



Médecins Sans Frontières

CAPITALISATION & LESSONS LEARNT

MSF and Likhaan, story of a partnership

Sexual and Reproductive Health project in a Manila Slum -
Philippines, 2016 - 2020

Realized by Yann Santin
Paris, April 2020



The **RIDER** is an interdisciplinary network involving MSF, Epicentre and the Crash. Its mission is to support the executive and the associative bodies in the production of rigorous and useful knowledge for action, using skills from social sciences and epidemiology.

The support from RIDER members takes various and flexible forms, including *methodological support* for work entirely managed by the initiator, the *co-piloting* of study projects associating, for example, external researchers and MSF consultants, or the *realization* of certain studies on behalf (and with the participation !) of the initiator.

This capitalization and lessons learned project was carried out at the request of the Cell 7 in collaboration with the Philippine mission and the field team of the Manila sexual and reproductive health project. The RIDER was commissioned to accompany the documentation of this original partnership project with the national NGO Likhaan and to nourish reflection on this way of working, in order to inspire future initiatives. The interpretations and opinions contained in this report remain those of the author.

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Study accompanied and supported by Eric Pujo, manager of cell 7 and Jean-Luc Anglade, head of mission Philippines.

Thank you for the great availability of all the people interviewed for this work, at the Tokyo cell and in Manila, MSF and Likhaan staff, as well as all the former MSF staff who gave their testimony of the first years of the project.

Acronyms

BEmOC :	Basic emergency obstetric care
Cecap :	Cervical Cancer Prevention
CMs :	community mobilisers (position of Likhaan)
CRR :	Center for Reproductive Rights (American association of lawyers doing advocacy work in the field of reproductive health).
FAD :	Field Associative Debates (MSF's annual day of associative debate)
GAC :	Global Affairs Canada (ministry in charge of Canadian cooperation)
Interpares :	Canadian Association engaging in partnerships abroad to carry actions promoting justice and equality.
JhPiego :	Johns Hopkins Program for International Education in Gynecology and Obstetrics
JV :	joint-ventures
MAP :	Mise à Plat (biannual strategic and operational planning exercise at MSF)
MTL :	Medical Team Leader (position MSF)
PC :	Project coordinator (positions at MSF and Likhaan)
PhilHealth :	Social security in the Philippines
SV :	Sexual violence
UNFPA :	United Nations Population Fund

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INTRODUCTION

In the Philippines, access to sexual and reproductive health care and information is the subject of a fierce struggle between the powerful Catholic Church and women's rights activists. Those most affected by restrictions on these services are adolescents and the poor.

In 2016, MSF starts a five-year project on this topic in Manila's largest slum. The model chosen is original. The activities are carried out by a mixed team of MSF staff and staff from Likhaan, an activist Filipino NGO that has clinics in the slums.

After four years of this partnership, the Tokyo cell wants to look back at the experience to draw lessons that can be used by others.

It is intriguing to see how two organizations with very different identities and profiles have designed and implemented joint operations, how they have worked together and what the results have been. It is equally stimulating for MSF to take advantage of the mirror effect: what is the other organisation's perception of our ways of doing things, of our organisational habits.

This review began with the consultation of archives, the most useful being the exploratory reports, initial proposals, partnership agreements, monthly reports, visit and handover reports, as well as organisation charts. It continued with the meeting and interviewing of 27 people among those who have been involved in the project since mid-2014.

The initial question proposed to revisit the underlying assumptions of the partnership, the model adopted, the constraints encountered, the successes, failures and the benefits for each party. In the end, the crucial question was: and if we had to do it all over again, here or elsewhere, what could be reproduced, what would have to be changed?

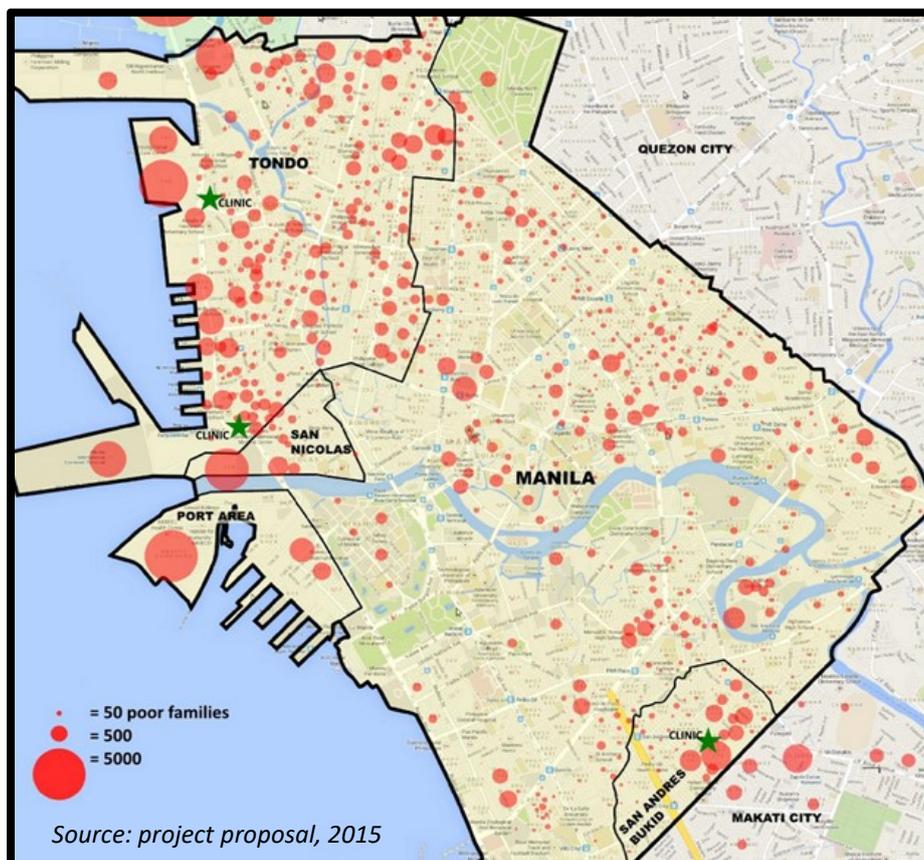
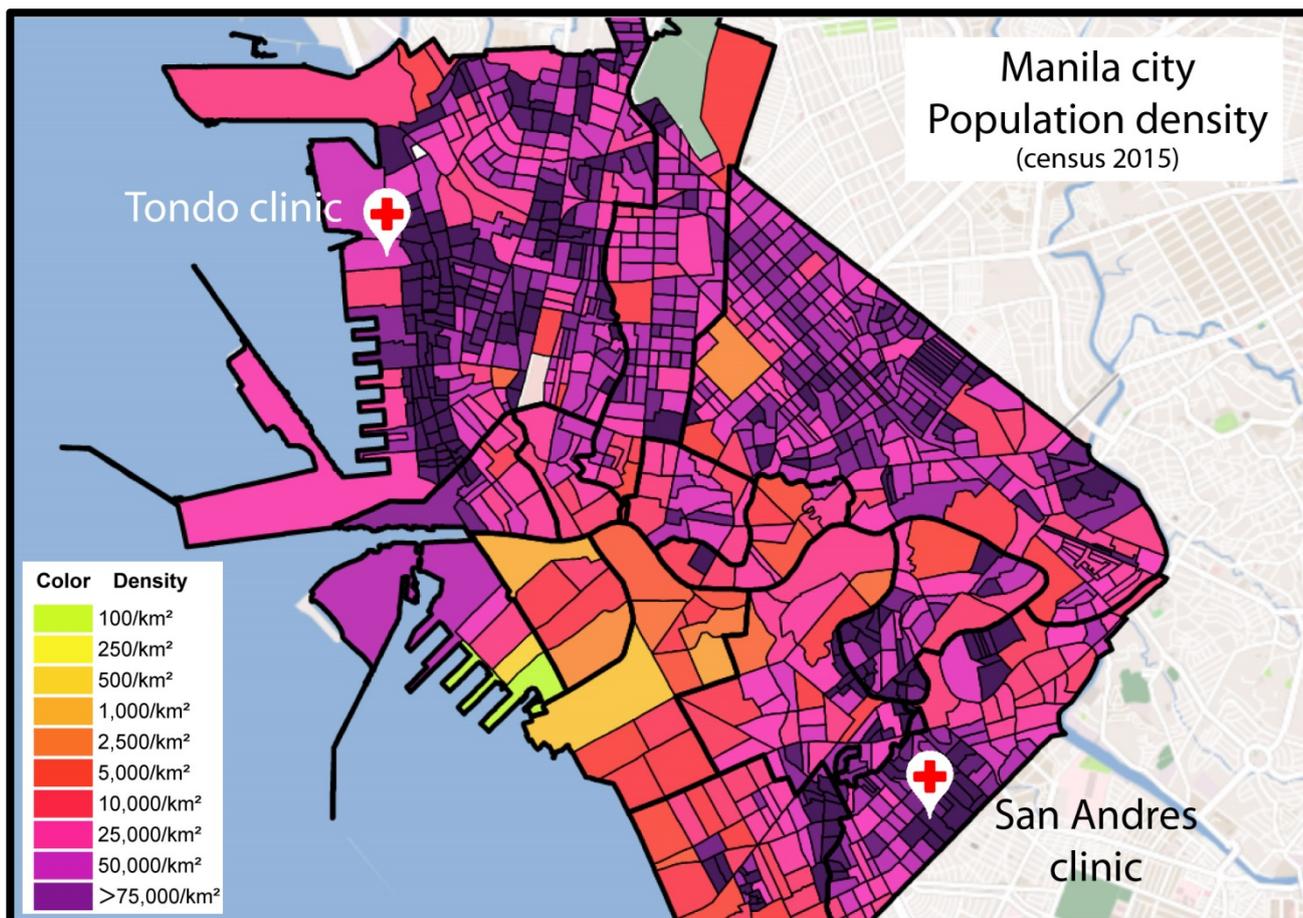
But how to work through the subtle tangle of events and conclude with a positive or negative result without manichaeism? How to extract from the cascade of causalities a list of good practices without draining them dry and finally expressing platitudes?

This document presents an oriented account of the project. It tells its story through the prism of the relationship between the two organizations. It starts chronologically, with the identification of needs by MSF, the encounter with Likhaan, the writing of a proposal, the setting up of operations and the description of selected activities with contrasting fates. A second part explores topics such as the collaboration strategy, the sustainability, or the cultural differences.

The aim is not to draw out ready-to-use recommendations, but rather to document a particular story, in order to provide food for thought and to share learning that can inspire others.

Two remarks as a preamble to the reading. This work is commissioned by the MSF cell in Tokyo, to serve internal reflection. It is therefore a choice to be more introspective than Likhaan-oriented. Secondly, the distanced critical observation does not do justice to the involvement of all those who have worked for the good progress of the project. I apologize to them if some remarks seem harsh or too hasty.

Maps of Manila



ACCOUNT OF THE PROJECT

The birth of a partnership

From typhoon to the slums

In 2016, when MSF-France starts the Sexual and Reproductive Health (SRH) project in the slums of Manila, the organization has been almost continuously present in the country for 30 years, aside from a short interruption (2005 to 2008).

The archipelago is indeed one of the most exposed countries in the world to natural disasters. Between 1984 and 2012 the different sections of the association carry out a dozen programmes following typhoons, two after major floods and one after the eruption of Pinatubo, one of the most massive of the 20th century. Moreover, the region of Mindanao, in the south, experiences strong political tensions and an insurgency movement whose confrontations with the Philippine army periodically flare up. MSF is therefore sometimes involved in conflict-type missions, alongside disasters ones.

Long term interventions are also developed, such as the street children program conducted in Manila by MSF Switzerland for 13 years, until 2005.

At the end of 2013, super typhoon Haiyan – locally called Yolanda –, one of the most powerful tropical cyclones ever recorded, devastates portions of Southeast Asia, particularly the Philippines where it caused over 6000 deaths. By the end of 2014, Marie-Noëlle Rodrigue, the director of operations, acknowledges that the need to deploy from scratch following the events had delayed the answer. Considering the recurring cycle of closing and re-opening of emergency missions in the country, she suggests to set up an “anchor project” that would allow for a permanent base in the country.

In the 2019 project sheet, the team summarizes the strategy at the time:

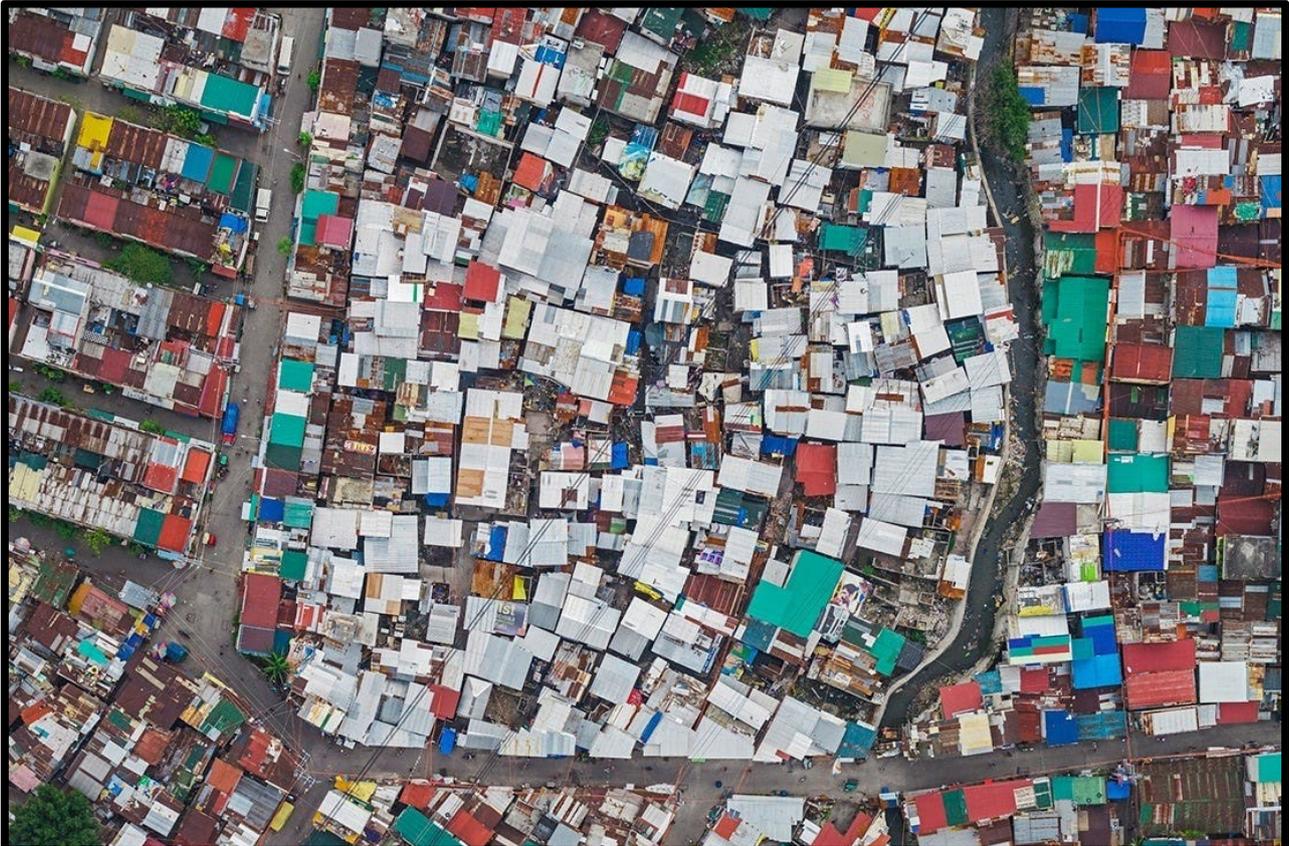
“To respond to a natural disaster emergency more promptly, MSF OCP decided to stay in the country with a long term project in 2015 after Typhoon Haiyan”.

