give full means to families to rebuild homes, in an area that was particularly damaged.

**Food:** OCG was the only one distributing food mid-December, as they noted that access to food became an increasing problem especially on the islands. They targeted 10,856 households; 9,892 households were provided with food by MSF and 964 households were served by ACF, additionally a total of 48 tons of high energy biscuits were provided to supplement the food baskets from WFP. Following its food distribution, OCG lobbied for other organisations, more specifically WFP, in order for this type of intervention to be renewed.

### 2.2.6.8 Supply

All supplies transited Cebu airport, which was not prepared to receive large cargo shipments and became quickly overwhelmed. It was described as a bottleneck. All steps were challenging: customs clearance, unloading planes, finding warehouses, organising transport by plane or by boat for example. Whereas OCB placed a dedicated team of five people for supply in Cebu very early on, the organisation of the other OCs in terms of supply was “lighter” and concerns were raised during the interview that the supply strategies of some OCs remain an issue to be worked on.

As some OCs questioned their setup in terms of supply, they propose a different organisation for next time. OCA\(^{18}\) states the following in its final report:

“Even if the intervention is intended to be small scale, the initial setup and cargo reception will require substantial logistical input. We should not limit ourselves by sending only a five-expat team as was the approved initial team. Not considering the capacity needed for the actual activities, a Log Coordinator, a base log per location and a supply log in coordination to receive international cargo as well as a full purchase log should be the minimum team.”

In an OCP report from Eric Pujo Colog the following is stated:

“At the beginning of the operation the number of logicians in Cebu was not enough for all the international freight reception and created some disorganisation within the team. The following was proposed for a future set-up: 1 supply coordinator; 1 on air strip for reception of freight & dispatch; 1 on air strip for military planes (organisation & follow-up); 1 in customs office for clearance and truck loading; 1 in MSF warehouse (reception & truck loading); 1 in charge of supply delivery to the field”.

### 2.2.7 Cost of the interventions

As can be seen from the raw data of the financial accounts per OC, there is a clear disparity in spending during the first seven weeks of the emergency with regards the total amount spent by each OC. As can be seen, OCB spent €8,210,314 while OCA spent €1,002,229 during the first 7 weeks. This overall figure does not explain the reasons behind the difference in spending levels for each OC which we have tried to explain below.

\(^{19}\) OCA end of intervention report

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Table 7: Budget spending between 8 November and 31 December 2013\(^{19}\)
### Graph 3: Percentage of total budget spent per OC

<table>
<thead>
<tr>
<th>Philippines 2013 expenses</th>
<th>Total expenditure</th>
<th>OCB</th>
<th>OCP</th>
<th>OCA</th>
<th>OCBA</th>
<th>OCG</th>
</tr>
</thead>
<tbody>
<tr>
<td>International staff</td>
<td>€ 1 654 998</td>
<td>468 453</td>
<td>457 086</td>
<td>220 199</td>
<td>209 876</td>
<td>299 384</td>
</tr>
<tr>
<td>National staff</td>
<td>€ 345 369</td>
<td>82 215</td>
<td>109 590</td>
<td>59 213</td>
<td>26 341</td>
<td>68 010</td>
</tr>
<tr>
<td>Medical and nutrition</td>
<td>€ 2 893 873</td>
<td>1 165 452</td>
<td>772 266</td>
<td>88 910</td>
<td>277 164</td>
<td>590 081</td>
</tr>
<tr>
<td>Logistics and sanitation</td>
<td>€ 6 599 782</td>
<td>3 550 010</td>
<td>1 159 073</td>
<td>327 069</td>
<td>1 001 351</td>
<td>562 279</td>
</tr>
<tr>
<td>Transport, freight, storage</td>
<td>€ 5 448 460</td>
<td>2 747 454</td>
<td>895 090</td>
<td>242 631</td>
<td>913 727</td>
<td>649 558</td>
</tr>
<tr>
<td>Others</td>
<td>€ 540 357</td>
<td>196 730</td>
<td>110 809</td>
<td>64 207</td>
<td>31 209</td>
<td>137 402</td>
</tr>
<tr>
<td><strong>TOTAL in Euros</strong></td>
<td><strong>€17 482 838</strong></td>
<td><strong>8 210 314</strong></td>
<td><strong>3 503 914</strong></td>
<td><strong>1 002 229</strong></td>
<td><strong>2 459 668</strong></td>
<td><strong>2 306 713</strong></td>
</tr>
</tbody>
</table>

*‘Others’ includes operational running costs, training and local support, consultants and field support and others*

Graph 3 above shows that OCB was responsible for 47% of the overall spending in the first seven weeks of the emergency while OCA accounted for only 6%. In part this can be explained by the fact that while most OCs focused on remote locations, OCB intervened in the most affected area which was more difficult to access and required expensive transport solutions but it is also linked to operational choices and strategies as explained in chapter 2.2. For example, OCB like OCG, provided assistance to island communities badly affected by the disaster. As can be seen by the pictures below this added an additional complexity and cost to the intervention. The island assistance comprised of health care and several stages of NFI and shelter distributions including shelter kits which were designed to provide a temporary replacement structure.\(^{19}\)

\(^{19}\) International Office Typhoon Haiyan budget overview 20

\(^{20}\) International Office Typhoon Haiyan budget overview 21

\(^{21}\) Photos taken from the OCB Philippines OR field visit report Dec 2013
In addition, OCA, OCG and OCBA all took the decision to close their projects and leave in January quite quickly as the needs decreased. Therefore, the majority of their spending took place during the first 3 to 4 weeks of the emergency, whereas both OCP and OCB continued their activities in 2014.

