STOCKHOLM EVALUATION UNIT

MSF-USA'S COVID-19 EVALUATION OF SEVEN PROJECTS

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EXECUTIVE SUMMARY

The Médecins Sans Frontières (MSF) intervention across seven sites in the United States (U.S.) was a direct response to the severe acute respiratory syndrome coronavirus 2 (Covid-19) pandemic, which was declared on March 11, 2020.[1] Projects were implemented in New York, Puerto Rico, the Pueblos, Navajo Nation, Florida, Michigan, and Texas. The overall intervention ran from March to October 2020, with varying timeframes for each of the projects. While each project had distinct objectives, the overall purpose of the intervention in the U.S. was to assist with the Covid-19 pandemic in local contexts, as well as to show solidarity with what was happening in the home countries of MSF staff.[2]

The purpose of this operational evaluation was to provide an independent assessment of the seven projects operated by MSF in the U.S. The evaluation was conducted between January and March 2021 and questions were based on four evaluation criteria defined by the Organisation for Economic Co-operation and Development's Development Assistance Committee (OECD-DAC). The questions were:

Relevance

- In what ways could the projects have had more relevance when considering both the medical humanitarian needs and the capacity and principles of the organization?

Appropriateness

- In what ways could the project activities have been better adapted to the context and target population?

Effectiveness

- In what ways could the effectiveness of the projects have been improved?

Impact

- How much of a difference did the projects make and for whom, under what circumstances?

[1] https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200311-sitrep-51-covid-19.pdf?sfvrsn=1ba62e57_10

[2] Key informant interview (KII) with Key Personnel

RELEVANCE

The project was well aligned with the epidemiological trends at the time the intervention began. By late March 2020, the U.S. had more cases of Covid-19 than any other country.[3] The decision to intervene at each of the seven sites across the U.S. was based on feasibility and the epidemiological data for underserved populations in each location. The emphasis on underserved groups in these contexts is relevant to MSF's work, given that the charter states that the organization "provides assistance to populations in distress, to victims of natural or man-made disasters, and to victims of armed conflict. [They do so] irrespective of race, religion, creed, or political convictions."[4] Further, the MSF mission is "to provide lifesaving medical care to those **most in need**,"[4] which also speaks to vulnerability.

The needs addressed by each intervention were relevant to the context at each location, given the capacity of MSF to intervene at the time. Needs were identified and selected based on three overlapping, but distinct pathways: 1) national epidemiological data on underserved groups, 2) opportunities for MSF to intervene, and 3) on the ground assessments at each of the identified sites.

The existing limitations of the organization which impacted its capacity to intervene included the inability to provide direct medical care due to liability issues (and/or perceptions of liability), limitations on staff availability (experienced staff, medical staff, and overall number of staff with rights to work in the U.S.), and lack of personal protective equipment (PPE) stock. Project stakeholders indicated that there was a greater need for health promotion (n=5), while across the sample, direct medical service delivery (n=23) was identified as the greatest unmet need. Meeting these needs would have made the projects more relevant to the context. However, given the limitations just mentioned, it may not have been possible.

APPROPRIATENESS

Evidence shows that there are some influencing factors that would have made the project activities more appropriate to the context and target populations. This includes cultural awareness and sensitivity, time, local staff, and different activities. Cultural awareness and sensitivity would have allowed project materials to be accessible to all segments of the target groups as well as improved relationships between MSF staff and beneficiaries in some contexts. Having additional time or arriving at the project sites sooner would have given MSF staff more opportunities to adapt activities to local contexts. Including more local staff on the teams would also have been an asset to the projects, as it would have given insight into the local context as well as addressed some of the lack of cultural awareness. For the majority of projects,

[3] https://www.nytimes.com/2020/03/26/health/usa-coronavirus-cases.html

[4] https://www.doctorswithoutborders.org/who-we-are/principles/charter#:~:text=Our%20mission%20is%20to%20provide,to%20victims%20of%20armed%20conflict.

expanding the intervention to include different activities or scaling up activities would have increased the level of appropriateness.

However, across the projects, the evidence suggests that the activities that were implemented were well-adapted to the local context and target populations. While the specific activities varied depending on the project site, they all aimed to directly address the needs of underserved groups and included advocacy and handover strategies. Most of the projects also included health promotion activities. Activities were tailored to the local context by adapting to the needs on the ground through adding or cancelling activities and tailoring activities' materials and content.

EFFECTIVENESS

Effectiveness of the projects could have been improved by addressing the major constraints associated with the interventions. This includes human resources (HR) issues (quantity and quality of staff, recruiting staff, and hiring processes and barriers), supplies (lack of PPE and other supplies), access to beneficiaries, and issues associated with implementing direct care (i.e., medical licensure, credentials and liability). All of these constraints affected outputs due to delays they caused during the limited timeframe of the interventions.

The interventions could have reached more people and activities could have been increased if these issues had been resolved. HR constraints were attributed to the operational structure of the U.S. intervention as a whole, which relied on both the U.S. COVID-19 Cell and MSF-USA to manage different facets of the hiring process. While the evidence points to administrative lags and little active recruitment strategies on the part of MSF-USA, the underlying reasons for this are unclear. Issues associated with implementing direct care and problems with the supply chain are attributed to MSF's inexperience working in the U.S. context. Evidence suggests that these constraints could be addressed in the future, if MSF were to intervene in the U.S. again. Access to beneficiaries could have happened more efficiently if more local staff were involved in the interventions from the beginning or if the teams had more time to become familiar with local contexts, including cultural characteristics.

Despite these constraints, there were numerous opportunities across the projects, which helped the teams to achieve the various outputs. This included building relationships with local partners, collaborators, and other stakeholders, and the work with specific underserved groups that are often overlooked in the U.S. context. This was an opportunity for MSF to advocate for these groups (both actively and passively), as well as to advocate for MSF's work in the U.S. Across the projects, this advocacy influenced the effectiveness of the intervention by holding local stakeholders accountable, which led to direct actions that enhanced the local Covid-19 response to support underserved groups.

IMPACT

The projects made a difference for beneficiaries and other stakeholders. This is evidenced by overall stakeholder satisfaction with MSF's presence and actions at the various project sites. This was communicated directly by local partner organizations as well as documented across the projects which kept some records on formal and informal feedback provided by beneficiaries.

Likely outcomes from the interventions for beneficiaries included increased knowledge from trainings and improvements in wellbeing (e.g., decreased fear and increased comfort). Evidence also suggests that local partner organizations and collaborators had increased capacity to manage the Covid-19 response. There were some unintended negative and positive effects reported for some of the projects, including the environmental implications of PPE disposal and the development of a new non-profit organization to continue MSF's work in Puerto Rico.

For MSF as an organization, capacity-building for future U.S. operations was a likely outcome.[5] This includes drawing on the relationships developed through the interventions. While stakeholder satisfaction was high overall, there were factors that impacted outcomes, which include time and the quantity and quality of staff. It is important to note that there were some instances when MSF's staff working in these domestic operations did not have good working relationships with local stakeholders. However, due to lack of data on these relationships, it is not possible to determine how they impacted the projects' appropriateness, effectiveness or outcomes.

LESSONS LEARNED FOR FUTURE MSF US OPERATIONS

- Include context-specific cultural briefings as part of U.S. mission
- Explore different operational HR models
- Ensure supply chain support for U.S. mission
- Increase recruitment of local staff on MSF teams
- Strengthen knowledge of U.S. regulations regarding direct medical care
- Strengthen knowledge of U.S. and state regulations regarding HR

[5] This was noted by various project documents and KIIs across the projects (key personnel, Florida, Michigan, Puerto Rico, and Texas).

ACRONYMS

AFC	Adult Foster Care
MSF	Médecins Sans Frontières/Doctors Without Borders
Covid-19	[Severe acute respiratory syndrome coronavirus 2]
DOH	Department of Health
SEU	The Stockholm Evaluation Unit
IEG	The Intersectional Evaluation Group
LTCF	Long-Term Care Facilities
OC	Operational Center
OCP	Operational Center Paris
OCB	Operational Center Brussels
AI/AN	American Indians and Alaska Natives
HP	Health Promotion
SoN	Schools of Nursing
OECD-DAC	Organisation for Economic Co-operation and Development's Development Assistance
IPC	Infection Prevention and Control
EQ	Evaluation Question
SQ	Evaluation Sub-Question
KI	Key Informant
PC	Project Coordinator
SitReps	Situation Reports
U.S.	United States

BACKGROUND AND CONTEXT

Since 1971, Médecins Sans Frontières (MSF) has provided medical and humanitarian assistance to more than 70 countries. MSF's work is based on the idea that all people should have access to healthcare. MSF's practices of helping populations in distress, victims of natural or man-made disasters, and victims of armed conflict, are rooted in medical ethics. The organization is built on the humanitarian principles of impartiality, independence, neutrality, bearing witness, and transparency and accountability.[6]

The MSF movement's executive structure includes five Operational Centres (OCs) (Brussels, Paris, Barcelona-Athens, Amsterdam, and Geneva) with five corresponding Operational Sections. In addition, there are Partner Sections (n=23) – such as the MSF USA office, based in New York City, and branch and delegate offices (n=17). The OCs directly manage MSF's humanitarian action in the field, and in collaboration with the field teams, decide when, where, and what medical care is needed. Whereas the partner sections are offices that support field work mainly through recruiting staff, organizing fundraising, and raising awareness on the humanitarian crises MSF field teams are witnessing by home society advocacy.

Historically, MSF operations in the U.S. have been limited, but include responding to natural disasters (i.e., Hurricane Sandy[7], Hurricane Harvey[8]), the immigrant and migrant crisis (i.e., Texas-Mexico border in[9]), and Chagas disease.[10]

US INTERVENTION

Covid-19 is responsible for over 2.9 million deaths worldwide.[11] MSF was quick to respond to the global crisis and started efforts to do so in January 2020 in Hong Kong with outbreak preparedness and response measures, even before it was declared a global pandemic.[12] MSF has responded to the Covid-19 pandemic in more than 70 countries across Asia & Pacific, the Middle East & Northern Africa, Africa, Europe & Central Asia, and the Americas. MSF provides expertise in emergency response to countries with robust health systems and direct care in low-resource settings with fragile health systems. MSF also supports critical medical activities that need to be maintained or adapted during the global health crisis, such as malaria prevention and cholera outbreaks.[12] In the Americas, MSF's response included activities in Brazil, Venezuela, Colombia, Ecuador, Argentina, Honduras, El Salvador, Haiti, Guatemala, Mexico, Canada and the U.S.

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[6] "RESPONDING TO Covid-19: Global Accountability Report 1, March 2020-May2020." Médecins Sans Frontières, 2020.
[7] Sandy SitRep, November 3, 2012
[8] Hurricane Harvey Report, 2017
[9] 202001 MexicoUSA border proposition Explo team 082019, January 2020
[10] Mays, Michelle. "Draft Internal Evaluation Report: Introduction." Médecins Sans Frontières, 2020.
[11] "WHO Coronavirus Disease (Covid-19) Dashboard." Accessed April, 2020. https://covid19.who.int.
[12] "RESPONDING TO Covid-19 : Global Accountability Report 1, March 2020-May2020." Médecins Sans Frontières, 2020.

In March 2020, MSF began developing projects in seven sites across the United States (U.S.) in response to the Covid-19 pandemic health crisis. As Operational Centre Paris (OCP) already had a decentralized Cell in New York, they started the Covid-19 assessment and activities. In April, Operational Centre Brussels (OCB) also started a Covid-19 response in the US, bringing the model they used in Europe to support long term care facilities (LTCFs) to Michigan and Texas. OCB was responsible for the operations of the projects in Michigan and Texas and OCP was responsible for the five other projects. While the OCP Cell in New York was originally responsible for the management of all the projects, as the operations grew rapidly, a new OCP-funded cell was created in New York solely to manage the US Covid-19 response.

Between March and October 2020, MSF implemented projects at seven sites across the U.S. The projects were located in Michigan, Texas, Florida, Navajo Nation, the Pueblos, New York, and Puerto Rico and were designed to help those most affected by the Covid-19 emergency. The target populations included individuals experiencing homelessness and housing insecure, workers of LTCFs, migrant farmworkers, indigenous peoples, isolated and marginalized communities, sex workers, and people who use drugs.

MICHIGAN AND TEXAS

In Michigan and Texas, the objective of the MSF projects was to reduce transmission of Covid-19 (and other infectious diseases) in LTCFs amongst residents and staff in the Detroit tri-county region and Houston areas.[13] As OCB had already launched initiatives in LTCFs in Belgium and Italy, they had developed an approach for working in LTCFs during the Covid-19 pandemic, which they applied to the U.S. context.

People living and working in LTCFs are at increased risk of developing severe illness from Covid-19 due to the communal nature of the centres, as well as the characteristics of the residents, who are often older adults with underlying medical conditions.[14] Additionally, the staff are often people of colour who are poorly compensated, adding another layer of vulnerability.[15] In the U.S., as of December 2020, the Covid-19 pandemic has resulted in over 100,000 deaths among residents and employees of LTCFs, which account for 38% of all deaths.[16]

In Michigan, the project ran from mid-May-July 2020. MSF created a support program for more than 50 LTCFs in order to improve infection prevention and control (IPC) practices as well as address mental health concerns among staff.[17] [12] The activities consisted of mobile teams, wellness support, digital health

[13] "MSF-OCB/USA: Houston – LTCF Support, Covid-19 , End of Mission Report." Médecins Sans Frontières, 2020.
[14] CDC. "Covid-19 and Your Health." Centers for Disease Control and Prevention, February 11, 2020. https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-in-nursing-homes.html.
[15] Heather Pagano, Marybeth Wargo, and Anna Schwartz. "Michigan — LTC Support, Covid-19 ," July 24, 2020.
[16] Times, The New York. "More Than 100,000 U.S. Coronavirus Deaths Are Linked to Nursing Homes." *The New York Times*, June 27, 2020, sec. U.S. https://www.nytimes.com/interactive/2020/us/coronavirus-nursing-homes.html.
[17] "Responding to the Crisis in Long Term Care Facilities in Michigan Doctors Without Borders/Médecins Sans Frontières (MSF), Briefing Paper." Médecins Sans Frontières/Doctors Without Borders, August 2020.

promotion (HP), and health education. Further, the Michigan team promoted IPC modules within Michigan Schools of Nursing (SoN) and did a handover when the project was complete. [15] Another component of this project is the advocacy campaign and the *Failing Our Elders* publication by key team members.[18]

In the Houston area, the project ran for 10 weeks, from Aug. 3 – Oct. 16, 2020. The overall structure of the program was based on the Michigan project. The project team provided on-site IPC and health and wellness support for 24 LTCFs, established relationships with regional SoN for a handover initiative (ongoing through January 2021 in regional SoN), built operational/experiential knowledge and legitimacy for future advocacy campaigns and US operations.[18]

FLORIDA

In Florida, 42% of adults are considered at risk for severe illness if infected with Covid-19.[19] Florida also has a significant population of migrant farmworkers, who are considered a vulnerable population due to poor living and working conditions, lack of eligibility for specific work-related health care (e.g., sick leave), and poor access to healthcare. Working with this population can be furthered complicated by cultural and language barriers, as well as the seasonal nature of their work.[20]

The MSF Florida intervention ran from May 2-June 22, 2020 with the objective to medically assist the vulnerable migrant farmworker community, the majority from Mexico, Guatemala and Haiti, in the context of the Covid-19 pandemic. MSF established three activities, including HP in conjunction with the Coalition of Immokalee Workers (CIW) in Spanish and Haitian Creole, roving mobile clinics providing telehealth services with onsite Covid-19 testing, and contact tracing/Isolation of Covid-19 positive patients. Activities were also open to year-round residents of Immokalee (15,000 people).[20]

MSF was contacted by CIW, an internationally-recognised worker-based human rights organization comprised of farmworkers in Immokalee, Florida, located in Collier county.[21] At the time of the MSF intervention, Collier county was consistently around 8th in the number of cases out of 67 counties.[20] MSF conducted an initial needs assesment and found vulnerabilities among migrant farm workers, which included no work stoppages in response to Covid-19, restricted access to testing, and low-access to healthcare facilities.[20]

[18] "MSF-OCB/USA: Houston – LTCF Support, Covid-19 , End of Mission Report." Médecins Sans Frontières, 2020.
[19] Dec 08, Published:, and 2020. "State Data and Policy Actions to Address Coronavirus." *KFF* (blog), December 8, 2020. https://www.kff.org/coronavirus-Covid-19 /issue-brief/state-data-and-policy-actions-to-address-coronavirus/.
[20] Susan Doyle, and Sarah Kuech. "MSF Florida Covid-19 Response Closure Report." Médecins Sans Frontières, 2020.
[21] "About CIW – Coalition of Immokalee Workers." Accessed December 9, 2020. https://ciw-online.org/about/.

THE PUEBLOS AND NAVAJO NATION

The MSF project in the South West, involved two intervention one in the Pueblos (New Mexico) and one in Navajo Nation (Arizona). The main objective was to reduce morbidity and mortality from Covid-19 among vulnerable populations. In New Mexico, the target population was the Pueblo Communities, but MSF added individuals experiencing homelessness in Albuquerque when it became clear there were specific needs for this vulnerable population.[22]

In the U.S., American Indians and Alaska Natives (AI/AN) are disproportionately affected by Covid-19. One study found that 2.7% of cases in their sample from 23 states were AI/AN.[23] In general, AI/AN suffer from historical trauma and racial discrimination, which create health disparities among this population. MSF worked in Zia and San Felipe Pueblos, Navajo Nation, and in Albuquerque over the course of the project, which ran from April 14-June 30th, 2020. Project activities included, IPC training and sensitization, assessments and recommendations, community health promotion, and increase Indian Health Service (IHS) clinic capacity.[22]

NEW YORK

The MSF intervention in New York targeted individuals experiencing homelessness and housing insecurity and ran from March to June 2020. Evidence shows that the homeless have been disproportionately impacted by Covid-19, as there have been high rates of infections in shelters across the country, and individuals experiencing homelessness are twice as likely to be hospitalized.[24] There are also intersecting vulnerabilities, as people of colour experience homeless disproportionately.[24] There were various objectives of the project, including the following.

- Target population had access to medical, social and emergency services
- Target population had to handwashing and hygiene facilities
- Organizations supporting target population had access to personal protective equipment (PPE) (especially face coverings/masks) and thermometers
- Target population understands the risks Covid-19 poses and is empowered to protect themselves with access, materials and knowledge
- Target population has access to showers and hygiene materials
- To ensure the target population has access to testing, is included in contact tracing efforts, and has access to and the resources needed for proper isolation and quarantine.

