Akonolinga - Buruli Ulcer Project
Cameroon, 2002 - 2014

EVALUATION REPORT

JULY 2014

Low clouds over the Nyong River

Evaluators:
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MANAGED BY THE VIENNA EVALUATION UNIT
In Yaoundé, we were thrown into the thick of an emergency, with a substantial proportion of the key interlocutors, including the chef de mission, occupied and preoccupied by the situation in the Central African Republic, not to mention the Ebola emergency in Guinea. Despite these adverse circumstances, the availability of our interlocutors was in general satisfactory.

On the Buruli Project in Akonolinga, we enjoyed the co-operation and unfailing commitment of Field Manager Stéphanie Remion, who often went above and beyond our many and varied needs. Together we established an inspection program at the hospital and in the health centres that met our objectives.

Throughout the mission, we maintained a professional relationship with Mzia Turashvili in Vienna, and we were able to meet with officials from MSF OCG at the conclusion of the mission. We give them our thanks.

We were greatly interested in carrying out this evaluation. The particular nature of the environment linked to this greatly neglected illness is no stranger to us.

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Executive summary

Background

Following the first International Conference held by the World Health Organization (WHO) on combating and research into Buruli Ulcer, Bénin, Ivory Coast and Ghana were the first countries to invest themselves in the illness, along with a series of actors such as MSF, in order to advance the detection, treatment and research in all fields affected by the disease (over thirty countries, worldwide).

The wide gaps in knowledge that still exist with regard to Buruli Ulcer, its origin, its development, and the world-wide level of morbidity, explain the trial-and-error approach that has characterized the treatment of this disease.

The primary objective of the evaluation was to identify the lessons learned throughout the period that the BU Project was in operation in Akonolinga, from its launch in 2002 until its conclusion in late June 2014. To accomplish this, the assessors relied on existing documentation, interviews with persons directly or indirectly involved with the project, and on any observations that they made during their time in the field.

The project

The approach chosen by MSF for the BU project was, from the outset, highly medical, surgical and vertical. The organization applied the same rules to the BU Project as were used for emergency operations. The treatment of BU was intended to be lasting in nature and therefore needed to be incorporated into the local fabric, from both a socio-economic standpoint and from the standpoint of the procedures and protocols used in Cameroonian and international medical circles.

This operational choice on the part of MSF was no doubt conditioned by the desire to be successful, by imposing quality criteria, in an attempt to obtain tangible results as quickly as possible. The vast majority of observers who have seen MSF and its teams at work in Akonolinga acknowledge that it has the professional qualifications needed to successfully complete such a project, but find it difficult to understand its desire to operate alone.

The findings presented in the evaluation deal essentially with the study of the project phases, its strategic evolution, its management, the partnerships entered into by MSF, decentralisation, awareness-raising campaigns and advocacy activities. One major chapter is devoted to an analysis and an appreciation of medical activities, with their therapeutic choices, performance, support elements and the research carried out in and around the project. The evaluation also looked at planning for the disengagement phase and on the legacy left by MSF after twelve years of engagement.
Overall conclusion

MSF qualities that characterised the project were courage, expertise, commitment, credibility, stubbornness, and the desire to position itself at the patient’s bedside.

A total of 1231 patients with ulcers, including 435 confirmed cases of BU, were diagnosed. They received institutional care, based on quality standards and methods which were unknown in Cameroon until now. Numerous research papers, training courses and a multi-disciplinary approach were also part of the care given over the years. A modest advocacy action was carried out. All these activities were developed against a background that highlighted a reduction in the incidence and number of new BU cases detected, not only on the national level, but also on the international level. Also, with time, there was a growing threat to the sustainability of activities after MSF had left.

The highly positive elements observed in the project were tempered by a closed-circuit method of operation, vertical management, uneven planning, with human resource assignments and project management unsuited to the context, a short-term vision, lengthy delays in preparing and planning for the disengagement, and a loss of substance.

Recommendations (formulated with an eye to the launching of similar projects in Cameroon or other countries)

For Headquarters

- Examine the advisability of formulating a policy on engagement for medium- and long-term projects that incorporates the requirements of sustainability and permanence, and provides a definition of an exit strategy.
- Develop an operating procedure framework that can be applied to projects that are not urgent in nature, while keeping in mind:
  - the need to closely associate the medical and institutional approaches with openness to the field of public and community health;
  - the need to weave the intervention into the local fabric, on both the socio-economic level and on the level of the procedures and protocols in effect in national and international medical circles;
- Establish the mechanisms needed to allocate human resources based on actual needs of a long-term development project;
- Use management tools that make it possible to support, monitor and evaluate long-term projects in a well-planned, on-going fashion.

For the Field

- Establish a regular, transparent mechanism for reporting a project’s development and share it with interested parties at headquarters and in the field;
- Implement a diversified internal information process that will enable staff, whether or not directly involved in the project to follow its development and take an interest in it (buy-in);
Use capitalisation tools to regularly and accurately track the project’s acquired knowledge and expertise, and facilitate access to it by researchers, both internal and external;

Manage project databases in such a way as to optimise the content for future users.

**For Partners**

**Public services and authorities:**

- Establish a co-operation agreement that clearly sets out the division of roles and responsibilities;
- Display institutional pride, while at the same time resisting group-think; respect all stakeholders;
- Agree on an exit strategy for the project that accurately describes the place of stakeholders and sets out the nature and scope of requests intended to support continuation of the project;
- Establish a project inspection programme for all stakeholders concerned with its current or future development;
- Ensure that there is transparency at all times in the exchange of information;
- Establish an atmosphere of trust.

**Private organisations:**

- Ensure complementary nature of what others can bring before entering into a partnership;
- Clarify exactly what the role of each organisation will be during and after the project, as appropriate;
- Ensure a regular flow of high-quality information;
- Conclude co-operation agreements, where necessary;
- Ensure that there is clarity, legibility and predictability in behaviours on both sides.
**Abbreviations**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>AEMC</td>
<td>Access to Essential Medications Campaign/MSF</td>
</tr>
<tr>
<td>BS</td>
<td>Health care office (attached to district)</td>
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<tr>
<td>BU</td>
<td>Buruli Ulcer</td>
</tr>
<tr>
<td>C+R</td>
<td>Clarithromycin + Rifampicin</td>
</tr>
<tr>
<td>DB</td>
<td>Data Bank</td>
</tr>
<tr>
<td>CHU</td>
<td>Centre hospitalier universitaire (University Hospital Centre)</td>
</tr>
<tr>
<td>CPC</td>
<td>Centre Pasteur Cameroon</td>
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<tr>
<td>HoM</td>
<td>Head of Mission</td>
</tr>
<tr>
<td>EWMA</td>
<td>European Wound Management Association</td>
</tr>
<tr>
<td>FM</td>
<td>Field Manager</td>
</tr>
<tr>
<td>HUG</td>
<td>Hôpitaux universitaires de Genève (University Hospitals of Geneva)</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>IO</td>
<td>International Organisation</td>
</tr>
<tr>
<td>MEDCO</td>
<td>Medical Coordinator</td>
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<tr>
<td>MoU</td>
<td>Memorandum of Understanding</td>
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<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MSF</td>
<td>Médecins sans frontières</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-governmental Organisation</td>
</tr>
<tr>
<td>NTD</td>
<td>Neglected Tropical Diseases</td>
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<tr>
<td>OCG</td>
<td>Operational Centre Geneva</td>
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<tr>
<td>PCM</td>
<td>Project Cycle Management</td>
</tr>
<tr>
<td>PCR</td>
<td>Polymerase Chain Reaction</td>
</tr>
<tr>
<td>PNLUB</td>
<td>National Programme against Leprosy/Buruli Ulcer</td>
</tr>
<tr>
<td>SC</td>
<td>Steering Committee (disengagement)</td>
</tr>
<tr>
<td>SWOT</td>
<td>Analysis based on Strengths – Weaknesses – Opportunities – Threats</td>
</tr>
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<td>WHO</td>
<td>World Health Organisation</td>
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</tbody>
</table>
1 Introduction

1.1 Background and project environment

Cameroon’s apparent stability within a turbulent region cannot be taken for granted. The co-opting of the elites resulting from the distribution of the State’s resources and the out-migration of large numbers of educated young people provide a safety valve against tensions, but the failure of reforms and the continuation of practices indicative of bad government have led numerous Cameroonians to lose faith in a lawful State or the possibility of a peaceful political transition.

Now, a few words on the historic roots of the current impasse.

Cameroon history consists of a series of periods of apparent stability followed by violent crises. Over long periods (early 1950s and the 1970s), problems were covered up, but never resolved. In the late 1950s, generalised troubles led to a ban of the main party opposed to French domination, and this resulted in a long and bloody guerrilla war. Independence was granted in 1960, but against a background of extensive violence. In 1961, when the southern portion of English-speaking Cameroon that was under British rule voted to re-join the French-speaking part of the country, the North chose to remain within the Nigerian federation.

The late 1960s and the 1970s saw relative peace. The regime fed an obsession for unity and stability following the traumatic events of the 1950s, but, after having fought the only true liberation movement, it lacked historic legitimacy. It was autocratic. Pluralism and diversity were accused of unacceptably threatening the nation-building project. Nevertheless, the economy was growing and real development was taking place.

The resignation of President Ahidjo in November 1982 and the transfer of power to Paul Biya, his Prime Minister, took place peacefully, but tensions soon emerged, and led to an attempted coup d’état in April 1984, allegedly led by followers of Ahidjo. It was violently repressed and was not followed by any type of reconciliation process. The violence of the time remains a source of bitterness among many of the inhabitants of the North, the region that was home to Ahidjo. As well, some in the South, including the security forces, fear that matters have not been put to rest and that there could still be acts of community vengeance to come, following the 1984 repression.

In the early 1990s, opposition parties emerged, and multi-partite elections were held. For two and a half years, the regime was seriously threatened at the voting stations and in the street. Frustrations led to generalised violence in 1991. After surviving these new challenges, President Biya and his party were able to repeal the reforms and reinstate a number of authoritarian practices limiting democratic expression.

Currently, the nation-building project is running out of steam, the economy is stagnating, and unemployment and inequality are increasing. The economy is being pulled down by corruption and inertia. The population has not benefitted from the economic growth that

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1 Excerpts (adapted and updated) from Rapport Afrique, May 2010, International Crisis Group
has been generated primarily by the exploitation of the country’s natural resources. The forces to mobilise the opposition have been weak and uncoordinated.

The regime has retained its long-standing conservative reflexes, at a time when the expectations of a young population have evolved. The political opposition has been weakened by internal divisions and the erosion of the democratic space. The explosion of anger in February 2008 resulting from Biya’s decision to change the constitution to give him another presidential term highlighted the dangers in this situation.

Cameroon shares a number of characteristics with countries that have experienced civil conflict, including notably highly centralized and personalized rulers, political manipulation of ethnic tensions and wide-ranging corruption. The possibility of a deterioration that could be enough to trigger open conflict cannot be excluded. President Biya has been in power since 1982, and unless there are fatal circumstances, his successor will not come in before 2018, since he was re-elected for a new seven-year term (his sixth) in 2011.

The international community has often supplied aid that has been decisive for the Cameroonian regime. While such aid has come with pressure to implement reforms, very few have taken place.

Most backers and other international powers have been reluctant to criticize the regime and seem prepared to tolerate his cat-and-mouse game of false political and economic reforms. But an unstable Cameroon, or even just a few more years of bad governance could threaten a region that is still fragile (Ivory Coast, Boko Haram in Nigeria, Chad, CAR, etc.). These problems raise legitimate concerns beyond the Cameroon borders and suggest a classic case for early prevention of conflict.

The fragility of this context is one of the key arguments prompting the international community to maintain a presence in Cameroon, as a platform from which to observe the regional disturbances.

1.2 Methodology

Scope of evaluation

The primary objective of the evaluation is to identify the lessons learned during the entire period that the BU Project ran in Akonolinga, from launch in 2002 until handover at the end of June 2014. To accomplish this, the assessors relied on existing documentation, and interviews with persons directly or indirectly involved in the project, as well as any observations that they were prompted to make during the time spent in the field.

In addition to the evolution of the project over this twelve-year period, they also analysed the process for handing over the project, with respect to both its design and its timetable, as well as its actual implementation.

The operational elements, as well as the project’s medical outcomes, represent the basic framework around which the evaluation was constructed.

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2 See 5.1 Terms of reference.
Evaluation tools and methods

To comply with the requirements posed by the terms of reference, the evaluation is built around a certain number of commonly used and accepted tools, such as:

The sorting and analysis of documentation supplied by MSF, which produced a table indexing the key teachings that would be useful in the evaluation.

A search for additional relevant documents (WHO and other scientific publications).

The development of semi-structured questionnaires designed to support interviews with MSF’s internal and external interlocutors participating directly or indirectly in the development of the project.

A gathering, sorting and synthesis of the information gathered daily throughout the evaluation process, in particular during the three weeks devoted to field visits.

Drawing up, an on-the-spot list of positive elements or subjects for discussion gathered in the course of the mission, for the purpose of facilitating the drafting of the evaluation report.

Follow-up of the evaluation is based on what is known as the workstream method, which makes it possible to progressively track the tasks required by the evaluation and ensure that they are completed according to deadline. This method is also supposed to foster a dialogue between the assessors and the parties who mandated the evaluation.

1.3 Limitations

As frequently happens in other contexts, the evaluation mission encountered a number of constraints that it attempted to overcome; these are not without consequences for the finished product that is the Evaluation Report.

