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PATERSON: This is David Paterson and today is November 10th; I'm speaking with Mr. Nicolas Dupont who is Director of Procurement and was the Interim Emergency Coordinator during the Ebola epidemic. We are at MSF (Médecins Sans Frontières) Supply Offices in Brussels and it is just before noon. Thanks so much for meeting with us today, as I know you are still pretty busy.

DUPONT: My pleasure.

PATERSON: The way that we like to structure our interview is that we have four sections.

DUPONT: Okay.

PATERSON: The way we structure it is we have some general questions about your background and then we move into how your role changed during the outbreak. Then I ask some more technical, specific, logistical questions depending on your background and then finish with some overall reflections or conclusions where I think some of the notes that you were taking would fit in nicely. To begin our readers and our listeners always like to hear a little bit about the careers of the people that we interview. Would you briefly tell us a little bit about your current position, your training and your background and then the roles that you played during the response to the outbreak?

DUPONT: Sure. Briefly I had a business background, graduated from business school in France in General Management. Then I worked in consulting in private business in France and in Scotland and then I moved to Belgium where I joined MSF. First in the operational center, I started in finance, in management control and I moved to this position where I have been for over three years.

The position itself, I had two main focuses, one was to really change the way procurement was performed here which was a change that a lot of different businesses went through over the last—depending on the maturity of the business, twenty years or ten years ago. Some businesses haven't started. Procurement was a mainly a tactical function we transformed it to be more strategic. To be closer to the needs, have a better understanding of the market and approach things with contracts to structure things better, supplier performance management and relationship management and not just focusing on tactical pricing. That was the first focus.

The second focus is to build a real global strategy for purchasing that encompasses not only what is bought here at the supply center internationally, but that also includes all the local procurement done by the different missions. So that was the two main focus. Then obviously one key element of what we do is to respond to emergencies.

Usually my department is not that much impacted by emergencies because we prepare ourselves with emergency stock that has been thought up for different scenarios. Then usually what happens is there is an emergency and then okay, we need to replace the stock and do more. So that impacts the part of my team that is looking after inventory management. I've got three different, really type of professionals in my department. I have the people very validating the sources doing the quality assurance which are either pharmacists for the medical side or engineers for the logistical items.

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I have of course the buyers, strategic buyers and tactical buyers to look after all the commercial negotiations, contractualization and supplier relationship management. And I've got a team of replenishment people that look after the inventory management and the supplier orders.

So usually it is these people that are impacted but not so much the quality people and the strategic buyers because it is more the stock management and replenishment that is affected in an emergency. Every once in a while you have a big emergency. Once recent one was we had the typhoon in the Philippines, before that it was the Haiti earthquake, before that it was the tsunami where it was so big. Then you have a situation in the market where you have bottlenecks because all the different global actors want to get the same thing for their response.

PATERSON: It must be very challenging.

DUPONT: *It is very challenging but most of it would be on some specific items. So Haiti was on Ringer's Lactate* (a solution used to rehydrate people who have contracted cholera), *you see that is the rehydration that is used. So there was a problem with Ringer's Lactate, we were focusing on that. What happened with Ebola was very different and that is why it was really impacting my team. It was linked to two factors. One was the exponential growth of the number of cases after the threshold of March when we started hitting the summer. So we really had exponential growth which meant we needed a high amount of different things.*

On top of that because we were on a specific disease with a specific virus, it required specific PPE, personal protection equipment– these are the yellow suits that people might remember from the media coverage at the time.

PATERSON: Right.

DUPONT: *Because we had in the past only a small number of cases to deal with we had enough of this PPE only one supplier, a reliable supplier, because it takes time to validate a proper source and we never expanded beyond that. So the problem that we had was really twofold. As I mentioned the exponential growth but also items that were unisourced. Because as I mentioned before, in other emergencies you can have exponential growth but it is a limited number of items and on top of that most are not mono-source, so you have more suppliers you can work with.*

PATERSON: Right.

DUPONT: *So that is why Ebola was impacting us at least from a procurement point of view because in an emergency context we had to do validation of resources, validation of resources that was complex because you were talking about the direct protection of our staff.*

PATERSON: Right.

DUPONT: *So it required analysis of the results of the different certificates. It required testing in the field. Then on top of that we had the bottlenecks in the market and we can come back to that.*

PATERSON: Just to let me make sure I understand. So your quality assurance or validation team—those standards obviously didn't change because you had certain

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technical standards you needed to make in order to keep your staff safe. You were trying to identify additional vendors that would still meet those standards.

