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# EVALUATION OF MSF-OCB'S MALARIA PROJECT IN BILI, DRC

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This publication was produced at the request of MSF-OCB under the management of the Stockholm Evaluation Unit.

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## ACRONYMS

<b>ACT</b>	Artemisinin-based Combination Therapies
<b>ASSP</b>	<i>Accès aux Soins de Santé Primaire</i> (access to primary health care)
<b>BCZ</b>	<i>Bureau Central de Zone</i> (health zone central office)
<b>CCMm</b>	Community Case Management of malaria
<b>CDR</b>	<i>Centrale de Distribution Régionale</i> (regional centre of distribution)
<b>CHWs</b>	Community Health Workers
<b>CMR</b>	Crude Mortality Rate
<b>CODESA</b>	<i>Comité de Développement de l'Aire de Santé</i>
<b>DfID/FCDO</b>	Department for International Development/Foreign Commonwealth and Development Office
<b>DRC</b>	Democratic Republic of Congo
<b>HDI</b>	Human Development Index
<b>HGR</b>	<i>Hôpital Général de Référence</i> (district hospital)
<b>HQ</b>	Headquarters
<b>iCCM</b>	integrated Community Case Management
<b>IEC</b>	Information, Education and Communication
<b>IMA</b>	Interchurch Medical Assistance
<b>IMCI</b>	Integrated Management of Childhood Illnesses
<b>ITN</b>	Insecticide-treated nets
<b>IPTi</b>	Intermittent Preventive Treatment in infants
<b>KIIs</b>	Key Informant Interviews
<b>MoPH</b>	Ministry of Public Health ( <i>Ministère de la Santé Publique, MSP</i> )
<b>MR</b>	Mortality Rate
<b>MSF</b>	<i>Médecins sans Frontières</i> /Doctors Without Borders
<b>MUAC</b>	Middle Upper-Arm Circumference
<b>OCB</b>	Operational Center Brussels
<b>ORS</b>	Oral Rehydration Solution
<b>PMI</b>	President's Malaria Initiative
<b>PNLP</b>	<i>Programme National de Lutte contre le Paludisme</i> /National Malaria Control Program

<b>PUC</b>	<i>Pool d'Urgence Congo</i> (Emergency Pool)
<b>RDTs</b>	Rapid Diagnostic Tests
<b>SANRU</b>	<i>Santé Rurale</i> (the National Rural Health)
<b>SEU</b>	Stockholm Evaluation Unit
<b>ToR</b>	Terms of Reference
<b>U5</b>	(Children) Under 5

## EXECUTIVE SUMMARY

This evaluation aims at assessing the Bili project in DRC, since its start in July 2017 until its closure in November 2019. The evaluation focuses on reviewing the project relevance and appropriateness, effectiveness, efficiency, impact, and sustainability – with a special attention to community case management of malaria (CCMm) or integrated Community Case management (iCCM) to the extent it has been implemented. It seeks to analyse achievements and challenges and to document lessons learned. The findings and recommendations of this evaluation are meant to be used by MSF to inform decisions and improve implementation in future project(s) in DRC and similar contexts.

Limitations to this evaluation include the fact that no direct project beneficiaries were consulted since the evaluation was conducted entirely remotely by the consultants' team. Furthermore, this meant that only primary qualitative data were used, while secondary quantitative data were drawn from reports and surveys conducted in the area.

The evaluation highlights how the project and the logic of the intervention appear relevant to some needs identified during the assessment phase but at the same time the Bili project missed opportunities to provide a more complete health package. The Bili project addressed malaria morbidity and mortality which were high, especially for the U5 population, and enhanced access to quality care which was challenging in the area. Nevertheless, some issues which might have contributed to the decrease of mortality for children under five, as per project objective, were partially overlooked in the project and logframe conceptualization, such as malnutrition.

Project contribution to the overall reduction in mortality in such a short time frame can be considered remarkable. Although the main – and very ambitious objective – of halving U5 mortality was not fully achieved, according to mortality surveys conducted by MSF, MSF did measure mortality reductions, including a decrease in overall mortality rate, as well as an increase in health seeking rate at primary level. There is concrete doubt whether those gains can be long lasting since sustainability was a major issue in the Bili project. MSF proved to be a 'too much of a big machine' altogether and finding a replacement was hard. It is understood that sustainability of this intervention was not among the main goals and objectives of the Bili project.

Furthermore, the noted independence of the MSF team and lack of collaboration with the three primary malaria donors (Global Fund, PMI and FCDO/DfID) and their implementing partners – such as SANRU and the local MoPH – caused operational frustrations, for example related to stock-outs. In fact, the Bili vertical program design and implementation caused missed opportunities to establish MoPH buy-in to support the project and build capacity throughout the project.

The advocacy strategy as presented did not seem necessarily appropriate for this project; it appears that by investigating and displaying shortcoming and issues with the drugs procurement and stock-outs, MSF got involved in a 'blame game' which deteriorated the relationship with the on-the-ground partners.

The design of the intervention and the related strategy were not well communicated or disseminated internally in MSF (at project level, and between project, coordination and HQ) and externally with communities in Bili, the MoPH at national, provincial, or health zone levels, as well as with other actors. This created confusion and the evaluation shows a gap between designing the strategy – including the advocacy one – and planning the operational details. This includes a disconnect between very ambitious objectives, short timeframe, geographical spread, and the reality of planning and delivery activities in a complex operating environment.

Lack of clarity regarding the strategy greatly affected the capacity of the project of being effective. Repercussions can be seen at different levels. Proximity and involvement of beneficiaries can be described as weak. Communities were considered passive recipients of a community-based intervention and not sufficiently mobilized and involved in the project activities. Furthermore, the community engagement component was implemented only in the last months of the project life and MSF expectations from communities were unrealistic, e.g. provision of free labor.

The evaluation shows that the Bili project incorporated CCM of both malaria and diarrhoea and while very effective in reducing mortality, the project design did not apply certain elements of global operational guidance, best practices, and lessons, specifically in not systematically positioning the CCM components as extensions of the national health system with integrated training, supervision, and data collection systems. As such, outreach to and implication of regional and health zone staff was noted as problematic throughout project implementation, thus reducing MoPH and key partner buy-in during the project. This also affected the possibility to establish clear handover after MSF withdrawal.

Supervision, communication, pace of work, and decision-making, were somewhat different than in an emergency MSF project and this frustrated some staff who came to the field with the expectations to save lives whereas they ended up involved in a community-based project with a much slower pace and more long-term outputs. This also led to profiles of international staff not always matching needs. Local staff were also hired outside of the Bili area since no qualified medical staff were available in the region. This affected proximity to beneficiaries and the understanding of their needs since none of the MSF staff – except for few low-ranking positions such as cooks and guards – were originally from the area.

In terms of efficiency, the project managed to guarantee access to care with a relatively low cost per consultation, but other costs related to international staff and import of drugs decreased the chance of a potential hand-over.

## RECOMMENDATIONS

### ⇒ Recommendations specific to the Bili project itself are:

- **Conducting a follow up and post-closure visit** to evaluate the few elements such as the ‘residual’ impact of the project one year after the MSF exist. This could help addressing the disputed sustainability elements/dimension of the project and increase lessons learnt related to sustainability.
- **Interviewing direct beneficiaries and communities** as well as more local authorities to include their perceptions and perspectives into this evaluation.

**Recommendations to MSF to design and implement a project with similar characteristics to the Bili project – either for the adoption of iCCM or focus on specific diseases – are:**

### ⇒ Recommendations related to Relevance:

- **Site selection:** In identifying future potential project locations for iCCM interventions, prioritize areas with low access to health services and high under-five morbidity and mortality (as it was the case for Bili and as per MSF Strategic Framework) but do strongly consider selecting areas which have not recently received any emergency response interventions – especially led by MSF. Consider also implementing this strategy in a smaller area rather than a whole “*zone de santé*” (*health zone*) and consider scale-up once there enough evidence of a functioning system. Weight cost effectiveness – if another emergency MSF project is present, it would be cheaper to start from existing structure but keeping in mind the different nature and focus of the new one.

### ⇒ Recommendations related to Design:

- **Stakeholder coordination:** Gather stakeholders’ inputs (national and local levels) to inform project design and implementation, and maintain a participatory process during project life, not least for potential adaptations. Mutually determine key roles for each stakeholder in ensuring successful results of the project, as well as sustainability after the departure of external resources.
- **Global iCCM strategy and planning tools:** Develop a global strategic and more detailed MSF iCCM strategy document and accompanying planning tools, to guide staff implementing or planning to implement iCCM.
- **Review the advocacy approach** – Consider prioritizing a focus on working with the MoPH and key health stakeholders, to leverage MSF’s unique expertise and experience to strengthen systems rather than setting an objective to critique things that may not be going so well e.g. supply chain management.
- **Review the available health data evidence** and discuss MSF’s approach to inclusion of malaria, diarrhoea, and pneumonia case management. Final decisions to include, or not, each component will vary by context and field teams will benefit from clear guidance on how to implement other components in the final package of interventions selected.

Recommendations related to Effectiveness and Sustainability →

⇒ **Recommendations related to Effectiveness and Sustainability:**

Prioritize community mobilization and involvement of communities from start, and at every level of the project cycle such as during the project design, during the planning phase and in the data collection for monitoring. Use the available community resources well, including CHWs to enhance outreach activities as well as diagnostic and treatment. For this, most common child illnesses should be involved and CHWs trained on diagnostic and treatment.

Choose adequate HR, focusing more on availability of local medical staff instead of looking for other external 'inputs'. Supervision and capacity building will be key to bring these staff up to speed, but there are tangible gains in having local staff and diminishing number of international and relocated staff. International staff should be also advised to the slightly different nature of an iCCM project and coaching accordingly, e.g. slower pace of work, focus on training of CHWs and generally on community involvement and engagement, close collaboration with local MoPH.

## INTRODUCTION

The Médecins sans Frontières (MSF) Operational Center of Brussels (OCB) has maintained operations in the Democratic Republic of Congo (DRC) since 1985 when it first responded to an influx on Angolan refugees in Katanga Province. In 2015, MSF started activities in Bili, located in the North Ubangi province. Bili is one of the 11 *zones de santé* of the North Ubangi province which alone covers a surface of 7339 square kilometers and serves a population of 192,192 people, including 36,139 children under the age of five (U5) (MSF, 2018). The area is relatively calm and stable and has not faced major security threats and disruption as other provinces in DRC. It is very isolated with limited geographical access, and mostly accessible only by motorbike or pirogue. The health system in the area is weak and quality of care provided in the existing and staffed health structures is also questionable, due to the lack of resources and the constant ruptures in the drugs supply system. The local Ministry of Public Health (*Ministère de la Santé Publique*, MoPH) constantly faces challenges in providing health to remote and widespread populations.

According to a mortality survey conducted by MSF in the Bili area in 2016 (MSF, 2016), Crude Mortality Rate (CMR) was estimated at 2.8/10.000 and the U5 MR reached 5.7/10.000, with malaria being hyper-endemic; parasitaemia in the general population was estimated around 74.5%.

## PROJECT BACKGROUND

The Bili area is bordering the Central African Republic and at the end of 2014, due to insecurity, approximately 20,000 Central African refugees crossed the DRC border and settled in the region, which was already stretched for resources and lacking health care. MSF stepped in in February 2015, providing emergency response through the *Pool d'Urgence Congo* (PUC) and assisting refugees from Central African Republic as well as host communities. The emergency response project included support to three health centres and to the *Hôpital Général de Référence* (district hospital, HGR) in Bili. The intervention focused on the provision of free basic health care as well as mental health support and maternal health care.

The PUC emergency response was extended three times, up to December 2016. In 2017 a new approach for the project was designed and finalized. MSF decided to move away from the basic health care support provided and focus on specific morbidities and target population. The approach was identified after a needs assessment conducted in 2016 – including a mortality and vaccination coverage survey – and entailed provision of health care with focus on malaria for the U5 population - prevalently host communities and refugees - with an emphasis on the community engagement component. The project aim was reducing morbidity and mortality for children U5 in the Bili *zone de santé*. The project started in July 2017 and continued until November 2019 when it was closed without handover.

The main axes of intervention for the project included (see Table 1 below):

**Table 1.** Axes of intervention of the Bili project in 2017 (MSF, 2020).

AXES OF INTERVENTION	ACTIVITIES
Community health level	Support to 33 health posts and 12 community health sites for malaria care and simple diarrhoea for the U5 population
Primary health care level	Support to 17 health centres of the Bili health zone (one health centre per health area) focusing on 3 most frequent pathologies i.e. malaria, diarrhea and acute respiratory infections in the U5 target group
Secondary health care level	Support to Bili HGR for emergency and intensive wards, neonatology, paediatrics, in-patient nutritional care for patients below 15 and blood transfusion. To diminish the influx of patients to the HGR and reduce delays in receiving healthcare, the project also included support to three health centres - Baya, Gbangi and Pandu - to receive in-patients
Referrals	Facilitation of referrals between supported facilities
Environmental health	Conducting health promotion activities focusing on malaria prevention and vector control in Bili health zone

The objectives of the intervention are summarized in the table below (Table 2).

**Table 2.** Objectives and results for the Bili project (MSF, 2020).

OVERALL OBJECTIVE
Morbidity and mortality of the U5 is reduced in the Bili <i>zone de santé</i>
SPECIFIC OBJECTIVE
The U5 population in the <i>zone de santé</i> uses high quality curative and preventive health services
RESULTS
<u>Result 1:</u> Malaria and simple diarrhoea treatment is available at the health posts and health centres in Bili
<u>Result 2:</u> High quality and free basic health care services are available for the U5 population in the <i>zone de santé</i> and they are based on Integrated Management of Childhood Illnesses (IMCI) package
<u>Result 3:</u> Secondary health care services are available at the Bili HGR and the health centre in Baya, Pandu and Gbangi
<u>Result 4:</u> Malaria health promotion and vector control activities are available in Bili;
<u>Result 5:</u> Advocacy data collected in Bili are used for operational advocacy to improve the implementation impact and to show the impact of decentralized rural community health
<u>Result 6:</u> The exit strategy is completed according to the chronogram.

The project was implemented with the Congolese *Ministère de la Santé Publique* (Ministry of Public Health, MoPH) at all levels of the health pyramid structure. At the time of the project implementation, three main donors provided funding for malaria in DRC - the Global Fund, the U.S. President's Malaria Initiative (PMI), and the UK Foreign Commonwealth and Development Office (FCDO, formerly DfID). FCDO still funds the *Accès aux Soins de Santé Primaire* (ASSP, Access to Health) project, which is based on complementarity with Global Fund-funded programs providing a large share of malaria commodities. ASSP is implemented by Interchurch Medical Assistance (IMA) which in partnership with the Protestant Church of Congo manages the *Santé Rurale* (SANRU) rural health program. SANRU is both a Global Fund and FCDO implementing partner in DRC.

