
IMPROVING THE AVAILABILITY AND USE OF SGBV SERVICES

IN THE KANANGA PROJECT,
CENTRAL KASAI, DEMOCRATIC REPUBLIC OF CONGO
RESULTS FROM THE PHASE 2 EVALUATION

OCTOBER 2023

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The views of the authors expressed in this publication do not necessarily reflect the views of Médecins Sans Frontières and the Stockholm Evaluation Unit.

CONTENTS

ACRONYMS	3
EXECUTIVE SUMMARY	4
INTRODUCTION	7
OVERVIEW OF SEXUAL- AND GENDER-BASED VIOLENCE IN DRC	7
BACKGROUND OF THE KANANGA PROJECT	8
THE “DECENTRALIZATION INITIATIVE”	9
EVALUATION RATIONALE AND OBJECTIVES	11
KEY FINDINGS AND RECOMMENDATIONS FROM THE PHASE 1 EVALUATION	11
EVALUATION APPROACH AND METHODOLOGY	13
THEORETICAL FRAMEWORK.....	13
EVALUATION FRAMEWORK	13
METHODS.....	14
DATA ANALYSIS.....	15
FINDINGS	17
ACTIVITIES IMPLEMENTED AND THEIR OUTPUTS.....	17
RELEVANCE	18
COHERENCE	22
EFFICIENCY	27
EFFECTIVENESS.....	28
PROSPECT FOR IMPACT.....	31
PROSPECT FOR SUSTAINABILITY	34
GENDER AND HUMAN RIGHTS CONSIDERATIONS.....	36
LIMITATIONS OF THE EVALUATION.....	38
RECOMMENDATIONS	40
REFERENCES	41
ANNEXES	45
APPENDIX I: TERMS OF REFERENCE	45
APPENDIX II: SAMPLE MATRIX.....	54
APPENDIX III: BIOGRAPHIES OF THE EVALUATION TEAM MEMBERS	62

LIST OF FIGURES

Figure 1. Map of Central Kasai Province	8
Figure 2. Phases of the decentralization initiative.....	10
Figure 3. Number of sexual violence cases managed at the CSK.....	28

LIST OF TABLES

Table 1. Analysis of the quality of post-sexual violence care at the CSK.....	31
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LIST OF ANNEXES

APPENDIX I: TERMS OF REFERENCES.....	45
APPENDIX II: SAMPLE MATRIX.....	54
APPENDIX III: BIOGRAPHIES OF THE EVALUATION TEAM MEMBERSErrror! Bookmark not defined.	

ACRONYMS

CSK	Centre de Santé Kamuandu (Kamuandu Health Centre)
DHIS2	District Health Information System 2
DRC	Democratic Republic of the Congo
ECZ	Equipe Cadre de la Zone Santé (Health Zone Executive Team)
GBV	Gender-based violence
HC	Health Center
HIV	Human Immunodeficiency Virus
HZ	Health Zone
HGRPK	Kananga Provincial General Referral Hospital
MoH	Ministry of Health
MoU	Memorandum of understanding
MONUSCO	United Nations Organization Stabilization Mission of the DRC
MSF	Médecins Sans Frontières
MS	Microsoft
NGO	Non-governmental organization
OECD	Organization for Economic Cooperation and Development
PEP	Post-exposure prophylaxis
SEU	Stockholm Evaluation Unit
SGBV	Sexual- and gender-based violence
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
UN	United Nations
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

BACKGROUND AND JUSTIFICATION

Sexual- and gender-based violence (SGBV) is a widespread phenomenon in the Democratic Republic of Congo (DRC). In 2017, Médecins Sans Frontières (MSF) launched the Kananga project to provide emergency medical assistance to people affected by the Kamwina Nsapu conflict in the Central Kasai. To adjust to the evolving context in 2020, MSF initiated the “decentralization violence.ve” which: aimed to 1) Improve access to SGBV care, including contraception and abortion care; and 2) Build staff capacity to provide holistic medical support to survivors at the health center level. From April 2022 to March 2023, MSF piloted the decentralization initiative at the Kamuandu Health Center (CSK) in the Tshikula Health Zone. Before the decentralization initiative, the CSK did not formally integrate post-sexual violence care.

PROJECT EVALUATION

In 2022, the Stockholm Evaluation Unit (SEU) commissioned a two-phase developmental evaluation of the decentralization initiative. Conducted from July to November 2022, Phase 1 assessed the design, planning, and prospective implementation of the decentralization initiative. The Phase 2 evaluation, which is the focus of this report, was carried out in June 2023 and assessed the results of the implementation and handoff of the decentralization. We employed a concurrent mixed-methods approach combining desk review, secondary analysis of routine data from the CSK, case study methodology of the CSK, and 18 semi-structured interviews with providers (n=4), survivors (n=5), MSF staff (n=7), and external stakeholders (n=2). We analyzed the primary qualitative data for content and themes using inductive and deductive techniques and computed descriptive statistics to analyze secondary quantitative data. We addressed the primary evaluation questions through seven criteria: relevance, Coherence, efficiency, effectiveness, impact, sustainability, and gender and human rights mainstreaming.

MAIN FINDINGS PRESENTED BY EVALUATION CRITERIA

Relevance and appropriateness

The decentralization initiative was relevant to the local needs and the DRC government’s SGBV priorities, although its overall appropriateness was moderate. The capacity-building-related activities aligned with the needs of the CSK healthcare providers. However, a more holistic approach prioritizing survivors’ comprehensive medical and psychosocial needs and adequate planning and resourcing of the community mobilization-related activities would have enhanced the appropriateness of the Pilot.

Coherence

The evaluation highlighted an alignment of the Pilot’s strategy with the DRC government's priorities and national strategy for combating SGBV and considered complementarity with other SGBV programs operating in Central Kasai. Thus, the external Coherence was high. In contrast, internal coherence was more mixed. Some notable activities of the Pilot’s delivery model were not aligned with its intended outcomes and implementation context.

Efficiency

Appropriate resources were allocated to the clinical component of the Pilot to secure free post-sexual violence care at the CSK. However, more resources should have been allocated to the health promotion component of the decentralization initiative.

Effectiveness

Evaluation findings revealed an increased number of survivors accessing post-sexual violence care at the CSK and an improved capacity and self-confidence of healthcare providers to care for survivors. However, it was challenging to conclude categorically whether the Pilot has fully achieved its intended outcomes without a benchmark for comparison.

Prospect for impact

The potential impact of the Pilot is relatively high, given that its design included strategies proven to have great potential for transformative change. However, our evaluation identified a number of planning and implementation pitfalls and the DRC's health systems constraints reduced the Pilot's prospect for impact.

Prospect for sustainability

The findings show that the Pilot presented limited potential for sustainability. Key informants were skeptical about the ability of the CSK to continue to offer free, high-quality care to survivors after the Pilot's close-out. Lack of medical supplies and financial support were reported as significant obstacles to continuity of care. The evaluation findings revealed an increased number of survivors accessing post-sexual violence care. However, the specific characteristics of the Pilot's implementation context (gender norms that fuelled sexual violence and social vulnerability of girls and women) and the inherently complex nature of the sexual violence and health behavior change posed an immediate threat to the sustainability of these achievements.

Gender considerations, inclusivity, and human rights considerations

The Pilot aimed to improve access to and use of post-sexual violence services. As such, it was clearly gender-responsive. However, special attention could have been given to the neglected issue of boys and men as survivors. High-quality post-sexual violence care was provided to all survivors who presented at the CSK regardless of their gender identity, ethnicity, or other socio-demographic characteristics. However, little evidence indicates that the Pilot was explicitly inclusive for all sub-groups of beneficiaries. The Pilot was designed and implemented as a "one-size fits all" intervention without explicitly addressing intersecting vulnerabilities of survivors, including ability/disability status, age, and literacy.

LIMITATIONS

We could not reach thematic saturation with the survivors of SGBV partly because of the limited number of clients available during our data collection window. The lack of a concrete results framework and theory of change limited the Pilot's evaluability, specifically its effectiveness. Further, we relied on routine quantitative data not collected for the purpose of this evaluation to assess the Pilot's effectiveness. This limited our ability to conduct a more granular analysis of the Pilot's effectiveness. We could only make approximate cost calculations due to unreliable operational data. Finally, it was premature to assess the impact of the Pilot. Instead, we only appraised its prospects for impact, which we consider a major limitation.

KEY RECOMMENDATIONS

Our key recommendations to both MSF headquarters and MSF staff include: 1) Consider developing a holistic strategy and comprehensive theory of change for a multi-sectoral SGBV program/response; 2) Consider designing and implementing a clear theory-based, multi-component, and coherent intervention that matches the country's wider response to SGBV and the global MSF strategy (once elaborated); 3) Ensure an appropriate collaborative and multi-sectoral response to SGBV; 4) Integrate from the outset and effectively resource community-driven initiatives, including allotting sufficient time for implementation; 5) Develop a stand-alone monitoring and evaluation plan for initiatives intended to be piloted and replicated, this will increase their evaluability and likelihood of achieving their expected results, hence their replicability; 6) Incorporate human rights, health equity, and intersectional issues related to gender into all project phases; and 7) Consider MSF staff rotation and other health system issues in project planning. If possible, develop a training plan that recognizes and potentially capitalizes on the pre-scheduled turnover of MSF staff.

INTRODUCTION

OVERVIEW OF SEXUAL- AND GENDER-BASED VIOLENCE IN DRC

Sexual and gender-based violence (SGBV) is any harmful act committed against a person's will because of their gender identity or perceived adherence to socially defined norms of masculinity and femininity [1]. SGBV includes physical, psychological, and sexual violence and denial of resources or service access and is widespread in the Democratic Republic of the Congo (DRC), whether in conflict, post-conflict, or non-conflict contexts. In 2014, a national survey revealed that one in four women in the DRC had experienced SGBV in their lifetimes. Over half suffered physical or sexual violence [2]. In 2022, the United Nations Organization Stabilization Mission in the DRC (MONUSCO) reported 701 cases of conflict-related sexual violence, around 99% of which involved women and girls [3]. However, this figure is far from comprehensive as most SGBV cases remain hidden due to fear and stigma and thus go unreported.

The power imbalance in relationships and harmful gender norms of the broader community toward women and girls contribute to the high rates of SGBV in the DRC. In addition, decades of armed conflict in the eastern DRC, recurrent insecurity in various parts of the country, and rampant impunity in the justice sector have exacerbated sexual violence against women and girls [3]. Most girls and women are victims of non-state armed groups, state actors (DRC armed forces, police, and security agents), intimate partners, and people in positions of authority (community leaders, in-laws, teachers, humanitarian workers, etc.) [4,5].

A note on terminology:

Much of the existing literature and project-related documents use either the term SGBV or the term gender-based violence (GBV). These terms are generally used interchangeably to refer to any harmful act committed against a person's will because of their gender identity or perceived adherence to socially defined norms of masculinity and femininity. We understand that language is evolving and increasingly Médecins Sans Frontières and other stakeholders are differentiating between sexual violence, intimate partner violence, and GBV. Throughout this evaluation we have preserved the language of the original source material and attempted to specify when statistics, services, or outreach are specifically related to sexual violence.

As part of its response to SGBV, the DRC developed a national strategy to combat SGBV in 2009 (revised in 2020) and published the Maputo Protocol in 2018 in the Official Journal, guaranteeing rape survivors the right to abortion care [6]. The Congolese national strategy to combat SGBV provides free, holistic, and multi-sectoral services (health, legal aid, protection, and socio-economic reintegration) for survivors. Despite these commitments, challenges such as the limited number of qualified health personnel, lack of infrastructure to ensure privacy and confidentiality, shortages of medicines, taboos surrounding abortion

care, and inadequate referral systems are at the root of considerable gaps in the availability of sexual violence-related services [7-9]. Additional obstacles to an adequate response to SGBV are insecurity and the fragile social and health systems in the conflict zones [10,11].

In areas where sexual violence-related services exist, survivors face numerous obstacles to use, including experiencing internalized and externalized stigma, navigating long distances to access facilities, having to pay out-of-pocket for services and care, and limited access to resources and socio-economic opportunities for women and girls [12-14]. For example, less than half of the survivors of sexual violence reported in the country in December 2022 received care within the recommended 72 hours after a sexual assault [15]. Due to the limited availability and use of sexual-violence services, survivors are at increased risk of various mental and physical sequelae, including depression, unwanted pregnancies, and sexually transmitted infections (STIs)/human immunodeficiency virus (HIV) [16-19].

BACKGROUND OF THE KANANGA PROJECT

In 2017, Médecins Sans Frontières (MSF) launched the Kananga project to provide emergency medical assistance to those living in the Central Kasai province of the DRC (see Fig. 1). Initiated during the Kamwina Nsapu rebellion [20], the project began as an autonomous MSF clinic in the Kananga Provincial General Referral Hospital (HGRPK). At that time, the Kananga project focused primarily on responding to medical emergencies, including surgical emergencies, generated by the security crisis related to the Kamwina Nsapu rebellion. As the context evolved, the Kananga project experienced frequent changes in strategy and focus.

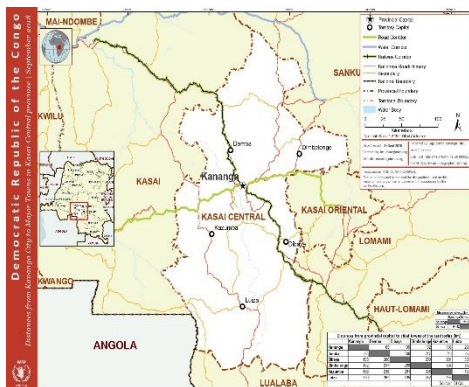


Figure 1. Map of Central Kasai Province

In April 2019, the project adopted a “vertical” approach by focusing solely on medical and psychological care for survivors of SGBV at the HGRPK. Mass awareness campaigns and peer education sessions on the impact of SGBV and the availability of services were also conducted at the community level to create demand for services. The availability of SGBV services at HGRPK, coupled with this multi-faceted demand creation strategy, resulted in a substantial increase in the use of services. The number of survivors

receiving SGBV care at the HGRPK increased to over 200 per month between 2019 and 2020; this surge led to congestion at the health facility.

THE “DECENTRALIZATION INITIATIVE”

To tackle this congestion and expand SGBV services at the peripheral health centers, in 2020 Médecins Sans Frontières initiated the “decentralization initiative”¹ to improve access to and utilization of sexual- and gender-based violence related services in Central Kasai. This initiative consisted of integrating SGBV-related health care into existing health services at the health center (HC) level. The decentralization initiative aimed to: **1) Improve access to SGBV care, including contraceptive and abortion care; and 2) Build staff capacity to provide holistic medical support to survivors at the health center level.** From April 2022 to March 2023, the decentralization initiative was Piloted at the Kamuandu Health Center (CSK) in the Tshikula Health Zone (HZ). Located in a rural area, the CSK serves an estimated 10,000 people, spread across 10 villages within a radius of 9 kilometers. Prior to the decentralization initiative, the CSK did not formally integrate post-sexual violence care. The decentralization initiative included five core intervention components, referred to as “phases” in the Kananga project’s 2022-2023 roadmap (see Fig. 2) [21].

