



CARE INTERNATIONAL SWITZERLAND SUDAN

CIS South and East Darfur Emergency Assistance Project

Final Evaluation – 2017/18 and Baseline Report 2018/19

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ABBREVIATIONS

AAO	Alsawaad Alkhadra Organization
ANC	Antenatal Care
AWD	Acute Watery Disease
CHV	Community Health Volunteer
CHW	Community Health Worker
CTC	Cholera Treatment Center
EmOU	Emergency Obstetric Unit
CHP	Community health Promoter
JMCO	Jabal Marra Charity Organization
IDP	Internally Displaced Person
IPs	Implementing Partners
MAM	Moderate Acute Malnutrition
NCV	National Community Volunteer
PLW	Pregnant and Lactating Women
PNC	Prenatal Care
SAM	Severe Acute Malnutrition
SCMP	Standard Case Management Protocol
SMOH	State Ministry of Health
WFP	World Food Program
WHO	World Health Organization
WASH	Water, Sanitation and Hygiene

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OVERVIEW

The information presented in this report was collected through field visits to the project sites in South and East Darfur States during the period 11-19, November, 2018. The field work conducted included meetings with the project staff, ministry of health and WASH officials. Direct information is obtained from interview of 265 households and organization of five FG sessions with community representatives, one in each location of the 4 sites in SD and one site in ED.

CIS South and East Darfur Emergency Assistance Project is implemented over a duration of 15 Months, including a non-extension cost period of about 3 months. The project aimed to contribute to the immediate life-saving needs and development of sustainable services for the reduction of morbidity and mortality among IDP, returnee and affected host community men, women, girls and boys in four conflict affected localities in South Darfur and one locality in East Darfur,. This is to be achieved by provided multi-sectoral interventions that included health, nutrition and WASH, with each sector divided into a number of subsectors that comprise a set of integrated interventions.

In the health sector, the evaluation revealed that CIS has performed more than 95% of its plans during the project period. Where, Cis rehabilitated and provided maintenance for 7 Health clinics and an Emergency Obstetric Unit (EmOU). These facilities are supplied with necessary medical equipment and drugs in cooperation with UNICEF, in addition to necessary support for the operation of the health facilities. The support also included training of health cadre and Community Health Workers (CHWs) and midwives. The health facilities are well functioning and providing necessary consultations and treatment for the beneficiaries. The project has also intervened during Acute Watery Diarrhea (AWD) outbreak that occurred during project duration and supported the immunization campaigns of the SMoH.

The health support facilitated population access to health services and improved the quality of services, where about 50% of the households interviewed affirmed relevance and high quality of the health care they received. The occurrence of diseases among the population is estimated at 11%, least being 0.42% among < 11 months age category and highest 4.2% among the age category 5 to 14 years. Malaria emerges as most common disease with percentage of 6.6%, in addition to chest infections and diarrhea. The visits of the health facilities reflect the high demand on the services while about 20% of the target population reported that they have visited health facility during the past six months. This suggest a health situation in the camps, in which IDPs are relatively more subject to communicable diseases and at the same time reflects the importance of sustaining the support to the health services.

In the nutrition sector, the project was able to establish and maintain functioning of 15 nutrition centers in the different locations of the project for treatment of MAM and SAM cases. Necessary training is provided by Mubadroon organization for about 230 NHWs, who were provided with IEC materials and supplementary food, which is regularly delivered in coordination with WEP. Mother support groups are also established to contribute and disseminate nutrition messages among community members.

Prevalence of malnutrition is estimated at 10.4% among the population for those who received treatment during the last year or undergoing treatment. Slightly more than 89% of the women indicated tendency to deliver at health facility, however, the rate of ANC is relatively low and women tend to go for checkup during the last month of the pregnancy, which imposes high risks on newborn and mother health, and suggests to continue and expand deliver of **reproductive health** awareness messages among women and men as well.

The WASH interventions included construction and maintenance of five water stations four of them are operating by solar energy, in addition to 14 water pumps nine of them were repaired by OFDA, and implemented in coordination with WES, Mubadroon and UNICEF. WASH committees are trained to manage the water use and repair the small damages and pay for the guards' incentives. Water treatment, discharge and quality are regularly monitored. Volunteers from IDPS and host community were trained on health and hygiene practices to increase the awareness of the people about the health. Water yards are drained, 270 latrines are constructed and garbage disposal tools are distributed and garbage collection campaigns are organized in the target locations.

