Stockholm Evaluation Unit

BIKENGE REVIEW

Deciding and Launching Process

[July 2016]

This publication was produced at the request of Médecins sans Frontières. It was prepared independently by ***Eva P. Rocillo Aréchaga***.

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ACRONYMS

ARO	Annual Review of Operations
CBC	Community Based Care
Cell M	Cell Medical Deputy Operations Directors
Cell OC	Cell Operations Coordinator
COPRO	Project Committee ("Committee de Projet")
dHoM	Deputy Head of Mission
dMCo	Deputy Medical Coordinator
DRC	Democratic Republic of Congo
ARI	Acute Respiratory Infection
FC	Field Coordinator
HoM	Head of Mission
HP	Health Post
HQ	Head Quarters
HR	Human Resources
STI	Sexual Transmitted Infection
MCo	Medical Coordinator
MedCo	Medical Coordinator
Med-Op	Medical and Operational
MSF	Médecins Sans Frontières
MSF-OCB	Médecins Sans Frontières-Operational Centre Brussels
OCB	Operational Centre Brussels
OD	Operations Director
OPD	Outpatient Department
PATIO	Technical Support Platform for Operational Initiatives[1]
PUC	Congo Emergency Pool
RHC	Reference Health Centre
TB/HIV	Tuberculosis / Human Immunodeficiency Virus
WHS	Water Hygiene and Sanitation

[1] Translated from French "Plateforme d´Appui Tecnique pour les Initiatives Operationnelles", the term also refers to a "Physical intermediate space" (usually between house and garden) of and adjacent room where people meet.

PROJECT BACKGROUND

MSF-OCB is present in DRC since 1985. Different emergencies and mid-long term interventions have been carried out since then. Primary, secondary and tertiary care level experiences have been part of projects by choice, where different strategies and models of care were put in place with different results. Among many others, special reference should be made to Equateur and Lubutu projects, as two recent experiences significantly present during the process analysed in this review. Equateur 2003-2005, a large project supporting three general hospitals and around 70 health facilities was confronted with difficulties in monitoring the quality of care. Lubutu 2006-2012 reached proper standards and quality of care in the supported regional hospital but the outcome of the handover was questioned.

With the wiliness to open a new project in DRC, a new exploratory mission in different areas of Maniema (DRC Province limiting with North and South Kivu to the East) was carried out in February 2014. As a result, Bikenge (an isolated mining area) was selected as the most suitable location for a new project by choice. In October 2014 the project was approved focusing (as mentioned in the project proposal document) on the three main killers (Malaria, ARI, Diarrhea) and STI. The two main strategies were defined as 1) supporting existing primary health care structure in Bikenge and 2) implementing community based health care in the isolated mining camps.

Bikenge project was opened in January 2015, and medical activities started on March 2015. Six months later, in October 2015, the decision was made to close the project during ARO discussions. According to interviews conducted during this review, this was followed by a feeling of frustration, the impression that invested resources were wasted and that this closure could have a negative impact on the population and MSF perception.

An evaluation was requested with the objective of evaluating the process of decision making for starting the project. Designed as a retrospective review, its goal is to identify the lessons from this experience to be used by operations department in order to avoid similar situations in the future.

Framed in this objective, although based in the specific case of Bikenge, the intention of this report is mainly to generalize the identified lessons rather than providing details on the Bikenge project.

EVALUATION METHODS & LIMITATIONS

This retrospective review was carried out from May 30th until June 28th. Methods included semi-structured interviews with MSF staff involved and review and analysis of available project documents. The period under review ran from February 2014 (first exploratory mission) until November 2015 (decision to close the project).

A total of 24 national and international MSF staffs at field, coordination and HQ level were interviewed face to face or by skype. The selection was done in order to cover the key positions involved in the decision and launching process, to draw as many opinions and viewpoints as possible and to cover all different phases of the studied period. Two of candidates initially identified for interview could not be reached. The list of people interviewed is in Annex II.

Reviewed and analysed documents included: project proposals (COPRO, ARO); assessments reports (initial field visits, watsan, epidemiological, anthropological); field reports (monthly, quarterly, medical and no-medical), and end of mission reports. Project monitoring tools (medical and financial) were also analysed as well as information exchange documents such as mails and power points (used during information/discussions meetings). For more details, please see Annex III.

Although this review was initially focused on three main questions, a fourth one relating to the launching process was added during its implementation. This decision was based on initial interviews. Although it was defined later, it´s presented in the findings as the third question in order to present them in a chronological sequence.

A presentation of initial findings of the review was carried out in HQ on June 28th. Discussions with participants resulted in a better understanding of the context and events and improved formulations of findings and identified lessons.

The fact that the initial phases of studied period occurred more than 18 months before the interviews may have resulted in significant recall bias and blurred memories and narrative imprecision. This delay may have also contributed to a wider, more serene, distanced and analytical narrative and opinions of people involved.

