Evaluation of the DEC-funded CAFOD Health and WASH Project in the DRC

January 2010

Jannes van der Wijk
Euclide Balume Mwezi
Luellen Kazan

MDF Afrique Centrale - Training & Consultancy

Caption cover picture:

Two year old Willy is happily recovering from Kwashiorkor in the Notre-Dame du Carmel Therapeutic Nutritional centre in Goma. From January - March 2009 CAFOD supported 11 nutritional centres, 1034 malnourished children were treated in three months and by 31 March 2009, 983 of them had recovered and had been discharged.

MDF Afrique Centrale, Training & Consultancy

243 Avenue de la Paix, Goma, République Démocratique du Congo
mdfac@mdfac.org, http://fr.mdf.nl/mdf-ac, +243 999 305 631

Executive Summary

This is an external evaluation commissioned by CAFOD in order to assess a DEC funded Health and Water, Sanitation and Hygiene (WASH) project implemented by CAFOD and its partner organization, Caritas Goma. The project was implemented from January to December 2009, and took place in the territories of Masisi and Rutshuru in North Kivu Province, DR Congo.

The purpose of the evaluation is threefold: (i) to enhance accountability to beneficiaries, (ii) to guide future decisions on the humanitarian strategy for the DRC, and (iii) to improve the response to emergencies in the health and WASH sectors. The intention is for the evaluation to be useful to DEC, CAFOD, Caritas Goma, and the greater humanitarian community in Goma, DR Congo.

The four main issues that the evaluation seeks to address are:

1. The extent to which proposed objectives and outcomes have been achieved
2. The extent to which the ICRC Code of Conduct, Sphere Standards and HAPI benchmarks have been respected
3. The level of involvement of and accountability to beneficiaries
4. The extent to which past lessons or recommendations have been fulfilled

The extent to which proposed objectives and outcomes have been achieved is discussed in terms of effectiveness, efficiency, coverage, sustainability, and coordination. Particular attention is also given to the element of providing free health services.

The evaluation began in January 2010 and was carried out over a period of three weeks by three consultants with backgrounds and expertise in health, WASH, and social science research. The methods used in the project evaluation included a literature review, interviews, and focus group discussions (FGD) with key stakeholders, including project beneficiaries, Caritas Goma agency staff, local authorities, and other local NGOs.

Effectiveness

Without a doubt the accessibility of health centres, hospitals, and nutritional centres was significantly increased during the project implementation period thanks to the gratuity of health care and the rehabilitation of facilities, such as Birambizo. Consultancy numbers in some of the health facilities in the target areas rose by nearly tenfold. Mortality rates among IDPs in the target areas decreased from an inacceptable 1.33 per 10,000 per day to an acceptable 0.43.

Increased access to potable water through the WASH component of the project responded to a big need expressed by the local population. Beneficiaries and statistics indicate that the project led to a significant reduction in waterborne diseases. The water distribution points also offered protection for beneficiaries. For example, the risk of rape for women while fetching water was estimated to have gone down by 80%. It was however found that there is an insufficient amount of potable water available to certain communities due to the presence

of many IDPs in the areas. Also, a lack of proper maintenance of WASH structures is currently a barrier to the effectiveness of the intervention.

Efficiency

The project was strong in terms of efficiency in that all WASH and health supplies came from three different suppliers[1] chosen for their levels of quality, price, and timeliness of delivery, as well as the fact that beneficiaries contributed building materials such as sand and stones when possible. Labour costs were reduced by involving beneficiaries in construction activities and the transport of materials. Working with local organizations and through community structures also helped to reduce personnel costs in contrast to similar INGO interventions who used more expensive international staff.

One might question whether it is efficient to pay the staff of hospitals and medical centres 6 to 10 times more salary than they used to get before the start of the programme. The salary levels were however based on comparing the salaries that local health staff received in similar programmes run by Save the Children, IRC, Merlin, MSF and Johanniter.

Coverage

When analysing the number of people who had access to free Health, Nutrition and WASH services during the project period, the conclusion is that the coverage was high.

An estimated 30,000 households had access to free health care. Free health care combined with well organized sensitization campaigns resulted in a nearly tenfold rise in consultation rates in some of the supported facilities. Around 30,000 households are estimated to use the water supplies.

Sustainability

Access to health facilities during the project was high. However, with the reintroduction of user fees at the end of the project, it is the most impoverished families who no longer benefit. Hospital staff consistently confirmed that most of the population is unable to pay even $1 for medical treatment. No exit strategy for the free distribution of drugs has been found throughout project sites.

In some places the same accounts for access to potable water, such as water points where families will have to contribute financially towards maintenance in order to be allowed to use them. The issue of WASH maintenance also weighs heavily on the sustainability of the intervention.

Coordination

For over four decades, Caritas Goma has been a significant health provider in North Kivu Province. As such they coordinate and cooperate very closely with the provincial health authorities and health structures.

[1] Exceptions were made for Intravenous fluids that were bought from the BDOM own pharmacy production unit in Goma and oral Quinine which was bought from Pharmaquina in Bukava (the latter is the national policy)

In general, coordination and communication appears stronger at community level than at the cluster level, since local Congolese NGOs do not regularly participate in the cluster meetings. Caritas technical staff takes part in both the WASH and Health Clusters, but they expressed the feeling that the clusters are often dominated by the International agencies and INGOs and that local NGOs are left out of major discussions and decisions.

Gratuity of Health Care

Providing free health care was the best and only option CAFOD /Caritas had in the insecure and unstable context of the project area. All other International NGOs active in the health zones of Mweso, Birambizo, Rutshuru and Rwanguba supply free health care. It is not certain how long they will continue to deliver care without charging user fees; this will largely depend on how the security situation in the area develops. The situation is evaluated every 6 months and the next evaluation is planned for the end of June 2010.

The best and probably the only realistic exit strategy for free access health care projects in North Kivu is to continue supporting the health facilities and at the same time reinforce the capacity of the health care managers and technicians in the health zone. Once security is re-established in the zones, the population will become more settled and will be able to pay a little for their care. These Health Zones will also then be integrated into the PS9FED (Programme Santé 9ème Fonds Européen de Développement).

Adherence to Humanitarian Standards

Overall the ICRC Code of Conduct was respected in the execution of the project as local cultures, structures, customs and languages were taken into consideration in the making of In addition, the choice of beneficiaries was made without distinction of sex or ethnicity and the most vulnerable groups of the population, such as IDPs, benefitted from the project. Where possible, local capacities were strengthened, local staff employed, local materials purchased and business done with local companies.

Sphere minimum standards in nutritional centres are well met because the centres received food from the WFP and have to respect the WFP standards. While the staff at Caritas Goma HQ demonstrated some knowledge of the Sphere standards, the WASH technicians in the field did not. This was reflected by many of the WASH structures visited.

There were mixed results in terms of adherence to the HAP-I benchmarks.

The Level of Involvement and Accountability to Beneficiaries

Beneficiary participation has been integrated throughout the project cycle in both the Health and WASH components. The target communities participated in the initial needs assessment for the project, and influenced decision making during project execution. For the WASH component the local population took responsibility for the transport of building materials and assisted in the construction of WASH structures. In the Health component hospitals and medical centres had a voice in the selection of medicines that they received. The views of the Health Committees were consistently taken into account.

Information about the project and free healthcare were successfully made available to the public via local radio, word of mouth, announcements in churches, and by informing local village chiefs. Also, educational posters on hygiene mentioning Caritas, CAFOD, and DEC were observed in several health centres and hospitals. Despite this none of the interviewees in the field were actually aware of DEC, which shows that the origin of the funds is not generally known. Caritas is known by nearly all of the interviewees.

Fulfilment of Past Lessons and Recommendations

The CAFOD emergency Health and WASH project was included in a DEC monitoring mission that took place in April 2009. 12 DEC funded organizations included in the mission, and based on the findings 10 key recommendations were made. Out of those recommendations the ones relevant to this project evaluation deal with the issues of (i) pre-crisis preparedness, (ii) coordination between different actors, (iii) implementation of the Sphere standards in project execution, and (iv) beneficiary participation in the project cycle. The feedback from the DEC monitoring mission in April was well noted by CAFOD. Their responses demonstrate that they agree with the need to address certain key issues, and are making an effort to do so.

In an effort to increase the usage of the Sphere standards in emergency response, CAFOD has assisted Caritas Goma in the development of a new tool for needs assessments based on the Standards. CAFOD acknowledges that more training of local partners is needed in order to improve the level of adherence to the standards and the mainstreaming of fundamental principles.

Based on the findings of the evaluation, the following recommendations are made:

1. Develop a realistic transition from free health care to the regular health finance system in North Kivu.
2. Improve the coordination with key stakeholders in the project area and use a common approach when providing healthcare
3. Ensure there is a stock of medicines and medical material for at least three months left when support ends
4. Ensure that WASH technicians in the field are trained in the Sphere standards
5. Reinforce the public health capacity of the WASH technical team
6. Improve the maintenance of WASH structures
7. Ensure that implementing partners are included in communications with donors
8. Adapt the report formats of the implementing partner Caritas so that they resemble the report formats CAFOD uses to report to DEC.

Table of Contents

Acronyms and abbreviations

ACT	Artemisinin Combination Therapy
ALNAP	Active Learning Network for Accountability and Performance in Humanitarian Action
CAFOD	Catholic Agency For Overseas Development
CNDP	Congrès National pour la Défense du Peuple
DAC	Development Assistance Committee
DEC	Disasters Emergency Committee
DRC	Democratic Republic of the Congo
DRP	Disaster Response Programme
ERP	Extended Response Programme
FARDC	Forces Armées de la République Démocratique du Congo
FASS	Fonds d'Achat des Services de Santé
FDLR	Forces Démocratiques de Libération du Rwanda
HAP-I	Humanitarian Accountability Partnership - International
HC	Health Centre
HGR	Referral Hospital
ICRC	International Committee of the Red Cross
INGO	International Non-Governmental Organisation
INRUD	International Network for the Rational Use of Drugs
MDF-AC	Management for Development Foundation - Afrique Centrale
MIP	Provincial Health Inspector
M&E	Monitoring and Evaluation
NFI	Non Food Items
NK	The province of North Kivu
OECD	Organisation for Economic Cooperation and Development
PEP	Post Exposure Prophylaxis (to prevent HIV infection after rape)
PS	Health Post
PS9FED	Programme Santé 9ème Fonds Européen de Développement
RBF	Results Based Financing
RDU	Rational Drug Use
SK	The province of South Kivu
ToR	Terms of Reference
WASH	Water Sanitation and Hygiene
Watsan	Water and Sanitation[2]
WFP	World Food Programme
WHO	World Health Organisation

[2] Although in Caritas and CAFOD project documents the abbreviation Watsan is used for al Water, Sanitation and Hygiene activities, in this evaluation report WASH will be used instead.

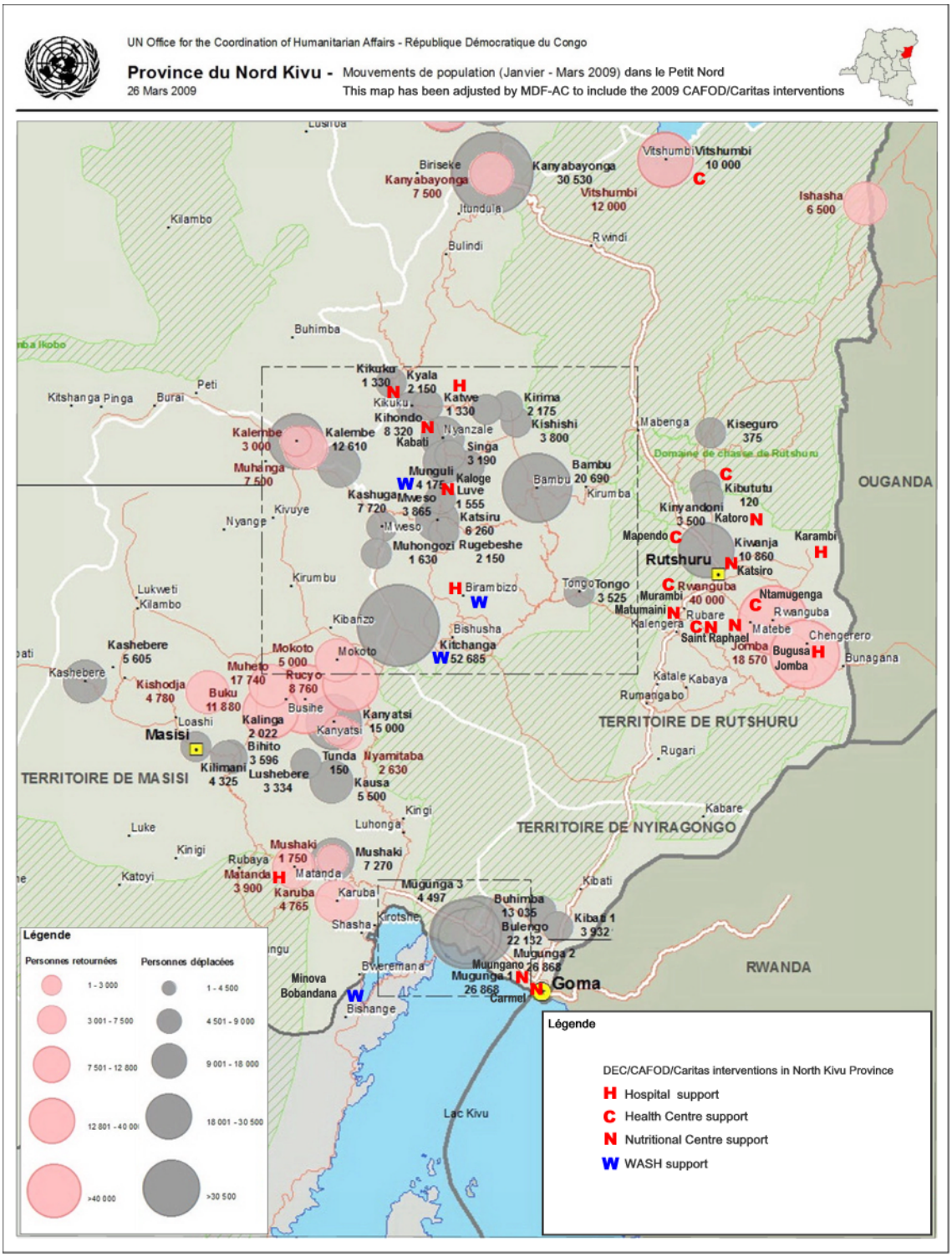


Figure 1. Map of the project area Rutshuru and Masisi Territory, North Kivu DR Congo

