MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS

Meta-review of MSF hospital evaluations 2008 - 2012

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Managed by the Vienna Evaluation Unit

Consultant:
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Acknowledgements

I would like to thank all the people who helped us to make this meta-review of 14 MSF hospital evaluations feasible. Also, I would like to thank Sabine Kampmüller and her team from the MSF Evaluation Unit Vienna for their support, professional guidance, and for making this evaluation possible.

Abbreviations

Cf	confer
€	Euro
Eg	exempli gratia
i.e	id est
IR	intra-rectal
HQ	headquarters
HGR	Hôpital General Régional
HR	human resources
MSF	Médecins Sans Frontières
MoH	Ministry of Health
MOU	memorandum of understanding
NGO	non-governmental organisation
OCG	Operational Centre Geneva
TB	tubercle bacillus, tuberculosis

The Vienna Evaluation Unit

The Vienna Evaluation Unit started its work in 2005, aiming to contribute to learning and accountability in MSF through good quality evaluations. The unit manages different types of evaluations and learning exercises and organises training workshops for evaluators.

More information is available at: http://evaluation.msf.at.

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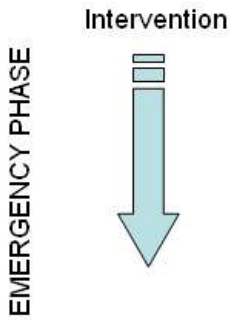
Key lessons – Meta-review of hospital evaluations

Provision of good quality secondary health care to underserved populations has always been one of MSF's concerns. Around the globe, MSF runs many hospitals in very different settings. The challenge of managing those, mostly in precarious settings, remains a difficult one.

The ambition to improve hospital care outcomes is a high priority in the MSF movement today. Over the past few years evaluations of hospital projects have been carried out by all the operational MSF sections at various points in time.

The aim of this meta-review of 14 evaluations is to highlight lessons learned and identify some of the major themes, which emerge for discussion.



Lessons learned

1 Hospital projects don't usually stop at the end of the emergency phase

64 % of hospitals evaluated were set up in an emergency setting: seven out of eleven. Nine of the hospital programmes were set up in a MoH facility, six other hospitals were built by MSF. Most hospitals started with a surgical approach and in all cases MSF was still present after the emergency phase.

Since the overall aim is mostly stated as reducing mortality and morbidity, it is difficult to define when the emergency phase is over.

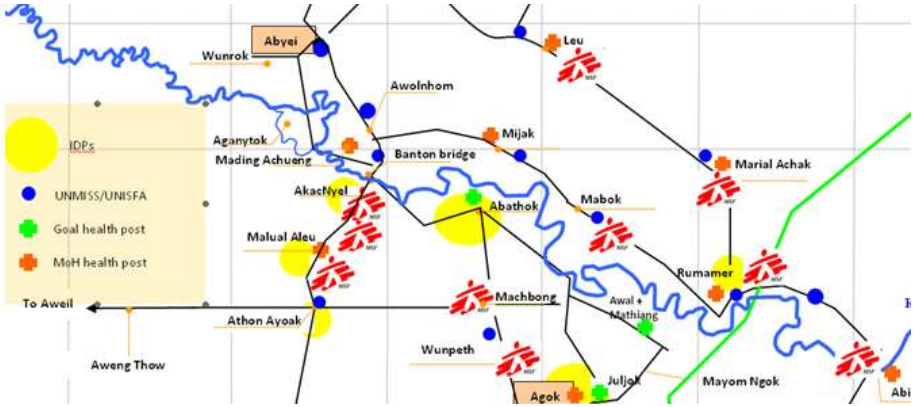
In 70 % of the evaluations (8/11) MSF was covering all hospital departments for a given period of time. Afterwards, MSF shifted to specific activities (eg, mother-to-child and/or nutrition programmes or burn units).

At this transition moment, MSF is confronted with the difficulty of defining the limits of the programme as well as priorities and objectives according to the orientation of the programme.