From mid-2014, the field team who was closing the activities post-typhoon is therefore tasked to identify operational opportunities in the country. The medical coordinator makes a first broad search, sweeping across various themes at national level such as HIV, tuberculosis, non-communicable diseases and sexual & reproductive health. On his side, the head of mission analyses the needs in the area affected by the typhoon.

After narrowing down their search, they conduct two assessments in the beginning of 2015, one in the province of Northern Samar looking at the situation regarding obstetrics, tuberculosis and Shistosomiasis, and one in Manila slums looking at sexual and reproductive healthcare.

Manila is the most densely populated city in the world, with 43,000 inhabitants per square kilometre. But it is in its huge slums that overcrowding is the worst. Tondo is the largest of them: 650,000 inhabitants concentrated in run-down housing sometimes built on top of waste landfill along the industrial port. The tremendous wealth disparities are reinforced by the lack of basic infrastructure and the low level of public services. Criminality, gangs and violence are the images associated with such neighbourhoods.

It is in this grim picture that comes the specific situation of reproductive health in the Philippines. In 2002, the president, aligned with the conservative Catholic Church, requested the government to adopt reproductive health approaches “that respect our culture and values”, a synonym for severe restrictions. Going a step further, the mayor of Manila totally banned contraception in the city. This situation lasted for a decade, until the shift of powers in the beginning of the years 2010. But change remains slow. Adolescent sexuality is stigmatized: minors must produce written authorization from their parents to access contraceptives in state clinics, and pregnant adolescents are unwelcome in maternity wards. As for abortion, it is forbidden, Philippines’ law being among the strictest in the world.



Aerial view of the slums - Manila, 2017

© Bernhard Lang

First encounters

As the medical coordinator prepares for the assessment in the slums, she gets to know that the German Red Cross faced difficulties to establish projects there due to the mistrust of residents towards foreign actors. Besides that, a feeling of insecurity in the slums invites to be shepherded by local stakeholders.

While doing background search on reproductive health in the Philippines, she reads several reports mentioning the advocacy work of the NGO Likhaan. The organization was actively involved in the passage of the 2012 Reproductive Health Law that made birth-control accessible countrywide, ending the embargo by the Catholic Church. She enquires with agencies likely to know this association, in order to ensure their reliability. UNFPA gives positive feedback on Likhaan and provides their contact.

Likhaan is composed of a head office, hosting the dozen or so members of the management committee responsible for the different departments (community mobilization, advocacy, project coordinators, finance...) and of seven clinics located in poor neighbourhoods, mainly in Metropolitan Manila and surroundings. They carry out family planning activities, providing oral contraception, IUD, implants and pregnancy screening. They also run reproductive health education through their team of community mobilizers, who rely on a network of volunteer health promoters.

In June 2014 they open the doors of their clinic in Tondo and share some of their reports with MSF. This first field assessment and the consideration of their resources that include EU funds, gives a good impression.

Ideas take shape

To guide her analysis, the medical coordinator uses an assessment support document produced by MSF's women's health medical unit in Sidney. It details the range of sexual and reproductive health activities with

which MSF is familiar. The unit's referent advises her to observe in particular the situation of services available in the areas of family planning, abortion and sexual violence.

In July 2014, the medical coordinator presents her preliminary findings to the Tokyo cell through a "discussion paper". At this stage she has a limited set of data, mainly national. Contraceptive prevalence is 49%. The fertility rate among the poor population is 5.2, compared to 3.3 for the total population. She outlines the context, obstacles to healthcare access, and gaps in the system. Based on these elements, she considers that:

"Focusing efforts on sexual violence, adolescent's access to friendly reproductive health services and abortion and post-abortion care could represent a pertinent intervention in the slums".

She adds that:

"We could also include a component of lobbying and expertise to the implementation of the RH law." (Karina, Medical Coordinator, 2014-2015, MSF)

At this stage, it is a matter of suggesting that further research be carried out, while at the same time identifying preferred avenues. She is not yet at the point of proposing operational options. While she already has in mind the possibility of working with Likhaan, she considers it premature to raise this idea, knowing MSF's preference for autonomous actions.

The cell is not fully convinced, so the head of mission and the medical coordinator suggest them to see by themselves. They prove right. The visit also allows for a common understanding that an intervention besides Likhaan would be absurd, due to the difficulty to set up independent programs and the counter-productive dimension of having competing services. The potential for a partnership start to emerge. The idea would be to support Likhaan's existing activities and to expand them through new services.

Encouraged by the cell's interest, the head of mission and the medical coordinator carry out new assessments in the slum between December 2014 and February 2015. They present their findings in a "strategic document for the Philippines". They propose to establish a partnership with Likhaan to continue existing services and expand them with STI treatment, HIV screening and emergency contraception, while developing an approach to attract adolescents.

A genuine seduction

In addition to the many operational assets a collaboration with Likhaan offers, a determining aspect of MSF's attraction to this organization lies in its history, the personality of its leaders and the values it represents.

The story starts with a group of doctors, political activists and academics, members of the CPP - Communist Party of the Philippines - that fought against the dictatorship of president Marcos. They are mid-level leaders or support of the CPP from the 1980s, doing both legal and illegal organizational work: launching protests, campaigns, organizing students, professionals and poors. They belong to a Marxist-feminist group called Gabriela (*General Assembly Binding Women for Reforms, Integrity, Equality, Leadership, and Action*), founded in 1984, that emerges from clandestinity in 1986 following the fall of Marcos. In 1990 Dr. Junice Melgar - the current Likhaan's executive director - becomes the co-coordinator of Gabriela commission on women's health and reproductive rights.

In 1994 the United Nations call an international conference on Population and Development in Cairo. It results in the recognition that sexual and reproductive health and rights are the cornerstone of global development. The program of action that follows set goals for access to family planning and becomes the steering document for the UNFPA.

This period is marked by divisions within the Filipino leftist movements. A few months after the international conference, the question of accepting a UNFPA funding reveals a rift within Gabriela. Some consider that the United Nations, incarnation of Western imperialism, belongs to the enemy. Others believe that the essential struggle of the moment is between progressive and conservative forces, and that in this battle UNFPA stands on the right side.

These opposing views lead to a parting of ways and in 1995 Dr. Junice Melgar and Dr. Sylvia Estrada Claudio found the organization Likhaan with the aim to provide healthcare services to women in marginalized communities.

Likhaan's early activities revolve around community-based women's health programs including malnutrition, common infections or maternal and child health. They then shifted to the provision of family planning services. The drift of the country towards restrictive policies through the decade 2001-2012 prompts them to start lobbying. Joining forces with the *Center for Reproductive Rights*, a New York based legal advocacy organization, they campaign against the Executive Order No. 003 issued by the Manila Mayor to halt contraception in the capital.

In 2014 when MSF meets Likhaan, the organization is well established in the political and activist landscape. It is deeply involved in the campaign to change the Philippine law on reproductive health and can count on its relays in the government and in the parliament. It participates actively in the various forums on the topic and enjoys a fair media coverage.

Although there is a clear interest from Likhaan in the potential funding from MSF, discussions do not revolve around money. What is at the heart of the exchanges is values and convictions. For instance, for Likhaan, the fact that MSF is an organization openly supporting the right to termination of pregnancy, is key in their appreciation.

"We are a controversial organization in the Philippines. Our concern was whether MSF was willing to be part of this controversy". (Jun, Program director, Likhaan)

"This is something I liked a lot: that they were militants going against the strongest powers in the country. When we could feel their eagerness to support reproductive health rights, that was a click. Of course they needed funds, but the money was not the reason. The reason was a genuine fight for the reproductive rights." (Karina, Medical coordinator, 2014-2015, MSF)

"Likhaan leaders are top level people, intellectually and politically. There is a Homeric struggle in parliament between the hard-line conservatives and a very progressive camp, on the questions of contraception and abortion, in which they play a direct role. The positions are very divided. We are right in the centre of a medico-social topic that is important for the country, together with brilliant people." (Pierre, Deputy operations director, MSF)

The choice of the partner is therefore not made through a process of identification of potential organizations, comparison between them and selection of the most promising one. It is the result of a seductive encounter that turns into an opportunity: the contact is promising as the organization is attractive and a partnership seems interesting in many ways. It would indeed permit to develop activities, each party benefitting from what the other brings to the table.

The setting up of activities

Project design

In 2014, Likhaan is looking for a transition to follow its European Union funding that finishes at the end of 2015. The association is accustomed to working with donors, i.e. to conceive and write, according to its know-how, operational proposals that can fit within the framework of funding lines. With MSF the process is different as the donor will carry out the activities with them. It is a combination of two medical organisations, each with its own analysis of the health situation, its own capacities and its ideas for activities.

Likhaan wishes to continue with its family planning and sexual and reproductive health information activities out of its clinics. For its part, MSF comes with a flexible budget and a relatively wide "toolkit" of medical expertise. It therefore finds itself in a position to propose new operational developments.

The outlines of the project that MSF wishes to embark on with Likhaan are sketched out in the "Strategic paper for the Philippines", written by the medical coordinator and the head of mission following the exploratory missions they carry out until February 2015. The field team considers it tricky to integrate Likhaan further while the proposed intervention has not been validated by an MSF project committee. The medical coordinator explains:

"I wrote the note. Likhaan was not involved at this stage, because at that moment there were several options like NCDs or maternal health and TB in Samar. There were several options for the committee to choose, because it's difficult to convince with one single option, especially when you're not in Africa and the needs are not overwhelming." (Karina, Medical coordinator, 2014-2015, MSF).

Nevertheless, the members of the two organisations exchange views on the content of the project. Some sticking points appear regarding the role that MSF is taking on.

"At the beginning of the discussions it was very friendly, diplomatic. Then there were a few discussions where we had to make it clear that if they wanted the collaboration to go well, we also had to have a field of activities that we were interested in. We had conceptualized on our side because we wanted to do things quickly. We came up with a concept that we had already put together and presented it to them. We were the ones who pushed what we wanted to do. We presented them with attractive things: logistical support, complementing each other, broadening the service that patients could benefit from. They didn't shape the package, everything that was added came from us.

The frustration came when they realized that we weren't simply there to support them, letting them the lead. That's when things evolved a little bit in the relationship: they understood that we were a partner who was going to implement directly and that they would lose a bit of control over the whole package. It was kind of hard for Junice at that point to accept it." (Olivier, Head of mission, 2014, MSF).

In February 2015 a new head of mission replaces Olivier. She delves deeper into the directions sketched out by the previous team. Notably, following a visit by colleagues from the MSF Access Campaign, she adds a cervical cancer prevention and treatment component to the project. After completing further assessments and pursuing back and forth discussions with the medical and operations department in Paris, she undertakes to develop an intervention proposal. To do this, she spends time with Likhaan, attends their meetings, follows their field activities and discusses the project. But it is she who writes the operation proposal, finalized in June: "Comprehensive Sexual and Reproductive Health (SRH) Programming in the Tondo Slums of Manila in Partnership with Likhaan, a local NGO". It will later be validated by a project committee meeting at MSF headquarters in the last quarter of 2015.

The project will run for 5 years. It intends to develop the activities of two existing clinics, which will be relocated to larger premises. In addition to the continuation and expansion of the health education and the family planning consultations already provided by Likhaan, the project includes new activities:

- Screen and treat STIs.
- Cervical cancer screening and treatment.
- HPV mass vaccination.
- A birthing facility including prenatal consultations, deliveries, post-natal follow up and an ambulance to refer complications (this fold of activity is included based on Likhaan's proposition).
- A mobile clinic to extend the offer to remote areas of Tondo.
- A centre for adolescents, including social and educational activities to encourage and facilitate their access to the medical services offered.
- Advocacy towards PhilHealth (the Philippine social security system) and the Manila health authorities to expand free medical coverage for reproductive health activities, especially for adolescents.

The project also aims to complete the process of accreditation of Likhaan with PhilHealth, which will eventually enable it to obtain funding for the delivery of care included in the health coverage, contributing to its financial autonomy and thus to the sustainability of its activities.

To put into perspective the image of MSF's unilateral imposition of its ideas, three elements should be mentioned. First of all, the proposed activities are standard. It is essentially a choice among usual services in the field of sexual and reproductive health. Secondly, some of the activities directly echo the suggestions of the Philippine association. Finally, the enthusiasm of Likhaan leaders for the perspective presented to them should not be overlooked.

For Dr. Junice:

"It is our dream to have integrated reproductive health services – contraception, including for adolescents, STIs, some degree of maternal care – in a primary health care setting, subsidized by social health insurance so that the poor can access them. And that our experience can be used to improve government approach, to demonstrate that it can be done, that it is affordable." (Junice, Executive director, Likhaan)

To a large extent the two organizations are aligned, their interests are converging and the operational perspectives stimulate both partners. Nevertheless, in the spirit and the method, something is being established during this initial phase. The project design process concedes a rather congruent space to Likhaan and carries an asymmetry in favour of MSF.

"I think there's something we somewhat failed on, and that is it's always complicated to jointly build a proposal when we don't know each other. Likhaan may have been a bit overwhelmed by MSF's 4,000 ideas of what we could do. Maybe we didn't listen to them enough, maybe we didn't give them enough space to express themselves on the initial proposal. It may have been built together, but not with the same input from both sides, it was with an MSF lead." (Eric, cell manager, MSF)

However, Likhaan should not be thought of as a malleable and ill-established organization. Along their way they have navigated through the requirements and constraints of funders, being opportunistic in seizing opportunities as long as these enabled them to pursue their goals.

