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DOCTORS WITHOUT BORDERS

ENRICHED OR CONFINED?
MSF-ENGAGEMENT IN LOCAL PARTNERSHIPS

EVALUATION REPORT
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The Vienna Evaluation Unit

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

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

EXECUTIVE SUMMARY

This evaluation has been commissioned to gain perspective on and learn from the current partnership practices, to inform the debate on MSF's policy on partnerships and to provide guidance for future engagement. The two evaluators conducted four separate field evaluations and a desk review of seven additional partnerships.

The following definition of partnerships has been used for the evaluation:

> ***MSF partnerships are mutually beneficial, planned and formalized alliances made with diverse organizations who espouse the same humanitarian values to achieve commonly defined objectives.***

Four main purposes can be identified for partnerships between MSF and local actors: gaining access, finding an exit strategy, advocacy and complementing activities. Each case study offers particular lessons to learn:

> In Kenya MSF partnered with the (national) DNTD in order to advocate for patient care. MSF adjusted its earlier plans, created a new position and postponed its withdrawal from the KA treatment centre for a year. The relationship between MSF and all partners is based on open communication, inclusion and trust. Having aligned with national protocols already while advocating for better, more affordable options for patients, and through considering the strategy early on, the mission gains a significant advantage in meeting its final objectives of a successful handover.
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> In Niger, MSF engages with partners as a way to reduce activities and free up resources and allow MSF to focus activities on emergency response. The fact that MSF engaged in a tripartite partnership which includes an international organization that assists and builds capacities of the local NGO points to an interesting model that could be explored for other contexts.
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> Having been involved in women's health in DRC, MSF engaged with a socio-judicial organization with a plan to hand over activities. The idea to complement the legal services with medical services seemed logical, but to transform a non-medical organization into a medical organization brought frustrations, constraints and risks.
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> At the border of North Korea, MSF has a long history of partnering with organizations that are in proximity of North Korean migrants. Completely illegal, MSF chose to have a presence by using intermediary NGOs, meanwhile negotiating with the Chinese and North Korean governments to get clearance. The model is unusual and the impact is very low, but the aim of keeping a presence in North Korea and gaining an understanding of that context is being met. The biggest challenge for MSF here is finding its role while being in a position of relatively little power.

In general, effectiveness of partnerships is difficult to establish, because expected outcomes are rarely agreed upon at the onset of and during the partnership. There are currently no tools or methods systematically in use to help the parties to establish meaningful objectives for partnerships.

Overall there is little risk analysis done on potential consequences of partnerships for MSF's image, security of staff, access/acceptance for patients, and so on.

Evaluators observed an inconsistency in the level of engagement, mostly due to the changing views, commitments and investment made by the different persons in charge at any given moment.

In most of the observed case studies MSF is in a stronger position (by providing resources and know how) and therefore has the power to impose decisions, give directions and place demands on the partners.

There are good practice examples in terms of formalizing and practically implementing partnerships. However, those have not been translated into a coherent approach and/or standardized tools for all missions.

The implementation of the partnership strategy requires several practical steps to be taken. These include carrying out a mapping of actors, conducting Risk Assessment of the potential partners including assessing their technical skills, and their legal status, followed by developing a relationship, formalizing the agreement and planning for the end of the partnership.

Evaluators conclude that a de facto decision for partnerships as one modus operandi has long been made. A full assumption of this reality and the definition of a policy and corresponding tools are still to happen.

➔ **The following recommendations are made:**

MSF-OCG, as an organization, should

1. Establish a formal policy regarding partnerships to ensure clarity in the organization
2. Develop the supporting tools
3. Develop a strategy on how to build the capacity of local partners (e.g. by creating a capacity for capacity building or through other organizations)
4. Make a strong, consistent and coherent commitment to the partnership at all levels of management

For every partnership, the MSF team must

5. Carry out a mapping of actors (including local actors), local agencies working in the project area to decide on potential and alternative partners
6. Engage in participatory dialogue with the partner and formalize the agreement
7. Assess the capacity of the partner to engage in the partnership and ensure that the roles and responsibilities are clearly stated and understood before making a commitment
8. Conduct a Risk Assessment (acknowledging, understanding and evaluating the organizational risks) of the involvement in a partnership at a strategic level
9. Establish and implement mechanisms and controls to hold all parties accountable and measure the success of the partnership
10. Assign one person that will be coordinating the entire process of partnership, and ideally supervising the whole period of the partnership (on the side of MSF and on the side of the partner)

LIST OF ACRONYMS

ALIMA	Alliance for International Medical Action
ATFC	Ambulatory Therapeutic Feeding Centre
BEFEN	Bien Être de la Femme et de l´Enfant au Niger
CMT	Country Management Team
DNDi	Drugs for Neglected Diseases Initiative
DNTD	Department for Neglected Tropical Diseases
DRC	Democratic Republic of the Congo
EACF	East Asia's Children Funds (Japanese NGO)
ECHO	European Community Humanitarian Office
GIZ	Gesellschaft für internationale Zusammenarbeit
HoM	Head of Mission
HR	Human Resources
INGO	International Non-Governmental Organization
KA	Kala Azar
KEMRI	Kenya Medical Research Institute
LFNKR	Life Funds for NK Refugees (Japanese Human Rights Organization)
LNGO	Local Non-Governmental Organization
MoH	Ministry of Health
MOHSW	Ministry of Health and Social Welfare
MoU	Memorandum of Understanding
MSF	Médicines Sans Frontières
NGO	Non-Governmental Organization
OCB	Operational Centre Brussels
OCG	Operational Centre Geneva
ONG	Organisation Non Gouvernementale
ROI	Return on Investment
SMART	Self-Monitoring, Analysis and Reporting Technology
SOFEPADI	Solidaritée Féminine pour la Paix et le Développement Intégral (Congolese NGO)
SONGE	Soutien aux ONG de l'Est
SV	Sexual Violation
TAC	Treatment Action Campaign
USAID	United States Agency for International Development
WHO	World Health Organization

INTRODUCTION

Because of its commitment to independence, MSF has chosen, for most of its programs, a direct implementation approach which excludes the involvement of local partners. However, there are factors that force the organisation to consider alternatives and, in some cases, engage in partnerships with local organizations including the MoH, other local authorities, and local non-government organizations.

