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AN EVALUATION OF

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POOL D'URGENCE (PUC)

IN THE DEMOCRATIC REPUBLIC OF THE  
CONGO

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September 2025

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All evaluators contracted by the SEU must adhere to the SEU Ethical Guidelines for Evaluations.

The evaluation was conducted independently by Amelia Goldsmith & Claire Weil, and the report produced by Amelia Goldsmith.

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The authors' views expressed in this publication do not necessarily reflect the views of Médecins sans Frontières and the Stockholm Evaluation Unit.

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## ACRONYMS

ACF: Action Contre La Faim

BALI: Bureau d'Appui et de Liaison Intersections

DPS: Provincial Health Directorate (Division Provinciale de la Santé)

DRC: Democratic Republic of the Congo

ESP: Equipe de Support Pays (Country Support Team)

FGD: Focus Group Discussion

HQ: Headquarters

HR: Human Resources

INRB: National Institute for Biomedical Research

KII: Key Informant Interview

MoH: Ministry of Health (MSPP in French for Ministère de la Santé Publique, Hygiène et Prévoyance Sociale)

MSF: Médecins Sans Frontières

OCB: Operational Centre Brussels

OCBA: Operational Centre Barcelona-Athens

OCP: Operational Centre Paris

PdR: Pool de Réserve

PUC: Pool D'Urgence Congo

RST: Regional Support Team

SEU: Stockholm Evaluation Unit

SITREP Situation Report

SoE: Strength of Evidence

ToC: Theory of Change

USAID: United States Agency of International Development

UNHAS: United Nations Humanitarian Air Service

V&D: Veille et Détection (Surveillance and detection)

WACA: West and Central Africa Operational Directorate (MSF)

WASH: Water, sanitation and hygiene

WHO: World Health Organization

## EXECUTIVE SUMMARY

Médecins Sans Frontières's (MSF) Pool d'Urgence Congo (PUC) is an emergency response project administered by the MSF Democratic Republic of the Congo (DRC) country program, within the Operational Center Brussels (OCB). It covers 15 provinces in the western DRC, focusing on rapid detection of and response to medical and humanitarian crises. The DRC experiences frequent infectious disease outbreaks and medical humanitarian emergencies, often in hard-to-reach locations due to a diverse and complex geography. The PUC maintains an extensive surveillance network across 293 health zones, conducting both passive and proactive monitoring through seven established surveillance offices which collect both outbreak and crisis related data through local networks. When crisis *alerts* reach internally established thresholds, the PUC can deploy rapid response teams to verify information via an *exploration*, and later on confirm and document the crisis via an *evaluation*, with the aim to assess a prospective intervention. In 2019, the PUC experienced a significant restructuring to address perceived challenges around responsiveness and flexibility, to improve the PUC's speed and effectiveness in reducing morbidity and mortality during crises.

This 2025 external evaluation, conducted through MSF's Stockholm Evaluation Unit (SEU), assessed the PUC's relevance, its strategic positioning and the effectiveness of its operational approach to address emergency needs in the DRC. The evaluation adopted a comprehensive theory-based approach. The evaluation team first developed the Theory of Change (ToC) through a workshop held in-person in Kinshasa in March 2025 with PUC staff. The ToC allowed for the evaluation to test the conceptual basis of PUC's current operating model in practice. In May and June of 2025, the evaluation team reviewed documents and collected data through a mixed methods approach, which included key informant interviews with stakeholders, focus group discussions with emergency roster<sup>1</sup> Pool de Réserve (PdR) staff, an online survey, and an analysis of recent interventions, in order to assess the PUC's operating model when compared to the ToC.

The evaluation shows that despite many changes over the last 30 years, the PUC's activities remain highly relevant to the current needs in the DRC. The PUC's Veille et Détection (V&D) system fills a critical gap in the DRC's disease surveillance architecture, providing timely and detailed data that complements the Ministry of Public Health, Hygiene and Prevention's (MoH) reporting. Despite this, the V&D system appears less capable of detecting humanitarian crises and atypical events and could become more sensitive with the support of revised crisis thresholds. The geographical coverage and current mandate of the PUC also contribute to a low exposure to humanitarian crises. Because of the epidemiological context, the PUC often responds to measles outbreaks, which can limit its exposure to other types of crisis and induce a certain degree of specialization.

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<sup>1</sup> While the term "pool" is more common in French, the word roster is more commonly used in English to describe this kind of HR structure.

The PUC's exceptional logistical capacity is one of its greatest assets and sets it apart from its peers, but, due to the sheer size of the 15 provinces that it operates in, the PUC must be selective about its decisions to intervene. Dependence on unreliable commercial airlines or UNHAS flights has complicated mobility and efficiency. The PUC must also maintain a balance between obtaining information from its network of community informants and only intervening when necessary, while managing community expectations.

The PUC's multi-layered decision-making and budget validation processes are time-consuming. This limits the reactivity of the PUC and creates tensions between the PUC and other bodies within MSF-OCB (country program, RST, HQ). The approval process does not currently include *systematic* analysis of trends in decision making across interventions, despite the availability of key data internally as well as recent progress with regards to establishing proactive organizational learning processes. Information from previous interventions is gathered but not used for adaptive management purposes, to ensure that discussions around systemic changes are data informed. Reliance on paper-based systems and insufficient digital skills among PUC staff (e.g. advanced excel) hinder efficient and adequate record keeping.

The PUC's HR engagement with Pool de Réserve (PdR) staff is time-consuming. PdR staff who were interviewed during the evaluation found that they did not have sufficient information regarding selection criteria. This could contribute to higher attrition rates, as well as other factors such as temporary nature of the contracts and competing employment opportunities. Despite improvements, team sizes for interventions are still considered large.

Strong collaboration with the MoH was described but there are concerns about dependency due to structural weaknesses within MOH. The PUC needs to further invest in the MoH's integration and partnerships during interventions to improve efficiency. While there is interest towards and effective collaboration with external partners, the PUC's independent culture and differences in operational models has at times made this challenging. Despite this, PUC personnel are interested in further formalizing collaboration with other humanitarian actors, collaborating with the MoH and other MSF entities to improve budgetary efficiency, especially given current funding restrictions.

## RECOMMENDATIONS

- **Mitigate measles specialization risk:** Increase exposure to more diverse scenarios through interventions when appropriate and conduct quarterly scenario-specific training for other infectious diseases and humanitarian crises to ensure broader crisis exposure.
- **Innovate the current V&D system to increase sensitivity:** Complement indicators if necessary, expand secondary network contacts in silent zones, and strategically define thresholds for PUC response to humanitarian crises, towards or in complement to other actors, including MSF ones.
- **Consider streamlined validation processes that could speed up interventions** such as pre-validated intervention packages for measles interventions.
- **Consider increasing the budgetary validation thresholds** to allow for greater budgetary autonomy and trust in the PUC while maintaining scrutiny for above-average budgets.

- **Conduct a cost-benefit analysis of purchasing a plane for the PUC:** Compare costs of purchasing a dedicated aircraft versus current dependence on commercial or UNHAS airlines, factoring in organizational value of improving speed and mobility.
- **Critically assess the best opportunities to incorporate polyvalent staff into interventions:** Assess which skills could be taught to existing staff and map out which partners should house multiple technical abilities to create leaner teams.
- **Modernize data management and learning systems:** Transition from paper-based to digital record keeping, invest in digital skills training, and provide tablets for interventions.
- **Establish learning sessions for key PUC activities:** Systematize organizational learning through quarterly strategic reflection by different departments to institutionalize best practices and address intervention challenges. While inter-PUC learning exchanges exist, they should be established as regular events.
- **Create a template to track and standardize records of key timepoints between alert and intervention stages:** Systemically track elapsed time between each stage in a dedicated template which is visible across all decision-making levels to enable data-informed discussions about delays. Systemically analyze these intervals as part of broader organizational learning initiatives.
- **Hold a workshop between all decision-making levels in the validation process:** Use timepoint data to structure dialogue about priority adjustments to enable faster response capacity and set quantitative targets for ideal pace.
- **Improve communication and engagement with PdR staff:** Establish dedicated PdR focal point, ensure that PdR staff better understand overall system and selection criteria, as well as feedback mechanisms, and provide more training opportunities between interventions.
- **Formalize opportunities for increased mutualization and collaboration with other MSF entities:** Develop operational framework with WACA, systematize regular inter-PUC learning exchanges, and prioritize resource mutualization opportunities. To achieve this, inter-PUC exchanges and collaborations should be backed up by institutional buy-in and a more formal framework at the level of the OC/ODs.
- **Invest in further integration within the Ministry of Health:** Assess areas where the PUC could further collaborate with the MoH, to enable increased partnership and ownership.
- **Formalize partnership approaches by transitioning from a more independent mentality:** Conduct strategic mapping of partnership actors and provide internal training to promote collaboration preparedness when and where possible.
- **Invest further in exit and handover strategies:** Communicate more strategically with all the stakeholders, including but not limited to the MoH, establish standardized handover protocols, and share lessons learned and best practices.
- **Continue on the path of increased engagement with the BALI, the MSF intersectional DRC support and liaison office, to improve advocacy efforts:** Increase opportunities to engage with BALI during government discussions, clarify communication protocols, and ensure PUC expertise is considered in national-level health discussions.

# INTRODUCTION

## PROJECT OVERVIEW

The Democratic Republic of the Congo (DRC) has a long history of both humanitarian crises and infectious disease outbreaks due to a combination of factors, including weak governance, political instability, conflict, and limited infrastructure. Emergency responses must contend with complex logistical challenges across a diverse range of geographies, including dense forests and river systems, with limited roads outside of urban areas. The Pool d'Urgence Congo (PUC) is an emergency response unit focusing on outbreaks and humanitarian crises across 15 provinces in the DRC. It is administered by the DRC country program within Operational Center Brussels (OCB). With roughly 80 permanent staff and 300 Pool de Réserve (PdR) staff available on their roster, the PUC aims to reduce morbidity and mortality within populations affected by emergencies, through the rapid deployment of emergency teams. The PUC maintains an extensive surveillance network, internally known as "Veille et Détection" (V&D), through established surveillance points, which actively monitor infectious disease outbreaks and humanitarian emergencies to enable early detection. The V&D system maintains active monitoring across 293 health zones through direct contact with the Ministry of Public Health, Hygiene and Prevention (MoH, MSPP in French) officials at the provincial and health zone levels while also reviewing reports and data from health facilities. This information is triangulated with information from secondary sources including community leaders, civil society organizations, religious officials, social media, and other local relationships.

After tracking and triangulating information about a prospective emergency to confirm its veracity and accuracy, the PUC issues an alert prior to determining whether a field visit with a small team, known as exploration or evaluation<sup>2</sup>, is warranted. In the case of an infectious disease outbreak, the alert threshold (seuil d'alerte) is based on standard epidemiological thresholds for specific diseases such as measles, yellow fever, or cholera based on standards followed by the World Health Organization (WHO) and the MoH. After the completion of a field visit, the PUC will then determine whether to launch an intervention, based on a variety of criteria, such as the potential for saving lives, concurrent needs across the 15 provinces, cost and other factors. These interventions include several operational activities such as patient care, vaccination campaigns, and health promotion activities. Interventions are designed to be limited in scope and time, with an exit planned within 8-12 weeks. The PUC's current capacity allows for two simultaneous interventions and one exploration/evaluation to assess the on-the-ground situation.

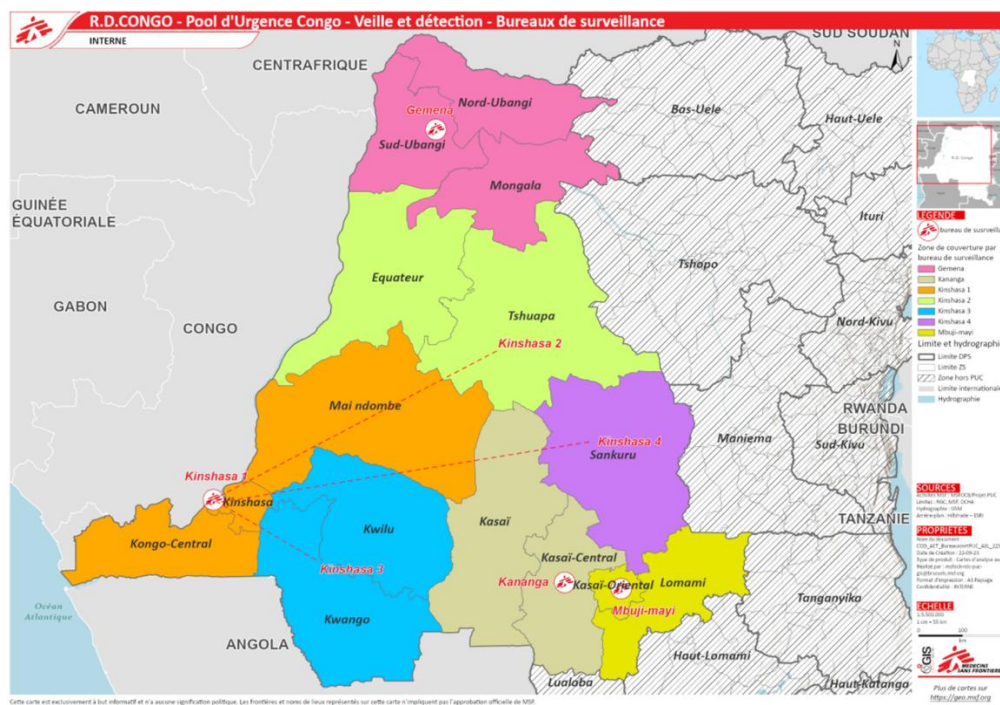
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<sup>2</sup> The PUC uses the terms "exploration" and "evaluation" to describe their assessment missions conducted to confirm outbreaks. While there are some differences between the two, the evaluation found that the PUC has recently often conducted only one or the other, or is referring to either or, instead of the sequencing of the two. For this reason, and also to avoid any confusion between field assessment called "evaluation" and other kind of external evaluative exercise, only the term exploration or exploration/evaluation is used in this report to describe the PUC's field assessment activities.

Throughout 2024, the PUC reached over 535,000 people, vaccinated over 320,000 children, provided outpatient care to approx. 13,000 patients, and inpatient care to over 1,800 patients<sup>3</sup>.

Since its inception in 1995, the PUC has undergone many phases of revision and restructuring including handing over several provinces to other emergency response teams administered by other MSF entities and establishing dedicated satellites for provincial level surveillance. It also carried an external evaluation in 2013 and an extensive restructuring in 2019. The 15 provinces that the PUC currently covers include the Western provinces north of Kinshasa along the boundaries of the ex-Katanga regions, west of Maniema, Tshopo, and Bas-Uele provinces.

Figure 1: The V&D system distributed across the 15 provinces where the PUC is active.



<sup>3</sup> PUC 2024 annual report.

## EVALUATION OBJECTIVE AND SCOPE

### OBJECTIVES

This evaluation aimed to provide a comprehensive analysis of the PUC's relevance based on the evolving humanitarian context in the DRC, its strategic positioning and the effectiveness of its operational approach. The assessment evaluated the project's processes and alignment with its core mission by generating concrete evidence that either validated existing approaches or identified areas for improvement. The PUC's effectiveness was assessed in terms of whether its approach is currently optimal to achieve its goals. While these goals include reducing morbidity and mortality, this evaluation focused on working processes and procedures rather than these endline targets globally or for specific interventions.