The head of mission 2015 reminds it in her handover report:

"They are down to earth and so nice that it's sometimes easy to forget they are also hyper educated and politically savvy and they wield power in national politics. They are scrappy and grassroots, as well as political players tapped to address UN assemblies." (Head of mission, 2015, MSF)

It is interesting at this stage to look at the situation against the values that MSF stands for and which seem essential to most of its members. Since the 1980s, financial independence has been at the heart of the MSF project, felt as an element that may not be sufficient, but that is largely necessary to the relevance of the interventions. The influence that donors exert on the operational strategy of NGOs is commonly seen internally as damaging to the sector and ultimately to the quality of operations. But as soon as one dons the suit of the funder, the natural inclination leads to the operating methods that are being criticized.

Motivation of the partners

What are the respective motivations of Likhaan and MSF representatives to engage in a partnership in June 2015? Partnering is about exchange and mutual benefit. Each party contributes to the relation and in return also gains from it. Looking back, one thing is striking: when the decision is made to join forces with the Likhaan, little is formulated about the expectations from this alliance.

Beyond the listing of existing services and the idea of complementing them, the exploratory mission report from March 2015 simply notes that:

“Entering in the slums is sensitive and not easy, it requires a strong and fine knowledge and understanding of the socio economic context. Establishing a partnership with a local partner might be a milestone and leverage for the implementation of a project. Recommendation: Considering the complexity of the context and the sensitivity of contraception, we consider that working in a partnership with a local NGO is the most appropriate way to go forward.”

The proposal that will serve as the basis for launching the project does not further elaborate. It only states that:

“Starting in partnership with an established local NGO provides an exit strategy for the project”.

Besides these general formulations, there is no description of the partners, no analysis of their motivations, no description of their respective contributions or description of how they will be articulated...

Actually it should be said that the exercise is a difficult one. In practice, each party brings a great variety of assets to a project: its infrastructures, its financial means, its technical skills, the potential of each of its members, its history, its image, its reputation, its patients, its address book... The basket is too full to be detailed and for sure any prior description will overlook several contributions that retrospectively will prove crucial in the unfolding of the events.

Another limitation of the exercise is that of any foresight. There will necessarily be a difference between expectations and reality, either because of misrepresentation of the other, or because of behaviour that differ from what is expected.

That being said, analysing the motivations of the parties remains fundamental because this is the ‘raison d’être’ of the partnership. What does each party see as essential in the vast potential of his future partner?

Motivation of MSF for the partnership

In addition to the broad outlines of the initial proposal, some statements of MSF's motivation can be found in two documents written after the start of activities: an internal briefing note from February 2016 and a visit report from the cell manager and the deputy director of operations from January 2017.

Source: internal briefing document - 2016 02

Quite simply, MSF gets Access from Partnering with Likhaan, at several different levels.

- *MSF would not be able to access these populations without a local, respected player like Likhaan.*

There are groups focused on fanning “anti-imperialist” sentiment in Philippines born from colonialist history. [For instance] the pro-life movement (e.g., branding contraceptives, abortion and divorce as lifestyles being pushed by the West).

We gain a ‘fast-forward’ with respect to our accepted presence within these marginalized populations. Without Likhaan, MSF may simply be branded as just another foreign NGO trying to impose its will on the population.

Today we can enter into absolutely ANY area of the slums with no difficulty and have access to populations that no other international organization would.

- *MSF also gains access to contacts (Department of Health, Government, NGO, etc) but more importantly than the contacts themselves, Likhaan is able to provide the critical context of each contact – with an informational history on why certain people are important contacts and their*

respective influence, power in the Philippines. This depth of understanding with regard to “who’s-who” can only be mastered by people who have years (decades) of proximal experience to the people in question. Again, it’s not the only country where we must master our contact lists – but with Likhaan, we gain powerful insight that would normally take us years to obtain.

- *Likhaan is also present in Mindanao. The current governor and his wife are longtime friends of Likhaan when they were not yet in government. If MSF wants to establish itself in the Philippines, Likhaan is a strong partner in bridging the gap between our objectives and the local context in which we must master to reach our objectives.*

Source: Visit report - Deputy Operations director and cell manager - 2017 01

Interest for MSF:

- *Strong link with the community and easier access to the target population.*
- *Potentially sustainability of the achievements: a strong point of the joint strategy with Likhaan is the search for the PhilHealth (public social security) accreditation: when the Likhaan activities will get accreditation they will access state funding for medical acts performed and achieve financial autonomy and sustainability.*
- *Effective advocacy at the top level of the state.*

These motivations outlined in the various documents and testimonies cover the four reasons for engaging in a partnership, as identified by the Vienna Evaluation Unit. The report *"Enriched or confined - MSF engagement in local partnerships"* (2012) provides a typology of partnerships:

- To gain access.
- For the purpose of advocacy (provide a local, legitimate, political voice to pressure the government into making some concrete changes).
- As an exit strategy (to ensuring continuity of services in a post MSF-setting).
- To complement activities.

MSF expatriates that were involved in the launch of the project recall similar motivations, sometimes insisting on other advantages, such as:

- The great time gained by using the already established network of Likhaan, a health provider well-known in the slums. As mentioned by the Tokyo cell manager, “Several foreign organizations tried and many have hit a wall as they did not have the right contacts. Without network it would have taken us years”.
- The security provided by Likhaan’s shepherding in this unsafe environment.
- The occasion for MSF to test a rather innovative way of working.

What the stated motivations omit

The different accounts outlining MSF's motivations for intervening in the form of a partnership systematically omit a major reason: intervening alone would have been tremendously long considering the legislation. If this fundamental aspect does not surface, it is probably because it is implicit.

The work of foreign organizations as well as health care institutions is highly regulated in the Philippines. In times of disasters, provided the state declares a state of “calamity”, International relief organizations are authorized to operate with minimum procedures. It is in this framework that MSF previously intervened. Outside this state of emergency, the normal regulatory system applies and it is quite complex and restrictive.

Some actors at the time also mention the fact that in the aftermath of Typhoon Haiyan, in 2013, the massive influx of foreign organizations triggered a regulatory reaction on the part of the authorities wishing to channel them.

When launching the project in Tondo, MSF is in the process of registering as a social services operator, one of the relatively simple ways to get recognized among more complex options. However this status does not

give the right to provide healthcare. To do so would have required a long process, taking several months or possibly years.

Whatever medical project we would have done, be it NCDs, maternal health, TB or reproductive health, it would most probably have been through an existing local structure. If not with a local NGO, then with an existing health centre from the local health authorities. The real choice was therefore not whether to intervene through a partnership, but which partner to choose.

As highlighted in the research done by MSF Holland's Reflection and Analysis Network "How does MSF relate to local actors":

In most of the cases in this review, MSF worked with local actors because it had to (push factors), and not because it actually wanted to (pull factors). Its strong preference was to work directly and independently, in substitution, as a "Cavalier Seul". Its conceptualisation of why it worked another way, closer to local actors, was a predominantly negative logic, and lacked a vision of strong positive potential. It was only when its preference was obstructed that MSF found another way.

The situation here is different from what the authors from MSF Holland observed. Nevertheless, while there are many pull factors, there is also indeed an initial difficulty in intervening autonomously.

Motivations of Likhaan for the partnership

The two documents setting out internal motivations also identify, from MSF's point of view, those of Likhaan.

Source: internal briefing document - 2016 02:

- *Likhaan has grown from a tiny, grass roots NGO in 1995 to a recognized and respected player in Philippine Health and Women's Rights issues. However, they have not yet had to 'professionalize'. They are largely informal, non-hierarchical. A more focused and strategic approach would lead to increasing their effectiveness and quality health care. MSF can offer tools, methods and experience to help Likhaan provide higher quality medical care. MSF can draw on its wealth of management and strategic experience to help Likhaan move in the direction it would like to. In order to do this, Likhaan must agree to adapt their current methodologies to fit the paradigm of a professionally recognized and accredited organization.*
- *Without MSF, two of their existing clinics will close due to lack of funds (MSF is currently supporting the 2 Clinics since January 1st). It is possible that they search for other Institutional Funds, but since mid-2015, they have planned for MSF as a funding partner.*

Source: Visit report - Deputy Operations director and cell manager - 2017 01

Interest for Likhaan according to them:

- *Funding of operations that will allow them to apply for accreditation*
- *Ideas Debate Contradiction*
- *Image (MSF brand)*
- *Medical expertise.*

The MSF members involved at the time recall a few other key ideas:

"Initially, their interest revolved largely around abortion issues. They were really interested in having a technical medical NGO, not just in funding but in providing them with logistical support either in medicine or equipment." (Olivier, Head of mission, 2014, MSF)

"Likhaan was used to small amounts of money here and there from different funders. Our support was a very attractive package for a small organization with a tiny budget. We were talking about 5 years with a big budget, about purchasing a building. They could further their cause with MSF backing them up." (Jordan, Head of mission, 2016-2017, MSF)

On the Likhaan side, without archives it is not easy to identify their original motivations. Today, the directors notably mention the prospect of improving the association's medical standards thanks to MSF's technical expertise, as well as the opportunity to expand their healthcare offer.

"We knew we needed external help to develop our services. I'm the only doctor and I'm not an Ob/Gyn. MSF has specialists so my idea was that MSF would provide the medical expertise." (Junice, Executive Director, Likhaan)

Early 2016, project launch

At the start of the project in January 2016, the organizational and operational set-up of the activities foreseen in the proposal has not yet been determined. It is the responsibility of the initial project coordinators and their management to define the size and composition of the teams, the responsibilities of each team member and the practical modalities of cooperation.

At that time, the Tondo clinic is run by two nurses and two midwives who carry out about 900 consultations per month, mainly family planning. The space is cramped, partitioned and cluttered with equipment and furniture. Six community mobilizers attached to the facility cover Health District 1, which represents the poorest half of the slum along the port area. They organize information sessions on reproductive health and refer participants to the clinic's family planning services. They also run a network of volunteer community health promoters, Likhaan relays among the population. The clinic in San Andres is smaller, with one clinician providing about 200 consultations per month and three community mobilizers.

MSF's first concerns are to regularise its legal situation, i.e. to carry out the steps to register the association in the Philippines, and to draft the partnership agreement that will bind MSF and Likhaan.

Co-management mechanism

Both organizations agree that a joint Likhaan-MSF team will carry out the activities from both clinics. The directorates remain separate: MSF country coordination on the one hand, and Likhaan central office on the other hand, each of them also following other projects. For Likhaan, these include the four clinics supported by the NGO Interpares with funds from the GAC (*Global Affairs Canada*), the Canadian cooperation.

The co-management mechanism for the project is very little formalized. Apart from financial and administrative procedures, the partnership agreement signed in April 2016 essentially sets out three measures. In terms of steering, a 'coordination committee' bringing together the management of the two NGOs and chaired by the MSF head of mission meets quarterly to define the strategy and arbitrate unresolved issues. At the project level, a "*Field committee*" chaired by the MSF project manager meets on request for day-to-day management. For monitoring purposes, a joint activity report is produced by the *field committee* and transmitted to the *coordination committee*. The budget is split between MSF and Likhaan: roughly speaking, each pays its own staff, MSF takes care of investments and part of the medical supplies, and Likhaan takes care of recurring costs. To receive the funds, Likhaan must submit a monthly cash request to MSF.

This arrangement will be only partially implemented. While the *coordination committees* ("*Coco meetings*") are held on a regular basis, the "*field committees*" are replaced by day-to-day informal exchanges. As for the activity reports, they are produced by MSF and have only started to be shared with Likhaan since 2019.