1. Introduction

This is an external evaluation commissioned by CAFOD in order to assess a DEC funded Health and Water, Sanitation and Hygiene (WASH) project implemented by CAFOD and its partner organisation Caritas Goma. The project was implemented from January 2009 to January 2010, and took place in the territories of Masisi and Rutshuru in North Kivu Province, DR Congo.

This evaluation is part of the DEC Accountability Framework that requires DEC members, on a sample basis, to commission and publish an independent evaluation of what their share of the appeal fund has achieved, including how they were accountable to the beneficiaries in the disaster zone.

The evaluation began in December 2009 and was carried out over a period of three weeks by three consultants with backgrounds and expertise in health, WASH, and social science research (short team biographies in **Annex 2**).

The purpose of the evaluation is threefold; (i) to enhance accountability to beneficiaries, (ii) to guide future decisions on the humanitarian strategy for the DRC, and (iii) to improve the response to emergencies in the health and WASH sectors. The intention is for the evaluation to be useful to DEC, CAFOD, Caritas Goma, and the greater humanitarian community in Goma. The four main issues that the evaluation seeks to capture are:

1. The extent to which proposed objectives and outcomes have been achieved
2. The extent to which the Code of Conduct and Sphere Standards have been respected
3. The level of involvement of and accountability to beneficiaries
4. The extent to which past lessons or recommendations have been fulfilled

Following a detailed description of the project background and evaluation methodology, the report will discuss the four primary issues mentioned above in the following format:

Section 4 discusses the achievement of proposed outcomes in specific relation to the effectiveness of the Health and WASH components, as well as project efficiency, coverage, sustainability, and coordination. Particular attention is also paid here to the element of granting free health services.

Section 5 is focused on humanitarian accountability and quality management. The main issues discussed are the levels of adherence to the ICRC Code of Conduct and Sphere Standards, the participation of and accountability to beneficiaries, as well as the accountability to DEC.

Section 6 highlights the application of past lessons and recommendations with a particular focus on those provided by a previous DEC monitoring mission covering the same project.

Section 7 reiterates the primary findings and conclusions of the evaluation, and offers eight recommendations to inform future programming

2. Background

In October 2008 a wave of violence broke out between the FARDC, the CNDP, the FDLR, and Mayi Mayi in the North Kivu territories of Masisi and Rutshuru (see **annex 7**, maps of North Kivu). Massive suffering and destruction resulted from the fighting and over 100,000 people were displaced from their homes.

After the major hostilities had ended in December 2008, many internally displaced people (IDPs) started slowly returning to their villages. Often their houses had been looted or destroyed and their fields plundered. However, throughout the province of North Kivu, sporadic hostilities continued throughout the year 2009. The areas most affected were Masisi and Rutshuru Territories[3]. As can be seen on the map in **figure 1**, large concentrations of returnees and IDPs temporarily settled in and around the major villages in these territories where they felt better protected. As water and sanitation facilities in these villages had either been destroyed or had deteriorated over years of insecurity and lack of maintenance, worries about waterborne diseases among the population was on the rise.

Many international non-governmental organisations (INGO) and some local NGOs gave emergency assistance during the year 2009. The International Rescue Committee (IRC) started a health programme in Rwanguba health zone while Merlin did the same in Birambizo and Rutshuru Health zones[4]. To guarantee access for the most vulnerable, both INGOs introduced a system of free healthcare in the health zones. Up until this time people had been accustomed to paying for health services. Health facilities supported by Caritas at the time had a system of partial cost recovery with a user fee of 0.5$ - 1.5$ per consultation and up to 50$ for a Caesarean section. In effect patients stopped frequenting the Caritas facilities and walked long distances to get free health care with IRC and Merlin.

CAFOD responded to this emergency in early 2009 with over £3 million in funding, £298,000 of which came from the Disasters Emergency Committee (DEC). The DEC funds were used to cover a Health and WASH project implemented by Caritas Goma, a CAFOD partner organisation in North Kivu.

The health component of the project has been rolled out in two phases. The first phase, named the Disaster Response Programme (DRP), took place from January to March 2009 and provided medications and medical supplies for three months to 5 hospitals, 5 health centres, and 11 nutritional centres in Masisi and Rutshuru territories. One of the hospitals, Birambizo, had been badly damaged by fighting and was rehabilitated. In addition, operating costs and personnel salaries were subsidised during 1 month in two nutritional centres in

[3] The province of North Kivu, with a population of around 5 million, is divided in 6 Territories : Beni, Lubero, Walikale, Rutshuru, Masisi and Nyiragongo and 3 major towns Beni, Butembo and Goma

[4] A Health zone has a population of between 150.00 - 300.000 inhabitants. Each Health Zone has around 20-30 health centres and one referral hospital. Often several Health Centres have developed into small hospitals; in some place health posts (dispensaries) are still functioning.

Goma and during 3 months in the other 19 facilities, in order to support these facilities in providing services to the population free of charge.

The second phase of the project, named the Extended Response Programme (ERP), was funded by an additional £166,000 provided by DEC, and was implemented from August 2009 until the end of January 2010[5]. Phase two provided continued support to 4 medical structures (2 were included in phase one and 2 were not) within the target North Kivu territories. See **table 1** for an overview of health project sites.

Table 1. Overview of health intervention project sites

#	Facility	Facility	DRP	ERP	Supported Activities	Visited
Kirotshe Health Zone						
1	Matanda	HC		X	Medicines, Equipment, Functioning costs*	Yes
Birambizo Health Zone						
2	Birambizo	H	X	X	Medicines, Equipment, Rehabilitation, Functioning costs	Yes
3	Katwe	H	X	X	Medicines, Equipment, Functioning costs	Yes
4	Kabati	NC	X		Medicines, Functioning costs	Yes
5	Kalonge	NC	X		Medicines, Functioning costs	No
6	Kikuku	NC	X		Medicines, Functioning costs	No
Rutshuru Health Zone						
7	Kibututu	HP		X	Medicines, Functioning costs	Yes
8	Vitshumbi	HC	X		Medicines, Functioning costs	No
9	Mapendo	HC	X		Medicines, Functioning costs	No
10	Murambi	HC	Xr		Medicines, Functioning costs	Yes
11	Matumaini	NC	X		Medicines, Functioning costs	Yes
12	Rubare	HC	X		Medicines, Functioning costs	Yes
13	Rubare	NC	X		Medicines, Functioning costs	Yes
14	Katoro	NC	X		Medicines, Functioning costs	Yes
15	Katsiro	NC	X		Medicines, Functioning costs	No
Rwanguba Health Zone						
16	Bugusa-Jomba	RH	X		Medicines, Functioning costs	Yes
17	Karambi	H	X		Medicines, Functioning costs	Yes
18	Ntamugenga	HC	X		Medicines, Functioning costs	No
19	Saint Raphael	NC	X		Medicines, Functioning costs	No
Goma Health Zone						
20	Muungano	NC	X		Medicines, Functioning costs	Yes
21	Carmel	NC	X		Medicines, Functioning costs	Yes

* Functioning costs include the salaries

[5] Originally the ERP was planned to last from June until November 2009 but the transfer of funds lasted longer than expected and the project couldn't start before the population had been well sensitised on free health care which also took longer than foreseen.

The WASH component of the project was implemented in 4 communities in Rutshuru and Masisi territories from the beginning of January to 15 July 2009[6]. WASH activities included (i) the construction of 2 new gravitational water distribution systems distributing to 16 water points, (ii) the rehabilitation of one gravitational water distribution system distributing to 8 water points, (iii) the protection of 20 natural springs, (iv) the construction of 80 household latrines and 10 public latrines, and (v) the training of management committees for water points and sensitisation of 22,000 households. See **table 2** for an overview of WASH project sites and construction and rehabilitation activities.

Table 2.Overview of WASH intervention project sites January - July 2009

#	Health Zone	Construction and rehabilitations activities					Visited
		Protection of natural springs	Water distribution systems	Water points	Family latrines	Public latrines	
1	Minova	10	1	8	23	4	Yes
2	Kitchanga	10	0	8	20	3	Yes
3	Mweso	3	1	8	20	2	Yes
4	Birambizo	10	1	8	20	2	Yes
	Total	**33**	**3**	**32**	**83**	**11**	

3. Methodology

The methods used in the project evaluation included a literature review, interviews, and focus group discussions (FGD) with key stakeholders including project beneficiaries, Caritas Goma agency staff, local field staff who had been involved in executing the project, local authorities, and International NGOs working in the project area. In total 14 of the 21 health and nutrition facilities supported by Caritas have been visited. In each facility health services were observed and patient registers, monthly reports and pharmacy management tools were consulted. The team was able to see all but one of the WASH intervention sites (Bishusha) and 20% of the latrines, 50% of the springs, 60% of the water points and 100% of the reservoirs were visited. During the field visits the team of consultants was accompanied by the Caritas Supervisor, the Caritas WASH coordinator and the CAFOD programme assistant.

The literature review included detailed project plans and proposals from CAFOD, and a series of implementation reports which had been submitted to DEC. This includes the final implementation report submitted for the first phase of the project in October 2009. Other documents included in the literature review were the Sphere standards, the new DEC Accountability Framework, the ICRC Code of Conduct, and the HAP standard in Humanitarian Accountability and Quality Management. (**annex 8**, consulted literature)

[6] Because of insecurity and bad roads in Birambizo the project period ended 15 days later than had been planned..

The broad sets of benchmarks within these frameworks were integrated into the evaluation. In addition, the OECD/DAC Evaluation Criteria determined the set of qualities used to address the 4 main evaluation issues. These qualities are:

- Relevance
- Coherence
- Effectiveness
- Efficiency
- Coverage
- Connectedness
- Coordination

Based on the review of documentation, the ToR, and discussions with CAFOD and Caritas Goma staff, the consultants prepared a detailed questionnaire for guiding field interviews and focus groups.

Picture 1. A focus group discussion with a group of mothers visiting Rubare Health Centre

A total of 25 interviews and 15 focus groups were held in Goma, Masisi, and Rutshuru territories. Five focus groups were held with women and girls only, and 10 were held with men, women and children. The visits to the Health and Nutritional centres included 5 in Masisi, 3 in Rutshuru and 2 in Goma. The WASH sites visited included 15 improved water sources, 3 gravitational water distribution systems, 20 water points, and 60 toilet facilities throughout the zones of intervention. The questionnaire guide and a list of interviewees can be found in **annex 3, 4 and 5** of the report. The itinerary and facilities visited can be found in **annex 6**.

Picture 2. Focus group discussion at the primary school in Kitchanga with two pupils from each class, each pupil taking care for maintenance of the CARITAS toilets left in the picture

The evaluation team used the pilot version of the ALNAP Guide “Real-time evaluations of humanitarian action” as guidance. Following the ALNAP approach the consultants have taken care to base their recommendations on conclusions, their conclusions on findings and

their findings on evidence. Method triangulation (using different methods to get information about the same issue) and cross-category triangulation (asking different people the same question) was used to guarantee that the evidence supporting any conclusion was drawn from a variety of sources.

