CARE International in Sudan

Final Impact Evaluation Report

Impact Evaluation of the Integrated Humanitarian Assistance Project that aiming to Reduce the Secondary Impacts of COVID-19 on the Most Vulnerable Populations in South and East Darfur

Lactating and pregnant women at Jabra village, EJM

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This publication was produced at the request of the United States Agency for International Development. It was prepared by Tayalla Elmedani tayalla66@gmail.com. Abdalla Adam Omer, abdallaadam072@gmail.com

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Acronyms

ANC	Antenatal Care Center
BCC	Behavior Change Communication
CHP	Community Hygiene Promoter
CHW	Community Health Workers
CIS	Care International Swiss
CNV	Community Nutrition Volunteer
CMR	Clinical Management of Rape
DWSU	Drinking Water and Sanitation Unit
ED	East Darfur
ECHO	European Civil Protection and Humanitarian Aid Operations
EJM	East Jabal Mara
EMONC	Emergency Obstetric and Newborn Centre
EMOC	Emergency Obstetric Centre
EPI	Expanded Program of immunization
FBMAM	Food-based prevention of Moderate Acute Malnutrition
FDG	Focus Group Discussion
FRC	Free Residual Chlorine
FLA	Field Level Agreement
JMCO	Jebel Mara Charity Organization
HC	Health Center
HCV	Health Community Volunteer
HH	Household
IEC	Information, Education and Communication
INGO	International Nongovernmental Organization
IDP	Internally Displaced People
IYCF	Infant and Young Child Feeding
IHEK	Integrated Health Emergency Kits
JMCO	Jabal Mara Charitable Organization
KII	Key Informant Interviews
NC	Nutrition Center
MOU	Memorandum of Understanding
MISP	Minimum Initial Service Package
MSF	Medicines Sans Frontiers
MAM	Moderate Acute Malnutrition
MSG	Mother Support Group
MUAC	Mid Upper Arm Circumference
MT	Metric Ton

NAHA	National Humanitarian Aid
NNGO	National Nongovernmental Organization
O&M	Operation and Maintenance
OFDA	Office of Foreign Disaster Assistance
OM&M	Operation ,Maintenance and Management
OTP	Outpatient Therapeutic Program
PNC	Postnatal Care
PHC	Primary Health Center
PPE	Person Protection Equipment
RC	Rider Circuit
RRK	Raped Respond kits
SADO	Sudan Assist for Development Organization
SD	South Darfur
SHF	Sudan Humanitarian Fund
SJM	South Jabal Mara
SLA_AW	Sudan Liberation Army _ Abdel Wahid Nour Group
SWC	State Water Cooperation
SAM	Severe Acute Malnutrition
SMOH	State Ministry of Health
UN	United Nations
U5	Under Five Years Children
U2	Under Two Years Children
VC	Village Committee
WASH	Water, Sanitation and Hygiene
WES	Water and Environmental Sanitation Project
WHO	World Health Organization
WUC	Water User Committee
WFP	World Food Program
WY	Water Yard

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1. Abstract

The evacuation intended to assess integrated WASH, health, nutrition, and multipurpose cash assistance (MPCA) programs. The evaluation conducted to answer questions related to quality and relevance of the project design, its activities and objectives in addressing the priority issues. This is in addition to assessment of project efficiency and to what extent the project resources have been used economically and in a timely manner. Moreover, the evaluation assessed the effectiveness and major achievements of the project to date. The evaluation also assessed the project impact and to what extent the project contributed to provision of sustainable, adequate, and lifesaving WASH, Health and Nutrition services to the targeted communities. This beside Identification of which positive outcomes that likely to continue after the project ends in addition to assessment of bottlenecks, opportunities and lessons learned to inform future planning.

Based on the desk review of available data, the evaluation was deploying different approaches to ensure rich data and triangulation of findings. These approaches were combining qualitative and quantitative methods to maximize validity and reliability. The main methods of data collection used were interviews with the primary stakeholders, observation, asking questions, review of documents and transect walking at sites. Different tools for data collections were used as well that included focus group discussions with different target groups, and observation check list, Key Informant Interview, questionnaire, asking open and closed questions with beneficiaries at water points and at health and nutrition centers.

The project is in line with national and State WASH plans. It was also found that, the project followed and complied with SMoH specifications and guidelines. The comprehensive community consultation indicated that all project activities, technology adopted, and outputs are quite relevant to the target communities and their actual needs and also appropriate for the selected areas.

Generally, the evaluation team concluded that, the planned activities were completed with same allocated initial budget. Despite difficulties and challenges in the SLA areas and at sites located in territories between the government and SLA areas the evaluation team believes that, the project is efficient in terms of implementation of the planned activities and management of resources.

Despite insecurity and rapid inflation rate, long rainy seasons, limited access to Jebel Marra along with the secondary impact ofCOVID-19, the evaluation team in consultation with WASH, health and nutrition partners and communities concluded that the project has achieved its objectives and played an essential and central role in improving lives of these vulnerable groups. Project partners and beneficiaries were satisfied with the project services, activities and problems addressed by the project and accentuated that no conflicts or disputes related to the project interventions in the target areas.

The evaluation team concluded that, some of activities especially training of midwives, provision and use of Tuktuk for O & M was very helpful and replicated by some partners especially SWC. Considerable WASH and health sector activities can be sustained by the local community or by the government institutions using their own resources. It was concluded that sustainability of nutrition services is difficult due to limited resources to run the nutrition centers.

2. Executive Summary

The project was developed based on CARE's January 2020 assessment in addition to other related assessment, which identified high needs for services especially for children under five to address issues of acute malnutrition, in addition to provision of WASH services in an integrated pattern. CARE Sudan carried out consultations with all partners including government line ministries to identify ongoing priority needs at the community level. The findings of this evaluation revealed that IDPs, host and resident communities in the South and East Darfur states continue to lack access to basic infrastructure because of the long-standing conflict. These communities are highly marginalized due to their remoteness from the seats of government and some of the in SLA controlled areas while much of the existing infrastructures are out of date, non-functional and don't not fulfill the needs of communities.

In response to this situation, CARE in Sudan (CIS) and its national partners (Shoa, SADO, JMCO & NAHA and the government line ministries) and in view of COVID-19 impact, have intervened and implemented the **"Integrated Humanitarian Assistance and Reducing the Secondary Impacts of COVID-19 on the Most Vulnerable Populations in South and East Darfur".** The main objective of the project is that 527,764 people from targeted conflict affected IDPs, resident and host community households will have improved access to integrated service of WASH, health, and nutrition to reduce secondary impact of COVID-19 and to basic water and sanitation services by the end of the project.

This final project evaluation was conducted in August 2022 to examine progress towards meeting the project objectives, responses to problems encountered on the course of project implementation, and its results on communities in the target areas. It was found that, the population was served by integrated project components directly or indirectly by WASH, health and nutrition services in most of locations.

The evaluation would further capture lessons learnt during the implementation of the project. Broadly, the evaluation assessed efficiency, effectiveness, relevance, sustainability and any marked changes in the lives of the target communities as a result of the project implementation.

To achieve evaluation objectives, the team adopted participatory evaluation process including rationale and the methodology used in the sampling procedures, data collection methods, techniques and analysis. A total of 11 locations, 6 in South Darfur and 5 in East Darfur were visited, and primary data was collected. Through 30 trained enumerators (15 F & 15 M) from the local communities, 402 households were sampled and interviewed, this is in addition to KII and FGD with project beneficiaries. The collected data was analyzed and interpreted to reflect the main findings of the evaluation as described hereafter. The project and its objectives were found relevant to the situation based on the following:

- The project addressed CARE International identified core issues affecting the life of vulnerable people in the two states, which indicates that WASH, health and nutrition project is in consistent with key aspects of CARE approach and with the local CARE strategy.
- The project objectives are in line with SDGs, East and South Darfur WASH strategic plans and

following WASH, health and nutrition facility construction guidelines and also addressing the strategic sector priorities related to sustainable provision of services to such deprived groups.

- The project was formulated based on the results of the assessments. The comprehensive consultation indicated that all project activities, design, technology adopted, and outputs are quite relevant to the target communities. This is evident by the fact that, all project activities either run by government staff from SMoH, SWC or the local communities.

The long-term displacement, protracted conflict, and continued cycle of displacement, and nonstop relief operations have created a high level of dependency among the IDPs, host and resident communities, and this constrains their ability to contribute and effectively to participate in sustaining their facilities. The project considered gender approach to enhance sustainability, as for example; all trainings involved both women and men such WUCs, Public Health Committees. Most of project committees received training on gender in WASH & health with sessions on gender, harassment, and women rights in the society. Some activities were allocated for women only such Mother Supporting Groups (MSG) and training of midwives, these were mainly diverted to support women.

This final evaluation process reviewed project performance; compared planned targets to achievements, it is envisaged that the project is generally efficient, and targets are either fully or partially achieved. Most of planned activities were achieved with no cost extension despite delays in some activities which, indicated efficiency in using the project resources(personnel, supplies and logistics) in a rational manner, the rest of activities were in progress at the time of evaluation. BHA and CIS project results and its effectiveness are revealed in the following:

- ✓ Support provided and the adopted activities were from the local environment and cost effective with easy operation and maintenance. The provided Tuktuks to SWC O&M, health and nutrition equipment from the local market and technically well-known such as delivery kits, bed screens, etc. the staff at SWC and SMoH is aware of and familiar with O&M of these equipment and tools.
- ✓ Provision of integrated WASH package along with health and nutrition components maximized the project results and reduced vulnerability and improved resilience of the target population e.g. people in Fiena, Kidneer, Kass, Bakhit, etc. are using the provided improved water supply along with health and nutrition services and other project benefits.
- ✓ Generally, according to household survey before the project implementation, 32% & 18% of the population in all project sites waiting less than 15 & 30 minutes respectively, after project implementation situation improved and this percentage increased to 42% & 21%. In the same way percentage of those who are waiting more than an hour at the water points decreased from 20% & 30% before project implementation to 16% each after project completion.
- ✓ CARE International and their local partners conducted comprehensive awareness program, despite the difficulties related to long dependency on relief. CIS succeeded to build the capacity of these communities and supported them along with the local partners to rely on their local resources and indigenous knowledge, and related management experience to sustain their services, to improve their resilience and to reduce their vulnerability. This is especially valid where the WASH program implemented water tariff systems in Greida and Fiena etc.
- ✓ The project has been running all of health and nutrition centers in all project location without supply gap exceeding seven days over two years. The project provided medical consultation to more 167,000 persons and more than 118,000 persons benefited from nutrition program

especially U5.

- ✓ The project provided tangible support to the most vulnerable people in SLA controlled areas and the especial support through provision of integrated package of services including training of midwives is highly appreciated by the local communities.

The evaluation process checked the monitoring system within CARE International. The evaluation team found that MEAL system is improved and working vertically between state and national levels, it will be very effective if it is contributing to improvement of the project performance. Improvement of linkages between national and state levels as well as between the MEAL and programs will be very helpful to improve projects performance as well.

On visibility side, all partners and most people met during interviews and FGD at the community level, are all aware of CIS contribution. Signboards and logos displaying BHA and CIS logos were fixed closed to all constructed and upgraded facilities e.g. health and nutrition centers at Fiena, Surhan, etc. and at upgraded and rehabilitated Mini Water Yards at Fiena and Kass.

3. Background information

The proposed integrated and lifesaving WASH, health, and nutrition services were implemented in a two-pronged strategy, preventive and response. The preventive approach consists of water supply services, provision of sanitation facilities, promotion of good hygiene, sanitation, health, and nutrition behaviors and practices, cash distribution, and development of self-reliance through capacity building. The response strategy includes the provision of comprehensive primary health care services package: treatment for different cases of diseases; provision of Sexual and Reproductive Health (SRHR) and Expanded Program of Immunization (EPI) services, treatment of malnutrition cases for children under the age of 5 and pregnant and lactating women. This is in addition to referral services to secondary health care services. Furthermore, the proposed intervention mitigated the secondary impact of the COVID-19 virus on sustaining essential WASH, health, nutrition, food security, and protection services, including gender-based violence responses. The response was fully coordinated with all actors working in the areas, including local government and communities, to avoid unnecessary duplication and maximize cost-efficiencies. Many people adopt harmful coping mechanisms such as reduced quality and quantity of diet, and taking up arms as a perceived substitute for livelihood security services to multiply the negative impact on the political, economic, and social trajectories.

The South & East area of Jebel Mara in South Darfur, which is under the control of the Sudan Liberation Army-Abdul Wahid (SLA-AW), where no humanitarian organizations had been present for nearly ten years, has become accessible to humanitarian partners in November 2019 and CARE started providing limited health, nutrition, and WASH services in January 2020, and the need remains significant. As CARE is scaling up its' programming in the Jebel Mara area, it was coordinating its response with other humanitarian partners to ensure there is no duplication of efforts.
The psychosocial stresses of the protracted crises inevitably took their toll in terms of people's overall capacity for resilience and self-reliance. Therefore, there was an urgent need to support the most vulnerable groups' livelihood to enhance their resilience, including via cash-based assistance.

4. Purpose and objectives of the assignment:

The final project evaluation was conducted to provide the project stakeholders with information about the performance of the project in relation to its stated objectives, covering the project's implementation in its entirety from 15th August 2020 to 30th August 2022. The evaluation's assessment of the project's relevance, efficiency, effectiveness, impact and sustainability will be key in informing the development and implementation of future CARE projects and initiatives in Sudan and beyond, which will build on the lessons learned and practical recommendations from this project. The evaluation is looking not only at the project's intended results, but also at evidence of unintended results (both positive and negative). The ***specific objectives*** of the evaluation are as follows:

- Assess the quality and relevance of the project design (its activities and objectives) in addressing the priority issues in the targeted communities and institutions.
- Assess to what extent the project resources have been used economically and in a timely manner (efficiency).
- Assess the major achievements of the project to date (effectiveness).
- Assess bottlenecks, opportunities and lessons learned.
- Asses to what extent the project contributed to provision of sustainable, adequate, and lifesaving WASH, Health and Nutrition services to the targeted crisis-affected and vulnerable community in two States (impact).
- Identify which positive outcomes of the project are likely to continue after the project ends (sustainability).

The evaluation's findings and processes will be used and shared by relevant stakeholders, including OFDA CARE International in Sudan (CIS), the CARE International Confederation more broadly, and any other national, regional and international stakeholders looking to replicate or build on the work carried out under this project.

5. Methodology

To assess the two years' projects 2020 to 2022, the evaluation team conducted series of meetings with CIS teams at the two states mainly to have common understanding on the SOW and get background on the project implementation history, critical areas to be focused on, and to prepare visits to concerned partners and finally to develop the tentative plan for the sites visited.

The strengths of the evaluation it considered; cultural and geographic aspects, type of provided services, natures of community and distance of sites from the Nyala and Eldien. In addition to that, the evaluation team succeeded to visit some sites under control of SLA controlled areas. The strengths of the evaluation also the use of various data collection methods and techniques that were appropriate for each level and category in addition to that, the evaluators recruited data collection teams from the local communities in addition to use of stratified sampling for FGD that considering disaggregation of community into different categories. Samples were collected from 11 project areas that distributed over the two states. The limitations mainly in some areas and villages it was very difficult to find well educated people in addition to that most of communities engaged into farming activities and were available only on market days. The limitations and diffuclties were also included restricted movement in JM area and heavy rains in Darfur and distribution of project locations over vast area.

The evaluation adopted participatory process and rationale methodology in sampling procedure, data collection methods and techniques, data analysis and processing and the team used the key issues and formats provided by CARE International Sudan for the evaluation report. The consultants met all related and concerned CIS staff and partners at national and state levels. Also visited all planned locations that hosting IDPs, host and resident communities and returnees. The consultants conducted field and onsite visits to check physical conditions of the constructed and rehabilitated and medical stores. Also held meetings with communities at the village level, this is in addition to household survey.

However, despite that, the evaluation team selected and visited 11 representative sites (6 in SD & 5 in ED). The initial compilation of data conducted in the field using the same data collectors on purpose to give clarification for some outstanding and up normal phenomena and contradicting issues. Methodology and procedures are summarized as per following details:

5.1. Training and orientation of data collectors and pre – testing

The evaluation team in collaboration with CIS selected experienced enumerators who exposure to previous training in data collection by CIS and other partners to make use of their accumulated experience and to facilitate communication in local language to ensure data reliability. However, for the purpose of this evaluation, in all selected locations, 30 data collectors (males 15 and females 15); were selected from local communities, trained and used for data collection as indicated in annex IV. Table 4 in the annex 4, shows the No. of local data collectors and Mobile enumerators for the evaluation. The consultants reviewed the questionnaire with the data collectors and provided orientation session on the evaluation process and data collection methods and techniques and finally, a pre-test was conducted. Image 1 in annex 3, shows the orientation session to review the questionnaire with enumerators at Kass.

Table 1: Local and mobile enumerators for data collection

No	Location	Females	Males	Total
1	Kass IDP camp and host community	6	4	10
2	Elsalam IDP camp	5	6	11

3	Fiena	1	2	3
4	Jabra	1	1	2
5	East Darfur mobile team	2	2	4
Total		**15**	**15**	**30**

5.2. Sampling procedures

The evaluation team applied participatory evaluation process to selected representative locations for sampling in term of site and number of samples for HH data collection. The evaluation team used the following techniques to enhance representative sampling:

To estimate samples for evaluation at HH level, the following Glenn.I., 2002 method: Sample size (n) = Total Population (N) / ($1+N*r^2$) (r is a margin of error (degree of accuracy).Using 5% as margin error and the total targeted people are about 528,000 the sample size calculated as 400 individuals to be consulted using HH structured questioner. Sample size (n)=528,000/($1+528000*0.05^2$) = 400; n = Targeted sample size (400). To estimate samples per state; percentage of served population was used to calculate total samples as indicated in the table below:

Table 2: planned distribution of samples over States:

State	target population	% of target population	Total No. of samples
South Darfur	382,764	73%	290
East Darfur	145000	27%	110
Total	527,764	100%	400

Based on this total samples of South Darfur estimated at 290 samples including 200 samples of IDPs and total of 110 samples is the share of East Darfur State covering all sectors.

The planned distribution of samples is affected by two factors; first MPCA activity was implemented at Gorlanbang only out of four locations, Gorlanbange was not accessible at the time of evaluation so samples were not collected. Secondly the host population generally is small compared to the resident community that distributed over more than 15 project sites so a minor change in the distribution of sample was done to fit into the situation. The consultant compensated these by adding the 52 samples for different sectors to bring the total No. of samples to 402 as indicated 3.

Distribution of sector samples over locations considered; population served, geographic factor, all sectors in addition to accessibility considering security and rains. However, 11 locations (6 in SD & 5 in ED) were selected for site visits as indicated in table 1 in annex 4; the distribution of samples among different states is shown in the table below:

Table 3: Summary of actual samples distributed by sectors

State	WASH	Health	Nutrition	MPCA	Total
Total for South Darfur	90	97	60	0	247
Total for East Darfur	60	53	42	0	155
Grand total	135	135	96	0	402

To enhance full community representation, capture their views, interest and to see the project results and benefits upon these categories, stratified sampling was applied in selecting community layers for FGDs and meetings that included women, Village Health Committees, hygiene promoters, community leaders, men, and water committee members, midwives, public health committee, medical assistants etc. Cluster sampling was applied to capture different cultural aspects and situations and to ensure representation of groups of different cultural aspects.

6. Data collection methods:

Data collection is most important and critical part of the evaluation process. The evaluation team adopted participatory approach and deployed different methods to collect, cross check, validate and triangulate evaluation data. Qualitative and quantitative assessment methods were applied, and different techniques and tools were used. Application of different tools allowed and provided optimum chance for cross checking the collected data and to check reliability and validity of findings.

The data collection methods applied included, interviews, discussion, and review of project related documents along with transect walking combined with observations. Techniques applied in data collection included observation checklist, structured, semi-structured and unstructured questions, structured and open- end questionnaires, closed interview (questionnaire) in addition to FGD with different community layers.

6.1. Literature review

The evaluation team started data collection by desk review of project related documents, at Khartoum, South Darfur, and East States. The team, verified, reviewed, and used this information as secondary data sources and references. These documents included Information related to the original project proposal, performance report, monitoring and evaluation plan, OFDA 2020-21, OFDA 2020-22 CARE Sudan, USAID/OFDA; monitoring matrix; health facilities VIP latrine design and estimated cost and OFDA Baseline report, this is in addition to field visit reports. The performance and status of the project implementation in all locations of the project were compiled from these reports.

6.2. Site Observations

The project evaluation team conducted field visits to project implementation sites in thetwo states to assess the quantity and quality of constructed and rehabilitated facilities. These facilities included motorized water supply system, installation of solar system, and rehabilitation of hand pumps and provision of generator and submersible pumps. This is in addition to the rehabilitation of health and nutrition centers and medical stores.

The team used observation checklist - attached in annex 10 - combined with transect walking inside villages with community leaders, head of WASH committees, Public Health Committee and CIS staff.

Plate 5g: **Medical store at Kass Health Center**

Plate 5h: **Hybrid system at Kass to operate water supply system**

Generally, observations were used to cross check the validity and reliability of collected data and validate project achievements and results, however, some sites were visited and checked as indicated in table 2 in annex 4.

6.3. Latrines investigation and verification:

This USAID/BHA funded project supported the construction of 1,127 HH latrines and means of safe excreta disposal distributed over four locations: Kass, Elsalam, Greida and Kalma IDP camps. However, to check the quality and accuracy of the reported figures of constructed and rehabilitated latrines, two locations were selected at IDP camps of Kass and Elsalam.

In each location latrines had been given a serial number with red paint color. Kass latrines from 1 to 200 and in Elsalam from 1 to 42. To cross check accuracy and quality of construction the consultant applied systematic random sampling and selected specific range of numbers at each location as indicated in plate 5a & 5b in annex 3. However, based on

that, 20 latrines in Kass and 10 latrines in Elsalam were identified and physically checked.

6.4. Key Informant Interviews, Consultations with CIS staff and Partners:

The evaluation team conducted key Informant Interviews with different key stakeholders with diverse background to facilitate validation of information from different sources and to capture their perspectives and interests. The evaluation team conducted KIIs with more than 60 key persons as indicated in annex 6. They were representing more than nine institutions, with different interests, and at various levels in addition to key people at community and health facilities.

Plate 5n: Interview with HP at Surhan

Plate 5o a meeting with lactating women at Kidneer

Additional consultations and discussions were held with implementing partners in the two states that included SADO, SHOA, NAHA and JMCO. The purpose of this consultation is to assess partner's implementation capacity and their efficiency and accountability in implementation.

At the community level, consultation was conducted with 26 key community leaders and extended to include Head of H&N Centers, Midwives, Sheikhs, Shartais, IDP community leaders, health workers, water management committee members, water yards operators and attendants indicated in annex 6. Interviews were mainly focused on how to maximize project results in addition to discussion of issues related to O&M and sustainability of services after project phase out.

Plate 5p: a meeting with MPCA beneficiaries at Kidneer Plate 5q: Women with U5 waiting Bakhit Nutrition Center

6.5. Household survey

The evaluation team adopted systematic and random sampling at village/camp level to conduct HH survey to shed light on status of WASH, health and nutrition services at HH level and to check efficiency of hygiene and health promotion components, and also to capture key factors related to water supply collection and use. The questionnaire is also to check efficiency of health education program especially with pregnant and lactating

women and its possible impact on their children. The consultant selected 11 sites to collect data by 402 HH questionnaire as indicated in table 1 annex 4.

The household questionnaires were designed to collect data by asking questions and in some cases by observation. to the household questionnaires were also designed to cross check achievements such as hygiene and cleaning campaigns, and health and nutrition related issues. These households were visited over the 11 locations as indicated above and samples were collected and analyzed, and the results of the questionnaire used for analysis. Despite the host community is of small number compared to IDPs, the host community was considered in sampling of HH questionnaire.

6.6. Focus group discussions (FGDs):

The evaluation team did wide community consultation with questions relevant to each audience to capture their perspectives in relation to the project impact on them, sustainability of the project, best practice, gender issues along with cross checking of some project achievements at camp/village levels. The team conducted series of 16 FGD with different community layers and categories. This included pregnant & lactating women, women at health facilities and HH level, and people at the water points, WUCs and hygiene and health promoters along with midwives, community leaders, and health and nutrition staff at the community level as indicated in photos below and in annex 3. This wide range of community consultation is to ensure reliability of provided data and to cross check reported achievements along with collecting some data related to the project.

Plate 5s: FGD with women group at Kass IDP camp

Plate 5t: FGD with WUC at Elsalam IDP camp

7. Compilation, processing, and data analysis:

The evaluation team worked hard to compile field and office data. The data collected from different sources included project proposal; performance report, monitoring reports. This is in addition to data from consultation with WASH, health, nutrition and MPCA partners, FGD, along with the results of questionnaire and observations. The HH questionnaire data initially compiled by the same HH data collectors at the field level – as indicated in photos below - to give clarification for some issues.

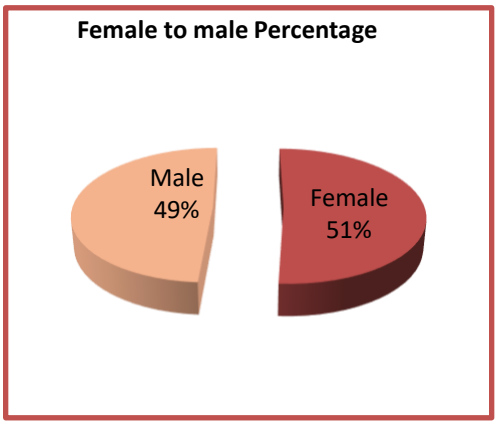
Plate 6a: compilation of HH data at Jabra, EJM **Plate 6b: The team collected Fiena data**

However, data from these various sources were compiled, filtered, tabulated and correlated using computer programs excel sheets and other related procedures to ensure reliability and validity and then converted into different visible forms that included figures, charts, histograms and tables for easy interpretation.

8. Demography:

The evaluation process collected data from 402 households in the two states; the total population covered by household survey, focus group discussion, meetings, and interviews along with field observations and side discussion was 3,555 persons (1,808 females and 1,747 males). Household details are indicated in figure 1 & 2 including both U5 & U2.

The household size varies among different target communities but in all cases the number of women is higher than men except in resident communities. However, high percentage of women among IDPs and host communities may be related to the war effect. It is observable that U5 have the same percentage whereas girls U2 are smaller compared to boys. It is observable that, across areas of evaluation and according to HH survey 27% were headed by women for different reasons as indicated in figure 3 in annex 2, this is very common in war affected zones. In more details, HH headed females are common among IDPs and to some extent in the host communities. However, this may provide support and highlight areas of future support for CIS projects that targeting women headed HHs.



