PHASE 1 – Interim Report
EVALUATION OF

IMPROVING THE AVAILABILITY AND USE OF SEXUAL AND GENDER-BASED VIOLENCE SERVICES IN CENTRAL KASAI:
A MULTI-PHASE EVALUATION OF THE KANANGA PROJECT

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ABBREVIATIONS

BCZ	Bureau Central de la Zone de santé
CDK	Caritas Development Kananga
CODESA	Comité de Développement de l'Aire de Santé
DPG	Division Provinciale du Genre, de la famille, et de l'enfant
DPS	Division Provinciale de la Santé
DRC	Democratic Republic of the Congo
ECZ	Equipe Cadre de la Zone de Santé
FP	Family Planning
HC	Health Center
HGPRK	Kananga Provincial General Reference Hospital
HZ	Health Zone
KHC	Kamuandu Health Center
M&E	Monitoring and Evaluation
MOH	Ministry of Health
MoU	Memorandum of understanding
MSF	Médecins Sans Frontières
NGO	Non-governmental Organization
NSGBV	National Strategy to fight Gender-Based Violence
OECD	Organization for Economic Co-operation and Development
PAP	Provincial Action Plan
PMR	Project Medical Referent
SEU	Stockholm Evaluation Unit
SGBV	Sexual and Gender-Based Violence
SRH	Sexual and Reproductive Health
TOP	Termination Of Pregnancy
UN	United Nations
UNFPA	United Nations Population Fund
WHO	World Health Organization

EXECUTIVE SUMMARY

CONTEXT AND JUSTIFICATION

Sexual and gender-based violence (SGBV) is widespread in the Democratic Republic of the Congo (DRC). Although the constitution and several international and African conventions ratified by the country guarantee gender equality and the right to sexual and reproductive health (SRH) for all, women and girls in conflict, post-conflict, and non-conflict areas of the DRC are exposed to SGBV by known and unknown perpetrators. Despite the high prevalence of SGBV, the gap in the availability of and access to quality services for survivors remains considerable. Several factors account for the service gap, including low institutional capacities on both the national and local levels to implement a complex and comprehensive SGBV prevention, mitigation, and response effort. Since April 2022, Médecins Sans Frontières (MSF) has been piloting the decentralization initiative in the Kamuandu health center (KHC) that aims to: 1) Improve access to SGBV care, including contraceptive and abortion care; and 2) Build staff capacity to provide holistic medical support to survivors at the health center level.

PROJECT EVALUATION

This report shares the findings of Phase 1 of a multi-phase developmental evaluation of the decentralization initiative carried out in Kasai central in July 2022. In line with the MSF Stockholm Evaluation Unit's terms of reference, the Phase 1 evaluation aimed to evaluate the design and planning of the decentralization initiative for the KHC and its prospective implementation process. We employed a concurrent mixed-method approach that included a desk review, 17 semi-structured face-to-face and remote interviews with key MSF project team members (n=6), local stakeholders (n=5), and project beneficiaries (n=6), and observation of operations of the KHC. We addressed the primary evaluation questions through seven criteria: relevance, coherence, efficiency, effectiveness, impact, sustainability, and gender and human rights mainstreaming.

FINDINGS

The decentralization initiative's relevance to the DRC's and MSF's SGBV objectives and the multisectoral needs of survivors and community members is high. However, the provision of safe abortion services and non-medical referrals, part of the broader decentralization initiative package, has not been fully implemented at the KHC level. Further, the initiative is only moderately relevant in the implemented Tshikula health zone, given the comparatively low SGBV caseload.

The internal coherence of the decentralization initiative is relatively low and there is a need for more consensus amongst the MSF staff as to what the decentralization initiative is; external coherence is stronger. Although a results framework exists for the larger Kananga project, the decentralization initiative lacks a logic framework. The decentralization initiative package of care aligns with the global standards of

SGBV care and management; however, there is a lack of coherence between the government of DRC and MSF's standards of care protocols and management information systems.

The inputs for the decentralization initiative are incorporated in the larger Kananga project's budget forecast, making it challenging to identify the resources allocated to the initiative and evaluate its prospect for efficiency**.**

The capacity-building activities and the community mobilization have the potential to be effective. However, it is not yet clear whether local health authorities can independently take over the initiative at the end of the 15-month project timeframe. For this Phase 1 evaluation we are not able to assess impact. However, our evaluation of the decentralization initiative suggests that the prospects for impact are modest, largely because of the short timeframe. Some elements of the initiative have a high probability of replication, but the overall sustainability potential is moderate. Although the initiative has considered gender and human rights issues, the needs of some sub-populations, including adolescent girls and persons living with disabilities, have not been explicitly addressed.

LIMITATIONS

We did not reach thematic saturation due to the limited number of clients available for interviews at the KHC. Although we are confident that our results are transferable, for Phase 2 we will endeavor to interview a larger sample of beneficiaries from a larger range of geographic areas. Our Phase 1 evaluation is also limited by both existing program documents and materials and our access to those documents. However, this uneven documentation of the decentralization initiative is also a finding of our evaluation and suggests a possible next step for strengthening the decentralization initiative and its potential impact.

RECOMMENDATIONS

For the remaining project period, our major recommendations is that the field team review the project design elements with the aim of : 1) Developing a clearer better of the nature and scope of the decentralization initiative; 2) Outlining more explicit criteria for site selection; 3) Harmonizing and coordinating more with national and provincial regulations and approaches; and 4) Developing a post-hoc logical model, making some adjustment to the implementation activities, and using an integrated community approach. On the project management side, we recommend strengthening monitoring and evaluation mechanisms and developing a stand-alone budget for the decentralization initiative.

INTRODUCTION

Sexual and gender-based violence (SGBV) is widespread in the Democratic Republic of the Congo (DRC). Although the constitution and several international and African conventions ratified by the country guarantee gender equality and the right to sexual and reproductive health (SRH) for all,[1] women and girls in conflict, post-conflict, and non-conflict areas of the DRC are exposed to SGBV by known and unknown perpetrators [1]. In 2021, the United Nations Office for the Coordination of Humanitarian Affairs (OCHA) documented 74,275 cases of SGBV; 94% of these cases involved women and girls [2]. Societal norms that favor men and boys and undermine gender equality influence women's status, roles, and power within relationships, households, and communities [3,4]. Political and socio-economic fragility resulting from decades of recurrent armed and inter-ethnic conflict has exposed women and girls to SGBV and weakened state authority, indirectly exacerbating broader, intersectional vulnerabilities [5].

This fragility of state authority has led to institutional weaknesses in the effective implementation of regulatory frameworks and interventions to prevent and respond to SGBV. Despite the high prevalence of SGBV, reporting to authorities and access to and availability of SGBV services remain low in conflict and post-conflict settings [6]. Several factors may account for this low reporting rate, including social stigma, shame, and fear of retribution from the perpetrator [7]. SGBV care and support services (including healthcare, legal and judicial assistance, socioeconomic reintegration services, and protection support) are not often available or not of the quality that meets the standards set by the United Nations Joint Global Programme on Essential Services for Women and Girls Subject to Violence, even though the revised national strategy to address SGBV encourages a holistic, multisectoral approach to management [8,9]. Several reasons may explain these gaps in the availability of quality SGBV services, including low capacity for multisectoral and intersectoral coordination [10], underfunding of holistic care and support services for survivors [11], scarcity of medical supplies, and the lower number of healthcare providers trained in managing sexual violence [12].

In the few areas where quality SGBV services do exist, survivors face countless barriers to accessing them. Some of these barriers include a lack of information about existing services, a mistrust in the health system, and physical barriers to accessing static SGBV services due to conflict, displacement, or considerable distance between communities and health facilities offering SGBV care [8,12]. As a result, women and girls who are survivors of SGBV are at higher risk of adverse health outcomes such as unintended pregnancies, unsafe abortion, and unintended births due to a lack of access to contraception and safe abortion care [13,14]. In Central Kasai province, gaps in the availability of support services for SGBV survivors have

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[1] The articles 12, 13, and 14 of the DRC constitution contain almost all the rights and freedoms enshrined in the Charter of the United Nations (UN) and the Universal Declaration of Human Rights. The country is also party to: 1) The UN Convention on the Elimination of All Forms of Discrimination Against Women; 2) The Declaration on Elimination of Violence Against Women (1993); and 3) The African Charter on Human and Peoples' Rights and The Protocol to the African Charter on the Rights of Women in Africa (Maputo Protocol) (2003). The Maputo Protocol guarantees the promotion, realization, and protection of the civil, political, economic, social (including sexual and reproductive), and cultural rights of women. This Maputo Protocol came into force in DRC in 2018 after its publication in the *Journal Officiel de la Republique*. However, as of 2022 the implementation of its article on access to abortion has yet to be fully realized.

increased in recent years due to the disengagement of several international non-governmental organizations (NGOs) during the COVID-19 pandemic.