In an effort to gain perspective on and learn from the current partnership practices, to inform the debate on MSF's policy on partnerships and to provide guidance for future engagement, MSF-OCG has requested that the Vienna Evaluation Unit look at various current and potential examples of partnerships with local organizations.

The evaluators conducted four separate field evaluations of partnerships in Niger, DRC, Kenya and North Korea. For each of them a detailed report is available. In addition seven desk reviews were conducted, including case studies from other sections (see table).

	Project / Country	Type of partnership
Field evaluations		
1	Kenya / Kala Azar (OCG)	Advocacy
2	North Korea (OCG)	Access
3	Niger (OCG)	Exit / Complimentary Activities
4	DRC / Bunia (OCG)	Exit
Desk reviews		
5	North Sudan (OCG)	Access
6	Somalia (OCG)	Access
7	Haiti (OCG)	Complementary Activities
8	Honduras (OCG)	Access
9	Kenya / Kibera (OCB)	Exit
10	Mer League / Liberia (OCB)	Exit
11	South Africa (OCB)	Advocacy / Complimentary Activities

The field visits consisted of interviews with stakeholders including MSF-staff, the partner organizations and other organizations involved in the process at field level. Project documents were reviewed and interviews, when possible, were conducted with Programme Managers and the equivalent positions of partner organizations.

The main findings and best practice examples of the evaluations can be divided into two distinct areas: First, the internal MSF-strategy, philosophy and long-term vision for engaging in partnerships, including concerns that were raised regarding the use of partnerships as a programme strategy, which will be addressed in this first part. Second is the implementation of that strategy and all of the activities that are required for the accomplishment of objectives.

Historically, there have been different trends in the way MSF viewed partnerships. In the 1980's and 1990's, several examples can be found where MSF developed and engaged in partnerships. This included MSF actively initiating the creation of and supporting of NGOs to take over projects or specific activities within a project. SONGE is an example

of MSF creating an organization in response to anticipated needs in the former Soviet Union after the end of the cold war. As Civil Society sprang up during this time, there was no longer a need for "traditional" intervention on the part of MSF, but there was still a need and MSF decided to support these groups. SONGE's purpose was to assist these newly developed organizations with funding, build professional and management competence and develop fundraising strategies.

The end of the 90's saw a change in the way MSF ran some projects when the organization began to treat HIV patients. MSF concentrated on treatment and advocacy of HIV because its mandate was still to handle emergencies. On the other hand, there was a gap in HIV related services, such as preventative and outreach activities, which MSF decided not to provide. This led to the implementation of a clear policy on collaboration and partnership with other agencies and Civil Society in order to offer comprehensive care to HIV patients. These included partnerships to provide preventative outreach activities, such as condom distribution, but also partnering with political organizations to provoke changes in local policies where MSF did not have access to the government. Simultaneously, there was concern within the organization about the perception of MSF's independence if it engaged in partnerships. Because of this concern, even now, emergencies remain one of the contexts where partnerships are the least developed.

Defining partnerships

Agreeing on a definition for partnerships brings clarity of purpose, draws a roadmap of expectations and provides a sense of direction for everyone involved with the partnership.

This definition also makes a distinction between simple cooperation, collaboration or recipient / donor relationships and partnership.

[1] To save lives and alleviate suffering

Breaking down the definition:

Mutually beneficial refers to the willingness to work collaboratively with the partner to engage in a win-win partnership. It recognizes that all parties have something to contribute that is required and should therefore benefit from the partnership.

Planning the partnership is essential because it will minimize (or at least provide understanding of) the risks and allow to make informed decisions regarding the partner and the partnership.

To ensure clarity of accountabilities, roles & responsibilities and to allow for measurement of success, the **formalization** of the agreement is essential.

We include **diverse organizations** because it is important to keep an open mind that sometimes partnerships can be entered into with "less typical" organizations, such as tripartite agreements (which will be discussed further), NGO's with a focus on advocacy or research organizations.

While restricting partnerships to organizations who **espouse the same humanitarian values** was debated, the inclusion of this statement is important as it reflects the raison d'être of MSF and the foundation of MSF-intervention, which cannot be ignored while engaging in a partnership.

The motivation of each partner organization can be different, for example, it can be understood that a young local NGO may have the motivation of growing and developing ensuring job security for its members, while the motivation of MSF is to disengage from a particular area and assure continuity of care after their departure as is the case in most handover situations. This scenario is acceptable as long as the **objectives of the partnership are commonly defined** and understood by all parties.

The definition above is a starting point to working in partnerships that will help MSF to have a holistic view on how to engage with other organizations to achieve operational objectives.

FINDINGS

Generally, planning and developing strategic plans and policies pertaining to partnerships will ensure clarity within MSF and help keep activities focused on established mandates. Specifically, this can be broken down into several areas, which are elaborated below.

Different types of partnerships

For the purpose of this evaluation we distinguish "types of partnerships" depending on their original purpose. We found four main reasons / interests for MSF to engage in partnerships (see figure).

Partnerships as an exit strategy

As we learned from the many handover evaluations and the resulting document entitled *Making an Exit: Advice on successful handover of MSF-projects* written by MSF-UK Programmes Unit (2011), there are many best practice examples of partnerships as part of an exit strategy. It is clear that local partnerships, as part of the project's exit strategy, are a sustainable and efficient method to ensuring continuity of services in a post MSF-setting (see bibliography for evaluation reports for the Hôpital Bon Marche disengagement in Bunia, DRC, the Lesotho evaluation, and others). In stable contexts and post conflict situations, engaging in partnerships (including the MoH) and making a longer term commitment to the exit process has become the norm in the last years. However, there are some risks and sometimes substantial investment involved and choosing the "right" partner will ensure greater successes for the future.

The example of SOFEPADI in Bunia, DRC is quite interesting. Having been involved in women's health since 2003, MSF-OCG decided to proceed with a disengagement of activities. During the transfer of most activities to the nearby government hospital, MSF engaged with a socio-judicial organization named SOFEPADI. This partnership allowed MSF to provide comprehensive care to women and victims of violence and as part of the exit strategy, MSF decided to hand over medical activities to the non-medical association SOFEPADI. The idea to complement the services provided by SOFEPADI with medical services seemed logical, but to transform a non-medical organization into a medical organization brought frustrations, constraints and risks.