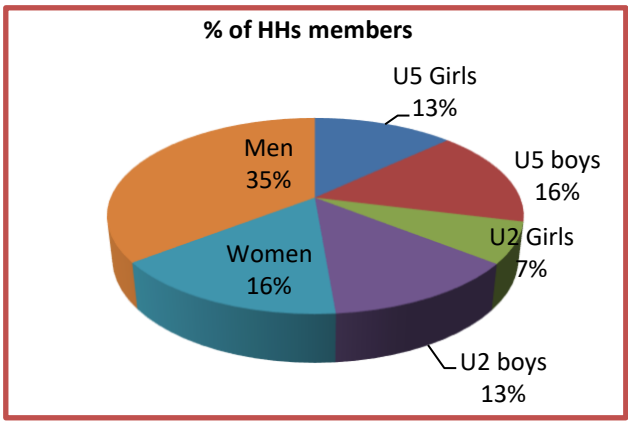


Fig. 1: population percentage. Fig. 2: Percentage of HH members.

9. Evaluation findings and analysis

9.1. Relevance of the project to the target population

The WASH, health, nutrition and MPCA project is in consistent with key aspects of CARE's mandate and approach and with the local CARE strategy. This is in line with preventive and curative strategies of SMoH. The project was developed based on CARE's January 2020 assessment and on 2020 HNO assessment, which identified high needs for services especially for under five to address issues of acute malnutrition. This in addition to provision of WASH services in integrated pattern.

The project gave especial emphasis to women and U5 to strengthen women roles in conservative communities, as both are constitute the most affected and vulnerable groups at the community level. However, in hygiene promotion committees, Mother Supporting Groups (MSG), CHW women are dominating. Moreover, specific training sessions on topics related to strengthening of women role were considered in the project design such as (MSG), midwives and all WASH facilities, health and nutrition opportunities have been gender- sensitive and transformative elements to ensure collaborative and inclusive systems at the HH as well as the community level.

The project is in line with national WASH plans aiming at achieve the SDG by 2030. Consultation also indicated that the project is also in line with East and South Darfur WASH strategic plan that aiming at improving water supply for the rural population and maintaining their dignity and also addressing the strategic CARE International priorities related to provision of WASH and health services and reducing service gaps to such deprived groups. Also, the project followed the WASH facility construction guidelines developed by the Drinking Water and Sanitation Unit (DWSU), UNICEF and WASH sector partners. It was found that, the project followed and complied with SMoH specifications and guidelines however, this quite relevant to address issues related to local communicable diseases and to serve children under five. The project is in line with SDG to reduce acute poverty and to improve access to safe drinking water and sanitation in addition to provision of health and nutrition services especially for vulnerable communities in rural areas.

The comprehensive community consultation indicated that all project activities, technology adopted, and outputs are quite relevant to the target communities and their actual needs and also appropriate for the selected areas. This was confirmed by the ability of communities to run these services in the concerned locations such as water supply facilities with solar system in Kass, and Fiena, H&N facilities at bakhit, Kidneer and other locations and hygiene promotion activities in many locations such as Jabra and Abu Zinba.

Hardware component of capacity building program especially provision of circuit Riders, delivery set, bed screen, height and weight scales are available in the local markets and their spare parts are accessible and available for future replacement. Software component of capacity building program is quite relevant to the local context. This is in addition to training of midwives, health committees and mothers support group (MSG) and hygiene promoters is quite relevant and played central role in community mobilization to care of children at household.

The evaluation team believes that the project adopted the consultation and previous findings from former projects along with assessments and surveys and provided integrated WASH, health, nutrition and MPCA lifesaving services and hence addressed CARE International identified priorities affecting the lives of vulnerable people in the country. Project design and identification of priorities is quite relevant to the context of the rural population in the two states and in line with the local community interest and addressing their needs.

9.2. Sustainability:

In South and East Darfur States, the long-term displacement and protracted conflict among different groups and continued cycle of mass displacement and nonstop relief operation has created high level of dependency among IDPs, host and resident communities, constraining their ability for contribution and effective participation in sustaining their service. However, the USAID/BHA funded CIS project contributed to provision of immediate and essential support to enhance sustainability of services by providing WASH, health and nutrition services to new displaced persons, resident and host communities in the two states with clear exist strategy.

CIS over two years contributed to developing an exit strategy and early recovery through strengthening of capacities at grass root level such as installation of solar system at Kass, Fiena and other locations to reduce overall O&M cost as indicated in plate 8b, application of water tariff and training of water yards operators and WUCs especially at Greida and Kass. In Kalma and due to strong resistance of community leaders to take over responsibility of O & M, CIS is still fully operating water supply facilities in their operational area inside the camp.

However, in all other locations outside IDP camps CIS signed MOU with SWC or with the local communities before interventions ensuring that O & M of water supply facilities and systems is either done by SWC or by the local communities. The example is from the SLA-AW the two rehabilitated and upgraded systems are completely run by the communities in these areas. The collected revenue from this hybrid (solar and diesel generators) water supply systems are usually used for payment to operators, guards, during the rainy season part of the revenue used for provision of fuel and lubricants.

The evaluation team believes that, generally sustainability of water supply services in project sites can be realized and sustained. However, this is very important step towards early recovery and full community involvement with tangible contribution to ensure ownership and sustainability. Moreover, at the time of evaluation it was found 80% of WUCs operational and following on WASH related activities.

In East Darfur provision of two Circuit Raiders (plate 8a) and water yards spare parts by CIS to SWC supported the sustainable operation and maintenance of water supply systems. It is worth noticing that these two circuit raiders and their technicians are completely part of and managed by SWC.

Plate 8a: Branded Circuit Raiders in ED

Plate 8b: Water facility in Fiena supported hybrid system.

CIS supported construction of latrines through the provision of slabs and two pieces of wood to support fixing of slabs. Community contribution in construction/rehabilitation of latrines is dependant upon sensitization and awareness by partners, this partial support is also part of CIS exit strategy for sanitation activities.

To strengthen and to enhance sustainability, gender was also considered in the project whereby, in most of CIS supported training and capacity building program female and male had have equal share in attendance and decision making such as Hygiene Promotion Groups, Health Committees, WUCs. In the case of midwives training and Mother supporting groups are for women only.

Plate 8c: Old HWY supported at Sarhan village

Plate 8d: Existing HWY supported at Fiena village

To ensure future operation of health and nutrition facilities, CIS used available SMoH at these centers and recruited technicians from the local community to fill the gap with an intention of smooth transition of manageent in the future. The SMoH confirmed that they can continue with their recruited staff to sustain services, however the SMoH also believes that they don't have financial capacity to sustain flow of drugs and payment for staff from outside SMoH system. More than 60% of consulted medical assistants and most of SMoH staff confirmed that, health services can be sustained at low scale and SMoH asserted that, nutrition services cannot be sustained by SMoH alone. The evaluation team concluded that, water supply can be sustained, health services can be sustained at lower scale and very difficult to sustain nutrition services due to limited resources of SMoH.

9.3. Project Efficiency:

The USAID and CARE International project implemented through six local partners NAHA, SHOA, JMCO, SADO, SWC and State Ministry of Health (SMoH). CIS Sudan provided technical support and back up for the project through offices at Nyala, Edien and professional core team of project managers, officers with frequent trips to the field.

Final evaluation process reviewed project performance; compared planned targets against achievements, it is envisaged that the CIS project is generally efficient. It was efficient in keeping the project functioning successfully for two years. The efficiency of the project is also clear from the implementation of all projects planned activities despite delays in implementation, associated changes in MPCA payment modality, and high staff turnover in East Darfur.

The project was able to show high level of flexibility when direct MPCA cash payment to beneficiary put CIS staff at risk. In consultation with donors, CIS succeeded in finding q solution. The project was able to pivot to a voucher payment system working with a selection of vendors a reasonable time. In some activities such as training of SMoH nutrition team on CAMAM protocols exceeded the targets in ED using the same allocated budget.

The project showed high level of flexibility also in O & M of water supply system in IDP camps, CIS exited from operation of Greida water supply system and partially supported Kass and fully operating in Kalma. These different levels of flexibility are strongly linked to the local conditions and availability of funds from other projects.

Gorlanbange village is telling a story of efficiency with high level of dedicated staff and strong CIS commitment.

The village is in SJM area under control of SLA-AW and serving all surrounding villages. CIS staff is travelling six hours from Kass to this site; three hours by cars and three hours using animals for transportation of staff and supplies as indicated in the plates 8e & 8f, despite these challenges CIS provided integrated services of WASH, health, nutrition and MPCA to these vulnerable groups.

Another example showing project flexibility is that in many locations to enhance project policy of integrated services the project built on existing services especially availability of water supply, this observed in many locations such as in kidneer, bakhit, Kass, Elsalam and Jad Elsied. In the same way, Kass IDP camps are highly in need of latrines rehabilitation rather than newly constructed ones however, in consultation with donors the project adjusted the plan of constructing 200 latrines to rehabilitation of the same quantity to reduce risk of outbreak of sanitation related diseases.

Evaluation team found that, the project was very efficient in effectively running 45 facilities (24 nutrition centers and 21 health facilities) over two years without supply gap exceeding seven successive days, this is confirmed by medical and nutrition staff at all visited facilities in GoS and SLA controlled areas.

Plate 8e: CIS staff travelling to Gorlingbange

Plate 8f: Transportation of supplies to Gorlingbange village

The evaluation process revealed that, CARE International Office Managers at SD & ED provided support and back up to the core project team through monthly meeting reviewing the operational and program issues, which facilitated the implementation process. However, it was noticed that regular review meetings of separate grants were conducted in SD only. Moreover, no regular review meeting was conducted on quarterly, mid-year or annual basis to review achievements against plans and to address constraints and challenges to ensure full efficiency and to avoid unnecessary delays. The evaluators observed that, in two locations in East Darfur State and due to high staff turnover integration of activities was not well implemented.

The evaluation team also noticed some delay of activities such as delay of MPCA to beneficiaries and construction of two water supply systems in Jabra and Kass areas which are in progress at the time of

evaluation; the delay of activities is either in SLA area or its territories such as Gorlanbange, Fiena, Kidneer and Jabra. The delay is mainly related to security issues related CIS staff, cash, and related resources. The team also noted diversion of some funds to be used in the same budget line but at account of the planned target such as provision of T-shirts for trainees in East Darfur due to project closure date. However, the project can accomplish most of activities before the implementation end date.

Generally, the evaluation team concluded that, as indicated in annex 5, about 75% of the planned activities were completed with same allocated initial budget and most of the remaining activities are somehow minor activities which are in progress and expected to be accomplished within this month, despite difficulties and challenges in the SLA areas and at sites located in territories between the government and SLA areas the evaluation team believes that, the project is efficient in terms of implementation of the planned activities and management of resources.

9.4. Project Effectiveness and immediate results

Despite the challenging environment of Darfur especially in SLA controlled and nearby areas, substantial improvements in HHs services were reported by beneficiaries appreciating the improvement of health, nutrition and water supply services in their areas, which is finally reducing impacts of COVID-19 and contributing to better life.

The projects supported and strengthened women roles through capacity building program, in addition to that in all visited nutrition centers, the evaluation team observed that the majority of nutrition staff are women, this is supported by the records that in South Darfur CIS seconded 49 staff members, 46 out of them are females. In addition to that considerable females are working in the health centers whereby all midwives and mothers supporting groups (MSG) are females. The evaluation team observed that, at the grass root level women role strengthen and taking responsibility in nutrition and health centers and improved at the village levels through involving them in the committees at village level which were in the recent past were exclusively men dominated. However, excluding WASH in East Darfur the percentage of females to males at this level is reasonable for other three components as indicated in table 4 and the average percentage for them is 57% females and 43% males. Table 5, annex 4 is showing capacity building program disaggregated by gender:

Table 4: Percentage of male and female trained over three programs:

Sector	Female	Male	Total	% of female	% of male
H & N South Darfur State	**428**	**169**	**597**	**72%**	28%
WASH South Darfur State	**260**	**264**	**524**	**50%**	50%
H & N East Darfur State	**264**	**267**	**531**	**50%**	50%
WASH East Darfur State	**82**	**288**	**370**	**22%**	78%

WASH Sector: In WASH the effectiveness of the project is envisaged in mobilization of local communities and their resources to cope with CIS exit strategy, particularly in IDPs camps. In addition to that, rural communities and SWC mobilized and operated the rehabilitated/constructed water supply systems at the time of evaluation. In the same way and based on consultation with communities at all locations, the project was able to implement its activities and to achieve reasonable results with different categories of communities (IDPS, host communities, returnees, and resident communities) in harmony and without any friction or disputes between these different groups at all locations.

According to WASH questionnaire and as shown in figure 3 all the respondents from IDP and host community are using safe water supply from motorized or hand pumps and 93% of resident community are using safe water

sources, however, on average 98% of project beneficiaries are using improved water sources.

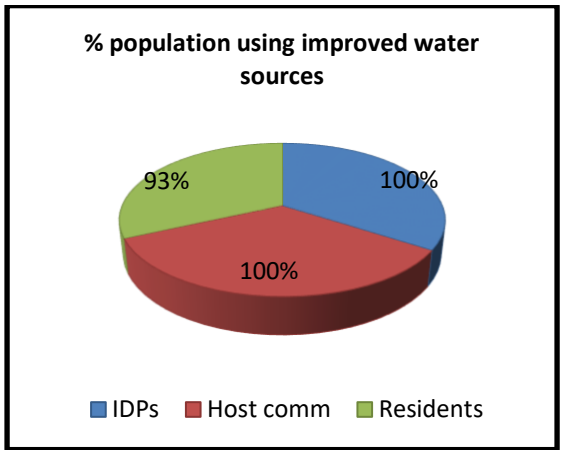


Fig.3: population using improved water sources.

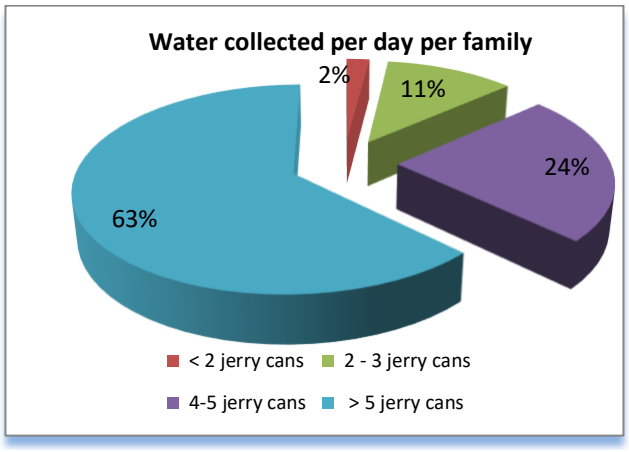
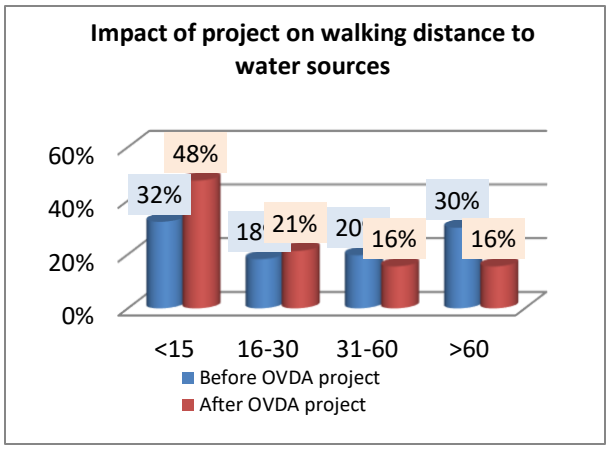


Fig. 4: HH water collected per day

The results of household questionnaire illustrated in figure 4 indicates that 86% of the respondent HHs collecting at least four jerrycans of water per day, which indicates that access of 87% of the total population to water is at least 18 l/c/d. However, on average the access among served population based on HHs survey is estimated at 16 l/c/d. comparing this to the baseline of 11 l/c/d.

Figure 5, indicated that, the project reduced walking distance to collect water (e.g. Fiena, IDP camps, Surhan and others). However, generally percentage of those travelling less than 15 minutes increased from 32% to 48% after project implementation, whereas for those travelling more than an hour, percentage decreased considerably after project implementation from 30% before implementation to 16% after implementation. This improvement related to construction of new facilities and rehabilitation/repair of existing water supply facilities. Most of water collectors are either women or women and children as indicated in figure 9, so far reduction of walking distance to collect water has direct impact on those vulnerable groups

The project also has direct impact on the most vulnerable; fig. 6 reveals that, IDPs, as they are the most vulnerable group, are paying the least amount for water supplies whereas, all host community and about 50% of the rural population are paying the highest prices per jerry can. This has direct impacts and it is serving two objectives supporting IDPs and in the same way supporting CIS exit strategy in sustaining water supply for other communities who will be operating their own water system through application of water tariff system.



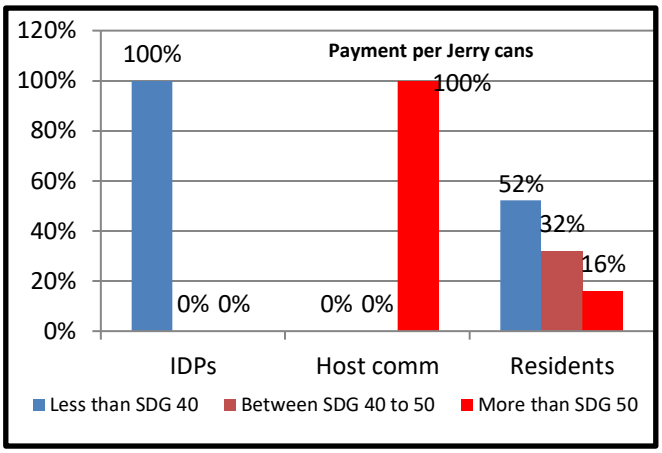


Fig. 5: Impact of project on walking distance to water sources

Fig. 6: Cost per jerry can of 20 liters

The project effectively impacted water supply in East Darfur State by supporting sustainable O & M of water supply system, through provision of two Tuktuks. These Tuktuks are cost effective, efficient, and appropriate technology to the local condition in terms of operation and maintenance. The project trained mobile teams of 10 persons per each locality from SWC staff. SWC is responsible for staff, operation and management of Tuktuks. These Tuktuks have very positive results in the area of operation. SWC applied these pilot activities and since it was successful they replicated their experience in other two localities of Yahsin & Muhagria to support O & M at these areas.

The project also constructed and rehabilitated total of 1,127 latrines in four IDP camps; 927 latrines were constructed and 200 ones were rehabilitated in Kass with significant contribution from IDPs at different location. These latrines serve at least 6,762 persons.

The sanitation coverage is generally high in host community 100% since they part of Kass town and then the IDP with coverage of 92% and finally the coverage among rural population is 78% as shown in figure 7. Moreover, latrine use is also following the same ranking and arrangement as indicated in figure 8. The average use for latrines by all family members is 87%. The evaluation team checked both rehabilitated and constructed latrines and found that, over these two years 50% of these latrines have been clean and in use. The remaining HH latrines either filled or collapsed due to high rainfall of this year. However, based on consultation with sector partners including UNICEF and comparing HH latrine use over two years with estimated cost of about SDG 1,300 for a latrine, the evaluation team believes these latrines are cost effective and contributed to the prevention of outbreaks of sanitation related diseases and served the objective.

Box (1) Tuktuks

Abdalla Abdel Karim is the DG of SWC of Bahr Elarab Mahalia, managing about 40 water supply systems.

Abdalla said the provided Tuktuks supported very much O & M at the Locality; decreased break down duration significantly, supported fuel transportation and sustained water supplies for many deprived population and as consequence increased SWC revenues. The most important impact continuous operation reduced disputes between SWC staff and the communities and built trust between them.

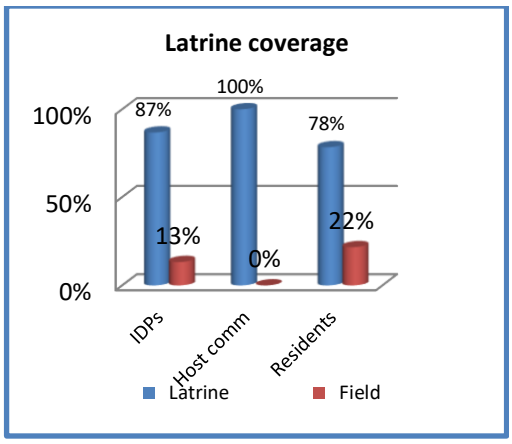


Fig. 7: Latrine coverage

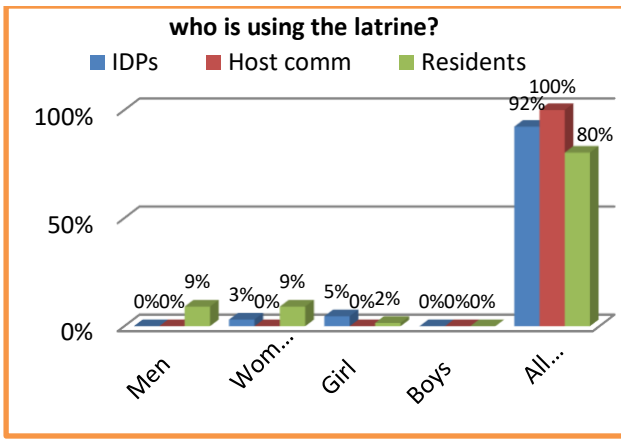


Fig. 8: Percentage of people using latrines

In general about 287,564 persons (58,663 women, 56,362 men, 87,995 girls and 84,544 boys) were benefitted from hygiene campaigns and solid waste management. Effectiveness of hygiene promotion as indicated in figure 9 may be envisage in the following ways:

- Latrine use is relatively high across all categories on average of 87%.

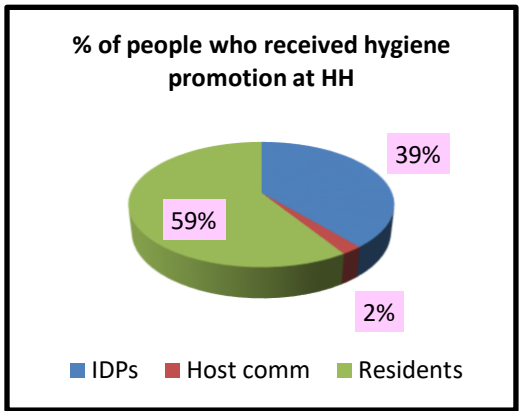


Fig. 9: People received HH hygiene

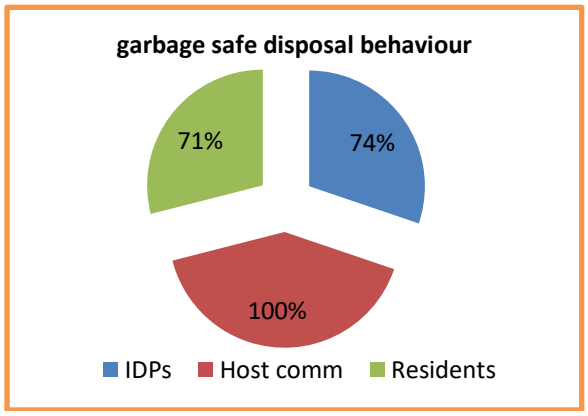


Fig. 10: People disposing garbage in safe way

- Household survey indicated that, at least 62% of the respondents from the target population were aware of three out of five critical times of hand washing. however, more efforts are needed to improve knowledge on handing washing at critical times and cleaning of latrines
- In the same 81% of visited HHs targeted by hygiene were reported to be clean and without evidence of feces and figure 10 indicated that, on average of 81% target population are disposing their garbage in safe way.

Multipurpose Cash Assistance: Four villages were identified for implementation of the project that included Gorlanbange, Jabra, Kidneer and Fiena with total population of 11,000 persons as indicated table 6 in annex 4. The cash payment modality in war affected areas is very challenging, risky, and putting staff and resources at high risk. To address the situation CIS changed the modality to voucher system based on consultation and approval of donors. However, at the time of assessment about 11% achieved as first payment to Gorlanbange before changing of cash modality and work is progressing at the stage of individual verification at other sites.

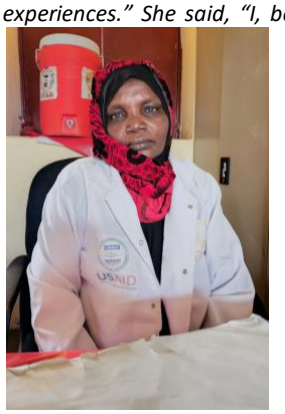
Groundwater monitoring needs preparation including availability of observation wells, provision of electronic loggers and training of staff and provision of essential supplementary equipment. This is mainly to ensure proper and effective implementation of groundwater monitoring especially in area of sedimentary aquifers to work as an early warning system and to support provision of data for water project planning. Despite groundwater monitoring started but in future preparations including involvement of field staff are essential and prerequisite to implementation.

Health Sector: Health sector is providing services through 21 centers in the two states, access to some of these locations is very difficult such as Golanbange and Fiena see plate 8e & 8f above. Over the project period, the health sector served a total of 167,701 persons (women 40,248, men 30,186, Girls 63,727 & boys 33,540).

These health centers supported consultation of 153,241 persons (M 71,051 & F 82,190), this represents 53% of health target population over the two states. Under five children consultation is 75, 540 children (M 35,976 & F 39,564) representing about 50% of the total consultations. The sector also provided considerable support on communicable diseases and total of 134,417 cases (women 32260, men 24,195, Girls 51,079 & boys 26,883) were diagnosed as communicable diseases and treated according to the national case management protocols and guidelines, unfortunately the records of deaths are not available at health centers and CIS records to estimate fatality rates. The communicable diseases represent about 88% of total sector consultations and 80% of the total population served by health sector.

***Box (2) saving life of pregnant**:*

Sakina Abdalla is a midwife from Miri village, graduated from Nyala Midwifery School, she has considerable experience. She was trained by CIS and supported with delivery kits to work at Fiena Health Center in SLA area. Sakina said, "I had been called from my village to support a young lady facing dystocia, traditional midwife has limited experiences." She said, "I, because of



critical situation we started our trip on a donkey, four hours walking I used my experience and I succeeded to rectify the situation and the lady received her 1st newborn."

Impact of health sector can also be recognized on the antenatal, about 2,575 pregnant women attended at least two times as indicated in figure 12, they represent about 85% of the total as per HH questionnaire. Moreover, about 204 community health workers were trained, 96% of them were very active and conducted regular public health surveillance.

The project impact envisages in training of considerable midwives especially in the remote and in SLA areas, however, total of 125 female midwives (95 in SD and 30 in ED) were trained and supported with delivery kits.

They all confirmed that, trained midwives distributed over vast areas to support such type of cases and currently about 53% of pregnant women from resident community delivered with support of trained midwives at health centers or at home. Roughly 254 births during the project duration represents about 68% of the total cases assisted by skilled attendants at birth. This along with provision of an ambulance indicate the impact of the project on women.

Figure 11 is indicates some of danger signs, whereby, considerable women were aware of risk of diarrhea

and severe fever and to some extent familiar with sever vomiting and acute respiratory infections. In the same way based on HH survey 54% of respondent women with U5 were identified at least three or more health danger signs, that need an urgent referral of children to the nearest health facility. This is also indicating impact of the project over women comparing this value of 54% from zero at baseline survey time.