In North Ubangi, the Global Fund was the main donor for the procurement of anti-malarial medicines and worked in close collaboration with SANRU who as implementing partner was responsible for malaria case management forecasting and procurement, implementation support, communication, and social mobilization of the community. The *Bureau Central de la Zone de Santé* (BCZ) together with the support of IMA-Health was responsible for the transfer of health commodities to Bili, where in-charge health staff from the various structures could come for resupply. In the area, the FCDO through ASSP supported increased access to health care by closely cooperating with IMA-Health and SANRU to manage commodity supplies for basic health care and supporting rehabilitation of health structures. The health commodity supply system suffered from several stock-outs at every level and MSF put in place a system of 'gap-filling' to support drug supply in the *zone de santé* while awaiting the next delivery from the *Centrale de Distribution Régionale* (CDR).

## EVALUATION SCOPE

The evaluation aims at assessing the Bili project since its start in July 2017 until its closure in November 2019. The evaluation focuses on reviewing its relevance and appropriateness, effectiveness, efficiency, impact and sustainability, with a special attention to integrated Community Case management (iCCM) to the extent it has been implemented. It seeks to analyse achievements and challenges and to document lessons learned. The findings and recommendations of this evaluation will be used by MSF to inform decisions and improve implementation in future project(s) in DRC and similar contexts. The complete ToRs of this evaluation are available as annex in this report, in Annex 4.

## METHODOLOGY

### CHOICE OF EVALUATION METHODOLOGY

In order to assess the project, this evaluation used a mixed-methods approach, collecting primary qualitative from informants and drawing secondary quantitative data from desktop review of project documents. This mixed-method approach should facilitate triangulation of data and increases validity and comprehensiveness of findings.

The 'Grounded Theory' approach was applied to the whole research (Babbie, 2010). The grounded theory is a research approach used in the field of anthropology and social sciences. It is a systematic methodology which implies the construction of theories through methodical gathering and analysis of data. This research

methodology operates inductively, in contrast to the hypothetical-deductive approach. A study using grounded theory usually begin with a question/s, or even just with the collection of qualitative data. In the data collected, repeated ideas, concepts or elements are tagged with codes and constitute the core of the research. This evaluation approach also entailed the concept of 'snowballing' whereby initial informants pointed out at other resources including other potential informants and documentation to be contacted and analysed.

For the qualitative data collection, semi-structured Key Informants Interviews (KIIs) were used to gather impressions and ideas about the program from staff and other relevant stakeholders. A list of the key informants is available in Annex 4.

Further quantitative data was drawn from desktop revision of internal documentation made available to the two consultants involved in the evaluation. This includes project reports and research, monitoring frameworks and any other relevant documents, including international guidelines, and peer-reviewed articles. These documents are referenced throughout the text and a list of consulted material is available at the end of the report.

The research approach and the data collection tools were developed by the lead consultant with input from the co-consultant and they were based on the OECD/DAC evaluation criteria and on the main research questions as set out in the Terms of References (ToRs) prepared for this evaluation. An inception report was submitted, reviewed by Commissioner and Consultation Group for the evaluation, and validated by MSF Stockholm Evaluation Unit (SEU). The inception report explained the approach and the evaluation matrix and presented the data collection tools. The data collection tools, and the evaluation matrix are available in Annex 4 and Annex 1, respectively.

Prior to each interview or discussion, an informant consent was requested. The consent was provided orally by the informants. The consent highlighted the non-mandatory nature of the interview and explained the scope of the evaluation, aiming to provide detailed information to MSF in order to understand degree of achievement and performance and to gather good practices and feedback. Informants were reassured that participating into the discussions would bear no discomfort or risk to them and the participation only implied a neglectable loss of time. Furthermore, informants were reassured that the data collected was treated confidentially and analysed as a whole so that there would not be any means to relate any information to a specific respondent. The informant consent is available as annex in the Annex 4 section of this report.

All the qualitative data was collected directly by the lead consultant and the co-consultant without the use of translators. The qualitative data was manually encoded and interpreted by the lead consultant. The quantitative data desktop data review was operated by the co-consultant and re-analysed/reformulated, where deemed necessary to address research questions and facilitate understanding.

## SELECTION OF INFORMANTS

No field visits were conducted in the framework of this evaluation. This was not only due to the travel restrictions in light of the Covid-19 pandemic, but also to current operational priorities and the fact that the MSF project in Bili closed in 2019.

Furthermore, the presence on the ground of the consultants might have been misinterpreted and associated with a potential return of MSF and its activities, raising expectations in the population, expectations too difficult and potentially risky to handle. Given the possibility to conduct remote interviews, the added value of visiting Kinshasa was deemed not sufficient to justify a field visit to DRC.

As a result, the evaluation research approach involved only interviews with former and current project staff at field, country, and Head Quarters (HQ) level for the qualitative data collection, as well as few selected external stakeholders. Triangulation was then sought through interviewing staff with different roles at different moments of the project life, to gather different perceptions from different workstreams, until saturation (repetition of the same information) was reached.

Not being able to contact direct beneficiaries obviously complicated triangulation of information since their point of view on the project implementation was not considered. Lack of field visits also affected observation which is another way to triangulate findings. No physical observation of structures was possible, so limited information is then available as regards to the sustainability of the project in its more practical aspects i.e. physical appearance of rehabilitated health structures, maintenance of logistical assets left by MSF and status of drug supply and storage.

## LIMITATIONS

The major limitation of this evaluation is the fact that many potential informants of the project were not involved or able to be contacted. They consist of final beneficiaries of the project, including communities targeted, as well as Community Health Workers (CHWs), staff from hospitals and health structures, either MoPH or hired by MSF, and other informants including representatives from SANRU, IMA-Health and UNICEF.

The reasons for not involving direct beneficiaries are explained above in the 'Methodology' section. Despite efforts made, several external actors identified as key informants were impossible to contact. Some informants within the MoPH have changed positions, contacts of staff from health centres were not known and other relevant actors did not provide feedback upon several requests of being contacted.

The partial involvement of those informants might have affected the overall perspective of this evaluation, which is slightly skewed to MSF staff. The beneficiaries' point of view is not known and since this was a community-based project, nothing is known in terms of community approach by the communities themselves, both what communities appreciated and valued from the intervention and the activities, but also what they did not like and their suggestions to improve next time. Unfortunately, this limitation cannot be addressed given the noted constraints.

The evaluation is based on first-hand qualitative data collected through interviews with some external stakeholders and mostly internal MSF staff, as well as second-hand quantitative data coming from project documentation and monitoring. Primary qualitative data yielded abundant information, but the lack of primary quantitative data e.g. collected directly in the field with direct beneficiaries - for all evaluation criteria complicated the data analysis. There is not a 'framework' of primary quantitative data to compare/collate these qualitative data with, so not much to be expressed in numbers and percentages and further explained and complemented by qualitative data analysis. Quantitative data used was secondary and coming mostly from internal MSF sources, so this information could not complement very specific OECD/DAC criteria research questions such as for instance the perceived impact and benefits beneficiaries have gained from the intervention or the sustainability aspects seen from the perspective of MoPH.

This evaluation was conducted entirely remotely so another limitation was availability of and accessibility to selected and/or suggested additional informants. Out of the 19 pre-identified MSF informants, some declined to be interviewed and some never replied or replied too late the request to be contacted for interview.

As this evaluation was largely based on primary qualitative data collected from selected informants and only secondary quantitative data, it was nearly impossible to replace informants as it can be done for instance in a household-based questionnaire where, in case of unavailability of one informant, another one with same characteristics can be rapidly identified, most likely next door. In this evaluation, each informant has or has had a unique role in the project, therefore the informant's contribution was unique and could not be replaced.

## FINDINGS

Data collection was conducted remotely between September 30th and November 6<sup>th</sup>, 2020 and during this timeframe, eighteen informants were interviewed; fifteen were either current or former MSF staff. Three were external stakeholders and one was a consultant. A complete list of informants is provided in Annex 3.

Evaluation findings across six thematic areas of project relevance, appropriateness, effectiveness, efficiency, impact, and sustainability are presented below.

### RELEVANCE

Relevance usually measures whether a given intervention responds to identified needs. For this evaluation, the concept of relevance was investigated in a more in-depth manner, looking at the indications provided by a needs assessment conducted at the start of the project and the relevance of the intervention for the MoPH health strategy at regional and national levels.

***Assessments indicated malaria a leading cause of death, followed closely by malnutrition and diarrhoea.***

Prior to the launch and the redesign of the intervention, several data sources were consulted and analysed to identify health priorities in the areas. Already in 2015, during the emergency phase of the project and following the population displacements from the Central African Republic, MSF conducted a vaccination coverage and retrospective mortality survey in the Bili and Bossobolo health zones (MSF, 2015). Findings included that most deaths were linked to febrile illnesses, including diarrhoea, malaria, and malnutrition. Reported coverage from the last measles vaccination campaign in 2013 was high (98% administrative coverage). A survey of 2,966 people was conducted and found malaria to be the leading cause of death among the host population in the two areas (21.4%), followed closely by malnutrition (19.8%); and diarrhoea (19%). Among refugees, malnutrition was the leading cause of death (17.4%), followed by diarrhoea and malaria both at 13%. In 2016 MSF conducted a baseline health status and behaviour survey (MSF, 2016) ‘in view of the change of strategy that will target the top pathologies affecting children –namely malaria, diarrhoea, and respiratory infections.’ Just after the project launch, in April 2017, MSF consolidated previous findings with another mortality survey (MSF, 2017) which showed high endemicity of malaria and low use of health services. According to this survey, most deaths occurred in the community: 49% at home, 11% on the road to the health facility, and 5% among traditional healers; and only 34% of deaths occurred in healthcare structures.

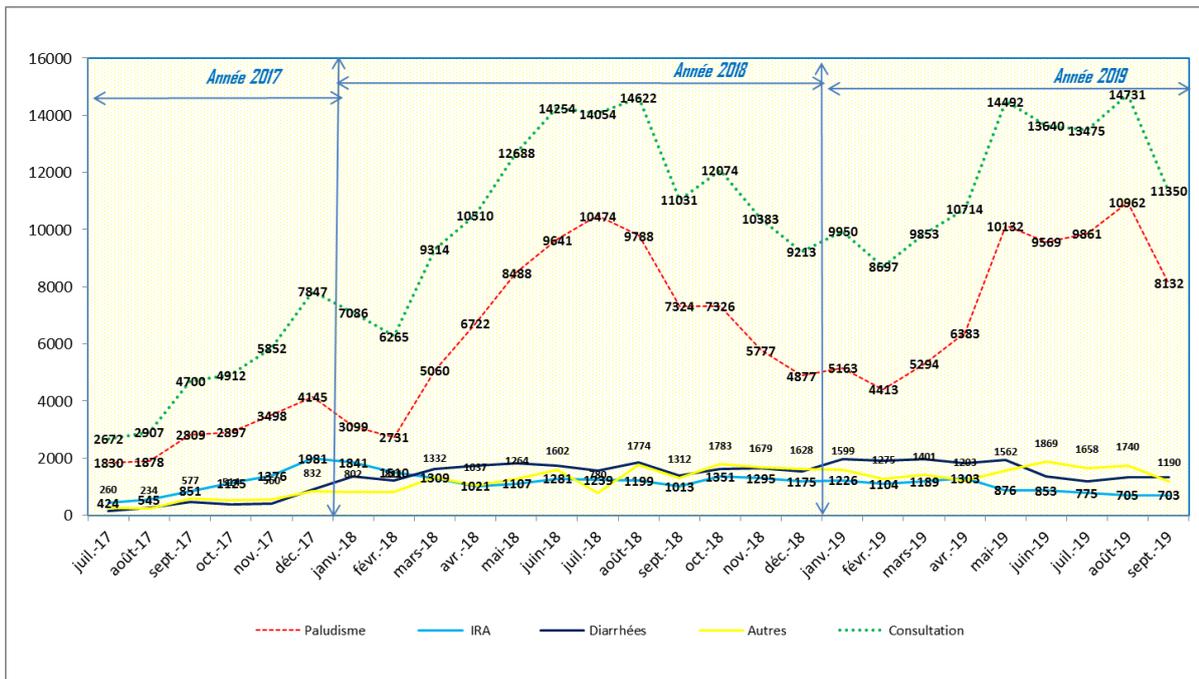
***Malaria among children under five selected as primary project focus, but malnutrition and pneumonia possibly overlooked.***

Informants confirmed the main findings from the vaccination and mortality survey conducted in the Bili area in 2016 and in 2017, that is high malaria parasitemia in the general population and a very high malaria mortality and morbidity in the U5 population. Furthermore, informants recalled that malnutrition appeared to be an issue as well – mostly stunting – and access to services or non-existing health services were also considered a contributing factor to the high mortality in the area. The high malaria burden led to decisions to focus the upcoming intervention on malaria detection and treatment especially for the U5 target group. Malaria for children under 5 was chosen given the high mortality and biological vulnerability of

young children before protective immunity is acquired. Pneumonia is also a leading cause of death in young children in the DRC, accounting for 18% of deaths (Stop Pneumonia, 2020) and only 7% of children in the DRC with suspected pneumonia receive antibiotics (PSI, 2019). Even in the face of organizational concerns regarding community provision of antibiotics, the Bili project could have considered inclusion of training and support to community health workers for breath counting and provision of antibiotics.

**The new intervention logic was relevant to MSF OCB strategic orientation.** The Bili *zone de santé* responded to many criteria from the MSF OCB strategic orientation (MSF, 2020) and future planned approaches. This strategy includes working in ‘those projects that respond to acute peaks in mortality and morbidity in situations where we [MSF] know that vulnerability and needs are most acute: conflict, natural disasters and epidemics’ and ‘to incorporate a capacity to respond to smaller crises, geographically dispersed and often with characteristics that do not always fit our [MSF’s] classic understanding of ‘emergencies’ (MSF, 2020). The Bili *zone de santé* is located in a challenging and remote environment with a high burden of diseases. MSF wanted to provide a continuum of care, moving away from the hospital setting and focusing work on community health in a whole *zone de santé*. And Bili proved to be one of the two high malaria burden zone in DRC, together with the Haut Uele according to the WHO 2017 World Malaria Report (WHO, 2017).

As shown in the figure below Figure 1, malaria remained a leading disease responsible for a majority of consultations in Bili.



**Figure 1.** Principal morbidity reports (facility and community levels) by month, July 2017-Sep 2019, Bili, North Ubangi, DRC (MSF, 2019).

**Intervention logic in the Bili project does not include outcome level indicators.** In terms of the project responding to pre-identified needs, the project logframe (MSF, 2019) indicates a goal of reducing under five child mortality by 50% in Bili. However, the specific objectives do not include outcome level indicators

responding to the three disease areas identified as the primary contributors to child illness and death. As noted above, these are malnutrition, malaria, and diarrhea.