BACKGROUND ON THE KANANGA PROJECT

In 2017, Médecins Sans Frontières (MSF) launched the Kananga project to provide emergency medical assistance those living in Central Kasai province (see map on Fig. 1) [15]. Initiated during the Kamwina Nsapu rebellion, the project began as an autonomous MSF clinic located in the Kananga Provincial Referral Hospital (the tertiary level of the DRC's health pyramid). At that time, the Kananga project focused primarily on responding to medical emergencies, including surgical emergencies, generated by the security crisis related to the Kamwuina Nsapu rebellion. As the context evolved, the Kananga project experienced frequent changes in strategy and focus (surgical interventions, malnutrition, primary care in mobile clinics, management of sexual violence, etc.).

In April 2019, the project adopted a "vertical" approach by focusing solely on medical and psychological care for survivors of sexual violence at the Kananga Provincial General Referral Hospital (HGRPK). Mass awareness campaigns and peer education sessions on the impact of SGBV and the availability of services were also conducted at the community level to create demand for SGBV services. The availability of SGBV services at HGRPK, coupled with this multi-faceted demand creation strategy, resulted in a substantial increase in the use of SGBV services. The number of survivors (both spontaneous and referred cases) receiving SGBV care at the HGRPK increased to over 200 per month between 2019 and 2020 [15]; this surge led to congestion at the health facility.
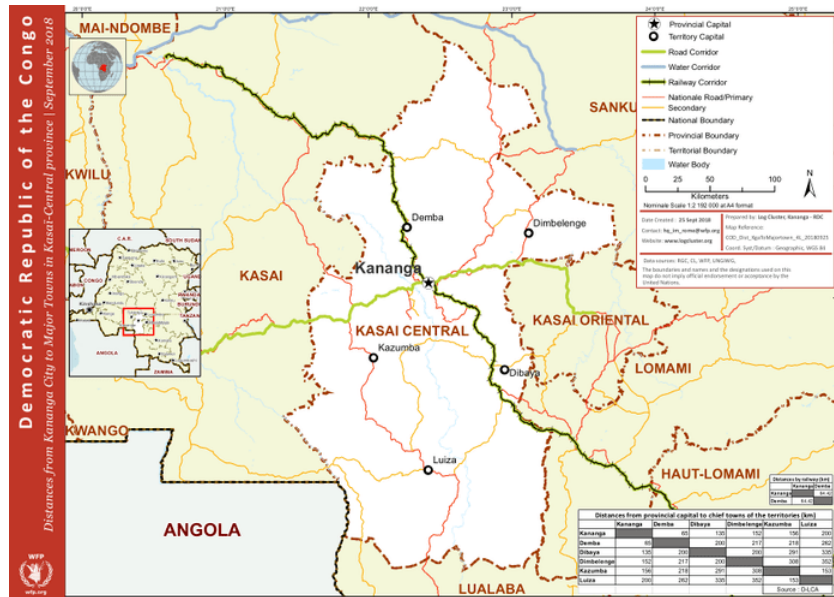

Figure 1. Map of Central Kasai Province

DESCRIPTION OF THE DECENTRALIZATION INITIATIVE

In 2020, the project moved to a "decentralized approach". This approach consists of integrating SGBV-related health care into existing health services at the Health Center (HC) level; one of the explicit aims was to address SGBV service-related congestion at HGRPK. As of January 2022, five HCs located in urban (Kananga and Bobozo) and peri-urban (Tshikaji and Lukonga) Health zones (HZs) were supported by MSF to integrate SGBV care.

The initial decentralization efforts in those five HCs were not standardized in terms of the duration of support and activities. Therefore, the project team decided to develop an "initiative" to standardize the decentralization efforts and ultimately facilitate their replication. The resulting

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

initiative includes five core intervention components, referred to as "phases" in the Kananga project's 2022-2023 roadmap (see Fig. 2) [15]. The decentralization initiative aimed to: **1) Improve access to SGBV care, including contraceptive and abortion care; and 2) Build staff capacity to provide holistic medical support to survivors at the health center level.** Since April 2022, this initiative has been piloted at the Kamuandu Health center (KHC) in the Tshikula HZ, with expected completion in March 2023. According to the Kananga Project roadmap, there are plans to replicate the decentralization initiative in two other HC in the Central Kasai province (HC2 and HC3) by July 2022 [15]. Replication will be informed by the learnings from the pilot phase.
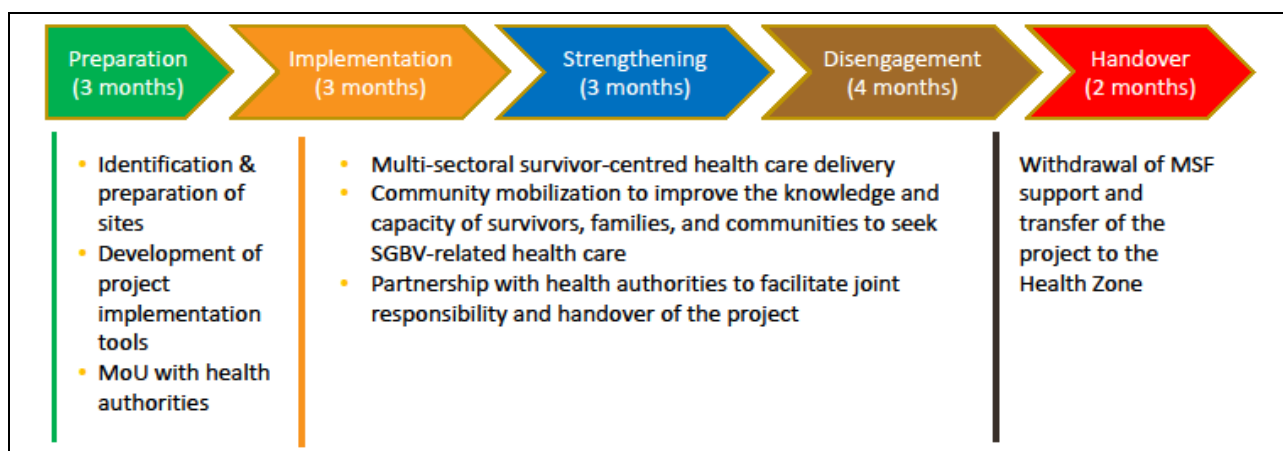

Figure 2. Phases of the decentralization initiative (2021)

Note: MoU = Memorandum of understanding
             MSF = Médecins Sans Frontières

The preparation phase refers to the planning of the integration of SGBV care at the HC level. It includes the following key activities: identification and preparation of sites, development of SGBV job-aids and guidelines, and signing of a memorandum of understanding (MoU) with health authorities.

The implementation, strengthening and disengagement phases are the core intervention components of the initiative. The activities to be implemented during these two phases are centred around the following three distinct but interrelated strategies:

1. Integration of multisectoral, survivor-centred health care: This includes
   a. *Direct support to the KHC to provide quality, survivor-centred, holistic health care (medical and psychological first aid).* This is done primarily through in-service training and formative supervision of healthcare providers to strengthen their capacity to provide quality, patient-centered care. In addition, MSF provides logistical support (provision of medical supplies, minor infrastructure rehabilitation, installation/restoration of hygiene, water, and sanitation infrastructure, etc.) and financial support (a monthly grant for the operation of the health center) directly to the health center. MSF provides commodities that are not included in the standard kit for the management of sexual and gender-based violence provided by the Ministry of Health (MoH), namely the vaccines against Hepatitis B and tetanus, and sexually transmitted infection (STI) related-supplies. The essential medical care package offered to SGBV survivors at the Kamuandu Health Center includes: 1) emergency contraception and abortion care; 2) HIV post-exposure prophylaxis (PEP); 3) PEP for STIs; 4) Hepatitis B and tetanus vaccinations; and 5) basic psychosocial support.
   b. *Screening and referral of survivors for non-medical support.* Health care providers, trained by the project team, screen clients for current risks and non-medical support needs (including legal aid, material assistance, and safe shelter). Screened clients are provided information about where and how to access non-medical resources. Collection and documentation of evidence for legal purposes are also performed.

2. Community mobilization to improve the knowledge and capacity of survivors, families, and communities to seek SGBV-related health care: Community relays, trained by the project team, conduct door-to-door visits to raise community awareness on what SGBV is, how it impacts their health, and where services are available. These encounters also allow community relays to gather information about and respond to questions/rumours about SGBV.

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

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

staff, handover meetings between the ECZ and the Project Medical Referent (PMR), supplying the HZ with a buffer stock of SGBV drugs for 3-6 months, and supporting the community to activate the resilience system.

SCOPE AND OBJECTIVES OF THE EVALUATION

Using a multi-phase developmental approach, this evaluation has two primary goals
- **Phase 1**: To evaluate the design and planning of the decentralization initiative for the KHC and its prospective implementation process. This phase had two specific objectives: 1) To determine the extent to which the pilot phase, as designed and planned, is likely to achieve its intended objectives (improved access to SGBV services, including comprehensive contraception and abortion care, and strengthened capacity of health center staff to provide quality care to survivors); and 2) To suggest adjustments to the decentralization initiative's design and planning, as necessary.
- **Phase 2:** To evaluate the results of the implementation of the decentralization initiative in the KHC, learn from this pilot phase, and inform the next phases of the initiative (exit and hand-over strategy for KHC and lessons learned for implementation in HCs 2 and 3).

