

13 YEARS – LOOKING BACK TO PLAN AHEAD MSF-OCG, MAGARIA LESSONS LEARNED

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OCTOBER 2019

MANAGED AND SUPPORTED BY THE MSF VIENNA EVALUATION UNIT



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Abstract

MSF-OCG has been present in Magaria, Niger since 2005. MSF is confronted with yearly peaks of severe acute malnutrition and malaria, which mainly affect children under five-years-old. Despite MSF's presence mortality rates during these months often rise above MSF standards, while periodically, mortality rates in the community rise above emergency thresholds.

Using both qualitative and quantitative data, we found the project to be relevant for MSF, but some changes could be made to ensure greater efficiency and effectiveness. This includes establishing a long-term strategy, the simplification of protocols, exploring innovative ways to treat malnutrition and malaria, and perhaps using this as an opportunity to revitalise the general interest in malnutrition.

KEYWORDS: Niger, Magaria, nutrition, malnutrition, malaria, ITFC, ATFC, mortality study, hyper-specialisation, paediatric unit

Abbreviations

ATFC	Ambulatory Therapeutic Feeding Centre
CI	Confidence Interval
CMAM	Community Management of Acute Malnutrition
CSI	Centre de Santé Intégré
ITFC	Intensive Therapeutic Feeding Centre
LLIN	Long-lasting Insecticidal Nets
MCD	Médecin Chef de District
MoH	Ministry of Health
MSF	Médecins Sans Frontières
NGO	Non-Governmental Organisation
OCG	Operational Centre Geneva
POA	Plan of Action
PU	Paediatric Unit
RUTF	Ready to Use Therapeutic Food
SAM	Severe Acute Malnutrition
SAE	Severe Adverse Event
SDG	Sustainable Development Goals
SMC	Seasonal Malaria Chemoprevention
U5MR	Under Five Mortality Rate
WFP	World Food Programme

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Executive summary

Médecins Sans Frontières (MSF) - Operational Centre Geneva (OCG) has been present in Magaria, Zinder region, Niger since 2005. Each year, MSF is confronted with peaks of severe acute malnutrition and malaria, which mainly affect children under five-years-old. Despite the presence of OCG during these months, mortality rates in the MSF-run inpatient therapeutic feeding centre (ITFC) and Paediatric Unit (PU) rise above MSF standards, while periodically, mortality rates in the community rise above emergency thresholds.

In a retrospective, macro-level review of the 13-year project, this evaluation concentrates on and attempts to answer what the impact of strategic changes were on project outcomes. This includes examining whether timely adaptations were made; how the target population evolved; and the changes in mortality rates.

To do this, we used mostly qualitative data gathered through interviews with key stakeholders. The quantitative data and document review also provided some information while corroborating – or not – the qualitative data.

In addition to the findings from the evaluation questions, we did come across a few themes that we thought important to mention:

- Advocacy and the role that MSF-OCG could play locally and in research on stunting and wasting, as well as reminding the international community of the Sustainable Development Goals #2.
- The extraordinary peak of 2018 was traumatic for many and MSF should review the period to avoid it happening again.
- A recurring subject during the interviews was the lack of clarity in the roles and responsibilities for the various decision-making and advisory levels. This caused frustration and probably had an impact on the outcomes of the project.
- The difficulty and length of time needed to obtain reliable data for this evaluation, showed how difficult it could be for individuals in a project to access data on which to base sound decisions. This may be a factor for some participants reporting that decisions are made based on intuition.
- There are other reviews that were conducted over the course of the project; we found one whose findings substantiate the findings in this evaluation. The Jemmy & Kircher evaluation¹ has more in-depth analysis and it is worth MSF reviewing it again.

In conclusion, most individuals believe the programme is relevant for MSF, but they also believe some things should be done differently: for example, creating a long-term vision that will be carried through for that period. This strategy should include outreach activities implemented consistently both in health centres/health posts and in the community; simplification of medical protocols during the peak periods, clarifying communication lines (and holding individuals to account) as well as roles and responsibilities.

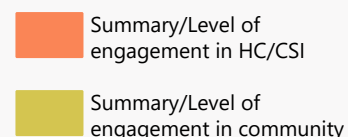
¹ Jemmy, J-P and Kircher, I ; « Projets Pédiatriques et Nutritionnels de MSF-OCG à Zinder et Magaria, Niger », 2014

Table 1: Main findings and recommendations on the evaluation questions

Evaluation question	Main findings	Recommendation
What was the impact of the strategic changes on the project outcomes?	<p>The lack of vision for the programme resulted in lack of planning and protocol changes.</p> <p>Hyper-specialisation of protocols were difficult to integrate during peak periods.</p>	<p>As one of the last and biggest nutrition programmes for MSF-OCG, there should be space and openness for innovation in Magaria. This opportunity should be explored in a planned and methodical manner, perhaps only outside of the peak periods, while returning to known and trusted methods during the peak.</p>
Were timely adaptations made in response to changes in the environment?	<p>Internal and external factors were not always considered in the project analysis which resulted in unplanned peak periods.</p>	<p>With the establishment of a three-year plan in 2020, it may be an opportune time to include the MoH in the development of this strategy and gain some commitment and accountability for their role.</p> <p>In addition, conducting an independent anthropological study in the Magaria area could help in learning the current challenges of the population and inform the new planning cycle.</p> <p>As the context is always evolving, it is recommended for the leadership of MSF in Magaria and Niger, to engage with local organisations, civil society, and others in a meaningful way. This does not seem to have been conducted consistently in the past.</p>
How did the target population change over the project life-cycle?	<p>It was difficult to find the reason regarding the change (evolution) in target population for the Magaria project. Most years were estimated; some years included Dungass, some years only considered the areas where there were outreach programmes.</p>	<p>Two evaluation questions are concerned with the decisions that were made and changes that impacted outcomes. In general, it was the difficult to obtain reliable data for this exercise; perhaps the lack of easily accessible, relevant data contributes the way decisions are made.</p>
What were the changes in mortality rates for children aged under five (U5) in the targeted communities during those years?	<p>Two years (2009, 2015) had an estimated under five mortality rate (U5MR) above 2/day/10,000.</p> <p>There is a strong correlation between effective outreach programmes, the number of patients admitted in the facilities and a decrease in the U5MR.</p>	<p>If contributing to the reduction of U5MR in the population remains the objective of the project, we recommend planning regular retrospective mortality surveys in a more consistent way; ideally every year, but could be every two years, covering the same period (June to January) in the same areas. Other survey objectives would have to adapt to these features or be conducted in parallel.</p>