[22] John Holland and Felicia Mancini. "MSF Southwest 1 Covid-19 Response Closure Report," 2020.
[23] Hatcher, Sarah M. "Covid-19 Among American Indian and Alaska Native Persons — 23 States, January 31–July 3, 2020." *MMWR. Morbidity and Mortality Weekly Report* 69 (2020). https://doi.org/10.15585/mmwr.mm6934e1.
[24] "Racism-Homelessness-and-Covid-19 -Fact-Sheet-_Final_2.Pdf." Washington D.C.: National Law Center on Homelessness and Poverty, 2020. https://nlchp.org/wp-content/uploads/2020/05/Racism-Homelessness-and-Covid-19_-Fact-Sheet-_Final_2.pdf

The objectives were met through various activities, such as HP and IPC support, showers, and COVID-19 testing/contact tracing/isolation.

PUERTO RICO

In Puerto Rico, the objective of the MSF intervention was to assist Puerto Rican individuals, Community-Based Organizations (CBOs) and health care providers in responding to the Covid-19 pandemic at numerous sites across Puerto Rico. More specifically, the objectives included:

- Improving their immediate and sustained capacity to ensure appropriate IPC practices
- Mitigating the risks of increased vulnerabilities
- Addressing identified gaps in medical care
- Addressing the needs and trauma caused or exacerbated by the Covid-19 pandemic[25]
-

MSF's decision to develop a Covid-19 response project in Puerto Rico was based on an MSF needs assessment, which found that in the context of Covid-19, residents of the U.S. territory had increased vulnerabilities. This includes a fragile healthcare system and a fragile population with a high proportion of elderly and people with chronic conditions. Additionally, the Puerto Rican population experiences more vulnerabilities than the general U.S. population, such as higher unemployment and high food insecurity.[25] The target population for the intervention included at-risk groups (people experiencing homelessness, people who use drugs (PWUD), sex workers and isolated and at-risk communities around the island (including elderly people)) and medical, paramedical and social workers at risk (Puerto Rico's public and not-for-profit health facilities, medical students and residents, blood banks and school for hearing-impaired children).[25] Activities included health promotion, IPC training, mobile shower, and donations of PPE to health facilities and CBOs, medical consultations for Covid-19 and non-Covid-19 patients in isolated areas both through pop-up clinics and home visiting, and monitoring and support of Covid-19 patients isolated at home. The program was launched on March 23rd and closed on September 30, 2020.

OBJECTIVES OF THE EVALUATION

This external evaluation was designed to provide an independent assessment of the seven U.S.-based Covid-19 projects operated by MSF in New York, Florida, the South West (Navajo Nation and Pueblos), Michigan, Texas, and Puerto Rico. This evaluation had two objectives.

1. To assess the seven Covid-19 U.S.-based projects' strategies, objectives, and outcomes in order to determine the achievements (or lack of) of the projects using relevant Organisation for

[25] Delaunay, Sophie. "Puerto Rico Closing Report." Médecins Sans Frontières, September 2020.

Economic Co-operation and Development's Development Assistance Committee (OECD-DAC) criteria (relevance, appropriateness, effectiveness, and impact)[26],

2. To provide evidence-based lessons from MSF's humanitarian intervention in the U.S., since working in the context of a high-income country with established health infrastructure is uncommon for MSF.

EVALUATION QUESTIONS

The evaluation questions (EQs) and sub-questions (SQs) were finalized by SEU before the evaluation team was hired. After speaking to key personnel from MSF (n=5), the evaluation team made a few changes to address some of the contextual nuances of the MSF U.S. Covid-19 response, including questions on who the stakeholders were, who was affected by the outcomes, and if the project met the stated objectives. The final EQs and SQs are presented in Table 1.

Table 1. Evaluation Questions

DAC CRITERIA AREA	EQ	SQ
RELEVANCE	EQ 1: In what ways could the projects have had more relevance when considering both the medical humanitarian needs and the capacity and principles of the organization?	▪ What needs did the different projects aim to address and how were they identified and selected? ▪ Did the projects respond to the expressed needs or demands of the different stakeholders? ▪ Who were the stakeholders and how were they identified and prioritized? ▪ Were there other needs that could have been addressed by the projects?
APPROPRIATENESS	EQ 2: In what ways could the project activities have been better adapted to the context and target population?	▪ What were the different activities carried out in the different projects? ▪ Were activities tailored to the national and local contexts and in what ways? ▪ What would have made the activities more appropriate to the context?

[26] https://www.oecd.org/dac/evaluation/revised-evaluation-criteria-dec-2019.pdf

EFFECTIVNESS	EQ 3: In what ways could the effectiveness of the projects have been improved?	▪ What were the outputs achieved in each of the project locations? ▪ What were the main opportunities and constraints during implementation? ▪ Are there things that would have made the projects more effective?
IMPACT	EQ 4: How much of a difference did the projects make and for whom, under what circumstances?	▪ What are the likely outcomes of the different projects? ▪ Who was affected by the outcomes? ▪ Did the project meet the stated objectives? ▪ Were there any unintended positive or negative effects? ▪ What would have made a bigger difference at the level of outcomes?

APPROACH AND METHODOLOGY

The team met the objectives of the external evaluation by systematically collecting and analysing data to answer the EQs and associated SQs (see Table 2 for an outline of the methodology in relation to the OECD-DAC criteria). The evaluation team relied on both primary and secondary data sources, including purposive semi-structured interviews with key informants (KIIs)(n=35) and desk review documents (n=134). While drawing on existing data from internally conducted surveys and interviews was part of the original evaluation design, this was not possible due to access issues, the format and content of available data, and the time limitations of this evaluation.

Table 2. Methodology and Analysis in Relation to the DAC criteria

DAC CRITERIA AREA	EQ AND SQ	METHODS	ANALYSIS
RELEVANCE	EQ 1: In what ways could the projects have had more relevance when considering both the medical humanitarian needs and the capacity and principles of the organisation? ▪ What needs did the different projects aim to address and how were they identified and selected? ▪ Did the projects respond to the expressed needs or demands of the different stakeholders? ▪ Who were the stakeholders and how were they identified and prioritized? ▪ Were there other needs that could have been addressed by the projects?	Document Review: -MSF charter -Project documents -Documentation regarding any ongoing operational project research initiatives	Content Coding -Needs -Demands -Cross-cutting themes Grounded Coding -Stakeholder experiences -Other relevant themes (e.g., gender equity)

APPROPRIATENESS	EQ 2: In what ways could the project activities have been better adapted to the context and target population? ▪ What were the different activities carried out in the different projects? ▪ Were activities tailored to the national and local contexts and in what ways? ▪ What would have made the activities more appropriate to the context?	Document Review: -Project documents -Documentation regarding any ongoing operational project research initiatives	Content Coding -Activities -Cross-cutting themes Grounded Coding -Stakeholder experiences -Other relevant themes (e.g., gender equity)
EFFECTIVENESS	EQ 3: In what ways could the effectiveness of the projects have been improved? ▪ What were the outputs achieved in each of the project locations? ▪ What were the main opportunities and constraints during implementation? ▪ Are there things that would have made the projects more effective?	Document Review: -Project documents -Documentation regarding any ongoing operational project research initiatives	Content Coding -Outputs -Opportunities -Constraints -Cross-cutting themes Grounded Coding -Stakeholder experiences -Other relevant themes (e.g., gender equity)
IMPACT	EQ 4: How much of a difference did the projects make and for whom, under what circumstances? ▪ What are the likely outcomes of the different projects? ▪ Who was affected by the outcomes? ▪ Did the project meet the stated objectives? ▪ Were there any unintended positive or negative effects? ▪ What would have made a bigger difference at the level of outcomes?	Document Review: -Project documents -Documentation regarding any ongoing operational project research initiatives	Content Coding -Outcomes -Effects (Positive and negative) -Cross-cutting themes Grounded Coding -Stakeholder experiences -Other relevant themes

SEMI-STRUCTURED INTERVIEWS

SAMPLING

A purposive sampling technique[27] [28] was used to identify KIs to participate in virtual semi-structured interviews (via Teams, Whatsapp, or Skype). A purposive sample draws on an existing sampling frame to identify KIs that can provide the most relevant perspectives on the topic under investigation, in line with the aims and objectives of the research.[2728] This ensures that data collection is focused and efficient. A purposive sampling technique was appropriate for this evaluation since a sampling frame was easily developed, the objectives had clear and specific aims, there were time limitations for the evaluation itself, and it took into account some ethical considerations identified during the preliminary interviews (for more details see *limitations and mitigating factors* and *ethical considerations*).

The team created a sampling frame of the entire pool of possible KIs. This included the individuals in the organigrammes provided by MSF, (all projects and COVID cell HR), the list of local partners and government institutions listed in the project documents, and other relevant KIs identified during preliminary interviews. It is important to note that due to the nature of the questions and the objectives of the evaluation, we only sampled from the technical staff directly involved with delivery of services, which does not include logistics, finance, or water and sanitation.

The evaluation objectives specifically identified the need to collect data on the Covid-19 U.S.-based projects' strategies, objectives, and outcomes. Therefore, the evaluation team identified KI criteria that provided diverse perspectives on these aspects of the projects. The team spoke to the head of mission (n=1), the emergency coordinator (n=1), all but one project coordinator (n=6), the most senior medical staff (n=4), and the managers/supervisors (n=9) for the main activity identified for each project. The lead evaluator also spoke with local hire staff (n=4) who engaged directly with program beneficiaries[29] and with implementing partners (n=6). In addition, key personnel (n=4) working for OCP, OCB, MSF-USA, and the COVID Cell were also interviewed. This comprehensive sample provided diverse perspectives at varying levels of implementation of each project. Overall, the team conducted 35 individual semi-structured interviews (see Table 3). It is important to note that some individuals (n=4) were involved in more than one project and were able to offer multiple perspectives.

[27] Bernard, H. Russell. Research Methods in Anthropology: Qualitative and Quantitative Approaches. Rowman & Littlefield, 2017.

[28] Campbell, Steve, Melanie Greenwood, Sarah Prior, Toniele Shearer, Kerrie Walkem, Sarah Young, Danielle Bywaters, and Kim Walker. "Purposive Sampling: Complex or Simple? Research Case Examples." Journal of Research in Nursing, 2020, 174498712092720. https://doi.org/10.1177/1744987120927206.

[29] While not only local hire staff engaged directly with program beneficiaries, in the context of the evaluation questions, getting the local hire perspective on this aspect of the way the projects were implemented is important.

DATA COLLECTION

Data collection began on January 21st and ended on February 17, 2021. Due to various factors (i.e., MSF consent process and accessing contact information), data collection began later than planned (originally planned to begin on January 4th). Additionally, due to some KIs limited availability and the lower-than-expected response rate, the data collection end date was extended (originally planned for February 1st).

All semi-structured interviews were conducted remotely, either via Teams or by phone (Whatsapp or Skype). Each interview guide was tailored to the specific context of the interview and the role of the participant. With permission of participants, most interviews were audio-recorded and stored on Office.com One participant did not want to be audio-recorded and the calls via phone were not audio-recorded. Interview transcripts were used for data analysis.

DESK REVIEW

The team reviewed MSF project documents, including project proposals, Situation Reports (SitReps), and project closure reports. These were shared with the evaluation team via SharePoint.

EXISTING DATA SOURCES

Regarding existing data, the evaluation team identified the following sources of data that might have been useful in conducting this evaluation: 1) Summarized survey results from the reflection exercise mentioned above; 2) Project-specific indicators and outcomes from project documents; and 3) survey data from the Michigan project. The team used the survey documents as comparison tools in order to identify similarities and differences with the key findings presented here and the survey results summaries. The project-specific indicators and outcomes were included in the analysis and are presented in the section on “impact”.

While the original evaluation design included utilizing existing data sources, such as interview transcripts or notes from the previous internal reflection exercise conducted by MSF staff, this was not possible due to the format of the accessible data and the inaccessibility of some data. Regarding the reflection document, the team had access to the author’s notes. However, the format of these notes, which were more of a summary, did not allow for data analysis. The notes did not include details regarding the sample (e.g., characteristics of respondents or sample size) or the interview questions or structure. The team did not follow up to gain access to additional materials (e.g., interview transcripts) because it became clear as the timeline for this evaluation shifted, that there would not be time to analyse additional interviews. The timeline for the project shifted significantly (with an originally planned end date of February 24th), which presented challenges for team members who had other projects started. The team did request beneficiary evaluations from MSF-USA but did not get a response. As this was during data analysis and close to the evaluation end date, the team did not have an opportunity to follow-up.

ANALYSIS AND REPORTING

Qualitative data (from semi-structured interviews) was analysed using a layered analysis approach, beginning with a round of content coding based on the evaluation questions and specified OECD-DAC criteria (relevance, appropriateness, effectiveness, and impact). The codebook included the OECD- DAC criteria and specific constructs associated with each sub-question (e.g., needs, demands, activities, outputs, opportunities, constraints, outcomes, positive effects, negative effects) (see codebook Annex 6). The team also included other cross-cutting themes, identified in the ToR, such as burden on health systems, critical supply shortages, and the subsequent impact on and experiences of at-risk populations (i.e., homeless, indigenous peoples, drug-users, housing insecure, sex workers, and the elderly). After the interview transcripts and desk review documents were coded for this content, a second round of coding was conducted using a grounded-theory approach. This technique is used to identify unforeseen themes in the data relevant to this evaluation. There was overlap between cross-cutting themes and interview responses.

Analysis was conducted using MAXQDA software.[30] This program allows for mixed methods analysis, used to explore both quantitative and qualitative dimensions of the data. This includes code frequencies, code co-occurrence (intersection of codes), and exploratory concept mapping.

VALIDATION OF RESULTS

Data validation is an important part of interpreting results. A validation tool was created using preliminary findings from each project, based on a technique called, "member checking".[31] Originally, the team planned to organize a validation workshop to discuss preliminary findings with key stakeholders and get feedback. However, due to the difficulty in scheduling and completing KIIs, the team decided to create a validation tool for each project with structured and unstructured questions. Everyone who participated in KIIs was contacted and given the opportunity to provide their feedback. The team received feedback from 14 KIs. Overall, the feedback was in agreement with the preliminary findings for each project. Some KIs left detailed comments, which were cross-checked with the final results to make changes when necessary. There was one case of disagreement regarding the overall findings. After the team cross-checked the information provided by the KI with other team members from that project it was clear that their views were not shared. Therefore, it was not possible to incorporate all of their feedback into the final analysis.

[30] https://www.maxqda.com/

[31] Birt, L., Scott, S., Cavers, D., Campbell, C., & Walter, F. (2016). Member checking: a tool to enhance trustworthiness or merely a nod to validation? *Qualitative health research*, *26*(13), 1802-1811.

LIMITATIONS AND MITIGATING FACTORS

There are a number of limitations and mitigating factors that impacted this evaluation. First, due to the limited time frame for which the evaluation was scheduled, it was not be possible to collect primary data from a large number of KIs. The evaluators created a specific sampling strategy to address this limitation.

Second, due to the low response rate (64.81%) and limited availability of KIs, a large sample was not possible. There was also a major storm in Texas the last week of data collection which prevented at least two KIs from participating. The team mitigated this by interviewing some KIs that were involved in multiple projects, to gain a broader perspective from these interviews.

Third, due to the diverse nature of the activities of the seven projects, as well as the differences in their documentation, the evaluation team tailored specific elements of the evaluation plan to each project. For example, the Texas project does not have a project proposal, therefore the team used Sitrep as a proxy for identifying project objectives and needs.

Fourth, in preliminary interviews, KIs indicated that it may be hard to reach some MSF project staff as well as beneficiaries in order to collect data. Staff have since moved on and may already be working at other field locations. The team did find that this was a case. Numerous KIs indicated that they were on mission without good internet access and therefore could not participate.

There were also some ethical considerations to take into account regarding accessing staff which are discussed in detail below. It was not possible to reach direct beneficiaries of the programs due to various reasons. The MSF projects worked with many vulnerable groups, such as migrant farmworkers, housing insecure individuals, and Native Americans. These populations are hard to access due to lack of contact information, historical issues of mistrust, and their mobility. Further, due to the nature of these underserved groups, records with contact information were not maintained. As most beneficiaries who received direct services from MSF were not accessible for this evaluation, the evaluation team treated some local partners (depending on the context of the project) as beneficiaries to gather relevant information.

The inability to access beneficiaries limits the perspectives shared across the KIIs. Additionally, no government institution and very few implementing partners (n=4) participated in KIIs. This extremely limits the scope of perspectives presented here. In the case of the Pueblos, we were told by a former MSF staff member KI that due to issues of mistrust they didn't feel comfortable sharing contact information for this evaluation. In New York and Florida, the team was advised by MSF-USA not to contact government stakeholders in these locales because of current ongoing operations or operational conversations.

Fifth, the team recognized certain limitations due to the Covid-19 pandemic. Namely, the team could not travel due to Covid-19-related restrictions and safety concerns, making the evaluation completely remote in nature. This came with its own challenges. Primarily, technology was a concern, regarding internet quality in some locations as well as access to both internet and communication applications, such as Teams. There were also limited opportunities to build rapport with evaluation participants which could impact how much they disclosed to evaluators during data collection. The inability to visit project sites also limited the team's ability to make observations on the ground, despite the fact that the projects have already ended.

Finally, the evaluation team recognized the limitations of assessing the projects' impacts due to a lack of baseline and closing data on indicators. In order to address this, the team designed data collection and analysis to be largely qualitative and supplemented this with available quantitative data from existing surveys and from local partners where available and when possible.

ETHICAL CONSIDERATIONS

MSF's humanitarian action in the U.S. across the seven sites involves work with at-risk populations. This requires an appropriate level of sensitivity that draws on evidence-based work on health disparities among these groups. The team considered each project setting and context when developing data collection instruments. While the team did not work directly with any of these populations for this evaluation, as described in the *Limitations* section, it was a consideration for data collection.

The team developed a standard verbal informed consent process for all evaluation participants to ensure their participation was voluntary, they understood why their information was being collected, and were aware of how it would be used. Regarding data management, all data was confidential and stored in a secure location. It was only accessible to authorized members of the evaluation team. During reporting, all data has been anonymous. Data was only used for the purposes of this external evaluation. Once the evaluation is completed, the Head of Evaluation Unit will be responsible for the disposal of data in accordance with MSF policy on the disposal of records. The evaluation team has also read the SEU ethical guidelines for evaluation and agrees to adhere to the practices outlined in the document.[32]

During KI interviews, other ethical considerations were identified. The evaluators were sensitive to the fact that this evaluation occurred very soon after some projects have ended. This is particularly relevant in the context of the ongoing pandemic and humanitarian crisis in the U.S., as most MSF project staff were from the U.S. One KI also pointed out that there may be burnout or fatigue among MSF team members which could have influence their willingness to participate in interviews. The evaluation team tried to be respectful of this. Finally, the evaluation team was aware that a thorough internal reflection exercise was already conducted with many MSF team members and wanted to minimize participant burden. The team reviewed the final sample with the Programs Advisor at MSF-USA to ensure that participants were not being overburdened by their request to participate in this evaluation.

[32] SEU Ethical Guidelines for Evaluation, MSF-OCB Stockholm Evaluation Unit, March 2020

RESULTS

RELEVANCE

EQ1: In what ways could the projects have had more relevance when considering both the medical humanitarian needs and the capacity and principles of the organization?