2 Stop and think at the transition moment

At the moment of transition from emergency to longer-term engagement, MSF is (even more) confronted with the difficulty of defining the limits of a programme. In several of the reviewed evaluations it became obvious that this point was missed (ie,

significant changes in the context did not lead to timely and required adaptations in the MSF programme). One of the recommendations that comes up several times is the importance of taking existing healthcare access, together with the needs of the population into account. For example: the evaluations noted that some MSF facilities were very close to each other offering similar care. This set-up was necessary at the beginning of the programme, because for security reasons the population was not able to move from one place to another.



Five years later, the security situation had changed. The population was able to travel freely from one place to another. During this transition period MSF should have adapted its set-up, taking into account the changing context and the other health actors present.

In another example, the already existing five-year plan including a withdrawal process was forgotten because of a re-emergence of the conflict. When the evaluation team arrived in the field, none of the team members were aware of the existence of this long-term plan.

In at least two of the evaluations, the hospital set-up extended haphazardly without any initial overall plan. The result of on-going demands and striving for improvement was a non-coherent setup in terms of patient flow, which directly impacted on the quality of care.

This described lack of general overview of the hospital functioning is partly explained by the primarily vertical approach to hospital management. Each field visit of a technical adviser provides specific recommendations concerning his or her subject only. When looking at the main issues in the reviewed evaluations, hospital planning or set-up is the priority subject. In a hospital set-up, the initial assessment of the programme is crucial but sadly often missing.

MEDICINE - 25 beds	NUMBER	EFFECTIVE SURFACE (ES) M²	TOTAL EFFECTIVE SURFACE	Comments
		ACCOMODATION ZONE		
Bedroom with 1 bed	1	16,00	16,00	with bathroom
Bedroom with 4 bed	6	44,00	264,00	with bathroom
patients toilet-shower	1	10,00	10,00	
Subtotal 1			*290,00*	
		NURSING ZONE		
Nurse office	1	12,00	12,00	
Nursing care preparation	1	14,00	14,00	
Dirty room, washing	1	6,00	6,00	
Sub-total 2			*32,00*	
		ANNEXES		
Storage	1	10,00	10,00	
Clean linen	1	8,00	8,00	
Cleaner room	1	8,00	8,00	
Dirty linen	1	6,00	6,00	
Waste	1	6,00	6,00	
Sub-total 3			*38,00*	
		COMMON SPACES FOR 2 x 25 BEDS UNITS		
Medical offices	2	12,00	24,00	
Staff dining quarter	1	12,00	12,00	
Staff toilets	1	4,00	4,00	
Rest office	1	15,00	15,00	
Sub-total 4			*55,00*	*27,5 m2 per unit*
TOTAL MEDICINE 25 BEDS			387,50	M² E.S.

Source: Programmation Hospital, Hocine Bouhabib.

All of the reviewed evaluations were conducted after two to ten years of MSF presence, always when the emergency phase was over.

In the majority of the evaluations, MSF doubled or trebled the bed capacity of the facility (see Table 2: Number of hospital beds for the 14 evaluations

over the programme period. Reasons provided for this include:

- Lack of time to organise an initial assessment, the priority was the emergency
- Constantly answering to new needs and demands
- Dilemma with the objectives and how to define priorities

The required bed capacity, according to population figures and other facilities, does not seem to be systematically established.

Only one evaluation shows a reduction of the number of beds from 300 to 123. MSF took this decision before the withdrawal process, in order to be in line with MoH standards. The evaluation underlines that the construction and rehabilitation was necessary and appropriate to provide the infrastructure required by the HGR to deal with the flux of patients and improve hospital capacity.

Programme impact/coverage is often looked at without taking other actors into account. In one evaluation, MSF noticed a decrease in admissions for severe malaria in the hospital during the malaria peak. The teams were worried about people not coming to the hospital. The real explanation was simply that other actors had started a large malaria prevention campaign in the community.