DUPONT: *Exactly.*

PATERSON: And still take into account things like some people didn't like wearing certain types of PPEs? Was that a factor as well because they were very hot or they were very cumbersome in the field? Was that not a factor? Some NGOs (nongovernment organizations) have reported that.

DUPONT: *Yes, the standard that was previously validated was—and that was most of the people at the beginning adapted, used the MSF standard.*

PATERSON: Because you had the most experience with Ebola previously?

DUPONT: *Yes, so, well except the Ebola really went into something different for that reason. But it was true that our suits were full protection to liquid barrier, 6 out of 6 in different criteria. So that was the Tychem C, which is a non-breathable material. So of course when you're there that is very hot. Of course that also—when we did look for a new source it is true that we were more looking for a micro porous—more breathable material. So we said, "Okay, but if we have to validate a new source let's validate something that is more breathable." Indeed that was a different option.*

PATERSON: Because it is so hot there.

DUPONT: *Yes, I mean the debate of the hot and not hot, it depends who you speak to. I mean WHO (World Health Organization) would say, "Yes, but MSF, you're crazy because your people can stay only forty minutes because it is so hot." Sure, that is one factor, but our people on the field would say in MSF anyway, "Because you need to be so careful about what you do when you're at the Ebola Treatment Center, from a psychological point of view and concentration point of view you shouldn't stay more than an hour." Some people after experience they could stay in these suits for an hour or so. Yes indeed, we looked for more breathable material in a certain light as well because we were thinking of the comfort of our staff, within the limitation of the minimum standard that we needed to meet to ensure protection.*

PATERSON: Okay, so going back to when the curve started to go up exponentially again and how that changed your operations. You were talking about that.

DUPONT: *Yes, it changed our operation for that reason. I had more of my team involved in this emergency to validate the source and then of course the purchasers tried to build the relationship because we were talking about the coveralls but there were also the boots, there were also the gloves. There was a list of basically thirty to forty items. The chlorine also, the chlorine that you used to disinfect. Unfortunately the body bags because something as simple as the body bags—you don't want body bags—.*

PATERSON: To leak.

DUPONT: *Indeed. Again you have to have something quality. Again a high volume in a short amount of time. Then there was also all that was happening on the ground impacting us. So a great idea of internal configuration that MSF thought about was a type of prevention kit. I don't know if someone mentioned that.*

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PATERSON: IPC (Infection Prevention and Control) kits? Infection prevention.

DUPONT: *Exactly. Again, a good idea but there was a high number of kits, 80,000, so you have to source all these different items. The idea was to not procure it locally because it will destabilize the local market. That was something that MSF learned from other emergencies that if you procure a high amount of products on the local market that people also need.*

PATERSON: I was going to ask about that.

DUPONT: *Like the soap. You could say, "Why didn't you procure the soap locally? There were two reasons. Where do we build the kit? Do we build them here or do we build them there? Even if we had taken the decision not to build them here, we probably would have shipped the goods from here to the field first because some items, according to health and safety and we needed a minimum validation—the masks, the aprons and things like that. But second, for that reason, to not destabilize the local market. We could have found soap on the local market. 80,000 kits and I think we had four bars of soaps in each thing. Can you imagine the impact on the local market for somebody locally who wanted to procure some soap to wash their hands if MSF comes in and buys that all locally? It would have had an inflation on the price. The price would have skyrocketed and that would not have been the right dynamic. So that is also what guided us not to do it internally.*

PATERSON: That is what happens when MSF moves on and the market is distorted and there are long-term results as well.

DUPONT: *Yes it is what happens when we move on but also what happens when we're there. If there are resources in the local market, there is already enough access to procure that and enough people trying to procure that for us not to destabilize that further. So that impacted that in terms of the exponential growth for the internal market.*

The response was adaptability on so many new requests; again it goes from the tents we were using for the Ebola Treatment Center. We had two in emergency stock using four to six a year and all of a sudden they needed six just for one treatment center. We ended up having to buy thirty and find that availability that quickly. Because we had to deal with so many bodies and no other actor on the ground we had to buy incinerators because that was the only way to deal with them. Can you imagine buying incinerators there? We had to find them in the UK and ship them there. Again, it was really the high level of flexibility, finding the right balance between while being there we need to focus and spend time doing the right thing and some of the times we just go and get things done.

PATERSON: When you have to buy a one-time large purchase like an incinerator do you have a pre-existing partnership with incinerator manufactures or—?

DUPONT: *No because we never expected that. So basically we had somebody from a technical reference in the operational center that did the research for this. Then they went there to say, "Okay, that would suffice," with somebody from our freight forwarding team to make sure it would be okay to send it and have a look. We didn't do any strong commercial negotiations. Again, you focus where you have to focus. There we just looked at the payment schedule to be sure that because we are untested that we wouldn't pay the full amount before we were sure it*

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worked on the field. In this emergency you sometimes have to forget the best practice of quotation, tender and all of that except on some of the items where you want to do it, but here we couldn't do it on every item. We had to be pragmatic.