### THEORY-BASED EVALUATION AND THEORY OF CHANGE

This evaluation used a theory-based approach which tested the underlying assumptions and preconditions that comprise the project's Theory of Change (ToC) (ToC available in Annex 3 and Assumptions Testing Grid available in Annex 4).

The ToC that underpins this evaluation was co-developed during a two-day workshop held in Kinshasa in March 25-27<sup>th</sup>, 2025. Facilitated by the evaluation team, the workshop brought together 20 permanent PUC staff members with the goal of documenting and visualizing the processes and outcomes underlying a relevant and effective PUC. This document created a framework to guide the evaluation's inquiry and represented internal perceptions of the PUC.

During the workshop, participants engaged in brainstorming sessions, SWOT analyses, and group discussions to identify the key enablers and pain points influencing the PUC's performance. Despite time constraints that limited all planned activities, the group successfully articulated a vision of an ideal PUC:

*“One that rapidly and precisely detects outbreaks and humanitarian crises, responds quickly with quality care where other entities cannot intervene, while maintaining synergy with other actors.”*

The resulting ToC has three primary pathways for achieving its objectives:

1. Veille & Détection: This pathway describes how timely and accurate outbreak detection<sup>4</sup> depend on a reliable network of informants, robust data collection, and rigorous triangulation. Preconditions such as staff training, community engagement, access to functioning laboratory networks, and harmonized case definitions were identified as essential to enabling early and precise crisis detection.
2. Intervention and Crisis Response: Once an outbreak or crisis is detected, the PUC's capacity to respond rapidly with quality care depends on several interconnected factors. These include clear decision-making processes, logistical autonomy, efficient deployment mechanisms, appropriately

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<sup>4</sup> Discussions of humanitarian crisis intervention and response were notably absent from discussions by the PUC concerning their core activities. The dialogue was almost exclusively centered on outbreak detection and response.

sized and skilled teams, and the ability to deliver care tailored to the needs and contexts of affected populations.

3. Synergy with Other Actors: The third pathway outlined the importance of coordination with the MoH, other MSF entities, and humanitarian partners. Clearly defined roles, compatible remuneration structures and operating models, and open information-sharing were seen as essential to avoiding duplication and enhancing collective impact.

Each pathway was further broken down into preconditions and assumptions, which served as the analytical foundation for the evaluation (available in Annex 5). The data collection process intended to confirm whether the PUC is currently operating as planned across these pathways. This allowed for the evaluation to determine whether the expected flow of activities and outcomes truly occur in practice and what factors facilitated or impeded this.

### EVALUATION CRITERIA

This evaluation observed these pathways and their supporting assumptions through primary and secondary data across the OECD/DAC evaluation criteria of *relevance*, *effectiveness*, *efficiency*, and *coherence*. The following questions were considered alongside the corresponding evaluation criteria.

Table 1: Evaluation Criteria and Corresponding Questions

Criteria	Corresponding Questions
Relevance	<ul style="list-style-type: none"> <li>• How relevant are the detection and response mechanisms (e.g., surveillance networks, alert validation, mobilization processes) to the types of emergencies the PUC aims to address?</li> <li>• To what extent are the PUC's interventions relevant to the current operational context in the DRC and the national emergency response apparatus based on MSF principles and priorities?</li> <li>• How relevant is the PUC modus operandi in responding to disease outbreaks?</li> <li>• How relevant is the PUC's modus operandi in responding to humanitarian emergencies?</li> </ul>
Effectiveness	<ul style="list-style-type: none"> <li>• How effective is the PUC in rapidly identifying and responding to crises at an early stage?</li> <li>• Are the PUC's structure and processes best positioned to achieve its ultimate goal of reducing morbidity and mortality during crises?</li> </ul>
Efficiency	<ul style="list-style-type: none"> <li>• Are decision-making processes streamlined and adapted to allow for timely detection, response, and coordination with other stakeholders?</li> <li>• To what extent are internal PUC and external human, financial, and logistical resources mobilized and used in an efficient/rational way during interventions?</li> <li>• What are the main internal and external enablers and constraints affecting the PUC's operational efficiency?</li> <li>• To what extent do decision-making processes support or hinder rapid deployment?</li> </ul>
Coherence	<ul style="list-style-type: none"> <li>• To what extent are PUC interventions complementary to or duplicative of other actors' responses?</li> <li>• How well does the PUC coordinate with other MSF entities operating in DRC?</li> <li>• What are the key enabling and constraining factors in the PUC's coordination with other actors?</li> </ul>

## METHODOLOGY

### DATA COLLECTION METHODS

The evaluation used a mixed methodology based on primary data from key informant interviews (KIIs), focus group discussions (FGDs), an online survey, and a rapid analysis of recent interventions. Mixed methods were used in order to corroborate findings from different data sources for triangulation purposes. All data were collected between May 12<sup>th</sup>, 2025, and June 9<sup>th</sup>, 2025. Data were collected in-person in Kinshasa between May 12<sup>th</sup> and May 23<sup>rd</sup> while additional interviews and focus groups were conducted remotely after the evaluation team left Kinshasa.

### Desk Review

A variety of internal PUC and MSF documents were reviewed during the Inception Phase, data collection, and the analysis phase of the project in order to support tool design and corroborate emerging themes (a full list of documents is available in Annex 2).

### Analysis of PUC Interventions in the Last Year

The evaluation conducted an analysis of 8 PUC interventions that occurred between February 2024 and February 2025 to determine the time that elapsed between key decision-making moments, before an intervention was launched. These intervals include the date that an alert was received, when the PUC decided to launch an evaluation/exploration, the date that the evaluation/exploration was completed, and the date that an intervention was launched. This analysis intended to assess the speed of the PUC in responding to crises, to be considered alongside perceptions of the PUC's speed as described in interviews with key informants.

## SAMPLING

*KIIs with key stakeholders:* A total of 54 KIIs were conducted, including with permanent PUC staff, MSF Support Staff, health authorities, external humanitarian actors, and community members. The MSF Support staff respondents hold positions across the organization, including within OCB headquarters, Regional Support Team (RST), Country Support Team (ESP)<sup>5</sup>, other MSF entities and the Bureau d'Appui et de Liaison Intersections (BALI).

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<sup>5</sup> This structure was still in place during the data collection period, however at the time of finalizing this report, this structure is no longer in use. OCB recently transitioned back to using a cell structure instead of the RST approach. Likewise, ESP staff now fall under the country coordination structure. However, to respect the anchoring of the evaluation in time, the body of the report refers for example to Regional Support Team (RST) and Country Support Team (CST) instead of Cell and Coordination teams.

Sampling for all KII participants was purposive. All contact information came directly from a combination of information from PUC management, the SEU and snowball sampling which was used until the evaluation team was confident of data saturation.

The types of respondents are categorized in the table below:

Table 2: KII Respondents by Organizational Affiliation

PUC Permanent Staff	MSF Support Staff	Health Authorities	External Stakeholders/ Humanitarian Actors	Community Members
21	11	6	12	4

*FGDs with PdR staff:* PdR respondents that participated in FGDs were selected based on having participated in recent interventions with MSF. Each FGD included contacts obtained directly from PUC HR staff and included PdR staff that were contracted for interventions in Lusambo in February of 2025, Bikoro in October of 2024 and Iboko in September of 2024. A total of 15 PdR members participated in these group discussions which were organized and conducted remotely via WhatsApp.

Table 3: Number of PdR Respondents by Intervention Location

Bikoro	Lusambo	Iboko
4	7	4

*Online survey:* An online survey was published and circulated by PUC managerial staff to 80 permanent PUC staff members and 300 PdR members. Eligibility for this survey was exclusively based on having an active contract as a PUC staff member or active registration within the PdR roster.

## ANALYSIS AND REPORTING

Data analysis of qualitative data was conducted in two primary stages: identification of emerging themes and qualitative coding using Dedoose software. During data collection, the evaluation team extracted direct quotes into an analysis grid organized by categories from the three pathways within the ToC, cross-listed with the evaluation criteria. This inductive coding approach identified a preliminary code list in preparation for the second phase of analysis. After data extraction, the team took the preliminary code list from the analysis grid extraction process and imported it into Dedoose, which allowed them to expand on these codes and conduct a deeper analysis of these themes.

Quantitative data from the online survey and the analysis of interventions produced basic descriptive statistics including percentages, ranges and averages. The results of these analyses were triangulated with the information available from the desk review. Stakeholder triangulation was conducted by cross-referencing data and insights from interviewed stakeholders to consider diverse perspectives and test each assumption.

The strength of evidence (SoE) of findings was determined by categorizing the SoE into three categories: Limited, Moderate or High. The categorization criteria can be viewed in Annex 6. The preliminary findings from these themes were presented to the consultation group of the evaluation (MSF staff from PUC, country and regional support teams, as well as HQ and technical support) in June 2025. This process intended to allow for an inclusive and robust approach to promote a shared understanding of the evaluation findings.

## ETHICS

SEU ethical guidelines<sup>6</sup> were strictly followed during data collection to ensure respectful engagement with participants. Respondents were referred to the evaluation team based on their professional roles rather than demographic characteristics. Before participating, respondents were informed about the evaluation's purpose, the sampling process, anonymity, and lack of incentives. They were also told that interviews would be recorded, transcribed, deidentified, and deleted after the evaluation. Verbal consent was obtained from all participants before recording.

## LIMITATIONS

***PUC Activities in progress during evaluation:*** The PUC is an emergency project and continued its surveillance and response activities throughout the ToC workshop and data collection period. Despite efforts to fully participate, PUC staff faced challenges due to deadlines and travel commitments, leading to lower attendance on the second day of the workshop and difficulties in following up on certain details.

***Changes in humanitarian donor landscape:*** The evaluation period (March-June 2025) coincided with significant changes in the humanitarian donor landscape due to the abrupt dissolution of USAID. This shift raised concerns among MSF staff and respondents about potential cuts to infectious disease programs and workforce reductions. Respondent bias may have influenced the information shared as respondents were concerned about their job security and potential restructuring. Mitigation measures included cross-validation of responses, broad participant inclusion, and probing for clarification.

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<sup>6</sup> Stockholm Evaluation Unit (2022) Ethical Guidelines. Available here: [https://evaluation.msf.org/sites/default/files/2023-01/GUI\\_2022\\_SEU\\_MAIN\\_EthicalGuidelines.pdf](https://evaluation.msf.org/sites/default/files/2023-01/GUI_2022_SEU_MAIN_EthicalGuidelines.pdf)

**Non-representative purposive sampling for qualitative data:** The evaluation used purposive sampling for qualitative data, which may not fully reflect the diversity of stakeholder experiences. Nearly half of the respondents were permanent PUC staff, potentially over-representing internal perspectives. These were balanced with information from other MSF decision-making levels.

**Insufficient response rates for online survey:** Only 29 out of over 380 PUC staff (permanent and PdR) participated in the online survey which limited the representativeness of quantitative findings. Reasons behind this low response were not explored but could include many factors, including limited availability and connectivity due to ongoing interventions, outdated contact details or unwillingness to participate. The evaluation relied more on qualitative evidence and featured quantitative responses only when extensive qualitative information was available for triangulation.

**Limited triangulation:** Some findings could not be fully validated through multiple sources, affecting the robustness of certain conclusions. The evaluation team flagged findings with limited triangulation, emphasized consistency across sources, and clarified the strength of evidence.

**Epidemiological analysis and quality of care outside evaluation scope:** The evaluation did not include an epidemiological analysis of the PUC's effectiveness or quality of care, focusing instead on perceptions of processes and structures rather than quantifiable health outcomes. The evaluation focused on the PUC's ways of working and the overall purpose of the PUC rather than an evaluation of individual interventions. This limitation should be considered when interpreting results.

## FINDINGS

### RELEVANCE

#### PATHWAY 1: VEILLE & DÉTECTION

**Finding 1: The PUC's surveillance activities fill an important gap and do not duplicate existing processes. (SoE: High).**

The PUC's surveillance and detection (V&D) activities address a critical gap in the DRC's disease surveillance system without duplicating existing activities. The PUC's V&D system covers 293 health zones and over 6,500 health areas through a sophisticated network of primary and secondary information sources to identify emerging outbreaks and crises. This multilayered approach incorporates provincial health data, proactive verification calls, communication with healthcare workers, and regular "Promo PUC" outreach to build local trust. This network is crucial for monitoring "silent zones" where traditional surveillance is hindered by connectivity and infrastructure issues.

Humanitarian actors and national health authorities recognize the PUC's role in providing reliable, detailed data through rigorous triangulation, compared to the MoH's one-dimensional monthly reporting. The PUC's independent data collection serves as a comparative tool for the MoH, helping to identify

discrepancies in health zone reports. Survey findings show that 64% of respondents view the PUC's system as complementary to existing processes. The PUC actively engages with the MoH, participating in national epidemiological surveillance meetings twice a month. This collaboration helps identify discrepancies in official reporting, with the PUC's data serving as a quality assurance mechanism.

The National Institute for Biomedical Research (INRB) acknowledges the PUC's role in filling gaps in sample collection and transport for outbreak confirmation. Many health centers across the country have not been adequately trained to collect samples which, according to interviewed INRB staff, leads to about 40% of the samples that the INRB receives being of suboptimal quality. With only two operational laboratories in Goma and Kinshasa, the PUC's proactive role in quality sample collection and rapid transport has been effective at speeding up outbreak confirmation. This role has been especially important due to the DRC's size, the lack of infrastructure in rural areas, and the frequency of outbreaks.

**Finding 2. Evolving humanitarian dynamics may further threaten surveillance data integrity. (SoE: Moderate)**

Some stakeholders expressed concerns that V&D informants may more frequently exaggerate disease outbreaks to be prioritized for interventions, as emergency programs dependent on American funding reduce capacity or close. PUC staff noted instances of inflated information from informants hoping for the PUC to intervene, leading to false alerts. This issue, while not entirely new, underscores the importance of exhaustive triangulation. Inaccurate reporting can be costly, demotivate staff, damage community relationships, and reduce the PUC's response capacity.

Many stakeholders observed an increase in alerts since the closure of USAID, though internal records lack systemic tracking of false alerts. This may reflect concerns about the evolving humanitarian and public health landscape in the DRC as foreign funding decreases rather than a true increase in the frequency of false alerts. An internal V&D staff member noted that reductions in NGO activities could lead to increased demands on the PUC. Stakeholders also reported that some partners are already delaying projects, reducing their workforce, and anticipating further cuts. These concerns highlight the importance of the PUC's rigorous triangulation process to avoid unnecessary and wasteful explorations.

**PATHWAY 2: INTERVENTION AND CRISIS RESPONSE**

**Finding 3: The PUC's response capacity was consistently described as highly adapted to and relevant for disease outbreaks in the DRC, especially for measles outbreaks, but the PUC must be highly selective about which crises it intervenes in.**

The PUC's crisis response capabilities, particularly for measles outbreaks, are recognized for their exceptional quality and effectiveness. Among survey respondents, 84% believed the PUC was well-positioned to respond to disease outbreaks in the DRC. Stakeholders highlighted the PUC's operational strengths, including speed, reactivity, specialized expertise, and superior logistics. The PUC's ability to access hard-to-reach areas, experienced personnel, and operational independence enable rapid

adaptation and flexible deployment of resources. As one humanitarian actor described it, *“There is no other actor as flexible and mobile in the west...a really unique capacity to cover such a large part of the country and to cover it well.”* Health authorities noted the PUC’s interventions as instrumental in reducing morbidity and mortality during outbreaks.