Graph 4 shows that within all OCs, except for OCG, the largest expenditure during the first seven weeks was for logistics and sanitation followed by transport/freight and storage. The difference for OCG was the implementation of a food distribution included within the medical/nutrition column. The expenditure on logistics/sanitation and transport/freight/storage is a direct result of the issues relating to the emergency where the medical needs were quickly addressed and the need for non-medical assistance was identified by the teams as a requirement which was addressed through Watsan, shelter and non-food item distributions. It must be noted that while each budget line is the same, what the money is spent is not necessarily the same. For example regarding shelter, the actual components of the shelter package offered by each OC is different. Therefore it is not always possible to compare from a financial or reporting perspective in the responses from each OC. Not all NFI or shelter distributions contain the same items and costs associated with the distributions vary depending upon ease of access to the targeted communities.
In graph 5 it is interesting to compare the actual expenses per main budget line as an overall percentage for each OC intervention. For OCB and OCBA, logistics/sanitation and transport/freight and storage comprised 76% and 78% of their budgets respectively. OCP, OCG and OCA spent 59%, 52% and 57% respectively. The main difference can be explained for OCB with their strategy and type of shelter distribution, which included the hiring of a barge to distribute the assembled shelter kits and for OCBA with their provision of the largest NFI distribution in quantity. During the interviews some expressed that there was an element of ‘over-shooting’ by OCB with regards to the procurement of non-medical items, which could also explain the budget line. As part of the OCB exit strategy, several containers were sent to Sierra Leone and Cameroun containing medical and non-medical items worth €1,206,806 to be used in other projects or re-integrated into the supply system in Brussels.

Regarding the medical analysis, as a percentage spent, OCA, OCB and OCBA are very similar, even though they had different strategies and with OCB and OCBA supporting hospital structures. One would expect OCP, through the provision of an inflatable hospital with surgery (type III FMT) to have a higher cost percentage regarding the medical budget and OCG, once the nutrition component is removed, to be more in line with the other OCs.

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22 International Office Typhoon Haiyan budget overview
This disparity can be explained to some extent by the locations where each OC responded; Guiuan in Eastern Samar was the most affected area with issues of accessibility, presence of fewer actors and the capacity to assist a dispersed population targeting Island communities, whereas in Roxas Island, Western Visayas, the resulting damage, size of affected population and subsequent needs where much less.

### 2.2.8 Timeliness

The ability to be operationally quickly when responding to a natural disaster, especially in the first days, is seen as crucial to meeting the medical needs of those most affected. In relation to the Philippines emergency, MSF was not the first on the ground but one of the first present with a response capacity. Other actors/journalists were able to get there first but with little or no equipment to respond. It is often perceived and experienced that in these type of emergencies the military is often quicker than MSF to be operational. However, in this emergency that was not the case in all locations. In Guiuan US/Philippines military secured the airport and helped clearing roads but did not provide medical services. This was different to Tacloban, where several military teams provided medical programmes but for a limited time frame.

MSF was not operational on the ground until five days after the typhoon struck. From a pure time frame perspective, MSF was late considering the possibility within the region to send a small team

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23 International Office Typhoon Haiyan budget overview
prior to the typhoon making landfall. OCB and OCP took the decision to intervene on 9 November and arrived in the Philippines on the 10th, then 2/3 additional days passed respectively until arriving in the subsequent project locations. While this delay can be questioned, the reality can be explained by the fact that MSF was not already present, there was no direct access to Eastern Visayas (Leyte and Eastern Samar provinces) and all logistics and supply were centralised through a logistics hub that was opened for the response by the authorities in Cebu, a neighbouring Island with limited airport logistics capacity. There were issues of securing means of transport with competition from other actors and between MSF teams and Tacloban airport not initially being open for air access. The DoH and Save the Children prepositioned medical and non-medical stocks in Tacloban which were lost due to the intensity of the typhoon and the 5 metres sea surge that followed.

Some operational choices can also be seen as having led to a delay in providing hospital services. The OCP inflatable hospital was not opened until 22 November, 14 days after the emergency. This was partly due to a week’s delay in transporting it from Cebu to Tacloban.

### 2.2.9 Exit strategy

OCA, OCG and OCBA had planned a short intervention between six weeks and two months from the beginning. With the main medical needs being met quite quickly, it allowed for each OC to plan early for their exit strategy. They started to reduce their activities mid-December and terminated their projects between January and February 2014 handing over activities mainly to local authorities and in some cases to other NGOs or discontinuing those that were only meant as a response to emergency needs after the disaster.

Table 8: MSF Typhoon Haiyan timeline of end of activities for OCG/OCA/OCBA

<table>
<thead>
<tr>
<th>Timing 2013/2014</th>
<th>Week 51</th>
<th>Week 52</th>
<th>Week 1</th>
<th>Week 2</th>
<th>Week 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>End of medical activities</td>
<td>OCG</td>
<td>OCA</td>
<td>OCBA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>End of distributions</td>
<td>OCG</td>
<td>OCA</td>
<td>OCBA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>End of Watsan activities</td>
<td></td>
<td>OCA</td>
<td>OCG</td>
<td>OCBA</td>
<td></td>
</tr>
<tr>
<td>Last team on grounds</td>
<td></td>
<td></td>
<td>OCA</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>OCG</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>OCBA</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

OCP stated its intention of planning a long-term intervention in the Philippines, which would not be linked to the Haiyan Typhoon emergency, early. By the end of 2013, a decision was made to merge the two emergency projects (Tacloban and Tanauan/Tolosa), considering the restart of some activities by DOH in some locations, the decreasing of the emergency in terms of the number of relative cases directly linked to the typhoon, the proximity of the two settings and the possibility to have referral systems between them. In January, the OPD in Tanauan remained open; the OPD in Tolosa and the IPD in Tanauan were closed.

In Tacloban, as repairs were done at Bethany hospital, activities run by the national medical hospital staff took place again, with some adaptations made around the question of free health care and MSF progressively withdrawing from the project. Considering the damages in the province of Leyte, OCP then decided to support the rehabilitation of the provincial hospital in Palo, with a specific objective to render it able to provide maternal and child care, and practising Caesarean Sections. MSF was planning to reinforce the medical teams in this hospital from May 2014 to develop the capacities of this hospital. Following the emergency, OCP conducted exploratory missions to identify future longer term projects.
OCB included the recovery phase as part of an intervention in response to such a natural disaster. Knowing that long-term reconstruction starts later and will become effective years after, there is a need to ensure the intermediary period. Having that in mind, OCB decided in December 2013 to construct a modular hospital to replace the temporary tented structure that would not be able to support the next typhoon/rainy season. The modular hospital was considered as a semi-permanent solution, meaning that it was guaranteed for five years. The construction of this hospital was run as a separate project managed by the logistics department in the headquarters. While the initial budget of the modular hospital was of €3.5 M, the actual cost was €2.5M (construction/Watsan: 1 360 000 €, freight/transport and storage: €685 000, HR: €430 000).