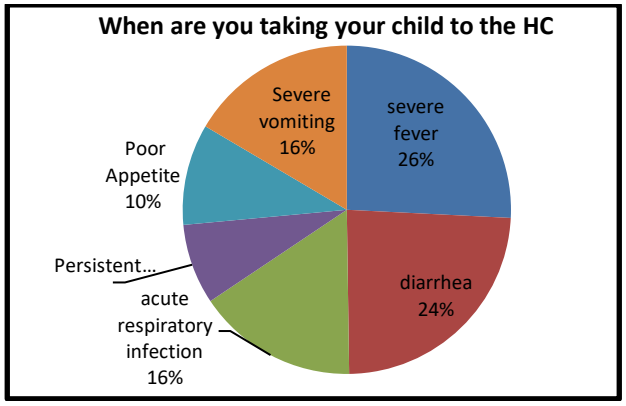


Fig. 11: Women aware of when taking child to health center

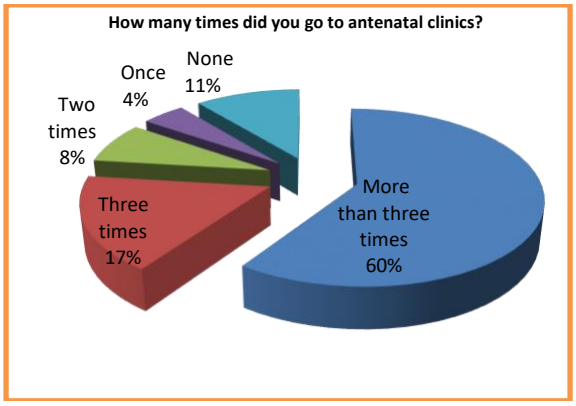


Fig. 12: Visits to antenatal clinics

Nutrition Sector: Over the project duration a total of 118,851 individuals benefited from preventive and curative BHA nutrition supported services. These services were provided through 24 nutrition centers in the two states. CIS trained 230 Mother Supporting Groups (MSG) raising awareness of lactating women on the benefits of breastfeeding.

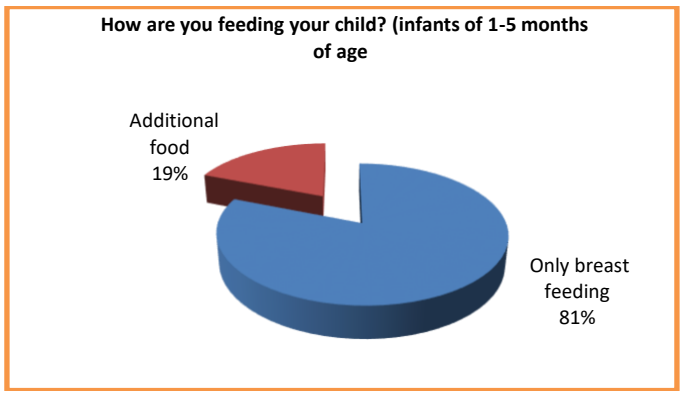


Fig. 13: Women practicing breast feeding a cross project area

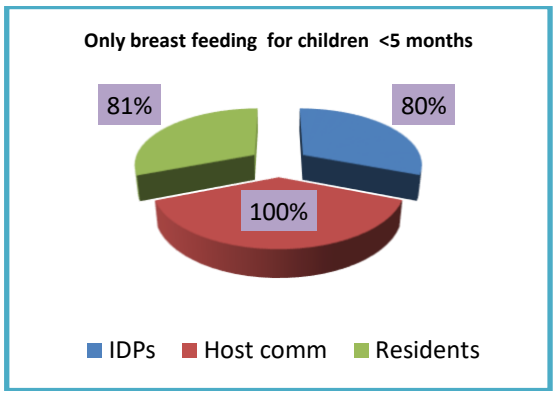


Fig. 14: Breast feeding among different communities

The results for women who breastfeed in the project operational area is indicated in figure 13 & 14 whereby, more than 80% of respondent women breastfed exclusively less than 5 months. This is related to awareness raising through MSGs, which in turn meet the baseline target of 81% and reflecting project impact on women. However, beside the MSG awareness sessions, CARE International is supporting community awareness sessions by trained community nutrition volunteers (CNV). The training sessions held were facility-based and camp-based, and IEC materials were used in dissemination of key messages to targeted groups.

Plate 8j: Women at Jabra, EJM women at Nutrition Center **Plate 8i: Women at Bakhit, ED at Nutrition Center**

In general the respondents, including all women with children 6 to 23 months indicated that 58% of them are receiving additional food for their children whereby 14% taking at least four food groups. Plate 8j & 8i above show women at nutrition centers to collect their childrens' food.

Table 5: Table showing No. of U5 admitted at nutrition centers over project durartion:

Item	No. of cases	% of cases
Total entries U5	17,879	
Cure	17,477	97.8%
Death	109	0.5%
Defaulters	243	1.4%
No response	50	0.3%

The imapct of the project also can be seen on over U5 admitted cases, as indicated in table 5 whereby about 17,876 were admitted at the nutrition centers and about 98% of children recovered and the death rate about 0.5%. When this is coupled with toal of 117,563 cases screened for malnutrition by community outreach workers, this is also indicaes the effectivness of the nutirion proram.

In conclusion, despite insecurity and rapid inflation rate, long rainy seasons, limited access to Jebel Marra along with the secondary impact ofCOVID-19, the evaluation team in consultation with WASH, health and nutrition partners at state and local levels in addition to community consultation process and household survey, concluded that the CIS integrated and lifesaving project has achieved its objectives and played an essential and central role in improving lives of these vulnerable groups and maintained their dignity despite the difficulties. During focus group discussions, bilateral meetings and meetings with different partners, most of the beneficiaries and project partners were satisfied with the project services, activities and problems addressed by the CARE project, especially in areas of integrated service of WASH, health and nutrition. The majority accentuated that there are no conflicts or disputes related to the project interventions in the target areas; however, in some areas especifically in East Darfur, the disintegration in some areas was observed at two locations; at Ban Jadeed and Korina.

10. Implementation aspect:

The USAID/BHA funded CIS project provided safe water supply services to 330,441 people (67,404 women, 64,761 men, 101,106 girls & 97,140 boys) through the operation and maintenance of 19 motorize schemes in IDP camp, operation of 21 hand pumps, and rehabilitation of 25 HPs in Jabal Mara areas, in addition to the construction of one water point in Gorlongbang and rehabilitation of some mini-water yards.

The actual implementation of the CIS integrated project *WASH, health and nutrition to reduce secondary impact of COVID-19 on vulnerable groups in South and East Darfur States* started in August 2020 at the beginning of the rainy seasons. CARE International implemented the project activities for the intended communities through a local NGOs SHOA, SADO, JIMCO & SAHA along with Ministry of Health and SWC. CARE International staff provided close follow up and continuous technical support and close coordination with concerned partners. The project achievements summarized as per the following details:

10.1. WASH component:

The WASH project component aimed at providing safe water supply, sanitation, and hygiene within reasonable distance to maintain dignity and safety of the displaced people, resident and host communities to reduce secondary impact of COVID-19. In South Darfur as indicated in table 8 water supply activities are operational in 19 water yards in IDP camps of Greida, Kass, Elsalam and Kalma.In addition to upgrading two productive hand pumps of reasonable yields into mini water yards with their elevated tanks, tap stands and fencing with fixed materials to provide safe drinking water. The project also added a solar-power to two systems with existing generators and the rehabilitation of three ones. This is beside the operation of 32 hand pumps and rehabilitation of other 40 in SJM & EJM areas. CIS also conducted water quality monitoring so far, in South Darfur a total of 2,389 FRC tests were conducted (1,094 water points & 1,295 at HHs), this have been periodically and continuously in IDPs camp.

In East Darfur States, BHA the supported provision of motorized water yards spare parts for Bahr al Arab and Ed Daein localities. This funding also supported the provision of essential tools, kits, and tuktuks to the circuit raiders in these two localities. The support benefitted at least 82,820 persons (16,895 women, 16,233 men, 25,343 girls and 24,349 boys). Provision of two Tutuks in East Darfur provided very essential support to O & M of water supply in Edien and Bar Elarab localities.

Plate 9a: Rehabilitated WY at Fiena village

Plate 9b: WY supported by solar system in Kass

At the time of evaluation, work is ongoing at four sites; Jabra, Logi, Kass and Geghainin. The team visited two sites at Kass and Jabar in EJM area, and work is progressing at different stages. As indicated in plate 9c annex 3, most of the work is completed in Jabra water yard.

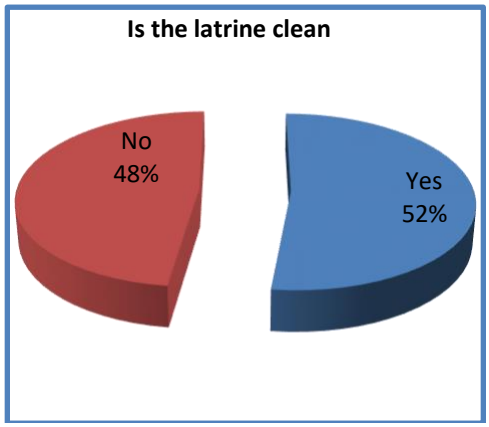
CIS is still operating the water supply system in Kalma camp and partially in Kass. To enhance sustainable O & M, CIS in East Darfur State provided spare parts for motorized water yards in Bahr al Arab and Ed Daein localities to work as revolving system. SWC resources are very limited so far, they can cover low cost spare parts but they don't have sufficient resources to cover high costs of some items, such as submersible pumps.

In the states of Kass and Jabar groundwater monitoring was not operational at the time of visits due to many challenges including the lack of observation wells for measurements, inadequate experience of staff in groundwater monitoring, high staff turnover in East Darfur State and insufficient budget along with

limited involvement of staff in the project design,;this is especially in East Darfur. Future planning for such activities should consider these entire factors in addition to provision of electronic loggers and involvement of government into the process of groundwater monitoring.

The USAID/BHA funded CIS project planned to construct 1,200 HH latrines in IDP camps, of which 1,127 latrines were completed representing about 94% of the total planned latrines. These latrines constructed at Kass, Kalma, Alsalam and Gerieda IDPs camps targeting the most vulnerable families in the camps. In Kass due to high need for rehabilitation CIS converted construction of 200 HH latrines into rehabilitation. The actual beneficiaries of these constructed and rehabilitated latrines are 6,760 people (1,722 women, 1,217 men, 2,569 girls and 1,352 boys). In addition to 13 blocks of school and communal VIP latrines being desludgedT in Kass IDP camp. The beneficiaries who befitted from the desludging activities are 8,477 people (1729 women, 1662 men, 2594 grills and 2492 boys). CIS also constructed six blocks of institutional gender sensitive latrines from permanent materials at health and nutrition centers (2 in Feina & 2 in Kass and 2 Gorlunbnge in SJM). The evalaution team found the constructed latrines to be branded and operational at the time of visits as per plate 9e in annex 3. The overall percentage of clean latrines is about 52%, as per figure 15 & 16, indicating that more efforts are needed especially among IDPs.

CARE and JMCO distributed 400 sets of cleaning tools distributed to Jabal Mara areas and Kalma IDP camp and handed over to Water User Committees. Meanwhile the community managed to conduct 200 general cleaning campaigns in EJM/SJM, Gorlanbang, Torntona, Golder, Globary Naro, Fagalum. EJM Gabra & Fiena. CARE and JMCO conducted more than 33 Jerry can cleaning campaigns in Kass IDPs camp, Gereida, Kalma and Jabal Mara areas.



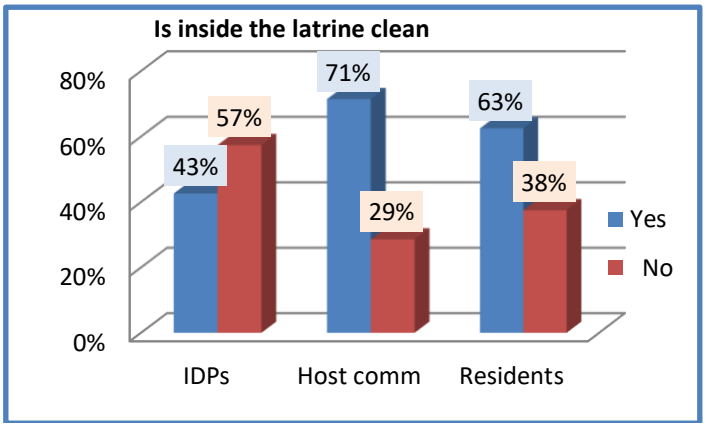


Fig. 15: Percentage of clean latrines over the whole project area **Fig. 16: Percentage of clean latrines per communities**

The participants were 21,743 peoples (4,436 women, 4,262 men, 6,653 girls and 6,392 boys) and at least 40,352 jerry cans were cleaned. CARE and JMCO provided technical support and powder soap, while the community contributed gravel and sand. In East Darfur about 280 general community cleaning campaigns were conducted in Umgrainat, Tayba, Keyak Barra, Sarhan, Almanara, Abuzainaba and Kouraina.
Over the project period, 480 hygiene promotion and cleaning campaigns were conducted in the two states with the objective to raise hygiene awareness. mainly focusing on sanitation and hygiene messages, use of safe water for different HH uses, essence of cleaning Jerry Cans regularly and the best way of water storage. The training and capacity building program summarized in the table 3 & 5 annex 4.

In summary, capacity was built for SWC staff trained on O & M and communities trained on topics including gender in WASH, and technical training of WUCs and VCs on operation and maitenance of motorized

systems and hand pumps. A s total of 894 people were trained (342 females & 552 males). A lot of effort is still needed to address gender in east Darfur, to ensure equal participation of both men and women in capacity building programming.

The project delays experienced were generally due to insecurity in some areas, high staff turnover, especially in east Darfur, and rapid changes in the exchange rate that affected the local market and as consequence the implenetation of activities through private sector. The project summary of WASH activities and achievements are shown in tables 1,2 & 3, annex 5 are indicating that. The average percentage of WASH achievement is about 75% and the rest were in progress during evaluation period.

10.2. Health program:

Under the health objective, the project has been running 21 health facilities (14 SD & 7 ED). Most of the H & N programs are the same centers for service delivery. In very limited cases the project provided one of these services in some villages and the other services were provided by other partners such as case of Elsalam IDP. All these facilities have either been repaired, furnished, and supported with all essential inputs to enhance proper operation. The support included provision of drugs and nutrition supplies, chairs, tables, stationary, generators, and fuel, ambulance, blankets and bed sheets. These facilities were supported with essential delivery equipment such as delivery sets, delivery bed, and bed screens, etc. The achievements summary is shown in table 10 and detailed achievements in annex 3.

In East Darfur, a total of 18,803 children (9,693 Girls and 9,110 Boys) received vaccines according to the schedule of routine vaccinations. In South Darfur, a total of 9,812 children (4,577 boys & 5,235 girls) and 2,310 pregnant women, children received vaccines according to the schedule of routine vaccination starting from the first hours after birth and completed by age of 18 months (2nd dose of measles).

Plate 9i: Meeting with Kidneer medical Assistant, EJM **Plate 9h: Nutrition staff at Fiena, EJM**

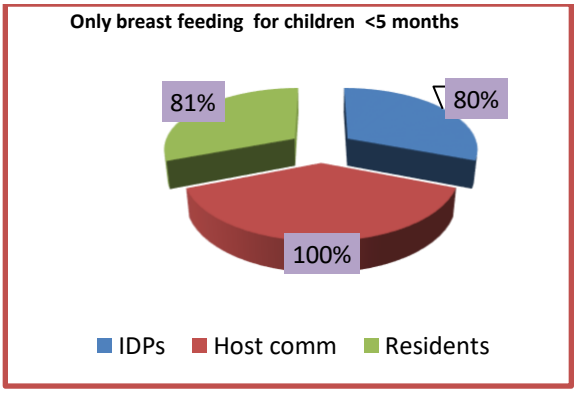
A total of 21,797 women benefitted from reproductive health, including 10,963 women who received antenatal care (ANC). There were 1,053 births with skilled birth attendants at home and in health facilities in Kass and Al-Salam. 1,065 women received postnatal care (PNC) and 392 pregnant women received standardized referral services to an appropriate secondary primary health center (PHC) . 147 women received different family planning tools. At the time of evaluation, the total completed activities represents about 75% of the planned ones (Annex 5), however some of them are in progress at the time of evaluation. The delay is related to insecurity in some locations, rapid inflation, and high staff turnover, especially in East Darfur.

10.3. Nutrition program:

In the two states, the nutrition program provided considerable services to target population, through 24 nutrition centers (13 SD & 11 ED). However, at the time of visiting the Sarhan Center of East Darfur

was under construction and only the health part was operational.

Over the project duration CIS treated 3,721 children (1,884 girls and 1,837 boys) under 5 with severe malnutrition (SAM) without medical complication in targeted OTPs and also treated 4,400 children (2,400 girls and 2,000 boys) with (SAM) with medical complication in Hospital SC as curative service. The overall performance indicators were satisfactory as following; (cured 98%, defaulter 1.1% and Death 0.6%).



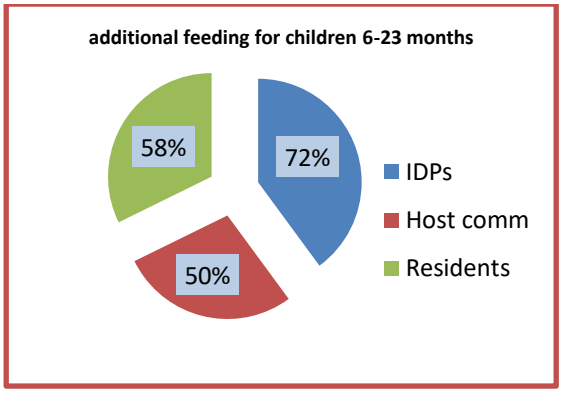


Fig. 17: Percentage of breast among different communities **Fig. 18: Percentage of children with additional feeding**

Over the project duration total of 51,445 people (31,162 Women, 9,867 Men, 4,812 Girls, and 5,604 Boys) received behavior change interventions to improve infant and young child feeding practices at the facility and community level through health Sessions. Figures. 17 & 18 indicate the level of breastfeeding and additional feeding. In addition, a total of 42,640 persons received nutrition education key messages on IYCF. In the two states, as indicated in table 19, a considerable percentage of women in IDP camps received message on child feeding.

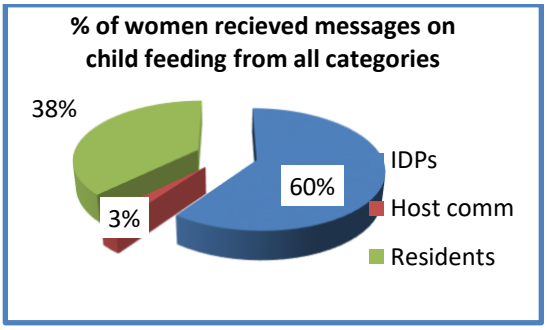


Fig. 19: Women received messages on child feeding **Plate 9k: Nutrition messages at Bkhit centers**

As indicated table 3 & 5 of annex 4, staff of SMoH along with CIS were trained to ensure quality of work. This is in addition to capacity building programs at center/village level to enhance raising of awareness and to support vulnerable people. Most important is the training of 125 midwives mostly in South Darfur State that provided essential support to women in remote areas.

Total of 1,228 individuals (female 692 & males 536) as indicated in table 5 were trained over the project duration women share is 56% over the two states. It was noticed that, women in South Darfur represented 72% of those trained, whereas trainee females in East Darfur represented only 42%. This

indicates that more efforts are needed to enhance gender representation in East Darfur States.

10.4. Multipurpose Cash assistant:

Multipurpose cash assistance is targeting the most vulnerable communities especially women-headed HHs and elders during the food gap period from August to October over two successive years. According to initial plan the target is 15,500 persons in South Darfur (Jebel Mara area), (Y1: 4,000 and Y2: 11,500). The CIS distribution plan is summarized in the following table:

Table 6: Total MPCA beneficiaries in JMA and status at the time of evaluation:

No	Location	Beneficiaries	Status
1	Gorlanbange	6,000	2,000 received their allocated funds
2	Jabra	1,000	Vendors identified and verification in progress
3	Kidneer	1,000	Vendors identified and verification in progress
4	Fiena	3,000	Vendors identified and verification in progress
		11,000	

The project beneficiaries indicated above represent about 71% of planned target of 15,500 persons. However, the CIS project distributed Cash to 1998 individuals in SJM Jabal Marra (Gorlombang cluster). The individuals received 36 USD for three months (each month $12) as a first round, the distribution was conducted through a cash facilitator. Overall, 359 HHs have benefitted from MPCA.

CARE also conducted a market assessment in Gabara, Kedineer, Feina and Gorlombang, to identify potential small business and IGAs opportunities, to seek local vendors or suppliers with financial capacity to enhance cash distribution through voucher for selected beneficiaries. The team also assessed nonfood and food items available in the markets to identify commodities prices and evaluated what types of businesses exist and which can be successful if supported.

However, at the time of evaluation two vendors at each location were identified, the distribution plan is in place and verification process is ongoing. The evaluation team conducted a meeting with MPCA beneficiaries of Kidneer as indicated in plate 9l. The evaluation team concluded that, they are meeting the basic requirements and selection was done in consultation with community leaders and sheikhs.

The evaluation team observed that, excluding MEAL Officers, state level staff is not getting the essential technical support on thenational level. Additionally, it is not clear in CIS system who responsible for implementation of integrated project strategies. This was observed in East Darfur, only hygiene promotion activities were implemented in a project location of no water supply such as case of Korina in Edien locality. The CIS program management meets monthly, but the evaluation team observed a lack of regular quarterly, midyear and annual review meetings on the national level to review progress against plans and to address challenges. Such types of meetings are very effective in addressing challenges at early stage to avoid delays and related problems.

11. Monitoring, Reporting and Documentation of the Project:

The evaluation team checked the monitoring within CIS system and how well has the internal monitoring system of CARE contributed to the evaluation and to ongoing program implementation. The evaluation team cross checked the monitoring system in terms of MEAL, reporting, regular planning/review meetings with partners, supply management, quality of reports, field trips and the filing and documentation of the whole process.

It was found that, the MEAL system is operational as one of the monitoring systems within CIS. The direct link between the State and national level was observed in terms of reporting and sharing of action points for further follow up. The evaluation team observed that, MEAL system has some tools and techniques to support the

process through establishment of; digital system of data collection using KOBO software; establishment of feedback and Accountability Mechanisms (FAM) at community level that included phone hot lines and feedback boxes – plate 9x - for communities to express their views. There are also focus group discussions and meetings supervised by MEAL field officers to hear community voice in addition to direct complaint. All these compiled at the field in feedback and complaint database sent to Khartoum. Feedback boxes were observed at all visited locations.

It was concluded from the interview and discussion with field MEAL officers, that sending regular reports to program and Khartoum on regular basis but delay of implementation plans was also observed across BHA project planned activities. CARE International has regular and ad hock meetings as required at the field level to review grants and implementation plans and to ensure that project activities will be completed within the planned timeframe. At national level, CIS has regular monthly meetings to review plans, constraints, and address challenges with the field offices. Moreover, CARE International closely supervised and monitored the project inputs, activities, outputs, and possible results.

Plate 9X: Complaint box at Kidneer Village

The consultation with communities and local partners and cross checking of available documents in the field and with CARE International at state level indicate that, local implementing partners at the state level provide regular reports to CIS on achieved activities which in turn are compiled by CARE International staff. At the State level the offices conducted monthly and quarterly grants and sector meetings. Sectors provided six months reports over the project duration without clear recommendations.

All partners including, UNICEF, SMoH, WES, local partners confirmed that, CARE International is active partner in WASH, health and nutrition and have been attending sector coordination meetings and providing updates and project progress and sharing achievements on regular basis.

CARE International in Sudan procurement process is established according to CARE policy and the supplier providing these inputs directly to the office and payment is against a receipt. Release of drugs from State to health facilities has been generally following the same system. In some sites in South Darfur supplies were sent with only one document to the field to be signed and sent back to CARE office, which is not in line with CIS supply system. The evaluation team noticed that the process of monitoring is inbuilt in CIS system and supported project implementation and also supported and facilitated the whole process to achieve 75% of the planned activities. Some activities were not completed at the time of evaluation, apparently because MEAL recommendations were not considered.

MEAL section provided useful documents to evaluation team however, CARE Sudan has limited documentation of events such as review meetings, and joint partners meetings, performance reports along with poor document keeping and filing systems coupled with quality of field trips reports has affected the monitoring system as well as the evaluation process. The evaluation team also observed that, the electronic archiving system is not very effective and considerable efforts are needed to ensure proper data management and access to electronic data should be managed and controlled. However, generally despite the efforts of CIS to improve performance, considerable delays were observed by the evaluation team across the project activities which

may be related to more than one reason. Capacity building of CIS staff in monitoring and reporting along with documentation and archiving is the most important areas for improvement.

12. Partnership, coordination, and perspectives of partners on project results:

Care International Sudan at State level has contributed to coordination of WASH, health, and nutrition services with partners. According to CIS, they conducted partners' capacity assessment and based on that, they selected four NNGOs that included SADO, SHOA, JMCO and NAHA. Stakeholders highlighted that CARE International has been coordinating with all partners as required in the two states. CARE International succeeded in building networks and establishing good relationships with several local authorities, UN agencies, INGOs and community in the project target areas, which contributed to the efficient implementation of the interventions.

They confirmed that CARE International is very active partner in these sectors. CARE International built good partnership with communities in all locations resulted in community contribution and participation in provision of services. CARE International is well recognized among partners and at the community level for their effective coordination, especially at the implementation level, which contribute to increase the geographic expansion of limited WASH, health and nutrition partners and maximized use of available resources. CARE International Sudan has very high profile among WASH, health and nutrition partners and stakeholders in South & East Darfur States. These were concluded from interviews conducted with different project partners and stakeholders and from various focus group discussions with communities.

13. Advocacy and Visibility

The consultants conducted wide consultations and series of meetings at different levels and categories and found that, all interviewees at state level were aware of and highly appreciated CARE International contribution and support. Most people met during FGD and KII at the community level, which included Sheikhs, women, community mobilizers, health and nutrition staff at village facilities and centers along with community leaders in addition to WUCs, VCs, hygiene promoters and public health committee members. All of them were aware of CARE International's contribution and support, especially for women.

Plate 12a: Visibility on signboard for H & N in Bakhit.

Plate 12e: Signboard fixed on latrine at Fien health center

Throughout the site visits the evaluation team observed that signboards displaying BHA and CIS logos along with local partners' logos were fixed close to constructed facilities. The evaluation team also observed the hygiene and health message with drawings printed on signboards and on the health facilities walls e.g. Bakhit, Kidneer, Surhan. Generally CIS is well recognized at community level in areas of intervention and highly appreciated by the government in the two state for effective contribution and support.

14. Constraints encountered during evaluation:

- The rainy season and accessibility to some areas increased the duration of the data collection and reduced selection options and as consequence affected the evaluation plan.

- Limited documentation and lack of accumulative and regular updated performance reports affected evaluation process and it took long time to track information and related data. Most of the data was provided verbally or from the field survey.
- IDPs approach of minimizing the level of available or provided services was observed during FGD, KII and general meeting. This is apparently to get more support. This approach consumed considerable time to penetrate to reality on the ground.