Most of these relate to the area of documentation:

– the supplied documents were highly fragmented;

– one major document resource became accessible only at the end of the mission, making it very difficult to examine them in great detail and incorporate into the overall random process;

– it is complicated to reconstitute a managerial logic based on the documents available, since the titles and the way they were constructed had varied considerably over the years;

– a substantial number of the documents were not signed or dated, causing the assessors to make deductions that were not always reliable;

– some documents were incomplete or were in the form of a draft, which leads to the possible conclusion that these were not official documents;

– a reconstruction of the monitoring of the objectives that were proposed in a document supporting the project, with actual accomplishments listed in the annual reports proved unreliable; however, it should be noted that the situation did improve, beginning in 2009;
it was difficult to find out what happened with documents referred to in the course of a single sentence, such as the Memorandum of Understanding covering the project exit process;

- the quality of the field inspection reports was quite uneven, with a number of pearls of wisdom here and that that need to be highlighted;

- the most sensitive issues (reduction in morbidity, institutional policies, disengagement strategy, etc.) are often drowned out by the vast amount of redundant information of secondary importance.

In addition, the assessors, when consulting the data bases available in Cameroon, were faced with a lack of key information. Further, certain data contained in the database did not reveal a high degree of reliability—a shortcoming that is acknowledged by headquarters, but was never corrected. This is especially true for the data on hospital patients (presence of sequelae upon admission, etc.) which are at the very heart of the BU Project.

Despite numerous entreaties, the assessors were unable to obtain complete data on human resources and budgets or outcomes covering the period under evaluation (2002-2014) for purposes of accurately determining staff turnover rates and presenting a more complete picture of the effectiveness of the project.

1.4 Information on Buruli ulcer

In 2000, that is, two years prior to the start of the MSF Buruli Ulcer Project, Gro Harlem Brundtland, the then-head of the World Health Organization (WHO) stated:

“Illness and death from many infectious diseases can be avoided at an affordable cost. Buruli Ulcer is one such disease. Yet, over the past few years, this disease has spread to new populations, causing a serious burden in an increasing number of countries and communities.

Since 1998, the WHO Global Buruli Ulcer Initiative has been providing a policy, research and support framework for Buruli Ulcer control. We have shown that through early detection and early treatment we can avoid the serious consequences of the disease at an affordable cost. By forging partnerships with other communicable disease control programmes, we aim at utilising existing resources efficiently and strengthening health services in order to reach Buruli Ulcer patients early with effective interventions.”

In its introductory summary, the same publication states that “as the treatment with antibiotics has been disappointing to date, at present surgery has become the treatment of choice.”

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3 Dr Kingsley ASIEDU, Dr Robert SCHERPBIER, Dr Mario RAVIGLIONE, Buruli Ulcer, Mycobacterium ulcerans infection, World Health Organisation – Global Buruli Ulcer Initiative, 2000.
Ten years later, the Global Buruli Ulcer Initiative (GBUI), which was established by WHO in 1998, has gathered a significant amount of useful information, which it has provided in a guide for active field health workers, noting the following:

- Buruli Ulcer is a natural disease that can be cured with antibiotics. It is important that it be diagnosed early.
- BU is a disease caused by a germ. It is not caused by witchcraft. It is neither a curse nor a punishment.
- BU cannot be transmitted by direct contact with an affected person.

The Initiative also acknowledges that “the exact mode of transmission is not always known.”

These few pieces of evidence, which may appear somewhat simplistic, are indicated here because, related to the professions of faith given over the years on and about this disease, they illustrate the immense chasm that exists between the reality experienced by the poorest populations and the concrete means used to help them. They also broadcast, through a halo of doubt, the contradictions seen throughout the years of practice which for those who are very rare, who have taken the risk to involve themselves in the treatment of this, the most neglected of diseases.

The wide knowledge gaps that still exist with regard to Buruli Ulcer, its origin, its development, and the world-wide level of morbidity, explain a goodly portion of the trial-and-error approach that has characterized the treatment of the disease. Yes, WHO organized its first International Conference on Buruli Ulcer in 1998. Bénin, Côte d’Ivoire and Ghana were the first countries to mobilise in the battle against the disease, but few players have invested themselves in it in order to significantly advance efforts toward the screening, prevention, care and research into all areas affected by the disease (over thirty countries throughout the world).

The WHO is not discouraged. Through its global initiative, it issued specific recommendations in 2008 to transition BU “from mystery to visibility.” These recommendations emphasized the need to:

- strengthen public/private partnerships to develop intervention strategies;
- improve surveillance capabilities for the disease;
- encourage research into the modes of transmission, early diagnosis and simplified antibiotic treatment;
- all without neglecting to emphasise advocacy designed to mobilise greater amounts of resources.

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4 WHO, Department of Control of Neglected Tropical Diseases, Buruli Ulcer: recognize act now: a guide for field health workers, 2011
5 Under the direction of Dr Lorenzo SAVIOLI, Department of Control of Neglected Tropical Diseases, WHO, Neglected tropical diseases, hidden successes, emerging opportunities, 2009.
The Cotonou Declaration,\(^6\) while acknowledging progress achieved thus far, brought its entire weight to bear on the themes set out above and reaffirmed the importance of no-cost treatment and the socio-economic reintegration those affected by the disease.

In the pages that follow, we will attempt to demonstrate whether and how a stakeholder such as Médecins sans frontières – Suisse (MSF CH) came, during the twelve years it was concretely involved in the field, to fulfil its overall objectives, based on its own operational methods and institutional priorities.

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\(^6\) *Cotonou Declaration on Buruli Ulcer*, adopted 30 March 2009 by 31 countries directly affected or supporting the fight against BU; four Foundations present; MSF did not participate.
2 Findings

2.1 During the project

2.1.1 Programming phase

Chronology of events

<table>
<thead>
<tr>
<th>Year</th>
<th>Event Description</th>
</tr>
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<tbody>
<tr>
<td>2002</td>
<td>Start of MSF CH project for the diagnosis and treatment of patients with BU, at the Akonolinga district hospital</td>
</tr>
<tr>
<td>2006</td>
<td>Introduction of physiotherapy and modern dressings for use in treatment of wounds</td>
</tr>
<tr>
<td>2007</td>
<td>Study on prevalence of Buruli Ulcer (BU); Introduction of voluntary screening for HIV and counselling for BU patients</td>
</tr>
<tr>
<td>2008</td>
<td>Start of decentralisation of BU treatment and early detection in district healthcare facilities</td>
</tr>
<tr>
<td>2009</td>
<td>Specific treatment using antibiotics Rifampicin + Clarithromycin for 90 days</td>
</tr>
<tr>
<td>2010</td>
<td>Training on treatment of BU for officials in charge of the twelve district health centres</td>
</tr>
<tr>
<td>2011</td>
<td>Start of Score Clinical study, including the differentiated diagnosis study in the treatment of all chronic wounds</td>
</tr>
<tr>
<td>2013</td>
<td>Workshop on treatment of chronic wounds in co-operation with the Yaoundé Faculty of Medicine and Pharmaceutical Science, the Douala Faculty of Medicine and Pharmaceutical Science, the School of Nursing at the Université catholique d’Afrique central, and the Geneva University Hospitals (HUG)</td>
</tr>
<tr>
<td></td>
<td>Development of a roadmap for handing the project over to the Ministry of Health and its partners in mid-2014. Common goals and indicators were defined in order to be able to monitor progress throughout the transition period.</td>
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</table>

Source: Terms of reference and MSF OCG documentation
Introductory comment: The changes to come in the approach and treatment of BU will be based on the national programmes conducted in various countries and the accumulated experience gained by the stakeholders involved in International Organisations (IOs) or NGOs. The compilation of this knowledge by WHO and the sharing of it with interested parties will serve as markers in the epidemiological contextual evolution and facilitate adaptation of the response to BU. In general, MSF will participate in these exchange and discussion forums and will follow, hesitantly, whatever avenues of intervention are proposed. In parallel, it will launch a number of research initiatives and gradually introduce, sometimes after significant delay, any new components of the treatment plan that are designed to foster an ever-expanding multidisciplinary approach that may also be distinct from the policy put forward by the National Programme (See Appendix 3, timetable).

A reading of the written documentation that has been available since late 2004 will shed light on the key aspects of the scenario. The term that best describes how the program phase of the project was to work is fragmentation. The juxtaposition of the strategies that have been formulated during the twelve years of the project shows no consistency. Instead, it highlights the extent to which the mobility of the human resources of an emergency-response organisation came into conflict with the requirements posed by carrying out a long-term project.

Throughout the life of the project, it was the subject of comments and proposals, which were often interesting, but had no genuine continuity. As a result, a number of constructive ideas became lost along the way and were never mentioned in any of the subsequent reports.

This tendency to forget was particularly strong in 2005 and 2006, the year in which the National Strategic Plan to fight Buruli Ulcer, a five-year plan (2007-2011) produced by the Ministry of Public Health and Population (MOH), in collaboration with Lepra.ch (formerly Aide aux Lépreux Emmaüs Suisse – ALES, now known as FAIRMED).

MSF dove blindly into the world of BU, knowing that the assessment of the disease workload, the prevalence and the epidemiological profile were completely unknown at the time the project was begun. Immediately, MSF opted for an approach that was highly vertical, medical-oriented and relatively isolated from its direct environment. It evolved into the offer of a bundle of multi-disciplinary services designed to improve management of the illness. The various phases and components involved in setting it up depended on those persons in charge and their vision, ranging from a medical-surgical and institutional approach to an openness to public and community health. During this lengthy evolution, characterized by frequent changes in direction, the degree to which objectives were realized varied significantly.

As an example: Operational research in the field of therapy needs to be carried out. The latest proposal received would use MSF UK and the Manson Research Institute, which is

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8 For example, there is the first investigation carried out jointly by ALES, the CPC and MSF in the northern Nyong Basin, where 400 cases were examined, which the Institut tropical de Bâle later confirmed as Buruli cases (in 2000).
9 Dr Elena Pagano, Medical Coordinator for MSF Suisse, Yaoundé, Quel futur pour le project Buruli à Akonolinga
heavily involved in the field of mycobacteria. In order to determine the most encouraging avenue to pursue and plan a well-conducted study, there first needs to be an analysis of all the possibilities—antibiotics, immunology, anti-toxins, hyperthermia, etc. Such a study would require several months of preparation and the approval of an ethics committee. The new therapy could be compared with the national protocol (randomisation).

As for surgical treatment, the Akonolinga hospital is some forty km from the one in Ayos (less than an hour over tarred road). Both hospitals have a general surgery department and one specifically for Buruli, and each has its strengths and weaknesses. In Ayos, there is an anaesthetist-nurse, oxygen tanks, two operating rooms and physiotherapy activities. Akonolinga has an oximeter (still in its original box), a device for the extension of grafts (very useful) and is recording a slightly higher number of patients. The question is whether it would be better to strengthen the section in Akonolinga or come up with a joint solution with Ayos. Theoretically, it is possible to envision a more efficient common surgical centre, with the addition of an x-ray machine, among others.

The years 2007 and 2008 also saw a tendency to conceptual round-tripping, sprinkled with constructive proposals and a goodly dose of optimism on a certain number of measures, such as joint management of the disease in co-operation with the MOH, decentralisation, looking forward, and conducting a study on the prevalence of the disease, rapprochement with WHO, etc.

“The project’s medical ambitions are not in line with the number, availability, motivations and skills of the project’s human resources, and therefore out of sync with an existing policy of integration into the national program and the Ministry of Health with a view to disengagement at the end of December 2009.”

However, reality can be harsh, as can be seen from one field report. The key questions, which were voiced throughout the life of the project, can be plainly summarized in this sentence. In the chapters that follow, the issues relating to human resources, the partnership with the MoH, and the disengagement plan will be developed.

During fiscal year 2010, a change seems to have emerged, moving more toward consistency and a tightening of priorities in the form of a three-year strategic plan (2011-2013). This comes across more clearly than in the past, thanks to a well-written 2010 Annual Report, which reflected an interesting series of questions regarding the types of activities that were being conducted.

Regardless, perceptions in the field can be quite different, as described by one returning field manager, who was disappointed by the dysfunction that she had to deal with, by the inconsistencies in decentralisation, by the paucity of the field apparatus (educators and community contacts) and the lack of operability when it comes to the essential working tools (electricity, Internet, water supplies, etc.). [These are] all shortcomings that she summarized under the heading of “omissions” and “inefficiency.”

Beginning in 2011, a serious reversion began, as a result of a more objective reading of the problems being encountered and a number of proposed solutions for the most urgent

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10 Project Justification and Strategy Sheet – Akonolinga Team, October 2008
problems. From this vast brainstorming exercise emerged a series of concrete measures (including the launch of the Score Clinical Study\textsuperscript{11}), along with preparations, still just as vague as ever, for an exit strategy now planned for end of 2013 … this after at least three previous tries.

The year 2012 saw the imbalances that seem to exist as part of the process for setting the project’s overall objectives in treatment, in the return of surgery, in the strengthening of partnerships through participation in a platform to coordinate the fight against neglected tropical diseases (NTDs). The 2012 operations report points out that by the end of the fiscal year no disengagement strategy had yet been put into place.

In 2013, events happened quickly: a handover strategy was developed in March 2013; a committee to supervise the disengagement was contemplated (ed: later became the Steering Committee), and a new advocacy and communication strategy was formulated; the MoU with the managers of the health district is still to be addressed.