One limitation to the collected data is the fact that the evaluation took place around 9 months after the activities that were part of the disaster response programme had finished. This was problematic for the health component in particular, for two reasons. First, in some instances there were no or few people left in the project site who had been present during the entire implementation period. Secondly, health centres often had so many ongoing activities to meet the needs of the population that it was difficult to recall the information about the support period so long after the end of the project.

Picture 3. The representative of the WASH committee in Minova showing the place where hundreds of IDPs were camping beginning of 2009

Picture 4. Group discussion with Mweso villagers around a water point

4. Achievement of Proposed Objectives and Outcomes

The full name of the project under evaluation is ‘Improvement of health conditions of vulnerable communities: support to subsidised healthcare and promotion of hygiene’.

The specific objectives were:

1. To reduce morbidity and mortality rates by ensuring affordable access to health care in 5 hospitals, 5 health centres and 11 nutritional centres
2. To reduce morbidity related to waterborne diseases and poor hygiene in areas overcrowded with IDPs in Birambizo, Kitchanga, Minova, and Mweso.

By and large the activities planned in order to meet these objectives have been carried out and some have even been exceeded based on the numbers of beneficiaries who received

assistance compared to those who were initially targeted. In the final CAFOD DRP report and the Caritas ERP report[7] the following results were given:

- from January - March 2009
    - an estimated 25,000 households were able to access free medical care;
    - 53,634 people were treated in the supported medical and nutritional centres;
- From January to July 2009
    - 2,000 households gained access to clean drinking water close to where they live;
    - 480 households gained access to latrines and
    - 22,000 households were sensitized in hygiene and sanitation by local committees.
- From August 2009 to January 2010 30,816 patients have been treated for free.

Monitoring of the project by Caritas Goma was regular and program data well recorded. From August 2009 - 2010 Caritas organised 20 supervision visits to the project.

The lack of support during the period bridging the first (DRP) and second phase (ERP) of the programme was experienced as very difficult, especially by the Birambizo and Katwe hospital staff. This period ("de vache maigre" as it was called by one of the doctors) lasted four months, from April to August 2009 and had a marked effect on the consultation rate, as illustrated in **figure 3**. It also caused misunderstandings in the community because after three months of free health care they first had to return to paying and then it became free once again.

4.1 Effectiveness of the Health Component

Without a doubt the accessibility of health centres and hospitals was significantly increased during the project implementation period, thanks to the gratuity of health care and the rehabilitation of facilities, such as Birambizo. Fewer people were resorting to the sometimes dangerous practices of traditional medicine, and there was a sharp decline in the unaccompanied deliveries of babies at home.

[7] The final CAFOD report on the ERP was not yet finished at the time of the evaluation.

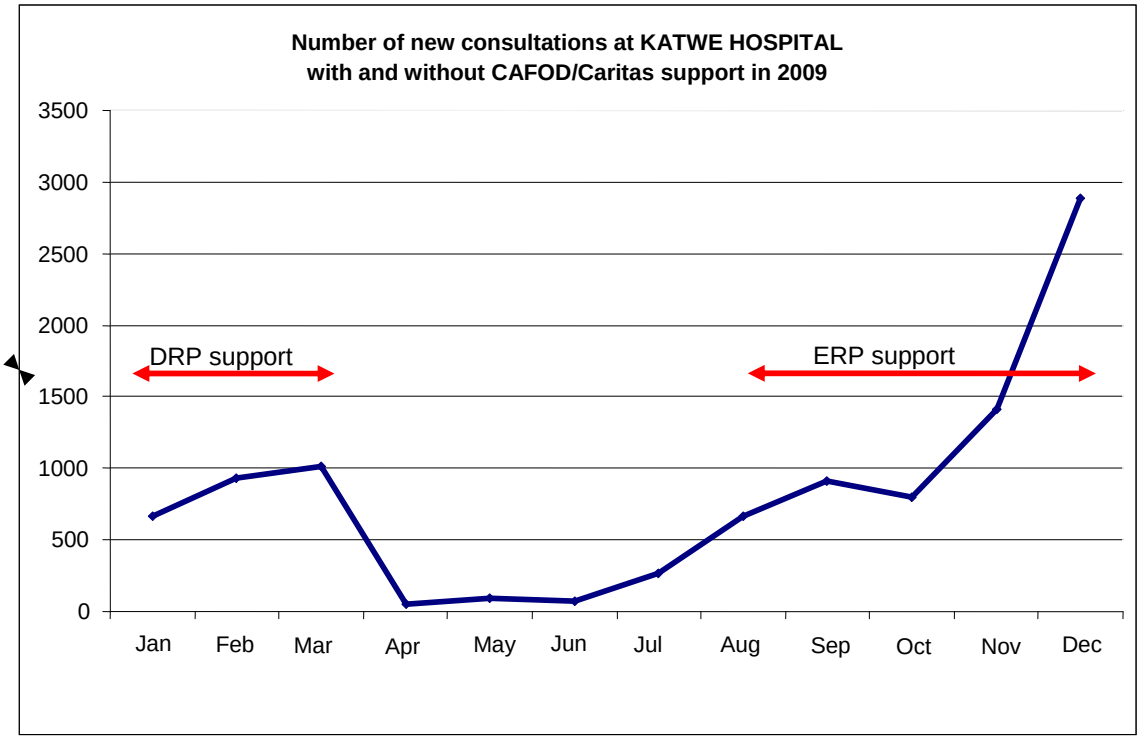


Figure 2. Number of new consultations per month in Katwe Hospital, with and without support

Deliveries in the maternity wards of the health facilities supported by CAFOD rose from a monthly average of 150 in 2008 to 310 in March 2009. Mortality rates among IDPs in the areas targeted by the project decreased from an inacceptable average of 1.33 per 10,000 persons per day to an acceptable 0.43 per 10,000 persons per day[8].[9].

During the assistance period nutritional centres were also highly frequented. WFP supplied these centres with food while Caritas distributed drugs and paid staff salaries. CAFOD supported 11 nutritional centres; 1034 malnourished children were treated in three months and by 31 March 2009, 983 of them had positively recovered and had been discharged.

The staff of the health and nutritional centres were very motivated by the payments they received from Caritas. Thanks to the project doctors and nurses received 6 to 8 times more money than usual (e.g. $250 per month for a nurse instead of the regular $35). However, a delay in the arrival of some of the medicines led certain health centres, such as Karambi, to purchase medications at the local market with part of the funds intended to pay the personnel.

The equipment that some of the health structures received should have a positive impact on the medium to long term needs of the population. For example, the Karambi health centre in Rwanguba Health zone now has a functional surgery room thanks to the project. In addition, the rehabilitation work done at the hospital in Birambizo has increased the rate of outpatients

[8] According to the Sphere project, the emergency threshold for the Crude Mortality Rate (CMR) in Sub-Saharan Africa is 0.9 and the normal, average CMR is 0.43

[9] Mortality data were collected and analysed by Caritas. It should be taken into account that in the same area and during the same period other humanitarian interventions were taken place as well.

consulted from 10 to 150 per day and the number of patients hospitalised from 3 to 50 per month. Before its rehabilitation this hospital had 18 functional beds, now there are 67 beds with an 85% occupancy rate. Unfortunately, some of the equipment given to health centres broke down quickly. For example Katwe hospital received a generator, essential for surgery, which broke down after only two months. They now have to operate with the help of storm lanterns.

It was also noticed that except for one health centre we visited (Kibututu), mosquito nets had been mounted over nearly all of the beds in hospitals, and over the observation and maternity beds in the health centers.

When introducing free healthcare, the supporting organisation should be aware that this is likely to result in a tenfold rise in consultations. This puts a heavy burden on medical staff and essential medicine stocks. In project planning, the budget, logistics and human resources should be elaborated with this in mind in order to prevent stock shortages and unmotivated personnel.

4.2 Effectiveness of the WASH Component

The Emergency situation started in October 2008. CAFOD responded by transferring their own funds to Caritas Goma for the distribution of emergency NFIs in late October 2008. The DEC appeal was launched in November 2008. CAFOD started pre-financing the DRP project at the beginning of January although the letter of agreement from the DEC was not received until 20 January 2009. The first beneficiaries were therefore not reached by CAFOD/Caritas assistance until January 2009. Timeliness could probably have been improved if the DEC processes were faster and more flexible.

Increased access to potable water through the WASH component of the project responded to a significant need expressed by locals in Birambizo, Mweso, and Minova. Before the project several women in these communities reported to have been sexually harassed while travelling long distances for water. Children were often arriving late at school due to the time spent fetching water in the mornings and there was a risk of drowning for children from bathing in the lake. Women in focus group discussions estimated that the risk of being raped while fetching water was 80% lower. The water distribution points thus offer protection for beneficiaries beyond the prevention of waterborne diseases.

In Minova provisions of water have increased from 10 to 15 litres per person per day. However, according to information from the focus groups discussions in Mweso and Birambizo, the quantity of water available per capita in their region has not significantly increased due to the arrival of many returnees from various IDP camps. This has not been confirmed by reliable data on returnee numbers in both health zones, but UN-OCHA data show that in between January 2009 and January 2010 the total of returnees in Masisi territory was 189,849 and in Rutshuru Territory 168,792, with 68% having returned during the first half of 2009. The high influx of returnees had not been anticipated when planning the project. During the year 2009 an estimated 117,377 IDPs in Masisi territory and 49,056 IDPs in Rutshuru territory slowly returned to their villages of origin. The insufficient amount of potable water available to the communities of Mweso and Birambizo has sometimes forced them to utilize other less sanitary sources of drinking water.

Picture 5. In Minova the population took care of the construction of a fence around their water point to protect it from cattle

Picture 6. In Mweso water points remained unprotected and spillage of water is not controlled

In Mweso none of the water points visited was protected against cattle, while in Minova the population had taken action themselves and constructed appropriate fencing. In Minova 80% of the participants in the focus groups expressed their joy about the availability of sufficient potable water, while in Mweso and Birambizo the quantity of available water is considered insufficient by all. Thus the WASH component significantly augmented the total quantity of available potable water, but it could have been more effective and closer to Sphere standards (20L per person per day) if conducted on a larger scale.

The proper maintenance of water distribution points and latrines has reduced the effectiveness of the WASH intervention. While at all WASH sites visited a Water Committee was present, little material for longer term maintenance was observed. Also, there are no proper maintenance systems in place for many of the family latrines in Mweso, which are actually used as public latrines, and Water Committees have not yet been trained in reservoir maintenance despite their requests.

Beneficiaries of the WASH component expressed the feeling that the project had led to a reduction in waterborne diseases and health centres, and hospitals have reported a decline in the number of cases of cholera. Analysing the 2009 statistics for Minova and Mweso Referral Hospitals, we see a stark diminution of waterborne diseases (diarrhoea) from April (just after finalizing the water installations) to August. After August the number of cases augmented again, although it stayed at a lower level than before the intervention. Further investigation is needed to know whether this is due to WASH structure maintenance, a general augmentation of consultations, or simply a seasonal effect.

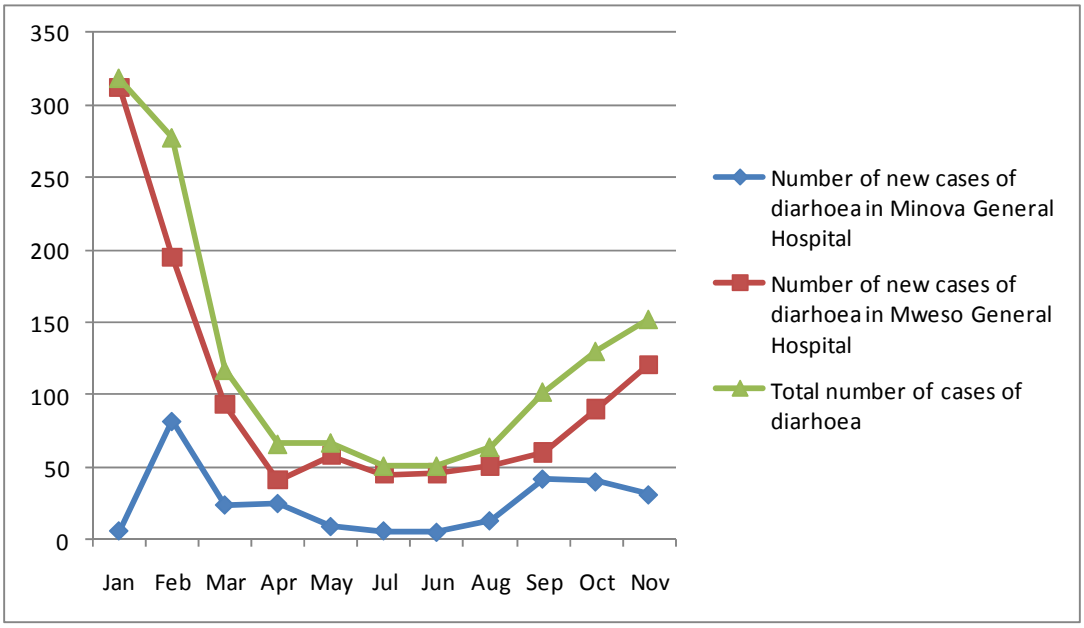


Figure 3. Number of cases of diarrhoea (bloody / non-bloody and cholera) reported during January to November 2009 in Minova and Mweso General Hospitals.

