Evaluation Management Response

Evaluation name: MSFAC / The MSF Academy's Basic Clinical Nursing Care Training
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PART 1: SUMMARY OF PROJECT AND EVALUATION

Summary of project:

The Basic Clinical Nursing Care (BCNC) learning programme is one of the earliest initiatives of the MSF Academy and was born out of the consensus in MSF that the quality of nursing care in many MSF-supported hospitals was problematic and the competency-level of the staff providing the nursing care were not at the required level, principally due to a lack of access to paramedical training of quality and the absence of continuous training systems in most countries where MSF works. The MSF Academy organised a couple of competency gap assessments, in collaboration with AMREF or the University of Ghent, to measure the competencies of the nursing teams respectively in South Sudan (Maban) and in CAR (Bangassou). These assessments largely confirmed this consensus. The purpose of the BCNC programme was to increase the competencies of the nursing teams in MSF hospitals and bring them up to speed with MSF standards and guidelines. As such, this programme aims to contribute to an improvement in the quality of care in MSF hospitals. A competency-based approach was chosen, and a strong emphasis on bedside clinical mentoring to ensure the transfer of the learning into daily practice was adopted and adapted to this purpose.

The level of nursing care in MSF hospitals in South Sudan is considered among the most problematic in the world and the BCNC is seen as an essential programme to improve quality of care. The programme started in Pibor (OCB hospital) and later in Agok. Both programs were suspended due to security problems. The implementation in Old Fangak was the first location where the curriculum was completed.
In Kenema, the MSF Academy contributed to the introduction and development of the nursing team in the start-up phase of the MSF hospital project, and consequently, it was agreed with all stakeholders to roll out the BCNC in this hospital.
Now, in April 2023, the implementation of the BCNC programme has gained cruising speed, having started in 21 hospitals, a total of 1.365 learners ever enrolled in the programme, of which 185 already graduated.

At the MSF Academy, we consider monitoring and evaluation (M&E) of the BCNC and all other Academy initiatives to be essential to measure the effects of the learning and to be able to adjust activities and approaches in due time. The MSF Academy has chosen to develop a framework and strategy for its M&E in parallel with the implementation of the first programmes, instead of waiting for the former to be designed to implement the latter. Such approach allowed to obtain concrete results on the ground relatively soon and to

progressively build an M&E strategy that is functional and adapted to the specificities encountered. All internal stakeholders support this approach, as otherwise it would be too slow to move towards the first effective activities and would risk that the MSF Academy lose its momentum in the MSF movement.

Summary of purpose and intended use:

The MSF Academy has worked since 2020 on the establishment of a more robust M&E framework to measure the effect of its learning programmes. Our ambition is to apply the HPass standard system as an overall framework and use as a reference the Kirkpatrick model to evaluate the learning programmes at different levels. For this purpose, a detailed framework of indicators is progressively being created and a database has been established to capture and analyse the routine data that are produced in the different programmes.

The MSF Academy also intends to use external evaluations to complement this M&E framework, especially to measure the impact of the programmes (Kirkpatrick level 4) beyond merely learning outcomes. The commissioning of the present evaluation of the BCNC programme, in collaboration with the Stockholm Evaluation Unit (SEU), had this purpose and was planned as an investment to start measuring the impact of the BCNC, especially on quality of care.

Unfortunately, the interaction between the evaluation team (ET) and the MSF Academy was very limited from the start, and the Commissioner and evaluation focal point were not concerted in the development of the evaluation purpose, which remained a discussion between the SEU and the ET. Ultimately, it did not end in an agreement between the ET and the MSF Academy commissioner and focal point. In that sense, the intended use of this evaluation was not reached.

Nevertheless, the evaluation still turned out to be an interesting exercise that revealed important findings and allowed to identify some significant challenges for which the MSF Academy executive team can develop a plan of action aiming to improve key aspects of the functioning of the BCNC programme.

Summary of findings and conclusions:

At the MSF Academy, we are pleased to see:
A clear documentation of the positive effect of the BCNC programme, indicating that it did indeed improve the skills and behaviour of the staff providing nursing care, which was the prime objective of the initiative.

That the bedside clinical mentoring is being recognised as extremely valuable within the adopted pedagogical approach. Clinical mentoring is the central component of our learning design.

