STOCKHOLM EVALUATION UNIT

MEDECINS SANS FRONTIERES
LÄKARE UTAN GRÄNSER

ANNUAL REPORT 2021

ACRONYMS

ALNAP	Active Learning Network for Accountability and Performance
CoC	Continuum of Care
DAC	Development Assistance Committee
DHP	Digital Health Promotion
DRC	Democratic Republic of the Congo
HIV	Human Immunodeficiency Virus
HP	Health Promotion
HR	Human Resources
INGO	International Non-Governmental Organization
LGBTQI+	Lesbian Gay Bisexual Transgender Queer Intersex
M&E	Monitoring and Evaluation
MSF	Médecins Sans Frontières
MoH	Ministry of Health
OCB	Operational Centre Brussels
SEU	Stockholm Evaluation Unit
TB	Tuberculosis
ToR	Terms of Reference

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 in charge of managing OCB evaluations[2] to drive quality through learning and accountability, supporting this culture on both project and organizational levels.

This annual report is a review of evaluations completed by the SEU in 2021[3] and a summary of some of the reoccurring and overlapping findings using the Operational Prospects 2020-2023 as its lens. As an exercise in capturing and synthesising learning, it aims to contribute to reflections both within the SEU and the Steering Committee, and more broadly within OCB, providing an overview of 2021's findings and insight into what OCB evaluated and how. As such, this report hopes to contribute to reflections on how to evaluate better as well as on areas to consider when working to improve operations vis-à-vis the Operational Prospects, specifically.

The SEU presented its first annual report in 2020, and this is thus the second. It continues to be a work in progress, as we seek to find the best way to cover what came out of a year of evaluations.

CONTENT

Divided into five sections, the report starts off with this introduction which includes the methodology and limitations of the report, as well as an overview of the 2021 evaluations. In the following two sections, the Operational Prospects are the focus. The second section examines the evaluations against the Operational Priorities and the third against the Strategic Orientations. The fourth section takes a more analytical approach by reflecting on the use of the Operational Prospects as a framework and what this says about the evaluations that the SEU completed in 2021. It presents a conclusion that closes the report while opening for further reflections and discussions.

METHODOLOGY

A desk review of nine evaluations completed in 2021 was carried out. The Operational Prospects 2020-2023, with its Priorities and Orientations, was used as the frame for analysis. When analysing the evaluation reports against the orientations, questions pertaining to each orientation were crafted and data from the reports was categorised according to these.

LIMITATIONS

Since the evaluations included in this report do not constitute a representative sample of OCB's project dossier, findings cannot be generalised to the whole of OCB's project portfolio for 2021. Thus, this report is not a conclusive assessment as to whether OCB lives up to the Operational Prospects.

It is recognised that the qualitative analysis on which this report is based includes subjective elements and has not been checked for consistency. Furthermore, the report does not include analysis of the quality of evaluations. In 2022, the SEU will work on a meta evaluation to explore this.

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

[2] SEU Steering Committee Framework (2019).

[3] The presentation of findings cannot capture the evaluation in an entirety, but this report hopes to inspire readers to seek out an evaluation based on a topic of specific interest that might not be what the project was exclusively about (i.e., human resources).

OVERVIEW OF EVALUATIONS

Table 1. Evaluations included

Evaluation	Scope	Geographical Coverage	Requesting Unit
Gutu	Cervical cancer	Zimbabwe	Cell 5
Mbare	Adolescent Sexual and Reproductive Health	Zimbabwe	Cell 5
Eshowe	HIV	South Africa	Cell 5
Mumbai	Tuberculosis, policy advocacy	India	Cell 5
Bolivia	Maternal and Child Sexual Reproductive Health	El Alto, Bolivia	Cell 5
Ebola	9th, 10th, and 11th Ebola interventions	DR Congo	Cell 1
US Covid	Covid-19	United States of America	MSF US
Digital HP	Covid-19	Global	Medical Department
Arche	Centre of Traumatology	Burundi	Cell 1

The SEU completed thirteen evaluations in 2021[4]. The majority were commissioned by the operational cells (primarily cells one and five), though many requests were initiated in close cooperation with the project directly. Representatives from across different departments were involved in the evaluations in many different ways. About half of the nine evaluations were conducted at the end of the project, although OCB has the ambition to have more evaluations happening at mid-term. Five evaluations; Mbare, Eshowe, Digital HP, Bolivia and Mumbai, were conducted at mid-term while the Ebola, Arche, Gutu, and the US Covid evaluations were carried out towards the end of the project or after project closure.