4.3 Efficiency

The budget for the first phase of the programme (DRP) was £298,261 and for the second phase (ERP) £166,651. Division of the funds per budget line can be observed in **figures 4 and 5**.

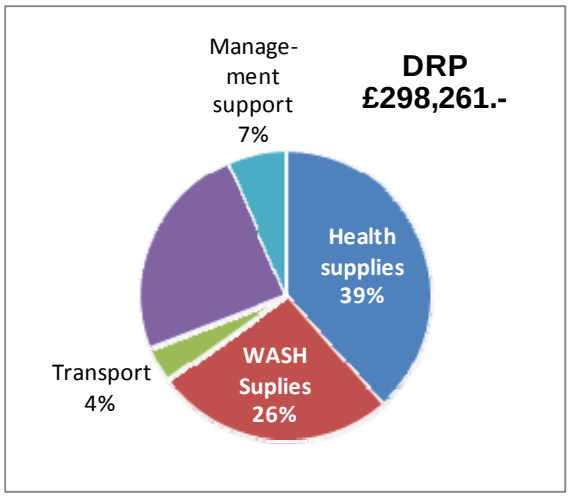


Figure 4. Use of funds Disaster Response Programme January - March 2009

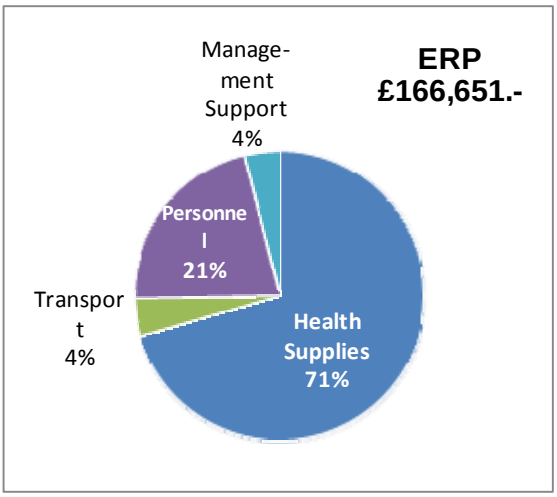


Figure 5. Use of funds Extended Response Programme August 2009 - January 2010

During the first project phase WASH supplies (i.e. construction materials, water pipes, taps) and Health supplies (medicines, medical materials and equipment) covered 65% of the funds. During the second phase in total 71 % of the funds were used for medical supplies. Caritas tender procedures were respected: three suppliers were contracted for all supplies[10]. The choice of where to buy was based on quality, price and procurement time. When possible, to reduce costs, building materials such as sand and stones were contributed for free by the beneficiaries.

Although all health staff and WASH construction staff received payment, only 23% of the total budget was spent on labour costs. Labour expenses were limited by involving the beneficiaries in construction activities and the transport of materials. Working with local organizations and through community structures helped to reduce personnel costs in contrast to similar INGO interventions that used more expensive international staff.

One might question whether it is efficient to pay the staff of hospitals and medical centres 6 to 10 times more salary than they used to get before the start of the programme. The salary levels were however based on comparing the salaries that local health staff received in similar programmes run by Save the Children, IRC, Merlin, MSF and Johanniter.

[10] Exceptions were made for Intravenous fluids that were bought from the BDOM own pharmacy production unit in Goma and oral Quinine which was bought from Pharmakina in Bukava (the latter is the national policy)

In order to improve project efficiency the following three trainings were organised for health and administrative staff included in the project:

2. A training in drug management, which focused on clear record keeping and prevention of stock outs
3. A training in improved prescribing habits with the help of standard case management protocols (algorithms), which was meant to guarantee quality treatment and to reduce unnecessary drug prescribing.
4. A course on health information reporting and the basics of financial management

In order to check whether the medicines were rationally and efficiently prescribed the drug prescribing behaviour in three health facilities (Rubare and Murambi health centres and Karambi hospital) was observed. Pictures were taken of 553 at random consultations that were entered in the registers. Three of the 13 WHO/INRUD indicators to measure rational drug use (RDU) were used to analyse drug use in the facilities. This rapid evaluation produced the following results:

- Average number of drugs prescribed per encounter: 2.4 (recommended value <2)
- Percentage of encounters with an antibiotic prescribed: 42% (recommended value <30%)
- Percentage of encounters with an injection prescribed: 6% (recommended value <10%)

Based on two earlier studies in the region in 1995 [11] and in 2001[12] with 3.3 drugs prescribed per encounter in the former and 2.7 prescribed in the latter, prescribing behaviour in the CAFOD/Caritas supported centres was relatively good. However, based on the recommended[13] value of less than 2 medicines per encounter, prescribing behaviour could be further improved. The data show that some over-prescribing of medicines, especially antibiotics is practiced. This is probably caused by lack of proper training and diagnostic means (lab, microscope, centrifuge...) and the fact that the medicines are for free. The percentage of encounters with an injection prescribed is within the norms.

Picture 7. In Kibututu health post the algorithms, detailing the diagnostic path and treatment for fever, diarrhoea, and cough were put on the wall, which is very handy for improving prescribing habits. The head nurse had attended the Caritas training in good prescribing practices.

[11] HealthNet International (1995), Drug-Use Patterns and Prescribing Behaviour at Primary Health Care Level in North Kivu

[12] ASRAMES, RD Congo (2001), Enquête sur l'utilisation des médicaments dans les Centres de Santé au Nord-Kivu, RDC

[13] Recommended by INRUD/WHO

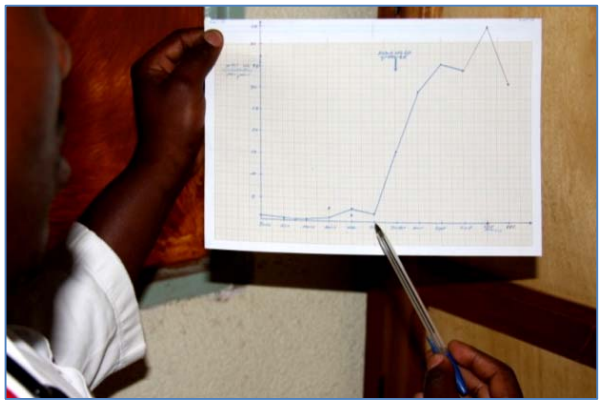
4.4 Coverage

Coverage is discussed in terms of whether or not the major population groups, including the most vulnerable, have been reached by the project and provided with assistance proportionate to their needs. Important to keep in mind is the fact that the vast majority of the population could reasonably be defined as vulnerable, with differences in the 'layers' of vulnerability that people face. The blanket cause of vulnerability in the project target areas is poverty, which remains very high. From this point forward vulnerability levels differ depending on certain factors such as whether or not people are handicapped, elderly, orphaned, and/or displaced.

When analysing the number of people who had access to free Health, Nutrition and WASH services during the project period, the conclusion is that the coverage was high.

An estimated 30,000 households had access to free health care. Free health care combined with well organized sensitization campaigns resulted in a nearly tenfold rise in consultation rates in some of the supported facilities. In March 2009 Birambizo Hospital treated 1,403 patients, nearly 50 per day, compared to 5-10 per day before the project.
The average access rate to medical services in all of the targeted areas combined rose from 35% of the population to 78% during the month of January[14]. In total 53,634 people were treated during the three months of DRP support.

Picture 8. The graph showing the augmentation of curative consultations in Kibututu health centre had been stuck on the wall



Picture 9. The doctor in Katwe hospital shows the rise in consultations when in august 2009 free health care was introduced.

During the ERP another 30,816 out patients were treated for free in the 4 health facilities concerned and an important rise in deliveries, hospitalisations and surgical interventions was registered. Participants in the focus groups were happy that free care was now available in the health facilities where they used to go and that they longer needed to walk 5 to 10 km to reach the health structures supported by the other INGOs.

From January - March 2009 CAFOD supported 11 nutritional centres; 1034 malnourished children were treated in three months, and by 31 March 2009, 983 of them had recovered and had been discharged.

[14] The access rate is the number of consultations over a period of a year times 100, divided by the number of population served.

The construction of 3 gravitational water distribution systems and the protection of 20 natural springs in theory provided enough water for 4400 households, taking into account the Sphere minimum standard of 20 litres per person per day. In reality the total population that utilizes the water is estimated to be around 30,000 households

Picture 10. This reservoir at Minova serves the village, 2,596 IDP families, the hospital, one maternity ward and 3 schools.

Picture 11. The 30 cubic meter reservoir constructed in the hills overlooking Mweso provides clean drinking water for 1,450 IDP families, Mweso hospital, 4 schools and indirectly most of the villagers.

4.5 Connectedness

During the project, access to health facilities was high but with the reintroduction of user fees at the end of the project the most impoverished families no longer benefit. Hospital staff consistently confirmed that most of the population is unable to pay even $1 for treatment.

In some places the same goes for access to potable water. For example, in Bobandana/Minova each family will have to contribute 200 Congolese Francs (= $ 0.20) per month to get access to the water point in order to enable the water committee to pay for maintenance. Project staff expressed the opinion that this will cause most people to discontinue using the water point because they are too poor to pay even such a little sum.

No exit strategy for the free distribution of drugs has been found throughout project sites, and the halting of financing threatens to break down the health system. The primary hurdle for sustainability of the Health component in the target areas is the fact that people remain very poor. There is still a large presence of IDPs and returnees with no income who have found that their homes have been destroyed and/or their roofs taken. The resilience of returnees will take time, as they need 2 to 3 harvests (1-2 years) before they will be able to earn a living and pay for their own health care.

With the majority of the local population unable to pay for health care, the health centres and hospitals are unable to keep a stock of the most essential medicines without outside support. In fact, most of the structures visited were out of stock of several essential medicines already.

The issue of WASH maintenance weighs heavily on the sustainability of the intervention. Beyond this, there is a potential for inter-personal conflicts to arise around WASH activities; particularly in Minova and Bobandana where the source is located in the province of North Kivu while the reservoir and the water points are located in South Kivu. Also, land property conflicts may arise because adduction pipes are crossing the land of owners who do not benefit from the project, presenting the risk of sabotage. Caritas Goma was conscious about this and has been very careful while designing and planning the project, involving the community leaders and local administrators as much as possible. Frequent meetings of the water committee provided the opportunity to rapidly intervene and negotiate whenever tensions risked hampering the project.

4.6 Coordination

For over four decades, Caritas Goma has been a significant health provider in North Kivu Province. As such they coordinate and cooperate very closely with the provincial health authorities and health structures. The provincial medical health inspection (MIP), the Médecins Chefs de Zone (MCZS), as well as the UNOCHA medical cluster were informed in writing about the content of the project.

In general, coordination and communication appears stronger on the community level than at the level of the clusters, as local Congolese NGOs do not regularly participate in the cluster meetings. Caritas technical staff takes part in both the WASH and Health Clusters, but they expressed the feeling that the clusters are often dominated by the International agencies and INGOs and that local NGOs are left out of major discussions and decisions. None of the INGOs active in the region have taken the initiative to harmonize and coordinate their projects with those of local NGOs, such as Caritas.

An example of strong local coordination was found in Birambizo where the Health Zone Central Bureau holds monthly meetings with the NGOs present in the zone (Johanniter, Merlin, and MSF-F), local authorities, and the local priest. In Kitchanga hospital management personnel was involved in the planning and implementation of the Caritas WASH interventions, and the construction of toilets was complementary to the support given by the hospital's other partner, Johanniter. As nearly all displaced persons had left the compound, the Caritas latrines were closed and they will be used again once the other toilets are filled.

CAFOD and Caritas Goma successfully coordinated with AVSI in the joint construction of latrines for a school in Kitchanga. There also exists a good level of coordination between Caritas Goma and WFP in supplying medical care and food to nutritional centres. There were also found to be good referral systems in place and retro information shared between nearby health structures.

NGOs have no coordinated salary policy for the salaries they pay to locally hired staff. For the payment of health staff Caritas made a serious effort to harmonise their salaries with what the other NGOs in the area pay. The locally hired Caritas WASH staff complained because according to them they were receiving much less than their colleagues working with INGOs. Salary policies should be discussed and harmonized in the Cluster meetings.

