ANNUAL
REPORT
2020

ACRONYMS

ARV	Antiretrovirals
CCM	Country Coordinating Mechanism
CoC	Continuum of Care
EBE	Experts by Experience
HIV	Human Immunodeficiency Virus
HR	Human Resource
MHPSS	Mental Health and Psychosocial Support
MOH	Ministry of Health
NCD	Non-Communicable Disease
OCB	Operational Centre Brussels
OP	Operational Priorities
PHC	Primary Health Care
PODI	*Point de Distribution d'ARV Communautaire* (Community ARV Distribution Points)
SEU	Stockholm Evaluation Unit
SO	Strategic Orientations
ToR	Terms of Reference
U5	[Children] Under Five
VoT	Victims of Torture

TABLES

INTRODUCTION

Operational Centre Brussels (OCB) is committed to a culture of evaluation as per its Strategic Orientations 2020-2023[1]. The Stockholm Evaluation Unit (SEU) is charged with managing OCB evaluations[2] to drive quality through learning and accountability, supporting this culture on both a project and organizational level[3]. Based on evaluations concluded in 2020, and with an eye to contribute to conceptual learning on an organizational level, the SEU is for the first time presenting an annual report.

This annual report uses OCB's strategic plans, and more specifically the described in the Operational Prospects 2020-2023, as a starting point to examine both the evaluations' scope (including evaluation questions) and the findings of evaluations completed in 2020. The Prospects contains Strategic Orientations (SO) that set direction and Operational Priorities (OP), which are more thematic – both are referred to in this report.

The report has three parts beginning with this *Introduction*; an overview of which evaluations were included, the basis for analysis, the report's methodology, and its limitations. The second part, *Overview of Evaluations*, describes the characteristics of the evaluations; specifically, what type of evaluation they were, the geographical coverage, and which (medical) OP they covered. An overview of the focus and scope of each included of evaluation also appears, assessing whether the evaluation questions were formulated to drive learning towards a specific

SO. The last section *Evaluations and Strategic Orientations* presents a discussion on how the evaluation findings speak to the SO. Finally, we close the report with a *Conclusion*.

EVALUATIONS INCLUDED

This annual report analyses four evaluations of operational field projects finalized in 2020, namely:

- *Evaluation of MSF-OCB's Decentralization Initiative of HIV Project in Kinshasa*
- *Evaluation of Clinical Mentoring in MSF's Non-Communicable Disease (NCD) Project in Embu, Kenya*
- *Evaluation of MSF's Malaria Project in Bili (2017-2019), DRC*
- *Evaluation of MSF Treatment & Rehabilitation of Victims of Torture (VoT) Programs in Four Locations*

BASIS FOR ANALYSIS

OCB is strategically guided by its Strategic Orientations 2020-2023. A part of this are the Operational Prospects 2020-2023, which provide operational guidance to OCB. In addition to discussing trends and the humanitarian landscape, the Prospects set forth the Strategic Orientations (SO) giving direction on who, what and how, and the Operational Priorities (OP), which are more thematic in nature. Below is a complete list of the SOs and OPs included in the 2020-2023 plan.

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[1] Based on the OCB's document entitled Operational Prospects 2020-2023.

[2] SEU Steering Committee Framework (2019).

[3] During 2020, the SEU was engaged in work on 16 evaluations, of which six (6) were completed during the

course of the year. While two (2) were eventually cancelled, the others carried over into 2021 and will be completed during the course of the year. In addition, the SEU worked to document and reflect on MSF's response to Covid-19 in Belgium.

Key elements of OCB's Operational Prospects 2020-2023	
Strategic orientations	Operational priorities
(1) medical-humanitarian identity, * (2) focus on vulnerability and neglect, * (3) patient at the centre, * (4) continuum of care, * (5) témoignage and speaking up, * (6) managed a diverse portfolio, (7) field recentralization and regional hubs, (8) the right staff set up, * (9) being a risk-taking organization, and (10) responsibility and accountability.	(1) epidemics, ** (2) conflict and violence, ** (3) migration and detention, ** (4) sexual, reproductive and women's health, (5) child health and nutrition, ** (6) trauma care, (7) chronic infections (HIV, TB, Hepatitis), ** (8) non-communicable disease, ** (9) continuum of care, ** (10) clinical care, ** (11) antibiotic resistance, and (12) environmental health.
* strategic orientations reflected upon in this report. ** operational priorities that evaluations included in this report considered.	

