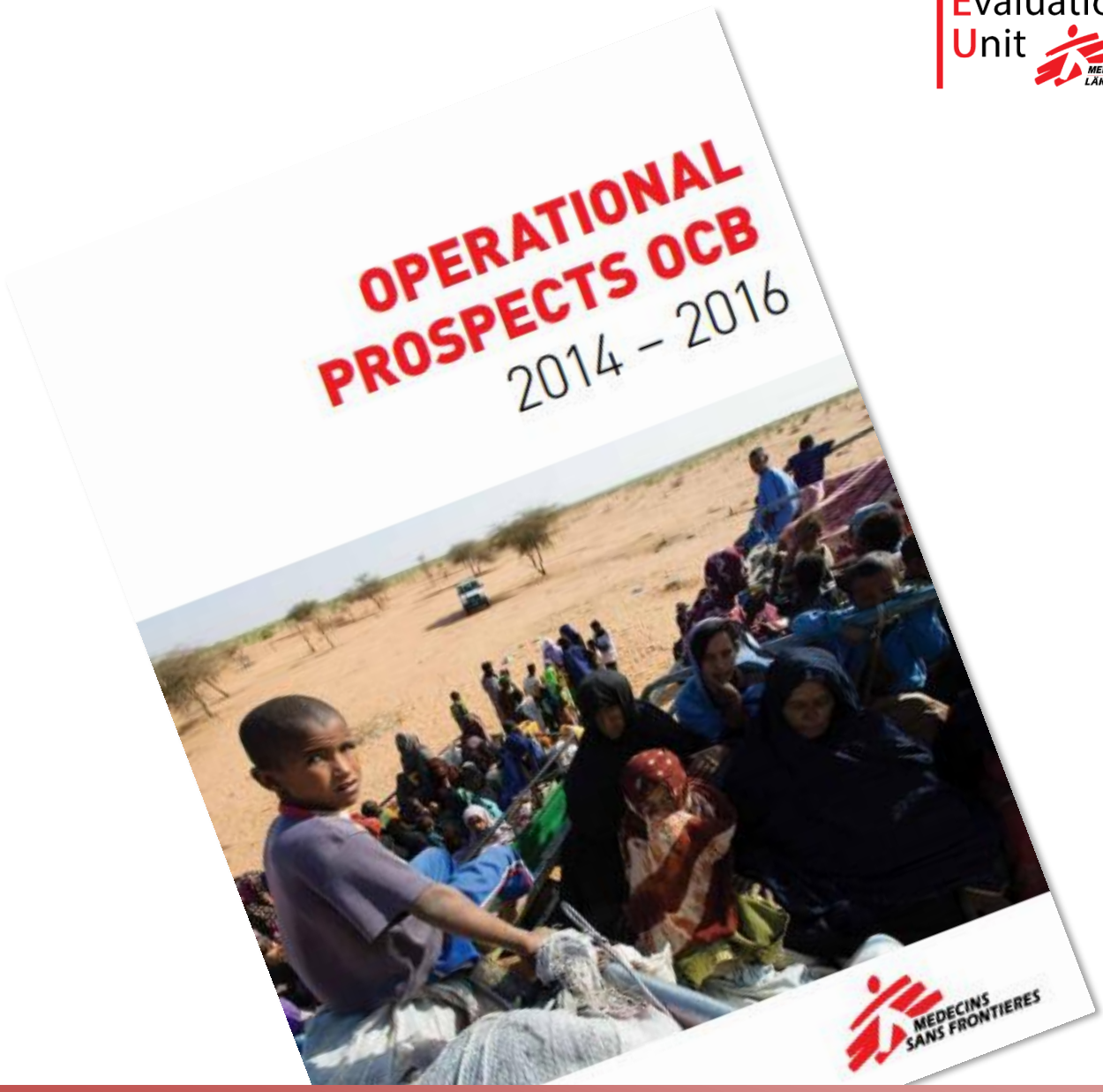
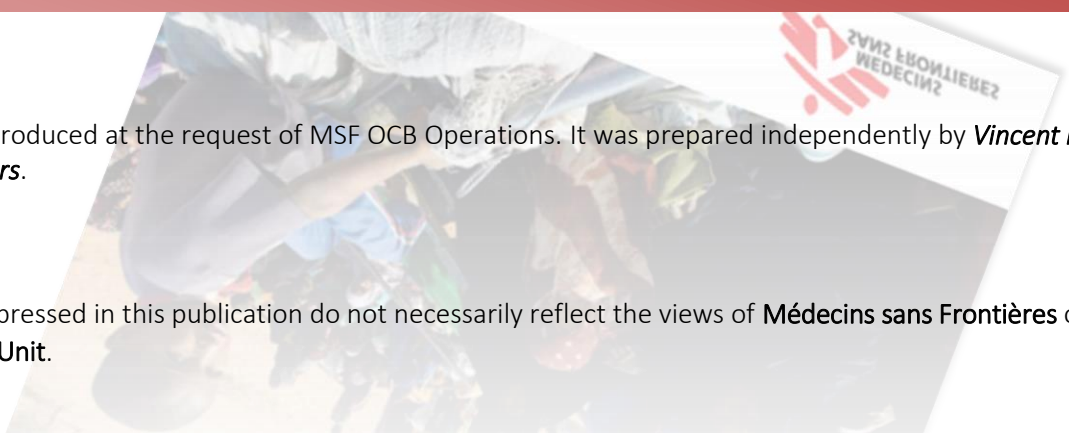
Stockholm Evaluation Unit

MEDECINS SANS FRONTIERES
LÄKARE UTAN GRÄNSER



OCB OPERATIONAL PROSPECTS 2014-2017 REVIEW



AUG 2017

This publication was produced at the request of MSF OCB Operations. It was prepared independently by *Vincent Mudry of Philanthropy Advisors*.

CONTENTS

ACRONYMS

ARO	Annual Revision of Operations
CPP	Country Policy Paper
DS TB	Drug Sensitive Tuberculosis
FTE	Full Time Equivalent
GBV	Gender Based Violence
HepC	Hepatitis C
HIV	Human Immunodeficiency Virus
HQ	Head Quarter
IPD	In Patient Department
LogFrame	Logical Framework
MDR TB	Multi Drug Resistance TB
MoH	Ministry of Health
MSF	Médecins Sans Frontières
NGO	Non-Governmental Organisation
OC	Operational Centre
OCB	Operational Centre Brussels
OPD	Out Patient Department
PHC	Primary Health Care
TB	Tuberculosis
WASH	Water Sanitation and Hygiene
Watsan	Water and Sanitation

INTRODUCTION

As part of the revision process of the OCB Operational Prospects ending in 2017, a review exercise has been launched with the support of the Stockholm Evaluation Unit.