That is, by the way, I think that is probably a side remark and I don't know if that fits into what you do but I think that is where I think the way humanitarian organizations are funded is broken and doesn't help doing the right thing. What I mean by that is—I was emergency coordinator at the time that we were dealing a lot with the external partners such as International Medical Corps, the French Red Cross, ALIMA (Alliance for International Medical Action), so they come to us because we are a humanitarian procurement center so that is very helpful for them. So we are validated by a ECHO, I don't know if you know that status. We are working through the same validation with USAID (United States Agency for International Development). Actually I think we just got it. Which means that if an organization is funded by the European Union (EU) or by USAID, they can come to us and then we would be notated for our purchasing procedure and therefore they don't have to do three quotations.

If USAID asked an organization for a purchase between $10,000 and $50,000—.

PATERSON: They have to do a series of quotes.

DUPONT: A series of quotes. As long as they come to a validated international supply center that's fine; they don't have to do it because they rely on our own procedure. We do have emergency derogation and things like that.

PATERSON: MSF is a validated supply center?

DUPONT: MSF supply? Yes, it is a validated supply center for as long as I know it, ten, fifteen years, I don't know. You can go on the ECHO (European Commission's Humanitarian Aid and Civil Protection department) website and look at HPC (Humanitarian Procurement Center) validation and you have the list of all the different humanitarian procurement centers.

What I mean by that is we were lucky because we can move MSF because we are 90% funded by private funds. So yes, we get funds later but we weren't tied by that. When I was discussing with a large NGO we worked with, their main issue was like can you hold that volume for me because I still need to get the approval from my institutional donors to do that. So we were able to work something out but unfortunately for them in the market sometimes they lost orders because they weren't able to confirm quickly enough because they had to wait for the institutional approval.

PATERSON: Compared to other people who could pay right away, other programs.

DUPONT: I think for me the way institutional funding works at the moment doesn't drive the right thing.

PATERSON: Yes.

DUPONT: Because that slows down the reactivity capacity.

PATERSON: They're trying to be accountable but in an emergency it should be streamlined.

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DUPONT: *We saw that in Liberia but then because an organization that contracted some funding with that donor, they were still building their treatment center in Liberia and when it wasn't needed there any more.*

PATERSON: Another example of once the curve had collapsed in Liberia they had all of these supplies that suddenly arrived and all of these trained local workers and it was still right across the border but there was an issue ongoing, I think in Guinea and the government of Liberia said, can we send, temporarily send some workers and supplies because we don't have as much of an issue any more but because of donor restrictions that said they had to be used in Liberia they couldn't move that capacity.

DUPONT: *That is the part I wanted to draw on a bit. You have donor restrictions that impact your personnel capacity, but it also impacts your spending capacity. Of course you need act within it. Of course they need to comply. But I would have felt bad for that NGO we worked with, something like that, their activity and they were delayed. I think maybe you should get the chance to interview them and you can get a different angle; I can give you the contact of their procurement responsible there, a great man working there.*

PATERSON: Sure I would love that.

DUPONT: *I think if it wasn't for us working things out with them they would have struggled, I think there is something there, at some stage somebody needs to look at the influence of USAID, to influence other donors and say in the scale of such an emergency what flexibility can you give to the organizations.*

PATERSON: This is really important and I'll note it down and when you get to the later section that is definitely impacted in more detail. Those are the type of details that we definitely want to highlight. Just before we get there let's talk a little more about how your policies changed things.

As the outbreak unfolded were there any protocols in terms of organizing supplies or changing procurement to streamline the process? Were any protocols developed or any changes in organizational practice as a result?

DUPONT: *Sure when you had to change, how we approached the field supply design, how we had the taskforce also. All of that was doing a lot more direct shipment from suppliers to the field, adding a lot of protocols going through that.*

PATERSON: As opposed to coming through the MSF warehouse it would go directly to the field?

DUPONT: *Yes, the volumes were so huge that we didn't need to come here to consolidate. We would send it directly to the airport for consolidation there then shipment.*

PATERSON: Is that usual?

DUPONT: *No it was usually consolidated here but the volumes were so huge that sometimes we were consolidating at the airport because that is where the charter would leave.*

PATERSON: Was that specific to Ebola or whenever you have a large-scale emergency?