15. Lessons Learnt:

1. Integration and synergy of services in specific project sites is essential to make difference for the project beneficiaries. Such as provisions such as f water supply, medications, drugs and nutrition supplies contributed significantly to improving resilience and reducing vulnerability of the target population especially for women because they are the main water collectors in general and the main child caretakers.
2. Project design and identification of priorities of the rural population was in line with the local community interest and addressed their needs. This coupled with relevant project activities, technology adopted and outputs, this facilitated community engagement, operation and maintenance of facilities, and easy takeover as well as project implementation such as the case of Tuktuk in East Darfur and all health and nutrition centers operation system.
3. Effective coordination and collaboration with sector partners especially UNICEF, WHO, WFP and local communities, INGOs and government institutions maximized use of resources, especially drugs and nutrition supplies, WASH services and enhance geographic expansion and as a result reduced vulnerability and improved community resilience of a considerable number of people at project sites.
4. The high level and genuine participation of the local communities in the project activity along with high level of appreciation is attributed to the fact that the selected activities and outputs are a real reflection of the urgent and actual needs of local communities in the project area.
5. Local communities can be mobilized and sensitized to adopt interventions if scientific approaches are deployed at project planning and implementation phases to encourage community participation and when the project outputs are a real reflection to the needs of local communities in the project area. So far, the community-based institutions such as the traditional leaders, Health Committees, WUCs and VCs have substantial roles to play in the process of mobilization and sensitization of local communities.
6. CIS exit strategy from services provision will be very effective and achievable if it is part of sector exit strategy. CIS is to encourage sectors to prepare strategic direction for handover of facilities to the government institutions and communities.
7. High staff turnover and lack of institutional memory affected project implementation and work quality. Availability of technical experts and close follow up from national level with field staff will better facilitate project implementation and will enhance work quality.
8. Conducting evaluation during the rainy seasons and poor documentation of events and meetings and lack of proper filing system impacted the evaluation process.

16. Conclusions and recommendations for future projects:

1. Provision of integrated services approach is very effective with direct impact and provides support to vulnerable communities and indirectly supporting their livelihoods by providing WASH, health and nutrition service for the target communities. The CIS approach of integrated services has impact, reduced vulnerability and improved community resilience.

2. Despite difficulties related to long dependency on relief, the organization succeeded to build the capacity of these communities and supported them along with the local partners. CIS succeeded in construction of facilities and handing them to the local community. This has enhanced sustainability and CIS is recommended to follow the same procedure in the future.
3. In Jebel Marra Area and specifically in SLA controlled areas, movement is very restricted and there are no vehicles for transportation. People are relying on animals and walking long distances to support pregnant women or a sick person. CARE International provided comprehensive package of services and series of trainings addressing different categories and community groups and layers e.g. training of midwives, health and nutrition staff etc. Although the project provided essential support to those communities in these remote areas such as in Gorlanbange and Fiena, saving energy, time and reducing their vulnerability while enhancing their resilience. Although most beneficiaries are pleased and satisfied with the performance ofthe project, still many of them are vulnerable and they don't have access to services. They are hoping to scale up the interventions and to increasethe number of the beneficiaries and for an expansion of the geographic area.
4. Improving the overall CIS reporting and documentation system will help CIS in quick response and maintaining CIS good tracking of performance and roles in the different sectors. Despite that CIS conducting regular monitoring of supplies at all levels, Intensive monitoring of supplies at the end user stage and at health and nutrition facilities levels after handover of drugs and other inputs to the Medical Assistant and related staff, this is especially essential to minimize leakage of these supplies to the local markets.
5. The evaluation team observed that, CARE International field offices in South and East Darfur have WASH, health, and nutrition staff of considerable knowledge, responsible for both implementation and documentation of the projects. This core team needs to improve knowledge on reporting and documentation of events and filing for easy access to the data and for knowledge management. Additionally, this team and local implementing partners staff requires capacity building especially around result-based monitoring, results-based management and monitoring for effectiveness, in addition to technical trainings.
6. BHA and CIS integrated project provided essential support to most vulnerable groups, and it is recognized by community and sector partners, especially in the area of health and nutrition. The support to nutrition Stabilization Centers (EC) is highly recognized and appreciated by SMoH due their significant contribution in management of complicated malnutrition cases which resulted in improving children status, reduced travel distances and economized resources of the most vulnerable communities not only in the project implementation sites but all over the state.
7. The evaluation team observed that, most of the project services especially health and nutrition either target mothers or their children in addition to that, all established committees such as Hygiene Promotion Groups, Water User Committee, Mother Support Groups, and Public Health Committees. In all these committees despite community conservations, representation of both women and men was considered. So far, gender was considered in the project design and in implementation, whereby both men and women were participated in trainings and project activities, because of this, in some location's women managing their own business and resources like the case of MSG and midwives.
8. CARE International project objectives were largely met, and the planned activities are 75% completed with the rest in progress. The project reduced the secondary effect of COVID–19 which contributed to reduction of vulnerability and improving resilience of beneficiaries in the target locations. This mainly related to proper design of project activities, high community interest in the project activities and outputs because it is relevant to their needs and requirements.

9. CIS has no programs experts at the national and adopting decentralization policy that maximizing use of technical experts at the field level. The limited follow up from national level affected project implementation and follow up including groundwater monitoring, construction, and rehabilitation of water supply systems, and Completion of trainings at early stages to support implementation. Other factors that affected the project's implementation long rainy seasons that reduced the project duration, high inflation rates, high staff turnover, and restricted movement in SLA. Proper planning, early preparation, regular review meetings along with implementation of MEAL recommendations are crucial to ensure timely implementation of activities to enhance reliability and quality of products. It is highly recommended to consider these factors to support management of emerging risks during implementation.
10. Most of the people met during interviews, (FGD, KII and meetings at the community level) included men, pregnant and lactating women, WUCs, Public health committees and community leaders, individuals at the water points, and partners t at state level, are all aware of CIS project contribution and services. The evaluation team also observed that signboards and drawings displaying BHA and CIS logos were placed/closed to all upgraded water facilities, health and nutrition supported facilities and Center and visible for all visitors.
11. The project contributed significantly to penetrate these conservative communities and enhanced womens' role within their societies using different modalities that were accepted by the local communities such as training of villagers on sensitive issues like gender based violence and discussing of roles and responsibilities of women and men, early marriage in addition to contribution of women in decision making at village based committees.

17. Annexes:

Annex 1: Indicators and means of data collection:

Sector I	**WASH**	
Objective	Provision of sustainable, adequate, and lifesaving WASH services to crisis-affected and vulnerable host community members and IDPs in East and South Darfur	
Sub-sector Name	**Water Supply**	
Indicator 1 (OFDA)	Number of people directly utilizing improved water services provided with OFDA funding	330,441 persons (67,404 women, 64761 men, 101,106 girls & 97,140
Indicator 2 (OFDA)	Percentage of water points that are clean and protected from contamination	100%
Indicator 3 (OFDA)	Average liters/person/day collected from all sources for drinking, cooking, and hygiene	16 l/c/d
Indicator 4 (OFDA)	Percent of water user committees created and/or trained by the WASH program that are active at least three (3) months after training	80%
Indicator 5 (OFDA)	Total USD value of vouchers redeemed by beneficiaries	USD 37,227
Sub-sector Name	**Sanitation**	
Indicator 1 (OFDA)	Number of people directly utilizing improved sanitation services provided with OFDA funding	6,762 persons
Indicator 2 (OFDA)	Percent of households targeted by latrine construction/promotion program whose latrines are completed and clean	50%
Indicator 3 (OFDA)	Proportion of men, women, boys and girls who last defecated in a toilet (or whose feces was last disposed of in a safe manner)	87%
Indicator 4 (OFDA)	Percent of excreta disposal facilities built or rehabilitated in health facilities that are clean and functional	100%
Sub-sector Name	**Environmental Health**	
Indicator 1 (OFDA)	Number of people receiving improved service quality from solid waste management, drainage, or vector control activities (without double-counting)	287,564 persons (58,663 women, 56,362 men, 87,995 girls and 84,544 boys)
Indicator 2 (OFDA)	Average number of community cleanup/debris removal activities conducted per community targeted by the environmental health program	12
Indicator 3 (OFDA)	Percent of households targeted by the WASH promotion program that are properly disposing of solid waste	81%
Sub-sector Name	**Hygiene promotion**	
Indicator 1 (OFDA)	Number of people receiving direct hygiene promotion (excluding mass media campaigns and without double-counting)	287,564 people were benefitted (58,663 women, 56,362 men, 87,995 grills and 84,544 boys).
Indicator 2 (OFDA)	Percent of people targeted by the hygiene promotion program who know at least three (3) of the five (5) critical times to wash hands	62%

Indicator 3 (OFDA)	Percent of households targeted by the hygiene promotion program with no evidence of feces in the living area	81%

Sector II	***Health***	
Objective	***Provision of integrated and high-quality primary and reproductive healthcare services to the targeted crisis-affected and vulnerable host community members and IDPs in East and South Darfur***	**Means of data collection**
Sub-sector Name	**Health Systems and Clinical Support**	
Indicator 1 (OFDA)	Number of health facilities supported	24
Indicator 2 (OFDA)	Percentage of total weekly surveillance reports submitted on time by health facilities	88%
Indicator 3 (OFDA)	Number of outpatient consultations	153,241 CASES (male 71,051& Females 82,190)
Indicator 4 (OFDA)	Number of health facilities rehabilitated	23
Indicator 5 (OFDA)	Number of health care staff trained	1,134 persons over the two States
Sub-sector Name	**Communicable Diseases**	**Means of data collection**
Indicator 1 (OFDA)	Number of communicable disease consultations	134,417 persons (32,260 women, 24,195 men, 51,079 girls & 26,883 boys)
Indicator 2 (OFDA)	Case fatality rates for communicable diseases	Estimation of fatality rate is depending upon No. of admitted cases which is available at the HF and the No. of death cases not available at the HF.
Sub-sector Name	**Reproductive Health**	**Means of data collection**
Indicator 1 (OFDA)	Number and percentage of pregnant women who have attended at least two comprehensive antenatal clinics	2,575 women , 85%
Indicator 2 (OFDA)	Number and percentage of newborns that received postnatal care within three days delivery	779 children, 29%
Indicator 3 (OFDA)	Number and percentage of births assisted by a skilled attendant at birth	254 births, 68%

Indicator 4 (OFDA)	Number and percentage of pregnant women in their third trimester who received a clean delivery kit	946 women, CDK 163 and the rate is 17%.
Sub-sector Name	**Community Health**	**Means of data collection**
Indicator 1 (OFDA)	Number of Community Health Workers (CHW) supported (total within project area and per 10,000 population)	204 person
Indicator 2 (OFDA)	Number and percentage of CHWs conducting public health surveillance	196 represents about 96% of the total
Indicator 3 (OFDA)	Number and percentage of community members who can recall target health education messages	278,937 persons (56903 men, 54671 women, 85355 Girls and 82,008 boys); (97%
Indicator 4 (Custom)	Percentage of mothers with children under-five who can identify three or more health danger signs, that need an urgent referral of the children to the nearest health facility	54%
Sub-sector Name	**Pharmaceuticals and Other Medical Commodities**	**Means of data collection**
Indicator 1:	Number of people trained in medical commodity supply chain management	61 persons (26 females & 35 males)
Indicator 2:	Number of health facilities out of stock of any medical commodity tracer products, for longer than one week, 7 consecutive days.	0

Sector III	**Nutrition**	**Means of data collection**
Objective	Provision of integrated and high-quality curative and preventative nutrition services to vulnerable and malnourished U5 children and pregnant and lactating women in East and South Darfur	
Sub-sector Name	**Infant and Young Child Feeding in Emergencies**	
Indicator 1 (OFDA)	Proportion of infants 0-5 months of age who are fed exclusively with breast milk	81%
Indicator 2 (OFDA)	Proportion of children 6-23 months of age who receive foods from 4 or more food groups	25%
Indicator 3 (OFDA)	Number of people receiving behavior change interventions to improve infant and young child feeding practices	42,640
Sub-sector Name	**Management of Acute Malnutrition**	
Indicator 1 (OFDA)	Number of health care staff trained in the prevention and management of acute malnutrition	494 staff was trained as in details 182 + 198 MSGs + 114 nutrition assistants
Indicator 2 (OFDA)	Number of supported sites managing acute malnutrition	23 centers

Indicator 3 (OFDA)	Number of people admitted, rates of recovery, default, death, relapse, and average length of stay for people admitted to Management of Acute Malnutrition sites	Total entries 17,876 U5 cure 97.8%; death 0.5% defaulters 1.4%; 0.3% Average length of stay 7 days
Indicator 4 (OFDA)	Number of Management of Acute Malnutrition sites rehabilitated	23 sites
Indicator 5 (OFDA)	Number of people screened for malnutrition by community outreach workers	117,563 individual

Sector IV	**Multipurpose Cash Assistance**	**Means of data collection**
Objective	Provision of multipurpose cash assistance (MPCA) to the most vulnerable community members that are affected by the protracted conflict in Jebel Mara area and enable them to meet their variety of needs rapidly with dignity	
Sub-sector Name	**Multipurpose Cash**	
Indicator 1 (OFDA)	Total number of people assisted through multipurpose cash activities	11,000 persons
Indicator 2 (OFDA)	Percentage of households who report being able to meet the basic needs of their households (all/most/some/none), according to their priorities	Market survey completed, vendors selected, Verification completed, distribution plan is in place and distribution work is in progress at all sites at the time of evaluation
Indicator 3 (OFDA)	Percentage of beneficiaries reporting that humanitarian assistance is delivered in a safe, accessible, accountable, and participatory manner	Market survey completed, vendors selected, Verification completed, distribution plan is in place and distribution work is in progress at all sites at the time of evaluation
Indicator 4 (OFDA)	Percentage of households reporting adequate access to household non-food items	Market survey completed, vendors selected, Verification completed, distribution plan is in place and distribution work is in progress at all sites at the time of evaluation
Indicator 5 (OFDA)	Percentage of households who have reduced essential WASH related basic needs expenditures	Market survey completed, vendors selected, Verification completed, distribution plan is in place and distribution work is in progress at all sites at the time of evaluation
Indicator 6 (OFDA)	Percentage of households using an unsafe water source because they cannot afford to use a safer water source	Market survey completed, vendors selected, Verification completed, distribution plan is in place and distribution work is in progress at all sites at the time of evaluation
Indicator 7 (Custom)	Total USD amount of cash transferred to beneficiaries	Market survey completed, vendors selected, Verification completed, distribution plan is in place and distribution work is in progress at all sites at the time of evaluation

1. List of figures

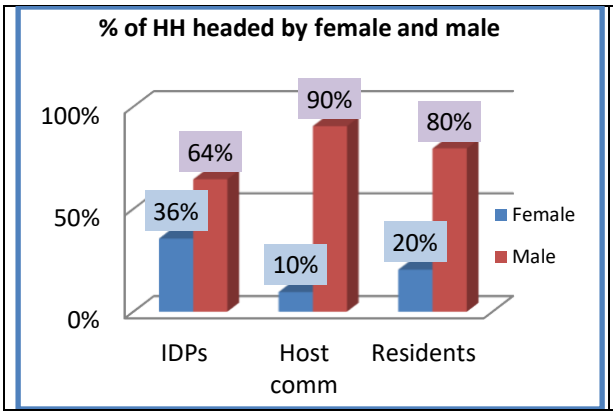


Fig. 1: Percentage of HH heads.

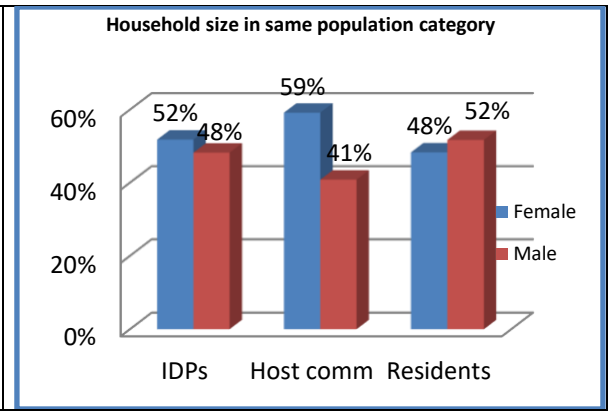


Fig. 2: Percentage of male to female

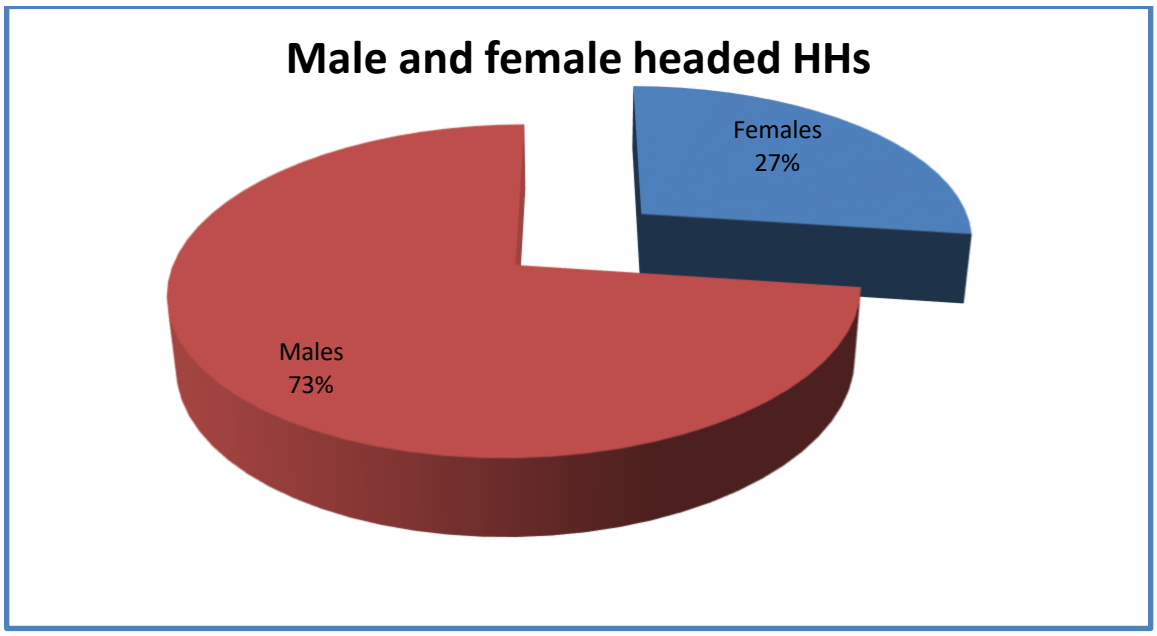


Fig. 3: Percentage male to females headed HHs in the project area

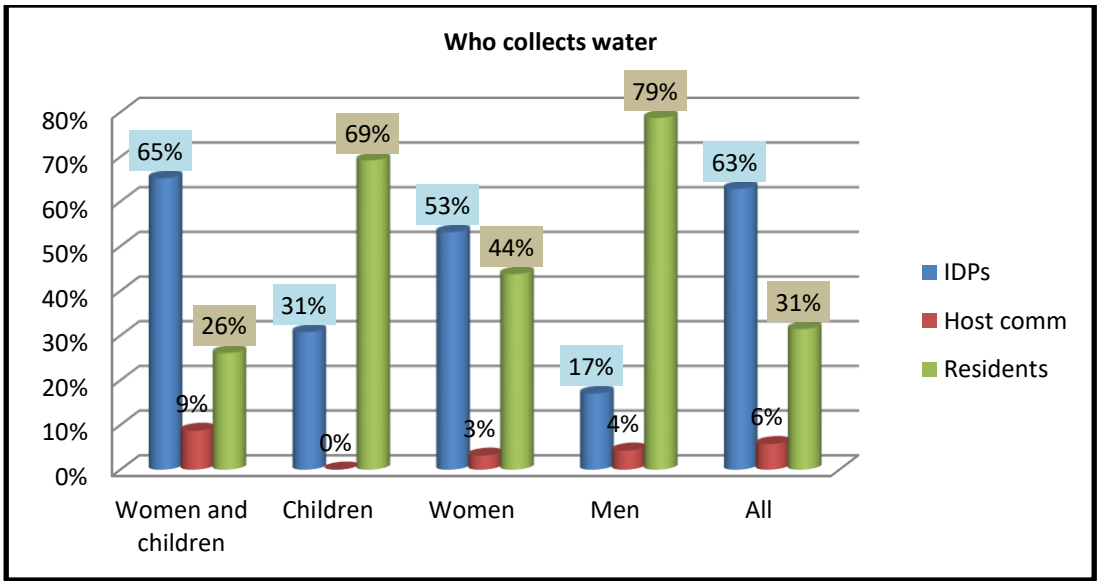


Fig. 5: who is collecting water from water sources?

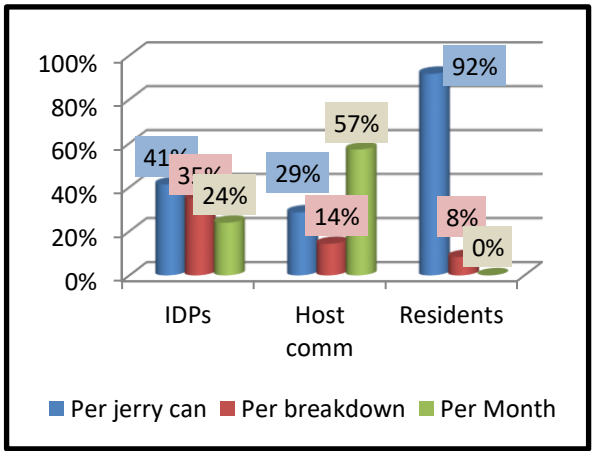


Fig. 6: Payment modality

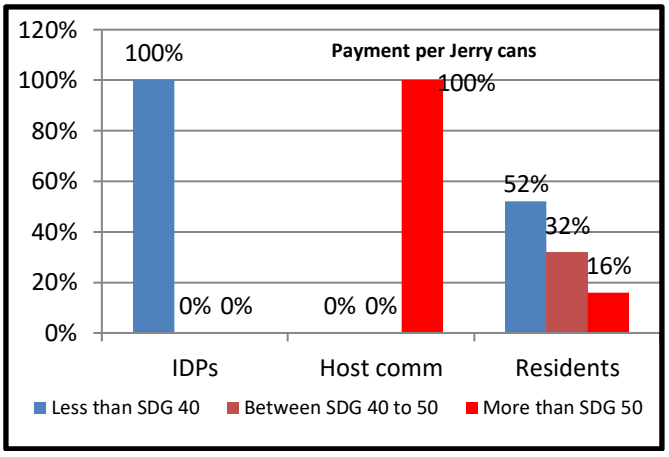


Fig. 7: Cost per jerry can of 20 liters

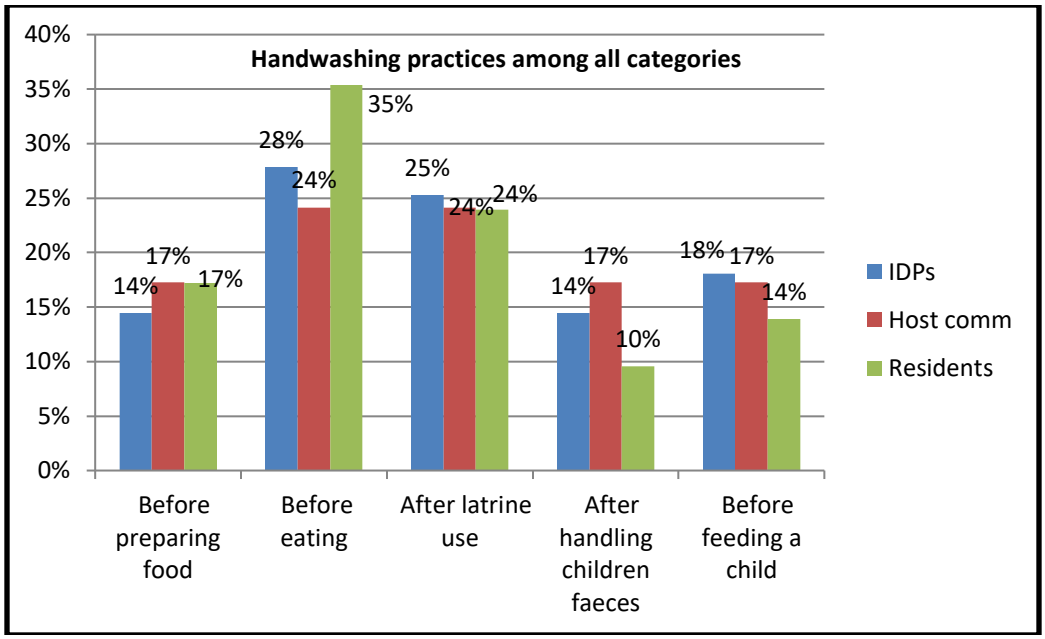


Fig. 8: Hand washing among different communities

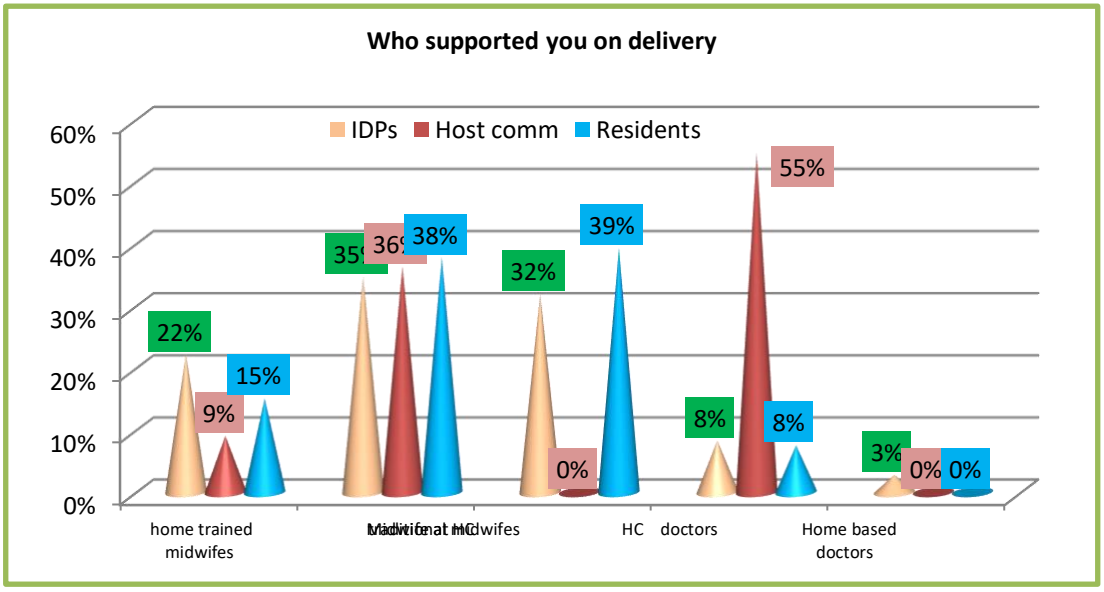


Fig. 9: Percentage of delivery as per HH survey

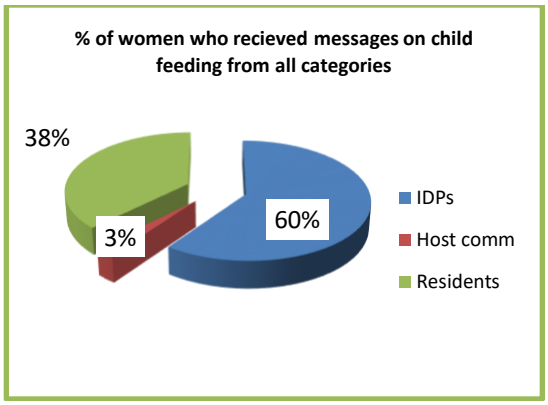


Fig. 10: Women received messages on breast feeding food

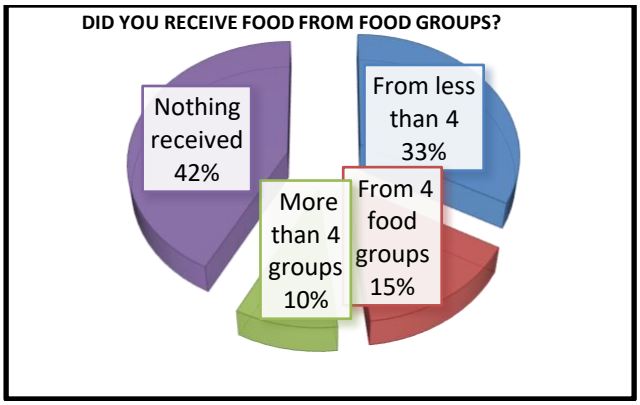


Fig. 11: Children of age less than 23 months who received

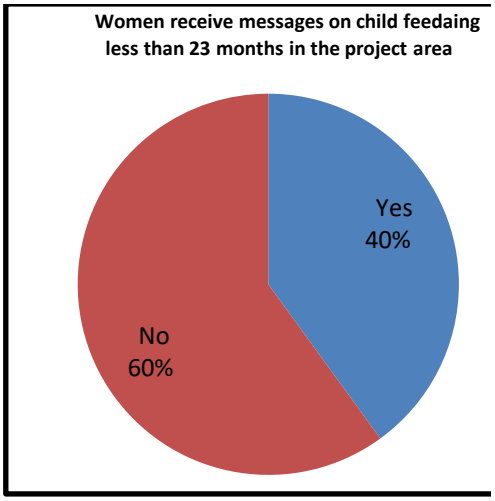


Fig. 12: Women received child feeding messages in project area

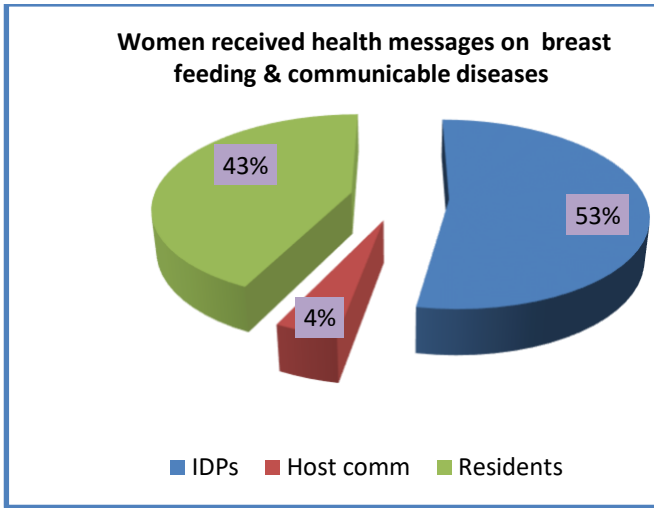


Fig. 12: Percentage of women received message on breast feeding

2. List of plates:

Plate 3a: Orientation session with enumerators in Kass on the assessment tools and review of questionnaire