The PUC’s crisis response model is highly relevant due to the DRC’s unique epidemiological and operational context, characterized by recurring outbreaks in challenging environments. The PUC’s logistical agility, using diverse transport methods, allows it to establish comprehensive interventions within 72 hours of arrival, providing integrated packages of case management, vaccination, surveillance, community engagement, and WASH activities. Respondents from the UN and other NGOs described not having the operational or regulatory agility to respond as quickly. A MoH official described these packages as particularly useful in providing comprehensive support across several key domains.

Despite its extensive surveillance capacity, the PUC’s crisis response capacity is limited to two simultaneous interventions and one exploration, which means that the PUC must be selective about when it intervenes. Only 31% of survey respondents agreed that current operational capacity was sufficient, with many noting unanswered alerts and the need to expand exploration capacity. In 2024, 3.5% of alerts resulted in an intervention<sup>7</sup>. Stakeholders also noted that the PUC’s rigid adherence to predetermined intervention timeframes does not always match the operational context, potentially requiring the PUC to wrap up interventions before crises are fully resolved.

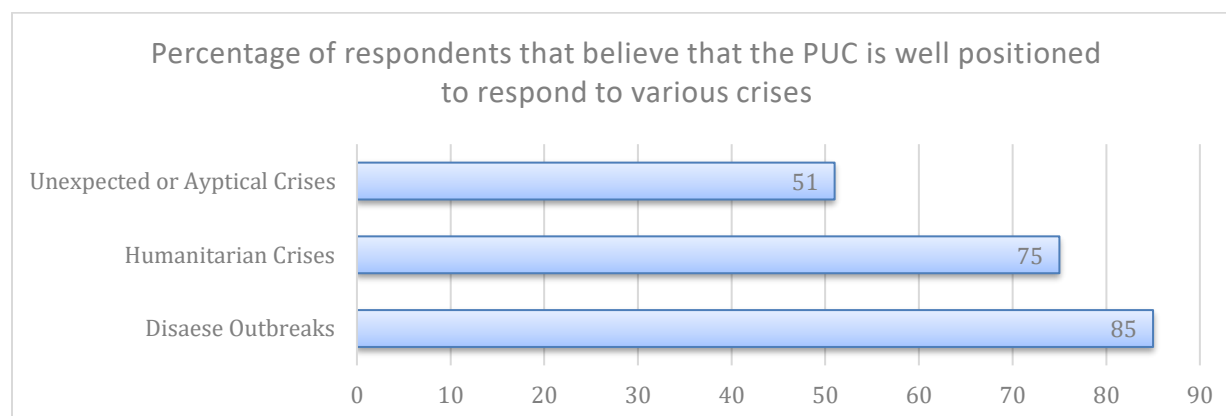
**Finding 4: The PUC's role and readiness to respond to humanitarian crises is less well defined, in part due to a lack of clarity on the scope and criteria for interventions and limited recent exposure. (SoE: High)**

Partially due to the part of the DRC where the PUC operates, the PUC's positioning to respond to humanitarian crises is less clearly articulated compared to its role in infectious disease response, and its exposure to humanitarian crisis is more limited. Overall, 75% of survey respondents believed the PUC was well-positioned to respond to humanitarian crises, compared to 85% for infectious disease outbreaks. However, only 51% felt the PUC was prepared for atypical or unexpected crises.

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<sup>7</sup> PUC 2024 Annual Report

Figure 2: Survey respondent belief that the PUC is well positioned for crisis response by scenario type



Unlike epidemic surveillance, which has established thresholds and protocols, humanitarian crisis interventions have a more flexible framework. A PUC support staff member explained, *"for humanitarian crises, we don't have rigid thresholds. It's really a bundle of arguments that validates deploying a mission."* This ambiguity made it challenging to assess a flooding alert in Kinshasa in early 2025 for example, as PUC V&D staff noted difficulties in determining the extent of the impact due to a lack of clear denominators. Internal staff also expressed concerns about their preparedness to coordinate with external actors during humanitarian crises.

While the PUC has specific thresholds for displaced persons and mortality rates, these criteria are insufficient for diverse crisis scenarios. Additional factors like water and sanitation risks, high birth rates, and degradation of human dignity are considered but are inadequately developed for proper assessment. Some informants recommended establishing clearer parameters on the PUC's positions to respond to population movements and other humanitarian crises across the country level and HQ level. The PUC receives few alerts from man-made emergencies (1% in 2024) or natural disasters (3% in 2024)<sup>7</sup>, limiting staff exposure to these scenarios. In 2024, the system detected nine humanitarian alerts, including six natural disasters and three IDP/violence-related incidents.

Table 4: Percentage of Alerts by Scenario Type by Year Based on the 2024 PUC Annual Report (Rounded to whole numbers)

Year	Man-Made Emergencies (Displacement, Conflict or Violence)	Natural Disasters (Floods, Fires or Climate-Related)	Infectious Disease
2019	5%	1%	94%
2020	3%	1%	96%
2021	10%	0%	90%

2022	5%	1%	94%
2023	4%	3%	93%
2024	1%	3%	96%

Geographic agreements with other MSF entities have reduced the PUC's coverage of conflict-affected areas, as provinces experiencing frequent displacement are covered by other MSF entities. Many PUC staff from the online survey and interviews described never having participated in a humanitarian intervention with the PUC.

After an alert for a humanitarian crisis in Mai Ndombe in 2024, the lack of a clear framework for collaboration between the PUC and MSF West and Central Africa Operational Directorate (WACA) created coordination challenges that prevented a joint humanitarian intervention. A permanent PUC staff member noted that blurred geographic boundaries between the PUC and WACA and the lack of a formalized collaborative framework hindered collaboration despite a shared interest. The external evaluation team found no formal record of the PUC and WACA's decision-making dialogue which ultimately led to the choice *not* to intervene jointly. This dialogue was relegated to email exchanges but also based on verbal discussion; these were not outlined in notes and limited analysis of the decision-making process concerning Mai Ndombe.

Staff capacity further limits the PUC's adaptability to humanitarian crises, as they require more than medical expertise. A permanent PUC staff member stated, "*The PUC is excellent with measles. But for humanitarian crises, we feel a lack of expertise. We need to strengthen versatility*". Stakeholders described the organization's modus operandi as "*too standardized and vertical, with a very effective approach for short and targeted interventions but poorly adapted to complex crises*". Consequently, while the PUC has demonstrated exceptional competency in well-established scenarios, its readiness to expand and adapt to atypical situations is unclear. During the ToC workshop, PUC staff often omitted humanitarian crises response when describing core activities.

#### Finding 5: Stakeholder concerns about measles specialization could affect the PUC's strategic relevance and adaptability to evolving crisis patterns. (SoE: Moderate)

The PUC's mandate requires it to focus on the crises that lead to the most morbidity and mortality. In recent years, the dominant epidemiological need has stemmed from measles outbreaks<sup>8</sup>. Because the majority of the PUC's recent interventions have been in response to measles outbreaks, this has honed staff technical competencies. However, this also risks making the PUC more technically prepared for

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<sup>8</sup> It is worth noting that at the time of conducting this evaluation, measles had been the dominant epidemiological need in the previous years in the PUC's coverage area, but that this is not always the case.

measles as opposed to other kinds of crises. Out of 50 interventions between 2019 and 2024, 34 were for measles, with approximately 85% of all explorations and interventions dedicated to measles outbreaks.

Table 5: Number and Types of PUC Intervention by Year<sup>5</sup>

Year	Cholera	COVID	Viral Hemorrhagic Fever	Typhoid Fever	Malnutrition	Population Movements	Mpox	Measles	Total
2019						3		4	7
2020		1	1		1		1	4	8
2021	2					1		6	9
2022			1			1		9	11
2023							1	4	5
2024						1	2	7	10
Total	2	1	2	0	1	6	4	34	50

This concentration is due to several factors, including geographical coverage and current repartition between the PUC and other MSF entities, as well as the fact that measles is endemic in the DRC, while less common outbreaks like Ebola are rare. When faced with other kinds of crises, the PUC still assesses the appropriateness of an intervention through the same processes. However, this trend may limit the PUC's capacity for alternative approaches and creative thinking. As one permanent PUC staff member observed, "*We discussed the relevance of different crisis scenarios a lot, particularly measles, because we were only doing measles... initially, we called it the PUR, the Measles Emergency Unit<sup>9</sup>, and then it became the PUC. But in the end, we still find ourselves mostly doing measles.*" Stakeholders emphasize the need for diversification to maintain strategic relevance and technical preparedness. Permanent PUC staff acknowledge the risk of becoming too routine and argue for responding to more diverse crises to push the PUC's limits. Despite maintaining emergency preparedness for other scenarios, stakeholders stress the need for the PUC to evolve to avoid missing future crises. Balancing effectiveness in measles with strategic diversification is essential for long-term relevance.

<sup>9</sup> Noting that this name is anecdotal but reflected in report as illustrative of PUC response trends.

## EFFECTIVENESS

### PATHWAY 1: VEILLE & DÉTECTION

**Finding 6. V&D activities paired with explorations are rapid and precise, but respondents noted examples where certain crises were missed. (SoE: Moderate)**

The PUC's V&D system is highly regarded for its speed and accuracy. Survey findings show that 86% of respondents perceive the V&D system as enabling faster crisis identification than other actors. Operational data supports this, indicating that 78.5% of epidemic-related alerts are detected within seven days and 73.1% through active surveillance strategies.

The system's advantage stems from weekly alert cycles, comprehensive data triangulation, and proactive calling, enabling early verification of emerging situations. As one MSF staff member noted, "*They [the PUC] have a really up-to-date contact list... they do these proactive calls and analyze the databases in advance... this allows us to gain a few days.*" Performance metrics demonstrate the system's operational effectiveness, with 100% detection and confirmation of alerts within PUC intervention zones and 84.1% of detected alerts shared within 24 hours<sup>7</sup>. However, 21.5% of epidemic alerts do not meet the seven-day detection target<sup>10</sup> due to communication and accessibility challenges. Delays are often caused by poor infrastructure and lack of early detection training among rural health providers.

Significant detection failures highlight potential vulnerabilities. The delayed detection of Mpox in Kinshasa in 2024 represented a critical gap. MSF support staff acknowledged, "*We learned about Mpox in Kinshasa through parallel networks. It was from Brussels that we were told that it's heating up in Kinshasa... we had a surveillance and detection team that should normally have been reading the epidemiological situation.*" These instances suggest that while the V&D system performs well overall, less routine scenarios and crises in silent zones may allow for less sensitivity, creating vulnerabilities in an otherwise robust surveillance architecture.

**Finding 7: The V&D system's reliance on proactive calls and a secondary network of community informants is its strength but can create expectations for an intervention that may not happen. (SoE: High)**

The PUC's V&D system is highly effective at identifying and confirming crises by coupling surveillance activities with exploration missions. This effectiveness stems from long-standing relationships, community trust, and a network of stakeholders, including health authorities, community leaders, NGOs, and UN agencies. Among survey respondents, 80% believed the PUC maintains strong relationships with community members and informants. These relationships enable impressive performance metrics,

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<sup>10</sup> Internal PUC 2024 medical operations report

including over 90% successful call rates and proactive outreach to 95% of health zones under alert in 2024.

However, this dependency on community goodwill is vulnerable when expectations are not met. The proactive surveillance approach generates community anticipation for intervention, and repeated surveillance without action risks damaging trust and willingness to share information. This dynamic is compounded by inadequate communications infrastructure and poor DPS (Division Provinciale de la Santé) data quality, intensifying reliance on secondary networks. Extracting information without resultant intervention can confuse local partners and affect their interest in future engagement. Permanent PUC staff and humanitarian actors reported community feedback about the fact that these dynamics have created occasional frustration from informants.

**Finding 8: While their partnership is effective, the PUC's established V&D capacity coupled with limited MoH surveillance capacity at subnational levels comes with the risk of dependencies. (SoE: Moderate)**

The V&D system operates within a compromised national health surveillance infrastructure, where capacity gaps at the DPS level create dependencies that threaten sustainability. Despite improvements at the national level, subnational MoH capacity remains inadequate. Field staff are inadequately prepared due to insufficient supplies and technical training. This prevents provincial health departments from fulfilling their surveillance responsibilities and confirming outbreaks locally, forcing reliance on the PUC for sample transport.

The PUC's effectiveness inadvertently masks systemic weaknesses in national surveillance architecture. PUC coordination staff often inform DPS offices about health events in their own jurisdictions, highlighting the reversal of expected information flows. Contradictory data from provincial health authorities necessitates routine PUC verification at health zone levels which positions the PUC as a quality assurance mechanism for the national system.

These structural challenges raise questions about the role of the V&D structure when it compensates for, rather than strengthens, national capacity. Some permanent PUC respondents expressed concerns that this dynamic could disincentivize the MoH from making necessary internal adjustments. Some health authorities welcomed the idea of the PUC taking on a more expansive role and requested a "*permanent presence*" in certain areas, suggesting that the MoH has become accustomed to the PUC compensating for certain gaps.

Despite concerns about dependency, the collaboration between the PUC's surveillance and detection team and INRB laboratories has achieved a functional working relationship. Both the PUC and INRB expressed satisfaction with the current 3-5 days confirmation timeframe for processed samples. Stakeholders confirmed that this integrated approach has sped up the ability for the INRB to confirm disease outbreaks but could not provide examples of the INRB demonstrating new skills as a result of this partnership.

## PATHWAY 2: INTERVENTION AND CRISIS RESPONSE

**Finding 9: The PUC's logistical capacity is unique but limited by external factors that affect its speed and effectiveness particularly due to mobility restrictions. (SoE: High)**

The PUC's logistical capabilities distinguish it from other humanitarian actors in DRC, yet its agility is limited by factors beyond MSF's control. Despite strong logistics competencies once an intervention has begun, the PUC's operational reach has been restricted by the loss of a dedicated plane<sup>11</sup> and dependence on external aviation companies or the United Nations Humanitarian Air Service (UNHAS). This dependency creates operational challenges, with 62 flight cancellations out of 273 reservations through the third quarter of 2024<sup>7</sup>, contributing to zero interventions meeting the 14-days' deployment target. When flights are canceled, the PUC is still responsible for hotel reservations, staff per diems, and other associated costs.

Overall, 68% of survey respondents identified external logistical limitations as significantly affecting effectiveness and efficiency, making it the most frequently cited challenge facing the PUC. Beyond transport disruptions, evolving pharmaceutical regulations have created supply chain delays which have created stock-outs that force reliance on emergency borrowing from other projects. DRC regulations on pharmaceutical imports contribute to these delays including a rule requiring imported medications to be labeled in French, which limits procurement options. Delays in customs processing can mean that orders are not released to the PUC for months, limiting the shelf life of medications once available for use.