This project raised some concerns amongst the teams in the field. There was a general agreement on the necessity for MSF to provide a mid-term solution for the hospital in Guiuan, the previous one being destroyed and with no possibility of repairs, a replacement hospital was not expected before 2 or 3 years, and no other actors ready to invest for the mid-term period. However, the “ready to use” solution that was adopted was considered as not having explored enough alternative solutions, such as local ones (using more local materials, employing more local human resources) as well as not having taken in consideration the consequences of establishing such a structure with its constraints (number of human resources, services, size etc.) The land was privately owned but this was the only solution, as no municipal or DoH land was available at the time.

The decision was taken in Brussels considering not only the importance of recovery but also seeing it as a pilot initiative to test the ability of MSF to provide a safe health structure in a short time period (three months was the objective installation time-frame).

Meanwhile, the teams continued to provide support in specific departments of the hospital and run outreach water and sanitation activities (well cleanings and installation of water pumps was seen as the exit strategy from water trucking). At the beginning of the year, a second batch of construction materials was distributed. Operational research on Dengue prevention also took place during the first semester of 2014. OCB finally handed over and exited the Philippines in October 2014.

2.2.10 Constraints/obstacles

The environment is generally reported as a favourable one considering the facilities and support provided and organised by the national authorities, the space to intervene and the absence of major security concerns. The main obstacles described by the different operational teams were, not surprisingly, related to supply and logistics. In such a major and media driven emergency, a huge number of relief cargos will be sent to the affected areas during a very short period of time.

2.2.11 Role of communication

The size of the communications team sent to the Philippines was questioned by some when comparing with other ongoing emergencies at the time, such as Central African Republic. In reality, this emergency had captivated the international media and would have been difficult to avoid especially after MSF had responded operationally.

2.3 Role of regional offices

The review examined the existing resources and capacity which existed in the region and was either available or used as part of the Haiyan response. In addition, the regional strategies being
developed by the different MSF offices (Hong Kong, Japan and Australia) were looked at with regards to the question of added value.

2.3.1 Regional office capacity

Within the three regional offices there has been an investment in resources aimed at providing a monitoring and networking capacity. MSF Japan and Australia, with the support of MSF France, invested in a regional emergency preparedness role which was shared between the Australia and Japan offices. Its main role was to build up links, networking and context monitoring. Several assessments were also conducted, especially in the Philippines, linked to possible emergencies resulting in small interventions. The decision to discontinue this position was taken prior to Typhoon Haiyan but remained in place at the time of the emergency.

There was also a Tokyo desk but it was not directly involved in the management of the emergency. The desk will close next year, but one position remains, a super-log of the desk which is based in the Philippines and working in the ongoing OCP projects. This position will also have the responsibility of emergency surveillance within the region, linked to MSF Japan.

MSF Hong Kong is the most developed in relation to establishing a regional capacity through an Operational Support Team (OPS). This was established in 2012 and incorporates three primary components of which one is seconded from the International Office;

- Emergency Response Support Unit (ERSU, established 2010): Emergency Preparedness and Response
- Programme Development Unit (PDU): Research and Context Monitoring
- Regional Humanitarian Representation (RHR-International MSF position): Advocacy and Representation-ASEAN

The RHR role is planned to move to Jakarta, Indonesia, during 2015 for proximity to ASEAN networking. The main role of this unit is to provide a similar role to monitor emergencies in South East Asia and to provide a response support; ideally after getting a buy-in from an OC. From the Hong Kong office perspective, the capacity in the region has improved markedly with many assessments having been undertaken but no response as yet required. The OST geographical coverage is focused on Myanmar, Thailand, Laos, Cambodia, Singapore, Malaysia, Vietnam, Indonesia, Papua New Guinea, Philippines and China. In addition, 'Antennas' have been established in different countries using former MSF expatriates to engage regularly with the authorities and humanitarian actors within their countries. They are also to be alerted for emergencies and available for deployment in case of emergencies. This network is changing regularly and training is provided as required.

Apart from having shared the emergency position with MSF Japan, MSF Australia has developed a register of expats available for emergency response. There was a good coordination and information sharing between the positions based within the region which impacted positively during the initial days with good working relationships already having been established.

2.3.1.1 Typhoon Haiyan support

Prior to the typhoon making landfall, updates were sent from the Hong Kong office to the different OCs and while seen as useful in some cases, it was not clearly stated that they were not used as a...
decision making tool prior to the emergency. Not all OCs remembered receiving or using the information that had been provided. It is also not clear if the information replaced or provided something different than what already existed in each OC.

Discussions did take place on whether the two emergency roles from Hong Kong and Japan should pre-position themselves in the Philippines but it was decided against it. The first teams to arrive in the Philippines were from the Hong Kong and Japan offices. The networking and relationship building undertaken in the months before was definitely seen as a benefit which opened doors and allowed a quick response/contact with the authorities which was very much based on the developed personal relationships.

Both the regional emergency positions, following their arrival in the Philippines, quickly assumed coordination roles for OCB and OCP, based in Guiuan and Tacloban respectively.

### 2.3.1.2 Regional HR support

This was seen as one of the most important aspects of regional capacity which was utilised to the benefit of the emergency response. MSF Hong Kong, through their regional human resource recruitment was able to contact Philippines and other expatriates from the region, on their lists and quickly activate a group of experienced human resources available to respond as part of the initial emergency teams. During the first week of the emergency, 18 staff were contracted/detached or facilitated through the Hong Kong office. In total 37 positions were filled through the Hong Kong office until the beginning of January 2014 and came from Indonesia, Thailand, Singapore, Philippines, Hong Kong and China, Belgium, Austria and Pakistan. 21 of these positions were from the Philippines.

At the time it was thought that this HR support was provided to all sections and responded to the aim of MSF Hong Kong to be a regional resource to the MSF movement. When checked the reality however was that of the 37 expats and national staff supported through the Hong Kong office, only five worked for OCP, OCA and OCG. The remainder worked for OCB. Of the 145 expatriate OCB positions up until October 2014, 32 or 22% were filled by MSF Hong Kong.

Several coordination positions were filled through the HR from the Hong Kong office including e.g. emergency, medical, project and human resources coordinator roles. One additional benefit of the availability of Philippines human resources was their ability to activate local networks and contacts which provided a very positive impact on the teams and was a very useful resource.

