

EVALUATION OF

**MSF-OCB'S EBOLA INTERVENTIONS
IN THE DEMOCRATIC REPUBLIC OF CONGO
(2018-2020)**

DECEMBER 2021

This publication was produced at the request of Médecins Sans Frontières (MSF) - Operational Centre Brussels (OCB) under the management of the Stockholm Evaluation Unit (SEU).

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DISCLAIMER

The authors' views expressed in this publication do not necessarily reflect the views of MSF and the SEU.

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The events covered by this evaluation have affected the people involved, many of them deeply. Over the three interventions and support to them, their work produced interviews that often surfaced feelings of regret, confusion, frustration, but also pride and accomplishment. We greatly appreciate the dozens of interviewees who generously recounted their experiences and offered their insights.

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ACRONYMS

CE	Community Engagement
CG	Consultation Group
DRC	Democratic Republic of Congo
DSP	FRE. <i>Département de Santé Provinciale</i> (ENG. Provincial Health Department)
EmCo	Emergency Coordinator (at OCB)
Epool	Emergency Pool (Brussels-based)
EQ	Evaluation Questions
ETC	Ebola Treatment Centre
ETU	Ebola Treatment Unit
EVD	Ebola Virus Disease
FARDC	FRE. <i>Forces Armées de la République Démocratique du Congo</i> (ENG. The Armed Forces of the Democratic Republic of the Congo)
FCDO	Foreign, Commonwealth & Development Office
HP	Health Promotion
HPG	Humanitarian Policy Group of ODI
HQ	Headquarters
INGO	International Non-Governmental Organization
INRB	FRE. <i>Institut National pour la Recherche Biomedicale - RDC</i> (ENG. National institute for biomedical research in DRC)
IRC	International Rescue Committee
KI	Key informant
KII	Key informant interview
MCZ	FRE. <i>Médecin Chef de Zone</i>

	(ENG. Zonal medical director (of the MoH))
MedCo	Medical Coordinator (at OCB)
MoH	Ministry of Health
MONUSCO	FRE. <i>Mission de l'Organisation des Nations Unies pour la Stabilisation en RD Congo</i> (ENG. United Nations Organization Stabilization Mission in the DR of the Congo)
OC	Operational Centre
OCB	Operational Centre Brussels
OCG	Operational Centre Geneva
OCHA	Office for the Coordination of Humanitarian Affairs
OCP	Operational Centre Paris
ODI	Overseas Development Institute
PHC	Primary Health Care
PPE	Personal Protective Equipment
PUC	FRE. <i>Pool d'Urgence Congo</i> (ENG. Emergency Mission Congo Response Team, Kinshasa-based)
RISD	Research Initiatives for Social Development
SEU	Stockholm Evaluation Unit
USAID	United States Agency for International Development
WBG	World Bank Group
WFP	World Food Programme
WHO	World Health Organisation

EXECUTIVE SUMMARY

Since 1977, Operational Centre Brussels (OCB)/Médecins Sans Frontières (MSF) has constructed an exceptional history in the Democratic Republic Congo (DRC), including its leadership in every official Ebola Virus Disease (EVD) outbreak, as support from other Operational Centres (OCs) increased in recent years. In commissioning this evaluation its three recent outbreak responses (DRC EVD #9, #10, #11), OCB is also reckoning with a decades-long history of 'total response', whereby MSF teams, with their superior resources and EVD experience, directed operational strategy and multiple response pillars, from surveillance to treatment to psychological care for survivors. Historically these interventions were conducted autonomously with Ministry of Health (MoH) support, as was consonant with OCB/MSF's mission of saving lives in dangerous situations.

This autonomy was not unique to Ebola in DRC but was standard in other outbreaks from Uganda to Gabon. Controlling this chain of command meant providing all necessary equipment, logistics, financial resources, teams of technical and medical experts, who then had to customize effective, life-saving interventions often in remote areas with limited support from health authorities. Yet this enormous responsibility—and privilege—began shifting towards increased national ownership after the 2014-16 West Africa Ebola pandemic, when [OCB called for greater engagement¹](#) by national institutions and the WHO. Echoes from this call to increase national responsibility in EVD response were not felt in DRC until mid-2017 in [Likati²](#), where MoH and WHO teams directed the response, and where OCB was active. This vision of more actors and greater resources, led by national authorities, had by 2018 effectively materialised with the outbreak in Bikoro, in Equateur Province (#9).

Not unwelcome in principle, the rise of new Ebola authorities under whom OCB would play a supporting role came nonetheless as a surprise. After calling for an increase in resources and actors after West Africa, MSF was not involved in translating this vision into action in DRC or other Ebola-prone countries. Given the strength of its relations with MoH in DRC and elsewhere, and its rapport with WHO, MSF could easily have informed and shaped these discussions. It did not.

While the focus of this evaluation is limited to OCB performance in three DRC outbreaks between 2018 and 2020, this cannot be assessed without appreciating the complexity of the shifting politics and power dynamics of EVD response that were playing out at the same time. In each of the three interventions, new national priorities and institutional interests weighed heavily on OCB's ability to engage, usurping its prior autonomy and limiting its operational latitude. Not least, OCB/MSF found itself working under the authority of the government, a cog in their response. This inversion of roles had direct consequences on OCB performance that are addressed throughout this report.

Another major factor influencing OCB performance across the three outbreaks is relations with affected communities. Where conflict is ongoing, armed groups threaten access, and the state is party to hostilities, a government-led EVD response with which MSF is associated may fail to secure public trust and support. As one OCB Ebola expert noted, *"You cannot control an outbreak if people*

¹ <https://www.msf.org/ebola-west-africa-epidemic-requires-massive-deployment-resources>

² <https://reliefweb.int/report/democratic-republic-congo/drc-response-ebola-virus-disease-outbreak-bas-uele-likati-first>

don't let you do your job.". The years of insecurity and despair in North Kivu and Ituri found a new enemy in the government-led Ebola response, resulting in attacks on medical structures and staff. OCB facilities were targeted, as were WHO and others, and risks were deemed too high to stay. By contrast, in rural Equateur, the site of #9 and #11, communities were neither suspicious of the existence of Ebola nor resented the resources allocated to its containment, as happened in #10. OCB enjoyed greater public trust and could work effectively, albeit under the direction and oversight and restraint of MoH/WHO leadership.

Through an extensive desk review process and interviews with over 71 key informants (KIs), including a three-week country visit, the evaluators noted the following themes:

1. **OCB KIs view DRC's official EVD response architecture (vertical, MoH-led) as a major constraint and challenge** to MSF independence and OCB's traditional ways of working. In #9 and #10, OCB submitted to MoH direction and leadership, with mixed results, as local politics and physical terrain also effect outcomes. #11 is seen by OCB KIs as slightly more successful, because OCB deliberately managed MoH relations with the aim of reclaiming space for its independent way of working. As of now, OCB is assessing how it might work under MoH Kinshasa and alongside multiple EVD actors, with potentially reduced roles for MSF.
2. **No clear effort by OCB leadership to negotiate or resist MoH appropriation of OCB operational space.** OCB KIs viewed the loss of autonomy and reduced space differently in #9, #10, #11, but cumulatively expressed anger at the reduced impact on EVD, shame at dysfunctional inter-OC politics (especially in #10), and sadness over diminished MSF credibility. 'Never again' (to EVD in DRC) was heard often from OCB KIs.
3. **Questions over OCB leadership.** Reactive and ad hoc context management, in contrast to OCB's technically proficient EVD teams, weakened overall impact in #9, #10, and #11. Across the three interventions, OCB field engagement with all external actors, not just MoH Kinshasa, was seen to struggle, with little clarity on ways forward. In the case of intersectional disagreements in #10, Headquarters' (HQ's, located at OCB, in Brussels) leadership bears responsibility for asking field teams to operationalise a marriage whose parties disagreed over basic roles and purpose. Absent effective steering and vision, OCB failed to leverage its EVD experience to improve outcomes.
4. **Unprecedented complexities of #10 leave unresolved questions and frustrations in OCB.** Besides a lack of strategy, fragmented inter-OC relations, turf battles across the *Emergency Pool* (EPool) in Brussels, the *Emergency Mission Congo Response Team* in Kinshasa (referred to as: the *Pool d'Urgence Congo*, PUC) and the OCB Mission structures, and conflictual relations with MoH/WHO, the #10 response environment was beset by immense donor pressure and explosion of the 'Ebola business', to which MSF was unwillingly entangled. Other contextual challenges, none of them novel, included: armed groups, xenophobia/opposition strongholds, EVD denial. Between public rejection, disunity across OCs, and strained MoH/WHO relations, many KIs asked if failure was inevitable in #10.
5. **Some improved performance in #11.** While OCB consensus over the function and goals of Health Promotion (HP) and Community Engagement (CE) is perceived by many KIs as lacking, there were

clear examples of demonstrated effectiveness and value in HP/CE approaches in each outbreak, but most evident in #11. Lack of clarity over roles and responsibilities between PUC, EPool and Mission dominated in #9 and #10, but improved in #11, with PUC initiating the response and receiving later support from EPool.

This evaluation report is divided into two main sections, Findings and Analysis. Following a short introduction and methodology section, Section I presents five sets of main findings, per the key questions of the evaluation ToR (see Annex). In brief, the five questions ask whether OCB interventions were:

- **Relevant** to local needs and context? How did OCB respond to changing needs; how were MSF core principles applied, such as independence and Do No Harm?
- **Appropriate** to the context, with clear strategy and objectives? Which approaches work best; what are the pros and cons of decentralisation vs Ebola Treatment Centres (ETCs), for example?
- **Effective** – did the results match the intentions and aims of the intervention? What were the challenges and risks, and how did OCB adapt? Any unintended outcomes?
- **Efficient** – was there a proportionate balance of key resources: time, materials, staff? What opportunity costs arose?
- **Connected** – was there unity of effort and vision with EVD partners and across OCBs? Proximity to populations, including national health authorities? Was the response integrated or parallel to local health systems?

The Analysis section is divided into four themes:

1. Context: transformed response landscape
2. Partnership, collaboration, engagement
 - MoH, communities, MSF, OCB internal
3. Leadership + Principles
4. Added value and Comparative advantage

Each of these four themes are explored in order to deepen OCB reflexion of issues raised in the Findings section. The Analysis section tries to connect the problems and opportunities of the three interventions to a wider consideration of their implications and next steps for the organisation. For example:

- OCB's Ebola interventions in #9 and #10 were blindsided by its failure to anticipate and adapt to the implications of post-West Africa improvements in both the global and Congolese Ebola response capacities.
- For a more effective engagement with the MoH, actionable two-way trust is currently a missing ingredient, and requires OCB/MSF changing more than the way it feels about the MoH, it must foster MoH trust in OCB/MSF.
- OCB leadership deserves a great deal of credit, and it deserves scrutiny in areas such as the setting of strategy; directing the establishment of connections and collaboration with other actors (including other parts of MSF), and with communities; combatting harmful organisational narratives; and ensuring that principles guide actions.
- As the exceptionalism of Ebola diminishes, OCB must recalibrate a number of operational decisions and calculations, because the balances and trade-offs have shifted, as has its comparative advantage over other actors.

And in this regard, this retrospective evaluation has been driven by the future. The challenges experienced by OCB, and in particular the threat to a core element of its identity – its global pre-eminence in Ebola response – have prompted the need to understand what happened over the course of three DRC outbreaks. Many in OCB claim to have learned from these three outbreaks and this evaluation can accelerate and consolidate that learning process, particularly in the Findings and Analysis sections. The paper's Conclusion section highlights the most critical concerns specific to future Ebola response and the surrounding organizational culture. Key points include:

- To better position itself in EVD response, MSF needs to analyse and assess the wider humanitarian sector, the global public health system, regional crisis dynamics, and then determine its place therein.
- Effective Ebola response in DRC requires developing a stronger, strategic, and long-term engagement with the MoH.
- To adapt to changes in the broader external environment and the specific landscape of a given response, OCB requires shared strategic direction and dedicated change management.
- To improve the quality and consistency of decision-making in operations, specific guidance should exist in the form of strategy, leadership, and clarity on matters of principles and ethics.

INTRODUCTION

BACKGROUND TO THE EVALUATION

Operational in the Democratic Republic of the Congo (Republic of Zaire) since 1977, a year after the Ebola viral strain was first identified (Yambuku, 1976), OCB teams have responded to every official outbreak in the country, with increasing assistance from other Operational Centres (OCs). Based on field experience from Kampungu (2007) forward and noting an increasing role for other actors since Isiro (2012), several key informants described a history of 'total response', whereby MSF teams, owing to their superior resources and experience, led the main strategic element and response pillars, from surveillance to treatment to psychological care for survivors, all with complete Ministry of Health (MoH) endorsement. Essentially given carte blanche to design and deliver its best effort to contain and stop a given Ebola Virus Disease (EVD) outbreak, OCB/MSF's public identity as saving lives in dangerous situations was generally welcomed by the MoH, whose deployment involved coordinating functions.

MSF's control over this chain of command, to provide all necessary materials, resources, and experts, to strategise and deliver life-saving services freely and without approval or oversight from national health authorities – this long-standing precedent of privilege owing to uncontested expertise underwent a reversal during the 2018 to 2020 period of the three EVD outbreaks (#9, #10 and #11) evaluated here. Already in 2014 in West Africa, OCB was [calling for more leadership](#)³ and resources from WHO, national health systems, donors, and other medical agencies. This vision of more actors and greater resources, led by national authorities, had effectively transpired by 2018 and the Bikoro outbreak, although MSF played no direct role in translating this new vision into action within the Congolese MoH. For an Ebola response in DRC, things were suddenly very different.

This gradual progression toward MoH control of EVD response was reportedly first felt in Likati (Bas Uele), the 2017 outbreak that preceded #9 in Bikoro. The progression climaxed with the North Kivu outbreak later in 2018, with numerous other donors, emergency medical International Non-Governmental Organizations (INGOs), and UN agencies entering the scene, all funded via the Congolese Ministry of Finance that then disbursed to the MoH, who contracted services to treat and contain EVD. Independently funded, OCB was still required to submit to MoH/WHO authority and given a limited response role. Relations between Operational Centre Paris (OCP) and OCB started constructively but deteriorated, with team members speaking of 'divorce' and MSF 'balkanization'. Despite the massive global response to #10, second only to West Africa in 2014-16, number of deaths were far lower than a simultaneous measles epidemic (more than 11,000 lives), while countless others died from insecurity and lack of access to essential healthcare.

Although it began as retrospective analysis – evaluating the three interventions to identify lessons, strengths, and weaknesses – this evaluation gained a prospective or forward-looking element. Many KIs and Consultation Group members wanted to know – with so many new and experienced actors, including the MoH, what can OCB and other OCs do differently to contribute to better control and contain future Ebola outbreaks? The most recent outbreaks were small – #11 in Mbandaka and #12

³ <https://www.msf.org/ebola-west-africa-epidemic-requires-massive-deployment-resources>

in Beni – causing no international panic or biosecurity reflex from national authorities. While positive, the political and security conditions that led to #10 are still very present and unchanged, and OCB has yet to consolidate its lessons from that experience, widely seen as a failure.⁴

PURPOSE OF EVALUATION

At the highest level, this evaluation aims to contribute to OCB's discussion of its identity and role as it engages with a changing world, now and into the future. The response in DRC to three successive outbreaks, and in particular the difficulties encountered during the larger and longer #10 outbreak in the Kivus and Ituri, pushed OCB to question its strategy, management, and approaches. This is partially evident in an altered delivery model in #11, while the intervention goal of saving lives, alleviating suffering and ending the epidemic remained constant.

The ToR sets a two-fold objective for the evaluation:

1. To systematically document and describe the different strategies, approaches, and activities during the three outbreaks and identify the reasons for these choices and decisions.
2. To present evidence of what worked, for whom, why, and under what circumstances, and help the organization develop recommendations and potential future scenarios for Ebola response, in DRC and potentially other contexts.

Following our initial period of desk research, Consultation Group (CG) interviews, the Stockholm Evaluation Unit (SEU) exchanges, and further study of the ToR, it was agreed to shift some weight in the direction of using a bi-focal analytical lens that will be both retrospective and prospective, or backward and forward looking. This will help generate evidence-based proposals for improved scenarios and examples of 'good practice' for future Ebola outbreaks. More generally, these findings will contribute to ongoing discussions around the roles and work of the organization within a changing global landscape.

METHODOLOGY

The primary direction of the evaluation is to establish an empirical narrative of OCB's outbreak response in the three DRC outbreaks, from which forward-looking recommendations can be drawn. The work of the evaluation team was supported by Research Initiatives for Social Development (RISD), a Congolese group of experienced researchers based in Bukavu. RISD provided critical feedback to the evaluators, arranged, and conducted interviews in Congo, and organised a roundtable discussion in Goma with five locally-based organisations.

ELABORATION OF THE EVALUATION QUESTIONS

The ToR calls for assessing OCB's Ebola interventions through five evaluation criteria – relevance, appropriateness, effectiveness, efficiency, and connectedness. In short, this evaluation asked key informants (KIs) questions and reviewed documentation to assess the relevance of the three interventions (were the *right* needs addressed?); their appropriateness (was the right strategy

⁴ "We cannot let #10 happen again, and yet we have just seen in Guinea a near repeat of those failures", OCB KI.

used?); their effectiveness (quality, quantity of delivery), their efficiency (use of resources), and their connectedness (key relationships).⁵ More specifically, this framework produced the set of five Evaluation Questions (EQs) and their sub-questions, which form the headings of the Findings section that follow (see also Annex 1).

DATA COLLECTION

In sum, our approach involved a thorough assessment of mostly primary qualitative and to a less extent of secondary quantitative sources, including 71 key informant interviews (KIIs, see table below) from inside and outside MSF and an extensive document review. This evaluation relied upon the analysis of data by the relevant experts (KIIs and internal OCB/MSF findings). See for example research questions 3.1 and 4.1 in Annex 1. The bulk of these source materials were provided by OCB/SEU, though the evaluation team added to these from its own desk research, industry connections and previously published papers. The breakdown of KII groups and their estimated number are presented below. A bibliography can be found at the end of the report.

Our purposive selection of KIs aimed for a representative sample of OCB and connected staff from field missions and HQ, and MoH and collaborating response agencies (ALIMA, WHO, OCHA, etc.) that were directly involved in each of the three interventions. Where useful we asked KIs to recommend further KIs (snowballing method). We deliberately sought Congolese voices close to each intervention (from MoH, OCB, PUC staff) and some responding agencies. To register community voices involved in the three interventions, we relied upon (a) existing perception surveys conducted by partner agencies, such as IFRC and [others](#)⁶, (b) discussion and interviews with national staff and in particular those closer to the community such as health promoters, (c) meeting with relevant local organizations or local staff of INGOs (#10, Goma only), (d) critical review of the findings by Congolese experts (see below), and (e) analysis of MSF and OCB's documentation of and data related to community engagement.