The recognition of the value of the certification and the external recognition by the health authorities in South Sudan. However, it is disappointing that the ET failed to see that this is also the case in Kenema, where the MSF Academy obtained a comparable agreement with the Sierra Leonean health authorities and the Nurses & Midwives Board Sierra Leone – all completion certificates are co-signed.

We recognise and acknowledge a series of challenges observed by the ET and have a strong ambition to improve our practice in this regard:
The need to ensure a more detailed contextual assessment in each site of implementation of the BCNC, priori to the roll-out of the learning activities, so that the programme, the learning approach and the curriculum can be more adapted to the learners' needs and expectations. Since the start of the BCNC in Kenema and Old Fangak, we have advanced already in this regard, but the observations and recommandations motivate the Academy to make more progress on this. We will adapt the initial assessment strategy to achieve a better understanding at baseline and increase the adaptability of the BCNC implementation approach and the support we can provide from the HQ team in this regard.

The need to improve communication and exchanges with all key stakeholders. It was the ambition of the Academy from the start to have a very good interaction with everyone involved, especially the operational teams. The ET's observations in this regard clearly indicate that we failed at least partially in this objective. We need to strengthen and improve communication, exchanges and interaction with all key stakeholders at all levels, and to make sure to keep this individualised, to palliate from loss of transmission in case of turnovers. We will develop a plan (and tools) to ensure all MSF Academy staff continuously play their role to optimise the interaction with all key stakeholders, and to regularly communicate and exchange on rationale, progress, challenges, solutions, outputs and impact relating to learning programmes' implementations.

The communication and interaction with the learners hold also important learning points. We agree with the findings that we need to be better organised to capture and use the feedback of learners at different stages in the implementation of the programmes. This is

also a good way to exchange on and manage the learners' expectations. The current practice is a basis but is not sufficient.

The need for more attention to gender-based risks and cultural specificities and needs of the learners is the most remarkable observation. Although the majority of the MSF Academy clinical mentors are gradually locally hired staff, the evaluation shows that we have underestimated this aspect in the implementation strategy and approach of the BCNC. Based on the findings, we will develop a plan to improve our work in this sense.

While we have been responsive to the field teams' feedback and adjusted many aspects of the learning programme already, we failed to document this and to share our learning in a structured manner. We do need to continue improving our documentation and capitalisation throughout.

We were hoping this evaluation would give us an insight of the impact of the BCNC. We acknowledge it was early in time to evaluate impact but we were expecting more input on what would be interesting to look at in the future. The ET just mentions that we should evaluate the impact without any advice on how we might do this.
Finally, we do not recognise a certain number of observations of the ET:

The described level of disconnect between the MSF Academy (its objectives, activities and teams) and the MSF field teams and learners in the field. We recognise that the Academy did not always achieve the level of co-ownership with operational teams in the field that we aimed for, but the description and overall impression given by the evaluation report does not reflect the reality as we experience it in many occasions. The ET, seeing the very limited time spent in the field (less than initially planned) and the prioritisation in interviewees' selection did not allow to capture a complete view of the reality; the perceptions collected from the interviewees were often not triangulated with MSF Academy staff that followed the project from beginning up to evaluation point. It is disappointing to see that they do not notice the efforts in the design of the MSF Academy set-up to work on an optimal ownership with the field teams.

The described absence of Theory of Change (ToC) framework and the consequences it has on building ownership and transparency creates a false impression that the MSF Academy does not want to invest in measuring the results of the training and in ensuring accountability. It is clear that the ET judges the choice of the Academy to have started building up activities in the field before having completed a detailed M&E and ToC framework as unacceptable. This position colours quite a bit the interpretations of the findings and the overall judgement of the BCNC's design and implementation. A good system of M&E remains our ambition, and already in these first implementations of the BCNC, interesting information is yielded that allows a first degree of accountability.

The described absence of external recognition of the training certificates by the authorities as described by the ET for Sierra Leone is a mistake, and it is a bit difficult to understand how the ET misses the reality on the ground. Since 2020, regular interactions have been established by the MSF Academy Representative with the MoH and the Council of Nurses. This has led to a formal recognition of the BCNC curriculum, confirmed in a written agreement. More recently, the MSF Academy has been working with these instances to assist them in the creation of a continuous professional education system for nurses at national level. This would create a credit-based system, and it seems that once this exists, the authorities would be eager to accept the BCNC into this credit system.