Additional HR support was provided through communication positions from Hong Kong and Australia which were geared towards the general communication needs of MSF. MSF Japan also provided Japanese international staff and supported OCP and OCG through sourcing suppliers: getting contacts for boats and plane as well as providing free satellite phones and running costs and free flights for Japanese staff.

The final HR support was the placement of the RHR position in Manila to act as a liaison officer for MSF towards the authorities and other actors. This has been covered in an earlier section and was seen as a very successful deployment.

While MSF Hong Kong wishes to provide a strong regional presence offering services to all of MSF, in this emergency the support and resources were very orientated to OCB needs. If this continues to be the case in such future situations, then the added value of a regional office providing support to the MSF movement as a whole will be diminished. It also reinforces the perception in other OCs that MSF Hong Kong's primary focus in an emergency will remain towards OCB and cannot be relied

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25 See 2.2.8 Timeliness for further analysis
upon as an additional resource when OCB decides to respond alongside other OCs. It is not clear how much of the context analysis undertaken by the PDU is currently being utilised by each section of MSF. It could be of interest to evaluate this component separately.

2.4 Perception and added value

MSF’s general response to Typhoon Haiyan was overall very favourable with positive feedback from both the authorities and other organisations. MSF was perceived to have been timely, good at sharing information, providing a wide geographical coverage, able to work independently and provided the services communicated to the authorities. MSF was seen by the World Health Organisation as one of the main contributors to the Foreign Medical Teams surveillance which was being used for the first time in a large scale emergency. MSF contributed a significant proportion of the FMTs and the resulting consultations and inpatient services.

UNOCHA, who coordinated the shelter cluster, viewed the shelter contribution provided by MSF as making an important contribution to the overall shelter response. The strategy undertaken by OCB was particularly highlighted as pertinent, especially with the focus on remote and difficult to access communities.

The departure of MSF was also seen as positive with the authorities informed of the exit strategies and attempts to coordinate or handover activities during the handover. The strategy of OCB was particularly highlighted as a good example as it switched quickly from emergency to recovery and as part of the exit strategy included a mid-term solution to the provincial health care needs through the provision of a modular hospital, replacing for up to five years the destroyed fixed type 1 hospital.

MSF was rated by the DoH as one of the top five organisations or agencies in terms of sharing information both at field and capital level. Similar feedback was also received from UN agencies, with the recognition that this was a change from previous responses, and while MSF was not seen as a cluster member, the participation and presence of MSF at cluster meetings was seen as pertinent.

From the perspective of the DoH, when discussing the relevance of MSF providing medical assistance during natural disasters, MSF was recognised as having played a significant role which allowed the authorities to focus on other needs and geographical areas where MSF was not present. The ability for MSF to work independently, requiring minimal logistical or supply support was highlighted as one of the main benefits of MSF’s role in the disaster response.

MSF was perceived to have been timely and while not necessarily the first organisation on the ground MSF’s capacity to be able to quickly establish access to health care was comparable to other actors including the military teams. On this point, it was also noted that a large part of the foreign military response teams stayed only a short time and the capacity of MSF replaced their activities after their departure, especially through the OCP inflatable hospital in Tacloban. It should be repeated here that through the inflatable hospital MSF provided one of only two type III level of access to health care as a foreign medical team. The only other registered type III access was provided by the Chinese peace ship, which stayed only two weeks and treated 48 patients.

Through its activities targeting isolated and remote communities, specifically the affected islands, MSF provided important access to health care. For the authorities and WHO, this assistance identified an inequality in access to health care, which existed prior to the emergency. It was noted by WHO that in such situations, if MSF shared their data and information with WHO, they could

26 WHO FMT monitoring presentation 2014
follow up with the authorities to try and address these issues after the emergency. Also, through the mental health activities of MSF and others, it was expressed by the authorities that a gap in needs had been highlighted that would be addressed after the emergency.

While discussing how MSF can continue to respond to emergencies in the Philippines in the future, UNOCHA explained that they regularly respond to emergencies during a calendar year by continually opening and closing coordination offices and being very flexible with their approach. No permanent UNOCHA offices exists in the provinces. While there are several emergencies during a year, the coping capacity of the authorities and organisations usually means that the needs are often short-termed.

Regarding post-emergency projects, it was expressed by several organisations that there are significant challenges to find projects to spend the allocated funds raised during the appeals. There is competition between organisations to find projects which are in addition to pre-existing projects. The 'Build Back Better' approach from the authorities to ensure that the rehabilitation process of the infrastructure managed by the government means that only short-term and low cost rehabilitation is being requested in the short-term while the longer term planning takes place. For example, a post-emergency assessment of 28 health clinics in Eastern Samar province undertaken by OCP identified only two structures which required some rehabilitation support, because there were already plans or organisations providing support to the other 26.
3 Conclusion and discussion

Overall the response by MSF to Typhoon Haiyan was well perceived by all involved – with good geographical coverage, including a focus on the more rural and isolated communities, pertinent activities and services, a timely response compared to other actors, excellent coordination and information sharing with the authorities and other actors and good communication relating to the different exit strategies.

The response was timely compared to other actors, but the first MSF consultations were only done six days after the emergency and MSF’s surgical services commenced only after two weeks. MSF missed the opportunity to send small regional teams prior to the emergency which could potentially have saved a day or two but this is not definite. The focus on rural and isolated communities, such as the islands, was an important strategy with high impact. In pure time terms relating to the treatment of the injured following a natural disaster, it can be said that MSF was late in some locations.

In relation to the registered FMTs, when comparing the data provided by WHO and MSF, it is possible to conclude that MSF was a major contributor of medical care and provided +/-30% of the total consultations, hospitalisations and deliveries from the FMTs. MSF-OCP provided the only type III unit under the FMT register, which remained longer than two weeks.

The very low surgical activities done by OCB and OCBA raised the question of pertinence of the decision to send and setup an OT, especially as they were not functioning until two weeks after the typhoon. This indicates that MSF’s medical role in such a natural disaster (in a country where MSF is not present) will not be the immediate care of the wounded, but is more orientated towards the re-establishing of health care services that have been interrupted because of the disaster.

There was an identified gap in the provision of treatment of patients with diagnosed psychiatric conditions whose care and treatment has been disrupted as a consequence of this emergency.