The objectives of this evaluation are to:
1) Identify strengths and weaknesses in the conceptualization, planning, and implementation of the decentralization initiative.
2) Produce useful lessons and identify practices that illuminate successful and/or unsuccessful strategies for achieving results; and
3) Collaboratively produce clear and actionable recommendations by identifying concrete actions and responsibilities that MSF should undertake to further expand the decentralization initiative.

EVALUATION APPROACH AND METHODOLOGY

Guided by the approved inception report and initial conversations with MSF team members, we used a concurrent mixed-methods design for the Phase 1 evaluation. We determined this design was appropriate given the characteristics of the decentralization initiative, including its non-proscriptive guidelines (the possibility of changing the intervention strategy being implemented). We also believed that this design would allow us to understand innovative elements of the design and/or implementation of the decentralization initiative and would be consistent with a developmental evaluation approach. A developmental evaluation approach involves a dynamic learning process because it gives knowledge users the opportunity to react in real-time to evaluation data, use it to adjust their program, and thus learn from their experiences [16].

THEORETICAL FRAMEWORK

Given the stated desire to replicate the decentralization initiative after completion of the pilot phase [15], we used Rogers' theory of diffusion of innovations [17,18] as the theoretical framework for the overall evaluation. We assume that the generation, dissemination, and adoption of emerging lessons and good practices will involve a stepwise progression from awareness of the need for a new intervention to a decision to adopt (or reject) the new intervention to continued use of the new intervention. We anticipate that four main factors will influence the adoption of the lessons and best practices identified from this evaluation:

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

Although this theoretical framework undergirds the overall evaluation, it is most explicitly relevant for Phase 2.

EVALUATION FRAMEWORK

Given the evaluation questions suggested by the Stockholm Evaluation Unit (SEU), we based the Phase 1 evaluation on the revised Organization for Economic Co-operation and Development (OECD) framework for evaluating humanitarian and development actions [19]. We have expanded this conceptual framework to include gender and human rights considerations. Specifically, in addition to the focus on women and girls who are the most frequent victims/survivors of SGBV (especially in conflict situations), we have also examined how sexual and gender minorities (i.e., lesbian, gay, bisexual, and transgender people) affected by SGBV are included in the pilot phase, as well as men, boys, and people with disabilities.

We designed the Phase 1 evaluation around seven criteria to answer the following questions:
- **Relevance**: Do the decentralization initiative objectives appear relevant to the observed and expressed needs, context, and priorities of MSF and the DRC government (local and national, if applicable) and do they consider the needs of the various stakeholders and project beneficiaries?
- **Coherence:** Is the process of strategy, design, planning, and forward implementation consistent given the context and existing resources? How could the decentralization initiative become more coherent?
- **Efficiency:** What resources did the decentralization initiative design require, were they available, and could they have been mobilized more effectively?
- **Effectiveness:** Is the decentralization initiative likely to achieve its objectives and expected results within the allocated time frame?

- **Impact:** Is the decentralization initiative expected to have an impact?[2]
- **Sustainability:** What are the prospects for the successful transfer of the decentralization initiative to health authorities? What are the prospects for replicability in other health centers in Central Kasai and beyond?
- **Gender and human rights mainstreaming:** Have gender and human rights perspectives been integrated into the conceptualization and design of the decentralization initiative? Could the decentralization initiative as designed reach different ethnic groups, sexual and gender minority populations, and people with disabilities in terms of service delivery and health promotion?

METHODS

We began the Phase 1 evaluation with the development of an inception report. Creation of this report involved a preliminary review of available documents, initial interviews with field-level staff, and feedback from the Consultation Group. This process allowed us to develop our primary and secondary evaluation questions, draft instruments for data collection, and engage with stakeholders early in the evaluation process.

For the Phase 1 evaluation, we used multiple methods of data collection to address the primary evaluation questions. This included:

- **Conducting a desk review:** This component of the project included reviewing project documents, such as the roadmap, budget, operational plans, monitoring plans, and annual or other reports. We also reviewed documents relevant to the context published in peer-reviewed journals and by international NGOs and UN agencies as well as key unpublished source material obtained during the field visit in Central Kasai. We provide our desk review protocol in Appendix A.
- **Conducting interviews:** We conducted 17 semi-structured face-to-face and remote interviews with key MSF project team members (n=6), local stakeholders (n=5), and project beneficiaries (n=6). We conducted the majority of interviews (n=15) in French; we also conducted interviews with two SGBV survivors in Tshiluba. We obtained oral informed consent from all participants and with permission we audio-recorded all interviews, which lasted 30–60 minutes. We include a copy of example interview guides in Appendix B.
- **Observing operations:** A member of the evaluation team was based in Central Kasai for two weeks in July 2022 to assemble materials for the desk review, collect primary data, and observe the operation of the KHC. These observations, along with feedback from an in-person meeting with MSF team members and ongoing discussions, informed our analysis and recommendations.

We received approval to conduct this evaluation from the Research Ethics Board at the University of Ottawa and used a trauma-informed approach in our interviews with survivors.

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[2] As outlined in the inception report, the Phase 1 evaluation did not focus on impact, as this phase of the evaluation centers on conceptualization, design, and early implementation of the decentralization initiative. However, we have included some reflections on potential impact in our analysis and thus include this dimension in the report.

DATA ANALYSIS

We used the five-phased approach outlined by Levac and colleagues [20] to analyze the documents secured as part of the desk review. This included charting and summarizing the data and identifying narrative themes. We also analyzed the quantitative data we obtained as part of the desk review using descriptive statistics to identify percentages, frequencies, and temporal, geographic, and demographic patterns.

We analyzed the primary qualitative data for content and themes using both inductive and deductive techniques [21]. We coded verbatim transcripts, field notes, and summaries using the seven evaluation criteria (relevance, consistency, efficiency, effectiveness, impact, sustainability, and gender and human rights mainstreaming). We also considered emergent findings that did not fall into one of these *a priori* criteria. We triangulated data from different sources to ensure the credibility and trustworthiness of the information. We provide information about the evaluation team in Appendix C.

FINDINGS

We organized the results around the seven evaluation criteria. We highlight both strengths and areas for improvement.

RELEVANCE

By relevance we assessed the alignment of the decentralization initiative's objectives to its context of implementation, the needs of its direct beneficiaries, and the DRC's and MSF's SGBV strategic objectives in Central Kasai. Per the Kananga project's 2022-2023 roadmap, **the decentralization initiative aimed to 1) Improve access to SGBV care, including contraceptive and abortion care; and 2) Build staff capacity to provide holistic medical support to survivors at the health center level.** Based on our review of the SGBV literature and relevant documents from MSF Kananga and interviews with the MSF Kananga staff and direct beneficiaries, we assessed the relevance of the decentralization initiative to the implementation context, the multi-sectoral needs of survivors as high, and the DRC's and MSF's SGBV objectives in Central Kasai province.

The relevance of the decentralization initiative to the context of Tshikula HZ
The province of Central Kasai is emerging from a conflict that had a devastating impact on institutions, the economy, and the social fabric. The province is at the post-conflict transition stage, but the security situation remains fragile due to military and police harassment, an increase in cases of night-time armed robberies, and pockets of inter-community conflict over access to traditional power and natural resource management [22]. In this context of post-conflict transition and fragility, SGBV, and particularly sexual violence against women and girls, remains at unacceptable levels.

MSF's clinical data revealed that 2,257 survivors of sexual violence received medical and psychosocial care through the Kananga project between January and August 2021 [15]; this is inconsistent with the DRC government's target of zero gender-based violence [16]. By the end of July 2022 (approximately four months after the integration of SGBV-related services at the KHC), 20 survivors were treated at the KHC as evidenced by the KHC clinical data. At the provincial level, the Division provinciale du genre, de la famille, et de l'enfant (DPG) statistics for 2021 reported 20,791 documented incidents of SGBV throughout the province, 21% of all reported cases nationwide [23]. In the first quarter of 2022, the DPG documented 2,040 survivors at the provincial level [24]. The majority of victims/survivors (46%) were from the Kananga HZ, with smaller percentages from the Dibaya (8%) and Masuika (8%) HZs and fewer than 50 cases from the Tshikula HZ [24].

These figures, combined with the fragile security situation that still characterizes the province of Central Kasai, demonstrate that it is crucial to continue and intensify prevention, mitigation, and response efforts against SGBV. The absence of significant action against SGBV could further increase the vulnerability of women and girls to the risks of SGBV and its deleterious health and social consequences. Yet, the gap in the provision of SGBV-related services in the province is currently considerable due to the disengagement of many stakeholders in the fight against SGBV amidst the COVID-19 pandemic [25,26].

Considering this overarching context, the Kananga project's 2022-2023 road map calls for the integration of SGBV-related services into existing services at the HC level to improve sustainable access to care for survivors, which is very relevant. Indeed, in resource-constrained settings where universal coverage of SGBV services cannot be ensured, evidence has shown that integrating SGBV services into existing health services (for example into HIV/ STI or maternal care services) can be cost-effective [25-27]. Although there may be some value in piloting programs in relative "low need" settings, evidence on programme implementation suggests that health interventions should be integrated where they are most needed in view of the level of risk of exposure and opportunity costs [28]. Based on the available evidence, the SGBV burden is considerably lower in the Tshikula HZ compared to the Kananga, Dibaya, and Masuika HZs. Further, the decentralization initiative was developed to implement and then replicate the initiative elsewhere; since effectiveness is the key feature for replicability [29], clearer justification of site selection would enhance the relevance of the decentralization initiative.