Three potentially relevant documents (final COPRO and meetings notes related to validation and closing decisions) either do not exist or are yet to be found. Although this may represent a significant gap on detail of managed information, the reviewer tried to mitigate it with a detailed assessment during the interviews of people who attended those meetings and later crosschecking of information provided by all them. The absence of these documents reinforces some of the main findings and identified lessons of this review.

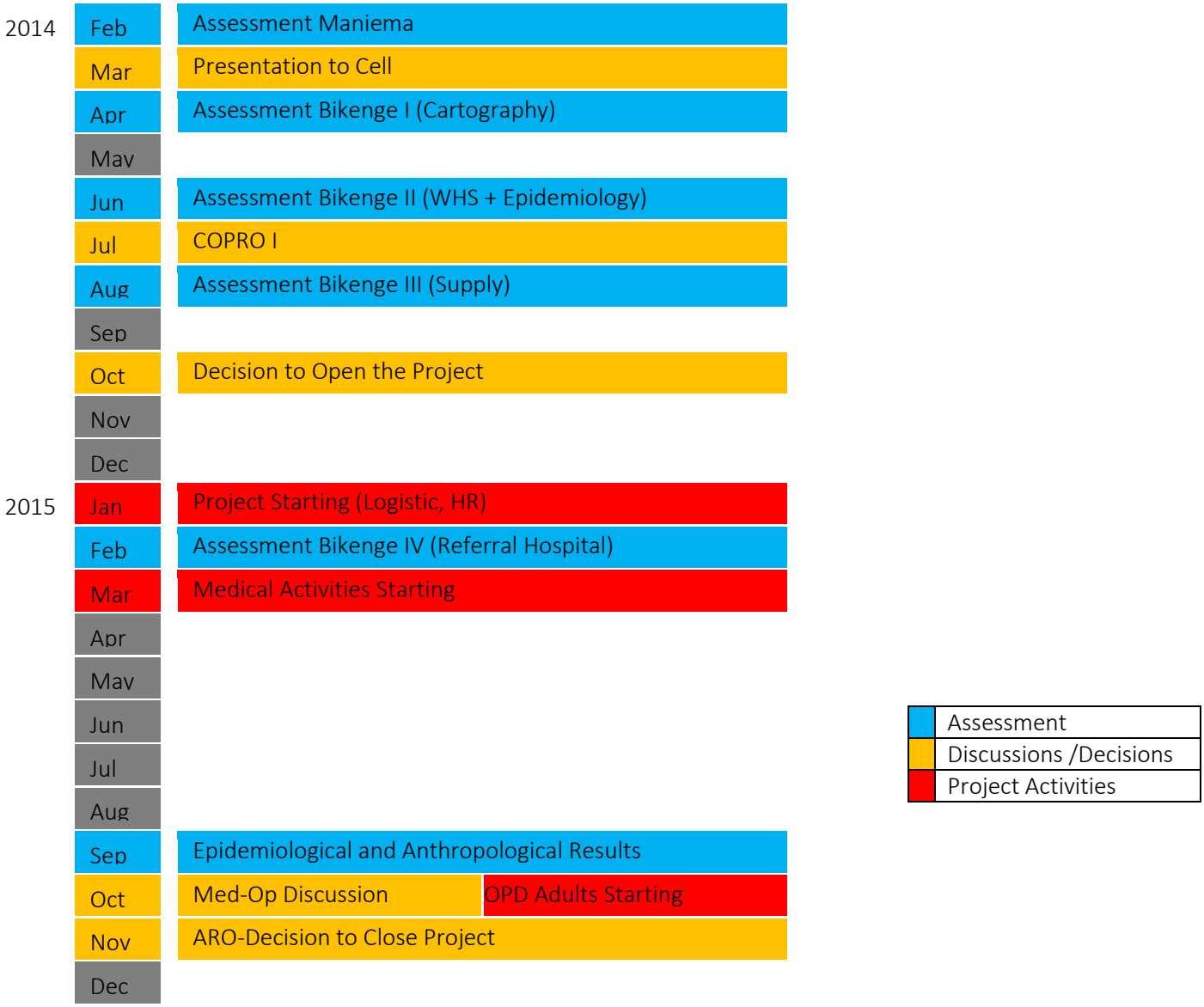
The terms of reference of this review did not include the analysis of the decision to close the project. This question, however, might have been relevant in order to cover more comprehensively the whole project cycle.

FINDINGS

TIMELINE

A timeline of main events related to decisions and launching of the project was documented. Colour code was used to facilitate the identification of the three main type of events: assessment, discussions and decisions at HQ and field activities.

Figure 1. Timeline of the main types of project events colour-coded by type of activity, February 2015 to November 2015.