The ALNAP criteria for evaluation of humanitarian aid (adapted DAC-criteria)[5] were used in most of the evaluations. These included Relevance, Coordination, Impact, Appropriateness, Effectiveness, Efficiency, Connectedness, and Coverage.

The stated purpose or intended use of these evaluations include: to document lessons learned, to determine the achievements of the project, to guide adaptation of the intervention, and to inform decisions on similar future projects. The Ebola evaluation goes beyond this, stating that the evaluation aims to contribute to discussions of MSF's identity and role. In so doing, it is the only evaluation out of the nine which more explicitly aims to promote conceptual and persuasive use.

For most of the evaluations, the intended user is stated to be MSF or OCB. In the Eshowe, Mbare, Gutu, Arche, and Bolivia evaluations however, the evaluation findings are also intended for broader use by the government, the MoH, or by other stakeholders including regional and international actors.

Operational Priorities

Within the Operational Prospects, the Operational Priorities provide guidance on medical themes. The nine evaluations included covered a range of Operational Priorities. *Sexual, Reproductive and Women's Health*, *Chronic Infections: HIV, TB and Hepatitis*, and *Continuum of Care* appeared most frequently

[4] SEU managed evaluations that were out of OCB network or that do not evaluate projects focusing on direct medical care activities were not included.

[5] See https://www.alnap.org/help-library/evaluating-humanitarian-action-using-the-oecd-dac-criteria.

covered. *Epidemics* was covered in two separate evaluations evaluating Covid-19 projects as well as Ebola. *Antibiotic Resistance* and *Environmental Health were the* only two Operational Priorities not covered.

Table 2. Operational Priorities evaluated

	Gutu	Mbare	Eshowe	Mumbai	Bolivia	Ebola	US Covid	Digital HP	Arche	TOTAL
Epidemics						X	X	X		3
Conflict and Violence					X[6]	X			X	2
Migration and Detention					X					1
Sexual Reproductive and Women's Health	X	X	X		X					4
Child Health and Nutrition		X	X		X					3
Trauma Care									X	1
Chronic Infections: HIV, TB and Hepatitis	X	X	X	X						4
Non-Communicable Diseases	X	X								2
Continuum of Care	X	X	X		X	X			X	6
Clinical Care	X					X			X	3

[6] The Bolivia project aimed to provide services to victims of sexual violence.

Three evaluations, Gutu, Mbare and Eshowe, shared as many as three of the same priorities, (*Sexual, Reproductive and Women's Health*, *Chronic Infections: HIV, TB and Hepatitis*, and *Continuum of Care)*. The Bolivia project covers two of these priorities, and the priority *Child Health and Nutrition.* As they worked on adolescents' SRH, *Child Health* is also covered by the Mbare and Eshowe evaluations.

Conflict and Violence was an important factor in the Ebola, Arche and Bolivia interventions; the latter project in that it provides services to sexual violence survivors while Ebola and Arche for the context in which the projects were developed. Meanwhile the priority *Migration and Detention* was only arguably covered by the Bolivia project as the indigenous Aymara population in El Alto served by the project can be described, and is described in the evaluation, as migrants. The reason for certain priorities appearing more often than others will not be assessed in this Annual Report. The ad-hoc way in which projects and priorities get evaluated is recognised.

STRATEGIC ORIENTATIONS

In this section, the Strategic Orientations, as outlined in the Operational Prospects, are summarised and used as a framework for analysis of the evaluations conducted in 2021.