In Niger, MSF-OCG decided to engage in a partnership with ALIMA/BEFEN as a way to reduce and eventually hand over activities, free up resources and allow MSF to focus activities on emergency response. This alliance is an atypical and particularly innovative model of partnership for exit/handover because it includes a third party international organization (ALIMA) who assists the local NGO (BEFEN) in the management and supervision of activities. In the two years since the beginning of the partnership, the roles and responsibilities have changed and evolved from MSF at the beginning being an implementation partner to currently providing ALIMA with legitimacy to channel funds from ECHO.

Partnerships for the purpose of advocacy

The second type of partnership is for the purpose of advocacy. An example is the MSF-OCG partnership with the Department of Neglected Tropical Diseases in Kenya. This MoH department was created recently with the initial objective to develop a National Strategic Plan for neglected diseases. They approached MSF to become a partner as subject matter experts in KA, which MSF agreed to.

The coalition for the design of the plan also included the DNDi, the KEMRI and the WHO. MSF took this opportunity to advocate for patients and to push for better diagnosis and treatment options which was accomplished in collaboration with DNDi and KEMRI. Following the launch of the plan, MSF will be in a position to continue its support of the DNTD to ensure a continued voice within the MoH for patients suffering from this neglected disease.

In Honduras, the experience developed in the early 2000's to assist street children has shaped the current design of the new OCG project there. Atypical partnerships were due to be defined since the approach had to be multidisciplinary and anchored in an urban context with highly specific medical issues such as drug addiction. Partnerships are developed with health authorities, universities and faith based organizations in order to de-stigmatize victims of street violence and promote a change in the medical management of the victims.

Another example of this type of partnership is the MSF-OCB / TAC partnership in South Africa. In the early 2000's in South Africa MSF's objective was to change the perception, treatment and diagnosis of HIV/AIDS. However, it was very difficult for MSF to provoke these changes as the government was closed to the idea and threatened to eject MSF from the country. MSF partnered with TAC, a local organization dedicated to fight for the implementation of HIV/AIDS treatment programs in public structures, to partner on some practical outreach projects. MSF also supported TAC in their advocacy campaigns by

providing medical legitimacy through reporting on treatment and results. TAC provided a local, legitimate, political voice to pressure the government into making some concrete changes with regards to HIV/AIDS. The alliance managed to provide access to first and second line, generic treatments to South Africans in public structures and continues to conduct operational research to improve treatment and diagnostic.

Partnerships to gain access

In contexts such as Iraq or North Korea, where MSF does not have direct access to the target populations (most of the time due to insecurity), there are examples of partnerships developed to gain access to these beneficiaries through organizations that are less at risk or seen by the concerned government as less threatening.

In China for example, at the border of North Korea, since MSF cannot be either registered or directly involved, MSF has a long history of partnering with organizations that are in proximity with North Korean migrants. Completely illegal, MSF chose to have a presence at the border between North Korea and China by using intermediary NGOs, meanwhile negotiating with the Chinese and North Korean governments to get clearance. The model is unusual and the impact is very low, but the aim of keeping a presence in North Korea and gaining an understanding of that context is being met.

In North Sudan the national policy obliges INGOs to pair with LNGOs. Though there is little space for negotiation, MSF-OCG was able to find an understanding with the LNGO which took on community mobilisation and health promotion and left medical activities to MSF.

Partnerships to complement activities

This type of partnership is seen mostly in HIV programmes where MSF believes in providing care to patients, but does not have the capacity to provide the entire spectrum, including preventative care. In these cases, partnerships were developed to complement and support the activities provided by MSF. In another context, this type of partnership can allow MSF to concentrate on different aspects of programmes as exemplified partly by the ALIMA / BEFEN partnership in Niger. By partnering with ALIMA/BEFEN, who carry out a portion of the activities of a comprehensive program (ATFC in 14 health centres), MSF is able to free some capacity for emergency response.

The ongoing debate regarding whether or not MSF should provide preventative care (for example condom distribution in HIV prevalent areas) may well be answered by this type of partnership. Engaging in partnerships for this reason can free up resources that can be used for emergency or curative activities and result in a positive impact on beneficiaries on various levels.

➔ Recommendation on types of partnerships

As MSF-OCG turns towards partnerships in a deliberate way to support its programmes, the organization must define the need and understand the reason for the partnership. This will guide the organization in the choice of partner that will be best suited to achieve the desired outcomes.

Consistent level of engagement

The level of engagement (time, human, financial commitment) of MSF often determines how successful objectives of the partnership will be attained. In relation to that, the determining factors for the necessary investment are the desired outcome of the partnership combined with the capacity of the partner organization.

In some case studies we observe an inconsistency in the level of engagement, mostly due to the changing views, commitments and investment made by the different persons in charge at any given moment.

In Niger, where MSF wants to reduce its activities in Magaria region, the only potential partner is a very young local NGO (Hadinkai) who lacks fundamental project management experience. The level of engagement required for a successful partnership, in this case, will necessarily be greater than it would be if MSF partnered with a fully operational organization.

In Kenya, when MSF agreed to partner with the DNTD with the objective to advocate for patient care, they made a substantial effort in developing the required relationships with the members of the group. This included the creation of a new position, the KA Focal Point, which was tasked with developing and maintaining the relationship with the department while advocating for different diagnostic and treatment options for patients. Included in the commitment was the postponement for one year of the withdrawal from the Kacheliba KA treatment centre which provided a clinical space for MSF to continue treatment and where studies could be conducted. This change in priorities illustrates how the objectives of the partnership will sometimes dictate how the programme is managed and require MSF to adapt. It is important to understand, however, that the partnership itself is not as malleable and once a commitment has been made, MSF should strive to respect that engagement.

In North Korea, where MSF has been trying for years to gain access to the North Korean population remotely from China, it was demonstrated that a persistent organizational commitment to engage in partnerships over many years yields success.

➔ **Recommendation on Level of Engagement**

A strong, consistent and coherent commitment to the partnership must be made at all levels of management. Once the decision is taken institutionally, it must be accepted and followed and changes in the decision must be commonly justified, agreed and recorded.

Objectives of the partnership

It is important not to confuse the motivation of partner organizations and the objectives of the actual partnership. The motivation refers to the internal position of the organization regarding what it wants to strategically achieve through the partnership (as described in the "Types of Partnerships" above). Objectives, on the other hand, are the common goals and outputs that are jointly defined and agreed by the partners regarding the desired outcomes and the means of achieving them.