The preparation phase referred to planning the integration of SGBV care at the HC level. It included identifying and preparing sites, developing SGBV job aids and guidelines, and signing a memorandum of understanding with health authorities.

The implementation, strengthening, and disengagement phases were the core intervention components of the initiative. The activities implemented during these three phases were centered around the following three distinct but interrelated strategies:

1. Integration of multi-sectoral, survivor-centered health care. This included:

- a. *Direct support to the KHC to provide quality, survivor-centered, holistic health care (medical and psychological first aid).* This was done primarily through in-service training and formative supervision of healthcare providers to strengthen their capacity to provide quality, patient-centered care. In addition, MSF provided logistical support (provision of medical supplies, minor infrastructure rehabilitation, installation/restoration of hygiene, water, and sanitation infrastructure, etc.) and financial support (a monthly grant for the health center's operation) directly to the health center. MSF provided commodities that were not included in the standard kit for the management of sexual violence provided by the Ministry of Health (MoH), namely hepatitis B and tetanus vaccines, abortion medicines (mifepristone and misoprostol), and azithromycin. The essential medical care package offered to SGBV survivors at the Kamuandu Health Center included: 1) Emergency contraception and abortion care; 2) HIV post-exposure

¹ The decision to adopt a decentralized approach within the overarching Kananga project is referred to by a variety of terms in different project documents. These terms include model, approach, Pilot, sub-project, and activity. Field staff also refer to this effort as the Kamuandu project or Kamuandu model given its location. For this evaluation we use the term decentralization initiative and refer to these early efforts as a Pilot.

- prophylaxis (PEP); 3) PEP for STIs; 4) Hepatitis B and tetanus vaccines; and 5) First-line psychosocial support.
- b. *Screening and referral of survivors for non-medical support.* Health care providers, trained by the project team, screened clients for current risks and non-medical support needs (including legal aid, material assistance, and safe shelter). Screened clients were provided oral information about where and how to access non-medical resources. Collection and documentation of evidence for legal purposes was also performed.
2. **Community mobilization** to improve the knowledge and capacity of survivors, families, and communities to seek SGBV-related health care: Community ambassadors, trained by the project team, conducted door-to-door visits to raise community awareness on what SGBV is, how it impacts health, and where services are available. These encounters also allowed community ambassadors to gather information about and respond to questions/rumors about SGBV. The community-mobilization model of the Pilot also included the organization of focus groups with community members and the setting up of local resilience committees to promote community engagement to sexual violence.

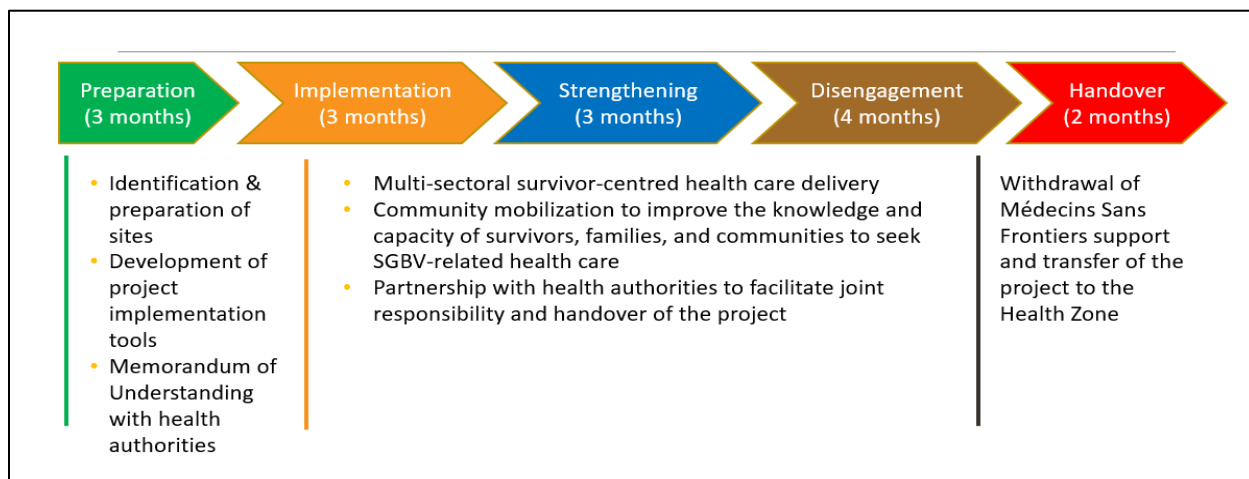


Figure 2. Phases of the decentralization initiative (2021)

3. **Partnership with health authorities** to facilitate joint responsibility and handover of the project: Joint formative supervision visits between the project team and experts from the Ministry of Health (Provincial Health Division and Tshikula Health Zone) were to be conducted quarterly at the KHC to facilitate the skill development of health care providers, increase their knowledge of SGBV guidelines and support their professional development.

The handover phase corresponded with the withdrawal of MSF support and the project transfer to the HZ. Key activities in this phase included joint supervision with the Equipe Cadre de la Zone de Santé (ECZ) and the MSF staff.

EVALUATION RATIONALE AND OBJECTIVES

In 2022, the Stockholm Evaluation Unit (SEU) and MSF commissioned a two-phase developmental evaluation of the decentralization initiative. An external multi-disciplinary team led both evaluation phases. The Phase 1 evaluation, conducted from July to November 2022, aimed to assess the design and planning of the decentralization initiative at the CSK and its prospective implementation process. We provide a summary of the findings and recommendations from the Phase 1 evaluation here and the full report is available [here](#).

The Phase 2 evaluation, which is the focus of this report, occurred from June to July 2023 and covered the implementation of the decentralization initiative at the CSK from April 2022 to March 2023. More specifically, Phase 2 objectives were to:

1. Determine whether the decentralization initiative has achieved its objectives by assessing changes in
 - a. The access to and utilization of sexual violence services, including contraceptive and abortion care, by survivors at the CSK level
 - b. The ability of CSK providers to offer “quality” holistic support to survivors of sexual violence
2. Assess the process and progress of implementing the decentralization initiative in HC2 and HC3
3. Identify learnings and (best) practices that illustrate successful and unsuccessful strategies for implementation and replication
4. Produce clear and actionable recommendations that MSF should undertake in the project's next phase.

The evaluation also examined the handover process, focusing on successes and lessons learned.

KEY FINDINGS AND RECOMMENDATIONS FROM THE PHASE 1 EVALUATION

KEY FINDINGS

- The Pilot was highly relevant to the DRC’s SGBV priorities and consistent with survivors’ primary care needs, but specialized services and comprehensive contraceptive care needed to be addressed.
- The design of the Pilot needed some improvements for greater coherence.
- Community mobilization required appropriate resources to be fully implemented.
- Capacity-building activities and community mobilization were potentially effective. The effectiveness of the partnership model with HZ has limited evidence.
- The one-year timeframe for implementation could hamper the Pilot’s prospect for impact.
- Some elements of the initiative have a high likelihood of replication and sustainability, but the overall potential to sustain results is moderate.

- The intersecting vulnerabilities of adolescents and people with disabilities, as well as gender dynamics in Central Kasai, have not been explicitly addressed.

RECOMMENDATIONS

- Develop a clearer understanding of the nature and scope of the decentralization initiative for greater coherence and internal consensus.
- Develop a post-hoc logical model, making some adjustments to the implementation activities, and using an integrated community approach.
- Strengthen monitoring and evaluation mechanisms and developing a stand-alone budget for the decentralization initiative.
- Outline more explicit criteria for site selection
- Harmonize and coordinate more with national and provincial regulations and approaches
- Develop a stand-alone budget for the decentralization initiative.

EVALUATION APPROACH AND METHODOLOGY

THEORETICAL FRAMEWORK

Given the stated desire to replicate the decentralization initiative after the completion of the Pilot phase [21], we used Rogers' theory of diffusion of innovations [22] as the theoretical framework for the overall evaluation. We assume that the generation, dissemination, and adoption of emerging lessons and good practices will involve a stepwise progression from awareness of the need for a new intervention to a decision to adopt (or reject) the new intervention to continued use of the new intervention. We anticipate that four main factors will influence the adoption of the lessons and best practices identified from this evaluation:

- **Relative advantage:** The extent to which a new intervention is considered better than the idea, program, or product it replaces
- **Compatibility:** The degree to which the new is consistent with the values, experiences, and needs of service beneficiaries, potential adopters, and other stakeholders
- **Complexity:** Degree of difficulty in understanding or using the new intervention
- **Observability:** The extent to which the new intervention provides tangible results

Although this theoretical framework undergirds the overall evaluation, it is most explicitly relevant for Phase 2. Specifically, we relied on this framework to get in-depth insights into the handover and replication processes, both successes and lessons learned.

EVALUATION FRAMEWORK

Given the evaluation questions suggested by the Stockholm Evaluation Unit (SEU) (see ToR in Appendix I) we based the Phase 2 evaluation on the revised Organization for Economic Cooperation and Development (OECD) framework for evaluating humanitarian and development actions [22]. The criteria included relevance, coherence, efficiency, effectiveness, impact,² and sustainability. Based on the lessons drawn from Phase 1, during Phase 2 we moved beyond the relevance (overall goal and purpose) of Piloting the decentralization initiative in the context of the Kamuandu health area to further assess the appropriateness of its model of delivery. This allowed us to determine the extent to which the activities implemented were tailored to the needs of their direct beneficiaries and consequently reinforced local community ownership and resilience [23]. Further, we expanded this conceptual framework to include gender and human rights considerations to capture the extent to which the decentralization initiative has been gender-responsive and inclusive of minorities (sexual and ethnic minorities and disabled people). We linked each evaluation criterion to its related questions:

² This evaluation did not assess the decentralized initiative's impact per se as it was not feasible to demonstrate that the Kananga Project has achieved high-level effects within the timeframe of this evaluation. However, this evaluation did assess the potential for impact.

1. **Relevance and appropriateness:** Did the design of the decentralization initiative sufficiently consider and respond to the needs and priorities of different stakeholders (survivors included)?
2. **Coherence:** Is the process of strategy, design, planning, and forward implementation coherent, given the context and existing resources? How could the decentralization initiative become more coherent?
3. **Efficiency:** What resources did the implementation of the decentralization initiative require, were they available, and how could they have been mobilized appropriately? Whether the resources available were used to get the best value for money and yield?
4. **Effectiveness:** Did the decentralization initiative achieve its objectives and intended results?
 - To what extent do the achievements meet the quality standards and expected results?
 - What are the reasons (facilitating or hindering factors, expected or unexpected challenges) why the decentralization initiative achieved its expected results or not?
 - If the Pilot did not achieve its expected results, how could it become more effective?
5. **Prospect for impact:** given the short time frame, has the decentralization initiative expected to have an impact (negative and positive consequences, expected or unexpected ones)?
6. **Prospect for sustainability:** What is the capacity of the local health centers/government of DRC to support the decentralization initiative (trained staff, equipment, supplies, logistics) after MSF's withdrawal? What is the capacity and intention of "other humanitarian medical organizations" to replicate the Pilot in other health centers in Central Kasai and beyond?
7. **Gender and human rights considerations:** To what extent has the decentralization initiative been gender responsive and inclusive? Has the Pilot successfully reached different ethnicities, sexual minority populations, and people with disabilities in terms of service delivery and health promotion?

METHODS

We began the Phase 2 evaluation by reviewing existing data sets and holding discussions with field-level staff and the consultation group to get their initial feedback. This process allowed us to update the interview guides used for Phase 1 and to develop the Phase 2 evaluation matrix. This matrix details more specific indicators, data sources, and methods used for data collection and analysis (see Appendix II).

For Phase 2, we used a mixed-methods approach to collect data given the nature of the evaluation questions and MSF's desire to replicate the decentralization initiative elsewhere. This data collection approach included the following:

1. **Desk review** of relevant documents from CSK and external stakeholders.
2. **Secondary analysis of data** from the Ministry of Health (MoH) District Health Information System 2 (DHIS2) system and the Kananga project database. We extracted routine data from DHIS-2 and exported to MS Excel®.
3. **Case study approach** to obtain in-depth insights on a) the readiness of the CSK to provide clinical care to survivors; b) the practices of healthcare providers in providing post-sexual violence care; c) the perceived self-efficacy of healthcare providers; and d) the estimated costs of providing post-sexual violence services. To assess the readiness of the CSK to care for survivors and estimate the cost of delivering post-sexual violence services, we used the Gender-Based Violence (GBV) Quality Assurance

Tool Minimum Care Version³ and the GBV cost calculator developed by the Health Policy Projects funded by the USAID,⁴ respectively [24, 25].

4. **Semi-structured interviews** with healthcare providers from the CSK (n=2), members of the Tshikula health zone management team (n=2), survivors (n=5), key MSF staff (n=7), and external stakeholders (n=2). We conducted most interviews in person but conducted two interviews with key MSF staff virtually. We completed most interviews (n=13) in French and interviewed survivors (n=5) in Tshiluba. We used interview guides developed specifically for this evaluation. We obtained oral informed consent from all the individuals interviewed (N=18) and with their permission we audio-recorded all interviews, which lasted 30–60 minutes.

This evaluation required survivors to discuss their experiences seeking health care in the wake of sexual violence. We recognize that this placed participants at risk of psychological discomfort and safety concerns, as is often the case when researching “sensitive” topics with vulnerable populations [26]. We employed survivor-centered and trauma-informed approaches in our interviews with survivors to [27] minimize these risks and ensured that participants had access to appropriate support in the wake of the interview, if desired and to the degree available. This included calibrating the interview guide and process to prioritize participants’ comfort, emphasizing during the informed consent process the voluntary nature of participation and the fact that interviewees could end their participation at any time, and reassuring participants that their involvement in the evaluation would not be tied to eligibility for current or future health services. We paid special attention to adolescent survivors by involving a trusted healthcare provider in planning the interviews and obtaining their consent. We conducted all interviews face-to-face and in safe spaces. We anonymized all data, including quotes, by redacting or masking potentially identifiable content. We also adhered to all requirements laid forth in Canada’s Tri-Council Policy Statement (2022) [28].