In the end, the evaluation team interviewed 71 key informants, and had numerous conversations with members of the CG. Most interviews were conducted remotely, save those KIs available in Kinshasa and Goma during the evaluator visits. The breakdown on the KI interviews:

Table 1. Key Informant Categories and Number of Interviews

KEY INFORMANT CATEGORIES	INTERVIEWS
OCB HQ leadership & staff involved in #9 - #11	10
OCB field staff directly involved in #9 - #11 (international and national; EVD only and OCB mission)	40
Other MSF (OCP specifically)	3

⁵ In addition to these OECD-DAC evaluation criteria, we also consider whether these three interventions reflect/embody MSF's four foundational principles: humanity, impartiality (aid is needs-based, targeting *unmet* needs, as resources are finite), independence (autonomy in operational choices, free from political interests), and neutrality (nonpartisan, irrespective of local identity distinctions/differences).

⁶ <https://www.socialscienceinaction.org/>

MOH Kinshasa and provincial (#9 - #11)	8
Response actors: donors, UN, WHO, international + local aid agencies (#9 - #11)	9
Miscellaneous expertise (Congo, Ebola, etc.)	1
TOTAL	71

Marc DuBois visited DRC August 1 to 24 to conduct interviews, hold meetings, and discuss OCB's Ebola interventions with mission staff. The majority of his time was dedicated to Kinshasa (including one-week quarantine upon arrival) and then a final four days in Goma. Congolese researchers from RISD assisted with the Goma visit. See limitations for rationale behind focus on Kinshasa and Goma only.

Ethics

The focus of interviews was upon the actions of the organization and participants' analysis/opinions of them. We viewed the potential risk to participants of interviewing and other information gathering as very low. Due to the ongoing ethical review led by OCB's GAREC⁷, some risks may have been particularly elevated in relation to outbreak #10.

The information gathered included only minimal personal data, and this was recorded only by the evaluators. All oral and written output of the evaluation has been anonymised, and attributions placed into anonymised categories wherever possible (e.g., "one senior project manager stated ...").

Prospective interviewees were sent a brief explanation of the evaluation and the expected areas to be discussed. Consent was obtained in two ways: (a) sending a statement relating to consent and the interviewees' rights; or (b) covering this directly at the beginning of each interview, where the evaluators described the purpose of the interview and the rights of the interviewee to refuse to answer and terminate at any time. Verbal consent was obtained at the start of the interview.

Our DRC-based researchers were briefed on and held to the standards set out in these protocols.

Covid-19-related risks. As most of the work, meetings, and many interviews are conducted remotely, there are no specific Covid-19 risks raised by this assignment to the evaluators or many of the various stakeholders. During the field work in DRC, all appropriate regulations/guidance were followed per the restrictions/protocols of the mission.

Conflicts of Interest. The two evaluators have no conflict of interest to declare and will not benefit directly from the evaluation beyond contract terms. The subcontracted support from DRC-based research group RISD were screened to ensure that there are no conflicts of interest.

⁷ Group for Advice and Research on Ethics and Conduct (OCB).

Special measures related to the GAREC-led ethics review of EVD outbreak #10. The Evaluation team spoke with members of the ongoing GAREC-led ethics review of #10 in order to (a) determine any overlap and avoid duplication, and (b) understand where their review might reach findings relevant to this one in areas such as local perceptions of OCB/MSF, internal security management (that impacted on strategy), or access/acceptance issues.

Working with OCB's team in the DRC mission, measures were taken to eliminate confusion between this evaluation and the ethical review.

Analysis

Moving from collected data to initial findings involved a process of scanning the material for patterns, recurrent themes and trends that emerge independently of any externally imposed framework or theoretical filter. A 'disinterested' assessment of the data minimised subjective bias and projection of evaluator interests onto the data in favour of a desired outcome or preferred interpretation. Groupings of themes were then organised by frequency (i.e., representative of the sample), their relevance to individual evaluation questions, and to overarching aims.

Salient findings qualified for inclusion owing to their recurrence and frequency, the sophistication of their insight, or the contrarian or challenging voice that they bring. Were the reported findings, perspectives, and data consistent across the literature review, interviews with OCB staff, Congolese health officials and relevant emergency actors, and other secondary sources? This initial triage allowed the evaluation team to ensure validity of conclusions, i.e., that the findings were true (accurately reflect the situation) and credible (supported by the evidence). Concretely, this first level of 'internal' triangulation helped identify correlations, patterns, and probability between findings, intended intervention outcomes (as well as humanitarian principles and strategic pillars) and modifications made to adapt to field realities. Through these comparisons, we found evidence of how MSF teams learned and applied lessons across each of the three interventions.

We then triangulated our initial groupings of themes and findings through a series of additional exercises (see 'Critical Reflection' below) to ensure the integrity of the findings.

The review generated feedback from different stakeholders inside and outside of MSF/OCB. These critical review exercises were designed to help corroborate and validate the evaluation's conclusions and analysis, by giving different interlocutors the chance to react, correct or deepen the analyses and assessments made.

DEVELOPMENT OF THE REPORT, CRITICAL REFLECTION AND REPORT FINALISATION

We have used a three-step process to develop and finalise the report:

1. Preliminary findings and conclusions were presented (virtually) to the SEU and CG on September 15th. Based on that discussion, a first draft report was prepared.
2. The first draft report was circulated to obtain written feedback upon which the final report will be prepared. Per usual process, the first draft went to the CG and SEU.

3. Based on the written feedback, finalisation of the report by the evaluators.

Led by OCB/CG (and supported by the evaluation team), a set of further post-publication exercises will enrich critique and help disseminate the analysis and recommendations of the final report. These events aim to help the report communicate its findings directly to a wider audience (OCB HQ, DRC mission, other MSF), to stimulate reaction, reflection, digestion, and to solicit critical feedback. So, by turning the written word into the subject of reflection and debate, we hope to reinforce the report's more actionable content.

EVALUATION SCOPE AND LIMITATIONS

The scope of the evaluation set forth three key directives. First, the evaluation period covered three DRC recent outbreaks: #9 (Equateur Mbandaka, May to August 2018); #10 (North/South Kivus + Ituri, August 2018 to June 2020); #11 (Equateur six health zones, June to November 2020). This excludes, for example, 2021 events in Guinea that generated related issues. The breadth added methodological complexity and sheer volume to the evaluation, justified by the crucial ambition of being able to gauge the strategic and tactical development – OCB's internal learning – across the three outbreaks.

Second, the evaluation's focus was OCB, and thus touches upon but cannot insightfully assess key inter-OC or MSF-wide themes, such as the OCB-OC 'marriage' and 'divorce' in #10 or the lack of central MSF coordination or OC lead.

Third, the evaluation targeted strategies, approaches, tactics; and did not assess the operational medical and technical aspects of the three interventions. Nor did it assess key areas of OCB effort such as security management, recruitment/HR processes, financial administration, or psychosocial support to staff. Finally, it did not examine what happened after the three outbreaks, and so did not explore how OCB held itself accountable for its efforts.

Several limitations constrained the evaluation:

1. Travel and mobility were limited by Covid-19 and insecurity in the East. Given the time lapse between the time of this evaluation and the outbreaks themselves, and the mobility of MoH and MSF staff, we decided against field visits to Equateur or beyond Goma.
2. Regarding secondary source material, a significant obstacle was the absence of meeting minutes or any 'paper trail' that documents real-time decision-making around strategy and coordination within OCB, OCB-MoH, and between the OCs. For this we have relied on KIIs and corroborating between individual accounts.
3. Availability of key informants was mixed during the data collection period, and especially during the limited time in Kinshasa. While over 70 KIIs were conducted, the size and complexity of these outbreaks resulted in dozens of issues, events, relationships, and perspectives. Additionally, several years have passed since the three outbreaks under evaluation. This distance from events plus the ongoing preoccupation with Covid-19 appears to have limited the interest and availability of some actors. Finally, the field visit in August meant that holidays also prevented some interviews.
4. While external KIs contributed many helpful insights, they were unable to differentiate among OCs, and hence often responded with views on MSF generally.

FINDINGS

MAIN THEMES

The twenty pages of findings presented below are worth close examination; many contain direct quotes from EVD experts inside and outside OCB. They are presented within the framework of the evaluation methodology itself. In doing our analysis of KI responses it became clear that certain themes are more common than others. We list these here below, as they also provide the structure for our analytical section that follows. We have also provided a short narrative summary of each outbreak for additional context.

1. *The evaluation found that OCB KIs view DRC's official EVD response architecture (vertical, MoH-led) as a challenge to OCB's traditional way of working.* In #9 and #10, OCB submitted to MoH direction and leadership, with mixed results. #11 is seen as slightly more successful, because OCB deliberately managed MoH relations to reclaim its own space and familiar ways of working. Currently, OCB has not yet decided how it will work under MoH Kinshasa and alongside multiple EVD actors, with reduced roles for MSF.
2. *OCB KIs viewed the loss of autonomy and decreased operational space differently in #9, #10, #11, but cumulatively expressed: anger at reduced impact, shame at dysfunctional inter-OC politics, and sadness over diminished MSF credibility.* 'Never again' (to EVD in DRC) was heard often from OCB KIs. Concrete proposals for improved MoH collaboration at Kinshasa and provincial levels were few and non-specific.
3. *Reactive and ad hoc context management (vs technically capable EVD teams) weakened OCB impact in #9, #10, and #11.* Across the three interventions, OCB engagement with all external actors, not just MoH Kinshasa, was found to be ad hoc, reactive, and non-strategic. Consequently, OCB was unable to leverage its deep EVD experience to improve outcomes.
4. *Unprecedented complexities of #10 leave many unresolved questions and frustrations in OCB.* Difficulties of the #10 response environment included lack of strategy, fragmented structures and coordination processes, immense donor pressures and explosion of 'Ebola business', to which MSF was unwillingly complicit. Contextual factors compromising access in #10 included: armed groups, xenophobia/opposition strongholds, EVD disbelief, government missteps, inter-OC conflict, and MSF alignment with MoH/WHO. Unhealthy internal relations in #10 caused a frustrating and inefficient drain on resources that included a fragmented, leaderless approach to MSF intervention, a fraught OCB-OCP partnership, and turf battles across EPool – PUC – Mission structures.
5. *Some improved performance in #11.* While OCB consensus over the function and goals of Health Promotion (HP) and Community Engagement (CE) is perceived by many KIs as lacking, there were clear examples of demonstrated effectiveness and value in HP/CE approaches in each outbreak, culminating in extremely effective performance in #11. Lack of clarity over roles and responsibilities between PUC, EPool and Mission dominated in #9 and #10, but improved in #11, with PUC initiating the response and receiving later support from EPool.

OVERVIEW OF THE THREE OUTBREAKS

The short narrative summary of the three outbreaks below is intended to help contextualise the presentation of findings that follow. For methodological purposes these findings are organised in response to the evaluation questions (not per outbreak).

The three interventions considered by this evaluation encompass more than OCB's ability to anticipate and adapt to different social, political, and logistical manifestations of the same pathogen, itself a frequent subject of study and institutional reflection. The challenges of EVD operations in DR Congo are a major recurring theme of each outbreak, within the wider historical context of OCB's long history of vital and pioneering humanitarian action in the country, not just in EVD response but in many other medical domains. A second major theme in these findings is the role MSF's guiding principles have played in shaping EVD response and strategy, against an extreme pressure to respect and save lives.

Overview of #9: Equateur Province (May-August 2018). A novel outbreak in several respects, the three-month intervention saw 38 cases and 14 confirmed deaths in Mbandaka, Bikoro, and Iboko health zones. Unique primarily as an urban outbreak among mobile populations, the risk of rapid, wide-reaching transmission was real. It was also the first time an experimental vaccine was used to control viral spread. OCB was involved in all pillars. Coordination with other OCs, WHO and MoH was publicly described as positive but was also reported by many KIs as tense and conflictual. All KIs on the ground for #9 reported the 'shock' of losing operational autonomy and subordination to an authority whose decisions and priorities OCB found suspect or misguided. For team members coming directly from the recent 2017 outbreak in Likati, these shifts were alarming.

Overview of #10: North Kivu and Ituri (August 2018-June 2020; 3470 confirmed cases, 2287 deaths). Across the country in Mangina, North Kivu, Congo's 10th outbreak was announced on August 1, 2018. It would spiral into the largest outbreak ever in DRC, replacing the Gulu outbreak (2000) as the world's second most lethal (after West Africa), and would not close until June 25, 2020. It was the first registered outbreak within an active conflict zone, where agency mobility was constrained and physical presence high risk.

Under this more aggressive MoH leadership, OCB agreed to hire local MoH staff, with little EVD experience. OCB worked alongside many new actors and was treated as dispensable/replaceable by national authorities. As #10 evolved and the Ebola Treatment Centres (ETCs) failed to attract and retain suspected cases, OCB reasoned that without better community engagement and intensive health promotion, transmission rates would only escalate. Given local conflict dynamics, OCB understood why Kinshasa MoH and state security were rejected, and how the entire response operation intensified local hostilities and compromised treatment efforts. Yet OCB was unable to convincingly distance itself from the state-led response structure, or to persuade communities of its good intentions.⁸

As the outbreak spread into Ituri, OCB recalibrated its community engagement (HP and surveillance) by pivoting away from its 'patient-centric' approach, dominated by ETCs. Yet this had little effect on the 60-70% mortality rate, roughly equivalent to West Africa where experimental treatments and vaccines were not available. To many Congo observers, the fact that no Ebola cases were detected in

⁸ "I once asked one of our local staff why there was so much anger towards the response. She answered: 'If you cared about us, you would ask us our priorities. My priority is security and making sure my children don't die from malaria or diarrhoea. My priority is not Ebola, that is your priority'." [EBOLA: "UNLESS CHANGE HAPPENS, THE OUTBREAK ISN'T GOING TO END,"](#) MSF blog, Aug, 2019.

Uganda or Rwanda, nor any cases in the region's massive IDP camps or its large urban centres (Goma), made it a success (Crawford et al., 2021). After 18 months the outbreak was declared over, but for MSF it unleashed a stream of internal debate, frustration and reflection that continues today. As one [MSF blogpost](#)⁹ described, “[#10] cannot be labelled as anything other than a systematic and catastrophic failure that left thousands dead.”

Overview of #11: Equateur (June-November 2020; 55 deaths, 130 confirmed cases). Just weeks before outbreak #10 would close, Congo's eleventh Ebola outbreak was announced on June 1, 2020. It lasted nearly six months, killing 55 and infecting 130 persons in 13 of Equateur's 18 health zones. Patients were scattered over a vast area without transport, communication, or health infrastructure. Compared to the North Kivu/Ituri epidemic with its average mortality rate of 67%, in #11 mortality was 43%. Preliminary research suggests that MSF's key strength in this response was its geographical familiarity and preparedness for remote river travel to reach and set up in far-flung areas, requiring capacity and resources unavailable to MoH counterparts in Kinshasa and Mbandaka. The 11th outbreak came less than two years after the last outbreak in the same sub-region, affecting remote and hard-to-access villages. Response teams focused on engaging local health workers, supporting people to conduct local case surveillance, and limiting the use of personnel from outside the community. Authorities declared the outbreak over on November 18, 2020.

OCB did many things differently in #11. The unspoken objective was to avoid the errors of #10, to reclaim operational space and decisional autonomy. Reversals of negative patterns from #10 were widely noted by KIs in the areas of: inter-OC relations, operational relations (PUC, Mission, EPool), strategy and coordination with MoH/WHO, and wider acceptance from communities. Outright innovations were also noted, particularly in HP strategy regarding marginalised groups (indigenous Twa or 'pygmy' peoples) concentrated in southern EQ around Bikoro. OCB HP teams appreciated both the cultural challenge of gaining acceptance from these groups, and their strategic importance to ensuring surveillance and controlling transmission. Hiring, training, and integrating Twa staff into the HP workforce was key, despite resistance from Congolese staff.

Unlike #9 and #10, OCB teams in #11 decided on a community-focused approach based on semi-autonomous micro-structures embedded in local healthcare facilities, deliberately close to patients, their families, and communities. As one OCB KI described, *“By #11, we were close to the community and could respond to their concerns, questions and anxieties before they turned violent. Our relations [with affected communities] were definitely better because we changed our way of working with a decentralised approach.”* Speaking directly to families helped convince suspected cases to commit to isolation in the local centres.

Was the lower number of deaths in #11 due to the remoteness of the outbreak and its limited human mobility compared to the Kivus and Ituri, with their densely populated, dynamic economies bordering Uganda? *“Because the morbidity numbers were so low, it's hard to know for sure if this way of working is systematically better. But we definitely saw increased receptivity from local leaders”* (OCB KI). Several OCB staff claimed that this deliberate investment in better community engagement resulted in greater

⁹ <https://www.msf.org/how-ebola-response-failed-people-drc>

willingness to share information on suspected cases and to assist with contact tracing. OCB and OCP used different community engagement strategies, which were compared in an after-action review.¹⁰

FINDINGS PER EVALUATION MATRIX

EQ1: How relevant were the OCB interventions when considering the needs, MSF principles, and respective context? How can relevance be improved in the future?

- **EQ1.1: What were the needs of the populations in crisis? How were these needs assessed and translated into OCB's strategies/approaches?**

Equateur province has limited public services, little transport and communications infrastructure, yet it is comparatively safer and more stable than the country's eastern provinces particularly the site of #10. Mortality and morbidity in Equateur today have not changed much since [OCB's mortality surveys in the region¹¹](#) in 2003, which documented the primary causes of death and illness as infectious diseases and lack of access to basic health care. North Kivu and Ituri have experienced conflict-driven crises and chronic health emergencies, from infectious diseases to malnutrition, for over two decades. Health care and basic public services are slightly more available than in Equateur, primarily due to the concentration of well-funded emergency INGOs and UN agencies.

Initially, OCB EVD teams focused on EVD as their mission objective for #9, #10, and #11, but in #10 were soon confronted with a population threatened by competing priorities. EVD was not one of them. Needs assessments in each outbreak did not formally incorporate community input or perspectives, but in #10 the diversion of views between EVD response agencies and the population was stark, a source of hostility. In #11 KIs reported that through effective dialogue with EVD-affected rural communities, the public understood the need for rapid effective action to contain the virus and trusted the expertise of outside actors alongside their more familiar healthcare providers and facilities.

