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PRESIDENT'S MALARIA INITIATIVE EXPANSION PROJECT IN THE DEMOCRATIC REPUBLIC OF THE CONGO FINAL PERFORMANCE EVALUATION REPORT

December 2017

This publication was produced at the request of the United States Agency for International Development. It was prepared independently by Jeannie Brown (Team Lead), Hilaire Zon, Leonard Kasereka, and Bavon Mupenda.

Cover Photo: A woman holding a USAID-funded insecticide-treated bed net at a Maternal and Child Health Center in Kinshasa, Democratic Republic of the Congo. Credit: Kaukab Jhumra Smith/USAID

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ABSTRACT

The President's Malaria Initiative (PMI) Expansion Project (PMI-EP) is a five-year USAID cooperative agreement through the PMI initiative started on October 18, 2012, and scheduled to end on October 17, 2017. The purpose of the project is to support the Democratic Republic of the Congo in efforts to increase coverage and use of key malaria interventions and to strengthen the health system to provide sustainable, high-quality preventive and curative services.

This final performance evaluation is intended to help assess: 1) increased use of malaria prevention interventions; 2) improved malaria diagnosis and treatment; 3) strengthened health system to support malaria programs; 4) facilitating and limiting factors; 5) innovative approaches; and 6) recognition of USAID and PMI support. The evaluation consisted of a review of project background documents, field visits for data collection, and triangulation to compare existing baseline data to currently available data.

The key findings revealed overall the project has made significant contributions to the increase in availability and access to malaria prevention, diagnostic, and treatment interventions. This is especially commendable given the constraints the project has faced in terms of inadequate communications networks and extremely poor condition of roads, weak existing capacity of the health system and supply chain management system, and lack of adequate financial motivation of health workers.

Based on these evaluation findings, it can be concluded that PMI-EP has contributed to an increase in availability and use of malaria prevention and treatment products and services. It is recommended that future malaria projects expand upon and sustain these achievements.

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ACRONYMS

ACT	artemisinin-based combination therapy
ANC	antenatal care
ASF	*Association de Santé Familiale*
CCS	Community Care Sites
CDR	*Centrale de distribution régionale* (regional distribution center)
CHW	Community Health Workers
DHIS2	District Health Information System software 2
DHS	Demographic and Health Survey
DPS	*Division Provinciale de la Santé* (Provincial Health Directorate)
DRC	Democratic Republic of the Congo
EPI	Expanded Programme on Immunization
FC	Congolese franc
FGD	focus group discussion
GH Pro	Global Health Program Cycle Improvement Project
GODRC	Government of the DRC
HC	Health Center
HF	Health Facility
HMIS	Health Management Information System
HSS	Health System Strengthening
HZ	Health Zone
IHP	Integrated Health Project
IMCI	integrated management of childhood illness
IPTp	Intermittent Preventive Treatment in pregnancy
IR	intermediate results
KII	key informant interview
KSPH	Kinshasa School of Public Health
LLIN	long-lasting insecticide-treated net
LSTM	Liverpool School of Tropical Medicine
M&E	monitoring & evaluation
MICS	Multiple Indicator Cluster Surveys
MOH	Ministry of Health
NMCP	National Malaria Control Program

PMI	President's Malaria Initiative
PMI-EP	President's Malaria Initiative Expansion Project
PSI	Population Services International
RDT	Rapid Diagnostic Test
SBCC	social behavior change communication
SCM	supply chain management
SNAME	*Système National d'Approvisionnement en Médicaments Essentiels*
SOW	scope of work
SP	sulfadoxine-pyrimethamine
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

EVALUATION BACKGROUND, PURPOSE AND QUESTIONS

The President's Malaria Initiative Expansion Project (PMI-EP) is a five-year cooperative agreement. The project complements other PMI-funded projects in the Democratic Republic of the Congo (DRC). The project started in October 18, 2012, and is scheduled to end October 17, 2017.[1] Population Service International (PSI) leads the consortium implementing the project, and partners have included three international organizations, Liverpool School for Tropical Medicine (LSTM), Hera, and Greenmash, as well as three local organizations, *Association de Santé Familiale* (ASF), Caritas Congo, and the Kinshasa School of Public Health (KSPH). Project partners also work closely with the National Malaria Control Program (NMCP), and all levels of the Ministry of Health (MOH)—central, provincial, zone, community. The purpose of PMI-EP is to support the government of the DRC (GODRC)/NMCP in efforts to increase coverage and use of key life-saving malaria interventions and to strengthen the various levels of the health system to be able to provide sustainable, high-quality preventive and curative services.

This final performance evaluation is intended to help determine to what extent its original goals have been achieved and what could be changed or improved upon for similar future malaria initiatives. The fieldwork for the evaluation was conducted in two provinces, and available data from routine reporting was used for all nine provinces where PMI-EP operates. Program targets for Year 5 take into account the rationalization of Health Zones (HZs), after which the number of project-supported HZs declined from 68 to 54 in six provinces.

The provinces where fieldwork was conducted were selected based on considerations related to security, accessibility within the timeframe for the evaluation, presence of other malaria partners (Sud-Kivu) and hard-to-reach zones (Tshopo), and upon agreement with USAID PMI staff. The evaluation, funded by USAID and conducted in May and June 2017, consisted of five steps: review of projects and other relevant projects'/programs' background documents/materials; field visits for data collection using semi-structured interviews with key informants; triangulation to compare existing baseline data to currently available quantitative and qualitative data; preliminary presentation to USAID and implementing partners, as well as NMCP; and this report.

The evaluation sought to answer six questions, three of which are directly related to the intermediate results (IR) expected of the project:

1. To what extent has there been an increased use of malaria prevention interventions, particularly the increased availability and use of intermittent preventive treatment in pregnancy and increased supply and use of long-lasting insecticide-treated nets (LLINs)? (IR1)
2. To what extent have malaria diagnosis and treatment interventions been improved? (IR2)
3. To what extent has the health system been strengthened to manage malaria preventive and treatment interventions? (IR3)
4. What main factors, including those that are gender related, facilitated or posed challenges to the successful achievement of the project objective?
5. What innovations has the project introduced and consolidated?
6. How well are PMI and USAID support activities through PMI-EP recognized?

1 The end date of PMI-EP was changed to December 31, 2017.

MAIN FINDINGS

Overall, PMI-EP has made significant contributions to the increase in availability and access to malaria prevention, diagnostic, and treatment interventions throughout the health system. This is especially commendable given the constraints that the project has faced over the last four years, in terms of infrastructure, security, and certain commodity supply issues that were out of its control.

Question 1 (IR1): Demand for LLINs seems to have reached a "tipping point," as observations indicated that the majority of families use at least one, most of which were obtained through an antenatal or child health visit at the Health Center (HC) or through a mass campaign. A vast majority of households visited with pregnant women and children under 5 owned at least one LLIN, and their use by these vulnerable groups is widespread and considered a priority by all. Use of Sulfadoxine-Pyrimethamine (SP) is also widespread, and the number of women making antenatal visits to HCs has steadily increased. In 2016, on average, 62.5 percent of women had a least two doses of Intermittent Preventive Treatment (IPT) at antenatal care (ANC) visits, compared to 41 percent in Project Year 1. The percentage of HCs with SP stockout dropped from 54.3 percent to 10.7 percent.

Frequent stockouts of LLINs and SP are the main barriers to further increases in prevention of malaria in pregnancy. Nearly all focus group participants who did not use an LLIN said that they did not have one because the Health Facility (HF) did not have any when they attended their ANC visit.

While some of these stockouts may have been due to factors outside the control of the project, PMI-EP has not adequately addressed supply chain management (SCM) (Question 3, IR3).

Oversight of the work of the Community Health Workers (CHWs) has not been rigorous. SBCC efforts carried out by CHWs at the community level need to be strengthened, as CHWs have resigned in some sites, while other CHWs had limited tools to support their efforts. Most of those interviewed in the communities had received their information from health providers at the HCs.

Question 2 (IR2): Availability of Rapid Diagnostic Tests (RDTs) and artemisinin-based combination therapy (ACT) through the HCs and especially through the community care sites (CCSs) has improved access to early diagnosis and treatment of malaria.

However, as with IR1, stockouts of these products have also been common at the HCs and in the community. This has sometimes led to a regression in treatment approach such that all fever is treated as malaria, or available treatment medicines have been divided into smaller doses for children. Treatment of complicated malaria at referral hospitals is also constrained by weak availability of artesunate injectable.

Financial barriers have also affected treatment-seeking behavior. While government policy dictates that malaria-related commodities for prevention and treatment are to be offered free of charge, all users in the HCs visited were required to pay between 1,000 Congolese francs (FC) and 2,000FC ($1.50 to $3.00) prior to accessing services or products through antenatal visits or vaccinations. This could be prohibitively expensive for many in remote communities.

Question 3 (IR3): With regard to health system strengthening (HSS), one of PMI-EP's most important achievements has been the expansion and operationalization of the CCSs to bring services and products closer to families. This has eliminated barriers related to travel time or transport, as well as delays in diagnosis and treatment. The comprehensive training of health workers has been another of the project's important successes, as the training has clearly led to improved services offered to clients at the HCs and in the communities. The establishment of regular monitoring and evaluation (M&E) review

and analysis meetings in the HZs has also contributed to strengthening the health system, as they have encouraged providers to submit more complete and timely reports from the HCs. In 2016 the internal and external completeness rate of HCs reports was, respectively, 96.2 percent and 96.1 percent. The promptness rate was 89.2 percent.

However, one of the critical components of HSS—strengthening SCM (IR 3.3)—has largely not been addressed. Evidence of this is the frequent stockouts that have plagued the project over the last four-and-a-half years. During the evaluation, the team observed that three out of eight HCs visited did not have SP, two did not have ACT for infants and children, and two out of eight CCSs visited did not have ACT for infants and children. One out of four HCs in Tshopo did not have LLINs, while none of the four HCs in Sud Kivu had LLINs. The main factors affecting SCM were the limited capacity of HCs and CCSs in managing inventory; the limited logistical capacity of HZ offices to transport commodities to HCs and CCSs; failure to comply with agreed-upon supply schedules; and failure to implement critical systemic SCM strengthening activities as planned, such as the mHealth solution MANGO, an innovative cell phone technology application owned and installed by Greenmash, or any alternative to it.

Ability to manage commodity supply was not consistent across HCs, and in most cases supply management was the responsibility of someone who had another primary job. In addition, infrastructure and security barriers made timely transport from provinces to HZs to communities unreliable. Some of the challenges are not directly controlled by the project, but nevertheless might have eventually been mitigated through MANGO, which was originally included in the project proposal, or by other proposed interventions that could have replaced MANGO when it was terminated.

Question 4: Many factors have facilitated results as well as created barriers to achieving results. Important facilitating factors include placing staff in each province to support implementation of activities, the quality and coverage of training for health workers, the expansion and reinforcement of CCSs, conducting regular M&E meetings at the zone level, as well as the contributions of other malaria projects implementing activities in the same locations.

Among the challenges PMI-EP has faced in achieving results are an inadequate network and extremely poor condition of roads, the weak existing capacity of the health system and SCM system, lack of adequate financial motivation of health workers, and certain management issues.

Importantly, gender did not seem to be a direct barrier to seeking any services at HCs or CCSs.

Question 5: MANGO was to be the primary intervention by which the project would strengthen the existing SCM system. However, this initiative was never fully implemented despite a full investment into it, and the agreement with Greenmash was terminated in October 2016.

Question 6: PMI-EP, PMI, and USAID are well-known by project partners and collaborators, but not by community members. However, everyone recognizes the impact of their activities. Interviews and observations suggest that the marking plan was not implemented effectively.

MAIN CONCLUSIONS AND RECOMMENDATIONS

There are separate and more detailed conclusions and recommendations for each evaluation question in the body of this report. The following are the main overarching conclusions and recommendations:

General: Based on both quantitative and primarily qualitative findings from this evaluation, it can be concluded that PMI-EP has contributed to an important increase in availability and use of malaria prevention and treatment products and services. It is generally recommended that future malaria projects expand upon and sustain these achievements.

Prevention: The project has strengthened access to preventive measures at the HCs. Pregnant women are consistently seeking ANC for IPT, and most women have received at least two doses of SP. Pregnant women and all women and men with children under 5 indicated that they understood the importance for these vulnerable groups to sleep under the nets. It is recommended that SBCC continue both at the HCs and in the community, and be strengthened in future projects to consolidate recent improvements. It is also critical that the SCM system be strengthened to ensure prevention products are consistently available for all pregnant women and children under 5.

Diagnosis and Treatment: As the result of comprehensive training of service providers and CSS community health workers, diagnostic and treatment interventions within HCs and communities now conform to national standards, and access to these services within the nine provinces where the project currently operates has improved. However, as mentioned under Prevention, the timeliness of resupply of products through the supply chain system needs to be improved.

Health System Strengthening: Although PMI-EP was able to make important improvements in some areas of HSS, arguably its weakest aspect was in strengthening SCM, which ultimately affects results for all IRs. Perhaps the most important contribution that future projects could make to sustain and scale up the impact of PMI-EP would be to support the expansion and strengthening of the existing SCM system. Consideration should be given to allocating a greater share of resources toward this goal.

The development of CCSs has removed logistical and infrastructure barriers for families seeking care for their children. The strategic expansion of these sites into the most remote areas and where the need is greatest should be considered.

Health worker training and improvements in data collection and analysis through regular M&E meetings in the HZs have improved management of malaria in the health system at all levels. These interventions are critical to building management and technical skills for service providers and should be continued. Because of frequent staff turnover, it is particularly important that training be continued and systematic.

Quality supervision is not consistently implemented. Ensuring supervisors are technically qualified and offering training on quality supervision in a cascade approach should be considered to ensure rigor in supervision.

The cost of services, including posted and unposted, is a continuing barrier to seeking preventive and curative services at HCs. Donor coordination meetings should continue to discuss the issue of health personnel salary payment and the establishment of an incentive rewarding mechanism (e.g., performance-based financing).

Management: Management of a complex project such as PMI-EP is challenging in any setting. In DRC, this is particularly true because of the vastness of the geographical coverage and travel distances; the extremely weak health system infrastructure, including limited capacity of staff and health workers; and the broken road systems and communications networks. Project leadership persevered through these challenges and succeeded in achieving important results. Nevertheless, based on the findings of this evaluation, it is recommended that future projects put more emphasis on establishing clear expectations and roles for subcontractors at the project design phase (prior to signing agreements); on engaging project sub-partners more in decision-making, including the project operational planning to ensure buy-in and ownership; and on offering regular occasions and channels for communications to strengthen partner relationships—both internal to the project and external. Furthermore, it is recommended that all major interventions, such as MANGO, be carefully assessed within the DRC context prior to being included in project design and proposals.

Infrastructure: Weak infrastructure systems and logistical breakdowns have enormous impact on the efficiency and effectiveness of project implementation. Similar future projects should consider allocating a larger share of resources to these challenges and how to strategically mitigate them.

Partnerships: Stakeholders perceive that they have not been involved enough in the project strategic and operational planning. Soliciting their input more regularly through coordination meetings may strengthen local ownership and sustainability.

I. INTRODUCTION

Though the Democratic Republic of the Congo (DRC) has tremendous natural resources to be developed, it has one of the lowest gross national incomes per capita in the world ($420).[2] An estimated 70 percent of the population lives below the poverty line and half live in extreme poverty.[3]

The DRC health system lacks financial and material resources and supply chain breakdowns are widespread, particularly in remote areas. This leaves a majority of the country with limited access to health care services, and those that exist are often of poor quality. Access to primary health care remains a challenge, with 70 to 80 percent of the population having difficult or no access to health care or not utilizing the care available.

Malaria is reported by the Ministry of Health (MOH) to be the principal cause of morbidity and mortality in the DRC, and the World Health Organization (WHO) reported about 42,000 deaths from malaria in the DRC in 2015. Malaria accounted for more than 40 percent of all outpatient visits and for 19 percent of deaths among children under 5. Plasmodium falciparum accounts for approximately 95 percent of all infections. The 2013-14 Demographic and Health Survey (DHS) supplemental malaria report showed estimates of national malaria prevalence in children 6-59 months ranging from 23 percent to 34 percent. Prevalence based on both microscopy and Rapid Diagnostic Tests (RDTs) increased with age and was higher for those living in rural areas as compared to those living in urban areas.

However, progress has been made over the last 10 years. Malaria-related morbidity and mortality rates have fallen significantly, largely due to malaria control efforts financed by multiple donors, including the President's Malaria Initiative (PMI). The President's Malaria Initiative Expansion Project (PMI-EP) is one of several projects that support service delivery and health system strengthening (HSS) in different geographic areas in the DRC.

I.1 EVALUATION PURPOSE

The purpose of this performance evaluation is to qualitatively assess the extent to which expected project outcomes will be achieved and to inform future USAID/DRC health strategy and design. It also sheds light on the successes and challenges of project implementation and lessons learned for future malaria interventions.

The audience for this evaluation is the USAID/DRC Mission, specifically the Health Office and Program Office, and the PMI-EP implementing partner, Population Services International (PSI). USAID will use the report to adjust its current malaria interventions as appropriate and to share lessons learned with other stakeholders.

I.2 EVALUATION QUESTIONS

The activity objective for PMI-EP is to assist the Government of the Democratic Republic of the Congo (GODRC) in achieving its target of reducing malaria-related mortality by 50 percent, compared to pre-initiative levels. Related to this objective, there are six questions that the evaluation seeks to answer. The first three are aligned with intermediate results (IRs) that the project is expected to achieve, as described on the next page.

[2] World Bank, 2016.
[3] United Nations Development Programme (UNDP) 2014.

Evaluation Question	Intermediate Results Expected
1. To what extent has there been an increased use of malaria prevention interventions, particularly the increased availability and use of intermittent preventive treatment in pregnancy and increased supply and use of long-lasting insecticide-treated nets?	IR1: Increased use of malaria prevention interventions • *1.1 Increased availability and use of Intermittent Preventive Treatment in pregnancy (IPTp)* • *1.2 Increased supply and use of long-lasting insecticide-treated nets (LLINs)*
2. To what extent have malaria diagnosis and treatment interventions been improved?	IR2: Improved malaria diagnosis and treatment interventions • *2.1 Improved diagnostic capacity and use* • *2.2 Improved case management of uncomplicated and severe malaria*
3. To what extent has the health system been strengthened to manage malaria preventive and treatment interventions?	IR3: Strengthened health system capacity to manage malaria prevention and treatment interventions at the operational level (province, health zone (HZ), community) • *3.1 Enhanced technical knowledge, skills, and competencies of health service personnel* • *3.2 Improved provincial, HZ and community capacity to collect, manage and use malaria health information for monitoring and evaluation (M&E)* • *3.3 Improved provincial and HZ capacity in supply chain management* • *3.4 Improved provincial and HZ management teams' capacity to coordinate stakeholders*
4. What main factors, including those that are gender-related, facilitate or pose challenges to the successful achievement of the project objective?	Crosscutting
5. What innovations has the project introduced and consolidated?	Crosscutting
6. How well are PMI and USAID support activities through PMI-EP recognized?	Crosscutting

II. PROJECT BACKGROUND

PMI-EP, a cooperative agreement funded by USAID, began on October 18, 2012, and is scheduled to end on October 17, 2017. It is implemented by a consortium of organizations led by PSI. The consortium includes PSI's local affiliate, Association de Santé Familiale (ASF); two international sub-awards, Liverpool School of Tropical Medicine (LSTM) and Hera; and two local sub-grantees, *Caritas Congo Développement* and the Kinshasa School of Public Health (KSPH). The agreement with Caritas ended in April 2017. A sub-award with Greenmash ended in late 2016.

A PMI-EP banner displayed at a Health Center. *Credit: Jeannie Brown*

The purpose of the project is to support the GODRC/ National Malaria Control Program (NMCP) in efforts to increase coverage and use of key life-saving malaria interventions and to strengthen the various levels of the health system to be able to provide sustainable, high-quality preventive and curative services. PMI-EP complements other USAID-funded and donor-supported malaria programs. It provides assistance to implement a subset of activities outlined in the PMI strategic plan and the annual PMI/DRC Malaria Operational Plans, in accordance with the NMCP guidelines and standards.

The project is supporting routine key malaria interventions, namely correct use of long-lasting insecticide-treated nets (LLINs) among pregnant women and children under 1 year old, intermittent preventive treatment in pregnancy (IPTp) using sulfadoxine-pyrimethamine (SP), and systematic use of RDTs and artemisinin-based combination therapy (ACT) for uncomplicated malaria cases. PMI-EP also supports crosscutting activities to increase the demand through social behavior change communication (SBCC) activities, improved local capacity building, and enhanced monitoring and evaluation (M&E).

The project strategies and approach are summarized in Table 1.

Table 1. PMI-EP Intermediate Results and Key Activities

Intermediate Results	Key Activities
IR 1: Increased use of malaria prevention interventions	• Support the organization of antenatal care (ANC) in health facilities (HFs) to provide IPTp according to the NMCP policy to pregnant women. • Coordinate with the MOH/NMCP and partners to ensure that the national policy of free IPTp is implemented in all HFs in the targeted Health Zones (HZs). • Harmonize pricing for ANC services: conduct advocacy with national and provincial MOH to encourage that ANC services be offered with the lowest possible user fee, and see that this is harmonized among project HZs and nationally. • Support the organization of ANC at HFs to distribute LLINs according to the NMCP policy to pregnant women. • Support the organization of Expanded Programme on Immunization (EPI) in HFs to distribute LLINs according to the NMCP policy to children under 1 year old at the completion of their immunization schedule.

Intermediate Results	Key Activities
	• Provide consistent transport and logistics support to ensure permanent LLIN delivery from HZ to HF level and avoid stockouts. • Reproduce, distribute, and ensure that harmonized tools for routine LLIN distribution tools, such as the beneficiary register, the LLIN inventory sheet, stock reception, and movement documents among HZs, are available at HZ and HF levels. • Coordinate with MOH/NMCP and partners via the Malaria Task Force and during the provincial work planning process to ensure that the national policy of free LLIN distribution is implemented.
IR 2: Improved malaria diagnosis and treatment interventions	• Improve diagnostic capacity and use to ensure systematic parasitological confirmation of malaria in HFs, via malaria microscopy at referral facilities and via RDTs at HFs and Community Care Sites (CCS). • Organize transport of ACT, RDTs, and pre-referral artesunate suppositories from regional distribution centers (CDRs or *centrales de distribution régionales*) and ensure that they are available at HZ, HF, and CCS levels. • Ensure that laboratory technicians, health providers, and community health workers (CHWs) are compliant with the MOH policy regarding malaria diagnosis, through supervision visits and data analysis. • Implementing and monitoring a quality assurance/quality control system for diagnostics. • Ensure that patients suspected of having malaria at HF and CCS levels are diagnosed with RDTs. • Ensure that all patients with confirmed uncomplicated malaria receive appropriate ACT treatment. • Ensure that all referred patients with severe malaria receive appropriate pre-referral artesunate suppositories. • Organize and ensure prompt, appropriate, and documented referrals within the health system tree. • Coordinate with MOH leaders and partners to ensure that the national policy of highly subsidized ACT is implemented in all public HFs.
IR 3: Strengthened health system capacity to manage malaria prevention and treatment interventions at operational level (province, HZ, community)	• Support good standard integrated supervision visits at all levels of the health system to provide ongoing program improvements. • Support MOH to strengthen M&E systems. • Support the MOH/NMCP and the 5th Directorate for Primary Health Care to collect, analyze, and use data to improve planning. • Build M&E human resources capacity at each health level. • Provide short-term technical assistance to support the project team and CDRs to implement CDRs' improvement plan, to align project Supply Chain Management (SCM) activities with national policy, and to improve supervision and M&E at every level of the supply chain with a focus on building capacity of public structures sufficiently to take over by the end of the project. • Coordinate with the MOH, *Fedecame, Système National d'Approvisionnement en Médicaments Essentiels* (SNAME), CDRs, and implementing partners in the targeted HZs to organize transport and supply project commodities to 54 HZs, including LLINs, SP, ACT, RDTs, pre-referral artesunate suppositories, oral quinine, and injectable severe malaria kit treatments. • Reinforce MOH monitoring meetings.

Intermediate Results	Key Activities
	• Support the coordination and planning process, and actively participate in coordination and work meetings at both national and provincial levels. • Support the implementation of the NMCP organizational assessment recommendations in coordination with USAID and other partners. • Support local capacity building.

Geographical coverage of the project has evolved over the years. During the Year 1, it was implemented in 44 HZs in the four provinces[4] of Sud Kivu, 58 in Kasai Oriental and Kasai Occidental, and Katanga. It expanded into 24 additional HZs in Orientale Province starting in Year 2, for a total of 68 HZs. In June 2016, donor coverage for DRC provinces was restructured to be more strategic and concentrated. This donor rationalization of geographical areas led to the discontinuation of PMI-EP activities in Orientale Province at the end of 2016 and the addition of HZs in Lomami and Tanganyika. Currently, PMI-EP implements malaria activities in 58 HZs in six provinces. This includes 1,301 health facilities and 731 functional CCSs.

Because of security issues that have persisted in several provinces and HZs, project activities and support have necessarily been sporadic in those areas. As of early 2017, 67 percent of the HZs covered by the project have been affected by these security problems. In the provinces of Lomami, Kasai Oriental, Kasai Central, and Kasai, many of the Health Centers (HCs) and CCS are not operational, and where they are, it is often difficult to transmit data. There are also security concerns arising periodically in Sud Kivu, Tshopo, Bas Uélé, and Tanganyika, which also have negatively affected the use of services offered in the concerned provinces.[5]

[4] In 2015 the National Assembly passed a law on the new administrative divisions of the country for the creation of 26 provinces out of the current 11. This geographic subdivision has shifted the number of provinces covered by the project from five in 2012 to nine in 2015.
[5] PMI-EP Annual Report, Year 3.