The two orientations: *Have a Managed Portfolio Diversity* and *Think Global, Act Local* were not included in the analysis as they pertain more to a whole dossier rather than specific projects**.**

Table 3. Strategic Orientations evaluated

	Gutu	Mbare	Eshowe	Mumbai	Bolivia	Ebola	US Covid	Digital HP	Arche	TOTAL
Medical Humanitarian Identity	X	X	X	X	X	X	X	X	X	9
Focus on Vulnerability and Neglect	X	X	X		X		X	X	X	7
The Patient at the Centre	X	X	X	X	X	X	X	X	X	9
Continuum of Care	X	X	X		X				X	5
Témoignage and Speaking Out	X	X	X	X			X	X	X	7
Getting the Right Staff	X	X	X		X		X	X	X	7
Be a Risk-Taking Organisation				X		X			X	3
Act Accountable and Responsible	X	X	X	X	X	X	X	X	X	9

MEDICAL HUMANITARIAN IDENTITY

OCB's medical programmes respect human dignity and stand in solidarity with neglected populations. OCB puts the human being at the centre of projects, thus making sure they are relevant to the patients' needs and local contexts. Emphasis is placed on the medical impact and quality of care of responses. Priority will be given to those interventions in settings with excess morbidity and mortality and acute suffering.

The evaluation findings show that most of the evaluations (8 out of the 9 included in this report) discuss whether projects are appropriate to the patients' needs and the local context, in terms of both positive and negative examples as well as in terms of suggested improvements or recommendations.

An example, the Gutu evaluation concludes that most of the key informants found the project to be appropriate to meeting the affected population's needs, though the project was developed with very limited input from the potential patients themselves. In the specific case of women diagnosed with invasive cervical cancer however, the evaluation highlights gaps in the continuum of care due to lack of proper planning of referral mechanisms.

Acting as more positive examples of this aspect, findings of the Mumbai evaluation show that the project's model of care effectively supported changes to relevant DR-TB guidelines by demonstrating best practice, and the US Covid evaluation concludes that beneficiaries of the intervention got increased knowledge from trainings and improvement in wellbeing.

Information on whether priority was given to interventions in settings with excess morbidity, mortality and acute suffering can be found in most of the evaluations in the section which outlines project context in terms of mortality rates, prevalence of the specific disease etc. In the Bolivia evaluation, as an example, Bolivia's maternal mortality rate is first compared to that of the region, justifying the choice of country for the intervention. The city of El Alto is then presented as a location where women are especially vulnerable, justifying the choice of city.

The evaluation of the Ebola interventions in DRC concludes that although the three locations of intervention did experience excess morbidity and mortality from Ebola, in site #10 especially, other needs causing morbidity and mortality were neglected and side-lined due to the focus on Ebola.

FOCUS ON VULNERABILITY AND NEGLECT

OCB will focus on populations in need, who have been affected by conflicts, epidemics, natural disasters, exclusion, economic crisis etc. Especially vulnerable persons include victims of violence, women, sex workers, men having sex with men, IV drug users, migrants, ethnic minorities.

Whether projects had been able to reach vulnerable populations or not is assessed in five of the nine evaluations. In the case of the Eshowe project, for example, the evaluation concludes that the project was able to reach populations at higher risk of HIV, such as young boys and girls, and that door-to-door testing was a good method for accessing hard to reach communities. The Mbare project, on the other hand, needs a better strategy to reach key populations, such as LGBTQI+ youths, and giving them access to SRH, according to the evaluation.

Not quite as many evaluations mention whether the projects assessed the needs of particularly vulnerable groups (3 out of the 9). Among the ones that did, the US Covid evaluation presents a positive example as it concludes that the decision to intervene in specific locations was based on feasibility and epidemiological data for underserved populations in each location. In the Digital HP

project however, lack of data collection made it difficult to assess the needs of the particularly vulnerable, according to the evaluation.

THE PATIENT AT THE CENTRE

OCB will engage with and involve patients, communities, and civil society as active participants in order to ensure relevance and accountability. We will act on feedback and needs and provide patients with information so that they can make decisions regarding their own health.

An example of one orientation overlapping with another, The Patient at the Centre includes components covered under Medical Humanitarian Identity, such as whether the project was appropriate to and took into consideration patients' and communities' needs. Confirming what has already been mentioned under Medical Humanitarian Identity, most of the reports address this component.