EVALUATION QUESTIONS

1. <u>Identify the weakness in the assessment before opening the project</u>

As can be noted in the above timeline, assessment activities were **fragmented** along a period of more than one year from the first assessment until the presentation of the results of the last ones. This long period allowed ample time for potential changes of the context during the assessment phase. More importantly it resulted in the practical impossibility of common discussions and perspective exchanges by people involved (more than 10). This prevented the defining within MSF of a strong and supported intervention proposal adapted to the findings and conclusions of the assessment.

Epidemiological, anthropological and referral hospital assessments were **done after the project started**. Epidemiological and anthropological assessments were carried out after medical activities started. Although they were initially proposed to define a baseline for later impact analysis, they ended up questioning the relevance and pertinence of proposed interventions and the project itself.

In part related to these two elements mentioned above and also because of the option chosen, the **project proposal was not detailed enough.** Medical activities package, logistic solutions and budget were not defined in detail in the initial proposal. The main reasons for this choice were to facilitate MSF acceptance by population (anthropological and epidemiological assessments to be done simultaneously with MSF medical activities) and to ensure enough flexibility for the project to adapt to the context progressively as it would be better understood. Although it can be considered as a justified operational decision, other factors (see below) paved the way for later confusion and misunderstanding.

These weaknesses were compounded by both the *context and strategy specificities,* out of the area of usual MSF expertise. The mining context with its specificities and the dynamics of its population was not familiar to MSF. On the same line community based health care and context adapted intervention (and the consequent tensions with MSF standards) represented an additional challenge. A deeper understanding of the context and a detailed proposal definition were especially relevant.

In addition, it is important to mention the potential added value of a well-defined *communication strategy with population* to be included in the assessment phase. A concrete strategy to communicate the objectives and timelines of MSF intervention may have limited the risk of inappropriate expectations by the community and facilitate a better management of perceived (or existing) pressure by population.

2. Highlight the dynamics and expectations in the headquarters during this period that led to the opening of the project

With the final objective of facilitating sustainability in MSF interventions there was, during the time of initial discussions about Bikenge, a clear interest to **develop community based health care** components within some projects both at HQ and mission level. The interest of HQ for new approaches in DRC (with the background of previous experiences in Equateur and Lubutu), as well as the geographical situation of the mining camps offered a seemingly ideal context to implement this kind of intervention.

An interest to **explore environmental/toxicological** interventions was also identified, mainly by the medical department. Initially defined as an additional component to be explored (and potentially developed) during a second phase of the project, it became the perceived main driver of the project by many of the people involved. Details and factors relating to this evolution are covered later in the document.

The pressure to open this project was perceived during the period of opening decision by most of the people involved. The main reasons alluded to by interviewees for this pressure were the following: not any other project by choice planned to be opened by OCB in this year, the need of an additional project to justify coordination expenses in DRC, and the significant delay in the assessment and decision process of this project (nine months). Apparently, this pressure was mainly felt from and transmitted by operational directors.

The COPRO of July 2015 decided not to validate the Bikenge project. It *requested to expend on specific areas* before presenting the project to a second COPRO and put these clarifications as conditional to the opening (minutes of discussion by mail of 31st July 2014). These areas included: preparation of base line and anthropological studies, clarification of medical package and justification of different phases proposed. These requests are in line with some of the weaknesses of the assessment already mentioned in the first part of this report. Although they were requested, it appears they were not addressed. No other COPRO document or a written summary of the meeting when decision to open was made have been found. According to interviewees, the project was finally validated in October 2014 during ARO discussions. This review has not been able to clearly determine under which conditions the decision to open was finally made.

3. Characteristics of launching process

People involved in the launching process presented significant **divergence in their understanding of the project** reasons and strategy**.** Although it is notable in the different project components (medical package, logistic solutions…) this discrepancy was even more obvious regarding the main rationality of the project. Despite being presented in the project document as a potential component to be assessed, the toxicological component was considered by significant number

of people on that time as the initial main driver. To quote one of the interviews: *«Toxicological component become the less written but the most talked issue about Bikenge»*

During the initial months of the project, the established modus operandi was more similar to **emergency mode** than to a project by choice. The presence of coordination members in the field to prepare and initiate the project activities, the support provided by PUC unit during this phase, a full team sent relatively early to the field, the established deadlines, and the availability of resource unrelated to project size are in line with this modus operandi. It can explain, at least in part, the light involvement of HQ departments in some of the decisions as well as the not so rational (probably excessive and unbalanced) use of the resources (both easily justifiable in emergency responses) during this period of time.

The evolution of the project during the first months occurred under **little control** making difficult a proper and participated monitoring of the implementation of the early phases of the project. Discussions and decisions taken were mainly oriented to concrete solutions, not necessary framed in a wider perspective neither in line with initial proposal. The significant number of field visits by technical positions in a short period of time and other factors (such as coordination workload and existing tensions both at coordination and cell level) which will be mentioned later, seems to have contributed to this lack of control.