Instead, the logframe objective is specific to increasing the use of quality preventive and health services. The logframe expected results include:

1. Provision of free malaria and diarrhea case management at community health posts (via community health workers);
2. Free quality primary healthcare based on the IMCI package is available for children under five throughout the health zone;
3. Free quality secondary healthcare is available at the general reference hospital in Bili and three reference health centers;
4. Malaria health promotion and vector control activities are available in Bili;
5. Advocacy data collected in Bili are used for operational advocacy to improve the implementation impact and to show the impact of decentralized rural community health;
6. The exit strategy is completed according to the chronogram.

**Activities and objectives were adequate to answer identified needs**, according to almost all informants, although especially *objectives were very ambitious* to be appropriately implemented with a very short timeframe. Furthermore, activities were meant to cover a large and mostly inaccessible *zone de santé* for whose population geographical access to care was extremely challenging. According to mostly field staff, the project was equipped with relatively few resources, particularly in terms of human resources.

Only one external informant stated that the MSF project was not relevant because the Global Fund was already financing comprehensive malaria activities all North Ubangi health zones. This created overlap and confusion, rather than providing added value. The informant also noted that MSF did not follow national standards and supplied health facilities directly rather than passing through the national or health zonal supply chain. This led to duplication of efforts, overstocks of some medicines, expiry, and in some cases diversions of health commodities.

The same informant did also recognize the MSF contributions, including improved referral networks through engagement of motorcycle taxis, construction and rehabilitation of the hospital and reference centers, and expansion of community care sites, although the informant added that the latter were not implemented according to the DRC *Guide de l'Approche Communautaire*. Additionally, the informant noted that MSF provided capacity building within the health system via training for malaria case management among providers, training in resuscitation, and reinforcement of obstetric and surgical emergencies which improved the quality of care and reduced morbidity and mortality.

**Informants considered all implemented activities as relevant but identified missing activities.** For example, the approach focused on malaria and never managed to comprehensively include other child illnesses - such as pneumonia - as initially planned in the scope. Additionally, the logframe indicated that the project should follow an IMCI approach, however in practice the team implemented a health systems strengthening at hospital, reference center, and health center levels and the malaria and diarrhea case management components of an iCCM approach to respond to the needs to manage cases of childhood fever directly in the

community. A further analysis of the confusion created between the use of IMCI and iCCM is included in the Findings on Relevance section below. Informants – especially those who worked in the field – expressed the concern that many community-based activities and generally the community health approach was largely overlooked until nearly the end of the project. Only a few activities were planned in terms of community engagement and participation in project design and roll-out. And much more could have been done in terms of activities for the prevention of malaria and other child illnesses, for instance by looking at use of ITN (Insecticide-treated nets), handwashing, sanitation, and other preventive measures. While large-scale ITN campaigns are implemented periodically throughout DRC, it is widely established that ITN access deteriorates due to physical degradation of the nets (as pictured), other loss due to population movement or displacement, and the addition of new sleeping spaces due to births. MSF could have discussed the possibility of ITN availability with the three primary malaria donors and offered to ensure quality distribution through project-supported health services to pregnant women, vaccinated children, or to community members with identified uncovered sleeping spaces.



**Figure 2.** An example of ITN physical quality, Gbadri. Photo credit: P Taffon (2017).

1. 1 of relevant actors, such as MoPH as well as FCDO/DfID to overcome the ongoing challenges.
2. Demonstrating that the MSF model implemented in Bili could be a relevant and attractive one from a hand-over and replication perspective, should have served to showcase MSF's unique approach to high-quality iCCM program design and operational effectiveness.

As noted in the *Findings related to Effectiveness* (see section below), the advocacy approach as it was written focused on external oversight rather than as a trusted partner of the MoPH and donors to resolve bottlenecks.

**The Bili project was partially aligned with national strategies and priorities.** From a desktop review of documentation, the project was apparently relevant to the DRC MoPH strategy. The Bili project supported some of the national priorities outlined in DRC's *Plan Stratégique Nationale (PSN) de Lutte contre le Paludisme 2016-2020* (MoPH, 2015). Approved activities in this *(PSN) de Lutte contre le Paludisme* aimed to reinforce and extend secondary and tertiary reference facilities providing free quality primary health care. This included support of iCCM through community-based health care to the population, including support to health post staff and trained community health workers to diagnose and treat malaria, diarrhoea, and pneumonia. The Bili project was responsive to the malaria and diarrhoea components of the national strategy but did not include the recommended pneumonia component. For malaria, the *(PSN) de Lutte contre le Paludisme* includes reinforcement of diagnosis with Rapid Diagnostic Tests (RDTs) and treatment with Artemisinin-based Combination Therapy (ACT), elements which were part of the MSF Bili project. These elements were directly supporting the MoPH overall mission of guaranteeing universal access to the most effective measures and the directing principles of evidence-based strategies and equity; and the objective of ensuring treatment for 100% of people who test positive. Both CCMM and iCCM have been carried out by other implementing partners with support from financial partners including Global Fund, PMI, and previously with the former Canadian International Development Agency.

The Bili project addressed some of the structural limitations of the MoPH as identified in the *Plan d'Action opérationnel du programme national de lutte contre le paludisme* (MoPH, 2019). For human resource priority needs, the Bili project addressed the identified issues including low motivation of health staff, by providing salary incentives (primes) and supporting staff training to address competency concerns. For material needs, MSF supported rehabilitation of health structures and provided equipment for blood banks, laboratory diagnosis, and other priority supplies in three reference clinics and one reference hospital. Project contributions of RDTs and ACTs, when health centres, health posts, and CHWs experienced stock outs, supported program performance as well.

When requested to comment about the relevance of the Bili project for the MoPH priorities, MSF internal informants, especially from MSF HQ and the DRC coordination team, believed that the strategy and the approach implemented in Bili should have helped the MoPH to concretize the priorities of making health care accessible by strategically supporting a network of health centers and posts which were not further than 5km from villages.

## DESIGN AND APPROPRIATENESS

Design and appropriateness assess to which extent the project implementation was appropriate to its design and whether its design met quality standards and was based on prominent best practices. For this evaluation, project design and appropriateness were additionally investigated by focusing on the design of the advocacy strategy, planned coordination with other actors, and by examining the issue of proximity to the project beneficiaries.

***Bili project aligns with global iCCM Guidance and MSF OCB frameworks.*** The appropriateness of the strategy and the financial model adopted was reviewed in comparison to global and national documents. First, it was compared with WHO/UNICEF iCCM strategy (WHO/UNICEF, 2012) and 2018 MSF's iCCM – OCB framework (MSF, 2018). In the 2012 Joint Statement, WHO and UNICEF support the iCCM approach and its effectiveness in increasing access to essential treatment for the leading killer diseases of young children. The Joint Statement identified low levels of availability for diarrhoea treatment, antibiotics for pneumonia, and finger/heel stick testing for malaria and presented evidence that “an integrated strategy can be effective in achieving high treatment coverage and delivering high-quality care to sick children in the community.” The Joint Statement also included six key activities and milestones to guide iCCM. These are: Coordination and policymaking; Human resources; Supply chain management; Service delivery and referral; Communication and social mobilization; Supervision and performance quality assurances; and Monitoring, evaluation, and health information systems.

MSF's iCCM OCB framework (MSF, 2018) aligns with the WHO and UNICEF guidance. The OCB framework defines iCCM as “patient management for children between 2 months and 5 years at the community level, provided by community health workers, integrating diagnosis and treatment for the main acute killer diseases, more specifically malaria, pneumonia, diarrhoea, while other activities - such as screening for malnutrition - can be added.” The framework includes “malaria diagnosis based on RDTs and pneumonia diagnosis based on respiratory rate combined with cough, treated with ACT and antibiotics respectively, and Oral Rehydration Solution (ORS) + Zinc for diarrhoea.” Furthermore, it reinforces the importance of involving the community in the establishment and design of iCCM interventions, and it includes the importance of strong primary health care systems in place and functioning to ensure success.

As outlined above, the project strategy aligns with WHO/UNICEF and MSF OCB guidance for iCCM in a number of ways: the goal focuses on reducing under five child mortality by 50% in Bili area and the provision of free malaria and diarrhoea case management at community health posts and sites via CHWs and malaria health promotion. But while the WHO/UNICEF and MSF strategies also underscore the importance of operating iCCM programs within a strong and reinforced health system, the Bili project actually included these components within the project itself to lead the development of and manage concurrent hospital and health facility reference facilities within the same project.

Informants contacted for this evaluation agreed that the design of the strategy was in essence adequate and appropriate to the needs identified in the area, although very ambitious and with a massive coverage area and a very short implementation timeframe. Everyone agreed that the understanding of the strategy and the actual implementation has been extremely challenging throughout the project timeframe.

***Challenging design of the Bili project.*** Informants provided some background regarding the actual initial design of the project, which was meant to be a facility based maternal health intervention, as requested from the field teams in late 2016. This original project approach was rejected by the MSF DRC coordination team during the revision and approval phase and the coordination team apparently rewrote and redesigned the overall approach with more focus on pediatric malaria. This project proposal was then sent to the HQ for approval, although it has been written without any input from the field and apparently without consensus. The field teams then, when they came to know about this change in the project design, used the ‘field

opportunity envelope' tool which allows field teams to submit a project proposal directly to HQ without any prior coordination approval or intervention. The focus was again more generally on maternal and child health. According to some contacted internal informants, this latest project version was then approved by HQ, so the project was meant to be launched as a facility-based maternal health intervention as per the proposal submitted with the field opportunity envelope. The field coordinator - who was the main contributor to this project proposal - left and shortly afterward a new one came who was not aware of the actual history of the proposal. According to some informants, this new field coordinator was 'brainwashed' - as informants report - into implementing the U5 community-focused malaria approach requested by the coordination team. Although this particular story might be anecdotal, it illustrates the lack of alignment between the field and coordination teams, also confirmed by other internal informants. Additionally, this informs the discrepancy later seen between the design of the strategy and the implementation of the project, due to major issues noted stemming from this misunderstanding and disagreement.

***Divergent visions for the Bili project.*** It appears that MSF staff visions for the project varied at different levels. For some levels, the project was meant to be a vertical pediatric malaria intervention – this interpretation was more common at HQ level – with focus on other child illnesses -such as diarrhea and pneumonia - in order to decrease the overall burden on mortality. The focus on U5 was indicated given the increased vulnerability of children under five and the community approach is important given the importance of prompt diagnosis and treatment in children who can progress to severe illness and death in as little as 24 hours. For some staff, the understanding was that the project was supposed to provide basic facility-focused health care and for others, it was an IMCI project with a strong community involvement – as per objectives in the proposal, not specifically an iCCM project. These different viewpoints and lack of a shared vision created a “*cacophonie totale*” (total cacophony) as a previous MSF staff described it. This alone led to various implementations issues, discussed later in the *Findings related to Effectiveness* chapter.

***Options for reorientation were considered but never implemented.*** The desktop review shows that just after the reorientation from the emergency project in 2017, several additional options for re-orienting the project again were being considered in light of some outstanding challenges such as the serious human resources gaps at project and coordination levels, that would limit a project pivot (MSF, 2017). These options included a primary health care with community extension model, malaria focused model with operational research of new tools, algorithms, and possibly Intermittent Preventive Treatment in infants (IPTi) as well as considerations for a baseline survey, mappings of actors, health structures, and communities and the financial/incentives approach. These options must have been discarded at a later stage, since no further trace is found in following documents and in interviews with stakeholders.

***Staff perceptions differ from project documentation.*** According to internal MSF informants, the initial design was not subjected to major changes despite consideration of options as shown by the desktop review. The project area remained the same and the beneficiaries target – the U5 groups – were later extended to cover the under fifteen as well. Another health structure was organized to become a reference centre (Baya) and allowances for referral were increased. Informants confirmed that additional activities described above, and other project changes were not implemented, partly because of the “rigid” MSF system – as one informant said, partly due to the lack of comprehensive insights in priorities of beneficiaries, as explained later in this chapter.

These minor adjustments in terms of design somewhat collide with evidence collected through the desktop reviews showing that MSF faced some challenges in understanding the beneficiaries and their needs, consequently partially failing in adapting and developing the right strategy to approach them.

**Communities engaged too late.** According to internal documents (Taffon, 2017; MSF, 2018), community engagement action plans were not developed as part of the project design. While MSF worked with the *Comité de Développement de l'Aire de Santé* (CODESA) as needed for specific activities, such as finding welcoming families or contacting village chiefs, their overall implication from project start was minimal, missing the opportunity of using CHWs such as providing community inputs into the roll-out of community interventions and ensuring ongoing clarity regarding the project for community relays and members. Initially, MSF did however train community leaders, including community relays, traditional leaders, youth group leaders. The results of these trainings only had limited impact on the project, as these were primarily information sharing (one-way) trainings and the information was insufficiently transmitted further to communities. As a result, despite MSF's emergency health activities, the project was not as well-known as might be expected, and Information, Education and Communication (IEC) activities were not well structured.

**MSF was not sufficiently close to beneficiaries and able to understand their needs and priorities,** according to internal MSF key informants contacted for this evaluation. They confirmed via practical examples how the community engagement component was implemented only in the last months of the project life and reported that MSF expectations from communities were unrealistic. Community engagement was understood as unpaid work provided from beneficiaries for road building, rehabilitation and weeding, for which MSF would have provided tools and materials, but for which communities requested payment to compensate loss of work. In the Bili project, communities were also expected to provide free accommodation for MSF staff when travelling to the field, an arrangement which worked out only initially and then payment for lodging was requested. The issue of paying beneficiaries for work created debate within the field teams; some believing that MSF should have given even more in terms of incentives and paid work, some believe that what was given was too much but once the precedent was set, it was very hard to roll back.

**Human resource constraints.** Lack of understanding came from the staff composition as well, according to some MSF former field-based informants. Bili was a region where MSF never worked before so there was not much historical knowledge within the mission. Once the project was started, many PUC staff became permanent staff in the region and MSF hired additional medical staff e.g., nurses, nurse aides and doctors to reinforce resources at the supported health centers and hospital. Since MSF has very strict parameters for hiring medical staff, it became clear that medical personnel had to be 'imported' from other regions in DRC as locally available medical staff did not have sufficient qualification or work experience to comply with MSF hiring requirements. That resulted in a complete estranged field staff, with MSF international and local staff who was not local but rather imported into Bili. The only local staff hired *in loco* by MSF were low-ranking positions such as cooks, cleaners, and guards. This not only created tension with the local population who felt they could not benefit from work opportunities arising from the project, but to a certain degree alienated MSF field staff in the informants' view.