In January 2014, a document originating in the field\textsuperscript{12} clearly set out the disengagement measures for the first time, including actions that needed to accompany the entire process. The 2014 Stratégie de la Mission Cameroon [strategy for Cameroon mission] – the latest available document – marks the high point of this process by sketching out the planned profile that MSF will have in Cameroon following handover of the Buruli Project.

2.1.2 Strategic issues

A reading of the documentation, discussions with past and current MSF stakeholders, interviews with persons involved with the project—everything leads to the same conclusion: The approach chosen by MSF for the BU project was, from the outset, highly medical, overly surgical and especially too vertical. This is another way of saying that the organisation applied the same rules to the BU Project as are used for emergency actions, even though treatment of BU was intended to be lasting in nature and therefore needed to be incorporated into the local fabric, from both a socio-economic standpoint and from the standpoint of the procedures and protocols used in Cameroonian and international medical circles.

Nevertheless, this vertical bias has prevented the project from nurturing a goal of sustainability. It has led to choices and behaviours that have hindered the harmonious development of the project. It has gone against the establishment of productive working relationships with its closest partners. It is at the base of a halting decision-making process that has compromised the implementation of such measures as genuine decentralisation, or support activities, such as physiotherapy and the psycho-social environment. Finally, it has delayed the launch of major research-related initiatives.

\textsuperscript{11} A clinical score is a medical decision-making tool which combines a number of clinical observations into a single value. It gives a weighting to certain relevant signs (anamnesis, para-clinical examinations, etc.) and aggregates them into a single numerical value that is representative of the diagnosis or the prognosis.

\textsuperscript{12} Serge ST-LOUIS, Head of Mission (HOM), Stéphanie REMION, Field Manager (FM), project document: “Chronic Wounds and Buruli Ulcer,” 8 January 2014
This operational choice was undoubtedly based on the desire to be successful in imposing high-quality criteria from the outset, in order to obtain significant results as quickly as possible, which was the case, as has been acknowledged by the vast majority of observers, either active or passive, who witnessed MSF and its teams at work in Akonolinga.

Consequently, it was not until 2007, or five years after the project began, that active research and a study on prevalence were undertaken in order to engage more with patients living on the periphery and get a better picture of circumstances as they are and of the parameters of the disease.

In 2008, steps were taken toward making early detection a reality. Co-operation with the network of health centres began, and became more periodic than systematic. Continuation of the research work and collection of reliable and useful data were compromised by inadequate preparatory work, leaving this exercise without a major portion of its substance and relevance.

As for the changes in direction undertaken beginning in 2013 – and partly in 2011 with regard to the Clinical Score - they only served to highlight the shortcomings in the long-term strategic vision that should have been the backbone of the project. Some of the commendable, but late-arriving, initiatives include:

- A new decentralisation strategy that was initiated in order to be account for the very limited number of patients being followed in the peripheral health centres;
- An active research campaign that was launched in the schools and the communities to improve detection;
- Training that was offered to the MoH community contacts to support the joint action with the traditional doctors;
- The disengagement plan developed in mid-2013 was launched during the final quarter, but all the internal and external players did not come onto the scene jointly until April 2014, which was three months prior to the end of the project;

2.1.3 Management of the project

For medium- and long-term commitments, MSF relied on proven management systems. This applies to both financial resources and human resource capacities. International staff are recruited and trained based on requirements for short- or long-term cycles, normally only a few months, or up to a year, and some for a few weeks (surgical teams, anaesthetists, etc.). The organisation’s day-to-day operations do not cover the needs generated by long-term actions, either at headquarters or in the field.

As a result, a project such as the one dedicated to the fight against Buruli Ulcer was bound to suffer the constraints imposed by short-term commitments, and did not allow for either appropriation or the transmission of lessons learned regarding the life of the project.

While it may be easy to understand that adapting to these new circumstances could not come quickly, it becomes difficult to admit that once they became aware of the situation, management officials, either at headquarters or in the field, out of necessity, did nothing to improve it.
As a result, the BU project had to be satisfied with a constant coming and going of staff, who were undoubtedly qualified, but who had no opportunity to build a lasting relationship with the project’s permanent employees, and found it difficult to understand why they were forced to endure this endless back-and-forth of international specialists.

Not only did this situation have a negative impact on the performance of many, but it prevented work on building up the project throughout this time. It gradually destroyed the memory of the project and made it difficult to comprehend. Various tensions and errors ensued because the corpus of the acquired knowledge was poorly understood, and there was often a lack of consideration for the work that had been done by those who had been there before.

The lack of suitable management tools for a long-term project only served to make things worse. If Project Cycle Management had been in place, the most damaging slip-ups could have been avoided. Unfortunately, the BU Project did not have the benefit of any technical controls appropriate for its profile. The tools that were available within MSF provide for monitoring project cycles that last one year, sometimes three to five, but no more. To the best of our knowledge, nothing has been planned to date for periods of 10 years or more.

2.1.4 Partnerships (ministries, IOs, NGOs, traditional doctors)

MSF is justifiably proud of its expertise and convinced of its ability to carry out excellent work in its preferred fields. Furthermore, these qualities have been recognized in MSF by all those who have approached it, even by possible detractors. This creates a climate of confidence and hope that it will be able to establish close and promising working relationships.

In reality, the development of relationships with natural and potential partners has been successful and has also seen a number of blips, which have been the result of the operational choices made by MSF in its implementation of the Buruli Project.

Below is a brief selection of opinions expressed by various stakeholders interviewed by the assessors; these paint a picture of MSF’s relations with its Cameroonian environment.

**Ministry of Public Health**
- “MSF preferred to remain at the patient’s bedside, rather than strategically and politically playing in the big peoples’ yard.”
- “It created a model treatment facility in Akonolinga. It made major resources available.”
- “MSF set the bar so high that the standards of quality are unattainable with the State’s resources.”
- “The MoH will take over MSF’s responsibilities after it leaves, but will have to adapt its model to the reality of things here in Cameroon.”
(By way of comparison, the cost of a BU patient in Ghana is approximately $750, whereas the cost per MSF patient in Akonolinga can be estimated at $5500. This information comes from a quick study carried out by the Cameroonian MOH’s National Program along with its counterparts from Ghana; the non-availability of data from MSF OCG, despite our requests, prevented us from making our own calculations. However, initially, we can still estimate that the cost per BU patient in Akonolinga is higher than the amount quoted above.)

- “The MoH regrets that MSF did not establish a co-operation mechanism with its services to make them available to its staff in treating BU, preferring instead to hire its own staff at rates that are disproportionate to the MoH’s normal practice.”

- “MSF has sometimes been short on trained staff, notably for the introduction of physiotherapy, which was brought in quite late, like the decentralisation strategy, where they prepared to work in parallel with the health centre apparatus.”

The MoH will have to make a financial effort to include treatment of BU on the list of no-charge diseases, such as malaria in children under age five, HIV, and TB. To date, it still has not confirmed its position on this subject.

For the last three months, WHO has been supplying clarithromycin to the Ministry at no charge.

In Cameroon, decentralisation is still a theoretical exercise, due to the lack of resources to support the work on the peripheral level.

MSF has been very conservative when it comes to capitalising on its experience, launching only a few, or very limited number of studies, when it comes to publishing the results of its actions (dressings, choice of antibiotics, etc.), hence very limited leverage on health policies and a virtually non-existent influence on WHO recommendations. Generally speaking, its lobbying was poor. The Score clinical study is obviously promising, but the results will not be known until six months after MSF leaves.

**WHO**

- “Very positive feeling regarding progress with the disease, its treatment and the enormous investment agreed to by MSF, but concern for the future, during the post-MSF period. BU requires complex and costly treatment. National financial and human resources will not be able to keep up.”

- “MSF lacked transparency. Its research into innovative treatments and their introduction only came afterwards. No collaboration or sharing. MSF’s opacity and individualism during the initial years of the project prevented an assessment of the impact of the various treatment strategies introduced during the project.”

**Universities and research institutes**

At the Centre Pasteur du Cameroun (CPC), opinions on the work of MSF were extremely positive.

- “MSF has true expertise. One of its strengths is that it is able to re-examine itself. It is very laudable on its part for investing itself in a neglected disease. The division of tasks
between the two institutions has always been clear: MSF manages the day-to-day operations, and the CPC prepares for the future. It’s based on closeness. The CPC has always been involved with Buruli Day put on by MSF; public conferences were held jointly, in partnership with the IRD (Institut pour la Recherche et le Développement). This network is very important in dealing with this disease, and this is why the CPC does not want to see MSF exit the project. Also, it will be impossible to validate the data collected by MSF during the project. MSF’s reasoning consists of saying: “we are in emergency operations, so we’re not staying,” but twelve years later, they are still here. This dual positioning and the consequences from it need to be better handled. Rotations of expatriate staff occur too frequently with MSF, while national staffs remain stable. This can affect cost-effectiveness, and then creating ties becomes complicated. Also, it seems that there is a wide chasm between headquarters in Switzerland and the field.”

The relationships that were formed over the past several years with The Geneva University Hospitals (HUG) in themselves would merit a development that this evaluation did not have an opportunity to tackle in depth, given the lateness in receiving information on the subject and the large number of projects involved. These working relationships are positive and promising for the future (see below, Item 11, Scientific research work.).

NGOs

Relations with the NGO FAIRMED (previously known as ALES) fall into the category of “I love you, me not so much.” They date back many years, because both NGOs collaborated with the CPC on the very first collection of data on BU in Cameroon (2000). Nothing happened until 2002, when officials from ALES and from MSF (Laura Ciaffi, HoM) worked together with representatives from the MoH in the district with a view to taking over the 400 known cases. Akonolinga was proposed as the site. Both NGOs, with highly complementary approaches, could have worked together there, but ALES headquarters in Switzerland chose Ayos as the site of the operation. Apart from this slight geographical difference, the two NGOs continue to collaborate. They have very different operational policies: ALES/Fairmed works on the principle of supporting the public healthcare system and provides support for government efforts, whereas MSF develops its own model, outside the regular system, with effective, imported medication that is not permanent. As far as Fairmed is concerned, the MSF model, which is highly centralised, is not manageable over the long term. Relations between the two NGOs chilled along the way, primarily because of the very frequent changes in MSF managers, not to mention the fact that the two headquarters in Switzerland were unable to come to an agreement with respect to co-operating with one another.

Fairmed, which withdrew in 2011 from a substantial portion of its projects, especially in Ayos, plans to resume operations in 2015.

13 An opinion that is obviously based on one unpleasant incident relating to the use of data collected by the two institutions under a Data Sharing Agreement, which led to a negative outcome following the legal objection formulated in Geneva; and by another dispute surrounding the publication of the results of research done with MSF as co-author, a proposal that was vetoed by headquarters, claiming that the study had not been approved by MSF’s Ethical Board.
Health centres, contacts and traditional doctors

Because these were relationships established in the field, outside the hospital system, they were strongly influenced by the very distinct, sometimes contradictory, approaches taken over the years (see Item 5, Decentralisation, below). Health centres received a monthly visit from MSF. Field tours of the “mobile-clinic” type were welcomed by the managers of the centres, who could then refer their patients quickly and at no charge before going to the hospital. They also appreciated the training provided, not only to the staff in the centres but also to the community contacts.

The traditional doctors, long seen in an unfavourable light by the MSF team in Akonolinga because of their behaviour designed to protect their own interests and avoid transferring patients to the hospital, gradually became acknowledged interlocutors. Rumour had it that it was they who continued to follow the greatest number of Buruli patients, compared with those who favoured Akonolinga. The relationship between MSF and these direct respondents in the field remains fragile, however. It is coloured by the personality of each traditional doctor and the way in which they carry out their role of first referrer in matters relating to the physical or psychic health of the people.

2.1.5 Decentralisation

In 2008, six years after the project began, or at mid-point, the idea of instituting a mechanism for decentralisation was raised, based on a double mirror image: one the one hand, fostering access to patients and continuity of care, and on the other hand, facilitating patient access to care by allowing them to avoid hospitalisation, which was often seen as too difficult and too long, given the socio-economic environment of the patients affected with BU. This type of approach was also designed to help unburden the Akonolinga hospital, which was then very busy with “counter-referrals” to the outlying health centres closer to where the patients lived.

Implementation was limited to an advanced strategic exercise and mobile clinics, held simultaneously with the introduction of an alternative protocol intended to impose oral antibiotic therapy. The original idea was never fully realized. The MSF players were dispersed, each with their own personal contributions, with no monitoring to validate performance following decentralisation.

The term “decentralisation” should be taken to understand a strengthening of services and skills in the peripherally located health structure. By integrating these services into the centres’ normal activities, treatment could have been simplified and early detection of the disease improved. This would have had the advantage of being more efficient and more sustainable, compared with the mobile clinic that travels throughout the health territory in search of BU cases, based on prevalence.

A number of strategies have been drawn up by various individuals who came to visit the field in the past several years. In 2009, the so-called decentralisation affected one health area (Ebem). There is virtually no more physiotherapy, and treatment using antibiotics is not completely followed. However, the experience has proven to be positive for early detection, more specifically for the screening for BU at the primary, non-ulcerative stage. It shows that the number is relatively low and that the use of mobile clinics then becomes very expensive, given the client base.
In 2011, in support of the prevalence study carried out by Epicentre, decentralisation became timely, under a different form, where the previous objective involving 12 health centres was abandoned, as these would then have to first be completely rehabilitated, not to mention the training that their staff would need. The new approach would be focused more on “mobile clinics” and the supply of a type of “health centre kit” that included the materials required to provide care for one week, with sterilisation remaining in the hands of the roving teams from MSF—a very complicated process that does not seem to held maintained attention for very long.