4. Understanding the reasons why the project was quickly questioned in terms of its objectives and its relevance

The first reason the project relevance was questioned was the **lower than expected mortality rate** measured in the epidemiology study (15.3/1.000 person/year). Designed as a door to door survey to determine the baseline to assess the impact of the project, it was conducted in July 2015. Its results (finally presented in September 2015) did not match with previous data obtained during emergency responses in the area (2.7/10.000 person/day) neither were significantly higher comparing with the national mortality rate (13.7/1.000 person/year).

Questions about the validity of epidemiological study results (specially related to mortality rate) were raised considering that this retrospective study was carried out after MSF medical activities started. Together with other technical issues regarding its design, it was hypothesised than the impact of medical activities already carried on influenced survey results.

Anthropology study results in September 2015 questioned the decision that community based health intervention was the most appropriate solution. Relevance of this approach was questioned because the access to health services by mining population was better than initially envisaged. Most importantly, the existing but dysfunctional health posts systems highlighted the potential negative impact of CBC interventions on these structure. *"Nous considerons egalement que MSF reconnait que lorsque les sites officiels de soins primaires sont défaillants ou déficient, il est dommageable de créer des sites alternatifs tenus par des non-professionnels"*[2]. Based on these findings, the anthropologic study recommended to reinforce the existing health care centres instead of creating a new system in parallel to the existing one.

Eventually, during ARO discussions in November 2015 the Medical department showed **no interest to develop toxicological component** in Bikenge project. There seem to be three main reasons. Discussions with other MSF-sections and external experts highlighted the technical complexity of this kind of intervention and the need to mainly focus on prevention activities. In addition, it became clear that the mobility of the Bikengue population did not match the need of long term exposure to toxic products to see a health impact on population. In this context, the feasibility of environmental component was questioned. The absence of cases of intoxication identified passively (i.e. coming forward with symptoms during medical consultations), reinforced the proposal not to develop this component.

Cost vs perspective/impact. At the time of closing decision, expenses for Bikenge project were significantly higher than initially planned (forecast of 21% of variance from initial budget)[3]. In addition to that, some of the proposed strategies presented in ARO 2015 (secondary level of care, 50 beds hospital construction, support to new health posts…) would have required an additional investment. The balance between investments needed on the one hand and new perspective and impact of intervention on the other (at the light of three above mentioned factors) was another factor considered during the close decision.

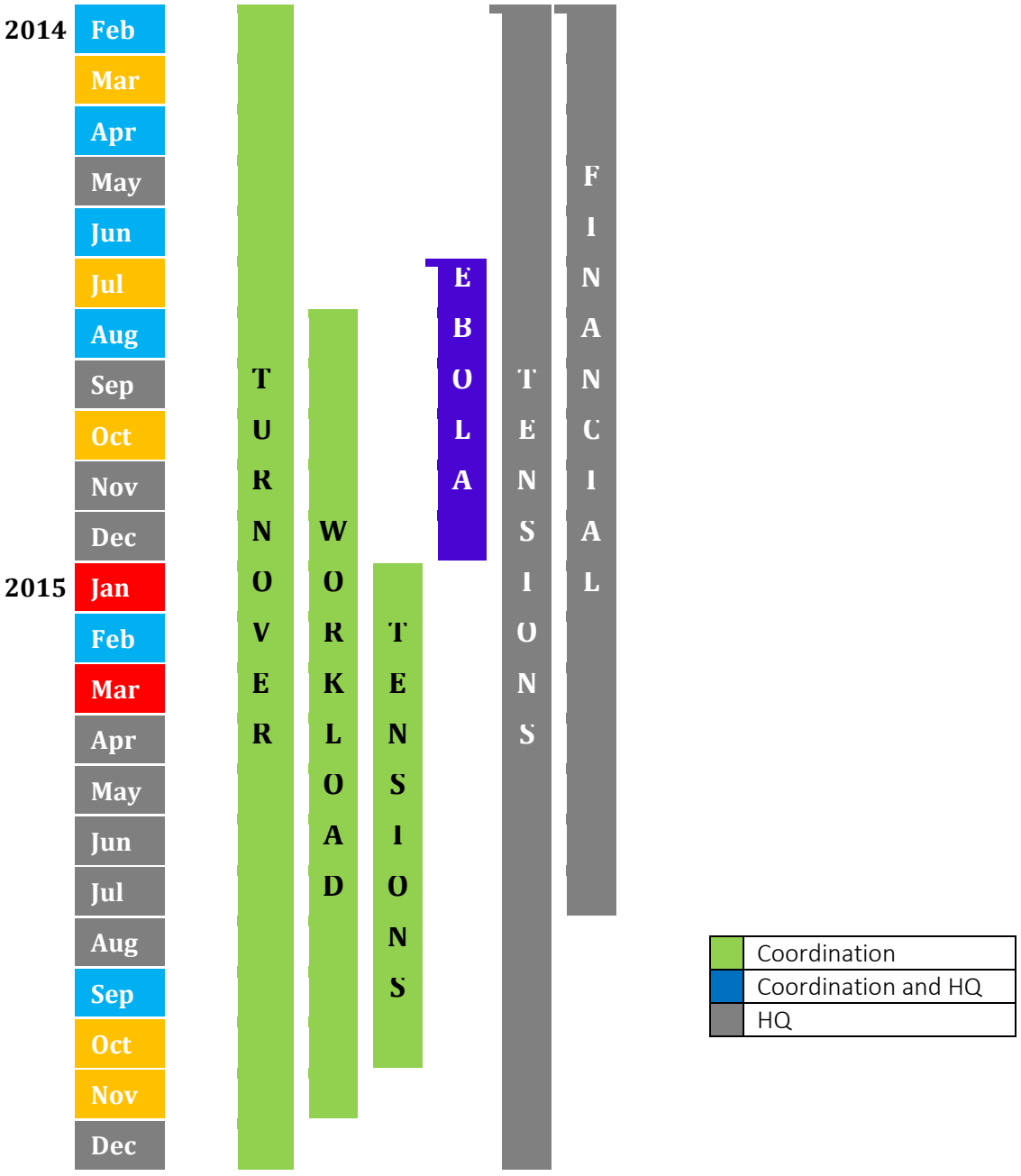
[2] Bikenge anthropological study report, Pierre Trbovic, pag 57