DATA ANALYSIS

We used an iterative approach to analyze qualitative and quantitative data collected during Phase 2. We analyzed the primary qualitative data for content and themes using inductive and deductive techniques [29,30]. Using ATLAS-ti, we coded verbatim transcripts, field notes, and summaries using the seven evaluation criteria (relevance, coherence, efficiency, effectiveness, impact, sustainability, and gender and human rights mainstreaming). We also considered emergent findings that did not fall into one of these a priori criteria.

³ The minimal version of the tool lists 25 standards for the provision of high-quality post-SGBV care in health facilities in the following areas: 1) availability and appropriateness of services; 2) facility readiness and infrastructure; 3) identification of patients who have experienced intimate partner violence and/or sexual violence; 4) patient-centered clinical care and communication; 5) referral system and follow up of patients; 6) training and quality improvement; 7) health care policy and provision; and 8) reporting and information systems.

⁴ The GBV cost calculator is an MS Excel-based tool the Health Policy Project developed to examine the cost of GBV services provided in health facility settings. The tool enables the user to look at total service delivery costs and unit costs, compare costs of various services, and determine cost drivers for an individual health facility.

The quantitative data analysis focused on the indicators systematically collected to monitor the decentralization initiative and reported in the MoH DHIS2 system and/or the project Kananga database. From the information available, we selected key performance indicators to detect and monitor changes in the provision and use of SGBV services. We then performed descriptive statistics to identify percentages, frequencies, and temporal, geographic, and demographic patterns wherever possible. We triangulated the data from different quantitative and qualitative sources (i.e., we performed an intra- and inter-category comparison) to enhance the credibility and reliability of the information.

We also conducted a contribution analysis to establish causal inference concerning the results and effects observed. This analysis component involved engaging with the Kananga project's implicit theory of change and linking it to the qualitative and quantitative results. This contribution analysis also assessed the influence of external factors that may explain the observed results and effects. Finally, to enhance the results' credibility, reliability, and transferability, we triangulated the findings from the different components of Phase 2 and related these to those previously published during Phase 1.

We provide information about the evaluation team in Appendix III.

FINDINGS

Based on our analysis of the existing documents and interviews with key project staff and those involved with the Pilot, we first outline the activities implemented and their resulting outputs. We then draw from all sources of data used in this evaluation to present the findings for each evaluation criterion in detail. We use the progress and results against each criterion to highlight strengths as well as areas for improvement.

ACTIVITIES IMPLEMENTED AND THEIR OUTPUTS

OUTCOME 1: IMPROVE ACCESS TO SGBV CARE

- INCLUDING CONTRACEPTIVE AND ABORTION CARE

To promote existing post-sexual violence care at the CSK and to increase demand for these services, the Pilot built on three community-led approaches:

1. MSF staff trained male community ambassadors to conduct door-to-door discussions with community members and identify and refer potential survivors. We found limited documentation on the extent of door-to-door outreach (i.e., number of community ambassadors trained, number of outreach visits conducted, number of people reached, and their demographics, etc.). Nevertheless, community ambassadors' engagement proved valuable, as evidenced by the high proportion (78%)⁵ of survivors who were referred/escorted to the CSK by the ambassadors or heard about the services through these channels.
2. The MSF health promotion team, in collaboration with the community ambassadors, conducted thematic group discussions with community members. Due to limited documentation, we could not determine the extent of these discussions (i.e., frequency, location, topic, and target and reach). However, the ambassadors reported they occurred mainly in communities close to the CSK, leaving remote and out-to-reach villages uncovered.
3. MSF identified about 16 pre-existing women-driven community initiatives in the CSK catchment area to serve as the basis for resilience committees for survivors. The project staff reported that they had yet to be fully implemented.

OUTCOME 2: BUILD STAFF CAPACITY TO PROVIDE HOLISTIC SUPPORT

- TO SURVIVORS OF SEXUAL VIOLENCE AT THE HEALTH CENTER LEVEL

The decentralization initiative supported the development of CSK healthcare providers' capacity to care for sexual violence survivors through three key activities and outputs:

1. All four CSK healthcare providers received 16 documented on-site training sessions on knowledge and clinical skills for responding to sexual and intimate partner violence. Providers received training from

⁵ Source: CSK clients' medical charts.

MSF on the essential elements of care, including the provision of first-line support⁶ (both medical and psychological), referrals or linkages to other services, management of children and adolescents who have experienced sexual violence, principles of patient-centered care, how to ensure confidentiality and privacy, collection of basic forensic evidence, and the sexual violence reporting and information systems.

2. CSK care providers benefited from 12 documented monthly and two quarterly supervisions conducted respectively by MSF and conjointly by MSF and HZ supervisors. The supervision log revealed that these visits focused mainly on auditing the quality of post-sexual violence care and data collection practices.
3. The CSK is an inclusive, safe environment that promotes the well-being of survivors and provides free, quality post-sexual violence care and support. CSK received logistic and financial support from MSF to improve its capacity to care for survivors in line with recognized standards of quality post-sexual violence care. This support included minor renovations to the CSK premises to ensure privacy and confidentiality and enhance safety, monthly financial subsidies to provide free post-sexual violence care, and the provision of abortion drugs (mifepristone and misoprostol), azithromycin for STIs, and hepatitis B and tetanus vaccines to complete the SGBV kit provided by the HZ.

RELEVANCE

To measure relevance, we assessed whether the overall objectives and inputs of the decentralization initiative were in line with the local needs and priorities of the government of the DRC. To complement the relevance, we also sought to determine the appropriateness of the Pilot. Specifically, we assessed whether the Pilot's core set of interventions – the post-sexual violence care package and capacity-building-related activities and community mobilization – were tailored to the needs of healthcare providers, survivors, and community members, respectively.

Our evaluation revealed that the decentralization initiative was relevant to the local needs and the DRC government's SGBV priorities, although its overall appropriateness was moderate. The capacity-building-related activities aligned to the needs of the CSK healthcare providers. However, a more holistic approach prioritizing the comprehensive medical and psychosocial needs of survivors, and an adequate planning and resourcing of the community mobilization-related activities to be more functional, would have enhanced the appropriateness of the Pilot.

Relevance to the priorities of the Congolese government and local health authorities

We found that of post-sexual violence health care at the CSK corresponded to the priorities of the DRC government and the Tshikula HZ's efforts to prevent and respond to SGBV, particularly sexual violence. The national strategy to combat SGBV in the DRC calls for holistic, multi-sectoral care and support to ensure survivors' health and social well-being. However, evidence shows that the Congolese government still needs appropriate resources (technical, financial, and logistical) to provide a comprehensive service

⁶ Essential SGBV care includes first-line support, defined by the WHO as basic empathetic counseling using LIVES: Listening, Inquiring, Validating, Ensuring safety, and Support through referrals, HIV and STI post-exposure prophylaxis, emergency contraception, and referrals, as needed [31].

package to the survivors [10]. This gap in post-sexual violence service provision is critical in both conflict and non-conflict areas. However, the dominant discourse frames sexual violence in the DRC as “a weapon of war” and attention and resources focus on conflict zones, leaving non-conflict and post-conflict areas underserved [32]. In addition, significant disparities in SGBV services between rural and urban or peri-urban areas are reported in most provinces [10].

In the case of the Tshikula HZ (a rural, post-conflict area), MSF was the only medical actor to offer comprehensive support (technical, financial, and logistical) to the health zone to integrate post-sexual violence care into the CSK from April 2022 to March 2023. Moreover, during data collection for the Phase 2 evaluation, we found no potential actors capable of taking on this role after the MSF’s withdrawal.

The local health authorities considered the Pilot relevant to the Tshikula HZ’s efforts to respond to sexual violence and pleaded for continued MSF support to sustain post-sexual violence care at the CSK. As a member of the Tshikula HZ executive team commented:

“It’s true that MSF’s support was limited to the Kamuandu health center, but what we appreciated most was that MSF’s support enabled the most vulnerable to access [post-sexual violence] care for free, and then the quality of this care was also good...Our advocacy is to see MSF continue its support to ensure the continuity of activities. We cannot deny that with the withdrawal of MSF, [post-sexual violence] care will no longer be the same...Personally, I would like MSF to continue its support. “

RELEVANCE TO THE NEEDS OF COMMUNITY MEMBERS

- INCLUDING COMMUNITY ASSOCIATIONS AND AMBASSADORS

To ensure the effectiveness and sustainability of the Pilot, MSF planned to liaise with existing community-driven initiatives to create resilience committees. However, there was a bit of a disconnect between the priorities of the decentralization initiative and the priorities of community associations, thus undermining appropriateness. One Kananga program staff member emphasized that these committees were meant to lay the foundation for the recovery, resilience, and empowerment of survivors. However, this key informant acknowledged that the resilience mechanisms could have been more functional if they had been better planned and resourced and pointed out that the livelihood-focused priorities of these community initiatives diverged the from scope of the Pilot.

In addition to the promotion of services and communication and information for behavior change led by the community ambassadors, it was important that we also had a resilience component in the decentralization initiative... We planned to rely on existing community-driven associations to ensure the social integration of victims of sexual violence. We thought, but I don't know to what extent, that income-generating activities run by community members would help finance the provision of post-violence care in the CSK...We had designed this model to ensure continuity in the provision of post-sexual violence and

family planning services in the absence of MSF...In the case of the Tshikula health area, community-based activities are focused on agriculture, which does not fit in with MSF's priorities. Also, the perception of community members was that MSF would fund their activities, whereas we expected them to self-organize. For example, one of the associations hoped to receive agricultural inputs from us, whereas MSF is not involved in agriculture... As long as there are no resources to ensure the operation of these community-led associations, [we] understand that they cannot function well, despite good ideas and their obvious willingness to get involved.

On the other hand, MSF worked with a cadre of volunteer community ambassadors to conduct door-to-door outreach on sexual violence and identify and refer/escort potential survivors to the CSK for care and support. All of the community ambassadors we interviewed expressed a commitment to addressing sexual violence in their community. This reflects the overall relevance of the Pilot to the community. As one community ambassador reported, *"We do free work; we work for free because, as community ambassadors, we are responsible for linking community members with the health centers. We do this work out of love for our community without expecting anything in return."*

However, community ambassadors also noted that MSF could have considered compensating them for their time and/or giving them adequate resources to engage with their communities, which would have enhanced the appropriateness of the project to the local context:

"[We] encountered difficulties in carrying out this work; sometimes, we had to walk very long distances and sometimes we had to go and do these sensitizations without financial compensation or any snacks...All we had received from MSF were leaflets, not megaphones. The megaphones were given to the health center, not to the community ambassadors. We believe that the community ambassadors should be financially compensated because every job deserves [compensation]. The projects must consider compensating for the work of the community ambassadors, giving us outfits and equipment to work during the rainy season...if we have boots and raincoats, this could also protect the community ambassadors. We even lacked pens and notebooks to document and report our activities."

RELEVANCE TO THE NEEDS AND EXPECTATIONS OF HEALTHCARE PROVIDERS

To assess the relevance and appropriateness of the decentralization initiative to the expressed needs and expectations of the CSK providers, we interviewed two providers. Both felt that the Pilot had met their expectations regarding capacity building in the provision of comprehensive post-sexual violence care, including abortion care, and viewed the Pilot as appropriate. Before the Pilot, both providers had been trained in managing sexual violence cases and supplied with medical commodities for family planning and sexual violence by a previous stakeholder. However, they feel that the Pilot's comprehensive (technical, financial, and logistic) support has been especially beneficial. Further, the minor renovations of the CSK enabled them to provide private and confidential post-sexual violence care and the monthly subsidies from MSF guaranteed all survivors free access to post-sexual violence care. As one provider stated:

“Thanks to MSF’s support, we were able to offer quality care to survivors of sexual violence in our health area free of charge. Moreover, other health centers were referring survivors to us because they knew we had adequate resources and skills to care for them. Thanks to MSF, we could offer survivors medical and psychosocial care, using a clear protocol of care set up by MSF... Also, we were providing family planning services to women and abortion services to survivors who wish to interrupt pregnancies resulting from rape.”

RELEVANCE TO THE NEEDS AND EXPECTATIONS OF SURVIVORS

Overall, the Pilot aligned to the physical and medical needs of survivors but fell short of meeting their psycho-social needs. Most of the survivors we interviewed felt that the Pilot was relevant given the community context and satisfied their medical needs. For example, one survivor noted:

“[After the sexual assault] I had back pain. They did the tests and gave me the results and the medication; it was the same day [I went to the CSK]. Later, I came back to explain that my abdomen hurt too much, especially during the night. They gave me the medication, and my health returned to normal. They treat their patients well.” Another survivor stated, “I will tell [other survivors] to go to the center. They are treating [survivors] free of charge to prevent consequences [of sexual assault] and other illnesses; I can give them my example.”

However, some adolescent survivors expressed unmet needs for contraception and abortion care. A 16-year-old survivor explained, “*My concern [request] is that you can’t help me with contraceptives. I was afraid [to ask the provider]. I told myself that they might accept or refuse.*” A 13-year-old survivor reported:

“I came to CSK for both the pregnancy and the violence. They tested me to see if I had health problems. They told me I had lost my virginity and that I was pregnant. They [CSK providers] gave me products to keep me pregnant. They told me to keep the pregnancy [and that] if I abort it, I will die. Provider X told me not to have an abortion...[and] did not inform me of the possibility of having a safe abortion.”

Although MSF has trained the CSK providers in the provision of comprehensive abortion care and made available both mifepristone and misoprostol available, taboos surrounding sexual care for adolescents and unmarried women and negative attitudes of some healthcare providers toward abortion constituted ongoing barriers to the effective delivery of comprehensive care at the CSK level.

Moreover, while the Pilot met the healthcare needs of the majority of survivors we interviewed, all survivors felt that the Pilot could have more strongly considered their needs for social support, including justice, economic aid, and social reintegration. As one adolescent survivor explained, “*Since I was raped,*

no one helped me with school [fees]. I should continue my studies. I stopped because of [the rape]. I am just seeking your help.” Another survivor reported:

“I feel bad – he destroyed my home where I could be cared for. He abused me. When I see him walking around [free], I feel bad. I thought he could be arrested so I could feel justice had been done. [But as] I am not from the village, he was released... I am seeking help to raise my children as I currently have no resources... I still feel bad. I thought he could be arrested. Even my mother-in-law mistreats me. She tells me, “My son, who could keep me left because of you!” I thought he could be arrested... The chief asked him for a goat, five chickens, and 50,000 Congolese Francs. I do not know if he paid.”

Both national and global guidance emphasize the importance of prioritizing the rights, needs and expectations of survivors when designing and implementing sexual violence programming to address their complex needs (legal aid, shelter/protection, healthcare, economic support, and social reintegration) [33-37]. One key informant from MSF called for a paradigm shift in MSF’s approach to responding to sexual violence, from a medically focused approach to a more holistic and integrated approach to address the complex needs of survivors:

“[The survivors] were more concerned about where they were going to...what they were going to eat. How do I provide for my child because I can’t go home? But these protection mechanisms [are] kind of outsourced to other actors...What I hear from the debriefings or from the documents [is that] we’re not comprehensive, and the problem is that our organization focuses very much on medical care. So, we will say we have met the needs of the patient medically, but they may not see that they need psychological support because shelter and food, economic issues are what they see as their priority.”