Plate 5a: Rehabilitated latrine in Kass

Plate 5b: Constructed latrine at Elsalam

Plate 5J: Tuktuk to support O & M in ED

Plate 5k: Signboard at Fiena HC in SLA EJM area

Plate 5l Interview Medical Logistic, Edien

Plate 5m: Meeting with CIS partners, SADO at Edien

Plate 5u: FGD with CHW at Kidneer H & N facilitiy

Plate 5r : Fiena Community leaders and commanders

Plate 9c: Jabra WY under construction

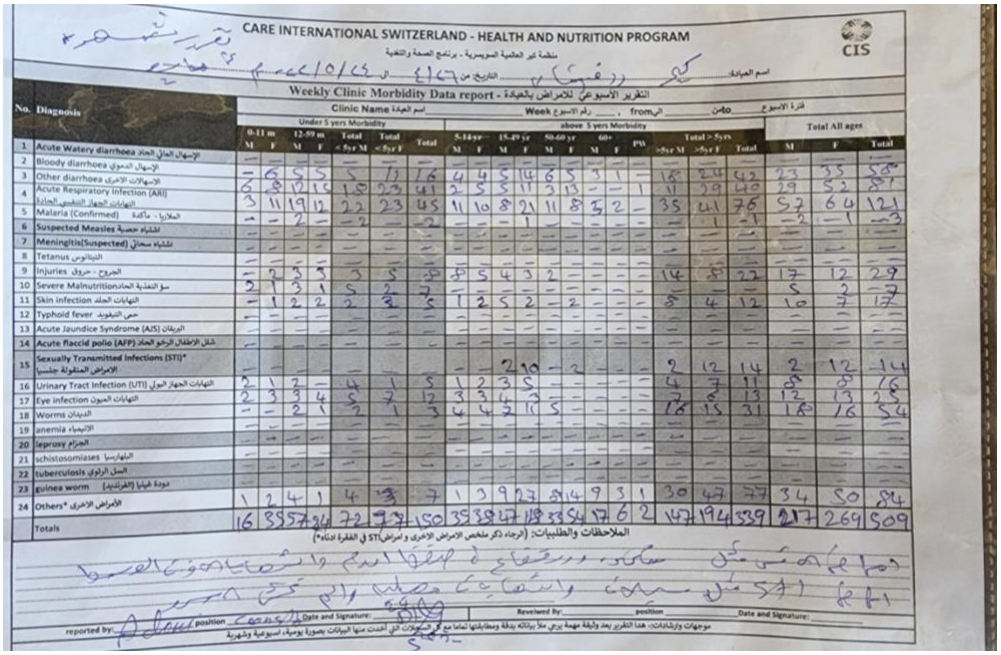
Plate 9d: Fiena rehabilitated WY

Plate 9e: Males and females latrines constructed at Fiena H & N center.

Plate 9l: Meeting with MPCA beneficiaries at Kidneer.

Plate 9j: Surhan health and nutrition centers, under construction

Plate 5y: FGD with community leaders at Elsalam IDP camp



CARE INTERNATIONAL SWITZERLAND - HEALTH AND NUTRITION PROGRAM

CIS

Weekly Clinic Morbidity Data report - التقرير الأسبوعي للامراض بالعيادة

Clinic Name اسم العيادة ... Week رقم الاسبوع ... from ... to ... فترة الاسبوع

No.	Diagnosis	Under 5 yers Morbidity						above 5 yers Morbidity										Total All ages		
		0-11 m M	0-11 m F	12-59 m M	12-59 m F	Total <5yr M	Total <5yr F	Total	5-14 yr M	5-14 yr F	15-49 yr M	15-49 yr F	50-60 yr M	50-60 yr F	60+ M	60+ F	PW	Total >5yr M	Total >5yr F	Total	M	F	Total
1	Acute Watery diarrhoea الإسهال المائي الحاد	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
2	Bloody diarrhoea الإسهال الدموي	—	—	6	5	5	—	—	7	1	6	4	4	5	6	5	3	1	—	—	18	24	42
3	Other diarrhoea الإسهالات الأخرى	6	8	12	16	18	24	42	2	5	5	11	7	3	1	—	—	1	11	19	30	43	73
4	Acute Respiratory Infection (ARI) التهابات الجهاز التنفسي الحاد	3	11	19	12	22	23	45	11	10	8	21	11	8	3	2	—	35	41	76	57	64	121
5	Malaria (Confirmed) الملاريا - مأكدة	—	—	2	—	2	—	2	—	—	—	1	—	—	—	—	—	—	1	1	2	1	3
6	Suspected Measles اشتباه حصبة	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
7	Meningitis(Suspected) اشتباه سحائي	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
8	Tetanus التيتانوس	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
9	Injuries - جروح الجروح	—	—	3	3	3	3	6	5	4	3	2	—	—	—	—	—	14	8	22	17	12	29
10	Severe Malnutrition سو التغذية الحاد	3	1	3	1	5	2	7	—	—	—	—	—	—	—	—	—	—	—	—	5	2	7
11	Skin infection التهابات الجلد	—	1	2	2	2	3	5	1	2	5	2	—	2	—	—	—	8	4	12	10	7	17
12	Typhoid fever حمى التيفويد	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
13	Acute Jaundice Syndrome (AJS) اليرقان	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
14	Acute flaccid polio (AFP) شلل الأطفال الرخو الحاد	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
15	Sexually Transmitted Infections (STI)* الأمراض المنقولة جنسيا	—	—	—	—	—	—	—	—	—	2	10	—	2	—	—	—	2	12	14	2	12	14
16	Urinary Tract Infection (UTI) التهابات الجهاز البولي	2	1	2	—	4	1	5	1	2	3	5	—	—	—	—	—	4	7	11	8	8	16
17	Eye infection التهابات العيون	2	3	3	4	5	7	12	3	3	4	3	—	—	—	—	—	7	8	15	12	13	25
18	Worms الديدان	—	—	2	1	2	1	3	4	4	2	10	5	—	—	—	—	15	15	31	18	16	34
19	anemia الأنيميا	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
20	leprosy الجزام	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
21	schistosomiases البلهارسيا	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
22	tuberculosis السل الرئوي	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
23	guinea worm دودة غينيا (الفرنديد)	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
24	Others* الأمراض الأخرى	1	2	4	1	4	3	7	1	3	9	7	3	4	9	3	1	30	47	77	34	50	84
	Totals	16	8	35	24	72	71	150	35	38	47	118	33	34	17	6	2	147	194	339	217	269	509

الملاحظات والطلبيات: (الرجاء ذكر ملخص الامراض الاخرى وأعراض STI في الفقرة ادناه*)

reported by: position Date and Signature:

Reviewed By: position Date and Signature:

موجهات وارشادات: هذا التقرير يعد وثيقة مهمة يرجى ملأ بياناته بدقة ومطابقتها تماما مع كل السجلات التي أخذت منها البيانات بصورة يومية، اسبوعية وشهرية

Plate 5f: Sample of the monthly report from Fiena Health Facility

Plate 12c: Visibility signboard at Surhan H & N center

Plate 12d: Visibility signboard at Fiena H & N center

3. Annex 4: List of tables:

Table 1: Selected project sites for field visits & HH samples:

Locality	Location	WASH	Health	Nutrition	Total
South Darfur State					
Belil	Elsalam IDP Camp	29	33	25	87
Kass	Kass IDP Camp	38	40	22	100
	Kass host community	7	10	4	21
East Jebel Marra Area	Fiena	10	10	6	26
	Jabra	6	4	3	13
Total for SD		**90**	**97**	**60**	**247**
East Darfur State					
Abu Karinka	Bakhit	0	20	15	**35**
	Jad Elsied	0	18	12	**30**
Bahr Elarab	Sarhan	22	15	15	**52**
Eldien	Korina	20	0	0	**20**
	Abu Zinba	18	0	0	**18**
Total for ED		**60**	**53**	**42**	**155**
Grand total for the two States			**135**	**96**	**402**

Table 2: Physical check of facilities:

Location	Site visit and checking	Date of visit
South Darfur State		
Abu Jabra	Water point, under construction, H & N facilities rehabilitated	8/8/2022
Kidneer	H & N facilities rehabilitation, institutional latrines	8/8/2022
Fiena	Two water supply system, H & N centers & institutional latrines	9/8 to 10/8/2022
Kass IDP & Host community	Four water supply systems, two H & N facilities, Medical Store, 20 latrines.	13/8/2022
Gomaiza, Kass area	H & N facilities	14/4/2022
Kass	Medical Store	14/4/2022
Elsalam IDP camp	Health facility and 10 latrines	15/8/2022
Nyala	Medical Store	16/8/2022
East Darfur State		
Bakhit	H & N	21/8/2022
Sarhan	WASH, H & N	23/8/2022
Jad Elsied	H & N	24/8/2022
Korina & Abu Zinba	WASH	25/8/2022
Edien	Medical Store and Tuktuk	22/8/2022

Table 3: showing trainings provided through H & N programs:

Activity	SD			ED			Grand total
	Female	Male	Total	Female	Male	Total	
Training of SMoH seconded nutrition team members on CAMAM protocols	46	3	49	30	40	70	**119**
Training of public health committee members on community-based primary health care service provision.	17	54	71	79	56	135	**206**
Training of mothers, per each of the targeted OTP/TSFP facilities, on different topics	130	0	130	0	100	100	**230**
Training of men on IYCF awareness raising promote improving caregivers' practices including exclusive breastfeeding (80 men)	0	80	80	15	15	30	**110**
Training of key health service providers (CARE and SMOH staff members) on emergency preparedness, surveillance, outbreak management, COVID19, (target over achieved)	48	10	58	12	9	21	**79**
Training of village midwives (5 per facility) in the targeted areas.	90	0	90	0	35	35	**125**
Training of health cadres/health service providers on primary health care service (target over achieved)	94	13	107	48	49	97	**204**
Formation and training of village committees (VCs),one committee per facility with seven members	0	0	0	36	23	59	**59**
Gender in health and nutrition training for 69 Village Committee (VC) members	0	0	0	21	14	35	**35**
Drug management and rational use	3	9	12	23	26	49	**61**
Total for South Darfur	**428**	**169**	**597**	**264**	**367**	**631**	**1,228**

Table 4: Local and mobile enumerators of the evaluation

No	Location	Females	Males	Total
1	Kass IDP camp and host community	6	4	10
2	Elsalam IDP camp	5	6	11
3	Fiena	1	2	3
4	Jabra	1	1	2
5	East Darfur mobile team	2	2	4
Total		**15**	**15**	**30**

Table 5: WASH capacity building porgram for the two States:

No.	Activity	SD			ED			Grand total
		Female	Male	Total	Female	Male	Total	
1	Formation and training of 10 Community/SWC joint management committees 7 persons each	0	0	0	0	70	70	**70**
2	Formation and training of a circuit rider (10 members) in Ed Daein locality	0	0	0	0	20	20	**20**
3	Training of public health committee	140	140	280	41	99	140	**420**
4	Gender in WASH training for 69 Village Committee (VC) members	0	0	0	41	99	140	**140**
5	Training of 11 water user committees (9 to 11 persons,	55	44	99	0	0	0	**99**
6	Training of 11 groups of hand pump mechanics, each with 5 members in Jebel Mara areas	20	35	55	0	0	0	**55**
7	Conduct refresher training for an existing 90 community hygiene promoters	45	45	90	0	0	0	**90**
	Total for WASH in South and east Darfur	**260**	**264**	**524**	**82**	**288**	**370**	**894**

Table 6: Total MPCA beneficiaries in JMA and status at the time of evaluation:

No	Location	Beneficiaries	Status
1	Gorlanbange	6,000	2,000 received their allocated funds
2	Jabra	1,000	Vendors identified and verification in progress
3	Kidneer	1,000	Vendors identified and verification in progress
4	Fiena	3,000	Vendors identified and verification in progress
		11,000	

4. Table of achievements:

Table 1: WASH achievements in South Darfur:

No.	Activity	Target	Achieved	% achieved	Status
South Darfur State					
1	O & M of water supply facilities in IDP camps	20	19	95%	
2	Upgrading of hand pumps to mini water yards with solar & diesel-powered systems	4	2	70%	Construction is ongoing in Jabra 70% and Geghainin village 85% completed
3	Adding solar system to existing diesel-powered water supply facilities	2	1	50%	ongoing work in Hamdi IDP camp in Kass town 50% completed
4	Rehabilitation of water supply systems	3	2	66%	ongoing in Logi/SJM 80% completed
5	Adding solar system to support operation of four diesel-powered booster pumps on 3" pipeline	4	4	100%	
6	Improving water quality and ground water monitoring of the targeted motorized wells	12	?	?	started but not operational the time of evaluation
7	Purchasing Oxfam tank liner (with repair kit)	4	4	100%	
8	Routine 35 hand pump repairs	35	32	91%	
9	Alsalam and Gereida IDP camps voucher based water distribution system per HH	8731	8731	70%	3675 ongoing in Alsalam at the time of visit.
10	Multipurpose Cash distribution (MPCD) in Jabal Mara	11,000	1998	11%	Delays due to security reasons and change in payment modality
11	Rehabilitation of 45 hand pumps in Jebel Mara area	45	40	90%	
12	Training of 11 water user committees (9 to 11 persons,	11	11	100%	
13	Training of 11 groups of hand pump mechanics, each with 5 members in Jebel Mara areas	11	11	100%	
14	Construction of 1,200 household latrines in (year 1: 500 and year 2: 700)	1200	1127	94%	200 latrines were changed to rehabilitation.
15	Provide 6 blocks of gender-segregated VIP latrines	6	6	100%	Construction at health and nutrition centers
16	Conduct refresher training for an existing 90 community hygiene promoters	90	90	100%	
17	Training of 280 public health committee members (14 committee X 20 members)	280	280	100%	
18	Conduct 320 hygiene promotion and cleaning campaigns, refreshment costs for the 280 public health committee	320	200	63%	
19	Purchase cleaning tools for cleaning campaigns	400	400	100%	
20	Gender in WASH training	40	40	100%	

Table 2: WASH achievements in East Darfur:

East Darfur State					
1	**Activity**	**Target**	**Achieved**	**% achieved**	**Remarks**
2	Provision of motorized water yards spare parts for Bahr al Arab and Ed Daein localities	2	2	100%	Completed
3	Formation and training of 10 management committees 7 persons each, in Bahr al Arab and Ed Daein localities	10	10	100%	Completed
4	Formation and training of a circuit rider (10 members) in Ed Daein locality	10	20	200%	Completed
5	Provision of essential tools, kits, and Tuktuks to the circuit riders in Ed Daein locality and Bahr Alarab localities	2	2	100%	Completed
6	Conduct monthly ground water monitoring in Bahr al Arab and Ed Daein localities targeting 15 boreholes	15	4	27%	Started through manual measurements in pumped wells.
7	Training of 140 public health committee members (7 committee X 20 members)	140	140	100%	Completed
8	Conduct 280 hygiene promotion and cleaning campaigns	280	280	100%	Completed
9	Gender in WASH training for 69 Village Committee (VC) members	69	100	145%	Exceeded the target

Table 3: Detailed H & N achievements:

Act #	Activity (as per Logframe / Narrative)	Target	Achieved	% achieved	Remarks
	South Darfur State				
1	Training of 49 SMoH seconded nutrition team members on CAMAM protocols.	49	49	100%	(3 male, 46 female) This was basic training in addition to many on job training and refresher training
2	Provide supplementary allowance to 49 SMoH seconded nutrition team members, 34 at the OTP/TSFP sites and 15 at the SC,	49	49	100%	(3 male, 46 female)
3	Minor maintenance of 13 OTP/TSFP sites	13	13	100%	
4	Furnishing and consumable supplies for 13 OTP/TSFP	13	13	100%	
5	Routine MUAC screening campaigns (water & biscuits for kids)	4	4	100%	Conducted by NAHA the national partner
6	Support operations and maintenance of generator and fuel	3	3	100%	
7	Blankets and bed sheets	800	325	41%	
8	Fresh food for care takers at the center	40	577	1443%	
9	Routine operation and maintenance costs (plumbing, cleaning, etc.)	1	1	100%	
10	Training of 39 men on IYCF awareness raising including exclusive breastfeeding	39	80	205%	
11	Conduct 260 IYCF awareness raising discussions/campaigns and household visits, targeting men,	260	192	74%	192 session + 2 campaigns
12	Training of 130 mothers, 10 mothers per each of the targeted OTP/TSFP facilities.	130	217	167%	
13	Provide monthly incentives to 130 mother support group leaders	130	130	100%	
14	Rehabilitation of 14 health facilities.	14	14	100%	
15	Furnishing and consumable supplies for 14 health facilities (chair, table, cupboard …	14	14	100%	
16	Stationary support for 14 health facilities including medical and non-medical stationery (register, books,	14	14	100%	
17	Referral support of reproductive cases from rural area to secondary level treatment centers (Nyala and Kass hospitals),	300	125	42%	(16 male , 109 female) CARE supported the referral of complicated cases to the secondary Primary Health Care level.
18	Provide curative and preventative outpatient consultations for 14 health facilities	14	14	100%	
19	Fuel for Camp based PHC generators and Ambulance	3	3	100%	Fuel to operate the ambulance and generators of Kass Kabeer, Alkifah and Alsalam IDPs camp HFs.
20	Training of 42 key health staff from CIS and SMOH staff on emergency preparedness, surveillance, COVID19 ….	42	58	138%	(10 male, 48 female) CARE trained 58 health staff from all supported health facilities
21	Training of 103 health cadres/health on primary health care service including mother health, SGBV, etc	103	107	104%	CARE trained 107 (13 male, 94 female) health staff from all supported health facilities.

22	Train 280 public health committee members (14 committee X 20 members) on community-based primary health care service	280	71	25%	Trained committees trained from Kass IDPs, Kass rural areas, EJM. 71 (54 male, 17 female)
23	Provide monthly incentives to 280 Public Health Committees members	280	212	76%	Payment for 14 committees and their volunteers 212 ((64 male, 148 female) from Kass IDPs, Kass rural and EJM areas
24	Formation and training of 14 village committees (VCs), one committee per facility of seven members.	14	14	100%	CARE and its partner NAHA established and trained 14 village committees from Kass IDPs, Kass rural areas
25	Support EPI activities in the targeted areas, including community mobilization for vaccination campaigns and snacks	6	6	100%	CARE supported SMOH to implemet immunization campaigns in Kass rural areas and East Jabal Marra.
26	Emergency supplies for outbreak preparedness and control	2	2	100%	
27	IEC/BCC materials for health education/promotion on malaria and self-referral, STI/HIV prevention, etc	100		0%	This activity is under CARE partner in the pipeline
28	Provision of water for14 health facilities	14	14	100%	
29	Training of 70 village midwives (5 per facility) in the targeted areas of South Darfur,	70	90	129%	This activity is under CARE partner, NAHA has trained 90 village midwives
30	Provide monthly incentives to 70 village midwives, members, 5 per each of the targeted health facilities,	70	14	20%	The rest will be in kind incentive, now under procurement, will be distributed in Aug-22
31	Set up a quarterly community consultation meetings to review the action and address challenges	8	8	100%	
32	Gender in health and nutrition training for 138 Village Committee (VC) members	130		0%	Planned in the pipeline
33	Seconded SD MoH Staff Vehicle rental for nutrition feeding centers	4	4	100%	
34	Transportation of Nutrition goods from Nyala to field sites (E&SD)	14	14	100%	
35	Transportation of Health supplies from Nyala to Kass and Alsalam	8	8	100%	
36	Emergency repair and spare part for PHC generators	3	3	100%	
37	Maintenance of ambulance – SD	1	1	100%	
38	Vehicle rental for MoH staffs in Kass and Alsalam	2	2	100%	
39	Visibility Costs	1	1	100%	
40	Local Partner Cost	1	1	100%	
East Darfur State					
1	Train 52 SMoH seconded nutrition team members on CAMAM protocols for 5 days	52	70	135%	26 trained in year one and 44 trained in Year 2, it over due to increase the target of year two and budget availability
2	incentives to 52 SMoH seconded nutrition team members, 32 at the OTP/TSFP sites and 20 at the SC	52	52	100%	monthly incentive Seconded staff

3	Minor maintenance of 10 OTP/TSFP sites including fixing broken windows and doors	10	10	100%	5 clinic was rehabilitated in Year 1 and 5 clinic rehabs in year 2
4	Furnishing and consumable supplies for 10 OTP/TSFP sites (chair, table, cupboard,	10	10	100%	Furnisher and equipment provided to 11 nutrition unit including SC during 2 years
5	Routine MUAC screening campaigns (water & biscuits for kids)	2	17	850%	17 campaign conducted, the number increase due to conduct the activity on monthly bass
6	Blankets and bed sheets (600 cases*$10)	600	560	93%	Purchasing of 400 in Year 1 and 160 in Year 2, it is less than target due to inflation in year two
7	Fresh food for care takers at the center (50 mothers*$3*7 days/month)	1200	1367	114%	It is above the target due to food security issue which effecting in nutritional statues, and the budget managed to cover this number.
8	Routine operation and maintenance costs (plumbing, dislodging, cleaning, etc.)	1	1	100%	
9	Train 30 men on IYCF awareness raising to help men become more engaged	30	30	100%	Partner
10	Conduct 200 IYCF awareness raising discussions/campaigns and household visits,	200	200	100%	Partner
11	Training of 100 mothers, 10 mothers per each of the targeted OTP/TSFP facilities	100	100	100%	Done by CIS and partner
12	Monthly Incentive 100 mothers & CNVs, 10 mothers per each of the targeted OTP/TSFP facilities,	100	100	100%	Partner
13	Minor rehabilitation of 7 health facilities.	7	9	129%	Over target achievement. Additional new centers at Sarhan and Hiy Alnil in Mohajeria with same budget
14	Furnishing and consumable supplies for 7 health facilities	7	9	129%	providing of furniture to two new clinics, Sarhan and Hiy Alnil in Mohajeria, addition to existing 7.
15	Stationary support for 7 health facilities, including medical and non-medical stationery	7	7	100%	supply 7 addition to 2 new
16	Emergency supplies for outbreak preparedness and control	2	1	50%	supplies provided in year 1 and the balance will be utilized to provide the same tools and Year 2 due to limitation of budget
17	Referral support of reproductive cases from rural area to secondary level treatment centers	200	153	77%	budget covered only 77% due to inflation and late starting of implement.
18	Provide curative and preventative outpatient consultations, incentive rate is based on SMOH's	75	83	111%	Additional seconded staff and budget availability to cover additional staff

19	Train 21 key health staff (CARE and SMOH staff members)	21	36	171%	Budget availability cover more than the target
20	Training of 82 health cadres/health service providers on primary health care service	82	140	171%	82 trained in Year 1 and 58 in Year 2, Budget availability cover more than the target
21	Training of 140 public health committee members (7 committee X 20 members)	140	135	96%	absence of 5 from the target and selected
22	Provide monthly incentives to 140 Public Health Committees members, 20 per each health facilities	20	10	50%	The budget used to cover 50% of the total planned activities and the rest reallocated to provide visibility including T-shirts and side cap, this is due delay of activity implementation.
23	Form and train 7 village committees (VCs), one committee per facility with seven members.	49	69	141%	Establishing of 7 committee with 10 member instate of targeted 7 member per committee
24	Support EPI activities in the targeted areas of East Darfur, including in the targeted facilities,	8	6	75%	Budget covered only 75% of planned activities
25	EC/BCC materials for health education/promotion (different health messages	2	2	100%	
26	Provision of water at the targeted 7 health facilities	7	7	100%	
27	Train 35 village midwives (5 per facility) in the targeted areas of East Darfur	35	35	100%	
28	Provide monthly incentives to 35 village midwives,	35	35	100%	
29	Set up a quarterly community consultation meetings	8	4	50%	due to delay in implementation only 50% achieved with the same budget
30	Gender in health and nutrition training for 69 Village Committee (VC) members	69	35	51%	Due to budget availability, initial funds used to train 5 persons per facility instead of 10 (since additional fund received late the money will be refunded)