[3] Project finance data (on June 2015) showed 3,442,058 euros expended until June 2015, versus 2,650,797 initially budgeted for all the year

FACTORS

Different interrelated events occurring during the studied period may have influenced project decision making and implementation. They are presented in the figure 2. The colour indicates their impact on coordination or HQ, and the space where they have been placed in the figure is related to the timing of their occurrence.

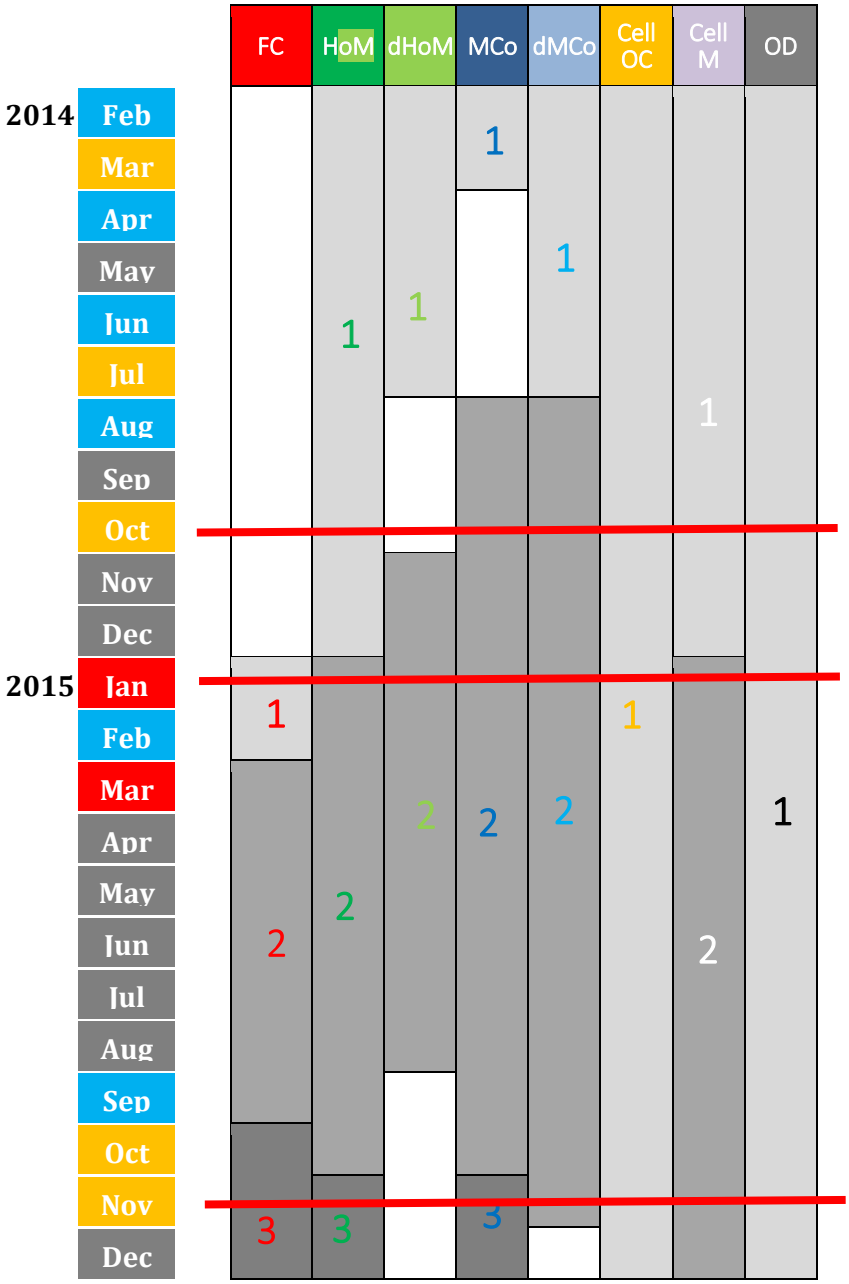
Figure 2. Timing of factors influencing project colour-coded by level in the decision line, February 2014 to November 2015