MSF activities were seen as helping to identify gaps that existed prior to the emergency and acted as a stimulus for being continued as part of the normal health care services. It was mentioned that if MSF can coordinate and update the WHO, then it is possible that the WHO can play a role after the emergency in addressing the gaps in access to health care identified by organisations like MSF.

MSF used this specific emergency to pilot or test new tools or strategies: the bubble OT (OCBA), modular hospital and reconstruction kits (OCB). OCB also gained experience in this specific context in terms of its capacities to set up the inflatable OT.

The presence of five OCs allowed for a good geographical coverage which was appreciated by the authorities and it allowed for a good contextual understanding and provision of a wide range of assistance. The fact that all OCs were present was not seen as a negative but many of those interviewed in hindsight thought three sections would have been sufficient. The evaluation findings echo this opinion. In a context where there is a capacity to respond to emergencies which are a regular occurrence and where there is an active civil society and other organisations are present, there is no obvious justification for 5 OCs.

The question however in these large scale emergencies, under such media coverage is how an OC can avoid sending a team to assess the situation, especially when there are no other operational priorities, which in the case of Typhoon Haiyan was the reality. There is no current mechanism to quickly agree how many OCs should respond nor who would be given priority.

There was a cost disparity regarding the different operational choices and strategies which resulted in a wide difference between budgets. The disparity between the sections is explained firstly by their different policies towards a natural disaster response and secondly on the location of each
OC; which was a major factor in subsequent operational choices and the strategies of each OC. Because of their policy commitments, OCP and OCB were the first to decide to intervene; hence they chose the areas most affected. In addition, it must be remembered that both OCP and OCB continued to provide services in 2014, whereas OCA, OCBA and OCG all took the decision to wind down their activities in December and exit in January 2014. Proportionately, there was not a huge difference in terms of costs of activities when the figures are broken down which cannot be explained by the chosen strategies.

The **MSF response** was perceived as having had an added value and played an important role in the overall response, especially regarding the input provided by MSF as part of the foreign medical teams. In addition, the strategy of MSF–OCB was particularly highlighted as an example by the authorities and UN agencies, especially WHO and UNOCHA which addressed the short and mid-term needs required by the communities and authorities.

**The main obstacle** remains the difficulty of access in natural disasters. From an MSF perspective the issue of supply remains a constraint, even though this doesn’t seem to be the case for OCB. How many resources are allocated towards managing supply in an emergency is still an issue for some OCs. Initially insufficient resources were provided to manage the supply chain in Cebu and solutions to share roles and responsibilities between OC teams were ad hoc and not pre-defined. There is no agreed strategy or structure in place prior to an emergency on how to collaborate and share responsibilities and resources and prevent competition between supply teams during an emergency.

The **role of the regional offices**, especially Hong Kong, was very useful regarding the provision of human resources; particularly experienced by Philippine staff. However, there were missed opportunities to send teams prior to the typhoon making landfall. However, whether this would have made an impact is debatable, but the opportunity was there. MSF Hong Kong’s wish to support all OCs did not materialise as desired with the majority of support being directed towards OCB, especially human resources. There remains the question regarding the roles of the regional offices and requests for this to be clarified within the movement.

While **natural disaster policies exist** in each OC, few are clearly formalised and none have been updated recently.

**The management of information** was again a problem for the Philippines evaluation with the some of the documentation difficult to retrieve or find the relevant information. Not all information was initially available and the differences in how information is reported in each OC make the collection and analysis of the information both time consuming and difficult. As this problem has been repeatedly identified in evaluations, no particular recommendation is made, but MSF may want to consider addressing it.
4 Recommendations

⇒ Each OC should update or establish a written natural disaster policy and share with the different OCs. A common discussion should take place between OCs to identify complementarity strategies and activities and define areas of specific investment for example, shelter, supply, Watsan, NFI.

⇒ Regarding the implementation of the mid-term modular hospital solution it is recommended as part of the ongoing learning process to conduct a specific evaluation of its pertinence and cost, integrating its functioning after 1 to 2 years.

⇒ MSF should consider implementing a liaison position for MSF international representation in a large scale emergency providing the link between the authorities and other agencies at national level.

⇒ MSF medical teams should be able to provide first care to the populations in need as early as possible. This could mean a dedicated specific mobile team to conduct this activity in the very early stages, in parallel to teams conducting assessments. In addition, it needs to be ensured that necessary supplies are available for teams when they arrive on site.

⇒ Each OC should consider psychiatric patients to be included in mental health strategies.

⇒ Each OC should consider how to reinforce supply lines when responding to natural disasters on such a scale. If there is the commitment between the OCs, the emergency supply set-up and shared intersectional positions should be discussed as part of the working group.

⇒ The ExCom and RIOD should be clear on their vision for the role of the regional offices. Different approaches are possible:
  • OC lead i.e. regional offices linked to specific OC
  • Multiple approach where different regional offices provide support to different OCs
  • Hong Kong lead providing resources and support to the movement from the region
5 Annex

5.1 Terms of reference

Terms of reference for Haiyan critical review

<table>
<thead>
<tr>
<th>Commissioned by</th>
<th>MSF Executive Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duration of evaluation</td>
<td>10 weeks</td>
</tr>
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1. BACKGROUND AND OBJECTIVE

Typhoon Haiyan hit the central Philippines on 8 November 2013. 16 million people lost their homes or livelihoods and more than 6,000 people were killed.

MSF put in place a big emergency operation to respond to the humanitarian needs.

All 5 Operational Centres decided to intervene in this emergency, operational engagement and choices varied significantly, with the proxy indicator of finances showing a striking differences ranging from some spending below 1 million euro while others going above 10 million euro. MSF spent a similar amount for the tsunami in 2006, which affected a much wider range of people and countries.

The MSF Executive Committee has requested to undertake a review of MSF response to this emergency from an operational and a fundraising perspective (not part of these TOR). The operational critical review will analyse the operational strategies put in place by each OC and the use of regional capacity (MSF, HK, Japan and Australia) and their added value in the response. This review should not aim to be a fully exhaustive but provide the main elements in terms of timeliness, relevance, (regional) support, differences around operational choices and lessons learnt from the response.

2. SCOPE OF THE REVIEW

The operational critical review will mainly focus on the first week of the emergency but will also provide an overview to cover the 6 months period from November 2013 to April 2014.