About 71.2% of the IDPs and rural communities' households indicated having access to clean water source. And 84.5% reported use of public or private latrines. In light of the high benefit the beneficiaries realized, about one third of them want the project to continue with the same activities, however, the remaining two thirds want the project to expand to new locations with more nutrition centers and water resources, which represent the top priority for target IDPs and host communities, which they think would alleviate the pressure on the services which is shared with neighboring communities.

The project has made substantial progress in achieving the stated results by reaching 309,981 persons affected by conflict, of whom 228,086 are IDPs, who benefited directly and indirectly from the project support.

A total of 36,893 people are regularly benefiting from the health and nutrition services. Another 14,712 beneficiaries received consultation services, diagnosis and treatment per standard protocols and national guidelines, 1,024 patients received comprehensive antenatal services, 148 women delivered at a health facility assisted by trained health cadre, and 168 women at reproductive age received family planning advice during the project period.

A total of 10,425 persons benefited from therapeutics and supplementary feeding, education and awareness raising targeting children under five and pregnant and lactating women (PLW), while, WASH interventions supported 241,418 individuals, with access to clean water, hygiene promotion and environmental campaigns.

Below is a summary of the quantitative and qualitative findings that can serve for both end-line and baseline indicators;

Indicator	Project start indicators %	Final evaluation indicators %	Explanation	Remarks
Sub sector: Water supply and sanitation				
Access to clean water	40%	55%	71.5 of the 265 HHs the survey covered in 9 locations	The % is relatively high compared to CBS, HBLs,2009 that estimated access to clean water at an average of about 40% for the five localities, with a walking distance to water of 49-59 minutes. Thus, the percentage is corrected according.
Access to clean water Yassin		43.6%		Significant improvement in access to clean water took place in the target locations.
% of households with no evidence of faeces in the living areas	25%	30%	Baseline based on No of households that uses latrines in the camp and those who deface in the field	Though 60% of the locations reported no evidence of deface in the living area, people reported no faeces; this % is much less by half as people deface in the open when they are in the field The construction of latrines and the environmental hygiene campaigns has much improved the camps surroundings
% of HHs using latrines	25%	84.5%		84.5% in overall and 64.9% in Yassin locality of the respondents said they use latrines but while out to the field, open defecation is common
% of HHs using latrines Yassin locality		64.9%		
Received Hygiene promotion awareness Yassin locality		81.3% 11.4%		81.3% average for most areas while Yassin is lower
Nutrition Rates of admission, default, death, cure, relapse, nonresponse-transfer, and length of stay				

Cure rate	None (Sphere 89.2%)	84.0%	The cure rate is acceptable and healthy	Use against sphere indicator
Default rate	None (Sphere 7%)	12%	Baseline based on the estimated prevalence of malnutrition of 10% among population	Treated or undergoing malnutrition treatment
Death	None (Sphere 1%)	0.6%		Low and good success
Health				
Percent of those who received consultations	NA	88.2%	Reveals high tendency among communities to seek health treatment when ill	More efforts are needed to reduce occurrence of communicable diseases
Prevalence of illness and sought treatment during last 3 months Chest infection Diarrheal Malaria	NA	10.9% 0.46% 0,6% 5.7%		
Frequency of visit to health facility	NA	22%		Very low health seeking behaviour
Attended delivery	47%	50%	Project start indicator is based on the CBC, HBLs, 2009	The % of attended delivery suggests more support to EmOU and deliver of messages to encourage women deliver at HCs and hospitals
% of community members utilizing health education messages	50	60%	80% of beneficiaries indicated having received hygiene promotion awareness. But in practice this percentage drops to 60%	Means for practicing and adopting health education messages need to be enforced and consolidated more.
PNC in first 3 days	75	50%	The low rate is attributed to women tendency to deliver at home	Enhance women to deliver at HC or hospital and reduce at home delivery. This is from those who attended third semester visit only

1. INTRODUCTION

During the past years, CARE has been providing emergency assistance services to the IDPs and host communities affected by war in Darfur state in a number of lifesaving sectors such as WASH, health and nutrition. Over the past five years CARE has been supporting peace building and good governance through empowerment and inclusion of communities in the economic and decision making and support of community based conflict resolution mechanisms;'

The war and the recurrent climate crisis in the region have severe negative impact on the livelihood of the population, who, with loss of production assets due to displacement, become more vulnerable to shocks and greatly dependent on the humanitarian and lifesaving assistances provided by the international community.