**Finding 10: Speed of deployment once the PUC has started an intervention is perceived by stakeholders to be appropriate given contextual limitations. (SoE: High)**

Despite external logistical constraints, the PUC's deployment speed once interventions have begun is consistently recognized by stakeholders as exceptional within the challenging DRC context. The organization's rapid response capability stems from well-established operational systems and experienced field teams who can quickly establish functional healthcare infrastructure in rural settings. As one ESP staff member noted, *"Once the team is already in the field, given that it's a really experienced team, they have the capacity [...] to design things quickly to provide medical care under good conditions."*

This agility is enabled by pre-established operational tools including data collection instruments, evaluation frameworks, epidemic geolocation systems, and predetermined budgetary and HR structures, allowing teams to *"respond to the specific needs of populations where the ministry of health cannot go."* Multiple stakeholders characterize the PUC as a *"well-oiled logistical machine"* capable of establishing comprehensive interventions quickly once deployment decisions are finalized. Stakeholders across all groups expressed satisfaction with these refined deployment capabilities and set the PUC apart from its peers.

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<sup>11</sup> The PUC could previously rely on an MSF/ICRC airplane, but this is not the case any longer at the time of conducting this evaluation.

**Finding 11: Minimal capitalization and learning mechanisms mean that the PUC has little proactive adaptation capacity, limiting it to constant reactivity with little strategic and proactive planning. (SoE: Moderate)**

The PUC's capacity for proactive adaptation and strategic planning is limited by insufficient knowledge capitalization and organizational learning mechanisms, keeping it in a cycle of reactive crisis response. Despite generating substantial data through continuous field operations, the program lacks systematic processes to turn operational experience into improved long-term processes. One ESP staff observed, *"the PUC is also a repository of an important wealth of data... It goes on site, so they know what happens in the field. I think there must be awareness of the richness of all this data."* This data remains largely underutilized because 'pause and reflect' sessions are not systematically conducted, and cross-intervention analyses are not done.

The continuous operational tempo exacerbates this problem, with field staff working under tight deadlines, which affects the quality of data. This reactive reality and mentality make it difficult to create dedicated time for meaningful reflection and learning. While 83% of intervention reports are shared externally within six weeks of completion, only 62.5% of interventions produce substantive analyses with targeted recommendations based on secondary data exploitation and lessons learned. While these analyses are done for over half of interventions, reflections on these lessons are not systematically organized at regular intervals. The absence of robust learning mechanisms means that the PUC does not leverage its extensive experience for strategic planning and proactive adaptation. While efforts have been made to establish "inter-PUC" sessions across MSF emergency response teams, these have not become routine and would benefit from being systematized.

## EFFICIENCY

### PATHWAY 2: INTERVENTION AND CRISIS RESPONSE

**Finding 12: There are firm and divided opinions within the decision-making chain about the efficiency and importance of budgetary validation requirements within the pre-approved budget envelope. (SoE: High)**

Interviews revealed long-standing tensions between MSF-OCB decision-making levels (ESP, RST, HQ) and permanent PUC staff regarding budgetary validation. Concerns about aid diversion and fraud in DRC were highlighted: *"In Congo, we know it's fertile ground for many problems... it's easy to have corruption."* RST, ESP, and HQ staff prioritize financial oversight to prevent fraud and waste, while PUC staff emphasize that rapid response capacity has been compromised. PUC staff repeatedly requested more budgetary autonomy within the pre-allocated emergency budget, describing the current process as too slow and hindering outbreak response, despite concerted efforts and some corresponding improvements. One PUC staff member said that despite the need to respond to crises immediately, *"There's too much ping-pong between actors about the budget."*

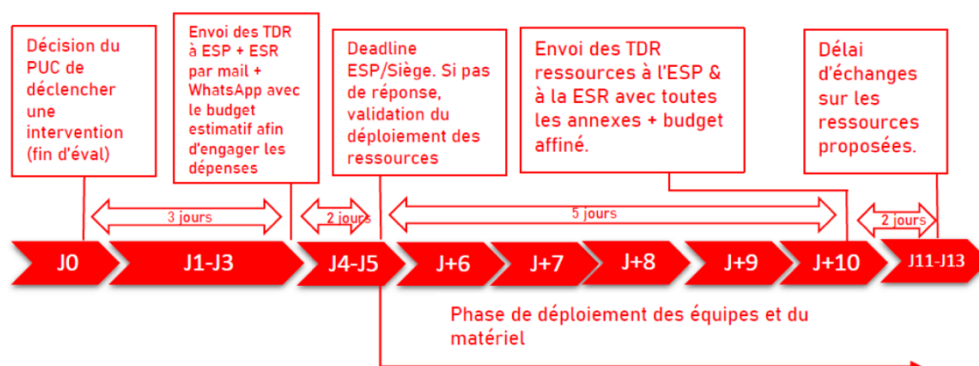
While the higher decision-making levels were certain that fraud prevention was an unavoidable and crucial dimension of their work, some stakeholders questioned whether these multiple levels of approval and the current processes in place are actually effective in preventing fraud. Some MSF staff explained that these processes will not only fail at preventing fraud but may make MSF feel false confidence that fraud has been averted. One MSF staff member described this by saying, “*We’ve showered the project with processes, but actually...it’s even easier to commit fraud... because you just have to show that you respect the process. Behind it, you can do even more corruption.*” Consequently, there is staunch disagreement within the decision-making chain concerning the efficiency and usefulness of these practices which many believe should be structurally revised and streamlined.

**Finding 13:** Speed of internal decision-making is a considerable pain point where systematic analysis of data is needed to fully understand which portions of the decision-making process are most problematic. (SoE: Moderate)

The speed of internal decision-making is a major bottleneck for the PUC, but the lack of systematic monitoring limits the ability to identify the cause of delays. While a lot of data is collected and available in documents such as intervention reports, the PUC lacks *centralized* tracking and analysis of critical intervals between the dates of reception of each alert, exploration start and end dates, dates of key approvals, and intervention launch dates. While dates related to crisis monitoring exist within the PUC’s V&D system, they are not systemically tracked and analyzed within a dedicated location and alongside decision-making timepoints, such as requests across the decision-making chain and approvals. The evaluation aimed to understand and crosscheck narratives about speed and delays but was unable to do so due to this lack of systematic and standardized monitoring, including standard terminology for tracking key moments.

Figure 3: Validation Process for an Intervention

4-3 **Frise chronologique pour le lancement d'une intervention :**



While PUC staff witness the slow pace of the multilayer approval process, stakeholders at each decision-making level believe their stage is not to blame. Respondents provided anecdotal examples when explaining the source of these delays but could not cite quantitative trends across interventions.

Consequently, opinions about the true source of delays remain impressionistic and subjective rather than data driven.

Table 6: An analysis of time intervals between outbreak alerts and interventions in the past year, based on PUC Terms of Reference Documents

Province	Locality	Date of the Alert	Date of the start of the intervention	Type of Alert	Time interval between the alert and intervention in days	Time interval between the alert and intervention in weeks
Équateur	Lotumbe	9/19/23	19/02/2024	Mpox and Measles	153	21.9
Équateur	Ingendé	16/01/2024	03/04/2024	Measles	78	11.1
Sankuru	Katakokombe	29/02/2024	05/06/2024	Measles	97	13.9
Équateur	Iboko	26/03/2024	09/09/2024	Measles	167	23.9
Tshuapa	Bokungu	24/01/2024	18/09/24	Measles	238	34
Équateur	Bikoro	04/02/2024	28/10/2024	Measles	267	38.1
Tshuapa	Bokungu	30/09/2024	20/11/24	Mpox	51	7.3
Sankuru	Lusambo	16/12/2024	19/02/2025	Typhoid fever and Cholera	67	9.3
Average					140 days	20 weeks

Analysis of 2024 interventions showed an average of 140 days between alert receipt and intervention start, with timeframes ranging from 2 days to 7 months. Most of this time is spent in active alert monitoring before reaching evaluation thresholds. For explorations where data were available, the time interval between reaching the alert threshold and launching an evaluation ranged from 2 days to 31 days. None of the PUC's interventions in the last year were launched within the 14-day target from the end of an exploration. PUC staff explained that this range is due to various factors, including disease-specific thresholds (e.g., measles requires increasing cases over 3 consecutive weeks), surveillance system gaps requiring data triangulation, limited response capacity and competing priorities when multiple alerts occur simultaneously. The PUC must economize its resources and be selective about which crises it intervenes in. Alerts are tracked for extended periods to ensure selection of crises where the greatest impact can be achieved.

Table 7: An analysis of time intervals between the completion of an exploration/evaluation and the start of an intervention in the past year

Province	Locality	Date of completion of evaluation/exploration	Date of the start of the intervention	Time interval between completion of the eval/explo and start of the intervention in days	Time interval between completion of the eval/explo and start of the intervention in weeks
Équateur	Lotumbe	01/02/2024	19/02/2024	18	2.6
Équateur	Ingendé	12/03/2024	03/04/2024	22	3.1
Sankuru	Katakokombe	N/A	05/06/2024	N/A	N/A
Équateur	Iboko	17/08/2024	09/09/2024	23	3.3
Tshuapa	Bokungu	23/08/24	18/09/24	26	3.7
Équateur	Bikoro	29/09/2024	28/10/2024	29	4.1
Tshuapa	Bokungu	N/A	20/11/24	N/A	N/A
Sankuru	Lusambo	N/A	19/02/2025	N/A	N/A
Average				23.5	3.4

An analysis of internal PUC documentation revealed that no actor has access to all start/end dates for approvals in a single location, although some key V&D timepoints are systemically shared between certain actors in the decision-making chain. Key dates including dates of requests for approvals and dates of final approvals are scattered across email exchanges and non-standardized Terms of References. Additionally, records do not contain enough contextual information concerning the speed of approvals at the different levels. Records of all key milestones and decision-making moments are stored in silos, not systematically analyzed, and sometimes missing key dates.

While some of this information is reflected upon, there is no centralized location for recording these key dates, and no transversal effort to analyze the intervals between keys dates and corresponding contextual details. While some of this information is reflected upon and some actors know where certain dates are recorded, the absence of transversal monitoring and analysis across interventions means basic questions about timing and validation cannot be externally verified. Data shared during the validation process is relegated to practical information that will allow for the request to be assessed at various decision-making levels. Consequently, while many respondents have firm opinions about this process, some of these opinions may not be supported by evidence that could be generated if transversal analyses across interventions were available.

**Finding 14: Several key moments in the validation process lead to delays as well as incomplete Terms of Reference documentation. (SoE: Moderate)**

Despite challenges in triangulating qualitative responses about delays, PUC stakeholders and MSF colleagues at RST, ESP, and HQ levels identified key areas where delays occur. Many permanent PUC staff believe these delays are mainly linked to structural deficiencies in the RST and ESP decision-making process, but these could not be definitively verified by data. Decision-making outside of standard office hours can create delays<sup>12</sup> and this is exacerbated by the fact that some ToRs can lack key details, which leads to extended back-and-forth exchanges before being fully complete, according to some key informants. Despite this, management emphasized the need to maintain high standards, which they believe could be achievable because the PUC works with recurring outbreak patterns.

**Finding 15: Recruitment and deployment of optimal HR require efforts that hinder the PUC's efficiency. (SoE: High)**

HR recruitment and deployment is a structural challenge for the PUC which both provides staffing flexibility but also causes delays. The PdR system allows for streamlined recruitment of specialized professionals on a contract basis, but only 31% of survey respondents find it effective, while 38% do not and the remainder either did not know or had a neutral opinion. HR has a two-week window to fill positions before an intervention launches, but staff availability is problematic, with some PdR personnel unavailable after long periods without deployment. The paper-based recruitment process creates administrative burdens, and the PUC struggles to attract and retain specialized personnel due to competition for more stable or better-paying positions.

Geographic distribution of PdR staff across the DRC exacerbates these challenges. Those outside Kinshasa lack training opportunities between interventions. Many PdR staff are frustrated with long intervals between contracts and unclear selection criteria, from their perspective. The PUC has implemented a digital recruitment system to prioritize fairness, but PdR staff seem unaware of these measures. The lack of engagement increases the risk of PdR members being recruited by other organizations. The security situation in the DRC further complicates deployment, with PdR staff in the east dependent on the Goma flight hub. With Goma falling to M23 rebels and flights to Kinshasa suspended, PdR staff must use costly and lengthy alternative routes. Despite these challenges, the PUC has made efforts to improve its HR structure, and many permanent staff are satisfied with the current model.

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<sup>12</sup> It is worth noting that this was the case at the time of data collection, but that it seems to have been addressed at the time of finalizing the evaluation.

**Finding 16: Team sizes were deemed too large by some PUC and MSF staff, while some expressed an interest in prioritizing polyvalence training for PUC staff or recruiting polyvalent PdR staff. (SoE: High)**

Reducing intervention team sizes is a priority, as current teams may be unnecessarily large for certain scenarios, wasting funds and limiting PUC capacity. While team sizes have decreased from 60-65 to an average of 40 people per intervention since the 2019 restructuring, further reductions could be beneficial. Investing further in polyvalent staff, those cross-trained in multiple areas, rather than simply reducing team size was suggested by several MSF and PUC respondents. For example, logisticians could be systematically trained in WASH and construction skills, and vaccination campaigns could be managed more efficiently with fewer specialized roles. This approach would enable the PUC to deploy smaller, more versatile teams without compromising on necessary skills.

However, this strategy requires intentional training and skill development. Respondents emphasized that staff should not be expected to perform multiple roles without proper preparation. PdR staff particularly highlighted the need for structured, scenario-specific training to enable this polyvalence, noting that current training is largely informal and on-the-job. By investing in comprehensive training programs, the PUC can ensure that staff are well-equipped to handle multiple responsibilities in order to have more efficient and effective interventions.

**Finding 17: Limited digital literacy and a dependence on paper-based systems limit record keeping and strategic reflection. (SoE: Moderate)**

The PUC faces substantial challenges in data management and strategic analysis due to limited digital literacy and reliance on manual, paper-based systems for record keeping and reporting during interventions. Despite testing digital tools like Kobo for certain surveys, tablet use remains limited due to access issues, poor connectivity, security, and lack of training. This reliance on manual methods makes data entry and follow-up difficult and hinders strategic analysis of PUC interventions. Addressing this digital literacy gap through training would improve efficiency and record-keeping quality.

The operational context in rural DRC and the fast-paced work environment within the PUC further complicate data management. Poor connectivity makes paper records attractive, as workflows do not need to be interrupted until Wi-Fi is available. However, this dependence on paper comes with risks, including the potential loss or damage of paper files during transport back to Kinshasa. The evaluation noted that the PUC has already on-going efforts to address this through investments in archiving and information management.

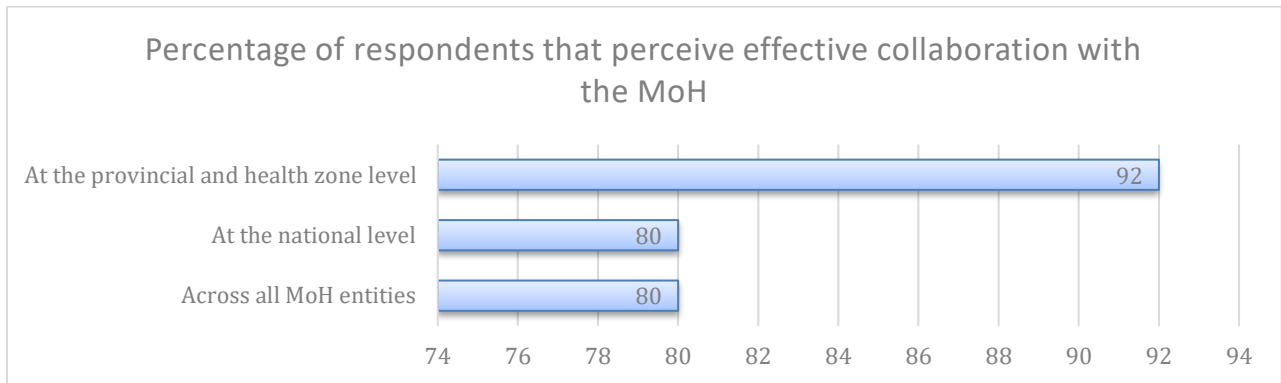
## COHERENCE

### PATHWAY 3: SYNERGY WITH OTHER ACTORS

**Finding 18:** Collaboration with the MoH at multiple levels is consistently perceived to be positive. (SoE: High)

Collaboration with the MoH across multiple administrative levels is consistently perceived as positive and effective, with particularly strong partnerships at subnational levels. Survey data show that 80% of respondents indicate effective collaboration with MoH entities overall, 80% at the national level, and 92% at subnational levels.