The project was well aligned with the epidemiological trends at the time the intervention began. By late March 2020, the U.S. had more cases of Covid-19 than any other country.[33] The decision to intervene at each of the seven sites across the U.S. was based on feasibility and the epidemiological data for underserved populations in each location. The emphasis on underserved groups in these contexts is relevant to MSF's work, given that the charter states that the organization "provides assistance to populations in distress, to victims of natural or man-made disasters, and to victims of armed conflict. [They do so] irrespective of race, religion, creed, or political convictions."[34] Further, the MSF mission is "to provide lifesaving medical care to those **most in need**,"[4] which also speaks to underserved populations.

The needs addressed by each intervention were relevant to the context at each location, given the capacity of MSF to intervene at the time. Needs were identified and selected based on three overlapping, but distinct pathways: 1) national epidemiological data on underserved groups, 2) opportunities for MSF to intervene, and 3) on the ground assessments at each of the identified sites.

According to project documents and KIIs, the existing limitations of the organization which impacted its capacity to intervene included the inability to provide direct, in-person clinical medical care due to liability issues (and/or perceptions of liability), limitations on staff availability (experienced staff, medical staff, and overall number of staff with rights to work in the U.S.), and lack of personal protective equipment (PPE) stock. Project stakeholders indicated that there was a greater need for health promotion (n=5), while across the sample, direct medical service delivery (n=23) was identified as the greatest unmet need. Meeting these needs would have made the projects more relevant to the context. However, given the limitations just mentioned, it may not have been possible.

SQ1A: WHAT NEEDS DID THE DIFFERENT PROJECTS AIM TO ADDRESS?

Across the sample, there was a recognition that the projects aimed to address the needs of underserved groups (n=28) (see table 3). All seven projects (n=7) identified underserved populations as target groups, including the homeless and housing insecure, communities of colour, LTCF staff, migrant farmworkers,

[33] https://www.nytimes.com/2020/03/26/health/usa-coronavirus-cases.html
[34] https://www.doctorswithoutborders.org/who-we-are/principles/charter#:~:text=Our%20mission%20is%20to%20provide,to%20victims%20of%20armed%20conflict.

isolated and marginalized communities, sex workers, people who use drugs, and indigenous communities (see table 4 for a list of underserved groups for each project).

Approximately half of the project documentation which was coded for *needs* indicated that IPC training and education (n=27) was the most common need identified among these groups. It is important to note that while the delivery direct medical care was discussed prior to exploratory assessments at each project location, the decision was made to ultimately exclude this possibility due to perceived liability, credentialing, and licensing issues in the U.S. context (key personnel involved in this decision-making). Despite this, some projects (n=4) (Puerto Rico, Florida, New York, and the Pueblos) identified direct medical care as a need to be addressed through the intervention, which came across in over a quarter of the project documents coded for (n=14).

Table 3. What needs did the different projects aim to address?

RELEVANCE SQ1a: What needs did the different projects aim to address? All Project Documents (n=169)		
	Documents	Percentage
Underserved Groups	28	52.83
IPC Training and Education	27	50.94
Medical Care	14	26.42
Testing	11	20.75
Donations and Supplies	11	20.75
Isolation and Quarantine	10	18.87
Health and Wellness	8	15.09
Health Promotion	8	15.09
Hygiene and Sanitation	7	13.21
Contact Tracing	6	11.32
Community Buy-in and Mobilization	2	3.77
Epidemic Response	1	1.89

Advocacy	1	1.89
Adapt to Changing Understanding of New Virus	1	1.89
DOCUMENTS with code(s)	53	100.00

While the specific needs of each project varied depending on the context (see Appendices A-H for summaries of the findings for each project), most projects aimed to address needs involving IPC training and education (n=6), isolation and quarantine (n=5), and health promotion (n=5)(see Appendix I). Some projects also aimed to address needs associated with delivery of direct medical care (n=4), hygiene and sanitation (n=3), donations and supplies (n=3), contact tracing (n=3), and health and wellness (n=2). Other needs mentioned were community buy-in and mobilization (n=2) and advocacy (n=1). Three projects did not aim to address delivery of direct medical care and therefore were outside of the scope of MSF's mission "to provide lifesaving medical care to those most in need."[35] While four projects did attempt to meet needs associated with direct medical care delivery (Puerto Rico, Florida, New York, and the Pueblos), only Puerto Rico was successful in doing so (this is discussed further in the sections on effectiveness and impact).

Table 4. Underserved Groups Targeted for Each Project

PROJECT	UNDERSERVED GROUPS
New York	Homeless, housing insecure, Communities of colour
Michigan	Long-term care facilities staff
Texas	Long-term care facilities staff
Florida	migrant farmworkers
Puerto Rico	Isolated and marginalized communities Sex workers People who use drugs Homeless
Navajo Nation	Indigenous communities
The Pueblos	Indigenous communities

[35] Ibid.

SQ1B: HOW WERE NEEDS IDENTIFIED AND SELECTED?

As a couple of KIs (key personnel, Michigan) noted, in early 2020, MSF operational centers, as well as MSF USA, were following global epidemiological trends to determine where MSF should intervene in order to address humanitarian needs associated with the pandemic. One KI (key personnel) who was involved in the initial decision-making process explained that the U.S. was a good candidate for an intervention based on these data. On March 11, 2020, the WHO declared the coronavirus outbreak as a pandemic.[36] At that time, Europe, China, and Korea were the hardest hit, but by March 26th the U.S. had more cases than any other country.[37]

Once the decision was made to intervene in the U.S., the project sites and their needs were identified through three non-chronological pathways; 1) national epidemiological data on underserved groups (see table 5), 2) opportunities, and 3) on the ground assessments at identified sites.

Table 5. COVID-19 Risk Data Underserved Populations

LOCATION	DATA POINTS FROM PROJECT DOCUMENTS	DATE
The Pueblos (New Mexico)	While Native Americans make up only 10.7% of the population of New Mexico, they account for 55.43% of COVID cases[38]	May 5, 2020
Navajo Nation (Arizona)	>32% of COVID cases in Arizona on Navajo Nation[39]	May 5, 2020
Puerto Rico	Health infrastructure impacted by 2017 earthquake and 17,000 health professional left. High comorbidity risk, 42% vs. 31% for the U.S.[40]	March 2020
Michigan	While African Americans make up only 14% of the population in Michigan, they account for 31% of COVID cases and 40% of deaths Michigan has 5th highest number of COVID deaths in the U.S. Long term care staff have pre-existing disparities that put them at greater risk of COVID (Low-income, people of color, poorly compensated)[41]	June 15, 2020

[36] https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200311-sitrep-51-covid-19.pdf?sfvrsn=1ba62e57_10
[37] https://www.nytimes.com/2020/03/26/health/usa-coronavirus-cases.html
[38] Country sheet 2020 COVID-19 Southwest 1
[39] Navajo Nation Sitrep Week 1 (NN Epi Report)
[40] Puerto Rico Sitrep Week 17
[41] Long-term care facilities US COVID response final project proposal

Texas	Harris County (where Houston is located) had the most COVID cases per 100,000 (98,506 total cases) in Texas[42]	August 2020
Florida	36% positivity rate for migrant farmworkers. Migrant farmworkers are a low-healthcare seeking population and high barriers to care[43]	May 2020[44]
New York	63,000 people sleeping in shelters each night. In December 2019, 14, 792 families slept in shelter each night. Already vulnerable population is at greater risk.[45]	March 2020

Code co-occurrence modeling shows the qualitative data on the identification and selection of needs across the sample clusters in three groups (see Appendix J). Relevant to MSF's mission, underserved populations were identified through epidemiological data. Needs were also identified in an opportunistic way. KIs across five projects (New York, Puerto Rico, the Pueblos, Florida, and Michigan) noted that personal connections at the project sites led to initial investigation into underserved populations in these regions. While all of the projects involved an assessment prior to the start of intervention activities, key personnel were already aware of the constraints that MSF had in starting operations in the U.S. This ultimately influenced the needs that MSF identified and prioritized for each of the project. A number of KIs outlined (n=5) these limitations (key personnel, Michigan, New York, and Puerto Rico), which included the inability to provide direct medical care due to liability issues (or perceptions regarding liability), limitations on staff (experienced staff, medical staff, and overall number of staff available), and lack of PPE stock.

The assessment process for the U.S. intervention deviated from MSF's typical work. While MSF usually sends an exploration team to conduct an assessment before a project proposal is developed, there were limitations in the U.S. which prevented this from happening in most cases. One KI (key personnel) noted that the COVID-19 related travel restrictions ad quarantine requirements in U.S. at the time the projects were starting was a major barrier to sending an exploratory team. The same individual also recounted that finding experienced staff that could successfully engage in that activity was also a limiting factor. According to project documentation, an exploratory team was sent prior to project implementation in two sites (Florida and Puerto Rico). For the other projects, assessments were conducted remotely by reaching out to potential stakeholders or conducted on the ground once the team already arrived. In those cases, the project proposals were written simultaneously.

[42] Texas Sitrep Week 34, August 23rd 2020
[43] Florida Project Proposal
[44] While the project proposal does not have a date, May 2020 is alluded to in the document
[45] New York Assessment of Homeless Needs, March 2020

It is important to note the key differences between the interview documents and project documents in understanding how needs were identified and selected for the U.S. projects. While most of the project documentation emphasized the importance of identifying needs of underserved populations (n=12)(see table 6), interview documents highlight the role that on the ground assessments (n=17) and opportunities (n=15) play in determining needs in the context of the limitations that MSF was experiencing as an organization (see table 7). This illustrates the behind-the-scenes work that was happening in order to identify needs that MSF could address. This is not necessarily reflected in the project documentation but is important for understanding the realities of working in this context.

Table 6. How were needs identified and selected? (Project Documents)

RELEVANCE: SQ1b: How were needs identified and selected? All Project Document (n=169)		
	Documents	Percentage
Underserved Populations	12	66.67
On the Ground Assessment	7	38.89
Epidemiological Data	5	27.78
Opportunistic	4	22.22
Existing Limitations	2	11.11
Exploratory Assessment	1	5.56
Virtual Assessment	1	5.56
DOCUMENTS with code(s)	18	100.00

Table 7. How were needs identified and selected? (KIIs)

RELEVANCE SQ1b: How were needs identified and selected? KI Interview Documents (n=39)[46]		
	Documents	Percentage
On the Ground Assessment	17	43.59
Opportunistic	15	38.46
Underserved Populations	10	25.64
Epidemiological Data	9	23.08
Existing Limitations	5	12.82
Virtual Assessment	4	10.26
Exploratory Assessment	2	5.13
Organization of Administration	1	2.56
Political Economic	1	2.56
DOCUMENTS with code(s)	30	76.92
DOCUMENTS without code(s)	9	23.08
ANALYZED DOCUMENTS	39	100.00

SQ2: DID THE PROJECTS RESPOND TO THE EXPRESSED NEEDS OR DEMANDS OF THE DIFFERENT STAKEHOLDERS?

While the overall perception among KIIs was that stakeholder needs were met (n=29, 74.44%), it is difficult to answer this question without additional data. Only 12 local stakeholders participated in KIIs, half of which (n=6) were MSF staff during the project implementation. There is some qualitative data on informal and formal feedback from project stakeholders and beneficiaries. These data indicate stakeholder satisfaction (n=21) for most of the projects (n=5) (Texas, the Pueblos, Puerto Rico, New York, Michigan, and Florida) and will be discussed further in the section on *impact*.

[46] While the sample size for KIIs is 35, some individuals worked on more than one project. Transcripts were dived into two documents (one pertaining to each project). Therefore, the sample size for interview documents is 39.

SQ3: WHO WERE THE STAKEHOLDERS AND HOW WERE THEY IDENTIFIED AND PRIORITIZED?

The projects had a variety of stakeholders. They can be characterized by their level of participation in the activities of MSF during each project. MSF worked with many collaborators across the seven sites. This type of stakeholder is hard to define, as some collaborators were clear implementing partners, while others may have publicly supported MSF in the field but were not directly involved with implementation of project activities. In some contexts, government institutions were collaborators (e.g., Michigan DoH), while in others they reluctantly worked in parallel to MSF (e.g., Florida DoH). In other contexts, government institutions were beneficiaries (e.g., Indian Health Services clinics) or were absent completely (e.g., Puerto Rico). Direct beneficiaries can be defined as any group or individual that participated in project activities and/or who received support via MSF activities. The results presented here refer to stakeholders (some of whom are beneficiaries) in general when discussing relevance, appropriateness, effectiveness, and impacts. Due to the variability across the projects, using the broad category of stakeholders allows trends to be described for the sample as a whole.

SQ4: WERE THERE OTHER NEEDS THAT COULD HAVE BEEN ADDRESSED BY THE PROJECTS?

Data shows that there were needs that could have been addressed by the projects but that went unmet. There are some noticeable differences between the overall trends in the data and the responses from local stakeholders (n=12). Local implementing partners or collaborators from Puerto Rico (n=1), New York (n=2), Florida (n=2), and Michigan (n=1) participated in key informant interviews (KIIs). Additionally, some of the MSF staff hired were local residents and responded as such when asked about other needs that could have been addressed by the projects (n=6).

Direct medical care was the most frequently mentioned unmet need (n=16). This was followed by quarantine (n=8), and chronic needs associated with LTCF (n=7) (see figure 1). In the world cloud in figure one, the larger the word, the greater its representation across the sample (for a complete list of the unmet needs see Appendix K).

Figure 1. Unmet Needs

APPROPRIATENESS

EQ2: In what ways could the project activities have been better adapted to the context and target population?

Evidence shows that there are some influencing factors that would have made the project activities more appropriate to the context and target populations. This includes cultural awareness and sensitivity, time, local staff, and different activities. Cultural awareness and sensitivity would have allowed project materials to be accessible to all segments of the target groups as well as improved relationships between MSF staff and beneficiaries in some contexts. Having additional time or arriving at the project sites sooner would have given MSF staff more opportunities to adapt activities to local contexts. Including more local staff on the teams would also have been an asset to the projects, as it would have given insight into the local context as well as addressed some of the lack of cultural awareness. For the majority of projects, expanding the intervention to include different activities or scaling up activities would have increased the level of appropriateness.

However, across the projects, the evidence suggests that the activities that were implemented were well-adapted to the local context and target populations. While the specific activities varied depending on the project site, they all aimed to directly address the needs of underserved groups and included advocacy and handover strategies. Most of the projects also included health promotion activities. Activities were tailored to the local context by adapting to the needs on the ground through adding or cancelling activities and tailoring activities' materials and content.

SQ5: WHAT WERE THE DIFFERENT ACTIVITIES CARRIED OUT IN THE DIFFERENT PROJECTS?

Across the seven projects, the activities differed based on the needs identified during the initial assessment (see Appendix x for individual summaries of each project). The most common activities across the projects were local advocacy (n=7), handover (n=7), and health promotion (n=6) (see Appendix L). Projects also conducted assessments and made recommendations (n=5), managed medical supplies and donations (n=5), and provided wellness support (n=4).

ADVOCACY

In Florida, local advocacy involved appealing to the Department of Health (DOH) to increase Covid-19 testing for migrant farmworkers as well as to local companies to not fire farmworkers for medical leave. In Michigan, advocacy and awareness raising for LTCFs was integral to the project and resulted in numerous communications activities (e.g., press releases, social media campaigns), which culminated in the "Failing Our Elders" report, meant to educate policymakers, and the general public. In the Southwest (the Pueblos and Navajo Nations), closed-door advocacy applied pressure on Arizona and New Mexico state governments to direct funding to sovereign nations within their borders. In the Pueblos, the team arbitrated on behalf of local partner organizations and was successful in getting more staff for an isolation

center and clinic, which included national guard and medical professionals. In New York, MSF used their platform to show how housing and homeless insecure are affected by the pandemic.

HANDOVER

All of the projects also engaged in handover activities, although some were more successful than others. In Florida, community-based testing was handed over to local health care entities (DOH and the Health Care Network (FQHC)). It is unclear if they continued the work. According to KIs interviewed, the work was not continued in a way that accommodated migrant worker populations. In speaking with one of these local entities they did indicate that they continued services. This conflicts with some of the information provided by other KIs. Therefore, it is unclear if they continued the work or not, and in what capacity.

In Michigan and Texas, collaborations with local schools of nursing were developed to handover the IPC toolkit to be integrated in the curriculum. At the time this report was written, MSF had a dedicated staff member who was continuing this work with schools of nursing and school of social work. Unfortunately, as of this writing, none of the schools of nursing in Texas have agreed to participate in adopting MSF's toolkit and curriculum but others outside of the original operational locations have continued. In New York, the team handed over hygiene and sanitations stations to a local collaborator (Shower Power), who, at the time of the writing of this report, was planning to re-open the showers once the winter had subsided. In Puerto Rico, some of the local hire nurses decided to start their own non-profit organization to continue MSF's work. Subsequently, MSF helped them secure funding and handed over their direct medical care activities, which are ongoing. In the Pueblos, the team worked with all of their partner organizations to close the project and handed over soft copies of literature and messaging. It is unclear from the project documentation if the activities were continued after MSF's departure.

HEALTH PROMOTION

Health promotion activities were variable across the sample. They ranged from creating digital health promotion materials in Spanish (Michigan), to hiring local artists to do street art with HP messaging (Puerto Rico) (See the appendices A-H for summaries of each project).

SQ6: WERE ACTIVITIES TAILORED TO THE NATIONAL AND LOCAL CONTEXTS AND IN WHAT WAYS?

The activities for each project were tailored to the local context. KIs indicated that they couldn't speak about the way activities related to the national context but were keen to describe the ways that their projects were tailored locally. The most common way that activities were tailored to the local context was through adding or cancelling activities (n=23)(see table 8).

Table 8: Were activities tailored to the national and local contexts and in what ways?

APPROPRIATENESS SQ6: Were activities tailored to the national and local contexts and in what ways? All Projects Documents (n=169)		
	Documents	Percentage
Adding or Cancelling Activities	23	33.33
Activities Materials and Content	18	26.09
Needs	15	21.74
Activity Strategy	11	15.94
Activity Format	11	15.94
Adapt Team Characteristics	10	14.49
Collaboration	9	13.04
Community Engagement	7	10.14
Medical Support	7	10.14
Cultural and Demographic Characteristics	4	5.80
DOCUMENTS with code(s)	69	100.00

ADDING OR CANCELLING ACTIVITIES

In the Pueblos, the team added a target population (i.e., homeless) and added activities at the Western Emergency Housing Center in Albuquerque in response to learning that many Puebloan peoples utilized this facility. They also added mental health referrals for clinic staff. In Michigan, activities at adult foster care (AFC) facilities were added after learning that they are another underserved sector of LTCF and embedding was added to LTCF site assessments to improve the quality of the intervention. In Michigan, the psychosocial support originally planned transitioned to a health and wellness component due to the point in the epidemiological curve. In Texas, the health and wellness component of the intervention was added based on observations of IPC fatigue in LTCFs. In New York, the team added virtual training for supportive housing facilities, a voucher program (clothing donations) for beneficiaries of the hygiene and sanitation stations, and a helpline, which was developed when there were delays in other options for direct care (i.e., telemedicine).