3 Ensure clear objectives and indicators

Over the last five years, MSF has been trying to develop more and more three-to-five-year action plans. The difficulty seems to make this adaptable with the current planning cycle of reviewing the entire project twice a year.

One recommendation on this suggests reflecting how MSF could change its approach for long-term programmes. One evaluation shows that difficulties during the pull-out process emerge due to lack of detailed objectives in terms of time and outcomes.

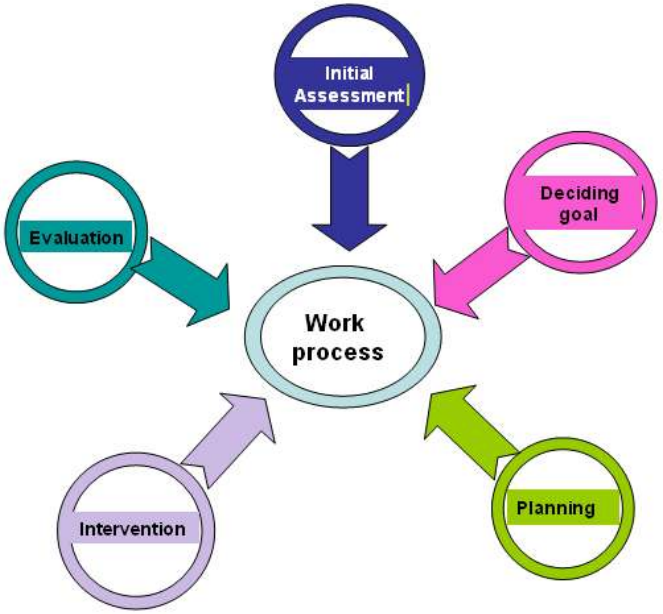
In another evaluation, the team was not able to measure the impact of the "emergency room" on the population, as overall mortality data were not available.

In terms of indicators, one of the evaluations shows the importance of working together with other actors on admission and discharge criteria. In this particular programme, MSF was providing care to severely malnourished children and another actor was providing care for moderately malnourished children outside the hospital. As the admission/discharge criteria were not the same, it was very difficult to refer children from one programme to the other.

Very rarely are there any indicators for education of patients, except for a specific quality evaluation. There seems to be little follow-up on patients' understanding and adherence to prescribed treatment. One of MSF's major objectives is to reduce mortality. Though evaluations affirm MSF's impact on hospital mortality, there are no data or indications for an impact on mortality or morbidity amongst the general population.

In terms of setting specific objectives and priorities, one evaluation describes the tension between field and HQ. HQ rapidly wanted to implement a "full" MSF package in order to lower the mortality rate but the field team first wanted to strengthen the hospital set-up.

A current study by OCP on hospital indicators will offer important guidance.



4 Need to reinforce data management

42 % of the evaluations note a major weakness in the collection and analysis of data.

Hospital mortality data were often neglected or insufficiently covered in evaluations. Teams do not seem to go through patient files systematically to analyse hospital mortality. Mortality is often expressed in terms of numbers and pathology only. In seven evaluations, the hospital mortality is used as a quality control mechanism, without analysing patient history in detail and other potential (care-related) causes of death.

In MSF settings, data on mortality of the general population are usually expressed in terms of retrospective mortality. In one evaluation, a conflict appeared between field team and HQ – HQ being concerned to rapidly reduce the high retrospective mortality rate in the general population (epidemiological survey) and the field team being more focused on how to implement the programme step by step in the hospital with the MOH.

As described many times elsewhere, the different sections of the MSF movement do not use the same data collection tools. This makes comparison and analysis difficult. For example, in a multi-sectional evaluation, it was difficult to compare data, because the definition of the indicators was not the same. In another example, before setting up a neonatology unit, patients were registered in different units using different data formats (paediatrics, maternity, etc), making the comparison or analysis of data very complicated.