Findings of the evaluations that the SEU completed in 2020 were reviewed and examined as to how they speak to six of these SO (as highlighted in the chart above) and touched on several of the operational priorities. SO #9 on being a risk-taking organization was excluded since none of the evaluations focused on the theme of working in risk-filled environments. Additionally, as to SO #7, while some of the projects were being implemented in areas where field recentralization is happening, none of the completed evaluations in 2020 sought to speak to this. SOs #6 is not necessarily specific to individual projects but rather to look at a total dossier. Since this annual report does not assess how evaluations were chosen and because it considers a small number of evaluations, it is not relevant to delve into this. Lastly, besides the given correlation to SO #10, which mentions a commitment to evaluation, evaluations conducted in 2020 did not look at issues related to accountability to patients and communities (though it is to some extent addressed under SO #3), nor to how MSF upholds ethics in its work.

An in-depth assessment of portfolio diversity vis-à-vis the SOs or OPs is not a part of this report, but an overview of which operational priorities the evaluated projects cover is (under *Focus of The Evaluations)*.

It is important to note that this is not a summative or conclusive assessment as to whether OCB lives up to each of the SOs. Findings were limited to the scope and focus of the evaluations and does not then speak to all of OCB's projects, nor always to the whole of the specific project evaluated (as the scope might have been narrowed).

METHODOLOGY

A desk review of the evaluations of field project completed in 2020 was done along with its associated Terms of Reference (ToR) and inception reports. The evaluation questions and the evaluation criteria presented in the ToRs, and the evaluation findings and recommendations were extracted into a database for analysis.

A frame of analysis was formulated by crafting questions that are linked to how the evaluation speaks to the relevance, appropriateness, or effectiveness of the interventions based on the different SOs. These three criteria were considered as they were most commonly explored in the ToRs of all evaluations included in

this report. Themes in each evaluation which address or are associated with the question were considered and findings were grouped and presented according to their commonalities.

LIMITATIONS

This annual report is limited by some factors. An assessment of the quality of evaluations was not conducted, and thus not the quality of the findings. That said, because of the methodology employed to conduct evaluations, there is an increased confidence that findings have been prepared taking potential bias and objectivity into consideration.

An analysis of how the evaluations were identified and selected, i.e. which evaluations OCB chose to pursue, was not conducted. Considering findings are only included from evaluations that OCB requested, there is a potential limitation related to which evaluations OCB opted for or prioritized to complete.

Very important to remember is that the number of evaluations included in the report is low, thus, findings of this annual report cannot be generalized to the whole of OCB's project portfolio. Not all evaluations covered all SOs, therefore when reference is made to quantity, it should never be interpreted as an indicator vis-à-vis adherence to the SOs. Furthermore, some of projects that were evaluated were initiated during a previous strategic period, and thus were developed with another set of strategic orientations and operational priorities in mind.

The report has been completed by the SEU, and as these evaluations are the unit's products, bias related to the selection of which findings were included and how they have been interpreted may appear. That said, the report was not prepared by any of the evaluation managers who directly managed and guided the included evaluations, though of course they did review the final version of this report.

OVERVIEW OF EVALUATIONS

This section explores the characteristics of the evaluations included in the report, such as the type of evaluation, coverage, and which OP the evaluations considered. Additionally, an overview is provided on how the evaluation questions in the ToR speak to the specific SO and drive learning in each area.

