Subject/Mission	**Ebola Emergency Response**
Review Sponsor	Brice De Le Vigne (OCB Director of Operations
Review Manager	Sabine Kampmueller- Stockholm Evaluation Unit (SEU)
Review Team Leader	David Curtis- Consultant
Starting Date	15/06/15
Duration	80 days, 55 days and 55 days respectively

Terms of Reference: Medical

REASON FOR THE REVIEW

One year after MSF (OCB) launched its response to the Ebola outbreak in Western Africa, and due to the complexity and challenges that have stretched the organisation, MSF OCB requires an **extensive multi-sectorial** review of its intervention.

PURPOSE AND SCOPE

The overall objective of the review is to provide: a picture of the intervention through a series of timelines identifying important events and milestones, a critical analysis of the intervention and choices taken with a focus on areas which challenged the organisation to change, adapt or develop new ways of working in response to the Ebola outbreak.

The review will look at the time period of 1st March 2014 to 31st March 2015.

The review should focus on the appropriateness of the chosen strategies/approach and provide an analysis of the effectiveness of the intervention. The analysis should identify key learning areas based on examples of good and bad practice as well as make recommendations for possible future best practices which can potentially improve guidelines, departmental strategies and learning.

The reviews scope is limited to all areas of the intervention under the direct operational management of OCB in the three countries most affected.

SPECIFIC EVALUATION TOPICS

1. **How effective was the design and implementation of the OCB Ebola intervention?**

Using existing guidelines, protocols or other strategic documents as references.

1. What were the objectives at the onset of the outbreak? (Appropriateness)
2. Did these objectives develop over time and if so, how? (Appropriateness)
3. Were adaptations made in response to changes in the operational environment? If so, were they timely? (Appropriateness)

4. Were there adaptations in the strategic design across the different locations (Rural and urban, national, trans-boundary, other?) (Appropriateness)
5. Were there adaptations of strategy resulting from changes in implementation? Was Strategy adapted before changes in implementation? (Effectiveness)
6. To what extent was the objective of implementing the protocols/guidelines reached in each of the different locations (urban, rural, national, trans-boundary, other)? (Effectiveness)
7. What were the main factors influencing this? (Effectiveness)
8. To what extent were the protocols/guidelines implemented in each location? (Effectiveness)
9. What were the main opportunities and constraints with implementation of protocols or guidelines? (Effectiveness)
10. What factors can be said to have limited the OCB implementation of protocols/guidelines? (Effectiveness)
11. Could the implementation of the protocols/guidelines have been improved? If so, how? (Effectiveness)
12. Were any particular communities/beneficiaries/patients/stakeholders excluded? (Coverage)
13. If so what factors contributed to the exclusion of some communities/beneficiaries/patients/ stakeholders? (Coverage)
14. Was the intervention response in Guinea/Sierra Leone/Liberia timely? (Timeliness)
15. What factors can be said to have contributed to the timeliness of the response? (Timeliness)
16. How did the OCB response link up with the strategies of other actors (e.g. local/national authorities, NGOs, donor agencies)? (Connectedness)
17. Did the MSF Ebola response influence the choices of other actors and vice versa? (Impact)

1.1 Experience in Ebola

Low level of Ebola experience/magnitude of the epidemic (inexperienced staff/lack of knowledge in Ebola; only few experts in MSF)

- Was it pertinent for OCB to respond simultaneously in the different locations (needing 4 independent teams)?
- How did OCB manage the implementation of knowledge and protocols with inexperienced staff?

1.2 Balance of treatment versus prevention

- How effective was the coordination with other organisations for implementation of the 6 pillars?
- Was there the correct balance between treatment and a public health approach? Was the correct balance found between treatment and prevention strategies?
- What was the place of health promotion in the overall response and in the governance structure (e.g. taskforce)?
- Were different resources looked for in order to implement the “non-case management” pillars?

1.3 Access for non-Ebola patients

- Was the triage effectively implemented?
- How far was the non-Ebola pillar considered?
- How was the closure of GRC (Sierra Leone) compatible with the emphasis on access for non-Ebola patients?
- To what extent was health promotion involved for non-Ebola patients?