Very clear and concrete examples of how an evaluation highlighted a project's ability to put the patient at the centre can be found in the Eshowe evaluation, which shows that communities were mobilised for testing, prevention and treatment, and were accepting and supportive of those affected by, and infected with, HIV and TB citing that efforts MSF invested in community engagement paid off.

When it comes to patients being able to make decisions regarding their own health, there are few examples given in the evaluation reports, suggesting that this is a component that was not often evaluated in 2021. In the Ebola evaluation, this is cited as a component MSF did not consider a key principle of the intervention. The examples that were found come from the Gutu, Mbare and Bolivia evaluations, where in the case of both Gutu and Bolivia, the evaluation findings conclude that women patients were given respectful treatment, and the chance to choose birth postures (in the Bolivia case) and female nurses (in the Gutu case). In the Mbare evaluation, an issue is pointed out in that adolescents did not get to choose between using reusable pads or menstrual cups or be able to express an interest regarding condoms.

How projects adapted to evolving and changing needs is touched upon in six of the evaluations, the US Covid evaluation being a good example. According to the evaluation, project documentation shows that teams were attentive to local needs by responding to changing circumstances. In the OCB projects in Michigan and Texas, some project components were added onto projects while others were cancelled to best suit the target population. The Arche evaluation highlights that the project strategy was modified according to the changing context and needs. In the case of the Ebola intervention, however, the evaluation reads that in response #10, good adaptation to changing needs was lacking.

CONTINUUM OF CARE

OCB is committed to a functioning continuum of care system which starts with primary health care on the community level, continues with primary health care facilities and ends on a hospital level. The goals and objectives of a project decides at which level a project should intervene.

More than half of the evaluations (4 out of 9) address this orientation in terms of whether the project had a functioning referral system between different health care levels. Whereas the Mbare evaluation reads that no data was provided for the outcome of referrals made from the project, the Eshowe evaluation concludes that MSF's data and management system contributed to successful linkage to care. In the Gutu project, an issue addressed in the evaluation was that a lot of women who were supposed to be referred to tertiary

centres for chemo-radiation therapy and palliative care were not.

How the projects assessed at what level of healthcare to intervene is not mentioned in any of the evaluations.

TÉMOIGNAGE AND SPEAKING OUT

OCB will place speaking out at the core of its identity and will thus develop strong private and public positions on the human suffering we witness in the field and on global topics. We will also advocate for new diagnostic or treatment strategies. Operational research will always be integrated into projects. We will give a voice to our patients.

The Gutu, Mbare and Mumbai evaluations all mention that advocacy efforts could have been strengthened in the projects. In the US Covid project, on the other hand, advocacy played an integral part. The evaluation concluded that working with underserved groups led to opportunities to advocate for these groups and to advocate for MSF's work in the US.

In the Mumbai and US Covid evaluations, the production of evidence for advocacy purposes is covered. In Mumbai, the project's operational research activities directly influenced five WHO publications, and, in the US, the MSF publication "Failing our Elders" was produced to educate policymakers and the public on Covid-19.

Although several evaluations, as addressed previously, mention putting the patient at the centre of care and listening to the patient's needs, the aspect of giving patients a voice, as emphasised in this orientation, is not mentioned in the 2021 reports.

GETTING THE RIGHT STAFF IN THE RIGHT PLACE, TIME AND ROLE

OCB has an HR approach which aims to take away the labels of national, international and HQ staff while continuing to ensure competent, professional, and autonomous staff members. Training of staff will be a priority.

All the nine evaluations mention human resources in one way or another. Staff trainings specifically is covered in five out of the nine evaluations. In Eshowe, training and mentoring was effective for ensuring that doctors and nurses were well informed and equipped and in the digital health promotion project, field teams learned technical skills through the DHP trainings, according to the evaluations. The Arche evaluation notes that trainings received by staff who will remain in the health system once the project closes will continue to be of value.

Power imbalances between staff is brought up in the Mbare and Digital HP evaluations. In the case of Mbare, hierarchies between peer educators and MSF staff limited peer educators from contributing to program decision making. In the Digital HP project, the evaluation points out power imbalances between field staff and Digital HP Unit staff.

On a more positive note, the efforts made regarding HR management in Bolivia, was something the evaluation cited as a factor of success.