CHARACTERISTICS OF THE EVALUATIONS

This annual report considers three project evaluations and one multi-project evaluation that the SEU completed in 2020. These were projects that responded to malaria, HIV, Non-Communicable Disease (NCD) and Victims of Torture (VoT) (Table 2). The scope of the evaluations were (1) the strategy to decentralize HIV care in Kinshasa, Democratic Republic of Congo (DRC), (2) the clinical mentoring component of an NCD project in Embu, Kenya, (3) the malaria project in Bili, DRC and (4) a transversal evaluation of four projects directed at care for VoT. The Embu, Kinshasa and VoT evaluations were conducted as the projects were still going on, while the Bili evaluation was conducted after the project was closed. The evaluations informed the OP: continuum of care, chronic infections, clinical care, epidemics, NCDs, child health, conflict and violence, and migration and detention.

Table 1. Characteristics of evaluations included in this annual report.

Evaluation	Scope	Geographical Coverage	Requesting Unit	Operational priorities
Kinshasa Evaluation	Decentralization of HIV care	Sub-national (Kinshasa, DRC)	Cell 1	- Continuum of Care - Chronic Infections: HIV, TB, and Hepatitis - Clinical Care
Embu Evaluation	Mentoring Component of a Project	Sub-national (Embu, Kenya)	Cell 3	- Non-communicable Diseases - Clinical Care - Continuum of Care
Bili Evaluation	Malaria project (with community aspect)	Sub-national (Bili, DRC)	Cell 1	- Epidemics - Child health
VoT Evaluation	Transversal evaluation of VoT projects	Multi-country[4]	Cell 2	- Conflict and Violence - Migration and Detention - Clinical Care

FOCUS OF THE EVALUATIONS

This section examines the scope and direction of the evaluations, looking at how the ToRs and more specifically at whether the evaluation questions align with the SO.

In general, the evaluation questions covered several of the SO. Yet MSF's *medical-humanitarian identity* and human resources management (*the right staff set up*) reoccurred more than any other.

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[4] Due to sensitivities, the locations of the VoT project are not made public.

Table 2. Linkage of the evaluation questions to the Strategic Orientations.

Strategic Orientation	Kinshasa evaluation	Embu evaluation	Bili evaluation	VOT evaluation
Medical – Humanitarian Identity	☒	☒	☒	☒
Focus on Vulnerability and Neglect	☐	☐	☐	☒
The Patient at the Centre	☒	☐	☒	☐
Continuum of Care	☒	☐	☒	☐
Témoignage and Speaking Out	☐	☐	☒	☐
The Right Staff Set Up	☒	☒	☒	☒

Questions related to MSF's identity mostly pertained to whether projects were relevant to the local context. Specific to the VoT evaluation, questions were on the definition of rehabilitation of VoT as seen through the lens of the movement's mandate, principles, and operational policies.

The VoT evaluation sought to answer questions on the suitability of interventions for VoT in resource poor and volatile contexts thereby contributing to understanding on vulnerability and neglect.

Regarding patient-centred care, the Kinshasa and Bili evaluations explored questions about MSF's proximity to patients and communities, looking at whether the project took their needs into account and if the quality of interventions was acceptable for them. The Bili evaluation also examined how communities were involved in the design and implementation of the project.

Both the Kinshasa and Bili evaluations sought to understand the priorities set at each level of care, with the Bili evaluation looking specifically at how activities took into consideration priorities at different levels of the health pyramid, and the

Kinshasa evaluation considering it to better understand the quality of the decentralized approach.

The Bili evaluation looked into questions about how the project addressed advocacy needs.

As for the SO on human resources, several ToRs included questions asking how the intervention contributed to building the capacity of local staff, and the extent to which resources, including human resources, were available, efficiently managed, and maintained. Additionally, questions on the appropriateness of HR strategies to the context was included, notably in the evaluation of clinical mentoring in the NCD project in Embu, Kenya.

Despite the evaluation questions not being specific to every SO, findings showed that other elements of the SOs were explored in the actual conduct of the evaluations. For example, though there were no specific evaluation questions related to *Témoignage and Speaking Out* in the VoT evaluation, findings that speak to this did appear in the final report. Discussion of these findings can be found in the next section.