1. **In outbreaks # 9 and #11, both in Equateur province, the evaluation found no reason to dispute recognition of Ebola as the greatest need and hence the primary objective of OCB's intervention. Other key identified needs included:** gaps in nutrition, critical infrastructure, and access to healthcare. Significantly, numerous KIs affirmed that on average the basic living standards in Equateur are lower than in the Kivus. These needs were understood to be structural or poverty-related, rather than crisis-related or humanitarian in nature. This tacit distinction helped clarify, for local populations and EVD intervention teams, that EVD response in #9 and #11 was the most urgent priority. This urgency was not shared by affected populations in #10.
2. In outbreak #10, there was agreement between many KIs and recent EVD literature that **the greatest need in North Kivu and Ituri was security.**¹² Long a focus of diverse humanitarian interventions and specific areas of crisis, KIs reported that **local communities consistently prioritised non-EVD humanitarian needs:** water, access to healthcare, and illnesses such as malaria and measles. Unfamiliar with the disease and suspicious of claims about it, local

¹⁰ "Rapport de capitalisation : expériences et 5 leçons tirées" Mission d'Urgence Ebola à Beni / RDC, Promotion de la Santé – 12 Novembre au 21 Décembre 2018 – Florence METRAILLER

¹¹ <https://onlinelibrary.wiley.com/doi/abs/10.1111/1467-7717.00225>

¹² See reports by [Congo Research Group](#) on Ebola in DRC.

populations did not perceive Ebola as a priority threat nor as deserving of resources as non-EVD needs.¹³

3. At the start of the #10 outbreak in August 2018, the overarching goal of OCB's intervention was to address Ebola (with a strategy of containing transmission). In the early stages, **OCB did not conduct a needs assessment**, nor engage with communities with the intention of gauging their needs. This prioritization of EVD mirrored that of major donors, MoH, and WHO, leaders of the official intervention strategy (*'la riposte'*). As with other specialised medical interventions (measles, Marburg, malaria, etc.), a singular, exclusive focus is common practice.
 4. EVD as the primary need in #11 was tackled with a **parallel approach to that of MOH** that aimed to reclaim synergies and healthy collaboration that was lost in #10.
- **EQ1.2: How did the needs of people change over time? How well did OCB adapt its response to these changes?**

Communication and understanding of EVD and its response mechanisms was registered as a critical need in all three interventions. OCB HP staff distinguish their two-way approach from the one-way methods of information dissemination that characterise all forms of public messaging in DRC regarding elections times and locations, vaccine campaigns, and any time-sensitive, public interest concern. EVD requires understanding and trust as conditions for cooperation with contact tracing, identifying suspected cases, and reporting to treatment facilities for testing. KIs were unanimous that in #10, this component of the official response was poorly adapted and therefore failed to gain public trust or cooperation. In #9 this was more successful as a community engagement component was built into the OCB response, and in #11 this was critical to success.

5. **Community engagement lags behind project set-up, recruitment, installation of structures— with negative consequences.** In #10, OCB paid attention to the geographic spread of the EVD outbreak, but lacked community engagement, systems or relationships in place to understand where gaps in the riposte left unmet needs. In particular, there was no programmatic anticipation of the degree to which these gaps resulted from MOH pulling staff from the provincial healthcare system, diverting resources and capacity from pre-existing humanitarian programmes in the region. For example, OCB epidemiological surveillance showed that a 2019 measles outbreak caused higher mortality in Beni and Bunia than did Ebola.
6. **In #10, the official response limited OCB space, but so did OCP.** Measures that might have enhanced OCB's assessment of needs in the region were hampered by the security and programmatic restrictions placed on operations by OCP (related to its management of the 2013 kidnapping of its staff). From the start of the outbreak, OCP sought to control access and movement of other OCs, based on this unresolved security incident. This caused friction with other OCs, which began to mirror the tensions between MSF and MoH/WHO, who were controlling the general response.

¹³ "In NK medical priorities and perceived needs of people were NOT Ebola, regardless of what agencies were doing to contain it. Security and violence were the biggest problems; no measles vaccination, maternal healthcare and pregnancy were big issues. And this made them very suspicious of anyone involved in the Ebola response: why all this money for Ebola when they suffer in greater ways. This mistrust determined every aspect of our engagement, resulting in burning our centre. Even if they believed that Ebola was real, they didn't agree with huge resources and the vertical response applied... hard to imagine a different way of working but we must envision a different way of working that responds to this mistrust and hostility." OCB KI

7. **More freedom to adapt and design its approach in #11.** In Equateur 2020 (#11) OCB assessments showed that the influx of funding and agencies provided sufficient response capacity in some zones (e.g., Mbandaka) but gaps in others (e.g., Bikoro, Bolomba). In this case OCB shifted its resources accordingly, investing in areas of greatest need and adapting its coverage and style of approach (decentralised, home-based care where feasible). Based on the resistance of MoH, OCB accelerated its decentralization and built trust without declaring that as its strategy. OCB proved its efficacy first before declaring its strategy and opposition to an ETC, because the authorities would have said no.
8. **In #10, KIs arrived to find hostile communities and no trust, but also no investment in HP outreach.** Many KIs stated that HP/CE was insufficiently prioritised in #9 and #10. This KI explains how it improved after greater focus from OCB staff. *"In my short time, my goal was to get us out into the community. We had a big HP team in place, but they were only working at the treatment centre, they hadn't been properly trained. In the rush to set up activities, no training goes on.¹⁴ So I had to assess the staff, determine their capacity. They were doing low quality work, or no work at all, just sitting around on payroll with no oversight – this was giving a bad impression to the community."* The KI started training them and they responded excellently, with clear explanations of roles and responsibilities, taking them from ETC and into communities. They needed a new orientation and new skills to deal with hostile communities, to de-escalate tensions and to appreciate biosecurity. *"But most neglected by the project had been basic communication with communities. Community dialog is not an information session, it must be two-way. MSF is typically bad at community dialogue, but this can often be person-dependent. But we saw where face to face dialog was needed and went and did this, even where it was dangerous and difficult."*
9. **Communication is essential regardless of context dynamics.** This KI explains how information needs differ per context, but the value of targeted information campaigns and dialog is indispensable. *"Biggest change of needs between #9 and #10 was in community information. #9 was a very rural context with a poorly educated population, who could see that EVD was the main threat; they were clearly afraid of it. Their other biggest need was food (no malnutrition, but we did not dig into other large needs). For us, communication was the main need to explain EVD to people and to dispel misinformation and disbelief. Our communications were not optimal—a big challenge for us, but this is always a problem in EVD outbreaks. In #10, communication with populations was the biggest need: Beni is wealthy, and people are highly educated, very politically minded. EVD wasn't perceived as their biggest problem, compared to politics and security."*
10. **Changing needs in #10: OCB able to adapt thanks to its surplus of resources and materials, giving a short-term boost that wasn't sustainable.** Material inputs and training without longer-term support can help in the moment but fade quickly. *"Ebola was raging at the beginning of #10, but once it seemed we had it under control, we saw that we were spending huge resources on EVD, while many other forms of morbidity were killing people. So we started treating other illnesses that came to us because we had all these medical resources... it was clear that OCB should have either left or done something else. When I went to Kaina 100km from Butembo, MSF was working in little centres de santé where Ebola was suspected but not confirmed, so we worked on other forms of*

¹⁴ "We routinely underestimate the volume of work that needs to be done at the start – training, building infrastructure, launching of all activities, and discharging the backlog of work that accumulated prior to our arrival (e.g. burial of the dead). **Rather than starting small and scaling up, Ebola requires the reverse, starting strong and then scaling back.** As our initial presence is often not scaled to do all that is needed, some things are inevitably neglected. Community engagement is a frequent victim." (OCB KI)

treatment and training. There were no health staff from MoH present (unpaid salaries), so I became the local doctor. Very narrow roles had been dictated by MoH, but we spent tons of money and resources on Kaina hospital, so this gave us some leverage. But after our departure it returned to its previous state."

11. **How did MSF build trust in the response and increase understanding of preventive action?** Size and scale of an outbreak directly determine the amount of work required to build trust and gain access. *"We could build trust in #9 because the geographic size of the outbreak was much smaller. By treating patients, we created ambassadors who went back to their villages—this generated trust in the EVD response, which in turn improved our contact tracing missions (on top of our intense communication campaigns). This dynamic didn't apply in #10 because numbers of deaths were higher and communities were hiding from the response ("if you go to ETC you will die"), so there was no way to build trust. [Consequently] the numbers coming to us were too low to create this same ambassador dynamic. Also, a fear of being seen as a traitor to the Nande community also meant no participation with the response."*
- **EQ 1.3: How did OCB apply key principles and ideals in the shaping of its intervention strategies, objectives, and approaches?**

Humanity

12. The principle of humanity guided OCB's three interventions in an abstract sense. The principle was not used to guide more specific areas of operational decision-making, such as the role of community participation in shaping or contributing to the response. See the Analysis section for further discussion.

Impartiality

13. In the three outbreaks, needs were considered but not within the framework of MSF principles (i.e., impartiality), and OCB never asked if non-EVD were a priority until after withdrawal/post-Katwa. Various KIs were concerned that OCB compromised impartiality by allowing the sensational health risk (EVD) to cloud its judgment of other competing, or even greater, needs.

Independence/Neutrality

14. Many OCB KIs from #10 believed that **OCB should have preserved its operational independence and neutrality by refusing to work under the official response system**. Other KIs see this sort of isolation as counterproductive, and that direct engagement with MoH will enable MSF to safeguard its operational space and independence. This tension on the level of principled and strategic engagement lies at the centre of defining OCB's future role and operability in DRC.
15. Despite all the resistance and criticism of MoH-led EVD response, mostly due to the loss of OCB autonomy, some KIs were able to see that **in principle government leadership is not only acceptable but desirable. Problems arise in how that leadership is conducted**, how it treats patients and affected communities, and in this regard KIs remain deeply critical of DRC national health institutions, despite close relations with individuals within those institutions. *"If MSF cannot distance itself from that apparatus, it will be seen as complicit. And in that case, we should leave."*

Do No Harm/Unintended Consequences

16. **Independence should not mean aversion to compromise.** Several MoH KIs and national staff raised concerns that OCB operations and policies have negative long-term consequences: (a) OCB does things to too high a standard (unrealistic), and the MoH is unable to take over and continue services at the same level. This has consequences for the quality of services and the reputation of the ministry; and (b) OCB's insistence on no-cost assistance at the point of care, which MoH officials and many donors (World Bank; USAID; Foreign, Commonwealth & Development Office or FCDO, primarily) dismiss as financially unsustainable.
17. **Transparent cost accounting is one basis for MoH negotiations** around shared responsibilities and OCB support. OCB systems are not designed to track the full measure of resources employed in an EVD outbreak. Yet not knowing the cost of interventions makes it impossible to estimate efficiency through a basic cost-benefit analysis and compare with other actors, particularly the MoH. Affordability should be the starting point for discussions around EVD partnership and MoH capacity development.

EQ2: How could OCB's interventions be more appropriate regarding context?

- EQ2.1: What (if any) objective(s) and expected results did OCB set to guide its interventions? Did these objectives or results shift over time? If so, how?

OCB's emergency responses to the three Ebola outbreaks were not formally structured as projects, with logframes, dedicated budgets, clear roles/responsibilities, or specific objectives. Besides the unspoken objective of saving lives, KIs spoke of 'informal' goals within the responses, such as investing in new staff, testing the usefulness of vaccines and novel treatments, or assessing the efficacy of a decentralised model.

1. **KIs agreed on a different level of impact between #9 and #10, and the causes.** There were *"[d]ifferent goals between #9 and #10. In #9 a few things changed but the overall goal of stopping EVD was the same till the end, we achieved that. We left when cases were nearly complete, we agreed with authorities. Goal of intervention was fulfilled, we could train people, manage ETC and handover in safety. External comms needed more support but cases were so low and could be handled by remaining MoH staff. In #10, goals were different because we had no commitment to stop the entire epidemic, we weren't naïve. Our goal was to reduce transmission and to bring our small contribution to the wider effort. But in that we failed because what had we achieved when we left? Not much. We built a centre, but when we left the quality of care there was poor. Community was not better informed about EVD transmission, cases were not lower. We did save a few lives while managing this centre. We made a big donation to the Treatment Centre of PPE so they could keep working. We left because we were threatened and afraid, fearing for our lives."*
2. Shifts in burial practices helped increase trust and build acceptance in #10 - Morgue design in Katwa was cited as a good example of lesson learned and best practice.¹⁵

¹⁵ "Everyone could view the bodies safely. Hundreds of people came for some deaths, our HP teams did crowd control. The viewing of bodies was necessary to confirm that no organs were harvested, it was very tense/volatile. Burials were outside the safe zone because families insisted on their own burial locations, and MSF had been accused of stealing bodies. After negotiating with a family, they allowed us to transfer the body with our vehicle to the cemetery. We helped the family do a safe burial in tense conditions: we felt we succeeded, it was a turning point for us. We thought: we can do this regularly; we were optimistic. But soon our clinic was attacked and burned, we ceased

- **EQ2.2: What approaches were taken during the three outbreaks? What alternative approaches existed?**

Response approaches in both #9 and #10 were dictated by the official strategy and structure, which involved a division of labour that was decreed by MoH, and not a product of joint reflection. OCB roles were initially limited to make room for other actors, all of whom were receiving funding via the MoH (except other OCBs). MoH KIs and others noted the desire for partners who would report directly to MoH chain of command, and contractual accountability is the best way to ensure this. Despite its vast experience and deep pockets, MSF independence may have been perceived as threatening to MoH officials, whose priority was a multi-actor operation under their complete control. Alternatives to the MoH response structure were limited in #9 and even more restrictive in #10, but by #11 PUC decision-makers on the ground were taking a more aggressive diplomatic stance, seeking to reclaim 'lost operational space'.

3. **In #9, OCB struggled to find a space in which to be more effective**, after being restricted to patient care, instead of all aspects of EVD response. KIs specifically criticised the fact that substantial changes by MoH to the architecture and capacities of Ebola response caught OCB by surprise, and no compromises or alternatives were agreed with MoH.
4. In #10, key strategic departures from #9 included the **partnership with OCP, testing the utilisation of vaccines and treatment options** in the ETC. OCB's overall goal was to reduce transmission, not to stop the epidemic. This more limited objective was taken in function of the high number of actors on the ground and the reduced operational role for MSF as imposed by the MoH.
5. **Stocktaking exercises and after-action reviews were discussed but never happened.** Both MoH and OCB KIs noted that shared difficulties in #9 led to plans for a joint reflection. This was postponed due to the immediate onset of #10 and has still not materialised. Even so, OCB continued its manner of engagement with government counterparts—ad hoc, person-dependent, and ineffective to meet OCB's operational needs. Multiple KIs believe the OCB approach to the MoH in #10 was purely reactive, lacked purpose and coherence, in part because MSF was disunited. For this they blame OCB leadership, not the MoH.
6. **In #10, doing treatment without community engagement condemned OCB to be labelled as pro-Kinshasa.** OCB's strategic focus on treatment in #10 led to HP objectives aimed at health and sanitation messaging but lacked two-way engagement that emphasised people as part of the response. KIs believe this lack of dialog contributed to poor public trust. For HP to be effective, it needs to be integrated with the operational response at the strategic level. Many KIs, especially HP staff, stated that Operational managers are inconsistent in their understanding and use of HP.
7. **In #11, as cases spread into rural areas, OCB switched to a decentralised and HP-based *approche zonale***, with care delivered in existing MoH health facilities at the communal level. Moving fast and reaching rural areas quickly was seen as critical to slowing transmission in the periphery, although overall cases were low. Two other strategic aspects led to positive results: (a) the pairing of an OCB HP with an Ebola-experienced medical staff (from OCB or MoH), then paired in direct support to a local nurse; and (b) negotiating space with the local MoH whereby OCB could do contact tracing and surveillance. The successes of this approach were reportedly shown to national MoH officials, who claimed to appreciate their differences and that these experiences would

operations and evacuated. We know the community did not burn the health centre. It was driven by local authorities opposed to the Kinshasa government, as were other attacks on other NGO facilities.”

influence MoH future response models. Importantly, some OCB KIs noted that had there been a higher caseload as in #10, the MoH would not likely have granted OCB such latitude.

8. **MSF sections decided against a single OC to lead the #10 response**, although OCP forbade access to areas where it was managing a kidnapping case. This resulted in competition and no common strategy to guide the intervention, public communications, or engagement with MoH. This 'dérapage' was seen by many KIs as the source of immense confusion and wasted energy in #10, in part because the tensions were viewed as HQ-driven.
9. **Working away from hotspots, OCB found limited success in #10.** Forced out of #10 due to attacks and its inability to negotiate space in the official response, OCB turned its attention to a modest intervention in Mabalako. While not directly operational in terms of EVD, its healthcare work in Mabalako prepared the community for Ebola in a non-threatening way. This raises the possibility of an intervention into non-EVD health needs which also brings an important benefit to the Ebola response. Other KIs saw HP and CE as nimbler in #10 and able to carve out innovative space away from the 'hotspots'.¹⁶
10. **In hindsight, many KIs saw how #10 could have gone very differently**, if OCB had pressured MoH/WHO from the very beginning to demand a different role in the response. To use a press release in the place of direct engagement with the MoH was inappropriate. *"#10 not at all a success, even though we had new tools – more actors, more vaccines, new treatments. From a data perspective, it was one of the worst outbreaks we handled... we failed to intervene effectively because we were too shy to go for high level discussion with riposte leadership (MoH, WHO). We didn't push this high-level relationship with the government, but just agreed with what they told us to do, a much-diminished role. And we had all these new tools but we didn't deploy them correctly – and data shows bad results in terms of mortality and impact."*¹⁷

Operational Approaches, HP, Community Engagement and Acceptance

11. **For EVD in armed conflict (#10), experience negotiating with armed groups is not enough.** OCB staff include numerous people with experience in meeting and negotiating with armed groups to improve access and acceptance, and this expertise was deployed in #10. No one viewed this as having a direct impact on OCB performance in #10, however, as so many other causal factors were at play.¹⁸ *"We weren't used to this situation, which required political savvy not medical technical expertise."*
12. **The strategic value and aims of HP/CE are not shared by operational decision-makers in OCB**, per some KIs. Major questions remain: Is HP a component of the medical strategy, or of security management, or to increase local acceptance? Is it foundational to EVD response or is it optional, circumstantial? Is it primarily about OCB transparency and public messaging or is its aim to

¹⁶ "In 10 we worked around hot spots with primary care across the EVD zone, a tactical choice we made, which was good. When everyone is in the hotspot, it's better to be on the periphery. Whoever arrives first in a place has decision-making power. Otherwise, you take orders. Better for us to stake out the periphery first so we can control that space ourselves instead of fighting for access with lots of other actors. In #11, we took space in every pillar, but there were fewer actors, less resources, and a more accepting MOH."