Figure 4: Percentage of Respondents (n=29) that perceive effective collaboration with the MoH



These partnerships are built on formalized agreements and clear operational frameworks guiding collaboration during explorations and interventions. National-level collaboration shows institutional maturity, with the PUC designating focal points who participate in coordination meetings and provide feedback on recommendations. At subnational levels, collaboration is fluid during disease outbreaks, with signed agreements facilitating alignment on approaches and thresholds. However, subnational partners are interested in increased responsibility and capacity building opportunities. Despite these strengths, collaboration becomes less formalized and more ad hoc in non-epidemic humanitarian crises, where roles, responsibilities, and communication channels lack clarity.

**Finding 19:** PUC staff believe in the importance of more synergies and partnerships with external actors but are unsure how to incorporate this due to discrepancies in operational models and priorities. (SoE: High)

PUC staff are committed to enhancing partnerships with external actors, particularly the MoH, to improve efficiency and coherence. There is widespread acknowledgment that the PUC must evolve to become more collaborative. As one PUC staff member noted, *“Partnership means less decision-making*

*autonomy...We need a change in posture: moving from 'parallel' intervention to a true partnership approach with authorities."*

Health authorities seek MSF's expertise and are open to training on intervention thresholds and team deployment. However, practical implementation is challenging due to operational discrepancies and internal resistance to change within MSF. Differences in working styles, quality standards, pace, and internal systems make some PUC staff unsure how to bridge these gaps to support collaboration. One PUC staff member explained that the MoH does not work at the same pace as the PUC, which would mean that partnerships may come with sacrificing speed.

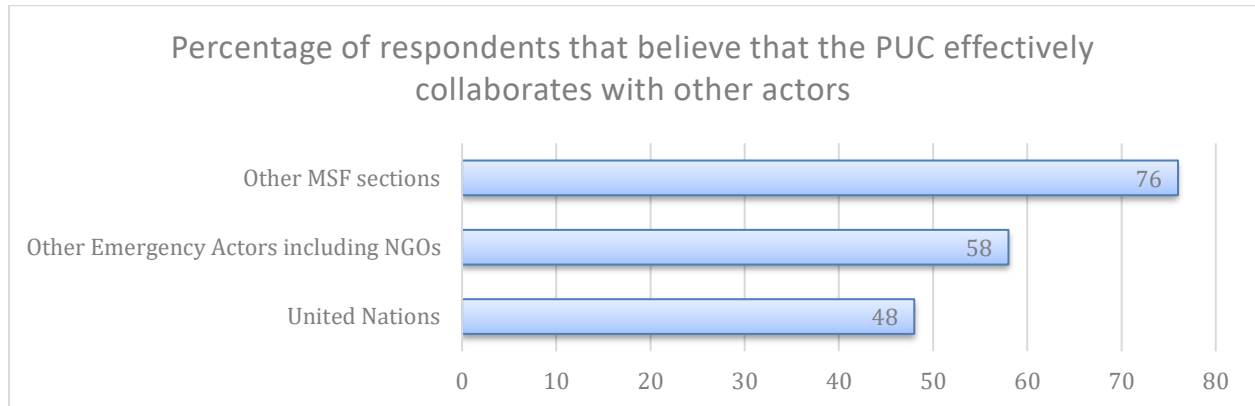
MSF and non-MSF stakeholders indicated that MSF's highly independent culture can sometimes engender a sense of superiority. An ESP level staff member observed, *"It's the change of mentality, because I think we're a bit formatted like this, when we arrive, we're the knowledgeable ones, we have a lot of expertise,"* while PUC staff acknowledged, *"We work as lone riders."* MSF respondents were conflicted about whether interventions would be less efficient if additional time was required to implement training for partners to ensure the same level of quality during interventions or whether having less control was the cost of working with others.

**Finding 20: The PUC's mandate to operate where others are absent can make partnership less of a priority, but collaboration tends to work best when technical capacity and expectations align. (SoE: High)**

The PUC's mandate often places it in a position where it fills gaps left by other humanitarian actors who lack the logistical capacity to intervene in remote areas. This reinforces the PUC's relevance but limits collaboration opportunities. Survey data shows that 48% of respondents believe collaboration with UN entities is adequate or strong, while 48% are unsure, and 4% find it insufficient. Additionally, only 58% agree that the PUC effectively coordinates with other humanitarian actors, excluding other MSF entities. PUC leadership acknowledges this, noting, *"Most often, we go alone... Where no one wants to go, that's where we go."*

When actors with sufficient technical capacity are present, the PUC collaborates effectively. Examples of successful partnerships include joint explorations with WACA, exploratory missions enabling other MSF entities to establish projects, and coordination with DPS for targeted vaccination campaigns. Survey findings support this, with 76% of respondents agreeing that coordination between the PUC and other MSF entities is effective.

Figure 5: Percentage of Survey responses (n=29) that believe that the PUC effectively collaborates with Other Actors



These findings suggest that partnerships can succeed when partners have the appropriate technical capacity and a shared vision. PUC documentation shows that the PUC has considered partnerships and assessed their feasibility in recent explorations. However, email exchanges with potential partners like ACF reveal the complexity of coordination, where capacity misalignments can prevent partnerships. Field observations confirm that successful collaboration requires both partner capacity and clear operational frameworks established in advance, rather than just an interest in partnership.

**Finding 21: The PUC has not strategically invested in exit strategies which can lead to lapses in handover processes. (SoE: High)**

PUC interventions are limited to three months which may mean that outbreaks can still be ongoing after the PUC's departure. Current exit practices rely on informal arrangements which can risk continuity of care and potentially limit the effectiveness of interventions if handovers are not properly done. The PUC does not currently have a comprehensive exit strategy; community authorities are verbally informed to continue activities, but these processes are not formalized. Both PUC leadership and humanitarian partners recognize this as a problematic and error prone approach. Some partners described confusion during outbreaks after PUC withdrawal, leading to uncertainty about which activities had been conducted and what should be prioritized. Without structured documentation, formal training on external partnerships, and proactive community engagement, the PUC may compromise health outcomes and the trust towards the PUC may be affected. The lack of systematic identification of partners to continue activities further exacerbates this issue.

**Finding 22: Resource mutualization and increased knowledge exchange with other MSF entities is attractive in theory but lacks a structured way forward. (SoE: High)**

There is widespread recognition of the value and necessity of resource mutualization between MSF entities. The PUC stands to benefit from resource and staff mutualization, especially in the current

financing environment where many actors have had to close programs or lay off staff due to the loss of USAID funding. One PUC staff highlighted the potential benefits of reducing PdR salary costs by saying, *"Mutualizing PdR or working with MoH staff could reduce salary costs."* National health authorities observed that mutualization seems to only occur *"in extreme conditions"* or in the event of unexpected problems, suggesting that the current approach is more ad hoc rather than planned.

Current collaboration primarily occurs through informal channels and remains person-dependent rather than systematically structured. Staff detachment between OCB and Operational Center Paris (OCP) represents the most developed sharing mechanism. Practical resource sharing includes operational assets and medical supplies between projects, but these practices have been implemented based on management interest rather than a clear framework.

Interviews with other MSF entities reflected a strong respect for the PUC and a key interest in more opportunities for knowledge exchange. Knowledge sharing between the PUC and other MSF entities remains casual with no formal dissemination process, while positive initiatives like inter-PUC workshops have lost momentum. Despite collaborative potential and recognition that resource and knowledge sharing is mutually beneficial, the absence of formalized frameworks means meaningful collaboration depends on individual initiative rather than institutional prioritization.

**Finding 23: Collaboration with the BALI has not historically been smooth and effective but the PUC could benefit from taking advantage of this new trajectory. (SoE: Limited)**

The relationship between the PUC and BALI has evolved from a historically tense dynamic to one showing signs of improvement. The BALI serves as *"a support and intersectional liaison office... whose purpose is to pool the constraints and difficulties that are common to each section and address them to the relevant authorities, for example, to the Ministry of Health to avoid each section going individually to address certain questions."* However, this institutional arrangement has created tensions with the PUC's established operational patterns. The PUC operates somewhat independently and has a lot of autonomy compared for example to ESP. One ESP colleague emphasized, *"Everyone needs to recognize their place... The PUC cannot go see the ministry without going through BALI."*

The root of this tension lies in the PUC's three decades of direct relationships with health authorities, creating a dynamic where working through BALI is an adjustment for both parties. The evolving relationship requires continued attention to role clarification. This has created dynamics where PUC representatives are not always present or involved in direct dialogue and meetings when BALI is advocating on behalf of the PUC. Among survey respondents, only 50% believed that the PUC is effectively advocating for its value at the national level. While roles remain "blurry" and sometimes create tension, stakeholders acknowledge the relationship is *"much better than before."* There is an opportunity for the PUC to further invest in this collaborative communication mechanism by leveraging its established field relationships and BALI's strategic positioning for higher-level advocacy and policy engagement.

## Finding 24: The PUC serves as a training ground for key epidemics and emergency personnel across the country. (SoE: High)

Respondents repeatedly described the PUC as “*a school*” due to its demonstrated effectiveness in developing staff competencies, functioning as a professional development hub for emergency response personnel. PUC-trained personnel contribute expertise to other projects within MSF. PdR staff also benefit from the PUC’s rigor and standards, which help them progress in their technical abilities. PUC experience is recognized by external partners as valuable preparation for other emergency roles, due to both formal training before interventions and on-the-job exposure during interventions.

Beyond internal MSF skill development, the PUC contributes to broader national emergency response capabilities as some PUC national staff move on to roles within the Ministry of Health<sup>13</sup>. Despite this positive perception, PUC internal staff expressed uncertainty over whether their MoH partners had implemented concrete changes as a result of their collaboration with the PUC. This suggests that while there is extensive evidence of skill transfer within the PUC, staff were not confident that technical skills transfer to partner organizations as a result of mere collaboration.

## CONCLUSIONS

The PUC has undergone many changes throughout its 30-year tenure but has successfully maintained its relevance to the present day. It continues to fill key gaps in national capacity to respond to the frequent disease outbreaks and emergencies across the 15 provinces where it operates. The PUC has demonstrated a sustained commitment to serving the needs of crisis-affected communities in the most remote parts of the DRC.

V&D activities are seen as complementary to those implemented by the MoH through a proactive network of calls and triangulation of secondary data sources to add depth to the data being collected by the MoH. SITREPs are published on a weekly basis and read by both the MoH and other humanitarian organizations across the country. Despite the PUC’s highly specialized V&D processes, which are effective at detecting infectious disease outbreaks in DRC, particularly measles, the criteria used to detect humanitarian crises are not as clearly defined, which leaves some stakeholders unsure of the PUC’s ability to detect humanitarian crises and atypical situations. As measles constitutes both the highest disease burden in the provinces where the PUC operates and the most frequent type of crisis that the PUC responds to, this comes with the risk of the PUC becoming overspecialized in measles detection and response. While the V&D system is largely effective, it does not always have the sensitivity to detect slowly developing or atypical crises.

Both internal and external stakeholders held the PUC’s logistical capacity in high esteem and believed that it distinguished the PUC from other humanitarian actors. This is due to both the PUC’s capacity to

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<sup>13</sup> It is worth noting that the reverse is true as well: some PUC staff are former MoH staff.

use multiple modes of transport and experience responding to outbreaks in some of the most remote parts of the country. Despite these strong internal competencies, the PUC's agility is hampered by its dependence on commercial airlines and the UNHAS. This can lead to costly delays in deployment due to flight cancellations which come with a variety of associated costs including paying per diems and housing for staff that are unable to deploy. Yet, the PUC has maintained a reputation for rapid deployment capacity and external stakeholders believe in its speed of action once in the field.

While the PUC's internal decision-making processes, including its budgetary and technical validation processes, have been adjusted many times, there is strong disagreement within MSF-OCB and the PUC concerning whether the current multi-layered approval process is the best approach for preventing fraud and waste or whether it causes unnecessary delays. There is agreement across MSF-OCB that the PUC is not currently responding quickly enough to crises while the PUC didn't meet its 14-day target of deployment after the completion of an evaluation for any of its interventions in 2024. While all interviewed respondents across these decision-making levels had strong opinions about the current budgetary and validation structure, examples justifying their position were anecdotal and not based on data. This is due to a lack of systemic analysis of key time points and the pace of decision making, from the moment that an alert is received until an intervention has been launched. This corroborated a broader theme across the PUC's V&D and response activities in which records of key information are not systematically tracked or analysed to enable adaptive management and incorporation of lessons learned from the PUC's wealth of experience. This is in part due to the PUC's overreliance on paper-based systems, lack of standardized reporting mechanisms and emergency response mentality where staff are reactively responding to crises rather than formalizing processes to allow for planning in advance.

While there are key areas for improvement, professional experience at the PUC is well-respected within both MSF and throughout the DRC. Many emergency actors have honed their technical skills during their time at the PUC which has helped them advance in their careers and enabled them to bring these skills elsewhere. As the PUC's operating environment has changed dramatically over the last three decades so has the capacity of its primary partner, the Ministry of Health. Both PUC staff and MoH staff are keen to further invest in their partnership to allow for the MoH to take on more ownership and further integrate staff into intervention teams. This has the potential to improve internal PUC efficiency, expand the PUC's capacity to respond to more crises and to increase the impact of its interventions.

The PUC's independence and focus on quality also comes with the risk of creating dependencies within the MoH particularly when it comes to disease surveillance activities. While the willingness to work more with external actors and partner organizations was expressed by PUC staff, some were unsure of how to move past well-established practices where MSF is habituated to a "*lone wolf*" mentality to then adapt to working with organizations with differing levels of technical capacity and diverse operational structures. Likewise, the PUC has not adequately invested in exit strategies despite its own requirement to end interventions after three months. This leaves the PUC with an opportunity to both formalize its working relationship with other MSF entities and external actors as well as the chance to deepen its technical collaboration with the MoH to improve efficiency and better integrate into the national humanitarian architecture.

## RECOMMENDATIONS

### RELEVANCE

**Address measles specialization risk:** The PUC could address the risk of becoming overly specialized in measles detection and response by trying to strategically increase its exposure to more diverse scenarios. This should be done while remaining responsive to the most pressing needs in its service area. The PUC should ensure that it conducts scenario training on a quarterly basis on less common outbreaks, humanitarian crises and complex situations which challenge PUC staff to use critical thinking skills to better prepare for unexpected events.