Factors in Coordination

Turnover of staff in key positions at coordination and field level was high during the period under study. Staff in key positions changed three times in 18 months, from the initial assessment until the decision to close the project. As shown in figure 3, for example, none of the members of the coordination team involved in the launching project was part of the team who participated in the project definition. This turnover created limited project continuity at mission level.

Figure 3. Timing of changes of staff by type of position, February 2014 to November 2015.



High level of **workload**, especially since the last months of 2014, was also mentioned by all coordination interviewees (ie: ebola response, new conflicts). This made proper follow-up of Bikenge project difficult because of the need to prioritize other projects. As an illustration, it is notable that Bikenge project was directly managed by both Deputy HoM and Deputy MedCo.

Tensions within the coordination team were experienced during the initial months of project launching. This limited the quality and the intensity of interactions indispensable for a proper project support and follow-up.

Factors in HQ

During all studied period, **tensions** in the cell 1 occurred both internally and in the interactions with other departments in HQ. These tensions complicated a coordinated and participatory decision processes during all project phases and reduced project support and monitoring.

The Financial situation of MSF changed significantly after Ebola crisis. Although it is beyond the scope of this review, an interaction between the financial situation before and after Ebola and MSF operational ambitions may also be considered, especially with respect to the evolution of the project since its initial definition until its implementation.

Affecting both coordination and HQ, the Ebola emergency outbreak is a significant factor to be considered. The need of prioritization of resources (both at HQ and mission level) seems to be directly related to the observed absence of activities related to Bikenge project during a fairly long period (September-December 2014) and to the delay in epidemiological and anthropological assessments (gaps in human resources). As mentioned above, Ebola can be also considered a relevant factor relating to perceived pressure to open a new project in the last quarter of 2014.

A comparison of the main project documents is presented in figure 4. The evolution of the project supports some of the findings presented in this document. Notably: 1) the evolution of toxicological component; 2) the potential adjustments to be done after surveys results; 3) the context adapted intervention vs secondary level of care proposed in ARO 2015

Figure 4. Comparative summary of the three main project documents, February 2014 to November 2015.

	CELL PRESENTATION (March 2014)	COPRO I (July 2014)	ARO (November 2015)
GENERAL OBJECTIVE	Reduce morbidity and mortality Bikenge	Reduce morbidity and mortality Bikenge	Reduce morbidity and mortality area
INDICATOR	Mortality rate specific to malaria	Mortality rate specific to malaria	Mortality rate (general and less than 5)
TARGET		Malaria, Diarrhea, IRA +STI (TB/HIV 2 phase)	
SPECIFIC OBJECTIVE	Reference health center services are used	Reference health center services are used	Project provided services are used
R.1	RHC recovers its capacity on quality services	RHC recovers its capacity on quality services	Primary health care (RHC and 3 HP)
R.2	Diagnostic and treatment HIV	Diagnostic and treatment HIV	Secondary health care in Bikenge RHC
R.3	CBHC* in isolated mining camps	CBHC* in isolated mining camps	Community care sites in identified areas
R.4	Vaccination	Vaccination	WatSan and malaria prevention
R.5			Mercury intoxication research
R.6			Emergency response
Potential Activities	Watsan	Watsan	
	Mercury intoxication	Mercury	
	Health promotion	Health promotion	

*CBHC= Community Based Health Care focused on Malaria, Diarrhea and Malnutrition

Others	Basic and adapted RHC vs MSF standards
	Quantitative-qualitative survey after approval
	Activities adjusted based on survey results
	*Project defined in two phases

Project Reasons	Intoxication research
	Community care sites
	HIV/STI/SV prevalence

IDENTIFIED LESSONS

⇒ Importance of carrying out **detailed assessments** before deciding to open a project by choice. These assessments should be implemented together and should be timely and comprehensive, including epidemiology and anthropology studies as well as assessment of existing health structures.