The hardships the Darfur people suffer, particularly the IDPs and rural communities are manifested in the poor access to basic social services and human development indexes. Where, according to the national households' baseline survey, CBS, the illiteracy is as high as 57% among 15 year and above age category. The majority of the population, 51% depend on hand pumps and shallow wells for drinking water, with a mean water walking distance of about one hour, while the population who depend on water filtering stations with common networks doesn't exceed 4%. About 31% of the households have no latrines and garbage disposal methods are heaps and burning, which represent 63% of garbage disposal methods.

The table below shows some of the indicators for WASH, nutrition and reproductive health for the five locations the project targeted.

Sudan s3 core indicator		children 6 - 59 month						mother of children 0-5 year					Households		
State	locality	stunning global	wasting global (WHZ)	wasting SEVRE (MUAC)	child vitamin A supplementation	Age appropriate full vaccination	Good diarrhoea treatment	Mean number of illness danger signs	Exclusive breast feeding	At least one ANC visit	four or more ANC visits	Attended delivery	Improve water source	Improved sanitation facility	Five critical hand washing points
	key	>30 %	>15 %	>3 %	<60%	<50%	<50 %		>70 %		<6%		<50 %	>50 %	
	Khartoum	20.2	8.2	1.3	79.7	89.4	22.2	1.5	55.2	95.8	84.4	96.7	90.4	47.9	2.1
	Belil	37.1	15.9	0	96	84.2	28.3	2.6	66.7	88.5	43.8	58.3	13.5	12.5	3.5
	El salam	47.2	29.1	4.4	74.3	7.1	3.9	2.5	94.4	78.4	38.9	26.1	27.8	2.3	2.6
	Geriada	0	17.7	0	61	91.3	14.3	1.9	100	100	75	75	33.3	6.1	2.3
	Kass	38.1	14.5	3.8	78.6	48.9	34.2	2.2	82.9	80.9	40.6	32.9	47.3	3.1	2.6
	Yaseen	42.6	22.6	5.7	5.8	89.6	Na	1.8	0	56.3	48.4	42.2	25	10.9	2

Source, Federal Ministry of Health

1.1 The Project Background

The project under evaluation is a one-year project from May, 2017 to May, 2018, but closed in 14 August, 2018, after a none extension period of 3 months. The project is supported by OFDA and was implemented in one locality in East Darfur and other four localities in South Darfur with total budget of 2.7 M \$, with the objective to contribute to the immediate life-saving needs and development of sustainable services for the reduction of morbidity and mortality

among IDP, returnee and affected host community men, women, girls and boys in East Darfur and South Darfur. This objective is tailored to be achieved through a number of activities and associated outputs, grouped into the main sectors of health, nutrition and WASH.

The project activities are implemented in participation with national NGOs, Mubadroon, AAC and JMCO and international agencies, UNICEF and WFP.

Since, the project has completed its duration; CAER is willing to conduct the final evaluation of the project to measure achievements, inform future planning and set baseline indicators for the subsequent similar projects that may be implemented by CARE and others.

1.2 The evaluation objective and coverage

The final evaluation aim is to inform the stakeholders about the project progress and performance and come up with practical and feasible recommendations for future improvements. Thus, the evaluation measures the physical progress of the project as expressed by the actual implementation of the activities as compared to plan. The evaluation also reviewed the performance of the project in terms of its relevance, efficiency, effectiveness, impacts and sustainability. The evaluation findings and generated indicators would serve as baseline for the new project that will be supported by the same donor.

The final evaluation covered the IDP and host communities the project targeted in Yassin locality in East Darfur and - the four localities of Kass, Kalma, Gereida and Alsalam localities in South Darfur. In addition, the evaluation consulted with the project beneficiaries, implementing partners (JMCO and AAO) and the line ministries of health and water.