4.7 Gratuity of health services

Providing free health care was the best and only option CAFOD /Caritas had in the insecure and unstable context of the project area. All other International NGOs active in the health sector in the health zones of Mweso, Birambizo, Rutshuru and Rwanguba supply free health care. It is not yet certain how long they will continue to deliver care without user fees; this will largely depend on how the security situation in the area develops. The situation is evaluated every 6 months and the next evaluation is planned for the end of June 2010.

IRC and Merlin chose not to include the health facilities supported by Caritas into their free health care programs. A direct consequence of this strategy was that, as the Caritas facilities provided care patients needed to pay for, these structures lost their patients and some were ready to close, i.e. Katwe hospital. With help of the CAFOD/Caritas project this has been prevented, as those structures that had great difficulty due to other INGO funded projects managed to compete and in some cases augmented their consultation rates tenfold. Thus Caritas Goma's approach to gratuity of health services was appropriate.

The best and probably the only realistic exit strategy for free access to health care projects in North Kivu is to continue supporting the health facilities and at the same time reinforce the capacity of the health care managers and technicians in the health zone. This is what both Merlin and IRC are currently doing. Once security is re-established in the zones, the population will become more settled and will be able to pay a little for their care. These Health Zones will also then be integrated into the PS9FED (Programme Santé 9ème Fonds Européen de Développement).

The main donor for health programmes in North Kivu is the European Union. Their programme PS9FED started in 2006 and ends in October 2010, but will most probably continue with 10th FED funding. This programme is piloted in four DRC provinces and is slowly including all officially recognized health structures of North Kivu[15]. One of its main objectives is to improve access to quality health care by introducing a system of results based financing (RBF)[16]

Before a health zone and its health facilities are allowed to integrate in the programme, a whole range of criteria is applied, including the level of security. Due to insecurity, 5 Health zones are not yet included in the PS9FED programme (Pinga, Birambizo, Rwanguba, Mweso and Binza) and only the secure parts of Rutshuru, Kayna and Lubero health zone are included (maps in **annex 8**).

The user fees are low under the PS9 FED. For example, one might pay $0.5 for a therapeutic consultation, $2 for a normal delivery and $10 for a major intervention in the hospital. The rest of the costs are covered by the FASS. In order to guarantee access to

[15] Beginning 2010, 343 of the 489 health facilities in North Kivu had signed a contract (contrat d'intégration) with the FASS (Fonds d'Achat des Services de Santé) giving them the right to be integrated in the PS9FED programme.

[16] Detailed information about the PS9FED is available at : http://ps9fed.609.be/

health care for the most vulnerable people, an equity fund providing waivers for the poorest is installed.

In some cases, such as in Karambi, Merlin is beginning to replace CAFOD financing. Handing over to an other NGO may be a valid option if CAFOD should decide to stop further support.

5. Humanitarian Accountability and Quality Management

To evaluate humanitarian accountability and quality management, the evaluation team assessed the programme's adherence to the ICRC Code of Conduct, the respect of the Sphere Standards and the compliance with the HAP 2007 Principles of Accountability.

5.1 Adherence to the ICRC Code of Conduct

Overall the ICRC Code of Conduct was respected in the execution of the project. The local cultures, structures, customs and languages were taken into consideration in the making of tools for sensitisation, and via the participation of the local population in project activities. CAFOD's policy of working with local organisations, who are generally more familiarized to local customs and values, is certainly an added value.

The choice of beneficiaries was made without distinction of sex or ethnicity and the most vulnerable groups of the population, such as IDPs, benefitted from the project. Where possible, local capacities were strengthened, local staff employed, local materials purchased and business done with local companies.

5.2 Respect of the Sphere Standards

Sphere minimum standards in nutritional centres are well met because the centres received food from the WFP and have to respect the WFP standards. Registers in the nutritional centres were very well kept, services were regularly supervised, and visits are well recorded.

Adequate staffing levels to deal with the influx of patients after the introduction of free health care were achieved everywhere and during the project period clinicians never consulted more than 50 patients per day (Sphere standard).

From visits to the pharmacies and the study of stock cards, registers and prescriptions it can be concluded that health workers adhered to the standardised national essential drugs list and respected drug management procedures. Stock shortages for some of the key drugs were frequently seen, mainly due to high consultation figures.

Three of the four second line health facilities had at least one PEP-Kit in stock for prevention of HIV infection after acts of sexual violence. Such cases are frequently reported in the project area. For example, Mweso hospital reports 10 to 15 cases of rape per month.

A standardised health information system is in place in all supported health facilities. Surveillance data are submitted monthly to the Central Bureau of the Health zone.

There is room for improvement in terms of adherence to the Sphere Standards, particularly for the WASH component. While the staff at Caritas Goma HQ demonstrated some knowledge of the Sphere standards, the WASH technicians in the field did not. The latrines in general respected the Ventilated Improved Pit (VIP) design but often suggestions for some improvements had to be made.[17]

Picture 12. Kitchanga primary school has a well constructed 6 cubicles toilet, but the vent pipe is not covered with a fly screen

Picture 13. A family latrine in Kitchanga where the vent pipe is too short and covered by the roof, no fly screen is attached and too much light inside

The distances between latrines and households and the number of latrines built were also problematic across all target zones. For some beneficiaries the latrines were as close as 2m to households and in Mweso it was observed that 20 households use one family latrine[18].

In addition, only a few of the distribution points the evaluation team visited had a drainage system for used water. The stagnant water near fountains attracts flies and mosquitoes and is sometimes used as a drinking place for cows thus presenting a high level of risk for mosquito borne diseases and damage of the water points.

CAFOD/Caritas makes a real effort to involve local communities as much as possible, and beneficiaries can be proud of their contributions. However, it should be noted that this high level of community involvement may also have had a negative effect on the consistency and quality of the WASH structures that were built, compared to what might have been achieved if they were constructed by professionals. For example, the construction details of VIP latrines were not respected, which may not have been the case had trained experts been responsible for the job. In the future, it may be more efficient to identify the tasks for which a

[17] Several times the fly screen was missing at the top of the vent pipe, sometimes the vent pipe was not up to standards (>10 cm higher than the roof). All latrines had too much light inside because of open spaces larger than the standard (a cross sectional air opening of three times the vent pipe size)[17]. A well constructed VIP latrine is an excellent fly trap and will control odours ***only if all construction details are respected*.**

[18] According to Sphere standards latrines should be 50 metres from the dwelling and be used by up to 20 people (50 maximum).

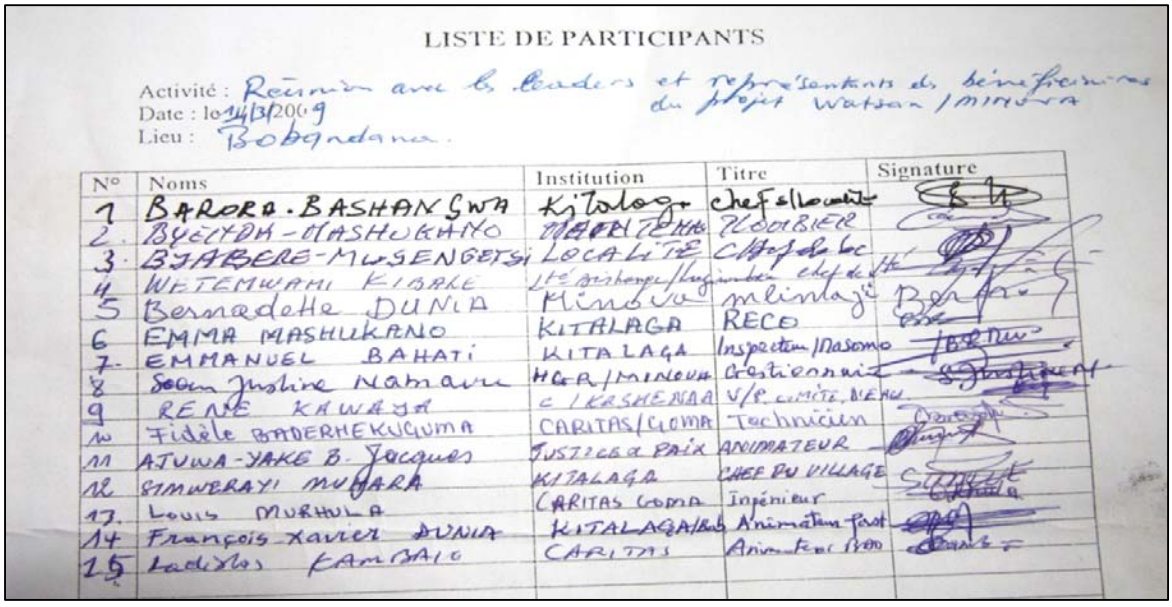
WASH professional is necessary in order for works to be completed according to the standards, even if their role is to supervise and ensure quality control.

5.3 Compliance with the HAP 2007 Principles of Accountability

The HAP-I (Humanitarian Accountability Partnership - International) benchmarks were generally complied with. Standards were largely known by CAFOD staff, but had so far been insufficiently shared with partner organisation Caritas, which is the main reason why mixed results in terms of adherence to the benchmarks were found.

Accountability to Beneficiaries and their Level of Involvement

Beneficiary participation has been integrated throughout the project cycle in both the Health and WASH components. The target communities participated in the initial needs assessment for the project and influenced decision making during project execution.



LISTE DE PARTICIPANTS

Activité : Réunion avec les leaders et représentants des bénéficiaires du projet Watsan / MINOVA
Date : le 14/3/2009
Lieu : Bobandana.

N°	Noms	Institution	Titre	Signature
1	BARORA-BASHANGWA	Kitalaga	chef s/colline	
2	BYELYDM-MASHUKANO	MAGRITEHA	RECEVEUR	
3	BYABERE-MUSENGETSI	LOCALITE	Chef de loc	
4	WETEMWAMI KIBALE	Ltt Bashange/Ingénieur	chef de Ltt	
5	Bernadette DUNIA	Minova	mélinage	
6	EMMA MASHUKANO	KITALAGA	RECO	
7	EMMANUEL BAHATI	KITALAGA	Inspecteur/Maçonne	
8	Soeur Justine Nabaweu	HGR/MINOVA	Gestionnaire	
9	RENE KAWAYA	C/KASHENAA	V/P. COMITE. WEAU.	
10	Fidèle BADERHEKUGUMA	CARITAS/GOMA	Technicien	
11	AJUWA-YAKE B. Jacques	Justice & Paix	ANIMATEUR	
12	SIMWERAYI MUHARA	KITALAGA	CHEF DU VILLAGE	
13	Louis MURHULA	CARITAS GOMA	Ingénieur	
14	François Xavier DUNIA	KITALAGA/Lab	Animateur Prot	
15	Ladislas KAMBALE	CARITAS	Animateur Prod	

Picture 14. The Bobandana Water committee holds regular well frequented meetings with stakeholders and beneficiaries.

For the WASH component the local population took the responsibility for the transport of some of the construction materials and assisted in the building of WASH structures. In addition, women were consulted to decide where to put the water reservoirs. In some places such as Birambizo the population used their own means to construct fences around the water points to protect them from damage caused by cattle. The water committees were chosen by the beneficiary populations, election procedures were closely monitored, and reports were produced. All CAFOD supported WASH interventions are monitored by water committees, some of which are well organized i.e. the ones visited in Bobandana and Kitchanga.

In the health component, hospitals and medical centres had a voice in the selection of medicines that they received. The Matanda Health Committee meets every month to discuss the project and then shares their feedback with Caritas Goma. Issues such as user fees, staff salaries and maintenance as well as the monthly health information reports are

discussed and decisions are taken to improve accessibility and working conditions in the centre. Minutes are made available.

Picture 15. "The inhabitants of Birambizo, 1) Drink water coming from sources or water points, 2) Use clean containers to poor or conserve water, 3) Wash hands with soap before touching or preparing food, breastfeed a child, after having visited the toilet and wash the children after toilet visits. 4) Have a toilet for every family, 5) Keep the house and the environment clean".

In Kitchanga it was brought up that instead of 'importing' Congolese staff from elsewhere, recruitment should be done locally. This is a sensitive issue in the region. Just a few days after the evaluation mission, the road to Matanda-Masisi was blocked by local people protesting against the fact the local staff was underused by INGOs.

Information about the project and free healthcare were successfully made available to the public through local radio (in the local language), by word of mouth, announcements made in churches, and by informing local village chiefs. Also, educational posters on hygiene mentioning Caritas, CAFOD and DEC were seen in several health centres and hospitals. The Caritas, CAFOD and DEC were also mentioned on notice boards observed in Kitchanga, Mweso, and Birambizo describing the intervention (see picture). In Birambizo a sensitizing campaign was organized using a large banner showing programme details (see picture). Despite this, none of the interviewees in the field were actually aware of DEC which showed that the origin of the funds is not generally known to beneficiaries. Caritas is known by nearly all of the interviewees.