Activities were also cancelled in response to the local context. In Texas, the digital health promotion activity was cancelled as it didn't fit within the scope of the original project and target population. In Florida, telemedicine was cancelled after implementation started because the target population was not interested. While telemedicine was also cancelled in New York and the Pueblos, this was not due to MSF adapting to context, but other factors (lack of decision-making on liability issues and the inability for local collaborators to take ownership).

ACTIVITY MATERIALS AND CONTENT

The teams also tailored specific activity materials and content to the local context. This included tailoring hygiene kits based on local needs, such as including pads for the elderly in Puerto Rico. In Michigan and Florida HP materials were adapted by creating Spanish messaging (Michigan and Florida). Michigan also adapted the IPC tools from the LTCF intervention in Belgium to include CDC and other localized guidelines. In the Southwest, HP materials presented current CDC recommendations in a realistic way. For example, one KI pointed out that up to 40% of Navajo Nation residents leave the reservation for work and reside with others during this time, making it hard for them to follow stay-at -home recommendations.

NEEDS

In addition, project documentation shows that teams were attentive to local needs by responding to changing needs (as evidenced by the examples above) (n=15). One KI (Florida) indicated that they went in with a "blank slate" and that everything they did was based on requests once the teams were on the ground. Another KI (New York) noted that activities were tailored to local needs simply by addressing basic human needs.

ACTIVITY STRATEGY AND ACTIVITY FORMAT

Activities were also tailored by changing the strategy (n=11) through which activities were carried out, as well as their format (n=11). For example, in Michigan, while the initial strategy was to target a larger geographic area, the team changed their approach after they understood more about the need and decided to focus on the Detroit area. Due to the limited time of the intervention and the decision to add embedding to the project, the team also took a targeted approach to identify priority LTCFs by collaborating with local entities; deciding to go for quality over quantity. The format of the activities was also tailored to local context in some cases. In the Navajo Nation, it became clear that due to access issues (i.e., problems with internet, physical access to facilities, and cultural differences) IPC trainings would be hard to implement. The team changed the format to a training of trainers model and passed along thumb drives and PPE to facilities, such as the corrections department.

ADAPTING TEAM CHARACTERISTICS

Some teams (Michigan, Puerto Rico, and Texas) also had to shift team responsibilities and team characteristics (n=11) to adapt their projects to a local U.S. context. For example, one KI (key personnel) pointed out that teams had to manage their activities while also doing tasks that they normally hire local

staff to do in the field (i.e., renting cars and feeding themselves). In Michigan, the team deviated from a typical OCB emergency team model to a polyvalent model, in which nurses were cross trained to implement various aspects/activities during the intervention (e.g., assessments and reporting, embedding, and clinical trainings). Michigan also recruited a local hire towards the end of the project who could relate more to the beneficiaries, which helped them to adapt the health and wellness component. In Puerto Rico, the team transitioned from "expats" to more locals, which was an asset for understanding the context for the project activities, and ultimately led to the project handover to the newly formed organization, Puerto Rico Salud! In Texas, it was hard to find staff that were qualified to carry out the activities as needed, so they hired a local staff member from the Michigan project as a consultant to travel to Houston to train the staff.

SQ7: WHAT WOULD HAVE MADE THE ACTIVITIES MORE APPROPRIATE TO THE CONTEXT?

The most common trend across the project documents regarding the ways that the activities could have been more appropriate to the context involved cultural factors (n=8) and more time (n=8) (see table 9).

CULTURAL FACTORS

In Florida, one KI noted that having more multi-lingual HP materials in both written and oral form would have made this activity more appropriate, as there are segments of the population from Haiti as well as some who speak specific Guatemalan dialects. Project documents also indicated that a better insight to the Haitian population would have been beneficial and appropriate. Documentation from the project in Navajo Nation indicated that many elders in the community only speak the native language, Diné. This caused confusion among this population as there is no word in Diné for coronavirus and it was translated to pneumonia-19. While there is no project documentation indicating that materials should be tailored to this multi-cultural environment, this would have made the activities more appropriate. One KI (Navajo Nation) noted that a cultural briefing, similar to MSF practice in non-U.S. settings, would have left the team more time to focus on the activities surrounding the implementation, which would have been more appropriate. One KI from the Pueblos project disclosed that more cultural sensitivity is needed in general in working with Native American groups in the U.S. They indicated that while the Pueblos are a sovereign nation, they were referred to as part of New Mexico or part of the South West. This KI attributed this lack of understanding to the mistrust that existed and continues to exist within these communities. This project was also negatively impacted by MSF communications on this intervention, which is discussed more in the section on "unintended negative effects".

Table 9: What would have made the activities more appropriate to the context?

APPROPRIATENESS SQ7: What would have made the activities more appropriate to the context? All Project Documents (n=169)		
	Documents	Percentage

Cultural Factors	8	28.57
More time	8	28.57
More Local Staff	6	25.00
Different Activities	6	21.43
More Resources	2	7.14
Better Networking in US	1	3.57
More Experience in US	1	3.57
More Documentation	1	3.57
Guidance from MSF	1	3.57
DOCUMENTS with code(s)	28	100.00

TIME AND MORE LOCAL STAFF

KIs (n=7) from Florida, Michigan, and New York also agreed that having more time or arriving sooner would have allowed the teams to understand the context in a way that would have made the activities more appropriate. There was agreement among KI from three projects (the Pueblos, Florida, and Michigan) that having more local hires or having them from the beginning would have helped to tailor project activities (n=6).

DIFFERENT ACTIVITIES

There was also some evidence that different activities would have been appropriate for the context. Two KIs (key personnel and New York) agreed that engaging in direct medical care would have been more appropriate, given the needs. As one of them noted, this may have been a missed opportunity. Two KIs (Michigan) commented that the mental health component of their project could have been much stronger. As previously noted, it was changed to a health and wellness activity and was not carried out until the end of the project (week 25). Other KIs (n=2) noted that shifting the target for HP (from Spanish speakers to LTCF staff communities) (Texas) or offering isolation (Florida) would have been more appropriate to the context. The KI from Florida did note that it would have been difficult to actually implement an isolation centre due to limited resources (i.e., staff, funding, and time).

EFFECTIVENESS

EQ3: In what ways could the effectiveness of the projects have been improved?

Effectiveness of the projects could have been improved by addressing the major constraints associated with the interventions. This includes human resources (HR) issues (quantity and quality of staff, recruiting staff, and hiring processes and barriers), supplies (lack of PPE and other supplies), access to beneficiaries, and issues associated with implementing direct care (i.e., medical licensure and liability). All of these constraints affected outputs due to delays they caused during the limited timeframe of the interventions.

The interventions could have reached more people and activities could have been increased if these issues had been resolved. HR constraints were attributed to the operational structure of the U.S. intervention as a whole, which relied on both the U.S. Cell and MSF-USA to manage different facets of the hiring process. While the evidence points to administrative lags and little active recruitment strategies on the part of MSF-USA, the underlying reasons for this are unclear. Issues associated with implementing direct care and problems with the supply chain are attributed to MSF's inexperience working in the U.S. context. Evidence suggests that these constraints could be addressed in the future, if MSF were to intervene in the U.S. again. Access to beneficiaries could have happened more efficiently if more local staff were involved in the interventions from the beginning or if the teams had more time to become familiar with local contexts, including cultural characteristics.

Despite these constraints, there were numerous opportunities across the projects, which helped the teams to achieve the various outputs. This included building relationships with local partners, collaborators, and other stakeholders, and the work with specific underserved groups that are often overlooked in the U.S. context. This was an opportunity for MSF to advocate for these groups (both actively and passively), as well as to advocate for MSF's work in the U.S. Across the projects, this advocacy influenced the effectiveness of the intervention by holding local stakeholders accountable, which led to direct actions that enhanced the local Covid-19 response to support underserved groups.

SQ8: WHAT WERE THE OUTPUTS ACHIEVED IN EACH OF THE PROJECT LOCATIONS?

Each project achieved its own outputs, which reflected the variety of activities carried out across the projects (see Appendices A-H for outputs for each project). The overlap between projects is presented below (see figure 2). However, there are not enough similarities to report on the U.S. intervention as a whole. It is not possible to determine effectiveness of the projects based on outputs, as there are no baseline measurements in the project documentation.

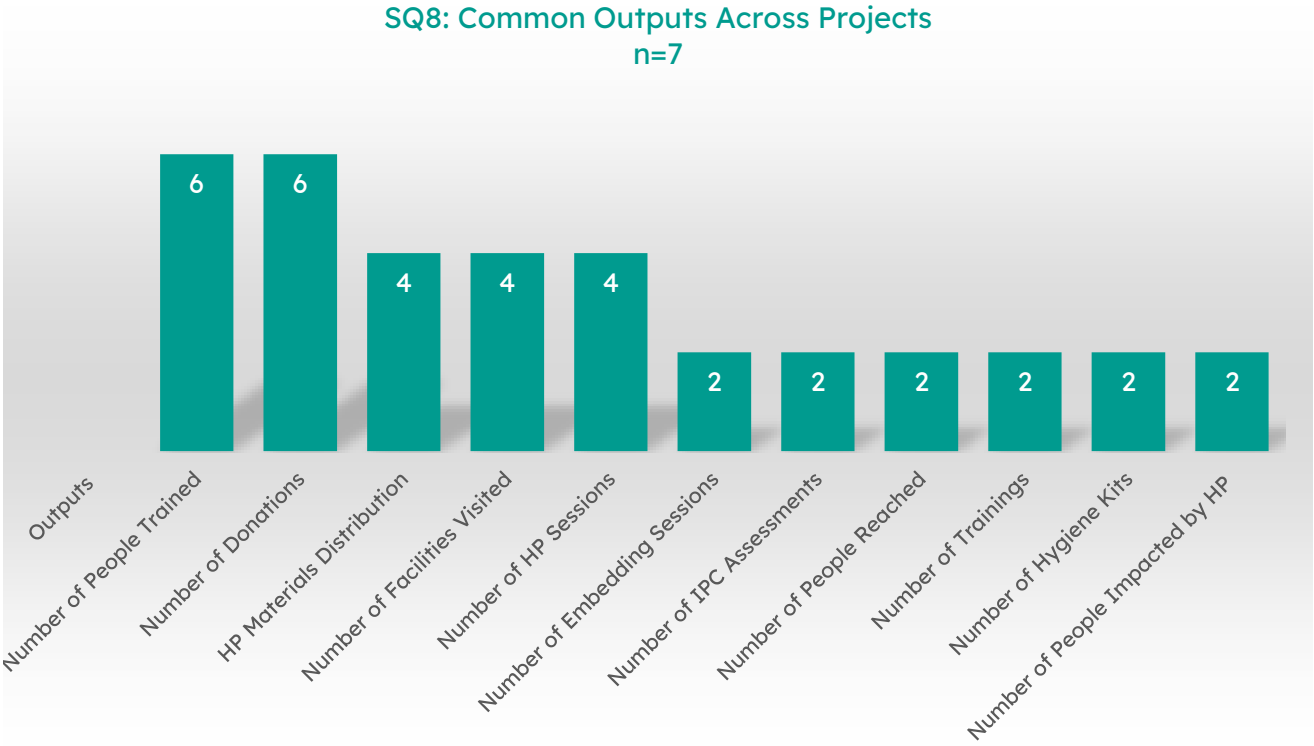


Figure 2. Common Outputs Across Projects

SQ9A: WHAT WERE THE MAIN OPPORTUNITIES DURING IMPLEMENTATION?

It has already been noted that an opportunistic approach was taken regarding the identification of project needs and the subsequent activities designed to meet those needs. Each project had unique opportunities during implementation.

In Texas, there was an opportunity to learn from Michigan, as the team applied the model of working in LTCFs. As one KI noted, they were much more careful when reviewing local regulations in Texas based on their experience in Michigan. Another KI mentioned that they were also able to help the save facilities money on biohazard disposal by teaching up-to-date practices. A different KI involved with the project also recognized the inclusion of ACS from the beginning of the intervention as part of the opportunity to apply the Michigan model.

In the Pueblos, KIs and project documentation noted that working with Native American communities was an opportunity to build relationships and trust for future work, as there are many unmet medical needs in these communities. In Navajo Nation trust and relationship-building was also mentioned by KIs and described in some project documentation. As one noted, this was an opportunity for MSF since they have a desire for outside medical professionals to work with them since they don't trust federal authorities or the IHS.

In Puerto Rico, KIs also recognized that relationships led to various opportunities. One KI was able to draw on their MSF connections in Latin America for HP materials. Their relationships on the island gave them an opportunity to implement project activities by getting them access to underserved and isolated groups.

In Michigan, the project was an opportunity to adapt the model from Brussels to the U.S. LTCF context. This project was an opportunity to advocate for LTCFs, due to the systemic and chronic issues associated with the treatment of staff in these facilities. There was also an opportunity to work with the local DOH, as they had trouble accessing these facilities due to deep-seeded mistrust within this system.

In New York, the opportunities were unintended, as the project originally started through personal connections of an MSF staff member. This continued, and one KI indicated that the entire project was based on following the leads of various opportunities to partner with local organizations, such as the Brownsville Family Health Center (FQHC) and the Coalition for the Homeless.

In Florida, the team identified opportunities through their local partner organization CIW. This enabled them to build relationships that led to HP activities in packing houses and testing and education on farms. One KI also noted that this was an opportunity to bring awareness about migrant farmworkers as an underserved group. While MSF did not do any direct advocacy work, one partner organization pointed out that the presence of MSF, an international, humanitarian medical organization in the area was advocacy enough.

These trends are also common across KIIs, which indicated that relationships (n=13), working with underserved groups (n=6), and advocacy (n=2) were the main opportunities during project implementation.

SQ9B: WHAT WERE THE MAIN CONSTRAINTS DURING IMPLEMENTATION?

Numerous constraints were identified across the sample. As these data pertain to the OECD-DAC criteria on effectiveness (EQ3, SQ9b), constraints were identified as such if documentation (either KII or project documentation) clearly associated these factors with impacts on operations or the effectiveness of the project and/or the related activities. General challenges that were not clearly associated with operations were not included in this portion of the analysis. These challenges are outlined in the conclusion.

The most common constraints identified across the sample were HR issues (n=24), followed by supplies (n=16), access (n=16), relationships (n=16), and direct medical care issues (n=16) (see table 10).

HR

HR constraints involved quality and quantity of staff ("staff", n=17), difficulty recruiting staff, including staff who can legally work in the U.S. ("staff recruitment", n=8), lengthy or cumbersome hiring processes ("hiring process", n=6), and barriers associated with hiring local staff ("hiring barriers", n=4), such as the lack of local hiring permits in the case of Puerto Rico. These issues with HR ultimately led to projects starting later than anticipated and shifting project activities. In Puerto Rico, direct medical care started 50 days after the program start date due to hiring barriers, COVID-19 regulations (i.e., quarantine for incoming staff), lack of supplies, and legal barriers associated with providing direct medical care in the U.S. The lengthy time it took to hire local personnel for the mental health component of the Michigan project led to the need to shift the focus of the activity from mental health to health and wellness. This also did not give the new local hire much time for the activity before the project close date. One KI (Michigan) noted that they were available for 3 or 4 weeks before MSF completed the hiring process.

SUPPLIES

There was consensus that the issues with the supply chain, particularly the lack of PPE, was a constraint (n=16). In the Pueblos, they received PPE so late that stakeholders didn't need it anymore. Some projects received supplies, but they weren't useful. In Navajo Nation, they received PPE that was not approved for medical use. In Puerto Rico, they received electronic equipment for operations that couldn't be activated on the island and had to be sent back to New York. There was also concern that the lack of supplies in general impacted the team's ability to do project activities, such as create an alternate care site in the Pueblos or adequately create resources-boards in Michigan. The team in Michigan was also sourcing supplies locally, due to the overall lack of supplies. This was a big undertaking for the team to organize. Lack of testing materials in Florida delayed testing activities until the team could collaborate with other partners who had resources.

ACCESS

Overall, the interventions were constrained by access (n=16). This includes access to reliable and accurate data (KII, key personnel) as well as accessing beneficiaries (Michigan, Texas, and Florida). For the OCB projects (Michigan and Texas), access to LTCFs impacted how many facilities they visited and which facilities they visited. Relevant to this is the constraint of the typical LTCF environment (n=5). The punitive model, along with the characteristic that they are understaffed, led to difficulties for the teams to enter facilities and recruit beneficiaries (i.e., LTCF staff). In Florida, there was limited access to the homes of migrant farmworkers, which was originally part of an IPC activity, as most farmworkers live in multi-family crowded living spaces that are conducive for the spread of infectious disease.

RELATIONSHIPS

Relationships (n=16) with local communities, local government entities, and potential beneficiaries delayed activity timelines and interfered with planned activities. In the context of Michigan and Texas, where there is a lot of mistrust among LTCFs, the fact that MSF was previously unknown to most

beneficiaries added an additional layer of challenges when attempting to access facilities. In the Pueblos, trust between the Puebloan government and outside entities also contributed to access issues. In one instance, MSF published information against the wishes of the Puebloan government, contributing to the already tenuous relationship. This resulted in the community ignoring future offers for help from the MSF team (KII, the Pueblos).

DIRECT MEDICAL CARE ISSUES

Issue regarding medical licensure and liability issues (e.g., liability insurance) were also a constraint (n=16). A couple of KIs noted that the perception of these issues as a constraint was the real barrier to attempting direct medical care as part of the intervention, not the actual issues surrounding liability (key personnel). There is some evidence to support, this, such as the implementation involving direct medical care in Puerto Rico.

Table 10: What were the main constraints during implementation?

EFFECTIVENESS SQ9b: What were the main constraints during implementation? All Project Documents		
	Documents	Percentage
HR	24	40.00
Staff	17	
Staff recruitment	8	
US citizens	3	
Hiring process	6	
Hiring barriers	4	
Supplies	16	26.67
Access	16	26.67
Direct Medical Care Issues	16	
Perception of direct care issues	3	
Time	15	25.00
Relationships	15	26.67
MSF unknown	7	
Finances	14	23.33
Local Operational	13	21.67
Partners	12	18.33

MSF Operational Structure	10	16.67
MSF Communication	9	15.00
LTCF Environment	5	8.33
COVID Regulations	3	5.00
US Regulations	3	5.00
Language	2	3.33
Migrating Population	1	1.67
One Size Fits All Model	1	1.67
MSF Administration	1	1.67
DOCUMENTS with code(s)	60	100.00
ANALYZED DOCUMENTS	169	-

SQ10: ARE THERE THINGS THAT WOULD HAVE MADE THE PROJECTS MORE EFFECTIVE?