**Perceptions of beneficiaries regarding switch from free health care for everyone to focus on U5.** Bili's population is described by former MSF field-based staff as neglected and poor, and historically used to receiving few donations and subsidies from the government so it is not familiar with the concept of community engagement and mobilization. Furthermore, beneficiaries were used to the previous MSF approach in the area which was an emergency response during which care was free for everyone and all was provided for. The switch from the emergency response to the more long-term programming was implemented without enough consultation with the communities, who played only a minor role in the consultation for the project design and lack sufficiently clear explanations. For example, informants reported that beneficiaries had trouble fully understanding that in the new approach care was only free for children under five. They questioned the rationale behind this decision since they felt that adults are breadwinners providing to their families so they should be assisted for free. If not, they would not be able to work and to feed their children. The Bili project was meant to be implemented in collaboration with different levels of the health pyramid, especially at regional and local levels in line with national malaria policy.

*“What was critical was that when MSF came to implement the project in Bili, they did not come to us or the other malaria donors to coordinate. Also, the MSF approach was different from what was in place.”*

**Key informant, Bili Evaluation**

MoPH leadership and partner collaboration is key to delivering lasting effective results for malaria control in DRC. Malaria activities in DRC are led by the Programme National de Lutte contre le Paludisme (PNLP), and delivered via the health system in place, with the support of donors, technical, and implementing partners. As one informant noted, malaria donors meet frequently and with the PNLP have established a mapping of malaria interventions as well as a collaboration agreement to ensure coverage across health zones. Through

the collaboration agreement, participating partners can share malaria resources and commodities as needed. Additionally, FCDO/DfID provides antibiotics and ORS/zinc to complete the package of interventions for iCCM.

**The MSF approach diverged from the other similar projects in the province.** An external informant indicated that they were presented the MSF project as part of the monthly malaria partners meetings organized by the PNLP. The informant indicated that the MSF approach to provide free health services via the MSF project in Bili differed from the cost recovery approach implemented by other partners in the health zone. The informant noted that the project design was presented after implementation had already started, and that when concerns were raised that this approach was not harmonized with other interventions in the province, MSF indicated that it was not possible to change the approach already in place, and that free provision of services and treatment was mandated as this was a humanitarian approach.

**Re-instating fee reduced health seeking behaviour.** An internal informant clarified that the free health services were provided for all hospital services during the humanitarian phase of the project and that following the project pivot, services remained free at the hospital level for children under 15 and at community level for children 1 month to five years. Adults paid a general consultation fee of 4,000 FC (1.75 Euros and pregnant women paid 2,000 FC/0.88 Euros) for ANC visits. This informant confirmed that re-instating service fees reduced health seeking behaviors during implementation of the Bili project.

**Challenges to collaboration.** MSF informants - especially from the field team- claimed that it has been challenging to involve the MoPH at regional and district level. The district health officer in charged was frequently absent and this complicated building a relationship. The Bili project regularly informed the health district about activities and shared medical data, MSF provided capacity building for health staff, filled the gap with regards to drug supply and paid incentives of staff, but this never led to a consolidated and mutually collaborative relationship, MSF informants report.

Several internal informants confirmed that the MSF team did not involve the MoPH – both at regional/provincial level and at national one - in the program design prior to or during project implementation and did not follow MoPH processes for data collection or for training and supervision of health staff and community health workers. One informant noted that it was particularly problematic that MSF did not involve the Provincial Health Directorate in the project that this became a subject of complaint. While another partner working in the health zone was expected to support training of health providers and CHWs, during the time that the Bili project was operational the partner only conducted one training which included two doctors from the Bili health zone for use of injectable artesunate. The partner indicated that MSF’s entry into the health zone where they were already operational and implementing malaria activities caused confusion and overlap.

“MSF is not taking into consideration guidance from the government. They may work with one focal point at MoPH but they don’t consider provincial or health zone level staff. They may show collaboration to a certain point, but primarily a lot of independence.”

Key informant, Bili evaluation

External informants described the MSF approaches in the Bili project with MSF staff leading training of health personnel at each health center and each CHW trained individually at their home or community health site. MSF staff conducted supervision visits and collected data which were brought back to the project. On a monthly basis, MSF shared data with the health zone office and did discuss project implementation to coordinate where possible. This approach replaced MoPH staff with MSF staff at every level of the health pyramid. While this approach maintained quality of interventions during the MSF-led Bili project, it did not begin or build the usual capacity building components that other iCCM programs develop over time by undertaking the standard MoPH-led and partner supported cascade approach described above for training, supervision, and data collection.

Another actor which MSF worked with was SANRU, an NGO and Global Fund recipient, responsible for RDT and ACT forecasting, malaria program support to the MoPH, as well as consumption forecast and procurement. MSF internal informants shared that MSF involved these actors only once the project had started. MSF informed SANRU about the upcoming activities and considerable amount of the SANRU procured commodities were use in facilities supported by MSF. MSF informants explained that SANRU procured drugs based on an average monthly consumption estimate, based on previous consumption data, and that procurement was carried out months in advance within Global Fund procurement guidelines. With the arrival of MSF, malaria consultations and prescriptions significantly increased and SANRU faced major difficulties in keeping up with the procurement, ‘blaming’ MSF for this increase of work and loss of income. In fact, SANRU maintained the health facility approach to collect ‘*ticket modérateur*’ that is the fee paid by patients for malaria consultation, which was removed for the U5 as per MSF policy. This, and in general MSF approach, which was felt as dominating and non-participatory, deteriorated the relationship with SANRU which

informant described as “difficult”. This is particularly important, as SANRU as Global Fund recipient likely was the best placed to ensure sustainability of the interventions after project closeout.

**Advocacy strategy viewed as very ambitious, broad, and counter to project objectives.** The 2018 ‘Plaidoyer Projet Bili’ (MSF, 2018) document provides a detailed workplan with clear time-bound objectives and concrete activities. MSF informants – especially those involved more directly in humanitarian affairs – confirm that programming the advocacy component was designed together with the more general project conceptualization. They considered the strategy very ambitious and broad in its scope. Furthermore, the advocacy strategy timeframe and the objectives were felt as not necessarily time-bound but rather considered ‘one shot’ and too simplistic to be translated into the day-to-day management and implementation of the project. To some MSF informants the advocacy strategy was felt as ‘intruding’ in the project objectives. These same informants stated that they felt advocacy was not taking into consideration more relevant project related issues.

## EFFICIENCY

Efficiency represents how economically resources and inputs are converted to results. For this evaluation, it was investigated to which extent the use of resources contributed to their efficient use and economies of scale. The results of the project economic evaluation conducted in the Bili area in 2019 were taken as a benchmark to further analyse the project efficiency from a broader perspective which included also views from informants.

The 2019 economic evaluation (Jouquet, 2019) focused on cost-effectiveness and compared the Bili outreach activities supported by MSF with the neighbouring Bossobolo *zone de santé* which was not supported by MSF. This research showed that resources invested in the Bili outreach activities increased attendance to health structures and improved access to care. In the Bili *zone de santé* a sharp increase in access to healthcare for children U5 was recorded; 4.06 consultations per child U5 per year in 2018 against 1.66 in 2017 in the Bili health zone and 1.25 in the health zone of Bossobolo in 2018.

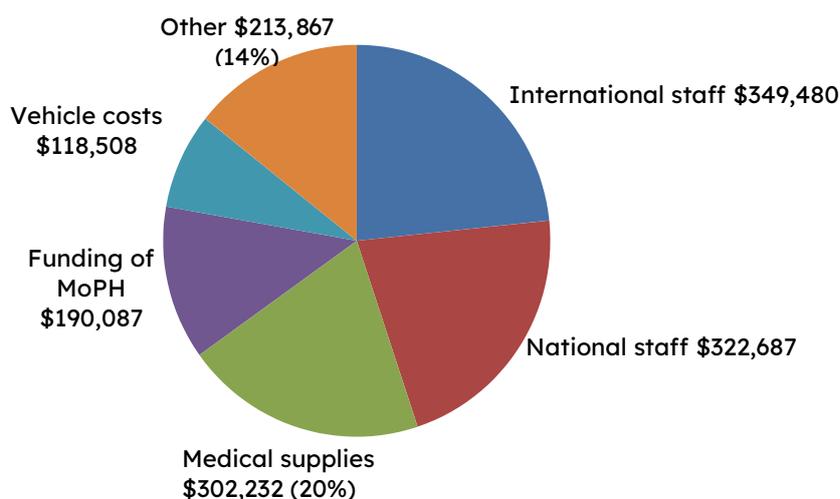


Figure 3. Project operational costs, 2018 S2 (Jouquet, 2019).

**High project expenses for expatriates did not translate in better management.** The review of the of economic evaluation highlighted that some project expenses were disproportionate with regards to actual gains. Costs sustained for international staff, who were five to ten times more expensive than local staff, in some informants’ opinion did not necessarily translate in better project management and vision. Internal MSF informants reported that it is the MSF approach and policy to hire expatriate staff for certain management and supervision positions to ensure better quality of care but, in fact, some costly hired international staff were inexperienced in the implementation of community health programs, and not able to provide that expected level of supervision and management. This frustrated and demotivated local staff. So, in the informants’ opinion, their higher costs did not really contribute to a tangible project gain.

**High costs for importing of drugs.** Another debated issue was the importation of medicines. Given documented concerns regarding the lack of drug regulation and limited availability of quality-assured ACTs in the DRC, the project understandably procured WHO approved antimalarials. Internal informants explained that MSF tended to import medicines from overseas. Justification for that was that MSF wants to guarantee high quality and efficiency drugs and usually avoids buying locally available drugs. By buying drugs in bulk overseas, drugs might have been cheaper as well. In reality, the cost of freight, customs, transportation and storage was not precisely calculated so these shipments resulted in being more expensive than the locally purchased drugs, given that drugs of good quality could have been available – this option was not explored. This cost-effectiveness aspect also affected relationships with the MoPH since the import of drugs and the ‘gap filling’ put in place by MSF seriously affected the procurement system organized by the government and its necessity to be cost recovery based. Overall, all the contacted internal informants agreed that the project was expensive, therefore not affordable for handover to any potential partners which did not have the same financial independence as MSF, and less attractive for institutional donors too.

## EFFECTIVENESS

Effectiveness is considering whether the results and outputs met the intended objectives. It also considers which potential challenges might have affected the implementation and how those challenges were addressed or avoided. For this evaluation, effectiveness also considers limitations and opportunities in the approach and factors which boosted or hindered achievement of objectives.

As previously explained in the chapter on *Findings related to Design and Appropriateness*, the activities were to a large extent carried out as planned, although options for change in the design were considered at some point.

**Limited timeframe.** The project went through a pilot phase in which the project was designed, and this phase served as reality check. Activities were gradually rolled out in the implementation phase and reached a stable running phase which should have lasted 18 months in total. A hand over phase was then planned. In fact, one of the major factors hampering the activities and the achievement of objectives was the limited timeframe of the project, which MSF informants insisted was significantly too short. This matter appears in several documents analysed for this evaluation criterion. For instance, in the 2019 ARO document (MSF, 2019) it is clearly stated that ‘it seemed difficult to achieve the objective set by relying on community efforts. If the primary goal of MSF is to demonstrate the effectiveness of a community-based care method, it would be relevant to question the closure of the project planned for 2019. The project would like the closure to be postponed by one year - end of project in 2020 - in order to be able to observe the impact of the actions implemented by the entire team’.

MSF informants also reported a late start of activities in 2017 – June instead of January – and a suspension of the project between August and November 2017 due to the arrival of a new head of mission who decided to put the project in stand-by while clarifying project format and scope with HQ. So, in June 2018 the initial phase of the project was over with an estimated delay of one year. The project was then closed about 18 months later, in November 2019.

**Late involvement of CHWs and community outreach.** The issue of time is, as discussed, strictly linked with proposed strategy of a community-based approach to health care and the initial misunderstanding of project focus. Informants stated that the ‘interest’ in the community approach came too late – real focus was given only in the last six months of the project. This was due to the pressure felt by MSF staff ‘to save lives’ as reported by many field-based informants. Staff felt the pressure to achieve objectives, reducing mortality, and addressing U5 morbidities by conveying most of the project efforts into continuing the curative care interventions already in place. These curative care interventions were hospital-based mostly, and required significant ongoing support, so did not allow staff much time to go out and really work with the communities and the volunteers. As one MSF field staff stated, ‘the Bili project actually never left the hospital’ referring to the outreach and community engagement activities. As reported in the 2018 Analyse Communautaire (MSF, 2018), ‘given the very limited duration of the project, it seems difficult to achieve the objective set by relying on community efforts. The project must now decide whether it chooses to i) focus on its main objective, namely to decrease mortality, to the detriment of community involvement or ii) reduce its financial

involvement in favour of a better chance of sustainability of activities but to the detriment of achieving the main objective.’

Informants felt that this was a missed opportunity as well, on many levels; for example, CHWs already trained by the MoPH, were in place and expected to conduct the majority of work in outreach and tracing of patients in a community-based project. However, as the community activities were started only near the end of the project, the CHWs were only able to provide limited help for a short time in the diagnosis and referral of malaria cases and simple diarrhoea. No inclusion of pneumonia diagnosis or treatment was planned at community level as part of the MSF project. Informants also note that CHWs were not supposed to handle antibiotics as part of the project. In spite of moderate levels of malnutrition identified in the need assessment surveys, the project did not include nutrition screening or management, an activity which could have been carried out by CHWs.

Furthermore, according to the 2019 Final CODESA report (MSF, 2019), CODESAs were involved relatively late as well and they were not aware of their roles and responsibilities in coordinating and leading community interventions. Additionally, it noted that no action plans were in place, limiting community health development. According to the report, MSF developed a CODESA training approach and trained more than 150 CODESA members to improve their involvement and reinvigorate their role. The participants appreciated the training and developed action plans; however, concerns were also voiced that the training happened late and just prior to MSF’s departure.

#### WHO DEFINITIONS

##### iCCM:

An equity-focused strategy that complements and extends the reach of public health services by providing timely and effective treatment of malaria, pneumonia, and diarrhoea to populations with limited access to facility-based health care providers, and especially to children under 5’.

##### IMCI:

An integrated approach to child health that focuses on the well-being of the whole child. IMCI aims to reduce death, illness, and disability, and to promote improved growth and development among children under five years of age.

Another issue which affected achievement of results, as noted above, was **the different interpretations of standard iCCM and IMCI strategies** at different levels of the organization. This topic has been already discussed in the *Findings related to Design and Appropriateness* section of this report, but the lack of clarity affected implementation and overall effectiveness. The logframe includes a key expected result as “High quality and free basic health care services are available for the U5 population in the *zone de santé* and they are based on IMCI package”.

As defined by WHO and in line with standard operational approaches to each, IMCI is very

different from iCCM. IMCI is a comprehensive health-facility based approach which promotes the accurate identification of childhood illnesses in outpatient settings, ensures appropriate combined treatment of all major illnesses, strengthens the counselling of caretakers, and speeds up the referral of severely ill children. In the home setting, it promotes appropriate care seeking behaviours, improved nutrition and preventative care, and the correct implementation of prescribed care. An iCCM intervention is a community-based approach, most often implemented through the public health system to train CHWs to provide diagnostics

and treatment for the leading causes of child mortality, including most frequently pneumonia, diarrhea, malaria, and which may also include undernutrition, and other leading illnesses of children, targeted to families with difficult access to case management at health facilities, often families who live more than five kilometres from a health centre. CHWs are generally linked to health facilities and receive supervision and supporting for appropriate case management, data collection, health commodity supply management, safe disposal of sharps and safe storage of medicines.