To summarize, what MSF has attempted to do is not what is truly understood by decentralisation. They send mobile clinics out onto the road to work in liaison with two health centres, but without giving them the means to become true partners. They do early detection, but without equipping the laboratories in the centres. Then, they identify and equip four more centres with laboratories and staff training. But this is not the final result, because these actions were undertaken at the last minute. And the authorisation to supply sterilisers or other heavy equipment was denied by headquarters, which meant that some of the centres monitored by MSF sterilise their medial equipment by flame or by boiling, as observed during the evaluation inspection.

All sorts of this type of initiative are taken, haphazardly, with no clearly defined plans for their sustainability because once the centres have exhausted what was supplied by MSF, there is a greater risk that nothing more will be done.

**Conflict between two strategies** – on the one hand, there is a concentration of resources and services at the hospital, and on the other hand, there is the never fully defined decentralisation. There has been no happy outcome to this conflict. The proponents of active research and treatment at the community level through a strengthening of the health centres have not been able to prevail, let alone convince the supporters of a vertical, individualistic, even rigid, approach which, despite its excellence, has been shown to have its limitations.

### 2.1.6 Awareness raising, communications and advocacy

MSF has invested itself in activities designed to raise awareness and disseminate basic information intended to demythify the disease, recognize it, and accept the necessity of getting treatment. Because this is a condition that is largely unknown by the population, people easily fall under the influence of traditional doctors, who are interested in retaining their power over the people living in their zones of influence. Numerous messages have been designed and disseminated through various channels to explain the disease and describe the types of treatment available within the hospital network or in open structures. It is critical to convince not only potential patients but also the community at large, civil and health authorities, and traditional doctors of the importance to provide medical treatment that is tailored to the gravity of each individual case.

During the project wind-down phase, a broad-ranging awareness-raising program was instituted, which saw the participation of dozens of community health agents who were able to contact an average of over 3000 persons per month in their homes, as well as groups of persons at the village level. In addition, early detection was carried out in the
schools and in 12 health areas, along with communication events intended primarily for the general public and the university milieux (radio, conferences, etc.).

Also, beginning in 2010, advocacy activities dealt with modern dressings from WHO, its Programme on Neglected Tropical Diseases, and the MOH, to select and include certain products on the list of essential medications. These also supported the introduction of teaching modules on BU in faculties of medicine within Cameroon (Yaoundé and Douala), and the training of staff working in endemic areas.

In 2012, the communication efforts went international, with a presence in Brazil at the invitation of the Access to Essential Medicines Campaign (AEMC) and an intervention with the European Wound Management Association (EWMA).

By contrast, and generally speaking, testimony activity remained below the requirements for a project such as BU. This can be partially explained by the vagueness that characterised some of the phases of the project and the lack of clarity with respect to institutional positions.

**MEDICAL AND PARAMEDICAL ACTIVITIES**

### 2.1.7 Therapy choices

The choice of a therapy is determined by the adopted strategy and approach. In the case of Buruli Ulcer, MSF chose a highly technical approach focused on the disease and its consequences. This was an option that favoured verticality and developed in parallel with the Cameroonian health care system. As far as MSF was concerned, BU is the disease that needs to be fought. Individuals and the public health environment become secondary.

Toward the end of the project and on a few rare occasions during its twelve years, a number of short-lived attempts followed the public health path, less by conviction than by reaction, in order to correct the project’s drift.

MSF began treating the wounds and ulcers by improving the technique as it went along, then more slowly, by adding new elements to complete the package—which consisted of care, surgery, grafts, rehabilitation and physiotherapy, nutrition, antibiotics, integration of treatment specific to patients co-infected with HIV, therapeutic education, and pain management—and ended with the clinical score, psycho-social support and decentralisation.

All these elements are not only pertinent, but they are also necessary. They are part of an overall multi-disciplinary approach, but the BU Project came up against a lack of a clear strategy for the medium term. As a result, these components were introduced one after the other, then halted, only to start up again a few months later, such that, based on the average length of a hospital stay and the number of patients, only a small portion of them will have benefited from complete treatment in the twelve years of the project.

The multi-disciplinary approach to the treatment of BU is part of a learning process based on experience gained at the patient’s bedside in an open environment. It requires many years of practice, the application of working techniques tailored to the situation and incorporating approaches, some innovative, some not, that are attuned to the social and health-care realities of each country.
After the initial contact and positioning phase, MSF and its partners (HUG, EEMC, Epicentre, Manson Unit, etc.) should have taken a much more aggressive and forward-thinking attitude in terms of patient care (treatment and diagnosis), decentralisation, and strengthening of health services, etc. That way, they would have ensured a certain level of permanence.

As for the general matter of therapeutic approach, the thousands of hours of work, and the quality of care and dedication of the MSF field teams must not be forgotten—one more reason to regret not having gained greater benefit from this outstanding experience. Despite this investment on the part of so many individuals, there are a lot of questions that remain unanswered:

- What is the reason for all this excessive medicalization in search of a certain level of excellence (modern dressings)?
- Why did MSF begin treatment by antibiotics (Rifampicin + Streptomycin) in 2005, based on recommendations by WHO in 2003-2004, without more consistently protesting the constraining nature of this treatment?
- Why did MSF begin, again too late (2006-2009), a test with Rifampicine + Clarithromycin, based on a limited sample of 16 patients and very inconclusive results?
- Why did the quick diagnosis methods, which can be applied in a decentralised setting, enabling early diagnosis of Buruli, generate so little interest and limited commitment on the part of MSF?
- What about psycho-social support for the patients?
- Why was MSF hesitant to provide the means necessary for physiotherapy or radiology, when substantial amounts were spent on modern dressings tied to a donation but which in the end proved to have a cost efficiency that fell like a guillotine on the hopes to see the project continued after it left?

By its choices and the point at which they are implemented, and despite the quality of services offered, compared with the national average, MSF has missed a beautiful opportunity to have an impact, not only on the approximately 1500 patients (1231, including 435 confirmed cases of BU) who passed through its hands, but also on the disease itself and the future of its treatment.

Under normal conditions, and despite the tensions in the field and at headquarters between the defenders and the detractors of the project line, it should have changed direction quickly, after starting out and move more toward a project that would have envisioned BU not as a disease, but as a problem of public health affecting several thousands of persons in Cameroon and throughout the world. A public health problem that needed to be treated with the concurrence of the Cameroonian health-care system, hand-in-hand, by strengthening its capacities and incorporating BU treatment into its existing health-care priorities.

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14 The Manson Unit is a service established by MSF UK, bringing together experts whose mission is to improve the quality of medical services provided by MSF throughout the world.
The logic associated with decentralisation and co-operation with traditional doctors would have become obvious. The first benefits from it would have been reduced periods of hospitalisation, attenuation of the ostracism experienced by patients, and a reduction in physical and psycho-social sequelae.

With its virtually unique type of experience, a cohort of close to 1500, the completion of genuine clinical studies or tests that made it possible to catalyse a number of key processes, such as antibiotic treatment, rapid, early detection, the decentralisation of services, a clinical score that could have been put to use at the start of the project and not ten years later, the knowledge surrounding the epidemiological evolution of the disease and its modes of transmission, MSF could have been part of a demonstration that was as practical as it was forward-looking.

2.1.8 Medical performance

Medical performance can be analysed both quantitatively and qualitatively. BU is a neglected disease which, compared with other tropical diseases, has a limited number of cases, and this number was trending down over the years in which MSF was involved. The cause of this decline is not known. It can perhaps be attributed to the depletion of the pocket in the Nyong River Basin, and in the districts of Akonolinga and Ayos, the lack of an active search for patients, or a break in the chain of transmission (still not known) resulting from the massive distribution of impregnated mosquito nets by the anti-malaria programme in March 2011 (see Appendix 5).

There could also have been a return by patients to traditional medicine, which takes less time and is closer to their communities, fostering family contacts and social activities, or it could even be attributable to one of the characteristics inherent in the transmission of the disease associated with seasonality factors.

Unfortunately, no one is able to confirm or refute these hypotheses.

One fact is undeniable: when the project was handed over to the MOH, the number of persons hospitalised in Akonolinga was very much lower than it was when the project began.

These figures show a progressive decline in the number of cases treated under the project that is in line with a world-wide decline.

<table>
<thead>
<tr>
<th>Country/Location</th>
<th>2011</th>
<th>2012</th>
<th>% Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Côte d’Ivoire</td>
<td>1659</td>
<td>1386</td>
<td>26.5%</td>
</tr>
<tr>
<td>Ghana</td>
<td>971</td>
<td>572</td>
<td>41.1%</td>
</tr>
<tr>
<td>Bénin</td>
<td>492</td>
<td>365</td>
<td>25.9%</td>
</tr>
<tr>
<td>Cameroon (Akonolinga)</td>
<td>143</td>
<td>65</td>
<td>54.55%</td>
</tr>
</tbody>
</table>

15 Sources: WHO and MSF OCG
Given the lack of awareness as to the mode of transmission, no one so far has been able to explain this gradual decline or even advance serious and conclusive theories on it. MSF OCG is no further ahead in terms of its knowledge of the subject. Only a convergence of circumstances, such as the massive distribution of impregnated mosquito nets by the national malaria programme, may have influenced this decline (see Appendix 6). More research is needed.

It was after 12 years of MSF work in Cameroon that the difficulty in identifying new cases in the early stages of the disease was noted. The very mediocre performance of the active research and educational activities to urge new BU patients to follow a treatment that is less aggressive and without sequelae is one more indication of the interest in carrying out an effective decentralisation and implementing treatment that is closer to the patient and his or her surroundings, through an approach that is more community-based than institutional.

### Number and presentation of new BU cases in Cameroon, 2011-2012

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>New cases in Cameroon</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total cases diagnosed per year</td>
<td>256</td>
<td>160</td>
</tr>
<tr>
<td>% of cases confirmed by PCR</td>
<td>56%</td>
<td>41%</td>
</tr>
<tr>
<td>% of patients who took antibiotic treatment</td>
<td>94%</td>
<td>88%</td>
</tr>
<tr>
<td>% of patients ≤ 15 years</td>
<td>43%</td>
<td>45%</td>
</tr>
<tr>
<td>% women</td>
<td>46%</td>
<td>46%</td>
</tr>
<tr>
<td>% cases with limited movement</td>
<td>24%</td>
<td>29%</td>
</tr>
<tr>
<td>% ulcerative forms</td>
<td>84%</td>
<td>87%</td>
</tr>
<tr>
<td>% Category I wounds</td>
<td>41%</td>
<td>34%</td>
</tr>
<tr>
<td>% Category II wounds</td>
<td>18%</td>
<td>21%</td>
</tr>
<tr>
<td>% of Category III wounds</td>
<td>40%</td>
<td>45%</td>
</tr>
</tbody>
</table>

Based on the data shown in MSF annual activity reports for Akonolinga, there can be seen not only a significant reduction in the number of new BU cases detected, but also a reduction in the percentage of cases confirmed through PCR; this could be explained by an economic downturn at the time the cases were included in the program, despite the existence of the clinical score. Also to be considered is the fact that the health-care teams wanted to recruit new BU cases in order to maintain a certain workload level that was necessary for the smooth operation of the project, at a time when even the prevalence of the disease was showing a clear decline. Similarly, and paradoxically, with regard to the level of severity of the lesions at the time the BU cases were included, a slight deterioration was seen in this indicator, even though, based on the natural evolution of the operation, one would have expected the opposite.

In Akonolinga, the situation in 2012 was worse, with 94.65% of patients with ulcerative lesions—a situation that showed an urgent need to ramp up decentralisation and awareness-raising activities through the community contacts.
Evaluation of the Akonolinga - Buruli Ulcer Project, Cameroon, 2002-2014, July 2014

Type of wound, new cases – Akonolinga Project, 2012

<table>
<thead>
<tr>
<th>Type of lesion</th>
<th>Ulcer Size</th>
<th>NC BU</th>
<th>%</th>
<th>NC Non-BU</th>
<th>%</th>
<th>% suspected BU/T</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-ulcerative</td>
<td>-</td>
<td>3</td>
<td>5.3</td>
<td>1</td>
<td>6.2</td>
<td>75.00</td>
</tr>
<tr>
<td>Undefined</td>
<td>-</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>6.2</td>
<td>0.00</td>
</tr>
<tr>
<td>Ulcer</td>
<td>&lt;=5 cm</td>
<td>23</td>
<td>41</td>
<td>6</td>
<td>37.5</td>
<td>79.30</td>
</tr>
<tr>
<td>Ulcer</td>
<td>&gt;5 cm</td>
<td>30</td>
<td>53.5</td>
<td>8</td>
<td>50</td>
<td>78.90</td>
</tr>
<tr>
<td>Total</td>
<td>-</td>
<td>56</td>
<td>100</td>
<td>16</td>
<td>100</td>
<td>77.80</td>
</tr>
</tbody>
</table>

Again in 2012, the use of modern dressings continued. Despite the extremely high cost, according to a number of users in the BU ward, these products helped accelerate the speed of scarring and reduced workloads, thanks to the less-frequent need to change dressings, when compared with traditional dressings, but there have not been any serious studies at this point to confirm these assertions.