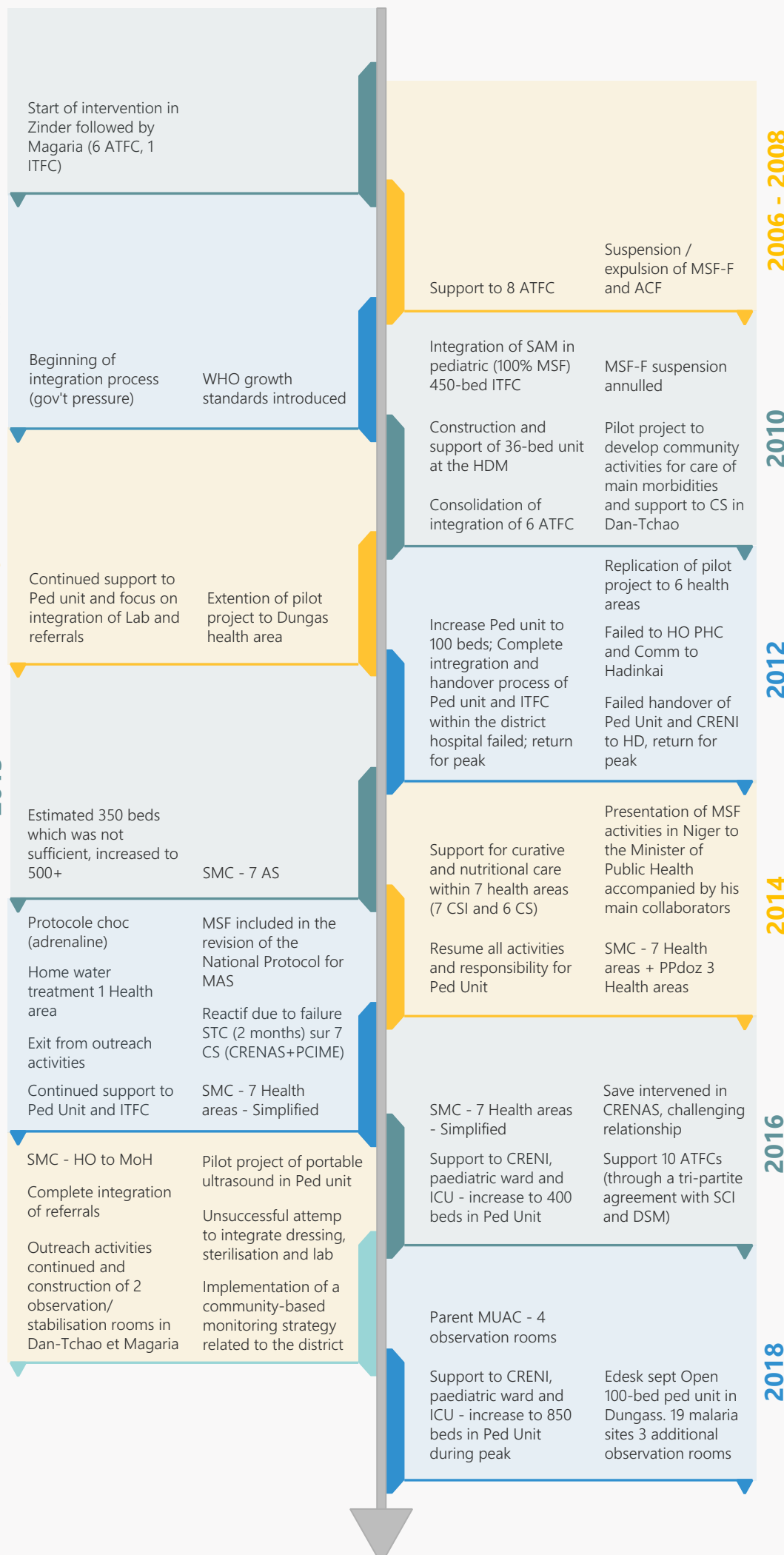
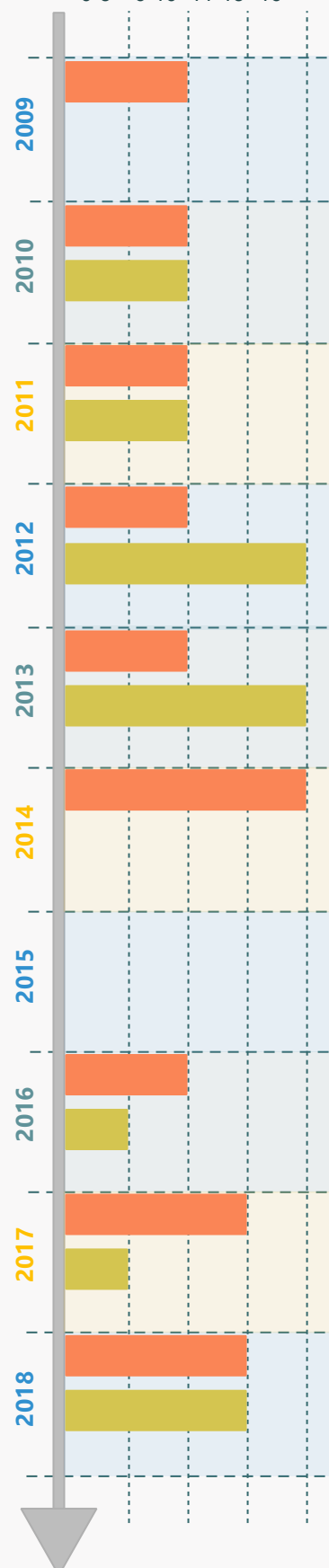
MSF-OCG in MAGARIA - TIMELINE 2005-2018

LEVEL OF ENGAGEMENT



Number of structures supported

0-5 6-10 11-15 16+



13 YEARS – LOOKING BACK TO PLAN AHEAD

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October 2019

BY ANNIE DESILETS & LAETITIA CHRISTIAENS - MANAGED AND SUPPORTED BY THE MSF VIENNA EVALUATION UNIT

BACKGROUND

MSF-OCG has been present in Magaria, Niger since 2005. Each year, MSF is confronted with peaks of severe acute malnutrition and malaria, which mainly affect children under five-years-old. Despite the presence of MSF-OCG during the peak periods, mortality rates in the MSF-run inpatient therapeutic feeding centre (ITFC) and Paediatric Unit (PU) rise above MSF standards, while periodically, mortality rates in the community rise above emergency thresholds.

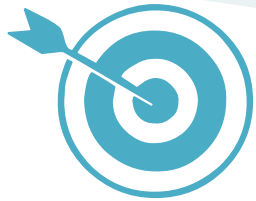


OBJECTIVES

With a macro-level view, this exercise examines the project life-cycle from 2005 to 2018, to better understand how the changes in strategy influenced project outcomes. The objective is to produce lessons learned from MSF's 13-year presence in Magaria to support operations and inform decision-making for the longer-term strategy.



EVALUATION QUESTIONS



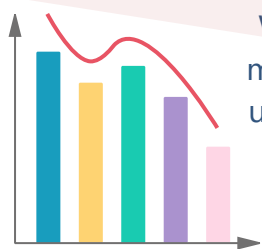
What was the impact of the strategic changes on the project outcomes?



Were timely adaptations made in response to changes in the environment?



How did the target population change over the project life-cycle?



What were the changes in mortality rates for children under five-years-old in the targeted communities during those years?

MAIN FINDINGS

- The lack of vision for the programme resulted in lack of planning and protocol changes.
- Hyper-specialisation of protocols were difficult to integrate during peak periods.

- Internal and external factors were not always considered in the project analysis which resulted in unplanned peak periods.

- It was difficult to answer this question; most years were estimated, with some years including Dungass and others only including areas where there were outreach programmes.

- Two years (2009, 2015) had an estimated under five mortality rate (U5MR) of above two per day/10'000.
- There is a strong correlation between effective outreach programmes and the number of patients admitted in the facilities, and a decrease in the U5MR.

RECOMMENDATIONS

- Actively explore opportunities for innovation in a planned and methodological manner, especially outside of the peak periods. Use of known and trusted methods is recommended during the peaks.

- Include the MoH when developing the strategy to gain their commitment and accountability;
- Conduct an anthropological study to learn the challenges the population faces and inform the new planning cycle;
- Engage with local organisations, civil society, and others in a meaningful way.

- Obtaining reliable data for this exercise has proven challenging. Perhaps, the lack of easily accessible, relevant data contributed to the way the project decisions were made.

- If the reduction of U5MR in the population remains the objective of the project, it is recommended to plan regular retrospective mortality surveys (ideally annually or at least two years apart) covering the same period (e.g. June to January) in the same geographical area. Other survey objectives would require adaptation.

ADDITIONAL RECOMMENDATIONS

Advocacy

There is space for MSF to work on innovative strategies and criteria to identify and treat malnourished children differently. MSF-OCG could develop a programme with criteria where stunted children are admitted and observed to see whether they are less prone to infections and wasting episodes.



Clarity of roles and responsibilities

A documentation of the rationale of decisions and a written/agreed predetermined timeframe would help to ensure continuity in activities and avoid misunderstanding.



Data

The difficulty in obtaining reliable data in the report needs to be highlighted, not only as a limitation to this review but as a caution for MSF.

CONCLUSION

Most people believe the programme is relevant for MSF, but think that some things should be done differently: for example, creating a long-term vision that could be carried through for the duration of the project. This strategy should include outreach activities implemented consistently both in health centres/health posts and in the community; simplification of medical protocols during the peak periods; clarification of communication lines and roles and responsibilities.