5 Adjust human resources to the set-up of medium to long-term programmes

Several evaluations noted that the HR and management set-up of hospital missions is currently not different to that of other missions, whether at HQ or on field level. These organigrams have consequences for the implementation of medium to long-term objectives. At the same time, one of the biggest challenges for effective hospital management is the high turn of international staff (at HQ and on field level). In 55 % of the evaluations, the turnover of coordination or field level posts was an average of six or nine months. This affects the programme implementation and will have consequences for the motivation of national staff.

Good practice examples demonstrate that a set-up, where each key position has a national counterpart ("mirroring positions"), avoids the loss of continuity in the event of a gap of staff and builds national capacity.

First mission positions in a hospital project are usually foreseen for only six months. This does not give them enough time to understand, to take their place, and to implement medium or long-term objectives.

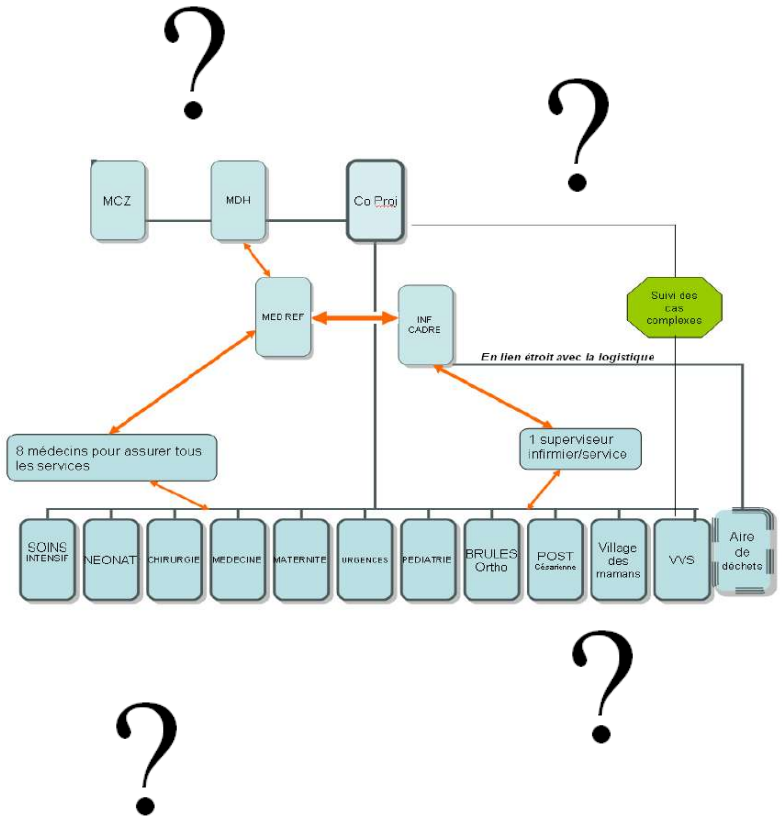
Another observation described in evaluations is that first missions are given clear instructions not to "change" procedures in place, but to take time to observe, analyse, and adapt themselves to the context.

While this certainly makes sense to avoid constant changes, it also discourages people from reporting incoherencies. Evaluations suggest that supervisors should take time for new staff in order to listen to them and use their views. Most evaluations note that field staff are either overwhelmed or insufficiently prepared for the task. Generally, they would require more training and guidance on hospital management. 82 % of the evaluations express some concerns about "training" but without clear recommendations.

Key HR questions concerning hospital projects do not seem to be answered today. These include the overall HR set-up, the position of medical coordinator vs. director of hospital, and responsibilities for staff as well as for links with partners.

The transition phase between management by the emergency and regular cell/desk, is critical – especially when the medium to long-term objectives are not so clear. Several evaluations show that these objectives need special attention.