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DUPONT: *No that was specific to Ebola. It was insane because of the kits and because of the volume that we were sending, sometimes we would have both a 747 leaving and an MD-11. I don't know if you see the different capacities but a 747 is around 80 tons and MD-11 is half, it is around 40 tons. But that is crazy, to have two charter flights leaving a week at some stage. So that is something new we did. We booked an MD-11, we booked it fully stocked to leave once a week for three months and it was definitely doing Liberia. Then another stop, every other week it would be either Guinea or Sierra Leone. So we had a taxi MD-11 booked just for us and the volumes.*

PATERSON: Did you organize that right away or once you saw that the scale would be really large?

DUPONT: *We started organizing that later in the summer, starting in July or August. In terms of the impact on purchasing, a change in policy I wouldn't say so, but a change in focus for sure, having to produce resources when you need it. It was an emergency sourcing that we never faced before.*

Then what we had to do internally to adapt our supply chain set-up—we had three European procurement centers within MSF.

PATERSON: Amsterdam and?

DUPONT: *Bordeaux in France. Bordeaux is as big as us, even bigger. Amsterdam is much smaller and they rely on us two.*

PATERSON: Okay.

DUPONT: *Sometimes they will go of course to Bordeaux but they will go directly to the suppliers. We said, "Right, we're going to have to change our setup." That was the other big change—we cannot all go to the supplier. We need to build a relationship with the supplier so they consider us as a strategic partners, and add the credibility. That is what we did with the PPE, overall and boot suppliers. . Because of all these bottlenecks on the market the only way we can work is if we have a good relationship management. It is not going to work if everybody goes to place the order. We need to consolidate the order placing and we need to consolidate because it was moving fast also from one country to another, we need to have all the stock in one place in Europe so then we can say okay, we switch from Sierra Leone to Guinea.*

So that change of model in that sense, in terms of both the commercial engagement of the market when we had one focal point that was here but also in terms of the logistic supplier ordering and inventory management. We also had the focal point here.

PATERSON: The process has been described to me briefly, but I was hoping to discuss with you in more details. Essentially the MSF supply took control with respect to approaching manufactures and purchasing as a united front because with different players it is more complicated.

DUPONT: *Yes.*

PATERSON: Would you be able to describe for us in a bit more detail how that step was initially strategized? How did you know—or how did—as an organization how did you come to realize that it was going to be too chaotic with three entities?

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DUPONT: *Again, that is only for ten items. It is just because the OCB (MSF Operational Centre Brussels) was at the forefront, therefore MSF supply, which is linked to the Brussels office, was at the forefront before the other MSF supply centers. So we had anticipated a lot of things. It just came naturally. I just, it was logical that when you have a shortage on the market you approach it united.*

So we do it on the other strategies, for anti-retrovirals, vaccines. We already have lead purchasers, lead buyers. But we went further than that in the sense that we wanted one single focal point for placing the order also. So it was touching on the supply chain rather than just the procurement. That came to be realized because even the supply sometime did not have the capacity; they were doing backorders. They had backlog. So every day we were contacted, we prioritized the order. You needed that reactivity and focal point to be able to discuss that with them and make the right decision. So, that came naturally as we were organizing. The others were onboard quickly also so that was quite helpful.

PATERSON: So how did you implement that change? Did some of the staff at those other places did they get seconded here temporarily?

DUPONT: *No, we had the capacity to deal with it because we were doing it for us. Of course, we had extra constraints in terms of warehousing but for my department that was fine. We had a call to expand strategy and we had that, then we were keeping them updated about the different availability of stock, the different constraints, so we had weekly calls with them to update them. We wanted to present it through the different channels.*

PATERSON: Okay.

DUPONT: *It didn't run that smoothly as I say because as usual when you try to coordinate you have frustrations of some people.*

PATERSON: I was going to ask about that, what kind of obstacles did you have?

DUPONT: *Of course, people have frustrations, not to have their independence free and go and place the order. But they understood the constraints of the market. They understood the added value for the MSF movement so more or less that went fine.*

PATERSON: Were there any steps taken in order to deal with those frustrations?

DUPONT: *Yes, communication in terms of explaining again why a bit to them where we were at, being transparent about the issues we have in terms of availability, in terms of what we were doing, in terms of sourcing, in terms of discussing with the manufactures.*

PATERSON: Do you remember more or less when this operational shift occurred?

DUPONT: *Again, it was all happening in the summer, I'd say August 2014.*

PATERSON: Great.

DUPONT: *Then the other element was the collaboration with the international global health actors. They were slow to start but once they came in that created a lot of issues.*

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PATERSON: Can you explain a little bit about those issues?