The review will cover four main areas:

The initial phase of the emergency response:

- Anticipation of the emergency and pre-positioning of OCs.
- Choices made by each OC, pre-assessments: geography, initial intentions in responding, etc.
- How “distribution of tasks” among OCs was decided?
- Timeliness of the response in view of needs and capacities deployed by other actors
  - When decisions were taken → which decisions?
  - What activities in relation to the needs/other actors
- Critical obstacles faced in assessing and deploying operations in the first days
The second phase, defining mid-term operational choices:

- Analysis of the situation (need / response) in each affected area (by OC)
  - How was this analysis formed?
  - How did this analysis impact on the initial operational choices and redirect the operations of each OC?
- What operational strategies were used across the sections?
- Was there any influence due to fundraising expectations in the development of the presence of OCs or choice of operations?
- What joint operational and support strategies did the OCs develop?
- What was the basis for the huge operational disparity between OCs and how benefits versus inputs decisions were made (“beneficiaries” vs money and HR input)?
- What is the perception (of main regional actors) of MSF added value in the response with respect to the overall situation (vs local civilians and army, other actors, etc.)? Which actors are perceived to have made the biggest difference for the populations?

What lessons learnt can we draw?

- Strategies used in relations to the global results obtained
- Future MSF role in this kind of disaster: which response, which magnitude, number of OCs required, which specific MSF know how to promote (e.g. logistic response, Medical response) etc.
- How shall MSF prepare/organise? /specialise? /coordinate? For the next ones (from floods to cyclone)?

Use of regional capacity

- How far there was a direct added value to regional capacities of MSF
- Role of these capacities in:
  - preparedness
  - anticipation of the cyclone
  - direct operational response
- Lessons learnt in the added value of regional capacity

3. METHODOLOGY

The review will be based on:

- Interviews of key actors in the response (all e-desks & teams, ODs, other actors)
- Review of key documents (correspondence, action plans, project committees, sitreps ...)
- Global review of medical and operational data (no in-depth analysis of outcomes)
- Interview of key external national and international actors
- 10 – 14 days visit to the field/region,
4. TIMEFRAME AND IMPLEMENTATION

The review will take place during the months from August to October, 2014
Total duration of the review is 10 weeks, including the field-visit
The first draft report will be ready to be discussed by the Executive Committee in October, 2014
Management of the evaluation process by the Vienna evaluation unit (VEU) of MSF

5. JOB PROFILE/S of EVALUATOR/S

- Two evaluators, one medical, one non-medical
- Experience in humanitarian response to natural disaster emergencies
- High level operational experience in managing humanitarian interventions
- Proven evaluation skills
- Writing skills
- Fluency in English
### 5.2 List of interviewees

<table>
<thead>
<tr>
<th>Name</th>
<th>Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Theodoro J. Herbosa</td>
<td>Under-Secretary of Health, DoH</td>
</tr>
<tr>
<td>Dr Paulyn Jean B. Rosell-Ubial</td>
<td>Assistant Secretary of Health, DoH</td>
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<tr>
<td>Dr Arnel Rivera</td>
<td>Health Emergency Management Staff, Response Division, DoH</td>
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<tr>
<td>Alfred S. Romualdez</td>
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<tr>
<td>Dr Jose Llacuna</td>
<td>DoH Regional Director, Region 8, Tacloban</td>
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<tr>
<td>Dr Patricia S. Trabado</td>
<td>Provincial Health Officer, Iloilo</td>
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<tr>
<td>Dr Marian Epefania Isiderio</td>
<td>Provincial Health Officer, Eastern Samar</td>
</tr>
<tr>
<td>Dr Aileen Riel-Espina</td>
<td>Chief Medical Professional staff, Eastern Visayas Regional Medical Center</td>
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<tr>
<td>Dr Nevio Zagaria</td>
<td>Team Leader, Emergency and Humanitarian Action World Health Organization, Regional Office for the Western Pacific, Manila</td>
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<tr>
<td>Dr Roderico Ofrin</td>
<td>WHO Health Cluster Coordinator for Typhoon Yolanda, EHA Team Leader WHO Regional Office of Southeast Asia</td>
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<tr>
<td>David Carden</td>
<td>Head of UNOCHA, Philippines</td>
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<tr>
<td>Jasper Engbory</td>
<td>UNOCHA Coordinator, Leyte province</td>
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<tr>
<td>Paulina Lawson</td>
<td>EVNET Director</td>
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<tr>
<td>Alain Grall</td>
<td>OCP Supply manager</td>
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<tr>
<td>Alexis Moens</td>
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<tr>
<td>Agnes Sobry</td>
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<tr>
<td>André Sardo</td>
<td>OCB manager of hospital project in Brussels</td>
</tr>
<tr>
<td>Anne Taylor</td>
<td>OCP Deputy emergency desk in Tokyo</td>
</tr>
<tr>
<td>Bart Janssens</td>
<td>OCB Director of operations</td>
</tr>
<tr>
<td>Caroline Séguin</td>
<td>OCP Emergency coordinator</td>
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<tr>
<td>Dounia Dekhili</td>
<td>OCP Emergency desk</td>
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<td>Eric Pujo</td>
<td>OCP Emergency Logistic</td>
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<td>Florent Uzzeni</td>
<td>Deputy OCG Emergency desk</td>
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<td>Hugues Robert</td>
<td>OCG Emergency desk</td>
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<tr>
<td>Ibrahim Younis</td>
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<tr>
<td>Irene Schiess</td>
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<td>Jean Plaetinckx</td>
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<td>Jean-Yves Nuttinck</td>
<td>OCB Water and sanitation emergency team</td>
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<tr>
<td>Name</td>
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<td>Jean-Sébastien Matte</td>
<td>OCG Emergency coordinator</td>
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<tr>
<td>Jeff Fesselet</td>
<td>OCA Logistic Coordinator</td>
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<tr>
<td>Jeremie Bodin</td>
<td>MSF Japan General Director</td>
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<td>Jerome Michon</td>
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<td>OCB Emergency response team</td>
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<td>Laurence de Barros</td>
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<td>Llanos Ortiz</td>
<td>OCBA Emergency desk</td>
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<tr>
<td>Maria Guevara</td>
<td>Regional Humanitarian Position (HART)</td>
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<td>Marie-Christine Féir</td>
<td>OCB Emergency Unit</td>
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<tr>
<td>Marie-Noelle Rodrigue</td>
<td>OCP Director of Operations</td>
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<td>Martine Flokstra</td>
<td>OCA Emergency Coordinator</td>
</tr>
<tr>
<td>Natasha Reyes</td>
<td>Hong Kong Emergency response manager</td>
</tr>
<tr>
<td>Olimpia de La Rosa</td>
<td>OCBA: Medical referent in emergency desk</td>
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<tr>
<td>Paul McPhun</td>
<td>MSF Australia General Director</td>
</tr>
<tr>
<td>Pete Buth</td>
<td>OCA Deputy Director of Operations</td>
</tr>
<tr>
<td>Raquel Ayorra</td>
<td>OCBA Director of Operations</td>
</tr>
<tr>
<td>Rémi Carrier</td>
<td>Hong Kong General Director</td>
</tr>
<tr>
<td>Thierry Boucher</td>
<td>OCB Log/Supply referent Emergency Unit</td>
</tr>
<tr>
<td>William Vannier</td>
<td>OCB Supply manager</td>
</tr>
<tr>
<td>Vince Hoedt</td>
<td>OCA Emergency Desk</td>
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## 5.3 Tables and sample questionnaires