The **light review** of the Prospects document encompasses two major objectives for the revision process: *testing the assumption that Prospects is still largely relevant while critically examining its relative success in reaching its ambitions*. The review has therefore developed two different aspects: i) Assessing the usefulness of Prospects as a tool for guiding OCB operations (appropriateness of indicators used, format, etc.), and ii) analysing aggregated OCB operations over the given period to pinpoint relative successes in achieving Prospects' ambitions.

This review was mainly executed through a desk review of the main OCB operational documents such as the CPP, Project documents, logframes, AROs, medical data and all the documentation available in the Ops database (project, missions, expenses, etc.), supplemented with targeted interviews with key informants.

The main analysis was made by comparing the ambitions and axis of Prospects with the presence of its contents in operational documents over the years so as to elaborate its use in operational design and assess its integration into operational thinking at both country and field level. A secondary exercise was a review of target attainment and an interpretation of successes and failures through the lens of operational documentation analysis.

Finally, by interpreting the successes and failures in reaching the set targets and analysing the use of indicators and references to Prospects in the operational documentation, the reviewer was able to analyse and comment on the relevance of the given indicators and advise on the usability of the tool as such in shaping OCB's operational ambitions

Preliminary findings were presented during the coordination week at a one-day workshop dedicated to Prospects' revision.

The aim of the presentation (see Annex III) was to provide and receive feedback on the primary analysis and re-incorporate this into the review outcomes.

The review exercise had its limits, such as the limited availability of updated documents (many missing and/or outdated CPP and project documents) and the absence of explicit references to Prospects' headlines in the ops documentation (CPP/Project documents), making it hard to accurately follow the implementation of Prospects' ambitions. Indeed, explicit references to Prospects' ambitions seem to be only present to conform to the requirements and are kept to general ideas (discussed further below). The vast number of documents to review in a short timeframe was challenging in terms of work load, so analysis was conducted through a systematised reading and search for key indicators of presence/absence (see annex II).

EVALUATION ANALYSIS

HEADLINE PRIORITIES

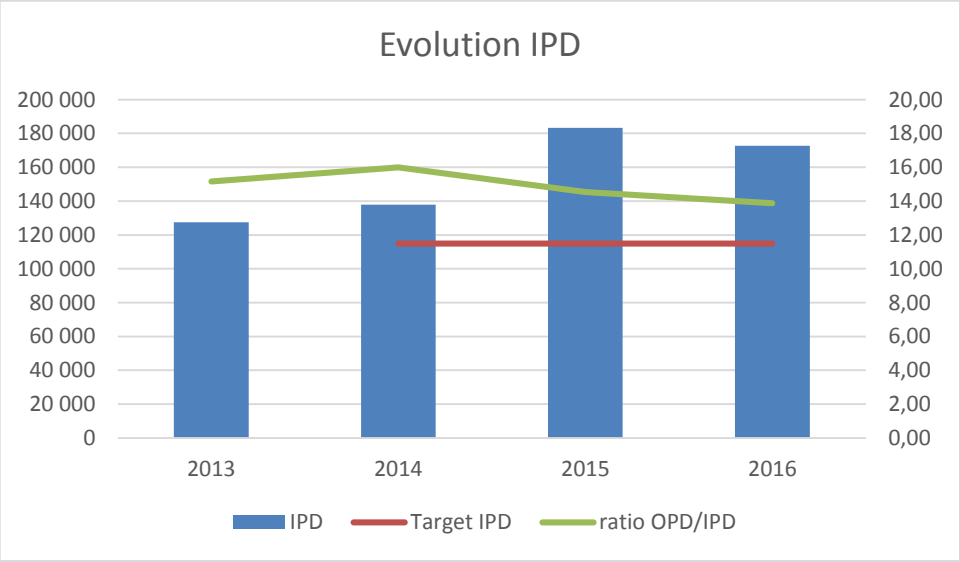
Prospects set two headline priorities for the period:

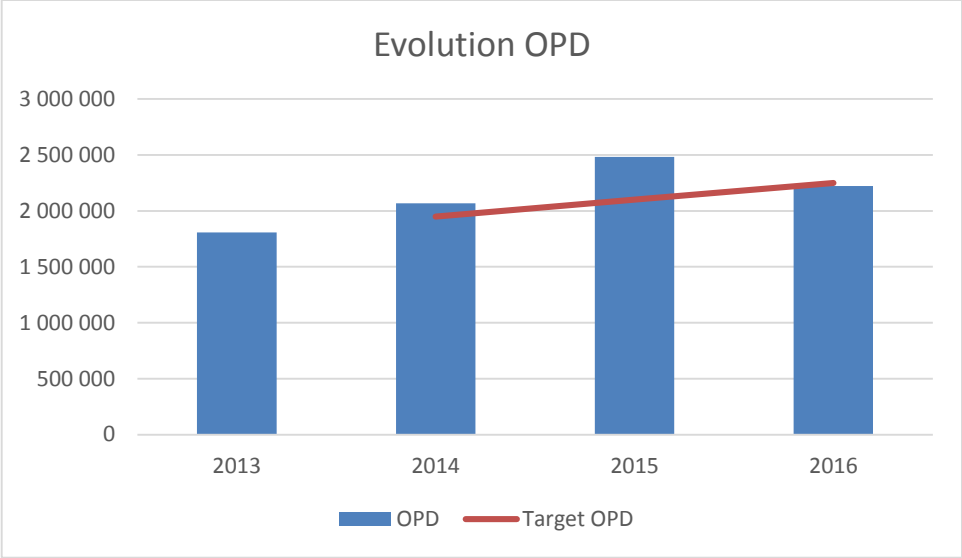
A) To develop a new balance between PHC and referral care.