¹⁷ "We lost a certain leadership role that MSF historically had, by accepting the situation and did not engage in discussion with high level authorities. In West Africa we met the Prime Minister, the Presidents of the three countries – in #10, we barely had meetings with MCZ and DSP. Didn't express our concerns at the right level, that is our fault. Instead, we just did a press release condemning the situation. We should have exploited the change of national government to push for a change in riposte at the time. We know these people, they know us, we should have pursued them instead of going for a press release – a childish and late reaction."

¹⁸ In #10, "We have examples of working with Mai Mai to reach villages for vaccination – you ensure our security and we vaccinate your people. This worked very smoothly – they wanted vaccines, no interest in harming us. It's possible to do this, we saw it. So the security issue was used by authorities to control the more vertical response, which of course later backfired horribly. Our work in communities was very different from MOH."

empower communities and the sick? OCB's answers to these questions do not seem definitive to many OCB KIs, creating questions about leadership, and frustrations at the perceived resistance of the EVD 'old guard' to new, effective (non-medical) approaches.¹⁹

13. At the top of OCB's structure and among those who worked at community level, there was an appreciation that **operational strategies depended upon personal relationships** – to officials and to communities – that in turn were dependent upon the posturing of OCB staff, a posture where humility and low-tech approaches were seen as the most successful. As one HP noted, the community looked at all our resources, and inquired as to why we had not come to their needs earlier: *"It was hard to admit [to them], but we had been wrong."*
14. **Pros and cons of ETCs.** ETCs were heavily criticised by many KIs, because they became synonymous with a vertical, centralised MoH approach. But others could recognise that *"There is a place and time for ETCs, same as the decentralised approach."*²⁰ *Cannot throw one out. High caseload, fast transmission rates – a transit centre or ETC can be the best way. But if you start at the beginning of an outbreak and you get in front of it, you can build a community approach. But it takes weeks to set up."*

Decentralised Approach in Equateur Province 2020

The following points focus on the pros, cons and trade-offs of successful decentralisation in #11.

15. **The decentralised approach in #11 was not new and might have been feasible in #10 if not for OCP's movement-related restrictions.** The approach was often presented in opposition to the centralised, vertical approach, and use of 'decentralised' seems to be clearer among OCB's EVD experts than among other OCB staff (e.g., who also refer to OCP's later approach in #10 as being decentralised).²¹ The more nuanced use of the term suggests a spectrum, rather than a dichotomy. For example, there are trade-offs between benefits and risks/disadvantages in how much treatment is decentralised. Decentralisation thus needs to be approached through a context-specific, adaptive lens rather than a standardised, formulaic application.
16. **Heavy training investment required--local knowledge cannot be assumed.** A core component of the decentralised approach in #11 required a steep learning curve by local MoH staff, who had low level qualifications. Central MoH and some OCB KIs expressed concern over the risks, of contamination due to poor adherence to IPC/protection protocols. KIs from the local MoH seemed to hold a more positive view of local empowerment and remarked on the degree to which knowledge learned from OCB in #11 (especially IPC) helped them safely deal with Covid-19. Staff who worked in the communities saw numerous advantages in terms of normalizing treatment of EVD, reducing stigma, and avoiding the risks associated with travel to far off ETCs.
17. **Resource intensity of a decentralised approach makes it less feasible for MoH.** KIs from WHO, the World Bank, OCHA, ALIMA, and ECHO all agreed that a decentralised approach can be useful in the right circumstances. But they share the concerns of the MoH: the safety of local staff and

¹⁹ Where HP was deprioritised by an intervention (i.e., initially in #10), the evaluators were unable to determine if this omission was part of a defined overall strategy with specific priorities that excluded HP for tactical reasons. This suggests the decision to use HP is circumstantial or reactive at best.

²⁰ "Overall, decentralization is only a good idea if it is necessary to attract the patients to a healthcare setting. Our failure to reliably make the central ETU sufficiently attractive is what has driven the decentralization discussion. We would prefer to have a "centre of EVD excellence" shining on a hill and drawing the sick from their homes all across the land. We are not there yet, and maybe we never shall be, and so decentralization will always be a consideration. How far we may go with it remains to be seen but will be very dependent on contextual variables."

²¹ The authors note the current prominence of 'decentralization' in terms of Movement's geographic and hierarchical structure, distribution of resources, and distribution of decision-making authority.

patients who may not respect strict preventive measures around transmission, the difficulty in 'policing' the coming/going of family members, the poor prospects of patient transfers when severely ill. The decentralised approach is also resource intensive, in contrast to the ETC with its centralised concentration of scarce resources. This raises the issue of sustainability (or realistic affordability) for an actor such as MoH that should not be discounted by MSF, who can afford to push for immediate results regardless of cost.

18. **Some KIs simply reject any attempt at large-scale EVD response. A bigger response, they believe, means less proximity to populations and greater chance of failure.** *"Best way to do it is small, in the communities, like back in the 1970s. Not with massive transit centres that they forced us to build, no one trusts these or wants to come to these structures. In #10, the French [OCP] saw this first. We wanted to reject transit centres and return to communities. OCP decentralised the care the quickest. And confirm patients there, this is how we will gain acceptance. That was opposed very hard by MoH. Small and simple isn't profitable, but they saw that it works. In 11, this is exactly what happened – care was decentralised, and it worked."*
19. **What did fast-moving, flexible decentralization look like in #11, in practice?** Outbreak #11 presented a scattered geography of cases, and OCB saw an opportunity to invest early in a localised, often home-based approach to case management. *"In Bikoro, we did outreach going to villages with positive cases helping them set up local isolation units to isolate positive cases faster, because transport to Bikoro was slow and ambulances were not available. We trained local staff in Bikoro, worked with MoH and WHO on how to react, directing the common strategy. In Bikoro hospital another NGO was running the ETC after taking it over from us [evidence of evolution and adaptation]. We mostly worked on public messaging where high-risk communities were or where positive cases had been identified. Training on how to deal with suspected cases arriving. We put 6 local isolation centres in place. 3-4 had patients, but not all had positive cases within them. They were supported by the local population, and we gave lots of medical supplies to local clinics, which the public and medical personnel appreciated greatly – without this input there would be no motivation to come to the local healthcare facility (i.e., nothing there to treat me if I have symptoms). So, this supported local acceptance by the population and encouraged them to be honest with us about their exposure to positive patients. In the end contact tracing was the responsibility of WHO – we had lots of operational space and good acceptance, so we shared our findings with them, even though their approach was totally different than ours (ours was localised, low key, and low visibility vs. their big convoys, loudspeaker info campaigns, etc.)"*
20. **Pros and cons of ETCs vs decentralised can change during an outbreak--flexibility is key.** A decentralised approach requires a high number of well-trained staff who can work autonomously and unsupervised in villages. But in ETCs *"it's easier to have non experienced staff who can fit into a labour centre and be trained while working. We set up huge ETCs with 70 beds, in Bolomba we built a 40 bed ETC.²² Medical staff must come from somewhere, so we took from the local health system and trained them. This created a breakdown in the local health system. So, [we] closed Bolomba ETC and replaced it with a wider net of local small structures (6-8 beds), then the decentralised isolation points are run through local clinics that do not drain local health systems."*

²² An opposing view of these pros and cons: "[In 11,] I saw that 40% did not belong in our ETC. We were putting people in a high-risk contamination zone, not getting the care they needed because they were sick with something else. I was shocked at the poor quality of Bolomba ETC. We were lucky it didn't become a super spreader place, because it was run by people with no EVD experience, and poor management by those teams. It was hard to find HR because of Covid-19, and the intervention was kept within PUC with no external support in order to prove that PUC could handle everything without EPool."

- **EQ2.3: How were the decisions to intervene (or not) taken? How were the various intervention strategies decided upon? How responsive were these strategies to the positions of various stakeholders?**

There was no apparent decision process in responding to suspected EVD in #9, #10 and #11. The overall strategy appears to have been: *“We will do what we have always done in DRC EVD; our results are proven and effective.”* Interventions were initiated following the ‘urgentiste’ reflex that OCB has spent decades practicing and perfecting, specifically regarding suspected EVD within the DRC context. The constraints and opportunities of the new response architecture and scope of MoH authority were not declared or revealed in advance. OCB encountered these new realities as it was deploying (via PUC, or EPool) to the reported outbreak areas for #9, #10 and #11. Tactics to shape and define the approach in each intervention arose in reaction to the institutional dynamics and relationships that OCB teams found on the ground in Mbandaka, Goma, and Beni. Strikingly, KIs noted that there was never any moment where OCB stopped to ask, collectively and deliberately, was the exclusive focus on EVD (or even OCB presence) justified, as the three response structures took shape on the ground. Individual discussions were frequent at all levels, but collectively no such reflection took place.

21. **The MSF reflex is to be first on the ground:** this is the public image and personal ethos of the movement. *“We decide which emergency needs warrant our resources – EVD in #10 clearly showed that we are not demand driven. The needs voiced by affected populations or the MoH do not determine our actions. Yet from 9 to 10 to 11, there was never a pause to ask: should we do this, are we even needed?”*
22. **Clear questions around MSF’s value-add in EVD going forward, that MSF is not discussing.** Veteran KIs recalled MSF advocacy in West Africa as foretelling the exact EVD response architecture of #9, #10 and #11 that MSF so disliked (vertical, MoH-led). When will OCB reckon with this new reality? *“Our advocacy after West Africa was successful, and the resulting loss of space means we are victims of our success – so many more actors now, with resources and readiness. Maybe we decide not to respond to Ebola at all. I can live with that. But we still avoid making this decision – rushing off to Marburg, we’re on the plane, etc. We need to push these realities into an uncomfortable place so that EVD experts will discuss the fact of our questionable value-add in future EVD outbreaks.”*
23. **Friction between mission, EPOOL, PUC – no single chain of command.** KIs all acknowledge the messiness of internal arrangements when EVD strikes. Some would like to see a prior agreement on sequencing and modalities of support, others are dismissive. *“EPool takes over management of response, upsets mission – this always happens. It’s collateral damage, I wouldn’t challenge that model. It is the fastest way to respond, too bad for those who get in the way. Because PUC is independent in DRC and not integrated into EPool, this leads to unnecessary tensions. PUC has created its own autonomy and sees EPool as invading its remit and turf. But PUC is basically a specialised measles response unit; this is 90% of their expertise.”*
24. **Non-transparency between OCs on financial, human, and material resources available for a response.** Hard to have a pre-set agreement on roles among OCs when resources can differ dramatically. In #11, *“Idea at first was OCB and OCP to work together, was a good marriage, but no agreement around philosophy of intervention or strategy. OCP goes into research, vaccination and OCB into community approach and case management. How to put resources in equitably to have clear division of labour? OCP had no human or material resources, but insisted they have a*

say in ops. Not clarified in advance, so their team was left alone with no capacity. Fault of Paris HQ. From OCB's side, we decided PUC would manage and that EPool from OCB would not lead the intervention."

- **EQ2.4: Were the interventions adapted to the contextual specificities in each of the outbreaks? Did they adopt to changes in context in a timely fashion?**

OCB reacted in various ways to the obstacles it perceived in the MoH-led response structure in the three outbreaks. Given its smaller size and fewer resources, there were fewer actors in #9 and MoH was able to impose its will effectively. EVD response actors, among them OCB and other OCs, were not happy with the vertical decision-making and the loss of autonomy, but they accepted it while pushing back on specific MoH decisions that were perceived as misguided or dangerous.²³ OCB never endorsed the government practice of enlisting security and defence forces (FARDC, PNC) to monitor public behaviour and search for suspect cases, but it did accept these practices as long as OCB remained a party to the official response effort. Later in #10, some KIs described innovative efforts to increase the reach of their community engagement and to build bridges where there had been only distrust and hostility before. Relations with MoH in #11 were handled diplomatically with the aim of restoring OCB operational autonomy; this was successful if initially tacit and inexplicit. The successes of OCB's HP approaches were shared with MoH officials after their positive impact was demonstrated and could be replicated.

EQ3: How effective were the OCB interventions?

- **EQ 3.1: What were the results achieved, and to what extent did they correspond to the objectives of the interventions?**

Interventions #9 and #11 were both contained in under six months, with OCB participating from start to near finish, leaving only when OCB was confident of no new cases (but before the official 42-day delay had lapsed). In both outbreaks OCB supported local healthcare facilities with equipment and staff training. As part of the MoH response structure, OCB hired local staff from the MoH and paid them promptly, unlike other response agencies who waited in frustration for the long-delayed MoH payroll to appear. In sum, the aim of the #9 and #11 interventions was to control transmission and end EVD, and in this OCB and its partners were successful. That view seems to be widely shared by other actors, per our research.

Intervention #10 was a very different experience, with OCB withdrawing after three months (and later coming back with a specific approach in Mabalako) in an outbreak that would last 18 months. Case fatality rates were reportedly higher than West Africa, despite the availability of vaccines and new experimental but effective treatments.²⁴ The aim of the mission was reduced, in function of OCB's more limited role, as decreed by MoH/WHO direction. Although OCB can be said to have contributed to patient care in its ETC and treatment facilities, this limited goal with its limited success does not

²³ KIs recalled MOH policies in Mbandaka such as 'ratissage' where FARDC searched residential quarters, supposedly for rats but in reality looking for unreported symptomatic cases. "We had to push back and stop it, but only as a united front: impossible if MOH has divided us."

²⁴ "Now, we have an effective treatment and vaccines that can prevent infection, yet case fatality rates have not declined in the most recent outbreaks. No matter how skilled our clinicians are or how advanced our treatments become, outbreaks are not stopped by the work happening in treatment centres. Epidemics begin and end in the community." <https://www.alnap.org/blogs/epidemics-begin-and-end-in-the-community>

translate into an effective intervention. Yet the official narrative of MoH, WHO, and many donors, is that #10 was a success, in that case fatality was considered low (compared, say, to West Africa) and the virus did not spread across international borders or infect critical urban centres. However, [independent researchers](#)²⁵ have since consistently argued that (a) the official response structure of #10 aggravated and intensified ongoing conflict in affected regions, and (b) the official response failed because it remained external to more trusted local health providers, in effect perpetuating Congo's systemic problem of parallel health systems.

1. In the big picture, **the first intervention in Equateur (#9) did not run smoothly**, as OCB struggled to fit into the structures and system of the official response led by MoH-WHO. Nonetheless, OCB contributed significantly to a response that ultimately ended within three months of being declared, and with only 17 confirmed deaths.
2. **The majority of OCB KIs see its #10 outbreak response as a failure** and remain frustrated by this. This frustration is of similar intensity as the West Africa outbreak, with one key difference. In West Africa, OCB responders often felt powerless against an overwhelming virus. In #10, OCB responders felt powerless against an overwhelming coordination structure that limited OCB's capacity to intervene. Frustration and blame were directed externally, towards MoH, WHO, World Bank, and internally at OCP and OCB decision-makers.
3. **Case fatality rates in #10 in OCB structures were deemed high. This was interpreted as poor performance** given the lessons of West Africa, availability of vaccinations, improved treatments and other therapeutic advances, as well as OCB success in #9. Ultimately a **true fatality rate was elusive** because many people did not present in the ETCs, with a majority arriving only in late stages.²⁶ On top of this, OCB treatment facilities were attacked in several locations, upon which the organisation withdrew.
4. **In outbreak #11, the early 'importation' of the same approach in #9 and #10 was seen as ineffective**, and inside OCB this prompted a shift towards a decentralised case management approach that worked in conjunction with a more two-way community engagement.
5. Within OCB, the **relations between the Mission, PUC and the EPool complicated performance** and formed a major preoccupation for leadership.
6. **What was most effective in #11?** Non-medical KIs generally held this view of HP and CE, particularly for #11. *"Decentralised approach – very important to stay in the community and to build isolation centres there, educate the community by being as transparent as possible. We gained trust this way – without trust, people will not come or tell you they have symptoms; same is true for Lassa. Need to take time to explain all this, because people are in great distress especially where mortality is moving. If #10 happened again, the #11 approach would have to at least be tried, attempted, but no guarantee that it would work."*
7. **In what ways was there loss of effectiveness, and why?** Ineffectiveness is generally attributed to outside forces, primarily MoH policies and restrictions, against which MSF is seen to have no persuasive response.²⁷ The various drivers and interests behind this shift towards scientific and technical control were not within the scope of this evaluation, and no KIs had specific insider

²⁵ <https://www.congoresearchgroup.org>

²⁶ "In Guinea between 2014 and 2016, for example, the case fatality rate was 66.7%, while in the tenth and current outbreak in the Democratic Republic of Congo (DRC) the fatality rate was 65.9%." <http://apps.who.int/Ebola/Ebola-situation-reports>

²⁷ In #10, inter-OC infighting was deemed by some as 'primarily responsible' for the poor performance of OCB, and as imposing significant costs in terms of time, especially the time of leadership.

knowledge of these dynamics. *"In #11, case management was contested by MoH, which is normally the province of MSF. Monoclonal antibodies were promoted without scientific approval by WHO and MoH, and OCB pushed back. [...]. We also lost control of the lab and the INRB took over, refusing to share medical operations in MBKA in 2020. They controlled clinical data, whereas before we controlled that. Lost our medical response effectiveness because we lost control over lab and research data treatment efficacy. Lack of cooperation with INRB and MoH. We will never get this back, until we have MOU with MoH so that we can use rapid tests for clinical use in the field. They are paranoid about the chain of command for knowing daily numbers of cases: the minister needs to know before clinicians in the field. Hence their control of labs. Political and economic power is at stake, but OCB does not use its leverage there."*

8. **Burnout and loss of faith are undeclared problems**, according to some KIs. *"If we want to go back to this type of context, we cannot afford constant fights between OCs – it's literally killing people, staff and patients. I said, 'never again' after that one – 'I will never do EVD in DRC again'."* Also: *"We train people, they get experience, then they say never again. This is a problem. If there was a survey, I am certain most would say 'never again EVD, never again DRC'."*
- **EQ 3.2: What challenges and risks were encountered (expected or unexpected)? How did OCB address them?**
9. In #11, one significant barrier to effective management of suspect cases was related to the **dependence on INRB laboratory testing**, which at certain points caused significant delays. Losing control over this aspect of clinical management is one example among many given by OCB KIs to show OCB's overall loss of operational space, without which it is impossible to ensure an effective intervention.
10. In #11, the **shift to decentralised points of care in remote areas** posed contextual challenges to logistical supply, and there is considerable praise for the way teams overcame such obstacles. One specific internal challenge resulted from MSF's kit system, designed in EVD outbreaks to supply large amounts to a central location, and from the poor suitability of some equipment to a region where pirogues and motorcycles offered the primary transportation.
11. **The challenge of a higher authority with whom OCB and OCs disagreed**, but failing to create a united front to address MoH's unacceptable policies and practices in #10 - *"Specific red lines? We couldn't decide who we could admit or not. We had to admit cases with no clear EVD symptoms. We had to take the staff that they sent us. We closed Mangina and handed it over to IMC. Wanted to open in Beni, and to use our Mangina staff, and MoH refused. They wanted us to hire their people, we had no say. We had no control over our own staff. Many other examples of this kind of problem. MoH were in our Mangina structure administering mAb114 without our acceptance or knowledge. We were outraged but we never left. These decisions to stay were made at BXL in Epool/cell. Why? OCB's biggest country is DRC. Too many consequences if we withdrew, it could affect the rest of our programs. Would we be able to do Ebola later if we left now? These were probably their pressures, but I don't know for sure."*
12. **Challenge of hiring staff provided by MOH, payment issues, training burdens, and how OCB adapted**. KIs raised hiring obligations as an example of the unwanted complexity and constant frustration of working under MoH Kinshasa. *"In Bikoro we couldn't hire our own people and got names from MoH, they were paid through MoH, pay scale was MoH based. Not so much tension around this as our own MSF staff were from PUC, and our other staff were from MoH with*

predefined salaries on government scale. All other NGOs and WHO had to wait for these workers to be paid, so their staff were unhappy and unmotivated. We chose to pay everyone on time, so we paid these staff ourselves, also to avoid us leaving at the end of the outbreak with unpaid staff. This would ensure that if we returned we would have good relations with potential staff. MoH wanted NGOs to pay them, then MoH would pay staff. We sought an exception because we knew our money would get lost in the system and our staff wouldn't get paid. We had this problem in 10, and wanted to avoid it in 11, even if it cost us extra money. MoH in Mbandaka was happy with us so they let us do this."