It is unclear when and how the IMCI strategy mentioned in the logframe was switched to a different iCCM concept, and whether this change happened willingly, or it was due to a misinterpretation at field and coordination level of the difference between the two approaches.

**Malaria commodity stock-outs**, especially in 2018, also affected project effectiveness. The project experienced on average 28 days of stock-out of supply per quarter (see Figure 4), which presented significant challenges for consistently meeting the needs of the population. Reasons for this often were depletion of buffer stocks, after not receiving expected stocks from the central pharmacy and a standby to all international orders by the mission until May 2018 to protest against customs harassment with the national authorities. One informant noted that because MSF began operations in the Bili health zone where Global Fund activities were already being implemented, it was difficult to ensure the good management of drugs and other inputs. The difficulties stemmed from two partners implementing different project designs in the same geographic area without an agreement in place clarifying roles and responsibilities. Furthermore, the MSF project design increased demand for commodities without MSF having participated in the national or provincial quantification exercises which establish funding envelopes for malaria commodities. As Global Fund procurement decisions and actions are established during grant-making every three years, it would be a lengthy process for SANRU to identify the increased needs, alert the Global Fund DRC country team, and undertake a reprogramming request, if that would be considered. These problems were not resolved by MSF and remained until the end of the project.

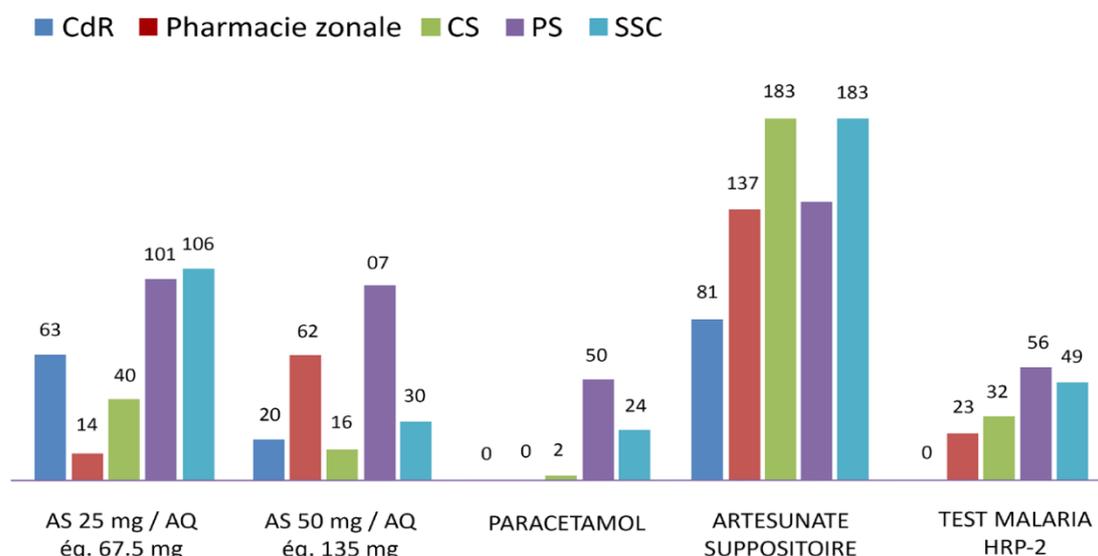


Figure 4. Median length of stock-outs (in days) of antimalarials, April-Sep 2018 (MSF, 2018).

**Challenges with human resources** - both in terms of quality and quantity - affected the implementation of the project strategy, according to MSF field-based informants. Some informants reported that given Bili's relative stability, it was a preferred posting for so called 'first missionaries', aid workers embarking on their first mission with MSF. Many were inexperienced and came with a clear 'emergency mode' mindset to a project whose pace and scope was more 'development' oriented. They struggled in understanding the context and purpose and often acted unprofessionally/unethically. Some informants pointed out that those first missionaries also lacked support and supervision which should have come from more high-ranking staff. High turn-over of staff was also a shortcoming. HQ human resources only provide six-month contracts to international staff for a project which needed a certain degree of continuity and stability and more long-term staff with prior experience in setting up and managing a community health program in line with global best practices and standard operational approaches.

**Incentives included in project implementation also created disappointment and were subjected to discussion.** Informants report that the primes system put in place was unfair, not in line with the MoPH prime structure and not discussed with MoPH. During the emergency phase, primes were paid only to hospital staff who directly supported MSF in their departments. In the second phase of the Bili project, an 'envelope' was paid for each health centres and the in-charge was responsible for division amongst staff which was in fact not uniform between health centres and never fair, but on which MSF had no control. Furthermore, those primes were paid in US\$, a currency difficult to use in Bili and people had to exchange it into local currency. The exchange rate was lower in this remote province than in Kinshasa for instance, so they lost about 20% of their *prime* every time they exchanged the US\$, causing disappointment and lack of motivation.

**Misalignments in tracking project progress made difficult to compare results with outcomes of other iCCM projects.** Project monitoring was based on medical data coming from the health structures supported by MSF and other data internally collected such from CODESA and villagers trained on specific health issues. Monitoring also appears to have been managed as an MSF-led intervention, with data shared at a later time with the MoPH. The Bili project monitoring sheet did not include standard iCCM indicators or monthly monitoring checking meetings between CHWs and health center staff. This makes it difficult to actually compare achieved results with outcomes of other iCCM programs. As previously discussed in the section *Findings related to Design and Appropriateness* the Bili project strategy was supposed to comply with the MSF OCB iCCM framework but the on-the-ground implementation slightly diverted from this framework, e.g., CHWs were not allowed to handle antibiotics and were not trained to address pneumonia. iCCM in MSF's framework was also intended to involve the community in the establishment and design of iCCM intervention itself, which was not the case in this project. Ideally, iCCM programs will also be implemented as an extension of a strong primary health care system in place and functioning to ensure success, a feature which was not fully pre-existing in the Bili area and which MSF stepped in to cover for.

**Ongoing supply chain issues.** For the advocacy strategy, the 2018 Elements Plaidoyer Bili (MSF, 2018) document summarizes activities and outputs for the planned advocacy strategy and its two main objectives. As regards the documentation of stock-outs, the MSF team decided to monitor and document procurement and supply chain disfunctions and stock outs for essential medicines and antimalarials. MSF conducted a study of the issues related to malaria stockouts and shared the report in July of 2019 with health stakeholders including IMA World Health, SANRU, the provincial health directorate, Global Fund, and the PNL. Feedback from meetings indicate mixed results – partners and MoPH leadership pointed blame in

different directions. And, in some cases, criticism was directed at MSF for ‘creating needs’ and increasing the demand for malaria commodities that were provided for free. As the needs outpaced the quantifications done, some partners felt that MSF did not coordinate as well as they could have to ensure visibility for increased needs, to be included in the lengthy quantification, procurement, and supply chain planning needed as part of Global Fund funding.

**Misalignment of advocacy and project objectives.** The other advocacy output was to advocate for an improved approach to health development programs of other donors, particularly FCDO/DfID which was also present in North Ubangi. However, MSF encountered several difficulties; successive project teams questioned MSF's approach in working with communities and there was general lack of understanding at field level regarding the project approach which undermined this objective. Instead of moving forward with this advocacy objective, the team decided to share training manuals with SANRU financed by Global Fund and IMA World Health financed by FCDO/DfID. MSF informants confirmed that objectives for the advocacy component were only marginally achieved.

They felt that activities related to advocacy were not correctly incorporated into the project implementation ‘routine’ and lacked specific indicators which complicated this incorporation. For instance, there was no common definition of ‘stock-outs’ for MSF and the MoPH, so it was hard to measure in practical terms and in advocacy related terms how to exactly measure those. Lack of dedicated staff on the ground further complicated implementation. In the initial phase of the project launch there was a dedicated humanitarian affairs officer in the project field-based staff but later on this position remained vacant and never filled again. There was only a humanitarian advocacy officer at coordination level.

## IMPACT

To evaluate impact, direct and possibly indirect changes produced by the intervention were considered. These changes include positive changes, which improved beneficiaries’ quality of life as well as unintended negative changes which in some ways affected beneficiaries. For this evaluation, possible long-lasting policy changes as direct result of the project were also investigated. It is understood though that impact is very challenging to measure since many other external factors can hamper or contribute to it.

**Partial achievement of the project goal, and significant public health achievement.** According to the 2019 Bili Monitoring sheet (MSF, 2019), the Bili project impact indicator did not achieve the target of a 50% reduction in under five mortality, as compared to the 2017 baseline, as often taken as reference for assessing the decrease in mortality and which takes into consideration also changes in context, e.g. generally improved health situation after refugee influx and return. While the project may not have achieved the ambitious target set at the impact level, it did contribute to a 22% annual reduction in mortality according to MSF mortality surveys. This is significant, considering the short implementation window (30 months). Furthermore, the Bili project might have contributed to increase the rate of primary health treatment seeking in a health facility and to the 86% increase of children referred from reference health centres to the general reference hospital in Bili. The project also extended malaria diagnosis and treatment to 33 health posts and 12 community sites and ensured 100% conformity to health center protocols at community level.

The 2019 Bili Rapport Annuel (MSF, 2019) notes that, in general, consultations increased in 2019 compared to 2018 and that the proportion of malaria cases in 2019 (65%) is greater compared to 2018 (62%) in spite of curative actions; this increase can be explained by easier access of the target population to quality free primary health care and the high proportion of malaria cases which constitute most of the consultations in MSF structures, i.e. 65% of morbidities over the whole year. One informant pointed out that the results in the Bili health zone were not solely the result of the MSF project alone, but that these represented the outcomes of interventions carried out by projects funded both by the Global Fund and FCDO/DfID.

“If MSF could have included even a nominal user fee of 100 francs congolais (FC, Congolese Francs) (0.044 Euros) would have maintained a baseline harmonization with interventions in other health zones, and reduced the difficulty of resuming cost recovery services after MSF’s closure of the Bili project.”

Key informant, Bili evaluation

**Mixed results.** According to MSF informants contacted for this evaluation, the impact generated from this intervention was visible and to a certain extent measurable – e.g. contribution to the decrease in mortality rates - but unfortunately not destined to be continued after project closeout. Informants reported that access to care was increased due to MSF presence and provision of free care to the U5, so MoPH clinics supported by MSF became the first reliable point of care for beneficiaries. Clinics were strategically located, not more than 5kms from most of the villages and they provided effective care which beneficiaries could access. The cost recovery system was suspended for U5 during the MSF intervention, which increased attendance, but it was necessarily reinstated as MSF left, given the necessity to cover costs in the absence of other outside funds. The risk being discouragement of the poorest people among the beneficiaries from seeking health care at the health centers and resorting to traditional healing or to cheap drugs sold by street-sellers.

**Investments by MSF made in capacity building of the health staff** including MoPH staff, which generally increased quality of care both at hospital and health centers level. But informants reported that most staff MSF had trained or hired, left after the closure of the project since they would not receive any incentives after project closeout. The health personnel hired by MSF were paid much higher salaries than their counterparts in the health system and one informant noted that this established a situation where there would not be a feasible way for the MoPH to cover salaries after MSF’s departure, nor for a donor agency to shoulder a very expensive project design that was out of sync with other interventions in the health zone, district, and province. MSF also improved some health clinics by creating a VHF radio system, installing solar panels and conducting general rehabilitation works. MSF also introduced more sophisticated diagnostic tools, e.g. Akku check for anemia, to improve diagnosis, but again this effort was not sustainable – most of the consumables are not available in country – although it contributed to the project impact while implemented. The presence of MSF guaranteed a more stable supply of drugs since MSF rapidly filled the gap if needed. This ensured availability of drugs and possibility to treat children but once again – informants pointed out – MSF ‘destroyed’ the local procurement system managed by SANRU and the MoPH and did not collaborate with other partners in the province to overcome systemic problems with the official supply chain, instead bringing in health commodities through parallel channels.

**No policy changes.** According to both external and MSF informants, MSF presence and intervention did not lead to any policy changes.

**Unintended positive impact.** MSF internal informants believe that this project had an unintended positive impact in the interest generated about the Bili region in DRC and within MSF as well. They believe that because of advocacy and communication conducted by MSF about the project, Bili came more into the spotlight which had not happened before, being less affected by crisis than other regions in DRC but certainly more neglected in terms of aid.

**Unintended negative impact.** In terms of negative but unintended impact, MSF internal informants fear that by hiring non-local health staff and ‘importing’ well qualified health personnel from other Congolese regions, MSF might have caused a ‘brain drain’ and depleted the health system from other regions by valuable and qualified staff who decide to leave their posting and join MSF, possibly attracted by more regular and certainly rewarding pay.

According to external informants, there were two main additional unintended negative consequences. First, the approach of providing free delivery of health services and malaria treatment negatively affected health seeking behavior after MSF closed the Bili project. One informant noted that, “communities have lost the sense of responsibility in self-care for health care following total free access during the ... MSF project. After disengagement, the community finds it difficult to afford the consultation form and this is already leading to a drop in the rate of service use.” The effects of this have persisted long after MSF closed the Bili project. As represented in Figure 5, the rates of curative and referral services in Bili remain below other health zones in North Ubangi at the end of the first semester in 2020, seven months after project close-out, according to MoPH North Ubangi *Division Provinciale de la Santé* analyzed data.

ZONE DE SANTÉ	REFERENCE (0-10%)	TX SC (55%)
Abuzi	4,5	63
Bili	2,3	23
Bosobolo	4,4	45
Businga	5,7	63
Gbadolite	5	60
Karawa	7,6	61
Loko	6	52
Mobayi Mbongo	5,2	68
Wapinda	5,6	54
Wasolo	7,7	52
Yakoma	4,1	52
DPS	5	53

**Figure 5.** Referral and curative services rates in Bili after MSF departure, Jan-June 2020.  
Source: Division Provinciale de la Santé du North Ubangi

Second, the higher salaries paid by MSF established a situation where neither the MoPH or donor partners could not feasibly cover salaries after MSF's departure, and therefore which made it difficult to restore health services in Bili after MSF's departure.

## SUSTAINABILITY

Sustainability investigates whether the benefits of an activity are likely to continue after MSF's departure. This evaluation focused on the sustainability of the MSF approach – including the community engagement and ownership - and the feasibility and actual implementation of the exit strategy. It considers also elements for replicability of the Bili project.