The integration of this priority was studied through the lens of the following chosen indicators:

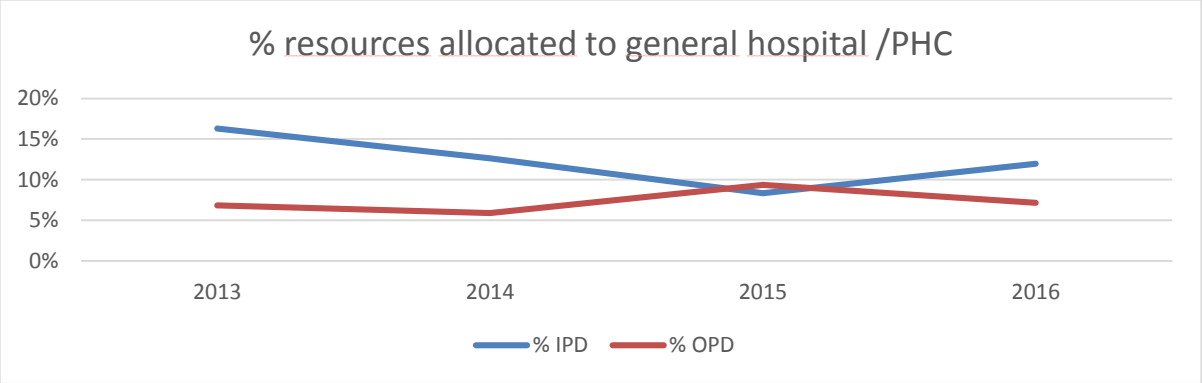
- Development of ambulatory care approach
- The enhancement of a referral system and a better integration of the IPD/OPD continuum
- The development of decentralisation strategies such as for deliveries in Afghanistan
- The development of community approaches in PHC (see also the second headline priority for this topic)
- Increasing patient autonomy
- Focus on main killers in emergencies
- The evolution of the IPD/OPD ratio in terms of patients
- The ratio between IPD OPD in terms of project expenses

While the 'soft components' of this priority in terms of referral systems, ambulatory care, community approach or focus on main killers in emergencies have seen an improvement and display a clear focus from the OC, with manifest 'hard' changes and enhancements, in terms of numbers, the results are more mixed. Indeed, as seen in the two graphs below, IPD and OPD numbers are over the target but follow the same trend with an almost constant OPD/IPD ratio over the period, showing no major changes.





In terms of resources allocated, numbers show that IPD was given fewer resources and OPD slightly more until 2015, but the trend reversed in 2016 with IPD being again favoured against PHC:



The conclusion is that enhancements were made in terms of methodology of intervention, with new comprehensive and context-integrated approaches being developed, but that it didn't fundamentally change the balance between the two components of the response.

However, as OPD and IPD numbers surpass their targets in terms of patients, and in the knowledge that they reflect the general level of activity, one interpretation could be that the OC has been adhering to needs and that the trends observed merely reflect those needs.

Despite the will of the OC to focus more on OPD rather than on IPD, the choice should be made on a case-by-case analysis at field level to define where OCB is best placed to intervene on one aspect rather than another depending on the needs of the population and the health system in place.

It is a matter of positioning of MSF towards other actors (NGOs, MoH etc.) in response to needs, rather than systematically prioritising primary or secondary health care approaches. **Efforts should be maintained to provide a comprehensive continuum between the two components of the response (adaptation of the methodology and approach, innovative referral systems, etc..). This seems more important than numbers or budget priority on one approach over the other.**

The second headline priority was the following:

B/ emphasis on a more comprehensive approach to the health-related needs of communities

The indicators for success in this priority were chosen as follows:

- The watsan needs are considered with consistency in all applicable fields

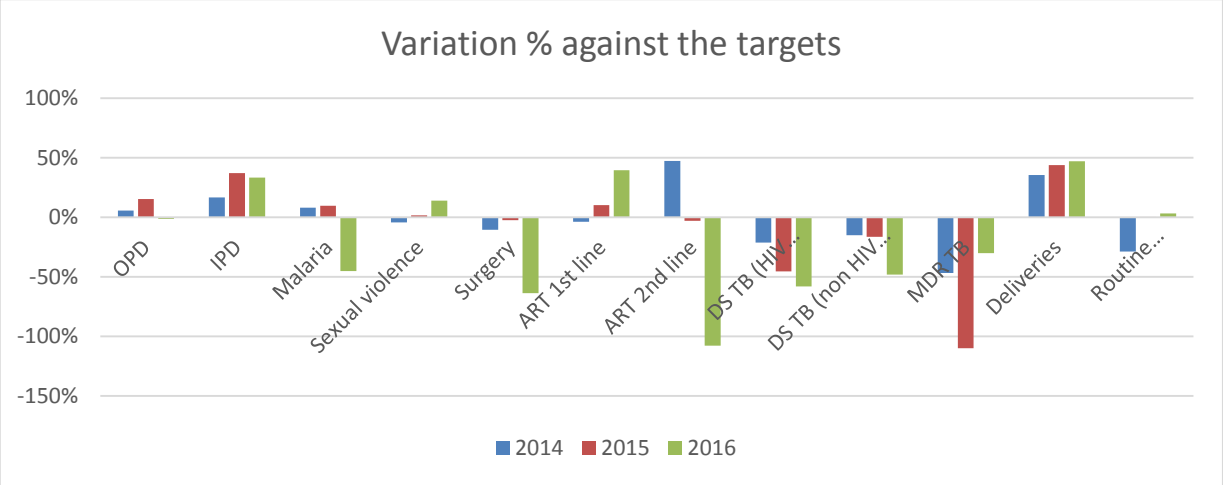
- Active case finding strategies are in place
- Community relays/health workers are used
- Home care approach is developed
- Community involvement is enhanced
- Community based chronic care is developed
- Projects use health promotion as a prevention tool
- Community involvement strategies are set
- Cultural mediators are used to better integrate the project with the communities.

With the recruitment of an FTE at headquarters, this headline priority has been quite well followed, with observable consistency in different fields and a strong dynamic appearing to have materialised around the topic. However, if the initial push has been successful, a continuous focus should be maintained to capitalise on the success to date. The push on watsan components of MSF response is somewhat guaranteed with the presence of watsans in the field and on e-responses, as they will take into consideration communities' watsan needs from project inception. However, other community-related components are not so intuitive in MSF culture and **thus an HQ referent can help in maintaining focus. Evaluations on usefulness and impact of the approach should be developed to showcase and argue for its sustained integration into the operational design**.