One specific dilemma is that in some missions, MSF does not recognise the validation of certain competencies. For example, in certain African countries medical doctors are validated to carry out certain life-saving surgical procedures (eg, Caesareans). MSF asks them to work only as general practitioners in MSF missions. Therefore, they do not practise their (limited) surgical skills. However, when there is a gap of qualified surgeons, they are asked to operate – with the risk of insufficient practice.



6 Promote technical competence by using and combining available tools

The MSF movement has a gold mine in terms of documents, guidelines, protocols, and check lists (at least 490 files from different sections) on hospital management. Evaluations note that those are neither well known nor well used. On direct observation, evaluators note that protocols for emergency medications are not always easily visible (not up on the wall), eg, valium protocols, IR, etc. The aspect of field libraries is neglected in evaluations.

95 % of the evaluations mentioned quality of care, which is one of the big challenges for MSF hospital projects. However, the reports do not go into any details (eg, focus on infection control or improve quality of care). One part of an evaluation focuses specifically on quality of care. Unfortunately, the tools are in a development phase and not yet shared with everyone. This evaluation provided an overview of quality of hospital care. It would be interesting to make the tools available for the movement and validate them before further usage by the MSF movement.

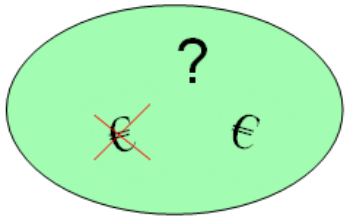
When MSF is involved in a MOH structure, there is often a dilemma whether to use MSF or national protocols. Where both are in use, national staff do not know which one to follow. One evaluation notes “the respect of national protocols was an asset in relationship building with MoH and patients”. It also notes “MSF aligns donation of medicine and training of MoH staff with national protocols”.

57 % of the evaluations describe the functioning of the pharmacy and note some dysfunctions (eg, shortage of drugs, not the same software between MSF sections, which again makes comparison difficult). In general, MSF has good knowledge on central pharmacy level but when it comes to the unit level most of the problems appear. A repeated recommendation is to add a position of expat pharmacist for a short time at unit level.

The hygiene committee, which is standard for any hospital set-up, is not mentioned in most of the evaluation reports; in some cases it is notably not in place.

During the evaluation processes, the evaluators themselves sometimes had difficulties in identifying which tools to use as a reference. Such circumstances result in unclear recommendations (eg, improve infection control but no detail on “how”).

7 Debate free access to health care after the emergency phase



The transition from MSF care free of charge in an emergency phase to the country specific system of cost sharing is often a difficult one. Also, patients' perception varies greatly: In one of the evaluations, free access to care for patients was viewed as poor quality care – people thought the more expensive, the better the quality.

In other evaluations, even if the context was more stable, the number of consultations or hospitalisations increased month after month, because care was free – the population "prefer to pay for transportation and come to a place where it is free of charge".

In different evaluated projects, MSF had several options for this dilemma: cost recovery (paying according to what the patient used), patient participation (paying a set price), or simply maintaining care free of charge before the withdrawal.

In one of the evaluations, MSF used pricing to regulate patient flow: the price of a normal delivery was twice as much in the MSF hospital than in the periphery in order to reinforce and promote normal delivery in the periphery. Complicated deliveries remain free of charge in the hospital.

Overall, it seems important to debate better solutions for this transition in the future.

8 Work on the collaboration with the MoH and other actors

Half of the evaluated MSF projects were set up in MoH structures. The main challenges for MSF are salary scales, protocols used, roles of the different actors, and the process of withdrawal. MSF usually uses a MOU to define the different responsibilities and who will be decision-maker for what.

In terms of salary scale, often two different ones exist (MoH and MSF). This creates a conflict between the medical staff and potentially affects the quality of care and team spirit. The salary scale is also often a subject of disagreement between sections or with others actors. Most of the time, MSF needs to increase salaries to attract qualified staff to remote areas.