**Difficult phase out implementation.** According to a desktop review of project documents, a chronogram was drafted already in 2018 to lead the project to either a hand over or to a closure. The Chronograms de Sortie Bili (MSF, 2018) is a detailed workplan which identifies a comprehensive set of activities for the project close-out and disengagement of the MSF team. The plan includes activities planned up to one year prior to project closure - in Nov 2018 - and covers technical and medical aspects of final data collection, joint supervisions and meetings with MoPH and medical staff at hospital, health center, health post and community health worker levels. It also describes improvements as well as infrastructures final inventories and plans to redeploy project equipment where needed. It also provides indication on logistics, admin and human resources close out management.

The actual implementation of the phase out proved to be more difficult. The 2019 Rapport de Fin Projet (MSF, 2019) identifies challenges encountered during project close-out. The report describes actions that the team undertook to address these where possible, including individual discussions with staff and partners as well as meetings with staff and the personnel delegates. Identified challenges include human resource challenges, stemming from ongoing issues during project implementation. For example, MSF internal controls uncovered cases of staff corruption and skimming/sale of project medicines and supplies. Staff turnover was high, which reduced continuity and slowed project closure implementation in some cases. Some members of the staff were having unprofessional personal relationships with others on staff, creating internal management difficulties. According to the report, lack of MoPH engagement in training and supervision of activities during the project translated into difficulties in handover of the project and low buy-in. A concentration of many complex activities which needed to be accomplished at the end of the project led to the need to retain staff longer than planned, not allow as much time as needed to then close out personnel contracts.

One informant noted that the Provincial Health Director complained in a stakeholders' meeting that MSF closed out of the Bili project without informing them, and that partners were not informed of the close-out plan.

**MSF model 'not for everyone'.** Informants confirmed that a phase-out chronogram existed but there was not an exit strategy as such since MSF was not able to come up with an alternative to the Bili project than the actual closure, since funds had by then become scarce within MSF, and no partner had been identified for handover. It was an operational decision then to close the Bili project.

The project approach appeared to be ‘not for everyone’ as some MSF informants said. The adopted model proved to be very expensive, so unattractive for other any NGOs/donors and unaffordable for the MoPH whom MSF had nevertheless not established a strong enough relationship with and which did not appear as a potential hand over solution. The other alternative was for MSF to reinstate a health cost-recovery system which was against MSF principles of providing free health care and against best practice for iCCM programs.

One donor informant confirmed that MSF presented an overview and costing as the project neared the end, but that MSF did not directly ask for follow-on funding. The informant indicated that the cost of the Bili project was too high, and not in line with the approaches in place, and thus would not have been a project for which they could have considered providing follow-on funding.

***Bili closed ‘without a reason’.*** Former field-based staff were also under the impression that the project was closed ‘without a reason’ as a staff reported, and that the coordination team in Kinshasa wanted to open another similar project elsewhere in DRC; they found this perspective very upsetting. They also felt that the Bili project was not at all sustainable due to the ‘gap-filling role’ MSF had gladly acquired for almost everything which was ultimately MoPH’s responsibility, from drugs supply to staffing and rehabilitation of health structures.

***Continuity.*** MSF did try to ensure at least some continuity by leaving behind a medicines stock for three months and medical and logistical assets were donated to the clinics. Training of MoPH staff was also identified as a contributing factor to sustainability although these staff accounted for only 20% of the staff employed in the health structures. The rest was hired by MSF and left after the project closure. Finding partners for hand-over, including gradual handover of activities to SANRU, and inclusion of budgeted needs in subsequent funding requests to the Global Fund, would have definitely enhanced sustainability according to informants. One informant noted that SANRU did step back in to take over malaria activities to ensure supplies of antimalarials through Global Fund funding after the Bili project closed. However, the demotivation of health staff may have had a negative impact. The late and insufficient community involvement component also affected continuity since communities did not develop any sense of ownership for this project and were not sufficiently motivated to take over or continue any activities.

***Elements to be replicated.*** Despite challenges described above, MSF informants identified a few elements from the Bili project which could be and should be replicated elsewhere. Being stable, the Bili area provided ample opportunity to conduct field-based research e.g. mortality, entomology, resistance survey which can provide useful ground to report against for project impact but also to steer and adjust activities and approaches as suggested by some MSF informants. The iCCM model is valid in all the informants’ opinion and it should be replicated, building on lessons learned in Bili as well as other MSF iCCM programs, with a focused vision and trained staff from the outset, and including involvement of communities from project design.

## DISCUSSION AND CONCLUSIONS

The project and the logic of the intervention appear relevant to some needs identified but missed opportunities to provide a more complete package. Malaria morbidity and mortality were high, especially for the U5 population and access to quality care was challenging in the Bili area. In the consultants' view, some issues which might have contributed to decreased mortality for children under five as per project objective were partially overlooked in the project and logframe conceptualization. For instance, addressing malnutrition – both severe and moderate – could have further contributed to the achievement of the project objective. Malnutrition outreach activities, as well as related health education and preventive home-based care as recommended in the MSF OCB iCCM framework would have been relevant considerations for the Bili project. Additionally, the project missed an opportunity to train CHWs to assess respiratory rate and provide quality assured antibiotics.

The project was partially relevant to the MoPH *PSN de Lutte contre le Paludisme and Plan d'Action operationnel du programme national de lutte contre le paludisme* which focused on increasing access to care and on building capacities for treatment and care, but its actual implementation collided with the general principle of the Congolese health system based on a cost recovery scheme. In practice, the income generated by the '*tarif forfaitaire*' paid by patients provides economical support for each health structure and personnel and helps making the health system more sustainable at grassroot level. Although the equity of this system and the actual good use of the funds generated by the cost recovery scheme might be subjected to a long debate, if MSF decides to collaborate with the local MoPH it should also take into consideration pre-existing schemes and negotiate the option of contributing, improving and supporting these schemes for the sake of sustainability and coherence. Additionally, the Bili project was only partially responsive to the *PSN de Lutte contre le Paludisme* policy of supporting iCCM of malaria, diarrhoea, and pneumonia in that the Bili project omitted the pneumonia component.

MoPH leadership and partner collaboration at all levels of the health system is key to delivering lasting effective results for malaria control in DRC and globally. However, the noted independence of the MSF team and lack of collaboration with the three primary malaria donors and their implementing partners caused operational frustrations, for example related to stock-outs. This also diminished opportunities to seek continued financial support of the Bili project or possible extension through FCDO/DfID, Global Fund, or PMI resources. Furthermore, CHWs roles were limited within this project and did not reach their full potential as expected in an iCCM project.

Vertical program design and implementation caused missed opportunities to establish MoPH buy-in to support the project and build capacity throughout the project. MSF did not implement a standard training cascade approach, whereby implementing partners normally work directly with the PNL and provincial health directorate to train a cadre of trainers to train health staff and then for the health staff to train community health workers. In a standard cascade system, future data gathering, and supervision mechanisms are also generally established. For example, in other iCCM programs the CHWs are trained as a cohort by the health center in-charge, and then monthly CHWs return to the health center to provide their monthly reports with case management data to be included in the health center's monthly reports to the districts for reporting in to the provincial and national health data collection and a management system. During these monthly

meetings, CHWs share experiences and receive feedback from the health facility in-charge, review health commodity stock availability, and receive commodity resupplies to take back to their communities.

The way the advocacy strategy was implemented (action plans) did not seem necessarily appropriate for this project and above all it was not well communicated and sufficiently familiarized among the partners which might have misunderstood scope and goal of the strategy; to partners, it might have appeared that by investigating and displaying shortcoming and issues with the drugs procurement and stock-outs, MSF got involved in a 'blame game' which deteriorated the relationship with the on-the-ground partners such as FCDO/DfID, IMA and the Global Fund, which were there to stay long term and whose collaboration should have been instrumental to achieve a good degree of cooperation and sustainability.

Underpinning the advocacy strategy is a focus on MSF's role of calling out ongoing supply chain problems, alongside the Global Fund audit, and maintaining visibility of stock management problems. While the desired impact of this advocacy strategy is the reduction of stock-outs, the strategy as written is focused more on an MSF role of external oversight, rather than working with the MoPH, donors, and implementing partners to identify and overcome the overwhelming challenges of the health commodity supply chain in DRC. An alternative approach to consider would be to leverage MSF's experience and expertise to work with the MoPH and supply chain partners to identify and implement innovative solutions during the life of the project to help the MoPH and all partners to do better and thus showcase MSF's expertise and experience.

**The design of the intervention and the related project strategy were not well communicated** or disseminated internally in MSF (at project level, and between project, coordination and HQ) and externally with communities in Bili, the MoPH at national, provincial, or health zone levels. This created confusion from every side and generated frustration and misunderstanding. In the consultants' view, it appears that, although the 'what to achieve' of the project was clear, the 'how to achieve it' was not completely understood or clarified to the field team. The consultants believe that there was possibly a gap between designing the strategy – including the advocacy one - and planning the operational details. This includes a disconnect between very ambitious objectives, short timeframe, geographic spread, and the reality of planning and delivery activities in a complex operating environment. In the consultants' opinion, the confusion might have been caused from the logframe itself; in the logframe the project is briefly described a IMCI but then at some point – it is unclear exactly when from the interviews conducted and from the review of documents – labelled/interpreted as an iCCM intervention without changing the IMCI definition in the logframe itself. Consultants suppose that the change in the logframe was perhaps possible due to the funding system; since MSF does not rely on institutional funding, it is therefore not subjected to strict funding, reporting and adjusting procedures as other NGOs which normally would need to request the donor for amends to the logframe and related activities after project approval and funding. However other internal validation mechanisms exist within MSF and seem here not to have worked fully.

**The logframe lacks outcome indicators for the three main diseases** tackled by this intervention (malaria, diarrhoea and pneumonia) and no specific IMCI/iCCM indicators either. The consultants believe that these indicators should have been included, to better measure outcome for each single disease and enhance monitoring and potential contribution to the general objective. In case a clearer view of which strategy had been adopted for the Bili project – be it iCCM or IMCI – relevant indicators should have been included. These

standard indicators would help monitoring and comparing the intervention with others using the same approach.

**Lack of clarity regarding the strategy greatly affected the capacity of the project of being more effective.**

Repercussions can be seen at different levels. Proximity and involvement of beneficiaries can be described as weak. Communities were considered passive recipients of a community-based intervention and only involved in construction activities with the expectations of providing work for free. Initial involvement of communities can be classified as 'community consultation' rather than 'community action' (WHO, 2002); communities were informed about the upcoming intervention and consulted to receive approval. This distance set between beneficiaries and project staff might have also affected adaptation of the project to beneficiaries changing needs, an aspect which could have not been sufficiently explored in this evaluation. As previously discussed, a reorientation of the project was considered but never actually implemented to the fullest. It is unclear to the consultants what the reasons were, in consideration of the flexibility MSF has in managing its own funding and readjusting its interventions, but it appears that in this project some rigidity was applied in complying with certain set standards e.g. no giving in to the cost recovery system, hiring better qualified non local staff etc.

It is not clear to the evaluation team that a robust application of iCCM global operational manuals, best practices, and lessons took place in the design of the Bili project, given that this is the approach pursued during the implementation. Outreach to and implication of regional and health zone staff was noted as problematic throughout project implementation, thus reducing MoPH and key partner buy-in during the project. This also affected the possibility to establish clear handover after MSF withdrawal. Evaluators conclude that the desk review and interviews did not show that project staff benefited from any baseline training to understand the basic elements of a standard iCCM program or core training on the fundamentals needed to move the community components forward. iCCM programs are often extensions of the public health system and supervision and training leadership generally extends from the MoPH personnel in place from central to peripheral levels. Partners often support the many complex components of an iCCM program, but generally this is done in tandem and under the MoPH leadership. As the Bili project was designed and implemented more as an extension of MSF's secondary and tertiary program, the elements of training, supervision, and reporting were managed directly by the MSF team, with reports shared with the MoPH as needed. On another aspect, while some procurement and supply chain elements for essential components of the project were coordinated with SANRU through the supply chain in place – coordination with SANRU was lacking and led to divergent expectations between the two partners regarding stock quantification and supply needs.

**In some cases, field staff did not have the right profile for this intervention.** The issue in the view of the evaluation team was not necessarily having 'too many first missioners' but having 'the right ones'. The ability to communicate and to 'convince' field staff that this was not an emergency intervention but more a community-based, development oriented one, would have greatly benefited this project. Supervision, communication, pace of work, decision making were somewhat different than in an emergency MSF project. Furthermore, the project transitioned from an emergency intervention, it retained many staff involved in the emergency phase. Expatriates were hired on short term contracts and there was a reduced presence of staff coming from the Bili area – especially in medical and implementation positions. All of this certainly complicated understanding of the project, fine-tuning of activities and general effectiveness of the intervention. Similar challenges were faced by the advocacy component which ended up not being fully integrated in the project 'routine'.

**In terms of efficiency, the project managed to guarantee access to care with a relatively low cost per consultation,** but other costs related to international staff and import of drugs decreased the chance of a potential hand-over. To reduce costs, consultants believe that the reduction of the number of expatriate staff could have helped and training local staff and building capacity could have also been more in line with the overall community based, development-oriented approach. The issue of importing drugs to fill in for the stock rupture does not only affect project costs, but also impact on the coordination and collaboration with other actors on the ground.

**Project contribution to the overall reduction in mortality in such a short time frame can be considered remarkable.** Although the main – and very ambitious objective – of halving U5 mortality was not fully achieved, according to mortality surveys conducted by MSF, MSF did measure mortality reductions, including a decrease in overall mortality rate, as well as an increase in health seeking rate at primary level. MSF did provide quality of care and treatment in this *zone de santé*. Unfortunately, these achievements were deemed not to be long-lasting, lacking a reliable partner to continue the implementation as a whole or in some parts.

**Sustainability was a major limitation for the Bili project,** and it goes back both to its design and implementation. Sustainability is often a challenge in iCCM programs; therefore, building on global learning from countries which have established national community health policies and structures is critical to understanding key strategies and approaches for setting future iCCM activities up for better longevity. In Bili, lack of or late involvement of communities hampered the creation of a sense of ownership and empowerment which might have motivated the communities to possibly take over some components. Difficult or intermittent relationships with other potential partners – particularly MoPH- during the project implementation – affected ‘buy-in’ and opportunities for inclusion in future MoPH initiatives or those funded by the Global Fund, as well as hand over to other potential partners. The strategy in place for the phase-out shows how MSF was a ‘too much of a big machine’ altogether and finding a replacement was hard. The consultants believe that the capacity built in the MoPH staff might have been left behind, and assets such as drugs and some logistics certainly kept the health clinics afloat for some time, but those measures did not provide a long-term solution. The gap-filling role MSF had throughout the project implementation was instrumental to keep the action ongoing but impossible to fully substitute.

## RECOMMENDATIONS

### ⇒ Recommendations specific to the Bili project itself are:

- **Conducting a follow up and post-closure visit** to evaluate the few elements such as the ‘residual’ impact of the project one year after the MSF exist. This could help addressing the disputed sustainability elements/dimension of the project and increase lessons learnt related to sustainability.
- **Interviewing direct beneficiaries and communities** as well as more local authorities to include their perceptions and perspectives into this evaluation.