The partnership strategy, involving clear, quantifiable objectives and reflection on the desired outcomes of the partnership, provides the parties and their teams with clarity

during the partnership, allows the partners to know when objectives have been met (thus signalling that this phase of the partnership is over) and allows for measurement of the success (and ROI) of the partnership following the conclusion of the partnership. This lack of overall objectives can create an activity focused environment where tasks are performed because MSF thinks or feels that these are the right things to do (and maybe they are), but cannot be measured.

It has been observed that there are currently no tools or methods systematically in use to help the parties to establish meaningful objectives[2]. In most case studies, the objectives of the partnership were driven mainly by MSF's interests. Furthermore, it was observed that MSF played a much more directive role when the perception was that they were in a position of power and employed a more participatory approach when the power was perceived to be balanced (for example in the partnership with ALIMA/BEFEN in Niger and EAFC in North Korea).

The partnership with the DNTD in Kenya shows that most parties had a different objective; the DNTD's objective was to complete the National Strategic Plan, while others wanted to pursue a research mandate and MSF wanted to ensure that patient care remained a priority within the activities. In the end, because of the common goal to work together to develop the National Strategic Plan, each party's objective was achieved, but some parties expressed that a more formal dicussion on objectives would have been helpful to establishing clearer responsibilities.

There are examples of partnerships that are struggling, in part because objectives are so divergent that it is difficult to find any common ground. One example is the Japanese human rights organisation working with MSF for North Korea. The overall goal of assisting migrants transiting into China is the objective, but the social mission of both partners is different (the partner has a Human Rights focus, MSF has a humanitarian mandate). MSF has redefined its objectives to include medical activities and it is difficult to reach some common objectives.

Similarly, the objective in Bunia was the medicalization of a non-medical NGO. Though the idea to build the (medical) capacity of an NGO that already worked for victims of sexual violence (legally) was interesting, it led to some difficulties designing the program and objectives in a collaborative manner because of the power imbalance.

The ultimate goal of the partnership should be to jointly achieve the commonly defined objectives; that will be the determinant for the definition of the length of the partnership as well as the definition of the means to be put into the partnership.

➔ Recommendation on Objectives

MSF must have a dialogue and formal agreement with the partner organization about the objectives. This includes developing a robust framework around the definition of clear objectives and measurable outcomes with the partner – not for the partner – to provide better chances of achieving these goals.

[2] For an example of a tool used in handover settings, see Guillaume Jouquet's document.

Return on Investment (ROI)

A question that MSF often asks is whether the (often heavy) investment in partnerships is worth the outcome.

The level of engagement and commitment to the partnership on the part of MSF has a direct impact on the ROI. Therefore, understanding how much is required and making an informed decision based on this will help MSF to determine the necessary resources for the success of the partnership and ensure that these are available.

However, to quantitatively measure the ROI of partnerships requires solid baseline data, clear objectives, measurable indicators of success, as well as forecasted and actual financial disbursement. As these data are rarely available in regular MSF-projects and were not available for the evaluated projects, it is difficult to assert that partnerships are a good "investment" for MSF. There is also no clear formula that can dictate what the "right" amount of investment is. Nevertheless, there are some projects that show how a moderate level of investment can yield positive outcomes for beneficiaries.

The Lesotho project is unique within the MSF-OCB portfolio of AIDS projects in that it was given the specific challenge to envision and carry out an exit strategy from the beginning of the project and to utilize relatively limited MSF-resources and input, instead emphasizing the building of local capacity with a view to ensuring continuity of services over the long-term, independent of MSF. The overall project costs for the four years were minimal, with only three expats, and a few supporting national staff. As recently reported, the partner, MOHSW, is still providing treatment to patients in the decentralized facilities and has started to implement this strategy in other regions of Lesotho. For more details on this project, see *Lesotho Handover Report* on Tukul.

Currently, MSF is negotiating with a young local NGO (Hadinkai) in Niger for the handover of activities in three ATFC's to allow MSF to focus on emergencies instead of the chronic malnutrition in that area. There are large gaps in the capacity of the NGO in the areas of project and financial management and governance. These areas will require time and commitment from all parties to build their capacity to a level where Hadinkai will be able to function autonomously and the financial investment on the part of MSF will be considerable. Nevertheless, if the organization is able to ramp up their skills in a time frame that is determined to be adequate and they are able to provide the services to the beneficiaries, then the investment will still have been worthwhile. In this case, the risk of additional time and resources must be considered.

➔ **Recommendation on ROI**

MSF must put the means in place to adequately establish sound baseline data, clear objectives, and measurable indicators of success including collection and analysis of the data, otherwise it will be impossible to evaluate the ROI.

Relationship, responsibility and accountability

In some cases, relationships are easily developed. Take, for example, the partnership with ALIMA/BEFEN, in Niger. ALIMA is an organization that was created by former MSF-staff with the same values and similar objectives, which facilitated the process. Even when there are disagreements, the foundation of the relationship is solid enough to overcome these obstacles.

In Kenya MSF-OCB/DNTD partnership, all partners stated that the relationship was based on open communication, inclusion and trust. According to the MSF-KA Focal Point, the relationship did take some time to blossom, but with patience and perseverance managed to build a strong relationship. The effort and its results provide the project with a solid foundation to successfully accomplish the next steps, which include the continued advocacy for patients and the handover of activities of the Kacheliba project to DNDi/MoH.

The MSF-OCB project in Kibera, Kenya and the partnership with the MoH shows how rocky beginnings can be turned around. Since 2002, there had been numerous negotiations and promises made to the MoH to build a hospital and it wasn't until 2010 that an official (formalized) agreement was reached. After the visit of a consultant, who helped to facilitate the discussion of roles and responsibilites of both parties, a roadmap was established and the MoH was included in the decision-making process through the creation of a joint steering committee with three sub-committees. This process, according to the HoM, helped to build trust and provided a framework for responsibility and accountability for both partners.

In most of the observed case studies MSF is in a stonger position (by providing resources and know how) and therefore has the power to impose decisions, give directions and place demands on the partner.

The partnership with the Japanese NGO is an exception as both partners are perceived to be on equal footing. The observation of this relationship is that MSF has difficulty to find its place as it is not at liberty to act as it would wish.

This is where working in the "spirit of equality" is the most crucial because it is during this phase that all the parties make the commitment to the partnership and accept responsibility for specific outcomes. It is about taking the time to dialogue with the partners and not impose MSF's expectations or demands.

MSF diligently reports on the expenditure of funds to the donors through annual reports and by respecting controls put in place by the donor.