13. **Hiring local MoH staff meant entering a kickback scheme, but there were no alternatives.** This was seen as another compromise MSF had to make to 'get along' with MoH Kinshasa, but which created new headaches to manage and tarnished MSF's reputation. *"MSF accepted the staff contracted by MoH, but no one checked if they were experienced or where they had come from. We suspected it was a job creation racket for friends and family who paid kickbacks in order to be hired – 'retrocommission', 'operation retour', etc."*²⁸ All MoH partners were part of this scheme. This was a smaller ethical dilemma that formed part of a much larger debate over everything that was "clearly unacceptable": where do we draw the line, do we stay, what is important to us?²⁹
14. **Militarization of #10 response; marrying riposte to security concerns.** All KIs expressed opposition to MSF accepting the presence of military forces in treatment facilities. *"When did we start militarizing response? For MoH and WHO in late 2018, North Kivu was a Mai Mai hotspot with no access – so they went in with [Forces Armées de la République Démocratique du Congo] (FARDC). MSF left the response drifting into military hands more and more, to a point where the FARDC had a guardpost next to the centre, effectively making the humanitarian and military operations indistinguishable. This problem could have been resolved earlier on with agreement with MoH – we need to agree on the threshold of our engagement amongst ourselves before doing technical discussion with MoH/authorities."* In future scenarios, many OCB KIs asserted, MSF should agree on a common approach to such externalities, and then seek agreement with MoH on MSF's role and position relative to that of national health authorities when they align with security forces.
15. **"Everyone underestimated the compromises and consequences of working under MoH in #10"** – North Kivu has long suffered from violent conflict, and for some KIs gaining the public's trust was not a realistic goal under the circumstances. *"From the minute we joined the official response, MSF principles were not respected, especially neutrality and impartiality. We could not choose our own staff. We were told who to hire for most positions, with lists coming from MoH on who we would recruit for specific posts. These were outsiders and not known or trusted by local populations, who saw foreigners and Congolese outsiders arriving in waves, none of which helped instil confidence or trust. So, they were hostile. And this was met with violence by state security forces. The Army tried to force people to stay in treatment centres, contrary to MSF principles and approach. This militarization was the face, the front end, of the entire Riposte. We were restricted to doing only medical services and not allowed to do community aspects – especially community engagement approach and community outreach in general – this pillar we weren't allowed to do."*

²⁸ See Congo Research Group's [report](#) on 'Ebola Business'.

²⁹ "That we allowed forced admissions to take place -- so unacceptable! All our attention to a specific disease that is not a primary concern for the population, and which detracts from major everyday killers – malaria, measles, absence of health care system, violence."

So we concentrated our work around our centres. For the most part, we were also not distinguished as MSF, we were just one actor among others, not understood as MSF, as neutral and impartial. Our position towards communities was not the position that I know. I understood these decisions to be imposed by MoH, not by MSF."

- **EQ 3.3: What were unintended effects of the approach chosen in each outbreak?**
16. **Response strategy in #10 was imposed by MoH, with distinct consequences.** Divisions between OCB coordination and field staff created competing interpretations of where the intervention was going. Some KIs could see violence coming, others chose not to see. *"We all knew things were bad and that we needed to change our strategy, specifically to get away from ETCs and into the communities. But no one inside of OCB's coordination team listened to us. The medical staff in the centre did a great job but had no idea of the external environment, they did not listen to HP staff who saw all the negativity building. I am sure the community knew what was going on before the attack; I could feel a very different vibe in my interactions. Even the way people looked at me the morning of the attack as I was going to the centre--they looked at me like they knew something had changed, I noticed it distinctly and remember it clearly. I didn't fully realise what it meant until after the attack. Then I knew it was not just some random Mai Mai violence but that planning and execution was from inside local leadership and the community, not from outside."*
 17. **Loss of space under MOH meant huge sacrifices, but in #11 there were small victories.** OCB KIs that described the successes of #11 generally framed this as MSF reclaiming its old way of working, based on the negative experiences of #10. Some KIs, like this one, could see that collaboration with MoH was possible, but on MSF's terms. *"The biggest [small victory] was the space that we had, and that we managed to keep. At first, it seemed impossible because they wanted to control everything we did. But later they let us do much more than were first allowed."* What made MoH become more generous towards MSF? Was it personal relationships, or that MSF was not perceived to threaten their business? *"At field level in Bikoro/Bolomba, the national staff who was responsible for the intervention (small fieldco) was Congolese (from PUC). This helped with MoH relations, and over time they saw that our approach was more efficient, that we were accepted by the community where they were not. They said openly, your approach is better. At first, they were openly against us. Later we were negotiating access for them. They saw that big convoys create hostility. They could still do their business better this way..."*
 18. **Primary Health Care (PHC) needs and how to address these alongside EVD priorities.** Many KIs see EVD response in rural DRC as requiring a wider PHC strategy, with adequate resources and planning. *"In #10 we had long debates about increasing PHC between [Operational Centre Geneva] (OCG) and OCB, but no steps were taken. In #11, we did this with the surrounding aire de santé. We donated PHC kits to ensure continuity of PHC. We supported at least 10 structures in the wider EVD suspect area. The negative impact of EVD on the HC system in North Kivu was much greater than in EQ. But in both cases, many more people were dying from other causes than EVD, so we tried to direct our support to PHC and to do advocacy with donors who had huge sums for EVD but little for PHC. We tried to influence those donors, specifically USAID. Late detection is the biggest problem in Congo in EVD outbreaks – so it's better to invest in communications using simple HF radios and antennas, which improves detection for EVD but also for measles. We also advocated for free [healthcare] during all EVD outbreaks. Donors say it leads to overconsumption of [healthcare], but this is good during EVD, we argued."*

19. **Despite the challenges of conflict and widespread scepticism, contact tracing was tried and successful in #10.** Occasional examples of success in #10 were offered by KIs, such as this: *“OCG said to us, this is not going well. I said we need to place people in communities to contact us when someone has symptoms. OCG said, impossible. But then they gave [this KI] a budget for 1000 community health workers (relais communautaires), and staff went from 20 to 826 in two months. The Recos called us when problems were noted. They also helped reintegrate survivors back into their communities post treatment. They helped with contact tracing and built an information network where new villages were infected. EVD orphans were reunited with their biological families instead of going to orphanages. This powerful network was built in a short period and was expanded by the HP who followed me. It was fully integrated into existing channels used by communities and linking these to our emergency response structures.”*

- **EQ 3.4: How were the main areas of OCB's interventions managed, and by whom?**

20. **No time for evaluations or After-Action Reviews between outbreaks.** Numerous OCB KIs in senior positions (as well as a MoH KI) lamented that the onset of #10 just as #9 was ending spoiled MoH-MSF plans for an after-action review of the #9 response. Various OCB KIs also complained that there has still been no evaluation or internal review, and that focus of this evaluation, like those being conducted by other OCs, focuses on OCB only, and does not consider MSF holistically. This Evaluation finds:

- Despite the overlap of #9 and #10, assessment in real time remained a possibility, or immediately following the intervention (as with #11 AAR);
- The failure to self-assess reflects a wider perception of senior management as preoccupied with day-to-day decision-making, reactive tactics without forward-looking vision, and providing insufficient leadership for field teams in crisis.

21. **Inconsistent policies and behaviour by different OCs toward MoH, or questions of approach, stem from the lack of shared, coherent vision.** KIs consistently described how decision-making fell to individuals in charge, particularly at the level of managing the response in the field. The delegation of operational responsibility to the field allowed for flexibility in the response, and to adapt to local challenges. Yet this same flexibility extended to key components of response management, such as the engagement with the MoH, or the role of HP in a response (i.e., one OC coordinator could decide to avoid the MoH in the name of independence, then weeks later another OC calls for greater partnership). These strategic orientations of the response should not vary according to individual interpretations of MSF's principles or OCB's strategic orientation--provided these are clearly defined and well understood by all. Consequences included a lack of clear internal agreement on key programme components, and externally in the perception of MSF as inconsistent or unreliable.³⁰

³⁰ “The field should not be left alone to make big decisions. At least we should avoid conflict between OCs. Before we go, identify a set-up that allows one single coordination and decision-making structure and one representative face to other partners. Need a coherent system internally before we go – we are accused of killing people, we are threatened – our staff needs to know that behind them is a strong system of support.”

EQ4: Were the OCB interventions efficient?

- EQ4.1: In what ways did the use of resources stand out as highly efficient or inefficient?

Efficiency here is understood in terms of resources, human and financial. Did MSF leverage *all* of its available resources, including other OCs, or its access to certain senior MoH officials? No, for various reasons, but primarily due to the political complexity of MoH relations and with other OCs. There are many trade-offs between efficiency and efficacy in EVD response that OCB KIs are not ready to make.

1. **Subordination to national health authorities requires coordination which consumes valuable time.** The difficult engagement with MoH exerted heavy time/resource cost on the mission and response coordinators, and distracted from field management, medical service delivery, and time on the ground with communities. Daily MoH coordination meetings in #10, for instance, lasted a minimum of two hours - time away from managing staff and operations.
2. **EVD effectiveness in rural Equateur is high cost.** The low profile, community-based, decentralised model employed in #11 is expensive. Such an approach is thus available to few actors and (at this time) an unrealistic model for MoH to use in future responses. Most KIs prefer quality over quantity – bigger teams mean more moving parts and quality is sacrificed. Although less efficient and more labour intensive, “when we invest in every single case, we know we can cut the train of transmission.” Breaking the chain of transmission is time consuming and adds cost to EVD response, but could it be done with less cost?
3. **In terms of value for money, OCB KIs preferred effectiveness over cost efficiency, or ‘quality over quantity’.** Ebola budgets were essentially unlimited. Some KIs questioned this surplus of resources. In #10, the cost-benefit equation raised significant concerns due to perceptions of excess, because OCB's huge investments generated few results. This perception of excess is to some degree unwarranted, however, because excess capacity and resources was always part of the calculation in Ebola response to avoid the risks of insufficient capacity.
 - In the past, with exclusive control over pillars and the entire zone of response, OCB's EVD interventions had greater impact than in #9, #10, or #11. OCB's comparative advantage over other actors meant that in assessing efficiency, the effectiveness side of the equation (lives saved, chains of transmission halted, etc.) outweighed the vast expenses. That overall effectiveness was less in #9, #10, and #11 due to the smaller role of OCB.
 - However, if OCB plays a limited role in an outbreak that is quickly contained with limited mortality (as in #11), this is an inestimable net gain for Congolese health authorities—success to which MSF contributed and of which it should be proud.
 - KIs raised several inefficiencies that result from inadequate HR and supply management, specifically the failure to consolidate resources and HR across OCs and a combined MSF presence that seemed “hugely disproportionate” to scale of medical needs in #10; or time-consuming at the mission level of internal arrangements such as EPool-PUC-Mission relations.
4. **How can PUC and EPool best work together?** In #11, *“Kinshasa mission was in charge, but HPs were inexperienced national staff from PUC – this was very tricky. We pushed for EPool to take over, then things improved. This was rough for [PUC lead] but we needed expats to come to the field to train staff and make things move. Struggles between Kinshasa mission and HQ, but we worked closely with PUC. I would send EPool in first, then hand over later to PUC or to mission. More knowledge in EPool: faster, more effective.”* This relationship is currently under discussion.

- EQ 4.2: Did OCB address questions of opportunity cost in the three interventions? If so, how?

Within the first two outbreak responses, two main areas of missed opportunity with critical consequences are the failure to stand as one MSF, particularly in #10, and a failure to invest heavily in HP from the start of each outbreak. This error was most costly in #10. In #11, lessons were clearly learned, obstacles were fewer, and OCB deployed HP strategies and staff very effectively. Additionally, per Findings related to relevance, questions emerge on the cost of not addressing non-EVD health needs. Finally, this evaluation cannot assess whether the substantial investment of resources in responding to DRC Ebola might have been more productive elsewhere in the world.

5. **Missed opportunity to stand as one MSF in #10.** Failure to reach and sustain collaboration between sections weakened each individual OC's ability to operate. This was particularly true, for many KIs, in the duplication of human resources, supply stocks and procurement procedures: *"Supply and procurement we should have done together in bulk, and shared human resources, but we couldn't get agreement on this. We could have been much more coordinated with a common approach. In my second mission – OCP integrated, we kept a vertical approach, creating confusion and we lost effectiveness. Worst was our decision to leave when the epidemic was still going on. I agreed with the decision, but we didn't use this departure to send a message to MoH or to WHO internationally, but we left silently because OCP and OCA were remaining. We couldn't say, 'MSF is leaving', it was only one section. This could be an advocacy tool, but it had no effect because it wasn't shared by all sections."*
6. **Failure to share resources in #10:** Details on the absence of a combined, coordinated efforts across MSF were offered by different KIs: *"OC coordination was hard--we proposed one pharma management system, but couldn't work because we have different supply systems and tools between sections. Lending medicines and HR between sections was impossible because of our incompatible systems. We couldn't hire staff from other OCs with EVD experience. We still managed to do what we had to do. Some complications were purely technical (different supply systems that don't match, so we can't track our stocks if we give them to you...). But also cases of OCB hiring nurses and sending them to our [OCG] project. Was it ego and competition between OCs? Rigidity of procedures in HR, medical stock management? The blockage was much more from the OCG side, I would say, not with OCB."*
7. **Failure to invest heavily in HP from the start, and resistance to it from medical staff, were missed opportunities. This improved by #11.** Veteran KIs offered a historical perspective on how important HP can be to EVD outcomes: *"The misconception of HP among coordination is that community engagement takes too much time and is more linked to development than emergency response. These participatory approaches are dismissed by EMcos, and EPOOL. From Foya, we saw how a very resistant community who attacked us later became super collaborative and supportive through HP and comm engagement. Shows if you miss early steps of capturing trust and shaping public narrative, you cannot catch that train, it has left and from then you will be doing only damage control. Community engagement can be translated into SOPs and very concrete activities with specific outcomes... but this isn't known or appreciated by EMcos. Community is not their comfort zone; it is the medical apparatus. This prioritization was not present in 9, 10, but yes in 11. We also did contact tracing much better there in 11, better than WHO, part of dialog with*

communities, but we had more time available, and it was prioritised, which is key. No commitment or willingness from MSF in 9 or 10, but by 11 it was there.”³¹

EQ5: How can the connectedness of the OCB interventions be enhanced?

- EQ5.1: How did OCB work and coordinate with other MSF OCs? With key non-governmental actors?

MSF in DRC in #10 failed to act and speak with one voice and resulted in what most describe as a failure. OCB elected to work under OCP, leading to numerous operational problems, poor access to communities, and ultimately an acrimonious divorce. OCB responses in #9 and #11 were less complicated with fewer actors, outside resources and pressures, and OCB served under MoH Kinshasa, not without friction. By #11 OCB was connected to provincial coordination structures but was working relatively independently through local health facilities to reach and treat remote cases and vulnerable communities. Within MSF, other OCs worked under OCB leadership in both #9 and #11, although more productively in #11.

At the strategic level, OCB's approach to connecting with communities was undermined by inconsistent leadership and decision-making on the necessity and purpose of HP and community engagement.

1. Widespread view among KIs that **MSF must engage with the government with a single voice**. Non-MSF KIs made the same point: Balkanization among OCs was self-defeating. Speaking as one MSF was seen as a precondition for defending MSF's brand of humanitarian action and for effective advocacy. Lack of internal unity results in a failure to perform – *“We can't have 5 EMcos show up in one place to decide who does what. MoH quickly looks for how to divide MSF sections and between MSF and other actors, WHO particularly.”*
2. #10 was a full-blown illustration of **OCs not marching under one flag**, each pursuing its vision, to the detriment of the movement and its brand. The response *“was shaped by political pressures from MoH and between OCs, not according to MSF principles”*, and *“It was a politicised response in every way, even between OCs. OCB has lots of expertise in general, we wanted to be part of #10, but very little space to negotiate. Should we stay or go, with so many actors? Our whole coordination team was preoccupied with that internal struggle and not with operations and environment.”*
3. In these three cases of EVD response, **the application of MSF's principle of independence translates as isolation** from other OCs, other actors, MoH, from DRC health care politics. This leads to negative surprises and a failure to adapt constructively.

With World Health Organisation (WHO) or World Bank Group (WBG)

4. **MSF's disconnect from global humanitarian and public health actors** led to gaps in anticipating or adapting to changes. One senior HQ KI noted that there has long been a plan to meet and discuss with the WHO's Regional Office for Africa (Brazzaville), this materialized only in November 2021.

³¹ This quote from an HP perspective is corroborated by external analyses of structural failures of #10: “The fact that the response remained external to the health structures familiar to the community significantly compromised its efficacy, potentially prolonging the epidemic and contributing to violence.” [Ebola in the DRC: The Perverse Effects of a Parallel Health System](#),” Congo Research Group, 2020.

The World Bank's healthcare and outbreak response programming is another identified gap. Though beyond the scope of this evaluation, it is worth noting that MSF's level of investment in these discussions appears to be insufficient.

- **EQ5.2: At the strategic level, how did OCB work and coordinate with the MoH as well as other DRC authorities? How was OCB's intervention integrated into the overall response and how might this be done differently in the future?**

The **nature and means of engagement with MoH Kinshasa proved problematic** across all three outbreaks, though in #11 demonstrated elements of positive collaboration with provincial MoH officials. Typically, the quality of engagement was person-dependent, with significant variation in terms of the diplomatic skills and approaches of the OCB representative, and more importantly the absence of any overarching engagement strategy, objective, or vision.