The relevance of the decentralization initiative to the multisectoral needs of survivors and community members

> "[We] live in a very remote area and the sub-station [of the police] is very far away at 17-18 km, and the police station is further far away, about 80 km. In the past, I had a hard time dealing with it [sexual assaults], when such cases were brought to me, I did not know where to start to manage them. I did not know where I was going to start to solve them, but recently, I am starting to feel somewhat relieved...I notice the presence of Médecins Sans Frontières in our area. If someone has been raped, I send her to the center where she can be treated for free. I feel somewhat relieved"
>
> Key informant from Kamuandu village

Women and girls affected by SGBV, including those living with disabilities, require holistic, multi-sectoral care to ensure their physical, mental, and social well-being [30]. Holistic care means that care is tailored to the specific needs and preferences expressed by each survivor, considering one's vulnerabilities and specificities (33).

To assess the relevance of the pilot to the expressed multisectoral needs of its direct beneficiaries, the evaluation team interviewed a sample of community members and clients of the KHC to gather their perspectives. As reflected in the quotation that opened this sub-section, they unanimously confirmed that their needs for free medical and psychological care were met thanks to the pilot.

However, we heard from several beneficiaries that they felt that their needs for abortion care were still unmet.

> "I am 15 years old. I was made pregnant [raped] by two men and they ran away...I didn't have the money to come for treatment [in time]. It was only after...two days that I started to get sick, but I did not have the money to come to the Center... I was sick and I became too pale. It was the people in the community who took pity on me to bring me here to the health center...I had a pain in my belly and when I came, it was [specific provider] who examined me and confirmed that I was pregnant...but I had been told not to have an abortion."
>
> Client at the KHC

The individual experiences of survivors were confirmed by Kamuandu staff and an MOH expert we interviewed. They explained that the lack of dissemination of the Maputo Protocol constitutes a significant barrier to the effective integration of abortion services at the KHC level.

"Comprehensive abortion care, by the way, has already been integrated at the national level. But in Central Kasai we have not yet done so…Why? Because the law concerning comprehensive abortion care for women has not yet been enacted here [in Central Kasai]…We did surveys on pharmacies, we did surveys on health facilities to see how the implementation of activities could be done. Right after [this study], it remained a dead letter because the training of provincial trainers never followed. While the provincial trainers were supposed to train people locally, this is why in Central Kasai, this activity is not yet integrated."

MOH representative

In addition to gaps in abortion care, several clients we interviewed expressed an unmet need for nonmedical services. Referral for nonmedical services is a core element of the decentralization initiative, as a "one-stop-shop" falls outside its scope [15]. Distance and lack of appropriate resources act as barriers to effective referrals.

"My husband decided to kick me out of the house. As a result of this act, unfortunately I have no parents or place to go. My mother passed away when I was 5 months old, my in-laws asked me to leave their house, so I have no place to go. I have no living relatives, I have no one who can take care of me or bear the burden [of the pregnancy]. He abandoned me while I am pregnant, he sent me the message that he does not need me anymore, and I can go anywhere I want to go. I cried a lot, as I have no place to go at this moment. My uncles live very far away, so who can take care of this pregnancy? That is why I came to you so that you could plead for my case."

Client at the KHC

Our review of the results of a mapping exercise of organizations to which KHC providers are supposed to be referring clients for non-medical needs revealed that all of these organisations are located more than 8 kilometers (radius) from the HC; the national standard for spatial availability of services is set at within 8 kilometers [32]. Healthcare providers from the KHC argue that they need appropriate resources (transportation and credits for communication) to ensure the effective referral of clients.

Based on both the documents we reviewed and the interviews we conducted, the relevance of the decentralization initiative to survivors' expressed needs is clearly high because the provision of multi-sectoral SGBV care and support is included in the intended scope of the initiative. However, abortion-related care and referral to non-medical services merit additional implementation efforts, as the provision of a fragmented package of care could undermine the uptake of SGBV care over the time [33].

<u>The relevance of the decentralization initiative to MSF's strategic orientations for 2022-2023 and to the DRC's high-level objectives on SGBV</u>

The decentralization initiative contributes directly to the implementation of the National Strategy to Fight Gender-Based Violence in the DRC (SNVBG) and its corresponding provincial action plan (PAP). The SNVBG constitutes the normative reference framework for all stakeholders in the fight against violence against women, young people, and girls in the DRC. Built on the global strategy, the SNVBG encompasses five components: 1) Strengthen law enforcement and the fight against impunity; 2) Prevent and protect against sexual violence; 3) Reform of the security and justice system; 4) Operationalize multisectoral management, which covers medical, legal and protection aspects, as well as socio-economic reintegration and community recovery; and 5) Manage data and information. The intended scope of the decentralization initiative includes ensuring multi-sectoral support to survivors, through on-site provision of holistic medical and psychological care, and referral for nonmedical services. Thus, this aligns with the fourth component of the DRC's SNVBG. Also, the decentralization initiative is in line with the continuity of SGBV response efforts in Central Kasai, as outlined in MSF Kananga's roadmap for the fiscal year 2022-2023.

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COHERENCE

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To assess the coherence of the decentralization initiative, we examined the extent to which its design process, implementation strategy, planning, and prospective implementation approach align with its implementation context and existing resources. By resources, we mean human, material, medical, and financial inputs as well as tools and instruments required for implementation in the pilot phase.

Our findings on the consistency of the decentralization initiative are based on the review of relevant documents from MSF Kananga [34,35], on interviews with and ongoing feedback from MSF staff (from both the Kananga project and the medical coordination unit), and observation of the activities in the field. Based on our evaluation we internal coherence of the decentralization initiative appears to be low although external coherence is stronger.

MSF staff views on what the decentralization initiative is

"[To] support the implementation of activities in this health center. So basically, [the decentralization initiative is] not something new that we found, but the system that we found before could not allow us to improve this care."

"It's about bringing health care closer to the community, supporting health centers to provide SGBV care. Decentralization was done to facilitate access to survivors who came from far away to access services. The goal of decentralization was not only to disengage the hospital but also to reduce physical barriers to accessing care."

"We train the staff of the Health Center, after these trainings, there is also their accompaniment. Coaching visits that every time we go there to supervise them in the [provision] of care."

"It is a model of capacity building for providers, with different phases and each phase has a specific duration, with specific activities."

"Modeling means the implementation of a systematic approach organized around five phases for an envisaged duration of 15 months per supported health centers."

<u>The internal coherence of the decentralization initiative is low and there is lack of consensus as to what the decentralization initiative is</u>
There is a need to develop a comprehensive description of the decentralization initiative to inform its consistent implementation over time and increase its evaluability. Repeatedly in our evaluation we observed that different MSF staff view the "decentralization initiative" differently (see text box, above). Consistent with the different terms used to describe the initiative, some perceive the decentralization initiative as a tool for supporting health centers to provide SGBV care at the HC level (in terms of supplies, training, and supervision). For others, the decentralization initiative is a model for planning activities to strengthen the capacity of health facilities to provide care to SGBV survivors in a systematic way. For others, the decentralization initiative is an activity of the larger project.

For the sake of building a common understanding within MSF and beyond it is imperative to develop and disseminate a comprehensive description of the decentralization initiative. This includes defining the range and scope of the initiative and using consistent language about the purpose of the pilot phase. Based on our review of MSF Kananga documents and our observations of the way the initiative is being implemented in the field, there is no doubt that the decentralization initiative being piloted concerns the delivery of SGBV health services. However, the range and scope of what has been decentralized regarding the delivery of services is unclear. Further, although replication is a stated aim, it is not clear if this a model for service delivery or a model for the management and processes of decentralisation (e.g., decision-making, resource allocation).

In addition, given the relatively frequent turnover of staff within MSF, comprehensive documentation of the decentralization initiative could help foster a common understanding and support steady implementation over time. Accompanied with clearer definitions of the criteria used to screen and select priority sites for replication, this could help ensure a systematic and rigorous process for scale up. This would also enhance the evaluability of the initiative and the transferability of conclusions drawn from the Phase 2 evaluation.

<u>The external coherence of the decentralization initiative</u>
The lack of internal coherence or a shared definition of the decentralization initiative and its scope influences external coherence. However, as part of the decentralization initiative, MSF intends to liaise with health authorities to support accountability (Fig. 1). The accountability strategy aims to decentralize governance and authority at the district level for the delivery of health services [36-39]. This represents a significant innovation. Indeed, shifting the authority for SGBV service delivery from an international NGO (MSF) to the heath district authority to improve service uptake in a post-conflict setting reflects an underexplored element in health systems building in the humanitarian and fragile setting space.