**Innovate the current V&D system to increase sensitivity:** The PUC should consider formalizing complementary indicators including case severity, local response capacity, presence of other actors and geographic accessibility and expanding its secondary network contacts to individuals with frequent mobility into silent zones. Likewise, the PUC should further invest in strategically defining its thresholds for intervention in humanitarian crises to better position the PUC vis-à-vis other actors, including MSF, regarding prospective interventions in more diverse crises.

### EFFECTIVENESS

**Consider streamlined validation processes that could speed up interventions:** The PUC could for example consider establishing pre-validated intervention packages specifically designed for measles interventions.

**Consider increasing the budgetary validation thresholds for explorations and evaluations:** While interventions benefit from the predefined €4 million annual envelope and do not require threshold-based approvals, explorations and evaluations are subject to validation thresholds of €25,000 for the PC and €50,000 for the HoM. The PUC could consider raising these validation thresholds for explorations and evaluations to reduce administrative burden while maintaining appropriate oversight. Given that explorations and evaluations are critical preparatory activities that inform intervention decisions, streamlining their approval process could enhance the PUC's responsiveness. Any threshold adjustments should be based on rigorous financial analysis and risk assessment, as this was not within the scope of this evaluation.

### EFFICIENCY

**Conduct a cost-benefit analysis of purchasing a plane for the PUC:** The PUC should conduct a cost-benefit analysis of purchasing a dedicated aircraft. This should consider the upfront cost of purchasing a plane compared to the cost of being dependent on commercial and UNHAS airlines and the waste that occurs when flights are cancelled. While some components can be quantified, the PUC should also factor in the value added of increasing the PUC's ability to better fulfil its mandate by improving the speed of their responses. This will also allow for a more preventative approach to disease transmission by intervening earlier during crises.

**Critically assess the best opportunities to incorporate polyvalent staff into interventions:** Polyvalence training for PUC staff could allow for PUC teams to be leaner and increase efficiency during interventions. The PUC should conduct a critical assessment of which skills could be most easily taught to existing staff and map out which partners should house multiple technical abilities.

**Modernize data management and standardize records:** There are already efforts made towards information and knowledge management and the PUC should invest further in this, including transitioning to digital record keeping, moving beyond paper records. The PUC must invest in advancing digital skills training for staff to increase both confidence and capacity to manage digital records. The PUC should also invest in tablets where this information can be recorded during interventions and then uploaded as soon as connectivity is available to cut down on the burden of transporting paper records and to standardize records.

**Establish regular learning sessions for key PUC activities:** The PUC should systematize organizational learning through strategic reflection on lessons learned, best practices and brainstorming ways to avoid challenges during interventions. This could be done quarterly for different specializations or departments such as V&D, HR and field coordination. These efforts could be supported by more standardized and regular record-keeping.

**Create a template to track and standardize records of key timepoints between the alert and intervention stages through a formalized capitalization document:** Outline the key timepoints between the receipt of an alert until the launch of an intervention to track the time that elapses between each stage, in addition to key context including all approvals and any reasons for delays. This should be visible across decision-making levels to allow discussions around delays to be data informed. After multiple interventions, analyses can identify trends and better inform discussions about optimization.

**Hold a workshop between all decision-making levels in the validation process to map out areas for optimization:** Once the PUC has analyzed time points across decision-making processes, this information could help structure dialogue surrounding priority adjustments to processes to enable faster interventions. This workshop should be framed as an opportunity for compromise between current processes and revisions that promote faster responses. Exact quantitative targets should be set for the ideal pace of at each stage prior to interventions and itemize priority changes to increase speed.

**Improve engagement with PdR staff:** The PUC could improve communications with PdR staff through a dedicated PdR focal point and increasing transparency around selection criteria. The PUC should better manage expectations concerning the frequency of interventions so that PdR staff do not expect year-round opportunities. PdR staff should also be given training opportunities to reaffirm the PUC's commitment to them and to increase contact between interventions.

## COHERENCE

**Formalize opportunities for increased mutualization and collaboration with other MSF entities:** Both the PUC and other MSF entities are interested in formalizing partnership opportunities. For other MSF entities, this was predominantly due to an interest in learning from the PUC. Permanent PUC colleagues

want an operational framework with WACA due to their geographic overlap and the need for WACA to have more exposure to training as a new emergency program. Formalizing resource mutualization could be useful due to funding cuts and as the PUC assesses whether purchasing a plane is viable. Establishing regular inter-PUC learning exchanges could advance these efforts and simultaneously allow for PUC staff to learn more about humanitarian crisis response. Inter-PUC exchanges and collaborations require stronger institutional buy-in and a more formal framework at the level of operational centers/directorates.

**Further invest in partnering with the Ministry of Health:** The PUC should assess areas where the PUC could further collaborate with and integrate MoH staff into their interventions. If the PUC could rely on the MoH to conduct certain tasks during evaluations and interventions, it could reduce the burden on the PUC, improve budgetary efficiency and potentially allow for the PUC to expand its current operational capacity. Surveillance activities could be a priority area to consider further integration into the MoH with the goal of handing over certain responsibilities. This could also balance out risks of inadvertently creating MoH dependency on the PUC. While the PUC is an emergency program, they depend on permanent infrastructure within the MoH to operate which makes close collaboration essential for both coordination and skill development for both MSF and the MoH.

**Formalize partnership approaches by transitioning from a historically independent mentality:** Conduct a strategic mapping of actors that the PUC can partner with during certain kinds of interventions to better understand preparedness and opportunities for further partnership. This assessment can help identify key areas where weaknesses in other actors can be mitigated. Internal training should be conducted to promote open-mindedness and preparedness for collaboration with other actors and provide strategies for anticipated challenges.

**Invest in exit and handover strategies:** The PUC should communicate more strategically with all stakeholders, including but not limited to the MoH, in order to limit further the risk of confusion and clarify what has been done and is left to be done. Invest in establishing standardized handover protocols to partners in order to ensure that communities experiencing crises are best served after the PUC's departure. This includes a clear mapping of actors who can pick up certain activities after the PUC departs and a more tailored and strategic communication, including on which activities the PUC completed prior to closing an intervention. Lessons learned, challenges and best practices should also be shared to optimize the activities of actors who remain after the PUC's 2-3 months intervention.

**Further develop the increased engagement with the BALI to improve advocacy efforts for the PUC:** The PUC should prioritize additional opportunities to engage with the BALI and to be physically present during advocacy discussions with the government. Clarifying certain roles and communication protocols between the PUC vs. BALI and the MoH could clarify the parameters of their working responsibilities and further improve relations. This could also ensure that PUC technical expertise is further taken into consideration in national-level discussions and could inform health system strengthening and emergency preparedness advocacy at the country-level, which could support outbreak and crisis prevention.

## ANNEX 1: TERMS OF REFERENCE

Doctors Without Borders/Médecins Sans Frontières (MSF) is an international medical humanitarian organization determined to bring quality medical care to people in crises around the world, when and where they need regardless of religion, ethnical background, or political view. Our fundamental principles are neutrality, impartiality, independence, medical ethics, bearing witness and accountability.

The Stockholm Evaluation Unit (SEU), based in Sweden, is one of three MSF units tasked to manage and guide evaluations of MSF's operational projects, and works primarily with Operational Centre Brussels. For more information see our website [evaluation.msf.org](https://evaluation.msf.org).

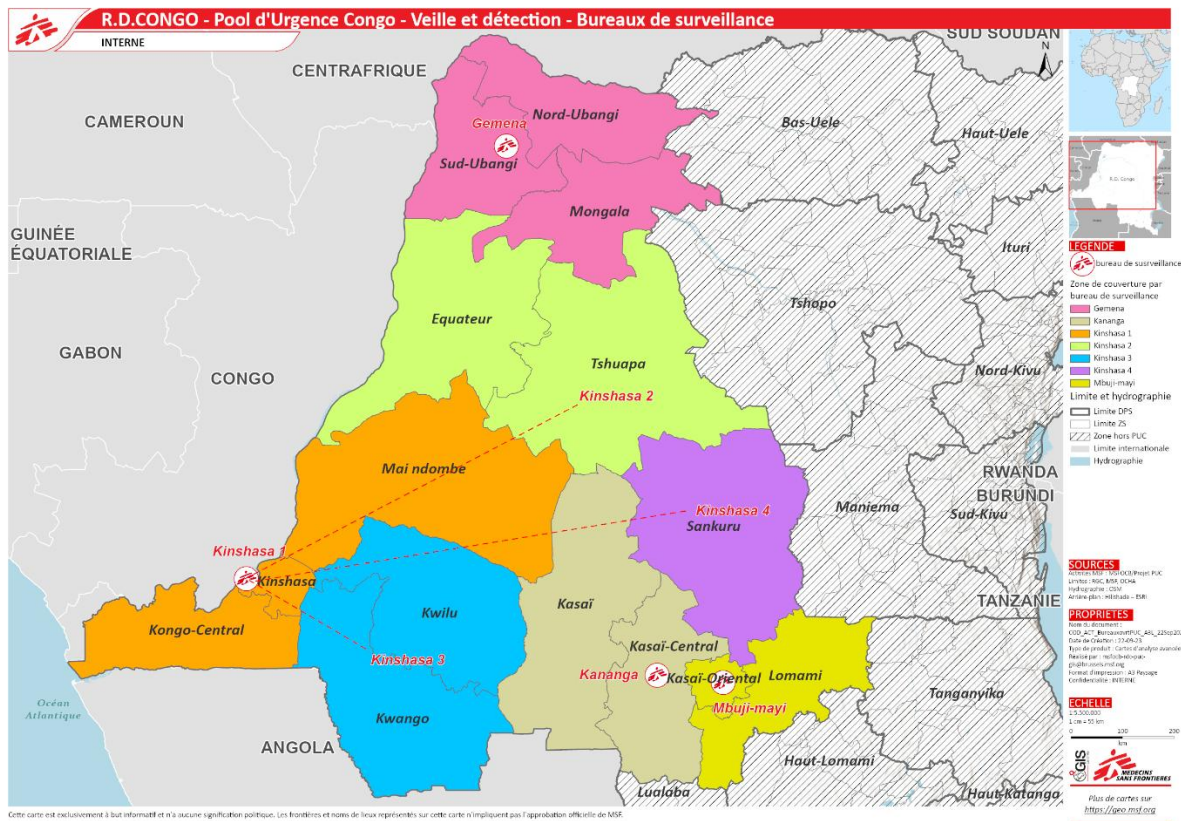
Promoting a culture of evaluation is a strategic priority to be accountable, seek for continuous improvements and achieve organizational learning. MSF does not evaluate only because of external requirements, for example donors related ones. These Terms of Reference should be seen as a starting point for the evaluation process. The evaluator(s) are welcome to challenge them and suggest for example different or additional perspectives, as they see fit during the inception phase. The evaluation process should rely on solid methodology to achieve credible results and should also ensure to put values and use in the forefront. The evaluation must involve and include different actors and counterparts in an adequate manner during the whole process.

Evaluation of Pool d'Urgence Congo, DRC (2024-2025)	
<b>Starting date:</b>	February 2025
<b>Duration:</b>	Final report to be submitted <i>by latest</i> June 27 <sup>th</sup> , 2025
<b>Requirements:</b>	Interested applicants should submit: <ol style="list-style-type: none"> <li>1) A technical proposal</li> <li>2) A financial proposal</li> <li>3) CV</li> <li>4) A previous (appropriate) work sample</li> </ol>
<b>Deadline to apply:</b>	15 January 2025 – 23:59
<b>Send application to:</b>	<a href="mailto:evaluations@stockholm.msf.org">evaluations@stockholm.msf.org</a>
<b>Other:</b>	We value quality over quantity. Providing only the requested and necessary information will prove your interest, capacity and competency in the best possible manner.

## BACKGROUND

The objective of the Pool d'Urgence Congo (PUC), as formulated in its project documentation, is to reduce mortality and morbidity among populations affected by medical and humanitarian emergencies in the 15 provinces covered by the PUC.<sup>14</sup> The PUC consists of 2 pillars: 1) surveillance and early detection of emergencies, and 2) emergency response.<sup>15</sup> The PUC may launch a response to eight key scenarios: cholera; measles; MPox; viral haemorrhagic fever; yellow fever; typhoid fever; mass casualties and humanitarian crises.<sup>16</sup> Other scenarios are possible as well but not part of the main ones. The nature of the PUC is to act where no other medical or humanitarian actor is present or does not have the capacity to effectively intervene.

### Map of surveillance outposts and provinces (15) covered by the PUC:



<sup>14</sup> Translated from French: “La mortalité et la morbidité des populations affectées par les urgences médicales et humanitaires dans les 15 provinces où le PUC intervient sont réduites” (Logical Framework, 2025)

<sup>15</sup> 2020 Project Document

<sup>16</sup> Strategic Narrative 2025

Since its creation 29 years ago, the PUC has undergone several changes. In recent years, an external evaluation conducted in 2013<sup>17</sup> led to some structural adjustments. In 2019, the PUC underwent important changes to address a number of identified issues, such as the lack of responsiveness and flexibility, slow emergency management, and the lack of early detection of emergencies. The restructure was organised around three main pillars: HR restructuring; revision of scenarios and modus operandi; review of surveillance and detection.

The vision for the restructure was outlined in the 2019 Action Plan: "The aim of this action plan is to give the PUC the ability to go back to basics without going backwards. A PUC that becomes reactive again, that is able to make decisions quickly, based on early detection both at the epidemic level and in the humanitarian context. A PUC that is able to make quick assessments in order to confirm and describe situations. A PUC that is able to implement relevant and context-appropriate interventions with reasonable budgets and organograms. HR capable of making strategies, monitoring their budget and to be a driving force for proposals. And finally, a PUC coordination whose role is to give support to the field, to act as a mirror and not to replace or impose on the field."<sup>18</sup> The results of this restructure have not yet been evaluated.