**Medical activities per OC (including vaccination campaign and mental health activities)**

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<th></th>
<th>OCA</th>
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<th>OCP</th>
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<td><strong>Medical activities</strong></td>
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<td>Total OPD consultations during intervention</td>
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<td>22926</td>
<td>10021</td>
<td>9385</td>
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<td>Total patients seen in emergency room</td>
<td>1815</td>
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<td>Follow up consultations</td>
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<td>Dressings</td>
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<td>1584</td>
<td>2503</td>
<td>436</td>
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<td>Tetanus vaccinations delivered as part of wound care</td>
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<td>Total of facilitated emergency referrals</td>
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<td>Total number of admissions</td>
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<td>369</td>
<td>273</td>
<td>999</td>
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<td><strong>OT activity</strong></td>
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<td>Caesarean Sections</td>
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<td>9</td>
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<td>Minor</td>
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<td>Wound</td>
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<td>Other</td>
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<td><strong>Maternity activity</strong></td>
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<td>Number of admissions</td>
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<td>Number of delivery</td>
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<td>Number of ANC consultations</td>
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<td>Number of PNC</td>
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<td>Number of tetanus vaccinations</td>
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<td>Admission</td>
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<td>Group sessions</td>
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<td>74</td>
<td>56</td>
<td>167</td>
<td>132</td>
<td>345</td>
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<td>Total number of participants in group discussions</td>
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<td>769</td>
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<td>Individual consultations</td>
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<td>Psycho-educational sessions</td>
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<td>Total number of participants in psycho-educational sessions</td>
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<td><strong>Vaccination campaign</strong></td>
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<td>Measles (6 months-15 years) nr of children</td>
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<td>Polio (0-5 years)</td>
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Water and sanitation/food and NFI distribution activities per OC

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<th></th>
<th>OCA</th>
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<th>OCG</th>
<th>OCP</th>
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<tr>
<td><strong>Watsan water trucking and bucket chlorination</strong></td>
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<td>Target population water trucking/ bucket chlorination (at maximum activities)</td>
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<td>8165</td>
<td>23345</td>
<td>993</td>
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<td>Total amount of treated water provided m3</td>
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<td>993</td>
<td>4103</td>
<td>41132</td>
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<tr>
<td>Nr litres safe drinking water per person per day (average)</td>
<td>3,2</td>
<td>9,1</td>
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<td><strong>Aquatab and chlorine donation</strong></td>
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<td>Target population Aquatab/chlorine donation</td>
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<td>Aquatab/chlorine donation in m3 of potable water supply</td>
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<td>Well cleaning</td>
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<td><strong>NFI distribution</strong></td>
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<td>Distributed hygiene kits</td>
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<td>12115</td>
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<td>452</td>
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<td>Distributed NFI kits</td>
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<td>10256</td>
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<td>Distributed jerry cans</td>
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<td>960</td>
<td>6000</td>
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<td>Distributed blankets</td>
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<td>3760</td>
<td>1604</td>
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<td>Distributed tents</td>
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<td>2956</td>
<td>1529</td>
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<td>Distributed tarpaulins</td>
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<td>2280</td>
<td>1874</td>
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<td>Distributed reconstruction kit</td>
<td>4820</td>
<td>1250</td>
<td>2000</td>
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**Food distribution (households)** | 9892 | 9892 |       |       |       |       |

Interview questions to Directors of Operations

Anticipation / Preparedness

A. Was there a pre-decision to intervene when the Typhoon alert was made?
   a. Was there a budget/envelope identified?

B. Was there any discussions between the Dirop regarding who or how MSF might respond?

Situation Analysis

A. Did the situation analysis/assessments impact on the initial operational choices?
   a. Activities added/stopped(updated

Operational Choices and strategies

A. What factors influenced your ops strategy:
   1. Finance
   2. FR
   3. HR
   4. Media
   5. MSF pressure
6. Other ops choices/needs

Retrospective- what influenced/impacted at the time and looking back what was the impact positive or negative?

B. How proportionate do you think the response was? Vis a Vis other emergencies at the time?

C. Disparity between the operational responses
   1. What is your perception of the reason for this?

D. How timely do you think your OC response was?
   1. Where there delays in responding?
   2. If yes, what were the reasons?

E. How do you perceive the role of the regional offices (Japan, Australia/Hong Kong) in the different stages of the emergency?
   1. Was there a benefit for your section from the regional presence/knowledge/response?

Perception/MSF added value

A. What do you think in retrospect of the global MSF intervention?

B. What could have been done better/differently? Globally and by MSF. Was there any responses that were missing?
   a. Are there any lessons that can be learnt from this intervention?
   b. In retrospect what were the advantages or disadvantages for all 5 sections to be present?
   c. Was there a need for all 5 sections to be present?