EVALUATIONS AND STRATEGIC ORIENTATIONS

MEDICAL–HUMANITARIAN IDENTITY

In the Operational Prospects, the medical-humanitarian identity establishes the role of MSF as a medical humanitarian organization whose focus is to provide medical and health-related interventions in situations of conflict, natural disasters, displacement, and where there is extreme suffering – working in adherence to its humanitarian principles, including impartiality.

Responding to needs: The evaluation findings show that in the Kinshasa and Embu evaluations, elements of the projects were deemed appropriate to the needs of the population. Strong coordination and involvement of the Ministry of Health (MOH), local health authorities, and other stakeholders in the design and implementation of the projects contributed to this. The Bili project was found to be relevant in addressing some of the needs identified during the assessment like the malaria morbidity and mortality. However, it was not able to deliver a more complete health package which may have included malnutrition and pneumonia to further reduce Children Under 5 (U5) morbidity and mortality.

The design of the VoT project focused on more advanced levels (levels 2 and 3) of mental health and psychosocial support (MHPSS) to VOTs regardless of the level of the patient's needs. While levels 2 and 3 are highly relevant, needs of some patients encompassed the whole range of MHPSS services including basic necessities.

FOCUS ON VULNERABILITY AND NEGLECT

Evaluations completed in 2020 contributed to an understanding of vulnerability and neglect and how specific populations have been actively included in interventions. Three of the evaluations sought to consider elements of vulnerability and neglect. As per the ToR, the evaluation of Embu did not examine vulnerability and neglect, as the project focused on healthcare providers and community health workers who were mentored through the project.

Including vulnerable communities: The Bili evaluation concluded that the lack of community involvement led to missed opportunities in taking vulnerabilities that exist in the population into consideration in the project, impacting the way MSF was perceived and how the project's results could be sustained.

Access of some specifically vulnerable communities: Findings of the VoT evaluation show that, although the project clearly served migrants perceived to be vulnerable, MSF's definition of VoT (based on the United Nations Convention against Torture definition) is limited. It failed to include victims of torture where acts of violence were perpetrated by non-State actors or those whose link to the State was unclear, as well as those who were victims of human rights violations that may not fall under the terms of the Convention. The definition limited the project's reach, in that it could not engage members of the communities which also have vulnerabilities due to unattended basic needs and prevalent suffering. Findings also showed that there was not a proactive approach to reach VoT, which is needed as this group may not actively seek help and have significant barriers related to clinical access, privacy and confidentiality, documentation, as well as other economic and physical limitations.

Findings of the Kinshasa evaluation showed that MSF's approach did not seek out vulnerable groups (i.e., men having sex with men, injecting drug users, sex workers) but rather employed a broader approach. There was a lack of understanding around how these groups access services and what potential barriers were present for them.

PATIENT AT THE CENTRE

The strategic orientation on working with the patient at the centre looks at how care is provided close to the patients and how they are actively engaged in the development and implementation of the projects.

Patients and communities as active agents: The VoT evaluation findings presented the implementation of a survivor-centred approach in one project called the Survivor's Square Group or the Experts by Experience (EBE) aimed to empower torture survivors and to enable them to play an active role in shaping decisions that impact them. Yet, such an EBE experience was only found in one out of three project areas. Meanwhile, findings in another project area showed that the project's approach ignored the patients' capacity for resilience and prevented the victims' opinion about the intervention.

Correlation between engagement and outcome: Evaluations provided a positive correlation between positive examples of how MSF engaged with patients and communities and the outcomes of the project. Good collaboration between MSF and the patients and communities was found in the Kinshasa evaluation, contributing to its success with establishing a community-based HIV testing and treatment services through the *Point de Distribution d'ARV Communautaire* (PODIs, Community ARV Distribution Points). Findings of the Embu evaluation also showed that a key benefit of the mentoring program was how patients were educated on managing their condition, empowering them to make better choices about their health.

However, this good collaboration with communities and patients was limited in other projects evaluated, with the results affected accordingly. The Bili evaluation findings described involvement of beneficiaries as weak. Communities were considered as passive recipients and were not sufficiently involved in the project thus MSF faced challenges in understanding the beneficiaries' needs.