DUPONT: *Very quickly we got in touch with the WHO. They weren't quick to react but when they started reacting again it was August, we realized that we were sourcing on different standards. I'll come back to that because that is an issue in terms of structuring the market. UNICEF (United Nations Children's Emergency Fund) came into play. There was a lot of debate within the UN (United Nations) of should WHO take the lead for procurement or should it be UNICEF and all of that, but that was their own political debate not mine.*

We had good contacts with UNICEF, for all the strategies we worked on such as HIV diagnostics together, we did stuff like that. It was the same people. So updating and showing the constraints of the markets, trying to show the standards. We had a joint meeting that we organized here and I can send you also the presentation.

PATERSON: Sure, that would be great.

DUPONT: *We had the different actors coming in and to say well we need to lend each other, because we were contacted, MSF supply for so many different reasons. Some people just wanted to use the work we'd done and just asked, "give us the list of your suppliers and the products you've got validated" and all of that. Some of them they wanted us to serve them and be a customer, for us to be their supplier. That is completely fine, as a procurement center, that's what we do. So we've done it for a few NGOs. We couldn't respond to all the demands. We had some people who were getting frustrated, saying, "Why don't you have availability?" It is not the availability on the market and second, I need to prioritize MSF first and some of the key customers with impact on the field. We need to explain to people why we do it. Also in the meantime our operational center was trying to build the capacity to get support so they had in their training other organizations where they were training them how to deal with an Ebola response from a medical and logistical point of view. But of course, they were training them on the MSF standards. That means they were coming to us to do that.*

For example, some customers came to us and we had to say, "No, we're not going to help you, we don't have the capacity, we don't see you as a priority because we'd rather put the priority on organizations that we had trained." We knew exactly what they do in the field. There was a bit of that, so that created tension also.

PATERSON: Oh really?

DUPONT: *Of course, some said, "Why isn't MSF helping us?" We needed to prioritize. So we had a meeting here early September and said these are the rules of the game. If you want to come through MSF supply, to use us as a supplier, we will deal with it but we need to forecast what are your operational plans, how many number of beds are you forecasting, in what region. We need to validate jointly with the head of the taskforce because we won't be able to develop it.*

PATERSON: Did people meet these requirements or was there—?

DUPONT: *Yes, yes, that is why we decided to help Save the Children, ALIMA, but you'll see that in my presentation. The French Red Cross and International Medical Corps. So the external customers, never in an emergency did we have so many external*

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customers because usually for an emergency we would focus on ourselves but because that was good for the MSF movement, we needed people to come in otherwise we would have exploded. We needed people on the ground for dealing with the situation; that is what was needed. That is also a second question, to say that in the other emergencies that we see, the supplies to bottleneck, and the supply capacity from MSF is really a strength, how can we help the other organization whether or not sometimes they shout that MSF is there. We alone and what are the others doing. There is the institutional funding issue.

PATERSON: Right.

DUPONT: Which impacts the reactivity, that is for sure. But there is also the spare capacity.

That was the first meeting in September. Then the plan that happened on the market was everybody was moving on a first come first serve basis, like WHO, UNICEF, DFID (Department for International Development) the British government. And we recognized that that was the first problem, that everybody says I'm more a priority than you.

PATERSON: Yes. How did you—?

DUPONT: Our suppliers, we worked on the supplier relationship, to tell them about what we did. Our suppliers saw the credibility of MSF because they saw that we were really on the field and doing things.
Then we decided with UNICEF to organize an Ebola supply meeting in Copenhagen in November, a giant meeting with all the key international head actors and all the key suppliers because we wanted to talk about two things, try to give some forecast to the suppliers so they can get an overview and also talk about standards. One of the big issues was for the suppliers was how can I—and that is another angle I think for the research—we can come back to that. How can a supplier increase their capacity? That requires investment.

If you want to increase capacity, I said that year we needed 120,000 suits per month. The capacity of production of the item that we had initially validated is 30,000 per month.

PATERSON: From the manufacturers side.

DUPONT: That is the manufacturer that we use capacity. So okay, we need to look for others; how do they increase their capacity? What they did is they had to contract a sub-manufacture in Mexico, switch a whole factory to do that. The way we did it was through credibility from us providing them with forecast. So we had to talk with our operations director and see what forecasting we had. How internally can we say the number of bed we think we will need, that the organization capacity would be? So I said to my operations director—if you want me to guarantee the availability you need to give me a six-month outlook and I need to be able to put the money on the table tomorrow. That was the only way.

But first other organizations wanted to go and do so. Second, other organizations weren't playing the same roles. While MSF was aiming for six-week buffer stock on the field, we tried to be lean because of the availability, other organizations were aiming for three to six-month buffer stock.

PATERSON: Okay.