1.4 Epidemiology

- What was the place of epidemiology and the role of epidemiologist at field level?
- How was field epidemiology used as a tool for decision making?

1.5 Rural and Urban strategies

- Were there different strategies proposed for rural and urban context?
- Rural setting: how to implement project with mobility of population and lack of effective infrastructure?
- Which specific means were used to better control the outbreak in urban settings? How effective were they?

1.6 Interaction with the Communities

- How was information shared and communicated with and from the communities? Was the content the right information?
- How effective was the community acceptance/participation in the strategy?
- What impact did the rapid response teams have?

1.7 Health Promotion

- Were HP activities considered and implemented timely in the different settings?
- Health Promotion strategy; locally adapted to what success?
- How effectively was the HP activities absorbed by each group of field staff?
- Where the right target groups/interlocutors identified?
- What issues challenged the Health promotion strategy? What new ways of working were developed?
- Was the HP material adapted correctly to the communities?
- What new techniques/media were used to transmit messages; how successfully were they implemented and received?

1.8 Coordination with other actors

- How effectively did MSF participate in the coordination of the response in the three countries?
- Was the presence of MSF in the national taskforces sufficient to ensure a cohesive strategy?
- Conflict of messages on Health Promotion: did it have an impact?

2. Was the level of patient care acceptable?

1. Was the medical guidelines/strategy/objectives appropriate to ensure acceptable standards of patient care? (Appropriateness)
2. To what extent were patient care guidelines/strategy/protocols implemented in the different locations? (Effectiveness)
3. Where appropriate and timely adaptations made in response to changes and evolution in the operational environment and if so what were they? (Appropriateness)
4. What were the main factors influencing these changes? (Effectiveness)
5. What were the main opportunities and constraints to the implementation of strategies/ policies/guidelines and how were they addressed? (Effectiveness)
6. Did the strategies affect treatment outcomes? (Impact)
7. To what extent did the need for protection of staff impact on patient care and what strategies were in place to minimise this?

2.1 Resources /Working conditions

- What was the ability to deliver an acceptable level of care with the resources available?
- Were the limits defined acceptable for caregivers?
- Were material/supplies adapted to the context needs e.g. safe needles, IV sets? What solutions?
- How was the laboratory support organized and how did it evolve on time?

- How did the working conditions affect the implementation of the projects activities?
- Is it possible to develop an 'at risk time' calculation for the EMC patient care?

2.2 Adaptability

- How did MSF address the challenges from the evolving information/pre-conceived ideas developed because of the scale of the intervention?
- How were the medical teams able to adapt to the changing environment (number of patients)?
- How did the strategy develop from trying to control the epidemic to participating in the control of the epidemic?

2.3 Dealing with uncertainties

- Was the low corpus of knowledge on Ebola disease an impediment to implement protocols?
- How were field staff questions related to case management addressed?

2.4 Medical guidelines

- Were the medical guidelines explicit enough for the Ebola outbreak; what to do and what not to do?
- How were they transmitted?
- How were they used at field level?
- How far has the experience been capitalised upon?

3.0 How effectively did OCB participate in Operational Research: Therapeutic, Prevention and Diagnostic; what were the results and implications?

1. What guidelines/strategies/policies were in place for Operational Research in an emergency context? (Appropriateness)
2. What were the opportunities and constraints inherent in the approach? (Effectiveness)
3. Was MSF able to take advantage of the opportunities and how? (Effectiveness)
4. What legal implications were there for MSF and how were these addressed? (Appropriateness)
5. What has been the impact of the Operational Research on the operational strategies? (Impact)

- Was MSF timely enough to implement operational research?
- How was the agenda of OR determined?
- What were the constraints to run operational research? How where they addressed and dealt with?
- What type of collaborations did MSF develop for OR? Were they successful (reasons)? What perspectives do they open?

4. Transversal topics for Medical to contribute to:

4.1 RH/Management

- Was there the correct management capacity to support the intervention at field level? (complexity/number and diversity of pillars)
- Was the no first mission policy an obstacle to efficient implementation of activities?

4.2 Epidemiology/availability of data

- Was the mapping information available for the rural outreach settings?