The data available from MSF for Akonolinga show that 25,553 dressings were applied, which works out to 27 dressings per month, per patient, or one dressing every 1.11 days (whereas the recommended frequency for modern dressings is every 2 to 3 days). These figures indicate that there were too many dressings, too many surgeries, and too many cutaneous grafts. However, the reliability of these data is relative, since they cover only one statistical reality that is not placed in context with the patient’s individual circumstances.

In terms of performance, one could assume that MSF’s investment would have had a clear impact on simple indicators, such as the average length of hospital stay. An estimate was made for us, based on the BU project database, comparing the results for various periods highlighted by new strategies, such as treatment using antibiotics, or the introduction of modern dressings. The results were surprising.

Average hospital stay in MSF BU ward in Akonolinga prior to and after Introduction of modern dressings: March 2008

<table>
<thead>
<tr>
<th>Item / No. of patients/ days</th>
<th>Staff</th>
<th>Total No. days</th>
<th>Average Stay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharged cured with or without sequelae before use of modern dressings</td>
<td>362</td>
<td>60 444</td>
<td>166.97</td>
</tr>
<tr>
<td>Discharged with or without sequelae after use of modern dressings began</td>
<td>481</td>
<td>108 165</td>
<td>224.88</td>
</tr>
</tbody>
</table>
Average hospital stay in MSF BU ward in Akonolinga prior to and after Introduction of antibiotics: Jan. 2005: Streptomycin-Rifampicin  Jan. 2013: Rifampicin-Clarithromycin

<table>
<thead>
<tr>
<th>Item / No. of patients/ days</th>
<th>Staff</th>
<th>Total days</th>
<th>No.</th>
<th>Average Stay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharged cured with or without sequelae before use antibiotics</td>
<td>126</td>
<td>13 441</td>
<td></td>
<td>106.67</td>
</tr>
<tr>
<td>Discharged with or without sequelae with use of antibiotics</td>
<td>100</td>
<td>26 501</td>
<td></td>
<td>265.01</td>
</tr>
<tr>
<td>(streptomycin-rifampicin)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharged cured with or without sequelae</td>
<td>85</td>
<td>21 437</td>
<td></td>
<td>252.20</td>
</tr>
<tr>
<td>with use of antibiotics (rifampicin-Clarithromycin)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

There was an improvement in the quality of the diagnosis. Beginning especially in 2008, the percentage of non-BU patients included in the programme, compared with the percentage for BU patients has been declining. Accumulated experience and preparatory activities, plus the start of studies such as the clinical score, could be the reason for this improvement, even if it was tapering off in the last two years.

However, it is not a given that the reduction in the number of BU cases diagnosed can be interpreted as a possible reduction in the actual incidence and prevalence of the disease. This could also be explained by the slowdown in the active search for cases, cessation of activities, reduced presence of the stakeholders involved in the file or the fact that, at the same time, new cases continue to crop up.

Based on a rapid analysis of the information available as of the writing of this report, it was noted that the average length of hospital stay was greater after the introduction of new techniques or protocols that were supposed to shorten patient stays. While this may seem paradoxical, we found no explanation for it, except that a possible problem arose in monitoring the patients.

Comparative diagnosis: BU patients vs. non-BU patients, by year
There was other interesting information that emerged from the analysis of the number of new cases identified based on the period in which operations made it possible to actively recruit patients, as opposed to recruiting passively. With the gradual decline in absolute numbers of cases taken into account, we noted an increase in the percentage recorded for active searches, rising from 7.80% to 17.16%, or almost ten points higher than during the period before awareness-raising and search activities at the community and school level began.

Summary of active case searches: patients to MSF’s BU ward in Akonolinga prior to and after June 2008

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Active search</td>
<td>46</td>
<td>7.80</td>
<td>110</td>
<td>17.16</td>
<td>156</td>
</tr>
<tr>
<td>Passive search</td>
<td>376</td>
<td>63.73</td>
<td>420</td>
<td>65.52</td>
<td>796</td>
</tr>
<tr>
<td>Indeterminate</td>
<td>168</td>
<td>28.47</td>
<td>111</td>
<td>17.32</td>
<td>279</td>
</tr>
<tr>
<td>Total</td>
<td>590</td>
<td>100.00</td>
<td>641</td>
<td>100.00</td>
<td>1231</td>
</tr>
</tbody>
</table>

2.1.9 Trends in patient numbers

Trends in the number of cases admitted to the programme – Akonolinga 2002-2013

After a period of hesitation, the number of new cases admitted to the programme in Akonolinga accelerated beginning in the fall of 2002, then from May to September 2003 there were more patients who stopped treatment than there were cures. Later, the number of new cases stabilised again, compared with 2004 (see above). After a 2006 with particularly high staffing numbers, the upward trend seen in the first quarter of 2007 can be explained by the start of the prevalence study, plus the awareness-
raising activities. The second quarter was affected by the lack of field managers, and by the unexplained reduction in awareness-raising activities.

In 2010, the result grew, probably because of the active detection and awareness-raising activities. Beginning in 2011, there was an overall decline which followed the curve seen nationally and internationally.

In Akonolinga, in the second quarter of 2013, despite early detection activities carried out in the primary schools and then in the health district, just three BU cases were confirmed out of 24,206 children examined. One possible explanation for this could lie in the fact that there was a genuine reduction in the number of new BU cases because the still-unknown chain of transmission had been broken, or because the pocket of cases in Akonolinga is being exhausted. The drop could be explained, to a lesser extent, by the new diagnostic strategy being used since the clinical score with greater specificity, but the results of the study will not be known until late 2014.

Based on the patient profile (sex ratio) and the exception represented by 2002, we noted a higher percentage of males, which matches the ratios found in the community when the prevalence study was conducted in 2007, with 43.8% for females and 56.2% for males.

<table>
<thead>
<tr>
<th>Sex ratio / Year</th>
<th>% Females</th>
<th>% Males</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>54%</td>
<td>46%</td>
</tr>
<tr>
<td>2005</td>
<td>49.2%</td>
<td>50.8%</td>
</tr>
<tr>
<td>2007</td>
<td>44%</td>
<td>56%</td>
</tr>
<tr>
<td>2010</td>
<td>44%</td>
<td>56%</td>
</tr>
<tr>
<td>2013</td>
<td>48%</td>
<td>52%</td>
</tr>
</tbody>
</table>

With respect to the type of lesion, using the % of ulcerative lesions as an indicator, we observed values that were paradoxical, compared with project trends, where there was a gradual increase in ulcerative lesions compared with the non-ulcerative type, which may be explained by a breakdown at the diagnostic level at the time of identification, or by the presence of BU patients in the early phases of the disease.

<table>
<thead>
<tr>
<th>Year</th>
<th>% Ulcerative Lesions</th>
<th>% Non-ulcerative Lesions</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>80.0%</td>
<td>20.0%</td>
</tr>
<tr>
<td>2005</td>
<td>73.3%</td>
<td>26.7%</td>
</tr>
<tr>
<td>2007</td>
<td>83.4%</td>
<td>26.6%</td>
</tr>
<tr>
<td>2010</td>
<td>90.9%</td>
<td>9.1%</td>
</tr>
<tr>
<td>2013</td>
<td>89.0%</td>
<td>11.0%</td>
</tr>
</tbody>
</table>

Most cases were from the Akonolinga District (59% and 41% of cases).
2.1.10 Support activities (surgery, dressings, physiotherapy, TPE, pain management, nutrition, etc.)

Despite MSF’s capacity for innovation, its inclusion of the various components designed to improve treatment proved to be too slow, because too often it has been overly respectful of recommendations from WHO, [and] sometimes more conservative than WHO, which leaves cracks in its recommendations wide enough that they could have swallowed up MSF (for example the 2003 recommendation to use primarily oral antibiotics).

MSF reaction has also been somewhat weak or slow in coming when it involves incorporating physiotherapy or decentralising case management, including for the early diagnosis and care at the peripheral (1st level of attention) and community level. This restraint is in contrast with the very rapid and determined introduction of modern dressings.

Accordingly, in 2005, after three years of operations, the reviews were mixed.\(^{16}\)

On the whole, medical and surgical treatment by the care staff was unsatisfactory. It became just passable as soon as MSF supervision ended. For example:

- No treatment strategy for osteomyelitis cases, which require specialist staff and facilities and extensive financial means;
- Lack of a trained nurse-anaesthetist;
- Awareness-raising and screening activities were never carried out using an effective, long-term strategy;
- The case management of patients proves that the cost-effectiveness is bad;
- Lack of BU surveillance at the community level: no information on the magnitude of the health problem or on occurrence according to time, place and individual involved;
- Lack of efficient, reliable organisational procedures (because there was no reliable cold chain) for diagnosis of the disease;
- Lack of standardisation and loss of quality with respect to surgical care: excisions, skin grafts, amputations;
- Standardised procedures (equipment and technical) for dressings were not systematically applied, and not yet appropriate;
- Unreliable sterilisation procedures (due to lack of systematic use of autoclaves)

In 2006, MSF continued to perform surgery too frequently,\(^ {17}\) with an average of three operations per patient. Compared with the treatment of vascular or diabetic ulcers, or even eschars, in France (less than 5% of patients are operated on), this rate seems too high.


\(^{17}\) Source: MSF OCG, Inspection report, Medical Dept., 2006
Upon learning of these initial results, beginning in 2007, MSF OCG introduced a new operational procedure in conjunction with the National Programme to fight Buruli Ulcer, while retaining a certain level of operational autonomy, but remaining open to potential partnerships with available MoH collaborators.

Goals were set for the next three years, revealing for the first time a clear and relevant line, as seen below:

- Increase knowledge of the scope and epidemiological distribution of Buruli Ulcer by establishing a surveillance network through schools, villages and health structures;
- Improve the knowledge of BU within the communities through educational campaigns directed at administrative and school officials, in schools and villages;
- Establish a standardised, reliable system for diagnosing the disease at the referral centre level and the peripheral level (in co-ordination with the CPC);
- Increase detection and referral of cases in the communities by establishing a “suspected cases” surveillance and detection network. Decentralise the treatment of “early cases” of BU through the peripheral health structure and traditional doctors. Refer “advanced cases” to the Akonolinga District Hospital;
- Use appropriate case management and establish protocols and procedures (equipment and technical) with an operational physiotherapy unit and provide adequate treatment for patients with osteomyelitis. Access to patients for HIV screening and for HIV/AIDS treatment. Occupational activities (education, and technical or income-producing training) for patients and their support persons. Standardised, adequate nutritional case management. Standardised system for registering patients.

In 2009, after six years of operations, a slight improvement was observed, with more highly structured medium-term planning and programming, with clear objectives, complete patient treatment, a multi-disciplinary approach to BU cases that includes all components (see chart, Appendix 3) and a number of decentralisation activities.

One serious anaesthesia-related accident resulted in the death of a patient, causing all surgical activities to be suspended for more than a year.

In 2011, the project reached a critical point—closure, which MSF looked at very seriously. To prepare for it, MSF decided to optimise the resources, leaving in place the essential activities that can ensure the quality of care.

A simplification of care was contemplated, designed to involve the hospital’s medical staff in monitoring the patients and gradually withdrawing MSF physicians. Because nursing care is critical for the proper healing of wounds, MSF also wanted to review the list of medications and medical equipment.

As for the use of antibiotic therapy, the Manson Unit conducted an observational study on the efficacy/tolerability of the Rifampicin-Streptomycin combination in 2006. Because the research protocol conditions could not be implemented, following a threat to close down the project, the study was cancelled.
In 2008, Clarithromycin was used in a mobile clinic for certain patients at the hospital (pregnant women).

In 2009, there was a certain level of reluctance regarding the use of Clarithromycin. The Director of the Akonolinga Hospital and Dr Njih, Director of the National Buruli Ulcer/Leprosy Programme (PNLUB), called for use of this antibiotic to be halted, which MSF nevertheless continued to administer, at its expense.

The transition from classical dressings to modern dressings occurred in 2006, based on five indicators defined by MSF: the number of dressings applied, the amount of patient pain, the number of analgesics used, effectiveness of dressings on scarring, and length of stay. A training course was established by the Geneva school of nursing intended for trainers at the Yaoundé school of nursing. In 2008, there was a clear improvement, but some of the wounds became blocked after the sprouting phase.

In actual fact, hygiene in the treatment ward is deficient.

Osteomyelitis undoubtedly remains the most serious problem raised by Buruli Ulcers. It would be helpful to take systematic x-rays of bones where lesions are involved. In 2009, a new protocol for treating osteomyelitis, which resulted from the 2008 round table recommendations, was established but since then the situation has only partially improved. In effect, implementation of the recommendation was affected by the lack of a decision to equip the Akonolinga District Hospital with x-ray equipment, which is where the BU ward is located. This means that patients are systematically forced to travel to the capital three hours away by road, incur additional costs, and endure significant inconvenience.

2.1.11 Scientific research work

Below are a number of steps along the road to research that did not necessarily result in specific projects.

- MSF scored a goal with its work on HIV-BU co-infection and the impact of HIV on clinical manifestations of BU.

- Antibiotic treatment (C+R) – a delayed study (August 2008) was not a determining factor in convincing WHO to change its recommendations regarding the classic protocol (S+R). Two years later, Clarithromycin was unfortunately banned from the protocol advanced by MSF. In 2013, a world-wide disruption in the supply of streptomycin forced WHO and the MoH to introduce clarithromycin into the antibiotic protocol used in treating BU.

- BU and Osteomyelitis – one area in which the MSF-HUG partnership distinguished itself academically and in the field of training. Unfortunately, despite the insistence of the Medical Department and the field teams, it was not possible to provide radiology equipment to the hospital.