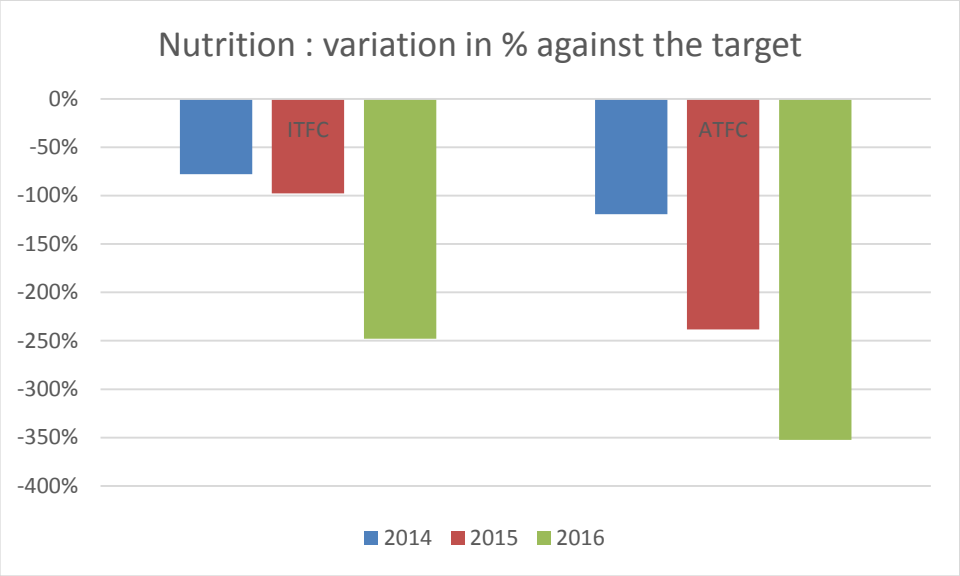
QUANTITATIVE ANALYSIS OF PERFORMANCE: TYPOLOGY

The Prospects document is structured around numbered targets in terms of medical activity performed and/or type of beneficiaries of such activities. When looking at the attainment of targets, performance is quite good for most of the categories and is in line with the Prospects ambitions. The attainment of targets (and/or over-performance) is particularly true for the most common medical acts such as OPD/IPD delivery and treatment of malaria which reflects the overall level of activity of the OC. It is worth noting that 2016 is the year with the biggest variation compared with the targets, probably informing on the difficulty of setting numbered targets 3 years in advance.

The following graph shows by category the percentage of variation against the targets for the different categories (excluding nutrition related activities to provide a scale which is readable).



Specific thematic activities such as HIV and TB during the period are further from the targets, which is also the case for nutrition (see the following graph).



Analysis

In-depth analysis of each category performance, including context related events and operational difficulties, wasn't part of the review scope; however, a reflection of broad tendencies of the performance against the set targets set has been done, as well as some reflections on the nature of the targets themselves.

For some of the targets (OPD, IPD, Malaria, delivery, etc.), rather than measuring performances, these numbers indicate the general activity level of the OC. Following the trends of field needs, these numbers are in direct relation to the coverage OCB has in terms of catchment areas, and to the needs in those catchment areas. However, these targets do not inform on the beneficiaries nor on the ability of MSF to provide medical services where these services are absent and needed. Therefore, attainment, over-performance or underperformance here are useful indicators for management and/or communication purposes **but do not necessarily reflect performance against ambitions**.

Numbers for the period show greater level of activity than expected, which appears impressive; however, this is mainly indicative of a level of need in MSF-reachable zones that was higher than expected and/or that MSF coverage was greater than planned. At this stage, it is not possible to explain which of these factors was most determinant.

However, this analysis puts into question the relevance of the chosen indicators to set ambitions. If these targets are useful for management and planning purposes and also very useful for communication and fundraising purposes (showing clear and easy-to-understand delivery outputs), they are not useful for setting medical humanitarian operational ambitions. Operational ambitions are defined (in Prospects) as being the ability to provide appropriate medical services in specific contexts, for specific categories of patients, in places where others do not provide such services - but the indicators and targets do not reflect or inform on the attainment of these ambitions. Therefore, **indicators of success and targets should be informed by the ambition to provide services in a specific context**: for example, number of OPD doctors in war zones, number of IPD beds, number of operating rooms, catchment area size for displaced/refugees etc. This issue is further unpacked in the following chapter.

Looking at more specific activities such as TB, HIV, HepC, GBV, etc., numbers show clear underperformance during the period. However, most projects involved in such activities are choice projects rather than default projects. Many reasons can explain the underperformance on these targets, the main ones being the overestimation of needs, or the ability of MSF to attract (or to actively find) patients. However, the main point of analysis lies in the fact that **for choice projects, the number of patients should not be the main indicator nor the main target**. Indeed, choice projects are set to be the catalyst of changes or the opportunity to experiment approaches and protocols. Such goals are not reflected in the targets set (even if minimum patient numbers are to be considered necessary) and do not appear in the Prospects. Therefore, for the next period, **new targets, other than patient numbers, should be set to reflect the ambitions. These targets should be constructed around the changes MSF intends to bring** (outside the curative successes of its own patients).

As for the very large underperformance on nutrition-related targets, a mix of context change (fewer needs) and operational choices (focus on nutrition was dropped by OCB during the period) largely explain this deviation.

To summarise, the significant gaps between targets and achievements (over the targets and below the targets) can be explained by two distinct phenomena:

- A structural/methodological reason: overall, numbered targets have been built regardless of the choice/default projects relied upon for achievement. Therefore, the relevance of these targets is questionable because they are context de-correlated: indeed, even if quantitative forecasts can be given for choice projects, this logic cannot apply to default projects that are context-driven and where the availability of services for a defined category of beneficiaries should be favoured, rather than a forecast of user numbers.
- Contextual reasons: context changes, operational opportunities, major unexpected humanitarian crises, etc. can and will affect the course of operations regardless of the targets. The targets as they are now set do not allow for the flexibility necessary. However, indicators around the ability to intervene, especially in emergencies, could be set for this.

THE PROSPECTS' FORMAT AND CONTENT

The indicators

The issues relating to indicators discussed above will be further unpacked here as relating to the overall usefulness of the Prospects tool itself.

As discussed, if numbers of patients using an MSF service are useful quantitative output indicators for monitoring the activity or performance (efficiency etc.) of the OCB, they appear to be insufficient for strategy and vision description.

Indeed, regarding the reactive nature of MSF to its environment, activity indicators can only inform on the use of MSF structures by patients, and do not indicate whether the service provided is relevant to the patients. Neither do they inform whether MSF positioning towards the needs and other actors and medical services is relevant or not. High numbers in OPD and IPD only indicate that patients use MSF services, but these numbers could be easily achieved in stable contexts, where medical services are present but where MSF is perceived as a better or cheaper provider (free vs cost recovery). Therefore, such indicators do not reflect the ambitions and specificity of MSF to provide medical humanitarian services where they are needed and not available. Such indicators, even if useful to plan resources, can therefore limit operational thinking and result in non-ambitious target achievements or stifle innovation in strategies, positioning or methods. Therefore, **indicators on the ability to operate/ to provide medical services should be set for default and emergency interventions**.

However, in the logic of choice projects, they can be useful to plan and anticipate if supplemented with change-driven thinking and qualitative indicators.

Other indicators being used in relation to the choice logic (pilot projects, capitalisation papers being developed, etc.) are useful for planning but could be expressed in a much more explicit manner, for example in a dedicated section. The explicit expression of changes pursued, represented by indicators, can help operational team members establish personal investment in the project, and consequently in ensuring implementation. Clearly associating indicators with the positive changes that they aim to achieve helps to ensure implementation.