KIs from Navajo Nation, Texas, Puerto Rico, Michigan, and New York indicated that having more time (n=5) and/or arriving sooner (n=2) would have made the project more effective (see Appendix M). KIs from Puerto Rico, Michigan, Texas, New York, and Florida also mentioned that resolving HR issues would have made the projects more effective (n=6). This included hiring sooner (n=1), having more local staff (n=1), having more medical staff (n=3), having more staff (n=1), a need to re-think the HR model (n=1).

While project documents also highlighted things that would have made the projects more effective (see Appendix N), the findings were similar when aggregated with the KIIs, as the most common themes were HR (n=12) (hiring sooner, local staff, more medical staff, more staff, rethinking the HR model, and the quality of staff) and time (n=9)(having more time or arriving sooner), followed by the implementation of different activities (n=6)(more multi-lingual or multi-cultural HP materials, medical activities, increased wellness support, and follow-up activities).

It is important to note that while cultural factors were not noted when KIs were asked about effectiveness, they did indicate that this would have made the project activities more appropriate (described in more detail in the previous section on “appropriateness”), which could have had an impact on their effectiveness as well. In line with this conclusion is the overlap between appropriateness and effectiveness regarding the hiring of local staff. KIs did indicate that hiring of staff who could relate to beneficiaries would have made the project activities more appropriate, such as in the context of Michigan. In this case, hiring a local African American social worker made the health and wellness component of the project more appropriate. In the Pueblos, there was recognition that due to cultural barriers, having locally led training would be more appropriate, and perhaps more effective. This resulted in the training of trainers

activity. Puerto Rico and Florida also emphasized the importance of hiring local staff. Originally, in Florida, the team wanted to hire a local farmworker, but legally and logistically it was not feasible.

IMPACT

EQ4: How much of a difference did the projects make and for whom, under what circumstances?

The projects made a difference for beneficiaries and other stakeholders. This is evidenced by overall stakeholder satisfaction with MSF's presence and actions at the various project sites. This was communicated directly by local partner organizations as well as documented across the projects which kept some records on formal and informal feedback provided by beneficiaries.

Likely outcomes from the interventions for beneficiaries included increased knowledge from trainings and improvements in wellbeing (e.g., decreased fear and increased comfort). Evidence also suggests that local partner organizations and collaborators had increased capacity to manage the Covid-19 response. There were some unintended negative and positive effects reported for some of the projects, including the environmental implications of PPE disposal and the development of a new non-profit organization to continue MSF's work in Puerto Rico.

For MSF as an organization, capacity-building for future U.S. operations was a likely outcome. This includes drawing on the relationships developed through the interventions. While stakeholder satisfaction was high overall, there were factors that impacted outcomes, which include time and the quantity and quality of staff. It is important to note that there were some instances when MSF did not have good working relationships with local stakeholders. However, due to lack of data on these relationships, it is not possible to determine how they impacted the projects' appropriateness, effectiveness or outcomes.

SQ11: WHAT ARE THE LIKELY OUTCOMES OF THE DIFFERENT PROJECTS? AND SQ12: WHO WAS AFFECTED BY THE OUTCOMES?

Likely outcomes were identified through KIIs and project documents. While there is no way to quantitatively measure the impact or effectiveness of the U.S. intervention due to lack of baseline data and broadly stated project objectives, there are some common trends in outcomes across the qualitative data

Stakeholder satisfaction was most frequently identified as an outcome of the intervention among local stakeholders (n=12) as well as across all project documents (n=21) (see table 11). This was noted for all projects except Navajo Nation. This was identified through informal feedback from beneficiaries and other stakeholders. In New York, one local stakeholder wanted to recognize MSF's work by honoring team members at an annual Gala. In Michigan, activity assessments showed that the trainings addressed

concerns and priorities. In Florida, a local hire who lives in the intervention community expressed their gratitude during the KII.

Table 11. What are the likely outcomes of the different projects?

IMPACT SQ11: What are the likely outcomes of the different projects? All Project Documents (n=169)		
	Documents	Percentage
Stakeholder Satisfaction	21	34.43
Increased Knowledge from training	13	21.31
Stakeholder Wellbeing	12	19.67
MSF US Ops Capacity Building	11	18.03
Advocacy	10	16.39
Behavior Change	10	16.39
Local Capacity Building	7	11.48
Increased COVID Support	7	11.48
Medical Outcomes	5	8.20
Can't Talk About Outcomes	7	8.20
Materials	3	4.92
Support of New Organization	3	4.92
Access	3	4.92
No Follow-up	2	3.28
No Recorded Changes due to Intervention	1	1.64
Meet basic needs	1	1.64
DOCUMENTS with code(s)	61	100.00

SQ13: DID THE PROJECT MEET THE STATED OBJECTIVES?

More than half of KIIs (n=20, 57.14%) across all of the projects (including key personnel) communicated that the project objectives were met. Only one KI indicated that the objectives were not met, although they acknowledged that some objectives were met, while others were not. Some KIs (n=6) noted that they weren't sure if the objectives were met as they were stated or that it wasn't possible to determine based on the stated objectives (key personnel, Michigan, Pueblos, Texas). It was difficult to determine if objectives were met due to the inability to measure the impacts of the objectives as they were worded (e.g., reduce morbidity and mortality) or due to lack of sufficient data (see Appendix O for objectives).

SQ14: WERE THERE ANY UNINTENDED POSITIVE OR NEGATIVE EFFECTS?

Overall, there weren't many unintended negative effects identified across the sample (see Appendix P). Additionally, there was no agreement in trends among project documents. In Florida, increased testing led to identification of more positive cases. However, positive cases were referred to the hospital, which inhibited migrant farmworkers from moving with the group. One KI noted that this may have resulted in a reluctance of farmworkers to get tested. Also in Florida, a local team member who lives in the intervention community commented that the intervention gave people hope, but that after MSF left, the impacts of the intervention didn't last.

In Navajo Nation one KI indicated that there was a discrepancy between the expectations of local stakeholders and what MSF could offer. In the Pueblos, the mistrust that developed after the publication of the MSF intervention (discussed earlier) may impact MSF's future work in this region.

In Puerto Rico, one KI noted that the lack of staff, as well as the team profile (too many staff with the same area of experience), may have impacted on the intervention, although they did not indicate how. Also in Puerto Rico, one KI commented on the environmental impacts of their PPE use, as it created a lot of trash.

One KI involved in both Michigan and Texas, commented that due to constantly shifting regulations within LTCF that the interventions MSF conducted could possibly lead to facilities being fined if they are not up-to-date with the most recent regulations.

Similar to reporting of unintended negative effects, there were not many unintended positive effects noted and there wasn't much overlap among respondents (see Appendix Q).

One KI from Florida and a key personnel KI involved with the OCP projects noted that the ways that MSF pushed local health care systems to do more was a positive effect of the intervention. For example, through MSF advocacy efforts, local health care systems began to do more for vulnerable groups in the Pueblos and Florida, this included bringing in more medical staff and offering increasing testing. In Michigan, one KI noted that advocacy for LTCF was also an unintended positive effect. This brought awareness to chronic issues within LTCFs.

One key personnel KI involved with the OCB projects and one partner organization in NY indicated that an unintended positive effect is the collaborations that formed for future MSF work in these settings. The same key personnel KI and a KI from the Michigan project pointed out the fact that the handover to the schools of nursing was not intended from the beginning of the intervention but was a positive effect. In Michigan, one KI noted that working with a local specialist had an unintended positive effect, as this staff member was integral to the project and went on to be an asset for the Houston project.

The same KI also noted that the project in Michigan enabled the project in Houston. In Houston, one KI commented that MSF staff went beyond IPC help and provided general recommendations that may have helped facilities to cost-cut, such as changing waste disposal practices. In Puerto Rico, one KI mentioned that the project brought more "human care" to patients. A local partner organization commented that MSF showed local organizations how to use mobile units effectively for health promotion. Additionally, some team members started their own organization, Puerto Rico Salud!, which continued MSF's activities after the project ended.

SQ15: WHAT WOULD HAVE MADE A BIGGER DIFFERENCE AT THE LEVEL OF OUTCOMES?

Similar to the proceeding results, findings on what would have made a bigger difference at the level of outcomes are variable. The most commonly cited factor was time (n=8) (see Appendix R). This includes a faster response (key personnel), having more time (New York, Puerto Rico, Michigan, Navajo Nation, key personnel), and not having administrative lags (Puerto Rico), and having more long-term interventions (Michigan). The next most common finding involves staff/team characteristics (n=5). This includes having more staff or volunteers (Florida and New York), more appropriate staff (better trained and local)(Michigan), and having more bilingual staff (Florida). This was followed by increased testing supplies (n=2), follow-up (n=2), and increased communications (n=2). A couple of KIs indicated that the projects couldn't have done better.

OTHER CHALLENGES

It is important to note that there were also challenges that the MSF teams faced in the field that were not included in the analysis on constraints, as there were no clear indications within the documentation that these challenges directly impacted operations of the projects. This included coordination within MSF, communication between MSF and the teams, and finance issues.

Coordination between the teams and MSF administration (coordination, the cell, and MSF USA) as well as among the various levels of the administration was a challenge for some KIs (Puerto Rico, Key personnel, New York). One KI noted, "The challenges and differences between the different sections could be felt and can affect the teams themselves". Another KI agreed that internal politics affected communication and leadership.

Overall communication was a challenge for some of the teams (Michigan, the Pueblos, Navajo Nations). A couple of KIs noted that they did attend regular meetings with the MSF Cell and Coordination, but that depending on which meeting they attended they got different messages. As one KI noted, “I did my best to keep an open ear and be dynamic and nimble as possible when I found the floor was lava.” As another KI observed, there were communication challenges between the team and MSF-USA regarding logistics. Someone else from that team said, “I feel like New York didn’t know it was an emergency.”

Issues with communications also overlapped with challenges regarding the budget and finances for some of the projects (the Pueblos, New York, Navajo Nation, Puerto Rico). For one project, information about the budget was not clearly communicated at the start. The team was under the impression (based on communication with MSF) that they had an ample budget to do what they wanted. However, they received their formal budget a month into the project and discovered their budget proposal had been altered with no explanation as to why. This was echoed by another team as well. In another project, credit cards were blocked due to thresholds inconsistent with the approved budget. Team members for two projects (Navajo Nation and the Pueblos) had to use their own credit cards to make purchases. For one of the projects, almost a month after the start date there was no reimbursement, credit card, or finance plan. Someone from the other project team noted they also had to use their own credit cards with no clear idea of when reimbursement would happen or what the budget was.

CONCLUSION AND LESSONS LEARNED

This evaluation addressed two main objectives. First, the team assessed the seven Covid-19 U.S.-based projects' strategies, objectives, and outcomes in order to determine the achievements (or lack of) of the projects using relevant (OECD-DAC) criteria (relevance, appropriateness, effectiveness, and impact). The evaluation found that the intervention was relevant overall, based on the epidemiological data at the time, which identified needs among underserved groups across the various project locations in the U.S. Each project also aimed to address needs within the limitations of the capacity of MSF to intervene as an organization. While the project activities were appropriate within this context, there are some things that would have made them more appropriate. This includes cultural awareness and sensitivity, time, local staff, and different activities. Although it was difficult to measure effectiveness and impact, trends such as various project outputs and positive stakeholder satisfaction indicate that the projects were effective to a degree and that they had a positive impact. The projects could have been more effective if HR issues, among other constraints, were resolved. Similarly, factors that could have improved outcomes were having more quality and quantity of staff as well as more time for the interventions.

Second, the evaluation aimed to provide evidence-based lessons from MSF's humanitarian intervention in the U.S., since working in the context of a high-income country with established health infrastructure is uncommon for MSF. Based on the evidence presented in this report, the evaluation team has outlined some recommendations (see table 12).

Table 12. Lessons learned for future MSF US Operations

LESSONS LEARNED FOR FUTURE MSF US OPERATIONS
▪ Include context-specific cultural briefings as part of U.S. mission ▪ Explore different operational HR models ▪ Ensure supply chain support for U.S. mission ▪ Increase recruitment of local staff on MSF teams ▪ Strengthen knowledge of U.S. regulations regarding direct medical care ▪ Strengthen knowledge of U.S. and state regulations regarding HR

These lessons learned are based on common trends identified across the qualitative analysis. Increasing cultural awareness and sensitivity can contribute to appropriateness and effectiveness of projects. As one KI noted, MSF typically has cultural briefings for staff before they go into the field, and it was felt that it would have been useful is to have cultural briefings for U.S. missions as well.

Issues with HR were noted in all sections of the evaluation. This includes administrative lags in hiring, the quality and quantity of staff, as well as the lack of local hires. One KI attributed the lag in hiring processes due to the shared responsibility of MSF-USA, the Cell, and Coordination when it came to HR and finances. Future US interventions would benefit from having clearly outlined roles and responsibilities for the different MSF bodies involved in the HR component of the response, to be shared and discussed with the implementing field teams. KIs also recommended increasing the recruitment of local staff on MSF teams. In some cases, this was hampered by HR regulations for specific segments of the population (e.g., furloughed nurses). Strengthening knowledge of U.S. state and national regulations regarding hiring and necessary medical credentials etc. will help to make the recruitment process faster and more efficient, should MSF decide to intervene in the US again in the future.

The issue of delivery of direct medical care (or perceived lack of it) was mentioned by numerous KIs in relation to questions of the projects' relevance, appropriateness, and effectiveness. While the support of testing and tracking of COVID-19 cases, and the provision of telehealth all fall under the umbrella of direct service delivery, there was clearly as distinction made between these activities and what the majority of MSF field staff interviewed deemed to be direct medical care. What constitutes direct medical care should be clearly defined and understood by all MSF members to avoid confusion in future activities and reduce the likelihood of frustrations among those delivering services. Any future activities in the US would benefit from MSF strengthening its institutional knowledge of U.S. federal and state regulations regarding delivery of direct medical care and hiring of medical staff. While direct medical care was possible in Puerto Rico, there were delays nonetheless due to regulations, licensing, and permits to operate in the region. While many KIs and project documents conflated liability with other issues (such as credentialling, medical licensure, privileges, and accreditation to practice) it is important to note that in the context of providing direct medical care, these topics are distinct (e.g., the institutional risk of liability and malpractice for MSF as an organization, vs the individual criminal act of practicing medicine without the necessary credentials) and should be addressed as such.

APPENDIX

APPENDIX A: KEY PERSONNEL RESULTS SUMMARY

MSF US COVID RESPONSE OPERATIONAL EVALUATION

Key Personnel

March-September 2020

Overview

Preliminary results from interviews conducted with key personnel (n=7) for the operational evaluation of MSF's US COVID response are presented here. For the overall evaluation, these results will be synthesized with findings from all of the U.S. projects, which include analysis of semi-structured interviews with stakeholders (n=36) and a systematic review of project documentation (n=161). The evaluation applied four criteria from the Organisation for Economic Co-operation and Development's Development Assistance Committee (OECD-DAC), including relevance, appropriateness, effectiveness, and impact.

Validation

Data validation is an important part of interpreting results. Before the team can finish analyzing the data as a whole, we would like to get some feedback from interview participants. The following data validation tool has been developed based on a technique called, "member checking".[47]

Results

Relevance

In what ways could the projects have had more relevance when considering both the medical humanitarian needs and the capacity and principles of the organization?

Main Finding:

The U.S. intervention could have had more relevance if the unmet needs identified by key personnel were met (see Table 1). Needs for the US COVID intervention were identified for each project after individual U.S. sites were chosen. Sites were chosen through a combination of epidemiological analysis and assessing where MSF would be able to practically intervene.

[47] Birt, L., Scott, S., Cavers, D., Campbell, C., & Walter, F. (2016). Member checking: a tool to enhance trustworthiness or merely a nod to validation?. *Qualitative health research*, *26*(13), 1802-1811.

The unmet need to provide direct medical care was a common theme. There was recognition that the perception of liability issues associated with working in the US would be a major constraint for operations. Additionally, MSF did not have medical staff available at the time. However, after successfully integrating direct care in Puerto Rico (the project that ended last) and attempting telemedicine in Florida, it became clear that direct medical care is possible.

Overall, the project was relevant based on the needs identified by key personnel and the activities carried out to address those needs (see Table 1).

Table 1

Relevance

Needs US Intervention Aimed to Address	Activities to Address Needs	Unmet Needs
● Adapt to changing understanding of a new virus ● Contact tracing ● Donations ● Epidemic response in US ● Health promotion ● IPC training and education ● Support long term care facilities (LTCF) ● Support vulnerable populations	● Assessments and Recommendations ● Donations (PPE, hygiene kits, cell phones) ● Direct medical care (home care) ● Handover ● Health promotion ● Hygiene and Sanitation (Handwashing and shower stations) ● Information aggregation ● IPC education and training (health facilities, detention centers) ● Testing ● Wellness support (mental health support)	● Advocacy ● Chronic needs of LTCF ● Could have done more ● Direct medical care ● Mental health ● Visit more facilities ● Supplies ● Staffing

Appropriateness

In what ways could the project activities have been better adapted to the context and target population?

Main Finding:

Key personnel indicated that the activities carried out during the U.S. COVID intervention were appropriate overall. The activities could have been better adapted to the context by providing direct medical care (discussed above), through better networking in the U.S., and through better organization surrounding the closing of the projects. One interview participant noted that having better connections and networking in the U.S. context from the beginning would have been helpful in the tailoring of activities

and their implementation at each of the sites. Another participant was clear to point out that the closing for the projects and the activities were not normal for MSF activities. There was a lot of documentation lost at the end of some projects due to the timing of the termination of contracts of key personnel as well as staff using multiple platforms to record their work (DB, Google Docs, SharePoint).

However, many activities were tailored to the local context. While activities were designed during the assessment phase of each project, the teams on the ground adapted each intervention based on the needs that they observed in the field. Key personnel provided examples of these adaptations which included tailoring pre-existing intervention models (e.g., training protocols) and included local staff hires as an integral part of their intervention.

Work with partner organizations was key to all of the projects, as MSF did not have pre-existing systems in place to implement the intervention. Therefore, activities were also adapted during ongoing work with these collaborators.

Effectiveness

In what ways could the effectiveness of the projects have been improved?

Main Findings:

Key personnel indicated that MSF's intervention in the U.S. could have been more effective if MSF was prepared to be operational in the U.S. Improvements in the organizational structure and the operational team model would have contributed to effectiveness. For example, the digital HP campaign was using the same channels as fundraising, and therefore was not as effective as it could have been. The lack of the coordination between the cell and the desk made it difficult for teams in the field to prepare and execute activities in a timely manner. One interview participant noted that in a U.S. context, all the levels that were operating simultaneously were not necessary (HQ, coordination team, HoM, and PC). While MSF has a hierarchy and organigramme that typically work in other settings, creating a specific structure for the U.S. would have led to more efficient processes and a way to hone in on people's skills more effectively for each project. Some interview participants indicated that although MSF was not prepared to work in a U.S. context, learning from these shortcomings is an opportunity to build MSF's capacity to work in this setting in the future.