Picture 16. Sign boards explaining the project were seen at all projects sites

Picture 17. "Water and a clean environment is my health"

Although there is no specific policy on complaint procedures, the impression is that any complaints can be ventilated freely and transmitted to local and centralized project levels via the different committees by which the beneficiaries are represented. In Katwe hospital an idea box where complaints can be dropped has been mounted to the wall.

Communication between the project sites and Caritas HQ in Goma is generally poor when no GSM network is available. The doctors in some of the health facilities expressed feeling poorly informed about the future of the project. They stated that it was difficult to plan strategically without knowing whether or not the project would be continued.

Accountability to DEC and to the British public

According to HAP principle of accountability no. 7, HAP members should maintain their commitment to the implementation of the HAP principles even when working through implementation partners. CAFOD has good knowledge of the Code of Conduct, good practices, WASH and Health standards, humanitarian accountability and quality management. However, this knowledge is insufficiently shared with their partner organization Caritas Goma.

When comparing Caritas project reports sent to CAFOD to those sent by CAFOD to DEC, an important difference can be noticed. While the former are concentrating on project activities, results and finances, the latter focus more on issues like impact, humanitarian principles, Sphere standards, accountability to beneficiaries, building on local capacities, coordination and lessons learnt. Consequently the missing elements in the Caritas reports were discussed in separate emails between CAFOD and Caritas.

It is recommended that these important M&E criteria are integrated into the Caritas reports. If specific training is needed in proper reporting, CAFOD should provide these trainings to their implementing partner organizations.

6. Fulfilment of Past Lessons and Recommendations

The CAFOD emergency Health and WASH project was included in a large DEC monitoring mission that took place in April 2009. 12 DEC funded organizations were included in the mission and based on the findings 10 key recommendations were made. As part of the DEC Accountability Framework, CAFOD gave feedback on the recommendations given by the Monitoring Mission in order to apply the lessons learnt.

Out of those recommendations the ones relevant to this project evaluation deal with the issues of (i) pre-crisis preparedness, (ii) coordination between different actors, (iii) implementation of the Sphere standards in project execution, and (iv) beneficiary participation in the project cycle.

CAFOD has established an emergency contingency planning process, which includes the capacity building of local implementing partners in order to reduce local vulnerability. For example: raising preparedness in case of a volcanic eruption threatening Goma and surroundings, or the occurrence of new hostilities causing displacements. However, in terms of the dissemination of risk reduction practices, CAFOD acknowledges the need for improvement in its ability to collect and disseminate lessons learnt.

The need for improved coordination between agencies is well recognized by CAFOD, particularly when it comes to strategic planning between agencies for medium and long term humanitarian and development concerns, and the sharing of a joint vision for recovery. CAFOD has engaged in lobbying the UN for increased support to local partners to enable them to better engage actively with coordination and funding mechanisms. CAFOD is also engaged in a UK consortium of NGOs that are implementing a project towards this end.

In an effort to increase the usage of the Sphere standards in emergency response, CAFOD has assisted Caritas Goma in the development of a new tool for needs assessments based on the Standards. CAFOD acknowledges that more training of local partners is needed in order to improve the level of adherence to the standards and the mainstreaming of fundamental principles. A gap between theory and action on the Standards remains.

CAFOD prioritizes working in close collaboration with local communities and beneficiaries. As previously mentioned in the evaluation, beneficiaries were included both in the planning and execution of the DRP and ERP projects.

The feedback from the DEC monitoring mission in April was well noted by CAFOD. Their responses demonstrate that they agree with the need to address certain key issues, and are making an effort to do so. Nevertheless, there is a glitch in the chain of communication as Caritas Goma was apparently not informed of the DEC feedback from the April 2009 monitoring mission.

7. Conclusions and Recommendations

The CAFOD Health and WASH project has been an appropriate emergency response. The project has covered real, often long term needs, particularly through the provision of medical equipment and the construction of WASH structures. The gratuity of health care was the best choice that CAFOD could have made, given the context. When analysing the number of people who had access to free health, nutrition and WASH services during the project period, the conclusion is that the coverage during the implementation period was high.

The sustainability of the intervention is an issue that needs to be addressed. Currently there is no exit strategy in place for the termination of free health care and no planning for the reintroduction of user fees, which creates the risk that access to healthcare becomes unavailable to the most vulnerable members of the population once support ends. People are still in a process of rehabilitation and recovery from losing their homes and their crops, and the presence of IDPs and returnees remains high (particularly in Masisi). Many people living in the target areas cannot pay the standard $1 consultation fee, let alone purchase essential medications. Putting an end to the funding threatens to urge health facilities to close and render healthcare inaccessible for the most vulnerable.

Caritas Goma is a significant health provider in North Kivu Province, and the organisation coordinates and cooperates very closely with the provincial health authorities and health structures. Coordination with other relevant stakeholders like the INGOs working in the

project area appears to have been rather lacking, although in the field it appears to be better organized than at central level.

Most of the humanitarian accountability standards have been respected. A significant number of examples of involvement of the beneficiaries in the design, planning, and execution of the project was observed. Although there is no special complaints system in place, local health and WASH committees regularly report to the Caritas project managers. Project signboards were placed at many sites, but beneficiaries are generally found to be unaware of the origin of the funding of the project.

The medical equipment provided to hospitals and health centres should have a positive longer term impact, as it has enabled the establishment of essential services, such as surgery, which were previously unavailable in certain places. The WASH facilities constructed for hospitals and health centres also considerably influence the overall levels of safety and sanitation for patients and staff. Moreover, WASH facilities are a source of protection for the most vulnerable beneficiaries, particularly women and children.

CAFOD has established an emergency contingency planning process, which includes the capacity building of local implementing partners to reduce local vulnerability. However, in terms of the dissemination of risk reduction practices they do acknowledge room for improvement. The need for increased coordination between agencies is well recognized by CAFOD and the organisation has engaged in lobbying the UN for increased support to local partners to this end.

Based on the findings and conclusions of the evaluation, the following recommendations are made to Caritas Goma and CAFOD:

1. ***Develop a realistic transition from free health care to the regular health finance system in North Kivu.***

CAFOD and CARITAS should study how to best continue the support to their health facilities in order to prepare them for integration into the PS9FED programme.
The best, and probably the only realistic strategy to move on from free health care projects in North Kivu, is to continue supporting the health facilities and at the same time reinforce the capacity of the health care managers and technicians in the health zone. This is what both Merlin and IRC are currently doing, at least until the situation is reassessed in June 2010. Once security is re-established in the zones, the population will become more settled and will be able to pay a little for their care (such as 10-20 dollar cents).

The fees should be determined based on economic household surveys that monitor the coping mechanisms of the population and take livelihood issues such as agricultural productivity and accessibility to markets into consideration. The capacity reinforcement of health care managers and technicians in the Health Zones will help their integration into the PS9FED (Programme Santé 9ème Fonds Européen de Développement) once the security situation improves.

2. ***Improve the coordination with key stakeholders in the project area and use a common approach when providing healthcare***

Inter-agency coordination between those providing free health care in proximity of one another is essential. Caritas should exploit its position of knowing the region the best and should reinforce the role it plays in the UN cluster meetings in order to improve the coordination between NGOs and other partners in the region. This will help to establish a common approach to free healthcare and to ensure that 'competition' between medical structures, as seen in the field, does not have a negative impact. Caritas should also define with the other stakeholders a coordinated transition strategy on how to get from free health care projects to integration into the PS9FED programme.

3. ***Ensure there is a stock of medicines and medical material for at least three months left when support ends***

There is a shortage of essential medications in most of the supported health centres and hospitals. Essential medicines such as Amoxicillin, Paracetamol, and ACTs should be prioritised.

4. ***Ensure that WASH technicians in the field are trained in the Sphere standards***

The Sphere Standards concerning the WASH component of the project have only partly been respected, which ultimately compromises the effectiveness of the intervention and could even be a source of increased risk to waterborne diseases. The WASH supervisor should check on all technical details and train technicians on the job.

5. ***Reinforce the public health capacity of the WASH technical team***

Key hygiene risks of public health importance need to be properly identified. Much more attention has to be given to hygiene promotion, community mobilisation and the mutual sharing of information and knowledge concerning hygiene. Pools of stagnant water next to water points, unprotected water points and piles of garbage next to latrines should be avoided.

6. ***Improve the maintenance of WASH structures***

It is crucial that sufficient material for long-term maintenance of WASH structures is provided. In addition the Water Committees and local technicians should be trained in committee management and reservoir maintenance in order to guarantee sustainability.

7. ***Ensure that implementing partners are included in communications with donors***

Follow up on the feedback provided by donors will go more smoothly if local implementing partners are kept fully informed of the recommendations coming from monitoring and evaluation missions and of the directions that donors would like to pursue.

8. ***Adapt the report formats of the implementing partner Caritas so that they resemble the report formats CAFOD uses to report to DEC.***

Apart from issues such as project progress and expenditures, it is also useful to include DEC reporting criteria such as the respect of humanitarian principles and standards and other key considerations that influence programming, as well as lessons learnt in the Caritas reports.

Annex 1: Terms of Reference

DRAFT TOR
for the evaluation of the DEC-funded project in the DRC

Background

CAFOD has been working in the Democratic Republic of Congo (DRC) since 1994, implementing both development and emergency projects through a network of local civil society partners. In the autumn of 2008, a new wave of violence caused much suffering and destruction and a large number of people were forced to abandon their homes. In the past year CAFOD has responded to this emergency with funds in excess of £3million. Part of this funding (£298k) came from the Disasters Emergency Committee (DEC) and were used to fund a project implemented by our partner in North Kivu, Caritas Goma.
The project consisted of two components: Health and Water and Sanitation.
The Health component provided medicines and basic medical supplies for three months to 5 hospitals, 5 health centres and 11 nutritional centres managed by Caritas Goma, in the territories of Rutshuru and Masisi. The project also subsidized salaries and running costs for one month, in order to help these facilities provide free of charge services to the vulnerable population. Birambizo hospital had been damaged by fighting and abandoned and was rehabilitated by the project. The Health component was implemented between January and March 2009. The needs of the population remain severe and local authorities have extended the policy of gratuity of healthcare; CAFOD decided to extend support to 4 medical structures in North Kivu for additional 6 months since. The DEC recently provided additional funds (£166k) to support this project.
The Water and Sanitation component of the project lasted 6 months between January and June 2009. It targeted 4 communities in the territories of Rutshuru and Masisi where it provided protection of springs and piping of water to distribution points; construction of public latrines and household latrines for the most vulnerable; and organisation of hygiene promotion activities.

CAFOD is seeking a consultant to provide an independent evaluation of the project funded by the DEC.

Purpose of the evaluation

This evaluation should help capture the lessons learned from the implementation of the DEC project in order to help CAFOD and Caritas Goma to:

- Enhance accountability to beneficiaries
- Guide future decisions on the humanitarian strategy for the DRC
- Improve response to emergencies in the watsan and health sectors

The evaluation should also fulfil the requirement of accountability to the DEC and to the public that contributed to the DEC Appeal.

Intended users of the evaluation

- CAFOD
- DEC and DEC member agencies
- Partners: Caritas Goma
- Humanitarian community in Goma

Qualities to be evaluated

The evaluation should assess the following general set of qualities.

Relevance/appropriateness: assess whether the response is in line with local needs and priorities.
Connectedness: assess whether short-term emergency activities are carried out in a context that takes longer-term and interconnected problems into account (i.e.: coordination, sustainability).
Coherence: assess whether there is consistency with relevant policies and in particular whether humanitarian and human rights considerations are taken into account (i.e.: conflict sensitivity, protection, and other CAFOD programmes)
Coverage: assess whether the major population groups including the most vulnerable are reached, providing them with assistance and protection proportionate to their needs.
Efficiency: measure the qualitative and quantitative outputs achieved in relation to the inputs and compare alternative approaches to see whether the most efficient approaches were used.
Effectiveness: measure the extent to which an activity achieves its purpose or whether this can be expected on the basis of the outputs.
Impact: look at the wider effects of the project (social, economic, technical and environmental) on individuals and groups (gender, age groups, communities and institutions).

More specifically, in line with the DEC evaluation policy and the priorities of the DEC accountability framework, the evaluation should specifically investigate the following:

1. the extent to which proposed objectives and outcomes have been achieved
2. the extent to which the Code of Conduct and Sphere Standards have been respected
3. the level of involvement of and accountability to beneficiaries
4. the extent that past lessons or recommendations have been fulfilled

With reference to the two components of the project, the following specific questions should be answered:

Watsan: To what extend did the work take into account the needs and concerns of beneficiaries? Were the needs of the most vulnerable addressed? To what extent were beneficiaries involved in the planning and execution of the water and sanitation project? Was input from beneficiaries used to appropriately change/improve the project?