1 Introduction

1.1 Background and purpose

Médecins Sans Frontières (MSF) - Operational Centre Geneva (OCG) has been present in Magaria since 2005. Each year, MSF is confronted with peaks of severe acute malnutrition and malaria which mainly affects children under five-years-old. Despite MSF presence during these months, mortality rates in the MSF-run ITFC and Paediatric Unit (PU) rise above MSF standards², while periodically, mortality rates in the community rise above emergency thresholds.³

MSF has been supporting the Ministry of Health (MoH) hospital in Magaria since 2005, and serves a population of approximately 1.1 million.⁴ This does not include patients arriving from neighbouring Nigeria, whose numbers cannot be estimated⁵, but have been reported in some years (2017 and 2018) at up to 34 percent of patients in the hospital.

With a macro-level view, MSF aims to look retrospectively at the project life cycle from 2005 to 2018, to better understand how the changes in strategy influenced project outcomes. The objective is to produce lessons learned from MSF's 13-year presence, to support operations and inform decision-making for the longer-term strategy planned for 2020.

1.2 Methodology

The methodology was designed to provide both qualitative and quantitative data that could be corroborated/triangulated to conclude on relevant findings.

We conducted a desk review and analysis of the project documents, including action plans (PoA), annual reports, previous evaluation reports, HQ field visit reports, etc. In addition, we were able to access data from QlikView.

We collected and reviewed relevant documents provided through Microsoft Teams and via email, as key informants made us aware of additional relevant documents.

To retrieve perceptions and qualitative data, we conducted interviews with 26 key stakeholders at HQ and field levels (operational and medical). We were unable to gain insight from any external collaborators, although we reached out several times.

1.3 Limitations

The main limitation we faced was due to the difficulty in accessing documents and data. Data, reports and information is sometimes difficult to obtain in MSF in general. As this study goes back over 13

² MSF-OCG Standard Medical Indicator Taxonomy-V3: <10% mortality rate

³ Sphere Standard: In the absence of a known baseline, the following constitutes an emergency threshold: USCMR >2/10,000/day

https://handbook.spherestandards.org/?handbook=Sphere&lang=english&chapter_id=ch009§ion_id=ch009_002&match=emergency%20threshold

⁴ These are often estimates based on the growth rate of the population. However, considering some actual numbers, the estimated growth from the beginning of the project, estimated at 700 000 persons, to current of 1,13 million would represent a growth of 3.8%, which is slightly higher than the average of sub-Saharan countries at 2.75% (<http://worldpopulationreview.com/continents/sub-saharan-africa-population/#undefined>)

⁵ Patients do not always self-report, for fear of not being treated, in addition, we were not able to find estimates for each year.

years, key reports like POAs, and annual reports were not available (or provided) for earlier years (2005 to 2008) as well as for some more recent years. The data for the earlier years was so sparse that we could not determine reliable findings and so the study concentrates on the period 2009 to 2018.

Additionally, we used several sources for quantitative data, such as QlikView for some years, and annual plans for others (2017/2018). To add to the challenge, there was contradictory data within the same reports or between reports.

Furthermore, the Dungass intervention was sometimes included in the Magaria project, and sometimes had its own project code. For the latter, we combined the data to try to ensure consistency.

However, these mitigation measures may impact the reliability of the data and should be considered when reviewing the findings and making decisions.

As the terms of reference specifically required a macro-level view of the project, this did not allow a deeper analysis of some recurring themes, which may be more useful for MSF. As an example, we took aggregated data over the course of each year without looking specifically at yearly peak periods.

A consideration when reading this report, is that it is based only on internal MSF perspectives. During the inception phase, we had agreed on the importance of capturing the perceptions of close collaborators (the MoH in particular). We were unable to conduct interviews/obtain information from any external collaborator, even after several attempts.

Finally, it was clear from the onset there was an emotional aspect of the Magaria project for many individuals in OCG. With this in mind, it was difficult to convince some interviewees to participate. In terms of the information gathered, we had sufficient interviews (26) but it may be difficult for the commissioners to use this report for decision making as some key individuals did not engage.

2 Findings

From the terms of reference, we extracted four evaluation questions:

1. What was the impact of the strategic changes on project outcomes? → 2.1
2. Were timely adaptations made in response to changes in the environment? → 2.2
3. How did the target population change over the project life-cycle? → 2.3
4. What were the changes in mortality rates for U5 in the targeted communities during those years? → 2.4

We endeavour to provide data-based answers to these questions where possible. However, we found the questions were often best answered using both data and the perceptions of those who were present during the various interventions.

Relevance of the project

Although this was not one of the evaluation questions, it is interesting to note that most people interviewed openly mentioned that the Magaria project is relevant for MSF and the local target population.

2.1 Impact of changes in implementation strategy

Sixty-five percent of those interviewed mentioned that there were unprepared, to some degree, for the changes to the implementation strategies and/or the objectives were not clear. This is a recurring theme in interviews from 2007 to 2018.

In response to the impact of strategic decisions and whether timely adaptations were made to correspond with changes in the environment, we focused on the type of changes that were made, the decision-making process and the impact this had on the project as a whole. The answer is not as simple as “yes/no” as many factors should be considered.

Timeline⁶

At its inception in 2005, the intervention in Magaria was a vertical nutrition programme that included one ITFC and six ambulatory therapeutic feeding centres (ATFC) in the Magaria health area. This was in response to a regional nutrition crisis that saw unprecedented levels of malnutrition.⁷ It continued as a vertical nutrition programme throughout 2006 and 2008, but increased its ambulatory response component to eight ATFCs.

With the exception of 2015, MSF was present in some capacity in either health centres, health posts or in the community, for the life-cycle of the Magaria project.

Vaccination campaigns were conducted in 2009 (meningitis), 2010, 2011 (pentavalent), 2014 (varicella) and 2015 (expanded programme on vaccination – EPI – three rounds).

2010 saw the introduction of a pilot project in Dan-Tchao to revitalise health posts, treat the three main U5 mortalities (malaria, diarrhoea, upper respiratory infections) and provide preventive activities called “Pratiques Familiales essentielles”. This pilot project was extended to a second health zone in 2011 and to six health zones in 2012. No rationale for the end of the pilot – or lessons learned

⁶ MSF USER, Niger : 10 Ans Après, 2015; POA, Annual Reports

⁷ WHO, “Niger 2005 food crisis” - <https://www.who.int/hac/donorinfo/campaigns/ner/en/>

from it – has been found in the reports, while yearly retrospective mortality surveys undertaken to follow the trend in the community showed a clear reduction of the U5MR.

In 2011, OCG started to support the PU alongside the ITFC, by expanding the unit to 40 beds (in 2010).

From 2010 to 2012, MSF followed the national integration process of management of severe acute malnutrition (SAM) with complications. The laboratory and some part of the PU were integrated in 2011.

In 2012, OCG attempted to integrate all activities within the MoH district hospital and handover the paediatric unit and ITFC but returned for the peak period when mortality rates soared. The handover of outreach activities to a local NGO also collapsed. Full support to ITFC and PU was restored in 2014.

In support to Magaria ITFC/PU, OCG opened an ITFC in Dungass for the peak period in 2012, 2015, 2016, and 2018. In 2017, Dungass was opened for the full year.

Seasonal malaria chemoprevention (SMC) therapy was introduced in seven health zones in Magaria in 2013, to try to reduce the burden of severe malaria cases coming to the hospital. This practise continued until 2016 and was handed over to the MoH in 2017.

All outreach and community activities stopped in 2015 but restarted during peak periods due to the severity of the cases at arrival in the hospital, and reports of the inefficiency of the referral systems in the “Centre de Santé Intégré” (CSI).

In 2015, a significant increase in the number of admissions was reported. According to QlikView, the increase in admissions from 2014 to 2015 was about 10 percent. In contrast, the increase in admissions from 2013 to 2014 was approximately 23 percent. This perception may have been influenced by the mortality rate, especially in the ITFC, which saw an increase from 6.3 percent to 8.4 percent. This may have been compounded by a U5 mortality rate in the community of 2.02 deaths/10,000/ day (1.48-2.57, 95 percent CI).