5. MoH KIs in Kinshasa complained of **disrespect on the part of some OCB representatives**. This perception of disrespect included attitudes that OCB has deemed unacceptable, such as treating people as if they are ignorant. Disrespect is also perceived in behaviour that OCB condones or approves of, such as (a) OCB not seeking approval for changes to its protocols, ways of working, or agreed areas of intervention, (b) OCB refusing to share information, such as reporting on its activities (including financial reporting), (c) or in making public statements, particularly if without having discussed with the MoH beforehand.
6. **Distrust from MoH Kinshasa toward MSF and other INGOs**. Even though OCB brings resources, each intervention involved a power struggle. Yet KIs perceived MoH Kinshasa rigidity as a reaction to the MSF attitude, which is often 'get out of our way and let us do our work'. For many KIs, MSF must accept that DRC is a very different environment today and that the MSF narrative needs to change. *"We had that neo-colonial space for a long time, it was a huge privilege for our operations, but we have to accept that it's over."* And: *"To continue to be relevant, we have to change how we work, be more part of the system without taking orders from it. The cowboy perspective has to go. We can be independent but more strategic by drawing on relations around us and who we build alliances with."*
7. **Today, MoH EVD response is vertical – but forever?** What are the best compromises between vertical and horizontal approaches? Vertical is easier in terms of logistics, but integrated approaches yield greater efficiency. Hospitals in endemic regions should be able to isolate suspected patients as quickly as possible – detect, test and isolate – all facilities in endemic regions should have this minimum capacity all the time, not only during outbreaks – with adequate materials in stock and human capacity available. Donors can provide resources, and OCB should increase its messaging with them to guide their inputs in this way. *"WHO knows OCB are the eyes and ears in rural Congo, they ask us what are the priority needs for populations, and for the health system. Donors have more power over MoH than we do -- because our resources are independent, we have no leverage."*
8. **A more cost-efficient future**. As noted elsewhere, if MSF wants to add value going forward, Pillar One is the most obvious point of entry. OCB *"should offer PHC in places where MoH cannot reach. The number of lives it could save daily would be exponential – yes, it is substitution, but it is essential care in dire conditions. Much better value for money than 50m euro hospitals in Afghanistan."*

9. **How to prepare with MoH Kinshasa for the next outbreak.** KIs had many views on working with MoH Kinshasa, which was a different challenge than the provincial MoH staff, with whom OCB generally enjoyed positive relations and collaboration. *“We are well positioned to build an effective surveillance system in remote areas for case detection. We can start building this in the inter-epidemic period; it will build a more sustainable response capacity for the long-term. We could be involved in training the human resources needed to run these comms systems, and create a pool of HR to respond. We could run refresher trainings for MoH EVD personnel in the field, and at Kinshasa level. Surveillance and training are the best way to support the MoH in the inter epidemic period, and to build a different image of MSF. Not the MSF who is only there in emergencies but that supports DRC MoH to better serve vulnerable populations. This would help us as well: our trainers would be engaged regularly, and we could leverage intersection coordination. The time is now to simulate another epidemic to determine how to intervene between sections – who does what and where – these concrete discussions need to happen now. We are very good in logistics, but not for strategy. We shouldn’t wait for the next epidemic to address all of this.”*³²
- **EQ5.3: To what extent were OCB’s interventions integrated into the local health system? How did they build on existing MOH or MSF capacity?**
10. **In outbreaks #9 and #11 OCB had a much easier time working with the provincial MoH,** for several reasons. Equateur province has not seen conflict since the end of the [Second Congo War](#), formally concluded in 2003. Its primary challenges, which OCB knows well, are limited transport and communications infrastructure, and difficult to reach, scattered communities. Inaccessibility and absence of revenue generation (no minerals or other resources) means a very low MoH budget, so health facilities have little to work with, and their staff are often not regularly paid. OCB chose to support local health facilities (Pillar One) during its EVD response, with different degrees of decentralization and home-based care between #9 and #11. Restocking medical supplies in local facilities and hiring local MoH staff may have been a temporary drain on local health provision but offered longer-term benefits as well (staff training, supplies).
11. **In #10, direct integration with the local health system was challenged by contextual factors (armed conflict, hostile populations, EVD disbelief) and by the structure of the official response itself,** which was an external imposition led by national authorities who are party to the local conflict. OCB association with this response structure (‘riposte’) cancelled any hope of independence, impartiality, and neutrality, which made access to communities and gaining their trust and collaboration near impossible. In #10 too, OCB was given lists of local MoH staff to hire but this was clearly a fictitious employment scheme as few of these candidates had any medical or EVD experience or were simply outsiders themselves. Their presence on EVD teams exacerbated local suspicions and fears over the hidden purpose of the EVD response.

Below are related points of interest raised by KIs alongside reflections by the evaluators.

³² “Our added value is first in logistical capacity and epi surveillance with an angle of circumscribing the outbreak area. Then by the time MOH deploys, do we have value in curative care? How good are these vaccines, we don’t know yet. We can also collaborate in terms of data collection, building a database. That isn’t through OC but through Epicentre - here we have value. First 4-6 weeks we have clear added value. After that serious discussion with MOH and specific HZ we need to decide our role. Maybe times have evolved, and we need to invest in new diseases, which we haven’t done.”

12. **Pros, cons, trade-offs of using emergencies to reinforce MoH capacity:** How did MoH balance the urgent and specialised response to Ebola against the desire to avoid building a parallel system that does not contribute to healthcare over the coming years? This is an important tension raised by KIs: MoH Kinshasa and riposte hostility to MSF in #10 was in part due to the dominant narrative (to which MSF unwillingly subscribed) that short term/emergency Ebola resources should serve the long-term development needs of the health system. In other words, use the crisis to build permanent health system infrastructure (ETCs could be later used as treatment facilities, etc.). At the same time, however, OCB sees daily how MoH Kinshasa fails to pay rural staff and cannot manage basic procurement needs to keep its local facilities well-stocked. Underestimating the significant administrative demands of a well-functioning health system, MoH Kinshasa appears naively to equate 'modern health system' with hard infrastructure and new equipment but is blind to its more essential failings in payroll, procurement, and quality provision of care. So many KIs agree that MSF 'substitutes for the MoH' because *there is no health system to begin with* in most rural areas.
13. **Kinshasa MoH and provincial MoH do not prioritise rural health care equally.** There is a "mismatch between national authorities' political interests and people's basic health needs in remote areas. This disconnect is classic to all these [EVD] countries, not least DRC." This reinforces the often-heard argument from KIs that OCB's greatest advantage is in supporting Pillar One, given its speed and prior presence in many crisis locations where state authorities and MoH are weak.
14. **Community acceptance of EVD response efforts is directly linked to a community's access to basic health care (Pillar One).** Many KIs reflected that it was unrealistic to expect communities to accept outsider-led EVD responses where there are no established, trusted health care services in place dedicated to people's basic medical needs. Many wondered about OCB's value add going forward, and if there would be gaps within a multi-actor response framework. Many noted that EVD response that isn't connected to communities will not gain their trust, and that the best way to gain that trust was not actually through EVD at all, but with essential medicines and treatment capacity through local health facilities and known service providers. These are the trusted medical authorities, not outsiders. *"We need to find a place where the financial interests of other actors are not so influential over the shape/design of the response approach. Where is our added value? No longer case management. Other actors can do this very well – Alima, among others. Our role could be in treatment, but only from a very decentralised level, as close to communities as possible. The further you are from the community, the more you lose access."*
15. **Donors are tired of funding INGOs to do the emergency work of the MoH, and have Sustainable Development Goal commitments to meet, both of which require a higher performing MoH.** WBG is a major driver behind MoH Kinshasa change of authority in #10. WBG in DRC and elsewhere is seen as anti-INGO and supports cost-based health care (user fees) except in emergencies. Ethiopia and Rwanda are its models for emulation by DRC's weak institutions: emergency INGOs should report to the MoH and follow its orders, not run loose without oversight or accountability, which undermines national sovereignty and fragments the health care system. Given DRC's chronic health emergencies, WBG and other donors pressure MoH Kinshasa not to delegate responsibility to INGOs, but to use them to reinforce national capacity and to develop health system infrastructure. All multilateral donors (WBG, UN) and bilateral donors now embrace this marriage of emergency and long-term development needs: hence the global commitments to a 'nexus' between relief and development. MSF is not involved in any of these policy

discussions, and so fails to anticipate their consequences for its own operational space and autonomy.

ANALYSIS

In arriving at the findings above, certain themes were repeated throughout our interviews and in the documentation:

1. ***The evaluation found that OCB KIs view DRC's official EVD response architecture (vertical, MoH-led) as a challenge to OCB's traditional way of working.*** In #9 and #10, OCB submitted to MoH direction and leadership, with mixed results. #11 is seen as slightly more successful, because OCB deliberately managed MoH relations to reclaim its own space and familiar ways of working. Currently, OCB has not yet decided how it will work under MoH Kinshasa and alongside multiple EVD actors, with reduced roles for MSF.
2. ***OCB KIs viewed the loss of autonomy and decreased operational space*** differently in #9, #10, #11, but cumulatively expressed: anger at reduced impact, shame at dysfunctional inter-OC politics, and sadness over diminished MSF credibility. 'Never again' (to EVD in DRC) was heard often from OCB KIs. Concrete proposals for improved MoH collaboration at Kinshasa and provincial levels were few and non-specific.
3. ***Reactive and ad hoc context management (vs technically capable EVD teams) weakened OCB impact in #9, #10, and #11.*** Across the three interventions, OCB engagement with all external actors, not just MoH Kinshasa, was found to be ad hoc, reactive, and non-strategic. Consequently, OCB was unable to leverage its deep EVD experience to improve outcomes.
4. ***Unprecedented complexities of #10 leave many unresolved questions and frustrations in OCB.*** Difficulties of the #10 response environment included lack of strategy, fragmented structures and coordination processes, immense donor pressures and explosion of 'Ebola business', to which MSF was unwillingly complicit. Contextual factors compromising access in #10 included: armed groups, xenophobia/opposition strongholds, EVD disbelief, government missteps, inter-OC conflict, and MSF alignment with MoH/WHO. Unhealthy internal relations in #10 caused a frustrating and inefficient drain on resources that included a fragmented, leaderless approach to MSF intervention, a fraught OCB-OCF partnership, and turf battles across EPool – PUC – Mission structures.
5. ***Some improved performance in #11.*** While OCB consensus over the function and goals of HP and community engagement is perceived by many KIs as lacking, there were clear examples of demonstrated effectiveness and value in HP/CE approaches in each outbreak, culminating in extremely effective performance in #11. Lack of clarity over roles and responsibilities between PUC, EPool and Mission dominated in #9 and #10, but improved in #11, with PUC initiating the response and receiving later support from EPool.

These concerns arose across many if not all our research discussions around OCB's DRC Ebola interventions. The analysis below aims to situate these common shortcomings, gaps, issues and factors within a discussion of deeper themes, such as OCB's approach to partnership, leadership and how the problems of today point to the issues of the future. The following section is structured around four themes:

1. **Context: transformed response landscape**
2. **Partnership, collaboration, engagement**
3. **Leadership + Principles**
4. **Added value and Comparative advantage**

CONTEXT: TRANSFORMED RESPONSE LANDSCAPE

THE NEW EBOLA OPERATIONAL LANDSCAPE

When it comes to Ebola, MSF has rightfully prided itself upon its accumulation of unparalleled technical expertise, experience, and response capacity, with OCB a recognised leader globally and within MSF. Yet **OCB's Ebola interventions in #9 and #10 were blindsided by its failure to anticipate the implications of post-West Africa changes.**³³ As OCB opened EVD operations in Equateur in 2018, it was confronted with the realisation that prioritised investment in global public health epidemic response yielded stronger (1) operational responsive capacities (e.g., MoH, WHO, Alima, IRC, UNICEF, WFP) and (2) firm central and provincial governmental coordination.

OCB knew the EVD response environment had shifted in the wake of the West Africa epidemic, towards national response plus more effective and well-funded global capacities. Yet OCB did not appear to investigate or adapt its own EVD engagement strategy accordingly. Undermining its vaunted medico-technical capacity, OCB's intervention model was ill-suited to Equateur in 2018 and then to the situation in the Kivus because it was heavily predicated on MSF being a 'solo' intervenor, staking claim or having permission to take over a wide range of outbreak response components. In the Kivus, the same blind spot arose: a lack of preparedness for the new reality on the ground, which was then compounded by resistance to change. These context difficulties frayed relations with other actors and notably led to **OCB distancing itself from MoH**. This inadequate connectivity also initially **hindered closer engagement with communities**.

These changes in the response landscape are profound. One key lesson for OCB is that **this new reality should not be viewed as static**. The next big outbreak response in DRC should not look like #10 because these same institutions – MoH, World Bank, WHO – claim to have learned lessons during #10, and which already shaped their response in #11). For example:

- Place community engagement at the centre of a response, and ensure that non-EVD needs are also (and visibly) addressed;
- Lessen central control and deployment of Kinshasa MoH authority, allowing the provincial health system to assume a greater leadership role;
- Address the perception of the 'Ebola business' – reduce 'importation' of foreign/outsider staffing, strengthen greater control over funding;
- Explore decentralised approaches, including care based in the community and family;
- Maintain sufficient funding while exerting greater accountability.

How did OCB's outdated intervention miss predictable/visible changes in the global and Congolese national EVD response architecture, given that it had called for these very changes in the wake of the West Africa epidemic? The blind spot suggests context awareness that places disproportionate MSF focus on armed militia groups rather than key aid/governmental actors, weak strategic orientation,

³³ In the West Africa outbreak, international responders were confronted by three relatively weak state governments that nonetheless insisted on being at the forefront of coordination, and who rejected a visible handing over of the reins to the international community. This was read by many as a sign of a shift in popular expectations, and a recognition that governments were under public and donor (e.g., World Bank) pressure to demonstrate their ability to assume their sovereign responsibilities.

OCB/MSF insularity and ineffective functional links to key actors such as the World bank, WHO's Regional Office for Africa (in Brazzaville), and a shallow connectivity to MoH.

THE EBOLA BUSINESS + EBOLA EXCEPTIONALISM

From a historical perspective, in its systemic neglect, staggering lethality, and heavy, specialised resource requirements, **Ebola has warranted being treated as an exceptional disease**. The fear factor, and the mediatization of Ebola – where one case anywhere in the world generates a BBC news headline – have produced further distortion of its 'legitimate' exceptionalism, which buttress the framing of Ebola as an exceptional existential threat that justifies the securitization of the response (see e.g., Nunes 2017). The Overseas Development Institute estimates that \$800M to \$1.2B was spent during the 22 months of outbreak #10 (Crawford et al., 2021), with very little of that strengthening the infrastructure of healthcare in DRC. This marks an extraordinary expenditure for a disease that, since discovery in DRC in 1976, has caused roughly 15,000 known deaths worldwide, the equivalent of about two weeks of global malaria deaths in 2019; and in a country where measles alone is a far more serious killer.

- Exceptionalism breeds attention and attention holds an opportunity cost – inattention somewhere else. **OCB staff in Kinshasa HQ complained of internal Ebola exceptionalism**. For example, there remains a pressure on the field to notify HQ of every and any potential haemorrhagic fever case, and HQ antagonism at the failure to do so even when judged by the field to be a false alert.
- In #10, communities were angry at corrupt practices and illegal profiteering of the “Ebola Business.” **OCB narratives functioned to exclude OCB from this “Ebola business,”** defining this business in terms of theft, corruption, sexual abuse, and other illegal practices. However, interviews with various staff working at the community level and the local NGOs participating in the roundtable discussion in Goma confirmed a different story. Community anger was similarly directed at the well-funded yet legal and orderly business of delivering aid for Ebola while ignoring their higher priority needs (security, access to basic health care). Community needs were ‘unexceptional’, garnered little comparable concern, and received scant comparable investment. Rather than the feel-good message of denouncing the Ebola business of others, OCB should have considered its own participation in this business.
- Looking back, the question arises: To what extent has OCB contributed to the ‘illegitimate’ (unscientific) or harmful exceptionalism of Ebola? Looking forward, the question shifts, and touches upon several decades of consistent OCB effort: **Should EVD continue to merit exceptional attention and resources**, given indications of reduced lethality (the advent of treatment and vaccination) plus the increased capacity and risk appetite of national governments, WHO, and other actors? The question is not simply MSF's need to think about a new role for itself, but about its impartiality and resource allocation. And as MSF-published, academic research has concluded, the exceptional ‘risk’ of Ebola was constructed by international actors upon “conventional tropes of an epidemic and humanitarian moralism.” (Hofman & Au, 2017; xxi). Is that the MSF We Want to Be?
- **Katwa attacks and OCB withdrawal – Costs of Ebola business?** The reasons for OCB withdrawal from Katwa following attacks on its ETC, and the consequences of this departure on MSF reputation in DRC, are important to distinguish and appreciate. No formal review of these events and their effect on MSF reputation have been conducted. The current study was not directed to fill this gap, yet many KIs shared their views. In general, OCB KIs did not criticise the decision to

leave, and many questioned whether OCB should have participated in the official EVD response at all. Few OCB KI described anything redeeming about #10 except the intensive PHC support to Mabalako, a peripheral, at-risk health zone. Most OCB KIs who served in the field decried and lamented the events and circumstances that led to the attacks on the Katwa ETC, the determinant factor behind OCB's departure. Reasons for the attacks appeared clear to OCB KIs, and many did not see OCB or MSF as the specific target of the violence. Primary reasons cited were: (a) anti-government populations with legitimate fears that the *Riposte* was a tool of targeted physical and political oppression, even ethnic cleansing; and (b) MSF inability to defend its independence and to differentiate itself from *Riposte* leadership, methods, and aims.

Some KIs wondered if the complexity and compromises of #10 had not condemned OCB to fail. Reasons for this view include: inexperience conducting political negotiations with MoH/WHO, complexity of local conflict dynamics where the state is party to violence, and MSF openly siding with the government (MoH) for EVD response. With the benefit of hindsight, MSF KIs were nearly unanimous in their view that without complete independence and operational autonomy, OCB should never have supported the *Riposte*. And by extension: believe that if a similar context ever arises again, in DRC or anywhere, OCB should abstain.