COHERENCE

We sought to determine the extent to which the process of strategy, design, planning, and implementation of the decentralization initiative was coherent, given the overarching context and available resources. Resources refers to the human, material, medical, and financial inputs, tools, and time required to implement the Pilot. Our evaluation indicates that external coherence was high but internal coherence was more mixed.

ALIGNMENT WITH THE DRC’S NATIONAL STRATEGY FOR COMBATTING SGBV

- FOLLOWING NATIONAL GUIDELINES FOR THE CLINICAL MANAGEMENT OF RAPE

The DRC’s national strategy to fight SGBV calls for a collaborative, multi-sectoral approach to address survivors’ comprehensive and holistic needs that include health, legal aid, protection, and socio-economic reintegration. The decentralization initiative as designed was aligned with this remit and the Pilot played

a significant role in meeting the medical component of this framework in the CSK. In particular, the decentralization initiative addressed a number of the Congolese health system's challenges through inputs such as coverage of medical costs, training, minor renovation of infrastructure, and clinical mentorship.

However, our evaluation did reveal some differences between the MSF protocol for the clinical management of rape at the CSK and the MoH's protocol in the Tshikula HZ. Among other things, the protocol of the decentralization initiative guarantees abortion care, vaccinations against tetanus and hepatitis B, and the provision of HIV-PEP outside the critical 72-hour window. These are not part of the national standard of care protocol. Indeed, the clinical management of rape protocol established by MSF at the CSK is more comprehensive and aligns with international standards for providing post-sexual violence clinical care [36,37]. However, given that the explicit outcomes of the partnership with the HZ, included sustaining the decentralization initiative at the CSK and replicating it elsewhere, additional efforts were needed from MSF to harmonize the two protocols. One healthcare provider highlighted his concern:

“We're still wondering how we're going to continue offering healthcare to the survivors because, as you know, our partner has left us. So far, we're using the stock of medicines they left us, but we're wondering how we'll be able to replenish our supplies. It must be said that certain medical commodities were supplied exclusively by MSF and were not included in the national kit for managing sexual violence. For example, the hepatitis B vaccine, exclusive to MSF, is unavailable from our Ministry of Health. When the stock runs out, we don't know how we're going to take care of the survivors. Another concern is abortion drugs, which only MSF provides. And when these drugs run out, we won't be able to offer abortion care. You know, there's also azithromycin and metronidazole 500 mg for STIs, which are only supplied by MSF. Once its stock runs out, we'll be stuck. We recognize that the support of any partner has a start and an end, but our wish was to perpetuate the Pilot's achievements and that the treatment of sexual violence continues here.”

Another unintended consequence of this disharmony was that the provision of abortion care at the CSK turned out to be a siloed activity. CSK healthcare providers did not document abortion-related care in official health information records or report abortion care to the national health information system, leaving limited room for monitoring or auditing their abortion-care-related practices by local health authorities. Moreover, some survivors stated that one healthcare provider from the CSK was reluctant to offer abortion care based on personal convictions and fear of reprisals. This has led to the inconsistent provision of abortion care by providers at the CSK, thus depriving some survivors of the opportunity to fully exercise their sexual and reproductive rights. The structural challenges to providing abortion care in Central Kasai, namely the taboo surrounding abortion-related care and the lack of dissemination of the Maputo protocol, undermine external coherence.

PARTNERSHIP WITH THE LOCAL HEALTH AUTHORITIES

- FACILITATED ENGAGEMENT IN AND SUPPORTED REPLICATION/INSTITUTIONALIZATION OF THE PILOT

Strong evidence shows that MSF embarked on a number of processes to secure the HZ's commitment to the decentralization initiative and thus ensure the continued provision of post-sexual violence care at CSK after MSF's withdrawal. These efforts included signing a memorandum of understanding with the HZ at the outset of the decentralization initiative, securing the involvement of HZ executives in the Pilot site selection, and conducting joint supervision of the provision of post-sexual violence care at the CSK. In addition, MSF used the pre-existing drug supply chain in the HZ to supply the CSK center with medical commodities.

However, the over-reliance of the local health system on external donors created a barrier for the uptake of the Pilot that MSF was not able to fully overcome. For greater coherence, the Pilot could have adopted or developed a more collaborative approach that would have fostered the local health authority's ownership of the decentralization initiative.

A MULTI-COMPONENT INTERVENTION

- REQUIRED TO ADDRESS THE COMPLEXITY OF SEXUAL VIOLENCE

In the post-conflict context of the Kamuandu area the survivors we interviewed reported that their intimate partners or community members in positions of authority (teachers and in-laws) were the perpetrators. This dynamic of community members being aggressors poses a significant obstacle to survivors' ability to seek post-sexual violence services, including healthcare, for fear of reprisals and rejection. As one survivor stated:

“One day, I was coming back from the field and my father-in-law's child touched me on my breast. I chased him, but he insisted...He told me later “You've become beautiful, we have to start having sex.” I asked him, “What are you doing?” ...Because he was a man full of strength, I didn't have the strength to run away from him. He took off my underwear and started raping me. When my husband heard about it, he divorced me.”

Our evaluation showed that adaptations had been made to the decentralization initiative to address the changing dynamics of sexual violence in Central Kasai Central after the conclusion of the Kamwina Nsapu conflict. MSF took both a clinical and community-based approach in the Pilot. We found that MSF also capitalized on the strong connections the pre-existing Health Area Development Committees⁷ had with

⁷ The mechanism for community participation in health domains in the DRC is embodied within the Comité de Développement de l'Aire de Santé (CODESA), translated here as the Health Area Development Committee. This is a community participation body, representing all the villages or streets in a health area. Depending on its composition, the committee is multi-sectoral and multi-disciplinary. The CODESA is the interface between a health center and its population; the volunteer community relays are key players in this component of the initiative.

community members to raise awareness of sexual violence [34], advertise available services, and identify survivors.

However, there were missed opportunities to tackle the dynamics shaping SGBV in Central Kasai through a more robust and better articulated multi-component response to sexual violence. Findings from both the document review and our interviews with HZ staff and community ambassadors revealed that the clinical and community components of the Pilot were implemented as two separate “interventions” with different efforts and resources and little connection. Specifically, there was an imbalance in planning and resource allocation to the community outreach component of the Pilot compared to the clinical intervention component of the initiative, leading to limited coverage of community outreach.

First, we found minimal written evidence of implementation and monitoring plans for the community outreach activities, including the audiences to reach, objectives, indicators, and targets. Second, the community ambassadors and senior staff from the HZ commented that the lack of resources (financial compensation, clothes and gear, transport, and communication materials) limited their ability to perform door-to-door outreach, especially during the rainy season and in hard-to-reach areas. A community ambassador commented:

We needed equipment to work properly...by equipment I mean transport to raise awareness in villages that are too far away from the Kamuandu Health Center, villages located two or three hours' walk from the health center. I go to raise awareness in these villages and come across a case of sexual violence, I'm talking here about communities living in the forests. How am I going to escort the case? Also, I think I needed boots, raincoats to work in rainy weather, and motivation bonuses; all this, I think, would have helped us a lot. We've raised awareness, but you know, our health area is made up of 10 villages...How can we reach the villages of Katshioko and Katubue, which are so far away? We only raised awareness in the village of Kamuandu and its surrounding area, targeting the inhabitants present when we visited. We carried out this work under the supervision of MSF, targeting at least 20 households and raising awareness under the supervision of MSF teams.

To ensure greater coherence between the clinical and community components of the Pilot, program staff could have linked them through an integrated theory of change and/or logic model, allocated adequate resources to both, and/or established a monitoring plan and a mechanism for cross-utilizing data to inform the implementation of both initiative components.

OTHER FACTORS INFLUENCING COHERENCE

MSF's contributed to the provincial health system response to SGBV through active participation in the GBV sub-cluster under the leadership of UNFPA. Specifically, the decentralization initiative fostered an integrated and effective effort to respond to sexual violence, avoiding duplication of effort and wasted resources. MSF aligned its supply chain with the pre-existing mechanism for providing post-sexual

violence services to HZs set up by the Ministry of Health with UNFPA support. Similarly, MSF piloted the decentralization initiative in the Kamuandu health area, which was not supported by any other actor in the fight against SGBV over the course of the Pilot, to avoid duplication of efforts.

MSF was also committed to collaborating with stakeholders from the wider protection sector as part of its multi-sector response approach to sexual violence. Indeed, MSF facilitated the development of a referral pathway at the CSK that included specialized service providers' names and contact information. Documents from an organization providing shelter to vulnerable women and children in Kananga showed that over the course of the Pilot MSF staff escorted two survivors from the CSK to the Kananga provincial hospital for further medical treatment. This protection service accommodated them during their stay in Kananga City for specialized medical care.

However, despite this commitment the decentralization initiative would have benefitted from more formal referral systems to link survivors to specialized services. This would have allowed for greater coherence between the program and the rural and remote context of the CSK. We were not able to identify an established tool for screening survivors for specialized services or standard operating procedures, including the “who, when, how, and where,” for referrals. Further, all the specialized service providers included in MSF's referral map were located in Kananga, more than three hours by vehicle from Kamuandu and no public transport exists in this region.

Findings from our interviews indicated that the absence of formal referral standards and resources made implementation of referrals ineffectual. Specifically, CSK healthcare providers stated that they often used their credit cards and phones to contact specialized service providers. They also reported having had sheltered survivors with an elevated safety risk in their own homes.

“We provided the survivors with all the help they needed to ensure their health and psychosocial well-being. As you know, the big problem in our community is that victims who report sexual violence are subsequently rejected by their families or husbands. Here in Kamuandu, we don't have a shelter or care facility for victims who have nowhere else to go. In many cases, I've had to house victims afraid to return to their families.”

In addition to referral challenges specific to the Pilot (namely the lack of standard operating procedures and resources), the limited availability of such services in the CSK catchment area undermined the comprehensiveness and quality of the overall response. *“We did our part by giving survivors the contact information for services specializing in the social care of survivors. But since most of these organizations are located in Kananga, this discourages victims. Also, these organizations have internal constraints that prevent them from taking care of all the victims referred to them.”*

EFFICIENCY

To measure efficiency, we evaluated the level of resources allocated for the decentralization initiative, whether these resources were sufficiently available, and whether the resources were used to get the best value for money and yield. We focus our analysis on the financial, medical commodities, human resources, and materials needed for the Pilot and our findings suggest that more resources should have been allocated to the health promotion component of the decentralization initiative.

COVERAGE OF SGBV COSTS AT THE CSK

Since fiscal year 2022, the Kananga project has been gradually reducing its humanitarian operations in Central Kasai. Despite this, the monthly subsidies of USD250 allocated to the CSK to secure free-of-charge post-sexual violence services remained unchanged. MSF's consistent commitment to providing free treatment for sexual violence survivors, as required by the Congolese legal framework for managing SGBV, was a key factor in improving access and utilization of post-sexual violence services. However, we were not able to secure accurate or complete operational data to assess costs associated with specific Pilot components (medical staff, support staff, drugs, equipment), the cost per survivor treated, or more granular information about the cost of different service delivery components (post-exposure prophylaxis, testing, forensic examinations, referrals). Without this information, it is difficult to develop financial models for either replicating or maintaining the initiative.

EFFICIENCY CONSTRAINTS

Our evaluation suggests that there are several factors that constrained the efficiency of the Pilot. Notably, MSF prioritized allocating resources to the clinical component of the initiative and invested far less in the health promotion and community engagement component of the initiative. Directing some resources to compensating and supporting community ambassadors could have been an effective way to enhance the yield of the health promotion/community engagement activities.

The MSF Health promotion team communicated, coordinated, and liaised with existing Health Area Development Committee (also known as the CODESA) to implement the community engagement component of the initiative. However, there were missed opportunities to ensure a more efficient use of community ambassadors. Our interviews with the community ambassadors revealed that the Health Promotion team was facilitating the thematic group discussions with community members, whereas this activity was meant to be an integral part the strategy of the Pilot to build community engagement and resilience to sexual violence. Devoting the facilitation of thematic group discussions to the community ambassadors could have relieved some of the burden on the Health Promotion team, who might then have had more time to focus on the supervision and monitoring of the community-based activities, a way to support the effectiveness of the Pilot. Further, devoting the full range of community mobilization activities to community ambassadors would have enabled them to gain appropriate skills and build community engagement on sexual violence, and thus sustain the Pilot's achievements over time.

Finally, we also identified inefficiencies in the supply of medications and the way that post-exposure prophylaxis kits were managed.

EFFECTIVENESS

The absence of a performance framework specific to the Pilot, including indicators with their baseline and end-line targets, makes assessing effectiveness challenging. The evaluation team attempted to use the larger Kananga project indicators. However, those indicators were more related to activities and outputs, rather than outcomes, and were not adapted to the Pilot. It is therefore difficult to conclude categorically whether the intended outcomes of the Pilot have been fully achieved or not without a benchmark for comparison. However, our evaluation denoted an increased number of survivors accessing post-sexual violence care at the CSK and an improved capacity and self-confidence of healthcare providers to care for survivors.

OUTCOME 1: IMPROVE ACCESS TO SGBV CARE

- INCLUDING CONTRACEPTIVE AND ABORTION CARE

DHIS2 data from prior to the implementation of the Pilot indicate that post-sexual violence care was not offered at the CSK. According to the same source, from April 2022 to March 2023, 76 survivors benefited from post-sexual violence clinical care at the CSK, or an average of 6 clients per month (see Fig.2). We do not have additional information by which we can disaggregate these data. Of the 76 survivors cared for at the CSK during the Pilot, 60 (79%) received the comprehensive PEP kit within the critical 72-hour window after the assault,⁸ compared to an estimated 49% and 61% at the national and provincial levels, respectively [15].

