

EVALUATION ON

Improving The Availability & Use of SGBV Services in Central Kasai, DRC**- RESULTS FROM THE PHASE 2 EVALUATION OF THE KANANGA PROJECT**

October 2023 | Angel M Foster, Cady Nyombe Gbomosa, Manizha Ashna, Meg Braddock and Nished Rijal

BACKGROUND

In 2017, Médecins Sans Frontières (MSF-OCB) launched the Kananga project to provide emergency medical assistance to people affected by the Kamwina Nsapu conflict in the Central Kasai. In 2020, MSF initiated the “decentralization initiative” aiming to 1) Improve access to SGBV care, including contraception and abortion care; and 2) Build staff capacity to provide holistic medical support to survivors at the health center level.

From April 2022 to March 2023, MSF piloted the decentralization initiative at the Kamuandu Health Center (CSK) in the Tshikula Health Zone.

In 2022, a two-phase developmental evaluation of the decentralization initiative was commissioned. Phase 1 assessed the design, planning, and prospective implementation of the decentralization initiative. Phase 2, which is the focus here, was carried out in June 2023 and assessed the results of the implementation and handoff of the decentralization.

METHODOLOGY**MIXED-METHODS APPROACH****DESK REVIEW****SECONDARY ANALYSIS OF DATA****18 SEMI-STRUCTURED INTERVIEWS****RECOMMENDATIONS**

- 1 • Develop a holistic strategy and comprehensive theory of change for a multi-sectoral response;
- 2 • Design and implement a clear theory-based, multi-component, and coherent intervention that matches the country’s wider response and global MSF strategy (once elaborated);
- 3 • Ensure an appropriate collaborative and multi-sectoral response to SGBV;
- 4 • Integrate from the outset and effectively resource community-driven initiatives;
- 5 • Develop a stand-alone monitoring and evaluation plan;
- 6 • Incorporate human rights, health equity, and intersectional issues into all project phases;
- 7 • Consider MSF staff rotation and other health system issues in project planning.

FINDINGS

The decentralization initiative was relevant to the local needs and the DRC government’s priorities but a more holistic approach prioritizing survivors’ comprehensive medical and psychosocial needs and adequate community mobilization-related activities would have enhanced its appropriateness.

The external coherence was high with an alignment of the Pilot’s strategy with the DRC government’s priorities and national strategy for combating SGBV, as well as complementarity with other SGBV programs. In contrast, internal coherence was more mixed: some activities were not aligned with intended outcomes and implementation context.

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

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

The potential impact of the Pilot is relatively high, with strategies proven to have great potential for transformative change. However, planning and implementation pitfalls and the DRC’s health systems constraints reduced the Pilot’s prospect for impact.

The Pilot presented limited potential for sustainability. Lack of medical supplies and financial support were reported as significant obstacles to continuity of care. The context and the inherently complex nature of the sexual violence and health behavior change posed an immediate threat to the sustainability of the achievements.

The Pilot was clearly gender-responsive. However, special attention could have been given to the neglected issue of boys and men as survivors. The Pilot was designed and implemented without explicitly addressing intersecting vulnerabilities of survivors, including ability/disability status, age, and literacy.