However, ensuring external coherence is not without its challenges. Health care providers that we interviewed pointed out inconsistencies between the DRC protocol for the clinical management of survivors and that of MSF. The two protocols differ in terms of the number of follow-up visits and the package of care to be offered to rape survivors with regard to post-exposure prophylaxis after 72 hours,

hepatitis B vaccination, and comprehensive abortion care. The MSF package is more comprehensive and consistent with international standards for clinical care of survivors of sexual violence [40]. Moving forward, it will be important for MSF to work with external stakeholders to harmonize standard of care protocols to ensure comprehensive services continue to be available; this will likely involve continuing to work proactively with stakeholders and partners to expand their package of services. Because MSF standards exceed local standards this will likely be challenging and therefore coherence is moderate. As stated by a UNFPA representative, "Certainly, the agreement [of Maputo] is at the international level. But abortion is still prohibited in our country. From that point of view, I am still doubtful."

EFFICIENCY

In order to evaluate efficiency, we sought to estimate the level of resources that were allocated to implement the decentralization initiative at the KHC and the extent to which these resources were available and could have been mobilized better. By resources, we mean human, material, medical, and financial inputs as well as tools and instruments required for the pilot phase of the "decentralization initiative". Overall, we found the efficiencies of the initiative were mixed.

<u>The efficiency of the decentralization initiative</u>
Based on our review of the budget and initial and ongoing discussions with MSF staff, it is clear that the decentralization initiative was not conceived as a financially distinct project or intervention. Therefore, all of the resources required to implement this initiative have been incorporated into the budget forecast of the larger Kananga project. This makes it difficult to evaluate the resources allocated to implementation of the decentralization initiative specifically. However, we have identified several ways that resources could be mobilized more efficiently.

Community outreach activities and referral of clients from the community to the KHC require an appropriate allocation of financial and material resources to ensure optimal implementation and efficient use of human resources. In this regard, the community health relays we interviewed stated that they needed additional materials and financial support (flyers, banners, megaphones, and communication and transportation means.) As explained by a community relay from the Tshikula HZ:

> "The difficulties we have here…are the distances between where the assault happened and where we live. It takes resources to get from where you are to there. It can take six hours of time, eight hours of time. If we had the means of transportation, the means of communication, we would start to do this job properly…If we had means of transport, we would have gone fast but we don't have that...The other difficulty is that we also find in this work [that] we never find even a soap [a minimal remuneration]! We have always been volunteers, they must begin to think about helping us…[And] I need a megaphone, telephone, means of transport, equipment that shows that this person is a worker in this or that organization."
>
> A community relay from the Tshikula HZ

The contact information of organizations that provide social services to survivors (legal aid, shelter, and socioeconomic reintegration) was made available to KHC staff by MSF. Our review of this list of contacts revealed that none of these facilities are located within a radius of less than 8 kilometers from the KHC. To ensure the efficient and effective transfer of survivors to these facilities, providers stated that they needed financial resources (transportation and communications reimbursement). The geographic and associated financial barriers are especially burdensome on adolescents and young girls seeking to initiate or continue care.

The management of health information remains parallel to that implemented by the Ministry of Health, which could lead to duplication of efforts and sub-optimal use of human resources. As the decentralization initiative involves partnerships with HZ authorities and holding them accountable for the integration of SGBV services, working to harmonize the data management system should be a priority. Eliminating duplicative registries is also important to increase efficiencies.

The perceived lack of alignment between MSF and the DPG in recording, counting, and reporting data affects the comparability of information from these two different sources. Aggregation of non-comparable data distorts the accuracy of SGBV statistics and could hinder the development and evaluation of a multi-sectoral and intersectional response at the systems level. As one government representative shared,

> "MSF sends us a report every month; it sends us its report in hard copy, in its own format. We [also] have data collection mechanisms. We have survivor forms that our partners have to fill out for every client they report, and these forms are filled out in terms of unique identifiers and other information so that a survivor cannot be reported twice because if she goes here and there, we will find out that she has already been somewhere…The coordinator usually visits [the agencies offering services to SGBV survivors] once a month to reassure itself of what the NGOs are doing in the field, but MSF has never agreed; we had asked the MSF coordinator [to make joint field visits], but they never agreed. They only send us reports, but we have never carried out joint-monitoring missions to make sure that the numbers they send us are correct or not correct because we have to make field visits and see, as I do with Caritas, PROSANI and UNFPA, UNDP and so on."
>
> A government representative

EFFECTIVENESS

We assessed the extent to which the decentralization initiative as designed and planned is likely to improve access SGBV services at the KHC and improve the skills of staff to provide quality SGBV care to survivors (the two stated objectives) within the 15-month timeframe. Given the short timeframe and the complexity of SGBV as an issue, we assess the overall effectiveness to be mixed. We based our findings on our review of the SGBV literature and relevant documents from the Kananga project [15,34] and on interviews with the MSF Kananga staff, the KHC staff, and MOH staff.

The core implementation component of the decentralization initiative centers on integration of quality care, community mobilization to challenge negative SGBV norms, and partnership with HZ authorities to hold them accountable for service delivery. The first two components derive from experience and evidence and could yield promising results in improving the uptake of services. However, there is little evidence that this type of international NGO-health authority partnership has been successful elsewhere and there are few models in the SGBV and sexual and reproductive health field that exist.

The potential effectiveness of capacity building interventions

To build the capacity of the KHC staff to deliver quality, patient-centered care, the plan is to train them all on the multi-sectoral approach to SGBV management, including the provision of holistic medical and psychological care, screening and referral to non-medical services, and SGBV awareness. Monthly formative supervision (by MSF staff) and quarterly joint-supervision (by both MSF and Tshikula HZ staff) are also planned to support skills development. In parallel to skills building, it is also planned to provide the staff with job aids on the multi-sectoral management of SGBV, financial subsidies, and medical supplies to enable them to work in optimal conditions. In this regard, the KHC staff reported that the training and supervision they have benefited from so far, coupled with the availability of medical supplies and job-aids, have improved their confidence and comfort with providing SGBV care. This indicates high prospects for improving their ability to provide quality care to clients within the 15-month period.

> "As far as the training received is concerned, I was trained on the provision of gender-based violence services, and I was also trained on family planning by the partner MSF...All the services that are offered in our health center, we can provide them in case [the nurse] is not present or one of the nurses is not on site; we can provide [SGBV] services because we have gained the skills; we receive training, briefing, and accompaniment on the ground. In addition to MSF, there is also UNFPA, who had trained us on gender-based violence; they support us with medical supplies such as [contraception] and PEP kits; this allows us to work well."

The potential effectiveness of community awareness raising strategies

The literature on SGBV interventions show that multi-faceted community mobilization strategies coupled with appropriate provision of multi-sectoral services to survivors can increase the use of SGBV services [41]. This is a strong and demonstrably effective component of the initiative design. However, integrating other stakeholders into this component of the initiative is critical. For example, door-to-door sensitization campaigns on SGBV and the existence SGBV services at the KHC will ultimately be conducted by community outreach workers under the authority of the Tshikula HZ. While joint supervision is proven to be effective in improving the quality of care by improving the quality of data for decision-making and the skills of staff to provide care in the DRC context, relying on community relays to conduct these interpersonal outreach activities in a rural area on a voluntary basis could affect the likelihood of success [42]. Further, there are gendered and age-related dynamics (see gender and human mainstreaming section below) that undermine the potential effectiveness of this component of the initiative.

The decentralization initiative centers on raising awareness at the individual-level. Inclusion of efforts that focus on raising awareness among target groups or at the community level could enhance the effectiveness of the initiative. Other culturally acceptable health promotion efforts, such as community

outreach plays, films, and radio broadcasts have been effective in other settings [43,44]. A representative from the Ministry of Health also identified the need for greater attention to health promotion efforts at the community level, "In prevention, we need to communicate [through] thematic group discussions and dialogue with youth associations, and that's what prevention is all about. It is especially necessary to determine what the real problem of youth is, what the real needs of youth are."

<u>The potential effectiveness of the handover of the decentralization initiative to local health authorities in the pre-determined 15-month timeframe</u>
Holding health authorities accountable for the cost, quality, and equity of care is an important way to improve service delivery and utilization [39]. The partnership component of the pilot phase of the decentralization initiative includes: 1) Signing MoUs with HZ authorities prior to the launch of the process; 2) Engaging in quarterly joint supervisions between MSF and HZ authorities; 3) Providing a six-month buffer of medical supplies; and 4) holding a handover meeting at the end of the process. There is little evidence as to whether or not this strategy will be effective in transitioning authority of the initiative. Several key informants questioned the degree to which this partnership is sufficiently and thoroughly prioritized. As explained by a representative from the MOH:

> "We have supervision reports that MSF carries out in the field, although our concern has always been that during these supervisions, the Ministry of Health should be part of the team. Why is that? Because the day MSF withdraws, the government will have to take over all the achievements left by MSF. I think one day they will be able to do that [but not yet]."
>
> A representative from the MOH

IMPACT

Generating and reinforcing health staff competencies and creating demand for SGBV services in addition to social inclusion and economic well-being of the survivors has the potential to reduce the incidence of and the morbidity and mortality associated with SGBV [44]. However, the potential impact of this type of intervention is likely to be shaped by the context in which it is being implemented as well as the design of the intervention itself. This also requires time. For this Phase 1 evaluation we are not able to assess impact. However, our evaluation of the decentralization initiative suggests that the prospects for impact are modest. The greatest challenge appears to the be the 15-month timeframe; it appears unrealistic that the decentralization initiative will have completed all phases, particularly disengagement and handover (see Fig.1), in the pre-determined timeframe.