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DUPONT: *So I mean they come in, take all the availability to stock in their warehouse, especially when they are not the one having the biggest roles. But it is really hard for a manufacturer. As a manufacture can you put your shoes of the business person and say, "Who would I rather serve between UNICEF and MSF, who would you prioritize?" Some don't really care, first come, first serve basis and didn't care that somebody came in to call on them. Others were more responsible and said,*
"Okay, that doesn't work." But you had no governance around that. There was no governance around this supply side except people trying to work.

PATERSON: Did that tighten up over time? Did that improve?

DUPONT: *Not really. The other problem was if I'm the manufacturer and I want to increase my capacity but then I've got two production lines because UNICEF or WHO is saying, "That's the type of standard," and MSF is saying, "That is the standard that I want." Other than the type of standard issue, the manufacturers also had to deal with the fact that, except MSF, nobody in the market was ready to put a commitment; nobody ever put a commitment on volumes. So they were like, "If you don't give us a commitment how can decide to increase our capacity. It is just that you're asking us in blind faith to increase our capacity with no guarantee of return on investment. I mean you need a production line, sometimes we need to buy new machinery, we need to hire staff so that is money we're putting on the table." You cannot ask private businesses that have to respond to their shareholders to just take a leap of good faith for the greater good like that and bank on the return of investment. You need to find another way to do so. So that was the reason for us to try to establish a forecast.*

PATERSON: Do those standards ever align at all or was that a pervasive issue?

DUPONT: *No. Obviously there were some meetings organized by WHO so we had some people from MSF participating in that. We had some meetings but we never managed to align. From a medical point of view, people had different opinions.*

PATERSON: But an acceptable risk?

DUPONT: *Do you go for coveralls or just for the apron? Do you go for a balaclava on top of a hood or not? Different agencies had a different opinion on the risks and solutions and it's hard to align.*

PATERSON: That's really interesting.

DUPONT: *How do we engage the private sector when you are hot in the middle of the emergency? But you cannot anticipate every emergency so is that something you can anticipate before? How do you work on products that are easily scalable? Also, how can institutional donors such as USAID help with the commitment on return on investment. Basically, it is all left to the different organizations to test risks. For me I see that in this crisis what USAID should have done is go and see some manufacture and say, "I'm going to guarantee you this volume."*

So whether you said it to your organization, great. If you don't say it, me as an institutional donor because I see this capacity issue and I'm guaranteeing it. In terms of financial mechanism, how to make that work; that is why I think there is a good academic topic there. How would you finance that, is that through a type of bond or whatever, I don't know. But we need to rethink again—I was saying

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we need to rethink how institutional funding works because here a clear mechanism of that—we are going to have other emergencies with a virus that happens. It won't be Ebola, it might be something else. We're going to have more of that. How can a donor help guarantee? Then they would have had the issue on what standard do we do it; that's another debate. But at least if they had guaranteed that to the supplier and then left it to the different NGOs to find or try to work together right from the beginning that would have helped immensely. That would have helped immensely.

I think I showed you another thing.

PATERSON: I'm writing these things down as things to follow up on because I know we don't have much time.

DUPONT: Yes, maybe that is for the follow up to discuss.

PATERSON: When we finish the interview today I'll type up some of the things that are really important and I'll send them to you so you can think about each of them and maybe add your own and then we can have—when you have some time a Skype interview and discuss those things.

DUPONT: Sure, of course. What I'll do is I'll send a couple of presentations. Some of them are public and can be found on Google.

PATERSON: Okay.

DUPONT: There is an article also on the Ebola response that we had worked on.

PATERSON: Great.

DUPONT: Is that okay if we try and wrap it up in five to ten minutes?

PATERSON: Sure. I understand. A lot of the questions have already been covered. I'll ask some general questions now as we close the interview. In thinking about some of the processes that you described especially with your insight in terms of procurement, are there any steps that you smoothed or eliminated or got easier as time went on? Are there any practices that you would like to highlight that were helpful in your operations that you tried out and you saw—?

DUPONT: Yes, as I said I think the idea of quickly setting up this focal commercial point and focal replenishment as we did was definitely something.

PATERSON: You mean the centralization of the—?

DUPONT: Yes, what we did also is that never in an emergency did we work so close with the operations. I think that was probably facilitated that I was both wearing the hat of emergency coordinator for a while and purchasing director. But I mean we really worked close—even in emergency context I think that was the first time that we said, "Okay, can we have a commitment on forecast?" We knew that the forecast wouldn't be right and in the end, it decreased much faster than we said. We reached 1000 beds and then we decreased a hundred beds per month. While we reached the 1000 beds, we did, but it decreased to 300 beds very quickly and then 50 beds very quickly. Fine, but that was the thing that given the context we were in we needed to have that commitment.