- “Modern” dressings – this topic remains controversial; observations were made by the users, but there was no actual study on pain reduction, the effects on the scarring phase, the frequency of care and the work load, or the less-frequent use of surgery. Work is under way on various levels (WHO, HUG, MoH) to determine an appropriate future choice of dressings that are essential for the Cameroonian health care system.
Physiotherapy, pain management and therapeutic education are three components on which MSF made irregular and belated progress. MSF’s preferred position in its lengthy exposure to physiotherapy should have encouraged it to strengthen the weight given to this therapy in the prevention of sequelae.

MSF partnership with HUG, which was established through a co-operation agreement signed in 2007, constitutes a key reference in the field of research into the improvement of BU case management, primarily with regard to the evaluation of the BU-HIV relationship, improvement in the treatment of co-infected patients, improvement in antibiotic treatment and the definition of internationally recognized standards for the treatment of wounds.

This collaboration produced concrete results, such as the publication of a series of scientific articles, clinical advice during visits to the project, telemedicine sessions on the management of clinical cases, and on the care protocol, and case management. Operational research and studies on BU-HIV co-infection, osteomyelitis, differential diagnosis, the monitoring of tools, and documentation on the care of wounds also resulted from this partnership.

HUG is also extensively involved in various training courses on the care of wounds and physiotherapy, not to mention their involvement in everything that affects chronic wounds, their prevention, and their consequences.

HUG’s valuable skills may have, as collateral damage, distracted MSF somewhat from its top-priority objective, which is the rapid and effective improvement of case management and its follow-up in the field. This would have meant overlooking the work accomplished by HUG professionals from HUG in the areas relating to wounds, physiotherapy, and HIV—all fields related to the treatment of the disease, but the closed, vertical approach of this academic research prevented direct sharing of the results with MSF health-care staff, thereby weakening the impact that these initiatives could potentially have had on patient progress. The timetable, objectives and means devoted to these research activities were not aligned with the priorities affecting the daily lives of BU patients and, as a result, they had only a limited direct impact on the improvement of their treatment.

The study on HIV-BU co-infection, as interesting as it was scientifically, related, from an operational standpoint, to just some 20 cases at the Akonolinga Hospital. Unfortunately, HIV screening was not done in the initial years of the project because HIV was not at the time perceived as being potentially part of the BU problem. As soon as it appeared that this parameter could affect, indeed complicate, the condition of BU patients, the HIV test was systematically introduced, based on a recommendation from WHO. Then, MSF requested the establishment of UPEC (a unit to treat co-infected patients) within the Akonolinga Hospital—a fine example of collaboration and lobbying, even though it came somewhat late.

Apart from the various academic, scientific, training and activities to improve case management, this **seven-year partnership** has essentially resulted in:

- a return to the use of the classic dressing that was virtually programmed after MSF left;
- a promise by WHO to provide antibiotic treatment (C+R) while awaiting a protocol that was capable of supporting the process of decentralising case management and diagnosis;
- the Clinical Score study, with publication of the results planned for 2104.
2.2 During the disengagement phase

2.2.1 Decision-making process

The disengagement process was not built into the project from the beginning. Three years after it began, the project shutdown was already being talked about, but no strategic information exists as to how the eventual wind-down phase would happen. Then, almost as a ritual, every three years, the shutdown was announced, resulting in a few ripples throughout the system, but these would later fade away. The project continued.

In 2012, rumours began to grow, but there was no disengagement strategy appearing on the horizon (Cf. 2012 annual report).

In March 2013, the program’s manager at Geneva headquarters announced the exit scenario, listed the specific objectives and sketched a timetable for the various events.

In June 2013, an informal discussion forum was held with MoH partners to address the measures that needed to be taken for handover of the project.

It was in January 2014 that a draft document was issued to officially launch the disengagement process, with a target date of mid-2014.\(^{18}\)

2.2.2 Implementation

MSF officials in Cameroon and their partners set to work drafting a logical framework,\(^ {19}\) which was to constitute the reference tool for implementation of the exit strategy. The unavowed notion underlying the exercise was to gradually reduce certain standards, in order to prepare the groundwork for a lowering of the quality of case management of the disease.

As a result, the Akonolinga Hospital saw (in March 2014) the withdrawal of the free food that BU patients had been receiving up until then because project management wanted to avoid the shock of suddenly ceasing all activities on June 30, preferring that the patients become accustomed, in some way, to being treated less well. This questionable approach was much discussed among the beneficiaries and the staff. It must be remembered that the patients were spending months, sometimes years, in the BU ward, making extended material support impossible for their families.

While this was happening, a gradual reduction in the premiums given to the national staffs was causing waves, but did not result in an ill-timed departure.

The dashboard and indicators set out in detail, in seven primary objectives, the measures to be taken by the partners with respect to:

- the early diagnosis and holistic case management of chronic wounds;
- medications and dressings;
- logistics and services;

\(^{18}\)Project document: *Plaies chroniques et ulcére de buruli*, Serge St-Louis, HOM, Stéphanie Remion, FM

\(^{19}\)See Appendix 7
– medical staff;
– the decentralisation of care at the peripheral level and the community strategy;
– funding of the Programme by the Ministry and its partners;
– the integration of the MSF and MoH pharmacy

In August 2013, the document became available (logical framework - Excel). The Strategy was sent to Geneva and re-transcribed into the Plan of Action (POA). It was validated in December 2013.

Previously, beginning in the final quarter of the year, a series of new activities were deployed in the field—sanitation of the BU ward, plans for full treatment of chronic wounds by the MoH, simplification of protocols, establishment of a list of essential dressings and medications for the MoH, a speed-up of awareness-raising activities, a new communication policy, lobbying WHO to supply antibiotics, increased training for district health care and hospital staff, etc. All these actions were intended to facilitate handover of the operation to other players.

From the MoH, nothing. The manager for the national programme was rehired in January 2014 by the Steering Committee. After a number of delays, including one caused by the validation by the MoH of Steering Committee members, the first official Steering Committee meeting took place on 2 April 2014. At that point there were less than three months remaining for joint implementation of the disengagement. At that meeting, MSF did not leave any additional departing gifts for the MoH, except for the donations of medical equipment, medications, and dressings that had previously been announced.

### 2.2.3 Acceptability of the process by internal and external partners

No one wanted to believe that MSF was really going to leave because its departure had been so often trumpeted about but never actually happened.

Today, the staff involved in the BU project and the partners associated with it are finding it painful to accept the fallout, which had been predictable, from the departure of MSF. They know that things will not end well, that a lot of expertise and tools are going to be lost. They fail to understand how someone can run the risk of seeing the disappearance of 70% to 80% of the not-inconsiderable means devoted to the project over so many years. Twelve years of work are being sent down the drain, they say.

All those who were closely connected with the project say they are sorry that advocacy did not come into play until ten years after the project began. It should have happened much sooner. The ambitious goals of the past several years would have been better supported.

Many are asking the question: “Someone should have known from the outset that this elite form of treatment was going to be costly for each patient. Shouldn’t the work have been shared, rather than offering everything at no charge? This is a concept that works fine in emergencies, but not for so-called “regular” projects, where chronic diseases are involved.”
Hospital staff do not yet know what their fate will be. Most of them will be unable to continue their co-operation. The MoH will only rehire a very small proportion of the staff. Training is currently being offered by MSF, but that does not represent a guarantee for the staff that they will be able to find work after June 30.

It is hoped that meetings with the Cameroonian surgeons will convince them to continue to share their expertise by taking advantage of the equipment that is still available on site. And what will happen with the modern dressings, once the MSF supply has been exhausted? Has anyone thought of replacement products?

A number also pointed out the fact that the MoH long relied on Fairmed and on MSF, but did nothing to prepare for the departure of the NGOs. What should have been a job that was done together ended up in an amicable divorce, where the victims in a way are the children, and in this case also the patients.

Because, for these patients as well, returning back to the former system will be problematic. They undoubtedly will not accept another model, and will go back to the traditional doctors. The issue was only touched upon lightly during the discussions surrounding the handover.

As someone involved so succinctly put it, “Today, we’re packing everything up and leaving.”

### 2.2.4 Transfer of the MSF legacy

There is nothing anywhere that states that a disengagement has to take place in a hurry. To understand this is to protect oneself against the risk of a botched departure and ensure that the exit is as honourable a one as possible, given the circumstances.

The relative speed at which the disengagement took place, at which the knowledge, but not the immediate implementation, of an exit strategy that had been available some 18 months prior to the end date of June 2014, brings with it great risk of compromising the passing forward of the legacy.

In comparison with the length of the project, the spirit, the energy and the dedication shown, the lasting results that MSF is likely to pass on can all be summed up and described as a pale shadow.

The scientific achievements can all be counted on the fingers of one hand. Material donations were limited to the surgical equipment and the inventory of medications and dressings. To that can be added an unknown quantity of grey matter residue.

The initiatives undertaken by MSF, in collaboration with HUG and the faculties of medicine in Yaoundé and Douala, which saw the creation of the Société camerounaise des plaies [Cameroon wound society] and joint workshops on the treatment of chronic wounds, is a positive sign. It will now be up to the officials in charge to ensure a certain level of permanency.

In order to be able to provide for a genuine knowledge transfer, beyond the agreed-upon efforts to improve the training of staff engaged in and around the action, the exit process should have been spread out over two years. During this period, partners interested in taking over some of the components could have been identified and convinced to commit
for a long term, even though MSF’s objective was not to seek out such partners. In relying on future “uptakers” MSF would have been in a better position to encourage the MoH to confirm its on-going commitment to the victims of this sorely neglected disease.
3 Conclusions

- MSF threw itself into the fight against Buruli Ulcer with courage and determination. It brought to bear its entire body of knowledge and expertise, and created a masterpiece out of nothing, which others could not ignore. Its expertise, its professional credibility, the high quality of case management, and the ability to innovate are all strengths that are universally recognized among those who had anything at all to do with the project.

- MSF decided, at the outset, to position itself close to the patient and set about building an operational plan that focused on direct medical actions conducted right at the patient's bedside. Over the years, the teams in charge sought out new approaches, with a view to making the project evolve toward an comprehensive, multi-disciplinary treatment. They brought in innovate solutions (e.g. modern dressings). The model that was in place was intended to reflect MSF’s desire to achieve excellence.

- MSF also invested itself in research into the disease, establishing scientific or applied research partnerships, specifically with the Cameroonian universities, HUG and the CPC. At the same time, there were sustained efforts to raise awareness and bring BU out of the darkness, to impress it upon peoples’ minds and ensure that the disease became a public health concern.

- It was in this spirit that it developed the strategy to hand the project over to the Ministry of Health, using a participatory method that involved the future players in the project. This approach also reflected MSF’s desire to communicate the lessons it learned during the twelve years that the project ran by broadening the broad range of future interventions to encompass all neglected tropical diseases.

These highly positive elements, which are an integral part the MSF experience with the BU project must nevertheless be tempered by a number of obvious facts that reposition its overall performance to a more modest level than the project’s stakeholders would have envisioned.

Consequently,

- In opting to work alone, MSF cut itself off from its direct environment—the Akonolinga Hospital—and from the Cameroonian health care system in general; not only was this dimly viewed by others, but it also created a gulf between NGO staffs and its entire potential pool. MSF found itself isolated, along with its patients, and withdrew into an opaque cocoon, from whence it attempted to emerge in the form of a chrysalis at the handover. By then it was too late.

- By positioning its activities in a part of the district hospital, by focussing exclusively on the treatment of BU, and by endowing the project with financially burdensome means, project managers were sending out a negative signal regarding the recurrent needs of a hospital such as the one in Akonolinga, of the needs of the district health centres and non-BU patients that they encountered. This sentiment was made even worse by the deliberate use of a vertical, parallel form of managing human resources, medical
equipment, and the medications that were reserved for the project, seen as a rejection of others, indeed as demeaning or potentially discriminatory behaviour.

- Because the project was unable to find common ground between the viewpoints of MSF’s medical and operational sectors, it was caught in a vice grip of the status quo, especially with regard to anything having to do with securing new resources or with a justified repositioning, prompting project managers to latch onto other stakeholders, such as Epicentre, HUG, the Manson Unit and l’Institut Pasteur, whose priorities did not necessarily coincide with those of the BU project. This led to a fragmentation of efforts, a choice of hesitant, ad hoc strategies and a flight forward in order to escape the clutches of headquarters, where unanimity was not a given, when it comes to the line that is to be followed in managing the Project.

- The absence of clear and practical guidelines over the medium and long term had a particular effect on the management of the human resources file, where the rotation rate was comparable to what is seen in emergency operations. For a project like the BU project, the consequences proved highly negative because they involved all those components that require continuity, such as the management of the project, integrated case management, capitalisation, memory, research, decentralisation, and the entire relational fabric that was seriously affected by the incessant changes occurring at the upper level of the mission and/or Project.

- The dithering that characterised the entire exit process, where dates conflicted with one another, cancelling each other out, one after the other, since 2011, considerably weakened the credibility of the exercise – which was otherwise very well designed – to hand the project over to the MoH and its partners. The action plan which, justifiably, originally called for implementation over a period of two years, saw its manoeuvring room narrowed, in parallel with the delays witnessed in obtaining process approvals, whether this was caused by foot-dragging in Geneva or a some sort of blockage at the Ministry level. The convergence of all these phenomena meant that a joint execution of the exit plan would benefit from a period of three calendar months. All of which is to say: mission impossible.