In 64 % of the evaluations, relations with the MoH were difficult. Disagreement was mainly concerning payments and rotation schemes of MoH staff. In one evaluation a disagreement was resolved by dismissing the staff of an entire department during the handover and recruiting (on the part of the MoH) a lower number of staff on a lower salary scale. All those involved were satisfied with the process and results.

In another evaluation the conflict issue between MoH and MSF was to decide who was in charge of the hygiene committee.

In those cases, where MSF has chosen to work in MoH structures, it was for good reasons but appropriate investment is needed in such collaborations.

9 Plan & prepare withdrawal in time

31 % of the evaluations describe a withdrawal process with other NGO's or the MoH. The observation is that evaluators themselves often take a sceptical attitude towards handover to the MoH, especially regarding the maintenance of quality.

On the other hand, the aspect of preparing withdrawal in time is only marginally covered in evaluations and only when the withdrawal process was going on. Interesting work around exit has been done by MSF-UK and – also based on evaluations - the guiding document *"Making an exit: Advice on successful handover of MSF projects"* has been created. The document, among others, highlights the need for a pre-determined timeline, which should be based on the objectives of the handover (and depending on what MSF wants to leave behind for patients). It also emphasises that not only the immediate effects of MSF's departure are to be considered, but also the overall effects of its involvement in the local community and health care system.

One of the evaluations specifically focuses on handover. It provides some good practice examples, eg, the creation of a special post of "disengagement coordinator" (a national staff who will follow the process from the beginning to the end of the project or a capacity building initiative for MoH personnel).

One interesting example is an (economic) evaluation, which was requested in preparation for a withdrawal. It succeeded to project the real hospital costs without MSF involvement for the future. The financial database of MSF, per family and code, is defined for MSF needs and would not have allowed such an analysis.

Conclusive remarks

Currently, there is a lot of reflexion and attention on hospital management in the different OCs. It seems important to clarify definitions and commitment in terms of medium to long-term programmes in MSF (strategy, objectives, exit strategy, data base, and free access to care).

Going through 14 hospital evaluations, we have identified and described eight key lessons in this report. The main observations are the following:

- All hospital programmes in MSF last longer than initially planned and go through an important transition between emergency response and medium to longer-term support before MSF withdraws. Both – transition and withdrawal phase – require better focus on (re)defining objectives and planning.
- A practical manual with an outline of steps how to set up a hospital programme could be an answer to some questions from field and HQ level.
- The need of human resources in MSF to run, follow, and analyse programmes should be revisited from HQ to field level, whenever MSF sets up a medium to long-term project.
- Capacity building / training for MSF staff and its counterpart's staff appear to be highly required in most programmes. MSF has already developed some e-learning or ready-to-use training courses on some specific topics (TB, etc), which could be considered for hospital management as well. This type of course would cost less and be accessible by a larger number of people, including national personnel (a possible answer to the high turnover).

When financial aspects were mentioned in the evaluations (which was the case in seven of them), the budget had at least doubled between the beginning of the programme and the date of the evaluation. The budget of these seven evaluated programmes was between € 2 and € 3.5 Mio. In some countries the MSF hospital budget is one third or half of the annual MoH budget. Evaluations did not address the question of how far MSF uses this financial (and therefore political) weight.

Reviewing a series of hospital evaluations also reaffirms that they served as a useful instrument to learn from past mistakes and good practices. New experiences, and also errors made in dealing with unknown situations, presented learning opportunities. Improvements depend on the provision of required tools and respective investments.

Today, MSF is still present in ten of the evaluated projects for the last five years. Five of them recommend a second evaluation; so far none has been carried out. Evaluations were done after two to ten years of MSF presence; most of the evaluation requests to assess a problem came a little late. Better and timelier solutions could have been found, if they had been carried out earlier.

Methodology

This meta-review is based on a review of 14 evaluation reports (see Table 1: Reviewed evaluations between 2008 and 2012

produced by the different MSF evaluation units since 2008. The evaluated projects have various priorities and pursue very different objectives.