III. EVALUATION METHODS & LIMITATIONS

III.1 EVALUATION DESIGN

The evaluation used descriptive cross-sectional methods, utilizing existing, currently available, and newly collected quantitative and qualitative data. The design also included a review of project background documents (project implementation plan, annual work plans and reports, M&E plans, and other documents relevant to the evaluation). Based on the scope of work (SOW, see Annex I) and the orientation from the USAID Mission in DRC, the Evaluation Team developed a protocol including data collection tools, which it shared with the USAID Mission for approval before the field visit. The data collection tools, comprised of interview and focus discussion guides, and checklists are presented in Annex II, showing the various methods used to answer the evaluation questions.

III.2 DATA COLLECTION METHODS

Between May 15 and June 10, 2017, data were collected from all levels of the health system, from the central level to the community level. The evaluation methods included a desk review of existing documents and data, and field-based data collection to provide answers to the evaluation questions. The desk review included a review of the secondary data [e.g., project indicator data, NMCP data, DHS, and Multiple Indicator Cluster Surveys (MICS)], and the relevant project documents. (A list of initial documents can be found in Annex III). The field-based data collection was conducted to gather additional qualitative/quantitative information on project implementation through key informant interviews (KIIs), observations, and focus group discussions (FGDs). Data were collected from project partners and clients/beneficiaries in two of the nine provinces where PMI-EP has been implemented, as agreed with USAID: Tshopo and Sud Kivu. The rationale for choosing these provinces included the need to select one province where only PMI-EP is implemented and another where more partners are implementing malaria activities. Other considerations were security, resource constraints (including time and budget), and accessibility. The data were collected from malaria control program stakeholders (i.e., PMI-EP's sub-recipients), who were purposely selected as described in Table 2 below. (See Annex IV for more details.)

Table 2. Stakeholders Met by the Evaluation Team

Stakeholder	Organizations/Institutions
Donors PMI-EP	USAID/PMI
Prime organization	Population Services International
Sub recipients	ASF, Liverpool School of Tropical Medicine, Greenmash, Hera, Caritas Congo, Kinshasa School of Public Health
Beneficiaries	Ministry of Health (health provinces, health zones, health facilities, regional distribution centers, NMCP, community care sites, households, projects target populations
Malaria Project	Integrated Health Project plus (IHP+)
Country Donors	WHO, United Nations Children's Fund (UNICEF)

A total of 412 people were contacted using individual face-to-face interviews; FGDs; meetings with donors, project's lead organization, and sub-recipients; and email questionnaires. The evaluation used a purposive sampling approach. The criteria for the purposive sampling was developed in consultation

with USAID/DRC. Figure 1 presents the sampling approach at each level, and Table 3 lists the HFs and communities visited for data collection.

Figure 1. Summary of Sampling Approach in the Selected Provinces

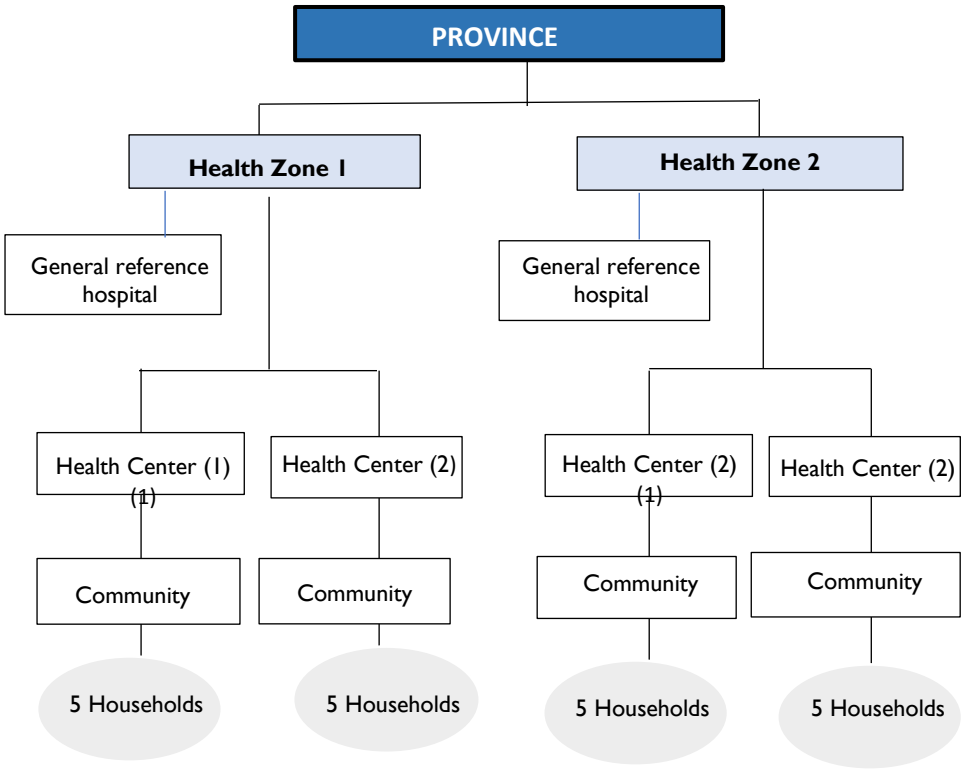


Table 3. HFs and CCSs Visited in the Two Selected Provinces

Provinces	HZs	General Referral Hospital	HFs	CCSs
Tshopo	Bengamisa	Bengamisa	Banjwadé	Azolo
			Bayangéné	Banzaye
	Isangi	Isangi	Yabotianogo	Yantaléma
			Yalosase	Yanda Rive Gauche
Sud Kivu	Fizi	Fizi	Malinde	Malinde
			Mshimbakye	Mshimbakye
	Nyantende	Nyantende	Nyantende	Nyantende
			Mumosho	Kalangwe

Questionnaires were sent by email to the director of the seven other health provinces (Bas Uele, Haut Katanga, Kasai, Kasai Central, Kasai Oriental, Lomani, and Tankaniga) to gather their opinions, experiences, and recommendations on the project. Despite reminder messages, none responded to the questionnaire; consequently, the findings from these provinces are based only on the project's global (aggregated) progress reports/data and Health Management Information System (HMIS) data.

III.3 DATA QUALITY ASSURANCE

Data were collected by the Evaluation Team. The selected project partners, health provinces, HZs, community leaders, and country authorities were informed about the evaluation objectives, scope, and methods. The Evaluation Team developed data collection tools and shared them with the USAID/PMI DRC Mission team for review and approval before the field visits. Interviews and FGD guides were written in French and translated into Kiswahili. The interviews and FGDs were transcribed verbatim in French and entered into Microsoft Word documents. All translated transcripts were checked for quality control and accuracy. The quantitative data from the HMIS (health facility data and records) were obtained from the NMCP, and the quantitative data from the project were obtained from the PMI-EP database.

III.4 ETHICAL CONSIDERATIONS

Ethical considerations were safeguarded throughout the entire evaluation process. Data were analyzed, reported, and stored in formats that do not allow identification of the individual participants. A verbal informed consent was obtained from each person participating in the study.This involved informing the respondent about the purpose for which the information would be obtained and its intended use in a manner the respondent could understand.

III.5 DATA ANALYSIS

The data collected through KIIs and FGDs have undergone a qualitative content analysis to ensure that only information that reflects reality as expressed by respondents has been retained and reported. Qualitative data from interviews and FGDs were analyzed in five main steps: reading for content, coding, displaying, data reduction, and interpretation or final analysis. Quantitative data (health facility data and records from HMIS) were processed and analyzed using Excel spreadsheets.

III.6 LIMITATIONS/CONSTRAINTS

With the exception of the data available from the NMCP—which is the same data PMI-EP has used for monitoring and reporting results—this is a largely qualitative performance evaluation. It is a cross-sectional study, taking a snapshot of the project at one point in time in the nine provinces where it worked. It was conducted toward the end of activity implementation. While a field visit was conducted in two provinces to gather additional qualitative information, a review of the project's and HMIS data/records and a KII at central level were conducted for all nine provinces. Consequently, the results are indicative of challenges and lessons learned for the seven provinces that have not been visited, and all the results cannot be considered conclusive or generalizable for all project sites. Where data were available from other sources (e.g., the project's baseline, DHS, MICS, and/or HMIS), the evaluation data were compared to measure differences (e.g., increases and decreases over time). Unfortunately, not all these data sources had comparable data. For example, PMI-EP implemented a baseline survey, but follow-up surveys were not conducted yet, as the project shifted to using primarily NMCP data to measure its performance.

The generalizability of the data is limited. Despite efforts to solicit a response from the Provincial Health Directorate (*Division Provinciale de la Santé*, or DPS) in all project sites, no response was received outside of the project sites visited. However, data obtained in the two provinces that were visited were substantial, allowing the Evaluation Team to triangulate these data with existing data in order to draw conclusions that apply to most project sites.

Due to limited resources, the evaluation used a purposive sampling in consultation with USAID and PMI-EP. The field visits were conducted in two out of nine provinces where the project was implemented. When reporting the findings of this evaluation, the time and place of data collection has been specified and the results may not appropriately reflect the situation in those provinces not visited.

IV. FINDINGS

IV.1 EVALUATION QUESTION 1

To what extent has there been an increased use of malaria prevention interventions, particularly the increased availability and use of IPTP and increased supply and use of LLINS?

The evaluation findings indicated that, overall, the availability and use of IPTp and LLINs has increased in the project target zones. As seen in Table 4, by Year 4, the project exceeded its targeted goals related to women receiving IPTp during ANC services, and distribution of LLINs to pregnant women and infants.

Table 4. PMI-EP Indicators for IPTp and LLINs in Targeted HZs

Indicator	Baseline	Year 1		Year 2		Year 3		Year 4		Year 5* (*Q2 cumulative*)	
		Target	Achieved	Target	Achieved	Target	Achieved	Target	Achieved	Target	Achieved
% of pregnant women who received at least 2 doses of SP for IPTp during ANC services[a]	14% (*DHS 2013-14*) 41% (*HMIS*)[b]	25%	40%	45%	50%	60%	73%	65%	67%	65%	70%
% of pregnant women who received at least 3 doses of SP for IPTp during ANC services[c]	—					60%	14%	20% (d)	46%	40%	53%
No. of LLINs distributed to pregnant women during routine antenatal visits in targeted areas[e]	33,565 (HMIS)	245,000 *pregnant women & children <5*	38,383 *pregnant women & children <5*	390,134	57,799	241,105	244,121	342,804	398,196	343,368	185,806
No. of LLINs distributed to children under 1 through routine service during completion of immunization[f]	7,096 (HMIS)			240,278	36,310	165,173	171,758	224,322	315,113	229,899	139,817

[a, c] Source of data (annual achievement): HMIS.
[b] PMI-EP lists 14% as baseline, as found in the DRC DHS, a household survey; the HMIS reports 41% among ANC service users.
[d] Targets were decreased for Year 4, as project management determined they had previously been set too high.
[e, f] Source of data (annual achievement): PMI-EP annual reports.

IV.1.1. Increased availability and use of IPTp

The Availability of SP Improved with the Support of PMI-EP: All HCs visited provide SP through ANC visits (once a week in Tshopo and Sud Kivu). As one health worker in Sud Kivu said, "Since the project began, we have seen better availability of SP." This opinion was confirmed by a

significant reduction in the percentage of HFs reporting stockouts[6,7] of SP, which decreased from 54.3 percent in 2013 to 10.7 percent in 2016. (See Question 3 on procurement and supply management, Table 5.) Among HFs visited by the Evaluation Team, only two of eight reported an SP stockout.

As illustrated in Table 5, among all the project-targeted HFs, on average, 68 percent of women attending ANC received two doses of IPTp in 2016, compared to 37 percent in project Year 1 (NMCP 2013). The baseline is estimated at 41 percent (HMIS).

The HMIS data from the project-targeted HZs shows, on average, 46 percent of women received three doses of IPTp at ANC visits in 2016. It is noted that data on three doses of IPTp were not available in the first two years of the project, because the HMIS data collection form did not include it during that period. Evidence from field visits supports these findings. Nearly all women interviewed said they had at least one dose of IPTp, and many said they had received up to three or four doses, especially in Sud Kivu. Data regarding four doses were available only since Year 4; 23 percent of women received four doses of IPT that year, and 34 percent received four doses in Year 5. The health workers at the HCs visited were aware of the new policy regarding the four doses of intermittent preventive treatment (IPT4), and many women (especially in Sud Kivu) were aware of the need for four doses, or had already received a fourth treatment.

Table 5. Proportion of Pregnant Women Who Received at Least Two and Three Doses of IPTp in Targeted HZs

Province	2013		2016	
	Received 2 Doses of SP (SP2)	Received 3 Doses of SP (SP3)	Received 2 Doses of SP (SP2)	Received 3 Doses of SP (SP3)
Bas Uele	52%	n/a	69%	38%
Haut Katanga	9%	n/a	70%	48%
Kasai	25%	n/a	72%	53%
Kasai Central	57%	n/a	81%	58%
Kasai Oriental	38%	n/a	62%	42%
Lomami	40%	n/a	60%	40%
Sud Kivu	37%	n/a	67%	46%
Tanganyika	44%	n/a	72%	53%
Tshopo	30%	n/a	60%	38%
Average	**37%**	n/a	**68%**	**46%**

One of the main reasons use of IPTp has increased overall is the availability of SP and the implementation of the outreach activities in communities that have limited access to HFs (e.g., in Tshopo, this strategy is implemented monthly), as well the free IPTp, and the sensitization and follow-up by CHWs. FGDs indicated that most women heard about ANC and IPTp through their CHWs and were referred to HFs by CHWs. None of the participants in women FGDs, including those who have sought ANC services in HFs during their last pregnancy, paid for SP tablets. This was confirmed by all the health staff interviewed.

[6] Stockout of SP at HC level, (as defined by HMIS): Lack of availability of SP tablets for more than one week during the last quarter.

[7] Definition of "availability of SP on the day of the visit": The Evaluation Team noticed the availability of SP tablets by conducting a cross-check of the drug stock card and the drug physical inventory in the depot.

IV.1.2. Challenges to IPTp

Fees for Services: Although the national policy dictates that malaria prevention and treatment commodities for children under 5 and pregnant women should be free, and this is generally respected, the fees for related services impede access to free malaria commodities. In all HCs visited by the Evaluation Team, the cost for a ANC consultation was posted as between 1,500-3,000 FC ($1-$2). This is prohibitive for many women in the targeted areas around the HC who are living on less than $1/day. While some women in Sud Kivu said they had paid $5 a year to join a *"mutuelle*" (community health insurance scheme) to help cover costs for ANC and other health care, not all were able to do that. One CHW said she could not afford $5/year, as she did not have the full amount at any one time, and when she did have it, she needed to spend it on food.

Inadequacy of IPTp Services Schedule to Services Users: The organization of ANC services at the HFs through which IPTp is provided presents challenges to women seeking services. In all centers visited, ANC visits were limited to only one day a week (very often Friday). One health worker stated, "When a pregnant woman wants to come on a day when ANC services are not offered, we give her an appointment for the day when ANC visits are normally scheduled, which is every Friday."

Women line up at an HC on the day of an ANC visit.
Credit: Jeannie Brown

While sensitization can raise communities' awareness on ANC schedule, the integration of IPTp services into other contacts or services, such as immunization or curative services, could enhance access and use of IPTp by minimizing the missed opportunities

Stockouts of SP: There is clear evidence that SP availability has increased with PMI-EP support. However, some stockouts still occur. For example, stockout of SP was observed in the HFs in Nyantende and Mumosho in Sud Kivu, so that women coming for ANC, even on designated days, were unable to receive IPTp**.** On the day of the visit, two of the eight HFs reported an SP stockout. However, it was later discovered that SP was available in the CDR/Depot in Sud Kivu, but had not been delivered to the HZ. Personnel at the CDR were not aware of the stockout at the HZ or HC. As will be discussed further in the section on HSS, this is an example of how poor SCM and coordination directly affect services.

IV.1.3. Increased supply and use of LLINs

The two principal channels of LLINs in the DRC are the mass campaign and routine distribution through HFs. PMI-EP focused on the routine distribution of LLINs to pregnant women through ANC services and children under 1 who have completed their immunization schedule.

Although stockouts of LLINs still occur, the supply for these targeted groups has improved over the course of the project. Data from the NMCP database revealed that more than 80 percent of the pregnant women and children under 1 in all the project zones in 2016 have received LLINs during ANC visits and immunization at the HF level. These data indicated that nearly 324,261 LLINs and 257,660 LLINS were distributed, respectively, to pregnant women and children under 1 (HMIS data–project-targeted HZs). In the province of Tshopo, the total number of LLINs distributed to children under 1 increased from 1,712 in 2012 to 43,828 in 2016, while in Sud Kivu it increased from 1,575 in 2012 to 18,729 in 2016.

Among those interviewed in Tshopo and Sud Kivu during household visits, 79 percent (11 of 14) of pregnant women declared that they slept under LLINs the previous night and, according to parents, 76

percent (49 out of 64) of their children under 5 slept under LLINs the previous night. For those who had not done so, the main reason given was the lack of LLINs in the household.

Most men interviewed in FGDs indicated that they, too, had slept under an LLIN the previous night with their wives and/or families. LLINs are clearly highly valued by everyone and, in the communities visited, seemed to have reached a level of acceptance that would indicate a change in normative behavior. In most households, there was more than one LLIN hanging. As one FGD participant said, "How can someone not have a mosquito net in their home in a situation like ours?"

WHO guidelines state that one LLIN should be present for every two people living in a household. Although the project focus was not on universal coverage, data collected from this evaluation indicate that on average only one LLIN was available for every 3.6 people.

IV.1.4. Challenges to LLINs

Stockout of LLINs: The main reason given by pregnant women and women who recently gave birth for not having an LLIN was that none were available at the time of the ANC visit. In fact, stockouts of LLINS were frequent over the life of the project. During the field visit, review of HC records and interviews with health staff revealed that during the quarter preceding the evaluation, all the four HCs in Tshopo and two out of four HCs in Sud Kivu experienced stockouts of LLINS. On the day of the evaluation one out of four HCs in Tshopo did not have LLINs, while in Sud Kivu none of the four HCs had LLINs. Over the last quarter, CDRs reported that LLINs were available in Tshopo warehouses but not in any warehouses in Sud Kivu province.

Women in all the sites visited in Sud Kivu and Tshopo also indicated that if they were not able to obtain an LLIN at their first ANC visit, they were not able to obtain one at all in the future. Health workers at the HCs told them that they could get an LLIN only at the first ANC visit, regardless of when stock would become available in the future.

One of the reasons for frequent stockouts of LLINs in HFs is the approach taken to limit the risk of their diversion. The project chief of party (PSI/ASF) said, "In some project zones, LLINs distributed free of charge by health facilities were later found for sale in local markets. This prompted the creation of restrictions in supplying health facilities awaiting investigation of these diversions."

During discussions on the causes of LLIN stockouts, one HF manager said, "When we send a request stating the number of LLINs we need to the health zone office, the quantity we're given is always less than what we ask for. We already run out by the next ANC visit." In addition to the restrictions due to diversion mentioned above, the quantity of LLINs available at the HZ level was often not sufficient to meet the needs and requests of HFs.

An LLIN hangs over a bed in a house. *Credit: Leonard Kasereka*

Consistent Use of LLINs: Nets are not always used at the household level. During the FGDs, the majority of participants said that they slept under nets every night. At the end of the discussions, a household visit was conducted. In one household in Tshopo, it was found that the LLIN was not hung and was still in its packaging. It was also observed that some households had hung the LLINs a few moments before the visit. (The net was brand new and the smell of insecticide was very strong.)

This situation could be explained by the weak implementation of health promotion and awareness-raising activities at the community level in the sites visited. For example, in the sites visited in Tshopo, all the CHWs in charge of health promotion, SBCC activities, and follow-up at the household level had resigned. In other sites, CHWs were working, but had limited tools available to support their efforts. In

general, there were very few promotional materials, including posters and counseling tools, observed in the HFs or in the communities. The project staff (PSI/ASF) recognized that some of the SBCC activities were not implemented as planned in the project document (e.g., radio spots and jingles) because the majority of project-supported HZs are in poor, rural settings that do not have power.

An LLIN remains in its original packaging in a household. *Credit: Hilaire Zon*

IV.1.5. Conclusions and recommendations for IPTp and LLINs

Availability and utilization of malaria prevention measures, including IPTp and LLINs, have increased in project areas. Data from WHO suggest that malaria morbidity and mortality have declined in DRC overall. This report has not specifically presented these figures at the HZ level, and it is not possible to directly link PMI-EP preventive interventions with the declines. However, observations and data collected by the Evaluation Team could presume that the project made significant contributions to these declines at the national level.

Nevertheless, some challenges exist that may limit or reduce the sustainability of results achieved to date if they are not addressed in future initiatives.

- It has been found that coordination has greatly enhanced the availability of malaria commodities (See IV.3.3, "Improved provincial and health zone capacity in supply chain management,"). Therefore, greater investments should be made in strengthening coordination to assure consistent and uninterrupted availability of SP and LLINs at the province, zone, and community levels. Better coordination will ensure that the links in the supply chain are connected and mutually responsive.
- Advocacy should continue for harmonizing pricing with the lowest possible user's fees. It would be ideal if ANC service fees were reduced, as this would likely enhance access to and use of free IPTp. Removing cost barriers will help to reduce lost opportunities for ANC, as well as improve distribution of LLINs and IPTp. This recommendation is also the case for malaria diagnosis and treatment.
- If a woman did not receive an LLIN because of unavailability at the first ANC visit, she should be offered one as soon as they are available at the HC. This would ensure the protection of pregnant women.
- Promotional efforts CHWs carry out at the community level need to be strengthened through awareness-raising sessions and home visits.
- Strategically expanding community outreach services to emphasize selected challenging/remote environments should be considered in future projects. This could be accomplished through additional support for existing CCSs in these locations, or creation of new CCSs, as well as extra support for activities from HCs. While directly addressing natural and infrastructure challenges is a long-term investment, helping women mitigate as many of these barriers as possible in the short term will enable them to have better access to preventive services and products.

IV.2 EVALUATION QUESTION 2

To what extent have malaria diagnosis and treatment interventions been improved?

The evaluation findings indicated overall that PMI-EP helped improve the availability and access to malaria diagnostic and treatment in project target zones and that performance indicators were achieved.

IV.2.1. Improved diagnostic capacity and use

The proportion of HFs with no stockout of ACT[8] has increased from 56.21 percent in 2013 to 90.05 percent in 2016. Data on RDTs was not reported at the project start, and data available in 2016 indicated that the proportion of HFs with no stockout of RDTs was 85.58 percent.

Table 6. Availability of ACT and RDTs in 2013 and 2016 in Project-Targeted HZs of Five Selected Provinces[9]

Province	Rapid Diagnostic Test		Artemisinin-Based Combination Therapy*	
	% HFs with no reported stockouts, 2013	% HFs with no reported stockouts, 2016	% HFs with no reported stockouts, 2013	% HFs with no reported stockouts, 2016
Bas Uele	n/a**	88.89%	46.20%	91.54%
Kasai Central	n/a	92.10%	79.67%	96.46%
Kasai Oriental	n/a	68.60%	48.57%	80.30%
Sud Kivu	n/a	90.00%	60.10%	93.07%
Tshopo	n/a	88.30%	46.50%	88.90%
Average	**n/a**	**85.58%**	**56.21%**	**90.05%**

* ACT for all ages combined.
** n/a = not available.
Source: NMCP database on PMI-targeted HZs.

During the field visit, seven out of the eight HFs and eight CCSs reported no stockout of RDTs during the last quarter. Six out of the eight HFs and eight CCSs reported no stockout of RDTs on the day of the visit.

IV.2.2. Improved case management of uncomplicated and severe malaria

Utilization of malaria curative services has increased in all nine provinces within the targeted HZs through an increase in malaria patients seeking services. The proportion of malaria cases among all causes of diseases in the outpatient departments increased from 45.70 percent in 2013 to 61.04 percent in 2016. This proportion among children under 5 increased from 48.33 percent to 65.91 percent during the same period.[10]

Regarding diagnosis and treatment, 90 percent of all malaria cases were confirmed in 2016 compared to 53 percent in 2013.[11] Nearly all the malaria cases that were confirmed positive (98.8 percent) were treated according to the NMCP guidelines throughout the project, which has also helped CCSs become operational, improving availability of and access to treatment for children. A total of 733 CCSs were opened and 731 are functional, according to the project staff.

The quality of malaria diagnosis and treatment in HFs also improved through better compliance with national diagnosis and treatment guidelines. According to one HC manager, "Now, any suspected case

[8] Stockout of ACT at the HC level, as defined in the HMIS: Lack of availability of ACT for more than one week during the last quarter.
[9] These are the original five provinces where the project was implemented before four new provinces were created, increasing the number of provinces covered to nine. These five provinces were selected for comparative purposes using the baseline data available from them.
[10] HMIS-NMCP database.
[11] HMIS-NMCP database.

[of malaria] is confirmed by RDT before being treated according to the national guidelines. This prevents treatment through trial and error and allows us to be sure we're treating malaria."