In 2015, OCG introduced the use of adrenaline in the treatment of shock in the PU. Later that year, an investigation into an SAE linked to the use of adrenaline in Magaria was conducted and concluded that the implementation of the adrenaline protocol was not adapted for the context.⁸

In the same year OCG organised home water treatment in one health area.

In 2016, the outreach programme was relaunched with support to eight ATFCs and integrated management of childhood illnesses (IMCI). In addition, following the lessons learned from 2015 (with the difficult situation in the PU) the patient circuit in the hospital was redefined, with the creation of an intensive care unit (ICU).

The treatment and case management of sickle cell disease was introduced in 2017, while a pilot project of point-of-care ultrasound for the paediatric unit was launched. Outreach activities continued, a community-based monitoring strategy was implemented in addition to two observation/stabilisation rooms in the CSI in Dan-Tchao and Magaria, in order to manage the number of children referred to the PU during the peak.

The intensity of peak period in 2018 took OCG by surprise, at a time when the strategy was to reduce MSF involvement. This resulted in an overall yearly ITFC mortality rate of 10.6 percent. At the height of the crisis, it was reported that more than 10 children were dying every day in Magaria⁹. In September, the emergency desk was deployed to the region and opened a 100-bed paediatric unit in Dungass, 19 malaria sites and three additional observation rooms in support to the project.

⁸ For full details, see: Alena Koscalova, “Report on Investigation of The Supply, Protocols, And Usage of Adrenaline in Magaria”, 2015

⁹ <https://www.france24.com/en/20180925-niger-hit-unprecedented-spate-child-deaths-msf>

Missing reports (POA/annual reports) and the absence of records outlining decisions, made it difficult to determine exactly why and how some choices were made. However, individuals have reported that most of the decisions were made as a reaction to specific events or based on emotions instead of facts and complete analysis of data/evidence.

Please note that the key events are also presented in the diagram “MSF-OCG in Magaria – Timeline 2005-2018”, in the beginning of this report.

Vision

Many of the individuals in coordination or at the direction-level mentioned that a project with the life-span of 13+ years, should have had more thought put into developing a longer-term strategy. After 10 years the medical department, with the involvement of operations, looked back at some of the lessons learned¹⁰, but these studies did not seem to yield concrete long-term plans. Individuals mentioned an attempt in 2017 to develop a three-year plan¹¹, but this strategy was abandoned in 2018 in order to move forward after the extraordinary peak occurred. A process is currently underway to review the project and establish a longer-term strategy in early 2020.

In practise, although objectives were clear during the peak malnutrition period, the lack of long-term vision meant objectives were unclear for the rest of the year. Another effect is how the peak period seems to have come as a surprise in some years, with a lack of anticipation and preparation. In those years, the outcomes (mortality rates in hospital) seems to be worse.

Finally, the lack of vision appears to have caused the project to overlook conducting the usual context analysis (food security, external factors). This may explain the lack of preparation for the early peaks, or the extra-severity of the cases in the hospital in some years. This, in turn, led to hurried decisions based on intuition instead of evidence, data and facts, that have sometimes bypassed the established communication channels.

Training

An area specifically impacted by the lack of planning is training. The implementation of new protocols, together with an increase in recruitment and patients, means the learning and development department had difficulty keeping up trainings and ensuring that staff had the necessary skills to meet the needs.

Hyper-specialisation

A recurring theme during interviews was the need for simplification in OCG’s intervention in Magaria. After further questioning and analysis, we found very specialised protocols or programmes had been implemented over time. This “hyper-specialisation” of medical protocols (such as the use of adrenaline in the treatment of shock, bedside ultrasound, patient circuit/phases) and implementation of complex programmes (neonatology, treatment and management of sickle cell disease) sometimes with little planning, had several consequences.

One reported impact was that staff were unprepared or lacked the competencies to implement and manage protocols effectively. Some protocols were implemented close to the peak period with little training, while many new staff were being recruited, which made it more difficult to manage the large increase of patients. Another impact is the financial pressure these protocols/programmes put on the project.

In addition, the high staff to patient ratio and misalignment with national protocols, will create more difficulties for MSF during the handover to another actor who will most likely not be able to sustain such specialisation.

¹⁰ Monica Rull, “Niger what's next”, 2016; Michel Quère, “10 ans de MSF au NIGER Leçons et perspectives”

¹¹ Th Plan of Action provided to us for 2017 is based on one year.

Recommendation:

As one of the last and biggest nutrition programmes for MSF, there should be space and openness for innovation in Magaria. This opportunity should be explored in a planned and methodical manner, perhaps only outside of the peak periods, while returning to known and trusted methods during the peak.

2.2 Internal / external factors

Throughout the span of the project there have been many external events that have affected decisions made in Magaria; below are a few notable events:

- Climatic influences such as drought or low rainfall (2009, 2010, 2014¹², 2017), insect infestation (2010, 2018¹³), higher than average rainfalls (2012), or lower than average crop yields (2011¹⁴, 2013⁵). In short, combined climatic factors have severe impact on the already high food insecurity which has been a factor for malnutrition and other morbidities in some years.
- Regional insecurity restricts access to healthcare services for target populations and has consequences on access to the project for international staff resulting in staff profiling.
- Collaboration with other actors:
 - Although some years saw some collaboration with the authorities, many interviewees report a strained relationship with Nigerien government and/or the MoH, sometimes described as hostile;
 - Presentation to MoH of MSF activities to discuss issues and develop solutions (2014);
 - Collaboration with MoH, steering committees, UN cluster (2014);
 - MSF included in the revision of the national protocol for severe acute malnutrition (SAM) (2015);
 - Joint MSF, Save the Children and MoH workshop for the preparation of the peak period (2017).
- Lack or deficit of interventions by other actors:
 - Potential partnership with a local NGO, Hadinkai, that did not materialise (2012);
 - Handover of health centre activities/ATFC to Save the Children who were unable to sustain activities (2015);
 - ECHO pulls most of their funding, all other actors design exit strategies (2017);
 - World Food Programme (WFP) suspends food distribution (2018).

In addition to the external factors above, some internal factors also had an impact on the project outcomes:

- The expulsion of MSF-France (2008) and the subsequent withdrawal of other sections;
- The profiling of international staff is seen to have put individuals in positions for which they weren't qualified;
- The blurred lines of communication, especially for decision-making;

¹² http://www.stat-niger.org/statistique/file/Regions/Zinder/Annuaire_Statistique_Zinder_2016.pdf

¹³ https://reca-niger.org/IMG/pdf/bulletin_phyto._08_dgpv_2019.pdf

¹⁴ <https://observers.france24.com/fr/20120619-niger-mali-criquets-pelerins-invasion-essaims-lutte-antiacridienne-sahel-insecurite-crise-alimentaire>

- Financial constraints¹⁵ and the difficulty in justifying interventions created a perception of financial pressure, which led to changes in implementation strategies. Some stating this as the reason for not continuing outreach efforts.

It is difficult to conclude which factors have had the most impact on the decisions OCG made in the past. One thing that was often mentioned by those interviewed is the lack of planning for the peak periods, and even often being caught off-guard by the peak and needing to switch to an emergency mode of operation.

It was also mentioned repeatedly during the interviews that in most recent years, OCG does not have a deep understanding or knowledge of the community, the environment and the context.

Recommendation:

With the establishment of a three-year plan in 2020, it may be an opportune time to include the MoH in the development of this strategy and gain some commitment and accountability for their role.

In addition, conducting an independent anthropological study in the Magaria area could help in learning the current challenges of the population and inform the new planning cycle.

As the context is always evolving, it is recommended for the leadership of OCG in Magaria and Niger to engage with local organisations, civil society, and others in a meaningful way. This does not seem to have been conducted consistently in the past.¹⁶

2.3 Evolution of target population

It was difficult to find the answer regarding the change (evolution) in target population for the Magaria project. The last government census was conducted in 2012¹⁷ and OCG population estimates for Magaria District are calculated according to the population growth for the country.

In some years, OCG has included only the population of the health areas where OCG intervened as the target population. This does not give an accurate calculation of the population in the district (which is the target population for the hospital). In addition, Dungass was sometimes included and sometimes not, bringing more complexity.