SUSTAINABILITY

We assessed the prospects for handing over and replicating the decentralization initiative. As a humanitarian organization we recognize that MSF does not generally prioritize sustainability as conceptualized within the development sector [45,46]. However, the decentralization initiative specifically

aims to transfer the initiative to HZ authorities, replicate the initiative at other health centers, and encourage adoption of the initiative within and beyond MSF. Drawing on the Kananga project's 2022-2023 roadmap, interviews, and observations of the implementation of activities in the field we believe the prospects for sustainability within the 15-month timeframe are modest.

Elements of the initiative have a high probability of being replicated, but overall the sustainability potential is moderate

Effective, evidence-based interventions have the potential for replicability, especially when planning, implementation, monitoring, and evaluation is rigorously documented [29,47]. The core components of the decentralization initiative are evidence-based and evidence-informed and are highly relevant to the local context. This enhances the potential for replicability.

However, there are a number of elements of the decentralization initiative, as currently conceptualized and implemented, that limit sustainability. Fundamentally, the lack of clarity on what the decentralization initiative is serves as a barrier to sustainability. In addition to developing consistent terms and definitions, it is also important to consider and detail a theory of change. Although theories of change are often most useful when developed at the outset of a project or initiative [48], there may still be utility in developing a post-hoc theory of change to ensure shared understanding of the key concepts and objectives.

Similarly, the decentralization initiative lacks a logic framework. Although a results framework exists for the larger Kananga project [34], we were unable to identify a logic or results framework specific to the decentralization initiative. Developing a set of SMART indicators and setting clear targets would increase its potential for replication, adoption, and scale-up. The decentralization initiative also lacks a systematic process for documenting implementation, resource allocation, and learnings. Understanding the costs and effectiveness of the initiative and being able to conduct an analysis of contribution of the initiative would enhance evaluability and ultimately replication and sustainability.

GENDER AND HUMAN RIGHTS MAINSTREAMING

The decentralization initiative aims to improve the provision and utilization of SGBV-related services in the Tshikula HZ and the Kamuandu health area, in particular. This project explicitly focuses on the needs of women and girls who are SGBV survivors. By definition, this project takes gender dimensions into consideration and thus overall gender mainstreaming is high. However, the age dynamics of the community where the project is being implemented have only been modestly considered and intersectional issues (including disability and sexual and gender minority status) have not been explicitly addressed.

Overall gender and human rights mainstreaming

Our document review on the profile of SGBV survivors in Central Kasai province revealed that approximately 98% of documented incidents in 2022 were reported by women, adolescents, and young girls [24]. Girls between the ages of 12 and 17 are disproportionately impacted by SGBV. Indeed, in the

first quarter of 2022, girls in this age cohort accounted for 44% of the 2,040 SGBV cases reported in Central Kasai [24]. At the KHC, 10 of the 20 survivors (50%) who sought health care through the end of July 2022 were under the age of 18 as evidenced by the KHC clinical charts. Rape and sexual assault are among the most reported incidents; the majority of these reported acts are allegedly perpetrated by community members (68%), by the DRC Armed Forces and police (23%), and by armed men not otherwise identified (19%). Community members who are perpetrators fall into four main categories: unknown (30%), known community members (21%), intimate partners (16%), and teachers (8%) [24]. Little information is available about men or boys who are survivors of SGBV.

Our review of initiative-related documents and interviews with key informants indicate that the health promotion messages and community awareness campaigns are aimed at a general population and not tailored to this younger subgroup of survivors [48]. Moreover, these messages are conveyed by community outreach workers, most of whom are men, through a door-to-door approach. This gendered dynamic – men from the community going door-to-door to reach women in the community and discuss SGBV and related services – may not be the most effective vehicle raising awareness, especially among adolescents and young girls. Combined with the geographic and financial barriers that adolescents and young girls living in harder to reach areas must overcome to initiate or continue SGBV-related care, it appears the decentralization initiative is not especially responsive to SGBV survivors in this age cohort.

The decentralization initiative would also benefit from being more intentional about addressing intersectional needs of beneficiaries, particularly with respect to women living with disabilities. As a key informant from the MOH explained:

> "Let's take the [deaf-mute] – the provider who listens has a barrier. That is, they have not been trained in sign language. So, communication with the survivor is going to be a problem. But it is a need; we had developed [and submitted] a proposal to a partner to ask if it would be possible …at the city level, to experiment with some trainings where people could learn sign language to communicate with deaf-mute [survivors]. They are there! [The activity has not yet been funded]."
>
> A key informant from the MOH

Although it may need time and resources to ensure that services are more inclusive, the decentralization initiative could collect routine information about the ability/disability status of SGBV survivors. Disaggregating information by age and disability status would help document differential needs and enhance gender and human rights mainstreaming.

LIMITATIONS

We were able to conduct data collection in the field over a two-week period in July 2022. Although we were well received by the local staff, there were challenges associated with data collection. First, we did not have a lot of time to recruit and interview program participants (SGBV survivors who sought care through the decentralization initiative). This limited the number of people we were able to engage with and thus we did not reach thematic saturation. Although we are confident that our results are transferable, for Phase 2 we will endeavor to interview a larger sample of beneficiaries from a larger range of geographic areas. Our Phase 1 evaluation is also limited by both existent program documents and materials and our access to those documents. We reviewed all materials provided to our evaluation team at both the outset and during the data collection phase of this evaluation. However, there may be other documents (for example, emails between program staff) or other internal forms of communication (group/team meetings and webinars) where information about the decentralization initiative was communicated that we were not privy to. There may be greater clarity around what to call the focus of this evaluation (model, approach, initiative, sub-project, activity) through these types of materials. However, this lack of clarity is also a finding of our evaluation and suggests a possible next step for strengthening the decentralization initiative and its potential impact.

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RECOMMENDATIONS

Based on our evaluation we offer a number of recommendations. We have grouped our first set of recommendations into stages of project design and development: conception, implementation, and follow-up. We appreciate that some of these recommendations, particularly those related to conception, may be "too late" for the decentralization initiative, as the initiative has already been conceptualized. However, we hope these recommendations will help the MSF Kananga team identify ways to refine the conceptualization of the initiative and increase clarity regarding its scope. We also hope these recommendations will be useful for MSF's future endeavors.

Recommendation 1: With respect to CONCEPTUALIZATION:

- Better define the scope of the initiative. This will enhance internal coherence and overall understanding.
- Make more explicit the criteria for selecting sites. Selecting the HZ based on the vulnerability of its population to SGBV would increase overall relevance and be more responsive to gender and human rights considerations.
- Develop an explicit theory of change and logic model to justify the choice of the decentralization initiative and its corresponding phases, strategies, and activities. This would enhance the effectiveness, potential impact, and sustainability of the initiative and ensure common understanding by all partners.
- Adjust its approach to integrating care in the KHC in collaboration with other local stakeholders. This would enhance both external coherence and effectiveness.
- Consider using an integrated health promotion approach instead of relying on door-to-door awareness raising. This would have the potential to improve the effectiveness of community outreach activities.

⇒ Recommendation 2: With respect to IMPLEMENTATION:

- Consider signing a detailed referral protocol with partner/receiving organizations in order to support better legal assistance and protection of SGBV survivors. This would enhance the effectiveness, potential impact, and sustainability of the initiative.
- Ensure coordinated implementation approaches in the Tshikula HZ to avoid duplication of efforts. This would increase efficiency and effectiveness.
- Establish the planned resilience committees. This would strengthen the prospects for sustainability.

⇒ Recommendation 3: With respect to FOLLOW-UP:

• Strengthen the monitoring and evaluation mechanism of the initiative. This would support informed decision-making, increase efficiency and effectiveness, and potential for replication.
• Consider setting up a simple monitoring system to determine legal aid outcomes and the extent to which project buy-in has been achieved. This system could also be designed to document facilitators and barriers to seeking and obtaining SGBV-related services. This would enhance the effectiveness and potential impact of the initiative.

⇒ Recommendation 4: With respect to RESOURCE ALLOCATION, MOBILIZATION, COORDINATION and ADVOCACY (These recommendations may apply throughout the initiative's life cycle and may also inform future MSF initiatives):

• The MSF Kananga team should develop a stand-alone budget for the decentralization initiative. This will enhance transparency and the potential impact and sustainability of the initiative.
• MSF should consider investing in monitoring and evaluation (M&E) capacity. In house capacity could assist with development of the M&E Plan for the overarching project as well as the decentralization initiative, including indicator selection, target setting, reporting, database management, and developing M&E /performance plans
• MSF should consider complying with the reporting requirements established by the DPG in order to provide data/indicators in a compatible format. This would enhance harmonization and efficiency.
• MSF should continue to advocate for the dissemination and adoption of the Maputo Protocol to ensure that rape survivors have access to comprehensive abortion care in the DRC. This would increase harmonization of standard of care protocols and enhance both effectiveness and potential sustainability.