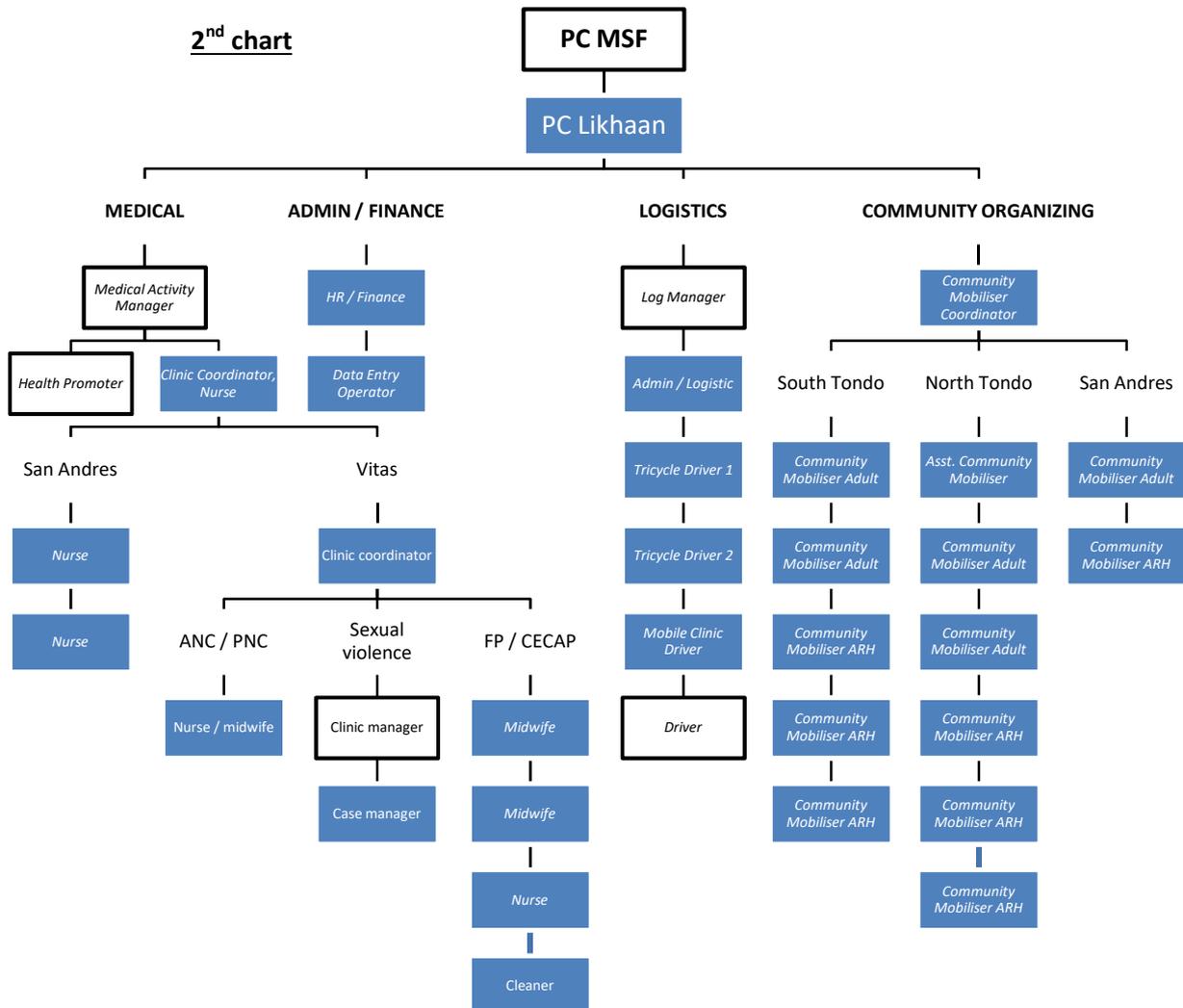
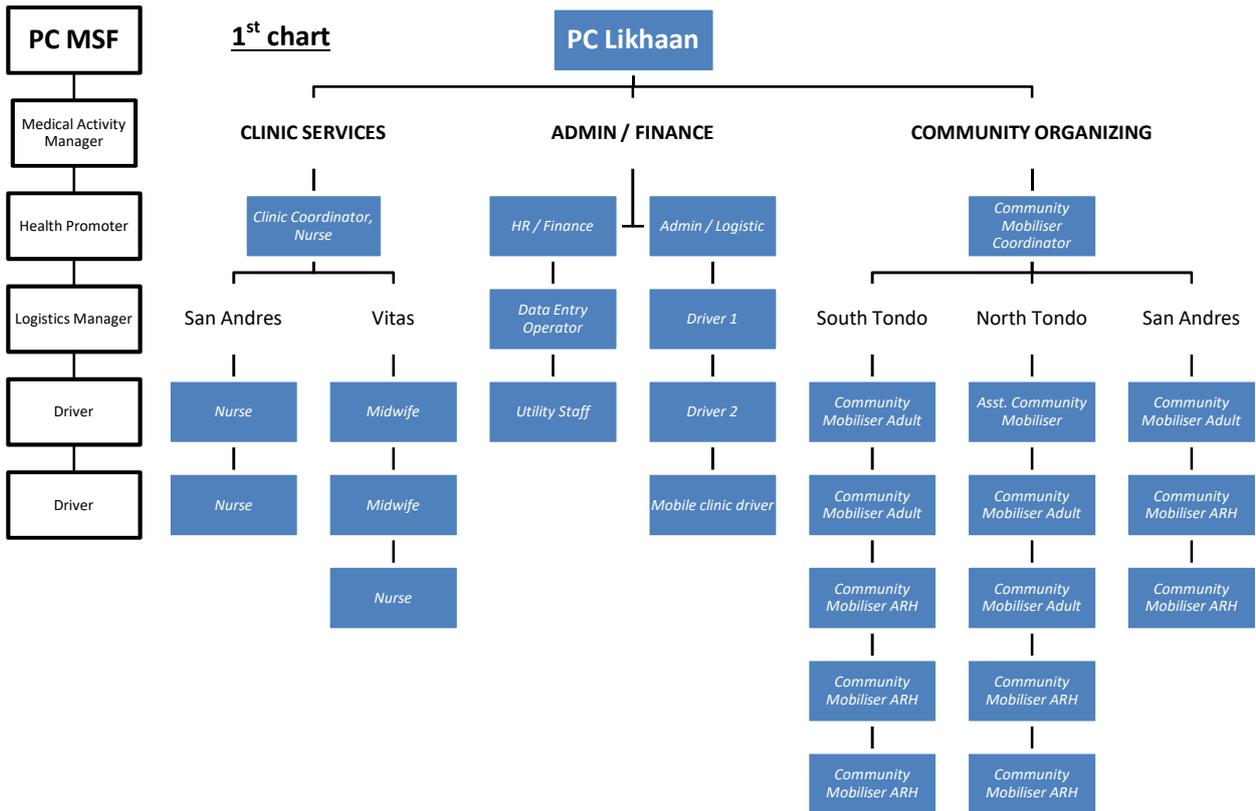
Building up the teams

The MSF team starts with two people and will gradually increase, as activities develop, to a total of eleven. There are between one and two permanent expatriates, plus occasional staff for short training missions or longer during the HPV vaccination campaign.

Likhaan's staffing for the two clinics increases from about 15 people at the start to just over 30 in 2020.

Despite the idea of a joint team, the initial organizational chart is distributed: MSF on one side and Likhaan on the other. Following a number of misunderstandings about communication and information transfer channels, a joint organizational chart is finally drawn up a little more than a year after the start of activities.

Organisational charts - beginning 2017



Its formalization reveals that not everyone had the same vision of the organization. The exercise is not simple and the result is similar to the classic MSF scheme: a pyramidal structure converging towards the project coordinator, with the originality that this management is two-headed: an MSF PC and a Likhaan PC assistant. The structure is then divided into four departments: medical and logistics under MSF managers, community mobilisation and administration under Likhaan. Within this structure, a part of the Likhaan employees are under the supervision of MSF managers.

According to Jordan, head of mission in 2016:

“We went into that, knowing that it would be quite difficult to have these two parallel systems. With this sort of mixed teams there’s who’s your boss on paper and who’s your boss actually. Maybe the bosses on paper weren’t necessarily the boss, not having the final say or not giving the leadership. That proved difficult of course. We knew that, but we would try as much as possible to create an environment where we’re more working together and eventually people don’t care if you’re MSF or Likhaan. We struggled with it but it wasn’t a surprise. We have to change our MSF psychology, to release a little bit of the control that we like to have. That highly depends on the personality of the people in place.”

Setting up activities

In addition to continuing existing services, the MSF and Likhaan teams approach institutions that can provide medical training for clinicians, especially on cervical cancer and sexually transmitted infections. They also initiate the preparatory phases for a HPV vaccination campaign. They also look for new premises to relocate the clinics, which is essential for the expansion of activities. In the meantime, a series of refreshment, fitting-out and safety works are being undertaken in the Tondo clinic to improve working conditions and patient care.

At the end of 2016, the cervical cancer activity is launched, with the provision of cryotherapy equipment to the clinics and initial training in screening and treatment techniques. Community mobilizers are also trained on this topic to conduct patient enrollment sessions.

At the same time, throughout 2016, the teams deepen their reflection on the perspective of dealing with sexual violence. To this end, they meet with the actors involved in this issue, discuss protocols and evaluate recruitment possibilities.

This completes the first year of the project. We will see how thereafter the different "pillars" of activity, as they are called, have known their own destiny.

Panorama of activities with varying fates

Within the project, each component of activity has followed its own pathway, smooth or knotty. Some have been very successful, some have had mixed results, and some have been difficult. One has even been abandoned in the middle.

Without seeking exhaustiveness, we will develop a narrative of a few selected activities, emblematic of contrasting scenarios and destinies. The idea is to shed light on the interactions, the collusion of interests, the alchemy that allowed certain facets of the project to succeed. Or, on the contrary, to see what dynamics, what misalignments between the partners have hindered their deployment. More than the results, which are project-specific, it is the observation of processes that can inspire others.

In this exercise, we will refrain from judging the success of activities based on an ex post reading of their relevance or design. In that respect, we will follow the recommendation of Bruno Latour and the thesis of Albert Hirschman.

*“Success and failure must be treated symmetrically.
If we say of a successful project that it existed from the beginning because it was well designed and from a failed project that it fell apart because it was poorly designed, we say nothing. We are just*

*repeating the words "success" and "failure" placing the cause of one or the other at the beginning of the project, at its inception."*¹

*"All projects are problem-ridden. The only valid distinction appears to be between those that are more or less successful in overcoming their troubles and those that are not."*²

Family planning

This is the historical activity of Likhaan, which was only marginally influenced by MSF. Supplies come from the Ministry of Health. MSF's main inputs were hygiene procedures, funding for certification training of new clinicians, and the provision of emergency contraceptives not available in the Philippines. The volume of activity remained remarkably stable at around 1,100 consultations per month. However, once the Department of Health began to provide implants with a three-yearly renewal, this number of consultations enabled more patients to be covered (due to the spacing of visits per patient). Among new patients adopting a contraceptive method, about half opt for implants, 20% for injectables, 20% for oral contraceptives, and 5% choose the IUD.

From 2016 to 2020, Likhaan was able to complete the lengthy accreditation process with PhilHealth and the two facilities in Tondo and San Andres are now recognized as "family planning clinics", entitling them to reimbursement of care by the social security system.

For this family planning component, MSF has taken on a role of facilitator for the activities organised by Likhaan, providing occasional support to fill in gaps. This complementary and non-intrusive way of working has made collaboration easy.

For MSF, what has been achieved throughout the project – over 1,000 consultations per month since early 2016 – is significant for two reasons. It is obviously a satisfaction to have contributed to this important service for the women of Tondo and San Andres. But it is also an important lesson to witness the scope that family planning can take - even in a context where the issue is sensitive - when the promotion component is carried out seriously. With its modest size, the project in the Philippines accounts for more than a third of the family consultations carried out by MSF France around the world. The contribution of the vast network of volunteer health promoters to this result would be interesting to explore. The model put in place here provides a learning opportunity for the association.

Cervical Cancer Screening and Treatment

The objective of this leg of the project is to implement the single-visit approach. The principle is to offer a diagnosis followed by immediate treatment in a single consultation. In concrete terms, this involves a visual inspection by applying acetic acid to the cervix to reveal potentially cancerous cells. These lesions are then frozen and eliminated using a small instrument, a technique called cryotherapy. This process is particularly valuable in settings where continuity of care is complicated, such as in the Tondo slum.

At Likhaan, from the very beginning the teams are convinced of the relevance of the approach and the prospect of being able to offer treatment to the women is exciting.

"Among the staff, all had known someone in their community who has died of cervical cancer. They wanted to provide this service to the community." (Head of mission, 2015, MSF)

"They had never dreamt about treating cervical cancer, they were excited." (Jordan, Head of mission, 2016, MSF)

¹ Latour B., 1992, p71-72, *Aramis ou l'amour des techniques*, Paris, La Découverte.

(quoted by Lavigne Delville, *Un projet de développement qui n'aurait jamais dû réussir ?*, Anthropologie et développement n°42-43, 2015.)

² Hirschman, 1967, *Development projects observed*, Washington D.C., The Brookings Institution (quoted by Lavigne Delville, *ibid*)

"In the integrated package, cervical cancer was very helpful to us, we are really grateful about it."
(Dr. Junice, Executive director, Likhaan)

Before that, Likhaan was already testing for cervical cancer, using smears that they sent to an outside laboratory. MSF analyses the results and questions the quality of the analyses. Just as the collaboration begins, this demonstration of competence is instrumental in convincing people of the added value of the association.

"MSF challenged it and it proved right. This demonstrated early in the process that MSF had positive impact on medical aspects." (Jun, Program director, Likhaan)

MSF equips the clinics with cryotherapy equipment and brings in an expert from JhPiego (*Johns Hopkins Program for International Education in Gynecology and Obstetrics*), a pioneering institution in the single-visit approach, to provide initial orientations. Then each year a group of 3 to 5 clinicians is certified by the *Philippines Cervical Cancer Prevention Network*, which provides one week of initial training followed by 6 to 9 months of supervision.

In 2017, MSF's logistics and medical teams transform a truck into a mobile clinic to serve isolated areas of the slum, increasing the number of cryotherapy sites to three.

Gradually the number of patients tested increases, from 70 per month at the launch of the service to nearly 400 by the end of 2019, with detection and treatment quality deemed satisfactory by the *medical team leader* (MTL) and positivity rates within WHO standards.

MSF teams recognise the great effectiveness of Likhaan's community mobilisers. These organise sessions by criss-crossing the slum. The topic is delicate. However, they manage to explain what is at stake in a way that immediately after the session, some of the women ask to be tested. They then board the Piaggio tricycles, designed by MSF to navigate the narrow alleys, and go to the clinic. Among those who test positive, less than 10% refuse treatment. In the same morning they are back home, after possibly also having undergone a family planning consultation and, if necessary, a symptomatic treatment in case of sexually transmitted infections.

The objective of this activity component is not to reach a certain population coverage, but to implement and demonstrate the feasibility of a model of care that is effective, simple, inexpensive and replicable. In the traditional Filipino health system, diagnosis can be made in primary care facilities, but treatment is provided in hospital. Here all is done in the clinic and by nurses and midwives.

In mid-2019, the results achieved in Tondo are jointly presented by MSF and Likhaan at the 8th "HPV summit" in Manila. The event is a landmark as it materializes the recognition of the actors of the sector for the achievements of the project.

In their vision for the future, Likhaan would like to integrate this service in all their clinics. For Claire, MSF's medical team leader ('MTL'):

"I don't think there are other nurses or midwives in the Philippines who have done as many screenings as the ones of Likhaan. For me they have gold in their hands."

The *Cecap* (Cervical Cancer Prevention) embodies a virtuous process where MSF and Likhaan share an initial diagnosis, bring each a know-how recognised as legitimate by the other - technical expertise for MSF, community network for Likhaan - and observe concrete results that validate the actions undertaken. As a bonus, a series of symbolic moments, such as the *HPV summit*, have contributed to the common interest and mutual respect of both parties. The combination of these ingredients for success allowed this activity to develop and become one of the solid foundations of the project.

There were, however, elements that could have led to the disintegration of the activity. For example, the fact that the care is not financed by PhilHealth and that the cost of human resources needed to carry it out is not negligible. But in this case, the positive forces of aggregation of interests and energies weighed much more heavily than the pitfalls.



Mobile clinic truck, 2019

© Melanie Wenger

The BEmOC

The BEmOC (*Basic emergency obstetric care*) is yet another scenario. On Likhaan's proposal, the activity had been added to the initial proposal, with the main objective of contributing to the long-term financial plan of the association. Indeed at that time the smallest possible level of accreditation to enter PhilHealth's reimbursement scheme was that of a *birth centre*.

The lumpsum fees for deliveries were expected to be sufficient to cover the costs of the service and to provide an additional margin for other clinic expenses. In 2016 the head of mission was optimistic that the clinic would be eventually 80% self-sufficient, leaving only 20% of the budget to be funded by donors.

At the end of 2017, a midwife, consultant for MSF, carries out a study prior to the launch of maternity care. In her conclusion, she considers the service irrelevant as it duplicates existing offers. In addition, one of MSF's main motivations was to provide care for pregnant minors, who are routinely stigmatised in health facilities. However, new national standards now compel minors to give birth in hospital, making it impossible to care for them in primary clinics. The MSF consultant therefore recommends giving up the idea of maternity and opening only an antenatal care service.

As for Likhaan, a closer look at the standards for accreditation of maternity wards reveals the need for costly investments and the calculation of expected revenues no longer seems so interesting. On the other hand, the PhilHealth rules have changed, introducing the accreditation of "family planning clinics".