Accountability to beneficiaries, however, is not as diligent mainly because there are no controls or systematic tools in place to measure how the services are perceived by the beneficiaries, and rarely does MSF report back to beneficiaries about the programs. The same thing is true for the accountability towards local partners. Without explicit documentation outlining expectations, it is very difficult for either party to respect their tactical engagements and be held to account for completing these.

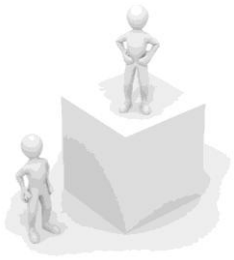
We have seen this in many cases, but for example, the MSF-OCB Kibera project in Kenya saw a very frustrated partner when discussions and verbal engagement on the part

of MSF to build a hospital in 2002 were not not respected until 2010. This lack of ownership, accountability and transparency created tensions and made negotiations very difficult.

➔ Recommendation on relationship, responsibility and accountability

MSF must take the time to develop the relationships with partners. Where the process gets derailed, external consultants may help to clarify roles, responsibilities and processes.

In every partnership MSF should establish and implement mechanisms and controls to hold all parties accountable and systematically monitor progress and readress any deviances.



Power Imbalance

The question of power and power asymmetries has been debated for many years. Suffice it to say that, for MSF and partnerships with local NGOs, only in rare situations are all partners on equal footing. However, partners acting in the "spirit of equality" will build trust and respect for the partnership and the process, which will invariably make reaching objectives easier.
In an article published in 2000, Sarah Lister (Power in Partnership? 2000) *lists elements identified by practitioners and observers which are essential for successful partnerships. These are similar to the issues and recommendations already discussed in this report and include: mutual trust, complementary strengths, reciprocal accountability, joint decision-making and a two-way exchange of information;*

- *clearly articulated goals, equitable distribution of costs and benefits, performance indicators and mechanisms to measure and monitor performance, clear delineation of responsibilities and a process for adjudicating disputes;*
- *shared perceptions and a notion of mutuality with give-and-take*
- *mutual support and constructive advocacy*
- *transparency with regard to financial matters, long-term commitment to working together, recognition of other partnerships*

Risks & dilemmas

Risks and dilemmas are inevitable in partnerships. In some partnership examples, an insufficient assessment and understanding of the risks involved led to complications, sometimes threatening the objectives of the partnership.

The partnership with SOFEPADI to provide medical treatment to victims of sexual violence in Bunia is an example. Because SOFEPADI is very politically involved in the area (as it also provides legal support to victims of SV, and accusations that they had are in opposition to the government), the chances of the organization being registered as a medical NGO are reduced. The risk that the government could decide not to grant the medical registration was not sufficiently weighed by MSF. In addition, the organization's political position poses a risk in terms of perception that could have an impact on security for the MSF team and project.

In North Korea, the partnership with EACF is a tense one because of the complexity of the context. Some of the causes of tension are due to the fact that the entire operation is

quite undercover, that MSF is not registered to work in China, that there is a need to keep a low profile and that there is a sense that EACF doesn't need MSF in the same way as a traditional partnership does (the power is more balanced) which means accepting that MSF is not totally in control of the projects. This is a dilemma for MSF because it is not making all the decisions and is not in a position to control activities or outcomes.

Furthermore, both organizations want to keep an eye on the border and try to access North Korea (probably through a third party "trading company"). However, MSF is at a stage where it would like to be more medically involved and is putting pressure on EACF to comply with these demands. For its part EACF claims that MSF is jeopardizing the activities because of its frequent visits and openness, putting the entire partnership at risk of collapsing if there is not a solution soon.

In Somalia, a partnership with a private practitioner enabled OCG to access an area with high insecurity. But due to contextual changes, the initial agreement changed and awarded the private practitioner increasing control, which impacted strongly on MSF's independence – begging the question of whether MSF considered the security and reputational risk of remotely accessing a population through a private practitioner. In Honduras, where MSF has engaged in a partnership with a pro Opus Dei organization, and although christianity is very mainstream and accepted, there is still a risk that MSF be perceived as biased.

In South Africa, MSF got caught in a highly political battle around ARV treatment. It started to treat HIV-positive patients jointly with the Treatment Action Campaign (TAC), a group of activists from the anti-Apartheid movement. TAC was strongly fighting for access to treatment in public health facilities. MSF contributed its legitimacy along with international visibility and financial support. It soon faced accusations of political interference. MSF played the multipartite card, allowing different political representatives to claim part of the credit for the first-time access to ARV treatment. Publicly, MSF kept its distance – an attitude which its partners found difficult to understand (see Magone, Neuman, and Weissman 2011).

One way to minimize the risks is to envisage the "worst case scenario" from the onset of the partnership and try to devise solutions for these or a "plan B". Look at alternative partners as you perform the mapping of actors and develop relationships with them early on to have the opportunity to open later.

As demonstrated above, organisational risks may arise in any of the following areas and should be given thoughtful consideration before engaging in any partnership.

- **Reputation impact / credibility / visibility** – MSF should be concerned about whether their reputation can be damaged by engaging in the partnership or by any repercussions should the partnership fail
- **Loss of autonomy** – working in a partnership inevitably means less independence
- **Conflicts of interest** – whether at strategic or operational levels, partnership commitments can give rise to situations where one person's impartiality is compromised

- **Drain on resources** – partnerships typically require a heavy 'front end' investment (especially of time) in advance of any appropriate level of 'return'
- **Perception of partnership, secondary / long-term impact** – partnerships can be positively or negatively perceived by the target population. Local NGOs can also be perceived positively or negatively by the MoH and their staff and tensions can arise

➔ **Recommendations on Risks and Dilemmas**

MSF should systematically conduct a Risk Assessment (ackowledging, understanding and evaluating the organizational risks) of the involvement in a partnership at a strategic level to allow decisions to be made, in every context, of whether the benefits of the partnership outweigh the risks.

IMPLEMENTATION

Choosing the right partner

As for any context where MSF is present, there is a need for a global view and therefore an understanding of who is present, and doing what with what means. The mapping of actors is the first step necessary but it needs to include the local partners, very often left apart in the analysis.

Building a partner starts when MSF's objective is clear on the type of partnership needed, by choosing the right partner out of the actors' mapping.

Mapping of actors

In many of the case studies performed, the mapping of actors was not available. It is a necessary step in the context and risk analysis and it must include not only international actors, but also donors, and national bodies.