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CONCLUSIONS

The objectives of the Phase 1 evaluation were to appraise the progress of the decentralization initiative, review whether the initiative as designed is likely to meet its objectives and suggest ways to strengthen implementation of the decentralization initiative. Through this evaluation we have identified a number of specific challenges and opportunities related to project design, the impact of external factors on the project, and the process of implementation. Decentralization in its fullest sense includes decision-making, resource allocation, and service provision and is ongoing process that requires good design and buy-in from all stakeholders. The initiative has made an impressive start but there are number of avenues by which the project team can improve implementation and enhance the relevance, coherence, efficiency, effectiveness, impact, sustainability, and gender and human rights mainstreaming.

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ANNEXES

ANNEX A: DESK REVIEW PROTOCOL

1.0 Objectives

The objective of this desk review is to gain insight into what information is available about sexual and gender-based violence (SGBV) services, including associated contraception and abortion care, in the Democratic Republic of Congo (DRC), with a focus on its availability and utilization of services in the Central Kasai region.

1.1 Primary research question

- What do we know about the availability and use of SGBV services, including contraception and abortion care, in the DRC with a focus on the Kasai Central region?

1.2 Secondary research questions

- What is the overall SGBV context in the DRC?
- What is the availability of SGBV services, including associated contraception and abortion care, in the DRC?
- What are the facilitators and barriers to the access and/or use of SGBV services, including associated contraception and abortion care, in the DRC?
- What are the roles and contributions of the DRC Ministry of Health, Médecins Sans Frontiers (MSF), and other humanitarian organizations in improving access to and use of SGBV services in the DRC?

2.0 Introduction

The DRC remains one of the most complex humanitarian contexts in the world. Waves of political unrest and armed conflict, combined with sporadic public health emergencies and natural disasters, continue to result in massive population displacement within and outside the country. United Nations (UN) agencies, international non-governmental organizations (NGOs), and international development agencies have operated in the country for decades.

Médecins Sans Frontières (MSF) has been working in the DRC since 1977, through varied long-term projects, as well as through local emergency response. In 2017 MSF launched the Kananga Project to provide emergency medical assistance to survivors of SGBV in the Central Kasai province, a region plagued by the security crisis. The Kananga Project aims to: 1) Improve access to SGBV and complex family planning care; and 2) Strengthen the capacity of health care providers to care for survivors of sexual violence at the health center level. With an objective to understand better whether the project has achieved the expected results and identify ways to improve the process for further replication and scale-up, MSF commissioned a team from Cambridge Reproductive Health Consultants (CRHC) and the University of Ottawa (uOttawa) to undertake a multi-methods evaluation. Through this desk review, the evaluation team will compile existing secondary data to document the SGBV context in the DRC, in general, and Central Kasai, in particular, and understand better the availability of usage of SGBV services, including associated contraception and abortion care.

3.0 Desk review approach

We have designed this desk review as a modified scoping review. Our approach adheres to the methodological framework first proposed by Arksey and O'Malley (2005) and later revised by Levac, Colquhoun, and O'Brien (2010).

3.1 Identifying the research question

We adopted our research questions from a preliminary review of the Kananga project documents and discussions within the larger project team. These questions will guide the scope of this review.

3.2 Identifying relevant data sources

We plan to consider a wide range of source material in this review. We expect to include any peer-reviewed published studies, policies, reports, and standard of care guidelines from the Government of the DRC, and reports and documents from MSF and other relevant NGOs (see below). In addition, we will go through the reference list of all relevant studies and reports to make sure we have captured other pertinent source material. Since Kasai Central province was a part of the Kasai Occidental Province prior to 2014 and we are particularly interested the SGBV situation after the Kamuina Nsapu insurgency in 2016 (Hoebeke, 2017), our review will focus on source material from 2014 to 2022 (inclusive). We will include literature published in English or French as well as documents that focus multiple countries and/or comparative studies, including the DRC.

Table 1. Inclusion and exclusion criteria

Population	All populations included
Included concept	Sexual and gender-based violence, contraception, abortion
Included context	Democratic Republic of Congo
Types of evidence source	All source types included
Inclusion date and languages	2014-2022, English, French
Exclusion date and languages	Before 2014, any language other than English or French

For the grey literature search, we will comply with the guidelines set forth by the Canadian Agency for Drugs and Technologies in Health (CADTH, 2019). We intend to conduct this search through Google Scholar. We will use the permutations of keywords "sexual and gender-based violence" and "the Democratic Republic of the Congo" and search the first ten pages for a total of 100 results of potentially relevant findings. We will chart the results and remove duplicates. In addition, we will review the websites of organizations actively working to provide SGBV, including contraception and abortion care, in the DRC.

The ongoing Kananga Project documents will be an important source of information for this desk review. We have access to key project documents through shared files and have requested additional documents from the MSF team. We are also in the process of collecting locally available data (from MSF, local health authorities and other humanitarian actors) from the field (Kasai Central.

3.3 Summarizing and reporting the findings
We will document characteristics of the collected source materials (type of publication, language, format, etc.) and we will generate a narrative summary of the findings using standard content, thematic, and discourse analytic techniques. We will report the findings using the *PRISMA Extension for Scoping Reviews (PRISMA-ScR)* guidelines.

3.4 Consultation
We will be holding validation workshops/meeting as part of the broader evaluation. We will incorporate our findings from the desk review into these session in order to get feedback from stakeholders and identify additional source material.

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APPENDIX B: INTERVIEW GUIDES

Semi-structured interview guide with external stakeholders

Introduction

Hello, my name is Dr. Cady Nyombe and I work for Cambridge Reproductive Health Consultants and the University of Ottawa. Thank you for taking the time to speak with me today. We would like to invite you to participate in this interview. I would like to learn about your knowledge and experience regarding health care services for the survivors of sexual and gender-based violence in Central Kasai and your collaboration with the Kananga Project. The interview will take about 30 minutes and would like to audio-record the interview so that I can capture what you say. However, your name and other personally identifiable information will not be shared with anybody except other members of the research team. We also will not attribute any quotations or other information to you as an individual in any reports or presentations that result from this evaluation. You can ask to turn off the recorder at any time.

Do you consent to participate in the interview?

Yes

No

Do you consent to recording the interview?

Yes

No

General information

1. Please begin by telling me a little bit about yourself.
   Probes/prompts: Professional role, educational experience, affiliated organization/institutions, duration of work in Central Kasai specifically?
2. Please tell me (more) about your work related to SGBV issues.
   Probes/prompts: Professional experiences, roles, duration of time, etc.

Safety and protection of women and girls, men and boys

Now I would like to ask you a series of questions about the security and protection conditions for women, girls, men, and boys in Central Kasai.

3. Please tell me about SGBV in this community.
   Probes/prompts: Prevalence of SGBV, types of violence, gender/demographics of survivors and perpetrators
4. In your opinion, what factors contribute to SGBV in this community?
   Probes/prompts: Gender, poverty, culture, disability status, education level, etc.
   Probes/prompts: Main/most important factor
5. Please tell me about any specific groups that are most at risk of the forms of violence you mentioned.
   Probes/prompts: Women, girls, particular tribes or ethnic/religious communities, people with disabilities, sexual minorities, etc.
6. Please tell me about any specific groups that are most likely to be perpetrators of the violence you mentioned?
   Probes/prompts: Men, particular tribes or ethnic/religious communities, military personnel, other family members, other groups

Community response to SGBV

7. What are community/local authority/civil society organizations (churches, mosques, NGOs) doing to prevent and respond to SGBV?
   Probes/prompts: Interventions against SGBV, major actors, policies
8. Tell me about what happens to perpetrators of SGBV in this community.
   Probes/prompts: Family, community, law enforcement

Care-seeking behaviours and community preparedness

9. Tell me what people usually do after they have been exposed to SGBV?
   Probes/prompts: Health center, religious institutions, family, health agent, village chief, community workers, police, etc.
   Probes/prompts: Types of violence

10. In your opinion what facilitates the ability of women and girls to seek SGBV services in this community?
   Probes/prompts: Family support, community support, type of violence, education, socio-economic level, other demographics
   Probes/prompts: Availability of services, accessibility of services, knowledge of services, quality of services, stigma, fear
   Probes/prompts: Is this different for men and boys who seek services? Specific sub-populations?

11. In your opinion what barriers do women and girls experience when seeking SGBV services in this community?
   Probes/prompts: Family support, community support, type of violence, education, socio-economic level, other demographics
   Probes/prompts: Availability of services, accessibility of services, knowledge of services, quality of services, stigma, fear
   Probes/prompts: Is this different for men and boys who seek services? Specific sub-populations?

12. In your opinion what facilitates the ability of women and girls to report incidences of SGBV in this community?
   Probes/prompts: Family support, community support, type of violence, education, socio-economic level, other demographics
   Probes/prompts: Availability of services, accessibility of services, knowledge of services, quality of services, stigma, fear
   Probes/prompts: Is this different for men and boys who seek to report? Specific sub-populations?

13. In your opinion what barriers do women and girls experience when seeking to report incidences of SGBV in this community?
   Probes/prompts: Family support, community support, type of violence, education, socio-economic level, other demographics
   Probes/prompts: Availability of services, accessibility of services, knowledge of services, quality of services, stigma, fear
   Probes/prompts: Is this different for men and boys who seek services? Specific sub-populations?