PART 2: RECOMMENDATIONS FOLLOW-UP

Recommendations

Recommendation 1: Needs analysis related actions for any given location which the BCNC is considered working in.		
Accept/Partially accept/Reject	Partially accept	
Responsible	Too many different recommendations to list the people responsible	
Timeframe:	To be defined for each sub recommendation	
Comment:	We subscribe to these recommendations but need to further analyse the feasibility of the last point.	
	Sub recommendation	Steps we will take in 2023-24
Steps for Follow-up:	Through a collaborative learning needs assessment (with MSF OCs and the sector) undertake research/contextual analysis to ensure an in depth understanding of the needs, opportunities and challenges for each context.	Start documenting the discussions on learning needs we have before deciding to start a training. We do consult a number of stakeholders but do not document it enough.
	Include a gender and diversity analysis to understand how power and access issues can be addressed during design to avoid further embedding gender inequality and contribute to gender equality.	Identify a team member to collaborate with relevant MSF working groups on this topic to gain expertise. Identify aspects to add in our initial assessments and take results into account to adjust the pedagogical approach
	Revise the competency framework to contain outcome level statements (rather than just clinical steps) and include required levels for each outcome	Revise competency framework and CGA, and adapt analysis tool (PowerBI dashboards) to reflect collected data per each outcome-oriented competencies.

	which the learning can be mapped against*. Use this during CGA. Use the CGA tool to assess individual learning needs and create different levels of learning cohorts depending on current capacity or individual learning paths, each cohort will then work at a different pace and content. Seek to improve the understanding of the CGA approach and look at ways of increasing its value for nurse learners, their supervisors, professional bodies and future employers.	Already the case for other MSF Academy programmes. Revise CGA to have an individual analysis of results and assess the feasibility of individual learning pathways and/or different level cohorts

Recommendation 2: Design and set up related actions in any given location		
Accept/Partially accept/Reject	Partially accept	
Responsible	Too many different recommendations to list the people responsible	
Timeframe:	When we start BCNC in a new project	
Comment:		
	Sub recommendations	Steps we will take in 2023-24
Steps for Follow-up:	Use early consultation and a participatory approach to make the BCNC more relevant and therefore more likely to be consistently applied by nurses. Through this consultation build on and research the following areas: o Nurses' motivation for taking training and the barriers associated with engaging in the training, these are such as enabling environment, pay and home:work balance. Include an assessment of learning preferences and the balance of classroom and mentoring time. Develop mitigation strategies to address any areas that may have impact on the nurses' motivation to participate in or complete the BCNC training. o Proactively creating and managing a shared understanding of the BCNC's objectives, content and delivery, along with collective buy-in to increase ownership of the BCNC, this will contribute to reducing differing expectations and frustrations (as demonstrated in both OFG and Kenema), and increased the BCNC's value to learners.	Include these aspects in an additional questionaire we will administrate during the pre training CGA, for all field-implemented learning programmes Underway: we have revised and completed a BCNC framework which includes clarifications on this. We have also have improved our communication plan, including briefings for medical team and learners. We also have discussions with local authorities on recognition of certificates. Such frameworks also exist for other programmes, and similar improvements are under way.

	o Recognise and discuss existing skills to reduce feelings of frustration amongst nurses. o Clarify the role of the BCNC in learners career development or CPD. A collaborative approach with the MSF learning and development (LND) units may be an appropriate approach. Complete an evidenced and comprehensive ToC, MEL and exit plans for each location to inform all stakeholders of the rationale, expectations and planned outcomes of the BCNC training. Consider the use of tools such as the RACI matrix to improve cross-sectional working and to clarify roles and responsibilities and communication, as well as expectations. Consider better alignment of the BCNC with national curricula to increase the value and utility of the BCNC beyond MSF. Review how LCs are integrated into programme for each specific context, where they add value, were safety and security is a concern plan for mitigating actions and how they can be recognised and compensated. Use a consultative approach to find alternative methods to manage the demand on mentoring vs caseloads and workloads for each context. This might involve mentoring in groups.	With individual analysis of CGA reports we will have a clearer view on existing skills. Depends mainly on what processes exist in the project/mission. We will investigate those and collaborate more with HR/L&D to make sure BCNC is integrated in existing processes for CPD or career development Underway: we are currently developing MEL plans and post-BCNC strategies While we always collect information on existing curricula for each country where we implement the BCNC and will keep on doing so, we believe aligning BCNC curriculum with national curricula contradicts our goal to be primarily focused on MSF needs and responsive to project-specific priorities. We will re-examine possible alignment if or when national CPD frameworks are being implemented (Sierra Leone). For the moment we are not aware of any CPD curricula in the countries where we deliver BCNC. Improve onboarding of LCs. Make sure they are aware of our feedback mechanisms. Communicate better on MSF hotlines and other channels they can use to report safety and security issues. We will identify the appropriate ways for us to detect and manage these issues. Better follow-up and support the LCs development, for example helping them obtaining the mentoring certificates and discussing their career development with the projects. Underway: recognising their skills by making them mentoring stations focal points Underway, we are now systematically identifying skills that are infrequently performed in a project and set up an action plan: remove them from curriculums, do rotations so that