One CHW assessed the impact of the improved diagnosis and treatment by saying, "Since the community care sites have been open, there are fewer deaths among children, which were once attributed to witchcraft. This has prevented conflicts between families and communities."

According to a head of household who participated in an FGD, "Access to malaria treatment for children under 5 improved in our communities with the establishment of community care sites where treatment is available."

HSS, which includes training of health workers on malaria diagnosis and treatment, development and distribution of integrated management of childhood illness (IMCI) and malaria management guidelines/algorithms, supervision, and SCM, has contributed to improved diagnosis and treatment. Details are presented under Evaluation Question 3 on page 17.

IV.2.3. Challenges to malaria diagnosis and treatment

While important progress has been made in diagnosis and treatment, some major bottlenecks remain:

Recurring Stockouts of RDTs and ACT in HFs and CCS: Although the percentage of HFs reporting stockouts declined overall, some continue to experience stockouts of ACT (see Table 6 under Evaluation Question 3). During the field visit, interviews and verifications of stock records revealed that two of eight HFs and two of eight CCSs did not have ACT for infants and children. Two of the eight HFs did not have RDTs.

This situation sometimes leads to practices that contradict the national guidelines. According to a CHW in Sud Kivu, "When we don't have drugs for children, we use adult ACT, which we divide in half." It was also stated by a nurse that when RDTs were not available, all fever was treated as malaria, contrary to national guidelines.

Uninterrupted availability of commodities remains one of the biggest concerns in communities, as one FGD participant explained. "If you want us to use the community care sites, just bring us the medicine." One CHW said, "Whenever I'm out of drugs, people in the community pressure me to go get more from the Health Center."

The unavailability of artesunate injectable was raised by the referral hospitals as a major obstacle to the management of severe malaria. The drug depots of HZs that the Evaluation Team visited, experienced recurrent stockouts of artesunate injectable, and none had this drug on the day of the visit. The referral hospitals and the staff noted that their role in malaria control was mainly the management of severe malaria, which would arise if the uncomplicated cases were not properly managed by HCs and CCSs.

Lack of Supervision at CCCs: CCSs are not consistently monitored or supervised by HC staff and health district management teams. The percentage of planned supervision visits conducted in 2016 by HCs to CCSs was 85 percent. It was also observed that in some CCSs, any visit from an HC or HZ team (e.g., to supply drugs or equipment, or conduct a study or survey) was often considered a supervisory visit. The inconsistent follow-up with CCSs creates risks of mistakes and practices that contradict the national guidelines. For example, one CHW in Tshopo gave injections that were not part of the minimum package of activities. During discussions, he informed the Evaluation Team that he was being trained as a nurse and was procuring injectables from the private market. The project staff reported that security issues and long distances, especially in Sud Kivu, were among the factors that prevent HCs and HZs from adhering to supervision planning.

The Quality Assurance Approach for Malaria Diagnosis Has Not Been Fully Implemented: According to the regional malaria program coordinator in Tshopo, the post-training follow-up of laboratory technicians and supervision by national experts was not conducted. This was confirmed by the HZ's laboratory technician, who said that he had not been supervised. However, the supervision and visits were conducted to ensure that health staff and CHWs were knowledgeable and compliant with NMCP policy regarding diagnosis and treatment.

Though the project distributes artesunate suppositories, they were not available in HFs or CCSs the Evaluation Team visited. The country adopted the policy of pre-referral treatment for children under 5, but it had not yet been fully implemented because a specific drug had not yet been pre-qualified by WHO until December 2016.

Geographic Barriers: Poor road conditions and natural barriers (e.g., rivers, streams, mountains) make it difficult, if not impossible, for community members to reach HFs quickly, and for HCs and HZs to conduct regular supervision visits.

Financial Barriers Caused by the National Cost Recovery Policy: These financial constraints limit communities' access to health services and malaria commodities. Any user of preventive services (e.g., a pregnant woman for ANC-IPTp) or curative services (e.g., a child under 5 with a fever) must pay a flat fee that varies from 1,000FC for a medical record for ANC to 2,000FC for a consultation for a fever before receiving any commodities or services. One CHW in Tshopo said he collected 1,500FC per sick child to operate the CCS (to purchase flashlight batteries, pens, etc.). One FGD participant angrily stated, "We don't understand the rates for Health Center services. For example, when your child is in the hospital, you have to pay for anything a health worker does. Even the person who comes and sets up the IV asks for money." Another participant echoed this sentiment, stating, "First, they tell you have to pay for a medical record that costs 1,000FC. But then you're asked to pay 500FC here, 1,000FC there." Another FGD participant added, "When you can't pay for the consultation or hospitalization fees, you have to pawn something of value, like a bicycle or fabric, to the Health Center." (This system, which was created by HC management committees to recover costs, was confirmed by HC managers in their interviews.)

The feelings of frustration and incomprehension expressed by these two FGD participants reflect a lack of communication between health workers and communities about the cost of health services and how to access free malaria prevention and treatment commodities. Informal discussions with HZ teams revealed that users often reported cases of overcharging or racketeering.

Moreover, not all health workers have a positive view of the free malaria commodities. According to some of the HC managers interviewed, offering free malaria commodities costs HFs income, therefore limiting the bonuses/gratuities they can pay health workers. This could explain why they have established a flat fee for medical records, which could be a way of getting around offering free malaria commodities, such as IPTp for pregnant women.

IV.2.4. Conclusions and recommendations for malaria diagnosis and treatment

Significant progress has been made in malaria diagnosis and treatment, and this has been enhanced by the strengthening of the health system, including:

- The availability of diagnosis and treatment commodities through improved coordination among various partners, including PMI-EP.
- Capacity building for health workers and CHWs through continuing training and supervision.
- The availability of management tools and materials such as guidelines/instructions for malaria case management and IMCI.
- The national policy of highly subsidized ACT.

- The creation of CCSs.

The following recommendations are linked to the diagnosis and treatment (Evaluation Question 2), and to the health system (Evaluation Question 3), which greatly influence the project results:

- Intensify efforts to strengthen the SCM system to ensure the availability of diagnosis and treatment commodities in HFs and CCSs.
- Training should continually be offered to CHWs and health workers, and high-quality post-training follow-up and supervision should be increased and conducted consistently.
- Ensure the effective implementation of the Quality Assurance Approach.
- Ensure the effective implementation of the pre-referral treatment strategy for children under 5 with severe malaria, as described in the Year 1 project implementation plan.
- Continue expanding CCSs into villages/communities with limited physical/geographic access to health services.

IV.3 EVALUATION QUESTION 3

To what extent has the health system been strengthened to manage malaria preventive and treatment interventions?

The four areas of HSS interventions within PMI-EP are training and capacity building (IR3.1), M&E (IR 3.2), SCM (IR3.3), and coordination (IR3.4).

IV.3.1. Enhanced technical knowledge, skills, and competencies of health service personnel

IV.3.1.1. Achievements in Training and Capacity Building

The implementation of the training program clearly strengthened the capacity of health workers to manage malaria. A large majority of health workers interviewed at all levels stated they had received training as part of the project, as shown in Table 7 below. They have been trained in uncomplicated and severe malaria case management, IMCI, IPTp, and laboratory diagnosis.

Table 7. Number of People Trained by PMI-EP over the Four Years by Training Topic

Topic	Number of People Trained
Malaria case management	7,622
Integrated management of childhood illness (IMCI)	4,571
Malaria diagnosis (Laboratory/RDTs)	12,540
Social behavior change communication (SBCC)	1,654
Mobile tech/stock management (MANGO)	543
District health information system software 2 (DHIS2)	902
TOTAL	**27,832**

* Source: PSI/ASF annual reports.

The project trained a total of 27,832 people in various topics. Nearly half were trained in malaria diagnosis (45.1 percent), followed by malaria case management (27.4 percent).

The project reproduced, and distributed malaria treatment and IMCI guidelines developed by the NMCP to HFs and CCSs. All of the HFs and CCSs had malaria case management and IMCI guidelines/instructions when the Evaluation Team visited. According to the providers interviewed, these training sessions greatly enhanced their knowledge and improved their malaria case management practices. One HC manager stated, "The biggest change brought about by the training was the

rationalization in drug prescriptions according to the national guidelines, which significantly reduced prescription drug costs for patients." Providers said that they learned to have confidence in the results from RDTs, which they had not had before the training. Thus, they began prescribing drugs only if test results were positive for malaria and not for just any fever. Along the same lines, a CHW stated, "I was trained in malaria [case management] and IMCI. Now I can easily tell the difference between uncomplicated malaria and other febrile illnesses and provide malaria treatment depending on the patient's age."

All of the CHWs visited were able to describe the different steps in treating a child with a fever. This is an indication that the training they received was effective.

The project has strengthened the implementing partners and beneficiaries' capacities (staffing, logistics). The appointment of Malaria Technical Advisors at the province level has helped to improve malaria activities planning, implementation, and M&E.

IV.3.1.2. Challenges to Training and Capacity Building

There was inconsistent and irregular monitoring and supervision of providers. The main reasons mentioned were the inadequacy of financial resources and means of transportation, which were not always suited to the reality on the ground. While teams were provided with means of transportation, sometimes it was not suited to the environment, particularly because of the geographic configuration of the areas in question. For example, in Tshopo, giving bicycles—instead of canoes—to those who live by the river was not appropriate. This also goes for distributing bicycles in mountainous Sud Kivu, where recipients asked that the bicycles that were given to them be taken back by the project manager because they could not use them. In this regard, an HC manager stated, "For monitoring and supervision in my health area, we use a motorized canoe that requires sufficient resources to pay for the fuel and the driver. The support we receive is not sufficient and is not enough for us to conduct regular monitoring."

In some places, those who had received bicycles stated they were of poor quality and did not last long. A CHW said, "We would like to have had Kinga 4X4[12] bicycles and not the bicycles they brought us, which can't last long in this environment."

A notable fact in Tshopo was the absence of bicycles in any of the four CCSs visited. The CHWs stated in their interviews that the bicycles were broken, but the Evaluation Team did not see them. It is also worth mentioning the crucial issue of maintenance. A large majority of the beneficiaries (Provincial Health Directorates, HZs, HFs, and CCSs) do not have the resources to maintain their fleet of vehicles, motorcycles, or bicycles on a sustainable basis.

The quality of support and supervisory visits needs to be improved. Observations indicated, among other things, a lack of commodity management at all levels, poor quality and organization of reporting documents in some CCSs, and improper practices at one CCS. It was also observed that in some CCSs, any visit from an HC or HZ team was often considered a supervisory visit.

Regarding the quality of support and supervisory visits, a country donor stated, "PMI-EP has contributed to strengthen[ing] the supervision policy/approach defined by the MOH. We must ensure the quality of support visits, meaning that qualified people must provide real support in implementing quality services at the peripheral level, which is a necessary condition for ensuring the impact of malaria control interventions."

[12] Kinga 4x4 is the brand name of a bicycle in the DRC.

Issues related to the health system that the project has little influence over presented challenges that impeded its achievements. These include:

- **HFs are understaffed.** In some HFs visited, the Evaluation Team noted a lack of staff, not only in numbers but also in terms of certain qualifications (e.g., to manage the dispensary). Many HC managers were doing multiple jobs with multiple responsibilities (e.g., curative consultations, ANC, and dispensary management).
- **Health workers are not adequately compensated.** At all levels, interviewees stated that they did not receive a salary and that their risk premiums/incentives were not regularly paid. One provider stated, "We are not paid, but we still have families to feed. How do you expect us to live? We have to live on whatever trickles down to us." Another provider expressed his disappointment in these terms: "I've been registered as a public employee for over 15 years, but I still don't get a salary. My registration number has become a telephone number."

  This situation discourages staff and could explain their sometimes negative opinion of the policy of free malaria commodities, along with certain harmful practices reported by health service users (e.g., overcharging and mechanisms to get around offering free services).
- **There is high staff turnover.** In all of the HZs visited, the majority of staff trained by the project had left their positions.

IV.3.1.3. Recommendations for Training and Capacity Building

- Provide sufficient financial/logistical support to provinces and HZs to ensure the supervision and monitoring of activities.
- Ensure quality monitoring and supervision of interventions at all levels of the health system by offering training on quality monitoring and supervision, as well as consistent oversight.
- Continue training providers (health staff, CHWs) in malaria case management and IMCI, particularly through the development of a suitable training plan.
- Through dialogue between the government and partners, identify and put in place a sustainable system/mechanism to provide staff with sufficient financial incentive.

IV.3.2. Improved provincial, HZ, and community capacity to collect, manage, and use malaria health information for M&E

IV.3.2.1. Achievements in M&E

Reporting, analysis, and use of data for decision-making has improved at all levels of the health system. There has been significant improvement in the functioning of the health information system, including the implementation of the DHIS2 database and supplying of facilities with computer equipment and internet connections. PMI-EP has supported the DHIS2 roll-out process by providing tools and training on the new HMIS form. Approximately 902 people at all levels were trained in health information management.

Regular M&E meetings are held at province and HZ levels, initiated and supported by the project. All of the informants interviewed in both provinces stated that these meetings were held regularly (once a month). All eight HC managers stated that they had participated in a monitoring meeting during the month preceding the day of the evaluation.

One HC manager said, "The monitoring meeting is where we discuss Health Center results and progress, problems, and solutions. We also use these meetings to do other things, like submit reports or procure medicines."

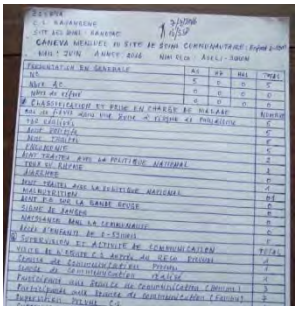
The revised data collection and reporting materials were available in all of the HZ facilities and HFs visited. The project supported the process of revising, reproducing, and distributing the HMIS data collection tools in collaboration with the MOH. In all of the HZ facilities, HFs, and CCSs visited, the Evaluation Team noted the presence of data collection and reporting materials. A health information manager in an HZ in Tshopo said, "The revision of HMIS materials reduced the number of tools and our workload. Before, each partner required indicators that weren't always relevant to us."

All of these activities helped improve the reporting, analysis, and use of data for decision-making at all levels of the system. In 2016, the external[13] and internal[14] completeness rates at the HZ level were 96.2 percent and 96.1 percent, respectively. The rate of on-time delivery of reports was 89.2 percent. HFs' and CCSs' monthly reports were available, and health information (tables, graphs, maps) were displayed in all the HFs and HZs visited.

IV.3.2.2. Challenges to M&E

The main challenges identified include:

Insufficient supplies of data collection materials in community care sites. Of the eight sites visited, four said they had recently experienced stockout of forms for their reports. When forms are not available, providers make them themselves by drawing them by hand (see photo, right).



A hand-written data collection form.
Credit: Leonard Kasareka

Delay in the submission of reports. While there have been important improvements in timeliness of reporting, 10 percent of reports are still submitted late. This could be due to the delay in the submission of CCSs' reports to the HFs, as well the submission of HFs' reports to the HZs. Other factors are limited access to internet connections or limited availability of energy sources to operate DHIS2 database tools and submit the HZs reports to the province level, long distances to where the data forms and reports have to be submitted, and security issues.

Inconsistent functioning of DHIS2 platform. This is due to the lack of reliable energy sources and internet connections.

IV.3.2.3. Recommendations for M&E

- Strengthen monitoring at all levels of the system by ensuring regular and consistent oversight, with a particular focus on the regularity and quality of supervision.
- Make data collection and reporting tools available at all levels.
- Explore the feasibility of providing renewable energy sources (e.g., solar panels) to operate the DHIS2 system in the HZs that do not have reliable energy sources.
- Support the process of improving the timely submission of reports by sending regular reminder messages to the CCSs and HFs, and providing reliable energy sources to HZs to operate the DHIS2 system.

[13] External completeness rate: The number of reports the HZ submitted to the province (DPS) against the number of reports expected.
[14] Internal completeness rate: The number of reports the HFs submitted to the HZ against the number of reports expected.

IV.3.3. Improved provincial and health zone capacity in SCM

IV.3.3.1. Achievements in SCM

There is an increased availability of pharmaceutical commodities at all levels. According to managers interviewed, commodity stockouts fell considerably since the beginning of the project, as reflected in the data shown in Table 8.

Table 8. Availability of SP and ACT in 2013 and 2016 in Targeted HZs of Five Selected Provinces[15]

Province[16]	Sulfadoxine-Pyrimethamine		Artemisinin-Based Combination Therapy*	
	% HFs that reported stockouts, 2013	% HFs that reported stockouts, 2016	% HFs that reported stockouts, 2013	% HFs that report stockouts, 2016
Bas Uele	61.50%	10.1%	53.80%	8.46%
Kasai Central	60.73%	3.02%	20.33%	3.54%
Kasai Oriental	61.16%	15.1%	51.43%	19.7%
Sud Kivu	*26.4%*	*6.86%*	*39.9%*	*6.93%*
Tshopo	*61.68%*	*7.86%*	*53.50%*	*11.1%*
Average	**54.29%**	**10.74%**	**41.29%**	**12.43%**

* ACT for all ages combined.

Source of data: NMCP database for PMI-EP supported HZs.

The availability of SP and ACT for all ages combined rose significantly in the two provinces visited. This trend was also seen in other provinces where PMI-EP was implemented, such as Bas Uele, Kasai Central, and Kasai Oriental. On average, the percentage of HF that reported stockout of SP decreased from 54.29 percent in 2013 to 10.74 percent in 2016. For ACT, it decreased from 41.29 percent in 2013 to 12.43 percent in 2016.

This improved availability was also confirmed by a provincial health director, who said, "One of the major results of the project is the decline in the magnitude of commodity stockout problems in health facilities." An HC manager said, "Before, medicines weren't available, and stockouts could last for months. But now, the commodities are available, and we can procure supplies from the Zone drug depot whenever there's a stockout."

The following factors helped improve the availability of commodities:

- The increased supply of malaria commodities with the support of PMI-EP and other country partners (e.g., UNICEF, Global Funds, and the UK Department for International Development).
- Support from PMI-EP to improve HZs' and provinces' capacities in SCM with a focus on transportation of commodities to HZs and monitoring consumption of commodities at HFs and CCSs.

[15] These are the original five provinces where the project was implemented before four new provinces were created, increasing the number of provinces covered to nine. These five provinces were selected for comparative purposes using the baseline data available from them.

[16] Ibid.

- The contribution of the CDRs for storing project commodities. PMI-EP collaborated with the CDRs to improve the stock management by making available the malaria commodities and their transports/distribution to HZs.

- Improved coordination and management of commodities through the provincial commodities working groups. A provincial health director said, "One significant achievement of the project was the pooling of each partner's contributions of commodities and the creation of a flexible management mechanism. Before, each partner delivered their commodities without any coordination, which sometimes led to overstocks and expired commodities. It was also not possible to move overstocked commodities from one Health Center to another that was out of stock. But now, the coordination framework has resolved all of these issues."

IV.3.3.2. Challenges in SCM

Despite the notable progress made in improving the availability of commodities, there are some challenges remaining related to SCM:

Recurring stockouts of commodities. While the percentage of HFs reporting stockouts fell, the data in Table 8 above indicate that an average of 8.59 percent of HFs experienced an SP stockout, and 9.95 percent experienced an ACT (all ages combined) stockout during 2016.

During the field visit, interviews and verifications of stock records revealed the following:

- Three out of eight HFs did not have any SP.
- Two out of eight HFs did not have any ACT for infants and children.
- Two out of eight CCSs did not have any ACT for infants and children.

The following are the main factors contributing to recurring stockouts:

- Despite the improvements in SCM mentioned above, there continues to be limited capacity to manage supplies in HFs and CCSs. For example, in certain HCs, no staff member is responsible for managing the drug depot. Sometimes supplies are managed by the president of the Management Committee, who does not have the necessary knowledge and skills. The evaluation also revealed supply management problems, such as a lack of tools, stock records not being kept up-to-date, and improper storage of commodities. This situation could explain some stockouts, as regular monitoring of supply levels is necessary to submit orders or requests when critical levels are reached.

- Poor road conditions and natural barriers (e.g., rivers, streams, mountains) preventing the transportation and distribution of commodities. In this regard, an HZ manager said, "Sometimes commodities are stored at the Health Zone level. Unfortunately, in the height of the rainy season, it can be difficult to get these commodities to the facility in their final destination. We don't have the proper means of transportation. And some facilities are more than 200 kilometers from the central Health Zone office. So even if commodities are available in the Health Zone pharmacy, there can often be stockouts."

- Limited logistical capacity of HZ offices to transport commodities to HFs and CCSs. HFs must often transport their commodities themselves by taking advantage of certain opportunities, such as monthly monitoring meetings at the HZ office, to pick up supplies. Larger commodities such as LLINs require significant logistical resources.

- Delays in delivering commodities to HZs related to a failure to comply with supply schedules developed with partners. In this regard, an HZ manager said, "We feel like partners deliver commodities according to their own schedule and not the needs of the Health Zones."

- The management guidelines PMI-EP gave to HZs to minimize the risks of LLIN diversion could have led to supplies being kept in an HZ drug depot. (See challenges for LLINs, Evaluation Question 1). During the first quarter of 2017 (January–March), six out of eight HFs had experienced LLIN stockouts, and five out of eight were out of stock on the day of the evaluation. During the same period, LLINs were available in three out of four HZ dispensaries.

Failure to implement certain critical SCM strengthening activities as planned. This includes the training and implementation of the information technology platform called MANGO, which was the main activity that the project proposed for improving SCM.

IV.3.3.3. Recommendations for SCM

- Continue strengthening coordination between partners to ensure malaria commodities can be redistributed to all HZs when they are needed.
- Build capacity in procurement and SCM at all levels.
- Build logistical capacity of regional distribution centers and HZ offices to ensure uninterrupted supplies at HFs and CCSs. This includes strengthening the role and capacity of the regional distribution system in distributing commodities, not only storage.
- Regularly monitor commodity management in HZ offices, HFs, and CCSs.
- Assess the possibility of a public-private partnership or other innovative system for getting commodities to particularly difficult-to-reach areas. For example, mining companies regularly travel to some of these areas.

IV.3.4. Improved provincial and HZ management team capacity to coordinate stakeholders

IV.3.4.1. Achievements in Coordination

The key activities that were conducted to strengthen DPS and Health Zone capacity for coordination include support to coordination of monitoring meetings, support to coordination of planning processes, and support to local capacity building. These efforts have enhanced and strengthened the DPS and Health Zone capacity to coordinate the stakeholders using regular monitoring or existing networking opportunities. These meetings are still being conducted where the project is closing out. One of the major achievements of the project related to improved coordination is the harmonization of different partners' support leading to a better availability of malaria commodities at all levels of the health system.

IV.3.4.2. Challenges to Coordination

Lack of formal coordination mechanisms for health/malaria partners. This occurs at the provincial and/or HZ levels, where coordination is most critical. Although some existing networking opportunities were used to better monitor commodity supply issues, as well as to avoid duplication of effort, there is a perceived need to have something more formal in place.

A provincial health director told the Evaluation Team, "Since there is no formal coordination framework for partners at the provincial level and health zone level, the monitoring meetings provide opportunities to bring all actors and partners together."

According to another provincial health director, a coordination framework must be created for partners working in the province, given the volume of interventions and assistance, and also to better monitor and coordinate their activities.

Resource constraints. The greatest constraint is the lack of resources to facilitate such coordination, which is why other opportunities (e.g., monitoring meetings, working group meetings) are being used to bring some partners together. Often, these opportunities do not allow for all partners to come together to discuss joint challenges around an important theme.

IV.3.4.3. Recommendations for Coordination

- Provide adequate resources to provinces and HZs to ensure the functioning of networking opportunities/meetings, including formal coordination mechanisms.

IV.4 EVALUATION QUESTION 4

What main factors, including those that are gender related, facilitate or pose challenges to the successful achievement of the project objective?

There have been many factors that have facilitated the results that PMI-EP has been able to achieve, including the following:

Location of Staff in the Field: This has been critical to effective implementation and follow-up on activities.

Quality of the Training: Related to case management, at clinics where health staff had received training through the project, responses to questions from evaluation instruments as well as direct observations of provider-client interactions indicated that clients received accurate, appropriate, and up-to-date information within ANC, diagnosis, and treatment visits. Responses in FGDs also indicate that clients were well-informed with up-to-date information. They received most of their information from HCs.

Development of CCSs: The operationalization of the CCSs has increased access for early diagnosis and treatment, and thus has been a key to project success.

Regular M&E Meetings at the Zone Level: These meetings were appreciated by all, at all levels, and recognized as helping HCs discuss the achievements and challenges and be more timely and complete in submitting their data each month.

Improved Coordination at the Health Province Level: In the province of Tshopo, cooperation among partners made it possible to improve the coordination and pooling of contributions, and improved the availability of commodities.

The many challenges the project has faced in achieving results include the following:

An Inadequate Network and Extremely Poor Condition of Roads: Virtually none of the roads are paved, and most are full of potholes, rocks, and small crevices that make delivery of commodities to remote areas almost impossible, particularly in the rainy season. In addition, in Sud Kivu, for example, there is only one main road going from Bukavu to Fizi and to other Itombe and Mwenge provinces. For security reasons, it is recommended that this road should not be used before 10 a.m. and after 4 p.m. In many cases, transporters are required to go through Rwanda to get to Fizi and the other provinces. This route is costly due to border crossing.

In many cases, transporters are required to use motorbikes to get to remote areas. However, motorbikes are often not possible, so the only means of reaching the HCs or CCSs is by foot, carrying

products on one's back, or walking motorbikes that hold products. This creates logistical bottlenecks for all the partners in carrying out their work and translates into additional time and associated costs to reach remote locations. One person working in Bukavu Province said that it could take up to two weeks to reach certain project covered-locations by foot.