5. Annex 6: : List of people met at different levels:

No.	Name	Agency	Title	Email	Phone
CIS staff met at Khartoum					
1	Arthur Molenaar	CIS	Deputy Country Director - Program	Arthur.Molenaar@care.org	0922333334
2	Nasreldin Saeed	CIS	MEAL Coordinator,	nasreldin.saeed@care.org	0912989203
3	Ishag Ahmed	CIS	Senior Partnership Officer	Ishag.Salih@care.org	0914642433
CIS staff met at Nyala					
4	Sheikh Eldin Mohamed Ahmed	CIS	MPCA Manager		0923333622
5	Ahmed Adam Hasan	CIS	MEAL Officer		0993333384
6	Farog Mohamed Abakar	CIS	H & N PM,		0923333811
7	Barelzaman Eisa Faragalla	CIS	WASH Officer, PM		0993333361
8	Ashraf Abdel Aziz Ahmed	CIS	Medical Logistic		0123188330
9	Abdel Rahim Ahmed Brima	CIS	WASH Manager		093333364
CIS met at Kass 13/8/2022					
10	Jalal Mohamed Salih	CIS	Deputy H & N Program Manager		092333595
11	Adam Yousif Adam	CIS	WASH Officer		0923333398
12	Zuhir Haroon Barsham	CIS	Nutrition Officer		0992333338
13	Adam Mohamed Elasair	CIS	Hygiene Assistant		0993333394
14	Hasanat Ahmed Elzain	CIS	Pharmacist Assistant		
15	Fatima Mohamed Gebreel	CIS	Health Officer		0993333387
16	Darelnaim Adam Ahmed	CIS	Nutrition Assistant		0993333386
CIS staff met at Eldien					
17	Malaz Alamin	CIS	Acting WASH Program Manager		0913316502
18	Osman SalihOsman	CIS	H & N Project Manager		0993333359
19	Abdel Halim Hafiz Eisa	CIS	MEAL Officer		0920333362
20	Misbah Ibrahim	CIS	HOPO		0126120512
21	Osman Salih	CIS	H & N Manager		
22	Ibrahim Ahmed Abdalla	CIS	Senior Health Officer		0122931982

List of CIS Partners met at South Darfur State

No.	Name	Agency	Title	Phone
1	Somia Omer Abdel	JIMCO	Hygiene Promotion Officer	0919863365

	Hamid			
2	Samia Ahmed Osman	JIMCO	WASH Officer	0909644385
3	Mohaned Mohamed Osman	UNICEF	WASH Especialist	0918263107
4	Yasir Yahia Tibin	SMoH	PHC Manager	0116537233
5	Eltigani Mohamed Salih	NAHA	Head of Office	0124532678
6	Eisa Musa	WES Project	WES PM	0911994866
7	Mohamed Mustafa Fadul	SWC	DG/SWC	0123843503

List of CIS Partners met at East Darfur State

No.	Name	Agency	Title	Phone
9	Osman Eisa Ahmed	WES Project	Acting WES PM	0123455970
10	Bushara Elsharif Ismail	SADO	PM	0912371445
11	Abdel Majeed Ahmed Shams Eldin	SMoH/ED	PHC Manager	0122972210
12	Abdalla Abdel Karim	SWC	Bahr Elarab Manager	
13	Adam Abdo	NIDO	Nutrition Officer	0122939182
14	Mukhtar Elsanosni Mukhtar	SWC	DG	0123196646
15	Salih Ishag Omer	SHOA	Head of Office	0122929739
16	Haja Mohamed Elhasan	SHOA	Nutrition Officer	0122748563

List of Key Informant Interview at the community level

No.	Name	Village/camp	Position	Telephone
1	Rashid Ali Saif Eldin	Kidneer	Community leader	0902395047
2	Mohamed Suliman Hasaballa	Kidneer	Shartai	0920973818
3	Elsadig Haron Ahmed	Fiena	HAC/SLA	
4	Adam Haron Adam	Fiena	SLA Commandor	No network
5	Husin Suliman Hasaballa	Fiena	Shartai	No network
6	Suliman Abakar Mohamed	Kass IDP camps	Head of Sheikhs	0926333595
7	Mohamed Adam Mohamed	Gerieda	Head of WUC	0927657742
8	Ismail Abdel Jalil Ibrahim	Gomaiza Komara	Sheikh	0924754745
9	Mohamed Abkar Musa	Gomaiza Komara	Sheikh	0997311314
10	Abdel Rahman Ismail	Head of Health		0928963453

	Adam	Committee		

South Darfur State
List of Key Informant Interviews held at the Health and Nutrition Centers

No.	Name	Village/camp	Position	Telephone
South Darfur State				
1	Yousif Eldoma Yousif	Jabra	Medical Assistant	0960259572
2	Eldom Agil Eldom	Jabra	Nutrition Supervisor	
3	Elrabie Husin Mohamed	Fiena	Medical Assistant	No network
4	Haroon Adam Haroon	Fiena	Nutrition Supervisor	No network
5	Fatima Musa Abdalla	Fiena	Midwife	No network
6	Sakina Abdalla Mohamed	Fiena	Midwife	No network
7	Fath Eljalil Mohamed	Kidneer	Medical Assistant	0964078842
8	Hiyam Mohamed Hasaballa	Kidneer	Nutrition Supervisor	093560323
9	Hawa Omer Atim	Kass IDP camp	Medical Assistant	0923841775
10	Adam Abdalla Sidig	Kass IDP camp	Nutrition Supervisor	0928066133
11	Afrah Ahmed Hasan	Kass Hospital	Nutrition Officer	0992250408
12	Fatima Adam Elnour	Elsalam IDP camp	Medical Assistant	0913410512

East Darfur State
List of Key Informant Interviews held at the Health and Nutrition Centers

13	Hasania Ahmed Omer	Bakhit	Medical Assistant	0925750895
14	Kaltoum Mohamed Ahmed	Bakhit	Nutrition Supervisor	0997216996
15	Elradi Ibrahim Elradi	Sarhan	Head of Health Committee	0925238862
16	Amna Abakar Elrihima	Sarhan	Health Committee	0920966123

6. Annex 7: List of numerators supported data collection and compilation

South Darfur State
Kass IDP camp and host community
From 13/8 to 14/8/2022

No.	Name	Position	Telephone
1	Adam Abdalla Sidig	Nutrition Officer	0928066133
2	Nora Daw eLbait Abakar	Nutrition Officer	0996226368
3	Afaf Eltahir Abdel Mula	Nutrition Assistant	094605519
4	Fatima Osman Mohamed	Nutrition Officer	096163037
5	Um Dai Ibrahim Bakhit	Nutrition Officer	0928330985
6	Amira Mohamed Yahya	Nutrition Assistant	0929788724
7	Wisal Ramadan Saeed	Nutrition Assistant	09971013886
8	Imad Gibreel Omer	Pharmacist Assistant	0922884504
9	Sir Elkhatim Mohamed Adam		0992249303
10	Adam Haroon Ishag	Hygiene Promoter	0990588669

South Darfur State
List of Elsalam IDP camp data collector
From 14/8 to 15/8/2022

No.	Name	Position	Telephone
1	Mariam Yagoub Abakar	Hygiene promoter	0902925386
2	DarElsalam Abakar Sabon	Hygiene promoter	
3	Salah Hasaballa Jumaa	Community member	
4	Yagoub Adam Ali	Teacher	
5	Adam Ibrahim Abakar	WASH member	0908079050
6	Ikhlas Mohamed Ali	Hygiene promoter	0901044232
7	Bashir Gibreel Mohamed	Hygiene promoter	0907747610
8	Adam Abdalla Shogar	WASH member	0960614146
9	Gisma Mohamed Hassan	Hygiene promoter	0962040560
10	Ibrahim Abdel Karim	WASH member	0997485177
11	Khadog Ibrahim Adam	Hygiene promoter	0901807251

South Darfur State
Fiena data collector
From 10/8 to 11/8/2022

No.	Name	Position	Telephone
1	Adam Haron Adam	Teacher	0993550080
2	Nowal Omer Ahmed	Graduate	
3	Adam Abdel Shafi Mohamed	Graduate	

South Darfur State
Jabra data collector
8/8/2022

No.	Name	Position	Telephone
1	Mona Omer Ahmed Mohamed	Hygiene Promoter	0997170130
2	Sabir Abdel Rahman Abdalla	Head of WUCs	0924486655

East Darfur State
Mobile data collector
From 21/8 to 25/8/2022

No.	Name	Position	Telephone
1	Ishraga Adam Sheikh Eldin	Trainee	0965701014
2	Khadiga Aballa Mohamed	Hygiene promoter	0118239788
3	Ibrahim Bushra Ziyada	Trainee	0100141569

7. Annex 8: Focus group discussion conducted at different locations:

South Darfur State
Elsalam IDP camp
FGD with community leaders meeting
From 14/8 to 15/8/2022

No.	Name	Position	Telephone
1	Ahmed Mohamed Hasan	Head of Sheikhs	
2	Musa Adam Bakhat	Section 10	0963054311
3	Ibrahim Abdel Karim Mursal	Section14	0997485177
4	Mohamed Hasan Shagaf	Section7	0903783558
5	Jamal Zakaria Mahmoud	Youth Representative	0908662248
6	Mohamed Eisa Adam	Youth Representative	0911218022
7	Adam Omeran Mohamed	Youth Representative	0917750569
8	Ibrahim Husin Ibrahim	Section 8	
9	Mohamed Yahya Mohamed	Section 10 central part	
10	Adom Adam Abdalla	Section 10 Northern part	0913164434
11	Babker Ibrahim Mohamed	Youth representative section 7	0900433217
12	Abdel Aziz Gantour	Section 10 Central	0961844661
13	Suliman Yonis	Section 10 east	0910482776
14	Adam Osman	Section 2	

South Darfur State
Elsalam IDP camp
FGD with community WASH Committee
From 14/8 to 15/8/2022

No.	Name	Position	Telephone
1	Yahya Mohamed Abakar	Head of purchasing Committee	0992530090
2	Eltahir Adam Mohamed	Secretary	9093783673
3	Khadog Ibrahim Adam	Store Keeper	0901807251
4	Fatima Abakar Brima	Latrine Supervisor	
5	Gisma Osman Adam	Hygiene Promoter	0964353562
6	Aisha Abdel Aziz Hamid	Hygiene Promoter	0911886042
7	Ibrahim Abdel Karim Mursal	Member	0997485177
8	Abdel Aziz Mohamed Elhasan	Water well supervisor	9015345540

South Darfur State
Elsalam IDP camp
FGD at Health Center
From 16/8 2022

No.	Name	Position	Telephone
1	Suad Adam Haroon	Statistic focal person	0127626332
2	Fatima Omer Fadalla	Midwife	0901861947
3	Azza Mohamed Nafi	Midwife	0122310426
4	Aisha Yagoub Yousif	Midwife	

South Darfur State
Fiena Returnee and resident community in SLA controlled area
FGD with Hygiene promoters
From 9/8 to 11/8/2022

No	Name	Position	Village	Phone
1	Bab Elginan Ishag Adam	HP	Basi	No network
2	Kaltoum Mohamed Adam	HP	Diri	No network
3	Jaddah Abu Elgasim Mohamed	HP	Fiena	No network
4	Fatima Mohamed Osman	HP	Basi	No network

South Darfur State
Fiena Returnee and resident community in SLA controlled area
FGD Water User Committee
From 9/8 to 11/8/2022

No	Name	Position	Village	Phone
1	Abakar Ahmed Bilal	HPM	Basi	No network
2	Abdel Manan Suliman Mohamed	HPM	Dir	No network
3	Elhafiz Abdalla Adam	HPM	Basi	No network
4	Ahmed Arbab Ibrahim	HPM	Basi	No network

South Darfur State
Fiena Returnee and resident community in SLA controlled area
FGD with CHW at the Health center
From 9/8 to 11/8/2022

No.	Name	Position	Mobile No.
1	Haroon Adam Haroon	Nutrition Supervisor	No network
2	Rasheed Suliman Hasaballa	Files keeper	No network
3	Abdel Gadir Abdel Mahmoud Ishag	Data collector	No network
4	Hawa Abakar Ismail	Nutrition Assistant	No network
5	Bab Elsalam Mohmed Nasr	Nutrition Assistant	No network
6	Rabie Husin Mohamed	Medical Assistant	No network

South Darfur State
Kidneer resident community
FGD with Community Health and nutrition Workers (CHW)
From 8/8/2022

No.	Name	Position	Telephone
1	Radia Adam Abdel Rahman	Medical Assistant	09885486
2	Hyam Mohamed Hasaballa	Nutrition Supervisor	09035560323
3	Fatima Ali Suliman	Nurse	0997551961
4	Fawzia Mohamed Omer	Fascinator	0924297705
5	Sara Adam Musa	Nutrition Assistant	0967595604

South Darfur State
Gomaiza resident community
FGD with Nutrition staff
From 8/8/2022

No.	Name	Position	Telephone
1	Elhafiz Eltybe Adam Haroon	Nutrition Officer	0993237392
2	Adam Abdalla Mohamed	Nutrition Assistant	0923039176
3	Mohamed Mohamed Nasr	Nutrition Store keeper	0925204021
4	Hanan Abkar Yagoub Sidig	Nutrition advisor	0924839576

South Darfur State
Kass IDP camp
FGD with community Leaders
From 14/8 to 15/8/2022

No.	Name	Position	Telephone
1	Suliman Abkar Mohamed	Head of Sheikhs	0926333595
2	Musa Mohamed Ismail	Sheikh	0963665772
3	Abdalla Musa Abdalla	Sheikh	0929609657
4	Fadul Abdalla Adam	Sheikh	0924772164

South Darfur State
Kass IDP camp
FGD with community hygiene promoters
From 12/8 to 13/8/2022

No.	Name	Position	Telephone
1	Fatima Mohamed Ahmed	Hygiene Promoter	0908702325
2	Islam Zakaria Ibrahim	Hygiene Promoter	
3	Hawa hasan Adam	Hygiene Promoter	
4	Mariam Idris Mahmoud	Hygiene Promoter	
5	Fatima Musa Abdel Gadir	Hygiene Promoter	
6	Hawa Ahmed Abdel Mula	Hygiene Promoter	
7	Fardos Abdel Rahman Abakar	Hygiene Promoter	
8	Rawda Mohamed Ali	Hygiene Promoter	
9	Ayat Anwar Abdel Gabar	Hygiene Promoter	
10	Hawa Mohamed Abdalla	Hygiene Promoter	

South Darfur State
Jabra Village
FGD with Health Committee

No.	Name	Village	Business
1.	Eisa Abdel Rahman Eldom	0923242155	Head of Health Committee
2.	Eldom Ismail Eldom	0997678388	Health Center Supervisor
3.	Abdalla Suliman Abdalla	0920849974	Pharmacist Assistant
4.	Yousif Eldoma	0960259572	Medical Assistant
5.	Amira HAmid Mohamed	0918467820	Nurse

South Darfur State
Jabra Village
FGD with Water User Committees

No.	Name	Position	Telephone
1	Abdalla Abakar Abdel Rahman	HPM	0921405586
2	Um Niel Omer Husin	House wife	
3	Makka Hasan Fadul	HP	0922380553
4	Kaltoum Abu Baker Farah	House wife	

East Darfur State
Bakhit Village
FGD with Health Committee
From 22/8 2022

No.	Name	Position	Telephone
1	Abdel Rahman Ismail Adam	Head of Committee	0928963453
2	Elnour Mohamed Ali Elnour	Committee member	0924256951
3	Elhadi Ajaballa Ahmed	Committee member	0924420243
4	Brima Adam Ahmed	Committee member	0991174123
5	Adil Husin Ismail	Committee member	0929736219

East Darfur State
Bakhit Village,
FGD with Hygiene Promoters group
From 22/8 2022

No.	Name	Position	Telephone
1	Elsayra Mohamed Ali	Hygiene Promoter	0923769311
2	Mona Ajaballa Ahmed	Hygiene Promoter	0993182182
3	Manasik Adam Mhamed	Hygiene Promoter	0924296860
4	Huwida Mohamed Daw Elbait	Hygiene Promoter	0929211219

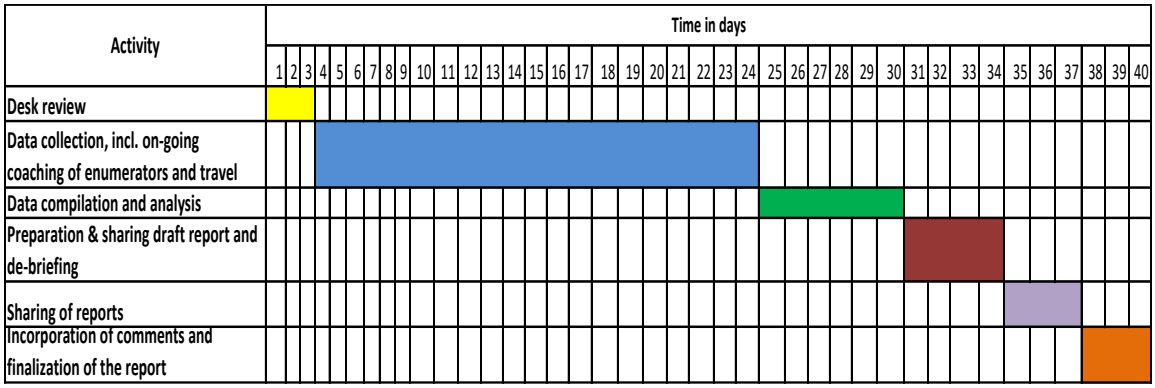
East Darfur State
Eldien Town
FGD with SADO Staff
From 21/8 2022

No.	Name	Position	Telephone
1	Iman Abdalla Abdael Karim	Hygiene Promotion Assistant	0117690646
2	Amna Mohamed Sidig	WASH Officer	0114230375
3	Arafa Mohamed Daifalla	Hygiene Promotion Assistant	
4	Rania Nazar Mohamed	PMZ assistant	0124556521
5	Namarig Mohamed Hamid	Finance Officer	0121333911
6	Omia Ahmed Eisa	Program Manager PMZ	0112275644
7	Ahmed Mohamed Yousif	Program Coordinator PMZ	0912264819

East Darfur State
Sarhan, Bahr Elarab
FGD with WASH Committee
From 23/8 2022

No.	Name	Position	Telephone
1	Ismail Taj Elnabi Ali	Head of the committee	099272728
2	Dar Elsalam Ali	Committee member	
3	Ibarahim Deto Sosal	Committee member	0928048704
4	Haja Yahya Adam	Committee member	0994245667
5	Fatima Adam Ahmed	Committee member	0994222773
6	Madina Osman Elnair	Committee member	09235568413
7	Fatima Adam yahya	Committee member	0990132034
8	Sakina Yousif Salih	Committee member	0920971306
10	Asma Musa	Committee member	0990833238
11	Ahlam Elsadig	Committee member	0992701820
12	Hibat Omran	Committee member	0993135843
13	Zahraa Ali	Committee member	0996155078

8. Annex 9: initial tentative evaluation CARE



9. Annex 10: Data collection check List

A. Key Informants Interviews (KIIs)

- **Khartoum Level**

1. Members of CARE Program Quality (PQ) Team.
2. CARE International program officer

- **State Level**

3. State water Corporation and WES representatives
4. CARE International WASH, health and nutrition managers and officers
5. CARE International Head of Office – Nyala & Edien
6. DG/WC locality levels
7. SHOA, SADO, JMCO and NAHA Head of Office and staff

B. Focus Group discussions (FGDs) in the three locations:

1. women groups, in the three locations
2. Youth in the three locations
1. Members of the Water Committee/hand pump technicians
3. community leaders
4. Implementing partners in the locality based
5. Hand pumps technicians and operators.
6. VCs members.

C. Spot Checks/visits

1. Water sources MWY, distribution points, HPs
2. HH latrine
3. Open deification if any
4. rehabilitated health and nutrition facilities
5. medical stores

10. Annex 11 Guidelines for Conducting Field Observations spot checks of facilities

1. **Location** ----------
   Name of Camp: ……..
2. **Population** Number: ……..
3. **Main Source of Drinking Water:**

☐Hand pump ☐Minim water yard ☐Improve dug well with hand pump ☐ Motorized dug wells ☐dam☐Open well ☐wadi/mashish

4. **Water quality**

☐ Acceptable ☐ Not acceptable

5. **Functionality of water source**

☐ Functioning ☐ Not functioning

6. **Fencing of water source (protection):**

☐ Fenced ☐ Not fenced

7. **Formation and functionality of water committees:**

☐ Formed …..Male and ……..female ☐ Functional ☐ Not Functional

8. **Water tariff, how community pays for Water in SDG?**

☐per jerry can:……. ☐ per breakdown:…….. ☐ per Month:…… ☐Free

9. **Spare part center :**

☐Established and exist ☐ Established but not exist: ☐ Not establish yet:

10. **Environment around water source :**

☐Clean ☐Dirty ☐Very dirty

11. **Rehabilitated health facility :**

☐ Acceptable ☐ Not acceptable

11. Annex 12: Guidelines for discussion

✓ **Key issues for interviews**

1. Background about the projects
2. Who are the main project partners?
3. How partner especially communities involved in project planning, implementation and management.
4. Did the project involved women and enhanced their role; if yes then how?
5. Are all project activities completed if not why?
6. Any opportunities not used during the project course.
7. what are main challenges and risks and what was done to address challenges
8. Do you think the project met the community needs? if yes how?
9. What has been done by the project to enhance sustainability of the activities?

10. Do you have regular reports submitted on regular basis, especially to donors?
11. Did project plan implemented according to the project proposal in term of time line and physical components without modifications or change in activities. If no why?
12. any recommendations

✓ **Guidelines for Focus Group Dissuasions (FGDs)**

- Focus group discussion is one of the key components of the Evaluation process in the selected village/IDP camps to validate information and data collected from the households and key informants interviews.
- Discussion will be held with health and nutrition workers, community leaders at the project locations; representatives of women groups; technicians; youth; end users (project beneficiaries male and female; especially water collectors from water sources and trainees, project staff...

✓ **Facilitation of the focus group discussions**

- Try to get ideas of everybody in the group.
- Don't let only one person to dominate the discussion.
- Ensure that names and occupations/titles of the participants in the FGDs are properly recorded.

✓ **Questions and points for discussion during FGD for different groups:**

- General questions on access to social services in this area with more emphasis on, WASH, Health, Nutrition and Multipurpose cash assistance (MPCA) to ensure smooth start.
- Gender aspects; role and involvement of women, youth and men in the project activities and services management and their involvement in committees…….
- Major improvement in the concerned services done by CARE International and how it contributes to resolve the problems in the area?
- How the provided services contributed to improve women status in the community.
- Who established committees and how members selected
- What type of trainings conducted and who provided these trainings and capacity building programs.
- How trainees selected and who is selecting them.
- Is there any cleanup/debris removal activities conducted over the last three months?
- How the VDCs, VSLAs, women groups and other community institutions were established?
- Are there any major risks that were not being considered?
- To what extent the project alleviated pressure on women and girls
- Do you think the cash you received is meaningful to support vulnerable community especially women? How?

✓ **FGD on issues related to water supply component**

- What are the on-going water supply and sanitation projects?
- Operational status (functionality) of the water sources and quality issues
- Management of the water facilities at the village/camp level

- The role of communities especially women in managing the WASH facilities including tariff system.
- Involvement of the community both women and men in planning their future water supply demand.
- How many times the water system broken over the last three months and who repaired the system?
- What types of training provided by CARE and who involved in the committees?
- Is there a water committee? If yes, how members selected? Did you have adequate training and reasonable tools to maintain your water facility?
- Did you have some conflicts associated with water sources in the project area

✓ **FGD on issues related to environmental sanitation and hygiene**

- What are the roles of communities and CIS in latrines construction?
- Are there any open defecation practices in the living areas?
- Do you trained on hygiene promotion? What are the key issues hygiene promoters have been trained on?
- Is there specific role and responsibly for women and men in hygiene promotion?
- Is there any hygiene promotion activities conducted? If yes how many times over the last three months? How many visits per month?
- Who is responsible for solid waste collection and disposal
- Are there any cleaning campaigns activities conducted? If yes how many times over the last three months?

✓ **FGD on issues related to Health:**

- Gender aspects; are women included in CHW and as health cadre and involved in the project activities and service management.
- Are CHW conducting public health surveillances?
- Major improvement in the concerned services done by CARE International and how it contributes to resolve the problems in the area?
- How the provided services contributed to improve women status in the community.
- Who established committees and how members selected?
- Due think the H & N services will be sustained after termination of Care support? If no how we can sustain these services.
- What is the impact of services provided by Care International program.

✓ **FGD on issues related to Nutrition:**

- Are both men & women included in nutrition program? How?
- Due think the H & N services will be sustained after termination of Care support? If no how we can sustain these services.
- Who trained as health cadre and involved in the project activities and service management.
- What is the impact of services provided by Care International program.

✓ **FGD with Multipurpose Cash Assistance (MPCA) project Beneficiaries:**

- Do you think the multipurpose cash assistance (MPCA) project supported its beneficiaries and how?
- How the Multipurpose Cash Assistance (MPCA) project identified vulnerable target groups especially female headed HHs and HHs?
- Are there any major risks that were not being considered?
- Do you think the cash you received is meaningful to support vulnerable community especially women? How?
- What is the impact of services provided by Care International program?
- Due think the MPCA services will be sustained after termination of CIS support? If no how we can sustain these services.

✓ **Coordination**

- Is WASH, Health and Nutrition sector coordination meetings conducted on regular basis?
- What are major roles of the coordination forum?
- Which are the main agencies attending these meetings regularly
- Is Care coordinating with the sector in area of planning and implementation of activities? How?
- Are communities aware of what CARE International have been providing in term of WASH, health, nutrition and MPCA services?