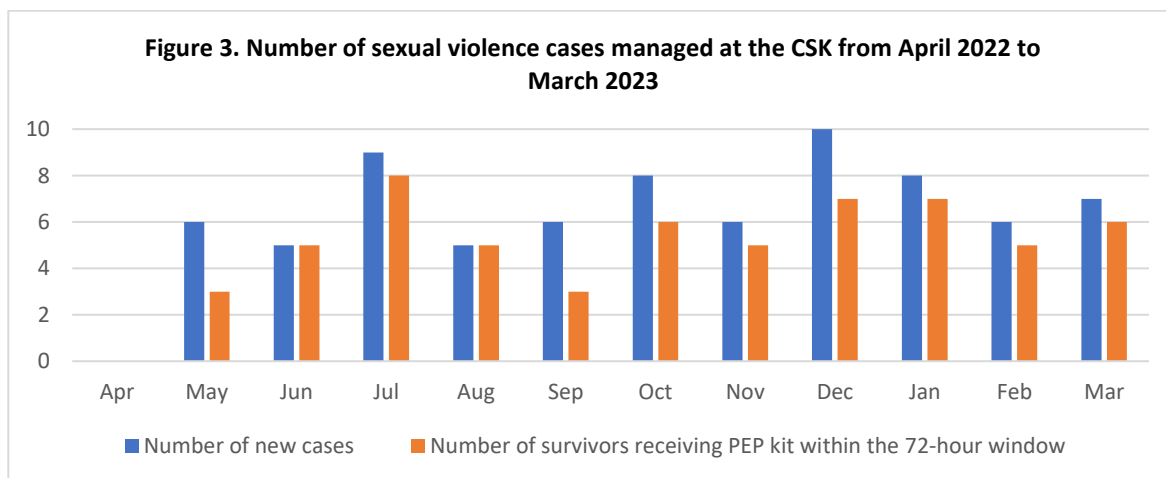


Figure 3. Number of sexual violence cases managed at the CSK from April 2022 to March 2023.
Source: DRC MoH’s DHIS2 report from April 2022 to March 2023

⁸ Source: DRC MoH’s DHIS2 report from April 2022 to March 2023

The Pilot made a substantial contribution to the Tshikula HZ's effort to respond to sexual violence. Indeed, data from the DRC MoH's DHIS2 revealed that of the 186 cases of sexual violence reported in the HZ from April 2022 to March 2023, 41% were managed at the CSK.

OUTCOME 2: BUILD STAFF CAPACITY TO PROVIDE HOLISTIC SUPPORT

- TO SURVIVORS OF SEXUAL VIOLENCE AT THE HEALTH CENTER LEVEL

To assess the effectiveness of the capacity-building activities (training, supervision, and logistical support), we used the clinical practices and perceived self-efficacy of healthcare providers and the readiness of the CSK to respond to sexual violence as indicators [38-40].

HEALTHCARE PROVIDERS' CLINICAL PRACTICES

Our evaluation centered on the clinical practices of healthcare providers using as criteria the proportion of survivors who received a range of services at the CSK per the clinical management of sexual violence protocol established by MSF at the CSK. We selected 20 random and diverse records (clinical, medical, and forensic) from April 2022 to March 2023 to do a deeper dive into provider practices and we ensured that these records involved different providers.

The overall proportion of survivors receiving post-sexual violence care at the CSK per the MSF established protocol was 94%, excluding abortion care.⁹ CSK healthcare providers demonstrated good clinical practices in a range of services as reflected in the high proportion of eligible survivors who received emergency contraception (90%), HIV PEP (92%), STI prophylaxis and treatment (96%), vaccination against tetanus (90%), vaccination against hepatitis B (90%), and psychological first aid (100%). In addition, healthcare providers documented basic forensic evidence per the established protocol in every case. In addition, 20 women, including 4 survivors, received abortion care at the CSK.¹⁰ Thus our evaluation suggests that the training, strong mentorship from MSF staff, and a robust drugs management system positively influenced the ability of CSK providers to care for survivors per the protocol set by MSF.¹¹ However, as noted previously, the program would benefit from standardizing the system for referrals.

HEALTHCARE PROVIDERS' SELF-EFFICACY

Drawing from our interviews with CSK providers, we explored three dimensions of self-efficacy: 1) Experience providing care to survivors before and after the implementation of the Pilot; 2) Perceptions of client trust; and 3) Self-reported knowledge and skills related to post-sexual violence care.

⁹ We do not know how many survivors were eligible for abortion care nor the number of survivors who requested abortion care and thus do not have a baseline number from which to assess adherence to the protocol.

¹⁰ Providers do not document abortion-related care in individual files. Instead, they record abortions provided in an aggregated format and specify those related to rape.

¹¹ Prior to the Pilot, the CSK did not formally integrate post-sexual violence care. However, providers also benefited from training in the clinical management of SGBV cases per the national protocol. This training, led by the HZ and UNFPA, took place around June 2022.

The providers we interviewed reported that they all felt inexperienced in providing care to survivors prior to the Pilot. Interviewees specifically mentioned the importance of MSF's training and ongoing mentorship from MSF staff as increasing their confidence in providing post-sexual violence care. Interviewees also mentioned the critical role that having commodities on hand played in their ability to offer services and that the quality of care and the financial subsidies increased the trust that clients placed in the providers. Ultimately, providers reported having confidence in their knowledge and skills related to the clinical management of rape and in their ability to provide high quality care that complies with the MSF protocol. This high level of self-efficacy among providers appears to be directly related to the Pilot and is largely in line with the clinical practices data.

READINESS OF THE CSK TO PROVIDE CARE AND SUPPORT TO SURVIVORS

To assess the quality of existing post-SGBV care services, we used the GBV Quality Assurance Tool Minimum Care Version [25].¹² We measured the quality of care by analyzing the post-SGBV services at the CSK against the 23-core standard. Our analysis showed that the CSK had achieved a high-quality level in a range of standards as displayed in Table 1. The overall proportion of adherence to the established standards was 78% (18 out of 23), showing that post-SGBV care is accessible and available, essential infrastructure, equipment, and services are in place, providers deliver respectful and high-quality care, relevant policies and procedures are followed, and staff have appropriate training and skills to deliver care.

¹² Per the guidelines, we used the minimum version of the tool because the CSK is located in a limited resource setting and the post-sexual violence service was under development.

Table 1. Analysis of the quality of post-sexual violence care at the CSK, from April 2022 to March 2023, using the revised 2021 GBV Quality Assurance Tool Minimum Care Version

STANDARD	#OF CRITERIA BY STANDARD	#OF CRITERIA MET BY STANDARD	% ACHIEVEMENT BY STANDARD
Availability and appropriateness of services	1	1	100
Identification of potential survivors of sexual violence or IPV in routine care	2 ¹³	2	100
Facility readiness and infrastructure	2	2	100
Patient-centered clinical care and communication	11	9	82
Healthcare policy and provision	1	1	100
Information and reporting system	2	1	50
Training and quality improvement	2	2	100
Referral system and follow-up of survivors	2	0	0
Number of standards considered and overall achievement	23	18	78

However, we also identified several areas where there is room for improvement: 1) Feedback mechanism for patients to anonymously report their level of satisfaction or any grievances with services, including any violation of their rights (e.g., suggestion box.); 2) Documentation of informed consent, specifically for minor survivors; 3) Assessment and responsiveness to the risk of immediate violence or harm after disclosure (i.e., safety planning); 4) Referral system in place to ensure the patient is connected to all necessary services; and 5) Patient follow-up for subsequent services.

PROSPECT FOR IMPACT

While many definitions of impact exist, for the purpose of this evaluation we conceptualized the impact of the Pilot as: 1) The formal decision of health authorities to adopt the Pilot via policies or to replicate it elsewhere or to extend its reach through increased coverage and/or resources; and 2) The transformative long-term effects of the Pilot on the healthcare-seeking behaviors around sexual violence. In the absence of a formal conceptual framework for measuring the impact of the decentralization initiative, for the sake of enhancing the evaluability of the initiative, we framed the Pilot’s impact as its transformative effect on local health authorities’ capacity to replicate the decentralization initiative and the long-term effect on survivors’ healthcare-seeking behaviors. Given that we carried out this evaluation three months after MSF withdrew from the CSK, we could only assess the Pilot’s prospect for impact as it is premature to assess its long-term transformative effects [32].

¹³ The standard includes 3 criteria. However, we only considered 2 criteria, as one was not applicable for the CSK.

PROSPECT FOR IMPACT ON THE CAPACITY OF LOCAL HEALTH AUTHORITIES

- TO REPLICATE THE DECENTRALIZATION INITIATIVE

The Pilot's partnership model with local health authorities was meant to create local ownership of the decentralization initiative aimed at sustaining the Pilot at the CSK or securing its replication elsewhere. This partnership model included, amongst other activities, the conduct of joint supervision by MSF and the ZS executive team once a quarter and handover of the Kamuandu health center to the health authorities at the end of the Pilot. This handover was reflected in closing meetings and the supply of a 6-month buffer stock of medical commodities to CSK. The model of partnership with health authorities could have been better elaborated by clearly specifying its intended outcome (for example, what exactly does constitute a successful handover process?) and the causal pathway to achieve such an outcome (i.e., how, and why this partnership model would have ensured the replication of the Pilot?). Our interviews with the CSK healthcare providers and key informants from the Tshikula HZ revealed that it is unlikely that this partnership model could enhance the ability of local health authorities to take over the Pilot and support its replication given some constraints specific to DRC health systems (overreliance on external donor financings to respond to SGBV, dependence on imported drugs, a poor supply chain, non-dissemination of the Maputo protocol in Central Kasai, etc.). Although these elements are outside of MSF's control, there do not appear to have been fully considered during the handover phase of the decentralization initiative.

PROSPECT FOR IMPACT ON THE CAPACITY OF SURVIVORS

- TO SEEK POST-SEXUAL VIOLENCE CARE AND SUPPORT

In terms of healthcare-seeking behavior changes, the Pilot's design includes strategies proven to have great transformative change on the capacity of survivors to seek for post-sexual violence care (i.e., community-driven interventions, including door-to-door outreach and thematic group discussions) [32,33]. However, there are a number of planning and implementation pitfalls and external factors to the Pilot that our evaluation suggests reduced the Pilot's prospect to change the healthcare-seeking behavior around sexual violence.

First, the one-year timeframe allocated to the Pilot is likely insufficient to change traditional gender roles fueling sexual violence, the stigma surrounding sexual violence, and healthcare-seeking behaviors among survivors in Central Kasai. As one community ambassador explained:

“In the community, when we find victims who make amicable arrangements with their aggressors, we insist they go to the health center for treatment. Apart from these out-of-court settlements, another major difficulty in accessing care is victims' failure to report sexual violence due to the power imbalance between men and women. It's the moral hold that aggressors have over their victims that prevents them from reporting. The men tell them [survivors], listen, don't denounce me; in exchange, I'll give you such and such present. Don't tell anyone. With such moral ascendancy

and the economic vulnerability of women in this community, the victims choose to keep their sexual assault a secret. Also, when her aggressor promises to marry her off, the victim chooses to keep quiet...The violent reaction of victims' families; when they are informed that their daughter has been raped, they make noise and try to attack the aggressors, which violates confidentiality and discourages denunciation and healthcare seeking. “

Second, designing a multi-component intervention requires anchoring various components to a comprehensive, embedded theory of change/logic model, including the inputs, activities, outputs, and expected outcomes for each component. The logic behind the Pilot could have been better articulated to inform the appropriate allocation of resources and better implementation consistency, especially given significant staff turnover. The relatively modest investment in health promotion and community-based activities had reduced the reach of the community mobilization, and subsequently undermined its prospect for impact. Further, the prospects for impact would have been enhanced had the resilience committee component of the intervention been implemented.

OTHER FACTORS INFLUENCING THE PROSPECT FOR IMPACT

Gender dynamics in Central Kasai, including the social and economic vulnerability of women and girls, should have been considered more deeply during the Pilot's design for potential impact on post-sexual violence care-seeking behaviors. In this regard, the Pilot could have also addressed women as “champions for change” to challenge the prevailing power imbalance that fuels sexual violence and undermines the seeking of support [12-14]. MSF took significant measures to adapt its SGBV response interventions to fit the Central Kasai region, including engaging community ambassadors. However, the lack of incorporation of women as community ambassadors, the challenges associated with engaging with community-driven initiatives, and the absence of the resilience committees dampened the prospects for impact as the initiative is less likely to address deeply rooted barriers – such as survivors' reluctance to approach official services.

The impact of any health intervention depends on its coverage/reach and potential ripple effect. The Pilot was implemented in a single health center (out of 40 health facilities in the HZ) and only four healthcare providers were trained on the clinical management of SGBV. Implement of a Training-of-Trainers Model could have had a ripple effect [43]. Given that one of the explicit goals of the decentralization initiative was to sustain the provision of post-sexual violence care at the CSK or replicate the Pilot elsewhere, such a training model could have increased the critical mass of staff trained in the management of sexual violence in the Tshikula HZ and provided an available trained workforce in the event of staff turnover at the CSK or when replication moves forward.

PROSPECT FOR SUSTAINABILITY

To assess the Pilot's likelihood of being sustained, we examined the extent to which the results achieved against the immediate outcomes could last after the withdrawal of MSF. More specifically, we made our judgment by considering the perceived capacity of local authorities to take over the Pilot (as evidenced by the interviews we conducted with members of the Tshikula HZ's executive team), the number of survivors accessing care at the CSK 3 months after the end of the Pilot, and the extent to which health promotion-related activities have been carried out and the time allocated for implementing the Pilot. The findings show that the Pilot presented limited potential for sustainability. Key informants were dubious about the possibility of the CSK continuing to offer free, quality care to survivors after the Pilot's close-out. Lack of medical supplies and financial support were reported as significant obstacles to the continuity of care.

OUTCOME 1: IMPROVE ACCESS TO SGBV CARE

- INCLUDING CONTRACEPTIVE AND ABORTION CARE

As a core component of the decentralization initiative, the health promotion-related activities (door-to-door outreach and thematic group discussions) supported the Kamuandu community in coping with and addressing sexual violence. This created supportive environments and strengthened community action and personal skills to assess and utilize post-sexual violence care at the CSK. In fact, data from the client chart review revealed an estimated 78% of survivors were referred/escorted to the CSK by the community ambassadors or heard about the services through these channels. Moreover, according to the data from the DHIS2, 79% of survivors accessed care within the optimal 72-hour window after the sexual assault, surpassing the estimated national average. This strong performance could be attributed to the involvement of community ambassadors in identifying potential survivors in the community and referring/escorting them to the CSK for early initiation of care, coupled with the availability of high-quality post-sexual violence services at the CSK level. At the time of data collection for the Phase 2 evaluation trends in the use of post-sexual violence services at CSK remained stable at around 5 cases per month cases as evidenced by data from the DHIS2. We partially attribute this stability to the 6-month buffer stock of medical commodities left by MSF as part of the exit strategy.

However, the specific characteristics of the Pilot's implementation context (gender norms that fuelled sexual violence and social vulnerability of girls and women) and the inherently complex nature of sexual violence and health behavior change posed an immediate threat to the sustainability of these achievements. The community ambassadors and health authorities we interviewed all agreed that additional efforts and resources, including time, were needed to guarantee the sustainability of community-led activities. As one community ambassador reported:

We need more awareness-raising sessions on sexual violence and its consequences. We have to keep telling women that if you keep your assault a secret, it's bad because you can contract diseases [as a result of your sexual assault] and these diseases can even lead to death. So, we need more awareness-raising

sessions for community members. We also need to train women in financial empowerment because many sexual assaults in our community happen when girls can't afford clothes, soaps, and beauty lotions.