14. Please tell me about any steps that are being undertaken by community/local authority/religious institutions to protect people from SGBV?
   Probes/prompts: Case detection, referral, awareness etc.

Availability and accessibility of services

15. Tell me about any organizations/facilities in this area that are actively providing assistance to SGBV survivors?
   Probes/prompts: Health center, religious institutions/leaders, family, health agent, village chief, police, etc.
   Probes/prompts: Type of violence

16. What services are generally offered by these organizations/facilities for SGBV survivors in your community/health area?
   Probes/prompts: Survivors' physical, sexual, and reproductive health, mental health, justice, safety, and socioeconomic reintegration needs.
   Probes/prompts: Type of violence

17. Are existing SGBV services accessible to all members of the community/health area? Please explain.
   Probes/prompts: People living with disabilities? Adolescents/young girls? Men and boys? Other sub-groups?

18. Please tell me about any collaborations or partnerships in this area that focus on preventing or responding to SGBV issues.
   Probes/prompts: Existing partnerships, partnership with MSF, opportunities/forums for partnership.

SGBV prevention and response programs in Central Kasai/DRC

19. What changes, if any, have you observed in the "landscape" of SGBV prevention and response in the last five years?

> *Probes/prompts: New actors, funding, outreach activities, Any changes in terms of prevalence and vulnerable populations? Any changes in terms of perpetrator profile?*

20. Can you describe for me a program or initiative that has been particularly successful?

> *Probes/prompts: Details*

21. Can you describe for me a program or initiative that has been particularly unsuccessful?

> *Probes/prompts: Details*

22. Are you familiar with the Kananga Project?

> *Probes/prompts: If yes, ask how participant learned about it, if participant knows anyone who has used the services, opinions about the project, how it could be improved*
>
> *Probes/prompts: If no, provide a brief description and ask for participant's opinion about the project*

Recommendations for services improvement, including access

23. In your opinion, what could be done to improve SGBV services in this area?

24. In your opinion, what could be done to improve SGBV reporting in this area?

25. In your opinion, what could be done to improve collaborations and coordination around SGBV prevention and response programs in this area?

Conclusion

Thank you very much! These are all questions I have.

- Is there anything else you would like to add?
- Is there anything you would have liked me to ask, but that I left out?
- Do you have any questions for me?

Thank you! This concludes our conversation today. Thank you for your participation. All the information you have given us today will be very useful to us. Again, we assure you that it will be kept confidential.

Semi-structured interview guide for Kamuandu Health Center clients

Introduction
Hello, my name is Dr. Cady Nyombe and I work for Cambridge Reproductive Health Consultants and the University of Ottawa. Thank you for taking the time to speak with me today. We would like to invite you to participate in this interview. We would like to learn about your knowledge of and experience with SGBV services at this health centre. The interview will take about 30 minutes and would like to audio-record the interview so that I can capture what you say. However, your name and other personally identifiable information will not be shared with anybody except other members of the evaluation team. We also will not attribute any quotations or other information to you as an individual in any reports or presentations that result from this evaluation. You can ask to turn off the recorder at any time.

Do you consent to participate in the interview?
Yes
No

Do you consent to recording the interview?
Yes
No

General information
1. Please begin by telling me a little bit about yourself.
    Probes/prompts: Age, marital status, number of children, education level, occupation, tribe/ethnicity, region/place of origin, etc.
2. Where do you currently live?
    Probes/prompts: Distance from health center

Access to general healthcare
Now I'd like to ask you some questions about health care in your community.
3. To begin, tell me about the most important health issues in your community?
4. Now I'd like you to tell me about the health services available in this community?
    Probes/prompts: Types of services, availability of services, organizations providing services
5. How do people in this community know about the availability of services?
    Probes/prompts: Sources of information, outreach activities, word-of-mouth
6. In your opinion what facilitates the ability of women and girls to seek health services in this community?
    Probes/prompts: Family support, community support, education, socio-economic level, other demographics
    Probes/prompts: Availability of services, accessibility of services, knowledge of services, quality of services, stigma, fear
    Probes/prompts: Is this different for men and boys who seek services? Specific sub-populations?
7. In your opinion what barriers do women and girls experience when seeking health care?
    Probes/prompts: Family support, community support, education, socio-economic level, other demographics
    Probes/prompts: Availability of services, accessibility of services, knowledge of services, quality of services, stigma, fear
    Probes/prompts: Is this different for men and boys who seek services? Specific sub-populations?
8. Please tell me about any gaps in the health services that are available in this area.
    Probes/prompts: Sexual and reproductive health, services for specific sub-populations of interest

Reproductive health history
Now I'd like to ask you a few questions about your reproductive health history.
9. How would you describe your reproductive health overall?
    Probes/prompts: Current problems/conditions
10. Please tell me about any important or memorable reproductive health events in your life?

Probes/prompts: Collect details of each event, including the number of pregnancies, deliveries, abortions, and miscarriages

11. Where do you usually seek sexual or reproductive health services?

Probes/prompts: Health center, hospital, NGO services, traditional practitioners/matrons, etc.

Probes/prompts: Why do you choose to obtain services from these providers?

Experience with sexual violence

I understand that you recently received services through the Kananga project. In order to learn about your experience with those services, I would like to ask you a few questions about the violence that you experienced prior to using the services. I know that it takes a lot of courage to talk about something so personal and I want to thank you for sharing your story with us. I also want to remind you that you can stop the interview at any time and that you don't have to answer my questions if you don't want to. We can also take a break if you need to.

12. Please tell me about the violence that you experienced that brought you to the health center for services?

Probes/prompts: Type of violence (sexual, physical, emotional, etc.), date/year, and location

Probes/prompts: Relationship to the perpetrator(s)

13. Have you spoken with anyone about the violence you experienced?

Probes/prompts: If yes, with whom and why? If not, why not?

Probes/prompts: Reactions of people you

Sexual violence care and support

Thank you for sharing this with me. Now I would like to ask you a few questions about the SGBV care that you received at this health center.

14. Tell me about what brought you to seek care through this health center/Kananga Project?

Probes/prompts: How did you know that SGBV care was available at this health center?

Probes/prompts: Source of information, referred by ambassadors, peers (another victim), police, etc.

15. How did you make the decision to seek health care?

Probes/prompts: Sources of support surrounding the decision to use health care

Probes/prompts: Types of care needed/desired

16. Please tell me about the care you received?

Probes/prompts: Walk through the first encounter, discuss subsequent encounters

Probes/prompts: Explore non-medical services – legal support, protection, family engagement

17. What do you think about the service you received at this health center?

Probes/prompts: Were needs and expectations met? Why/why not?

Probes/prompts: Tell us what you liked most and why?

Probes/prompts: Tell us what you didn't like most and why?

18. Please tell me about any challenges you experienced in accessing services in this health centre?

Probes/prompts: Family support, community support, type of violence, education, socio-economic level, other demographics

Probes/prompts: Availability of services, accessibility of services, knowledge of services, quality of services, stigma, fear

Probes/prompts: Intersectionality/sub-population issues

19. Would you recommend this health center to others in your community?

Probes/prompts: Why/why not? Explore sub-population issues

Recommendations for improvement

Thank you very much – we are almost done! Now I'd like to ask you some questions about how SGBV services could be improved in your community.

20. In your opinion, what could be done to improve SGBV services in this health center?

Probes/prompts: Availability of services, accessibility of services, knowledge of services, quality of services, confidentiality

21. In your opinion, what could be done to improve SGBV services in your community?

Probes/prompts: Availability of services, accessibility of services, knowledge of services, quality of services, confidentiality

22. In your opinion, what could be done to prevent SGBV in your community?
    Probes/prompts: Community support, awareness, socio-economic supports
23. In your opinion, what could be done to support SGBV reporting in your community?
    Probes/prompts: Family support, community support, awareness, socio-economic supports
    Probes/prompts: Availability of services, accessibility of services, knowledge of services, quality of services, stigma, fear, legal services, rehabilitation services

Conclusion

Thank you very much! These are all questions I have.

- Is there anything else you would like to add?
- Is there anything you would have liked me to ask, but that I left out?
- Do you have any questions for me?

Thank you! This concludes our conversation today. Thank you for your participation. All the information you have given us today will be very useful to us. Again, we assure you that it will be kept confidential.

APPENDIX C: BIOGRAPHIES OF EVALUATION TEAM MEMBERS

The evaluation team consists of five external evaluators with proven expertise in conducting program evaluations in humanitarian settings, conducting participatory and applied research, developing programs to respond to the needs of survivors of sexual and gender-based violence (SGBV), and disseminating findings to diverse audiences.

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

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

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

Meg Braddock, Senior Technical Advisor, is a freelance consultant with extensive experience in design, technical support and evaluation of sexual and reproductive health and rights and SGBV programmes in Africa, Asia, and Latin America. She has worked for United Nations agencies, country governments, non-governmental organizations, and donors, and has been involved in SGBV prevention and support programmes at policy development level as well as on the ground implementation in health systems and communities. She holds master's degrees in Physics, Operational Research, and Economics. She will provide technical support and input to the team in evaluation design, data analysis and report-writing.

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

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