Related to the above, another ongoing challenge has been the strengthening of the SCM system. Despite the significant progress made from the beginning of the project, some weaknesses identified by the evaluation have limited an even better availability of services and products that can be offered in HCs and CCSs. The proposed innovative mHealth intervention, MANGO, would have addressed some of the SCM issues observed had it been implemented as proposed, but the initiative was discontinued. While showing potential as a pilot in Kasai Oriental, MANGO was highly dependent on cell phone technology and consistent connection via phone or internet. Frequent power outages and phone system breakdowns created major roadblocks for its effective implementation and expansion, prompting project leadership to terminate the effort. Furthermore, the work of consortium partner HERA was reduced by 50 percent. Its role was to strengthen CDRs so a parallel distribution system would eventually not be needed.

Makeshift log bridge
Credits: Hilaire Zon

Inaccessibility of roads

Inaccessibility of roads

Limited Implementation of Community Outreach Activities: As part of the establishment of CCSs, two CHWs were identified by the community, one to provide care and the other to conduct health promotion/awareness-raising activities. In Sud Kivu, the evaluation found that all of the CHWs were present and carrying out activities, while in Tshopo, all of the CHWs assigned to raise awareness at the sites visited had quit. The main reason they cited was the lack of both financial incentive and support from the community. Moreover, the local/community radio communication activities planned as part of the project were not implemented. The main reasons cited by the PSI/ASF project manager were the absence of community radio stations in some areas and these stations' limited coverage in areas where they do exist.

Insufficient Financial Incentives for Health Workers: Despite the fact that this was not a focus area of the project, this situation discourages staff and has a major influence on the quality of activity implementation. There was a general feeling of frustration and dejection. To improve cost recovery and ensure payment of bonuses, health workers create mechanisms to get around having to offer free services, which limits the access to malaria prevention and treatment services.

Certain Management Issues Also Affected Implementation: All project consortium partners, local and international, stated that there had been insufficient coordination and communication between project leadership and sub-partners. While initially there were regular coordination meetings, these were discontinued because they were no longer considered necessary. In some cases, these communication issues made implementation of activities difficult or delayed—or impossible. For example, some partners complained of long delays in getting reimbursed for activities, leading to delays in release of funds for initiating new activities. Two partners also said that they had not been treated like

"real partners," although that had been their expectation upon joining the consortium. This affected the morale of project partners. One partner working to strengthen the existing SCM system indicated that their budget was cut by 50 percent without any discussion or warning, so that they could not complete their activities or plan for sustainability. They said that PSI did not communicate with them or "ever know what they were doing," nor had there ever been a supervision visit. Furthermore, a lack of coordination and communication with those who would be involved in the transition and in sustaining the project's achievements created uncertainty.

Gender Did Not Seem to Be a Direct Barrier to Seeking Any Services at HC or CCS: Both women and men expressed that women were free to seek ANC services, or any health services, for themselves or their children, without any approvals from anyone. *However, the promotion of gender equality in the project had not yet become a reality.* For example, in the sites visited in Tshopo Province, there was not a single female CHW. While leadership positions within PSI, the lead organization for the project, are gender-balanced, overall, many more men than women work for PSI in the DRC (about 2 to 1 ratio).

Recommendations

- Given the many infrastructure and SCM challenges, consideration may be given to increasing field support at the zone level, since that is the most critical point in the system for ensuring commodity availability for communities.
- Due to high staff turnover, training and refresher training should be continued on an ongoing basis.
- Expand CSSs strategically, including in terms of both number of sites and improving current services package (IMCI) offered by each CSS.
- Continue support for regular M&E meetings at zone level.
- It is important that future strategic plans and funding put greater emphasis on mitigating infrastructure and natural challenges to the extent possible, perhaps through increasing funding or re-allocating existing funds to better cover expenses related to these challenges. Advocacy with road-building projects might also be considered, to ensure that major routes to HFs within HZs where improvements are being made could be prioritized.
- Ensure supervision of community BCC and outreach activities by CHWs.
- To improve project-level communication and coordination, and to maintain strong partnerships, provide more consistent opportunities for team-building with project partners. Engage partners in decision-making and keep them informed of overall project/budget challenges on an ongoing basis. Periodically make joint visits with every partner to monitor and supervise their activities in a collaborative manner.

IV.5 EVALUATION QUESTION 5

What innovations has the project introduced and consolidated?

MANGO, an innovative cell phone technology application owned and installed by Greenmash, was to be the primary intervention by which PMI-EP would strengthen the existing SCM system. The application was introduced as a pilot in Kasai Oriental in the early months of the project, and after overcoming many challenges, it began working smoothly and data was being collected through it. Planning had begun for rolling it out into specific zones in the other four provinces. However, the initiative was never expanded, despite a full investment into it, and Greenmash activities were closed out by October 2016.

It is no longer operational anywhere. There are differing opinions about why this innovation could not be consolidated and rolled out to other provinces as originally planned.

IV.6 EVALUATION QUESTION 6

How well are PMI and USAID support activities through PMI-EP recognized?

PMI-EP, PMI, and USAID are well-known to health system officials at the central, provincial, and HZ levels, but at the community level, PMI-EP and USAID are not known by name. The most recognized partners at the community level were ASF and Caritas. The low recognition of USAID and PMI-EP is probably due to the fact that some implementing partners did not sufficiently promote the donor (i.e., USAID).

However, while communities do not know PMI-EP and USAID by name, the impact of their activities is recognized by everyone on the ground.

Several people noted that the name of the project had no meaning to local people, and this could be one important reason for not remembering it or recognizing it. Using a name that has local significance and that is in a language understood by local people could strengthen recognition of projects and donors connected to them. "Tolonga" was the original name proposed for the project; it is unclear why it was not used.

It is also not evident that the marking plan was implemented effectively. For example, one person noted that a vehicle seen in one province was marked with the ASF logo, but not the USAID logo, while carrying out project work. In future projects, rigorous application of marking plans should be monitored.

IV.7 OTHER MANAGEMENT FINDINGS

The implementation of PMI-EP project activities was made possible by the involvement of multiple partners and required working closely with all stakeholders. Coordination with implementing partners, the MOH, the National Malaria Control Program, and the DRC's long-standing partners contributed to the program's success. Dialogue among partners at the central level, through the Roll Back Malaria partnership, has also been an important coordination mechanism.

Challenges

- **Some stakeholders reported that their involvement was not very consistent** in the project's design and implementation. This feeling was widely shared by all of the Provincial Health Directorate and HZ managers. An HZ manager expressed his feelings in these terms: "We feel like our opinions do not matter. We often make relevant observations and suggestions based on the realities we face on the ground, but no one listens to us."

  A manager at the central level of the MOH echoed that sentiment, saying, "One of the major problems we've seen in all projects like PMI-EP is a lack of involvement of the NMCP in the operational planning of the project. This makes it impossible to take into account the real needs of different levels of the health system in order to best implement the project."

- **Lack of consistent coordination and communication** between the Lead Partner (PSI) and other project partners. Some of the project's implementing partners felt that PSI did not consider them "real partners," but rather implementers of a task assigned to them. This may reflect different understandings of roles and expectations, which were not clarified prior to signing partnership agreements.

  Related to this is the complaint by HZ staff about the lack of communication regarding the project's close-out. In HZs in Tshopo, where the project had closed, the HZ personnel

indicated that there were no formal discussions with the partner about the transition or how to sustain project achievements.

Recommendations

- Ensure a consistent involvement of all stakeholders in project strategic planning and operational processes.
- Improve communication with all stakeholders throughout the planning, implementation, M&E, and close-out processes.

V. CONCLUSIONS AND RECOMMENDATIONS

Conclusions and recommendations specific to the individual evaluation questions can be found in the Findings section of this report (p. 9). Below are more general conclusions and recommendations.

V.1 OVERALL CONCLUSIONS

Based on both quantitative findings from all nine provinces and qualitative findings from the two provinces obtained through this evaluation, and measured against the core evaluation questions as described in the SOW discussed herein, PMI-EP has achieved significant results and greatly contributed to improvements related to IR1 and IR2, increased use of malaria prevention and treatment services in DRC. This is a significant achievement, particularly given the challenging environment in which it has been implemented, where insecurity is widespread, infrastructure is very weak, natural physical barriers abound, resources—both human and financial—are extremely limited, and capacity to carry out interventions is not always adequate.

Regarding IR3, and based on the proposed interventions in the SOW from the Cooperative Agreement (which was the foundational document for this evaluation), the project has not been as effective, particularly as related to SCM (IR3.3). This suggests that longer-term sustainability of results achieved in IRs1 and 2 may be vulnerable, as commodity supply is still largely dependent upon financial support for a parallel distribution system, not existing systems as was the stated objective of the project:

> "As one of the original designers of the CDRs, HERA will lead the Team in strengthening the public sector logistics and SCM system while Greenmash will offer technology solutions. Support to the CDRs and the health zone level storage facilities will be in line with national and provincial level policies for strengthening national procurement and supply systems. While the team will focus on malaria commodities, this will be in the context of strengthening the supply chain system such that the whole system improves, not only the part geared toward malaria."

V.2 OTHER MAJOR CONCLUSIONS AND RECOMMENDATIONS

Other major conclusions and corresponding recommendations include the following:

V.2.1. Conclusion

The development of CCSs has removed logistical and infrastructure barriers for families seeking care for their children. Where these sites are operative, they are achieving the objectives intended for them.

Recommendation

Strategically prioritize expansion of CCSs into areas that are most remote and where the need is greatest, then expand into other less remote areas.

V.2.2. Conclusion

The project contributed to improved malaria management in the health system, particularly through health worker training and improvements in data collection and analysis. These interventions were considered highly effective by project stakeholders and health workers at every level of the health system.

Recommendation

Because of frequent staff turnover, it is important that training be continued and systematic, even if done through less formal settings.

V.2.3. Conclusion

Quality supervision is not consistently implemented. While supervision may be more cost-effective than formal training, the quality and regularity of supervision is critical to ensuring that high-quality services and information are being offered at all HCs.

Recommendations

1. Ensure that supervisors are technically qualified.
2. Offer training on quality supervision to supervisors in a cascade approach.
3. Closely monitor implementation of supervision plans to ensure regularity and quality.

V.2.4. Conclusion

SCM is still relatively weak, despite some efforts to improve it. Recurrent stockouts of commodities have likely diminished what could have been even greater results from project interventions. Stockouts of LLINs, ACT, and SP in several HZs early in 2017 may specifically negatively affect overall project results for Year 5.

Recommendation

Greater resources should be invested in strengthening the weak existing SCM system, as opposed to creating a parallel distribution approach. While some of the CDRs are not fully operational, resources applied to helping them become functional would be a better investment for improving SCM over the long term.

V.2.5. Conclusion

Weak infrastructure and logistical breakdowns have enormous impact on the efficiency and effectiveness of project implementation. This notably includes impassable roads (especially during rainy seasons), electrical outages, internet and phone breakdowns, as well as unavailable or broken down transport for delivering commodities and long walking distances to remote sites, which are all major barriers to ensuring availability and access to services and products.

Recommendation

Similar future projects should give greater consideration to these challenges and how to strategically mitigate them.

V.2.6. Conclusion

Stakeholders' involvement in the project strategic and operational planning was not sufficient.

Recommendation

Key stakeholders, such as NMCP and appropriate provincial and HZ staff, should be included, particularly in the project operational planning. This will ensure that needs and challenges at the local level are included in project work. It will also strengthen project ownership and sustainability at the local level.

V.2.7. Conclusion

The cost of services (including posted and unposted) is a continuing barrier to seeking preventive and curative services at HCs. Government policy indicates that malaria-related commodities should be free. Unfortunately, fees for services (e.g., consultation, medical booklets) hamper access to the free commodities.

Recommendations

1. Continue to use donor coordination meetings as a platform for discussing and addressing the issue of health personnel salary payment and the establishment of an incentive rewarding mechanism (e.g., performance-based financing).
2. Continue advocacy for harmonizing pricing with the lowest possible user's fees.

ANNEX 1. SCOPE OF WORK

Assignment #: 376 [*assigned by GH Pro*]

Global Health Program Cycle Improvement Project (GH Pro)
Contract No. AID-OAA-C-14-00067

EVALUATION OR ANALYTIC ACTIVITY STATEMENT OF WORK (SOW)
Date of Submission: 02/09/2017
Last update: 03/21/2017

I. Title: Final Performance Evaluation of President's Malaria Initiative (PMI) Expansion in the Democratic Republic of the Congo

II. Requester / Client

■ USAID Country or Regional Mission
Mission/Division: DRC / Health Office

III. Funding Account Source(s): (Click on box(es) to indicate source of payment for this assignment)

☐ 3.1.1 HIV	☐ 3.1.4 PIOET	☐ 3.1.7 FP/RH
☐ 3.1.2 TB	☐ 3.1.5 Other public health threats	☐ 3.1.8 WSSH
■ 3.1.3 Malaria	☐ 3.1.6 MCH	☐ 3.1.9 Nutrition
		☐ 3.2.0 Other (specify):

IV. Cost Estimate: Note: GH Pro will provide a cost estimate based on this SOW

V. Performance Period

Expected Start Date (on or about): May 1, 2017
Anticipated End Date (on or about): September 30, 2017

VI. Location(s) of Assignment: (Indicate where work will be performed)

DRC: Kinshasa, plus 3 other provinces. Most likely, site visits during the evaluation will be Kisangani (Tshopo Province), Kalemie (Tanganyika Province) and Mbuji Mayi (Kasai Oriental Province). Specific sites will be identified within each.

VII. Type of Analytic Activity (Check the box to indicate the type of analytic activity)

EVALUATION:

■ **Performance Evaluation** (Check timing of data collection)

■ Midterm ■ Endline ☐ Other (specify): _

Performance evaluations *encompass a broad range of* evaluation *methods. They often incorporate before–after comparisons but generally lack a rigorously defined counterfactual. Performance* evaluations *may address descriptive, normative, and/or cause-and-effect questions. They may focus on what a particular project or program has achieved (at any point during or after implementation); how it was implemented; how it was perceived and valued; and other questions that are pertinent to design, management, and operational decision making*

☐ **Impact Evaluation** (*Check timing(s) of data collection*)

☐ Baseline ☐ Midterm ☐ Endline ☐ Other (specify):

Impact evaluations *measure the change in a development outcome that is attributable to a defined intervention. They are based on models of cause and effect and require a credible and rigorously defined counterfactual to control for factors other than the intervention that might account for the observed change. Impact* evaluations *in which comparisons are made between beneficiaries that are randomly assigned to either a treatment or a control group provide the strongest evidence of a relationship between the intervention under study and the outcome measured.*

OTHER ANALYTIC ACTIVITIES

☐ Assessment

Assessments are designed to examine country and/or sector context to inform project design, or as an informal review of projects.

☐ Costing and/or Economic Analysis

Costing and Economic Analysis can identify, measure, value and cost an intervention or program. It can be an assessment or evaluation, with or without a comparative intervention/program.

☐ Other Analytic Activity (Specify)

PEPFAR EVALUATIONS *(PEPFAR* evaluation *Standards of Practice 2014)*

Note: If PEPFA-funded, check the box for type of evaluation

☐ **Process Evaluation** *(Check timing of data collection)*

☐ Midterm ☐ Endline ☐ Other (specify): _____

Process evaluation *focuses on program or intervention implementation, including, but not limited to access to services, whether services reach the intended population, how services are delivered, client satisfaction and perceptions about needs and services, management practices. In addition, a process* evaluation *might provide an understanding of cultural, socio-political, legal, and economic context that affect implementation of the program or intervention. For example: Are activities delivered as intended, and are the right participants being reached? (PEPFAR* evaluation *Standards of Practice 2014)*

☐ **Outcome Evaluation**

Outcome evaluation *determines if and by how much, intervention activities or services achieved their intended outcomes. It focuses on outputs and outcomes (including unintended effects) to judge program effectiveness, but may also assess program process to understand how outcomes are produced. It is possible to use statistical techniques in some instances when control or comparison groups are not available (e.g., for the* evaluation *of a national program). Example of question asked: To what extent are desired changes occurring due to the program, and who is benefiting? (PEPFAR* evaluation *Standards of Practice 2014)*

☐ **Impact Evaluation** *(Check timing(s) of data collection)*
☐ Baseline ☐ Midterm ☐ Endline ☐ Other (specify):
Impact evaluations *measure the change in an outcome that is attributable to a defined intervention by comparing actual impact to what would have happened in the absence of the intervention (the counterfactual scenario). IEs are based on models of cause and effect and require a rigorously defined counterfactual to control for factors other than the intervention that might account for the observed change. There are a range of accepted approaches to applying a counterfactual analysis, though IEs in which comparisons are made between beneficiaries that are randomly assigned to either an intervention or a control group provide the strongest evidence of a relationship between the intervention under study and the outcome measured to demonstrate impact.*

☐ **Economic Evaluation** (PEPFAR)
Economic evaluation *identifies, measures, values and compares the costs and outcomes of alternative interventions. Economic* evaluation *is a systematic and transparent framework for assessing efficiency focusing on the economic costs and outcomes of alternative programs or interventions. This framework is based on a comparative analysis of both the costs (resources consumed) and outcomes (health, clinical, economic) of programs or interventions. Main types of economic* evaluation *are cost-minimization analysis (CMA), cost-effectiveness analysis (CEA), cost-benefit analysis (CBA) and cost-utility analysis (CUA). Example of question asked: What is the cost-effectiveness of this intervention in improving patient outcomes as compared to other treatment models?*

VIII. Background

If an evaluation, Project/Program being evaluated:

Project Title:	President's Malaria Initiative (PMI) Expansion in the Democratic Republic of Congo (PMI – Expansion)
Award Number:	AID -623-A-12-00028
Award Dates:	October 18, 2012 to October 17, 2017
Project Funding:	$25 Million
Implementing Organization(s):	Prime: Population Services International (PSI) Subs: PSI local affiliate *Association de Santé Familiale* (PSI/ASF), Caritas Congo, Greenmash, Hera, Kinshasa School of Public Health (KSPH), and Liverpool School of Tropical Medicine
Project AOR:	Debbie Gueye
Development Objective (DO):	Lives improved through coordinated, sustainable development approaches in select regions

Background of project/program/intervention (*Provide a brief background on the country and/or sector context; specific problem or opportunity the intervention addresses; and the development hypothesis*)

The Problem
The Malaria Situation in the DRC

The Democratic Republic of the Congo (DRC) currently has one of the lowest gross national incomes per capita in the world ($190). An estimated 80 percent of the population lives below the poverty line and half live in extreme poverty.

The health system lacks financial and material resources and supply chain breakdowns are widespread, particularly in remote areas. This leaves a majority of the country with limited access to health care services, and those are often poor quality. Access to primary health care remains a challenge, with 70 to 80 percent of the population having difficult or no access to health care or who do not utilize the care available.

The Ministry of Health (MOH) and the National Malaria Control Program (NMCP) use population estimates of approximately 89,000,000 in 2017 and 92,000,000 in 2018, with the majority living in rural areas. An estimated 97% of the population lives in zones with stable malaria transmission lasting eight to 12 months per year. Malaria is reported by the MOH to be the principal cause of morbidity and mortality in the DRC, accounting for more than 40% of all outpatient visits and for 19% of deaths among children under five years of age. *Plasmodium falciparum* accounts for approximately 95% of all infections. The 2013-14 Demographic and Health Survey supplemental malaria report showed estimates of national malaria prevalence in children 6-59 months ranging from 23% to 34%. Prevalence based on both microscopy and the PCR test increased with age and was higher for those living in rural areas as compared to those living in urban areas.

The primary vectors of malaria in the DRC are *Anopheles gambiae*, *An. coluzzii*, and *An. funestus*. Resistance to dichlorodiphenyltrichloroethane (DDT) and permethrin has been found, with increasing resistance to deltamethrin being found. As of yet, little resistance to organophosphates and carbamates has been detected.

Malaria control efforts financed by PMI include the PMI-Expansion Project, the Integrated Health Project, Malaria Care, Measure Evaluation, DELIVER, and SIAPS.

PMI Expansion in the Democratic Republic of the Congo Project overview

The project is implemented by a consortium led by Population Services International (PSI) and its local affiliate *Association de Santé Familiale* (ASF). The consortium includes two international sub-awards, namely Liverpool School of Tropical Medicine (LSTM) and Hera, and two local sub-grantees namely *Caritas Congo Développement* and the Kinshasa School of Public Health (KSPH). A sub-contract with Greenmash was terminated in 2016 due to failure to deliver expected services.

The purpose of USAID/DRC PMI-Expansion Project is to increase coverage and use of key life-saving malaria interventions in support of the DRC's NMCP. This project complements the existing USAID/DRC Integrated Health Project (IHP) and other donor-supported malaria programs.

The PMI Expansion Project provides assistance to implement a subset of activities outlined in the PMI strategic plan and the annual PMI/DRC Malaria Operational Plans in accordance with the NMCP guidelines and standards. During the first year it implemented activities in 44 health zones (HZ) in the four provinces of South Kivu, East and West Kasai and Katanga. It expanded into 24 additional HZs in Orientale Province starting the second year, for a total of 68 HZs. The project supports 1,308 health facilities and 733 community care sites to implement routine malaria interventions. This includes (i) malaria prevention: IPTp and LLIN distribution to children under one-year old and pregnant women, (ii) malaria case management, (iii) SBCC and (iv) institutional capacity strengthening at the operational level.

Theory of Change of target project/program/intervention

If we increase use of malaria prevention interventions (Intermediate Result 1), and if we improve malaria diagnosis and treatment interventions (IR-2) and if we strengthen the health system capacity to manage malaria prevention and treatment interventions at the operational level (IR 3), then we will be able to achieve our activity objective of assisting the Government of the Democratic Republic of the Congo to achieve the target of reducing malaria-associated mortality by 50 percent, compared to pre-initiative levels.

Strategic or Results Framework for the project/program/intervention (*paste framework below*)

The activity objective and results are summarized in the following framework:

Activity Objective: Assist the Government of the Democratic Republic of Congo to achieve the target of reducing malaria-associated mortality by 50 percent, compared to pre-initiative levels.		
Intermediate Result 1: Increased use of malaria prevention interventions	**Intermediate Result 2: Improved malaria diagnosis and treatment interventions**	**Intermediate Result 3: Strengthened health system capacity to manage malaria prevention and treatment interventions at operational level (province, health zone (HZ), community)**
Sub-Intermediate Results	Sub-Intermediate Results	Sub-Intermediate Results
1.1. Increased availability and use of intermittent preventive treatment in pregnancy (IPTp)	2.1 Improved diagnostic capacity and use	3.1 Enhanced technical knowledge, skills and competencies of health service personnel
1.2 Increased supply and use of long lasting insecticide treated nets (LLINs)	2.2 Improved case management of uncomplicated and severe malaria	3.2 Improved provincial, HZ and community capacity to collect, manage and use malaria health information for monitoring and evaluation
		3.3 Improved provincial and HZ capacity in supply chain management
		3.4 Improved provincial and HZ management teams' capacity to coordinate stakeholders

What is the geographic coverage and/or the target groups for the project or program that is the subject of analysis?

DRC: South Kivu, East Kasai, West Kasai, Katanga and Orientale provinces. (When territorial reform was implemented in 2015/2016, the number of provinces increased from 11 to 26. The provinces supported by PMI-EP were then Tshopo, Bas-Uele, Lomami, Kasai Oriental, Kasai Central, Haut-Katanga, Tanganyika and Sud-Kivu.)

IX. SCOPE OF WORK

A. **Purpose**: Why is this evaluation or analysis being conducted (purpose of analytic activity)? Provide the specific reason for this activity, linking it to future decisions to be made by USAID leadership, partner governments, and/or other key stakeholders.

The purpose of this evaluation is to determine the extent to which project outcomes were achieved and to inform future USAID/DRC health strategy and design. More specifically, the performance evaluation will assess whether results of the project have been achieved as planned and whether the final goals are expected to be achieved and give light on the successes and challenges of project implementation and lessons learned for future malaria interventions.

B. **Audience**: Who is the intended audience for this analysis? Who will use the results? If listing multiple audiences, indicate which are most important.

The audience of the performance evaluation will be the USAID/DRC Mission, specifically the Health Office and Program Office, and the implementing partner. An executive summary and recommendations will be provided to the MOH. USAID will use the report to adjust as appropriate its current malaria interventions and to share lessons learned with other stakeholders

C. **Applications and use**: How will the findings be used? What future decisions will be made based on these findings?

D. **Evaluation/Analytic Questions & Matrix**:

a) Questions should be: a) aligned with the evaluation/analytic purpose and the expected use of findings; b) clearly defined to produce needed evidence and results; and c) answerable given the time and budget constraints. Include any disaggregation (e.g., sex, geographic locale, age, etc.), they must be incorporated into the evaluation/analytic questions. **USAID Evaluation Policy recommends 1to 5 evaluation questions.**

b) List the recommended methods that will be used to collect data to be used to answer each question.

c) State the application or use of the data elements towards answering the evaluation questions; for example, i) ratings of quality of services, ii) magnitude of a problem, iii) number of events/occurrences, iv) gender differentiation, v) etc.