Evidence on SGBV programming and health promotion has shown that community-driven initiatives have great transformational effects on gender norms that fuel sexual violence and she healthcare-seeking behavior [32,35]. However, it takes time to induce and sustain health behavior change, a process that is undermined by the one-year timeframe of the decentralization initiative.

Finally, service users' perceived quality of care is a factor that shapes their access to and utilization of healthcare [36]. The providers we interviewed anticipated that the lack of medications could later undermine confidence in the service and future service utilization.

The availability of medication encourages the use of services, as victims come to us confident that medication is available and that they will be well cared for...Victims who are satisfied with our care, in turn, recommend it to their peers, telling them: go there, you'll be well treated. The lack of medication will make it difficult for survivors to seek post-violence care. We will not get mifepristone and misoprostol from the HZ.

OUTCOME 2: BUILD STAFF CAPACITY TO PROVIDE HOLISTIC SUPPORT

- TO SURVIVORS OF SEXUAL VIOLENCE AT THE HEALTH CENTER LEVEL

Participants were confident in the long-term sustainability of their newly gained skills. They felt that this would allow them to sustain the provision of post-sexual violence care after the Pilot. However, they pointed out that the lack of financial resources and medical commodities will represent the main obstacles to the continued provision of free, high-quality, and reliable post-sexual violence care. As one provider explained:

The training we received from MSF has significantly strengthened our capacity to care for survivors of sexual violence...especially our ability to offer abortion care to survivors who request it. With the departure of MSF, it will be very difficult to ensure continuity of care for survivors in a holistic way. It's a pity that MSF is leaving because we won't be able to work properly! Where will we get misoprostol and mifepristone? No donor has taken over after MSF leaves, which is so sad!

A member of the Tshikula HZ Executive Team member concurred with this sentiment

[The] standard of care set by MSF at the Kamuandu Health Center can not be guaranteed...The staff in place are already trained and have acquired skills. But what I am saying is that the medical commodities are going to be lacking. That's what it's all about. The health center has a purchasing of service contract [with MSF] to ensure free care [for survivors of sexual violence], but what we see [predict] concerns about

abortion; hey, for the management of STIs, antibiotics may be available, but other medical commodities may no longer be available, such as hepatitis [B] vaccine...I'm talking more about medical commodities because the staff already have the technical skills.

A community ambassador shared similar concerns about the prospect for sustainability:

“I know that the activities will continue because the staff are trained and when there’s a case...the victims will continue coming to the health center for treatment...I’m going to say, however, that we need to supply medicines to the health center so that the care continues. Also, healthcare providers must continue to receive financial compensation for their work.”

The Pilot's exit strategy could have considered the partners' capacity and ownership at the start of the implementation period and their ability to sustain funding and medical commodities (specifically abortion drugs and hepatitis B vaccine) at the end of the intervention.

GENDER AND HUMAN RIGHTS CONSIDERATIONS

GENDER CONSIDERATIONS

The Pilot aimed to improve access to and use of post-sexual violence services. As such, it was clearly gender-responsive. However, the Pilot largely focused on women as “victims” or “survivors” of sexual violence and did not consider them as potential “agents of change” [37]. Community ambassadors, almost all of whom were men, were trained to conduct door-to-door outreach activities without considering the gender dynamics in Central Kasai.

However, given that the stigma and harmful customs shaping sexual violence in Central Kasai (almost all of which is perpetrated by men) also undermine access to and utilization of post-sexual violence services, the Pilot needed activities, outputs, and outcomes that explicitly targeted men. A key informant from MSF shared that men’s participation in thematic group discussions was lower than the participation of women. The systematic collection and use of sex-disaggregated data for community-led activities could have addressed this gap and/or informed other activities.

Finally, the decentralization initiative could have paid attention to the neglected issue of boys and men as potential victims/survivors of sexual violence. A community ambassador noted:

“I think it’s important that young boys are also made aware [that they can also be victims] because I had to deal with a case of a young boy who was sexually abused by an older woman. This young boy was also a victim of sexual violence and should also be cared for as such.”

INCLUSIVITY CONSIDERATIONS

Because of the Pilot, high-quality post-sexual violence care was provided to all survivors who presented at the CSK regardless of their gender identity, ethnicity, or other socio-demographic traits. However, little evidence indicates that the Pilot was explicitly inclusive of all sub-groups of beneficiaries. The Pilot was designed and implemented as a “one-size fits all” intervention without explicitly addressing intersecting vulnerabilities of survivors, including ability/disability status, age, and literacy. Indeed, the physical improvements at the CSK facility did not include adaptations to improve accessibility for those with mobility limitations. Further, community ambassadors (mainly adults) conducted community outreach using the same technique (door-to-door discussions), the same message, and the same version of communication materials for all target audiences, including adults/parents, children, adolescents, disabled people, and illiterate persons. Target-tailored and integrated outreach efforts would have been appropriate and had the potential to enhance the relevance, effectiveness, and potential impact of the overall program [23, 35].

LESSONS LEARNED

- An overreaching MSF strategy and theory of change to address SGBV is required to support project specific implementation, harmonize programming in various humanitarian contexts, and inform the design of package of interventions and results framework for all MSF sexual violence projects.
- SGBV is a complex and wicked issue requiring long-term and multi-faceted interventions which should be framed and designed accordingly.
- Multi-faceted interventions must be designed, planned, and implemented appropriately. The Community engagement of the Pilot was fully implemented and revealed a need to anchor the project’s components within a comprehensive theory of change/logic model to inform resource allocation, the appropriate implementation of activities, and project evaluability.
- A collaborative and multi-sectoral approach to responding to SGBV is critical for meeting survivors’ holistic needs. To be effective, the response requires well-planned and well-resourced interventions and a sound collaborative approach among SGBV stakeholders.
- Effective community-awareness programming is a key component of a comprehensive strategy to respond to SGBV. However, the health promotion component needed to be tailored to its target audiences to be effective.
- A strong monitoring and evaluation framework including indicators and their expected targets was needed to inform the implementation of the Pilot and to ensure its evaluability.
- SGBV is both a public health and social issue requiring a holistic and integrated approach to be addressed. Specifically, a shift from the medical paradigm to addressing SGBV is needed.
- The one-year implementation model showed promise. However, such a limited timeframe is unlikely to address traditional gender norms and stigma that prevent survivors for seeking healthcare and support. Long-term and continuous programming is critical to bringing about transformational changes around sexual violence.
- Partnership with local health authorities is critical for securing scale-up/replication of donor-driven initiatives. However, evidence-based partnership models with proven track records of bringing about changes should be prioritized.

- Early evaluation of the Pilot identified promising results and their potential mediators, as well as immediate threats to success. However, a certain degree of flexibility in programming is needed to ensure that the early phase of the developmental evaluation approach serves to inform the implementation of humanitarian interventions.
- Humanitarian actors face multiple demands and deadlines in responding to current and emerging crises. However, investing appropriate resources (including time and staff) in monitoring and evaluation, and adjusting ongoing interventions in the light of evaluation results, could support the effectiveness of humanitarian action, and increase the accountability to beneficiaries.

LIMITATIONS OF THE EVALUATION

For the Phase 2 evaluation we spent 2 weeks in the field for the purpose of data collection. The local MSF staff coordinated the field visit and we were able to conduct data collection as planned. However, this evaluation would have benefitted from the perspectives of more survivors and beneficiaries of services; we did not reach thematic saturation with this group. We also did not interview any survivors of sexual violence who did not use the services at CSK and thus we were not able to assess the unmet needs of this group. Future evaluations may benefit from longer or multiple data collection periods. The absence of a concrete results framework and theory of change limited the evaluability, and specifically our ability to assess the effectiveness, of the initiative. Further, we relied on routine quantitative data not collected for the purpose of this evaluation to assess the Pilot's effectiveness. This limited our ability to conduct a more granular analysis of the Pilot's effectiveness. We could only make approximate cost calculations given the absence of detailed information or a stand-alone budget. We also cannot make any casual inferences due to the lack of a comparator. Finally, as we conducted this evaluation a short time after the Pilot's close-out, we were not able to measure its impact and instead assessed its potential for impact, which we consider a major limitation.

EMERGING GOOD PRACTICES

What helped the decentralization of SGBV at the CSK?

The partnership between MSF and with the HZ executive team was key to the success of the decentralization initiative. This partnership was formally established through the signing of a memorandum of understanding at the outset of the Pilot, which included a focus on working with pre-existing community assets, such as a functioning health center, supply chain, and CODESA.

MSF's strong reputation in the implementation context was also an important ingredient in the success of the Pilot. Beneficiary communities saw MSF as a compassionate stakeholder who arrives first at a conflict scene and leaves last. The presence of MSF in a health center was perceived as a guarantee of quality of care by beneficiary communities as was their continuous formative supervision of CSK healthcare providers. Increasing staff capacity at MSF and supporting cooperation across the SGBV sub-cluster to bring consistent medical commodities (including abortion drugs) to the Tshikula HZ was a critical strength of the Pilot as was MSF's provision of financial support to ensure free services.

Finally, MSF's engagement with community-based associations, and CODESA specifically, through the community ambassadors eased the identification of sexual violence cases and survivors' early initiation of post-sexual violence care. Further, SGBV focal points from MSF included both men and women.

What hindered implementation and the handoff?

The overall context presented challenges. For example, the legal environment of the DRC, specifically the lack of dissemination of the Maputo protocol at the provincial level, makes it difficult to sustain abortion care at the CSK. The change of attitudes of partners also takes time. The shift from donor-driven governance to respond to SGVB to a local health authorities' leadership was needed to ensure the Pilot's replication and sustain its achievements. The overreliance of fragile health systems on external donors could hinder the transfer or/and the replication of the Pilot. Systems and institutional challenges also created obstacles for the ability of the program to provide free services and continue to have a stable supply of commodities.

Adopting a "new intervention" requires a structured and incremental approach per Roger's theory of adopting innovations. MSF undertook a structured process of building evidence on the effectiveness of the Pilot, namely by commissioning a two-phase developmental evaluation. However, awareness of the benefits of the Pilot should be conducted among potential adopters, including the Tshikula HZ and the SGBV sector, through appropriate communication channels. Limited documentation of the Pilot's theory of change, logic model, and expected outcomes likely hampered its adoption by potential adopters.

Finally, limited resources and agency to adapt or introduce new activities to address SGBV at the health zone level limit the potential impact and sustainability. The health policy-making process in the DRC follows a top-down approach. The central level is responsible for drawing up all health policies, while the health zone is responsible for implementing them. The decision to adopt an innovative model of care for survivors of violence such as the Pilot, which includes the provision of abortion care, goes beyond the sphere of influence of the HZ. Additional advocacy efforts are needed from MSF to bring about changes in policy, practices, and outlook.

RECOMMENDATIONS

- ⇒ **Recommendation 1:**
Consider developing a holistic strategy and comprehensive theory of change for a multi-sectoral SGBV program/response. Such a theory of change should clearly display the results pathway for each component of the multi-sectoral intervention and should be accompanied by a comprehensive results framework and indicators that could be tailored to different settings and contexts.
- ⇒ **Recommendation 2:**
Consider designing and implementing a clear theory-based, multi-component, and coherent intervention that matches the country's wider response to SGBV and the global MSF strategy (once elaborated). This could serve as a communication tool within MSF and beyond. This would also help shape appropriate resource allocation.
- ⇒ **Recommendation 3:**
Ensure an appropriate collaborative and multi-sectoral response to SGBV. Clear, transparent, and efficient referral channels between the various players must be defined by identifying the responsibilities of each party before implementation. Developing a short tool for SGBV screening and referral may also increase awareness and utilization of services.
- ⇒ **Recommendation 4:**
Integrate from the outset and effectively resource community-driven initiatives, including allotting sufficient time for implementation.
- ⇒ **Recommendation 5:**
Develop a stand-alone monitoring and evaluation plan for initiatives intended to be piloted and replicated, this will increase their evaluability and likelihood of achieving their expected results, hence their replicability.
- ⇒ **Recommendation 6:**
Incorporate human rights, health equity, and intersectional issues related to gender into all project phases. MSF has the potential to play an important role in drawing attention to the neglected issue of men and boy survivors of sexual violence.
- ⇒ **Recommendation 7:**
Consider MSF staff rotation and other health system issues in project planning. If possible, develop a training plan that recognizes and potentially capitalizes on the pre-scheduled turnover of MSF staff.

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ANNEXES

APPENDIX I: TERMS OF REFERENCE

Terms of Reference

Doctors Without Borders/Médecins Sans Frontières (MSF) is an international medical humanitarian organization determined to bring quality medical care to people in crises around the world, when and where they need regardless of religion, ethnical background, or political view. Our fundamental principles are neutrality, impartiality, independence, medical ethics, bearing witness and accountability.

The Stockholm Evaluation Unit (SEU), based in Sweden, is one of three MSF units tasked to manage and guide evaluations of MSF's operational projects. For more information see: evaluation.msf.org.

Project:	SGBV project, Kananga, RDC
Start/end date:	April 2022 - May 2023
Candidacy:	Interested candidates are invited to submit: 1) A proposal describing how the evaluation will be conducted (including a budget in a separate file) 2) CV (s) 3) A written example of a previously carried out evaluation
Deadline to apply:	April 20 th , 2022 - referencing 'KANAN'
Application to be submitted to:	evaluations@stockholm.msf.org
Special considerations:	<p>a) This evaluation has a time span of approx. a year. The evaluation is developmental in its approach.</p> <p>b) It is an evaluation divided into two main phases (ex-anted, mid-term) that should generate continuous feedback to allow the adaptation of the project during the implementation itself (and not waiting until the final report).</p> <p>The exact timing of the evaluation is likely to be adjusted according to the reality on the ground vs. planning, as well as the methodology suggested by the evaluation team.</p>

Promoting a culture of evaluation is a strategic priority to be accountable, seek for continuous improvements and achieve organizational learning. MSF does not evaluate only because of external requirements, for example donors related ones. Evaluation is seen as a duty, for MSF to be accountable, seek for continuous improvements and achieve organizational learning. These Terms of Reference should be seen as a starting point for the evaluation process. The evaluator(s) are welcome to challenge them and suggest for example different or additional perspectives, as they see fit during the inception phase. The evaluation process should rely on solid methodology to achieve credible results and should also ensure to put values and use in the forefront. The evaluation must involve and include different actors and counterparts in an adequate manner during the whole process.