Indicators and ambitions reflecting the building or reinforcement of ability to operate can be seen as very useful, however they are poorly expressed in terms of measurability.

As discussed further down, following the Choice/default operational ambitions, specific indicators for each category could be developed to better reflect the underlying ambitions of the two categories.

To better set the targets in a clear and concise manner, to better follow their attainment and progress made, for better visibility and readability of the operational ambitions, **a dashboard of indicators and ambitions could be present in the Prospects document**. Such a dashboard could increase the utilisation of the prospects tool, specifically to give more substance to operational strategic thinking.

It is noticeable that the downward operational documents, ambitions and objectives are often expressed in terms of activities rather than achievements of changes or services available to the population, which is coherent with the definition of ambitions in the prospects as it is today. Therefore, a shift in the use of the indicators and targets could bring a positive change down the line in how operations are envisaged, planned and managed.

Choice and default

The Default/choice categorisation is very relevant to a structure like MSF. However, in its current form it does not appear to be used to its full potential[1]. Indeed, it would seem necessary that there should be **different ways to design the project/logframe for choice and default projects** in order to achieve a better translation of the Prospects' ambitions into the operational reality. In the same way, as discussed above, the Prospects' ambitions should clearly segregate the two approaches with different but coherent ambitions and indicators/targets for improved clarity and coherence in the operational design.

Choice projects are likely to be more effective if backed by a solid theory of change: as change is their raison d'être. The objectives should therefore be based on the proposed/anticipated changes rather than be the definition of the service available to the population. It should be clearly understood that these changes are the main goal of such projects. Whether being influence on policies and protocols, test and innovation, training of staff or demonstration of the feasibility of a specific approach, it is these objectives that should be the subject of the key indicators to monitor outcomes and success.

Quantity of patient indicators should be kept for planning/management and monitoring of activities unless they have a specific impact on the outcome of the changes (i.e. critical mass of patients to attain etc.).

Concomitantly, as expressed above, **objectives and ambitions set for the choice projects should be expressed through relevant qualitative indicators in the prospects document in a specific section different from the default projects.**

Default project ambitions cannot be de-correlated from the context development, and the achievement of targets cannot depend on the context evolutions. **Objectives of such projects should therefore be expressed in terms of medical services available** (or responding to community needs) for defined targeted beneficiaries rather than expressed in volume of patients. Ambitions should therefore be expressed in terms of ability to respond to categorical needs and targets/indicators be oriented in that direction (see recommendations for suggested formulations).

Integration of the prospects into the downward operational strategy and design

One of the main limitations in reviewing the prospects (the difficulty of tracking Prospects implementation) is indicative of a poor interconnection between the different operational documents in terms of the expression of Prospects' ambitions. Indeed, without a request for a formal reflection on Prospects' ambitions, it is pretty much left to the CPP and projects authors to integrate the prospects ambitions and objectives in their operational analysis and strategy. References to Prospects are quite rare and vague and are often of the type: "in line with the prospects" expressed in three lines just to conform to the request a posteriori.

Asking the operational document authors to formally take position on the Prospects content into their operational thinking would force the positioning on the subjects and permit a much better tracking/reporting on the achievements. Indeed for example **CPPs could include a section named "specific actions/strategy considered to reinforce the MSF-community links" or "specific action to reinforce the PHC/Hospital continuity" etc.**

[1] It is understood that the new prospects is likely to introduce a dichotomy of "emergency/ catalyst"

FINAL CONCLUSIONS

In line with the aim of the review, the analysis shows that, in terms of performance, the OCB has done well in attaining the ambitions and deviations from the targets can be explained. Main priority headlines have led to useful changes in the operational approaches and the focus set, still relevant for the next period, should be maintained. However, if ambitions are mostly achieved, the revision process and the review are the occasion to go further in working on the relevancy and form of the tool as such. With slight adaptation in the definition of targets and indicators, and with adaptation in the approach to design targets, the Prospects document can be a more effective tool in shaping operations and in setting ambitions. A clearer definition of choice and default and the definition of different targets and indicators for the two categories will enhance the clarity of the ambitions.

In terms of articulation between the Prospects and the operational documents, more can be done to solicit the operational teams to take the Prospects' ambitions into consideration when designing operations. The use of objectives and indicators, adapted to the ambitions (capacity to provide medical services / catalyst of change) should be therefore reflected in the project documentation as well as in its reporting.

The use of medical data (eg: number of patients for specific acts and/or number of patients of certain categories of patients) should be kept outside the operational thinking when setting ambitions, but should be kept for planning, management and communication purposes. Those indicators only measure the activity of MSF and are useful to describe MSF output, but fail to inform on outcome and/or impact. They should be used for what they are - indicators to manage activity but not indicators to design operations in terms of ambitions. Of course, their use has a certain facility and they are in line with the medical culture of MSF, but it is important that they do not lead humanitarian operational thinking. Therefore, an exercise of indicator and target redefinition should occur to define what MSF wants to do and where. For its choice projects, the key question is: *what are the intended changes or use of such projects;* and for the default and emergency intervention and settings: *what capacity MSF wants to have to provide critical medical services to the populations*.

RECOMMENDATIONS

⇒ **Recommendation 1: Segregate *default* from *choice* logic and refrain from using medical data as targets**

Medical data (eg numbers of patients on specific issues) are quantitative output indicators useful to monitor the activity or performance (efficiency etc.) however they are insufficient for strategy and vision description.

Indeed, activity indicators can only inform about the use of MSF structures by patients. They do not inform if the service provided is relevant to the patients or if the right service is delivered at the right place. These indicators are very useful to plan resources and for reporting/communication so they should be kept for those purposes. If used as targets they can trap the operational thinking into non-ambitious target achievements or stifle innovation in strategies, positioning or methods.

While using different indicators to set targets, there is a need to better segregate targets of the Choice and Default logics. A clearer definition of the two notions is needed (one logic being based on the humanitarian imperative when witnessing crises and the other one having to do with the notion of catalyst of structural change). Different and alternative indicators/ambitions should be set for both Default and Choice interventions (see recommendations 2 & 3)

⇒ **Recommendation 2: For emergency/*default* projects: set indicators/ambitions reflecting the ability to operate**

The underlying logic of the default/emergency project is based on the necessity (and ability) of MSF to operate in given contexts of crises. Objectives sets for default/emergency intervention should therefore be expressed in terms of medical services made available (or medical responses given to community needs) for specific categories of beneficiaries (primary or secondary victims of conflicts, displaced, refugees, migrants, people affected by natural disasters etc.). Ambitions and targets in the Prospects should therefore be expressed in terms of ability to respond to categorical needs and indicators used be coherent with that. MSF ambition is not to treat a certain number of patients but rather to make sure a certain number of people in need can benefit from MSF's medical services. Therefore, indicators describing the ability to operate could be as follow (examples):

- Number of OPD consultant in conflict zones
- Number of IPD beds available
- Number of operating rooms
- Population in the catchment area of the MSF structures (population served by MSF)
- Number and timeframe of deployment of medical units to treat crush syndrome
- Number of emergency watsan logistician to be deployed in emergency interventions
- Etc.