PARTNERSHIP, COLLABORATION, ENGAGEMENT

MOH, MSF, COMMUNITIES, OCB INTERNAL

OCB/MSF developed ways of working and thinking about humanitarian action over decades of operating as a lone actor, addressing emergency needs without significant external collaboration. Using distinctions of principle and the superiority of resources, the national authorities were kept at a distance.³⁴ OCB's deeply troubling experiences in #10 (and, to a lesser degree, #9 and #11), raise concerns that this evolution has generated the humanitarian equivalent of a fish out of water. In short, **a lack of connectedness that directly undercuts OCB's relevance, appropriateness, efficiency, and effectiveness.** Both DRC's MoH (among many MoHs) and humanitarian healthcare have now evolved, **placing a rising premium on the capacity for engagement, interconnected programming, and collaborative efforts.** The experience in DRC highlights three principal areas of tension: collaboration and/or engagement with MoH, with communities, and within MSF and OCB.

COLLABORATION AND ENGAGEMENT WITH THE MOH

The experience in DRC corroborates recent MSF research showing that recognition of external change has outpaced internal adaptation to these changes (see Healy et al., 2020; disclosure – DuBois is a co-author). The more obvious need is (a) to prioritise different skill sets and people, to enhance diplomatic talent, local context expertise, relational savvy, and (b) to build the capacities to leverage a wider set of external global and regional actors. Another measure pushed by KIs is for OCB staff to develop and maintain stronger personal/professional relationships with government officials, from Kinshasa down to the provincial health zones. However, **boosting skills, resources, and relationships may prove necessary yet insufficient.** They can contribute to the development of an MOU, binding framework,

³⁴ One notable exception has been in the approach to HIV, where connectivity and collaboration have long been built into the response. As one Operational Director (non-OCB) recently remarked, though necessary, we do not yet manage to bring the HIV model into the mainstream.

or, as one senior MoH official would prefer, a multi-year agreement that includes accountability mechanisms to ensure its achievement. Yet for MSF/OCB to progress towards an effective engagement with the MoH, the experience in the Ebola outbreaks points to addressing four issues.

What Is The Strategy?

For all the financial and human resources that OCB commits to DRC, there is no strategy that sets out the direction of travel and which delineates a frame into which Ebola responses must fit. Our ToR asks for the evaluation to chart the shift in strategies over the three outbreaks. We found programmatic guidelines, protocols, approaches, and tactics that shifted over time, all contributing to a laudable and pragmatic goal of identifying effective actions, yet always in the moment.

As one MoH official said, “For MSF, the strategy changes with each manager who arrives.” That complaint was echoed by many OCB KIs. At the highest level, an intersectional MSF and OCB both need to define the nature of a relationship with the MoH that furthers the long-term objectives of the organization. That answer requires a multi-year vision that defines the strategic engagement, delineates certain red lines, and is then operationalised in annual plans, recruitment of mission leadership, etc. It needs to direct the decision-making of 2-month outbreak coordinators.

How Can OCB Overcome Its Ideological Obstacles to Such a Strategic Commitment?

At a higher level, OCB needs to reconsider how it views independence, neutrality, its legitimacy, and the role of government, because these effectively block collaboration.

- Nowhere in its definition do the principles of **independence or neutrality** require state avoiding behavior, or OCB isolation from the state. Arguments against collaboration, especially in #10, tended to view independence in black or white terms that led to protests against the crossing of red lines and tarnishing MSF's identity. Independence in decision-making was perceived as compromised by working with partners, and here friction arose with MoH just as it did with OCP.
- Across the three outbreaks (but especially #10), **the narratives used by certain groups of KIs to describe MoH were alarmingly reductive**, trafficking in stereotypes of greed and incompetence that demonised the government and justified non-collaboration, distance, withdrawal, rejection, and a unilateral dismissal of MoH authority. Even internally, these narratives were rejected by other KIs, typically but not exclusively Congolese staff, who held far more sophisticated views of MoH, and who often had to broker OCB's engagement. See Textbox on narratives, below. Another problem was raised by one KI in the DRC mission, the way MSF is rendered invisible in some MSF reporting and communication, so referring to the “MSF hospital” and not recognizing MoH contributions in reports.
- Several senior MoH staff interviewed in Kinshasa were clearly angry at treatment by MSF international personnel which crossed the line from disagreement to **disrespect**. **They felt that MSF treated the MoH as if it were inferior** (note the similarity to claims of some national staff regarding how they have been treated), and that MSF ignored the government's authority. Various observers criticised the legacies of ‘cowboy’ behaviour or the ‘lone ranger’ mindset. The former is outdated and the latter inaccurate.³⁵ Both are counterproductive.

³⁵ Recent OCA research found that while its staff perceived MSF as a solitary, independent actor, over three quarters of OCA projects involved direct partnership or collaboration with the MOH (Healy et al., 2020).

- **World Bank officials view DRC's response capacity through the lens of long-term development,** and the bank is financing strengthened areas of government competence within the emergency response space.³⁶ **Any structured engagement with the MoH will have to confront these policies.** For example, in both Equateur outbreaks MoH pressured OCB to construct isolation and treatment structures in concrete. OCB felt uncomfortable in being forced in this direction, seen as slow and contraindicated in EVD response; or worse, as a modern and sleek structure masking a system devoid of the ability to deliver care. Yet many OCB staff expressed sympathy for the underlying idea that work in DRC must be more sustainable, because the situation is one of protracted crisis. How can an organizational compromise be crafted? How can OCB contribute to the long-term while maintaining its humanitarian character; or at least not undermine it? How can OCB add nuance to the conversation stopper "MSF doesn't do development"? These ideological barriers are precisely the sort of issue requiring a shared OCB strategy, rather than sequential ad hoc approaches.

How Can OCB Establish and Build Its Trust of MoH?

Mutual interests – the reality that MoH and OCB need one another – form a solid yet incomplete basis for an effective OCB-MoH relationship. **Actionable two-way trust is a missing ingredient.** From its side, OCB will have to commit to the engagement which means it will have to overcome the aforementioned internal ideological barriers to compromise and engagement. Having the right people in place, and shifting to a more regional approach, seem to aim in a direction that bolsters OCB capacity to develop, sustain and leverage this relationship over time (i.e., longer than a typical Head of Mission contract).

³⁶ Part of the hostile context? From a development policy standpoint, humanitarian operations and organizations like MSF are seen as obstacles.

How Can OCB (Re)Build MoH's Trust in OCB?

Is MSF an unreliable partner? All but one MoH suggested or said as much. Can OCB 'own' and address this reality.³⁷ In various views, MSF: (a) abandoned communities and left the MoH stranded after it evacuated Katwa and Butembo and decided not to return; (b) took unilateral decisions to ignore MoH (and WHO) protocols and to hide such breaches; (c) recruited staff for projects without passing by the MoH for approval; and, (d) refused to respond to MoH requests for financial expenditure and supply data that were required for MoH accountability exercises (this is now being remedied). In the eyes of another ex-MSF external official, MSF used to be "needed", but is now only "tolerated." A WHO official who worked on location in both #9 and #10 explained that MSF's unreliability in terms of MoH cooperation poses risks to the management and coordination of the wider response. MoH/WHO in the future will balance this risk against MSF's many superior capacities. In simple terms, successful collaboration will depend on MSF changing more than the way it feels about MoH, it must foster MoH trust in MSF.

THE POWER OF NARRATIVES

Across interviews with staff who served in #10, OCB's description of the MoH was uniformly negative in terms of its management of the response. By way of contrast, the assessment found in ODI (Overseas Development Institute)/HPG's (Humanitarian Policy Group's) highly critical study of leadership and coordination in #10, offers a different view: "The government managed to limit and control EVD 10 within a densely populated region, among a highly mobile population with no previous experience of the disease. The area had long been characterised by decades of violence and armed conflict as well as weak health structures and ongoing acute humanitarian needs." (Crawford et al., 2021). The report also reminded readers that North Kivu was home to over a million IDPs and that Ebola did not significantly leak across the porous borders to Uganda or Rwanda. Without deciding which assessment of the government is more accurate, the invisibility of similar discussions among OCB staff highlights a lack of balance in OCB's dominant narratives, particularly among international staff. Such narrowness calls into question the analytical basis upon which major decisions were based, and hence OCB's strategic orientation, its approach to MoH, or its decisions to publish critical views.

ENGAGEMENT WITH COMMUNITIES

The need for more effective and meaningful CE remains aspirational and ill-defined. What level of community participation is necessary, what is possible, and under what circumstances? At a higher

³⁷ It is important to note that in interviews with MOH staff, KIs were occasionally able to specify the particular OC involved, but at other times spoke generally of MSF, especially at the Kinshasa level.

level of an being an objective: can OCB involve communities as agents in response to the outbreak affecting their community? **When it comes to CE, one key internal barrier is failing to situate this subject at the level of both policy and principle.** Both of these points have been made elsewhere in this report and by others in OCB. Already accepted by many MSF staff, including some leaders, some KIs proposed the need to reject altogether the subordination of community engagement to a top-down medicalised approach or to simple risk communication. External actors concur: the need is to avoid instructing community members to change their behaviour (paternalistic), as opposed to engaging in two-way dialogue to clarify false information and misunderstanding (see, Congo Research Group, 2020). As post-West Africa reflection makes clear, when engagement with communities attempts to align local priorities with outside or institutional ones (i.e., convince people that Ebola is the #1 priority), serious “Do No Harm” concerns arise (see Benton, 2017).

Those seeking an enhanced commitment to community engagement see the positioning of OCB leadership as critical. Building community trust prior to launching into action requires the confidence to put the brakes on a culture of doing the fast and the visible. As one Ebola expert explained it, OCB neglected its role in connecting with the community until it felt more on top of the medical side, but this *“always creates tension with communities”*. Further, *“we know all this but we still do a suboptimal job.”*³⁸

ENGAGEMENT ACROSS MSF AND WITHIN OCB

It is beyond the scope and capacity of this Evaluation to assess OCB's interventions within the intersectional dynamic, or to offer cogent analysis of **the problematic relationship between the EPool, PUC, and the mission** (aside from what appeared in the Findings). However, and adding to the points made elsewhere in this report, three observations. First, we have reviewed the proposed new strategy for organizing the intervention of PUC and EPool in future EVD outbreaks. The main proposition is for PUC to initiate the response and then, if necessary, handover to the EPool after 2 - 3 months to safeguard PUC's mandate and response capacity. This agreement holds some logic, and yet seems **too much an answer to the internal or institutional question of how OCB should organise its response**. It also avoids the unhealthy tension between HQ and field, as manifest in Epool-PUC friction. These institutional issues should be secondary. The first order of business is to design Epool-PUC arrangements that produce the best results given the new external environment and the new roles being ‘forced’ upon OCB Ebola response. Moreover, it would be difficult to fault MoH for disagreeing with a planned changeover of management, personnel, and approaches at the two-month mark of an outbreak; nor would such a planned disruption bolster OCB's image or reliability. The alternative is to forge a joint response, capitalizing upon the strengths of both the PUC and Epool, and to prioritise hiring people who can make that work.

Second, in the case of inter-sectional disagreements in #10, HQ leadership bears responsibility for asking field teams to operationalise a marriage whose parties disagreed over basic roles and purpose. Absent effective steering and vision, OCB failed to leverage its EVD experience to improve outcomes. As mentioned above, **the negative internal OCB narrative on the MoH, justifying a disengagement, was replicated in the internal OCB narrative on the divorce with OCP**. In short, a demonization, not

³⁸ “We should look at HP just as we look at access negotiations – an ongoing process, never a one-off. We do community engagement badly, because we show up to get a green light (access), then we stop communicating with trusted, influential people in that community. Coercion never works in EVD. How else can you appeal to people?”

of a foreign government but of a founding member of the MSF family. In similar fashion, certain KIs condemned the work and integrity of the PUC staff while others condemned the work and integrity of the EPool staff. And the successful access of Alima was dismissed and derided, as the price paid by a greedy organization that was happy to be the lapdog of the MoH. (An Alima KI offered a different view, one in which Alima leveraged its continued engagement with MoH to advocate and modify the policies it found unacceptable). What emerges is a pattern, a damaging tendency to self-servingly oversimplify and morally condemn the other side of what should be a collaborative (and even collegial) relationship, and to justify disengagement. The other thing that these deleterious narratives have in common is that their circulation was not interrupted or countered by OCB leadership.

LEADERSHIP + PRINCIPLES

Leadership deserves a great deal of credit – the three outbreak responses all demonstrated OCB's capacity to mobilise resources and expertise, and to overcome considerable challenges. Leadership also deserves scrutiny. Leadership-related shortcomings run through a large number of the Findings and this Analysis, with notable concentrations: the setting of strategy; directing the establishment of connections and collaboration with other actors, other parts of MSF, and with communities; the reinforcement of or non-intervention in damaging narratives that governed some areas of OCB's response; and its insufficient attention to the humanitarian principles and ethical issues (pushed aside by an almost exclusive focus on actions).

OCB'S USE OF ITS CORE (HUMANITARIAN) PRINCIPLES

Given the weight and complexity of the issues, **the explicit use of humanity, impartiality, independence and neutrality could have strengthened OCB's leadership**, especially in the Kivus. Instead, across the three responses, OCB referred to the principles less to shape strategies and frame decisions and more to give weight to arguments about them. In #10 particularly, three critical fundamental issues highlight the role of guidance (leadership, strategy, principles) from above.

What Role Should Have Been Played by Impartiality in Guiding OCB's Identification of its Objectives in the Kivus?

As found above, our evaluation criterion of operational *relevance* of OCB's #10 response raises important questions. Relevance invokes the substantive principle of impartiality, which instructs that aid must not be distributed (or withheld) on a discriminatory basis (race, religion, gender, etc), and should therefore be guided solely by need, **prioritising those in the most urgent distress** on the basis of an impartial assessment of needs. This evaluation does not pass judgement on whether or not OCB's prioritisation of EVD was correct. Our concern is the degree to which this necessary level of analysis was not the starting point of the intervention, particularly at Brussels level but also among decision-makers in the field.

From the beginning and at all levels, OCB understood its objective as mounting a response to EVD. Non-EVD *humanitarian* needs existed in North Kivu and Ituri, triggered by longstanding insecurity, forced displacement, and areas lacking access to healthcare or potable water. Some OCB staff in #10 recognised these needs, and many expressed dissatisfactions with the exclusive focus on EVD in the

early stages. In KIIs, they questioned the lopsided investment of resources, especially given the surplus of actors dealing with Ebola. We note that impartiality is not about needs as such, but *unmet* needs.

“In #10, we came and made the same mistake. We did not begin with the question of the needs, of the people or the gaps in the response.”

The discussion of programming thus remained on the level of activity and was not elevated to the level of principle. The starting point should be ‘What are the greatest needs of the people in crisis?’ and not ‘Where is the Ebola?’. **Impartiality should have been used to inform OCB on the objectives of the intervention and**

should have routinely triggered an ongoing discussion (or check-in) during the course of the outbreak, to ensure that changes to this calculation did not demand a course correction. To be clear, the principle of impartiality does not preclude OCB transparently deliberating and then deciding to compromise impartiality to achieve other goals (e.g., to maintain operational experience in EVD response).

The concern was not simply philosophical – **impartiality was central to community acceptance**. First, in #10, community repulsion and anger at the ‘Ebola business’ was intricately linked to people prioritising non-EVD needs that were (a) longstanding and (b) ignored by the enormous response capacity devoted to Ebola, hence calling into question the motivation behind the work. Second, the number of international and staff hired for and deployed to the three outbreaks was substantial – which raised issues or perceptions of disproportionality, opportunity cost, and fairness.

How Should the Principle of Humanity (and MSF's Chantilly Agreement) Have Guided OCB's Ebola Intervention and Decision-Making

Key operational questions also originate in the principle of humanity, and how it relates to impartiality. Specifically, in determining the objectives of OCB's response, what role should have been played by affected communities? What weight should OCB have given to the priorities being expressed by these communities? These questions collide awkwardly with longstanding practice across MSF, where it holds onto full authority to decide upon the content of its interventions (often mistakenly phrased as ‘independence’).

As an OCB HQ KI declared, OCB interventions must be based on need, as distinguished from being based on “demands” from the local population. Such beliefs seem old-fashioned and inaccurate. In the Kivus, **OCB essentially exercised its power to decide that communities were mistaken about their own priorities**, reasoning that people did not have a proper understanding of the risks posed by Ebola, nor in some cases even believe in its existence. OCB exercised this power without even conducting assessments of these other needs.

OCB's justification undermines ethical imperatives that require, at a minimum, **recognition of the widely accepted principle that “[p]articipation is a fundamental ingredient in the principle of humanity”** (Slim 2015, 83). **At the level of leadership, OCB's justification should be questioned rather than institutionalised**. This evaluation highlights (a) the mythical nature of OCB's self-perception that needs alone drive OCB's interventions, as was evidenced in the degree to which OCB and MSF institutional interests and politics so predominantly shaped OCB's response, (b) the outdated absence of holding community participation as a prerequisite to determining the greatest needs of a

community.³⁹ OCB's thinking in this regard buttresses the longstanding failure to interpret the principle of humanity or the definitional aspirations of MSF's Chantilly Agreement – to restore the capacity of people in crisis to have control over the forces affecting or governing their lives – in terms of higher order participatory inclusion (read: placing 'the patient at the centre'), such as allowing people decide what OCB will do or meaningfully participate in OCB's decision. The problem described herein is both a critique of OCB's actions in the Kivus and a suggestion that OCB's interpretation of *humanity* raises a paramount question in the emerging discussions of its future role and identity.

Where Could Independence and Neutrality Have Better Contributed to Strategic and Operational Guidance

In the heated #10 debates sparked by OCB's operational embeddedness in an MoH-dictated *riposte*, numerous KIs used MSF's independence as a battering ram, arguing that OCB was transgressing red lines and betraying its identity. HQ-based decision-makers were accused of not comprehending the reality on the ground in insisting that OCB should remain in its MoH-designated role rather than pull out (until the attacks on Katwa and Butembo forced its departure). In retrospect, **neutrality and independence could have provided guidance in navigating these thorny issues of identity and role**, though only if care is taken to avoid ideological confusion.

- The **Kivus marked a contested context, and many OCB staff recognised this as playing to one of MSF's strong suits** – its independence, its experience in delivering aid in conflict areas, and its operationalisation of neutrality and independence to gain and maintain trust or access. North Kivu was seen as the sort of context where the organisation's comparative advantages would potentially create 'space' for MSF to operate.
- In relation to the specific context in the Kivus, there also **needed to be a more nuanced appreciation of the dynamics of neutrality and independence**, and particularly of the perception of them. Certainly, perceived partnership with the government left poor perceptions in many communities. Still, the assertion that MSF would be tainted by working with the government was viewed by some KIs as opportunistic or overplayed. First, MSF in the Kivus has partnered for many years with the MoH to run a number of hospitals in this same area. Second, as a donor familiar with the Kivus pointed out, the people in this area are experienced with humanitarians and government (and MONUSCO, militia groups, etc) and differentiate apparatus related to the conflicts from others (such as health, education, etc.). As some saw it in #10, DRC was not, therefore, in a similar situation as e.g., Afghanistan or Iraq, where all state actors are considered as one and considered a target. Furthermore, maintaining neutrality requires rather than militates against engagement. Finally, many KIs pointed out that the perception problem was not simply the link to the government, but any association with efforts to fight Ebola.
- The narratives surrounding both principles, though, **often confused independence and neutrality with an aspiration of the freedom to do whatever it wanted to do**. OCB needed a more sophisticated debate, centered indeed on independence, and on the unavoidable trade-offs and compromise necessary to ensure the humanity and impartiality of the organisation. As noted above, to ensure these principles under the circumstances required state-engaging rather than state-avoiding strategies and relationships, and clear leadership on any red lines drawn by the

³⁹ The evaluation authors note that meaningful community participation is a commonplace component of outbreak response ethical guidelines.

principles. This is how independence works in practice, where compromise is inescapable and OCB is never 100% independent (or neutral, or impartial).