Beyond the scope of the orientation, human resources are recognised as a reoccurring theme throughout the evaluations included in this report. This will be discussed further in a later section of analysis.

BE A RISK-TAKING ORGANISATION

OCB works towards expanding networks, deepening analysis, and improving our ability to navigate complex political environments. We will keep our neutrality and impartiality central and negotiate our access to beneficiaries with tact.

Questions related to this orientation are concentrated in 4 out of the 9 evaluations and most thoroughly discussed in Ebola where the question of whether the project was aligned with MSF's principles plays a big part. The evaluation states that various key informants were concerned that OCB compromised the principle of impartiality by allowing Ebola to cloud the judgement of other competing needs. Further, Strategic Orientations of the response varied depending on individual interpretations of MSF's principles, according to the evaluation. In addition, the Arche evaluation notes that certain strategies, such as the installation of the project in a public structure, were not compatible with the need for an urgent humanitarian response to the crisis nor with MSF principles.

Due to the nature of the project settings, the Ebola and Mumbai evaluations address the component of navigating complex political environments. The Mumbai evaluation argues that the project could have better addressed the broader political context and how it would affect policy changes. At the same time, the political context was considered when, as the evaluation reads, a decision was made not to directly lobby or advocate the government due to government antagonism towards INGOs. In the case of the Ebola evaluation, the armed conflict is presented to have gravely complicated managing the project. Further, the poorly managed complex relationship between OCB and the MoH led to MSF not leveraging all of its resources, according to the evaluation.

ACT RESPONSIBLE AND ACCOUNTABLE

OCB will strive for accountability towards patients, communities as well as towards the rest of the movement and our donors. We will communicate our achievements, challenges and setbacks and engage in dialogue with our beneficiaries. Closure of projects should be responsible, accountable and have a realistic timeframe. Capitalisation, critical learning exercises, routine monitoring and evaluations of projects should be systematised. OCB is also committed to the principle of 'Duty of Care' towards staff and beneficiaries.

In all, 7 out of the 9 evaluation reports mention the project exit strategies with most of the comments referring to how handover and closure of the project could have been done better. In both the Mumbai and the Eshowe evaluations, the timeline of handover is mentioned as something that could have been improved. The Eshowe evaluation addresses that both project documentation reports and training of non-MSF medical staff could have been done earlier while in the case of the Mumbai project, the evaluation recognises that exit strategies lacked a defined timeline more generally.

Positive examples of exit strategies are found in the Bolivia, US Covid, and Arche evaluations. In the Bolivia project, MoH staff gradually started to perform delivery care as part of handover strategy while, in the US Covid project, (Michigan and Texas) collaborations with the local school of nursing were developed to handover the IPC toolkit to be integrated in the curriculum. The Arche evaluation brings up decentralization and skills transfer, as part of an exit strategy, to keep the project operational and responsive in the event of new wave of violence and conflict.

Mention of monitoring and evaluation frameworks is another component of this orientation which appears in a majority of the evaluation reports (in 7 out of the 9). The comments concerning this component are mainly negative which suggests that this is an area in which projects have room for improvement. Data collection, design of M&E systems, and more accurate and transparent M&E systems are stated as areas in need of improvement in the Arche, Mbare, Bolivia and Digital HP evaluations respectively.

Management of partnerships with involved actors also falls under this orientation and is another area where the evaluations detected

weaknesses in the projects. Whereas the Mumbai and US Covid evaluations present cases of successful partnerships – with institutions linked to the central government in Mumbai and with local partners, collaborators and other stakeholders in the US – the Bolivia, Ebola and Digital HP projects were less successful in this regard. The Bolivia evaluation concludes that lack of joint planning and M&E with stakeholders may have contributed to the weak engagement of MoH staff. In the Digital HP project there were disagreements regarding content of campaigns between field staff and DHPU. The Arche evaluation suggests that some of the main stakeholders and key actors of the project, including the Ministry of Health, were not involved in a timely manner, which may have had an impact on the collaboration with stakeholders throughout the project (until 2018). The Ebola evaluation states that inter-OC relations and relations with the MoH were fragmented and directly impacted the ability to deliver. Last, the Mbare evaluation concluded that the project's successful implementation will depend on successful partnerships.