4.3 Infection control strategy

- Was there flexibility in this strategy?

- Was the policy set at the right level? Were intermediate measures considered for different settings, different sectors of activities, different times?
- How far was the infection control strategy developed outside EMC (Health structures)?

EXPECTED USES AND OUTPUTS

- Interactive overview of the key milestones/decisions/context of the intervention
- Critical analysis of the strategic choices and decisions
- Critical analysis of the successes at the level of implementation
- Potential areas for learning
- Recommendations for the future best practices where relevant

The review should focus specifically on the areas of the response which challenged OCB to adapt the strategy, develop new solutions or change its way of working. The review is not a classic what was done and what was not done review.

The review will attempt to deliver components of the ToR during the allotted timeframe. The Review will deliver a report per sector and specific transversal questions, which will be synthesised into a final document.

METHODOLOGY PROPOSED

The review should incorporate a mixed methodology (qualitative and quantitative) based on the MSF guideline for evaluation e.g. based on the objectives of the response and DAC criteria[1].

Will include: review and analysis of key project documents, interviews with team members at HQ and field levels, interviews with local authorities and other organizations, Interviews with patients, surveys, natural group discussions, roundtables, focus groups and lessons learned workshops.

PRACTICAL IMPLEMENTATION OF THE EVALUATION

The number of days identified are for the period between 01/06/15 and 31/10/15. The report writing and triangulation is expected to take place during September and October

REQUIREMENTS: Medical/Operational

Consultant 1

- Minimum 5 to 10 years of experience in humanitarian and development assistance
- A minimum of 5 years (or 5 field missions or projects) in relevant contexts, experience in West Africa a plus
- Senior MSF Operational experience at both Field and Headquarters
- Public Health qualification or relevant experience
- Sound professional experience in conducting evaluations or other sector program and project evaluations and / or reviews essential
- Knowledge of humanitarian and emergency procedures with large international institutions essential, with knowledge and or specific experience with MSF a plus

[1] OECD DAC Criteria: Criteria for evaluation development assistance

- Strong analytical skills and experience
- English and French required

Consultant 2

- Minimum 5 to 10 years of experience in humanitarian and development assistance
- Experience in West Africa a plus
- Medical Qualification in their field of expertise
- Diploma in Tropical Medicine or relevant experience
- Experience and knowledge of infectious diseases management
- Experience and knowledge in field epidemiology and data management
- Experience in conducting evaluations or other sector program and project evaluations and / or reviews essential
- Knowledge of humanitarian and emergency procedures with large international institutions essential, with knowledge and or specific experience with MSF a plus
- Strong analytical skills and experience
- English and French required

Consultant 3

- Minimum 5 to 10 years of experience in humanitarian and development assistance
- Experience in West Africa a plus
- Medical Qualification in their field of expertise
- Diploma in Tropical Medicine or relevant experience
- Experience in implementation and evaluation of health education, health promotion and community based intervention
- Experience in conducting evaluations or other sector program and project evaluations and / or reviews essential
- Knowledge of humanitarian and emergency procedures with large international institutions essential, with knowledge and or specific experience with MSF a plus
- Strong analytical skills and experience
- English and French required

Consultant 1	Medical/Operational
Timing of the evaluation	Starting June 2015
• **For preparation (Days)**	3 weeks
• **For field visits (Days)**	4 weeks
• **For interviews (Days)**	4 weeks
• **Analysis and Triangulation**	3 weeks
• **For writing up report (Days)**	2 weeks
Total time required (Days)	**80 days**

Consultant 2	Doctor
Timing of the evaluation	Starting June 2015

• **For preparation (Days)**	2 weeks
• **For field visits (Days)**	3 weeks
• **For interviews (Days)**	4 weeks
• **Analysis and Triangulation**	1 week
• **For writing up report (Days)**	1 week
Total time required (Days)	**55 days**

Consultant 3	Nurse
Timing of the evaluation	Starting June 2015
• **For preparation (Days)**	2 weeks
• **For field visits (Days)**	4 weeks
• **For interviews (Days)**	3 weeks
• **Analysis and Triangulation**	1 week
• **For writing up report (Days)**	1 week
Total time required (Days)	**55 days**