MSF and Likhaan had come together on a shared project, with different objectives. This project is finally abandoned by mutual agreement, but again for separate reasons.

However, within this history has come into play another scene showing the differences between the two organizations. This scene is emblematic of a misadjustment that remained largely unthought of. What is it? MSF and Likhaan had agreed to open a maternity ward. The head of mission in 2015 had taken care to discuss this with Jun and Dr. Junice.

But the two organizations speak from very different perspectives. It's this unthought backdrop that has suddenly come up. While Likhaan carries out deliveries in two of its clinics, it does so on a very small scale and with very limited staffing. But when the discussions about the maternity ward started to become concrete in 2016, MSF began to talk about a structure of almost eighty staff. MSF and Likhaan leaders were not thinking of the same thing when they said "maternity". In the end, the project did not get off the ground, which eliminated the difficulties that were looming. But we will see later that these differences in perspective not taken into account had repercussions on the collaboration.

Sexual violence

From the first months of activity, the MSF team considers the issue of sexual violence and proposes to add this component to the project, which will be done through the partnership agreement signed in April 2016.

"That was very central to MSF interest. From statistics we knew SV was a huge burden in the Philippines. Matching that with the desire to run a comprehensive SRH program and the fact that we have quite an experience in other countries, made it appear as a natural add-on. It was even thought that once you open the door we would be flooded with cases." (Jordan, Head of mission, 2016-2017, MSF)

For her part, Dr. Junice is not convinced of the extent of the need:

"We had a debate with Jordan about the high expected outputs. He was saying «there's probably a lot of sexual violence but you are not seeing it». I replied «We have been here since 1995, what we have is domestic violence rather than sexual violence cases»."

In July 2016 MSF contacts the child protection unit at the Philippine General Hospital. The director confirms that they receive 350 sexual violence victims a year from Tondo and estimates that the number of actual cases is probably ten times higher.

Considering MSF's strong motivation, Likhaan agrees to test the activity:

"We expressed our apprehensions about the magnitude of consultations. Besides, in my experience, SV victim-survivors would prefer to talk directly to doctors and psychologists rather than confide with community mobilizers. But we agreed to work on it. We thought: MSF has a rich experience in sexual violence in Africa, let's see how it will be in the Philippines. We decided to be experimental and let the project settle the differences." (Junice, Program director, Likhaan).

Or, as Jun, the program director puts it:

“We would say «let’s try», with a sort of agnostic stand.”

The medical activity manager MSF and two Likhaan clinicians follow an online training course and a first presentation is made to the teams in November. Then the sexual violence referent from the Sidney unit visits the project to conduct the initial training sessions. However, as the months pass, no cases is referred to the clinic.

The activity report for the first quarter of 2017 notes that:

There is still recalcitrance from the part of Likhaan with regard to these services. They were not convinced that Sexual Violence is a problem, and even felt ‘confronted’ by MSFs drive to provide services in this area, even though this has always been a part of the plan from the Partnership.

MSF continues the trainings with an expatriate clinical psychologist and reinforces the instructions to the teams. Six months later, in September, the statistics are still at zero. Community mobilisers are reluctant to raise this subject during their sessions and MSF is gradually taking note of the fact that they are personally uncomfortable with a phenomenon that often occurs within the family circle.

The move to the new premises, in July 2017, allows for the expansion of the team. Two people are recruited to work exclusively on sexual violence: one on an MSF contract and one on a Likhaan contract. At the end of 2017, they finally receive their first cases, but it remains anecdotal until May 2018. From mid-2018 to mid-2019, from 5 to 10 patients per month come to the clinic, then around 15 in the second half of 2019. These victims are mainly identified and referred to the sexual violence team, either by in-house clinicians or externally by partner organisations. During the year 2019, this team will be reshuffled: a series of resignations and recruitments will lead to a team entirely under MSF contract from September 2019. From then on, the three rooms dedicated to sexual violence will form a purely "MSF" entity within the clinic.

Many explanations are given by the MSF teams to explain the difficulties of this activity to take off. Here are some of them. MSF's approach focuses on "sexual violence", whereas Likhaan's tendency would be to refer more to violence against women in general or domestic violence. / The topic is sensitive, with cases occurring within the family circle, making it difficult for community mobilisers, who are often familiar with their interlocutors, to address it. Moreover, they themselves are not immune to this potential violence. / The type of communication required for this topic does not fit with the techniques of the mobilizers, who are used to "fishing for clients" for the clinic. For family planning and cancer screening, their contribution is quickly and directly measurable, and therefore rewarding, in contrast to the hypothetical medium-term effect of raising awareness of sexual violence. / The fact that MSF is not in charge of community work makes it impossible for MSF to organise and supervise the community mobilisers to implement the activity. / At the clinic level, sexual violence is an additional activity that clinicians are asked to carry out, without any financial compensation.

No doubt there are real issues to be taken into account in this litany of explanatory factors. But objections or proposals can also be raised for each of them. All these difficulties appear more like the consequence of deeper divergences of opinion.

An Na, MSF project coordinator early 2018, analyses:

“For this activity it was mainly our decision, they didn’t get much involved in that part. The strategy was discussed, but the decision was ours. It was always a debate in the coordination meeting: they expressed their concerns and we answered. We try to convince them until they say yes - you know, typical MSF approach.

Even though they agreed, they don’t want to scale up this activity. It is something they are still in doubt. They agree to address GBV through health promotion and to guide people to other organizations where they will get services. But they don’t want to do it by themselves. There are medico-legal procedures, you need to keep certain documents, and Likhaan doesn’t want to cover that part. From Likhaan’s perspective, even though we would demonstrate we can get more cases, they don’t want it. For them it’s out of their scope.”

If we count the costs and benefits of the sexual violence component as it is designed, what do we see from Likhaan's point of view? In the cost column, we have community mobilisers, an additional clinician, a well-paid counsellor, and post-exposure prophylaxis treatment, which is difficult to obtain and expensive for a facility that is not HIV-accredited. In the benefit column, we have a new activity that is not very obvious in terms of need, ineligible for PhilHealth reimbursements, and for which there is not yet evidence of interest from potential donors.

One can understand Likhaan's initial wait-and-see attitude, which was reinforced by the total absence of results for more than a year, followed by a very timid start. But from MSF point of view, the activity cannot take off without the strong will of Likhaan and the strong involvement of its community mobilizers. The snake bites its own tail.

In the last year of the project, the question of Likhaan's takeover arises. And the teams have difficulty understanding each other.

For their part, the Likhaan teams affirm that they have committed themselves without hesitation to this field of activity and that the low level of consultation is in line with the initial diagnosis and the time needed for a new service to take off:

"We are on different wavelengths. MSF is saying let us do it at a high level because we have done it before. Likhaan is saying let us do it slowly because we have not done it before. You would call this failure, I would call it a longer « incubation » time considering the difficulty of the issue." (Junice, Executive director, Likhaan)

For Claire, MSF's MTL:

"What I find hard is that there is a dialogue of mutes. Things aren't being said. For months we've been asking them what they want to keep. If they told us that they were sure not to continue with the SV, we would tell them OK, fine, when it's over we'll stop. But they never say that. So I am developing it as an MSF activity, but I know that tomorrow it will certainly fall apart. I don't want Likhaan to cease to exist because we handed them something too big. But at the same time it's hard to know what they want. I think it's a bit cultural: not to offend the other person. Is sexual violence something they want? I don't think so, but it's never said. They keep telling that it depends on funding. I don't think they dare say they're not interested."

Community mobilization - A progressive separation of duties

An important reason for MSF's interest in working with a Filipino organisation is the knowledge and access to the population it provides.

"Our interest was the challenge that we have had in the past in urban environments and finding a way to integrate with the community. It would make for a successful intervention to go with a partner who had such deep roots and access to the community, as opposed to MSF coming in and trying to build a system like that from the ground up. With SRH it really has to be peer to peer and urban environment in that kind of neighbourhood has to be peer to peer as well." (Head of mission, 2015, MSF).

Over the past 20 years, Likhaan has developed strong skills in community mobilization. For 7 years, since the opening of the clinic in Tondo, they have built a large network of volunteer *community health promoters*, residents of the slum. These provide information on sexual health and the clinic's services to their acquaintances. They are Likhaan's permanent relays in the different neighbourhoods, on which the *community mobilisers* can rely.

The *community mobilisers*, employees of Likhaan, are organised in teams. Their activities are diverse. One is to refer patients to the clinic. The slum is divided into sectors, which are methodically covered. Each day, a team goes to one of them. In connection with the clinic and depending on how full the waiting room is during the day, they conduct information sessions and refer people for consultations using the tricycles. Another team precedes and accompanies the movements of the mobile clinic truck, in order to inform in advance the area authorities and local residents of its presence, and then to organize the flow of patients.

Finally, they conduct group information sessions with partner social support associations, as well as targeted individual sessions.

MSF teams unanimously recognise the effectiveness of this network. All are convinced that attendance at the clinic, use of family planning and acceptance of cervical cancer screening are made possible by the work of community workers.

In the early stages of the project, MSF becomes involved in this component, both regarding the content of the sessions and their organisation. The medical activity manager conveys the medical information to the team of mobilisers and periodically accompanies their sessions in the slums. MSF also recruits a social worker, in charge of providing training to the team, producing awareness-raising materials and participating in the organisation of the mobilisers' work.

But Likhaan feels that community work is neither a strength nor a priority for MSF. While they recognise the medical expertise of the teams, they question their added value in community work.

“The community mobilizers are the foundation of our health services. MSF does not understand their role, this is new to you” (Junice, Program director, Likhaan)

For Likhaan, while community work is the foundation of their organization and the key to the program's success, it is also its most complex component.

“Our services are primary health care, where medical technology is easy. Gaps are not because of medical difficulties, but because of social difficulties. Achieving socio-cultural changes is complicated; it requires strategy and a different mindset, medium to long term.” (Jun, Program director, Likhaan)

“The CHPs are our eye, ear and connection to the people. But to get people volunteer for SRH, when a lot of women are very conservative, is not an easy thing.” (Hope, PC Likhaan, 2016-2019)

It turns out that the people put on the front line by MSF to co-organise the community component have, it is true, little expertise in the field and therefore little legitimacy. In reaction to the increasing space that MSF is taking up and wishing to retain control of this activity, which is the foundation of their identity, Likhaan reaffirms its pre-eminence and reasserts its leadership of the team.

“To do trainings of CMs, you assigned staff who did not have that skill. Community work is Likhaan’s work. Why in the world are you asking someone to train our CMs when we have higher skills? That was one part that we had to ask MSF to change” (Hope, PC Likhaan 2016-2019)

“Your social worker asked community mobilisers to report to him. We asked this to stop. We agreed that on the medical side, MSF would be the lead organization and on the community side we would be the lead. Let’s defer to each other’s expertise.” (Jun, Program director, Likhaan)

A few points of contention add to the tension. MSF's 'medical' staff set rules that are felt as a lack of recognition of the role of the mobilisers. Thus the introduction of medical confidentiality rules reduces the information to which they have access. Limits are also set on the level of medical detail that they are allowed to provide during sessions with the population, being non-clinicians.

These "limitations" are symbolically significant because, as Hope emphasizes:

“Our CMs were trained as community health workers. When Likhaan did not have nurses, they were the ones manning our clinics, giving the pills and injectables”.

The division between the medical team, under the responsibility of MSF, and the community team, under the responsibility of Likhaan, is gradually crystallizing.

Ruth, Medical activity manager MSF recalls:

“Initially we were engaged in the community mobilisation, but as the time passed we got detached.”

To the extent that during their 20 months of mission, the PC and MTL arrived in mid-2018 did not attend a single one of the sessions conducted by the mobilisers in the field. It is clear, “we have no responsibility for this activity whatsoever”.

Nevertheless, on a day-to-day basis, relations are good. Communication is easy, there is no difficulty in organizing work sessions. But the strict decision-making and managerial boundaries that have been erected lead to frustration.

“We can't get the CMs to do things we want them to do” (PC MSF).

This is particularly the case for the sexual violence component, which, from MSF's point of view, has really suffered from the weakness of its awareness component. In this regards, by mid-2019, the MSF team has considered – and then dropped – the idea of recruiting a separate team of community mobilisers, specifically dedicated to this component.

The other activities

Other activities are carried out under the project: HPV vaccination campaign, sexually transmitted infections, antenatal care, adolescent programme. As stated earlier, the intention here is not to provide a systematic and comprehensive picture, but to highlight some emblematic and instructive paths from the partnership's perspective. For more details, further information can be found in the mission reports.

Overview of annual activities	2016	2017	2018	2019
Family planning - consultations	12 222	12 374	12 391	14 655
VIA (Visual Inspection w/ Acetic acid)	220	1 438	3 629	4 352
Cryotherapy	11	74	123	288
STI (TTT)	N#A	124	218	275
Sexual violence - consultations	N#A	7	65	128
ANC/PNC - consultations	N#A	15	1 729	1 123
HPV vaccination (Human papilloma virus) - Num. of doses	N#A	22 096	N#A	4 022

Qualifying the relationship

Partnership at MSF

In all documents, the relationship between MSF and Likhaan is referred to as a partnership. The set-up of the project in the Philippines does indeed correspond to the definition given to this term by MSF. In *“How does MSF relate to local actors?”*, MSF Holland describes three levels of interaction:

- A relationship is a broad category that includes information-sharing, coordination and any and all other manner of contact.
- A collaboration is a relationship that has a common and shared objective as well as activities towards that objective, but rather informal and little structured.
- A partnership is a specific type of relationship that is based on common and shared objectives and activities and which is structured, negotiated and formalised to some extent (e.g. via a project MOU).

In its study *“Enriched or confined? MSF engagement in local partnerships”* of 2012, the Vienna evaluation unit goes further and proposes another definition:

“MSF-partnerships are mutually beneficial, planned and formalized alliances made with diverse organizations who espouse the same humanitarian values to achieve commonly defined objectives.”

This definition is followed by a clarification, on which it is useful to dwell. The authors of the report point out that the *objectives* of the partnership itself, to which the definition refers, should not be confused with the *motivations* of the partner organizations. Objectives are common goals and outcomes that are jointly defined and agreed upon by the partners. Motivations, on the other hand, relate to the internal strategy of the organization in relation to what it wishes to achieve through the partnership. As we have seen, in the present case these motivations have been little articulated.

A terminology that is not so important

It is interesting to note that the project actors do not seem to give much weight to terminology. While all official documents use the term 'partnership', a variety of terms are used verbally by the different interlocutors: co-management, cooperation, collaboration. This has never given rise to debate or been a particular issue.

Words have their importance and are not equivalent, but ultimately it seems that it is not these broad, encompassing categories, that help to think about the relationship.