MSF had never planned to lighten its load, to jettison its ballast over time, in order to be able to quietly hand things off when the time came. In the views of national staff who are familiar with the organisation, MSF is seen as an organisation that proclaims: “In everything we do, we come to provide support. Then we leave.”

Then this same staff ask the question: “What’s going to be the legacy of these twelve years? How are we going to tot up the results? Isn’t there a risk that someone will say that the mountain laboured and brought forth a mouse?”

However, when all is said and done, one strong thought remains: “Somebody needed to take an interest in this disease.”
In summary

1 Appropriateness and opportunity: establishment and progress of the project

Project positioning: The decision to embark upon a project such as the fight against Buruli Ulcer should have had as an immediate corollary the insertion of this project into the Cameroonian health care system, or, at a minimum, the establishment of very close working ties that include the staffs of the MoH and foster the permanent and on-going nature of the project. The same applies to the means used in the fight against the disease; such means should have been better tailored to the financial capacities of the health-care pyramid (hospitals, health areas and health care centres).

Execution phases: It was not possible to determine the logic used in how the project phases were executed. Where one would have expected to see three-year renewable cycles, there was a juxtaposition of twelve different one-year projects, with a return to zero for the project’s main elements each fiscal year. With this type of scenario, it becomes risky to speculate about where the root cause of the changes in the manner that the project was implemented lies, because the changes appear to stem more from the succession of different managers, both at headquarters and in the field, than from a policy of adapting the project to circumstances and its own development. Most of the time, it was the circumstances and the environment that influenced the project’s directions and prompted changes to it, as was the case regarding the choice of antibiotic used (C+R), a choice that was made by default. The reasons that underlie other project-related decisions, such as those that relate to the attempts at decentralisation, are much less discernable.

Centralisation vs. decentralisation: The transition from centralisation to decentralisation was never fully accomplished because of a failure to adhere to a common definition of what the decentralisation process should consist, and also by reason of a centralised culture that was strongly tied to MSF practices, especially on this BU project. Further, prior to the project shut-down phase, the means needed to implement a true decentralisation process were not available while the project was up and running and had not been specifically identified, let alone budgeted. This is why the late strategic solution and the use of mobile clinics replaced what should have been a well-constructed, coherent and durable initiative, involving the supply of equipment designed to strength the system’s potential and that of the health care centres, the primary field partners. This type of development never took place.

Access to project: Thanks to a sustained awareness-raising policy that encouraged early detection of BU, especially in the schools, and thanks also to the effective actions of the community contacts and the good co-operation established with a number of the health care centre patients, who had up until then been accustomed to being in the hands of traditional doctors, began to trust and began to go to the hospital when their conditions required it. However, it is difficult to determine the percentage of persons affected by the disease presented themselves, compared with those who preferred to remain in their villages and allow themselves to be treated by traditional doctors. The continuing decline in the number of patients cannot be explained simply by a reluctance on the part of the
patients to be hospitalised. Other, more scientific, reasons should ultimately be able to shed light on this question.

2 Effectiveness: level of medical performance

Generally speaking, efficiency should be measured based on the cure rate, with the least percentage of sequelae, and on the capability to detect a maximum number of cases as early as possible.

Therapeutically, the cure rate remains high, although it varied throughout the various phases of the project.

However, as for the early detection of BU cases, there was an overly high percentage of late-stage and ulcerative forms, compared with what could have been an ideal evolution in a truly active search for cases, based on a truly decentralised strategy implemented at the proper time, that is, at the beginning, not at the end of the project.

This report does not assess the effectiveness of the various treatment components that are part of the “gold standard” for this type of intervention, or provide evidence of this effectiveness, i.e. modern dressings, antibiotic therapy, surgery, physiotherapy, nutrition, psycho-social support, TPE, treatment of complications, such as osteomyelitis or treatment of patients co-infected with HIV-BU.

Nor will this report provide further assessment as to whether or not the objectives defined in terms of quantity were achieved for the simple reason that over a period of twelve years objectives evolved, for better or for worse, in a virtually systematic fashion, with a series of very short implementation phases that made analysis difficult, or even impossible.

One thing is clear: if the various components of the project and of patient care had been put into place right from the beginning of the project, in a logical, pre-determined order, its effectiveness would have been clearly superior, especially considering the investments in terms of equipment and human resources that MSF OCG agreed to over those twelve years.

The effectiveness requirement cannot be limited just to patient care for BU cases in Akonolinga (Cameroon). It must also involve other, more policy-based and strategic aspects of the disease. The less-than-satisfactory choice of measures undertaken in the area of lobbying and advocacy ended up producing only poor results, given the potential for a long-term operation such as the BU Project. Less-than-satisfactory also with respect to the disease, and poor especially for future generations of victims of a disease that is so neglected on a world-wide basis.

3 Project continuity and sustainability

Overall arrangement: Given the compartmentalisation that characterised the MSF operation in the territory serviced by the Akonolinga Hospital and the very distant and tense working relationship with MoH officials in general, and the National Leprosy/Buruli Ulcer Programme in particular, it was not possible to establish a flexible and harmonious process for handover of the project. Also, MSF invested little in the search for replacement partners that were capable of supporting the efforts of the MoH after it left. One rumour
still circulating has it that Fairmed, with its experience in the field of BU, could come back, since the spot would now be vacant. No other hypotheses have materialised. The Ministry and its very tight budget therefore finds itself alone to take up the vacated role, because such is its responsibility to patients, in whatever condition they may be. The general consensus among observers of the situation in Cameroon, is that there is every reason to believe that the light is, at best, amber with respect to an effective continuation of the BU project. The priorities that the MoH has to deal with are so numerous and the BU cases so limited numerically that there are more reasons to worry about a positive outcome, or even envisage a possible shipwreck.

Challenges posed by sustainability: In the twelve years that MSF was involved in such a highly professional manner it is difficult to believe that the sustainability of its action has never risen to the top of its list of institutional priorities. This is due in part to the fragmentation of responsibilities, resulting from a human-resources policy that is unsuited to a long-term project, and to the extremely costly therapeutic choices that were beyond the reality of the situation in Cameroon and its health-care system. This situation is all the more regrettable because MSF invested all its talent and considerable material means into this project. Unfortunately, it chose to overlook the situation—except during the brief period of disengagement—on issues related to the transfer of assets and knowledge gained during this lengthy period. All one can do is hope that the idea of keeping a foot in Akonolinga for the purpose carrying out research can come to pass. This would allow MSF to keep an indirect eye on BU case management beyond June 2014, provided that it does not send a false signal regarding its new role in Cameroon.
4 Recommendations

Clarification: As called for in the Terms of Reference, these recommendations have been formulated in order to serve as a framework for reflection in the event that MSF should come to launch other similar projects involving a medium- or long-term commitment.

For Headquarters

– Examine the advisability of formulating a policy on engagement for medium- and long-term projects that incorporates the requirements of sustainability and permanence, and provides a definition of an exit strategy.

– Develop an operating procedure framework that can be applied to projects that are not urgent in nature, while keeping in mind:
  • the need to closely associate the medical and institutional approaches with openness to the field of public and community health;
  • the need to weave the intervention into the local fabric, on both the socio-economic level and on the level of the procedures and protocols in effect in national and international medical circles;

– Establish the mechanisms needed to allocate human resources based on actual needs of a long-term development project;

– Use management tools that make it possible to support, monitor and evaluate long-term projects in a well-planned, on-going fashion.

For the Field

– Establish a regular, transparent mechanism for reporting a project’s development and share it with interested parties at headquarters and in the field;

– Implement a diversified internal information process that will enable staff, whether or not directly involved in the project to follow its development and take an interest in it (buy-in);

– Use capitalisation tools to regularly and accurately track the project’s acquired knowledge and expertise, and facilitate access to it by researchers, both internal and external;

– Manage project databases in such a way as to optimise the content for future users.

For Partners

Public services and authorities:

– Establish a co-operation agreement that clearly sets out the division of roles and responsibilities;
– Display institutional pride, while at the same time resisting group-think; respect all stakeholders;

– Agree on an exit strategy for the project that accurately describes the place of stakeholders and sets out the nature and scope of requests intended to support continuation of the project;

– Establish a project inspection programme for all stakeholders concerned with its current or future development;

– Ensure that there is transparency at all times in the exchange of information;

– Establish an atmosphere of trust.

Private organisations:

– Ensure complementary nature of what others can bring before entering into a partnership;

– Clarify exactly what the role of each organisation will be during and after the project, as appropriate;

– Ensure a regular flow of high-quality information;

– Conclude co-operation agreements, where necessary;

– Ensure that there is clarity, legibility and predictability in behaviours on both sides.
5 Annex

5.1 Terms of reference

<table>
<thead>
<tr>
<th>Subject/Mission</th>
<th>External Evaluation Akonolinga Project, Cameroun Mission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commissioned by</td>
<td>Christine Jamet</td>
</tr>
<tr>
<td>Starting Date</td>
<td>5th of March 2014</td>
</tr>
<tr>
<td>Duration</td>
<td>about 9 weeks (47 working days)</td>
</tr>
<tr>
<td>Elaborated by</td>
<td>Serge Saint-Louis (HOM), Dr Geneviève Ehounou (Medco), Stephanie (Fieldco), Dr Eric Comte (Dmed), Barbara Rush (RMP)</td>
</tr>
<tr>
<td>Primary stakeholders</td>
<td>OCG, MOH/PNLB</td>
</tr>
<tr>
<td>Supported by:</td>
<td>Vienna Evaluation Unit</td>
</tr>
</tbody>
</table>

MEDICAL HUMANITARIAN CONTEXT

General Context

Cameroun located in central Africa is bordered by Nigeria, Tchad, RCA, DRC, Gabon and Equatorial Guinea. Cameroun population is estimated at 20.7 millions (2013), with a growth rate of 2.6% (EDS 2011) and still more than 40% of the population is leaving below poverty threshold. The country ranks 150/187 in the Human Development Index with an economic growth estimated at 4.8% in 2013 and forecasted to reach 5.6% in 2018. Cameroun is classified as a Low Middle Income Country (World Bank, 2011).

Since 1982 Cameroun is leaded by President Paul Biya funder of the RDPC (Rassemblement Démocratique du Peuple Camerounais). He organized in spring 2013 the first senatorial election since he is in power and successfully win majority of seat during the September parliamentarian election.

French and English are the two official language of the country.

Cameroun beneficiate from a relative stability compared to its neighboring countries, however the country is particularly affected in its northern part by the Nigeria conflict and its associated influx of refugees inside its territory as well as the wave of international kidnappings and cross border insecurity. The long-standing RCA internal tensions put Cameroun at risk of receiving another influx of refugees from RCA or at least suffering from proxy violence of the various groups involved and transiting through Cameroun.

Cameroun is part of la CEMAC (Communauté Economique et Monétaire de l’Afrique Centrale) and base its political economy on the DSCE (Document de Stratégie de Croissance et de l’Emploi). Compared to the others countries exporting oil, the economic growth of the country is deceiving and mostly due to the lack of proper governance and dilapidation of the infrastructures.

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20 Economist Intelligence Unit, Country report, Cameroun, 4th Quarter 2013
The EURO zone remains the main exportation market of the country. France is considered as one of the main bilateral donor, however US is re-investing in the country and China has clearly showed its interest with regard to investment in management of natural resources and infrastructures.

In Cameroun, the last ten years slow economic growth but still growth is not accompanied by significant poverty reduction or a rapid improvement of the living conditions of the population. A majority of Cameroun’s are still excluded from this growing wealth, increasing the risk of deterioration of the situation due to coexistence of a majority of poor with extremely rich elite. The regions of the North, Extreme North and Adamaoua in the west are particularly vulnerable to humanitarian crisis and remain priority area for intervention.

Cameroun performance with regard to health indicators remain extremely modest and seriously deteriorate for maternal health. While the country demonstrates below 500 maternal deaths for 100,000 live births in the 2000’s, today maternal mortality is reaching 782 maternal deaths for 100,000 live births. It is a unique situation for a country rated as a middle income country by the World Bank.

The main reason for consultation remains malaria and represents still 40 to 50% of the consultation burden while 23% of the hospitalisation. It is the first cause of death amongst the age group less than 5 year.

Health situation: Buruli Ulcer (UB) and Neglected Tropical Disease (NTD)

Several autonomous programs exist in Cameroun from which the National Committee against neglected diseases such as the Yaw, the Leprosis, the Leshmaniosis and the Buruli Ulcer. The national directives against BU have been adopted in 2012 with the support of MSF.

The MoH department for the fight against disease desire to ally all specific neglected disease program along a national coordination common platform so called NTD in order to optimize its funding, its response and its transparency.

Actors involved in the fight against BU are rare. Only WHO and MSF currently support still the National Program against BU. The Centre Pasteur is supporting operational research with regard to the establishment of the transmission chain of BU which is still partly unknown till now. Previously FAIRMED was directly involved in diagnostic, care and treatment in Ayos health district neighboring Akonolinga district but stopped in 2012 its involvement in the country.

In 2010, National Directive concerning the policy toward BU included BU management from diagnostic to treatment in the frame of primary health care with two identified referral centre: Ayos and Akonolinga district hospital. This Directive recommends an efficient and free management of BU.

Prevalence is badly known but a study has been performed in 2007 by PLOS and MSF which shows a 0.47% prevalence of BU in Akonolinga district. Expected annual incidence ranges around 5200 cases per year, however in 2012, only 160 BU cases were detected and treated nationally. The basis to reinforce the management and treatment of BU are present but the political will and funding remain insufficient.