Impact

How much of a difference did the projects make and for whom, under what circumstances?

Main Finding:

According to key personnel, the projects made a difference for stakeholders involved through advocacy and their participation in the intervention (see Table 3) [48]. The projects exposed the vulnerabilities of migrant farmworkers and LTCF. The projects also impacted MSF's capacity to work in the U.S. by identifying some of the weaknesses in this area (supply chain, operational structure, finance, IT support, HR). One interview participant noted that the intervention will serve as a model for other MSF interventions (e.g., Portugal and Ecuador) and that some materials created for the U.S. projects can be used in the future (e.g., Spanish HP materials).

A couple of participants were clear to point out it is not possible to measure the impacts of the projects using the data collected or in response to the objectives originally indicated (e.g., decrease COVID morbidity and mortality). Additionally, without follow-up, which didn't formally happen, there is no way to measure actual impacts.

Table 3 Outcomes: Informal Metrics
• Advocacy (migrant farmworkers, LTCF) • IPC toolkit • MSF capacity-building • Stakeholder satisfaction • Understanding vulernability related to COVID

APPENDIX B: FLORIDA RESULTS SUMMARY

MSF US COVID RESPONSE OPERATIONAL EVALUATION

Project: Florida

May 2, 2020-June 22, 2020

Overview

Preliminary results for the operational evaluation of MSF's COVID intervention in Florida is presented here. Semi-structured interviews were conducted with MSF stakeholders (n=5) and a systematic review of project documentation was undertaken (n=19) (explo documents, project proposal, closure reports, and sitreps). The evaluation applied four criteria from the Organisation for Economic Co-operation and Development's Development Assistance Committee (OECD-DAC), including relevance, appropriateness, effectiveness, and impact.

Validation

[48] There is no way to causally link the MSF activities with outcomes.

Data validation is an important part of interpreting results. For the overall evaluation, these results will be synthesized with findings from the other six US projects. Before the team can analyze the data as a whole, we would like to get some feedback from interview participants. The following data validation tool has been developed based on a technique called, "member checking".[49]

Results

Relevance

In what ways could the projects have had more relevance when considering both the medical humanitarian needs and the capacity and principles of the organization?

Main Finding:

The project could have had more relevance if the unmet needs were addressed. Direct medical care was limited by liability risk due to US regulations. The team did attempt to do Telemedicine to meet non-COVID healthcare needs. However, the team found that this was not relevant for the target population at the time and stopped the activity. While increased testing would have been relevant, the team was limited by liability risk and their subsequent reliance on partner organizations to provide volunteers for testing. Contact tracing was also inhibited by actions of a partner organization, leading the team to focus on post-testing follow-up phone calls instead. While conducting assessments for isolation and quarantine sites was part of the original explo as well as hiring community health workers from the target population, there is no evidence that this was part of the project activities. Team members indicated that increased community engagement would have been more relevant for this project.

Overall, the project was relevant based on the needs identified by stakeholders and the activities carried out to address those needs (see Table 1).

Table 1

Relevance

Needs Project Aimed to Address	Activities to Address Needs	Unmet Needs
● Contact tracing ● Health promotion ● Healthcare (COVID and non-COVID)	● Advocacy ● Contact tracing ● Handover (CIW and DoH) ● Health promotion	● Advocacy ● Community health workers

[49] Birt, L., Scott, S., Cavers, D., Campbell, C., & Walter, F. (2016). Member checking: a tool to enhance trustworthiness or merely a nod to validation?. *Qualitative health research*, *26*(13), 1802-1811.

● Isolation and quarantine ● Telemedicine ● Testing ● Vulnerable populations (migrant farmworkers)	● Hygiene kits ● Medical supplies and donations ● Mobile clinic (testing and telehealth) ● NFI distribution ● Referrals ● Relationship building	● Community engagement ● Contact tracing ● Direct medical care ● Health promotion ● IPC training ● Isolation and Quarantine ● Medical technical support ● Social support ● Testing

Appropriateness

In what ways could the project activities have been better adapted to the context and target population?

Main Finding:

The project activities could have been better adapted to the context and target population if the team had more local staff earlier on (constrained due to HR lag), more multi-lingual and multicultural health promotion materials (Haitian and Guatemalan dialects), and the capability to set up an isolation area. While an isolation center would have been appropriate in this context, staff recognize that this would have been hard to implement due to project constraint (staff and budget) as well as constraints associated with this population (reluctance of farmworkers to take time off of work to isolate). Staff also recognized the more time would have allowed the project activities to be better adapted to the context, but also acknowledged the fact that this is a migrating population and were already moving on toward the end of the intervention.

However, many activities were tailored to the local context and the emphasis on community-based approaches was clear throughout. For example, the team collected informal qualitative feedback from the community that could be incorporated into the following week's health promotion activities. The team also went into the community to do HP, which included visiting community gathering areas, neighbourhoods, testing events, and work sites. They also adapted the mobile clinic hours to fit with the farmworkers work schedules.

Effectiveness

In what ways could the effectiveness of the projects have been improved?

Main Findings:

The MSF team collected formal metrics regarding outputs (see Table 2) for the project. However, data were not collected in a way that makes it possible to measure the effectiveness. This could have included the collection of pre and post intervention indicators.

Stakeholders did identify some areas that would have improved the effectiveness of the project. For example, having more time for relationship building with local stakeholders could have made the identification of community leaders and COVID training with this group possible (see Table 2). Also, having additional staff and more local hires would have improved access to communities. One stakeholder noted that the low number of local staff and the delay in hiring may have been related to MSF's HR model, which includes rigorous screening in the hiring process to find staff with MSF experience. From their perspective, the same skillset normally required for an MSF mission (e.g., being able to fix a generator or live in a tent) is not required for this type of domestic endeavour. The project would have also been more effective if there were more multicultural HP materials to account for the diversity in the population (Haitians, Spanish speakers, Guatemalan dialects).

Table 2

Outputs: Formal Metrics

- Handwashing for clinic patients
- HP educational materials
- Informal qualitative feedback incorporated into the following week's materials
- Mapping key actors and locations
- Mask distribution
- Number of clinics
- Number of community leaders identified (0)
- Number of community leaders trained on COVID (0)
- Number of donations
- Number of HP locations
- Number if HP Sessions
- Number of hygiene kits
- Number of meetings with local actors
- Number of patients contacted for results phone call
- Number of people impacted by HP sessions
- Number of people tested
- Number of referrals
- Number of work places visited

Impact

How much of a difference did the projects make and for whom, under what circumstances?

Main Finding:

The project made a difference in mobilizing the COVID response for migrant farmworkers (see Table 3) [50]. Due to MSF's presence and advocacy, local stakeholders began to address the needs of this population, which were largely being ignored previous to MSF's intervention. Formal data reported low positivity rates for this region/population. However, through increased testing, MSF found up to 36% positivity rates in some of their clinics. This project exposed the needs of migrant farmworkers.

Informal feedback from beneficiaries indicated that they felt safe attending MSF's clinics. As many of these beneficiaries lack documentation, this has been a major barrier in healthcare seeking behaviour. Beneficiaries also said they felt seen and heard. Other local stakeholders also expressed their satisfaction with the project.

In the context of the MSF intervention, stakeholders noted that these projects exposed the underpreparedness of MSF to run domestic operations. However, keeping the project small may have contributed to the project's ability to continue and understand the capacity for future work. This project identified partnerships and potential avenues for working with migrant farmworkers in the future.

Table 3 Outcomes: Informal Metrics
• Self-isolation of some positive cases • Increase in local COVID response due to MSF presence and advocacy • Increased knowledge • Increased testing • Beneficiary satisfaction • Identification of positive cases • MSF US Ops Capacity-building

APPENDIX C: MICHIGAN SUMMARY

MSF US COVID RESPONSE OPERATIONAL EVALUATION

Project: Michigan

May 2020-July 31, 2020

Overview

Preliminary results for the operational evaluation of MSF's COVID intervention in Michigan is presented here. Semi-structured interviews were conducted with MSF stakeholders (n=7) and a systematic review of project documentation was undertaken (n=20) (initial assessment documents, project proposal, closure reports, communications documents, testimonials documents, and sitreps). The evaluation applied four

[50] There is no way to causally link the MSF activities with outcomes.

criteria from the Organisation for Economic Co-operation and Development's Development Assistance Committee (OECD-DAC), including relevance, appropriateness, effectiveness, and impact.

Validation

Data validation is an important part of interpreting results. For the overall evaluation, these results will be synthesized with findings from the other six US projects. Before the team can analyze the data as a whole, we would like to get some feedback from interview participants. The following data validation tool has been developed based on a technique called, "member checking".[51]

Results

Relevance

In what ways could the projects have had more relevance when considering both the medical humanitarian needs and the capacity and principles of the organization?

Main Finding:

The project could have had more relevance if the unmet needs were addressed. However, stakeholders and project documentation clearly acknowledged that the needs of Long-term Care Facilities (LTCF) in the U.S. ultimately could not be met within the timeframe of the project's 3-month intervention. The needs of this sector are chronic and involve systemic issues that could not be transformed during the project's limited time.

Overall, the project was relevant based on the needs identified by stakeholders and the activities carried out to address those needs (see Table 1). There was also consensus among interview participants that the identified needs were met through the intervention activities.

Table 1

Relevance

Needs Project Aimed to Address	Activities to Address Needs	Unmet Needs
● Advocacy ● Facility Buy-in ● Health and Wellness ● Mental Health Support ● Health promotion	● Advocacy ● Assessments and Recommendations ● Communications	● Advocacy ● Chronic needs of LTCF ● Health promotion (digital health

[51] Birt, L., Scott, S., Cavers, D., Campbell, C., & Walter, F. (2016). Member checking: a tool to enhance trustworthiness or merely a nod to validation?. *Qualitative health research*, *26*(13), 1802-1811.

● IPC training and education (especially for EVS) ● Support LTCF ● Testing ● Vulnerable populations (LTCF, AFC)	● Created training package for volunteers ● Data collection and evaluation ● Developed package to replicate project to other location ● Handover (schools of nursing) ● Health promotion (digital health promotion, expand to other states*) ● IPC education and training ● Networking and relationship building	promotion for Arabic speakers) ● Follow-up ● Vaccination support
* Planned activity not implemented		

Appropriateness

In what ways could the project activities have been better adapted to the context and target population?

Main Finding:

The project activities could have been better adapted to the context and target population if the team had more local staff earlier on (constrained due to HR issues). Some interview participants also agreed that expanding the mental health component of the intervention, which ultimately only involved wellness activities due to the limited time, could have made the activities more appropriate based on the mental health issues being reported by LTCF staff. Due to HR issues and issues gaining access to facilities, the wellness component to the project was carried out over an extremely limited timeframe.

However, many activities were tailored to the local context. The team adapted the operational structure of the activities, as well as the activities themselves (added embedding, AFC, and reports, and tailored trainings, IPC tools, and HP materials). Having local staff ensured that these activities were tailored to the context. For example, there was a notable enhancement of the wellbeing component of the project after the local staff was hired. Additionally, a local IPC specialist helped the project navigate challenges related to regulations, which allowed the activities to be tailored in an effective way.

Effectiveness

In what ways could the effectiveness of the projects have been improved?

Main Findings:

The MSF team collected formal metrics regarding outputs (see Table 2) for the project. However, data were not collected in a way that makes it possible to measure the effectiveness. This could have included the collection of pre and post intervention indicators.

Stakeholders did identify some areas that would have improved the effectiveness of the project. Arriving sooner and hiring sooner would have made the project more effective. There were various constraints surrounding HR, which made hiring difficult. Due to the confusion surrounding the administrative aspects of hiring (hiring via domestic or field HR), the hiring process was cumbersome and took longer than it should have. It was also difficult to find staff with the rights to work in the U.S., as well as local staff that were eligible due to restrictions for furloughed nurses. More support with recruitment from recruiting MSF-USA could have sped up this process.

Access to facilities and the overall environment of LTCF (punitive) were other major constraint of this project. As interview participants and documents revealed, relationship building and buy-in was important for the intervention. Overall, having more time or taking a more long-term approach to the intervention to allow for this trust-building would have made the project more effective, especially in light of the chronic issues associated with LTCF.

Table 2 Outputs: Formal Metrics
• Assessments and reports • HP educational materials • IPC Toolkit • Number of embedding sessions • Number of facilities visited • Number of IPC assessments • Number of IPC coaching sessions • Number of people reached • Number of people trained • Number of trainings • Number of wellness boards

Impact

How much of a difference did the projects make and for whom, under what circumstances?

Main Finding:

The project made a difference for the staff at LTCF as well as other stakeholders by increasing knowledge about COVID and IPC measures through training and embedding sessions (see Table 3)[52]. Surveys showed that training did address beneficiary concerns and priorities. Overall, beneficiaries reported satisfaction with the activities and the hands-on approach MSF took. Due to the punitive environment of LTCFs, staff appreciated the support that MSF provided in showing them how to improve their practices. Since there has been little follow-up with facilities post-intervention, the actual lasting impact of the activities is

[52] There is no way to causally link the MSF activities with outcomes.

unclear. One team member has visited at least one facility and noted that the IPC practices are in place, although they were not using the IPC binder that MSF created.

Table 3 Outcomes: Informal Metrics
• Behavior change (IPC protocols still being followed) • Capacity building for future MSF US Ops (trust-building) • EVS staff acknowledged and included in IPC • IPC Toolkit • Increased knowledge • Stakeholder and beneficiary satisfaction

APPENDIX D: NAVAJO NATION RESULTS SUMMARY

MSF US COVID RESPONSE OPERATIONAL EVALUATION

Project: Navajo Nation

April 27, 2020-June 30, 2020

Overview

Preliminary results for the operational evaluation of MSF's COVID intervention in Navajo Nation is presented here. Semi-structured interviews were conducted with MSF stakeholders (n=3) and a systematic review of project documentation was undertaken (n=11) (project proposal, closure presentations, and sitreps). The evaluation applied four criteria from the Organisation for Economic Co-operation and Development's Development Assistance Committee (OECD-DAC), including relevance, appropriateness, effectiveness, and impact.

Validation

Data validation is an important part of interpreting results. For the overall evaluation, these results will be synthesized with findings from the other six US projects. Before the team can analyze the data as a whole, we would like to get some feedback from interview participants. The following data validation tool has been developed based on a technique called, "member checking".[53]

Results

Relevance

[53] Birt, L., Scott, S., Cavers, D., Campbell, C., & Walter, F. (2016). Member checking: a tool to enhance trustworthiness or merely a nod to validation?. *Qualitative health research*, *26*(13), 1802-1811.

In what ways could the projects have had more relevance when considering both the medical humanitarian needs and the capacity and principles of the organization?

Main Finding:

The project could have had more relevance if the unmet needs were addressed. For example, there were so many requests for training that the MSF team could not meet the demand due to HR and budget constraints. There were direct medical care needs that required more staff, but according to team members, legal and regulatory restrictions in the U.S. prevented the team from providing direct medical care. The team also recognized that some needs were long-term or involved ongoing processes that were beyond the time frame for the project. For example, there is a need for data on testing and treatment bias, the impact of pandemic on Indigenous communities, and health care systems issues. Another example is the need to continuously adapt IPC protocols to real-life situations. One team member recommended that MSF continue telephone support after the project ended to meet this need. It is unclear from project documents if this support continued. Overall, the project was relevant based on the needs identified by stakeholders and the activities carried out to address those needs (see Table 1).

Table 1

Relevance

Needs Project Aimed to Address	Activities to Address Needs	Unmet Needs
● Contact tracing ● Health promotion-community-based approaches ● Hygiene and Sanitation ● IPC training and education in non-medical facilities ● Isolation and quarantine ● Mental health support ● Supplies ● Testing ● Vulnerable populations (Native American communities)	● Technical guidance ● Handover (COPE and Correctional Facilities) ● Community health promotion ● Site assessments and Recommendations ● Advocacy ● Wellness support ● Information aggregation ● Medical supplies and donations ● IPC education and training (nursing homes, group homes, residential schools, detention centers, police force, social services workers) ● IPC Trainer of Trainers	● Continued IPC guidance ● Data ● Direct medical care ● More training ● Staffing

Appropriateness

In what ways could the project activities have been better adapted to the context and target population?

Main Finding:

The project activities could have been better adapted to the context and target population if the team had cultural briefings before the project started. One team member noted that this is standard practice for missions but did not happen in the U.S. context. There was also some confusion on the part of Diné (Navajo) elders due to the translation of COVID-19 in their language (Diné). Including additional multicultural health promotion materials would have been appropriate. However, many activities were appropriately tailored to the cultural context, such as the development of the trainers of trainers IPC activity and using flash drives to deliver IPC education and training materials due to lack of internet access.

Effectiveness

In what ways could the effectiveness of the projects have been improved?

Main Findings:

The effectiveness of the project could have been improved if the project was longer. As already mentioned, the demand for more trainings and continued IPC guidance was a need that could have been addressed with more time. One team member also indicated that bringing other stakeholders into the assessment process would have made the intervention more effective, since MSF couldn't address all the needs identified. Finances were also an impediment to the project, as the team was still making purchases with their personal credit cards weeks into the project. This impacted their ability to initiate and continue project activities.

The MSF team collected formal metrics regarding outputs (see Table 2) for the project. However, data were not collected in a way that makes it possible to measure the effectiveness. This could have included the collection of pre and post intervention indicators.

Table 2 Outputs: Formal Metrics
• Number of hygiene kits • HP materials distributed • Number of donations • Number of people trained • Number of trainings • Number of facilities assessed

Impact

How much of a difference did the projects make and for whom, under what circumstances?

Main Finding: There was a recognition among MSF staff that outcomes can't be discussed because of the short timeframe of the project. However, some outcomes were noted based on the analysis (see Table 3) [54]. Anecdotally, team members received feedback from Social Services training participants that indicated that their fear was decreased because of the IPC trainings. Written evaluations of the training of trainers program for these stakeholders indicated that participants (n=7) felt the training was valuable and felt confident in their ability to present the information to others. The team also received emails from IPC participants expressing their gratitude as well as the hope that the education inspired. After the IPC training with the police, team members noticed more of them wearing masks and putting on gloves before they approached people.

Table 3 Outcomes: Informal Metrics
• Capacity building within the community • Increased use of PPE • Increased knowledge • Increased wellbeing through providing comfort and decreasing fear

APPENDIX E: THE PUEBLOS RESULTS SUMMARY

MSF US COVID RESPONSE OPERATIONAL EVALUATION

Project: The Pueblos

April 14, 2020-June 30, 2020

Overview

Preliminary results for the operational evaluation of MSF's COVID intervention in the Pueblos is presented here. Semi-structured interviews were conducted with MSF stakeholders (n=2) and a systematic review of project documentation was undertaken (n=13) (explo and closure reports and sitreps). The evaluation applied four criteria from the Organisation for Economic Co-operation and Development's Development Assistance Committee (OECD-DAC), including relevance, appropriateness, effectiveness, and impact.