Making a parallel with joint-ventures

Taking a step aside, towards the industrial and commercial sector, a parallel can be drawn between this project and *joint venture* (JV) arrangements.

A JV is a cooperation agreement in which two or more companies agree to pool resources in order to accomplish a specific task. In a JV, the two parties do not form a single entity, they simply establish a complementary partnership in terms of objectives, strategy, operational capabilities and/or market access.

JVs can bring together large or small companies to take on one or more projects, large or small. They can adopt any legal form, the most important being the agreement document, which sets out the rights and obligations of the partners.

A common use of JVs is the penetration of foreign markets. A company wishing to expand into a new country can enter into a JV agreement with a local company to benefit from an existing network. This is also useful in the case of countries imposing restrictions on foreigners.

There is an interest in performing this comparison. Indeed, while there are few reflections, documentary resources or methods concerning humanitarian partnerships, the literature on joint ventures is more

extensive. Among the classic toolboxes of the sector comes the "due diligence" approach. We will explore this notion in greater depth in the chapter "The due diligence approach".

The collaboration strategy

The May 2015 proposal includes a SWOT (Strengths, Weaknesses, Opportunities and Threats) analysis. Among the weaknesses, it mentions "MSF capacities to work in collaboration". From the outset, therefore, the challenge of developing a project in close collaboration with another association is on everyone's mind.

This is also the case for Likhaan. Jun, their program director, remembers:

"We knew what we were getting into. We have different ways of doing, with different time cycles, different resources, different capacities. I was expecting troubles, but also an interesting partnership."

In the face of this awareness, which methods have been developed to prepare the ground, avoid pitfalls and steer the partnership?

The proposal gives no indication on this aspect. Likhaan is only mentioned through a very general presentation, through an 8-lines box, and a note on the exit strategy. If these short passages were to be removed, the document could almost describe a project carried out autonomously.

If we now turn to another key document, the partnership agreement, as we saw earlier it is essentially legal and contains very few clauses on the modalities of collaboration.

When questioned afterwards, some of the project's stakeholders argue that it is important not to frame with overly rigid provisions the relationship between two entities that are getting to know each other. They prefer an ad-hoc co-construction of the partnership modalities, as experience develops.

During the course of the project, however, there is no trace of an analysis of the collaborative arrangement, a description of the problems encountered or a proposal for adaptation. There does not seem to have been a milestone or joint workshop to take stock of the collaboration.

Monthly reports sometimes indicate difficulties, but briefly and without developing an analysis or proposal. As for the end-of-mission reports, they are superficial and vague. If we take, for example, the reports of two successive project managers, all of the findings and recommendations appear in these lines:

Handover report, PC MSF (nov 2016 - jan 2018): "This relationship is and will remain as 'work in progress'. It will need a lot of tact and patience! Each party has its own working style and organization, so both parties are continuously improving the working relationships."

Handover report, PC MSF (jan - june 2018): "Overall, the relationship is continuously improving, although due to organization culture difference, it still needs lots of patience and diplomacy to ease the misunderstanding in the project."

Of course, whether through formal meetings or informal discussions, the protagonists inevitably had to organise their relationships and make arrangements for difficulties that arose. They planned, debated and decided together on strategic, operational, financial and HR issues. In short, the partnership was built, but in a rather reactive and non-formalized way.

With a distanced overview of the development of this project, we can propose some ideas to help think about the building of a collaboration strategy.

The due diligence approach

The *due diligence* approach is promoted in the industrial and commercial fields, as a preliminary exercise to the realization of joint ventures. This step is considered to be an essential precondition for the conclusion of an agreement. Due diligence is the investigation through which the parties want to get to know each other. The objective of this exercise is to add depth and texture to the initial image of the partner company and its strategic motivations. It has several components:

- The main goal is to assess what each party brings to the table to ensure that it is mutually beneficial.

- Beyond the partner's history and past achievements, it is a forward-thinking exercise that looks at the partner's trajectory to understand its potential and future goals.
- It also includes observing how the partner thinks: its corporate culture and decision-making process.

What was done on the project in the Philippines? MSF's initial assessment of what Likhaan brings to the joint project is essentially an inventory of the services offered in their clinics, of their community network and of their involvement in advocacy. On the Likhaan side, what is glimpsed of MSF is the association's reputation, its expertise as a medical actor and its financial contribution. These few mutual recognitions are complemented by a common interest in developing existing services, as well as a shared vision of the right of individuals to access to all modern means of reproductive health, without discrimination.

Apart from these broad outlines, the respective motivations of the two associations are not made explicit. There are only scattered fragments in a few documents subsequent to the start of the project.

The history of Likhaan is little explored, the culture of the organization even less so. Even after years of working together, MSF's knowledge of Likhaan's internal organisation, hierarchy and decision making processes remains rather sketchy. On some aspects it is limited to a few general and vague ideas:

"They have endless meetings where everyone has the right to speak, a functioning inspired by their activist background." (Cedric, Project Coordinator, 2019, MSF)

"Likhaan members are former rebels. They fought authority figures and keep this spirit until today. This almost anarchist orientation carries over in some parts of their professional life". (Jordan, Head of mission, 2016, MSF)

Similarly, some important aspects of Likhaan activities are not really well known by MSF teams:

"In terms of advocacy, I must admit we don't have a lot of information on what they do." (Cedric, Project Coordinator, 2019, MSF)

On the Likhaan side the situation is quite similar. Hope regrets it:

"If we could have levelled off our work culture, talk about what is the work culture of MSF, what is that work culture of Likhaan, that would have been better". (Hope, Project Coordinator, 2016-2019, Likhaan)

What can be said is that taking the trouble to formalize everyone's motivations, describe expectations, examine skills, explore identity and modes of operation, all of this provides valuable foundations in two ways. The first is to limit the unthought-of. The second is to help align the two organizations. In other words, it helps to understand each other and to tune up, more than mere formal presentations.

The point is not to imagine being able to make a precise radiography of the interlocutor from the outset, which would make it possible to know everything from the beginning and thus to plan everything in advance. It is certainly through action that we really get to know each other. What is needed, therefore, is initial work, but that extends throughout the activity with regular re-examination of the partnership's stakes and constant readjustment of what is known.

Regular milestones on collaboration

The approach that has been adopted of not rigidifying the modalities of collaboration through overly formal arrangements or too precise planning leaves room for adaptation and creativity.

This iterative and flexible approach could benefit from being combined with regular pauses, for example, on an annual basis, to take stock between the two organizations. Opportunities for exchange and analysis of the functioning of the partnership, the quality of interaction, satisfactions and difficulties. Workshops open to the expression of possible frustrations, misunderstandings or concerns. Moments, of course, also dedicated to review and discuss the nature and direction of activities.

Beyond the analyses and reorientations that the exercise allows, the habit of a critical exchange can contribute to making the dialogue more fluid and reducing tensions. It helps reduce drama in two ways, by getting used to the practice of dialogue and by serving as a regular safety valve.

There are periodic 'Coco meetings', moments of discussion in small committees, giving the opportunity to discuss current topics, usually frankly. But moments of hindsight and broad discussion are missing. During the preparation of the field visit for this review, a proposal was made to organise a collective MSF-Likhaan workshop to discuss collaboration. As this kind of approach is not usual, the mission expressed great reticence about the exercise, fearing that it could lead to a settling of scores or, on the contrary, to showcase speeches - sterile in both cases.

The question of sustainability

The question of sustainability is emblematic of all the complexity hidden behind a common objective. The strive for sustainability is obvious for both organizations, who share here a common purpose. This concern has been foreseen and prepared from the start. But we shall see that this joint objective in fact conceals as much potential for opposition as for convergence.

A short lived plan

From the very beginning of the project, the partnership with Likhaan was seen with the perspective of a withdrawal from MSF.

Concept note, april 2015:

Partnership with a local NGO from the beginning will make it easier to develop an exit strategy. Finally, when Likhaan is well integrated into the national health insurance scheme, MSF should be able to withdraw their support.

Even more positively, it is precisely the support of MSF that will provide Likhaan with the time and the means to access Philhealth accreditation, and thus their financial autonomy, a guarantee of sustainability.

"The entire plan about sustainability was to become PhilHealth accredited, which means that after 5 years, with maternity paying the most, all what Likhaan would have to do is to find another 20% from other funders to keep the services. PhilHealth would be replacing MSF as the primary funding source. It takes money to make money: to construct or renovate and take things up to the level to receive accreditation. They were slowly getting there but we could have been a faster track to phihealth funding." (Jordan, Head of mission, 2016, MSF)

At the end of 2017, the idea of opening a maternity ward is abandoned. The alternative accreditation as a *family planning clinic* completely changes the variables of the calculation, both in terms of operating costs and reimbursements. However, no precise new estimate is made. Philhealth will still be a source of income, but to what extent... the figures put forward are vague and the calculations are not detailed.

Accreditation is obtained at the end of 2019. Calculations of fee coverage remain uncertain - perhaps around 50% for the smaller clinics. Estimates for Tondo clinic have yet to be made.

In any case, the scaling of activities and budgets have never been based on a Philhealth financing plan or on the prospects of takeover by other funders.

A constant concern for Likhaan

For MSF, the aim is that the activities put in place and deemed relevant continue after the end of the project. This is integral to its exit strategy. For Likhaan, what is most important is the survival of the organisation and the continuation of useful actions within the framework of their mandate. The objectives of the two associations may coincide, but not necessarily.

With the financial support and involvement of MSF, the Likhaan clinics are scaling up, particularly in Tondo. The size of the premises quadruples, vehicles are purchased and a mobile clinic truck is built. Dedicated support services are created: logistics, pharmacy. The number of Likhaan staff in Tondo is around 30, and with those of MSF it reaches 40. A pivotal transformation for Likhaan is that MSF promotes staff specialisation. Previously, clinicians took care of logistics, administrative tasks, pharmacy, sterilisation or cleaning, they could also replace a community mobiliser on short notice. MSF's division of tasks initially caused reluctance, but eventually prevailed. Overall the changes are profound.

The gap between MSF supported clinics and the other clinics of Likhaan is significant, as each of these operates with 6 people only: 2 clinicians, 2 community mobilizers, 1 driver and 1 administrator.

Likhaan is involved in the transformations. They have validated the new activities; they are the ones who recruit and pay the staff. But it is MSF that is the driving force and Likhaan is worried about being dragged into operating modes that are unsustainable in the medium term.

Throughout the project, Likhaan leaders have expressed concerns about the scale of the project and their ability to find funding to sustain it in the future.

"We wanted to increase services on all fronts. That implied a significant increase in HR and they were nervous about how big the team would be. Down the road that's HR that cost the most and they were hyper aware of it. Our standard ratios were far more than what they were having, we wanted to increase also for quality reasons." (Jordan, Head of mission, 2016-2017, MSF)

"Their main concern is how to make the expanded clinic sustainable. If they could provide the same services they would like to, but they repeatedly told me that if they couldn't find the funding they couldn't keep the same size of project. When we had our regular coordination meeting they remind us the challenges they would face, mainly the HR and the rent, the maintenance fees of the building and vehicles." (An Na, project coordinator, 2018, MSF)

In 2018, one reaction impressed the logistics coordinator:

"A second customised mobile clinic vehicle was budgeted. They turned it down because they didn't think they would be able to maintain it after our departure. I found it remarkable that they did not accept it, thinking that they could always sell it afterwards".

From Likhaan side, the impression is that the two organizations do not speak from the same point of view. It is a matter of culture, standards, perspective. The financial and operational gap between the two organizations stands out clearly.

For Leena, Likhaan's community mobilization coordinator:

"From my analysis, the cost per patient is worthy of a luxury clinic, it will be hard to explain to a future donor that this number of patients costs 22 million pesos."

For Arnold, medical coordinator Likhaan:

"We acknowledge MSF commitment to quality. But we wonder: what about after MSF?"

For Jun, program director Likhaan:

"MSF is used to doing big things for short periods of time while we do small things on long periods. It could have been bigger: Jordan was preparing for more than 80 staff. We pushed back, we said we couldn't sustain this. But looking back, it could have been even reduced further. For the same amount we would have preferred a longer project at lower scale. But this is with a retrospective view."

And somehow the head of the Tokyo cell is in line with him, at least on the question of duration:

"If I had to do it again, I would propose a project over 7 years and not over 5".

Hope analyses differences in priorities:

"If you're ending a project, how would you like it to end? With a bang! Meaning this is successful, we have met the goals. But what about the sustainability?"

Moreover, for Jun:

"We are constrained by our funding and MSF isn't very sensitive to that."

Claire, MTL of the project for MSF in 2018 and 2019 has the same interpretation:

"We are in two completely different visions. From our side, we see what actions we want to do and then we mobilize the means. From theirs, they consider what means they have and then what they

can do with those means. We talk about the sustainability of medical activities, they talk about the sustainability of their NGO. We are not fighting the same battles. I understand that they have many questions, they have a responsibility: they set up an NGO, they don't want it to collapse. Somehow we don't take ownership of this problem. When we make a building too big, when we put air conditioning in all the rooms, it's true that we don't realize what it means to them."

The blunder of the building

From the conception of the project it was agreed that expanding the services offered at the Tondo Clinic would involve moving to larger premises.

Transforming an existing building into a clinic involves substantial modifications. In addition, the electrical and sanitary systems must be brought up to medical standards. Moreover, the general state of buildings in the neighbourhood implies major renovations. In this context, a purchase seems more appropriate than a rental, which is what is envisaged in the June 2015 proposal.

At the end of 2015 the team begins negotiations with the owner of a site near the clinic, on Maginoo Street. The contractual form of the transaction is defined with the legal department so that the property is transferred to Likhaan while ensuring usufruct to MSF.

Arnold, who was the first PC for Likhaan, remembers:

"I was so happy that MSF was looking for a structure that we could own permanently rather than renting. That would save us a lot of money."

However, after several months of discussion the negotiations fail. Another site is identified in October 2016, Road 10. It is a vast building of 3 floors and 500 square meters, which overlooks the avenue bordering the port.

In Paris, at MSF's headquarters, the operations department changes heads. The new team examines this plan of property purchase, all the more so as it is a rare practice on missions. The deputy operations director visits the mission in January 2017. The terms of reference for his visit include:

"Analyze the relevance of investing in the purchase of land and construction of a building."

He concludes in his report:

"The case for purchasing land and building a clinic as the first intention to address the issue of physical space is questionable. Achieving a higher volume of medical activity will not happen quickly and the question of the impact of MSF in the project will remain for a while. Until the scope and impact of the project are better established rental appears a more adequate solution. Action point: renting option for at least a year should be implemented ASAP."