#### Key facts PUC 2024<sup>6</sup>:

- Total number of staff: 85 permanent staff, and 262 reserve staff
- Budget: €7.8 million (4 million for emergencies and 3.6 million for operational costs)
- Eight fact-finding activities ("explorations")

N°	Typology	Health zone	Province
1	Cholera	Mushenge	Kasai
2	Measles and Mpox	Lotumbe	Equateur
3	Mpox	Budjala, Bulu	Sud-Ubangi
4	Natural disaster	Kananga, Ndesha	Kasai Oriental
5	Mpox	Monkoto, Lingomo and Ikela	Tshuapa
6	Measles	Ntongo	Equateur
7	Measles	Lisala	Mongala
8	Mpox	Bokungu	Tshuapa

<sup>17</sup> Evaluation managed by the Stockholm Evaluation Unit, [Evaluation of the « Pool d'Urgence Congo » Project, MSFOCB, DRC \(FR\) | MSF Intersectional Evaluation Group](#)

<sup>18</sup> Translated from French : "Le but de ce plan d'action est de redonner au PUC la capacité de revenir à l'essentiel sans pour autant revenir en arrière. Un PUC qui redevienne réactif, qui soit capable de prendre des décisions rapidement, basées sur une détection précoce tant au niveau épidémique qu'au niveau contexte humanitaire. Un PUC qui soit capable de faire des évaluations rapides dans le but de confirmer et décrire les situations. Un PUC qui soit capable de faire des interventions pertinentes et adaptées au contexte avec des budgets et des organigrammes raisonnables. Des RH capables de faire des stratégies, de suivre leur budget et d'être force de proposition. Et enfin une coordination PUC qui ait pour rôle de donner du support au terrain, de faire effet miroir et non de faire à la place ou d'imposer au terrain." (*Plan d'action 2019*)

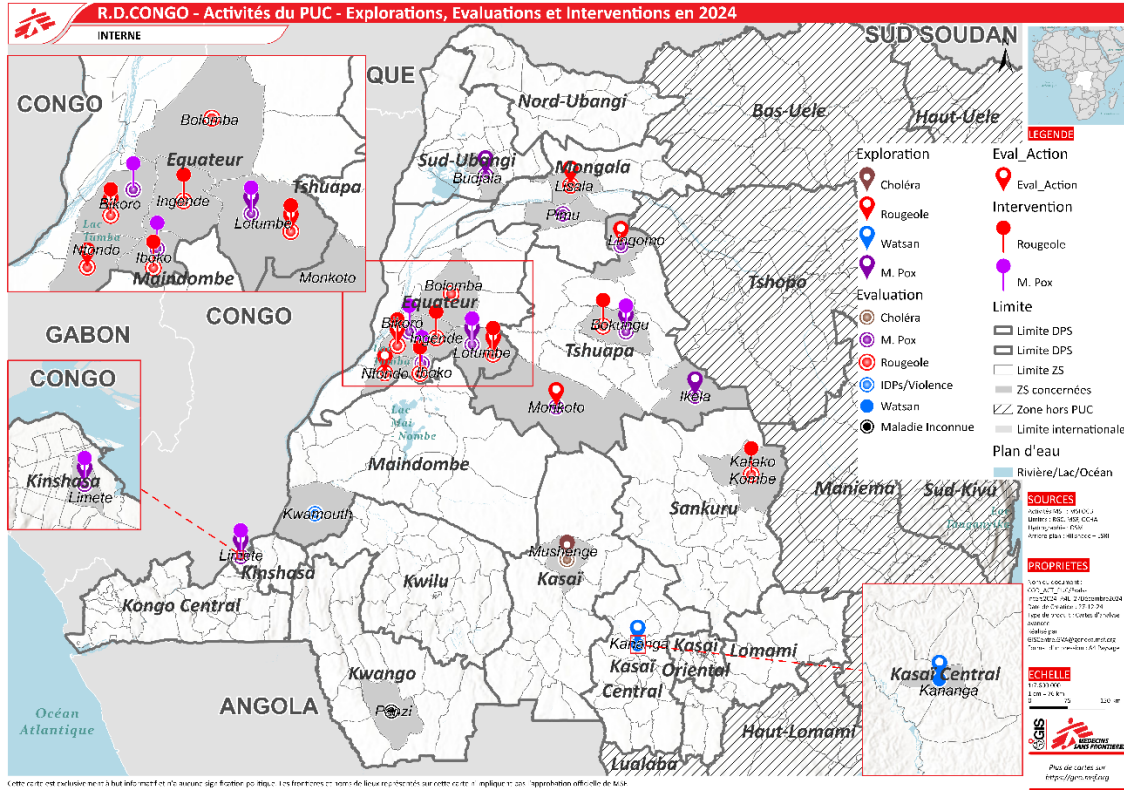
- Eleven assessments

N°	Typology	Health zone	Province
1	Measles and Mpox	Lotumbe	Equateur
2	Measles	Ingende	Equateur
3	Displacement	Kwamouth	Mai-Ndombe
4	Mpox	Bikoro	Equateur
5	Measles	Katako-Kombe	Sankuru
6	Measles	Bolomba	Equateur
7	Measles	Bokungu	Tshuapa
8	Mpox	Pimu	Mongala
9	Measles and Mpox	Iboko	Equateur
10	Measles	Bolomba	Equateur
11	Measles	Bikoro	Equateur

- Ten emergency responses

Below the types of responses and number of patients

N°	Health Zones	Measles		Mpox	Paludism	Mal-nutrition	Mobile clinics
		Case management	Vaccination				
1	Lotumbe	1357	46038	417	1585		
2	Ingende	646	66348		601	376	
3	Budjala, Bulu			38			
4	Bikoro	130		103			
5	Katako-Kombe	628	56130		3920	296	
6	Kwamouth						70
7	Bokungu	1008	45608				
8	Iboko	704	26270	96	1691	405	
9	Bokungu			on-going			
10	Limete			on-going			



## PURPOSE AND INTENDED USE

Since the 2019 Action plan, significant efforts have been made to adjust the ways of working of the PUC. The aim of the 2025 evaluation is to understand “how good” the PUC is today, its overall relevance and if it is fit for its purpose. The intended goal of the evaluation is not to lead to another restructure of the PUC, but to gather evidence that can support readjustments in the functioning of the PUC or confirm current functioning is fit for purpose.

The evaluation period is from the restructure in 2019 to the present day.

The evaluation will contribute to discussions at the annual review of operations in 2025, and therefore, the final report should be completed by July 2025 in order to be useful in that regard.

## EVALUATION APPROACH

The suggested evaluation approach should be seen as a point of departure for the evaluation work. The evaluator(s) are encouraged to bring their own reflections and to confirm or revisit the approach.

1. **In a participatory manner<sup>19</sup>,**
  1. **Confirm or develop the PUC's theory of change<sup>20</sup>** to generate shared understanding and ownership;
  2. **Define what "relevance" looks like for the PUC.**
  
2. **With the results of step 1 as a point of comparison, evaluate:**
  1. How successful is the PUC today in achieving its purpose?
  2. Is it still relevant? (including but not limited to: relevance to the context, to the needs, rationale behind the decisions to intervene, MSF principles, etc.)
  3. What are the main enablers and constraints?

It is anticipated that the precise evaluation questions and criteria will emerge as a result of step 1.

## EXPECTED DELIVERABLES

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**The final deliverables should be produced in English but given the primary users and audience of the evaluation being the PUC, they will be translated into French by the SEU.**

1. **Theory of change**  
As a result of a participative process, present the theory of change of the PUC and what relevance looks like for the PUC.
2. **Inception Report**  
Based on first step, confirm the evaluation questions and propose a detailed evaluation proposal to answer them, including methodology.  
*Primary audience: commissioner and consultation group for the evaluation – shorter version for evaluation participants / communication purposes.*
3. **Validation session(s)**  
At least one, more if needed, working sessions with the commissioner and consultation group for the evaluation. A sampling of evaluation participants could also be included. As part of the process to move towards findings, these sessions aim to create a space for discussion towards shared understanding of the findings, to facilitate discussions on lessons learned, co-create recommendations and enhance evaluation use.
4. **Draft and Final Evaluation Report**  
As per SEU standards. It will answer the evaluation questions and will include conclusions, lessons learned and recommendations, addressing feedback received during validation session(s) and written feedback loop.
5. **Other deliverables to be suggested by the evaluator(s) and/or discussed with the SEU and evaluation stakeholders during the evaluation process.**

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<sup>19</sup> Participatory approach would ensure shared understanding, trust and ownership as well as useful process and results. A broader group of participants could be identified to engage with the evaluators, ideally face-to-face, particularly in this first step.

<sup>20</sup> The PUC has a logical framework updated in 2024 but has not developed its program theory or theory of change.

## TOOLS AND METHODOLOGY PROPOSED

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In addition to the initial evaluation proposal submitted as a part of the application (see requirement chapter), a detailed evaluation protocol should be prepared by the evaluators during the inception phase. It will include a detailed explanation of proposed methods and its justification based on validated theory/ies. It will be reviewed and validated as a part of the inception phase in coordination with the SEU.

## PRACTICAL IMPLEMENTATION OF THE EVALUATION

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Number of evaluators	To be proposed by the candidate(s), suggestion 2
Timing of the evaluation	February-June 2025 It is expected that the evaluation requires at least one visit to DRC, maybe more. Suggestions to be made as part of the proposal submitted, and to be discussed and confirmed with SEU and evaluation stakeholders.

## PROFILE/REQUIREMENTS FOR EVALUATOR(S)

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- **Requirements:**
  - Proven competencies in evaluation, including proven experience in leading and facilitating participatory evaluation processes.
  - Proven competencies in humanitarian project design and implementation.
  - Proven competencies in designing and evaluating program theory (project logic/theory of change).
  - Management/leadership skills and experience.
  - Language requirements: English and French (Fluent)
  
- **Assets:**
  - Experience in humanitarian medical emergency response.
  - MSF experience and/or understanding.
  - Experience in DRC and/or understanding of the DRC context.

## ANNEX 2: DESK REVIEW DOCUMENTS

### Documents reviewed in the desk review include:

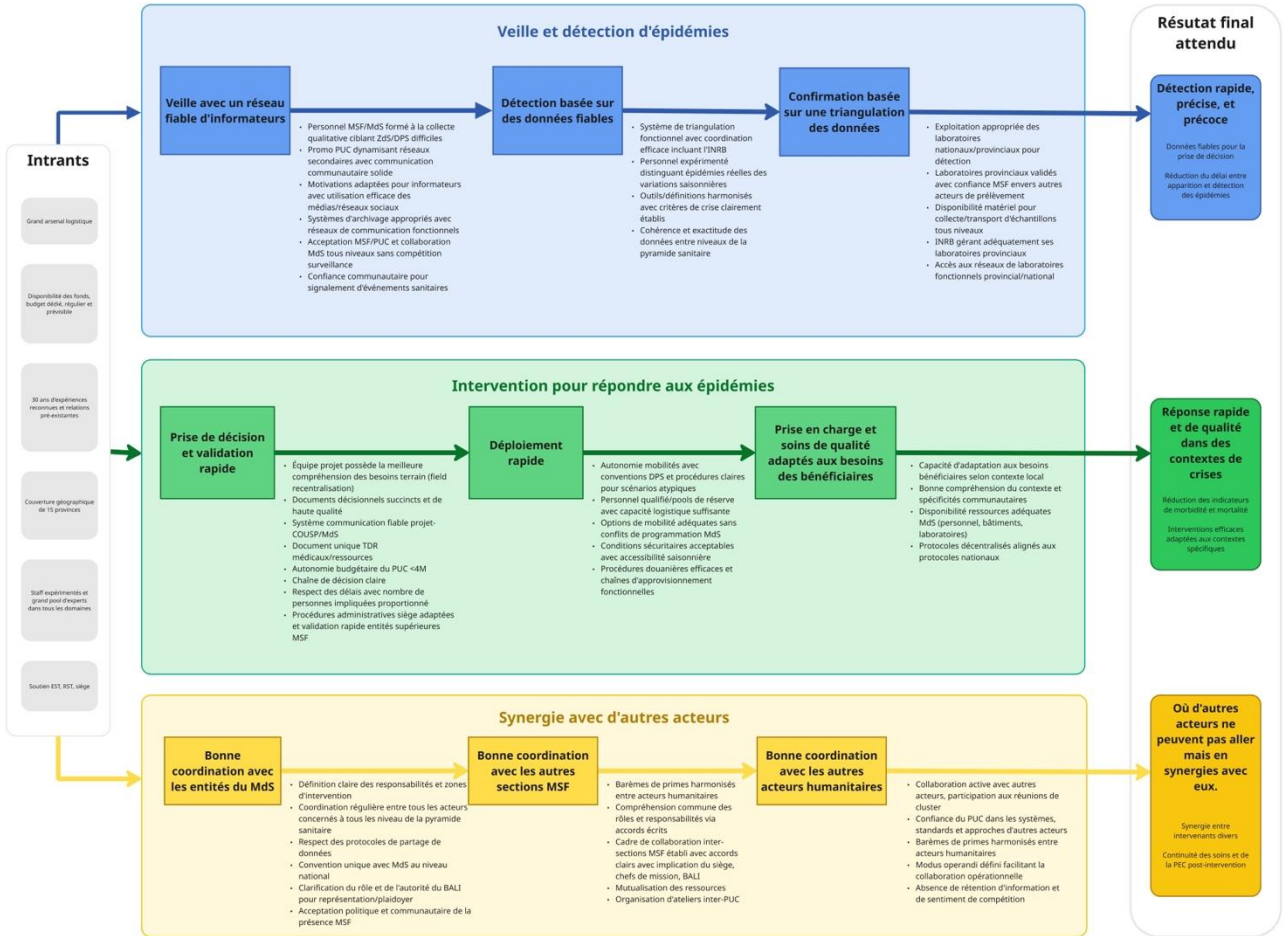
- Narratif\_OPS-ProjetPUC\_CDR\_OCB\_Sep-2022\_FR.docx
- Organigramme\_PUC\_RDC\_OCB\_202405\_FR.xlsx
- Présentation\_PUC\_MYARO-2025\_RDC\_OCB\_20241014\_FR.pptx
- All staff Briefing and di-Meeting Recording.mp4
- Evaluation Report\_MSFOCB\_PUC\_DRC\_2013\_FRE\_FINAL\_INCL\_ANNEXES.pdf
- EVL\_2025\_PUC\_briefing\_AllStaff\_Dec18.pdf
- EVL\_2025\_PUCEV\_SCO\_ScopingQuestions\_notes.docx
- Copy of Données Inter-Eval-Explo.xlsx
- Document\_Projet\_PUC\_2000.doc
- MAP\_COD\_ACT\_BureauxovrtPUC\_A3L\_22Sep2023.png
- MAP\_COD\_ACT\_PUCEvals-Inters2024\_A4L\_27Décembre2024.png
- Organigramme PUC ARO 25\_staff permanents.xlsx
- Plan d'action PUC\_2019\_FINAL.doc
- VF\_Cadre Logique PUC 25.xlsx
- VF\_nettoyee\_Narratif\_stratégique\_Med\_Ops\_ARO\_PUC 2025.docx
- Procédures Réponses PUC\_Révisée\_Mai\_2024.docx
- Document\_Projet\_PUC\_2020.doc
- PUC-Cadre Logique\_2024\_T4.xlsx
- VF\_PUC\_Rapport Annuel 2024\_26\_02\_2025.docx
- 2025\_Présentation PUC (photos).pptx
- VIRAPPORT FINAL\_INTER\_ROUGEOLE-MPOX IBOKO
- TDR + Rapport Eval\_Rougeole\_ZS-KATAKO KOKOMBE
- Table de Validation Terrain Dec 2024.pdf
- Table d'octroi d'avance terrain Dec 2024.pdf
- Table d'octroi d'avance Coordo PUC Dec 2024.pdf
- Standards opérationnels utilisés par la Veille et détection
- SitRep\_InterRGL\_Katako\_S26.xlsx
- Sitrep\_2025\_Bureau\_kin II\_S19.xlsx
- Seuils PUC\_2020\_A3.docx

- Septembre\_TDR strategique intervention -RGL ZS Bokungu
- Septembre\_TDR ROUGEOLE \_ZS IBOKO\_FINAL.docx
- RAPPORT HP FIN-INTER FT. ZS LUSAMBO 2025.docx
- Rapport Eval\_RGL Iboko docx VF.docx
- Procedures Réponses PUC 2023\_VF\_29062023 (002).pdf
- Octobre\_TdR Ressources\_InterRGL\_ZS BIKORO.docx
- Novembre\_TDR\_intervention -MPOX ZS Bokungu-DPS T
- Juin\_TDR\_Unique\_Inter Katakokombe.docx
- Fevrier\_TDR\_Intervention\_Lotumbe.docx
- Avril\_TDR RESSOURCES INTER ZS\_INGENDE-DPS EQUATEUR
- Analyse coût Int 2024.xlsx
- Alertes\_PUC\_2020-2024.pdf
- 20250216\_TdRs STRATEGIQUES \_INTER FT \_ZS LUSAMBO
- 20250114\_RIOD's Guidance Framework\_MSF Operation
- 20190228\_Rapport finale d'Intervention - IDPs Yumbi 2
- 2022\_06 Table de validation.pdf

# ANNEX 3: THEORY OF CHANGE

## Théorie de changement pour un bon PUC pertinent et efficace

**Contexte / Problème :** Les avis sont partagés sur le mode de fonctionnement et la pertinence du PUC aujourd'hui à répondre à des crises sanitaires et humanitaires nécessitant une réponse rapide et efficace



## ANNEX 4: ASSUMPTIONS TESTING GRID

The below grid displays all of the assumptions that were developed during the Theory of Change workshop that were tested during the evaluation.