12. Annex 9: Household survey questionnaire in English:

Name of village/camp_____Name of sector:_____
Data collector Name:_____Date:_____
Name of Respondents …… telephone _____
Village Name _____
Household category a. Host community ☐ IDPs ☐ Resident ☐

1.1. Demography

1) Household size_____
Number of females _____
Number of males _____
2) **Head of HH** a. female ☐ b. male ☐
3) No. Of children under 5 a. Girls 1 2 3 4 b. Boys1 2 3 4
4) **No**. Of children under 2 a. Girls 1 2 3 4 b. Boys1 2 3 4

1.2. Sanitation

5) Where do you go to the toilet (to defecate?
a. Latrine ☐
b. Field ☐
c. Other(Specify) ☐_____

If answer is a, then answer Q2-Q8, if **not a**, then move to Q9
6) Where is the latrine? (question)
a. At Household ☐
b. Neighbour ☐
c. communal ☐
d. Other(Specify) ☐_____
7) If YES, is the latrine slab clean? (observe)
a. Yes ☐
b. No ☐
8) How far the distance to the nearest latrine (to defecate?
a. < 50 meters ☐
b. 50 – 100 meters ☐
c. >100 meters ☐
9) Who is using the latrine? (Question)
a. Men ☐
b. Women ☐
c. Girl ☐
d. Boys ☐
e. all ☐

10) Is there regular cleaning campaigns organized in the village? (Question)
a. Yes ☐
b. No ☐
11) How many the cleaning campaign organized in the village over the last three months? (Question)
a. Four and more ☐
b. Three ☐
c. Two ☐

d. One ☐
e. Zero ☐

12) Where did you dispose your HH garbage? (Question)

a. Dropping them outside in the yard ☐
b. throwing it in an open bit ☐
c. containers outside ☐
d. burn it inside their houses ☐
e. not disposing my wastes, ☐
f. others specify ----------

13) Is there special support for women headed HHs in latrine construction? (Question)

a. Yes ☐
b. No ☐

if yes how:----------

1.3. Hygiene

14) When do you wash your hands? (question- co-ordinator to tick boxes)

a. Before preparing food ☐
b. Before eating ☐
c. After latrine use ☐
d. After handling children faeces ☐
e. Before feeding a child ☐
f. Other(Specify) ☐_____

15) What do you use when washing your hands? (question)

a. ash ☐
b. soil/sand ☐
c. soap ☐
d. water only ☐
e. other(Specify) ☐

16) Did you receive people providing hygiene messages? (Question).

Yes ☐
No ☐

17) Is there evidence of faeces inside the house area/fence?(observe)

a. Yes ☐
b. No ☐

1.4. Water:

18) From where do you usually collect water for drinking? (question)

a. Hand pump ☐
b. Motorized tube well ☐
c. Motorized open well ☐
d. Improved open well ☐
e. If not from these safe sources, move the following questions

19) Why you are not using water from the above mentioned water supply sources? (question)

a. Financial reasons ☐
b. Due to long distance ☐
c. Long queuing time ☐

20) **How many minutes do you have to queue to collect water before CARE intervention?** (question: estimate)

f. <50 ☐
g. 15-30 ☐
h. 31-60 ☐

i. >60 ☐

21) How many minutes do you have to queue to collect water after CARE intervention? (question)

j. <15 ☐
k. 15-30 ☐
l. 31-60 ☐
m. >60 ☐
n. ☐

22) How many jerry cans does your household collect each day? (questions)

o. Less than 2 ☐
p. 2 - 3 ☐
q. 4-5 ☐
r. >5 ☐

23) Who collects the water? (Question)

s. Women and children ☐
t. Children only ☐
u. Women only ☐
v. Men ☐
w. All ☐

24) What is mean you are using to collect your drinking water? (question)

x. Bucket or Jerry can ☐
y. Donkey carts ☐
z. Khuruj ☐

25) Where do you store your drinking water? (observe)

aa. Barrel ☐
bb. A pit in the ground ☐
cc. Cement reservoir ☐
dd. water pot ☐

26) How are you pay for water? (question)

a. per jerry can:……. ☐
b. per breakdown:.. ☐
c. per Month ☐
d. Free ☐

27) How much you paying for water supply per month? (question)

ee. Paying SDG 40 ☐
ff. between SDG 40 to 50 ☐
gg. more than SDG 50 ☐

28) Did you receive water supply voucher from Care? (question)

hh. Yes ☐
ii. No ☐
jj. If answer is yes move the following question.

29) For how long you have receiving this voucher? (question)

kk. For > 6 months ☐
ll. 6 to 12 months ☐
mm. 1 year to 2 years ☐

13. Annex 14: Health HH questionnaire:

Name of village/camp_____Name of sector:_____
Data collector Name:_____Date:_____
Name of Respondents …… telephone _____
Household category a. Host community ☐ IDPs ☐ Resident ☐

Demography

Household size_____
Number of females _____
Number of males _____
Head of HH a. female ☐ b. male ☐
No. Of children under 5 a. Girls 1 2 3 4 b. Boys1 2 3 4
No. Of children < 2 years a. Girls 1 2 3 4 b. Boys 1 2 3 4

1. **How many times did you go to antenatal clinics? (Question for pregnant women over last 24 months)**
   a. More than three times ☐
   b. Three times ☐
   c. Two times ☐
   d. Once ☐
   e. None ☐
2. **Did your new born received postnatal care? (Question for delivered women or with newborns)**
   a. Yes within three days ☐
   b. Yes after three days ☐
   c. never ☐
3. **Who supported you when you when you were on delivery? (question to women with new born)**

a. home based trained midwifes ☐
b. Mid-wife working at the health facility ☐
c. traditional midwifes ☐
d. health facility doctors ☐
e. Home based doctors ☐

4. **Did you receive messages on health promotion and communicable diseases? (question)**

a. Yes ☐
b. No ☐

If answer is yes move to the following question

5. **Can you recall some of these messages? (question)**

a. Type of communicable diseases (such as malaria, diarrhea, and acute respiratory infection} ☐
b. Transmission of communicable disease such as sexual transmission, Oral or by insect ☐
c. Prevention of communicable diseases such as mosquito net, spraying… ☐

6. When are you taking your child to the health centre? (Question)

a. When she/he has severe fever ☐
b. When she/he has diarrhea ☐
c. When she/he has acute respiratory infection ☐
d. Persistent crying ☐
e. Poor Appetite ☐
f. Severe vomiting ☐

I. Nutrition HH questionnaire:

1. How are you feeding your child? (Question to women with infants of 1-5 months of age)

a. Only breast feeding ☐
b. Additional food ☐

2. In addition to the breast feeding did you provide additional food for your child? (Question to women with children 6-23 months of age)

a. Yes ☐
b. No ☐

If answer yes move to the following question

3. Did you receive food from food groups? (Question)

a. Less than four food groups ☐
b. From four food groups ☐
c. More than four food groups ☐
d. Nothing received ☐

4. Did you receive health promotion message on child feeding? (question to pregnant or women with children of less than 23 months)

a. Yes ☐
b. No ☐

14. Annex 12: MPCA Household survey questionnaire:

Name of village/camp:_____Name of sector:_____
Data collector Name:_____Date:_____
Name of Respondents …… telephone _____
Village Name _____
Household category Host community ☐ IDPs ☐ Returnees ☐

Demography

1. **Household size**_____
Number of females _____
Number of males _____
2. **Head of HH** a. female ☐ b. male ☐
3. **No. Of children under 5 a. Girls 1 2 3 4 b. Boys1 2 3 4**
4. **No**. Of children under 2 a. Girls 1 2 3 4 b. Boys1 2 3 4
5. **According to your priorities did you able to meet the basic needs of your households because of this support? (Question)**
   a. All ☐
   b. Most ☐
   c. Some ☐
   d. None ☐
6. **Do you think the humanitarian assistance provided in a safe, accessible, accountable and participatory manner? (Question)**
   a. Yes ☐
   b. No ☐
   c. If no please clarify _____
7. **Did the MPCA support reduced cost of water, sanitation or hygiene related basic needs expenditures? (Question)**
   a. No ☐
   b. Yes ☐,
   c. If no please clarify _____
8. **How did you utilize the cash you received through MPCA? (Question)**
   a. To buy water ☐
   b. To buy soap ☐,
   c. To buy food ☐
   d. To buy clothes ☐,
   e. Spent for agriculture ☐
   f. To buy drugs ☐,

30) From where do you usually collect water for drinking? (question)

nn. Hand pump ☐
oo. Motorized pump. ☐
pp. Motorized open well ☐
qq. Improved open well ☐
rr. Improved hafirs ☐

If not from these above mentioned sources, move the following questions

31) Why you are not using water from the above mentioned water supply sources? (question)

a. Financial reasons ☐
b. Due to long distance ☐
c. Long queuing time ☐
d. No difference between water supply sources

9. How much money did you receive in total from Care international teams? (Question)

a. SDG 1,980 ☐

b. Less than SDG 1,980 ☐

c. more than SDG 1,980 ☐

d. If less than SDG 1,980 why _____

10. Are there any conflicts associated with the project activities?

a. Yes ☐

b. No ☐

11. If the answer to the above question is 'yes', conflicts are resolve through?

a. traditional leaders ☐

b. CARE ☐

c. court ☐

d. others ☐, specify; _____

12. Do you think, the activities of the project will fade away with phasing out of the project?

a. No ☐

b. Yes ☐,

If answer is yes specify _____

13. Are women active in participation?

a. Yes ☐

b. No ☐

14. How women approached to participate in the project?

a. Through traditional leaders ☐

b. Through the project ☐

c. Women willingness ☐

d. Local government ☐

15. Is women participation in the project activities confronted by obstacles?

a. No ☐

b.Yes ☐, specify _____

16. Is the project targeted female headed HHs and HHs with special needs?

a. Yes ☐

b. No ☐

17. Do you think the cash you received is meaningful to support vulnerable community especially women?

a. Yes ☐

b. No ☐

15. Annex 13: Household survey questionnaire in Arabic:

بسم الله الرحمن الرحيم
منظمة كير العالمية
اشتمارة استبيان جمع المعلومات الاسرية لتقييم قطاع المياه و اصحاح البيئة بولاية جنوب و شرق دارفور
اسم القرية أو المعسكر: ..... المحلية .....
اسم جامع البيانات.....تاريخ جمع المعلومات .....
الاسم صاحب المنزل أختياري: ..... رقم الهاتف .....
وضع صاحب المنزل: مجتمع مضيف ( ) نازح ( ) مقيم ( )

حجم الاسرة: أسأل

عدد الرجال .....
عدد النساء .....
رب الاسرة:

1. رجل ( )
2. انثي ( )

1) عدد الاطفال أقل من خمسة سنوات:

1. ذكر ( )
2. انثي ( )

2) عدد الاطفال أقل من سنتين: أسأل

1. ذكر ( )
2. انثي ( )

ا/ صحة البيئة:

3) اين تقضي حاجتك؟ أسأل

3. المرحاض ( )
4. الخلاء ( )
5. اخري ( ) وضح .....

اذا كانت الاجابة للسؤال اعلاه "المرحاض" جاوب علي الاسئلة من 2 – 8
واذا كانت الاجابة بالخلاء أذهب مباشرة الي السؤال رقم 9

4) اين يوجد المرحاض؟ أسأل

بالمنزل ( )
عند الجيران ( )
بمرحاض مجتمعي ( )
اخري ( ) وضح .....

5) اذا كانت الاجابة بالمرحاض هل داخل المرحاض يوجد براز؟ أسأل

1. نعم ( )
2. لا ( )

6) ماهي المسافة التي تقطعها لتصل المرحاض؟ أسأل

1. اقل من 50 متر ( )
2. 50– 100متر ( )

3. اكثر من 100 متر ( )

7) من انشا المرحاض؟ أسأل

رب الاسرة ( )
منظمة كير ( )
اخري, وضح .....

8) ماهي اسهامات كير في انشاء المراحيض؟ أسأل

1. التدريب ( )
2. مواد التشييد ( )
3. غطاء حفرة المرحاض ( )
4. اخري ( )

9) من الذي يستخدم المرحاض؟ أسأل

1. النساء ( )
2. الرجال ( )
3. البنات ( )
4. الاولاد ( )
5. كل أفراد الاسرة ( )

10) هل نفذت اي حملة نظافة بمنطقة المشروع؟ أسأل

1. نعم ( )
2. لا ( )

11) اذا كانت الاجابة "نعم" كم عدد حملات النظافة خلال اخر ثلاثة شهور؟ أسأل

1. أكثر من أربعة ( )
2. ثلاثة ( )
3. اثنين ( )
4. واحد ( )
5. لم يتم التنفيذ ( )

12) كيف تتخلص من الاوساخ المنزلية ؟ أسأل

1. رميها خارج سور المنزل ( )
2. وضعها في حفرة خاصة ( )
3. سلة اوصاخ في الخارج ( )
4. حرقها داخل المنزل ( )
5. ما قاعدين ننظف ( )
6. ذا كانت أخرى وضح .....

13) هل هناك دعم خاص للمراءة في مجال تصميم وتشييد المراحيض؟ أسأل

1. نعم ( )
2. لا ( )

اذا كانت الاجابة نعم: وضح .....

ب/ الاصحاح البيئي

14) هل زاركم مثقفين صحيين يتكلمون عن الصحة و السلوك؟ أسأل

1. نعم ( )
2. لا ( )

15) متي تغسل يديك؟ أسأل

1. قبل الاكل ( )
2. قبل اطعام الاطفال ( )
3. قبل أعداد الطعام ( )
4. بعد التعامل مع الفضلات الاطفال ( )
5. بعد قضاء الحاجة او الخروج من المرحاض ( )
6. اخري وضح .....

16) ماذا تستعمل لغسيل يديك؟ أسأل

3. رماد ( )
4. رمال او تراب ( )
5. صابون ( )
6. ماء فقط ( )
7. اخري وضح .....

17) هل هناك فضلات أدمية او براز بالمنزل او داخل سور المنزل؟ أسأل

1. نعم ( )
2. لا ( )

ج/ المياه:

18) من اين تتحصل علي مياه الشرب؟ أسأل

1. مضخه يدوية ( )
2. من ثانية عليها طلمبة ( )
3. ابار جوفية بطلمبة ( )
4. مضخات يدوية مركبة على ثانية( )
5. من حفير او خزان به فلتر ( )
6. اخري وضح .....

19) لماذا لا تتحصل علي مياه الشرب من المصادر اعلاه؟ أسأل

1. لا املك قروش لدفع القيمة ( )
2. المسافة طويلة ( )
3. زمن النتظار طويل ( )
4. كل مصادر المياه امنة ( )
5. اخري وضح .....

20) كمتستغرق من الزمن للانتظار للحصول على المياه قبل تنفيذ مشروع كير؟ أسأل و قدر

1. اقل من 15 دقائق ( )
2. 16 – 30 دقائق ( )
3. 31 – 60 دقيقه ( )

4. اكثر من ساعه ( )

21) كمتستغرق من الزمن للانتظار للحصول على المياه بعد تنفيذ مشروع كير؟ أسأل و قدر

5. اقل من 15 دقائق ( )
6. 16 – 30 دقائق ( )
7. 31 – 60 دقيقه ( )
8. اكثر من ساعه ( )

22) كم عدد الجركانات التي يجمعها افراد الاسرة في اليوم؟ أسأل

1. اقل من جركانتين ( )
2. 2 – 3 جركانه ( )
3. 4-5 جركانه ( )
4. اكثر من 5 جركانه ( )

23) من يقوم بجمع الماء؟ أسأل

1. النساء والاطفال ( )
2. الاطفال ( )
3. الرجال ( )
4. النساء ( )
5. كل افراد الاسره ( )

24) ما وسيلة نقل المياه التي تستخدمهاه؟ أسأل

1. جركانة أو جردل ( )
2. كارو ( )
3. خرج ( )
4. اخري وضح .....

25) أين تقوم بتخزين المياه؟ أسأل

5. براميل ( )
6. حفرة في الارض ( )
7. زير أو جرة ( )
8. خزان اسمنت ( )
9. اخري وضح .....

26) هل تدفع قروش للحصول على المياه؟أسأل

1. بالجركانة ( )
2. بالاسبوع ( )
3. بالشهر ( )
4. حسب الاعطال ( )

27) ماهي القيمة المدفوعه للجركانه سعة 20 لتر؟أسأل

1. اقل من40 ج ( )
2. 40 – 50 ج ( )

3. اكثر من 50 ج ( )

28) هل حدث ان استلمت دعم للمياه من منظمة كير ؟أسأل

1. نعم ( )
2. لا ( )

اذا كانت الاجابة نعم وضح؟ .....

29) منذ كم من الزمن انت تتسلم هذا الدعم؟أسأل

4. اقل من ستة شهور ( )
5. بين 6 الى 12 شهر ( )
6. اكثر من 12 شهر ( )

بسم الله الرحمن الرحيم

منظمة كير العالمية

اشتمارة استبيان جمع المعلومات الاسرية لتقييم قطاع الصحة العامة بولاية جنوب و شرق دارفور

اسم القرية أو المعسكر: ..... المحلية .....

اسم جامع البيانات.....تاريخ جمع المعلومات .....

الاسم صاحب المنزل أختياري: ..... رقم الهاتف .....

وضع صاحب المنزل: مجتمع مضيف ( ) نازح ( ) مقيم ( )

1) حجم الاسرة: أسأل

عدد الرجال .....

عدد النساء .....

2) رب الاسرة:

1. رجل ( )
2. انثي ( )

3) عدد الاطفال أقل من خمسة سنوات:

1. ذكر ( )
2. انثي ( )

4) عدد الاطفال أقل من سنتين:

1. ذكر ( )
2. انثي ( )

5) كم مرة ذهبت للعيادة اثناء فترة الحمل؟أسأل

1. أكثر من ثلاثة مرات ( )
2. ثلاثة مرات ( )
3. مرتين فقط ( )
4. مرة واحدة فقط ( )
5. لم اذهب للعيادة ( )

6) هل طفلك تحصل على رعاية صحية بعد الولادة مباشرة؟أسأل

1. نعم خلال ثلاثة أيام ( )

2. نعم بعد ثلاثة أيام ( )
3. لا لم يحدث ( )

7) من الذي قام بعملية التوليد ؟أسأل

1. داية مقيمة في القرية ( )
2. داية من المركز الصحي ( )
3. داية تقليدية ( )
4. طبيب العيادة ( )
5. طبيب القرية ( )

8) هل وصلتكم زائرة تتكلم عن التثقيف الصحي و الامراض المنقولة؟ أسأل

1. نعم ( )
2. لا ( )

اذا كانت الاجابة للسؤال اعلاه بنعم أذهب مباشرة الي السؤال التالي.

9) هل تتذكر أو تتذكرين بعض هذه الرسائل عن الامراض المنقولة؟ أسأل

1. انواع هذه الامراض كالملاريا أو الاسهال التهابات الجهاز التنفسي ....
2. كيف تنتقل هذه الامراض مثلا عن طريق الحشرات, الجنس, الفم .....
3. كيفية الوقاية من هذه الامراض مثلا عن طريق الناموسية, الرش, الدخان, غلي الماء

10) متى تاخذين طفلك للعيادة عند شعوره ببعض الالام؟أسأل

1. في حالة الحمى الشديدة ( )
2. الاسهال ( )
3. التهابات الجهاز التنفسي ( )
4. البكاء المستمر ( )
5. عدم الرغبة في الغذاء ( )
6. الاستفراغ الحاد ( )

بسم الله الرحمن الرحيم

منظمة كير العالمية

اشتمارة استبيان جمع المعلومات الاسرية لتقييم قطاع التغذية بولاية جنوب و شرق دارفور

اسم القرية أو المعسكر: ..... المحلية .....

اسم جامع البيانات.....تاريخ جمع المعلومات .....

الاسم صاحب المنزل أختياري: ..... رقم الهاتف .....

وضع صاحب المنزل: مجتمع مضيف ( ) نازح ( ) مقيم ( )

11) حجم الاسرة: أسأل

عدد الرجال .....
عدد النساء .....

12) رب الاسرة:

3. رجل ( )
4. انثي ( )

13) عدد الاطفال أقل من خمسة سنوات:

3. ذكر ( )
4. انثي ( )

14) عدد الاطفال أقل من سنتين:

3. ذكر ( )
4. انثي ( )

15) كيف تتم تغذية طفلك؟ للنساء الذين لديهم اطفال اعمارهم أقل من خمسة شهور؟ أسأل

1. الرضاعة الطبيعية فقط ( )
2. الرضاعة و تغذية أخري ( )

16) بالاضافة للرضاعة الطبيعية هل تتم تغذية أضافية لطفلك؟ للنساء الذين لديهم لديهم اطفال اعمارهم من 6 الى 23 شهرا؟ أسأل

1. نعم ( )
2. لا ( )

اذا كانت الاجابة للسؤال اعلاه بنعم أذهب مباشرة الي السؤال التالي.

17) بالاضافة للرضاعة الطبيعية هل استلمت تغذية أضافية لطفلك من مجمعات التغذية؟ للنساء الذين لديهم لديهم اطفال اعمارهم من 6 الى 23 شهرا؟ أسأل

3. نعم من اقل من أربعة ( )
4. نعم من أربعة ( )
5. نعم من أكثر من أربعة ( )
6. لا ( )

18) هل وصلتكم زائرة تتكلم عن تغذية الأطفال؟ أسأل

3. نعم ( )
4. لا ( )

بسم الله الرحمن الرحيم

منظمة كير العالمية

اشتمارة استبيان جمع المعلومات الاسرية لتقييم قطاع أداء المساعدات المالية للفئات الضعيفة بولاية جنوب و شرق دارفور

اسم القرية أو المعسكر: ..... المحلية .....
اسم جامع البيانات.....تاريخ جمع المعلومات .....
الاسم صاحب المنزل أختياري: ..... رقم الهاتف .....
وضع صاحب المنزل: مجتمع مضيف ( ) نازح ( ) مقيم ( )

1) حجم الاسرة؟ أسأل

عدد الرجال .....
عدد النساء .....

2) رب الاسرة؟ أسأل

1. رجل ( )
2. انثي ( )

3) عدد الاطفال أقل من خمسة سنوات: أسأل

1. ذكر ( )
2. انثي ( )

4) عدد الاطفال أقل من سنتين: أسأل

6. ذكر ( )
7. انثي ( )

5) حسب اولويات الاسرة هل تمكنت بسبب هذه المساعدة من توفير الاحتياجات الاساسية؟ أسأل

1. كل الاحتياجات ( )
2. أغلب الاحتياجات ( )
3. بعض ( )
4. لا شئ من الاحتياجات( )

6) هل تفتكر أن هذه المساعدات المالية تمت بصورة أمنة و مسؤولة و بمشاركة الجميع تسهل عملية الوصول؟ أسأل

1. كل الاحتياجات ( )
2. أغلب الاحتياجات ( )
3. بعض الاحتياجات ( )
4. لا شئ من الاحتياجات( )

اذا كانت الاجابة نعم وضح؟ .....

7) هل تفتكر أن هذه المساعدات الماليةساعدت في تقليل و خفض نفقات المياه و اصحاح البيئة و الخدمات ذات الصلة؟ أسأل

1. نعم ( )
2. لا ( )

أذا كانت الاجابة بلا وضح؟ .....

8) كيف توظف هذه المساعدات الماليةساعدت؟ أسأل

1. لشراء الماء ( )
2. لشراء الصابون ( )
3. المواد الغذائية ( )
4. لشراء الملابس ( )
5. لشراء الصابون ( )

6. للزراعة ( )
7. لشراء الادوية ( )

9) من اين تتحصل علي مياه الشرب؟ أسأل

1. مضخه يدوية ( )
2. من ثانية عليها طلمبة ( )
3. ابار جوفية بطلمبة ( )
4. مضخات يدوية مركبة على ثانية( )
5. من ثانية او بئر مفتوحة ( )
6. من حفير او خزان به فلتر ( )
7. اخري وضح .....

10) لماذا لا تستخدم مياه الشرب من هذه المصادر الامنة؟ أسأل

1. لاسباب مالية ( )
2. طول المسافة ( )
3. طول الانتظار ( )
4. كل مصادر المياه امنة ( )

11) كم جملة المبلغ الذي استلمته من منظمة كير العالمية؟ أسأل

1. 1,980 جنيه ( )
2. أقل 1,980 جنيه ( )
3. أكثر من 1,980 ( )

اذا كان أقل 1,980 جنيه وضح .....

12) هل توجد نزاعات ذات الصلة بانشطة مشروع منظمة كير العالمية في مجال الدعم المالي؟ أسأل

1. نعم ( )
2. لا ( )

اذا كانت الاجابة للسؤال اعلاه بنعم أذهب مباشرة الي السؤال التالي؟ أسأل

13) كيف تم حل هذه النزاعات؟

1. عن طريق القيادات المحلية ( )
2. عن طريق منظمة كير العالمية ( )
3. عن طريق المحكمة ( )
4. اخري وضح .....

14) هل تعتقد ان هذه الانشطه سوف تنتهي بنهاية المشروع؟أسأل

1. نعم ( )
2. لا ( )

اذا كانت الاجابة للسؤال "نعم" اذكر المبررات .....

15) هل المرأة نشطه في انشطة المشروع؟أسأل

1. نعم ( )
2. لا ( )

16) كيف تم اقناع المرأة للمشاركة في انشطة المشروع؟أسأل

1. القيادات المحلية ( )

2. المشروع ( )
3. مبادرة المراءة ( )
4. اخري وضح .....

17) هل هناك عوامل تحد من مشاركة المرأة؟أسأل

1. نعم ( )
2. لا ( )

اذا كانت الاجابة نعم وضح .....

18) كيف دعم المشروع الاسر التي تعولها أمرأة؟أسأل

1. بواسطة الدعم المالي ( )
2. التدريب ( )
3. الصناعات اليدويه ( )
4. توفير مواد مثل الصابون ( )
5. توفير مياه شرب ( )

19) هل تفتكر أن هذه المساعدات المالية ذات معنى و تساعد الشرائح الضعيفة خاصة المرأة؟ أسأل

3. نعم ( )
4. لا ( )

أذا كانت الاجابة بلا وضح؟ .....

16. Annex 17: Project Evaluation TOR

Integrated Humanitarian Assistance and Reducing the Secondary Impacts of COVID-19 on the Most Vulnerable Populations in East and South Darfur

Terms of Reference for Contract to Conduct External Final Evaluation

Background

CARE is a humanitarian non-governmental organization committed to working with poor women, men, boys, girls, communities, and institutions to have a significant impact on the underlying causes of poverty. CARE seeks to contribute to economic and social transformation, unleashing the power of the most vulnerable women and girls.

The Ended OFDA project proposed integrated WASH, health, nutrition, and multipurpose cash assistance (MPCA) program will adopt a two-pronged strategy (preventive and curative). It will ensure that communities understand that the wellbeing of their families and neighbors depends on continued positive WASH, health, and nutrition behaviors and practices. The preventive approach consists of water supply services, provision of sanitation facilities, and promotion of good hygiene, sanitation, health, and nutrition behaviors and practices, MPCA, and development of self-reliance through capacity building. The capacity building and the promotion activities will focus on ensuring communities know, understand, and have the skills to prevent or mitigate mortality and morbidity related to WASH, health, and nutrition. Depending on how the situation evolves, CARE will also raise communities' awareness on the prevention of COVID-19 and reducing its secondary impact on sustaining essential services, such as IYCF, social protection, and GBV. As part of sustaining the services beyond the project period, in addition to building the communities' capacities to maintain infrastructures and collect tariffs, CARE will install solar systems to run water facilities wherever applicable based on OFDA's solar guidance for Sudan, and CARE will ensure the safety of the systems as described under the water supply sub-sector. CARE will also install hand pumps and train community-based mechanics to continue the repair and maintenance work.