⇒ **Recommendation 3: Set indicators of change for c*atalyst* projects**

Change or catalyst project are operations for which the primary decision to run the project is not to treat the patients but to use the treatment of the patients for another objective of structural change. This change can be the promise of a new treatment through a pilot or research project, the demonstration of the efficiency of a given protocol, to train staff, to collect data for advocacy on national protocol change etc. Therefore, objectives, ambitions and targets should not be the number of patients to treat but the changes MSF want to achieve. Ambitions should be of that type (examples)

- Changing the XX protocol in xxx countries
- Running XXX number of research projects
- Publishing XXX papers on this disease
- Testing xxxx treatments
- Etc.

⇒ **Recommendation 4: Changing the "To develop a new balance between PHC and referral care" headline priority into "ensuring and enhancing a comprehensive continuum of care between PHC and referral care"**

Focusing on primary or secondary health care as a target can be a bit abstract if this is an organisational choice without consideration to the context of operations. While looking at the services provided by others (MoH, other NGOs, other OCs) and looking at the medical needs of the population, OCB should position itself in insuring that a comprehensive continuum

of care is provided, from the community health needs to the secondary needs. In some cases, the OPD outreach capacity needs reinforcement, in others there is a lack in OPD services. In some contexts, the link between the community and the medical services is too weak, in some cases the capacity of the medical services is the gap and in some other it is its quality. In many cases the main gap is in organising the continuum of care from the community to the full services hospitals.

OCB should therefore position itself in organising, enhancing, reinforcing a comprehensive continuum between the different components of the response. This can therefore be through adaptation of the methodology and approach in OPD, reinforcing IPD capacity, providing innovative referral systems, or organizing the full continuum itself. This concept gives more flexibility and is better need centered while permitting a comprehensive approach to health needs.

⇒ **Recommendation 5: Sustaining the effort on emphasising a more comprehensive approach to the health-related needs of communities**

A huge work has been achieved on the subject during the last period and OCB better integrates community issues and health needs into its operations. However, the subject can be a bit unorthodox to the usual MSF *modus operandi*, and OCB can easily lose focus if efforts are not sustained. Therefore, in order to maintain the effort and capitalize on the gains, the FTE HQ referent should be kept while evaluations on usefulness and impact of the approach should be developed to showcase and argue for its sustained integration into the operational design, within OCB or wider in the MSF movement.

ANNEXES

ANNEX I: TERMS OF REFERENCE

The final Terms of Reference can be viewed here.

ANNEX II: EVALUATION MATRIX

Axis/topic	indicator	where/what project	doc	method
rebalance PHC with hospital care (progress/improve on PHC approaches)	evolution ratio IPD/OPD	global	Master data	ratio
		Choice projects	Master data	ratio
	Presence of ambulatory care approach	Medical dept/Ops	Itw	ask for state of the art
	Presence of Innovation in community approaches and linkage OPD/IPD and or referral	Medical dept/Ops	Itw	ask for state of the art
	Presence of Community component in projects	Medical dept/Ops	Itw	ask for state of the art
	Presence of ambulatory care approach	IPD	project doc	comparison before after
	Presence of Innovation in community approaches and linkage OPD/IPD and or referral	OPD/IPD	project doc	comparison before after
	Presence of Community component in projects	all projects	project doc	comparison before after
	Increased patient autonomy approach	Medical dept/Ops	Itw	ask for it
	all indicator above	all countries	CPP	strategic approach expressed
OPD	main killer focus	emergency	project doc	presence
	effective referral care	emergency	project doc	presence
	capitalisation/use of Kibera slum project	Medical dept/Ops	Itw	ask for state of the art
	capitalisation on North West Guinea project	Medical dept/Ops	Itw	ask for state of the art
	analysis link PHC-hospital	IPD	CPP	presence of analysis
Main 2 : comprehensive approach to community health needs	Watsan needs considered	Non vertical thematic project	project doc	analysis of needs expressed/considered
	Watsan needs considered	all countries	CPP	watsan opportunity considered
	Active case finding	IPD/OPD/malaria/HIV/maternity/IDP/refugee/nutrition	project doc	expressed/developped
	community relays/Health workers	IPD/OPD/malaria/HIV/maternity/IDP/refugee/nutrition	project doc	expressed/developped

	Home care	IPD/maternity/ nutrition	project doc	expressed/developped
	community involvement strategy	all countries	CPP	expressed/developped
	Community based chronic care	IPD	project doc	expressed/developped
	Community based strategies	IPD	project doc	expressed/developped
	PHC activities/Health promotion	IPD	project doc	expressed/developped
	Research and capitalization paper/eval etc.	Medical dept/Ops	itw	ask for it
	Comprehensive paper of 2014/use and dissemination	Medical dept/Ops	itw	ask for it
surgery	evolution nb of acts	IPD/surg	Master data	figures
	trainings	medical dept	itw	ask for it
	capitalization	medical dept	itw	ask for it
	Innovation	medical dept	itw	ask for it
	Research	medical dept	itw	ask for it
	Pilots	medical dept	itw	ask for it
	Consolidation guidelines, technical support, medical material, etc.	medical dept	Itw	ask for state of the art
	Kits, protocols, intervention objectives updates	E cell	Itw	ask for state of the art
	One more longer term project	conflict/emergency	project doc	presence
New areas TB and HIV	evolution nb of projects	HIV/TB	Master data	figures
	overview	medical dept	itw	ask for state of the art
	Research	medical dept	itw	ask for it
	capitalization	medical dept	itw	ask for it
HIV/TB	research feasibility demonstration	medical dept	itw	ask for state of the art
	focus on special risk groups	HIV/TB	project doc	presence
	link between HIV and migration	HIV/TB	project doc	presence of analysis
	Overview	medical dept	Itw	ask for state of the art
TB	One extra cohort on XDR TB	all countries	master data	presence
	Integrate management of DR TB in other activities	all countries	CPP	presence
	Engage with ill-designed health system	medical dept	Itw	ask for state of the art
	Two new projects integrating TB care	all countries	master data	presence
E-resp in conflicts	overview	E cell	itw	ask for state of the art
	evolution nb of projects	E cell	Master data	figures
Key transversal determinants	priorities expressed as services	all countries	CPP	overview analysis
	outcome target (see specific targets and key rationales	all countries	Master data	analysis