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PATERSON: And that allowed you to guarantee to the manufacturers—.

DUPONT: If we never had that—and okay, we've got some overstock now, a bit, but if we had never done that we would have some stock ruptures for sure. So I think this commitment on focusing emergency was also something new that we need to look at again and working close with the head of the taskforce, trying, liked William talked about, all the field but trying to get an instant view of the stocks in the field and try to really see where we are at. When you are so lean, I mean we have pretty much nothing in stock, everything that came in went out straight away. You need to be sure to send it to the right place. So what we did I think from a supply chain end-to-end point of view purchasing was definitely impacted but we needed to have that view of what was for the field work, what were the needs and cross all that data.

I think that is our strength compared to other organizations, who don't have the control over the whole chain. We were asking that same information from our external customers so we could compare exactly where we are in terms of number of beds, in terms of use.

The thing that was really hard also was to try to think, "Okay, people are telling us the number of beds but what is the theoretical consumption that can anticipate for a given number of beds compared to the realistic, reality?" Because depending on the sectors, the Ebola Treatment Centers, some people were saying you need three PPE per day per bed but we saw that some of the centers were doing two, some others were doing five.

PATERSON: Why do you think there was such variation across it?

DUPONT: Because depending on the set up of the treatment center, if you do longer journeys and if the flow is not optimized, and that sort of thing.

PATERSON: What would you consider the most difficult logistical issues or obstacles that you encountered? I know we covered it a little bit but things that were really challenging and that you would want to highlight as things that we need to look at in the future? You mentioned some of the financing issues, but—.

DUPONT: Again for me as procurement director I would say it was really the bottleneck in the market. Bottleneck on the market on most key products in case of emergencies. It was the worst nightmare you can think of from a purchasing view. Then overall with my hat of emergency coordinator, I think where it was hard was really having all these people asking for help but that leads back also to the supply constraints and I have to prioritize between the different external customers creating frustrations there. Obviously overall, I'd say it was the impact on our structure; it was not just the Ebola. I don't know if you had somebody explain that to you but for when you look retroactively at our KPIs (Key Performance Indicators), there is with a clear picture that since the Philippines in November 2013, October 2013 se have been in the red.

The Philippines, Central African Republic, South Sudan, high intense level of emergency, and on top of that was Ebola. So overall our staff is completely on their knees in terms— beside the fact that we provided support.

PATERSON: Tired and—.

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DUPONT: *Just being tired. On the other hand, that is where you see the strength of our organization because then people have all that focus. A lot of their internal frustration we can have on other topics, other projects, priority areas, were forgotten for that time because everybody was focusing on going through that period. Now they're coming back as a boomerang effect because they're coming back even stronger and we need to do all those other things as directors. But for the time of the Ebola, we did it.*

When you look at what we did sometimes—I'm not saying, not to send us flowers, but I am still amazed by the capacity of my own structure of the flexibility, adaptability and capacity of absorbing that extra volume. All that we did I am still amazed by how we did it.

PATERSON: What do you think were the biggest things that enable you to be able to respond in that way, to be so efficient?

DUPONT: *Our people. When I see the people in my team; when I see the proactivity, when I see how sharp they are. I mean whether it was the pharmacists validating the new source, whether it was my strategic buyer creating the relationship, finding the right network, then the political impact also at terms in international—we all played our role. That is where we see that we have a talented team.*

PATERSON: So that talent was a really decisive factor?

DUPONT: *I think so. Again we are a flexible organization by nature. So it is like we see something, we adapt. I think that is the other thing in terms of culture and mentality that differentiates us from other global health actors. So we've got communication lines that go more quickly. We can have the information processed quickly and more importantly, people are ready to challenge themselves and do things differently.*

PATERSON: You also have quite flexible funding from what I understand.

DUPONT: *And the flexible funding. So these three factors, talent, the organization culture and also the flexibility of the funding.*

PATERSON: Great. This is always easier to do in hindsight but are there things that you would have done differently if you could do all of this over again?

DUPONT: *Yes. For sure. As you say with hindsight you can always improve. I think in our model, not linked to Ebola, but when we decided to centralize a lot of things, as soon as we decided that we should have started to think of okay, if this keeps on going we're going to need to see how we can decentralize other things. Not decentralize but we would pass our supply system that we brought into other contexts. It makes sense that we centralized the Ebola but for example other countries we serve maybe another MSF Supply center could have taken them. You see what I mean?*

PATERSON: Each supply center will take ownership of a given large-scale project?