Health: Were CAFOD and Caritas Goma able to coordinate effectively with the relevant stakeholders involved in the implementation of health services, including local authorities, UN cluster, and other health services providers? In particular, how does Caritas Goma's approach to gratuity of health services compare to other service providers? Does accountability to beneficiaries, coordination with stakeholders and cost-recovery planning guarantee the sustainability of the project's impact?

Expected Outputs
The main output of the evaluation should be a report, tentatively of no less than 10,000 and no more than 15,000 words. The report should consist of:

- Executive summary and main recommendations (tentatively 4 pages)
- Commentary and analysis addressing the issues raised in the TOR (4 specific targets)
- Conclusions and Recommendations including specific suggestions for taking forward lessons learned (specifically targeting CAFOD, Caritas Goma and the DEC)
- Evidence for the beneficiaries' feedback

Appendices should include evaluation terms of reference, maps, beneficiaries' feedback and bibliography. (All materials collected during the evaluation process should be lodged with CAFOD prior to termination of the contract).

The report and all background documentation will be the property of CAFOD (as the contracting organisation) and will be disseminated and publicised as requested by the DEC's evaluation policy.

Methodology

The evaluator will include a description of the preferred methodology in his proposal. A more detailed methodology and a work-plan will be later agreed by the evaluator and CAFOD. The methodology is initially expected to include:

- Use of international guidelines (Sphere, the Red Cross Code of Conduct, and HAPI; DEC Accountability Framework)
- Use of participatory approaches and feedback from participants, especially the beneficiaries

Management arrangements

The evaluator will be working independently, but will be able to rely on a CAFOD staff in London and in Goma, acting as focal-point for the evaluation process and providing support during field visits.

Timeframe

The evaluation will tentatively last between 3 weeks and 1 month (or 14 to 20 working days), including time for preparation; field work; writing; feedback; and finalization.

Process

- Initial meeting or teleconference to review background information and to review proposed methodology
- Drafting of detailed work-plan
- Desk review of key documents
- Field visit – interviews/focus group discussion with stakeholders: beneficiaries, Caritas Goma managers and staff, other NGOs, local government, and relevant coordination networks
- In-country presentation of preliminary findings to CAFOD and Caritas Goma
- Produce draft evaluation document (in English)
- Incorporation of comments received and preparation of the final report

Consultant's Proposal

Proposals should include:

- Proposed methodology of evaluation and tentative work-plan
- Description of outputs
- Detailed financial proposal (travelling and accommodation costs will be covered separately by CAFOD)

Key person specification

The evaluation will be conducted by one professional (or a team including international and local staff) with the following experience and skills:

- Fluency in French and English
- Relevant work experience in humanitarian relief, including health and watsan
- Relevant evaluation experience of humanitarian aid programmes, including with participatory evaluation methods with beneficiaries
- Ability to work respectfully with national NGO partners

Desirable:

- Experience of working with faith based agencies and national NGOs
- Experience, knowledge and clear understanding of DRC's humanitarian context

Annex 2: Short team biographies

Dr Jannes van der Wijk is a Public Health Specialist with over 20 years of experience in project management in the field of Humanitarian Assistance, Tropical medicine, and Public Health in West and Central Africa, especially the Great Lakes Region.
Dr Jannes is a senior trainer consultant in public health and development with MDF-AC and provides technical assistance to capacity building programmes in Eastern DRC. Since 1995 he has carried out consultancies, training and research activities (such as socio economic and access to health care studies, morbidity mortality household surveys, drug prescribing behaviour studies, CAP studies on HIV/AIDS, Malaria and health programme evaluations), most of it in humanitarian assistance settings in eastern DRC.

Mr. Euclide Balume Mwezi is a water and sanitation technician and has been working in the field of public health since 2006. He has worked in a variety of capacities of increasing responsibility with organizations such as Oxfam-GB, Solidarités, The International Rescue Committee (IRC), and International Emergency and Development Aid (IEDA-Relief). Euclide has experience in conducting needs assessments, strategy development, and monitoring and evaluation in the WASH sector within the context of Eastern Congo. He has substantial training and experience in performing evaluations on water chlorination sites, community-based approaches for hygiene promotion, and the construction of WASH structures.

Ms. Luellen Kazan has strong analytical capabilities and demonstrated success in qualitative and quantitative research. She is a capable writer with broad experience in the editing and composition of project proposals, reports, policy papers, and program evaluations. Through her education and diverse work background, Luellen has a solid understanding of the primary sectors in humanitarian assistance and development. She has a master's degree in International Educational Development, she has successfully completed a number of internships with major international non-governmental organizations, and she has worked as a writer and researcher for MDF-AC missions with DEC, Concern Worldwide, the NRC, and others

Annex 3: Focus group discussion guides

Guide des Questions pour les Focus groups SANTE et NUTRITION	
Sujets de discussion/Questions	**Ce que l'on veut savoir**
Qu'est ce que vous pensez de l'accessibilité de votre centre de santé / hôpital (couts, accueil, soins)	L'accessibilité des structures.
Est-ce que depuis le début du projet d'appui Caritas aux déplacés (janvier 2009) l'accessibilité a changé ?	Access to health care
Quels étaient vos besoins quand l'insécurité et les déplacements ont commencé ? comment vous avez pu s'exprimer sur vos besoins.	Appropriateness Accountability
Comment Caritas a pu répondre à vos besoins ? Est-ce que le plus vulnérables ont pu profiter de l'aide ? Quel sont les besoins qui ne sont pas couverts ?	Coverage
Qu'est-ce que pouvez dire sur la façon que les fonds pour ce projet ont été utilisés ?	Efficiency
Quelle a été l'effet de cette aide ? Qu'est ce que vous trouvez du résultat ?	Effectiveness, Impact.
Comment étiez-vous impliqué dans la planification et l'exécution du projet ?	Beneficiaries' involvement Participation,
Comment étiez-vous informé sur ce projet de Caritas ?	Accountability
Comment est ce que vous avez pu avoir influence sur l'exécution de ce projet ?	Accountability and participation
Est-ce que vous avez d'épreuves / exemples de votre feedback donné au projet ?	Accountability
Qu'est ce que vous pouvez dire sur la coordination avec d'autres ONGs. Avec les autorités ? Avec d'autre structures sanitaires ?	Coordination
Qu'est ce que vous pensez de la gratuité des soins ? Qu'elle est la différence entre structures Caritas et les autres ?	Comparison service providers
What do you think about re-introducing user fees ? Combien est ce que vous pouvez contribuer à une consultation CS/Hop.	Connectedness
Comment Caritas pourrait-il améliorer son assistance la prochaine fois ?	Lessons learnt.

Guide des Questions pour les Focus groups EAU & ASSAINISSEMENT	
Sujets de discussion/Questions	**Ce que l'on veut savoir**
Problèmes des maladies liées à l'eau, hygiène et assainissement. Y a-t-il des cas de choléra observés dans vos ménages avant et après le projet Caritas ? Si oui lesquelles sont les causes ? ; comment vous les éradiquer ?	Quel impact sanitaire du projet pour la population.
Où puiser vous de l'eau ? ; cette eau est-elle propre à la consommation ?, Y a-t-il une différence entre l'eau d'une source protégée et celle non protégée ? ; Y a-t-il un comité de gestion ?si oui, comment est-il constitué, est-il formé ?	Participation. Effectiveness. Impact, Connectedness
Vous puiser combien de fois par jour et avec quel récipient (quantité) ? , les récipients sont-ils lavés, si oui ou non pourquoi ?	Respect Sphere standards
Combien de temps faites-vous pour arriver au point d'eau, pour remplir un bidon de 20 litres et aussi pour puiser ?	Les normes sont-elles exactes ?
Que pensez-vous de la distance qui vous sépare des points d'eau ?	Normes sphères
Comment appréciez-vous les ouvrages hydrauliques aménagé et réhabilité par Caritas ?	La viabilité ou qualité des ouvrages (efficacité).
Comment pensez-vous mettre fin aux maladies hydrique ?, comment avez-participer aux activités du projet ?	participation, accountability efficacité)
Les femmes sont-elles satisfaites des ouvrages choisis pour la réhabilitation et de l'implantation des latrine	Respect du genre
Quelles sont les points positifs et négatifs observés par la communauté et autres organisations ? Qu'est ce que vous avez appris ?	Lessons learnt
Quels sont les changements enregistrés dans les pratiques sociales des communautés par rapport aux groupes cible ?	Quel impact social observé après le projet (Impact)

Annex 4: Interview guides

Interview guide COORDINATEUR et ou MANAGER DU PROJET	
Sujets des discussions /Questions	**Ce que l'on veut savoir**
Comment avez-vous eu les données sur la situation de la population bénéficiaire ? Est-ce que le projet était adapté au besoin réel de la population ? Le projet a-t-il tenu compte des propositions de la communauté ?	Pertinence, Relevance appropriateness.
Quel impact le financement DEC a-t-il eu sur les activités de programme général de l'organisation ?	Effectiveness
De quelle façon les activités financées par DEC étaient-elles compatibles aux activités d'autres organisations ? Comment étaient-elles coordonnées ?, Avaient-elles tenue compte du Plan d'Action Humanitaire et du DCRP ?	Connectedness Coordination
De quelle façon avez-vous pris en compte le respect des droits humains dans l'exécution du projet ?	Coherence
Les activités telles que prévues ont-elles été exécutée ?Ont-elles atteint leurs objectifs ? Est-ce les résultats sont atteint, les résultats non prévus se sont-ils produits, la communauté est-elle capable de se prendre en charge	efficacy, effectiveness
Les imputs et intrants du projet-ressources et durée ont-ils été suffisants pour atteindre les résultats ? Les mêmes résultats auraient pu être atteints à moindre coût ?	efficience
Quelles sont les difficultés rencontrées pendant l'exécution de ce projet ? (logistiques, sécuritaire, manque de staff)	contraintes, limites du projet et solutions prises
Participez-vous aux réunions de clusters, si oui combien de foi par mois ? Duplication des interventions ?	Coordination,
Comment une certaine pérennité de l'action est garantie ? (coordination, longer term problems taken into account).	Connectedness
Qu'est ce que vous pensez de l'accessibilité de votre centre de santé / hôpital (couts, accueil, soins). Systèmes différentes de financement ?	L'accessibilité des structures.
Est-ce que depuis le début du projet d'appui du Caritas aux déplacés (janvier 2009) l'accessibilité aux soins a changé ?	Si l'accessibilité des structures a augmenté
Comment vous avez pu exploiter les guides internationaux comme Sphere, Code of Conduct, HAPI, DEC accountability Framework ?	Use of international guidelines.
Quelles leçons est-ce-que vous avez appris ? (DEC, CAFOD, CARITAS, ….)	Conclusions Recommendations

Interview Guide AUTORITES LOCALES, COMITE LOCAL ET AUTRES ONG	
Sujets des discussions /Questions	**Ce que l'on veut savoir**
Qu'est-ce que vous connaissez en rapport avec l'approvisionnement en eau, l'utilisation des latrines et les pratiques élémentaires d'hygiène ? Est-ce vous êtes informé de ce que Caritas a fais comme intervention, était-il contacté pour ce fin ? y a-t-il eu votre contribution ?, Quel est le constat (négatif ou positif).	Accountability
Y a-t-il des réunions organisées au tour de l'eau, hygiène et assainissement ?	Redynamisation du comité ?
Quelles sont les difficultés que vous rencontrez pendant l'exécution de votre service ? Le comité est-il doté d'un kit d'hygiène, kit de maintenance des ouvrages ?	Lessons learnt
Comment trouvez-vous la réalisation de Caritas et celle des autres organisations ? Caritas a-t-il respecté les normes sphères, a-t-il tenu compte des ouvrages existants ?	Quality, effectiveness
Que pensez-vous de la durabilité des ouvrages construits ou réhabilités par Caritas ? Est-ce que Caritas a utilisé des matériaux durables (qualité tuyau, ciment, bois…)	Durability, Connectedness
Etes-vous satisfaits du projet Caritas dans votre village ? Si oui, pour quoi ? Quel est l'impact du projet vis-à-vis de la population ? La population est-elle satisfaite du projet, a quel niveau ?	Impact, Satisfaction
Quelle est votre opinion sur la gratuité des soins ? Comment continuer après la fin de l'urgence ?	Connectedness, Coordination