A simple follow-up table is included into OCG operational tools; the follow-up should include the objectives, the social mission, the followers, pros and cons of the organization, as well as the funders of the activities.

The more complete the mapping is, the easier it will be to choose the partner according to the criteria above.

Once the decision has been made to engage in a partnership, there are some practical steps that will guide MSF in determining the required level of engagement and associated operational risks.

Assessing Technical Skills of Partners

From the moment that there has been an institutional MSF-decision of partnering with a local organization, MSF cannot ignore the requirements of the partner organization for successfully fulfilling its part of the contract. In Niger, the solution was for the INGO ALIMA as a third party to build the capacities of BEFEN, the local NGO.

Different tools of assessment of local partners' technical skills already exist, mainly required by institutional donors (USAID, GIZ etc.). One of them is called 'The Institutional Development Framework' and contains three tools: Institutional Development Framework, Institutional Development Profile and Institutional Development Calculation Sheet. Access this tool on Tukul. It was specially developed for the assessment of a single organization and "helps an organization to determine where it stands on a variety of organizational components, identify priority areas for improvement, set targets, and measure progress over time".

But it can be simplified and made more user-friendly for field people to use in the projects. Within the four big families (choice of the right partner, formalization of partnership, capacity building and human resources), "sub-chapters" include the following criteria that will need to be assessed.

Practical Checklist

Conduct mapping of actors

Define objectives of the partnership

Assess risks related to the partnership / the partner

Assess technical capacity of partner

- Leadership
  - Who is the leader? Is there a power struggle?
- Mission/programme management
  - Project cycle
  - Proposal writing
  - Activity reports
- Administration / HR
  - Policies
  - JDs / employee contracts
  - Recruitment processes
- Finance
  - Day to day budget management
  - Financial management
  - Transparency / governance / controls
- Fundraising
  - Is there a current FR strategy between MSF / partner
  - Which one? Why? Why not?
  - Is there a FR strategy in place for after MSF?
- Supply
  - Is there a current strategy? Is there a strategy in place for after MSF?
  - Were other partners included in the strategy? (WHO, Clinton, etc.)
- Communication
  - Balanced, equitable, top down?
- Legal Status
  - Process of registration? Length of process
  - Composition, by-laws
- Funders approach

Formalize the partnership agreement

- Agree on and sign memorandum of understanding
- Define a responsible person for the partnership (on both – the MSF and the partner's – sides)

Evaluate the partnership

Ensure capacity building of the partner

➔ **Recommendations on choosing the right partner**

Systematically include local agencies working in project area in the mapping of actors.

Assess the capacity of the partner to engage in the partnership and ensure that the roles and responsibilities are clearly stated and understood before making a commitment to the partnership.

Negotiation & formalization (agreement, memorandum of understanding)

A key aspect of partnerships, which is sometimes left out and often done as a procedure, is the formalization of the partnership. This critical step can be the perfect opportunity to truly engage with the partner, have an open dialogue and agree on objectives, roles, responsibilities and expectations, as well as the type and level of commitment that each party is prepared and capable of giving.

An example is the jointly created roadmap between MSF and the MoH in the disengagement and handover of activities of the Hôpital Bon Marché in Bunia, DRC. Although this document was not part of the initial MoU, as the disengagement progressed, it became apparent that the MoH needed to be involved in the activities to ensure their commitment to the process. A new position (Disengagement Coordinator) was created to help with the negotiations and to oversee that both MSF and the MoH stayed true to their commitments. This methodology was later replicated in Zinder, Niger, for the handover of activities to the MoH.

Registration

During the current evaluation, two examples showed that delay in registration of the local partners led to a delay in the implementation of the partnership. In Niger, Hadinkai had to change its line minister, and register under the MoH. In Bunia, SOFEPADI is still in the process of being recognized as a medical entity. Both processes were longer than expected (SOFEPADI still ongoing), having consequences not anticipated by the teams.

➔ **Recommendations on formalization**

Document (formalize) the partnership agreement (most of the time, with a MoU). Once the terms of the partnership have been agreed and formalized, establish – in collaboration with the partner(s) – which results are expected of the partnership using SMART objectives and together assigning responsibility for outcomes, deliverables, tasks, etc.

Inconsistency and "surprises" can be avoided by framing the partnership agreement. The agreement must include both organizations' social missions, objectives, share of responsibilities and who is doing what. It must also include a "plan B" in case the "plan A" described in the proposal fails.

Evaluation of the partnership must be planned in the formal agreement; but the evaluation should aim at evaluating each partner's achievement (and not only the local partner's).

It is recommended that each of the partners assigns one person that will be coordinating the entire process of partnership, and ideally supervising the whole period of the

partnership. This will ultimately reduce the loss of institutional memory and inconsistency throughout the process.

MSF should also show curiosity in local partner's process of registration when it happens: What is the circuit, how long can it take, what is the probability of registration being denied. All these elements, when collected and understood, will help in anticipating potential blockages to the partnership.

Human Resources: Assigning the right people

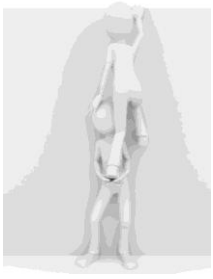
To engage in successful partnerships there are skills that are essential; skills like negotiation and mediation, facilitation and coaching of others, and the ability to work in teams.

In Kenya, for example, the position of KA Focal Point was created, among other responsibilities, to manage the partnership with the DNTD. The position brought stability, which in turn built the trust of the actors and the process. In other instances, such as Niger, the turnover of expat staff at the project and CMT level was frequent and delayed the negotiations with the partner (Hadinkai), which affects the partner organization and impacts the timeframe of the disengagement.

For North Korea one of the enabling factors to establish partnerships in this sensitive context was the fact that HoMs/Liaison Officers signed contracts for several years, and later on, in the process of disengagement from one project, OCG assigned one Project Coordinator to accompany the medical NGO taking over.

➔ **Recommendations on HR:**

Briefing, adherence to the strategy and knowledge of the context are important success factors. Some partnerships can be derailed by expats who do not buy into the partnership strategy.



Ensuring capacity building

Throughout the life of the project, MSF provides training to its entire medical and non-medical staff and in this context (where MSF is actively working) the training modules are relevant because MSF dictates the work methods and protocols and because MSF-expats are constantly involved and available for mentoring and guidance.