Level of change	Assumption and risks	Holds	Partially holds	Doesn't hold	Not enough data
Veille	Les ZdS et DPS à difficulté sont identifiés et ciblés dans les formations				x
Veille	Formation adéquate du personnel MSF et MdS pour assurer une collecte de données de qualité		x		
Veille	Un contact régulier en personne avec les communautés	x			
Veille	Une Promo PUC qui dynamise les réseaux secondaires	x			
Veille	Collaboration solide avec les leaders communautaires et d'autres parties prenantes pour renforcer le réseau de détection secondaire	x			
Veille	Des motivations (financières ou pas) adéquates pour mobiliser les informateurs			x	
Veille	Utilisation efficace des médias et des réseaux sociaux pour le suivi des rumeurs				x
Veille	Disponibilité de systèmes d'archivage et de capitalisation appropriés			x	
Veille	Existence de réseaux de communication fonctionnels (téléphones, internet) pour le partage d'informations		x		
Veille	Collaboration efficace et positive avec le MdS au niveau des ZdS, DPS, et national où les superviseurs DPS et des ZdS sont impliqués dans la V&D		x		
Veille	Pas de compétition avec d'autres acteurs dans leur mandat de surveillance	x			
Veille	Confiance suffisante des communautés pour signaler les événements sanitaires		x		
Veille	Acceptation de MSF et du PUC par les autorités locales et les responsables sanitaires	x			

Veille	Un turnover élevé des superviseurs qui assurent la formation et la supervision de la collecte des données				x
Veille	Rétention d'informations par d'autres acteurs ou autorités	x			
Veille	Manque de confiance de la communauté envers les équipes de surveillance ou demande de motivations financières		x		
Veille	Présence de biais dans la collecte des données (intérêts politiques, économiques)				x
Veille	Compétition avec d'autres sections MSF pour les mêmes informations				x
Veille	Accusation d'espionnage et autres, particulièrement dans des crises humanitaires				x
Veille	Rumeurs et infodémies	x			
Détection	Existence et bon fonctionnement d'un système de triangulation des informations	x			
Détection	Présence de personnel expérimenté capable de distinguer les véritables épidémies des variations saisonnières normales	x			
Détection	Bonne coordination et harmonisation avec d'autres acteurs, y compris l'INRB, pour une triangulation	x			
Détection	Définitions, cas, et outils de détection harmonisés avec d'autres acteurs	x			
Détection	Les critères et scénarios pour des crises sanitaires et humanitaires sont bien définis et compris		x		
Détection	Insuffisance des outils de collecte de données			x	
Détection	Faible capacité à analyser les données de surveillance correctement et personnel insuffisamment expérimenté pour analyser les signaux épidémiologiques			x	
Détection	Cohérence et exactitude des données partagées entre les différents niveaux de la pyramide sanitaire	x			
Détection	Le système de V&D du PUC est complémentaire aux autres systèmes de veille, et non pas parallèle.	x			
Détection	Le cycle de collecte des données est efficace et rapide. (autonomisé, archivé, analysé)	x			
Confirmation	Exploitation appropriée des laboratoires nationaux et provinciaux pour les tests de détection et confirmation	x			

Confirmation	Tous les laboratoires provinciaux sont validés pour la détection			x	
Confirmation	MSF fait confiance aux autres acteurs de prélèvement			x	
Confirmation	Disponibilité du matériel pour la collecte et le transport des échantillons au niveau des communautés et dans les laboratoires provinciaux			x	
Confirmation	L'INRB gère adéquatement ses laboratoires provinciaux			x	
Confirmation	Accès à des réseaux de laboratoires fonctionnels et bien équipés aux niveaux provincial et national			x	
Confirmation	Le matériel de prélèvement et les moyens de transports sont disponibles			x	
Confirmation	Pas de délais excessifs pour obtenir les résultats des laboratoires	x			
Prise de décision	Le PUC possède la meilleure compréhension des besoins sur terrain (field recentralisation)	x			
Prise de décision	Les docs nécessaires pour la prise de décision sont succincts, de qualité, centrés sur les infos essentielles			x	
Prise de décision	Disponibilité d'un seul document TdR, centralisé sur la stratégie med			x	
Prise de décision	Automnie budgétaire complète en dessous des 4M alloués			x	
Prise de décision	Un système de communication et de coordination fiable et rapide existe entre le projet et le COUSP/MdS	x			
Prise de décision	Leadership PUC possède une analyse critique pour mieux adapter les interventions et aller au-delà de la routine pour plus d'innovation / allant au-delà de la routine		x		
Prise de décision	Interprétation homogène des procédures			x	
Prise de décision	Chaine de décision claire et reflète des approches similaires à d'autres projets			x	
Prise de décision	Nbr de personnes dans la prise de décision est adaptée et proportionné au type de réponse			x	
Prise de décision	Procédure admin au niveau du siège sont adaptées à la nature du projet			x	
Prise de décision	Validation rapide des entités MSF au niveau supérieur (ESP, RST, siège)			x	

Prise de décision	Toutes les personnes dans la chaîne de décision respectent les délais.			x	
Prise de décision	Pas de pression externe sur le PUC pour intervenir dans certains cas "high profile"				x
Prise de décision	Pas d'interférence du siège dans des décisions opérationnelles		x		
Déploiement	Autonomie en termes de mobilités		x		
Déploiement	Conventions signées avec les DPS	x			
Déploiement	Procédures et systèmes clairs existent pour répondre à des scénarios inattendus ou atypiques			x	
Déploiement	Disponibilité du personnel permanent qualifié et pools de réserve compétent			x	
Déploiement	Capacité logistique suffisante	x			
Déploiement	Capacité opérationnelle limitée (2 interventions, 1 éval)	x			
Déploiement	Ruptures de stocks des intrants essentiels		x		
Déploiement	Options de mobilités suffisantes			x	
Déploiement	Absence de conflits de programmation		x		
Déploiement	Conditions de sécurité acceptables dans les zones d'intervention	x			
Déploiement	Procédures douanières efficaces pour l'importation de fournitures essentielles			x	
Déploiement	Chaînes d'approvisionnement fonctionnelles pour les matériels médicaux et logistiques	x			
Déploiement	Instabilité politique et sécuritaire affecte d'autres partenaires et fournisseurs	x			
Déploiement	Dépendance à un seul transporteur aérien pour le fret	x			
Déploiement	Le PUC capitalise sur les leçons apprises des interventions précédentes et ajuste ses approches progressivement			x	
PEC	Capacité d'adaptation aux besoins des bnf selon le contexte	x			
PEC	Bonne compréhension du contexte et des spécificités de la communauté locale dans les zones	x			
PEC	Personnel suffisamment qualifié pour les scénarios comme les crises humanitaires			x	

PEC	Disponibilités des ressources adéquates au niveau du MdS		x		
PEC	Protocoles décentralisés s'alignent aux protocoles nationaux				x
PEC	Pas de chevauchement des activités du MdS		x		
MdS	Définition claire des responsabilités et des zones d'intervention		x		
MdS	Tenue régulière de réunions de coordination		x		
MdS	Existence et création de protocoles de partage de données			x	
MdS	Convention unique du PUC avec le MdS au niveau national		x		
MdS	Clarté concernant le rôle du BALI et l'autorité de la représentation		x		
MdS	BALI fait le plaidoyer pour les priorités du PUC			x	
MdS	Acceptation sociale et politique de la présence de MSF	x			
MdS	Impact de certaines personnalités qui affectent le MdS				x
MdS	Confusion entre les différents mandats des sections MSF dans le pays				x
MSF OC	Barème de primes harmonisé			x	
MSF OC	Compréhension commune des rôles et responsabilités basée sur des accords écrits			x	
MSF OC	Volonté des autres OC de collaborer et partager les ressources		x		
MSF OC	Accords clairs au niveau des sièges concernant les cadres de collaboration			x	
MSF OC	Implication des décideurs de haut niveau (siège, chefs de mission, BALI) dans le développement des accords de collaboration			x	
MSF OC	Modus operandi de chaque OC permet la collaboration			x	
MSF OC	Absence de sentiment de compétition entre acteurs			x	
MSF OC	Atelier inter-PUC organisés			x	
Autres acteurs	Les sitreps et données du PUC sont partagées et utilisées par les autres acteurs	x			
Autres acteurs	Volonté de collaborer avec d'autres acteurs			x	
Autres acteurs	PUC a confiance dans le système, les standards, et approches des autres			x	

Autres acteurs	Volonté de participer aux réunions de cluster et systèmes de coordination			x	
Autres acteurs	Barème de prime harmonisés		x		
Autres acteurs	Modus operandi de chaque acteur permet la collaboration			x	
Autres acteurs	Absence de rétention d'information				x
Autres acteurs	Absence de sentiment de compétition entre acteurs			x	
Autres acteurs	Divergences sur les approches aux crises				x
Autre	Le financement international de réponse aux crises pour les acteurs qui complètent le travail du PUC ne diminuent pas.			x	
Autre	Le financement et les ressources de MSF pour le PUC ne diminuent pas.		x		
Autre	Les ressources du MdS pour la réponse aux crises ne diminuent pas.	x			
Autre	** Assumption missing around sustainability! **				x
Autre	** Assumption around advocacy is missing! **				x
Autres acteurs	Le PUC n'est pas tout simplement un service provider mais a de la plus value / cost benefit.		x		

## ANNEX 5: STRENGTH OF EVIDENCE CRITERIA

The following approach was used during the data analysis process to determine the strength of evidence for each finding:

SoE Level	Description	Criteria Met	Example of Finding
<b>High</b>	Strongly supported by multiple data sources and consistent across stakeholder groups that have insight into the specific activity and the PUC's processes.	Triangulated across $\geq 3$ sources (e.g. interviews, FGDs, documents) and stakeholders; low bias risk.	"The PUC consistently detects measles outbreaks faster than other actors, as confirmed by MoH, staff, and partners."
<b>Moderate</b>	Supported by several sources, though with some variation or minor gaps, or supported by several sources that have limited insight into the PUC's processes and mode of operation.	At least 2 independent sources and stakeholders; some contradictions in perspectives or partial data gaps.	"Coordination between the PUC and health zone teams occurs, but clarity on roles varies across provinces."
<b>Limited</b>	Based on few sources or primarily from one stakeholder group or from several stakeholders from different groups but with limited insight into the PUC's	One main data source or uncorroborated perspectives with high subjectivity or contextual specificity.	"Staff report improvements in financial management, though external validation from staff outside of the PUC is lacking."
<b>Anecdotal</b>	Based on outlier accounts; not validated elsewhere.	Single source with no corroboration across stakeholders or data types.	"A team member noted that epidemics would not return to the same regions five years after a PUC intervention."
<b>No evidence</b>	There is no sufficient or appropriate evidence to substantiate an assumption assessment, and the data was inconclusive.	There is no basis for drawing conclusions.	"The evaluation was not able to assess this assumption due to missing data."

## ANNEX 6: DATA SOURCES AND TOOLS USED FOR PRIMARY DATA COLLECTION

The table below displays the primary data sources used in this evaluation:

Tool	Respondent Type	Themes Examined
Online Survey	Permanent PUC staff and Pool de Réserve (PdR) staff	<ul style="list-style-type: none"> <li>• PUC positioning for health/epidemic crisis and humanitarian crisis response</li> <li>• Surveillance and detection system</li> <li>• Operational capacity and alert thresholds</li> <li>• Data sharing with external actors</li> <li>• Complementarity with other surveillance systems</li> <li>• Internal decision-making processes</li> <li>• Challenges affecting PUC interventions</li> <li>• Operational autonomy and logistical constraints</li> <li>• The Human Resource (HR) structure including PdR mobilization system</li> <li>• Collaboration with health authorities, UN entities, other NGOs and with other MSF entities</li> <li>• MSF OCB leadership</li> <li>• Advocacy at the national level</li> <li>• Suggestions for improvement</li> </ul>
FGD with PdR Staff	PdR staff that are currently on the PUC's roster	<ul style="list-style-type: none"> <li>• Participant role and experience with PUC interventions</li> <li>• Personnel and resource mobilization</li> <li>• Training provided by MSF</li> <li>• Mobilization process</li> <li>• Main challenges for PdR</li> <li>• Resource adequacy for intervention teams</li> <li>• PUC approach based on emergency needs</li> <li>• Challenges affecting PUC interventions</li> <li>• Response speed and quality</li> <li>• Community involvement</li> <li>• Coordination with local health authorities and other humanitarian actors</li> <li>• Suggestions for improvement</li> </ul>
KII with Permanent PUC staff	PUC staff with active contracts	<ul style="list-style-type: none"> <li>• Current health/humanitarian needs in the DRC</li> <li>• PUC modus operandi for epidemics vs. humanitarian emergencies</li> <li>• Perceptions of challenges faced by the PUC</li> <li>• The V&amp;D structure</li> <li>• The intervention process</li> <li>• Validation and decision-making processes</li> <li>• HR structure including PdR mobilization</li> </ul>

		<ul style="list-style-type: none"> <li>• Collaboration with health authorities, UN entities, other NGOs and with other MSF entities</li> <li>• Suggestions for improvement</li> </ul>
KII with MSF Support Staff	Other internal MSF staff including at the OCB, ESP, RST and HQ levels	<ul style="list-style-type: none"> <li>• Current health/humanitarian needs in the DRC</li> <li>• PUC modus operandi for epidemics vs. humanitarian emergencies</li> <li>• Perceptions of challenges faced by the PUC</li> <li>• The V&amp;D structure</li> <li>• The intervention process</li> <li>• Validation and decision-making processes</li> <li>• The HR structure including PdR mobilization</li> <li>• Collaboration with health authorities, UN entities, other NGOs and with other MSF entities</li> <li>• Suggestions for improvement</li> </ul>
KII with External Actors	Partners in the DRC that collaborate with the PUC including NGOs	<ul style="list-style-type: none"> <li>• PUC role in emergency response</li> <li>• Perceptions of the PUC's effectiveness</li> <li>• Strengths and weaknesses of the PUC's modus operandi</li> <li>• Experience collaborating with the PUC</li> <li>• Information/data sharing with the PUC</li> <li>• Suggestions for improvement</li> </ul>
KII with Health Authorities	MoH officials with direct experience with the PUC	<ul style="list-style-type: none"> <li>• PUC role in emergency response</li> <li>• Perceptions of the PUC's effectiveness</li> <li>• Strengths and weaknesses of the PUC's modus operandi</li> <li>• Complementarity with existing national systems</li> <li>• Information/data sharing with the PUC</li> <li>• Experience collaborating with the PUC</li> <li>• Suggestions for improvement</li> </ul>