	Evaluation Question	Suggested Data Sources (*)	Suggested Data Collection Methods	Data Analysis Methods
1	To what extent has there been an increased use of malaria prevention interventions, particularly the increased availability and use of intermittent preventive treatment in pregnancy and increased supply and use of long - lasting insecticide – treated nets?	- *DHS and national malaria reports;* - *data collected by the project, data at the facility and community level and HMIS.*	- *Document review at the Project and NMCP central, provincial and HF level.* - *Patient and community member interviews* - *Focus groups*	- *Data will be analyzed according to province.* - *Data, when available will be disaggregated by sex and age.* - *Case studies may reinforce quantitative results.*
2	To what extent have malaria diagnosis and treatment interventions been improved?	- *DHS and national malaria reports;* - *data collected by the project*	- *Document review at the Project and NMCP central, provincial and HF level.* - *Data verification by patient records and beneficiary interviews, review of laboratory records.*	- *ditto*
3	To what extent has the health system been strengthened to manage malaria preventive and treatment interventions?	- *Ditto* - *Review of data and reports related to issues such as supply chain management.* - *Interviews with stakeholders*	- *Data and report review* - *Interviews with key stakeholders*	- *Summary and, principally qualitative reporting,* - *Case studies.*
4	What main factors, including those that are gender related, facilitated or posed challenges to the successful achievement of the project objective?	- *Review of reports* - *Interviews with stakeholders*	- *Data and report review* - *Interviews with key stakeholders*	- *Summary and, principally qualitative reporting,* - *Case studies.*
5	What innovations has the project introduced and consolidated?	- *Stakeholder interviews*	- *Interviews*	- *Results summary*
6	How well are PMI and USAID support activities through PMI – Expansion recognized?	- *Partners* - *National, provincial and Health authorities* - *Community leaders and beneficiaries*	- *Interviews*	- *Results summary*

Other Questions *[OPTIONAL]*
(***Note***: Use this space only if necessary. Too many questions lead to an ineffective evaluation or analysis.)

E. **Methods**: Check and describe the recommended methods for this analytic activity. Selection of methods should be aligned with the evaluation/analytic questions and fit within the time and resources allotted for this analytic activity. Also, include the sample or sampling frame in the description of each method selected.

General Comments related to Methods:
During the Team Planning Meeting (TPM), the Evaluation Team will work with USAID/DRC staff, implementing partners, other donors and country counterparts finalize the methodology for the evaluations, sampling frames, and data collection instruments for the final PMI - Expansion Evaluation. The Team will be responsible for managing the evaluation and data collection in the field, working directly with program implementers, verifying data quality and preparing clean data sets, for analysis.

The final performance evaluation will use both quantitative and qualitative methods. Questions will need to be answered around all key outcomes/results resulting from IR 1, 2 and 3 interventions.

In addition to the methods listed below, the Evaluation Team may also want to consider Client Exit Interviews, data abstractions, observations and/or case studies. The exact methods to do this will be finalized during the TPM.

■ **Document and Data Review** (*list of documents and data recommended for review*)

This desk review will be used to provide background information on the project/program, and will also provide data for analysis for this evaluation. Documents and data to be reviewed include:

- Project health zone data including health zone lists and map
- Malaria Operation Plans
- Malaria Country Strategies
- DRC PMI Expansion Cooperative Agreement AID-623-A-12-00028
- DRC PMI Expansion work plans
- DRC PMI Expansion quarterly and annual reports
- Project PMP
- DRC DHS 2013-14 (http://dhsprogram.com/Where-We-Work/Country-Main.cfm?ctry_id=243&c=Congo%20Democratic%20Republic&Country=Congo%20Democratic%20Republic&cn=&r=1)
- MICS 2010 (http://mics.unicef.org/surveys)
- National malaria reports, strategies & publications

☐ **Secondary analysis of existing data** *(This is a re-analysis of existing data, beyond a review of data reports. List the data source and recommended analyses)*

Data Source (existing dataset)	Description of Data	Recommended Analysis

■ **Key Informant Interviews** *(list categories of key informants, and purpose of inquiry)*

Interviews will be held with key stakeholders to obtain information about their perceptions of the project, and particularly information needed to answer the evaluation questions.

- PMI – Expansion project staff
- USAID/DRC PMI staff
- National Malaria Program Staff (central and provincial levels)
- Ministry of Health Staff (central, provincial and zone levels)
- Community leaders

■ **Focus Group Discussions** *(list categories of groups, and purpose of inquiry)*

Discussions around malaria services received at health facilities and community care sites; use of malaria prevention measures at home and care seeking behaviors.

■ **Group Interviews** *(list categories of groups, and purpose of inquiry)*

Key informant interviews may be grouped, as long as the respondents feel free to express their opinions openly.

■ **Verbal Autopsy** *(list the type of mortality being investigated (i.e., maternal deaths), any cause of death and the target population)*

X. Human Subject Protection

The Analytic Team must develop protocols to insure privacy and confidentiality prior to any data collection. Primary data collection must include a consent process that contains the purpose of the evaluation, the risk and benefits to the respondents and community, the right to refuse to answer any question, and the right to refuse participation in the evaluation at any time without consequences. Only adults can consent as part of this evaluation. **Minors cannot be respondents to any interview or survey, and cannot participate in a focus group discussion without going through an IRB**. The only time minors can be observed as part of this evaluation is as part of a large community-wide public event, when they are part of family and community in the public setting. During the process of this evaluation, if data are abstracted from existing documents that include unique identifiers, data can only be abstracted without this identifying information.

An Informed Consent statement included in all data collection interactions must contain:

- Introduction of facilitator/note-taker
- Purpose of the evaluation/assessment
- Purpose of interview/discussion/survey
- Statement that all information provided is confidential and information provided will not be connected to the individual
- Right to refuse to answer questions or participate in interview/discussion/survey
- Request consent prior to initiating data collection (i.e., interview/discussion/survey)

XI. Analytic Plan

Describe how the quantitative and qualitative data will be analyzed. Include method or type of analyses, statistical tests, and what data it to be triangulated (if appropriate). For example, a thematic analysis of qualitative interview data, or a descriptive analysis of quantitative survey data.

All analyses will be geared to answer the evaluation questions. Additionally, the evaluation will review both qualitative and quantitative data related to the project/program's achievements against its objectives and/or targets.

Quantitative data will be analyzed primarily using descriptive statistics. Data will be stratified by demographic characteristics, such as sex, age, and location, whenever feasible. Other statistical test of association (i.e., odds ratio) and correlations will be run as appropriate.

Thematic review of qualitative data will be performed, connecting the data to the evaluation questions, seeking relationships, context, interpretation, nuances and homogeneity and outliers to better explain what is happening and the perception of those involved. Qualitative data will be used to substantiate quantitative findings, provide more insights than quantitative data can provide, and answer questions where other data do not exist.

Use of multiple methods that are quantitative and qualitative, as well as existing data (e.g., project/program performance indicator data, DHS, MICS, HMIS data, etc.) will allow the Team to triangulate findings to produce more robust evaluation results.

The Evaluation Report will describe analytic methods and statistical tests employed in this evaluation.

XII. Activities

List the expected activities, such as Team Planning Meeting (TPM), briefings, verification workshop with IPs and stakeholders, etc. Activities and Deliverables may overlap. Give as much detail as possible.

Background reading – Several documents are available for review for this analytic activity. These include PMI – Expansion program description, annual work plans, M&E plans, quarterly progress reports, and routine reports of project performance indicator data, as well as survey data reports (i.e., DHS and MICS). This desk review will provide background information for the Evaluation Team, and will also be used as data input and evidence for the evaluation.

Team Planning Meeting (TPM) – A four-day team planning meeting (TPM) will be held at the initiation of this assignment and before the data collection begins. The TPM will:

- Review and clarify any questions on the evaluation SOW
- Clarify team members' roles and responsibilities
- Establish a team atmosphere, share individual working styles, and agree on procedures for resolving differences of opinion
- Review and finalize evaluation questions
- Review and finalize the assignment timeline
- Develop data collection methods, instruments, tools and guidelines
- Review and clarify any logistical and administrative procedures for the assignment
- Develop a data collection plan
- Draft the evaluation work plan for USAID's approval
- Develop a preliminary draft outline of the team's report
- Assign drafting/writing responsibilities for the final report

Briefing and Debriefing Meetings – Throughout the evaluation the Team Lead will provide briefings to USAID. The In-Brief and Debrief are likely to include the all Evaluation Team experts, but will be determined in consultation with the Mission. These briefings are:

- Evaluation **launch**, a call/meeting among the USAID, GH Pro and the Team Lead to initiate the evaluation activity and review expectations. USAID will review the purpose, expectations, and agenda of the assignment. GH Pro will introduce the Team Lead, and review the initial schedule and review other management issues.
- **In-brief with USAID**, as part of the TPM. At the beginning of the TPM, the Evaluation Team will meet with USAID Health and Program Management officers and CO for introductions, and to discuss assumptions and expectations, review evaluation questions, and intended plans. The Team will also raise questions that they may have about the project/program and SOW resulting from their background document review. The time and place for this in-brief will be determined between the Team Lead and USAID prior to the TPM.
- **Workplan and methodology review briefing and document**. At the end of the TPM, the Evaluation Team will meet with USAID to present an outline of the methods/protocols, timeline and data collection tools. Also, the format and content of the Evaluation report(s) will be discussed. Following this meeting the workplan will be finalized and submitted to USAID and GH Pro. It will include: (1) a detailed evaluation design matrix that links the Evaluation Questions in the SOW to data sources, methods, sampling frame and/or criteria, and the data analysis plan; (2) data collection tools that include a consent statement; (3) a list of potential interviewees and sites to be visited; (4) known limitations to the evaluation design, and a timeline (calendar or Gantt chart).
- **In-brief with project** to review the evaluation plans and timeline, and for the project to give an overview of the project to the Evaluation Team.
- **Midterm and Interim briefings**: The Team Lead (TL) will brief the USAID weekly to discuss progress on the evaluation. Also, at the midpoint of the evaluation the TL will meet (in person or by phone as determined by USAID) with the COR and Health Office representatives to discuss the status of the evaluation, including potential challenges and emerging opportunities.
- A **final debrief** between the Evaluation Team and USAID will be held at the end of the evaluation to present preliminary findings to USAID. During this meeting a summary of the data will be presented, along with high level findings and draft recommendations. For the debrief, the Evaluation Team will prepare a **PowerPoint Presentation** of the key findings, issues, and recommendations. The Evaluation Team shall incorporate comments received from USAID during the debrief in the evaluation report. (***Note**: preliminary findings are not final and as more data sources are developed and analyzed these finding may change.*)
- **IP & Stakeholders' debrief/workshop** will be held with the project staff and other stakeholders identified by USAID. This will occur following the final debrief with the Mission, and will not include any information that may be procurement deemed sensitive or not suitable by USAID.

Fieldwork, Site Visits and Data Collection – The Evaluation Team will conduct site visits to for data collection. Selection of sites to be visited will be finalized during TPM in consultation with USAID. The Evaluation Team will outline and schedule key meetings and site visits prior to departing to the field.

Final Presentation – The Evaluation Team is expected to hold a final presentation in person or by web-conferencing to discuss the summary of findings and recommendations to USAID. This presentation will be scheduled as agreed upon during the in-briefing. Present during the meeting

should be members of the program and health offices and the implementing partner. As might be determined during the final presentation, an additional presentation would be given to the PNCP, donors and additional stakeholders

Evaluation/Analytic Report – The Evaluation/Analytic Team under the leadership of the Team Lead will develop a report with findings and recommendations (see Analytic Report below). Report writing and submission will include the following steps:

1. Team Lead will submit draft evaluation report to GH Pro for review and formatting
2. GH Pro will submit the draft report to USAID
3. USAID will review the draft report in a timely manner, and send their comments and edits back to GH Pro
4. GH Pro will share USAID's comments and edits with the Team Lead, who will then do final edits, as needed, and resubmit to GH Pro
5. GH Pro will review and reformat the final Evaluation/Analytic Report, as needed, and resubmit to USAID for approval.
6. Once Evaluation Report is approved, GH Pro will re-format it for 508 compliance and post it to the DEC.

The Evaluation Report **excludes** any **procurement-sensitive** and other sensitive but unclassified (**SBU**) information. This information will be submitted in a memo to USIAD separate from the Evaluation Report.

Data Submission – All quantitative data will be submitted to GH Pro in a machine-readable format (CSV or XML). The datasets created as part of this evaluation must be accompanied by a data dictionary that includes a codebook and any other information needed for others to use these data. It is essential that the datasets are stripped of all identifying information, as the data will be public once posted on USAID Development Data Library (DDL).

Where feasible, qualitative data that do not contain identifying information should also be submitted to GH Pro.

XIII. Deliverables and Products

Select all deliverables and products required on this analytic activity. For those not listed, add rows as needed or enter them under "Other" in the table below. Provide timelines and deliverable deadlines for each.

Deliverable / Product	Timelines & Deadlines (estimated)
■ Launch briefing	May 1, 2017
■ In-brief with USAID	May 15, 2017
■ Workplan and methodology review briefing	May 19, 2017
■ Workplan (must include questions, methods, timeline, data analysis plan, and instruments)	May 20, 2017
■ In-brief with PMI - Expansion	May 22, 2017
■ Routine briefings	Weekly
■ Debrief with USAID with Power Point presentation	June 23, 2017
■ Findings review workshop with IP & stakeholders with Power Point presentation	June 26, 2017
■ Draft report	*Submit to GH Pro*: July 14, 2017 *GH Pro submits to USAID*: July 19, 2017

Deliverable / Product	Timelines & Deadlines (estimated)
■ Final report	*Submit to GH Pro*: August 17, 2017 *GH Pro submits to USAID*: August 22, 2017
■ Final Presentation with USAID with Power Point presentation (via web-conference)	August 24, 2017
■ Raw data (cleaned datasets in CSV or XML with data dictionary)	August 17, 2017
■ Report Posted to the DEC	September 26, 2017
☐ Other (specify):	

Estimated USAID review time
Average number of business days USAID will need to review Evaluation Report? 15 Business days

XIV. Team Composition, Skills and Level of Effort (LOE)

Evaluation/Analytic team: When planning this analytic activity, consider:

- Key staff should have methodological and/or technical expertise, regional or country experience, language skills, team lead experience and management skills, etc.
- Team leaders for evaluations/analytics must be an external expert with appropriate skills and experience.
- Additional team members can include research assistants, enumerators, translators, logisticians, etc.
- Teams should include a collective mix of appropriate methodological and subject matter expertise.
- Evaluations require an Evaluation Specialist, who should have evaluation methodological expertise needed for this activity. Similarly, other analytic activities should have a specialist with methodological expertise.
- Note that **all team members will be required to provide a signed statement attesting that they have no conflict of interest (COI)**, or describing the conflict of interest if applicable.

Team Qualifications: Please list technical areas of expertise required for this activity:

- *List desired qualifications for the team as a whole*
- *List the key staff needed for this analytic activity and their roles.*
- *Sample position descriptions are posted on USAID/GH Pro webpage*
- *Edit as needed GH Pro provided position descriptions*

Overall Team requirements:
A member of the implementing partner will accompany the Evaluation Team during field visits to make sure appropriate introductions are made to officers of the MOH, PNCP, to health facility personnel, community leaders and members, and to other stakeholders. Appropriate arrangements should be made so that their presence does not affect the unbiased collection and analysis of information. Similarly, a member of the PMI malaria team may participate as an observer as the Evaluation Team conducts field visits. When it is determined by the Program Office and Evaluation Team that the presence of the PMI team member in the field visits has the potential of affecting the collection or analysis of results the PMI member will abstain from participating in the field activity.

Team Lead: This person will be selected from among the key staff, and will meet the requirements of both this and the other position. The team lead should have significant experience conducting project evaluations/analytics.

Roles & Responsibilities: The team leader will be responsible for (1) providing team leadership; (2) managing the team's activities, (3) ensuring that all deliverables are met in a timely manner, (4) serving as a liaison between the USAID and the evaluation/analytic team, and (5) leading briefings and presentations.

Qualifications:

- Minimum of 15 years of experience in public health, which included experience in implementation of health activities in developing countries
- Demonstrated experience leading health sector project/program evaluation/analytics, utilizing both quantitative and qualitative s methods
- Excellent skills in planning, facilitation, and consensus building
- Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners, and other stakeholders
- Excellent skills in project management
- Excellent organizational skills and ability to keep to a timeline
- Good writing skills, with extensive report writing experience
- Experience working in the region, and experience in DRC is desirable
- Familiarity with USAID
- Familiarity with USAID policies and practices
  - Evaluation policy
  - Results frameworks
  - Performance monitoring plans

Key Staff 1 Title: **Evaluation Specialist**

Roles & Responsibilities: Serve as a member of the Evaluation Team, providing quality assurance on evaluation issues, including methods, development of data collection instruments, protocols for data collection, data management and data analysis. S/He will oversee the training of all engaged in data collection, insuring highest level of reliability and validity of data being collected. S/He is the lead analyst, responsible for all data analysis, and will coordinate the analysis of all data, assuring all quantitative and qualitative data analyses are done to meet the needs for this evaluation. S/He will participate in all aspects of the evaluation, from planning, data collection, data analysis to report writing.

Qualifications:

- At least 10 years of experience in USAID M&E procedures and implementation
- At least 5 years managing M&E, including evaluations
- Experience in design and implementation of evaluations
- Strong knowledge, skills, and experience in qualitative and quantitative evaluation tools
- Experience implementing and coordinating other to implements surveys, key informant interviews, focus groups, observations and other evaluation methods that assure reliability and validity of the data.
- Experience in data management
- Able to analyze quantitative, which will be primarily descriptive statistics
- Able to analyze qualitative data

- Experience using analytic software
- Demonstrated experience using qualitative evaluation methodologies, and triangulating with quantitative data
- Able to review, interpret and reanalyze as needed existing data pertinent to the evaluation
- Strong data interpretation and presentation skills
- An advanced degree in public health, evaluation or research or related field
- Proficient in English and French
- Good writing skills, including extensive report writing experience
- Familiarity with USAID health programs/projects, primary health care or health systems strengthening preferred
- Familiarity with USAID M&E policies and practices
  - Evaluation policies
  - Results frameworks
  - Performance monitoring plans

Title: **Evaluation Malaria Specialist**

Roles & Responsibilities: Serve as a member of the Evaluation Team, providing expertise in malaria prevention, diagnosis and treatment, as well as health system capacity to manage malaria interventions. S/He will participate in planning and briefing meetings, development of data collection methods and tools, data collection, data analysis, development of evaluation presentations, and writing of the Evaluation Report.

Qualifications:
- At least 10 years' experience working on community health activities within primary health and/or health systems strengthening projects; USAID project implementation experience preferred
- Experience working on malaria intervention projects that have included prevention, diagnosis, treatment, and/or health system strengthening
- Familiarity with PMI
- Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners, and other stakeholders
- Experience conducting evaluations and/or related research, including development of data collection tools
- Experience conducting qualitative data collection and analysis, such as key informant interviews, focus groups and/or observations
- Proficient in English and French
- Good writing skills, specifically technical and evaluation report writing experience
- Experience in conducting USAID evaluations of health programs/activities

Other Staff Titles with Roles & Responsibilities (include number of individuals needed):

Local **Evaluation Logistics /Program Assistant** will support the Evaluation Team with all logistics and administration to allow them to carry out this evaluation. The Logistics/Program Assistant will have a good command of English, French, and Lingala &/or Swahili. S/He will have knowledge of key actors in the health sector and their locations including MOH, donors and other stakeholders. To support the Team, s/he will be able to efficiently liaise with hotel staff, arrange in-country transportation (ground and air), arrange meeting and workspace as needed, and insure business center support, e.g. copying, internet, and printing. S/he will work under the guidance of the Team Leader to make preparations, arrange meetings and appointments. S/he will conduct programmatic

administrative and support tasks as assigned and ensure the processes moves forward smoothly. S/He may also be asked to assist in translation of data collection tools and transcripts, if needed.

Local **Evaluators/Malaria Consultants** (2 consultants) to assist the Evaluation Team with data collection, analysis and data interpretation. They will assist in translation of data collection tools and transcripts, as needed. They will have familiarity with malaria prevention, diagnosis and/or treatment in DRC, as well as experience conducting surveys, interviews and focus group discussion, both facilitating and note taking. The Local Evaluators will have a good command of English, French, and Lingala &/or Swahili. They will also assist the Team and the Logistics Coordinator, as needed. They will report to the Team Lead.

Will USAID participate as an active team member or designate other key stakeholders to as an active team member? This will require full time commitment during the evaluation or analytic activity.

☐ Yes – If yes, specify who:
☐ Significant Involvement anticipated – If yes, specify who:
■ No

Staffing Level of Effort (LOE) Matrix:
This LOE Matrix will help you estimate the LOE needed to implement this analytic activity. If you are unsure, GH Pro can assist you to complete this table.

a) For each column, replace the label "Position Title" with the actual position title of staff needed for this analytic activity.
b) Immediately below each staff title enter the anticipated number of people for each titled position.
c) Enter Row labels for each activity, task and deliverable needed to implement this analytic activity.
d) Then enter the LOE (estimated number of days) for each activity/task/deliverable corresponding to each titled position.
e) At the bottom of the table total the LOE days for each consultant title in the 'Sub-Total' cell, then multiply the subtotals in each column by the number of individuals that will hold this title.

Level of Effort in **days** for each Evaluation/Analytic Team member
(The following is an Illustrative LOE Chart. Please edit to meet the requirements of this activity.)

	Activity / Deliverable	Evaluation/Analytic Team			
		Team Lead / Malaria Specialist	Evaluation Specialist	Local Evaluators Malaria Specialist	Logistics Program Assist
	Number of persons →	1	1	2	1
1	Launch Briefing	0.5			
2	HTSOS Training	1	1		
3	Desk review	7	7	7	
4	Preparation for Team convening in-country				2
5	Travel to country	2	1		
6	In-brief with Mission	0.5	0.5	0.5	0.5
7	Team Planning Meeting	4	4	4	4
8	Workplan and methodology briefing with USAID	0.5	0.5	0.5	0.5

Activity / Deliverable		Evaluation/Analytic Team			
		Team Lead / Malaria Specialist	Evaluation Specialist	Local Evaluators Malaria Specialist	Logistics Program Assist
9	Eval planning deliverables: 1) workplan with timeline analytic protocol (methods, sampling & analytic plan); 2) data collection tools				
10	In-brief with project	0.5	0.5	0.5	0.5
11	Data Collection DQA Workshop (protocol orientation/training for all data collectors)	2	2	2	
12	Prep / Logistics for Site Visits	0.5	0.5	0.5	2
13	Data collection / Site Visits (including travel to sites)	18	18	18	18
14	Data analysis	7	7	7	3
15	Debrief with Mission with prep	1	1	1	1
16	Stakeholder debrief workshop with prep	1	1	1	1
17	Depart country	2	1		
18	Draft report(s)	8	7	4	1
19	GH Pro Report QC Review & Formatting				
20	Submission of draft report(s) to Mission				
21	USAID Report Review				
22	USAID manages Stakeholder review (eg, IP(s), government partners, etc) and submits any Statement of Difference to GH Pro.				
23	Revise report(s) per USAID comments	4	3	2	
24	Finalize and submit report to USAID				
25	USAID approves report				
26	Final copy editing and formatting				
27	508 Compliance editing				
28	Eval Report(s) to the DEC				
	Total LOE per person	**60**	**55**	**48**	**34**
	Total LOE	**60**	**55**	**96**	**34**

If overseas, is a 6-day workweek permitted ■ Yes ☐ No

Travel anticipated: List international and local travel anticipated by what team members.

Travel to DRC for international consultants. Sites to be visited within DRC are Kisangani (Tshopo Province), Kalemie (Tanganyika Province) and Mbuji Mayi (Kasai Oriental Province).

XV. Logistics

Visa Requirements
List any specific Visa requirements or considerations for entry to countries that will be visited by consultant(s):

Consultants will need notarized invitation letter from the Mission. GH Pro should allow for a week to obtain this letter and approximately 2 weeks to obtain the visa.

List recommended/required type of Visa for entry into counties where consultant(s) will work

Name of Country	Type of Visa		
DRC	■ Tourist	☐ Business	☐ No preference
	☐ Tourist	☐ Business	☐ No preference
	☐ Tourist	☐ Business	☐ No preference
	☐ Tourist	☐ Business	☐ No preference

Clearances & Other Requirements

Note: Most Evaluation/Analytic Teams arrange their own work space, often in conference rooms at their hotels. However, if a Security Clearance or Facility Access is preferred, GH Pro can submit an application for it on the consultant's behalf.

GH Pro can obtain **Secret Security Clearances** and **Facility Access (FA)** for our consultants, but please note these requests processed through USAID/GH (Washington, DC) can take 4-6 months to be granted, with Security Clearance taking approximately 6 months to obtain. If you are in a Mission and the RSO is able to grant a temporary FA locally, this can expedite the process. If Security Clearance or FA is granted through Washington, DC, the consultant must pick up his/her badge in person at the Office of Security in Washington, DC, regardless of where the consultant resides or will work.

If **Electronic Country Clearance (eCC)** is required prior to the consultant's travel, the consultant is also required to complete the **High Threat Security Overseas Seminar (HTSOS).** HTSOS is an interactive e-Learning (online) course designed to provide participants with threat and situational awareness training against criminal and terrorist attacks while working in high threat regions. There is a small fee required to register for this course. [*Note: The course is not required for employees who have taken FACT training within the past five years or have taken HTSOS within the same calendar year.*]

If eCC is required, and the consultant is expected to work in country more than 45 consecutive days, the consultant may be required complete the one week **Foreign Affairs Counter Threat (FACT) course** offered by FSI in West Virginia. This course provides participants with the knowledge and skills to better prepare themselves for living and working in critical and high threat overseas environments. Registration for this course is complicated by high demand (consultants must register approximately 3-4 months in advance). Additionally, there will be the cost for additional lodging and M&IE to take this course.