**Recommendations to MSF to design and implement a project with similar characteristics to the Bili project – either for the adoption of iCCM or focus on specific diseases – are:**

### ⇒ Recommendations related to Relevance:

- **Site selection:** In identifying future potential project locations for iCCM interventions, prioritize areas with low access to health services and high under-five morbidity and mortality (as it was the case for Bili and as per MSF Strategic Framework) but do strongly consider selecting areas which have not recently received any emergency response interventions – especially led by MSF. Consider also implementing this strategy in a smaller area rather than a whole “*zone de santé*” (*health zone*) and consider scale-up once there enough evidence of a functioning system. Weight cost effectiveness – if another emergency MSF project is present, it would be cheaper to start from existing structure but keeping in mind the different nature and focus of the new one.

### ⇒ Recommendations related to Design:

- **Stakeholder coordination:** Gather stakeholders’ inputs (national and local levels) to inform project design and implementation, and maintain a participatory process during project life, not least for potential adaptations. Mutually determine key roles for each stakeholder in ensuring successful results of the project, as well as sustainability after the departure of external resources.
- **Global iCCM strategy and planning tools:** Develop a global strategic and more detailed MSF iCCM strategy document and accompanying planning tools, to guide staff implementing or planning to implement iCCM.
- **Review the advocacy approach** – Consider prioritizing a focus on working with the MoPH and key health stakeholders, to leverage MSF’s unique expertise and experience to strengthen systems rather than setting an objective to critique things that may not be going so well e.g. supply chain management.
- **Review the available health data evidence** and discuss MSF’s approach to inclusion of malaria, diarrhoea, and pneumonia case management. Final decisions to include, or not, each component will vary by context and field teams will benefit from clear guidance on how to implement other components in the final package of interventions selected.

Recommendations related to Effectiveness and Sustainability →

⇒ **Recommendations related to Effectiveness and Sustainability:**

- Prioritize community mobilization and involvement of communities from start, and at every level of the project cycle such as during the project design, during the planning phase and in the data collection for monitoring. Use the available community resources well, including CHWs to enhance outreach activities as well as diagnostic and treatment. For this, most common child illnesses should be involved and CHWs trained on diagnostic and treatment.
- Choose adequate HR, focusing more on availability of local medical staff instead of looking for other external 'inrats'. Supervision and capacity building will be key to bring these staff up to speed, but there are tangible gains in having local staff and diminishing number of international and relocated staff. International staff should be also advised to the slightly different nature of an iCCM project and coaching accordingly, e.g. slower pace of work, focus on training of CHWs and generally on community involvement and engagement, close collaboration with local MoPH.

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## ANNEXES

## ANNEX 1: EVALUATION MATRIX

CRITERIA	EVALUATION QUESTIONS	DATA COLLECTION TOOLS/INFORMANTS
RELEVANCE	<p>To what extent was Bili project relevant?</p> <ul style="list-style-type: none"> <li>- Was an independent needs assessment conducted? What indication did it provide?</li> <li>- Did project objectives and corresponding activities answer identified needs, including in terms of advocacy? Which other activities could have been included/implemented differently?</li> <li>- How did the activities take into consideration priorities as determined by the MoPH, at different levels of the health pyramid (national, local, community levels)?</li> </ul>	<ul style="list-style-type: none"> <li>- Desktop review of project documentation focusing on needs assessment in selected project areas/districts, identification of health needs and identification of potential beneficiaries in districts/communities, if available</li> <li>- Desktop review of advocacy strategy for the region/specific to Bili project area/malaria vertical</li> <li>- Desktop review of MoPH strategy in the area</li> <li>- Key Informant Interviews (KIIs) with project staff to understand their point of view about relevance of intervention and specifically which component(s) were felt as more relevant based on assessment conducted</li> </ul>
DESIGN AND APPROPRIATENESS	<p>To what extent was project design and implementation appropriate?</p> <ul style="list-style-type: none"> <li>- Was the strategy - including financing model- appropriate in order to achieve the objectives?</li> <li>- Was MSF close enough to the target population to understand their situation as well as possible changes in their needs (proximity)?</li> <li>- Were appropriate and timely adaptations made in response to changes in the environment?</li> <li>- How did the project take into consideration other actors?</li> <li>- Was the advocacy component defined at this stage of the project design? Were its components and objectives time-bound and specific?</li> </ul>	<ul style="list-style-type: none"> <li>- Desktop review of project documentation e.g. concept notes, funding policy and strategy, MSF mandate, country/region strategy, with specific focus on the advocacy component</li> <li>- KIIs with project staff to issues related to proximity and needs understanding and response adaptation including timeliness of response, including design of advocacy strategy</li> </ul>
EFFECTIVENESS	<p>To what extent have the agreed objectives been achieved?</p> <ul style="list-style-type: none"> <li>- Were the activities carried out as originally planned?</li> </ul>	<ul style="list-style-type: none"> <li>- Desktop review of project reports and progress documents including M&amp;E data and indicators achievement</li> </ul>

	<ul style="list-style-type: none"> <li>- What were reasons for achievement or non-achievement of objectives?</li> <li>- What were the limitations/opportunities inherent in the approach?</li> <li>- How well do the achieved results compare to quality standards? (MSF guidelines, WHO standards, etc.)</li> <li>- Were objectives related to the advocacy component achieved? If not or only partially, why?</li> </ul>	<ul style="list-style-type: none"> <li>- Desktop review of major guidelines for health standards to assess compliance with achievement</li> <li>- KIIs with project staff on projects achievements per activity and related challenges and opportunities</li> </ul>
EFFICIENCY	<p>How efficient was the project?</p> <ul style="list-style-type: none"> <li>- In what ways has MSF utilised available resources (internal and external, human resources, logistics, supplies, finance) to contribute to their efficient use and economies of scale?</li> </ul>	<ul style="list-style-type: none"> <li>- Desktop review of budget allocation and forecasted expenses vs real expenditure and allocation, including economic evaluation conducted for this project</li> <li>- KIIs with project staff on utilization of resources to achieve outputs and to maximize efficiency of management</li> </ul>
IMPACT	<p>What impact did the project have?</p> <ul style="list-style-type: none"> <li>- Did the project contribute to changes in access to healthcare and overall health status of target population? Did the project lead to policy changes?</li> <li>- Did MSF's presence have any unforeseen positive or negative impact?</li> </ul>	<ul style="list-style-type: none"> <li>- Desktop review of health data at national/regional/district level to understand potential impact of intervention</li> <li>- Desktop review of MSF health monitoring data to assess impact from a health point to view</li> <li>- KIIs with project staff to investigate projects' potential impact e.g. general health improvement, increased access to quality health and any negative impact the project may have caused</li> </ul>
SUSTAINABILITY	<p>How sustainable were the results achieved by the project?</p> <ul style="list-style-type: none"> <li>- Was the exit strategy (incl. advocacy and handover) planned for and implemented accordingly?</li> <li>- Did the exit strategy take into consideration potential challenges and how were they addressed?</li> <li>- What local capacities and resources have been identified? How did the project connect with these, particularly with an eye to sustainability?</li> <li>- Are there any specific enablers/obstacles to sustainability in the context of Bili?</li> <li>- Are there general elements which can be replicated in other contexts?</li> </ul>	<ul style="list-style-type: none"> <li>- Desktop review and appraisal of exit strategy design and plans at different level - district/regional</li> <li>- KIIs with project staff to investigate intervention's potential for sustainability of activities, enablers and obstacles and elements of replicability</li> </ul>

## ANNEX 2: TERMS OF REFERENCE

### TERMS OF REFERENCE

#### Project Description

Subject/Mission	Evaluation of Bili project, DRC
<b>Commissioner</b>	Ahmed Abd-elrahman, Deputy Cell coordinator, Brussels
<b>Evaluation Focal Point</b>	Maria Mashako, Deputy Medical Coordinator, Kinshasa
<b>Consultation group</b>	Maria Mashako (Deputy Medical Coordinator), Stéphanie Drèze (Humanitarian Access Advisor, Great Lakes Region), Martin De Smet (Leader of MSF Intersectional Malaria Working Group)
<b>Starting Date</b>	August 3 <sup>rd</sup> latest. Final report by October 30, 2020 (latest)

Médecins Sans Frontières (MSF) Operational Center of Brussels (OCB) started activities in Bili, Democratic Republic of Congo (DRC) in 2015, through an intervention by the MSF DRC based Emergency Pool (PUC) with the aim to respond to an influx of CAR refugees. This emergency intervention was reoriented mid 2017 towards a project focusing mainly on community case management of malaria, aiming at reducing morbidity and mortality for children below 5 in Bili health zone. The project started in July 2017 and ran until November 2019. The project was implemented in collaboration with the Ministry of Public Health (MoPH) at all levels of the health pyramid structure.

#### Axes of intervention:

1. Community level: support to 33 health posts and 12 community health sites for malaria care and simple diarrhoea;
2. Primary healthcare level: support to the 17 health centres of the Bili health zone (one health centre per health area) for Integrated Management of Childhood Illnesses (IMCI<sup>1</sup>) focusing on 3 most frequent pathologies: malaria, diarrhoea and acute respiratory infections;
3. Secondary healthcare level: support to Bili Hospital (*Hôpital Général de Référence, HGR*) in the following services: emergency and intensive wards, neonatology, paediatrics, in-patient nutritional care for patients below 15 and blood transfusion. In order to diminish the influx of patients to the HGR and reduce delays in receiving healthcare, the project also supported three health centres (Baya, Gbangi and Pandu) to receive in-patients.
4. Support to referrals between supported facilities. to/from facilities
5. Environmental health: Health promotion activities focusing on malaria prevention and vector control in Bili health zone.

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<sup>1</sup> PCIME in French

## Project Timeline<sup>2</sup>

<b>Q1 2017</b>	Preparatory phase of malaria project
<b>April 2017</b>	Mortality and access survey, anthropological study, trainings
<b>July 2017</b>	Start of malaria project
<b>December 2017</b>	17 Health centres are supported
<b>April 2018</b>	Support to Baya Health Centre including IPD.
<b>Q2 2018</b>	2 <sup>nd</sup> mortality survey
<b>August 2018</b>	Last phase in scaling up curative activities at community level (30 out of 33 health posts and 11 out of 12 community health sites) for a total of 58 supported structures (out of 62).
<b>April 2019</b>	3 <sup>rd</sup> mortality survey Costing study (released July 2019)
<b>May 2019</b>	Stock-out survey
<b>June 2019</b>	Support to IPD in Gbangi and Pandu Health centers.
<b>November 2019</b>	End of MSF support and departure from Bili.

## Reason for Evaluation/Rationale

In addition to documentation from project planning and monitoring, the last project team to work in Bili completed an End of Project document. Mortality and access to care surveys, costing study as well as stock-out survey have also been conducted but to date, the project has not been evaluated. There is now an interest to conduct an external objective assessment of the project.

## Overall Objective and Intended Use

The evaluation aims at assessing the Bili project since its start in 2017 until its closure in 2019. It focuses on reviewing its relevance, appropriateness, effectiveness, efficiency, impact and connectedness/sustainability, with a special attention to community case management of malaria, or ICCM (Integrated Community Case Management) to the extent it has been implemented.

It seeks to analyse achievements, challenges and document lessons learned. The findings and recommendations of this evaluation will be used by MSF to inform decisions and improve implementation in future project(s) in DRC and similar contexts.

## Evaluation Questions

### To what extent was Bili project relevant?

- Was an independent needs assessment conducted?

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<sup>2</sup> Timeline based on information collected in ARO 2018 (for 2019) documents as well as end of project document (Dec 2019)). The project saw some delays in implementation as compared to planning; this timeline refers to actual implementation.

- Did project objectives and corresponding activities answer identified needs, including in terms of advocacy?
- How did the activities take into consideration priorities as determined by the MoPH, at different levels of the health pyramid (national, local, community levels)?

#### **To what extent was project design and implementation appropriate?**

- Was the strategy (including financing model) appropriate in order to achieve the objectives?
- Was MSF close enough to the target population to understand their situation as well as possible changes in their needs (proximity)?
- Were appropriate and timely adaptations made in response to changes in the environment?
- How did the project take into consideration other actors?

#### **To what extent have the agreed objectives been achieved?**

- Were the activities carried out as originally planned?
- What were reasons for achievement or non-achievement of objectives?
- What were the limitations/opportunities inherent in the approach?
- How well do the achieved results compare to quality standards? (MSF guidelines, WHO standards, etc.)

#### **How efficient was the project?**

- In what ways has MSF utilised available resources (internal and external, human resources, logistics, supplies, finance) to contribute to their efficient use and economies of scale?

#### **What impact did the project have?**

- Did the project contribute to changes in access to healthcare and overall health status of target population? Did the project lead to policy changes?
- What did beneficiaries and other stakeholders affected by the intervention perceive to be the effects of the intervention on themselves?
- Did MSF's presence have any unforeseen positive or negative impact?

#### **How sustainable were the results achieved by the project?**

- Was the exit strategy (incl. advocacy and handover) planned for and implemented accordingly?
- Did the exit strategy take into consideration potential challenges and how were they addressed?
- What local capacities and resources have been identified? How did the project connect with these, particularly with an eye to sustainability?
- Are there any specific enablers/obstacles inherent in the context of Bili?
- Are there any general elements which can be replicated in other contexts?

### **Expected Deliverables**

1. An inception report including:
  - a. Preliminary document review (project, context, and stakeholders);

- b. Detailed methodology for addressing the evaluation questions;
  - c. Refined set of evaluation questions if necessary;
  - d. Theoretical framework (matrix) linking criteria for judgement, questions, indicators, data sources and data collection methods (including guiding questions);
  - e. Detailed schedule of activity, roles and responsibilities.
2. Restitution/debriefing at the end of the field visit with mission team to provide initial feedback and findings;
  3. Presentation and workshop with commissioner and consultation group to present findings and co-create recommendations;
  4. Final evaluation report in French or English (Maximum 30 pages) including executive summary, methodology and limitations, analysis and findings.
  5. Presentation of final report. Any additional dissemination activities to be agreed upon.

## Practical Implementation of The Evaluation

Timing of the evaluation	<b>Start ASAP.</b> Final report due October 30 <sup>th</sup> , 2020.
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Bili project is closed, and given current Covid-19 constraints, the evaluation is foreseen to happen remotely.

## Profile/Requirements: Evaluator(s)

- Evaluation competencies, with a proven track record in conducting evaluations
- Solid experience in humanitarian project management, with focus on healthcare delivery
- Ideally, public health/epidemiology/health economics background
- Experience working in low/middle income countries – experience in DRC highly desirable
- Advanced communication and interpersonal skills
- Language requirements: Fluent French and good English
- Valuable: understanding of MSF modus operandi
- Valuable: experience with ICCM interventions

## How to Apply:

Interested teams or individuals should submit an expression of interest to [linda.ohman@stockholm.msf.org](mailto:linda.ohman@stockholm.msf.org) referencing BILIC no later than **March 13<sup>th</sup>, 2020**.