		everyone can practice, do more in skills labs. will consider organising mentoring groups. We also developed an approach of ”mentoring stations” per service and will pilot it.
	Use the CGA findings to consider adaptations to the delivery for the BCNC.	Underway: we have already done this for BCNC in Yemen as CGA results showed higher level of competencies
	Actively consider the strategic use of international staff and how to improve their integration, understanding of the contexts in which they and nurses are working, and understanding of the BCNC's objectives and curriculum to allow them to better support nurses in the utility and application of skills and knowledge.	Improve briefings. Create functional link between mentors and medical team in the project

Recommendation 3: Delivery related actions		
Accept/Partially accept/Reject	Partially accept	
Responsible		
Timeframe:		
Comment:		
	Sub recommendations	Steps we will take in 2023-24
Steps for Follow-up:	Create a system that captures and responds to regular feedback from learners and staff (feedback should include whether the programme is appropriate, enjoyable, challenging, achievable and inclusive)	Underway. We are revising current satisfaction surveys to include those aspects more comprehensively
	Evidence how feedback about learners' progress amends the delivery process when required.	Underway. We adjust the content delivery depending on each inidividual learner's needs during catch-up and mentoring weeks. We will start documenting the contents of these flexible weeks. We also offer eLearning as a catch-up or reinforcement strategy.
	Demonstrate how learners' progress has been responded to, including where requests cannot be supported.	Underway. We now have additional functions in the database to track the progress. We also have clearer criteria to determine participation of learners in the programme
	Provide greater autonomy to the hospital and CMs to adapt the BCNC to	We disagree with this phrasing. Mentors (CMs) are completely entitled to make

	suit the context and to be more responsive to the hospital's needs, create change control processes for this that captures and justifies change but that is not overburdening or slow to respond and sign off. Consider additional learning techniques to allow nurses to share their experience and to promote group discussion - such as small group discussions at bedsides. Monitor risks during delivery and respond appropriately, including incorporation of actions from the Inter-agency Standing Committee (IASC) gender-based violence (GBV) GBV guidelines. Consider succession planning and retention strategies that reduce turnover whilst not setting so precedents that cannot be matched elsewhere (for example further education opportunities that cannot be offered to others).	changes as long as these are validated by the country pedagogical manager. They discuss contents as a team and amend the session plans and handouts contents. We can evidence this. We can only remind all mentors that they can make changes. Will pilot this We will read these guidelines to better monitor risks and identify potential appropriate actions to take Not in our control (HR responsibility) but we will keep on advocating for this. Also something that is part of our "post BCNC" discussion with the projects. To note though: most of the turnover actually happens in the OC teams, as most MSF Academy teams (whether locally or internationally hired) are quite stable

Recommendation 4: Assessment		
Accept/Partially accept/Reject	Accept	
Responsible		
Timeframe:		
Comment:	Some of the recommended actions already underway (include an indication of level of competence within the assessment)	
	Sub recommendations	Steps we will take in 2023-24
Steps for Follow-up:	Involve head nurses and supervisors in an assessment, include an indication of the learner's journey towards a certain competency level. Include an indication of level of competence within assessment. Continue to seek accreditation of the qualification with MoH and nursing and	Involving head nurses and supervisors in assessment is already done in some projects. We will extend this wherever possible, as this is indeed very important. We already updated the learner's assessment at bedside with 3 levels Underway. We already have changed the learner's logbook to 3 levels. We will further align when the competency framework is revised. Ongoing

	midwifery boards with the aim of recognised and transferal credits for the BCNC course.	