Check all that the consultant will need to perform this assignment, including USAID Facility Access, GH Pro workspace and travel (other than to and from post).

☐ USAID Facility Access (FA)
Specify who will require Facility Access: _____
☐ Electronic County Clearance (ECC) (International travelers only)
■ High Threat Security Overseas Seminar (HTSOS) (*required in most countries with ECC*)
☐ Foreign Affairs Counter Threat (FACT) (for consultants working on country more than 45 consecutive days)
☐ GH Pro workspace
Specify who will require workspace at GH Pro: _____
☐ Travel -other than posting (specify): _____
☐ Other (specify): _____

Specify any country-specific **security concerns and/or requirements**

XVI. GH PRO Roles and Responsibilities

GH Pro will coordinate and manage the evaluation/analytic team and provide quality assurance oversight, including:

- Review SOW and recommend revisions as needed
- Provide technical assistance on methodology, as needed
- Develop budget for analytic activity
- Recruit and hire the evaluation/analytic team, with USAID POC approval
- Arrange international travel and lodging for international consultants
- Request for country clearance and/or facility access (if needed)
- Review methods, workplan, analytic instruments, reports and other deliverables as part of the quality assurance oversight
- Report production - If the report is public, then coordination of draft and finalization steps, editing/formatting, 508ing required in addition to and submission to the DEC and posting on GH Pro website. If the report is internal, then copy editing/formatting for internal distribution.

XVII. USAID Roles and Responsibilities

Below is the standard list of USAID's roles and responsibilities. Add other roles and responsibilities as appropriate.

USAID Roles and Responsibilities

USAID will provide overall technical leadership and direction for the analytic team throughout the assignment and will provide assistance with the following tasks:

Before Field Work

- SOW.
  - Develop SOW.
  - Peer Review SOW
  - Respond to queries about the SOW and/or the assignment at large.
- Consultant Conflict of Interest (COI). To avoid conflicts of interest or the appearance of a COI, review previous employers listed on the CV's for proposed consultants and provide additional information regarding potential COI with the project contractors evaluated/assessed and information regarding their affiliates.
- Documents. Identify and prioritize background materials for the consultants and provide them to GH Pro, preferably in electronic form, at least one week prior to the inception of the assignment.
- Local Consultants. Assist with identification of potential local consultants, including contact information.
- Site Visit Preparations. Provide a list of site visit locations, key contacts, and suggested length of visit for use in planning in-country travel and accurate estimation of country travel line items costs.
- Lodgings and Travel. Provide guidance on recommended secure hotels and methods of in-country travel (i.e., car rental companies and other means of transportation).

During Field Work

- Mission Point of Contact. Throughout the in-country work, ensure constant availability of the Point of Contact person and provide technical leadership and direction for the team's work.
- Meeting Space. Provide guidance on the team's selection of a meeting space for interviews and/or focus group discussions (i.e. USAID space if available, or other known office/hotel meeting space).
- Meeting Arrangements. Assist the team in arranging and coordinating meetings with stakeholders.
- Facilitate Contact with Implementing Partners. Introduce the analytic team to implementing partners and other stakeholders, and where applicable and appropriate prepare and send out an introduction letter for team's arrival and/or anticipated meetings.

After Field Work

- Timely Reviews. Provide timely review of draft/final reports and approval of deliverables.

XVIII. Analytic Report

Provide any desired guidance or specifications for Final Report. (See *How-To Note: Preparing evaluation Reports*)

The **Evaluation/Analytic Final Report** must follow USAID's Criteria to Ensure the Quality of the Evaluation Report (found in Appendix I of the USAID Evaluation Policy).

- The report must not exceed 25 pages (excluding executive summary, table of contents, acronym list and annexes).
- The structure of the report should follow the Evaluation Report template, including branding found here or here.
- Draft reports must be provided electronically, in English, to GH Pro who will then submit it to USAID.
- For additional Guidance, please see the Evaluation Reports to the How-To Note on preparing Evaluation Draft Reports found here.

USAID Criteria to Ensure the Quality of the Evaluation Report (USAID ADS 201):

- Evaluation reports should be readily understood and should identify key points clearly, distinctly, and succinctly.
- The Executive Summary of an evaluation report should present a concise and accurate statement of the most critical elements of the report.
- Evaluation reports should adequately address all evaluation questions included in the SOW, or the evaluation questions subsequently revised and documented in consultation and agreement with USAID.
- Evaluation methodology should be explained in detail and sources of information properly identified.
- Limitations to the evaluation should be adequately disclosed in the report, with particular attention to the limitations associated with the evaluation methodology (selection bias, recall bias, unobservable differences between comparator groups, etc.).
- Evaluation findings should be presented as analyzed facts, evidence, and data and not based on anecdotes, hearsay, or simply the compilation of people's opinions.
- Findings and conclusions should be specific, concise, and supported by strong quantitative or qualitative evidence.
- If evaluation findings assess person-level outcomes or impact, they should also be

separately assessed for both males and females.
- If recommendations are included, they should be supported by a specific set of findings and should be action-oriented, practical, and specific.

Reporting Guidelines: The draft report should be a comprehensive analytical evidence-based evaluation/analytic report. It should detail and describe results, effects, constraints, and lessons learned, and provide recommendations and identify key questions for future consideration. The report shall follow USAID branding procedures. ***The report will be edited/formatted and made 508 compliant as required by USAID for public reports and will be posted to the USAID/DEC.***

The findings from the evaluation/analytic will be presented in a draft report at a full briefing with USAID and at a follow-up meeting with key stakeholders. The report should use the following format:

- Abstract: briefly describing what was evaluated, evaluation questions, methods, and key findings or conclusions (not more than 250 words)
- Executive Summary: summarizes key points, including the purpose, background, evaluation questions, methods, limitations, findings, conclusions, and most salient recommendations (3-5 pages)
- Table of Contents (1 page)
- Acronyms
- Evaluation/Analytic Purpose and Evaluation/Analytic Questions: state purpose of, audience for, and anticipated use(s) of the evaluation/assessment (1-2 pages)
- Project Background: describe the project/program and the background, including country and sector context, and how the project/program addresses a problem or opportunity (1-3 pages)
- Evaluation Methods and Limitations: data collection, sampling, data analysis and limitations (1-3 pages)
- Findings (organized by Evaluation/Analytic Questions): substantiate findings with evidence/data
- Conclusions
- Recommendations
- Annexes
    - Annex I: Evaluation/Analytic Statement of Work
    - Annex II: Evaluation/Analytic Methods and Limitations ((if not described in full in the main body of the evaluation report)
    - Annex III: Data Collection Instruments
    - Annex IV: Sources of Information
        - List of Persons Interviews
        - Bibliography of Documents Reviewed
        - Databases
        - [etc.]
    - Annex V: Statement of Differences (if applicable)
    - Annex VI: Disclosure of Any Conflicts of Interest
    - Annex VII: Summary information about Evaluation Team members, including qualifications, experience, and role on the team.

The evaluation methodology and report will be compliant with the USAID Evaluation Policy and Checklist for Assessing USAID Evaluation Reports

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The Evaluation Report should **exclude** any **potentially procurement-sensitive information**. As needed, any procurement sensitive information or other sensitive but unclassified (SBU) information will be submitted in a memo to USIAD separate from the Evaluation Report.

All data instruments, data sets (if appropriate), presentations, meeting notes and report for this evaluation/analysis will be submitted electronically to the GH Pro Program Manager. All datasets developed as part of this evaluation will be submitted to GH Pro in an unlocked machine-readable format (CSV or XML). The datasets must not include any identifying or confidential information. The datasets must also be accompanied by a data dictionary that includes a codebook and any other information needed for others to use these data. Qualitative data included in this submission should not contain identifying or confidential information. Category of respondent is acceptable, but names, addresses and other confidential information that can easily lead to identifying the respondent should not be included in any quantitative or qualitative data submitted.

XIX. USAID Contacts

Primary Contact		Alternate Contact 1	Alternate Contact 2
Name:	Debbie Gueye	Izetta Minko-Moreau	Karen Koprince
Title:	Malaria Team Leader	Health Office Director	Acting Deputy Health Office Director
USAID Mission:	USAID/DRC	USAID/DRC	USAID/DRC
Email:	dgueye@usaid.gov	isimmons@usaid.gov	kkoprince@usaid.gov
Telephone:	(243) 81-555-4433	243-81-555-4614	
Cell Phone:	(243) 81-707-4701	243-81-950-1206	

List other contacts who will be supporting the Requesting Team with technical support, such as reviewing SOW and Report (such as USAID/W GH Pro management team staff)

Technical Support Contact 1		Technical Support Contact 2
Name:		
Title:		
USAID Office/Mission		
Email:		
Telephone:		
Cell Phone:		

XX. Other Reference Materials

Documents and materials needed and/or useful for consultant assignment, that are not listed above

XXI. Adjustments Made in Carrying out This SOW after Approval of the SOW

(*To be completed after Assignment Implementation by GH Pro*)

ANNEX II. DATA COLLECTION TOOLS

FINAL EVALUATION OF THE PMI PROJECT EXTENSION IN THE DEMOCRATIC REPUBLIC OF THE CONGO (DRC)

Community Tool 3: Guide for Focus Group Discussions (FGD) with _____

IDENTIFICATION

Province

Health Zone

Health Center

Village

FGD Date /____//____/-/____//____/-/____//____/ (DD/MM/YY)

Facilitator

Introduction

Hello,

My name is _____. I am an independent consultant working on behalf of the USAID Mission in the DRC. Thank you for agreeing to take the time to speak with me today. The USAID Mission in the DRC is gathering information as part of an evaluation of the President's Malaria Initiative, or PMI, extension project, implemented by PSI/ASF. This evaluation aims to assess the project's achievements, to identify good practices, lessons learned, and suggestions, and to develop recommendations to improve the fight against malaria.

This discussion will last approximately one hour. All of your answers to the questions will be kept anonymous. Your answers may be noted or recorded during the discussion. If you feel uncomfortable for any reason at any time, you have the right to refuse to answer a question or to end your participation in the discussion.

Do each of you confirm that you have received sufficient information, that you voluntarily consent to participate in this discussion, and that I have your permission to record the discussion?

FINAL EVALUATION OF THE PMI PROJECT EXTENSION IN THE DEMOCRATIC REPUBLIC OF THE CONGO (DRC)

Community Tool 3: Guide for Focus Group Discussions (FGD) with Men

IDENTIFICATION

	Province	
	Health Zone	
	Health Center	
	Village	
	FGD Date	/____//____/-/____//____/-/____//____/ (DD/MM/YY)
	Facilitator	

IDENTIFICATION

Province

Health Zone

Health Center

Village

FGD Date /____//____/-/____//____/-/____//____/ (DD/MM/YY)

Facilitator

Introduction

Hello,

My name is _____. I am an independent consultant working on behalf of the USAID Mission in the DRC. Thank you for agreeing to take the time to speak with me today. The USAID Mission in the DRC is gathering information as part of an evaluation of the President's Malaria Initiative, or PMI, extension project, implemented by PSI/ASF. This evaluation aims to assess the project's achievements, to identify good practices, lessons learned, and suggestions, and to develop recommendations to improve the fight against malaria.

This discussion will last approximately one hour. All of your answers to the questions will be kept anonymous. Your answers may be noted or recorded during the discussion. If you feel uncomfortable for any reason at any time, you have the right to refuse to answer a question or to end your participation in the discussion.

Do each of you confirm that you have received sufficient information, that you voluntarily consent to participate in this discussion, and that I have your permission to record the discussion?

Yes /__/ No /__/

Yes /__/ No /__/

Yes /__/ No /__/

Yes /__/ No /__/

Yes /__/ No /__/

Yes /__/ No /__/

Yes /__/ No /__/

Yes /__/ No /__/

Yes /__/ No /__/

Yes /__/ No /__/

Yes /__/ No /__/

Yes /__/ No /__/

The participants voluntarily consented to participate in the discussion: _____

Please attach the list of participants.

Topic 1: Knowledge of malaria, preventive measures, and treatment

Causes

Vulnerable groups

Signs, and warning signs in children

Consequences

Preventive measures

Treatment

Topic 2: Experiences using health services, accessing services in the community and in health centers, facilitating factors, and challenges, including aspects related to gender and culture

Topic 3: Sources of information and partners/stakeholders

FINAL EVALUATION OF THE PMI PROJECT EXTENSION IN THE DEMOCRATIC REPUBLIC OF THE CONGO (DRC)

Community Tool 3: Guide for Focus Group Discussions (FGD) with Women

IDENTIFICATION

Province

Health Zone

Health Center

Village

FGD Date /____//____/-/____//____/-/____//____/ (DD/MM/YY)

Facilitator

Introduction

Hello,

My name is _____. I am an independent consultant working on behalf of the USAID Mission in the DRC. Thank you for agreeing to take the time to speak with me today. The USAID Mission in the DRC is gathering information as part of an evaluation of the President's Malaria Initiative, or PMI, extension project, implemented by PSI/ASF. This evaluation aims to assess the project's achievements, to identify good practices, lessons learned, and suggestions, and to develop recommendations to improve the fight against malaria.

This discussion will last approximately one hour. All of your answers to the questions will be kept anonymous. Your answers may be noted or recorded during the discussion. If you feel uncomfortable for any reason at any time, you have the right to refuse to answer a question or to end your participation in the discussion.

Do each of you confirm that you have received sufficient information, that you voluntarily consent to participate in this discussion, and that I have your permission to record the discussion?

Participant 1 Yes /__/ No /__/

Participant 2 Yes /__/ No /__/

Participant 3 Yes /__/ No /__/

Participant 4 Yes /__/ No /__/

Participant 5 Yes /__/ No /__/

Participant 6 Yes /__/ No /__/

Participant 7 Yes /__/ No /__/

Participant 8 Yes /__/ No /__/

Participant 9 Yes /__/ No /__/

Participant 10 Yes /__/ No /__/

Participant 11 Yes /__/ No /__/

Participant 12 Yes /__/ No /__/

The participants voluntarily consented to participate in the discussion: _____

Topic 1: Knowledge of malaria, preventive measures, and treatment

Follow-up

- Causes
- Vulnerable groups
- Signs, and warning signs in children
- Consequences
- Preventive measures
- Treatment

Topic 2: Use of health services

Follow-up

- Experiences using health services
- Access to malaria prevention and control services in the community
- Access to malaria prevention and control services in health centers
- Facilitating factors
- Challenges/constraints, including aspects related to gender and culture, and the role of women in seeking care
- Recommendations/Suggestions

Topic 3: Sources of information and partners/stakeholders

Follow-up

- Sources of information on malaria and available services
- Role of different actors in malaria control
- Knowledge of malaria control partners/support programs and the impact of their efforts in the community

FINAL EVALUATION OF THE PMI PROJECT EXTENSION IN THE DEMOCRATIC REPUBLIC OF THE CONGO (DRC)

Health Zone Tool 3: Interview Guide for the Health Information Manager

IDENTIFICATION

Health Zone	
Health Zone	
Interview Date	/____//____/-/____//____/-/____//____/ (DD/MM/YY)
Title	
Years in the Position	
Gender	/___/ M /___/ F
Interviewer	

Introduction

Hello,

My name is _____. I am an independent consultant working on behalf of the USAID Mission in the DRC. Thank you for agreeing to take the time to speak with me today. The USAID Mission in the DRC is gathering information as part of an evaluation of the President's Malaria Initiative, or PMI, extension project, implemented by PSI/ASF. This evaluation aims to assess the project's achievements, to identify good practices, lessons learned, and suggestions, and to develop recommendations to improve the fight against malaria.

This interview will last 30-45 minutes. All of your answers to the questions will be kept anonymous. Your answers may be noted or recorded during the interview. If you feel uncomfortable for any reason at any time, you have the right to refuse to answer a question or to end the interview.

Do you confirm that you have received sufficient information and that you voluntarily consent to participate in this interview? Yes /__/ No /__/

Do you confirm that I have your permission to record our interview? Yes /__/ No /__/

The participant voluntarily consented to participate in the interview: _____

1. Can you briefly describe the Health Information Management system in your Health Zone?
2. What is the mechanism for collecting, processing, and analyzing health information, particularly concerning malaria, in your Health Zone?
3. What do you think have been the biggest achievements and improvements in producing health information in your Health Zone? What are the biggest challenges?
4. In terms of producing health information, how would you assess the following:

- *Availability of data collection tools*

  /__/ Highly satisfactory

  /__/ Satisfactory

  /__/ Somewhat satisfactory

  /__/ Unsatisfactory

  Please explain: _____

- *Staff abilities/skills*

  /__/ Highly satisfactory

  /__/ Satisfactory

  /__/ Somewhat satisfactory

  /__/ Unsatisfactory

  Please explain: _____

- *Completeness of reports*

  /__/ Highly satisfactory

  /__/ Satisfactory

  /__/ Somewhat satisfactory

  /__/ Unsatisfactory

  Please explain: _____

- *Timely submission of reports*

  /__/ Highly satisfactory

  /__/ Satisfactory

  /__/ Somewhat satisfactory

  /__/ Unsatisfactory

  Please explain: _____

- *Data analysis and use in decision-making*

  /__/ Highly satisfactory

/__/ Satisfactory

/__/ Somewhat satisfactory

/__/ Unsatisfactory

Please explain: _____

1. Have you participated in any Health Information Management data validation meetings during the past three months? *Yes* /__/ *No* /__/
2. Have you received any Health Information Management training/retraining? Yes /__/ No /__/

   Year…… Topic……

3. If the interviewee received training: What added value did the training provide, and how did your work change as a result of the training?
4. Has your department received a supervisory visit during the past three months?

   Yes /__/ No /__/

5. Are you familiar with or have you heard of the PMI expansion project implemented by PSI/ASF (main support activities in the Health Zone)?
6. What major changes has the PMI expansion project made in terms of malaria control in general and the Health Information Management system in particular in your Health Zone?
7. Has the project provided any innovations in terms of the Health Information Management system in your Health Zone? Yes /__/ No /__/ If yes, please explain.
8. How would you suggest improving the production of health information in your Health Zone?
9. Is there anything else related to this topic that you would like to discuss?

Thank you for your time.

Note to interviewer: Make sure all answers are complete before ending the interview.

FINAL EVALUATION OF THE PMI PROJECT EXTENSION IN THE DEMOCRATIC REPUBLIC OF THE CONGO (DRC)

Health Center Tool 3: Interview Guide for the Person in Charge of the Health Center Drug Store

IDENTIFICATION

Province

Health Zone

Health Center

Interview Date /____//____/-/____//____/-/____//____/ (DD/MM/YY)

Title

Years in the Position

Gender /___/ M /___/ F

Interviewer

Introduction

Hello,

My name is _____. I am an independent consultant working on behalf of the USAID Mission in the DRC. Thank you for agreeing to take the time to speak with me today. The USAID Mission in the DRC is gathering information as part of an evaluation of the President's Malaria Initiative, or PMI, extension project, implemented by PSI/ASF. This evaluation aims to assess the project's achievements, to identify good practices, lessons learned, and suggestions, and to develop recommendations to improve the fight against malaria.

This interview will last 30-45 minutes. All of your answers to the questions will be kept anonymous. Your answers may be noted or recorded during the interview. If you feel uncomfortable for any reason at any time, you have the right to refuse to answer a question or to end the interview.

Do you confirm that you have received sufficient information and that you voluntarily consent to participate in this interview? Yes /__/ No /__/

Do you confirm that I have your permission to record our interview? Yes /__/ No /__/

The participant voluntarily consented to participate in the interview: _____

1. How does the Health Center procure essential medicines?

2. Have you received any training/retraining? *Yes* /__/ *No* /__/

If yes: Date……Topic……

If the interviewee received training: What added value did the training provide, and how did your work change as a result of the training?

3. Have you received any supervisory visits from the Health Zone during the past three months? *Yes* /__/ *No* /__/

4. How would you assess the availability of medicines, particularly antimalarial commodities, in your Health Center?

5. During the past three months, which of the following antimalarial commodities were out of stock (specify the commodity, length of stockout, and causes)?

Commodities	**Length of stockout**
SP	|__|1-2 weeks |__|3-4 weeks |__|4 weeks or more
Infant ACT	|__|1-2 weeks |__|3-4 weeks |__|4 weeks or more
Child ACT	|__|1-2 weeks |__|3-4 weeks |__|4 weeks or more
Adolescent ACT	|__|1-2 weeks |__|3-4 weeks |__|4 weeks or more
Adult ACT	|__|1-2 weeks |__|3-4 weeks |__|4 weeks or more
Artesunate suppositories	|__|1-2 weeks |__|3-4 weeks |__|4 weeks or more
RDTs	|__|1-2 weeks |__|3-4 weeks |__|4 weeks or more
LLINs	|__|1-2 weeks |__|3-4 weeks |__|4 weeks or more

6. Are you familiar with the PMI expansion project implemented by PSI/ASF (main activities in the area of procuring essential medicines, particularly antimalarial commodities)?

7. What are the biggest challenges in the management of essential medicines, particularly antimalarial commodities, in your Health Center?

8. Is there anything else related to this topic that you would like to discuss?

CHECKLIST: Check the availability of the following commodities in the drug store on the day of the interview.

Commodity	**Available?**	**Comments**

	Yes	**No**	
Sulfadoxine Pyrimethamine			
Infant ACT			
Child ACT			
Adolescent ACT			
Adult ACT			
Artesunate suppositories			
Rapid Diagnostic Tests			
Mosquito nets			
Are stock records up-to-date? |__|Yes |__|No			

Thank you for your time.

Note to interviewer: Make sure all answers are complete before ending the interview.

FINAL EVALUATION OF THE PMI PROJECT EXTENSION IN THE DEMOCRATIC REPUBLIC OF THE CONGO (DRC)

Health Center Tool 2: Interview Guide for the Person in Charge of Antenatal Care (ANC)

IDENTIFICATION

Province

Health Zone

Health Center

Interview Date /____//____/-/____//____/-/____//____/ (DD/MM/YY)

Title

Years in the Position

Gender /___/ M /___/ F

Interviewer

Introduction

Hello,

My name is _____. I am an independent consultant working on behalf of the USAID Mission in the DRC. Thank you for agreeing to take the time to speak with me today. The USAID Mission in the DRC is gathering information as part of an evaluation of the President's Malaria Initiative, or PMI, extension project, implemented by PSI/ASF. This evaluation aims to assess the project's achievements, to identify good practices, lessons learned, and suggestions, and to develop recommendations to improve the fight against malaria.

This interview will last 30-45 minutes. All of your answers to the questions will be kept anonymous. Your answers may be noted or recorded during the interview. If you feel uncomfortable for any reason at any time, you have the right to refuse to answer a question or to end the interview.

Do you confirm that you have received sufficient information and that you voluntarily consent to participate in this interview? Yes /__/ No /__/

Do you confirm that I have your permission to record our interview? Yes /__/ No /__/

The participant voluntarily consented to participate in the interview: _____

1. What are the primary actions or interventions performed in your facility to prevent malaria during pregnancy (in particular, what services are offered to pregnant women to prevent malaria)?
2. What ANC services must pregnant women pay for?
3. How would you describe pregnant women's use of ANC (frequent or infrequent, and what are the factors)?
4. What are the biggest problems your facility faces in offering ANC services?
5. What services does the community request that you cannot offer?
6. Are you familiar with the PMI expansion project implemented by PSI/ASF? If so, what are the project's main activities (how does the project contribute to malaria control)?
7. Have you received any malaria training/retraining? Yes /__/ No /__/

   If yes: Date……Topic……
8. If the interviewee received training: What added value did the training provide, and how did your work change as a result of the training?
9. Have you received any supervisory visits from the Health Zone during the past three months?

   Yes /__/ No /__/
10. Have you received any follow-up visits from PSI/ASF during the past three months? *Yes /__/ No /__/*
11. Is there anything else related to this topic that you would like to discuss?

Thank you for your time.

Note to interviewer: Make sure all answers are complete before ending the interview.

FINAL EVALUATION OF THE PMI PROJECT EXTENSION IN THE DEMOCRATIC REPUBLIC OF THE CONGO (DRC)

Health Zone Tool 2: Interview Guide for the Health Zone Pharmacist

IDENTIFICATION

Health Zone

Health Zone

Interview Date /____//____/-/____//____/-/____//____/ (DD/MM/YY)

Title

Years in the Position

Gender /___/ M /___/ F

Interviewer

Introduction

Hello,

My name is _____. I am an independent consultant working on behalf of the USAID Mission in the DRC. Thank you for agreeing to take the time to speak with me today. The USAID Mission in the DRC is gathering information as part of an evaluation of the President's Malaria Initiative, or PMI, extension project, implemented by PSI/ASF. This evaluation aims to assess the project's achievements, to identify good practices, lessons learned, and suggestions, and to develop recommendations to improve the fight against malaria.

This interview will last 30-45 minutes. All of your answers to the questions will be kept anonymous. Your answers may be noted or recorded during the interview. If you feel uncomfortable for any reason at any time, you have the right to refuse to answer a question or to end the interview.

Do you confirm that you have received sufficient information and that you voluntarily consent to participate in this interview? Yes /__/ No /__/

Do you confirm that I have your permission to record our interview? Yes /__/ No /__/

The participant voluntarily consented to participate in the interview: _____

1. What is the procurement mechanism for medicines and consumables (particularly antimalarials) in Health Zones?
2. Do you have a management, procurement, and distribution plan for medicines and consumables (for subsidized antimalarial commodities)? Yes /__/ No /__/
3. Has your department received a supervisory visit during the past three months? Yes /__/ No /__/
4. How would you assess the availability of medicines, particularly antimalarial commodities, in your Health Zone?
5. During the past three months, which of the following antimalarial commodities were out of stock? (Specify the commodity, length of stockout, and causes.)