KANAN Terms of Reference April 5th, 2022

THE PROJECT AND THE EVALUAND

Médecins Sans Frontières Brussels Operational Center (OCB) has been working in the Democratic Republic of Congo (DRC) since 1977, through varied long-term projects, as well as through a local Emergency Response Pool (PUC).

The Kananga project (Kasai Central) started in 2017 and experienced frequent changes in strategy and direction (surgery, malnutrition, primary care in mobile clinics, management of sexual violence) in line with the changing context. From October 2017, in line with its medical activities, MSF further engaged with the community to increase awareness of sexual violence (SGBV) and of MSF services in this area. New cases treated monthly quickly reached more than 200 per month. In April 2019, the project took on a more 'vertical' approach by focusing solely on medical and psychological care for survivors of sexual violence at the Kananga Provincial Referral Hospital (HPRK). The care package also included family planning (FP) for all patients who requested it at the HPRK level.

In 2020, the project added a decentralization component of its activities in the HPRK by integrating its SGBV and FP activities in the Health Centres of Kananga city. The decentralization strategy aimed to:

- Improve access to SGBV and FP care,
- Strengthen capacities of staff to provide care for victims of sexual violence at the level of Health Centres,

The decentralization support was gradually implemented in four Health Centres in the Kananga and Bobozo Zones de Santé (district health zones) from June 2020 onwards. Later in 2020 however, the project pulled out from the East District Health Centre in the Bobozo Zones de Santé due to the facilities being in poor condition and without the possibility of renovation and the low impact of medical activities.¹

In 2021, the support was extended to two new Health Centres in the peri-urban Zones de Santé of Tshikaji and Lukonga. During the last quarter of 2021, 25% of new SGBV patients (out of a total of 752 new patients) received care in structures supported by MSF's decentralization work. The project also saw an increase in the number of patients accessing care within 72 hours of the assault (43% in Q4 2021).

From January 2022, the project wishes to implement these activities in a decentralized and integrated way in a new Health Centre (referred to as CdS 1 – Centre de Santé - in these ToRs) while adopting a more systematic, planned, and concerted approach. This Health Centre still needed to be identified (as of February 2022), but it would be located within the Tshikula Zone de Santé.

A range of activities, tools and training will be set up in the CdS 1 by MSF teams to further strengthen the capacity of health providers, via the Ministry of Health (MoH) staff, in providing quality SGBV and FP care. Health promotion activities are also aimed at making these services known to the population and increase the use of a medical service within 72 hours after a rape. The community and provincial health authorities will be involved in the project as implementing partners. Indeed, it is key that they take ownership of the integrated approach so that services continue to be provided and used after MSF's activities are fully handed over to the Health Centre. Rehabilitation works are also planned if necessary.

¹ According to the "Roadmap 2022-23" of the Kananga project.

KANAN Terms of Reference April 5th, 2022

From July 2022, the Kananga project plans to follow the same approach as in Cds 1 in two other Health Centres (Cds 2 and Cds 3). Ultimately, the objective of the project is that the decentralized and integrated activities approach in the Health Centres is taken over by the MoH, or other humanitarian medical organizations and ideally replicated in other structures in the Province of Kasai Central, and potentially beyond. The project foresees a closure in September 2023, after the handover of activities in Cds 1, 2 and 3.

Fifteen (15) months are planned to implement these activities in each Health Centre: preparation (3 months), implementation (3 months), reinforcement (3 months), disengagement (4 months) and handover (2 months).

	01-22	02-22	03-22	04-22	05-22	06-22	07-22	08-22	09-22	10-22	11-22	12-22	01-23	02-23	03-23	04-23	05-23	06-23	07-23	08-23	09-23	
Nouveau Cds 1 - Pilote Modélisation		Préparation		Implémentation			Renforcement			Désengagement			Passation									
Nouveau Cds 2 - Modélisation							Préparation		Implémentation		Renforcement			Désengagement							Passation	
Nouveau Cds 3 - Modélisation							Préparation		Implémentation		Renforcement			Désengagement							Passation	

PURPOSE AND EXPECTED USE

This evaluation has a dual purpose:

- **(1) As a first step, to evaluate the design and planning of the project for CdS 1 and its prospective implementation process**, and to what extent it seems to be able to achieve the defined objectives, which are improving patient care, capacity-building of the Health Centre staff and MSF's quality of delivery of SGBV-related activities, as well as to suggest adjustments if applicable.
- **(2) In a second step, to evaluate the results of the implementation in CdS 1**, to learn from this first experience and to inform the next phases of the project (i.e.: exit and hand-over strategy for CdS 1 and lessons learnt for implementation of CdS 2 and 3).

This evaluation is divided into two main phases and will rely on continuous feedback throughout the project implementation to allow the adaptation of the project during the implementation itself. The exact timing of the evaluation is likely to be adjusted according to the reality on the ground vs. planning, as well as the methodology suggested by the evaluation team.

Here are below suggestions for the different phases of the evaluation:



	01-22	02-22	03-22	04-22	05-22	06-22	07-22	08-22	09-22	10-22	11-22	12-22	01-23	02-23	03-23	04-23	05-23	06-23	07-23	08-23	09-23	
Nouveau Cds 1 - Pilote Modélisation		Préparation		Implémentation			Renforcement			Désengagement			Passation									
Nouveau Cds 2 - Modélisation							Préparation		Implémentation		Renforcement			Désengagement							Passation	
Nouveau Cds 3 - Modélisation							Préparation		Implémentation		Renforcement			Désengagement							Passation	

The evaluation will foremost be used by the Kananga project to optimize its implementation in CdS 1 and draw lessons learnt for CdS 2 and 3, before handover of the project in CdS1, 2 and 3.

The evaluation may also inform other or future SGBV projects, MSF and non-MSF ones, in the DRC or elsewhere.

EVALUATION QUESTIONS

First phase: Evaluation of the project design and planning for CdS 1 as well as its prospective implementation process.

KANAN Terms of Reference April 5th, 2022



⇒ *Continuous feedback for real-time adjustment during CdS 1 project implementation as well as restitution and interim reporting by July 2022 at the latest.*

QE 0: Description of the project and its intended application in CdS 1 (activities and how they will be implemented)

QE 1: Do the project objectives seem relevant given the observed and expressed needs, the context, and MSF's priorities?

QE 2: Are the strategy, design, planning and prospective implementation process of the project coherent given the context and existing resources? How could the approach become more coherent?

QE 3: Has the implementation of the project been planned while sufficiently considering the different actors?

EQ 4: To what extent has the project design considered lessons learnt and experiences by MSF and, if relevant, by other actors?

EQ 5: What is the likelihood for the project, as it has been designed, to achieve its objectives?

QE 6: What are the prospects for replicability of the project, as it has been designed, and under what conditions?

Second phase: Evaluation of the results obtained in CdS 1 and informing next phases of the project.

⇒ *Continuous feedback as well as restitution and final report by May 2023 at the latest.*

QE 0: Description of the project as implemented in CdS 1 (activities and ways in/how they were implemented).

EQ 1: Were the project objectives relevant in view of the observed and expressed needs, the context, and MSF's priorities?

QE 2: Were the strategy, design, planning and implementation of the project coherent given the context and existing resources? How could the approach have become more coherent?

QE 3: Has the implementation of the project sufficiently considered the different actors?

QE 4: Has the project achieved its expected results?

- To what extent are the outputs in line with the quality standards and expected results?
- What were the reasons (facilitating or preventing factors, expected or unexpected challenges) for whether the expected results were achieved?
- How could the project have become more efficient?

KANAN Terms of Reference April 5th, 2022



EQ 5: What resources has the project required, have they been available, and could they be mobilized more efficiently?

QE 6: Has the project had an impact?

- To what extent has the project achieved its general and specific objectives?
- To what extent has the project achieved sustainable results?
- What are the effects of the project as perceived by patients and other counterparts?
- What are the negative and positive consequences, expected or unexpected, of this project?

QE 7: What are the prospects for replicability, by MSF or other actors (MoH, other organizations) and under what conditions? What are the lessons learnt to consider for CdS 2 and CdS 3?

EXPECTED RESULTS

1. Inception report in French.

According to SEU standards, after a preliminary desk review of documents and initial interviews with key informants. It will include a detailed evaluation proposal, including methodology and timeline.

Phase 1

2. Continuous feedback.

Continuous feedback (modalities to be proposed by evaluator) by sharing observations with the project team and the consultation group for the evaluation, in real time. This is particularly important in order to feed into the ongoing project implementation and to make any adjustments deemed necessary, without waiting for the draft interim report.

3. Interim report in French (Phase 1) - July 2022 at the latest.

According to SEU standards, it will answer evaluation questions and include conclusions, lessons learned and possible recommendations (where appropriate, and ideally generated collaboratively, see Working Session).

Finalization of the report after addressing the feedback received from the SEU and the Consultation Group.

4. Presentation during a restitution session.

Phase 2

5. Continuous feedback (see Phase 1 - point 2 above).

KANAN Terms of Reference April 5th, 2022



6. First version of the final evaluation report (Phase 2) - May 2023 at the latest.

According to SEU standards, it will answer evaluation questions and include conclusions, lessons learned and possible recommendations (where appropriate, and ideally generated collaboratively, see point 6. Working session). This report will also analyse the first phase of the evaluation and to what extent conclusions in the draft interim report were addressed by/in the project.

7. Working session.

With the participation of the Commissioner and members of the Consultation Group. This session is an integral part of the final report writing process: the evaluator(s) will present the findings, to gather initial feedback from participants, as well as start a discussion on it, lessons learned and recommendations (if applicable, and ideally generated collaboratively).

8. Final report in French (the SEU will organize the translation into English).

After sending the feedback received during the working session, as well as the written comments of the Evaluation Manager (SEU) and the Consultation Group, finalization of the report.

9. Webinar presenting the evaluation, questions and answers and discussion (target audience: MSF OCB all staff, and beyond if deemed relevant). *Other dissemination activities may be suggested during the evaluation, including by the evaluation team.*

TOOLS AND METHODOLOGY

In addition to the proposal submitted during the selection process (see the Evaluator Profile section below), a detailed evaluation protocol should be prepared by the evaluators in the initial phase of the evaluation and presented in the inception report. It will include an explanation of the proposed methods as well as a justification based on validated theory(s). This protocol will be reviewed and approved at the end of the initial phase, under the coordination of the SEU.

RECOMMENDED DOCUMENTATION

- Project documents (baseline, narratives, logframe, monthly and annual reports, medical database, flowcharts, presentations, visit reports, decision-making, etc.).
- Direct contact with person(s) in charge of collecting and managing medical and other types of data at project level.
- MSF sources (strategic orientations, operational priorities, protocols and policies, operational research, etc.).
- External literature, similar experiences, other actors, standards, etc.

KANAN Terms of Reference April 5th, 2022



IMPLEMENTATION OF THE EVALUATION

Number of evaluators	<i>To be suggested by applicant(s)</i>
Evaluation Timeline	April 2022-May 2023
Field visit for data collection	Field data collection in Kananga. Date(s) of data collection to be defined during the initial phase of the evaluation, in consultation with the SEU and evaluation stakeholders. Data collection will also need to take into consideration possible restrictions regarding COVID-19.

PROFILE/REQUIREMENTS FOR THE EVALUATOR(S)

- **Requirements:**
 - Demonstrated expertise in evaluation
 - Experience in managing humanitarian medical programs, ideally focused on sexual and reproductive health (SRH) and sexual and gender-based violence (SGBV).
 - Excellent command of French and English within the team. The evaluation will be conducted in French and ideally the evaluator(s) will produce the report in French and English (or organize the English translation once the report has been validated).
 - Adherence to humanitarian principles and MSF values.

- **Merits:**
 - Clinical experience and training in SRH, with a focus on SGBV.
 - Training in public/global health.
 - Experience and/or training in health systems, with a focus on capacity-building.
 - Knowledge of the context.

DISSEMINATION and USE OF EVALUATION

The purpose of this table is to provide ideas of activities that can be implemented to increase the scope and use of the evaluation. Indicative and non-exhaustive, to be discussed and finalized with stakeholders during the evaluation process.

KANAN Terms of Reference April 5th, 2022



WHEN	OBJECTIVE	ACTIVITY	TOOL	AUDIENCE(S)	BY WHOM?
Recommendations Response and Implementation					
During the evaluation	Adjustment based on preliminary results	Feedback in real-time	For example: field debriefing after data collection, working sessions (ideas to be proposed by evaluation team)	Project and mission (and partners)	Evaluation Team
Working session	Presentation and discussion of preliminary results, co-creation of recommendations	Working session	Presentation and discussion	Consultation Group	Evaluation Team
Once the report is validated	Implementation of recommendations and dissemination of lessons learned	Reading the report and taking ownership of the results, action plan for recommendations	Rapport final + Management response	Consultation Group - Project and OCB	Commissioner (+ Consultation and Project) Group
Dissemination of Evaluation Results					
Once the report is validated	Sharing learned lessons	Dissemination of the report - publication on evaluations.msf.org	Final Report	OCB (and MSF ?)	SEU
Once the report is validated	Sharing learned lessons	Evaluation Presentation and Discussion	Webinar	OCB (and MSF ?)	Evaluation Team
Once the report is validated	Sharing learned lessons	Shared report	Report	DRC mission, other Operational Centres (OCs), other SGBV projects	Project, mission
Once the report is validated	Sharing learned lessons	Information to partners, staff CdS1, MoH	Flyer? short version? Presentation	Partners	Project - SEU / AND support possible (to be defined)
Once the report is validated	Sharing learned lessons	Information for patients and communities?	Flyer?	Patients and Communities	SEU / AND support project possible (to be defined)
Discussions and Further Reflections					

KANAN Terms of Reference April 5th, 2022



APPLICATION PROCESS

The application must include a **technical proposal written in English**, a budget proposal, a curriculum vitae and a previous work sample. The proposal should include a reflection on how adherence to ethical standards for evaluations will be considered throughout the evaluation as well as the different values and perspectives of counterparts and the use of evaluation. The evaluator(s) will also need to demonstrate an understanding of context-specific issues and address the sensitivity of the topic at hand in the methodology as well as the team set-up.

Offers should include a separate quotation for the complete services, stated in Euros (EUR). The budget should present consultancy fee according to the number of expected working days over the entire period, both in totality and as a daily fee. Travel costs, if any, do not need to be included as the SEU will arrange and cover these. Do note that MSF does not pay any per diem.

The level of effort is to be proposed by the evaluator(s) and the initial phase of the evaluation will make it possible to plan the rest of the evaluation period. The evaluator(s) will not be hired full-time over the period.

Applications will be evaluated based on whether the submitted proposal captures an understanding of the main deliverables as per this ToR, a methodology relevant to achieving the results foreseen, and the overall capacity of the evaluator(s) to carry out the work (i.e., inclusion of proposed evaluators' CVs, reference to previous work, certification et cetera).