¹⁵ There are individuals at Field and HQ level (7 of 26 interviewed) who reported financial pressures, limitations or restrictions as a constraint on programming.

¹⁶ See Hamadi, Desilets, "Enriched or Confined? MSF Engagement in Local Partnerships", 2012

¹⁷ <http://www.stat-niger.org/nada/index.php/catalog/61>

Figure 1: Target population for Magaria – including Dungass

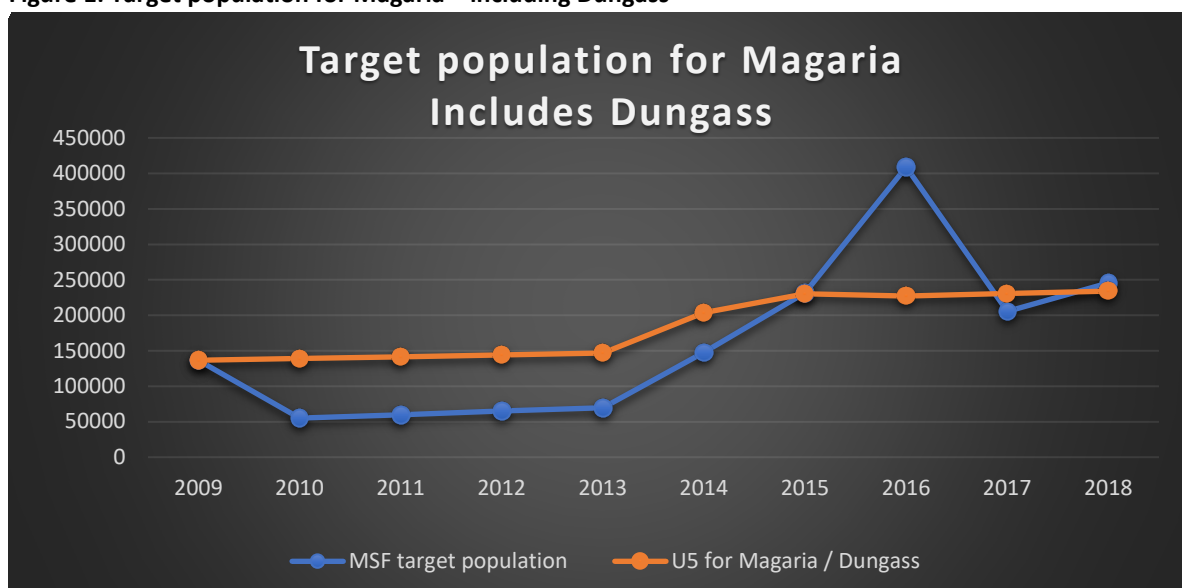


Figure 1 - represents the difference between the MSF reported target population and the estimated U5 population for the Magaria/Dungass health districts.

Source for MSF Target Population: POA

Source for U5 for Magaria / Dungass:

http://www.stat-niger.org/statistique/file/Regions/Zinder/Annuaire_Statistique_Zinder_2016.pdf

<http://www.stat-niger.org/nada/index.php/catalog/61> and POA for 2009

The number of patients from Nigeria who cross the porous border to gain access to care, has fluctuated over the years, but they have never been included in the target population. Some participants believe this population is under-reported as patients do not always accurately state where they are from. The graph below tries to provide some clarity.

Figure 2: Patients from Nigeria

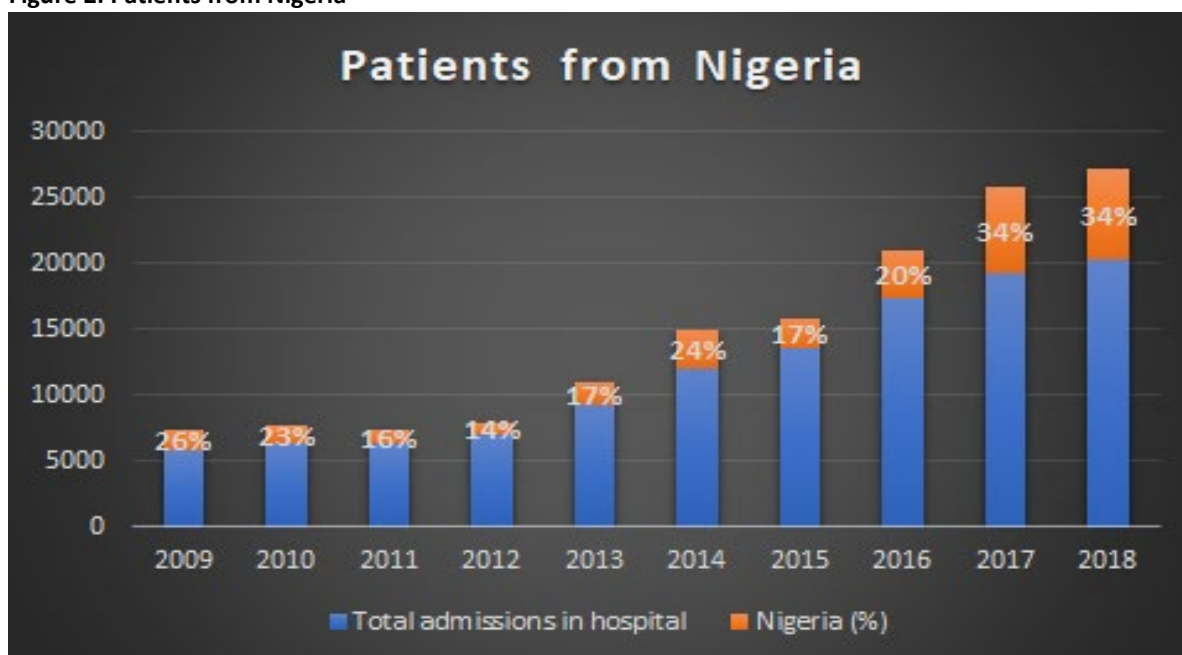


Figure 2 - Patients from Nigeria as a % of total admissions.

Source: Annual reports

2.4 Mortality

Seven retrospective mortality surveys were undertaken in the Magaria district between 2009 and 2019.¹⁸ They covered the peak season (malaria and the hunger-gap period) though the recall period duration varied.

Three surveys were undertaken in 2010, 2012 and 2013, comparing health areas where the pilot project for a package of preventive/screening activities took place in the community. For that reason, the geographical areas covered by the surveys were smaller than other surveys. We used the results of the U5MR of the health area where the pilot project started (Dan Tchao) because it represents the area where our intervention was the most consistent.

Two years (2009 and 2015) had a U5MR above the emergency threshold of two deaths/10,000/ day. The highest reported U5MR was in 2009 (2.84 deaths/10,000/day). We were unable to determine the reason explaining the high mortality rate.

It is worth noting that most reported deaths occurred during the peak months, which happened earlier in some years than others. Although we did not look at specific peak periods for most years, in 2017 and 2018 the surveys indicate the death rate was above the emergency threshold during peak months. For example: Jul-Nov 2017: 2.5 deaths/10,000/U5/day (2.0-3.1); May- Oct 2018: 2.9 deaths/10,000/U5/day (1.99-3.82)

“Home” was constantly reported as the first place of death by far (decreasing trend of 82 to 66 percent over the years) and the main reported cause of death was malaria/fever.

Table 2: Reported U5MR per recall period

Recall period	U5MR (# deaths/day/10,000)	95% CI
Jun 2009 - Jan 2010	2.84	(2.31-3.54)
Jun 2010 - Jan 2011	1.35	(1.11-1.60)
Jun 2011 - Feb 2012	1.17	(0.9-1.45)
Aug 2013 - Mar 2014	1.21	(1.00-1.43)
Jun 2015 - Feb 2016	2.02	(1.48-2.57)
Jun 2017 - Apr 2018	1.3	(0.9-1.5)
May 2018 - Apr 2019 ^[4]	1.81	(1.28-2.35)

It should be noted that there is no consistency of when and where the retrospective mortality surveys were carried out. Instead of conducting the surveys in the same area each year, they were conducted with other purposes such as mosquito net utilisation, vaccination coverage or plumpy nut distribution coverage. Having different geographical populations or recall period duration may limit the comparison of results.