The ways in which projects show accountability towards patients and the community is a component that is not touched upon a lot in the evaluations. The best example where it is mentioned comes from the Gutu evaluation where it is recognised that MSF utilized its existing good collaborations with stakeholders and beneficiaries in the implementation of the intervention in order to gain buy-in and support from the communities.

GOING BEYOND THE OPERATIONAL PROSPECTS

Many of the evaluation findings from 2021's evaluations do fit into the framework that the Operational Prospects provide for this Annual Report, which underscore that the orientations do capture priorities that OCB must address to achieve its medical humanitarian objectives and improve quality in operations. Yet there are still numerous, reoccurring findings in the evaluations reviewed that do not fit in into the OP framework, thus not included in this report, while constituting topics that OCB may want to consider. To illustrate examples of these missing findings and ways in which the analysis ought to be expanded, two examples are raised here.

Aspects related to human resources is one where there were important findings that did not fit into the scope of the Prospects. For example, and as has been discussed above, some of the evaluation explore the orientation *Getting the Right Staff in the Right Place, Time and Role*. Throughout the evaluation reports, however, additional points related to human resources – particularly in hiring of staff and high staff turnover – were repeatedly (five out of eight evaluations) appearing that do not align with how the orientation is explained.

In other cases, themes that were recognised as rather significant in the evaluation reports are mentioned in the orientations but do not carry the same weight as the importance allotted in the evaluations. Community engagement is one such theme, which, although it is mentioned within the orientations *The Patient at the Centre*, *Continuum of Care* and *Act Responsible and Accountable,* it is not given much space. Meanwhile, several of the evaluations speak quite directly to the way in which community engagement is done, as well as its impact.

Even though it is important to know whether the year's evaluations align to the Operational Prospects and its strategic vision, a deeper analysis for capturing and synthesising learning comes from identifying themes and occurrences that evaluations pick up from projects that go beyond this framework. For this, it is useful to access the paper on reoccurring themes produced by the SEU in

2021 for its OCB Evaluation Day[7] to consider a broader framework.

CONCLUSION

This report provides an overview of evaluations completed in 2021, along with insights into both the ways and the extent to which the evaluation findings align with the Operational Prospects. That said, caution is needed when drawing conclusions as the evaluations constitute a snapshot of the entire project portfolio that aims to deliver on OCB's strategic direction. It is however possible to draw some general conclusions.

The Prospects' Priorities do provide a valuable understanding of how OCB defines and understands operational relevance within the medical humanitarian context. One interesting area for further analysis may be in how the evaluations define relevance and gain an insight into how project relevance is negotiated within the framework of the Operational Priorities. Recurringly, the evaluations included questions on whether to intervene, where and with whom shape an understanding of this relevance. Developing this may provide useful insights into how evaluations can be better contextualised in the future while possibly identifying new or outdated priorities that can help guide OCB operations and operational decision making.

At the level of the Strategic Orientations, there is some alignment in terms of what is being discussed in the evaluations although it is difficult to draw firm conclusions. The orientations, by definition, identify specific directions to achieve longer-term aims although they are not systematically addressed in the evaluations. Going forward, the SEU needs to work towards ensuring that the Strategic Orientations are systematically addressed, including to better incorporate vulnerability, continuum of care and patient centred into the definitions of appropriateness.

Conclusively, though providing interesting reflections, the Operational Prospects are not comprehensive enough as a framework for reporting on the SEU outputs during the year. This suggests not only that the SEU must reconsider how to frame the Annual Report in coming years, but also that OCB ought to find a way to take into consideration broader learnings from the evaluations into its internal discussion on the strategic direction and ways to prioritize operations (both what and how). What this report has also highlighted is that there are significant opportunities to better incorporate the language and values of OCB into the evaluations and specifically into how the normative criteria are defined within the OCB context, as part of a discussion on quality. This would also improve the way in which evaluations are able to systematically account for the progress being made against the Operational Prospects.

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[7] Only some of the recurring themes are illustrated here. The SEU paper on these themes cites four overarching areas: program management, program quality, set up and data & analysis.

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