The sectors in which the project worked and the evaluation covered included health, nutrition and WASH sectors. Where, the physical progress of the project is measured at the output level for each of the outputs stated in the project statements. This included the sectors mentioned and the outputs stated under each main and sub sector outputs of the project statement. Further, the evaluation examined the project performance along the evaluation criteria stated in the terms of reference to explain the relevance, efficiency, effectiveness, sustainability and possible impacts of the project to provide answers for the questions mentioned in the TORs under each evaluation criteria.

1.3 The Evaluation Methodology and tools

The final evaluation adopted an approach that addressed the project concerns and encouraged participation of stakeholders and beneficiaries. This was achieved through regular consultations with the project, during the evaluation period and use of friendly tools to gather the information required for fulfilling the required tasks and gathering information from the suitable sources. Hence, different methods and tools are employed for obtaining and recording information at households and community levels, as well as at stakeholders' levels.

In specific, the information presented in this report is obtained through use of the following different methods and tools;

- **Outputs statement template** was used for review of the project documents during meetings with the project staff to collect quantitative data to fill the project outputs. The information obtained from the office documents and staff is verified during meetings with IPs, MoH and WES.
- Observation of the activity sites.
- **Partners' checklist** guided the structured interviews organized with IPs, SMoH, WES and health centers staff, to obtain sectors statistical information and information on the level of partners' participation in the activities the project has implemented and suitability of methods of implementation that the project followed.
- **Households' questionnaire** was used for interview of randomly selected representative sample of direct beneficiaries.
- **Community FGD questions** was used to facilitate in-depth discussion with the communities representatives on their opinions regarding the benefits they realized, relevance of these benefits to their urgent needs and their abilities to sustain the benefits. For evaluation tools refer to annex 1.

1.4 Sampling Provisions and Procedure

A representative statistical sample of 380 households of IDPs and host communities was calculated using the standard sample size calculation formula; $S = z^2 P (1-P)^2 / e^2$ where, S is the sample size, Z is the standard deviations coefficient = 1.96, P is probability = 0.5, e is the marginal error = 0.05 This sample is split equally between the 5 location, i.e. 76

households, say 80 per location. The location sample is then split evenly between the IDPs and host community, assuming there is an IDP and host vulnerable community in each of the five locations, which yield 40 households for each type of community. However on the ground, it is found that 3 locations don't have both types of communities (Kalma and Alsalam are all IDPs and Yassin are all returnees), hence, the sample size is reduced accordingly. This reduction in the sample size is not expected to affect the findings as the reduction in the sample size is proportional to the number of locations surveyed.

The collected households' data was entered and analyzed electronically using Tableau application for business analysis and a soft copy of the database in Excel is attached to this report

The distribution of the sample is shown in the below table.

Location	Kass	Kalma	Gereida	Alsalam	Yassin	Total
Kalam camp		43				43
Alsalam camp				40		40
Kelakely village					40	40
Dagma camp			31			31
Dar Alsalam camp			31			31
Lemo	20					20
Almowashi	20					20
Stagira	20					20
Veterinary camp	20					20
Totals	80	43	62	40	40	265

The households are selected for interviews randomly using the pencil tip method to select first household, then enumerators moved anti O'clock wise with a decided interval between households proportional to the number of location households and the allocated sample size to select the next household for interview. For some large or mixed host-IDP communities, such as Kass, communities are divided into zones for sampling to ensure that all clusters and groups, including women are represented in the sample.

The field survey was supervised by a field surveyor assisted by a data collector, both are lectures at the University of Nayala and University of Ed Dein and were assisted by four enumerators, all are selected locally.

2. OUTPUTS ACHIEVEMENTS

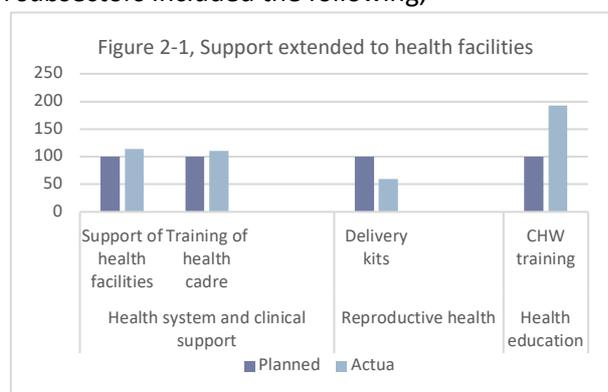
The project has made remarkable progress in the implementation of the activities which conform to the planned activities and exceeded targets in some cases, as depicted in the figures below along the three main activity sectors of health, nutrition and WASH.