¹⁸ Preliminary results for the 2018-19 survey

Outreach

There is a strong correlation between effective outreach programmes¹⁹ and the number of patients admitted in the facilities, and a decrease in the U5MR.

Results of the pilot project in the communities of up to six health areas between 2009 and 2011, can be associated with a clear decreasing trend of the U5MR which continued in 2013.

In 2015, MSF stopped supporting the “axe externe” and no other actors took over. That year, the U5MR rose above two deaths/day/10,000, and went down again in 2017 when MSF restarted the activities in the “axe externe”.

Though it could take years to see the impact of outreach programmes and preventive activities in the number of admissions into the secondary healthcare facilities²⁰, the graph below seems to suggest that impact of paediatric and nutrition activities outside of the hospital is quite immediate on the mortality rate.

Figure 3: Admissions/U5MR

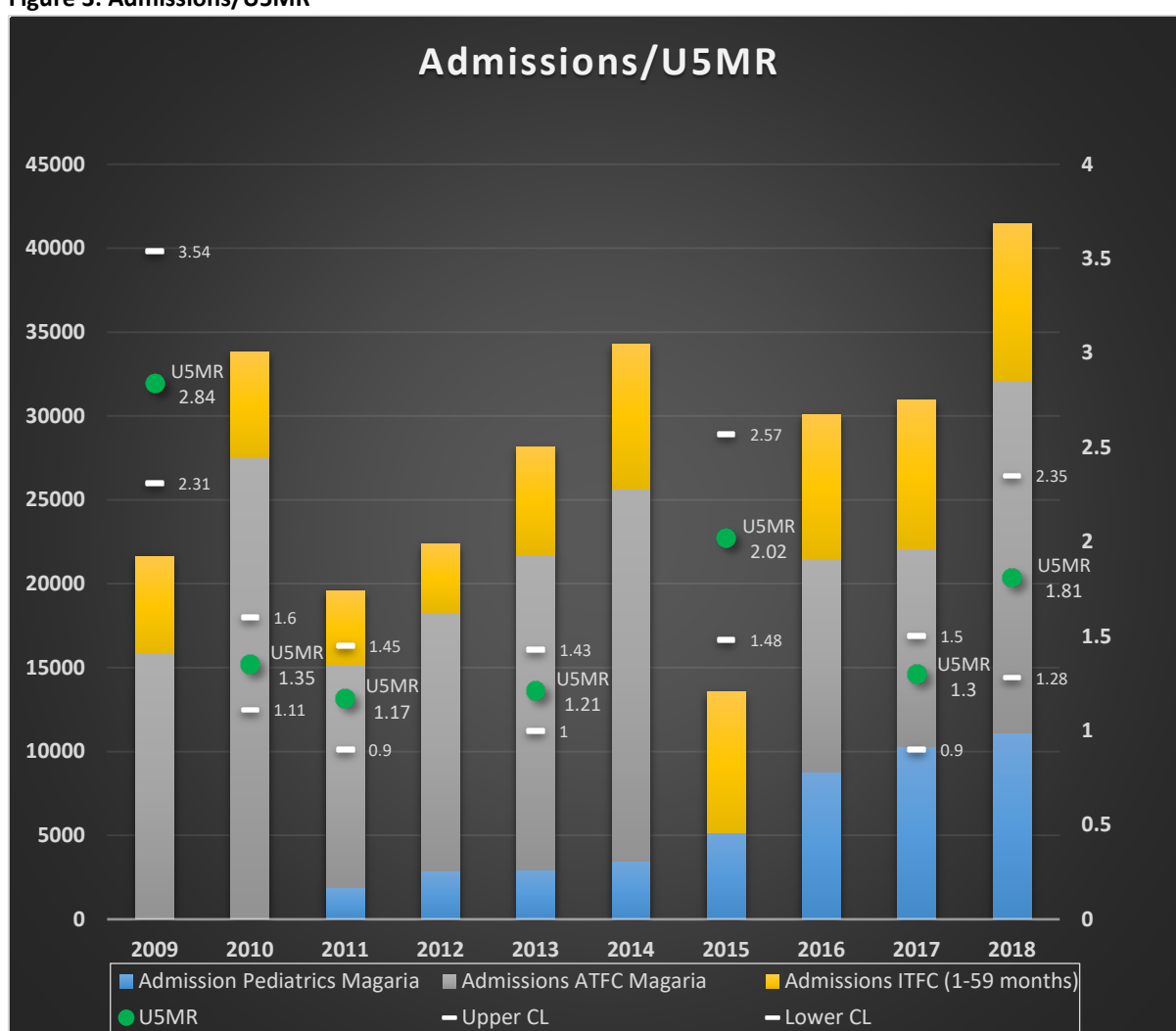


Figure 3 - Correlation between outreach programmes, # of patients admitted in all MSF services and decrease in the U5MR

Source: QlikView (2009 – 2016); Annual Reports (2017-2018); Mortality reports

¹⁹ This statement does not consider the activities of other actors if any

²⁰ This was repeated a few times by some key informants, but we were unable to find a reference.

Recommendation:

If contributing to the reduction of U5MR in the population remains the objective of the project, we recommend planning regular retrospective mortality surveys in a more consistent way; ideally every year, but could be every two years, covering the same period (June to January) in the same areas. Other survey objectives would have to adapt to these features or be conducted in parallel.

ITFC mortality

The evolution of the ITFC mortality rate is irregular (as depicted in the graph below) and is lower than the MSF standard of 10 percent²¹ for most years (though, as mentioned in the limitations, we did not separate this into monthly rates).

Figure 4: Admissions and mortality ITFC 2009 to 2018

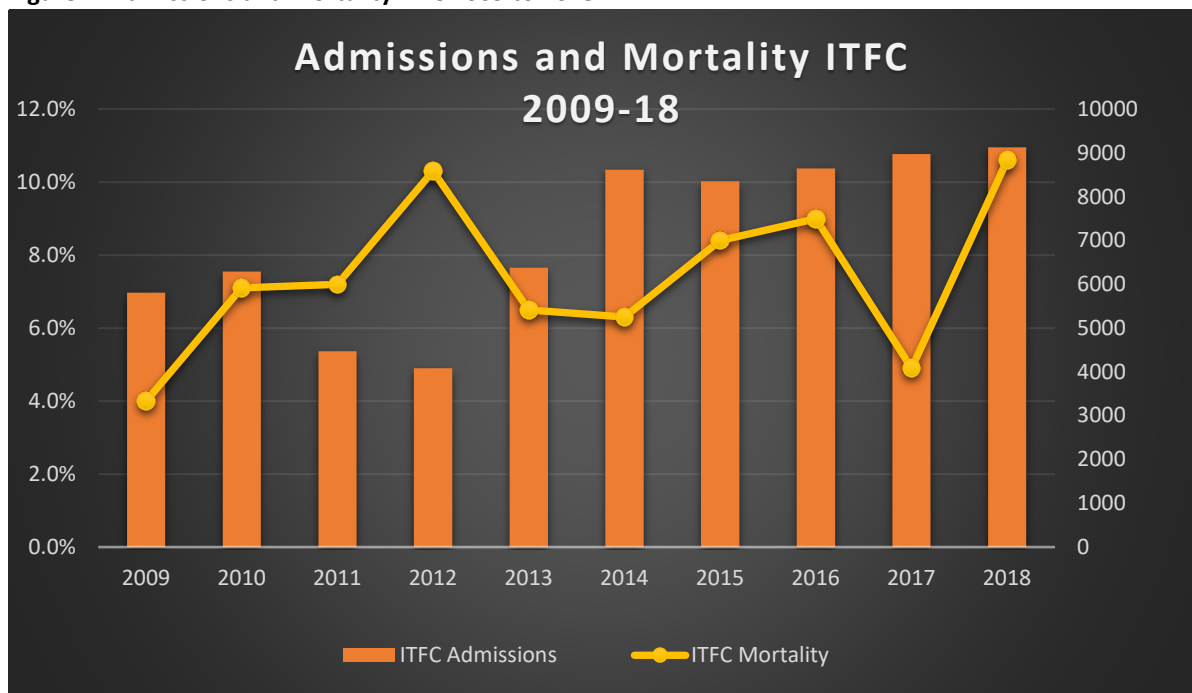


Figure 5 - Evolution of ITFC mortality rate compared to the number of children admitted in the Magaria and Dungass ITFC over time

Source: QlikView aggregated data (2009 – 2016); QlikView individual data (2017-2018)

We can see that in 2012 and 2018, the annual ITFC mortality rate rose above 10 percent. These are considered by many as critical years. 2015 is also mentioned as a “critical” year, with factors other than just hospital mortality giving this sense. In addition, although patient admissions stay relatively stable there is an increase in mortality rates from 2014 to 2018 (except in 2017). Again, because this review has been taken at a macro-level, it is difficult to explain why, but it is a trend that should be investigated - especially the deaths before and after 48 hours of admission.