⇒ Need to develop a written **detailed project proposal** before deciding to open a project by choice. This proposal should include a clear definition of project rationale, hypothesis, objectives, strategy, medical package, chronogram, and budget.

⇒ **Shared agreement/ownership** can become challenging, especially considering potential existing factors such as with turnover at field level, tensions, unclear definition of project proposal, innovative components… It stresses the need of clear and transparent communication between people involved. Cell plays a crucial role in **ensuring continuity** of project cycle.

⇒ **Space for reflexion** (ie: Patio early starting) is needed during initial implementation phases of project by choice in order to ensure continuity and to establish at the same time early adjustments if needed. This is especially relevant in challenging contexts or innovative strategies.

⇒ Need to take the **necessary time** to decide, implement and follow up the initial phases of projects by choice. Caution about pressure and falling into “emergency mode” in projects by choice should be ensured.

ANNEXES

ANNEX I: TERMS OF REFERENCE

Subject/Mission	
Evaluation Sponsor/ Owner:	**Brice de la Vigne**
Evaluation Focal Point:	Deputy CO, Brussels, Ahmed Abd Elrahaman
Primary Stakeholders/ Evaluation Communication Group:	Cell1, coordination team DRC, field team Bikenge, Dir OPs
Starting Date:	To be defined, ideally before the end of June 2016
Duration:	3 weeks
Time period to be evaluated:	February 2014 until November 2015

Terms of Reference to review the process of deciding and launching Bikenge project / DRC

CONTEXT

In March 2015 OCB launched a project in Bikenge / DRC which in the first year aimed at rehabilitating the health centre and providing access to care to the population.
The project was started based on different reasons:

1. The OCB Pool Urgence Congo (PUC) has reached Maniema province (where Bikenge is) frequently, it is close to South Kivu; therefore, considered un stable region.
2. OCB wanted to have new Primary Health Care projects with a "community approach"
3. Mining activities in the area are known to have attracted seasonal and long-term migrant workers. The assumption being that the community is fragmented with pockets of migrants, hence not only geographically isolated but with additional exclusion factors in terms of access to the health system. In this setting alcohol and prostitution were understood to be high with potential needs on SGBV care.
4. Intoxication problems with mercury were reported to be prevalent, due to mining activities.

First doubts about the identified needs appeared already during the Committee de Project when the decision for the project was taken (in August 2014). However, with some strong interest to work on this intervention, pressure from the field teams and commitments made to the population, the project was decided for.

An anthropological study and a mortality survey were foreseen, but were delayed until after the project start. Outcomes did not confirm previous assumptions. Mortality was around 0.47/10,000/day (half the emergency threshold and relatively low when compared with other mortality survey conducted by PUC during emergencies). The community did not seem to be fragmented and no signs of toxicological problems could be identified.

The toxicological expertise which was expected to support the project could not be made available and the medical department felt not ready for such support.

Six months after project start, during the annual planning process, a decision was taken to close the project in June 2016. The conclusion was that the main assumptions had not materialized.

REASON FOR EVALUATION / RATIONALE

The reason to evaluate the decision making process for Bikenge project is to understand how the gap between expected and real needs occurred and what lessons can be learned to avoid such a situation in future.

OVERALL OBJECTIVE and PURPOSE

Evaluate the process of decision making for starting this project
Identify lessons from this experience for the operations department

SPECIFIC OBJECTIVES / Evaluation questions

- Identify the weaknesses in the assessment before opening the project
- Understanding the reasons why the project was quickly questioned in terms its objectives and its relevance
- Highlight the dynamics and expectations in the headquarters during this period that led to the opening of this project

EXPECTED RESULTS

Reconstructing the timeline of decision making, including the factors, weaknesses that led to the gap between expected and real needs. Lessons learned in the process of deciding and launching the project.

TOOLS AND METHODOLOGY PROPOSED

- Review and analysis of project documents (see below)
- Meeting/discussion/interviews with key-team members at HQ and project level
    - Directeur médical, Bertrand Draguez
    - Directeur des Opérations, cellule 1: Brice De Le Vingne
    - Responsable des Opérations Cellule 1 :
    - Responsables médicaux Cellule 1 : Vincent Lambert et Ahmed Abd Elrahaman
    - Responsable financier Cellule 1 : Vincent Pâques
    - Resposable logestic cellule 1 : Alexis
    - Réferent Watsan Cellule 1 : François Catelain
    - Chefs de Mission RDC : Bertrand Perrochet et Joeren Beijnsberger
    - Coordinateurs Médicaux : Dr. Stathis Kurousis Dr. Hilde Vochten
    - Adjoint Coordinateurs Médicaux : Dr. Alain Ngoko Tchatchouang ; Emmanuel Lampaert
    - Responsables Projet : Mickaele Telaro, Jesse Verschuere,
    - Anthropologue : Pierre Trbovic,
    - Epidemiologist (Mortality survey focal point): Veerle HERMANS