Interview questions emergency desk

Anticipation / Preparedness

A. Did your OC have an E-prep plan in place for the Philippines prior to the emergency: for example.
   a. Pre-positioned stocks
   b. Operational strategies

B. What contact did MSF have in the country and what knowledge was available on the context?

C. What information was available to you, before Typhoon Haiyan hit the Philippines?
   a. Alerts
   b. Expected impact (UN/Gov etc.)
   c. Each OCs plan and how was this discussed with each section?
      • What mechanisms worked/did not work

D. Was there a pre-decision for your OC to intervene when the Typhoon alert was made?
   a. Was there a budget/envelope identified?

E. How was the decision to respond made?
   a. With other OCs?

Situation Analysis

A. How did the analysis impact on the initial operational choices
   a. Activities added/stopped/updated

B. What factors influenced your decisions on the type and proportionality of your OC response from the situation analysis?

C. What were the critical obstacles to responding?

D. What was the role of the regional offices and their e-desks?
   a. Did your response utilise the capacity and/or resources from the regional offices?
Operational Choices and strategies

F. What was the Ops Strategy of your OC?
   1. Type of activities
   2. Location/s
   3. Use of existing/separate structures
   4. Time horizon (specific - short-medium)

G. What other factors (if any) influenced your operational strategy: such as;
   7. Finance
   8. FR
   9. HR
   10. Media
   11. MSF pressure
   12. Other ops choices/needs

Retrospective- what influenced/impacted at the time and looking back was the impact positive or negative?

H. How proportionate do you think the response was? Vis a Vis other emergencies at the time?

I. “Disparity between the operational responses” stated in the ToR
   1. What is your perception of the reason for this?

J. How timely was the response of your OC?
   1. Where there delays?
   2. What were the reasons?
   3. In relation to other actors?

K. What was the role of the regional offices/e-desks in the implementation?

Coordination

L. What joint operational and support strategies did the OC’s develop?

M. What was the role of the regional offices/e-desks?

Perception/MSF added value

N. What do you think in retrospect of the global MSF intervention?
   a. In relation to the response by other actors including civilian, army, authorities and other organisations?
   b. Which actors are perceived to have made the biggest difference for the populations?

O. What could have been done better/differently by MSF? Was there any responses that were missing?
   a. Are there any lessons that can be learnt from this intervention?
   b. In retrospect what were the advantages or disadvantages for all 5 sections to be present?
   c. Was there a need for all 5 sections to be present?

P. What was the most important contribution of MSF?

Interview questions to emergency response teams

Situation Analysis

A. How did the analysis impact on the initial operational choices
   a. Activities added/stopped/updated
B. What factors influenced your decisions on the type and proportionality of your OC response from the situation analysis?

C. What were the critical obstacles to responding?

D. What was the role of the regional offices and their e-desks?
   a. Did your response utilise the capacity and/or resources from the regional offices?

Operational Choices and strategies

A. What was the Ops Strategy of your OC?
   1. Type of activities
   2. Location/s
   3. Use of existing/separate structures
   4. Time horizon (specific- short-medium)

B. What other factors (if any) influenced your operational strategy: such as;
   1. Finance
   2. FR
   3. HR
   4. Media
   5. MSF pressure
   6. Other ops choices/needs

Retrospective- what influenced/impacted at the time and looking back was the impact positive or negative?

A. How proportionate do you think the response was? Vis a Vis other emergencies at the time?

B. “Disparity between the operational responses” stated in the ToR
   1. What is your perception of the reason for this?

C. How timely was the response of your OC?
   1. Where there delays?
   2. What were the reasons?
   3. In relation to other actors?

D. What was the role of the regional offices/e-desks in the implementation?

Coordination

A. What joint operational and support strategies did the OC’s develop?

B. What was the role of the regional offices/e-desks?

Perception/MSF added value

A. What do you think in retrospect of the global MSF intervention?
   a. In relation to the response by other actors including civilian, army, authorities and other organisations?
   b. Which actors are perceived to have made the biggest difference for the populations?

B. What could have been done better/differently? Globally and by MSF. Was there any responses that were missing?
   a. Are there any lessons that can be learnt from this intervention?
   b. In retrospect what were the advantages or disadvantages for all 5 sections to be present?
   c. Was there a need for all 5 sections to be present?

C. What was the most important contribution of MSF?
Interview questions to external actors

Perception/MSF added value

Reason for MSF evaluation
A. What in your opinion where the most important needs in the first month of the emergency? 
B. Which actors played the most important roles in the response outside of the government? 
C. What do you think in retrospect of the MSF intervention? 
D. What could have been done better/differently? Globally and by MSF? 
E. Was there anything missing in the response? 
F. What do you think was the most important contribution of MSF? 
G. Which actors are perceived to have made the biggest difference for the populations? 
H. How timely was the MSF response?

Interview questions to regional office representatives

Anticipation / Preparedness
A. Did your office have an E-prep plan in place for the Philippines prior to the emergency: for example. 
B. What contact did MSF have in the country and what knowledge was available on the context? 
C. What information was available to you, before Typhoon Haiyan hit the Philippines? 
   a) Alerts 
   b) Expected impact (UN/Gov etc.) 
   c) Each OCs plan and how was this discussed with each section? 
      • What mechanisms worked/did not work 
D. How was your office involved in the response of the different OCs?

Situation Analysis
A. What was your role in providing context analysis for MSF? 
B. What were the critical obstacles to responding?

Operational Choices and strategies
A. What was the role of the regional offices and their e-desks? 
   a. Did the response utilise the capacity and/or resources from the regional offices? 
Retrospective- what influenced/impacted at the time and looking back was the impact positive or negative? 
A. How proportionate do you think the response was Vis a Vis regional capacity including other actors? 
B. “Disparity between the operational responses” stated in the ToR 
   1. What is your perception of the reason for this? 
C. How timely was the response? 
   1. Where there delays? 
   2. What were the reasons? 
   3. In relation to other actors? 

Coordination
A. What joint operational and support strategies did the OC’s develop? 
B. What was the role of the regional offices/e-desks?
Perception/MSF added value
A. What do you think in retrospect of the global MSF intervention?
   a. In relation to the response by other actors including civilian, army, authorities and other organisations?
B. What could have been done better/differently by MSF? Was there any responses that were missing?
   a. Are there any lessons that can be learnt from this intervention?
   b. In retrospect what were the advantages or disadvantages for all 5 sections to be present?
   c. Was there a need for all 5 sections to be present?
C. What was the most important contribution of MSF?