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21 Swiss NGO that was involved in neighbouring health district of Akonolinga in Ayos in addressing BU patients.
Project summary

For 2014 the general objective of the project is to handover the BU/Chronic wound Akonolinga project by mid year to the MOH and others partners while maintaining a quality management of patient affected by BU and chronic wound in Akonolinga district.

This general objective can be achieved through three results:

1. The confirmatory diagnostic and the holistic management of BU/chronic wound is assured by the Akonolinga District Hospital
2. The early diagnostic and sensitization in the community as well as the decentralized management of simple BU and chronic wound through the primary health care level is effective
3. The defined handover strategy and road map is in place, operational and completed by mid-2014

Target population

<table>
<thead>
<tr>
<th>Cameroun population</th>
<th>20.7 millions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Akonolinga population</td>
<td>113,479 persons</td>
</tr>
</tbody>
</table>

| Socio-cultural characteristics of the population            | 70% < 15 years |
| Majority rural population                                    |
| BU/HIV coinfection of 22%                                    |

| Direct BU cases per year                                      | 72 (in 2012) |
| Direct chronic wound cases per year                          | 286 (2012)   |

Major Orientations

<table>
<thead>
<tr>
<th>Period</th>
<th>Orientations</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>Initiation of OCG BU project : diagnostic and management of patient affected by BU in Akonolinga District Hospital</td>
</tr>
<tr>
<td>2006</td>
<td>Introduction of physiotherapy and modern dressing in the management of the wounds</td>
</tr>
<tr>
<td>2007</td>
<td>BU prevalence study</td>
</tr>
<tr>
<td></td>
<td>Introduction of HIV voluntary testing and counselling in BU patients</td>
</tr>
<tr>
<td>2008</td>
<td>Start of decentralised early diagnostic and care in the primary health care system of the district</td>
</tr>
<tr>
<td>2009</td>
<td>Introduction of specific antibiotherapy based on Rifampicine + Clarythormycine during 90 days</td>
</tr>
<tr>
<td>2010</td>
<td>Training of all head of 12 primary health care centre in the BU management</td>
</tr>
<tr>
<td>2011</td>
<td>Start of Score Clinic study (study on diagnostic differential of BU) including all chronic wounds with management and care</td>
</tr>
<tr>
<td>2013</td>
<td>Establishment of a workshop on management of chronic wounds in partnership with the Yaounde medical university and the Hopitaux Universitaire de Genève (HUG)</td>
</tr>
<tr>
<td></td>
<td>Establishment of the handover road map between all actors involved in BU nationally with identification of indicators allowing to follow up achievement of handover objectives</td>
</tr>
</tbody>
</table>
REASON FOR EVALUATION / RATIONAL

OCG has been involved in BU since 2002 and has always been the unique operational section working on this topic.

After more than 10 years involvement in the Akonolinga district toward developing and learning on how to better and earlier diagnose BU as well as on how to treat medically but as well through adapted surgery and modern dressing, MSF decided in 2012 to close its BU project due to various reasons.

The main reason is due to the decreasing number of cases detected that could be observed in the three graphs below.
Furthermore, a certain form of lassitude and frustration with regard to the ability of managing a long term project for a neglected disease with traditional MSF modus operandi that are not necessary adapted for such specific project.

Knowing that the closure of this project has been decided in the POA 2012 and that the handover road map has been prepared over the year 2013, as a part of this process MSF is foreseeing a project review since its inception to its closure as an integral component of the closure.

OVERALL OBJECTIVE and PURPOSE

The purpose of this review is to identify the lessons learnt from an OCG medical-operations project on Buruli Ulcer-Chronic Wound in Akonolinga, Cameroun since its initial times until its decision of handover.

The lessons learnt throughout the 12 years of life of this project will lead to issuing recommendations (medical and operational) for any further involvement of MSF in similar type of project, i.e. not only addressing Buruli ulcer but also any neglected disease programmes.

Furthermore, the recommendations should be addressed to and shared with the Cameroon MoH and the WHO Buruli Ulcer department.

The objective is to identify the different programmatic phases the project went through during the last 12 years since its initiation, the reasons for these different strategies (medical and/or operational) and the effects they had on the medical outcomes of the project.

While throughout these 12 years the project has been facing different phases from inception to handover, it would be necessary to identify and document the various periods of this project over its life span.

Secondly, the evaluation should identify the developments in the project that have led to strategy changes (along the processes of patient care: detection, diagnosis, treatment and follow up) - either in modus operandi and/or in advocacy/lobbying. Thirdly, it should whether and why the changes have been succeeding or not.

To evaluate the 12 years project (2002-2013 years) with:

1) an emphasis on the operational perspective over time since initiation of the project till decision of closure

2) focusing on the medical outcomes over time as well as identifying the supportive and hampering processes external and internal that could have influence the outcomes of the project.

SPECIFIC OBJECTIVES

Relevance and appropriateness: initiation and evolution of the project

- What was the operational rational (internal and external) to open the project and how appropriate were the program design and the operational approach to meet the identified goals of the interventions?

- What have been the different phases of this project over its life span?

- How did these defined phases of this project match to the context evolution? How clear were the reasons for changes and the steps to fill the identified gaps?

- What are the pros and cons of the centralized versus decentralized approach in this project (SWOT analysis)?
What were the main determinants for the patients to access the programme?
What differences did these phases make on the medical outcomes? Why?

**Effectiveness: medical outcomes review of the project**
- Proportion of BU patients detected over number of patients screened (review of the detection strategies (passive/active) and impact of each one)
- Proportion of BU patients discharged treated without sequel complication versus number of patients discharged treated with sequel.
- Proportion of BU patients discharged not successfully treated (non-répondant)
- Average length of stay in the programme comparing hospitalized, outreach and home managed groups of patients.
- Etc....cf logframe indicators for further outcomes review
This can help to recollect all the info needed.

**Continuity:**
- What local capacities and resources have been identified for continuity purposes? How does the project connect with these?
- What challenges to sustainability can be identified and how have they been taken into consideration?
- To what extent is the model of care replicable and are the apparent opportunities and constraints?

**EXPECTED RESULTS**
- Direct feedback to field teams.
- Evaluation report (internal) including executive summary and presentation/s (in French and English) detailing the issues related to the appropriateness, effectiveness, and continuity of the programme.
- External report (in French and English) addressed to the MoH of Cameroon and the department of WHO for Buruli Ulcer

The above-mentioned reports and presentations are expected to deliver:
- External analysis that will provide insight and appreciation on how the project evolved to allow the handover and what was its weight in the shaping of the national BU strategy in Cameroun.
- Recommendations on how MSF could have optimized the sustainability of the model of care developed while optimally and rationally developing further its innovative and strengthening role in the fight against Buruli.
- Recommendations on the current handover process
TOOL AND METHODOLOGY PROPOSED
→ Revision redaction and analysis of key document and literature
→ Meeting/discussions/interviews with key team members at HQ and field levels
→ Meeting/discussions/interview with key authorities and partners
→ Meetings/discussions/interviews with patients/former patients
→ SWOT review\textsuperscript{22} of the centralized versus de-centralized approach of the project (a meeting including different stakeholders could be considered)

RECOMMENDED DOCUMENTATION
- MSP Cameroun since beginning of the project
- Project document of Akonolinga since beginning of the project
- Logical Framework since beginning of the project
- Annual reports
- Operational Research performed in the project
- Prevalence study of Bu in Akonolinga
- National directive on BU management since beginning of the project to now
- HQ field visit reports
- BU guideline
- etc....

List of interviewees

In the HQs:
- Eric Comte (Medical Director, previous focal person on neglected disease)
- Previous Medical Directors: Isabelle ANDRIEUX-MEYER, Abyi Tamrat
- Yolanda Muller - Epicentre representative, GVA office
- Bruno Jochum (General Director, previously Operations Director)
- Christian Blanc (former Surgical advisor, med department)
- Matthias Kuge (Anesthesia advisor, med department)
- Reveka Papadopoulou (former desk-responsible) – email?

\textsuperscript{22} - What have been the internal strength and weaknesses of the project over time? (Common appropriation by different MSF departments, HR expertise/turn over, resources allocated, etc ...)
- What have been the external opportunities and constraints of the project over time? (Relation with authorities, positioning of WHO and others international partners, emerging medical knowledge, etc...)
Others

- BRAMU person involved in the previous evaluation
- Previous MedCo (Serge Mathurin KABORE)

PRACTICAL IMPLEMENTATION OF THE EVALUATION

<table>
<thead>
<tr>
<th>Number of evaluators</th>
<th>2</th>
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<tbody>
<tr>
<td>Timing of evaluation</td>
<td>5th of March – mid May 2014</td>
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<tr>
<td>Required amount of time (days):</td>
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</tr>
<tr>
<td>- For preparation (days)*</td>
<td>1.5 week (7.5 days)</td>
</tr>
<tr>
<td>- For field visits (days)</td>
<td>4 weeks (20 days)</td>
</tr>
<tr>
<td>- For interview (days)</td>
<td>1.5 week (7.5 days)</td>
</tr>
<tr>
<td>- For writing report (days)</td>
<td>2 week (10 days)</td>
</tr>
<tr>
<td>- Presentations (days)</td>
<td>2 days</td>
</tr>
<tr>
<td>Total time required (days)</td>
<td>&gt;9 weeks (47 days)</td>
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</table>

PROFILE / REQUIREMENTS: EVALUATOR(S)

<table>
<thead>
<tr>
<th>Evaluator 1</th>
<th>Evaluator 2</th>
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</thead>
<tbody>
<tr>
<td>Medical/epidemiology background</td>
<td>Operational/project management background</td>
</tr>
<tr>
<td>Evaluation experiences and competencies</td>
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</tr>
<tr>
<td>Fluent French written and spoken</td>
<td></td>
</tr>
<tr>
<td>Previous acquaintance of working with an MSF project is an asset</td>
<td></td>
</tr>
<tr>
<td>Previous acquaintance of working with an MOH structure is an asset</td>
<td></td>
</tr>
<tr>
<td>Previous acquaintance of working in the neglected disease field is an asset</td>
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</tr>
<tr>
<td>Previous experience on handing over projects is an asset</td>
<td></td>
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</tbody>
</table>

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*Visit to the HQs not necessary. Interviews could be done on distance.
5.2 List of interviewees

**MSF**
Genève
Bruno Jochum, directeur général
Jean-Clément Cabrol, directeur des opérations
Eric Comte, coordinateur médical
Christine Jamet, responsable Cell 1

Yaoundé
John Irwin, chef de mission
Dr Geneviève Ehounou, coordinatrice médicale
Dougo Mara, administrateur
André-Marie Tamba, directeur des finances
Christelle Ntsama, responsable de la communication et du plaidoyer

Akonolinga
Stéphanie Remion, responsable terrain
Dr Marie Tchaton, responsable médicale terrain
Prizka Nkolou, responsable des finances et de l’administration
Alain Bertrand Nomo, data manager UB
Jean Calvin, technicien de laboratoire
Dr Patrick Nkemenang, médecin du projet et assistant de recherche pour l’étude Score clinique
Dr Franck Wanda Djofang, responsable de la PEC co-infections
Dr Joëlle Nyandja, médecin
Jeanine Mfoumou, aide soignante
Michel Ze Beyene, responsable ETP
Armel Tassegning, physiothérapeute
Guy-Bertrand Tengpe, psychologue consultant
Cécile Newoua, infirmière principale
Dorkas Bilong, aide soignante

**Ministère de la santé (MoH)**
Programme national
Dr Njih, directeur du Programme national Lèpre/Ulcère du Buruli

Bureau de santé
Ngondang Etoundi, chef du Bureau de santé
Pierre Nnama, président du COSADI (Comité de santé du district)
Victor Mekon, responsable du Bureau de santé du district d’Ayos

Hôpital
Abanda Mevaa, infirmier diplômé
Jules Ze, Major Pavillon UB
Akoa Tsoungui, directeur de l’hôpital d’Akonolinga et président du district a.i.
Emmanuel Deumo, infirmier anesthésiste, Major Service Accueil

Centres de santé
Delphine Mepha, infirmière, Centre de santé Yeme Yeme
Joseph Edzeba, infirmier, Centre médical d’arrondissement, Endom
Dominique Paul Etoundi, infirmier, Centre de santé, Edjom
Simplice Ntse, infirmier principal, Centre de santé, Mengang
Hilaire Zo, infirmier principal, Centre de santé, Abem
Niveau communautaire
Emmanuel Ndjala, délégué de santé diplômé, relais communautaire, Edjom
Un tradipraticien, Edjom

Communauté scientifique
Centre Pasteur Cameroun
Dr Gaëtan Texier, chef de service d’épidémiologie et de santé publique

Faculté de médecine et des Sciences biomédicales
Dr Marc Leroy Guifo, chirurgien, CHU, Yaoundé

OI/ONG

OMS
Dr Léonard Mbam Mbam, représentant résident au Cameroun

Fairmed
Dr Alphonse Um Boock, représentant régional basé à Yaoundé, expert OMD Genève pour l’UB
Valérie Simonet, ergothérapeute

Autorités locales
Evina Banga, 3ème adjoint au Maire de Akonolinga

Populations bénéficiaires
Raoul Mvondo Akono, président de l’Association des victimes de l’UB
MM, 37 ans, femme, vendeuse de beignets, janvier 2014
GS, 46 ans, femme, commerçante, début 2013
EC, 10 ans, fille, 2013
EO, 60 ans, homme, maçon, 2012

Population de la rue

Total estimé : ≥ 50 personnes