Interested teams or individuals will submit their file to evaluations@stockholm.msf.org under referencing 'KANAN' no later than at 23:59 CET on April 20th, 2022. Please submit the documents in separate files (proposal, budget, CV, work sample, etc.). Please include your contact details in the CV(s).

Please indicate in your email application on which platform you saw this vacancy.

>...<

APPENDIX II: SAMPLE MATRIX

EVALUATION CRITERIA	DEFINITIONS OF CONCEPTS	EVALUATION QUESTIONS BY CRITERIA/ EVALUATION QUESTION (EQ) IN THE TERMS OF REFERENCE	INDICATORS/ MEASURES	DATA COLLECTION METHODS	MAIN DATA SOURCES/ INFORMATION	DATA ANALYSIS METHODS
Relevance and Appropriateness	<ol style="list-style-type: none"> The extent to which the decentralization initiative's objectives and design are relevant to beneficiary needs and sexual- and gender-based violence (SGBV) policies and priorities at the local and national levels. The extent to which objectives evolve in response to changing circumstances/priorities 	<ol style="list-style-type: none"> Did the decentralization initiative's design, planning, and implementation sufficiently consider and respond to the needs and priorities of different stakeholders (survivors included)? 	<ol style="list-style-type: none"> Needs/gap analysis on SGBV The degree to which stakeholders perceive the design and objectives of the decentralization initiative align with local needs, the Democratic Republic of the Congo's (DRC) country strategy and priorities around SGBV, and if targeting was based on needs. 	<ol style="list-style-type: none"> Desk review Key informant interviews Semi-structured interview with beneficiaries 	<ol style="list-style-type: none"> Central Kasai Provincial Gender Division: Annual Report on SGBV, 2022 DRC's revised Strategy on SGBV Médecins Sans Frontières (MSF) Kananga Project's Road Map, 2022-2023 Data from interviews with key 	Thematic and content analysis

			3. The degree to which the decentralization initiative was tailored to beneficiaries' needs.		MSF ¹⁴ staff, and the Tshikula Health Zone (HZ) senior staff 5. Data from interviews with beneficiaries, healthcare providers, and community ambassadors	
Coherence	<ol style="list-style-type: none"> The extent to which other interventions (and policies in particular) support the decentralization initiative and vice versa (external coherence). The extent to which the design, planning, and implementation of the decentralization initiative align with its intended outcomes (internal coherence). 	<ol style="list-style-type: none"> Given the context and existing resources, is the strategy, design, planning, and implementation process coherent? How could the decentralization initiative become more coherent? <p>EQ2: Were the strategy, design, planning and implementation of the</p>	1. Qualitative appraisal of the decentralization initiative's design, planning and its alignment with the implementation context (cultural norms on SGBV, health systems constraints, existing	<ol style="list-style-type: none"> Desk review Key informant interviews 	<ol style="list-style-type: none"> Kananga Project's Road Map, 2022-2023 Data from interviews with the Tshikula HZ senior staff, external SGBV stakeholders, and key MSF staff 	Thematic and content analysis

¹⁴ By MSF, we mean Kananga project, national coordination, and headquarters staff, whereas MSF project staff refers to Kananga project staff only.

		<p>project coherent given the context and existing resources? How could the approach have become more coherent?</p>	<p>policies, strategy, and existing interventions on sexual violence).</p> <p>2. Qualitative appraisal of the decentralization initiative’s design, planning, and alignment with its intended outcomes.</p>			
Efficiency	<p>The extent to which the decentralization initiative delivers, or is likely to deliver, results in a cost-effective and timely manner</p>	<ol style="list-style-type: none"> 1. What resources did the implementation of the decentralization initiative require, were they available, and how could they have been mobilized appropriately? 2. Were the available resources used to get the best value for money and yield? 	<ol style="list-style-type: none"> 1. Costs associated with the decentralization initiative’s specific components (medical staff, support staff, drugs, equipment). 2. Cost per survivor. 3. Cost of different service delivery components (post-exposure prophylaxis, 	<ol style="list-style-type: none"> 1. Desk review 2. Key informant interviews 3. Semi-structured interview with beneficiaries 	<ol style="list-style-type: none"> 1. Kananga Project’s Budget and operational data for the fiscal year 2022-2023 2. Data from interviews with the Tshikula HZ senior staff and key MSF project staff 3. Interviews with beneficiaries, healthcare providers 	<ol style="list-style-type: none"> 1. Thematic and content analysis 2. Cost analysis depends on the availability of operational data.

		<p>EQ4.3: <i>How could the project have become more efficient?</i></p> <p>EQ5: What resources has the project required, have they been available, and could they be mobilized more efficiently?</p>	<p>testing, forensic examinations, referrals).</p> <p>4. Qualitative appraisal of the rationalization of human resources.</p>		<p>and community ambassadors</p>	
Effectiveness	<p>The extent to which the decentralization initiative has met its objectives and outcomes, including differential outcomes between groups</p>	<p>Did the decentralization initiative achieve its objectives and intended results?</p> <ol style="list-style-type: none"> To what extent do the achievements meet the quality standards and expected results? What are the reasons (facilitating or hindering factors, expected or unexpected challenges) for why the expected results were achieved or not achieved? How could the decentralization initiative become more effective if 	<ol style="list-style-type: none"> Number of survivors who accessed and utilized post-sexual violence care at the Centre de Santé Kamuandu (CSK) from April 2022 to March 2023. Proportion of survivors who received the post-exposure prophylaxis (PEP) kit within the critical 72-hour window after the assault. Proportion of survivors who 	<ol style="list-style-type: none"> Secondary data analysis Desk review Semi-structured interview with beneficiaries Direct observation of operations of CSK 	<ol style="list-style-type: none"> DHIS2 sexual violence dataset Kananga project dataset Clients' chart review Notes from the direct observation of the CSK Data from interviews with healthcare providers and beneficiaries 	<ol style="list-style-type: none"> Descriptive statistics (number and proportion) We selected 20 random records from different providers (clinical, medical, and forensic) to assess the proportion of survivors who received services as per the established protocol. Thematic and content analysis to explore three dimensions of self-efficacy:

		<p>the results were not achieved?</p> <p><i>EQ4: Has the project achieved its expected results?</i></p> <p><i>a) To what extent are the outputs in line with the quality standards and expected results?</i></p> <p><i>b) What were the reasons (facilitating or preventing factors, expected or unexpected challenges) for whether the expected results were achieved?</i></p> <p><i>c) How could the project have become more efficient?</i></p>	<p>received services as per MSF's protocol on clinical management of sexual violence.</p> <p>4. Perceived self-efficacy of CSK healthcare providers to care for survivors.</p> <p>5. The extent to which post-violence care provided at the CSK met the standards of good quality care.</p>			<p>a) Experience providing care to survivors before and after the implementation of decentralization initiative;</p> <p>b) Perception of client trust; and</p> <p>c) Self-reported knowledge and skills related to post-sexual violence care.</p> <p>4. To assess the quality of existing post-SGBV care services, we used the GBV Quality Assurance Tool Minimum Care Version.¹⁵</p>
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¹⁵ Per the guidelines, we used the minimum version of the tool because the CSK is implemented in a limited resource setting and the post-sexual violence service was under development.

<p>Prospect for impact¹⁶</p>	<p>The extent to which the decentralization initiative has generated or is expected to generate significant positive or negative, intended, or unintended, higher-level effects</p>	<p>Given the short time frame, is the decentralization initiative expected to have an impact (negative and positive consequences, expected or unexpected ones)?</p> <p><i>EQ6: Has the project had an impact?</i></p> <p><i>a) To what extent has the project achieved its general and specific objectives?</i></p> <p><i>b) To what extent has the project achieved sustainable results?</i></p> <p><i>c) What are the effects of the project as perceived by patients and other counterparts?</i></p> <p><i>d) What are the negative and positive consequences, expected or unexpected, of this project?</i></p>	<ol style="list-style-type: none"> 1. Documentation established to adopt the decentralization initiative, replicate, or extend its reach and/or resources. 2. The transformative long-term effects of the pilot on the healthcare-seeking behaviours around sexual violence. 	<ol style="list-style-type: none"> 1. Desk review 2. Key informant interviews 3. Semi-structured interview with beneficiaries 	<ol style="list-style-type: none"> 1. Data from interviews with the Tshikula health zone senior staff and key MSF staff. 2. Data from interviews with healthcare providers, beneficiaries and community ambassadors. 	<p>Thematic and content analysis</p>
<p>Prospect for sustainability</p>	<p>The extent to which the changes achieved are sustained over time</p>	<p>What are the prospects for replicability?</p>	<ol style="list-style-type: none"> 1. Perceived capacity of local 	<ol style="list-style-type: none"> 1. Key informant interviews 	<ol style="list-style-type: none"> 1. Data from interviews with the 	<p>Thematic and content analysis</p>

¹⁶ We did not assess the decentralization initiative’s impact per se as it was not feasible to demonstrate achievement of transformative effects within the timeframe of this evaluation. However, we assessed its prospect for impact.

		<p>1. What is the capacity of the local health centers/Government of DRC to support the decentralization initiative (trained staff, equipment, supplies, logistics)?</p> <p>2. What is the capacity and intention of “other humanitarian medical organizations” to replicate the decentralization initiative in other health centers in Central Kasai and beyond?</p> <p>EQ7: What are the prospects for replicability, by MSF or other actors (MoH, other organizations) and under what conditions? What are the lessons learnt to consider for CdS 2 and CdS 3?</p>	<p>authorities and other stakeholders to take over the decentralization initiative.</p>	<p>2. Semi-structured interview with beneficiaries</p>	<p>Tshikula Health Zone senior staff, SGBV external stakeholders, and MSF staff</p> <p>2. Data from interviews with healthcare providers, beneficiaries, and community ambassadors.</p>	
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<p>Gender, inclusivity, and human rights considerations</p>	<ol style="list-style-type: none"> 1. The degree to which a gender and human rights perspective has been integrated into the decentralization initiative. 2. The extent to which the results achieved have contributed to the principles of non-discrimination and equality of gender and human rights, with an emphasis on women's rights and the inclusion of persons with disabilities and those from sexual and gender minority groups. 	<ol style="list-style-type: none"> 1. To what extent has the decentralization initiative been gender responsive and inclusive? 2. Has the decentralization initiative successfully reached different ethnicities, sexual minority populations, and people with disabilities with regard to service delivery and health promotion? 		<ol style="list-style-type: none"> 1. Desk review 2. Key informant interviews 3. Semi-structured interview with beneficiaries 	<ol style="list-style-type: none"> 3. Kananga Project's Road Map, 2022-2023 4. Data from interviews with the Tshikula health zone senior staff and MSF project staff. 5. Data from the interviews with healthcare providers, community ambassadors, and beneficiaries. 	<p>Thematic and content analysis</p>
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APPENDIX III: BIOGRAPHIES OF THE EVALUATION TEAM MEMBERS

The evaluation team consisted of five external evaluators with expertise in conducting program evaluations in humanitarian settings, conducting participatory and applied research, developing programs to respond to the needs of survivors of SGBV, and disseminating findings to diverse audiences.

Dr. Cady Nyombe, Lead Evaluator, is a Congolese PhD candidate in Population Health at the University of Ottawa. A physician by training, she is affiliated with the School of Public Health in Kinshasa as a teaching and research assistant. She has extensive knowledge of the health system the Democratic Republic of the Congo (DRC), has conducted evaluations of health programs in the DRC context, and has expertise in advanced statistical and qualitative research methods. A native French-speaker, Dr. Nyombe is also fluent the local languages spoken in Kasai (Lingala and Tshiluba), which will facilitate data collection and communication with the local MSF team, project beneficiaries, Ministry of Health representatives, and other stakeholders. Dr. Nyombe was responsible for coordinating the evaluation, managing day-to-day operations, and liaising with local and national stakeholders. She also led data collection, analysis, and dissemination efforts.

Nished Rijal, Evaluation Assistant, holds a Master's in Public Health from the École Nationale de Santé Publique de France and is a PhD candidate in Population Health at the University of Ottawa. Originally from Nepal, he worked in the emergency response to the Nepal earthquake as a health field supervisor for Médecins du Monde. He has also worked on both the implementation and evaluation of sexual and reproductive health projects in Nepal and Bangladesh. Mr. Rijal is fluent in English and professionally proficient in French. He served as an evaluation assistant and supported the development of the evaluation tools, data collection and analysis, and interpretation and dissemination of the findings results.

Manizha Ashna, Evaluation Assistant, is a PhD candidate in Population Health at the University of Ottawa. Originally from Afghanistan, she holds an MD from Balkh University and an MSc in Health Sciences from the University of Ottawa. Dr. Ashna previously served as the National Gender Officer at the World Health Organization (WHO) Country Office in Afghanistan. She has substantial experience in conducting multi-methods and mixed-method evaluations, as well as expertise in preventing and responding to SGBV in humanitarian contexts. She is fluent in English and professionally proficient in French. She served as an evaluation assistant and supported the development of the evaluation tools, data collection and analysis, and interpretation and dissemination of the findings.

Meg Braddock, Senior Technical Advisor, is a freelance consultant with extensive experience in design, technical support and evaluation of sexual and reproductive health and rights and SGBV programmes in Africa, Asia, and Latin America. She has worked for United Nations agencies, country governments, non-governmental organizations, and donors, and has been involved in SGBV prevention and support

programmes at policy development level as well as on the ground implementation in health systems and communities. She holds master's degrees in Physics, Operational Research, and Economics. She provided technical support and input to the team in evaluation design, data analysis, and report-writing.

Dr. Angel M. Foster, Senior Technical Advisor and Team Leader is the founder of Cambridge Reproductive Health Consultants and a Professor in the Faculty of Health Sciences at the University of Ottawa. She holds a doctorate from the University of Oxford, a medical degree from Harvard Medical School, and both master's and bachelor's degrees from Stanford University. Dr. Foster has led research projects and program evaluations in humanitarian settings in Asia, the Middle East and North Africa, and Sub-Saharan Africa, and has authored over 120 publications and co-edited three books. From 2016-2018, Dr. Foster led the revision process of the Interagency Field Manual for Reproductive Health in Crisis and currently serves as the co-chair of the Safe Abortion Care Sub-Working Group of the Interagency Working Group on Reproductive Health in Crisis (IAWG). Recently, she was the international principal investigator of a multi-country study assessing the feasibility of establishing a core set of sexual and reproductive health indicators in humanitarian settings, including the DRC, commissioned by the WHO. Dr. Foster was responsible for the overall design and implementation of the evaluation, management of the project team, and reporting.

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Médecins Sans Frontières

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