²¹ MSF-OCG Standard Medical Indicator Taxonomy-V3

The irregularity seems to correlate with the years where the peak came as a surprise. For example, many participants who were present before and during the 2018 peak, reported it as unplanned for, with the early onset taking the team by surprise. When comparing data from 2017 and 2018 (graph above), it seems to corroborate that statement.

Malaria

Malaria has consistently been the first cause of consultation and hospitalisation, and the main killer for children under five-years-old for MSF activities in Magaria²².

The macro-level view of the evaluation has not allowed for further investigation into the reported morbidities. Furthermore, although malaria has been considered as a compelling element in the contribution to the reduction of U5MR in Magaria, it has not been a theme developed by key participants.

For four years, the SMC strategy intended to reduce the burden of malaria in the population, and the number of severe malaria cases in the hospital. Although the SMC strategy showed a reduction in malaria incidence in the area, the impact of the SMC strategy in Magaria was mixed²³. The 2015 peak showed an increase in the number of admissions associated with severe malaria, with a rise in the number of blood transfusions.

However, the SMC strategy was adopted as a national strategy by the MoH. Some key participants reported the positive impact of the SMC in keeping regular contact with mothers and children and testing for malaria if there were relevant symptoms.

Severe anaemia and blood transfusions are reportedly a high burden in the Magaria hospital during the peak, in addition to the difficulties finding blood. Several participants expressed an interest in addressing this, while not over-specialising the care.

Furthermore, considering the emergence of insecticide resistance in mosquitos, the most efficient malaria control intervention, namely long-lasting insecticidal nets (LLINs) and indoor residual spraying, may be jeopardised²⁴. This may be an area for OCG to develop innovation regarding malaria treatment.

Recommendation:

As malaria continues to evolve and persists as a main cause of morbidity and mortality in Magaria and in many MSF projects, OCG could use this as an opportunity to develop innovative strategies to reduce the malaria burden in Magaria district and beyond.

²²2009-2018 Annual reports and all retrospective mortality surveys

²³ Capitalisation de la mise en œuvre de la chimio-prévention du paludisme saisonnier à Magaria-Mai 2016

²⁴ Insecticide resistance in Malaria Vectors: An update at the global scale Jacob M. Riveron et Al. July 2018

3 Conclusion and discussion

The Magaria project has seen substantial changes in the implementation strategy over the years, with various impact on project outcomes. Although many external factors and other internal influences must be considered, it seems that a reliable and consistent presence in health centres and the community has a positive outcome, while decisions made in silo, too quickly and based on emotions rather than facts, affected both the outcomes of the project and the motivation of individuals.

Maintaining implementation of a long-term vision will give individuals more clarity on objectives and should help to define appropriate and timely strategies. Simplifying the protocols, especially during peak periods, will help the project to be more effective and efficient.

The overview of mortality studies reveals the effectiveness of having interventions close to communities. Focus on secondary healthcare alone has not shown any positive impact on the U5MR or on hospital mortality rates (2015).

As the evaluation evolved, some topics arose repeatedly and although they were not part of the evaluation questions, we found it useful to include the following points in the report.

3.1 Advocacy

In the early years of MSF intervention, huge efforts in researching ways to improve malnutrition management were invested in Niger and the Magaria project. From this, great international initiatives were developed, such as the of Ready to Use Therapeutic Food (RUTF) and the start of what is today called the Community Management of Acute Malnutrition (CMAM) approach. The innovations allowed space for the care of more severely malnourished children at a lower cost. At the national level, OCG worked together with the MoH to develop a new national protocol and roll out the new changes.

Many efforts were also focused on understanding the community, food insecurity levels and trends (refer to food insecurity reports in 2009-2010 annual reports and anthropology researches) which seems to have been abandoned in more recent years with the focus/load in the hospital.

Since that period, MSF (all sections) has progressively disengaged work on nutrition innovations and some OCs even disengaged with nutrition programmes (OCB in Dakoro, OCP in Maradi).

In Magaria, despite 13 years of the project, there has been no real engagement or advocacy strategy with other actors, even at a local level, to address the root causes of malnutrition (intergenerational cycle of malnutrition, women's education, fertility rates, availability of food).

This has coincided with a decrease in funding from international organisations and international disinterest in this part of the Sahel region (attention refocused to the lake Chad/migration crisis).

However, the Sahel is one of the first regions where climate change has started to show its effect²⁵. The second Sustainable Development Goal (SDG) is "zero hunger" and the interest in climate change and environmental health, which affect first the most vulnerable, is an opportunity to reengage with international and local actors.

²⁵ Evolution of some observed climate extremes in the West African Sahel, <https://doi.org/10.1016/j.wace.2013.07.005>

New evidence has emerged of a progressive link between wasting and stunting and that wasting and stunting share common risk factors²⁶. A wasted child has a concurrent risk of stunting, while a stunted child is likely to have repeated episodes of wasting. There is a gap in programmes to address both types of undernutrition and a move to link both statuses²⁷.

Recommendation:

In terms of advocacy, there is a space for MSF to work on innovative strategies and criteria to identify and treat malnourished children differently. There is an opportunity to overcome this “fatigue” of nutrition programmes and also bring back the hope to “end **hunger**”. For example, OCG could develop a programme with criteria where stunted children are admitted and observed to see whether they are less prone to infectious and wasting episodes.

3.2 The extreme peak of 2018

The extreme peak in 2018, worse than any previous year, was a difficult phase of the project for all involved. During interviews, some people mentioned a certain relief in talking about the events of 2018, and some expressed surprise that OCG had not conducted a more thorough review of what happened. The sense that came through in the interviews is that while no one wanted to blame individuals, they did want to better understand what happened and try to uncover lessons to avoid a similar situation in the future.

In our broad overview of the events of 2018, some themes emerge as potential areas to strengthen:

- Conflict resolution mechanisms
- Decision-making processes and hierarchies
- Clarity of roles and responsibilities
- Relationship with/between staff
- Change management strategies
- Developing partnerships (see partnership report)
- Malnutrition in a medical silo
- Understanding of the needs of the population

Recommendation:

We strongly recommend a more thorough review of the events leading up to the extraordinary peak in 2018, not to assign blame but to uncover structural issues to prevent future occurrences.

²⁶ Beyond wasted and stunted –A major shift to fight undernutrition, Wells et al. 2019
[https://doi.org/10.1016/S2352-4642\(19\)30244-5](https://doi.org/10.1016/S2352-4642(19)30244-5)

²⁷ Child wasting and stunting: Time to overcome the separation (2018)
<https://www.enonline.net/resources/timetoovercometheseperation;>

3.3 Clarity of roles and responsibilities at the various levels

Many people interviewed mentioned some degree of misunderstanding or miscommunication between the various levels of decision-making/advisory bodies: field, coordination, cell, medical department, and the Medico-Operational Support Unit (MOSU).

Without going into detail to avoid blaming individuals, there did seem to be decisions often made outside of the established decision-making lines in the implementation of protocols. These same decisions not only bypassed the coordination and/or the Cell, but were also not communicated and came as a surprise for some. For some activities (e.g. sickle cell disease cohort) the rationale and strategy has been lost over the years with changes in key decision-makers.