However, when working in partnerships, the types of training that MSF provides must often be altered to include training on subjects that are less familiar to MSF, such as project management, management of resources and systems, leadership and governance, financial and budget management. This type of capacity building should be done in strong collaboration with the partner to ensure its relevance and value.

When it comes to partnerships and building the capacity in areas other than operations, such as management, finance and governance, there are two schools of thought. One is that it is neither MSF's role nor mandate to engage in building the capacity of actors MSF

is working with. The other tendancy is that MSF has no choice but to help the local partner so that activities are being sustained.

This point can and has been debated without bringing a clear direction. What is certain, however, is that from the moment that MSF makes a commitment to engage with a local partner and determines that there exists a gap in knowledge, a solution to bridge that gap must be found.

MSF's recent experiences, such as tripartite partnerships with an NGO, whose mandate is to support local initiatives and development, demonstrates innovative ways of building local capacity which can be replicated (MSF/ALIMA/BEFEN partnership in Niger) and in South Korea, OCG accepted to support the medical NGO Medipeace in the fundraising strategy targeting Western donors.

But it is not the only way. In order to make sure that specific requirements are met, big institutional donors (as GIZ or USAID) do provide training programmes to local agencies, including governmental bodies. In Niger for example training programs are provided by GIZ on project management and leadership.

➔ **Recommendations on capacity building**

MSF must commit to bridging the knowledge gap of the local partner (whether by building that capacity or through other organizations).

MSF must allow for sufficient time and monitor the development of the participants to ensure that the knowledge has been absorbed by the individuals. Adequate time must be allotted to capacity building and, as is recommended in Kenya, a "training of trainers" session can be conducted with selected members of the partner organization to build the capacity at a higher level and ensure the continuity of knowledge transfer.

CONCLUSION

Working in partnerships is a disputed choice within MSF-OCG. While the benefits are clearly acknowledged, there is unease in regards to the (potential) burden of becoming a funder, the unfamiliar business of capacity building and the threat to the loss of independence.

OCG today is engaged in a series of partnerships with a history of more or less successful partnerships over the past years. Naturally, the more difficult the context and hence the higher the need for a partnership (e.g. North Korea, Somalia, etc.) the more attention has been given to partnerships. In that sense a de facto decision about partnerships as one modus operandi has long been made. What seems to be missing is a full acceptance of this reality and the definition of a policy and corresponding tools. Two specific policy-points require a decision on their positioning: first, MSF's role in supporting the creation of NGOs (mainly from national staff) that could be partners (example Niger, Liberia), and second, in building fundraising strategies and capacities.

Out of the reviewed case studies, the majority of partnerships seems to be appropriate operational choices. Exceptions are those cases where risks were not assessed and objectives not defined carefully enough. In general, there is little risk analysis done on potential consequences of partnerships on either MSF's image, the security of staff, the access for/acceptance of patients, etc. MSF often relies on one partnership-option, while it may be worthwhile to explore and define alternatives.

Effectiveness of the partnership is difficult to establish, because expected outcomes are rarely agreed upon at the onset of, and during the partnership and also because results are rarely monitored after the fact (after the handover, after the end of the partnership). Nevertheless some partnerships can be considered successful due to a positive operational output.

The main threat to partnerships appears to be **the inconsistency in MSF's expectations and decisions**. Views and commitment (in terms of timelines and available resources) of MSF change with turnover in line with management. Successful partnerships were observed where there was a reliable institutional commitment for the mid- or long-term and/or where key positions within the organization remained stable.

Another key factor in partnerships is **capacity building for the local counterpart**. For areas outside the direct (technical) operational subject, such as management, finance and governance, there are two schools of thought. One is that it is neither MSF's role nor mandate to engage in building capacity, the other is that MSF has no choice. If MSF assumes responsibility for capacity building, it is often without the appropriate level of commitment and poorly designed. The dilemma in this situation is that MSF is usually not strong in promoting local staff into positions of power and – at the same time – needs "empowered" counterparts that in many instances may be exactly those former MSF-staff. Recent experiences, such as tripartite partnerships with an INGO, whose mandate is to support local initiatives and development, demonstrate innovative ways of building local capacity which can be replicated.

Poor planning and understanding of "why" a partner is the best solution led, in several instances, to confusion and ambiguity for all parties (including donors, local population and beneficiaries). Understanding the requirements and the needs of the partner allows MSF to understand the investment and thus to appropriately plan for the success of the partnership.

There are **good practice examples in terms of formalizing and practically implementing partnerships**. However, those have not been translated into a coherent approach and/or standardized tools for all missions.

The issue of **power in partnership remains largely unaddressed** in MSF. We generally observe an asymmetry of power, with MSF taking a directive and top-down approach, which is demonstrated, for example, in objectives and plans being defined unilaterally, and results in the accountability to the partner or beneficiaries being neglected. Where mutuality is given or MSF is in the weaker position, it appears difficult for MSF-teams to find and accept their role.

Capitalize on success stories: There are positive examples where innovative approaches had been found, such as North Korea, BEFEN-ALIMA. It is important to share these experiences and see whether they can be replicated or adapted to other contexts.

As the contexts, in which MSF is currently working, are again changing, the increase in partnerships provides the opportunity to examine and reflect on how to engage with other organizations. There is a strong sense, at least within MSF-OCG, that MSF should strive to engage in partnerships in all contexts, including emergencies. This strategy, then, begs the organization to **ensure that partnerships are entered into with a clear direction**.

BIBLIOGRAPHY

Desilets, Annie. *Lesotho Handover: Assessment of Handover Strategy of MSF-B HIV/TB Programme.* Evaluation Report, MSF-OCB, 2010.

Jouquet, Guillaume. *Building the Handover Strategy for 5 Clinics in Maseru District.* Evaluation Report, Brussels: MSF-Belgium, 2006.

Lister, Sarah. "Power in Partnership?" *Journal of International Development* 12, no. 2 (2000): 227-239.

Magone, Claire, Michael Neuman, and Fabrice Weissman. *Humanitarian Negotiations Revealed.* London: Hurst & Company, 2011.

Programmes Unit, MSF-UK. *Making and Exit: Advice on successful handover of MSF projects*. Findings, London: MSF-UK, 2011.

Tennyson, Ros. *The Partnering Toolbook*. International Business Leaders Forum (IBLF) and Global Alliance for Improved Nutrition (GAIN), 2003.