The owner is taking a long time to vacate the premises and the work does not begin before May 2017. On completion of the first phase of renovation, the medical activities - family planning consultations, sexually transmitted diseases and cervical cancer - are finally transferred from the old clinic in July. The space now available allows the installation of new activities: sexual violence, antenatal care, or later on a space dedicated to adolescents.

In September 2017, the ribbon is cut jointly by Dr. Junice and the MSF Head of Mission at an official inauguration ceremony.

A second phase of the work runs until April 2018. Once completed, the reception desk, antenatal care, sterilization and laundry are installed. The last finishing touches take place in May and from June 2018 the new Lila clinic is fully completed.

As for the St Andres clinic, a new building is rented in the second quarter of 2017 and minor electrical and sanitary renovations are made.

How is the turnaround regarding the purchase and donation of the building taken at Likhaan?

First of all, the information was apparently ambiguous.

For Jun, *“There was no clear notification and I don’t really know how the decision to rent rather than purchase was made.”*

Even more important, for Likhaan, the expected savings disappear and in addition the chosen building is larger than originally envisaged. The upcoming cost is all the more important. Rent and electricity amount to 150.000 pesos per month (2800 €), three times the cost of the other clinics of the association.

Junice summarizes: *“We were not included in the decision. It was a bombshell when we heard that we had to find our own funds to sustain the building. That was a big blow.”*

When to end the project?

In the original proposal, the 5-year project deadline was accompanied by a timetable setting out milestones. The outlook was as follows:

2020: Handover to Likhaan with the assumption of: - Likhaan accredited to Philhealth
- Likhaan self-sufficient

This vision became partially obsolete in 2017 with the dropout of the maternity ward. The horizon of the end of 2020 has nevertheless been maintained, without really a renewed scenario to replace the previous one. The absence of a new narrative may have avoided the artificial exercise of justification that Rony Brauman outlined in his introduction to the workshop [Should I stay or should I go? Médecins Sans Frontières and the « exit strategies » \(2017\).](#)

“Closing or continuing a project [...], for most NGOs facing this fundamental difficulty, the issue is settled by the donors. They are the ones who decide, in the end, sparing the organizations the pain of the decision.

A browsing through the documents available online shows that all the authors insist on the need to plan the exit right from the start, to structure the action in phases with specific objectives (targets) and to prepare the stakeholders (communities, authorities, other actors) for the withdrawal by evaluating the objectives remaining to be achieved, so as to know what has already been accomplished and who to hand over for what remains to be done. When reading these documents, one is struck by an absence: the reason for the end of the programme does not appear, as the authors seem to take it for granted, regardless of what happens next. The explanation is to be found in the source of the decision referred to above, namely the end of institutional funding, which corresponds to a global strategy of resource allocation for which the recipient NGOs cannot, of course, be held accountable. The aim is to give a rational appearance to a decision that is not directly related to the situation on the ground.”

Perhaps the commitment to a 5-year project cycle has also constrained the reflection and concealed certain potential avenues, which would benefit from being explored on an objective basis.

A real potential for the long term

Finally, I would like to add a personal postulate on this subject. Among the partnership experiences, some are made with rather fragile organizations, sometimes created from scratch. Perhaps these very unbalanced configurations provide MSF with a certain flexibility. Conversely, one can imagine that associating with established and autonomous structures carries the potential for rougher relationships. But on the other hand, they offer a promising potential for internal resources for long-term prospects.

Likhaan is an organization that has 25 years of history and an identity. Its leadership, made up of committed activists, has managed to build and maintain a network of clinics by navigating the aid system and obtaining the support of many organisations: UNFPA, Interpares, the Scottish Catholic International Action Fund, Merlin, Save the Children, MSF. Future funding will to a large extent determine what will be maintained of the services initiated with MSF. The volatility of these funding unfortunately makes any plan fragile. However, the vision, motivation and pragmatism of Likhaan's members offer great chances that the association continues, and with it a part of what has been collectively built.

Cultural differences and interpersonal relationships

In the context of collaboration between organisations of different nationalities, the question of interculturality arises. It is a classic concern in the management of international partnerships.

Spontaneously in the course of the interviews, two relational features associated with Filipino culture were mentioned. As a preamble, it should be noted that, whatever the influence of culturalism in the analysis of relations, these observations carry a universal dimension.

Expatriates turnover and mutual comprehension

The first of these features is that building trust takes time. Getting to know each other, adjusting to each other, appreciating one another, are long term processes. Is this a particularly marked phenomenon in the Philippines? In any case, it is a sufficiently general situation to be taken into account, in the Philippines as elsewhere.

Beyond the mechanisms put in place to organize the interaction between the two structures, the quality of the interpersonal relations between their members is an essential ingredient of cooperation. A first challenge in this relationship lies in the frequent turnover of MSF expatriates. Getting to know each other, adjusting, appreciating each other, takes time.

The first prolonged contact between MSF and Likhaan is ensured by the head of mission during the year 2015, in charge of preparing the proposal. She notes:

“Trust is probably a big factor for this kind of partnerships. Our style in MSF of changing so often can be difficult. It took me a while to build the trust, then the conversations were more frank and straight-forward. It’s a bit of a stereotype, but in Asia it takes more time to build the relationship and to get to the point where people feel comfortable. I think it’s just about the way relationships are built there, I do think there is this cultural aspect to it. The desk had pushed me to stay another year. If I had been able to do that, it would have been helpful to keep the continuity.”

Jessica, clinic coordinator in Tondo for Likhaan, has similar views:

“In the Philippines culture it takes time to open to a new person. So the change of expatriates is damaging.”

Although by MSF standards most expatriates stay in the Philippines for a relatively long period of time, the Likhaan teams have seen four heads of mission in five years and five project managers in just over four years.

For Hope, the Likhaan PC:

“It was just too much, the staff should be more long term”.

The second frequently mentioned "cultural feature" is that Filipinos avoid direct contradictions or opinions that may offend their interlocutor. This is regularly highlighted by MSF expatriates as complicating the interpretation of Likhaan's intentions.

This assertion obviously relates to more subtle mechanisms. But at least the fact that it is formulated, that the people involved in the relationship have it in mind, allows them to take it into account and to adapt their communication accordingly.

A phase of deleterious relationships

There is thus a perception among project stakeholders that national cultural differences have an influence on the quality of the dialogue and the relationship between the two organizations.

The observation of relations at the project level reveals a long period of marked tensions between early 2016 and late 2018. The reasons for these difficulties are manifold. On the one hand they are due to individualities. Nevertheless, a series of blunders can also be identified, linked to the failure to take cultural differences into account. However, it is not a matter of the globalizing features that we have just seen. It is about differences that are at play on a much more specific scale, the one of organizational cultures.

The mismatch begins with the start of operations. At the beginning of 2016, each organization assigns a project manager. But the duo doesn't fit together.

“Our clinic coordinator has seen the development of reproductive health in the Philippines, and because he was the most senior we thought it would be a good tandem, the midwife from MSF and him. But they did not work well together.” (Junice, Executive director, Likhaan)

This situation is fortunately mitigated by a good working relationship between the MSF head of mission and the Likhaan management. Moreover, the MSF head of mission is not convinced that the PC is well suited to the position, so that her mission is quickly shortened.

“Under Jordan (MSF HoM) we would have meetings monthly and any problem that came up was solved right away. What was wonderful with Jordan was that we were honest. We fed back that there were problems with this woman and she was withdrawn. That meant MSF reacts.” (Junice, Executive director, Likhaan)

After a short interim, a new PC takes over the position and MSF team members are recruited. On the Likhaan side the PC also changes. But once again tensions emerge and crystallize. The causes of disagreement are varied, partly related to individual issues. But beyond the personalities, one can also identify a combination of factors, which combined to give a colour to the way Likhaan perceived the MSF management team.

It is useful to consider the Likhaan culture in this regard. The association has militant communist origins and promotes a relatively egalitarian structure. This is, for example, the case for the salaries, which are also modest even by Filipino standards. It is noteworthy that their historical backer, Interpares, is also a strongly left-wing, feminist and egalitarian organization. Their logo "Interpares - Globalizing Equality" translates, for example, into a single salary for all their staff and a vocabulary that uses the term counterparts rather than partners to identify the NGOs they fund.

It is perhaps against this analysis that the points of tension that have emerged should be considered. What upsets Likhaan is a style, an attitude, especially from the expatriate PC and from the logistician manager who comes from the Filipino bourgeoisie. The Likhaan PC notes acrimoniously that these people had settled in the comfortable MSF coordination office rather than sharing the noisy, non-air-conditioned project office with them.

According to Junice:

“The MSF PC was just ordering people around, a leadership style that did not help in getting their trust.”

For Hope, PC Likhaan 2016-2019:

“The PC and the log were not like MSF. They were like corporate people, people who command and demand. The logistician was wearing long sleeves, never getting his hands dirty. When we had lunch they asked us to buy for them, they did not wash their plate.”

The cell manager is aware of this:

“Hope had tensions with this PC, major tensions.”

Attitudes perceived as authoritarian, doubts about the professional legitimacy of people with high salaries, situations perceived as privileged, all this makes up a cocktail that affects trust and relationships. When the clinic manager for sexual violence joins the MSF team, a position high up on the salary scale, with virtually no patients for many months, this contributes to the deterioration of the image.

Project coordinator for MSF from mid-2018, Cédric notes:

“When I arrived I discovered a Likhaan team that had contempt for the MSF team because these were arrogant, they had big salaries. It didn't work out because the MSF team wasn't collaborative, they were there like bosses doing supervision. The log came from high society and gave orders but did nothing. The sexual violence manager was arrogant, didn't do the job, was overpaid, and

everyone could see that. It certainly doesn't convey a very good image. We started by cleaning up our own backyard before giving advice."

The MTL, who arrives in mid-2018, makes the same observation:

"The logistician was totally lacking sensitivity, he did not fit in with the culture of the NGO. The fact that they were MSF managers, better paid, meant that if they didn't do their job, it created something very violent. This is what happened with the clinic manager. The Likhaan team knew that his salary was high while he had almost nothing to do all day. Our staff arrived late, at 9:00 a.m. They get paid more, they work less, and they're the managers. It all created an injustice. You can't change the salary, but you can change what you expect people to do. To feel you have the right to be late is to feel superior."

Hope mentions it as well:

"The MSF staff was acting like they were on a more privileged status. They had more money. Culturally your ego is attached to your salary."

These tensions are nevertheless counterbalanced by everyone's desire to carry out the activities successfully. As Hope, Likhaan project coordinator, summarizes:

"I think it is also the interpersonal relationship that holds the project together, because there's actually a lot of goodwill."

In the second half of 2018, part of the MSF team is renewed: new PC and MTL, the logistician resigns and the clinic manager's contract is terminated. Gradually, the dynamic of the relationship changes and becomes healthier. Since then it is, in everyone's opinion, much healthier.

The MTL feels it clearly:

"We spent six months gaining Hope's trust. In the beginning she was just defensive, talking about the mistakes done before. After six months we became confident enough to express our disagreements and then see how we could move forward, being aware that there listening or concessions were there".

However, it is during the initial phase of the project that the co-management modalities were established. And the relational difficulties during this period probably had lingering effects afterwards.

This probably contributed, as the MTL notes, to the fact that: *"the staff always felt that they were MSF or Likhaan, before feeling that they were members of the same project. The fact that the managers are mainly MSF staff has contributed to the positioning of the association as a leader and not according to a real sharing of responsibilities."*

For Eric, the cell manager: *"The PCs didn't get along. These tensions between people resulted in this being the MSF team, this being the Likhaan team."*

From these considerations, Jean-Luc, the 2019-2020 head of mission concludes:

"The HR is key for the management of such a project, with the constraints of frequent expatriate turnover, but also the profiles and expectations that expatriates may have. It is a partnership within the framework of a long project cycle, in a context of prolonged crisis with no emergency. From my point of view, a project for neglected populations that has full legitimacy, but which does not necessarily correspond to the expectations of some MSF volunteers, hence the importance of a sufficiently clear and detailed "briefing" of the expatriate even before the person is hired for the project."

Missed opportunities

Learning from Likhaan - the case of community mobilization

When designing this programme, MSF was very conscious of two challenges: to address a large and dense urban population, in particular on a very sensitive issue in the Philippines. The lucidity that we were not the

best equipped to do this was a determining factor in intervening jointly with an association that had made it its speciality.

Beyond the advantage it offered for this particular project, it was also a learning opportunity for the association.

Unfortunately, the progressive erection of boundaries around the community component, which eventually became Likhaan's domain, did not allow us to learn much from it.

For Claire, the MTL for MSF:

"We missed an opportunity to learn about community outreach."

For example, in 2020, as MSF assesses the opportunity to develop a tuberculosis programme, we are essentially at the same point of ignorance as four years earlier about how to organise the community component of the intervention.

However, the doors may not be closed as long as the approach displays sincere interest. Jun himself says:

"If MSF has not learnt from it, it should."

One idea could be to document Likhaan's approach to community mobilization: philosophy, set-up, recruitment and retention of volunteers, interaction with the population, communication... This may include any theoretical foundations of their method and discuss the trial and error encountered in their practice.

Without delving into the subject with Likhaan, a few thoughts collected during the interviews can be mentioned:

Concerning the motivation of the volunteers of the network:

"We give them a status. As one community health promoter tells me, 'it makes me feel good because the work I do for Likhaan makes me more than a housewife'»." (Hope, PC Likhaan 2016-2019)

Regarding the messages:

"How far would you teach community people about a disease? I think MSF would rather filter off the messages. But our experience is that although these people have not finished school, they are intelligent." (Junice, Executive director, Likhaan)

As for the approach:

"How do you increase health seeking behaviour of women? It's only by recognizing their intelligence, recognizing that they do have a choice, even if it is a choice we don't like, so that they feel they are owners of their decision." (Hope, PC Likhaan 2016-2019)

Fostering debate

Both MSF and Likhaan claim to be organisations that are open to debate.

"Debate is part of the culture in Likhaan. Many of us came from the communist party of the Philippines were routinely when we analyse project, part of that is you criticize yourself, you criticize others, you raise issues. It's common for those of us that grew in the party. We think it's healthy especially in a culture that tends to cover up the differences." (Junice, Executive director, Likhaan)

MSF expatriates also mention that, in Likhaan meetings, everyone expresses their opinion. As for Dr. Junice, she recalls her participation in the general assembly of MSF Hong Kong, where she was invited to present the project:

"There was a debate there whether MSF should engage in development work or stick to humanitarian. I had never seen an organization that debates in public. It's a culture of debate that we also want to propagate in Likhaan, because you can never be complacent about anything, right?"

In addition to feeding the discussion on the themes under question, the practice of debate provides an opportunity to better know the interlocutor. In the context of cooperation between two organisations, promoting opportunities for debate can help develop mutual knowledge and understanding. Whether they concern project-related topics or more general themes, discussions can reveal - and thereby clarify - differences in perspective or ways of thinking. Finally, it can also help to strengthen cohesion.