The curative strategy includes the provision of comprehensive primary health care services package: treatment for different cases of illnesses; provision of SRHR and EPI services; treatment of malnutrition cases for children under the age of 5 and pregnant and lactating women; and referrals to secondary health care services. CARE currently supports three isolation centers for COVID-19 in East Darfur. Depending on how the situation evolves at the beginning of the project, CARE will take an adaptive management approach to this response and will adapt/amend the program according to the needs, in consultation with OFDA. The curative strategy will also reduce the secondary impact of COVID-19 by sustaining supply and provision of essential health services and systems, such as sexual and reproductive (including maternal) health; preventing and

managing communicable and non-communicable diseases; managing emergency conditions; and ongoing management of nutrition programs

Scope

The implemented **"Integrated Humanitarian Assistance and Reducing the Secondary Impacts of COVID-19 on the Most Vulnerable Populations in East and South Darfur"** designed with four objectives covering foursectors as in the tables below:

Sector I	**WASH**
Objective	Provision of sustainable, adequate, and lifesaving WASH services to crisis-affected and vulnerable host community members and IDPs in East and South Darfur
Sub-sector Name	**Water Supply**
Indicator 1 (OFDA)	Number of people directly utilizing improved water services provided with OFDA funding
Indicator 2 (OFDA)	Percentage of water points that are clean and protected from contamination
Indicator 3 (OFDA)	Average liters/person/day collected from all sources for drinking, cooking, and hygiene
Indicator 4 (OFDA)	Percent of water user committees created and/or trained by the WASH program that are active at least three (3) months after training
Indicator 5 (OFDA)	Total USD value of vouchers redeemed by beneficiaries
Sub-sector Name	**Sanitation**
Indicator 1 (OFDA)	Number of people directly utilizing improved sanitation services provided with OFDA funding
Indicator 2 (OFDA)	Percent of households targeted by latrine construction/promotion program whose latrines are completed and clean
Indicator 3 (OFDA)	Proportion of men, women, boys and girls who last defecated in a toilet (or whose feces was last disposed of in a safe manner)
Indicator 4 (OFDA)	Percent of excreta disposal facilities built or rehabilitated in health facilities that are clean and functional
Sub-sector Name	**Environmental Health**
Indicator 1 (OFDA)	Number of people receiving improved service quality from solid waste management, drainage, or vector control activities (without double-counting)
Indicator 2 (OFDA)	Average number of community cleanup/debris removal activities conducted per community targeted by the environmental health program
Indicator 3 (OFDA)	Percent of households targeted by the WASH promotion program that are properly disposing of solid waste
Sub-sector Name	**Hygiene promotion**
Indicator 1 (OFDA)	Number of people receiving direct hygiene promotion (excluding mass media campaigns and without double-counting)
Indicator 2 (OFDA)	Percent of people targeted by the hygiene promotion program who know at least three (3) of the five (5) critical times to wash hands

Indicator 3 (OFDA)	Percent of households targeted by the hygiene promotion program with no evidence of feces in the living area

Sector II	***Health***
Objective	***Provision of integrated and high-quality primary and reproductive healthcare services to the targeted crisis-affected and vulnerable host community members and IDPs in East and South Darfur***
Sub-sector Name	**Health Systems and Clinical Support**
Indicator 1 (OFDA)	Number of health facilities supported
Indicator 2 (OFDA)	Percentage of total weekly surveillance reports submitted on time by health facilities
Indicator 3 (OFDA)	Number of outpatient consultations
Indicator 4 (OFDA)	Number of health facilities rehabilitated
Indicator 5 (OFDA)	Number of health care staff trained
Sub-sector Name	**Communicable Diseases**
Indicator 1 (OFDA)	Number of communicable disease consultations
Indicator 2 (OFDA)	Case fatality rates for communicable diseases
Sub-sector Name	**Reproductive Health**
Indicator 1 (OFDA)	Number and percentage of pregnant women who have attended at least two comprehensive antenatal clinics
Indicator 2 (OFDA)	Number and percentage of newborns that received postnatal care within three days delivery
Indicator 3 (OFDA)	Number and percentage of births assisted by a skilled attendant at birth
Indicator 4 (OFDA)	Number and percentage of pregnant women in their third trimester who received a clean delivery kit
Sub-sector Name	**Community Health**
Indicator 1 (OFDA)	Number of Community Health Workers (CHW) supported (total within project area and per 10,000 population)
Indicator 2 (OFDA)	Number and percentage of CHWs conducting public health surveillance
Indicator 3 (OFDA)	Number and percentage of community members who can recall target health education messages
Indicator 4 (Custom)	Percentage of mothers with children under-five who can identify three or more health danger signs, that need an urgent referral of the children to the nearest health facility
Sub-sector Name	**Pharmaceuticals and Other Medical Commodities**
Indicator 1:	Number of people trained in medical commodity supply chain management

Indicator 2:	Number of health facilities out of stock of any medical commodity tracer products, for longer than one week, 7 consecutive days.

Sector III	**Nutrition**
Objective	Provision of integrated and high-quality curative and preventative nutrition services to vulnerable and malnourished U5 children and pregnant and lactating women in East and South Darfur
Sub-sector Name	**Infant and Young Child Feeding in Emergencies**
Indicator 1 (OFDA)	Proportion of infants 0-5 months of age who are fed exclusively with breast milk
Indicator 2 (OFDA)	Proportion of children 6-23 months of age who receive foods from 4 or more food groups
Indicator 3 (OFDA)	Number of people receiving behavior change interventions to improve infant and young child feeding practices
Sub-sector Name	**Management of Acute Malnutrition**
Indicator 1 (OFDA)	Number of health care staff trained in the prevention and management of acute malnutrition
Indicator 2 (OFDA)	Number of supported sites managing acute malnutrition
Indicator 3 (OFDA)	Number of people admitted, rates of recovery, default, death, relapse, and average length of stay for people admitted to Management of Acute Malnutrition sites
Indicator 4 (OFDA)	Number of Management of Acute Malnutrition sites rehabilitated
Indicator 5 (OFDA)	Number of people screened for malnutrition by community outreach workers

Sector IV	**Multipurpose Cash Assistance**
Objective	Provision of multipurpose cash assistance (MPCA) to the most vulnerable community members that are affected by the protracted conflict in Jebel Mara area and enable them to meet their variety of needs rapidly with dignity
Sub-sector Name	**Multipurpose Cash**
Indicator 1 (OFDA)	Total number of people assisted through multipurpose cash activities

Indicator 2 (OFDA)	Percentage of households who report being able to meet the basic needs of their households (all/most/some/none), according to their priorities
Indicator 3 (OFDA)	Percentage of beneficiaries reporting that humanitarian assistance is delivered in a safe, accessible, accountable, and participatory manner
Indicator 4 (OFDA)	Percentage of households reporting adequate access to household non-food items
Indicator 5 (OFDA)	Percentage of households who have reduced essential WASH related basic needs expenditures
Indicator 6 (OFDA)	Percentage of households using an unsafe water source because they cannot afford to use a safer water source
Indicator 7 (Custom)	Total USD amount of cash transferred to beneficiaries

Geographical coverage:

The evaluation will target the project operation area in South Darfur and East Darfur states, the covered localities by different sectors are:
East Darfur: Ed Daein and Bahr al Arab, Assalaya, Abukarinka, Sheria, and Yassin localities
South Darfur: Bilel, Gereida, and Kass localities and East and South Jebel Mara areas

East Darfur: Assalaya, Abukarinka, Bahar Alarab, Ed Daein, Sheria, and Yassin
South Darfur: Bilel and Kass localities and East and South Jebel Mara areas

Purpose, Objectives, and Rationale

The External Final Evaluation will be conducted to provide the project stakeholders with information about the performance of the project in relation to its stated objectives, covering the project's implementation in its entirety from 15th August 2020 to 30th August 2022.The evaluation's assessment of the project's relevance, efficiency, effectiveness, impact and sustainability will be key in informing the development and implementation of future CARE projects and initiatives in Sudan and beyond, which will build on the lessons learned and practical recommendations from this project. The External Final Evaluation is planned to take place in Sudan from 20th June 2022– 30thAugust 2022.The evaluation is looking not only at the project's intended results, but also at evidence of unintended results (both positive and negative).

The ***specificobjectives*** of the evaluation are as follows:

- Assess the quality and relevance of the project design (its activities and objectives) in addressing the priority issues in the targeted communities and institutions.
- Assess to what extent the project resources have been used economically and in a timely manner (efficiency).
- Assess the major achievements of the project to date (effectiveness).

- Assess bottlenecks, opportunities and lessons learned.
- Asses to what extent the project contributed to Provision of sustainable, adequate, and lifesaving WASH, Health and Nutrition services to the targeted crisis-affected and vulnerable host community members and IDPs in East and South Darfur (impact).
- Identify which positive outcomes of the project are likely to continue after the project ends (sustainability).

Intended Users and Use

The evaluation's findings and processes will be used and shared by relevant stakeholders, including OFDA CARE International in Sudan (CIS), the CARE International Confederation more broadly, and any other national, regional and international stakeholderslooking to replicate or build on the work carried out under this project.

Evaluation Criteria and Questions

1) **Quality and Relevance of Project Design:** To assess the appropriateness and relevance of the project design (incl. adjustments during the project duration), the evaluation will consider the following guiding questions:
    a. To what extent does the project respond to the target beneficiaries key priorities/ needs?
    b. To what extent is the project rationale built on a realistic/valid problem analysis and Theory of Change (ToC)?
    c. Werekeyrisks adequately taken into account in the project design?

2) **Intervention Planning and Implementation (Efficiency):**To assess to what extent the available resources were used economically in delivering the project (in terms of quantity, quality and timeliness), the evaluation will consider the following guiding questions:
    a. Was the overall project action plan effectively used?
    b. Cost and value for money: To what extent have the project costs been justified by the benefits?
    c. What % of activities in the workplan was successfully delivered?
    d. Was monitoring data being collected as planned, stored and used to inform adaptive management?
    e. Project management questions:
        i. Was flexibility demonstrated in response to changes in circumstances or needs?
        ii. How were working relationships with partners, stakeholders and donors?
        iii. Were donor reporting deadlines met?
    f. What have been the contributions from partner government institutions, target beneficiaries and other authorities?

3) **Effectiveness:** To assess the major achievements of the project in relation to its stated objectives, the evaluation will consider the following guiding questions:
    a. Outcome 1:

i. To what extent has the project contributed to provision of sustainable, adequate, and lifesaving WASH services to crisis-affected and vulnerable host community members and IDPs in East and South Darfur?
ii. To what extent has the project contributed to provision of integrated and high-quality primary and reproductive healthcare services to the targeted crisis-affected and vulnerable host community members and IDPs in East and South Darfur?
iii. To what extent has the project contributed to provision of integrated and high-quality curative and preventative nutrition services to vulnerable and malnourished U5 children and pregnant and lactating women in East and South Darfur?
iv. To what extent has the project contributed to provision of provision of multipurpose cash assistance (MPCA) to the most vulnerable community members that are affected by the protracted conflict in Jebel Mara area and enable them to meet their variety of needs rapidly with dignity?

4) **Impact**: To assess the project's impact on target beneficiaries and communities

5) **Potential for sustainability, replication and scaling up:** To assess whether the project's interventions and outcomes are likely to continue (sustainability) and worthy of replication/scaling up, the evaluation will consider the following guiding questions:
   a. To what extent have the key stakeholders accepted and owned the project?
   b. Which organizations/stakeholders could/will ensure continuity of project activities?
   c. Is there evidence that any of interventions/models are being copied, scaled up or replicated by other projects or by the target communities themselves?
   d. What practical recommendations can be made for the sustainability and replicability of the project?

Evaluation principles and standards

The evaluation shall always respect the security and dignity of the stakeholders with whom CARE works, incorporating gender and power elementsduring the evaluation. Evidence should be disaggregated by sex, age and other relevant diversities in line with the project's Theory of Change.

Approach and Methodology

The External Final Evaluationwill take place in East Darfur and South Darfur States. The consultant will work with relevant members of CARE Program Team in Khartoum, program managers, project staff (including field-based staff) and partners in order to develop and refine the evaluation methodology. Building on the key points outlined below, the consultant can suggest to CARE any supplementary approaches that could support the effective collection and analysis of information. The specific methodology and tools to be used will need to be approved by CARE at the start of the evaluation, based on the following steps.

- Determine the study area with key program staff. Relevance, security, resource availability and feasibility will be determining factors.
- Together with relevant staff, review list of indicators for which evaluation data needs to be collected.
- Recruit, train and manage qualified enumerators for field-based data collection

The consultant will use, but is not limited to, the following key data collection methods for the evaluation:

a. Document review (secondary data): The evaluator will review project documents: the baseline report; PDM reports, project proposals; project reports (narrative and financial).
b. On-site visual observation: In conjunction with other methods, the evaluator will observe implemented activities; take photographs or videos as appropriate, etc.
c. Interviews: Semi-structured interviews will be conducted with key informants (groups or individual as appropriate).
d. Focus group discussions: With target beneficiary groups, as well as community leaders.
e. Questionnaires: The evaluator will design very specific and structured set of closed questions (yes/no or multiple-choice questions), as well as or they can also more e open-ended questions framed within the key guiding evaluations questions.

Comparability of data

If this evaluation is NOT a baseline, it needs to take its guidance on indicators, sampling, and methodology from the baseline so that data is comparable from the baseline to measurements. All survey tools, sampling frames, data sets, final reports, and other methodology from the baseline will be available to the consultant to ensure consistency of data across evaluations.

Profile of the Consultant

The consultant should be specialized in WASH, Public health, sustainable livelihoods, or any related background with excellent experience in monitoring and evaluation. The consultant will have the primary responsibility for conducting the evaluation and writing the final report to a publishable standard. The consultant should possess strong statistical skills and will be expected to coach data enumerators, as well as coordinating data collection, entry and analysis of data. All leadership of the tasks and expenses are to be covered by the consultant.
Specific requirements include:

- Advanced university degree in Engineering, public health , rural development, social science, , or related field.
- Extensive knowledge and experience working in Sudan.
- Demonstrated knowledge of project evaluations and strong research skills.
- Demonstrated skills in statistics.
- Experience in the development, monitoring and evaluation of donor-funded projects.
- Strong interpersonal and communication skills.
- Excellent spoken and written English and Arabic.
- StrongIT skills.

Expectations

Final Report Requirements

The external evaluator is accountable to maintain the requirements for the content, format, or

length of the final report, overall quality and approved timelines. They will produce a comprehensive report that assesses the project's achievements, relevance, coherence, coverage, effectiveness, efficiency, and results.

The contract will be a deliverables-based contract, and final payment will be contingent on receiving the agreed deliverables in their final versions at acceptable quality standards.

The report must include at least the following:

- **A Title:** A title that conveys the name of the project, location, implementation period, as well as the main impact or key finding of the report.
- An **executive summary that focuses both on process as well as impact** that is no more than 2 pages in length and is formatted so that it can be printed as a stand-alone 2-pager about the project.
- **A clear methodology section:** the methodology should explain the evaluation questions, and how the chosen methodology appropriately answers those questions. It should also contain key ethical considerations and a description of how the evaluators protected participants and personally identifiable information.
- **A results section**: The results section should be organized according to the five evaluation criteria and provide answers to the evaluation questions.
    - **The section on impact should include 3-5 key impacts/findings:** What changed because of the program? What happened in the project areas, and why did it matter? List the project's most significant accomplishments, supported by solid evidence.
    - **Bullets describing how the project got to impact**: It is important to have non-jargon descriptions of what a project did to get to impact. Sources of all evidence must be identified.
- **Conclusion and recommendations:** Conclusions must be based only on evidence presented in the report, and recommendations must directly correspond to the conclusions. These should be short, actionable, and the most important aspects of what the evaluation found. They need to be relevant and new for people outside of the direct program. They should also include highlights of what to improve in the future.

Evidence collected by the external evaluation from the conclusions and recommendations must be submitted along with the final report. All datasets, qualitative interviews, and underlying data are owned by CARE and are included in final deliverables.

The report must be submitted in English and must be of high quality (publishable standard). It should provide substantive evaluation against key indicators as outlined in the project work plans and the log-frame, and should be structured accordingly.

A draft report on key findings will be shared with MEAL coordinator for reviews and enrichment. MEAL coordinator will be the contact person between the consultant and CARE to ensure all outputs are delivered as per the ToR.

In line with CARE programming, the evaluation will be gender sensitive, participatory and promote a learning approach. The consultant will ensure that the assessment covers these essentials in the report:

A. Was the stakeholder involvement appropriate?
B. Did the project promote a gender sensitive approach?
C. Were women's priorities and aspirations adequately considered in delivering the interventions?

The report needs to match the format and instruction of BHA, see the guidance using the link below:

https://careinternational.sharepoint.com/:b:/t/ProgrammessharedData/EY8h7PEtcLpNq8D7V9ZDFUgBMtuCJBj53i8WGLcgSyfA3w?e=ljKzpX

Data Disclosure

The external evaluator should deliver, at minimum, all files including quantitative data sets (raw and refined products), transcripts of qualitative data and others in an easy to readformat and maintain naming conventions and labelling for the use of the project/program/initiative and key stakeholders.

All documents should be compliant with the following conditions:

- The external evaluator represents and warrants that all work created pursuant to any agreement shall be original work and that no third party will hold any rights in or to such work. The external evaluator agrees that CARE shall, solely and exclusively, own all rights in and to any work created by the external evaluator in connection with any agreement, including all data, documents, information, copyrights, patents, trademarks, trade secrets, or other proprietary rights in and to the work. By entering into any related agreement, the external evaluator hereby expressly transfers all such rights to CARE.
- During the term hereof and for three years thereafter, the external evaluator agrees not to disclose any matters of a confidential nature to which it may be or become part of as a result of an Agreement. Confidential information shall mean any information (written, oral or observed) relating to: (a) donors or potential donors; (b) participants; (c) employees; (d) business or strategic plans; (e) finances; or (f) a relationship with any governmental entity; and shall also include information specifically designated confidential by the owner or that the disclosing party knows or reasonably should know is not public. Confidential information does not include any information generally known to the public or readily obtainable from public sources. Further, confidential information may be disclosed to government authorities if the disclosure is required by law and the disclosing party has provided the owner notice and, if practicable, a reasonable opportunity to defend against such disclosure. Upon the expiration or termination of an Agreement, the external evaluator shall surrender to CARE all confidential material relating to CARE in his or her possession, of whatever origin.

- CARE requires that the datasets that are compiled or used in the process of external evaluation are submitted to CARE when the evaluation is completed.
- **Datamust bedisaggregated by gender**, age and other relevant diversity, in line with the project's Theory of Change.
- Datasets must be anonymized with all identifying information removed. Each individual or household should be assigned a unique identifier. Datasets which have been anonymized will be accompanied by a password protected identifier key document to ensure that we are able to return to households or individuals for follow up. Stakeholders with access to this document will be limited and defined in collaboration with CARE during evaluation inception.
- In the case of textual variables, textual datasets or transcripts please ensure that the data is suitable for dissemination with no de-anonymizing information **UNLESS** these are case studies designed for external communication and suitable permission has been granted from the person who provided the data. In these circumstances, please submit, with the case study, a record of the permission granted, for example a release form[1].
- Where there are multiple datasets (for example both tabular and textual datasets) identifiers must be consistent to ensure that cases can be traced across data lines and forms.
- CARE must be provided with a final template of any surveys, interview guides, or other materials used during data collection. Questions within surveys should be assigned numbers and these should be consistent with variable labelling within final datasets.
- Formats for transcripts (for example: summary; notes and quotes; or full transcript) should be defined in collaboration between CARE and the external evaluator at the evaluation inception
- All temporary or dummy variables created for the purposes of analysis must be removed from the dataset before submission. All output files including calculations, and formulae used in analysis will be provided along with any Syntax developed for the purposes of cleaning.
- We require that datasets are submitted in one of our acceptable format types.
- CARE must be informed of and approve the intended format to be delivered at evaluation inception phase. Should this need to be altered during the project CARE will be notified and approval will be needed for the new format.
- The external evaluator will be responsible for obtaining all necessary permissions, approvals, insurance, and other required permits needed for data collection. These include required permits related to data collection from human subjects, including

[1] All release forms should be agreed in advance with CARE.

necessary ethical review board approvals (ERB) and health and accident insurance for evaluation team members.

Work Plan & Schedule

The evaluation shall take no more than 40 staff time days starting from the day of signing the contract. The schedule below is intended as guidance for prospectiveconsultants to make their own proposal, to be reviewed by CARE and amended as necessary.

Evaluation Activities	*# Days*	*Key Outputs*
1. Preparatory activities: questionnaires, sampling strategy & interview guidelines; development of evaluation matrix in line with key evaluation questions shared with CARE for feedback; development field data collection plan	4	Evaluation tools & plans shared with CARE for review & approval
2. Incorporate feedback from CARE	3	Tools & plans reviewed and agreement with CARE to start fieldwork
3. Desk review, training of enumerators	3	Qualified enumerators identified & onboarded
4. Data collection, incl. on-going coaching of enumerators	15	Data collected
5. Data compilation and analysis	7	Data analyzed in line with evaluation matrix
6. Preparation & sharing draft report and de-briefing	5	Draft report shared
7. Incorporation of comments and finalization of the evaluation report	3	Publishable report finalized
Total days	***40***	

Budget

The proposed evaluation budget is to be presented by the consultant as follows:

Details	Unit	Rate (US$)	# of Units (Quantity)	Cost (US$)
Consultant's fees (including data enumerators' costs)				
Transport costs				
Vehicle rent for field data collection				
Subsistence costs (e.g. accommodation,				

communication, meals, etc.)				
Any other costs that are critical, but not provided for by CIS				

Logistical Support

CARE will support the necessary field arrangements, including any measures related to HAC and other related requirements. Standard logistical support (incl. scheduling of interviews with staff, arrangement of field accommodation during data collection, access to facilities including internet, documentation, printing, photocopying, etc.) will also be provided by CARE.

Required External Response to Terms of Reference

A technical and cost proposal based on this Terms of Reference (ToR) is requested from the consultant or consulting firm. The proposal should contain:

1. Detailed plan of action for field work indicating staff-days required
2. Specific roles and responsibilities of the team leader, supervisory chain and other core members of the evaluation team.
3. Schedule of key activities preferably in a format such as a Gantt chart.
4. Detailed budget with justification. The external evaluation proposal should include a realistic, detailed budget to cover all costs associated with the evaluation. This should be submitted by major activities and line items for CARE's review and decision. This includes a break-down of the cost to contract external evaluation team members, international and local travel, and in-country lodging and per diem. Other related costs that might be in the budget include expenditures for hiring local personnel (drivers, translators, enumerators and other local technical experts), translating reports, and renting meeting rooms for presentations/workshops.
5. Updated CV of Team Leader and other core members of the Evaluation Team
6. A profile of the consulting firm (including a sample report if possible)

Other Conditions

- The consultant must adhere to the CARE Code of Conduct and CARE Security Protocol during the entire duration of the assignment.
- CIS will not provide *per diems* or allowances. All out-of-pocket expenses must be taken into consideration when proposing daily fees.
- The consultant should budget for enumerators and translators and present this as a separate section in her/his proposal. CARE will consider reasonable rates and number of such hires.
- The consultant is solely responsible for the payment of enumerators, printing and data entry and analysis costs
- The consultant is responsible for any tax or other fees related
- Payment will be in two installments: 30% at the time of signing the contract and 70% upon satisfactory completion of the tasks and submission of the final report to publishable standard.

Interested candidates are invited to submit their applications together with curriculum vitae and 'Final Project Evaluation Application' mentioned in the subject to the following addresses:

Procurement: Hanadi.Algaali@care.org

MEAL: Nasreldin.Saeed@care.org

The deadline for submitting applications is as indicated on the advert. Only shortlisted candidates will be notified.

Annex 1: Overview of project Outcomes, Outputs and Activities

To achieve its objectives, Sawtaha Project implements the following key activities under each of the outputs:

Output	#	Activity
Outcome 1: Women/youth female empowerment for meaningful participation in leadership		
1.1 Enhanced capability for women's meaningful voice in leadership and decision making	1.1.1	Training women (from different groups) on leadership skills and public speaking skills
	1.1.2	Train women (from different groups) members on Gender, Peace and conflict Modules
	1.1.3	Awareness sessions on the participation of women in Decision making and conflict resolution using drama show campaigns
	1.1.4	Select model women for awareness sessions on gender, PSEA and peace-building to community members
	1.1.5	Engage women Groups in gender related issues forums and Discussions
1.2 Women are actively engaged in economic and social activities to enhance their decision making power	1.2.1	Provide business skills training to selected women (VSLA leaders + any income generators)
	1.2.2	Provide startup capital to women groups (it includes individuals)
	1.2.3	Provide food processing training to women Groups (including young women groups or women groups that majorly consist of young women)- Distributing startup tools and materials
	1.2.4	Support women engagement in market management committees
1.3 Women and girls have an increased awareness of their rights with regards to gender-based violence and PSEA	1.3.1	Engage Ypeer to raise the awareness of women through dialogues and discussion sessions with women on women rights and the existing risks and discrimination practices among women groups (gender, SGBV)
	1.3.2	Facilitate Radio campaigns to combat GBV and negative social norms against women and advocate for women participation
Outcome 2: Inclusive decision making spaces created and protection risks addressed		

2.1CBRMs are supported to be vibrant and gender transformative	2.1.1	Training CBRM leaders on GBV and the availabe referral systems
	2.1.2	Training in leadership and decsion making for CBRM leaders
	2.1.3	Training for CBRM leaders on gender in conflict situations, peace building, PSEA, and protection
	2.1.4	Training to CBRM members in management of disputes and, conflicts as well as reporting them
	2.1.5	Exchange visits for role model CBRMs members to advocate for women participation in decision making and conflict resoultion
	2.1.6	Identify and train gender champions at community level
2.2 Women actively participate in community groups and decision-making structures for peacebuilding, conflict resolution and recovery	2.2.1	Support the legalization and orgainization (by-laws)of women groups and to create a network for women groups and to link them with service providers and powerholders
2.3: Protection risks and gender based violence issues are recognized and responded to by structures in a survivor-centered approach	2.3.1	Training government officials and religious leaders on protection risks facing women, grils, youth and older people, how to manage them and the role of women and girls in addressing protection and conflict related risks
	2.3.2	dentify and train gender champions among CIS, government, NGOs staff and teachers
2.4: Safe spaces are created for women and youth to interact and engage to address their concerns and priorities collectively	2.4.1	Use Radio for commuity disscusion sessions with Hakimas, model men and religious leaders who support women's inclusion in conflict resolution structures - Communty discussion sesssions to support women inclusion in confict resolution structures - Field radio reporting
	2.4.2	Conduct dialogue and discussion sessions among different community groups on the spaces that should be made available to women and youth
<u>Output 1.3:</u> Women and girls have an increased awareness of their rights with regards to gender-based violence and PSEA		
3.1: The normative roots of gender	3.1.1	Facilitate dialogue and discussion sessions among community structures, leaders and CSOs on addressing the violence and protection risks

inequality, power, gender-based violence, and fragility of peace for sustainable recovery, including how they interact, are identified and discussed		
	3.1.2	Create a network for women, youth and CBRM groups and to link them with service providers and powerholders to address conflicts and peacebuilding
3.2: Change stories are captured and shared	3.2.1	Develop success stories for thematic areas that support the change process through films
	3.2.2	Share the 2019 research results on Gender (GaPI) - National and state level