Consequently, the organization partially failed to adapt and develop the right strategy to approach them, and effectively communicate changes in the project's orientations – from free care for all during the emergency phase, to targeted pathologies for children below five after the project reorientation.

CONTINUUM OF CARE

Continuum of Care (CoC) refers to how care starts at the community level, which primarily focuses on health promotion, patient and community empowerment, and community-based case prevention and management. It then continues to primary health care (PHC) facilities with prevention and case management and establishing referrals and counter referrals to and from a referral hospital.

Focusing on a specific level of care: The evaluations saw that when MSF focused support to a specific healthcare level this can either increase capacity at that level or divert attention from other levels that more urgently need support. That said, there were cases when projects supported the entire healthcare system through targeted input.

According to the evaluation findings, MSF was successful in two projects to improve and increase capacity at different levels of healthcare. The decentralization model evaluated in Kinshasa had been a success in expanding primary health care and establishing community level service delivery through the PODIs. This allowed for patients to access essential service packages more easily, and it reduced the number of visits to facilities especially when accessing ARVs. Findings show that this setup introduced task-shifting which increased the capacity of nurses and together with MSF's logistical support. Additionally, collaboration with MOH increased the reach of HIV testing and treatment.

The Embu evaluation findings also show how the project's support in terms of mentoring local

health staff increased the capacity at the local level (levels 2 and 3 facilities) hospital and facilitated access of patients to quality care.

The VoT evaluation, however, found that MSF's focus on a high level of mental health care did not match the larger, more pressing needs of harsh social and environmental conditions. This would have required community and primary healthcare level efforts.

A holistic and cohesive approach: The Bili evaluation showed that the shift from a facility-based to a community-based approach led to confusion within the system. This was affected by the lack of alignment between the field and coordination teams, divergent visions among the staff, lack of coordination with MOH and other actors, and lack of consultation with the communities.

Findings from the VoT evaluation showed that MSF's focus on rehabilitation and the functional recovery aspects of mental health care for VoT limited its provision of a holistic MHPSS intervention. Based on the intervention pyramid, holistic MHPSS intervention also covers aspects of psychosocial and community work. This was not presented in the findings.

TÉMOIGNAGE AND SPEAKING OUT

Whereas *Témoignage and Speaking out* relates to generating evidence to improve quality of care, it also encompasses giving voices to the patients and MSF's testimony on the reality of the communities that they serve. This section focuses on the latter, looking specifically at how evaluations address the effectiveness of advocacy initiatives, specifically when it comes to engaging patients, influencing policy, and leveraging advocacy to achieve project objectives.

Engaging patients in advocacy: The Kinshasa evaluation found that advocacy was one of MSF's

added value in the area. MSF was able to gain support from civil society organizations to raise issues of ARV stockouts to the MOH and carry out the advocacy strategies at all levels from the Country Coordinating Mechanism (CCM) to the National Multisectoral Program to Combat AIDS, and the main donors. As mentioned earlier in this report, the VoT evaluation discussed a Survivor's Square Group or the EBE, used to advocate for positive change and strengthen validity and accountability of MSF's advocacy strategy.

Influencing policy: As per the Kinshasa evaluation, MSF was also able to influence policy and promote feasibility of the decentralized model to scale up response to HIV needs and standardization of the approach with the main donors. This led to the expansion of the decentralisation model of intervention to Eswatini, Malawi, Kenya and South Africa with small steps taken in the West and Central Africa region.

Advocacy and objectives: In the VoT evaluation, it was seen that projects lacked an understanding of advocacy tasks and the need to collect and analyse advocacy indicators. In the Bili evaluation, the evaluators concluded that advocacy objectives were marginally achieved due to the disconnect with the project design and operational objectives. The project's approach to advocacy, namely criticizing the MoH rather than leveraging expertise, was not found to be appropriate.

Ability to conduct advocacy: One of the crucial components of VoT work, and especially in strengthening advocacy against it, is the documentation of torture. However, the evaluation showed that this was not practiced, undermining the ability to establish its presence in the project locations. In one VoT project, over-protectiveness to the patients led to active resistance to do advocacy work.