Opportunities may include the field associative debates, usually internal to MSF, but that could be adapted. But one could also imagine an event specific to the Tondo project.

In a more operational mode, there are also the "*mises à plat*", the preparation of which involved discussions between PCs or with the Likhaan administrator for the budget, but which was not used as a moment of collective strategic reflection.

For Eric, the cell manager:

"From my external point of view, I don't think Likhaan has been sufficiently involved in the MAPs. In hindsight, they were not invited."

Jean-Luc, the head of mission in 2019 confirms:

"The MAP process was not very participatory."

Opportunities could also have been seized, taking up interesting issues within the partnership as they emerge. For example, the timing of elections, necessarily viewed differently from the point of view of a militant and historically politicized organization, or from that of an organization defending a certain neutrality.

PARTNERSHIP APPRAISAL

In the preparatory questions for this study, the interrogation about the partnership results was asked as follows:

- Was this partnership beneficial for both parties despite internal working challenges for both?
- How integrating an existing organization accelerates our “operationality”?
- Does the implementation of the partnership answers operational challenges in the long run?
- What worked and what didn't?

In the report '*Enriched or confined*', the Vienna evaluation unit asked the question of the 'return on investment' of the 11 partnership cases studied, without reaching a conclusion. They therefore made a recommendation:

“MSF must put the means in place to adequately establish sound baseline data, clear objectives, and measurable indicators of success including collection and analysis of the data, otherwise it will be impossible to evaluate the ROI.”

This came after recognizing that:

“As these data are rarely available in regular MSF-projects and were not available for the evaluated projects, it is difficult to assert that partnerships are a good “investment” for MSF.”

On this subject, we can start by recalling the thesis of the anthropologist David Mosse, who argues that the success of a project depends above all on the ability of its supporters to impose a reading of it in terms of success. Or, conversely, that «*Projects do not fail ; they are failed by wider networks of support and validation.*»³

Following on from this diagnosis, it does not seem possible to give a clear and absolute answer to the questions posed above. It is up to the actors involved in the project to do so. We can, however, share a few points of reference to help with the reflection.

The feeling of the teams

The general feeling of those involved in the project is usually a good starting point. Naturally it differs from one person to another and what follows is neither totally rigorous nor exhaustive. What appeared during the interviews is that many of the respondents appreciated the experience, including the fact of seeing a new setup, an opportunity for innovation and learning.

“It was interesting to try this approach, particularly in the Asian context. I thought that it was worthwhile and I was really happy that the desk was keen to try something new.” (Head of mission, 2015, MSF)

“Looking back, if you ask me if I would like to go to this project, I would say yes, because it's a nice experience within MSF as we rarely have to occasion to work together with another organization.” (An Na, Project coordinator, 2018, MSF)

Another recurring impression is that many in MSF feel that Likhaan was the right partner. It is important as this choice did not follow the standards of good practice. Theoretically, it would have been necessary to map the different possible associations and evaluate their respective potential in order to select the most appropriate one. The potential candidates might not have been many, yet it is not the approach that was followed. This initiative therefore provides a successful counter-example to the prevailing doctrine.

“I think we've come across a good organisation overall.” (Jean-Luc, Head of mission, 2019-2020, MSF)

³ Mosse D., 2005, *Cultivating Development. An Ethnography of Aid Policy and Practice*, London Pluto Press.

"I am proud to work with them. It's a beautiful NGO. I admire their background, their commitment, I have a lot of respect and we share a lot of values. To have recognition and mutual admiration is important to work together." (Claire, MTL, 2018-2019, MSF)

The pace of the project

Has the partnership made it possible to go faster, has it "accelerated our operationality"?

By providing access to existing clinics and a built up community network, the partnership has undeniably enabled MSF to start activities very quickly. How much time saved? No one can say. Likhaan has been developing its network in the slum for years. As for getting approval from the health department to open a clinic ourselves, it is a very laborious process.

We have therefore saved time. Did we lose any? Working in pairs complicates the implementation of activities, decision-making mechanisms are slowed down. This is actually an inherent constraint to bear in mind when choosing this mode of operation. But it is not all about duration. When MSF's project coordinator says that *"everything is slowed down, complicated, doubly decided"*, it is not only a question of time, it also implies a modification of decisions. When you're a pair, you don't do the same things and you don't do them in the same way.

The proverb by which *"if you want to go fast, go alone, if you want to go far, go together"* is oversimplifying.

If the question of pace is a central issue in the project actors' reflections, it is also because in their minds it is intertwined with other dimensions of the partnership, and in particular with the collaboration strategy.

"We're two NGOs operating at completely different paces. At MSF expatriates are there on short assignments, each of them has his own objectives. But changes take time: everything requires negotiation and discussion. It doesn't mean that people don't accept changes, but I feel that if I go too fast, if I ask for too much, people will resist. First of all, you have to consult, you have to get buy-in from a lot of people before changing anything. You have to make sure that everyone is on board. It's much more participative; I've learned to be less directive in my management. It teaches you a lot, but it's a mission that requires you to make compromises, that requires you to go more slowly to better understand the other." (Claire, MTL, 2018-2019, MSF)

"We wanted to go at our own pace without making sure the partner was onboard. We wanted to impose things. That's one of the points that may have slowed us down in the development of the programme. Very often at MSF we want to get ahead of things, we think we have all the keys when we don't, and we missed the step of getting to know Likhaan well, of trusting each other and being able to move forward together. We wanted to move forward MSF style, with a partner who doesn't move at the same speed. We started dragging everyone so that things would move faster, without necessarily giving Likhaan the space to express themselves. They were saying OK, but was it really because they were volunteers, or because we hassled them so much that they felt obliged to say, well, we're moving forward then. It caused moments of tension, of blockage. What I would change is to take more time at the start, to make sure we're all on the same wavelength to get things up and running." (Eric, Cell manager, MSF)

Achievement of operational objectives

The fate of the different activities is contrasted. Some, such as family planning and the Cécap, have worked well, in connection with the community component. Others have struggled to take off and their future seems uncertain: antenatal care, sexual violence. In between, there have been some mixed results: sexually transmitted infections and vaccination campaigns. Last, the maternity component has been abandoned. In quantitative terms, it is difficult to give an opinion because the objectives have been periodically reviewed.

Generally speaking, what stands out from the project for Jean Luc, head of mission since 2019, is that:

"The single visit, the family planning, the Cécap, it is a valuable service offered to the women of Tondo and is very much appreciated."

For Leena, Likhaan's community mobilisation coordinator:

“Even if it would be temporary, we would have been happy to offer this service to the people of Tondo. They will remember having access to a clinic with this quality of service.”

Among the satisfactions for MSF and Likhaan is that they have demonstrated the feasibility of a low-cost, replicable and attractive model for cervical cancer screening and treatment. As Hope says:

“We proved that the nurse-led model works.”

For Claire:

“The success of the program is really the Cecap. At national level, the director of the Cecap network tells us that we are the best project.”

In terms of acquisition of knowledge for MSF, the high uptake of family planning thanks to the community network is a source of inspiration. A learning exercise on this model has been included in the project's objectives for 2020.

Achieving of initial expectations for MSF

Among the initial motivations for the partnership, some did not materialize. The hope that partnering with an organization whose leaders are familiar with political and medical circles would give us access to an exclusive address book did not take shape. Initially Likhaan introduced MSF to several civil society organizations and government stakeholders. They also invited MSF to attend a number of forums together, which was an opportunity to access to external contacts. However after four years, the mission contact list remains modest, far from the rich understanding of the *who's who* that was hoped for. As for the idea of relying on Likhaan's privileged connections for the opening of the project in Mindanao, it was not pursued.

The involvement in Likhaan's advocacy work, which was mentioned briefly at the beginning, was not actively pursued by MSF. Likhaan, for its part, has not expressed a need for support on this aspect of their activities.

On the other hand, the gain of time and the efficiency of access to the slum population made possible by the community network and the know-how of Likhaan is a reality and a great success of the enterprise. Even if one must mention the failure to mobilize this network for the sexual violence component.

As for the prospect of sustainability offered by the partnership modus operandi, it is too early to conclude while funding avenues are being canvassed.

Achieving of initial expectations for Likhaan

Among Likhaan's initial motivations as they were identified by MSF, some seem to stem from a projection by the teams of their own assumptions.

For instance, if we take the idea that Likhaan would benefit from MSF's image, in practice they did not show much interest in being publicly associated with us. Elliott, communications officer in Tokyo in 2017-2018, notes:

“Likhaan did not see a huge added value in being associated with MSF when it came to their relationship with international media. They had media knocking at the door all the time. The BBC, the Guardian, Al Jazeera, Vice, all came to broadcast what they were doing.”

In another field, the idea that Likhaan would benefit from MSF's HR, logistical or financial tools for its organisational structuring, did not correspond to a partner's expectation, but rather to MSF's idea of its own added value in terms of *capacity building*. In practice, only a few procedures were integrated.

Nevertheless, other motivations of Likhaan as perceived by MSF did actually correspond to their expectations. Thus, the project helped to strengthen their medical profile, develop their technical expertise, expand their range of services and improve the quality of care.

For Arnold, Likhaan's medical coordinator:

“We became more conscious about the medical standards, the quality of drugs, it is good for us.”

Hope, PC 2016-2019 for Likhaan, adds:

“We love that MSF has the highest medical standards: advanced sterilization procedures, integrity of the medical supplies. Before, we never even knew that our pregnancy tests had to be validated.”

Finally, from a funding point of view, the value of MSF's support was obviously significant. It made it possible to operate while carrying out the accreditation process by PhilHealth.

Where we stand today

At the time of writing this report, here is a quick update on the state of the outlook for the years 2021 and beyond.

Likhaan has secured a funding for adolescent services, cross-cutting across all clinics. This does not cover the core medical activities, for which they seek support from donors to complement PhilHealth reimbursements. The GAC, through Interpares, was a promising avenue to operate all clinics under one funding. It has become more uncertain lately. MSF is trying to provide support by identifying international calls for proposals that can match the activities.

A handover plan until the end of 2020 was written unilaterally by MSF and then submitted to Likhaan, who found it irrelevant, considering that they would probably need to shut down the facility and relocate it to a smaller building. For them, the future of the activities depends on the future funding, their amount and their orientation. Since uncertainty dominates for the moment, predicting scenarios seems premature.

Perhaps the question will arise of MSF support for a possible bridge between the end of the project and the start of something else, particularly in view of the temporary halting of certain handover activities, with everyone getting involved on the Covid19 pandemic.

ANNEXES

Annexe 1 - Elements of timeline

1984: Creation of Gabriela (General Assembly Binding Women for Reforms, Integrity, Equality, Leadership, and Action).

1986: Fall of the dictator Marcos, Gabriela comes out of clandestinity.

1990: Dr. Junice Melgar - current executive director of Likhaan - takes the lead of Gabriela's health commission.

1994: UN International Conference on Population and Development, which leads to the recognition of reproductive and sexual health rights as a cornerstone of development.

1995: Split within Gabriela, involving disagreement over acceptance of UNFPA funds and creation of Likhaan.

2001-2012: The country's drift towards restrictive sexual and reproductive health policies prompts Likhaan to engage in advocacy.

2007: Likhaan's contributes to the writing the advocacy report "Imposing misery", with the Center for Reproductive Rights, to document the impact of the contraceptive ban in Manila.

2012: Passage of the Reproductive Health Law, which guarantees universal access to methods of contraception, fertility control, sex education and maternal care, and for which Likhaan has been involved through advocacy.

End of 2013: Super Typhoon Haiyan hits the Philippines.

June 2014: MSF meets with Likhaan, who is well established in the country and who is looking for a bridge to European Union funding.

July 2014: The medical coordinator presents her first ideas to the Tokyo cell. Décembre 2014 - Février 2015 : série d'évaluations dans les bidonvilles, élaboration du « document stratégique pour les Philippines ».

June 2015: Operation proposal "Comprehensive sexual and reproductive health programme in the slums of Tondo in Manila, in partnership with the local NGO Likhaan".

January 2016: Start of the project.

April 2016: Signature of the partnership agreement.

November 2016: Presentation to the teams on sexual violence.

Late 2016: Launch of the cervical cancer management activity.

January 2017: Visit of the Deputy Director of Operations.

2017: MSF logistics and medical teams convert a truck into a mobile clinic to serve isolated areas of the slum, bringing the number of cryotherapy sites to three.

2nd quarter 2017: A new building is rented for the clinic in St. Andres and minor electrical and sanitary renovations are made.

May 2017: Start of renovation work of the new clinic in Tondo.

July 2017: Move to the new premises, possibility to increase the teams.

September 2017: Official inauguration ceremony of the new premises.

End of 2017: The clinic finally receives its first cases of sexual violence, but their number remains anecdotal.

Late 2017: An MSF midwife conducts a study prior to the launch of the maternity ward. This component of the activity is abandoned.

May 2018: The number of cases of sexual violence coming to the clinic increases (between 5 and 10 patients per month until mid-2019).

June 2018: Renovation of the new Lila Clinic is completed.

Mid-2019: The results achieved in Tondo on cervical cancer are jointly presented by MSF and Likhaan at the 8th "HPV summit" in Manila.

2nd semester 2019 : The number of sexual violence patients increases to around 15 per month.

End 2019: The accreditation as "family planning clinic" is finally obtained.

2019 : Beginning of sharing of MSF quarterly reports with Likhaan.

Beginning of 2020: Likhaan obtains funding for the adolescent component.

Annexe 2 – Project members quoted

Dr. Junice Melgar, Executive director, Likhaan

Jun Melgar, Program director, Likhaan

Arnold, Medical coordinator and project PC in the beginning of 2016, Likhaan

Hope, project coordinator, mid-2016 to end 2019, Likhaan

Leena, Community mobilization coordinator, Likhaan

Jessica, Tondo clinic coordinator, Likhaan

Pierre, Deputy operations director, MSF

Eric, cell manager, MSF

Elliott, Communication adviser, 2017-2018, MSF Tokyo

Olivier, Head of mission, 2014 - jan 2015, MSF

Karina, medical coordinator, 2014 - feb 2015, MSF

Jean-Luc, Head of mission, since feb 2019, MSF

Head of mission, fev 2015 - oct 2015, MSF

Jordan, Head of mission, oct 2015 - nov 2017, MSF

An Na, project coordinator, jan 2018 - june 2018, MSF

Cédric, project coordinator, june 2018 - jan 2020, MSF

Claire, MTL, june 2018 - jan 2020, MSF

Ruth, Medical activity manager, 2016 - 2019, MSF