The meta-evaluation attempts to summarise the main findings and lessons learned across very different interventions in regards to:

1. Hospital planning
   a. Criteria to define the number of beds
   b. Integration of hospital care with primary services / referral set up, etc
   c. Choice of services offered
   d. Physical set-up of hospitals
2. Human resources
   a. Staffing, cadres, ratios nurses/beds
   b. Turnover, retention
   c. Training
3. Hospital leadership & management
   a. Leadership & decision making
   b. Overall organisation: directors, supervisors, etc
   c. Managerial committees
   d. Reporting and data management
4. Quality of hospital care
   a. Factors influencing (structure, process, and outcome) quality in the reviewed evaluations
   b. Quality control mechanisms (mortality follow-up)
5. Collaboration with other actors:
   a. Main issues and strategies to address
6. Pulling out of hospital projects

This meta-evaluation also analyses the specific ToRs of the 14 evaluations.

Throughout the meta-review, examples from the evaluation reports were used to illustrate the different key lessons.

Table 1: Reviewed evaluations between 2008 and 2012

Year	Country	Project[2]	Section
2008	Liberia	Benson hospital project	OCBA
2009	South-Sudan	Aweil hospital project	OCP
2010	South-Sudan	Bor hospital project	OCB
	Iraq	Sulaymaniayah hospital project	OCP
	Congo	Butembo visit of religious hospital structure*	OCP
	Congo	Lubutu costing project*	OCB
	Congo	Bunia hospital project	OCG
2011	Sierra Leone	Bo, Lassa fever	OCB
	Congo	Rutshuru hospital project	OCP
	Central Africa Republic	Batangafo, Boguila, Paoua hospital project	OCBA, OCA, OCP
2012	Haiti	Leogane, Delmas, Drouillard, Tabarre container hospital project*	OCG, OCA, OCP, OCB
	Central Africa Republic	Carnot hospital project	OCP
	DRC	Capitalisation of emergency room in Dungu*	OCG
	South Sudan	Agok hospital project	OCG

*This evaluation concerns one specific subject.

Two of the 13 evaluations reviewed were intersectional ones (in CAR and Haiti) and 11 concerned the African continent.

Evaluations of single projects were carried out for various reasons and were initiated either by the programme managers or the field teams.

[1] For the final evaluation reports please consult https://tukul.msf.org.

Table 2: Number of hospital beds for the 14 evaluations

Name of project	N° of beds at beginning	N° of beds at time of evaluation	Multiplication by
Benson hospital		79	
Aweil hospital		105	
Bor hospital	60	119	2
Sulaymaniayah hospital		65	
Butembo visit of religious hospital structure*		300	
Lubutu costing*	40	165	4
Bunia hospital	300	123	-2,5
Bo, Lassa fever			
Rutshuru hospital	60	257	4
Batangafo hospital	90	159	1,8
Boguila hospital	50	116	2,3
Paoua hospital	60	125	2
Leogane container hospital		120	
Delmas container hospital			
Drouillard container hospital		250	
Tabarre container hospital*		100	
Carnot hospital			
Capitalisation of emergency room in Dungu*		130	
Agok hospital project		91	

*This evaluation concerns one specific subject.

Only the evaluation of Bunia hospital shows a decrease of the number of beds during MSF presence.