ANNEX 1: LIST OF INTERVIEWEES

Adélaide et Pierre-Louis	Resp. Terrain et Admin. Projet
Ahmed Abdikadir Malow	Clinical Officer (Trainer), MSF-OCG
Ali Abdou	Secrétaire Général Adjoint, Hadinkai
Andrei Slavuckij	Dept. Dir. Med. OCG; former Resp. Prog.
Annie Desilets	Consultante pour l'évaluation de la passation à l'HGR, 2010
Assani, Dr.	MCZ Bunia
Benoit Kayembe, Dr.	HoM, MSF-OCG, Niger
Bertrand et al.	Équipe de Coordination, Bunia
Boubacar Mahamadou	Trésorier Général, Hadinkai
Claire Lansard	Ex-Admin.
Daghee, Dr.	Field-Coordinator, Gedaref
Davis Wachira, Dr.	Leishmaniosis Control Focal Point, DNTD
Dorkas Alusala, Dr.	NTD National Coordinator, DNTD
Elena Velilla, Dr.	KA Focal Point, MSF-OCG
Emmanuel Goue	Former HoM Korea
Eric Ouannes	GD MSF-Japan, former HoM Korea (OCP)
Etienne Gignoux	Country Representative, ALIMA
Fabien Schneider	Resp. Prog., Cellule 3, GVA
Florencia Romero, Dr.	Med-Co, MSF-OCG, Niger
Francois Verhoustraeten	Resp. Prog. Cell 1, GVA
Francoise, Dr.et al.	Présidente, HoM, Resp. Terrain et Resp. Médicale, SOFEPADI
Gege Bedock	HoM Haiti
Guillaume Leduc	Programme Manager, ALIMA
Gustavo Fernandez, Souheil Reaiche	Resp. Prog., Adj. Resp. Prog., Cell 4
Hakim Chkam	Operational Department Geneva
Harrison Kuboka, Dr.	MSF Field-Co, Kacheliba
Hassan Maiyaki	Field-Co, MSF-OCG, Magaria
Hugues Robert Nicoud	Exploration Team Leader ("inside N.Korea")
Issoufou Moussa Maharou	Vice-Président, Hadinkai
Iza Ciglenecki, Oifa Bouriachi	Resp. Progr., Adj. Resp. Progr., Cell urg.
Joke Van Peteghem, Dr.	HoM, MSF-OCG
Kato	Director of LFNKR, one of the counterparts for EACF (based outside China)
Laurence Gaubert	HoM Honduras
Lonema, Dr.	MCD Bunia
Maidadji Oumarou, Dr.	General Co, BEFEN
Michael Makari	Clinical Officer In-Charge, Acting Medical Superintendant, Kacheliba Hospital
Monica Rull	Resp. Progr. Cell 2
Monique Wasunna, Dr.	Coordinator, DNDi Africa Liaison Office, Chief Research Officer (KEMRI)
Moussa Doudou	Gestionnaire, Hôpital de Magaria
Nytia Udayraj, Dr.	Med-Co, MSF-OCG
Ousmane Maarou	Chargé des Affaires Sociales, Hadinkai
Paul Yon	HoM Korea
Philippe Latour	Field-Co, Wanqjin project (counterpart of Medi-Peace)
Rabi Ibrahim	Chargée a l'Information et a l'Organisation, Hadinkai
Samuel	Local Leader, Kacheliba
Shin, Dr.	Secretary General, Medi-Peace
Tomi Tom	Local Councillor, Kacheliba

ANNEX 2: TERMS OF REFERENCE

Commissioned by: OD, cell 3, cell 1
Starting Date: Sept / Oct 2011
Duration: 4-5 months

ToR elaborated by: Sabine Kampmüller, Ops department

CONTEXT

Because of its commitment to independence, MSF has for most of its programs chosen to implement them directly and without the involvement of local partners. However there are factors that increasingly force the organisation to consider alternatives. First of all, when the security situation is precarious and access for international teams is restricted. Secondly also, in light of exit strategies, working with local partners often seems a logical option.

MSF-OCG currently practices (two / three) interesting examples of partnerships with local organisations: One in Niger with the Nigerian NGO BEFEN facilitated by another international organization, ALIMA. ALIMA focuses on working with local partners and was created by a former MSF staff.

A second example is Bunia/DRC, where OCG works with SOFEPADI, a local organization working on violence against women. They were originally concentrating on legal issues, but with the support of MSF now build medical competencies. MSF also supports them on administration and (institutional) fundraising. The advantage for MSF clearly is that the organization who is embedded in the society has much more leverage for advocacy.

In Kenya OCG is running a Kala Azar project through (low level) support to the MoH in Turkana. The main counterpart for MSF is the newly created department for neglected diseases. Through this partnership MSF is trying to lobby and advocate for access to treatment.

North Korea??

Possible consideration of other case studies in the movement….

OVERALL OBJECTIVE and PURPOSE

The overall objectives of this evaluation are

⇒ to determine the appropriateness and effectiveness of current partnerships between MSF, local organizations or the MoH
⇒ to draw lessons from current experiences of partnerships
⇒ to obtain and analyze possibilities and risks of partnerships

The purpose of this evaluation is to **learn from current experiences** in partnerships with local organizations, to inform the debate on MSFs policy on partnerships and **provide guidance for future engagement**.

KEY EVALUATION QUESTIONS

1. How is the set up of the partnership?
   a. Formal/informal, agreements / MoU
   b. Level of engagement (shared planning)
   c. Communication channels
   d. Type of support provided
2. What are the objectives of the partnership? Are they being achieved?
   a. Improved access? Exit strategy? Leverage on national level?
3. What are the strengths and weaknesses of the partnership?
4. How are responsibilities shared and defined?
5. What is the perception of this partnership by different stakeholders?

EXPECTED RESULTS and INTENTED USE OF THE EVALUATION

Description of best practices and lessons learned
Criteria for engagement
Rules of engagement (Checklist??)

Evaluation findings will be shared broadly and debated with operations managers and coordination teams, within and beyond (?) OCG. Guiding documents for future partnerships will be developed.

PRACTICAL IMPLEMENTATION OF THE EVALUATION

Field visits to Kenya, Niger and DRC, consideration/inclusion of more case studies through interviews with program managers (including other OCs).

TOOLS AND METHODOLOGY PROPOSED (if any):

Project visit
Interviews with program managers, partner organizations, stakeholders