THE RIGHT STAFF SET UP

Establishing the right staff set up not only constitutes building the competency of MSF staff and managing an appropriate mix and complementarity of the workforce, but also seeks an exchange of opportunities and the professional development of local non-MSF healthcare workers. It necessitates training, mentoring, and providing professional development. Aspects related to training and mentoring but also to setting up a well-functioning team and recruiting functions to needs are examined in this section.

Training and mentoring: One of the recurring themes in the evaluations is the strength of MSF in terms of training and mentoring. This was highlighted in the Embu evaluation report where MSF's mentoring program led to significant improvement in the capacity of the mentees to manage NCD cases. In the Kinshasa evaluation, capacity building and mentoring activities for both MSF and health facility staff enabled the creation of a pool of trained and motivated staff. This in turn contributed to increased capacity throughout the whole decentralized setup, from the PODIs to the health facilities. Additionally, findings highlighted that trained national MSF staff members were an essential component to the success of testing and treatment coverage of the project.

Team composition and set-up: In some evaluations, findings show the challenges in team composition, organization, and inter-team dynamics. The VoT evaluation showed that high turnover of expat staff created confusion and affected team cohesion. Also, negative team dynamics and tension between clinical and mission teams were observed stemming from power imbalance between expatriates and national level staff.

Matching capacities and needs: The Bili evaluation showed challenges in matching the right profile of staff with the project's needs. The staff deployed to the project lacked sufficient orientation and training on community-based programming. The recruitment criteria for local medical positions also led MSF to appoint staff from other places in DRC, resulting in a disconnect with the communities and challenges to sustain the project's results. In the VoT evaluation, it was found that the composition of the team was not appropriate to the needs of the patients and the nature of the work with more clinical staff rather than mental health staff.

CONCLUSION

The review of the SEU's 2020 evaluation findings showed a mix of positive gains and significant challenges as related to OCB's Operational Prospects' Strategic Orientations. Furthermore, the evaluation findings suggested synergies between different SO that are useful to consider, opening up for seeing the Operational Prospects more holistically.

Several evaluations discussed a link between several SO and the ability to identify and respond to needs. MSF's medical identity (SO1) confirms the organization's commitment to providing medical and health-related services in humanitarian settings with an adherence to its principles. Evaluations completed in 2020 found projects to be relevant in how they responded to needs that had been identified. The evaluations also presented findings that there was a positive correlation between employing a patient-centred approach to determine needs and successfully delivering against them. However, there was also a link between meeting needs and having the right staff set-up, as challenges related to how a project was staffed could hamper a project's ability to respond to needs in a relevant manner.

Patient and community engagement was found to be significant in order to guide inclusion of vulnerable and neglected populations as well as to drive continuum of care and advocacy. In contexts where the target population belonged to groups who are highly stigmatized or those who have undergone extreme suffering, such as in the case of VoTs, a patient-centred approach proved important to better design projects that could be better accessed by vulnerable populations. This collaborative work and community engagement approach was also able to contribute to a continuum of care by strengthening local or primary health capacity, that in turn facilitated greater access to care. This was seen not only in projects which delivered direct services to patients but also those which sought to strengthen human resource capacity in

healthcare. Finally, involving patients in advocacy involved them more directly in the projects. The intersection of being patient-centred with the SOs on advocacy and speaking out, vulnerability, and continuum of care constituted positive gains in the projects.

Looking at ways in which the SO intersect by analysing them through the evaluation findings, open up for seeing how they complement each other (or not). Having SO that mutually reinforce each other lifts it from potentially being viewed as a list different attributes and directions, to a more holistic, strategic vision. It has been the aim of this paper to bring thinking to a higher level of organizational learning. By considering this reflection on the Operational Prospects, and specifically the SO, both individually and in its entirety, we hope to contribute to this.

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Conclusively, this was the first time that the SEU produced an annual report, and we hope to build on this experience in the future. We hope that this product will continue to develop, and over time gather higher level points for conceptual learning that can help the organization make better use of the findings and learnings that are drawn from completed evaluations.

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