Validation

Data validation is an important part of interpreting results. For the overall evaluation, these results will be synthesized with findings from the other six US projects. Before the team can analyze the data as a

[54] There is no way to causally link the MSF activities with outcomes.

whole, we would like to get some feedback from interview participants. The following data validation tool has been developed based on a technique called, "member checking".[55]

Results

Relevance

In what ways could the projects have had more relevance when considering both the medical humanitarian needs and the capacity and principles of the organization?

Main Finding:

The project could have had more relevance if the unmet needs were addressed. The main constraint in meeting those needs was the lack of communication between the MSF Cell and the Pueblos team. For example, the team was unaware of the budget constraints and HR capabilities. If clearly communicated, this information could have enabled hiring staff for an alternate care site and channelling resources appropriately. While direct medical care was not possible due to characteristics of medical care in the U.S. (e.g., malpractice issues), some team members felt that this could have been navigated successfully, as other groups, such as travelling nurses have done. Overall, the project was relevant based on the needs identified by stakeholders and the activities carried out to address those needs (see Table 1).

Table 1

Relevance

Needs Project Aimed to Address	Activities to Address Needs	Unmet Needs
● Community buy-in ● Health promotion ● Non-COVID healthcare ● IPC training and education ● Isolation and quarantine ● Vulnerable populations (Native American communities)	● Case management support ● Medical technical support ● Handover (materials provided to partner organizations) ● Assist with reopening ● Healthcare capacity building ● Health promotion ● Site assessments and recommendation ● Advocacy ● Wellness support ● Information aggregation ● Medical supplies and donations ● IPC education and training	● Direct medical care ● Accessible alternate care site

[55] Birt, L., Scott, S., Cavers, D., Campbell, C., & Walter, F. (2016). Member checking: a tool to enhance trustworthiness or merely a nod to validation?. *Qualitative health research*, *26*(13), 1802-1811.

	● Quarantine and isolation ● Relationship building ● Cleaning ● Telehealth*	
* Planned activity not implemented		

Appropriateness

In what ways could the project activities have been better adapted to the context and target population?

Main Finding:

The project activities would have been more appropriate and better adapted to the context if the MSF team had more resources, which include increased budget, the ability to hire local staff, and supplies (PPE and general). In general, activities were tailored to the context by working with each Pueblo individually and by respecting the decisions made by those governing bodies. The MSF team also adapted their activities to the needs identified once they were on the ground, beyond the initial scope of the project. This includes connecting IHS clinic staff with mental health services, developing activities that supported the homeless population in Albuquerque, and assisting with reopening plans for services within the Pueblos. The team also translated national guidelines into local health promotion information, which was distributed.

Effectiveness

In what ways could the effectiveness of the projects have been improved?

Main Findings:

The effectiveness of the project could have been improved through increased trust between the Pueblos and the MSF team. Due to issues of mistrust, the team did not have access to the Puebloan populations as originally planned. While it is unclear exactly where the source of this mistrust developed, there was an incident in which the MSF Cell Communications team published materials that were in contrast with the desires of the Pueblos, which was communicated by the MSF team on the ground to the MSF Cell. After this incident, some of the Pueblos were unresponsive to the MSF team on the ground. Finances were also an impediment to the project, as the team was still making purchases with their personal credit cards weeks into the project. This impacted their ability to initiate and continue project activities.

The MSF team collected formal metrics regarding outputs (see Table 2) for the project. However, data were not collected in a way that makes it possible to measure the effectiveness. This could have included the collection of pre and post intervention indicators.

Table 2

Outputs: Formal Metrics
• Number of mental health referrals • Number of trainings • Number of facilities assessed • Number of people impacted by trainings and HP sessions • Number of HP sessions • Number of households impacted by HP sessions

While MSF is not responsible for the actions of partner organizations, it is important to note that the Telemedicine activity was planned but not implemented. This was due to disagreements between stakeholders (IHS and Tribal Administration) regarding the management of responsibilities associated with the activity. This highlights the importance of understanding local contexts (relationships between stakeholders, cultural, political, etc.) when planning activities to enhance their effectiveness.

Impact

How much of a difference did the projects make and for whom, under what circumstances?

Main Finding: The project made a difference for the stakeholders involved in different ways (see Table 3). The existing healthcare structures and other facilities were impacted by site assessments and trainings, which possibly[56] resulted in capacity building regarding IPC. The community was impacted by increased awareness of IPC. While there was a noted drop in prevalence and a decrease in infection rate towards the end of the MSF intervention, it is unclear what factors influenced these indicators.

Table 3 Outcomes: Informal Metrics
• Increased IPC awareness • Increased use of PPE • Isolation centers • Capacity building for existing healthcare structures • Communicated stakeholder satisfaction • Increased comfort and wellbeing of clinic staff • Drop in prevalence • Decrease in infection rate

[56] There is no way to causally link the MSF activities with outcomes.

APPENDIX F: NEW YORK RESULTS SUMMARY

MSF US COVID RESPONSE OPERATIONAL EVALUATION

Project: New York

March 23, 2020-July 3, 2020

Overview

Preliminary results for the operational evaluation of MSF's COVID intervention in New York is presented here. Semi-structured interviews were conducted with MSF stakeholders (n=4) and a systematic review of project documentation was undertaken (n=23) (assessment documents proposal reports, closure reports, sitreps, and follow-up documents). The evaluation applied four criteria from the Organisation for Economic Co-operation and Development's Development Assistance Committee (OECD-DAC), including relevance, appropriateness, effectiveness, and impact.

Validation

Data validation is an important part of interpreting results. For the overall evaluation, these results will be synthesized with findings from the other six US projects. Before the team can analyze the data as a whole, we would like to get some feedback from interview participants. The following data validation tool has been developed based on a technique called, "member checking".[57]

Results

Relevance

In what ways could the projects have had more relevance when considering both the medical humanitarian needs and the capacity and principles of the organization?

Main Finding:

The project could have had more relevance if the unmet needs were addressed. While contact tracing, telemedicine, support of an isolation center, and mental health services for alternate care site healthcare workers were identified as needs, these activities were not carried out for various reasons. Telemedicine and the support of an isolation center were proposed as part of the initial project. Due to US regulations regarding direct medical care (liability, malpractice, licensing), this was not possible. In addition, the partner organization for the isolation center requested a longer time commitment than MSF could offer. Contact tracing was not possible due to political reasons.

[57] Birt, L., Scott, S., Cavers, D., Campbell, C., & Walter, F. (2016). Member checking: a tool to enhance trustworthiness or merely a nod to validation?. *Qualitative health research*, *26*(13), 1802-1811.

Overall, the project was relevant based on the needs identified by stakeholders and the activities carried out to address those needs (see Table 1).

Table 1

Relevance

Needs Project Aimed to Address	Activities to Address Needs	Unmet Needs
● Donations ● Healthcare ● Hygiene and Sanitation ● IPC training and education ● Isolation and quarantine ● Testing ● Vulnerable populations (Brownsville community and homeless)	● Advocacy ● Site assessment and recommendations (supportive housing facilities) ● Contact tracing ● Handover (Shower Power) ● Health promotion ● Helpline ● Hygiene and sanitation (relief stations) ● IPC education and training ● Medical supplies and donations (cell phone distribution) ● Outreach ● Quarantine and Isolation ● Testing ● Volunteer management	● Contact tracing ● Direct medical care (telemedicine) ● Donations (increased demand for phones) ● Health promotion (local outreach) ● Isolation center ● Mental health ● Staffing and volunteers ● Testing

Appropriateness

In what ways could the project activities have been better adapted to the context and target population?

Main Finding:

The project activities could have been better adapted to the context and target population if the team was able to offer direct medical support in some way. This includes offering telemedicine or linking hygiene and sanitation station users with a mobile clinic or health center. One stakeholder also indicated that more medical leadership and guidance from MSF operations would have helped to tailor the activities. Another stakeholder noted that a lot of the activities that took place were part of a learning process, and that having more time would have helped.

However, many activities were tailored to the local context. The original project intended to target homeless, immigrants and refugees, and released prisoners. It became clear to the team that there was a great need for unsheltered individuals to access hygiene and sanitation. Additionally, at the local and national levels there were protests following the murder of George Floyd, which further contextualized

the activities at the partner organization in Brownsville, which primarily serves black and brown communities who were in greater need of support.

Effectiveness

In what ways could the effectiveness of the projects have been improved?

Main Findings:

The MSF team collected formal metrics regarding outputs (see Table 2) for the project. However, data were not collected in a way that makes it possible to measure the effectiveness. This could have included the collection of pre and post intervention indicators.

Overall, time, money, the ability to do direct medical care, operational support, and better organization were identified by stakeholders as factors that would have made the project more effective. The team experienced delays in activities due to slow decision-making and lag in hiring processes by MSF-USA.

Table 2 Outputs: Formal Metrics
• Number of actors who were provided IPC support • Number of testing shifts covered by volunteers • Number of donations • Number of facilities visited • Number of handwashing stations • Number of HP sessions • Number of IPC assessments • Number of phones donated • Number of shower users • Number of test shifts covered by volunteers • Number of toilet users • Number of volunteers

Impact

How much of a difference did the projects make and for whom, under what circumstances?

Main Finding:

The project made a difference in the lives of homeless individuals by providing basic human needs. This includes access to hygiene and sanitation (showers, toilets, hygiene kits with COVID masks, clean clothes)

as well as access to cell phones, which can assist them in a medical (or other) emergency (see Table 3) [58]. Follow-up communications indicate that some of the shower stations will continue to run through a local organization. The federally qualified health center reported an increase in testing and has implemented workflow changes suggested by MSF.

Informal feedback from beneficiaries indicated that MSF's presence mitigated anxiety during a troubling time and that they were grateful for the help they received with site assessments, so much so that they wanted to honor some of the MSF team members at an annual gala.

Table 3 Outcomes: Informal Metrics
• Access to cell phones • Access to sanitation • Increased testing • IPC solutions for facilities • Stakeholder satisfaction

APPENDIX G: PUERTO RICO RESULTS SUMMARY

MSF US COVID RESPONSE OPERATIONAL EVALUATION

Project: Puerto Rico

March 23, 2020-September 2020

Overview

Preliminary results for the operational evaluation of MSF's COVID intervention in Puerto Rico is presented here. Semi-structured interviews were conducted with MSF stakeholders (n=5) and a systematic review of project documentation was undertaken (n=36) (assessment documents proposal reports, closure reports, and sitreps, and other miscellaneous documents). The evaluation applied four criteria from the Organisation for Economic Co-operation and Development's Development Assistance Committee (OECD-DAC), including relevance, appropriateness, effectiveness, and impact.

Validation

Data validation is an important part of interpreting results. For the overall evaluation, these results will be synthesized with findings from the other six US projects. Before the team can analyze the data as a

[58] There is no way to causally link the MSF activities with outcomes.

whole, we would like to get some feedback from interview participants. The following data validation tool has been developed based on a technique called, "member checking".[59]

Results

Relevance

In what ways could the projects have had more relevance when considering both the medical humanitarian needs and the capacity and principles of the organization?

Main Finding:

While the project could have had more relevance if the unmet needs were addressed, overall, the project was relevant based on the needs identified by stakeholders and the activities carried out to address those needs (see Table 1). Some of the original activities planned to address needs were not carried out in the end, but were replaced with other, more appropriate activities for the context (e.g., the transition from a telemedicine model to direct care through home visits and a mobile clinic). Many of the continued unmet needs were partially addressed by the project. Direct medical care was provided, although this is an ongoing need. Mental health support was not directly provided but referrals were made for those in need and MSF did support other organizations that were involved in contact tracing.

Table 1

Relevance

Needs Project Aimed to Address	Activities to Address Needs	Unmet Needs

[59] Birt, L., Scott, S., Cavers, D., Campbell, C., & Walter, F. (2016). Member checking: a tool to enhance trustworthiness or merely a nod to validation?. *Qualitative health research*, *26*(13), 1802-1811.

● Health promotion ● Healthcare (COVID and non-COVID) and monitoring ● Hygiene and Sanitation ● IPC training and education ● Mental health support ● Supplies (PPE) ● Vulnerable populations (isolated and marginalized communities, sex workers, people who use drugs, homeless)	● Contact tracing (support to other organizations) ● Handover (Puerto Rico Salud) ● Health promotion (hygiene kits, outreach, mental health, street art) ● Home medical care ● Hygiene and sanitation (mobile showers) ● IPC education and training (psychological first aid training, inter-organization collaboration, training of trainers, isolation center*) ● Medical supplies and donations ● Mobile clinic ● Telemedicine* ● Outreach ● Referrals	● Contact tracing ● Continued direct medical care (primary care) ● Digital health promotion ● Isolation center support ● Mental health support ● Supplies (medications, printing materials, cleaning and hygiene products) ● Testing
* Planned activity not implemented		

Appropriateness

In what ways could the project activities have been better adapted to the context and target population?

Main Finding:

The project activities were well adapted to the context and target population as evidenced by the clear links between needs and activities, as well as the ways that the team adapted activities in the field. For example, a consistent theme across the data was the hands-on nature of the MSF activities. Doing in-person IPC trainings when others were virtual, gave confidence to participants in their ability to maintain a safe environment for themselves and others. Providing medical care in communities and at people's homes (both COVID and non-COVID care) addressed a major barrier in care (e.g., access) in this setting.

The project activities could have been better adapted to the context and target population if there was more time for the intervention and if the team had more local staff. However, it was noted that having experienced non-local MSF staff at the beginning helped with the organization of the project. Once HR issues were worked out, the project ultimately had more local staff, which helped to tailor the activities to the context.

Effectiveness

In what ways could the effectiveness of the projects have been improved?

Main Findings:

The MSF team collected formal metrics regarding outputs (see Table 2) for the project. Some data were collected in a way that makes it possible to measure the effectiveness, such as the number of vulnerable groups reached (the goal was 3, but the project reached more). For others, baseline data would be needed to assess the effectiveness (e.g., number of people trained in comparison to total trainings occurring in the area).

While team characteristics (expat vs. local) were already noted above, one stakeholder did indicate that inexperience of one initial expat team member delayed the organization of the project and its subsequent activities. Also, the lack of doctors and nurses on the team was identified by some stakeholders as a constraint. One stakeholder also noted that there was a lack of Spanish speakers on the original team, which could have been resolved through MSF HR hiring through the Latin American staff pool.

This project did involve many collaborations, although one stakeholder noted that pushing for more government collaborations could have made the activities more effective. Another stakeholder indicated that the reliance on partner organizations for access to communities was crucial for this context, but it also made the team dependent on others when doing home visits. Time was also a concern for many stakeholders, as they felt that more people could have been reached by the intervention.

There were delays in starting some activities, such as direct medical care. Delays were attributed to HR issues on the part of MSF-USA as well as ambiguity in decision-making due to the presence of both the desk (MSF-USA) and the coordination team (Cell).

Table 2

Outputs: Formal Metrics

- Number of Patients Monitored with COVID Symptoms
- Number of Patients Followed Up
- Number of Patients Medical Consultations
- HP Materials Distribution
- HP Murals and Videos
- Number of Collaborations with Civil Organizations
- Number of Collaborations with Government and Public Agencies
- Number of Collaborations with Health Facilities
- Number of Donations
- Number of Hygiene Kits
- Number of other Medical or Non-medical Materials Support
- Number of People Impacted by HP
- Number of People Reached
- Number of People Trained
- Number of Vulnerable Groups Reached
- Proportion of Local Procurement

Impact

How much of a difference did the projects make and for whom, under what circumstances?

Main Finding:

The project made a difference for beneficiaries who received direct medical care and for local organizations who received IPC training and support (see Table 3) [60]. It is likely that health promotion activities increased knowledge in the community at large, as it is calculated that 10,000 people benefited from the related activities. Stakeholder impact and satisfaction is evidence by informal feedback from beneficiaries indicating that MSF's presence mitigated anxiety during a troubling time, strengthened confidence and morale and also improved patient's control of care.

It is important to note that some local MSF staff started their own organization to continue the project activities after the intervention had ended. MSF assisted this organization in various ways to help them get established. At the time of the writing of this summary, the organization was continuing to offer direct medical care to vulnerable populations.

Another important point to note is that an unintended outcome of the project was a large amount of PPE waste. The medical team treated each patient as if they were COVID positive. Therefore, they had to change out PPE after each consult.

Table 3 Outcomes: Informal Metrics
• Better hygiene practices • Increased capacity of local organizations • Identify gaps in existing IPC practices • Increased knowledge • IPC toolkit • Increase MSF US Ops capacity (awareness, tools and relationships for future missions) • Access to sanitation • Increased testing • IPC solutions for facilities • Stakeholder satisfaction (mitigate anxiety, strengthen confidence and morale • Increase patient control of care (patient's ability to cope with diagnosis, increase patient transmission and protection measures) • Support new organization

[60] There is no way to causally link the MSF activities with outcomes.

APPENDIX H: TEXAS RESULTS SUMMARY

MSF US COVID RESPONSE OPERATIONAL EVALUATION

Project: Texas

August 3, 2020-October 16, 2020

Overview

Preliminary results for the operational evaluation of MSF's COVID intervention in Texas is presented here. Semi-structured interviews were conducted with MSF stakeholders (n=6) and a systematic review of project documentation was undertaken (n=11) (assessment documents proposal reports, closure reports, sitreps, and follow-up documents). The evaluation applied four criteria from the Organisation for Economic Co-operation and Development's Development Assistance Committee (OECD-DAC), including relevance, appropriateness, effectiveness, and impact.

Validation

Data validation is an important part of interpreting results. For the overall evaluation, these results will be synthesized with findings from the other six US projects. Before the team can analyze the data as a whole, we would like to get some feedback from interview participants. The following data validation tool has been developed based on a technique called, "member checking".[61]

Results

Relevance

In what ways could the projects have had more relevance when considering both the medical humanitarian needs and the capacity and principles of the organization?

Main Finding:

The project could have had more relevance if the unmet needs were addressed. This includes targeting other vulnerable populations, such as immigrants and detention centers. The other unmet needs identified are associated with chronic issues in long-term care facilities.

Overall, the project was relevant based on the needs identified by stakeholders and the activities carried out to address those needs (see Table 1).

[61] Birt, L., Scott, S., Cavers, D., Campbell, C., & Walter, F. (2016). Member checking: a tool to enhance trustworthiness or merely a nod to validation?. *Qualitative health research*, *26*(13), 1802-1811.

Table 1 Relevance		
Needs Project Aimed to Address	Activities to Address Needs	Unmet Needs
● Health and Wellness ● IPC training and education ● Vulnerable populations (LTCF Staff)	● Assessments and recommendations ● Embedding ● Handover (schools of nursing)* ● Health and wellness support (stress management, peer-to-peer support) ● Health promotion (digital health promotion)* ● IPC education and training ● Relationship building	● Advocacy ● Chronic LTCF needs ● Mental health ● Other populations (detention centers, immigrant) ● Vaccination support
* Planned activity not implemented		

Appropriateness

In what ways could the project activities have been better adapted to the context and target population?