Commodity	Length of stockout
Sulfadoxine Pyrimethamine	|__|1-2 weeks |__|3-4 weeks |__|4 weeks or more
Infant ACT	|__|1-2 weeks |__|3-4 weeks |__|4 weeks or more
Child ACT	|__|1-2 weeks |__|3-4 weeks |__|4 weeks or more
Adolescent ACT	|__|1-2 weeks |__|3-4 weeks |__|4 weeks or more
Adult ACT	|__|1-2 weeks |__|3-4 weeks |__|4 weeks or more
Quinine	|__|1-2 weeks |__|3-4 weeks |__|4 weeks or more
Injectable artesunate	|__|1-2 weeks |__|3-4 weeks |__|4 weeks or more
Artesunate suppositories	|__|1-2 weeks |__|3-4 weeks |__|4 weeks or more
RDTs	|__|1-2 weeks |__|3-4 weeks |__|4 weeks or more
LLINs	|__|1-2 weeks |__|3-4 weeks |__|4 weeks or more
Laboratory reagents and consumables	|__|1-2 weeks |__|3-4 weeks |__|4 weeks or more

1. Are you familiar with the PMI expansion project implemented by PSI/ASF (main interventions in the procurement of essential medicines, particularly antimalarial commodities)?

2. What major changes has the PMI expansion project made in terms of procuring medicines, particularly antimalarial commodities?
3. Has your department received any visits from PSI/ASF during the past three months? Yes /__/ No /__/
4. Has the project provided any innovations in terms of pharmaceutical management?
5. Yes /__/ No /__/ If yes, please explain.
6. What are the biggest challenges in the procurement of essential medicines, particularly antimalarial commodities, in your Health Zone?
7. Is there anything else related to this topic that you would like to discuss?

CHECKLIST - Health Zone Pharmacy: Check the availability of the following commodities.

Commodity	**Available?**		**Comments**
	Yes	**No**	
SP			
Infant ACT			
Child ACT			
Adolescent ACT			
Adult ACT			
Quinine			
Injectable artesunate			
Artesunate suppositories			
RDTs			
LLINs			
Laboratory reagents and consumables			
Are stock records up-to-date? |__|Yes |__|No			

Thank you for your time.

Note to interviewer: Make sure all answers are complete before ending the interview.

FINAL EVALUATION OF THE PMI PROJECT EXTENSION IN THE DEMOCRATIC REPUBLIC OF THE CONGO (DRC)

Community Tool 5: Survey Guide for Pregnant Women in Households

IDENTIFICATION

Province	
Health Zone	
Health Center	
Village	
Survey Date	/____//____/-/____//____/-/____//____/ (DD/MM/YY)
Surveyor	
Household Number	
Head of Household	
Age of Woman	
Gestational Age	

Introduction

Hello,

My name is _____. I am an independent consultant working on behalf of the USAID Mission in the DRC. Thank you for agreeing to take the time to speak with me today. The USAID Mission in the DRC is gathering information as part of an evaluation of the President's Malaria Initiative, or PMI, extension project, implemented by PSI/ASF. This evaluation aims to assess the project's achievements, to identify good practices, lessons learned, and suggestions, and to develop recommendations to improve the fight against malaria.

This survey will last 30 minutes. All of your answers to the questions will be kept anonymous. Your answers may be noted or recorded during the survey. If you feel uncomfortable for any reason at any time, you have the right to refuse to answer a question or to end the survey.

Do you confirm that you have received sufficient information and that you voluntarily consent to participate in this survey? Yes /__/ No /__/

Do you confirm that I have your permission to record our survey? Yes /__/ No /__/

The participant voluntarily consented to participate in the survey: _____

1. Have you heard of malaria? If so, where did you get your information?
2. How does someone get malaria?

3. For whom does malaria pose the greatest risk?
4. How can a pregnant woman protect herself and her unborn baby from malaria?
5. Did you sleep under a mosquito net last night? If no, why not?
6. Have you gone to the Health Center for Antenatal Care (ANC)? If so, how many times, and what services did you receive?
7. What Health Center services did you pay for? (If she paid for services, specify the services and cost.)
    - Service……..Cost……..
    - Service……..Cost……..
8. Do you have to ask permission from a family member before going to the Health Center? If so, who has to give you permission, and why?
9. What difficulties do you face in obtaining ANC from the Health Center?
10. How would you suggest improving pregnant women's access to Health Center services?
11. Is there anything else related to this topic that you would like to discuss?

Thank you for your time.

Note to interviewer: Make sure all answers are complete before ending the interview.

FINAL EVALUATION OF THE PMI PROJECT EXTENSION IN THE DEMOCRATIC REPUBLIC OF THE CONGO (DRC)

Community Tool 1: Interview Guide for Community Health Workers (CHW)

IDENTIFICATION

Province

Health Zone

Health Center

Village

Interview Date /____//____/-/____//____/-/____//____/ (DD/MM/YY)

Title

Years in the Position

Gender /___/ M /___/ F

Interviewer

Introduction

Hello,

My name is _____. I am an independent consultant working on behalf of the USAID Mission in the DRC. Thank you for agreeing to take the time to speak with me today. The USAID Mission in the DRC is gathering information as part of an evaluation of the President's Malaria Initiative, or PMI, extension project, implemented by PSI/ASF. This evaluation aims to assess the project's achievements, to identify good practices, lessons learned, and suggestions, and to develop recommendations to improve the fight against malaria.

This interview will last 30-45 minutes. All of your answers to the questions will be kept anonymous. Your answers may be noted or recorded during the interview. If you feel uncomfortable for any reason at any time, you have the right to refuse to answer a question or to end the interview.

Do you confirm that you have received sufficient information and that you voluntarily consent to participate in this interview? Yes /__/ No /__/

Do you confirm that I have your permission to record our interview? Yes /__/ No /__/

The participant voluntarily consented to participate in the interview: _____

1. What are your main responsibilities as a CHW in your community? When did you begin working as a CHW?
2. Is malaria a health problem in your community?

   Please explain:_____

3. What malaria control activities do you conduct?
4. Which malaria control activities do you think have had a positive impact in your community? Why?
5. As a CHW, what do you do when a patient has a fever?
6. How would you assess the availability and access of malaria prevention and treatment services:
   - In the community?
   - In health centers?
   - What are the biggest challenges?
7. In your opinion, based on your experience as a CHW, do men and women in your community have the same opportunity to access your services and those in health centers? Please explain.
8. Which malaria control services do you offer that patients must pay for?
9. Have you received any malaria training/retraining?

   Date……Topic……

10. If the CHW received training: What added value did the training provide, and how did your work change as a result of the training?
11. Do you have data collection materials (including reference sheets)?

    Yes /__/ No /__/ (Verify physical availability)

12. Do you have malaria treatment guidelines? Yes /__/ No /__/ (Verify physical availability)
13. Do you have educational/BCC materials on malaria? Yes /__/ No /__/ (Verify physical availability)
14. Did you receive a supervisory visit from the Health Center during the past month (May 2017)?

    Yes /__/ No /__/

15. Did you receive a visit from PSI/ASF during the past month (May 2017)?

    Yes /__/ No /__/

16. How many home visits did you conduct during the past month (May 2017)? /……//……/
17. During the past three months, did you participate in any monitoring meetings held at the Health Center? Yes /__/ No /__/
18. How do you submit your activity reports to the Health Center? Do you use a telephone to send information? Yes /__/ No /__/
19. During the past three months, which of the following antimalarial commodities were out of stock? (Specify the commodity, length of stockout, and causes)

Commodity	Length of stockout
Infant ACT	|__|1-2 weeks |__|3-4 weeks |__|4 weeks or more
Child ACT	|__|1-2 weeks |__|3-4 weeks |__|4 weeks or more
Adolescent ACT	|__|1-2 weeks |__|3-4 weeks |__|4 weeks or more
Adult ACT	|__|1-2 weeks |__|3-4 weeks |__|4 weeks or more
Artesunate suppositories	|__|1-2 weeks |__|3-4 weeks |__|4 weeks or more
RDTs	|__|1-2 weeks |__|3-4 weeks |__|4 weeks or more

CHECKLIST: Check the availability of the following commodities in the community.

Commodity	Available?		Comments
	Yes	No	
Infant ACT			
Child ACT			
Adolescent ACT			
Adult ACT			
Artesunate suppositories			
RDTs			
Are stock records up-to-date? |__|Yes |__|No			

20. What are the biggest challenges you face in doing in your job?
21. Are you familiar with the malaria control project implemented by PSI/ASF (how does the project contribute to malaria control in your community)?
22. What major changes do you think this project has made in your community in terms of malaria control?
23. Is there anything else related to this topic that you would like to discuss?

Thank you for your time.

Note to interviewer: Make sure all answers are complete before ending the interview.

FINAL EVALUATION OF THE PMI PROJECT EXTENSION IN THE DEMOCRATIC REPUBLIC OF THE CONGO (DRC)

Health Zone Tool 4: Interview Guide for the Health Zone District Hospital Director

IDENTIFICATION

Health Zone

Health Zone

Interview Date /____//____/-/____//____/-/____//____/ (DD/MM/YY)

Title

Years in the Position

Gender /___/ M /___/ F

Interviewer

Introduction

Hello,

My name is _____. I am an independent consultant working on behalf of the USAID Mission in the DRC. Thank you for agreeing to take the time to speak with me today. The USAID Mission in the DRC is gathering information as part of an evaluation of the President's Malaria Initiative, or PMI, extension project, implemented by PSI/ASF. This evaluation aims to assess the project's achievements, to identify good practices, lessons learned, and suggestions, and to develop recommendations to improve the fight against malaria.

This interview will last 30-45 minutes. All of your answers to the questions will be kept anonymous. Your answers may be noted or recorded during the interview. If you feel uncomfortable for any reason at any time, you have the right to refuse to answer a question or to end the interview.

Do you confirm that you have received sufficient information and that you voluntarily consent to participate in this interview? Yes /__/ No /__/

Do you confirm that I have your permission to record our interview? Yes /__/ No /__/

The participant voluntarily consented to participate in the interview: _____

1. What is the current overall malaria situation in the hospital (frequency, severity, increase or decrease in cases, and causes)?
2. What actions and measures are in place to manage malaria cases (availability and access to diagnosis and treatment)?
3. In your opinion, has your facility made progress in malaria case management? Please explain.
4. Which malaria case management services must patients pay for?
5. What are the biggest challenges your facility faces in managing malaria control activities in general and malaria case management in particular? What possibilities or solutions exist for improving malaria control efforts?
6. Do you have the national malaria case management guidelines?
   Yes /__/ No /__/ If yes, verify availability.
7. Have you received any malaria training/retraining?
   Year……..Topic……
8. If the interviewee received training: What added value did the training provide, and how did your work change as a result of the training?
9. Has your department received a supervisory visit during the past three months? Yes /__/ No /__/
10. Are you familiar with or have you heard of the PMI expansion project implemented by PSI/ASF? If so, what are the project's main activities?
11. What are the biggest challenges your facility faces in terms of malaria case management? What possibilities or solutions exist for improving malaria case management efforts?

Thank you for your time.

Note to interviewer: Make sure all answers are complete before ending the interview.

FINAL EVALUATION OF THE PMI PROJECT EXTENSION IN THE DEMOCRATIC REPUBLIC OF THE CONGO (DRC)

Province Tool 1: Interview Guide for the Provincial Health Director

IDENTIFICATION

Province

	Interview Date	/____//____/-/____//____/-/____//____/ (DD/MM/YY)
	Title	
	Years in the Position	
	Gender	/___/ M /___/ F
	Interviewer	

Introduction

Hello,

My name is _____. I am an independent consultant working on behalf of the USAID Mission in the DRC. Thank you for agreeing to take the time to speak with me today. The USAID Mission in the DRC is gathering information as part of an evaluation of the President's Malaria Initiative, or PMI, extension project, implemented by PSI/ASF. This evaluation aims to assess the project's achievements, to identify good practices, lessons learned, and suggestions, and to develop recommendations to improve the fight against malaria.

This interview will last 30-45 minutes. All of your answers to the questions will be kept anonymous. Your answers may be noted or recorded during the interview. If you feel uncomfortable for any reason at any time, you have the right to refuse to answer a question or to end the interview.

Do you confirm that you have received sufficient information and that you voluntarily consent to participate in this interview? Yes /__/ No /__/

Do you confirm that I have your permission to record our interview? Yes /__/ No /__/

The participant voluntarily consented to participate in the interview: _____

1. What is the current malaria situation in your province (main actions or interventions, results, challenges, and outlook)?
2. Who are the main malaria control partners in your province?
3. Is there a consultation framework for malaria control partners in your province? Yes /__/ No /__/

   Is the framework functional? Yes /__/ No /__/

   How often does it meet? /__/ Weekly /__/ Monthly /__/ Quarterly

   How many meetings were held during the past three months? /____//____/
4. What progress has been made in terms of coordination? What challenges remain?
5. Have you received any supervisory visits from the central level during the past three months? Yes /__/ No /__/
6. Have you participated in any Health Information validation or malaria control activity monitoring meetings in your province during the past three months? Yes /__/ No /__/
7. Are you familiar with the PMI expansion project implemented by PSI/ASF (main support activities in the province)?
8. What major changes has the PMI expansion project made in terms of malaria control in your province?
9. How would you describe your partnership with PSI/ASF as part of the PMI expansion project in your province?

   /____/ Very good collaboration

   /____/ Good collaboration

   /____/ Fair collaboration

   /____/ Poor collaboration

   If collaboration was fair or poor, what were the challenges or difficulties?
10. Have you received any follow-up visits from PSI/ASF during the past three months?

    Yes /__/ No /__/
11. How would you suggest improving the implementation of a similar project in the future?
12. Is there anything else related to this topic that you would like to discuss?

Thank you for your time.

Note to interviewer: Make sure all answers are complete before ending the interview.

FINAL EVALUATION OF THE PMI PROJECT EXTENSION IN THE DEMOCRATIC REPUBLIC OF THE CONGO (DRC)

Health Zone Tool 1: Interview Guide for the Head of Health Zone

IDENTIFICATION

Health Zone	
Health Zone	
Interview Date	/____//____/-/____//____/-/____//____/ (DD/MM/YY)
Title	
Years in the Position	
Gender	/___/ M /___/ F
Interviewer	

Introduction

Hello,

My name is _____. I am an independent consultant working on behalf of the USAID Mission in the DRC. Thank you for agreeing to take the time to speak with me today. The USAID Mission in the DRC is gathering information as part of an evaluation of the President's Malaria Initiative, or PMI, extension project, implemented by PSI/ASF. This evaluation aims to assess the project's achievements, to identify good practices, lessons learned, and suggestions, and to develop recommendations to improve the fight against malaria.

This interview will last 30-45 minutes. All of your answers to the questions will be kept anonymous. Your answers may be noted or recorded during the interview. If you feel uncomfortable for any reason at any time, you have the right to refuse to answer a question or to end the interview.

Do you confirm that you have received sufficient information and that you voluntarily consent to participate in this interview? Yes /__/ No /__/

Do you confirm that I have your permission to record our interview? Yes /__/ No /__/

The participant voluntarily consented to participate in the interview: _____

1. What is the current malaria situation in your Health Zone (main actions or interventions, results, challenges, and outlook)?
2. Who are the main malaria control partners in your Health Zone?
3. Is there a consultation framework for malaria control partners in your Health Zone?
   Yes /__/ No /__/
   - Is the framework functional? Yes /__/ No /__/
   - How often does it meet? /__/ Weekly /__/ Monthly /__/ Quarterly
   - How many meetings were held during the past three months? /____//____/
4. What progress has been made in terms of coordination? What challenges remain?
5. Have you received any malaria training/retraining? *Yes* /__/ *No* /__/

   If yes: Date…… *Topic*……
6. If the interviewee received training: What added value did the training provide, and how did your work change as a result of the training?
7. Have you received any supervisory visits from the provincial level during the past three months?

   Yes /__/ No /__/
8. Have you received any visits from PSI/ASF during the past three months? Yes /__/ No /__/
9. Have you participated in any data validation or malaria control activity monitoring meetings during the past three months? Yes /__/ No /__/
10. Are you familiar with the PMI expansion project implemented by PSI/ASF (main support activities in the Health Zone)?
11. What major changes has the PMI expansion project made in terms of malaria control in your Health Zone?
12. Has the project provided any innovations in terms of malaria control in your Health Zone?

    Yes /__/ No /__/ If yes, please explain.
13. How would you describe your partnership with PSI as part of the PMI expansion project in your Health Zone?

    /____/ Very good collaboration

    /____/ Good collaboration

    /____/ Fair collaboration

    /____/ Poor collaboration

If collaboration was fair or poor, what were the challenges or difficulties?

14. How would you suggest improving the implementation of a similar project in the future?
15. Is there anything else related to this topic that you would like to discuss?

Thank you for your time.

Note to interviewer: Make sure all answers are complete before ending the interview.

FINAL EVALUATION OF THE PMI PROJECT EXTENSION IN THE DEMOCRATIC REPUBLIC OF THE CONGO (DRC)

Province Tool 4: Interview Guide for the Health Information Manager

IDENTIFICATION

Province

Interview Date /____//____/-/____//____/-/____//____/ (DD/MM/YY)

Title

Years in the Position

Gender /___/ M /___/ F

Interviewer

Introduction

Hello,

My name is _____. I am an independent consultant working on behalf of the USAID Mission in the DRC. Thank you for agreeing to take the time to speak with me today. The USAID Mission in the DRC is gathering information as part of an evaluation of the President's Malaria Initiative, or PMI, extension project, implemented by PSI/ASF. This evaluation aims to assess the project's achievements, to identify good practices, lessons learned, and suggestions, and to develop recommendations to improve the fight against malaria.

This interview will last 30-45 minutes. All of your answers to the questions will be kept anonymous. Your answers may be noted or recorded during the interview. If you feel uncomfortable for any reason at any time, you have the right to refuse to answer a question or to end the interview.

Do you confirm that you have received sufficient information and that you voluntarily consent to participate in this interview? Yes /__/ No /__/

Do you confirm that I have your permission to record our interview? Yes /__/ No /__/

The participant voluntarily consented to participate in the interview: _____

1. Can you briefly describe the Health Information Management system in the province?
2. What is the mechanism for collecting, processing, and analyzing health information, particularly concerning malaria, in the province?
3. What do you think have been the biggest achievements and improvements in producing health information in the province? What are the biggest challenges?
4. In terms of producing health information, how would you assess the following:

- *Availability of data collection tools*

/__/ Highly satisfactory

/__/ Satisfactory

/__/ Somewhat satisfactory

/__/ Unsatisfactory

Please explain: _____

- *Staff abilities/skills*

/__/ Highly satisfactory

/__/ Satisfactory

/__/ Somewhat satisfactory

/__/ Unsatisfactory

Please explain: _____

- *Completeness of reports*

/__/ Highly satisfactory

/__/ Satisfactory

/__/ Somewhat satisfactory

/__/ Unsatisfactory

Please explain: _____

- *Timely submission of reports*

/__/ Highly satisfactory

/__/ Satisfactory

/__/ Somewhat satisfactory

/__/ Unsatisfactory

Please explain: _____

- *Data analysis and use in decision-making*

/__/ Highly satisfactory

/__/ Satisfactory

/__/ Somewhat satisfactory

/__/ Unsatisfactory

Please explain: _____

1. Has staff in your department received any training or retraining in Health Information Management systems? If yes:

   Year Topic Number of people trained

   _____ _____ _____

2. If staff received training: What added value did the training provide, and how did your work change as a result of the training?
3. Has your department received a supervisory visit during the past three months?

   Yes /__/ No /__/

4. Have you participated in any data validation or malaria control activity monitoring meetings during the past three months? Yes /__/ No /__/
5. Are you familiar with the PMI expansion project implemented by PSI/ASF (main support activities in the province)?
6. What major changes has the PMI expansion project made in terms of malaria control in general and the Health Information Management system in particular in your province?
7. Has the project provided any innovations in terms of the Health Information Management system?

   Yes /__/ No /__/ If yes, please explain.

8. How would you suggest improving the production of health information in the province?
9. Is there anything else related to this topic that you would like to discuss?

FINAL EVALUATION OF THE PMI PROJECT EXTENSION IN THE DEMOCRATIC REPUBLIC OF THE CONGO (DRC)

Community Tool 4: Survey Guide for Household Visits

IDENTIFICATION

Province

Health Zone

Health Center

Village

Survey Date /____//____/-/____//____/-/____//____/ (DD/MM/YY)

Surveyor

Household Number

Head of Household

Introduction

Hello,

My name is _____. I am an independent consultant working on behalf of the USAID Mission in the DRC. Thank you for agreeing to take the time to speak with me today. The USAID Mission in the DRC is gathering information as part of an evaluation of the President's Malaria Initiative, or PMI, extension project, implemented by PSI/ASF. This evaluation aims to assess the project's achievements, to identify good practices, lessons learned, and suggestions, and to develop recommendations to improve the fight against malaria.

This survey will last 30 minutes. All of your answers to the questions will be kept anonymous. Your answers may be noted or recorded during the survey. If you feel uncomfortable for any reason at any time, you have the right to refuse to answer a question or to end the survey.

Do you confirm that you have received sufficient information and that you voluntarily consent to participate in this survey? Yes /__/ No /__/

Do you confirm that I have your permission to record our survey? Yes /__/ No /__/

The participant voluntarily consented to participate in the survey: _____

Number of people living in the household: /____//____/

Number of children under 5: /____//____/

Number of pregnant women: /____//____/

How many LLINs do you have in your household? /____//____/

Who slept under an LLIN last night?

Number of people who slept under an LLIN: /____//____/

Number of children under 5 who slept under an LLIN: /____//____/

Number of pregnant women who slept under an LLIN: /____//____/

Where did you get your LLINs?

If the household has no LLINs, ask why:

What have been the challenges in using LLINs in your household?

Do you think the boys and girls in your household have the same opportunity to access health care in general and malaria control services in particular? Please explain.

Checklist

- Actual number of LLINs: /____//____/
- LLINs hung correctly? /____/ Yes /____/ No
- Condition of LLINs /____/ Good /____/ Bad

Thank you for your time.

Note to interviewer: Make sure all answers are complete before ending the interview.

FINAL EVALUATION OF THE PMI PROJECT EXTENSION IN THE DEMOCRATIC REPUBLIC OF THE CONGO (DRC)

Community Tool 4: Survey Guide for Household Visits

IDENTIFICATION

Province

Health Zone

Health Center

Village

Survey Date /____//____/-/____//____/-/____//____/ (DD/MM/YY)

Surveyor

Household Number

Head of Household

Introduction

Hello,

My name is _____. I am an independent consultant working on behalf of the USAID Mission in the DRC. Thank you for agreeing to take the time to speak with me today. The USAID Mission in the DRC is gathering information as part of an evaluation of the President's Malaria Initiative, or PMI, extension project, implemented by PSI/ASF. This evaluation aims to assess the project's achievements, to identify good practices, lessons learned, and suggestions, and to develop recommendations to improve the fight against malaria.

This survey will last 30 minutes. All of your answers to the questions will be kept anonymous. Your answers may be noted or recorded during the survey. If you feel uncomfortable for any reason at any time, you have the right to refuse to answer a question or to end the survey.

Do you confirm that you have received sufficient information and that you voluntarily consent to participate in this survey? Yes /__/ No /__/

Do you confirm that I have your permission to record our survey? Yes /__/ No /__/

The participant voluntarily consented to participate in the survey: _____

Number of people living in the household: /____//____/

Number of children under 5: /____//____/

Number of pregnant women: /____//____/

How many LLINs do you have in your household? /____//____/

Who slept under an LLIN last night?

Number of people who slept under an LLIN: /____//____/

Number of children under 5 who slept under an LLIN: /____//____/

Number of pregnant women who slept under an LLIN: /____//____/

Where did you get your LLINs?

If the household has no LLINs, ask why:

What have been the challenges in using LLINs in your household?

Do you think the boys and girls in your household have the same opportunity to access health care in general and malaria control services in particular? Please explain.

Checklist

- Actual number of LLINs: /____//____/
- LLINs hung correctly? /____/ Yes /____/ No
- Condition of LLINs /____/ Good /____/ Bad

Thank you for your time.

Note to interviewer: Make sure all answers are complete before ending the interview.

FINAL EVALUATION OF THE PMI PROJECT EXTENSION IN THE DEMOCRATIC REPUBLIC OF THE CONGO (DRC)

Health Zone Tool 5: Interview Guide for the Health Zone District Hospital Laboratory Manager

IDENTIFICATION

Health Zone

Health Zone

Interview Date /____//____/-/____//____/-/____//____/ (DD/MM/YY)

Title

Years in the Position

Gender /___/ M /___/ F

Interviewer

Introduction

Hello,

My name is _____. I am an independent consultant working on behalf of the USAID Mission in the DRC. Thank you for agreeing to take the time to speak with me today. The USAID Mission in the DRC is gathering information as part of an evaluation of the President's Malaria Initiative, or PMI, extension project, implemented by PSI/ASF. This evaluation aims to assess the project's achievements, to identify good practices, lessons learned, and suggestions, and to develop recommendations to improve the fight against malaria.