- One risk was that OCB would be sidelined or **lose access altogether in order to preserve an archetype of independence in its ideal form, hence at the cost of impartiality and humanity**. It seems crucial for OCB to recognise that independence, a tool that typically improves access, may have the reverse effect where independence threatens those who control access, such as the degree to which MoH cannot trust MSF because of its independent (read: “unilateral”) decisions to engage in public advocacy.
- MSF called for the US military to respond to the Ebola outbreak in West Africa, and for military medical staff to take up patient treatment; and certainly police and military were involved in the Covid-19 response in many Western nations. So while it is not surprising for OCB to deplore the MoH's noxious use of various security forces in various roles in the Kivus, **the narrative of many KIs places much incorrect belief in the idea that the government's actions inarguably violated a fundamental principle**. The problem with the latter lies in its enabling of a politics of differentiation and disengagement – borders, distance, and isolation – that overrides *sans frontièrisme*.

Did OCB's Framing of the Crisis in the Kivus Overemphasise the Public Health Emergency (the EVD Outbreak), at the Expense of a Humanitarian Health Perspective?

Numerous external KIs saw that **the first #10 MoH-WHO Ebola response strategies focussed exclusively on a public health response to a vertical crisis**, a framing of the crisis reinforced by WHO's mandate, the exceptionalism of Ebola, and the concentration of extraordinary donor funding upon Ebola. That framing left the pre-existing humanitarian crisis out of the picture, and it blocked recognition of how the EVD crisis generated crisis in other areas of healthcare and across other critical areas, as was markedly the case in West Africa. MOH-WHO maintained this narrow approach until spring 2019 (Crawford et al., 2021). **This framing effectively flipped humanitarian compassion on its head**, transforming the afflicted into threats to be controlled in the interest of the greater good of the not-yet-afflicted.

Especially in #10, a broader framing would have lined up well with the history and context, and recognised that other needs were left unaddressed or directly worsened by a disproportionate focus on and shift of resources to Ebola. As OCB EVD experts have learned over the years, and as many KIs observed in the Kivus, **the EVD outbreak predictably pulled resources away from public healthcare, and in places cut off access to healthcare altogether**. The 'Ebola business' attracted high numbers of staff away from the MoH and occupied the entire administrative infrastructure of the provinces (including, for example, the security forces).

- To what extent does OCB's positioning reinforce the securitisation of global health over the needs of people in countries such as DRC? Even with the security situation in the Kivus, OCB's voice did not challenge the public health framing's insulation of la riposte from humanitarian interventions, a strategic blunder finally halted by the intervention of the UN, World Bank, and other donors, calling for an integration (Crawford et al., 2021). We note that this issue of framing has been raised before, in critique of the framing of the West Africa outbreak (see Nunes, 2017).
- As a humanitarian health actor with a wider remit than WHO, and as an independent voice, **the crisis required greater OCB (and MSF) emphasis on a framing that included the pre-existing or**

emerging humanitarian issues and defended humanitarian health. Could OCB have advocated **against binary (either/or) or exceptionalist approaches** that did not reflect needs on the ground and risked leading to higher mortality than from Ebola itself? As above, the more important criticism here is the failure to engage with that question.

THE ETHICS OF COMPROMISE AND COMPLICITY

Collaboration with MoH necessitates compromise. Complicating matters, numerous OCB staff KIs indicated feelings of complicity in the bad behavior of MOH on account of compromises that were essentially created by OCB's decisions, including the decision to remain in #10 rather than pull out (before the attacks on Katwa and Butembo forced its departure). At a very simple level, **the idealism of the organisation makes compromise difficult, and yet the reality of working in DRC makes idealism difficult. The future management of compromise will become a core leadership task.** In the three outbreak responses, feelings of complicity among staff required the intervention of leadership and potentially ethical expertise because these narratives risk to drive decision-making in the wrong direction and, crucially, because they signal harmful moral distress of OCB staff.

On the issue of complicity, MSF research reached findings that OCB leadership could have operationalised by **nuancing the harmful narratives of complicity emerging from the field** (most importantly in #10; see Buth et al., 2018). The research shows how arguments based on complicity act as moral trump cards, designed to end discussion and force an end to the activity or relationship in question. The use of the term complicity thus interferes with the nature of compromise, and lumps together dirty hands, conspiracy, collusion; and ignores nuances related e.g., to intent, timing, knowledge, and so forth. Finally, the researchers argued that **"complicity does not help INGOs make tough decisions in morally compromising situations."** (Ibid.).

Compromise will often lead to dirty hands, such as working in an ETC that holds suspected cases in conditions that bring more risk of harm than benefit. Such dirty hands are not uncommon in MSF programming but are often hidden or counterbalanced by the substantial positive outputs and impact of its interventions. Though comparatively small points within the EVD response, this is generic to OCB's humanitarian mandate, and likely to become far more common as systemic connection and collaboration trend upward.

Leadership needs to treat damaging narratives of demonisation and absolutist positioning on the principles as an organizational risk, to be managed by bringing nuance to the debate and showing the way forward, forging an agreed compromise position or at least a shared understanding of the balance to be struck.

ADDED VALUE AND COMPARATIVE ADVANTAGE

Numerous KIs have put forward a set of similar ideas: prompted by the recognition that OCB's traditional Ebola response 'space' in DRC, if not globally, has been filled by the rapid development in Ebola expertise and experience, eyes have shifted to potential niche roles.

- **The moto gang.** To respond to EVD in areas that pose insurmountable logistical hurdles for other response actors, even if funding is available. The rural health areas of Equateur where OCB served in #11 offer one such example. Even though well-funded, MoH, WHO, and organizations such as

ALIMA could not assemble the prerequisite capacity in terms of logistics, communications, or sufficient experienced medical staffing to respond in such an inaccessible, remote setting.

- **The early bird.** To respond to EVD immediately, help gear up engagement, tracing, treatment and prepare for the arrival of actors, then departure when warranted (or transition to a lesser role). This capacity is based upon OCB's outstanding epi surveillance and surge capacity, as well as the financial independence of the organization.
- **The specialist.** As the name implies, the idea would be for OCB to build a specific capacity as well as building an MoH recognition of this specific capacity. A potential point of difficulty is that the MoH may value MSF for its treatment capacity, while this shifts MSF away from the more vital functions of community engagement, contact tracing, or (in the future?) vaccination.

These discussions are ongoing and should continue, though perhaps require additional reflection. While these may represent useful alternative models in the 'new' landscape, **they essentially envision not potential future models but a space in which to reproduce the old one**, where OCB can escape uncomfortable new realities. Similarly problematic is the idea of many KIs that with stronger negotiating power and engagement with the MoH, OCB will be able to reclaim its old space. The options above may be promising in some circumstances, but they sidestep OCB's need to also be able to function within the mainstream DRC response.

Beneath the discussion of operational 'space' lies a critical issue, the degree to which the changes to the DRC Ebola response landscape (if not global – see e.g., Guinea 2021) **have shifted the equation of OCB's comparative advantage**. In short, the enhanced capacity and risk appetite of other EVD actors effectively decreases OCB's added value.

MSF's comparative advantages have in the past created space for it to work and expand into leadership roles. Now, OCB EVD experts fear the reverse, that **without being present and active in all EVD pillars, MSF will lose skills, experience**, and its comparative advantages. The three DRC outbreaks required skill sets and expertise where OCB held a competitive disadvantage: poor collaboration capacity.⁴⁰ Nor, it is feared, will simply working in remote areas or early stages of EVD allow OCB to maintain global leadership, or retain a sufficient pool of skilled and experienced staff. Loss of 'space' hence poses an existential threat to OCB's capacity to respond to EVD.

- Mentioned by many KIs as a key comparative advantage of MSF, **some caution is warranted in believing that MSF's historic financial advantages will remain**. With various external KIs lauding the early and rapid funding from the World Bank, the future financing available to others may mean that the financing of MSF may no longer be the only actor able to start quickly. (Alternatively, Covid-19 may shift funding away from Ebola.).
- MSF's institutional added value combines with the potential lethality of Ebola to undergird many OCB's ways of working in Ebola. **The full spectrum of operational decisions or calculations – the balances and trade-offs – should be recalibrated**. For example: does the perceived dichotomy of speed of (medical) action continue to outweigh the benefits of good collaboration or engagement with communities? Do the benefits of OCB's non-compliance with governmental administrative

⁴⁰ See above for the argument that OCB must improve its capacity for collaboration with MOH and pillar-playing within a larger concerted effort.

regulations still outweigh the cost of 'cleaning up the mess' afterwards? Does the risk of too little stock/materials still outweigh the waste of overkill?

- A small number of KIs raised an interesting challenge to the discussion of comparative advantage, arguing that MSF and OCB's greater comparative advantage lies not in Ebola response, but in **the strength of its capacity to shift Ebola treatment to the primary healthcare system**. Not only would "mainstreaming" contribute to reducing stigma, in looking forward it fits better with EVD being both endemic and less lethal due to advances in treatment and vaccines. Such an approach, however, was described as requiring OCB to end its own "stigmatization" (exceptionalisation) of Ebola.

Finally, the issue of diminished comparative advantage raises the institutional question of opportunity cost: **should OCB seek to maintain its expertise in EVD**, or are there other areas where investment of similar resources would make a greater contribution to MSF's purpose? The question of whether or not OCB can justify devoting disproportionate resources to EVD was raised by KIs at both field and HQ level. That seems a good discussion question for 2022, and a crucial one in the coming years.

CONCLUSION AND RECOMMENDATIONS

This retrospective evaluation has been driven by the future. The challenges experienced by OCB, and in particular the threat to a core element of its identity – global pre-eminence in Ebola response – have prompted the need to understand what happened over the course of three DRC outbreaks as part of efforts to better tackle the next ones. Many people in OCB learned from the experiences in DRC and have been busy discussing and making changes. This Evaluation complements those efforts, identifying in the Findings and Analysis above issues to be addressed and questions to be asked, while avoiding duplication of these other efforts, which have been more operationally focussed. This Conclusion section highlights the most critical concerns specific to future Ebola response and the surrounding organizational culture.

The Consultation Group leading this Evaluation directed the Evaluation team to generate reflection and analysis on what happened in the three outbreaks and to offer potential ways forward. A typical list of recommendations was resisted. Below, a limited number of specific proposals are included. It is for OCB to discuss, debate, and determine the paths forward.

RECOMMENDATION 1: To more effectively position itself in crisis response, (together with MSF) OCB needs to analyse and assess the wider humanitarian sector, the global public health system, regional crisis dynamics, and then determine its place therein.

“MSF is an actor that does not believe in systems” – Congolese doctor and politician. A banal observation, perhaps. Yet it captures perfectly the two sides of MSF’s success: first, its uncompromising vision and steadfast commitment to saving lives and reducing suffering. And yet, it is this same intensity of focus that renders MSF blind to how completely it embodies the interests and behaviours of today’s global aid system. Yes, MSF is an extremely effective cross-border emergency responder, financially independent and free to decide its own action. The point is not to ask if MSF wants to be part of the system – that is already the case. The existential dilemma here is how to be uniquely strategic within that system. Given its overall objectives, how does OCB want to pursue health crisis and specifically EVD response within the emergent state-led framework? Second, what opportunities can OCB identify within the state-led system to improve MoH effectiveness, reliability, and replicability in future outbreaks? Has OCB/MSF established relationships that will allow it to anticipate and adapt now to the response ‘space’ in a future EVD outbreak in DRC and elsewhere (e.g., talking directly to WHO in Brazzaville and Geneva or the World Bank in Kinshasa and in Washington DC)?

[Recommendations 2-5 \(of 5\) →](#)

RECOMMENDATION 2: Effective Ebola response in DRC requires developing a stronger, strategic, and long-term engagement with the Ministry of Health.

This engagement must involve relationships that are personal-professional, unerringly respectful, and founded upon trust in both directions. It must also position OCB's DRC operations within a dynamic regional context. The conversations at HQ and Mission level already point in a number of potentially fruitful directions (e.g., PUC-MoH joint missions, emergency response training for dedicated MoH staff, etc.), and could be pursued not as 'charity' or 'development' but as intrinsic to MSF's own founding values and interests. But as difficult as it may be to reach an agreement with the MoH on a path forward, the greater obstacles for OCB are those internal to the OCB and the MSF movement. It is unlikely that OCB pursue the question of future MoH engagement with the full support of all OCs, although this would of course be ideal. Unilateral OCB-MoH engagement may be inevitable but may damage the movement's leverage and reputation.

- Specific Recommendation: Strong individual relationships with senior Kinshasa MoH staff, or provincial MoH/MCZ, should be supported by the mutual accountability of a cooperative framework. OCB should negotiate such a framework agreement as the foundation for well-delineated roles and responsibilities between it and MoH.
- Specific Recommendation: The MoH as well as other agencies based in DRC -- Alima, WHO, UN agencies -- are staffed by what essentially constitutes a fraternity of ex-MSFers (many ex-PUC). Where else in the world is OCB already so deeply embedded in the system, and hence primed for a qualitatively different engagement? OCB should capitalise on current efforts to form a recognised DRC Association given its operational potential to consolidate these potential relationships. Can these connections be expanded to the regional level?

RECOMMENDATION 3: When it comes to Ebola and global public health, OCB is in a unique position to understand its actions and their broader systemic consequences by capitalizing on previous work and experience. OCB's publication *The Politics of Fear* illuminates many issues that remained curiously forgotten in OCB's recent DRC Ebola responses (e.g., the linkage of Ebola's exceptionalism to the politics of gender, race, and class or the impact of increasing global securitization on EVD response). The level of discussion across hours and hours of our research rarely if ever reflected these (academic) insights into the West Africa epidemic, which leadership should have actively translated into an understanding of its DRC operations, role, and responsibilities that reflected more than the reflexive narratives of technical action.

- Specific Recommendation: As OCB elaborates its strategic vision related to Ebola response (globally and in DRC), it should discuss and establish clearer language on where OCB stands in relation to the contradictions between Ebola exceptionalism, global public health security and humanitarian health. Such positioning will depend upon decision-making that reflects improved contextual analysis and networking.

Recommendations 4-5 (of 5) →

RECOMMENDATION 4: To adapt to changes in the broader external environment and the specific landscape of a given response, OCB requires greater, shared strategic direction and dedicated change management.

Given OCB's acknowledged role as a global leader in Ebola response, there is no justification for being blindsided by changes in the response environment, particularly regarding the leadership of MoH-WHO. Improvement will depend on conclusion #1 and #2 above, and then the development of (a) a strategic vision of OCB's future role in future Ebola scenarios, (b) an internal strategy – not a plan of action – to adapt the organization accordingly, from Epool-PUC coordination to recalibrating OCB's comparative advantages, and to overcome the internal obstacles, and (c) application of a change management process that will bridge from strategy into these new capacities, processes, and structures. Any strategic reorganisation should answer the question of whether and what technical areas of expertise (e.g., new treatments, vaccination) may be necessary to maintain leverage and access.

- Specific Recommendation: Priorities in this regard include clarifying the future purpose and role of health promotion and community engagement in EVD response, and better defining OCB's orientation towards development/sustainability within its humanitarian work, especially in protracted crisis situations such as DRC.

RECOMMENDATION 5: To improve the quality and consistency of decision-making in operations, greater guidance should exist in the form of strategy, leadership, and clarity on matters of principles and ethics.

The evaluation found two particular areas of concern that require steering from leadership, strategy, and policies: oversimplified and negative narratives (e.g., other OCs, OCB HQ-field, donors, MoH, DRC government, etc.) that undermined deliberation and decision-making, and the disproportionate impact of ad hoc decisions that were overly individual-dependent. Additionally, ethical issues related to the humanitarian principles were not usefully recognised or used to frame decision-making (i.e., independence and complicity being instrumentalised to end debate).

- Specific Recommendation: OCB should explore the possibility of retaining dedicated expert support such as an ethicist to assist with operational ethical decision-making (in contrast to existing capacity on medical-clinical ethics).

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ANNEX: TABLE OF EVALUATION QUESTIONS

As stated in the Terms of Reference.

EQ1	Relevant? How relevant were the OCB interventions when considering the needs, MSF principles, and respective context? How can relevance be improved in the future?
1.1	What were the needs of the populations in crisis? How were these needs assessed and translated into OCB's strategies/approaches?
1.2	How did the needs of people change over time? How well did OCB adapt to these changes?
1.3	How did OCB apply key principles and ideals in the shaping of its intervention strategies, objectives, and approaches?
EQ2	Appropriate? How could OCB's interventions be more appropriate in regard to context?
2.1	What (if any) objective(s) and expected results did OCB set to guide its interventions? Did these objectives or results shift over time? If so, how?
2.2	What were the approaches taken in the course of the three outbreaks? What alternative approaches existed?
2.3	How were the decisions to intervene (or not) taken? How were the various intervention strategies decided upon? How responsive were these strategies to the positions of various stakeholders?
2.4	Were interventions adapted to the contextual specificities of each outbreak? Did they adapt to changes in context in a timely fashion?
EQ3	Effective? How effective were the OCB interventions?
3.1	What were the results achieved, and to what extent did they correspond to the objectives of the interventions?
3.2	What challenges and risks were encountered (expected or unexpected)? How did OCB address them?
3.3	What, if any, were unintended effects of the approach chosen in each outbreak?
EQ4	Efficient? Were the OCB interventions efficient?
4.1	In what ways did the use of resources stand out as highly efficient or inefficient?

4.2	Did OCB address questions of opportunity cost in the three interventions? If so, how?
EQ5	Connected? How can the connectedness of the OCB interventions be enhanced?
5.1	How did OCB work and coordinate with other MSF OCs? With key international responders?
5.2	At the strategic level, how did OCB work and coordinate with the Ministry of Health as well as other DRC authorities? How was OCB's intervention integrated into the overall response and how might this be done differently in the future?
5.3	To what extent were OCB's interventions integrated into the local health system? How did they build on existing MOH or MSF capacity?

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