	acceptation anaysis	all countries	CPP	presence of analysis
	resources 50% for default 20% emergency	all countries	Master data	analysis
	coordo costs less than 20	all countries	Master data	analysis
	30% first missions	all countries	Master data	analysis
IPD	Two new projects	all countries	master data	presence
	Number of IPD projects	emergency	master data	presence
Vaccination	Opportunity analysis	all countries	CPP	presence of analysis
	Pilot population-based strategies	Medical dept/Ops	Itw	ask for state of the art
	Risk assessment	all countries	CPP	presence of analysis
	Use of PCV and cholera vaccines	Medical dept/Ops	Itw	ask for state of the art
SRH	Ratio post natal consultations/deliveries	all countries	master data	analysis
	Planning neonatal care	maternity	project doc	presence
	One more vertical project	sexual violence	master data	presence
Hep C	Clinical experience/Routine testing Hep B	medical dept	Itw	ask for state of the art
Emergency	SRH and MH services	emergency	project doc	presence
	10 priorities	emergency	project doc	presence
	Public Health/Population based	emergency	project doc	presence
	Health promotion	emergency	project doc	presence
	Community needs	emergency	project doc	presence
	Home visitors HP	emergency	project doc	presence
Nut	Innovative choice projects/targeted populations	nutrition	project doc	presence
	Capitalisation evaluation CMAM	medical dept/nutrition	Itw	ask for state of the art
cholera	Building evidence based	medical dept	Itw	ask for state of the art
malaria	Efficacy monitoring of drugs	medical dept	Itw	ask for state of the art
AB resistance	rational AB use/resistance	medical dept	Itw	ask for state of the art
MH	Primary focus on MH	conflict	project doc	presence
NCD	Results project	medical dept	Itw	ask for state of the art
	Strategic paper available in 2014	OOPS		presence
WatSan	WatSan analysis	emergency	project doc	presence of analysis
	Successful handovers	E cell	Itw	ask for state of the art
	Few small short term WatSan projects	all countries	master data	presence

ANNEX III: WORKSHOP PPT PRESENTATION

PHILANTHROPY ADVISORS

Presentation: **Review of the 2014-2017 OCB prospects**

MEDECINS SANS FRONTIERES

Vincent MUDRY

METHODOLOGY OBJECTIVES

Testing the assumption that the prospects is still largely relevant and having a critical look at the relative success in reaching the ambitions.

Part 1: Assessing the usefulness of the Prospects as a tool for guiding OCB operations (appropriateness of indicators used, format, etc.)

- Part 2: Analysis of aggregated OCB operations over the period to inform on relative success in achieving the Prospects ambitions.

Desk review of

- **CPP**
- **Project documents**
- **Logframes**
- **AROs**
- **Medical data**
- **Ops database (project, missions, expenses, etc.)**
- **Etc.**

Targeted interviews
Workshop/discussion today

LIMITS

Accessibility of up to date documents

Reporting on emergency interventions

Medical data 2016 not yet available

Short time frame

Articulation between prospects and other ops documents

Global targets set for aggregated choice and defaults project

2.

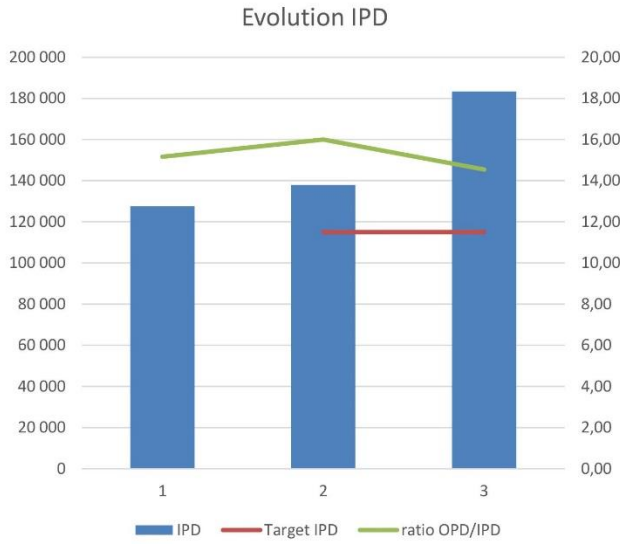
Performances : headline priorities

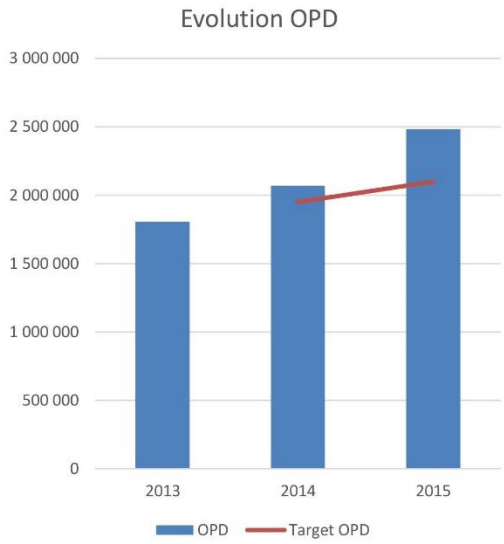
Main headline priority 1

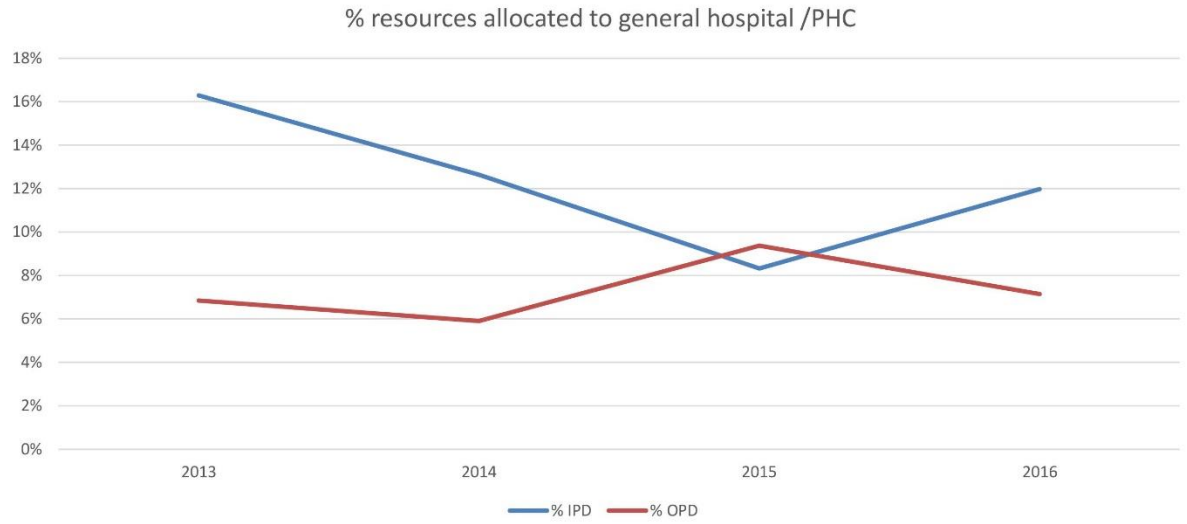
Develop a new balance between PHC and referral care