Main Finding:

The project activities could have been better adapted to the context by tailoring the digital health promotion to target communities where staff from LTCF come from. The digital health promotion component of the project was researched and prepared, but never carried out. It was determined that the funds would better be used elsewhere (e.g., schools of nursing IPC toolkit) since targeting Spanish speakers was not in line with the objectives and scope of the project. Additionally, while the team worked on activities surrounding the IPC toolkit for schools of nursing, they were unsuccessful in doing a formal handover. A notable challenge was the timing for the schools of nursing who would potentially adopt the toolkit, as it did not align with the timing of the MSF intervention. They turned over the materials to the stand-alone project involving the schools of nursing.

However, most of the activities were tailored to the local context. The team adapted the tools and activities from the Detroit project, while also drawing on lessons learned from that intervention. For example, the team was careful to review different regulations for the various LTCF sites to ensure the IPC training and embedding was appropriate. Also, based on the needs of the new phase of the pandemic, the team expanded the health and wellness component of the program, offering stress management and peer-to-peer support.

Effectiveness

In what ways could the effectiveness of the projects have been improved?

Main Findings:

The MSF team collected formal metrics regarding outputs (see Table 2) for the project. However, data were not collected in a way that makes it possible to measure the effectiveness. This could have included the collection of pre and post intervention indicators. There was an analysis conducted by the OCB projects (Michigan and Texas). The findings from this analysis show that 10 (of 24) facilities did not report any changes as a result of the MSF intervention.

Overall, changes in the team characteristics for the project could have improved their effectiveness. There were HR challenges in finding qualified nurses, which required that additional training be carried out before activities could begin. This caused a delay in activities.

There were also challenges working in the LTCF. Many facilities had never heard of MSF before which exacerbated the barriers in accessing the facilities, including a general mistrust of outsiders. Additionally, there were last minute cancellations or change in availability of LTCF staff for trainings.

Table 2 Outputs: Formal Metrics
• Assessment report reviews • Number of health and wellness activities • Number of embedding sessions • Number of facilities visited • Number of trainings • Total number of on-site sessions

Impact

How much of a difference did the projects make and for whom, under what circumstances?

Main Finding:

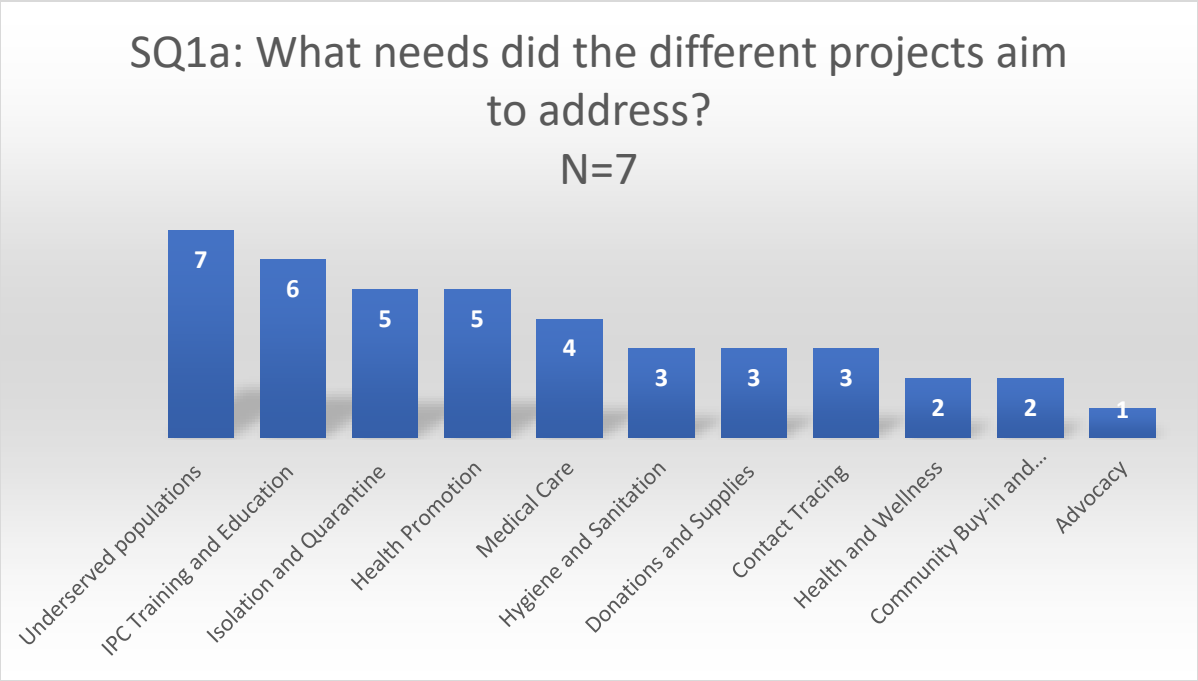
The project made a difference for LTCF by improving hygiene practices and the use of PPE within facilities (see Table 3)[62].

MSF staff received gratitude from stakeholders and observed increased comfort and decreased stress and anxiety among beneficiaries. One staff member indicated that expanding the wellness activity to a mental health component would have been beneficial.

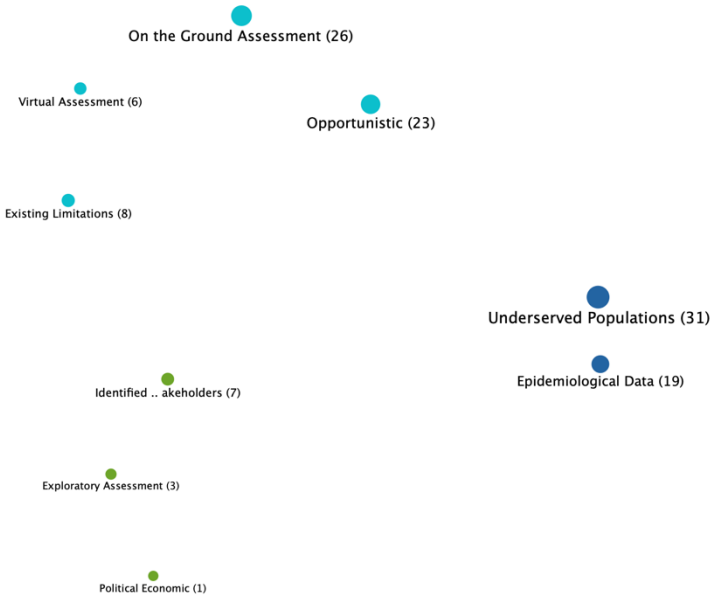
[62] There is no way to causally link the MSF activities with outcomes.

Table 3 Outcomes: Informal Metrics
● Behavior change (hygiene practices, use of PPE) ● Decrease COVID transmission ● Improve wellness (comfort, decrease stress and anxiety) ● Increased knowledge ● MSF US Ops Capacity Building (work in LTCF) ● Stakeholder satisfaction

APPENDIX I: WHAT NEEDS DID THE DIFFERENT PROJECTS AIM TO ADDRESS?



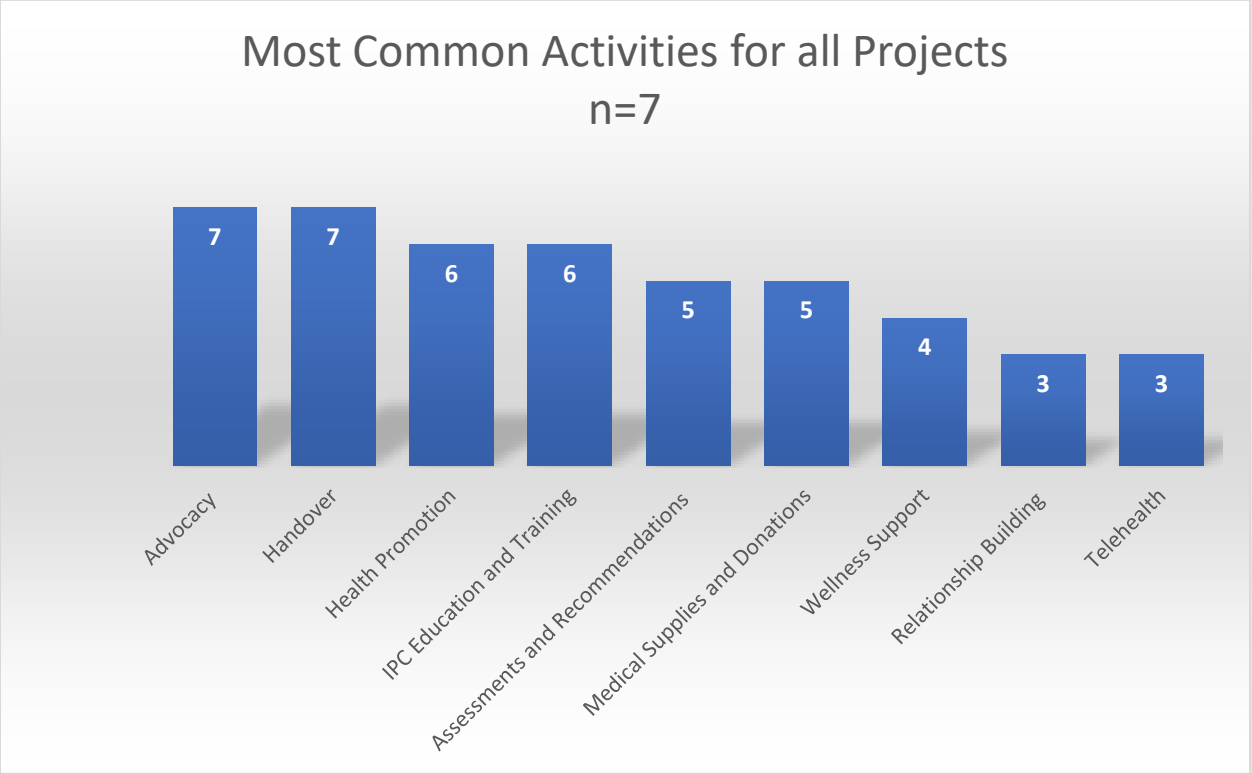
APPENDIX J: CODE CO-OCCURRENCE ANALYSIS



APPENDIX K: UNMET NEEDS

Unmet Needs (All Project Documents)		
	Documents	**Percentage**
Direct Medical Care	16	34.78
Quarantine	8	17.39
Chronic Needs LTCF	7	15.22
Advocacy	5	10.87
Contact Tracing	5	10.87
Staffing	5	10.87
Testing	5	10.87
Mental Health	4	8.70
Could Have Done More	4	8.70
Community Engagement	4	8.70
Health Promotion	4	8.70
Donations and Supplies	3	6.52
Other Populations	2	4.35
Vaccination Support	2	4.35
Continued IPC Guidance	1	2.17
Social Support	1	2.17
Medical Technical Support	1	2.17
Data	1	2.17
Follow-up	1	2.17
DOCUMENTS with code(s)	46	100.00

APPENDIX L: PROJECT ACTIVITIES



APPENDIX M: THINGS THAT WOULD HAVE MADE THE PROJECTS MORE EFFECTIVE (KIIS)

Effectiveness SQ10: Are there things that would have made the projects more effective? KII Interview Documents (n=39)		
	Documents	**Percentage**
Time	7	17.95
HR	6	15.38
MSF Operations	3	7.69
Different activities	2	5.13

More Collaborations	2	5.13
Bigger Budget	1	2.56
Different Approach	1	2.56
More resources	1	2.56
Prior Understanding of Context	1	2.56
Social Media	1	2.56
Team Approach	1	2.56
Trust	1	2.56
DOCUMENTS with code(s)	20	51.28
ANALYZED DOCUMENTS	39	100.00

APPENDIX N: THINGS THAT WOULD HAVE MADE THE PROJECTS MORE EFFECTIVE (ALL PROJECT DOCUMENTS)

Effectiveness SQ10: Are there things that would have made the projects more effective?

KII Interview Documents (n=39)

	Documents	**Percentage**
HR	12	38.71
Time	9	29.03
Different activities	6	19.35
MSF Operations	4	12.90
Different Approach	2	6.45
More Collaborations	2	6.45
Team Approach	2	6.45

Trust	2	6.45
Prior Understanding of Context	1	3.23
Social Media	1	3.23
Bigger Budget	1	3.23
More resources	1	3.23
DOCUMENTS with code(s)	31	100.00

APPENDIX O: WERE THE OBJECTIVES MET?

Project	Objectives	Objectives Met (Y/N/C)	Evidence
Michigan	• To reduce the morbidity and mortality of staff and residents in long-term care facilities in Michigan.	Cannot be determined	N/A
	• **To reduce the transmission and negative consequences of COVID-19 amongst residents and staff in LTCFs** by improving the knowledge of IPC and application of IPC measures, as well as providing stress-management support.	The first part of this objective cannot be determined with available data	
	• Improving the knowledge of IPC and application of IPC measures	Yes	IPC trainings-420 people (increased knowledge reported by beneficiaries in project documents)
			IPC coaching sessions-28
			Facility assessment and reports-31
	• As well as providing stress-management support	Yes	Wellness boards-12
			Wellness Sessions-28

Texas	• **Reduce transmission of CoVid-19 (and other infectious diseases) amongst residents and staff in Houston area LTCFs** by providing on-site IPC + Health & Wellness support	First part cannot be determined	
	• Health & Wellness support	Yes	Health and Wellness sessions-28
	• On-site IPC	Yes	IPC trainings-18
			Embeddings-27
			Facility assessments-24
	• Establish relationships with regional School of Nursing (SoN) for Handover initiative	No	Not able to build relationships with SON evident in project documents
	• Build operational/experiential knowledge and legitimacy for future advocacy campaigns and US operations	How is "legitimacy" defined and measured?	
Florida	• To medically assist the vulnerable migrant farmworker community, the majority from Mexico, Guatemala and Haiti, in the context of COVID-19 pandemic.	How is "medical assist" defined?	Did not provide direct care, but did provide testing and health promotion surrounding Covid-19
	The Haitian population was not fully included in this intervention due to language, cultural and geographic barriers identified in project documents		HP sessions-29 (1570 people impacted)
		Yes	Telehealth consults-20
		Yes	Testing-465 tests
		Yes	Referrals-13
		Yes	Clinics (telemed and testing)-12
Navajo Nation	Reduce morbidity and mortality among vulnerable populations and mitigate COVID-19 spread in tribal communities.	Cannot be determined	

Pueblos	• Reduce morbidity and mortality from COVID-19 among vulnerable populations in the Pueblos of New Mexico. This objective was further broken down into 7 sub-objectives:	Cannot be determined	
	• Improve immediate and sustained capacity to ensure appropriate IPC practices at the community and facility level	How is "sustained capacity" measured?	IPC sessions-25 (243 people impacted)
	• Decrease transmission of COVID-19 at both community and household level	Cannot be determined	
	• Improve ability of IHS clinics to safely see COVID and non-COVID patients	Yes	Isolation area created as reflected in project documents
	• Facilitate and improve the capacity for isolation facilities to care for COVID-19 positives and PUI's	Yes	Isolation area created as reflected in project documents
	• Assess gaps in education/training on IPC of isolation facility ancillary and para-medical staff	Yes	IPC sessions-25 (243 people impacted)
	• Provide education and training of IPC best practices at isolation facilities, ACS's, clinics, community, and households.		Facilities assessments-8
	• Assess need for telemedicine and capacity to implement	Yes	As reflected in project documents
Puerto Rico	• To assist Puerto Rican individuals, Community-Based Organizations (CBO) and health care providers in responding to the COVID-19 pandemic by:	Yes	Reflected in feedback from partners, KIIs and, and project documents.
	• Improving their immediate and sustained capacity to ensure appropriate Infection Prevention and Control (IPC) practices	How is "sustained capacity" measured?	106 people training IPC trainers
	• Mitigating the risks of increased vulnerabilities	Yes-but how can you answer this question without	HP-10,000 PPE donated- 79, 200 Hygiene kits delivered-5,500

		observing behavior?	
	• Addressing identified gaps in medical care	Yes	Medical consultations-1120 Patients covid monitoring-81 (home visits for isolated people)
	• Addressing the needs and trauma caused or exacerbated by the COVID-19 pandemic		
New York	• Target population has access to medical, social and emergency services.	Yes	Phones donated-1109
	• Target population has access to handwashing and hygiene facilities.	Yes	Handwashing stations-109
	• Organizations supporting Target population have access to PPE (especially face coverings/masks) and thermometers.	Yes	Masks donated 9, 350
	• Target population understands the risks COVID-19 poses and is empowered to protect themselves with access, materials and knowledge.	How is empowerment measured?	IPC suppport-80
			HP sessions 119
	• Target population has access to showers and hygiene materials.	Yes	Shower turnout-2749
	• To ensure the target population has access to testing, is included in contact tracing efforts, and has access to and the resources needed for proper isolation and quarantine.	Access to testing-yes	Testing shifts volunteers managed-158
	• Contact tracing support	Yes	Based on KI with implementing partner
	• Resources needed for proper isolation and quarantine.	Cannot be determined	

APPENDIX P: WERE THERE ANY UNINTENDED NEGATIVE EFFECTS?

Impact *SQ14: Were there any unintended negative effects?* **All Project Documents**		
	Documents	**Percentage**
Deter People from Getting Tested	1	14.29
Different Expectations	1	14.29
Mistrust	1	14.29
Staffing Issues	1	14.29
Environmental Disaster PPE	1	14.29
Intervention Didn't Last After MSF Left	1	14.29
Applying Regulations	1	14.29
DOCUMENTS with code(s)	7	100.00

APPENDIX Q: WERE THERE ANY UNINTENDED NEGATIVE EFFECTS?

Impact: *SQ14: Were there any unintended positive effects?* **All Project Documents**		
	Documents	**Percentage**
Pushing Local Systems	2	25.00
Future Collaborations	2	25.00
Schools of Nursing Handover	2	25.00

Advocacy	2	25.00
Capacity Building Local Orgs	1	12.50
Cost-cutting for LTCF	1	12.50
Local Specialist	1	12.50
Houston Project	1	12.50
More Human Care	1	12.50
DOCUMENTS with code(s)	8	100.00

APPENDIX R: WERE THERE ANY UNINTENDED NEGATIVE EFFECTS?

Impact: SQ15: What would have made a bigger difference at the level of outcomes?

All Project Documents

	Documents	**Percentage**
Time	8	38.10
Staff	5	23.81
Couldn't have done better	2	9.52
Increased Testing Supplies	2	9.52
Follow-up	2	9.52
Increased Communications	2	9.52
More collaborations	2	9.52
Support Hospitals	1	4.76
Data Management	1	4.76

Performance	1	4.76
Access to Nursing Homes	1	4.76
Trust Building	1	4.76
More Wellness	1	4.76
Increased Sanitation Sites	1	4.76
Advocacy	1	4.76
DOCUMENTS with code(s)	21	100.00
ANALYZED DOCUMENTS	169	-

Stockholm Evaluation Unit
http://evaluation.msf.org/
Médecins Sans Frontières

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