RECOMMENDED DOCUMENTATION

- Rapports d'évaluation de terrain
- Document narratif de Comité de Projet (COPRO document)
- Rapports mensuels rédigés par les équipes projet
- Rapport d'étude anthropologique
- Medical base line study
- Rapports médicaux trimestriels

PRACTICAL IMPLEMENTATION OF THE EVALUATION

Number of evaluators	1
Timing of the evaluation	May or June 2016
Required amount of time (Days);	
• **For preparation (Days)**	1 week
• **For field visits (Days)**	/
• **For interviews (Days)**	2 weeks
• **For writing up report (Days)**	1 week
Total time required (Days)	4 weeks

PROFILE /REQUIREMENTS EVALUATOR(S)

Language : Français
Experience MSF experience as condition

ANNEX II: LIST OF INTERVIEWEES

Name	Function	Date of Interview
Jeroen Beinjsberger	Medical Coordinator, Head of Mission (DRC)	1st.June.2015
Hilda Vochten	Medical Coordinator (DRC)	1st.June.2015
Emmanuel Lampaert	Deputy Medical Coordinator (DRC)	2nd.June.2015
Ibrahim Diallo	Field Coordinator (DRC)	4th.June.2015
Bertrand Perrochet	Head of Mission (DRC), Ops Coordinator (Cell 1)	6th.June.2015
Brice de la Vingne	Operations Director	7th.June.2015
Jesse Verschuere	Field Coordinator (Bikenge)	8th.June.2015
Clement Chauvel	Deputy Logistic Coordinator (DRC)	9th.June.2015
Alain Ngoko	Deputy Medical Coordinator (DRC)	9th.June.2015
Mandi Henshaw	Field Epidemiologist (DRC)	10th.June.2015
Stathis Kurousis	Medical Coordinator (DRC)	13th.June.2015
Veerle Hermans	Field Epidemiologist (Bikenge)	13th.June.2015
Michele Telaro	Field Coordinator (Bikenge)	13th.June.2015
Louise Rolland	Deputy Head of Mission (DRC)	14th.June.2015
Pierre Trbovic	Field Anthropologist (Bikenge)	14th.June.2015
Faida Kanyombe	Health Promotion Referent (DRC)	15th.June.2015
Vincent Lambert	Medical Officer (Cell 1)	16th.June.2015
Silvie Auerbach	Head of Mission (DRC)	16th.June.2015
Jean Paul Jenny	Deputy Medical Director (HQ)	20th.June.2015
Francois Cathelain	WHS Support Officer (HQ)	22nd.June.2015
Vincent Paques	Finance Officer (Cell 1)	23rd.June.2015
Ahmed AbdElrahman	Medical Deputy Operations Director (Cell 1)	23rd.June.2015
Alexis Moens	Logistic Polyvalent (Cell 1)	24th.June.2015

ANNEX III: INFORMATION SOURCES

Maniema assessment report. (2014)

Kyrousis, S. (2014). *Intervention strategy proposal for Bikenge*.

Lampaert, E & Chauvel, C. (2014). *Terms of Reference Bikenge Assessmen*t.

Lampaert, E & Chauvel, C. (2014). *Bikenge assessment report*.

Mandi, H. (2014). *Baseline epidemiological survey*.

Bikenge logistic assessment report. (2014)

Strategic COPRO Bikenge. (2014)

Project presentation power point. (2014)

Project logistic presentation power point. (2014)

Bertrand, C. (2014). *Mail with notes from Bikenge COPRO meeting feedbacks.*

Weekly project situational reports. (2015)

Monthly project reports. (2015)

Monthly project medical reports. (2015)

Quarter project medical reports. (2015)

Roland-Gosselin, L. (2015) *Mail with notes about WHS in Bikenge*.

Hermans, V. (2015). *Household epidemiological survey report*.

Trbovic, P. (2015). *Anthropological study report*.

Project Document Bikenge ARO. (2015)

Minutes from Medical and Operational Meeting about Bikenge. (2015)

Maes, P. Cathelain, F. & Calain, P. (2015). *Mails about intersectional meeting regarding intoxication component*.

ToR Patio Bikenge. (2015)

Budget monitoring tool. (2015)

All these reports and documents are available from the author.

My sincere gratitude and thanks to all the persons who contributed their time, participated and supported this review. Their availability, honesty in candidly expressing their opinions, self-criticisms, and expression of their feelings made it possible. This and their support in identifying relevant documentation show a mature and professional interest to strengthen accountability and learning processes within the organization.

Beyond the findings of this review, special mention and acknowledgement should be made to the work carried out by MSF staff as part of Bikenge project notably a total of 67,501 medical acts over the project life.

Stockholm Evaluation Unit

Médecins Sans Frontières