Annex 5: List of persons interviewed

#	Name	Agency and function	Gender	Date interview	Interviewer*
1	Michel Monginda	Humanitarian Officer CAFOD Great Lakes	M	13/01 9/02	JW, EB
2	Coco Kirenga	Superviseur BDOM Caritas Goma	M	13/01 9/02	JW, EB
3	Roger Ndagije	BDOM Caritas Goma	M	9/02	JW, EB
4	Celestin Tuyisenge	Coordinateur du BDD	M	13/01 9.02	JW, EB
5	Christophe Letakamba	Assistant Programme CAFOD	M	13/01	JW, EB
6	Ladislas Kambale	Coordinateur WASH BDD Caritas	M	9/02 16/02	JW, EB
7	Soeur Justine Namavu	Gestionnaire Hopital de Matanda	F	20/01	JW, EB
8	Dr	MD Matanda Hospital	M	20/01	JW, EB
9	Abé	Secretaire Paroisse Kitchanga	M	21/01	JW, EB
10	Dr Alexia	Medecin directeur Kitchanga hospital	M	21/01	JW, EB
11	Dr Elda Balikwisha	Doctor Kitchanga hospital	F	21/01	JW, EB
12	Dr Hypolyte	MCZ de Mweso	M	22/01	JW, EB
13	Dr Deo Chiza	Dr Katwe Hospital	M	22/01	JW, EB
14	Mme Ange	AGIS Katwe Hospital	F	22/01	JW, EB
15	Dr Clovis	MCZ Birambizo	M	23/01	JW, EB
16	Bazil Baziraki	IT Birambizo hospital	M	23/01	JW, EB
17	Soeur Primitive	CS Rubare	F	26/01	JW, EB, LK
18	Josue Kambale	IT A2 Kibututu	M	26/01	JW, EB, LK
19	Soeur Riberata	Coordinatrice de Pr. Murambi	F	26/01	JW, EB, LK
20	Dr Lucien	Centre Santé de Référence Karambi	F	27/01	JW, EB, LK
21	Florence	Nurse A1 Centre de Santé de Ref Jomba	F	27/01	JW, EB, LK
22	Dr Tierry	Dr in CSR Jomba	M	27/01	JW, EB, LK
23	Sœur Gertrude	Responsable CN Carmel	F	28/01	JW, EB
24	Dr Jean Luc Bwanaisa	Médecin CN Muungano	M	28/01	JW, EB
25	Sœur Françoise	Administratrice CN Muungano	F	28/01	JW, EB

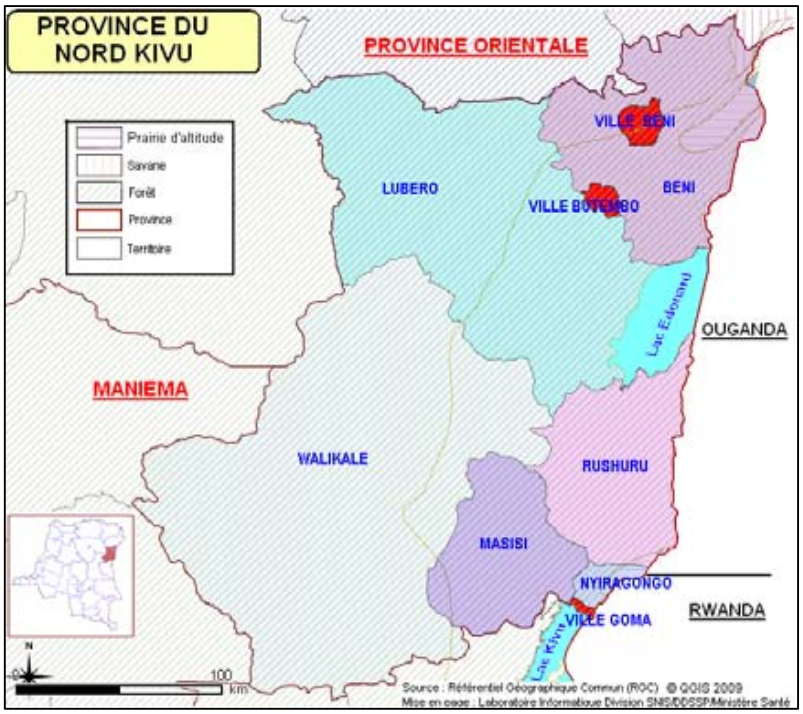
*JW = Jannes van der Wijk, EB = Euclide Balume, LK = Luellen Kazan

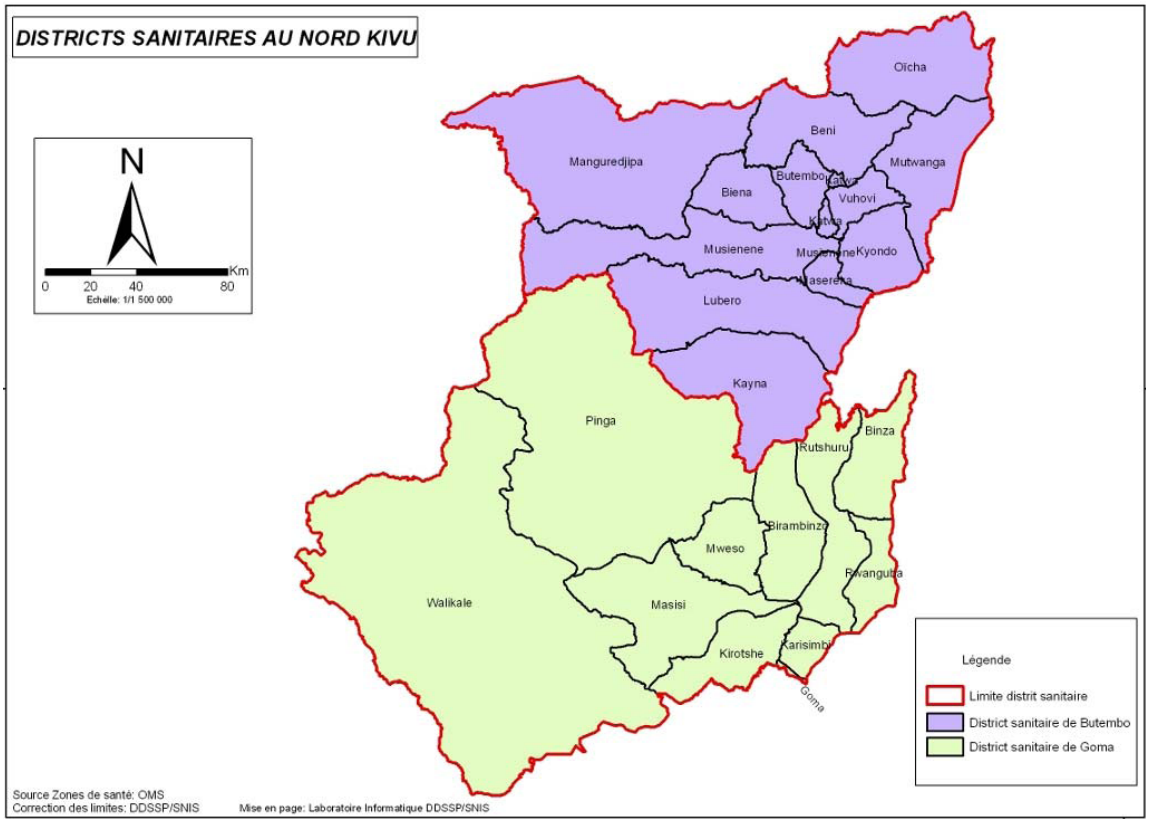
Annex 6: Team itinerary

Date	Venue	Activity	Consultants*
Tue 19 Jan	Minova Bobandana	Meeting water committee, focus group and visiting reservoir and water points, interview local administrator	JW, EB
Wed 20 Jan	Matanda	Meeting with extended Health Committee (25p), focus group, visit hospital, Interview hospital doctor,	JW, EB
Thu 21 Jan	Kitchanga	Visit Health Centre, meeting with Doctor, visit latrines, Visit primary school. Interview headmaster, meeting with schoolchildren, focus group	JW, EB
	Mweso	Visit water points, focus group, visit public and family latrines,	JW, EB
Fri 22 Jan	Mweso	Visit reservoir, interview local WASH technician. Interview Chief Health Zone Doctor,	JW, EB
	Katwe	Visit Katwe hospital, Interview Hospital doctor, Meeting with Staff Hopital, focus group, interviews with some patients	JW, EB
Sat 23 Jan	Birambizo	Visit Reservoir, Waterpoints and latrines, Focus group	EB
	Birambizo	Visit hospital, Interview doctor and hospital staff, visit toilets, interview with nurses, focus group, interview patients	JW
Mon 26 Jan	Rubare	Visit Rubare health centre, visit Rubare Nutritional centre, meeting with health centre staff, focus group discussion, interview some patients	EB, JW, LK
	Kibututu	Visit Kibututu health post, Meeting with health post Nurse, focus group discussion	EB, JW, LK
	Murambi	Visit Health Centre Murambi, visit Nutritional centre, interview health staff, focus group	EB, JW, LK
Tue 27 Jan	Karambi	Visit Karambi hospital, meeting with hospital staff, focus group discussion	EB, JW, LK
	Jomba	Visit Jomba Hospital, interview doctor, staff meeting, focus group discussion	EB, JW, LK
Wed 28 Jan	Goma	Visit Nutritional centre Notre-Dame du Carmel, Interview with head nurse,	EB. JW
		Visit to Nutritional Centre Muungano, interview with head of administration and Doctor.	EB. JW
Tue 9 Feb	Goma	Presentation draft report to Caritas Goma and CAFOD	JW
Tue 16 Feb	Goma	Feedback meeting on draft report with Caritas and CAFOD	JW

*JW = Jannes van der Wijk, EB = Euclide Balume, LK = Luellen Kazan

Annex 7: Maps of administrative territories, health districts and health zones in North Kivu





Annex 8: List of accessed information

DEC forms 6 - 14, Disaster Response Programme narrative and financial plan and reports [CAFOD]

DEC forms 16 - 17, Extended Response Programme narrative and financial plan [CAFOD]

DEC form 12, DRP Monitoring mission report [CAFOD]

The Caritas DRP and ERP plans and a series of implementation reports on Health and WASH that had been submitted by Caritas to CAFOD

John Cosgrave, Ben Ramalingam, and Tony Beck (2009), *Real-time evaluations of humanitarian action. An ALNAP Guide. Pilot Version.* London, Overseas Development Institute (http://www.alnap.org/publications/pdfs/RTEguide.pdf accessed 18 April 2009)

Overseas Development Institute London (March 2006). *Evaluating humanitarian action using the OECD-DAC criteria. An ALNAP guide for humanitarian agencies*. London, Overseas Development Institute (www.alnap.org/publications/eha_dac/pdfs/eha_2006.pdf, accessed 18 April 2009).

ICRC (1996) *The Code of Conduct for the International Red Cross and Red Crescent Movement and NGOs in Disaster Relief.* International Federation of Red Cross and Red Crescent Societies and the ICRC http://www.icrc.org/web/eng/siteeng0.nsf/htmlall/code-of-conduct-290296 accessed 4 April 2009)

HAP Editorial Steering Committee (January 2007). *HAP 2007 Standard in Humanitarian Accountability and Quality Management.* Geneva, HAP International (http://www.hapinternational.org/pool/files/hap-2007-standard(1).pdf, accessed 4 May 2009).

The Sphere Project (2004). *Humanitarian Charter and Minimum Standards in Disaster Response.* Oxford, Oxfam Publishing. (http://www.sphereproject.org/component/option,com_docman/task,doc_download/gid,12/Itemid,26/lang,english/, accessed 2 May 2009)

Oxfam GB (2007). *The Good Enough Guide. Impact measurement and Accountability in Emergencies.* Oxford, Oxfam GB, (http://www.oxfam.org.uk/download/?download=http://www.oxfam.org.uk/what_we_do/resources/downloads/good_enough_guide.pdf, accessed 2 May 2009).

People in Aid (2003.) *People in Aid, Code of Good Practice in the management and support of aid personnel.* London, People in Aid. (http://www.peopleinaid.org/pool/files/code/code-en.pdf, accessed 20 April 2009)

OCHA (2008) *Plan d'Action Humanitaire 2009 République Démocratique du Congo.* Bureau des Nations Unies pour la Coordination des Affaires Humanitaires, Kinshasa RDC (http://ochadms.unog.ch/quickplace/cap/main.nsf/h_Index/2009_DRC_HAP_FR/$FILE/2009_DRC_HAP_FR_VOL1_SCREEN.pdf?OpenElement, accessed 27 March 2009)

DEC 92008) An Introduction to the New DEC Accountability Framework, London, http://www.dec.org.uk/download/560/An-Introduction-to-the-New-DEC-Accountability-Framework.pdf, accessed 10 February 2010

DEC (2009) DEC *Accountability Framework: Member Agency Assessment Table "Quality Disaster Response",* London, available at DEC