In addition, there were reports of ongoing and transversal conflicts between these levels, which may have exacerbated the difficulty in responding to peak periods.

We bring this to your attention as a means to address these issues and/or prevent them in the future.

Recommendation

A documentation of the rationale of decisions and a written/agreed predetermined timeframe would help to ensure continuity and avoid misunderstanding.

3.4 Data

The evaluators understand that a lot of effort has been put into the area of information management in recent years. However, as we conducted this study, we realised early on how difficult it was to access data and were often required to “pick” data from different sources. We were not always confident in the reliability of the data.

We did work with the QlikView database to find some medical data (which was different to those compiled in the annual reports); but the data was organised as such that only individual data from 2017/2018 was available for the ITFC while the other years had been combined. We were unable to find data for the ATFCs and the paediatric ward for 2017-2018 and used the annual reports. Additionally, the database only contains medical data. The financial and HR data took some weeks to obtain and when it was received, it had some anomalies that were never resolved.

If we take for example the mortality surveys that were conducted in various health areas at different times of the year, it makes it very difficult to make reliable conclusions.

Because of this, we felt compelled to mention the difficulty in obtaining reliable data in the report, not only as a limitation to this review but as a caution for MSF. One of the points mentioned earlier is that individuals made some decisions based on intuition, perhaps the lack of easily accessible, relevant data is a cause.

3.5 Previous findings

In 2014, OCG commissioned an evaluation “to assess the relevance and effectiveness of programmes, the potential impact of regional and national changes on MSF's ability to achieve its goals and the relevance of adaptation strategies” (translated)²⁸. In our view, this study was conclusive and many

²⁸ Jemmy, J-P and Kircher, I; « Projets Pédiatriques et Nutritionnels de MSF-OCG à Zinder et Magaria, Niger », 2014

of their findings were corroborated even beyond the timeframe of this evaluation (the same issues persisted after the evaluation).

Recommendation:

Because many of the same issues persisted beyond 2014, this leads us to believe that the recommendations made by Jemmy & Kircher were not implemented. Although there were many recommendations (18) which were not developed into clear actionable plans, we suggest OCG review this report and its recommendations as they are still relevant today.

4 Recommendations

What was the impact of the strategic changes on the project outcomes?

As one of the last and biggest nutrition programmes for MSF, there should be space and openness for innovation in Magaria. This opportunity should be explored in a planned and methodical manner, perhaps only outside of the peak period, while returning to known and trusted methods during the peak.

Were timely adaptations made in response to changes in the environment?

With the establishment of a three-year plan in 2020, it may be an opportune time to include the MoH in the development of this strategy and gain some commitment and accountability for their role. E.g.: invite the MCD to the pre-POA meetings.

In addition, conducting an independent anthropological study in the Magaria area could help in learning the current challenges of the population and inform the new planning cycle.

As the context is always evolving, it is recommended for the leadership of MSF in Magaria and Niger to engage with local organisations, civil society, and others in a meaningful way. This that does not seem to have been conducted consistently done in the past.

How did the target population change over the project life-cycle?

No recommendations made.

What were the changes in mortality rates for U5 in the targeted communities during those years?

If the reduction of U5MR in the population remains the objective of the project, we recommend planning regular retrospective mortality surveys (e.g. two years apart) covering the same period (June to January) in the same geographical area. Other survey objectives would have to adapt to these features.

Advocacy

There is a space for MSF to work on innovative strategies and criteria to identify and treat malnourished children differently. There is an opportunity to overcome this “fatigue” of nutrition programmes and bring back the hope to “end hunger”. For example, OCG could develop a programme with criteria where stunted children are admitted and observed to see whether they are less prone to infectious and wasting episodes.

The extreme peak of 2018

We strongly recommend a more thorough review of the events leading up to the extraordinary peak in 2018, not to assign blame but to uncover structural issues to prevent future occurrences.

Clarity of roles and responsibilities

A documentation of the rationale of decisions and a written/agreed predetermined timeframe would help ensure continuity in activities and avoid misunderstanding.

Data

We felt compelled to mention the difficulty in obtaining reliable data in the report, not only as a limitation to this review but as a caution for MSF. One of the points mentioned earlier is that individuals made some decisions based on intuition, and perhaps the lack of easily accessible, relevant data is a cause.

Previous Findings

Because many of the same issues persisted beyond 2014, this leads us to believe that the recommendations made by Jemmy & Kircher were not implemented. Although there were many recommendations (18) which were not developed into clear actionable plans, we suggest OCG review this report and its recommendations as they are still relevant today.

5 Annex

5.1 Terms of reference



ToR Magaria
lessons learnt_0807:

5.2 List of interviewees

[First name Last name, Title]	[Function]
Ahmad Samro	NS +++ expérience
Alain Rouvillois	HoM
Alan Gonzalez	RMT 2017-2018
Alena Koscalova	CPS implementer
Ann Wairimu MUMINA	MedCo - Current
Christine Jamet	Operational Director
Coralie Lechelle	reinforcement Magaria 2018 -ops SPES unit
Daniel Martinez	ped advisor
Dorian Job	RP Cell 3 2017-current
Elisabeth CANISIUS	MedCo / Dep MedCo 2014 - 2017
Fabien Scheider	ARP cell 3 2009-2011
Florencia ROMERO	MedCo 2011
Geza Harcsi	Support médico-opérationnel aux Urgences en Afrique de l'Ouest et du Centre
Kalil Hamadoun TOURE	Medical 2012-2013
Mahamat Adji DALIL	HoM - Current
Marie Clarisse	Learning Unit
Marie Claude Bottineau	ped advisor and ped working group leader
Micaela Serafini	Medical Director / commissioner
Michel Quere	RMT for cell 3 2009-2017
Mohamed Arafan CISSOKO	HoM / Dep HoM 2016 - 2019
Monical Rull	Dep. Medical Director
Nicole Bulili MUBUTO	Dep MedCo / PMR 2013 - 2016
Roberta Petrucci	MOSU, paediatrician
Severine Ramon	ARP med
Souheil Reaiche	RP
Veronique VAN FRACHEN	Medco

5.3 Previous findings

Recommandations

Évaluation des projets pédiatriques et nutritionnels de MSF-OCG à Zinder et Magaria, Niger, 2014

Opérationnel

- Clarifier/spécifier la raison d'être de MSF OCG au Niger et aligner les projets sur cette dernière ;
- Analyser et documenter le rationnel soutenant les orientations programmatiques et sécuritaires ;
- Introduire la rédaction de documents stratégiques couvrant plusieurs années ;
- Investir sur la capacité effective de réseautage des coordinateurs ;
- Jouer un rôle plus actif dans le plaidoyer au niveau national et régional.

Par aire de responsabilité

Sécurité :

- Mettre en œuvre des outils effectif d'analyse de la sécurité ;
- Avoir une réponse adaptée et adaptable de la sécurité, impliquant une révision effective régulière.

RH :

- Poursuivre le renforcement de la transparence dans les procédures de recrutements et gestion du personnel;
- Analyser en profondeur le manque récurant de cohésion dans la coordination (ex : la méthodologie utilisée pourrait être « root cause analysis ») ;
- Elaborer une politique de développement du staff national, y compris un plan de formations.

Médicale :

- Améliorer la qualité des données médicales au-delà de la nutrition;
- L'objectif de l'axe externe doit être précisé et la stratégie revue³⁷ ;
- Un plaidoyer sur le rôle crucial des hôpitaux dans la prise en charge des malnutris sévère est important ;
- Documenter en détails le processus « d'intégration » de Zinder pour une dissémination des leçons apprises.

Logistique & supply :

- Mettre en place des procédures flexibles répondants aux besoins.
- Suggestions des autorités traditionnelles
- Maintenir une transparence dans la gestion des ressources de projet ;
- Associer (impliquer) d'avantage les autorités traditionnelles et la communauté au projet ;
- Inclure la prise en charge des femmes et l'accès à l'eau dans les projets. (Direct ou par plaidoyer).