Applications will be evaluated on the basis of 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 capacity of the evaluator(s) to carry out the work. (i.e. inclusion of proposed evaluators' CVs, reference to previous work, certification, etc). The proposal should contain reflection on how adherence to ethical standards for evaluations will be considered throughout the evaluation. The proposal can be in French or English.

Offers should include a separate quotation for the complete services. The budget should present consultancy fees according to the number of expected working days over the entire period. Travel costs do not need to be included, as the SEU will arrange and cover these. MSF does not pay any per diem.

## ANNEX 3: KIIS LIST

DATE	NAME	ROLE
23.09.2020	Jo Robays	Current OCB operational research coordinator/director LUXOR – former Malaria Referent
23.09.2020	Desire Kimanuka	Bili Field Coordinator in 2019
28.09.2020	Emily Dubuisson	DRC Advocacy Manager in 2018-2020
30.09.2020	Stephanie Dreze	Regional Humanitarian Advisor OCB
30.09.2020	Mea Ghislaine	Bili Nursing outreach in 2019
30.09.2020	Martin De Smet	Intersectional Leader for Malaria Working Group – OCB Referent for PHC and iCCM
01.10.2020	Frederick van der Schriek	DRC Finco in 2016 -2018 and HoM in 2019
01.10.2020	Guillaume Jouquet	Economic Evaluator – led 2019 economic evaluation
02.10.2020	Clara Karlson	DRC Deputy HRCO until January 2019 and currently Technical HR
05.10.2020	Maria Mashako	DRC Medical Coordinator (Adjoint)
05.10.2020	Orianne Mellini	Bili Project Coordinator in 2018-2019
08.10.2020	Ahmed Abd-elrahman	OCB Deputy Medical Cell coordinator (cell 1)
09.10.2020	Yvonne Nzomukunda	DRC Medical Coordinator
28.10.2020	Albert Mudingayi	FCDO/DfID DRC Health Adviser
30.10.2020	Toussaint Selemani	Former Bili Medical Doctor
02.11.2020	Primitive Gakima	MSF Intersectional Focal Point
05.11.2020	Marcos Patinio Mayer	The Global Fund Portfolio Manager
05.11.2020	Laurie Barnier	The Global Fund Senior Program Officer

## ANNEX 4: DATA COLLECTION TOOLS WITH INFORMANT CONSENT

### KIIS WITH MSF STAFF AND CONSULTANTS

#### KEY INFORMANT INTERVIEWS (KIIS) – MSF STAFF AND CONSULTANTS

##### Intro and Informant Consent

Hello, my name is **Caterina Monti** and I am the lead consultant for the Bili evaluation project, together with **Mary Kante**, who is the co-consultant. The evaluation was commissioned by **Ahmed Abd El-Rahman**, MSF OCB Medical Deputy Coordinator of Operations, Cell 1 and it is coordinated by **Kristen Bègue** from the MSF Stockholm Evaluation Unit.

**Description of the evaluation and participation:** The objective is discussing with former MSF Bili field and project staff relevance and sustainability of the project, challenges, and achievements in order to gather learning and lessons learnt for current and upcoming MSF interventions in similar contexts and geographical area. Your participation will require answering some questions and it will take around 30 to 45 minutes.

**Benefits of participating:** your information will help MSF to improve and better target the services provided in future interventions and to address issues related to strategy design and project implementation.

**Risks and discomforts:** There are no risks or discomfort associate to participation into the survey, I will only use some of your time.

**Protection of confidentiality:** All the collected information will be kept confidential, stored in documents protected by passwords, and managed directly by me. The data collected will be analysed as a whole, so that no specific info can be related back to you. The list of informants will not be disclosed until the publication of the report and none of your former colleagues will know that I have spoken to you. In case in the report some of your exact wording will be quoted to provide ground for the explanation of findings, your name will obviously not appear, and you will be quoted as 'field/HQ MSF staff'.

**Voluntary participation:** Your participation in this evaluation is entirely voluntary. You may choose not to participate now, and you may withdraw your participation at any time during the interview.

**Contact information:** If you have any questions or concerns about this study or if any problems arise, please contact me. You may also wish to contact directly the SEU, by reaching out to Kristen Bègue.

Do you have any questions?

If you agree with the statements above, I request your permission to start.

<b>General Information</b>
Name: ..... Role(s) in HQ/DRC/Bili project: .....                      From / To: .....
<b>General Introduction</b>
<ul style="list-style-type: none"> <li>▪ Can you give me a very general overview of the Bili project based on your recollection and experience there?</li> <li>▪ Can you please tell me the role and/or the engagement you had in the Bili project, describing to me the timeframe in which you were employed and the tasks you had?</li> </ul>
<b>Relevance</b>
<p>- I'd like to ask you if you remember whether an independent needs assessment was ever conducted in Bili? I'm referring to the switch from the emergency response to the final project set-up with a focus on malaria. Can you provide details on the findings of the assessment, the indications they provided and the discussion at project/country/HQ level regarding these findings? Any findings in your opinion which were meant to be regarded differently? Any findings which might have led to a different approach and/or a different design?</p> <p>- Let's focus now on the project design after the assessment; were the project objectives and corresponding activities answering identified needs? How? Can you please explain more in detail the advocacy strategy behind this intervention? How was that relevant to the intervention itself? What was its main goal?</p> <p>- Can you also please suggest any activity that you think it should have been included in this intervention and it was not? Any activity which was instead included but it was not necessarily relevant to the scope of the project and/or not adapted to communities' needs and priorities?</p> <p>- In terms of project relevance to Congolese MoPH, can you please explain whether priorities as determined by the MoPH, at different levels of the health pyramid (national, local, community levels) were taken into account and considered also relevant for this project? Can you remember which ones they were and how they were translated/incorporated into the project?</p>
<b>Design and Appropriateness</b>
<p>- Can you describe in more detail the strategy used in this project? Was it good to achieve the objectives set in the logframe? Any suggestions on how to improve it and/or adapt it to the context? How about the financial model? Was it at all appropriate? Can you describe it to me?</p> <p>- Do you remember whether the advocacy component was defined at this stage of the project design? Were its components and objectives time-bound and specific? Can you tell me your impression about this?</p> <p>- Do you recall the project being adapted/changed based on changes of context? What were those changes in the context? What were the adaptations put in place? Were they appropriate? Were they timely? Any comments or remarks to be made on this regard?</p> <p>- Could you please tell me whether MSF was close enough to the target population to understand their situation as well as possible changes in their needs? Can you describe to me the strategy put in place to mobilize community, to raise awareness about the project and to seek participation and engagement? In your opinion, was this strategy successful? If not, what do you think should be improved in a similar intervention?</p>

- Were other actors taken into consideration for the project? Which were those e.g. Ministry of Health staff? How were those actors engaged and involved and in which stages of the project e.g. design, design and implementation, monitoring etc.? Please share your point of view regarding the inclusion of other actors and comment on how this aspect could be improved.

#### Effectiveness

- Do you believe there have been any gaps, issues, or challenges in the implementation of the project? If so, could you explain which problems and how they have arisen? Be specific and refer for instance to your own domain and role within the project. Were those problems addressed and corrected by MSF on time? If not, could you explain how they might have hampered achievement of objectives in the project?

- Can you remember if any changes were made to the project and its activities during the project implementation? If so, can you remember why those changes were made and if they in fact contributed to improve the implementation?

- My understanding is that the malaria approach implemented in Bili was somewhat new and 'experimental' for MSF. Is that your opinion/experience of it? Can you tell me more about the opportunities this approach provided and its limitations as well and how they affected achievements of results and outcomes?

- Taking about the monitoring of the project, can you please talk to me generally about the M&E system and its indicators? How were project objectives and achievements tracked? Were any project indicators underperforming? If yes, what was the approach to get back on track for those indicators?

- In your knowledge, were objectives related to the advocacy component achieved? If not or only partially, why?

#### Efficiency

- Do you believe this intervention was cost effective and value for money? Do you believe the resources could have been differently or better allocated? By resources I mean not only the budget but also human resources, logistics, supply and any other project related expenses.

#### Impact

- Since the beginning of the intervention, could you pls tell us what in your opinion has changed for the targeted communities? Can you please be very specific and make examples before/after, especially in relation with access to health services, reduction to morbidities and mortality in children coordination and collaboration with other authorities etc.? If you believe that this intervention impacted positively on the targeted communities, do you believe this impact is long term?

- Can you also explain if the project led to any policy changes, both at national/local level and within MSF? If so, what were they and how long lasting they might be in your opinion?

- Do you believe that this intervention produced any negative effects in the communities? If so, could you pls describe what they are and whether the organization was made aware of this on time so to fix them?

- Do you believe this intervention produced any unintended and secondary consequences to the communities? E.g. something that happened as result of the activities, but it was completely unexpected.

## Sustainability

- What efforts has MSF made to ensure that the approach used in the project was sustainable, especially in terms of identifying resources and building capacities to guarantee a certain degree of sustainability? How would you evaluate these efforts? Were they successful? If not, can you please share your view on why?
- Was an exit strategy drafted before the project closure? Can you please share the details with me, especially for what different departments were concerned e.g. advocacy, collaboration with MoPH, community support and engagement etc. In your view, was that exit strategy implemented accordingly? If not, do you know the reasons why? What were the main challenges?
- Can you pls share your thoughts on the specific things which might have enhanced sustainability and what was perceived as obstacles to the sustainability in that context?
- Which elements of the Bili could be or should be replicated elsewhere? How and with which amends and adjustments?

## KIIS WITH EXTERNAL STAKEHOLDERS (MOPH, GOVT AUTHORITIES, INSTITUTIONS, OTHER NGOS)

### Key Informant Interviews (KIIs) – External

#### Intro and Informant Consent

Hello, my name is **Caterina Monti** and I am the lead consultant for the Bili evaluation project, together with **Mary Kante**, who is the co-consultant. The evaluation was commissioned by **Ahmed Abd El-Rahman**, MSF OCB Medical Deputy Coordinator of Operations, Cell 1 and it is coordinated by **Kristen Bègue** from the MSF Stockholm Evaluation Unit.

**Description of the evaluation and participation:** The objective is discussing with former stakeholders of the MSF Bili project relevance and sustainability of the project, challenges, and achievements in order to gather learning and lessons learnt for current and upcoming MSF interventions in similar contexts and geographical area. Your participation will require answering some questions and it will take around 30 to 45 minutes.

**Benefits of participating:** your information will help MSF to improve and better target the services provided in future interventions and to address issues related to strategy design and project implementation.

**Risks and discomforts:** There are no risks or discomfort associate to participation into the survey, I will only use some of your time.

**Protection of confidentiality:** All the collected information will be kept confidential, stored in documents protected by passwords, and managed directly by me. The data collected will be analysed as a whole, so that no specific info can be related back to you. In case in the report some

of your exact wording will be quoted to provide ground for the explanation of findings, your name will obviously not appear, and you will be quoted as ‘stakeholder’.

**Voluntary participation:** Your participation in this evaluation is entirely voluntary. You may choose not to participate now, and you may withdraw your participation at any time during the interview.

**Contact information:** If you have any questions or concerns about this study or if any problems arise, please contact me. You may also wish to contact directly the SEU, by reaching out to Kristen Bègue.

Do you have any questions?

If you agree with the statements above, I request your permission to start.

**General Information**

Name: .....  
Role(s) related to the Bili project: ..... From / To: .....

**General Introduction**

- Can you give me a very general overview of the Bili project based on your recollection and experience?
- Can you please tell me the role and/or the engagement you had in the Bili project, describing to me the timeframe in which you were engaged and the contribution you provided?

**Relevance**

- I'd like to ask you whether you believe that the MSF malaria intervention in Bili was relevant to the needs of the beneficiaries and fitting the strategy of the MoPH for the area, at different levels of the health pyramid (national, local, community levels)
- Can you also please suggest any activity that you think it should have been included in this intervention and it was not? Any activity which was instead included but it was not necessarily relevant to the scope of the project and/or not adapted to communities' needs and priorities?

**Design and Appropriateness**

- Could you please tell me whether MSF was close enough to the target population to understand their situation as well as possible changes in their needs? Can you describe to me the strategy MSF put in place to mobilize community, to raise awareness about the project and to seek participation and engagement? In your opinion, was this strategy successful? If not, what do you think should be improved in a similar intervention?
- Were other actors taken into consideration for the project? Like for instance the Ministry of Health staff? How were you personally engaged and involved and in which stages of the project e.g. design, design and implementation, monitoring etc.? Please share your point of view regarding the inclusion of other actors and comment on how this aspect could be improved.

**Effectiveness**

- Do you believe there have been any gaps, issues, or challenges in the implementation of the project? If so, could you explain which problems and how they have arisen? Be specific and refer

for instance to your own domain and role within the project. Were those problems addressed and corrected by MSF on time? If not, could you explain how they might have hampered achievement of objectives in the project?

- Can you remember if any changes were made to the project and its activities during the project implementation? If so, can you remember why those changes were made and if they in fact contributed to improve the implementation?

- My understanding is that the malaria approach implemented in Bili was somewhat new and 'experimental' for MSF. Is that your opinion/experience of it? Can you tell me more about the opportunities this approach provided and its limitations as well and how they affected achievements of results and outcomes?

#### Impact

- Since the beginning of the intervention, could you pls tell us what in your opinion has changed for the targeted communities? Can you please be very specific and make examples before/after, especially in relation with access to health services, reduction to morbidities and mortality in children coordination and collaboration with other authorities etc.? If you believe that this intervention impacted positively on the targeted communities, do you believe this impact is long term?

- Can you also explain if the project led to any policy changes, both at national/local level if any? If so, what were they and how long lasting they might be in your opinion?

- Do you believe that this intervention produced any negative effects in the communities? If so, could you pls describe what they are and whether the organization was made aware of this on time so to fix them?

- Do you believe this intervention produced any unintended and secondary consequences to the communities? E.g. something that happened as result of the activities, but it was completely unexpected.

#### Sustainability

- What efforts has MSF made to ensure that the approach used in the project was sustainable, especially in terms of identifying resources and building capacities to guarantee a certain degree of sustainability? How would you evaluate these efforts? Were they successful? If not, can you please share your view on why?

- Was an exit strategy drafted before the project closure? Can you please share the details with me on especially for what the collaboration with MoPH is concerned, or more specific to your role? In your view, was that exit strategy implemented accordingly? If not, do you know the reasons why? What were the main challenges?

- Can you pls share your thoughts on the specific things which might have enhanced sustainability and what was perceived as obstacles to the sustainability in that context?

Stockholm Evaluation Unit

<http://evaluation.msf.org/>

Médecins Sans Frontières

Independently written by  
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