Indicators for success:

- **Development of ambulatory care approach**
- **Enhancement of referral systems**
- **Decentralization strategies**
- **Community approaches in PHC**
- **Increasing patient autonomy**
- **Focus on main killers in emergencies**
- **Ratio IPD/OPD data**
- **Ratio IPD/OPD project expenses**







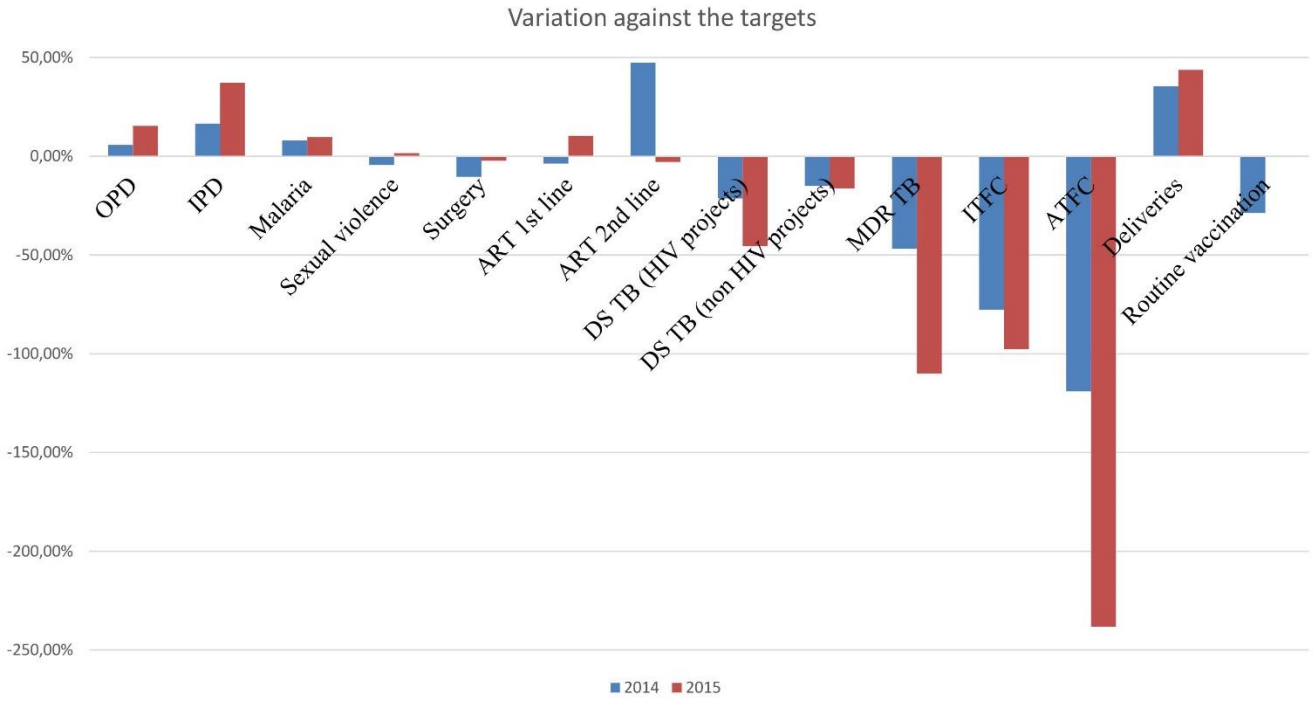
Main headline priority 2

emphasis on a more comprehensive approach to the health related needs of communities

Indicators for success:

- **Watsan needs are considered**
- **Active case finding startegies**
- **Community relays/health workers**
- **Home care approach**
- **Community involvement**
- **Community based chronic care**
- **Health promotion**
- **Community involvement strategies**
- **Cultural mediators**


2 Bis
Performances : Typology


Variation against the targets
50,00%
0,00%
-50,00%
-100,00%
-150,00%
-200,00%
-250,00%
OPD
IPD
Malaria
Sexual violence
Surgery
ART 1st line
ART 2nd line
DS TB (HIV projects)
DS TB (non HIV projects)
MDR TB
ITFC
ATFC
Deliveries
Routine vaccination
2014
2015

Questions it raises Findings

- Some targets are activity dependant (OPD/IPD/Delivery)
- Some targets are choice dependant (TB, VIH, hepC)
- Some targets are context dependant (ITFC, ATFC)
- Some non fully medical acticvities do not have targets (watsan)

Should all targets be numbers?

Are numbers reflecting changes? (choice projects)

Is the level of activity (eg : numbered targets) really reflecting the operational ambitions of MSF or its activities?

Should the targets for Choice and default be mixed?

Should the targets be context dependant?

3.

Findings and remarks

CHOICE and DEFAULT

- The question of indicators used for choice and default raises the question about what are the real objectives behind a choice or a default project?

- **Choice project: catalyzing a change (internal or external). What indicators for that?**

- **Default project: making an essential health service be available to a specific vulnerable population after a chock. What indicators for that?**

→ let's leave that to the next point in the agenda.

The prospects as a tool Indicators and targets

Output and activity indicators vs outcome or ambition indicators.

- **Planning and management tools vs operational ambitions**
- **Positioning and the targeting of specific population**
- **What about non medical activities?**
- **Indicators on capacity-building of the ability to provide services.**
- **Expressing the objectives in terms of services vs activity planning**

- **Setting ambitions through targets with indicators**
- **Readability of the ambitions (executive summary/dashboard of ambitions)**
- **Check lists of must-do analysis/ positioning (CPP, Project document etc.)**
- **Articulating the reporting with the ambitions**

M E R C I

Q&A and discussion

Stockholm Evaluation Unit

Médecins Sans Frontières

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