Recommendation 5: Evaluation and accountability related actions		
Accept/Partially accept/Reject	Accept	
Responsible		
Timeframe:		
Comment:	Some of the recommended actions are alreay underway (MEL plan using Kirkpatrick 4 levels, QoC indicators)	
	Sub recommendations	Steps we will take in 2023-24
Steps for Follow-up:	Within the MEL plan, develop a range of qualitative and outcome level indicators to better demonstrate progress towards the BCNC's objectives.	Underway, will be finalised by end of 2023
	Suggestions include the need for measures around QoC and for those less tangible outcomes such as participant and patient, even community, appreciation. A suit of QoC metrics could be tracked for ongoing process improvement, these could include nurse sensitive quality indicators (NSI) and consideration of methods to demonstrate associations between training and changes in QoC.	Underway, included in the MEL framework and tools we are developing We have developed and are implementing in every new project a QoC baseline assessment
	Determine if there is a need for a set of QoC indicators specifically for BCNC/Academy and work independently or with others (NCWG as intersectional) to agree NSIs. Include baseline data and benchmarks, data collectability, and align with BCNC content and MoH educational standards1 .	Underway We have developed and are implementing in every new project a QoC baseline assessment focusing on indicators BCNC can have an impact on We are discussing with NCWG to align the way these NSIs are measured across OCs
	Include a training monitoring and evaluation plan using Kirkpatrick's 4 Stage Training Evaluation Model. This can be linked to indicators in a MEL framework.	Underway, included in the MEL framework and tools we are developing. Satisfaction surveys and post-training surveys exist and will be revised by July 2023
	Create a policy and guide for supporting transparent and honest feedback from relevant stakeholders (including anonymised questionnaires).	Underway, we have added this to the BCNC framework. It is now applied to the implementation of every new BCNC training programme we start

Recommendation 6: Cross-cutting recommendations		
Accept/Partially accept/Reject	Partially accept	
Responsible		
Timeframe:		
Comment:		
	Sub recommendations	Steps we will take in 2023-24
Steps for Follow-up:	Continue to increase collaboration with nursing associations and the respective MoHs to inform future BCNC content and directions,	Underway, always included in MSF Academy representatives' tasks and action plans. It is a continuous activity.
	help develop career pathways for BCNC graduates, and foster discussion on the potential for alternative certifications for healthcare workers not meeting existing licensure and certification standards.	As regards career pathways with MOH though, this may well be beyond our scope
	Continue to seek accreditation of the qualification with MoH and nursing and midwifery boards with the aim of recognised and transferal credits for the BCNC course.	Underway, always included in MSF Academy representatives' tasks
	Strategize how to reduce international staff reliance and increasing contract length in field locations.	Underway, some positions have already been made national staff in 2023, more are planned in 2024
	Create support mechanisms for learners from underrepresented groups (specifically for women, people with disabilities)	Will pilot this in projects where the gender and diversity analysis shows they would benefit most
	Create a plan to decentralise the decision-making process for the BCNC	We disagree with this statement. We can clarify and communicate better about the decision-making process so that everyone understands how it works, but it was never meant to be centralised.
	Develop at design stage (see above) an exit strategy and ensure it is realistic particularly in terms of resources required.	Underway. We are developing a "post BCNC strategy" that we start discussing with the current projects before the end of BCNC and that we will include from the start with new projects

Part 3: General reflections

Even though this evaluation did not work on the intended question provided by the MSF Academy team, the exercise does deliver a good number of interesting, valuable and actionable findings and recommendations. These will be taken up by the team and integrated in the workplans.

As a final comment, we would like to express our disappointment with the choice of the evaluation team by the SEU, who they continued to support throughout the exercise. The members of this team clearly hold a large experience in the field of M&E and understand the technical aspects of learning in the context of development projects in low- and middle-income countries. However, in our experience, they lack a great deal of understanding on how MSF works and functions. In that sense, it appears that they have approached this evaluation in a rather orthodox application of their vision of how a programme should run and be evaluated. In our view, this does not offer a very helpful view on our work.

Ultmately, this exercise has demanded a lot of energy throughout, including quite a lot of negative energy, and it leaves us with the feeling that the investment did not bring the return that we hoped for, to help us direct the future of the programme.