DUPONT: *Yes, so maybe it could have been because when we started realizing that we were too far, it was a bit too late. We still managed to do it but if we had thought about that earlier that would have been good.*

PATERSON: Why are there three different supply centers in Bordeaux and—?

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DUPONT: *The one in Amsterdam is smaller and rely mainly on MSF Supply in Brussels and MSF Logistique in Bordeaux.*

PATERSON: I see.

DUPONT: *Why is there one in Bordeaux and in Paris? I think there are two reasons for that. The first is associated with the model of MSF. You have a strong operational center in Paris and a strong one in Belgium. Each wanted their independence and their own supply capacity. So organically that created two supply centers.*

PATERSON: I see.

DUPONT: *When we look at it now we anyway need that capacity because we have full capacity and they have full capacity.*

PATERSON: Coordinating is a challenge.

DUPONT: *We have hubs in Dubai, we have hubs in Kenya, so should all the model of having the two and a half let's say in Europe makes sense or should we look at more decentralization? That is probably a topic, but we need to think that MSF is a young organization. We have just over forty years of existence. The supply within MSF is young. MSF Supply itself just over 25 years, we celebrated 25 years last year. So of course, we need to think more of how do we go from a European-center model to maybe more hubs. That is a strategy we are considering. But at least that is how we arrived there at that model. But there are ways to improve, definitely.*

PATERSON: What would you consider your own personal most important contribution in the response? I know it is a team effort but—is there something you can think of that you are especially proud of?

DUPONT: *I think the political aspect because I had to work with WHO and other global health actors, I had to meet with the high level people in the manufacturers. I did that with my buyer who of course did the sourcing for that. But I think my personality and my way of convincing whether through honest facts, such as the commitments of the different parties because there were a few. I think I was kind of playing that role of putting the political face on the market of MSF, with credibility. I think maybe that is where I was successful. But also, not hesitating making the tough calls of placing an order for a high amount knowing that I had the power from my Director of Operations. Sometimes saying to my purchasers to go for it and being able to do that.*

Then also delegating because I would have exploded again.

PATERSON: To know when to delegate.

DUPONT: *Yes, I had to direct people but also delegating, saying, "Okay, you make the call, I have full trust in you. You go and represent MSF at that meeting." You know I wasn't in all places. We did that. So I think that was also good. I gave a lot of my own personal life, working the 80 hours, being emergency coordinator on top of other things, taking a lot of bullets for the team in terms of trying to reprioritize things even before they were impacting, things like that. I believe that is my role as a director anyway and so I would have said I was not doing anything out of the*

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ordinary but we took a lot of bullets, which is a bit ironic to use the word bullets in the context of MSF but you see what I mean.

PATERSON: Two or maybe one more question. If you could commission a series of case studies to help not only advanced students but real decision makers to think about how to improve responses to these types of crises what issues would you really think are the most important things to highlight?

DUPONT: I think we touched on it; to me it is really how the finance system, financing system now can hinder the reactivity of some organizations in the market. That is the first angle. But also, how it could be an enabler, for example by being more forward looking and a bit more innovative in the way of not funding NGOs but working with the manufacturers to increase capacity. I think there is really an angle there. Potentially it is two different case studies actually because one is really looking at how to work with the NGOs themselves and the other would be how to work with the manufacturers when there is a bottleneck issue. It all looks to finance but those would be the two; it would be a formula that would be very interesting.

Then there is the nonalignment with standards between the different organizations but I think, I'm not sure that would be really feasible. I'm sure there is that much to do.

PATERSON: That is very challenging.

DUPONT: If there would be an interesting case study there, I'm not sure.

PATERSON: Even just as a part of a case study, not a case study itself.

DUPONT: The collaboration between the different organizations at all different levels, from the professional point of view, from a supply point of view also. There are things that were positive; I think that was the first time that we organized a supply meeting with both the organizations and manufacturers. I think that is thanks to some key people in WHO and UNICEF and ourselves to say okay, we need that meeting, let's do that. In terms of outcome it wasn't that much productive but that was still the right step; it is a lot to engage, how can we do that further.

Then again we supply always into the operational and political directives of our organization so it is substantial always. As much as we try to collaborate because we see that, we still go for the interest of our organizations.

PATERSON: And lastly, are there any other thoughts that you'd like to share with us today?

DUPONT: No, I'm sorry I want to put—.

PATERSON: No this has been great for us.

DUPONT: I think we covered quite a lot, unfortunately I'm sorry I have this time constraint. I will send you a few things and then if you want to reschedule for later next week.

PATERSON: That would be wonderful. I'll send a note of some of the things.

DUPONT: And maybe I'll think of other things.

PATERSON: Thank you so much for meeting.

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