This interview will last 30 minutes. All of your answers to the questions will be kept anonymous. Your answers may be noted or recorded during the interview. If you feel uncomfortable for any reason at any time, you have the right to refuse to answer a question or to end the interview.

Do you confirm that you have received sufficient information and that you voluntarily consent to participate in this interview? Yes /__/ No /__/

Do you confirm that I have your permission to record our interview? Yes /__/ No /__/

The participant voluntarily consented to participate in the interview: _____

1. What are the main malaria control activities conducted by your department?
2. In your opinion, have your facility and the Health Zone made progress in malaria diagnosis? Please explain.
3. Which malaria case management services must laboratory patients pay for?
4. Do you have a malaria diagnosis Quality Assurance plan?

   Yes /__/ No /__/ If yes, verify availability.

   If yes, what are the main components?
5. Have you received any malaria training/retraining?

   Year……Topic……
6. If the interviewee received training: What added value did the training provide, and how did your work change as a result of the training?
7. Has your department received a supervisory visit during the past three months? Yes /__/ No /__/
8. Are you familiar with or have you heard of the PMI expansion project implemented by PSI/ASF? If so, what are the project's main activities?
9. What are the biggest challenges your facility faces in terms of malaria diagnosis? What possibilities or solutions exist for improving malaria diagnosis?

Thank you for your time.

Make sure all answers are complete before ending the interview.

FINAL EVALUATION OF THE PMI PROJECT EXTENSION IN THE DEMOCRATIC REPUBLIC OF THE CONGO (DRC)

Province Tool 3: Interview Guide for the Provincial NMCP Coordinator

IDENTIFICATION

Province

Interview Date /____//____/-/____//____/-/____//____/ (DD/MM/YY)

Title

Years in the Position

Gender /___/ M /___/ F

Interviewer

Introduction

Hello,

My name is _____. I am an independent consultant working on behalf of the USAID Mission in the DRC. Thank you for agreeing to take the time to speak with me today. The USAID Mission in the DRC is gathering information as part of an evaluation of the President's Malaria Initiative, or PMI, extension project, implemented by PSI/ASF. This evaluation aims to assess the project's achievements, to identify good practices, lessons learned, and suggestions, and to develop recommendations to improve the fight against malaria.

This interview will last 30-45 minutes. All of your answers to the questions will be kept anonymous. Your answers may be noted or recorded during the interview. If you feel uncomfortable for any reason at any time, you have the right to refuse to answer a question or to end the interview.

Do you confirm that you have received sufficient information and that you voluntarily consent to participate in this interview? Yes /__/ No /__/

Do you confirm that I have your permission to record our interview? Yes /__/ No /__/

The participant voluntarily consented to participate in the interview: _____

1. What is the malaria situation in your province?
2. What interventions have been implemented, and what have been the results?
3. What are the biggest malaria control challenges in your province (what is the outlook)?
4. Who are the main malaria control partners in your province?
5. Is there a consultation framework for malaria control partners in your province? Yes /__/ No /__/

   Is the framework functional? Yes /__/ No /__/

   How often does it meet? /__/ Weekly /__/ Monthly /__/ Quarterly

   How many meetings were held during 2016? /____//____/
6. What progress has been made in terms of coordination? What challenges remain?
7. Are you familiar with the PMI expansion project implemented by PSI/ASF (main support activities in the province)?
8. What major changes has the PMI expansion project made in terms of malaria control in your province?
9. How do you plan to sustain the achievements of the PMI expansion project in your province?
10. How would you describe your partnership with PSI as part of the PMI expansion project in your province?

    /____/ Very good collaboration

    /____/ Good collaboration

    /____/ Fair collaboration

    /____/ Poor collaboration

If collaboration was fair or poor, what were the challenges or difficulties?

1. Have you received any pharmaceutical supply and management training/retraining?
2. If staff received training: What added value did the training provide, and how did your work change as a result of the training?
3. Have you participated in any data validation or malaria control activity monitoring meetings during the past three months? *Yes /__/ No /__/*
4. Has your department received any supervisory visits from the central level during the past three months? *Yes /__/ No /__/*
5. Have you received any follow-up visits from PSI/ASF during the past three months? Yes /__/ No /__/
6. How would you suggest improving the implementation of a similar project in the future?
7. Is there anything else related to this topic that you would like to discuss?

Thank you for your time.

Note to interviewer: Make sure all answers are complete before ending the interview.

FINAL EVALUATION OF THE PMI PROJECT EXTENSION IN THE DEMOCRATIC REPUBLIC OF THE CONGO (DRC)

Health Center Tool 1: Interview Guide for the Health Center Head Nurse

IDENTIFICATION

Province	
Health Zone	
Health Center	
Interview Date	/____//____/-/____//____/-/____//____/ (DD/MM/YY)
Title	
Years in the Position	
Gender	/___/ M /___/ F
Interviewer	

Introduction

Hello,

My name is _____. I am an independent consultant working on behalf of the USAID Mission in the DRC. Thank you for agreeing to take the time to speak with me today. The USAID Mission in the DRC is gathering information as part of an evaluation of the President's Malaria Initiative, or PMI, extension project, implemented by PSI/ASF. This evaluation aims to assess the project's achievements, to identify good practices, lessons learned, and suggestions, and to develop recommendations to improve the fight against malaria.

This interview will last 30-45 minutes. All of your answers to the questions will be kept anonymous. Your answers may be noted or recorded during the interview. If you feel uncomfortable for any reason at any time, you have the right to refuse to answer a question or to end the interview.

Do you confirm that you have received sufficient information and that you voluntarily consent to participate in this interview? Yes /__/ No /__/

Do you confirm that I have your permission to record our interview? Yes /__/ No /__/

The participant voluntarily consented to participate in the interview: _____

1. What is the current malaria situation in your Health Center?
2. What are the main activities or interventions being conducted (and results)?
3. In your opinion, has your facility made progress in malaria case management and prevention, particularly in improving the community's access to and use of services?
4. Please explain: _____
5. Which malaria case management and prevention services must patients pay for?
6. What are the biggest challenges your facility faces in terms of malaria case management and prevention? What solutions are planned to improve malaria case management and prevention in your Health Center?
7. Are you familiar with the PMI expansion project implemented by PSI/ASF? If so, what are the project's main activities (how does the project contribute to malaria control)?
8. Have you received any malaria training/retraining?

   Yes /__/ No /__/ If yes: Date……Topic……
9. If the interviewee received training: What added value did the training provide, and how did your work change as a result of the training?
10. Do you have the national malaria case management guidelines?

    Yes /__/ No /__/ (If yes, verify availability)
11. Do you have data collection materials/tools?

12. Yes /__/ No /__/ (If yes, verify availability)

13. Have you participated in any Health Information Management data validation meetings during the past month?

    Yes /__/ No /__/
14. Have you received any supervisory visits from the Health Zone during the past three months?

    Yes /__/ No /__/
15. Have you received any follow-up visits from PSI/ASF during the past three months?

    Yes /__/ No /__/

16. Is there anything else related to this topic that you would like to discuss?

Thank you for your time.

Note to interviewer: Make sure all answers are complete before ending the interview.

ANNEX III. LIST OF DOCUMENTS REVIEWED

1. PROJECT'S BACKGROUND DOCUMENTS

USAID PMI-EP/DRC. Attachment B, Program Description, Cooperative Agreement # AID-623-A-12-00028 2012

USAID PMI-EP/DRC. Malaria Operational Plan FY 2017, Kinshasa, October 2016

PSI PMI-EP/DRC Baseline: *Evaluation pré-opérationnelle du niveau des indicateurs de lutte contre le paludisme et état de lieux des zones de santé d'intervention du projet PMI Expansion en RDC*. Kinshasa, April 2014

PSI PMI-EP/DRC. Quarterly Report Quarter 1, Year 5, Kinshasa, February 2017

PSI PMI-EP/DRC. Quarterly Report Quarter 2, Year 5, Kinshasa, May 2017

PSI DRC PMI-EP Year 5 Work Plan Oct 2016

DRC PMI-EP Detailed Implementation Plan Year 5 - Revised (FY 2016)

PSI PMI-EP/DRC. Quarterly/Annual Report Quarter 4, Year 4, Kinshasa, November 2016

PSI PMI-EP/DRC Workplan Year 4 Final, 27 Oct 2015

PSI PMI-EP/DRC Quarterly/Annual Report Quarter 4, Year 3, Kinshasa, October 2015

PSI PMI-EP/DRC Workplan Year 3

PSI PMI-EP/DRC Detailed Implementation Plan Year 3 2014 – 2015 - Revised

PSI PMI-EP/DRC Quarterly/Annual Report Quarter 4, Year 2, Kinshasa, October 2014

PSI PMI- EP/DRC. Year 2 Work Plan 2013

PSI PMI-EP/DRC Detailed Implementation Plan Year 2

PSI PMI-EP/DRC. Quarterly Report (Quarter 4 Year 1), Kinshasa, October 2013

PSI PMI-EP/DRC Detailed Implementation Plan Year 1

PSI PMI-EP/DRC Performance Monitoring Plan

2. NATIONAL MALARIA CONTROL PROGRAM (NMCP) DOCUMENTS

Programme National de Lutte contre le Paludisme. Plan Stratégique National 2016-2020

Programme National de Lutte contre le Paludisme. Rapport Annuel d'Activités 2012

Programme National de Lutte contre le Paludisme. Rapport Annuel d'Activités 2013

Programme National de Lutte contre le Paludisme. Rapport Annuel d'Activités 2014

Programme National de Lutte contre le Paludisme. Rapport Annuel d'Activités 2015

Programme National de Lutte contre le Paludisme. Rapport Annuel d'Activités 2016

National Health Information System (SNIS). Draft Activity Report for Health Centers and Reference Hospitals

3. OTHER DOCUMENTS

USAID (2016). Final Performance Evaluation Integrated Health Project in the Democratic Republic of Congo. Evaluation report

USAID ( ). Guidelines for National Malaria Control Program Monitoring and evaluation

USAID Mid-Term Program Evaluation of the MalariaCare Project, June 2016 USAID

USAID/ASIA (2014). Mid-Term Performance Evaluation: Control and Prevention of Malaria (CAP-MALARIA) in Burma, Cambodia, and Thailand. Evaluation report.

ANNEX IV. IMPLEMENTING PARTNERS AND STAKEHOLDERS MET

Name	Job Title	Organization and Location
Kinshasa		
Aboubacar Sadou	PMI Resident Advisor	USAID Mission DRC
Debbie Gueye	Malaria Team Leader/PMI-USAID	Malaria Team Leader/PMI-USAID
sMartine Esther Tassiba	Deputy Chief of Party (PMI-EP)	PSI/ASF
Louis Akulayi	Chief of Party (PMI-EP)	PSI/ASF
Roger Musumadi	Senior M&E Coordinator (PMI-EP)	PSI/ASF
Benie Angoran Hortense	Deputy Chief of Party	IHP PLUS
Alidor Kuamba		IHP PLUS
Moussa Traore		IHP PLUS
Kalambay Nzeba Josephine	Procurement Supply Management Specialist	CARITAS CONGO ASBL
Dr Rose Mukumu	Project Officer	CARITAS CONGO ASBL
Dr Blaise Mudekereza	PMI-EP	CARITAS CONGO ASBL
Neema Mujarwandarachel	Data Manager PMI-EP	CARITAS CONGO ASBL
Dr Leonard Kouadio	Health Specialist	UNICEF DRC
Patience Mashako		UNICEF
Dr Bacary Sambou	Health Program Officer	OMS
Dr Joris Likwela	Program Director	NMCP
Ag Nyembo Irenee	Head of Administrative and Accountant Unit	
Albert Kutekemeni	Head of Operational Research Unit	Head of Operational Research Unit
Dr Ngoy Marius	Head of Partnership Unit	NMCP
Dr Hyacinthe Kabeya	CD S&E	NMCP
Mobiah André	Partnership Unit	NMCP
Kaseya	Head of M&E Unit	
Marc Mweta	Data Manager	NMCP
Sud Kivu *Personnes Interviewées*		
Pépin Nabugobe	Chef DPS - Sud-Kivu	MOH/Sud-Kivu
John Muyaya	Point Focal PMI-EP	ASF-PSI/ Sud Kivu
Asende	Médecin Chef de Zone Santé	MOH/Fizi
Bashwira Furaha	Médecin Chef de Zone Santé	MOH/Nyantende
Yannick Katende	Superviseur	MOH/Nyantendev
Claudel Muzigirwa	Superviseur	MOH/Nyantende
Kudusi Watunda	Coodonnateur Provincial	PNLP/NMCP
Emmanuel Murhula	Infirmier Titulaire	MOH/Mumosho
Bwisengo Makano	Chargé de la CPN	CS Mshimbakye
Kilozo Amuri	Infirmier Titulaire	Malinde
Furaha Zigabe	Infirmier Titulaire	Nyantende
Frez Achacha	MD Hôp Fizi	Fizi
Emmanuel Bashagaluke	Pharmacien	BDOM
Michel Maneno	Chef De Bureau Appui Technique	DPS Sud-Kivu

Name	Job Title	Organization and Location
Aime Balagizi	Medecin Directeur	HGR Nyantende
Mumosho		
Kisangani		
Dr Baelongandi Folo Francis	Directeur Provincial de la Santé Tsho-po	DPS Kisangani
Dr Bene Antoine	Coordonnateur provincial PNLP Tshopo	DPS Kisangani
Kalibati Salama Muhindo	Cordonnateur ai/ Camekis Kisangini	DPS Kisangani
Dr Philippe Libandé	Chef bureau de l'information sanitaire DPS Tshopo	DPS Kisangani
Dr Bob Badjoko	Analyste en charge de l'information sanitaire DPS Tshopo	DPS Kisangani
Frederic	Représentant Provincial de PSI/ASF	Kisangani
Owekelokato Basomboli	Médecin Chef de Zone Santé	Zone Santé Bengamisa
Kukia Kakangela	Animateur Communautaire	Zone Santé Bengamisa
Atibe Oumo	Administrateur Gestionnaire	Zone Santé Bengamisa
Lumumbu Christophe	Chargé de la Pharmacie	Zone Santé Bengamisa
Bakatunga Charles	Médecin Directeur de l'Hôpital	Zone Santé Bengamisa
Kangola Libongo	Chef de Laboratoire de Hôpital	Zone Santé Bengamisa
Mbando Basingi	Infirmier Titulaire Bandjwadé	Zone Santé Bengamisa
Yumbena Albert	Président du Comité de Gestion Band-jawde	Président du Comité de Gestion Band-jawde
Emina Lowolo	Infirmier Titulaire de Bayangene	Zone Santé Bengamisa
Mangando Dieu Merci	Infirmier Titulaire adjoint Bayangene	Zone Santé Bengamisa
Lofole Gesangi	Infirmier Traitant Bayangene	Zone Santé Bengamisa
Ambeke Antoine	Président du Comité de Gestion Bayangene	Zone Santé Bengamisa
Agambu Jean	Réceptionniste Bayangene	Zone Santé Bengamisa
Bokumbe Clément	Relais Communautaire Banzaye	Zone Santé Bengamisa / Relais Communautaire Banzaye
Aseli Simon	Relais Communautaire Azolo	Zone Santé Bengamisa
Dr Franck Botalema	Médecin Directeur Hôpital	Zone Sante Isangi
Dr Papi Amili Mapou	Médecin Chef de Zone	Zone Sante Isangi
Likumo Tombo	Administrateur Gestionnaire	Zone Sante Isangi
Lutombo Botongandi	Animateur Communautaire	Zone Sante Isangi
Junith Melobi Melambo	Préposée à la Pharmacie	Zone Sante Isangi
Caroline Losimba	Responsable Laboratoire	Zone Sante Isangi
Lialila Boila	Infirmier Titulaire Yabotianongo	Zone Sante Isangi
Bolala Rocky	Relais Communautaire Yandja Rive Gauche	Zone Sante Isangi
Lobela Bondele Franck	Infirmier Titulaire Yalosase	Zone Sante Isangi
Interviews by Phone/Email		
Andrew Wyborn	Managing Director	Greenmash
Ed Vreeke	Senior Partner	HERA
Olivier Kakesa	Resident Advisor	MEASURE
Caroline Maxwell	Responsible for Clinical Case Management	LSTM
Not Reached		
John Gikapa	Former Project Director	DELIVER Project
Antoinette Tshefu	Professor	KSPH

ANNEX V. SCHEDULE OF FIELD VISITS

Dates	Location	Activities Performed
12-14 May, 2017		Team travel to Kinshasa
Meeting with Key Informants/Stakeholders at central level		
May 15, 2017	Kinshasa	In-brief meeting with USAID Mission in DRC
May 16, 2017	Kinshasa	In-brief meeting with PSI/ASF, project lead organization
May 23, 2017	Kinshasa	Meeting with IHP PLUS
May 24, 2017	Kinshasa	Meeting with PSI/ASF
May 25, 2017	Kinshasa	Meeting with Caritas Congo
May 26, 2017	Kinshasa	Meeting with National Malaria Control Program
May 27-29, 2017		Meeting with Provincial Director of Health of Tshopo
Team 1 Province of Tshopo: Health Zone of Bengamisa and Isangi		
May 30, 2017	Kinsagani	Meeting with Provincial Director of Health of Tshopo
May 31, 2017	Bengamisa	Travel to Bengamisa Health Zone, interview with the Health Zone's Head, Drug Depot's Manager, Referral Hospital's Director, Laboratory Technician
June 01, 2017	Bengamisa	Travel to Bayangéné; Interview with the Health Center's staff; Field work in the Community Care Site of Banzaye: Interview with the community health worker, Focus Group Discussions with Men and Women, Households Visits; Travel back to Bengamisa
June 02, 2017	Bengamisa	Travel to Bayangéné; Interview with the Health Center's staff; Field work in the Community Care Site of Banzaye: Interview with the community health worker, Focus Group Discussions with Men and Women, Households Visits; Travel back to Bengamisa
June 03, 2017	Kisangani	Travel back from Bengamisa to Kisangani
June 05, 2017	Kisangani	Meeting with Provincial Minister of Health, Provincial NMCP Coordinator, Deputy Director of Regional Distribution Center for Essential Drugs (CAMEKIS)
June 06, 2017	Isangi	Travel to Isangi Health Zone
June 07, 2017	Isangi	Travel to Yabotianogo and interview with the Health Center staff; Travel to the Community Care Site of Yantaléma: Interview with the community health worker, Focus Group Discussions with Men and Women, Households Visits; Travel back to Isangi
June 08, 2017	Isangi	Travel to Yalosase and interview with the Health Center staff; Travel to the Community Care Site of Yanda Rive Gauche: Interview with the community health worker, Focus Group Discussions with Men and Women, Households Visits; Travel back to Isangi
June 09, 2017	Isangi	Interview with the Health Zone's Head, Drug depot's Manager, Director of Referral Hospital, Laboratory Technician, Health Information Manager; Travel back from Isangi to Kisangani
June 10, 2017	Kisangani	Debriefing meeting with the Provincial Director of Health and the Provincial Minister of Health
June 10, 2017	Kinshasa	Travel back from Kisangani to Kinshasa

Dates	Location	Activities Performed
Team II Province of Sud-Kivu: Health Zone of Fizi and Nyantede		
May 30, 2017	Bukavu	Interview with Provincial Director of Health and Travel to Uvira
May 31, 2017	Bukavu	Travel, Interview with Health Zone Head, Interview with Head Nurse, Interview with ANC Matron, and Drug keeper
June 1, 2017	Baraka, Msimbakye	Field work: Interview with CHW, FGD with women and FGD with men and Household visits
June 2, 2017	Fizi, Malinde	Interview with Health Information Manager at Health Zone; Interview with the person in charge of drug depots, Interview with Hospital Head Doctor
June 3, 2017	Fizi, Malinde	Interview with CHW, FGD with women and FGD with men, Interview with pregnant women, Household visits and travel back to Uvira
June 5, 2017	Bukavu	Interview with Provincial M & E person; Interview with NMCP
June 6, 2017	Nyantende	Interviews in Nyantende at Health Zone and Hospital level
June 7, 2017	Nyantende	Field work at Health Center in Nyantende and Kalangwe Community Care Site
June 8, 2017	Mumosho	Field work for Health Center Level in Mumosho:
June 9, 2017	Mumosho	Field work in Mumosho Community Care Site and FGD with men and with women
June 10, 2017	Bukavu	Interview with Depot Pharmacist and NMCP
June 11, 2017		Travel back to Goma
Meeting with Key Informants/Stakeholders at central level (continued)		
June 12, 2017	Kinshasa	Meeting with UNICEF
June 14, 2017	Kinshasa	Meeting with WHO
June 19, 2017	Kinshasa	Presentation of Preliminary Findings to USAID Mission and PSI/ASF
June 22, 2017	Kinshasa	Presentation of Preliminary Findings to NMCP
June 2, 2017	Kinshasa	Meeting with PSI/ASF for complementary data collection

ANNEX VI. DISCLOSURE OF ANY CONFLICT OF INTEREST

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT PROJECT

USAID NON-DISCLOSURE AND CONFLICTS AGREEMENT

USAID Non-Disclosure and Conflicts Agreement- Global Health Program Cycle Improvement Project

As used in this Agreement, Sensitive Data is marked or unmarked, oral, written or in any other form, "sensitive but unclassified information," procurement sensitive and source selection information, and information such as medical, personnel, financial, investigatory, visa, law enforcement, or other information which, if released, could result in harm or unfair treatment to an individual or group, or could have a negative impact upon foreign policy or relations, or USAID's mission.

Intending to be legally bound, I hereby accept the obligations contained in this Agreement in consideration of my being granted access to Sensitive Data, and specifically I understand and acknowledge that:

1. I have been given access to USAID Sensitive Data to facilitate the performance of duties assigned to me for compensation, monetary or otherwise. By being granted access to such Sensitive Data, special confidence and trust has been placed in me by the United States Government, and as such it is my responsibility to safeguard Sensitive Data disclosed to me, and to refrain from disclosing Sensitive Data to persons not requiring access for performance of official USAID duties.
2. Before disclosing Sensitive Data, I must determine the recipient's "need to know" or "need to access" Sensitive Data for USAID purposes.
3. I agree to abide in all respects by 41, U.S.C. 2101 - 2107, The Procurement Integrity Act, and specifically agree not to disclose source selection information or contractor bid proposal information to any person or entity not authorized by agency regulations to receive such information.
4. I have reviewed my employment (past, present and under consideration) and financial interests, as well as those of my household family members, and certify that, to the best of my knowledge and belief, I have no actual or potential conflict of interest that could diminish my capacity to perform my assigned duties in an impartial and objective manner.
5. Any breach of this Agreement may result in the termination of my access to Sensitive Data, which, if such termination effectively negates my ability to perform my assigned duties, may lead to the termination of my employment or other relationships with the Departments or Agencies that granted my access.
6. I will not use Sensitive Data, while working at USAID or thereafter, for personal gain or detrimentally to USAID, or disclose or make available all or any part of the Sensitive Data to any person, firm, corporation, association, or any other entity for any reason or purpose whatsoever, directly or indirectly, except as may be required for the benefit USAID.
7. Misuse of government Sensitive Data could constitute a violation, or violations, of United States criminal law, and Federally-affiliated workers (including some contract employees) who violate privacy safeguards may be subject to disciplinary actions, a fine of up to $5,000, or both. In particular, U.S. criminal law (18 USC § 1905) protects confidential information from unauthorized disclosure by government employees. There is also an exemption from the Freedom of Information Act (FOIA) protecting such information from disclosure to the public. Finally, the ethical standards that bind each government employee also prohibit unauthorized disclosure (5 CFR 2635.703).
8. All Sensitive Data to which I have access or may obtain access by signing this Agreement is now and will remain the property of, or under the control of, the United States Government. I agree that I must return all Sensitive Data which has or may come into my possession (a) upon demand by an authorized representative of the United States Government; (b) upon the conclusion of my employment or other relationship with the Department or Agency that last granted me access to

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

Jeannie Brown	3/28/17
Signature	Date
Jeannie Brown	—
Name	Title

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

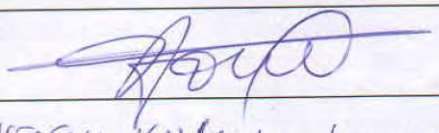
ACCEPTANCE
The undersigned accepts the terms and conditions of this Agreement.

Signature	Date
	27/03/2017
Name	Title
ZON HILAIRE	CONSULTANT

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE
The undersigned accepts the terms and conditions of this Agreement.

Signature		Date	23/03/2017
Name	KASEREKA KAVYAVU LEONARD	Title	CONSULTANT EVALUATOR

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE
The undersigned accepts the terms and conditions of this Agreement.

Signature

Date

BAVON MUPENDA

Prof.

Name

Title

ANNEX VII. SUMMARY BIOS OF EVALUATION TEAM MEMBERS

Jeannie Brown, Team Leader and Malaria Specialist. Jeannie Brown has led country teams in the implementation of complex health projects across several African countries and in Haiti. She is a senior leader of public health programs, both domestically and internationally.

Hilaire Zon, Evaluation Specialist. Hilaire Zon is an accomplished professional in public health and malaria control. He has extensive experience in health needs assessments, health program design, implementation, and monitoring and evaluation.

Bavon Mupenda, Local Evaluator. Bavon Mupenda is an experienced professional researcher, trainer of trainers, professor, and manager. He has years of experience with monitoring and evaluation programs focused on public health and development in Africa.

Leonard Kasereka, Local Evaluator. Leonard Kasereka is a professional evaluator of public health programs. His expertise includes monitoring and evaluation, training-of-trainers, and performance-based funding.

For more information, please visit

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