Annex

1 References to protocols, guidelines, and other guiding materials related to hospital care in MSF

MSF, Hospital Management, Field assessment report, 2007,

MSF-intersection (MSF-OCBA, OCA, OCP), Evaluation des projects hospitaliers, RCA, 2011

MSF-intersection (MSF-OCA, OCB, OCG, OCP), MSF en conteneurs, Haiti, 2012

MSF-OCB, Politique hopitaux, 2008

MSF-OCB, Internal Evaluation, Bor Project, South Sudan, 2010

MSF-OCB, Lubutu costing, RDC, 2010

MSF-OCB, Lassa Fever in Bo, Sierra Leone, 2011

MSF-OCBA, Benson Hospital Project, Liberia, 2008

MSF-OCP, Kit hôpital, 2010

MSF-OCB, Guideline for Planning and Design of Health Facilities, Draft, 2010

MSF-OCBA, Hospital Assessment tool, 2011

MSF-OCG, Agok hospital Evaluation, South-Sudan, 2012

MSF-Suisse, MSF-Suisse et les partenariats locaux, Bunia, RDC, 2011

MSF-OCP, External Evaluation of MSF Aweil Hospital project effectiveness, 2009

MSF-OCP, Hospital indicators, 2009

MSF-OCP, Viste Butembo, RDC, 2010

MSF-OCP, External Evaluation of MSF-OCP, Sulaymaniyah Project, 2010

MSF-OCP, Project hospitalier de Rutshuru, Nord-Kivu, 2011

MSF-OCP, Project de Carnot, RCA, 2012

MSF-OCP, Guide d'Hygiène dans les structures de soins, draft, 2012

MSF-UK, Making an exit: Advice on successful handover of MSF projects, 2011

2 Terms of reference

Terms of Reference for:
Meta-review of hospital evaluations in MSF

Subject / Mission: Meta-review of hospital evaluations since 2007

Starting Date: October 2012

Duration of review: ..... 5 weeks

Time horizon (period that is evaluated): 5 years

ToR elaborated by: ..... Mzia Turashvili, Sabine Kampmüller

1. CONTEXT

Provision of good quality secondary health care to underserved populations has always been one of MSF's concerns. Around the globe MSF runs many hospitals in very different settings. The challenge of managing those, mostly in precarious settings remains a difficult one.

The ambition to improve hospital care outcomes receives high priority in the MSF movement today. Over the past few years evaluations of hospital projects have been carried out by different MSF sections at different points in time.

This meta-review aims at comparing results and synthesising lessons learned, so they can be shared within the movement and feed the efforts for an improved performance.

2. OVERALL OBJECTIVE and PURPOSE

To conduct a meta-analysis of MSF hospital evaluations (over the past five years) in order to consolidate the main findings and describe lessons learned from hospital programs.

3. KEY QUESTIONS for the review

What are the main lessons learnt in MSF hospital evaluations, in regards to:

1. Hospital planning
   a. Criteria to define the number of beds
   b. Integration of Hospital care with primary services / referral set up, etc.
   c. Choice of services offered
   d. Physical set up of hospitals

2. Human resources
   a. Staffing, cadres, ratios nurses/beds
   b. Turnover, retention
   c. Training

3. Hospital leadership & management
   a. Leadership & decision making
   b. Overall organization: Directors, Supervisors, etc.
   c. Managerial committees
   d. Reporting and data management

4. Quality of hospital care
   a. Factors influencing (structure, process and outcome) quality in the reviewed evaluations
   b. Quality control mechanisms (Mortality follow up)

5. Collaboration with other actors:
   a. Main issues and strategies to address those

6. Disengagement from hospital projects

4. EXPECTED RESULTS and INTENTED USE OF THE EVALUATION

- A report of max. 15 – 20 pages is expected.
- A presentation of the findings to different forums on request.

5. PRACTICAL IMPLEMENTATION OF THE EVALUATION

- Collection of all relevant Evaluation reports for the review. Source: MSF evaluators' network, all OCs
- Desk review & analysis of all evaluation reports following the agreed framework
- Summarise references on protocols, guidelines and other guiding materials related to hospital care in MSF

6. TOOLS AND METHODOLOGY PROPOSED (if any):

Thematic analysis of the evaluation reports

7. DOCUMENTATION FOR READING:

To be completed

8. JOB PROFILE/S of EVALUATOR/S:

Operational experience in hospital projects of MSF
Evaluation experience
Excellent writing skills
Fluency in languages: English and French