The activities the project has implemented in the different health subsectors included the following;

2.1 Health Sector

At the construction level, the activities implemented under the health sector included rehabilitation, maintenance and equipping of 8 health facilities, including an EmOU in the localities of Beleil and Kass. The project has also extended support to CTC during the AWD incidence during; 06-10, 2017.

At the operational level, the facilities established are provided with necessary equipment and medicines necessary for provision of quality health services, which CARE was able to provide in collaboration with WHO. This support also included provision of logistics required for proper operation of the health facilities.



At the level of health cadre, health system support is extended to build the capacity of the health cadre and CHWs and volunteers, who are equipped with the basic skills they need to improve their performance, where, about 121 of the

staff and volunteers, of whom about 90 are females, are provided with relevant training on different relevant subjects as shown in table below, and are actively involved in the delivery of the health services.

Table 2-1, Numbers and subjects of training delivered to health cadre;

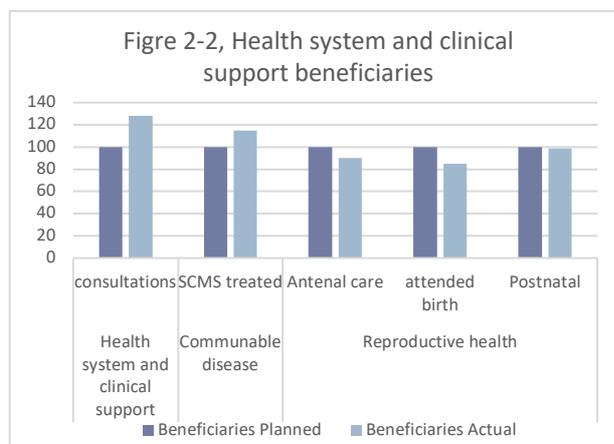
Health cadre	Midwives	Medical and pharmacists assistants	HCPs	CHVs	Medical assistants	Midwives	Nurses and midwives	Total
No trained	15	12	9	25	29	25	6	121

Moreover, the health support is extended to five rural clinics through establishment and training of five health committees. The project also provided the necessary logistics for the state vaccination campaign of measles, polio and Tetanus toxoid (TT) in Kass locality and paid monthly incentives for the SMOH vaccinators who were working at health facilities

These activities are implemented with CARE support, working in partnership with SMOH, WHO, Mubadroon and other local IPs, which succeeded in making available necessary medical equipment's and drugs as well as logistics that maintained proper functioning of the operation of the rehabilitated health centers and the EmOU.

Almost all activities implemented in this subsector exceeded targets, probably attributable to a higher demand and sharing of the health services with neighboring villages, except for minor reduction in the delivery of clean delivery kits, as shown in figure 1 to the right. This reduction is attributed to the relatively low pregnancy among IDPs women as indicated by the percentage of pregnant women, as discussed later.

The numbers of beneficiaries who benefited from these activities according to the project monitoring records are shown in figure 2-2, to the right. The figure reflects an increase in the of beneficiaries treated from communicable diseases as well as those treated by SCMP, when compared to planned, as well as minor insignificant drop in the number of the actual beneficiaries than expected who benefited from antenatal and attended birth care. The reduction in the expected number of beneficiaries is associated with the reproductive health subsector, which may be attributed to traditional tendency among women to deliver at home and suggests that more attention need to be exerted in health education and consolidation and expansion of the reproductive health messages at wider community levels.



Along the communicable diseases sector, adequate and appropriate cleaning materials, disinfectant and materials are distributed to health facilities and community members.

The health support also covered the reproductive health, where, PNC, attended delivery and PNC are made available for women, while family planning tools are distributed to the beneficiaries, accompanied by health education sessions.

2.2 Progress along nutrition sector

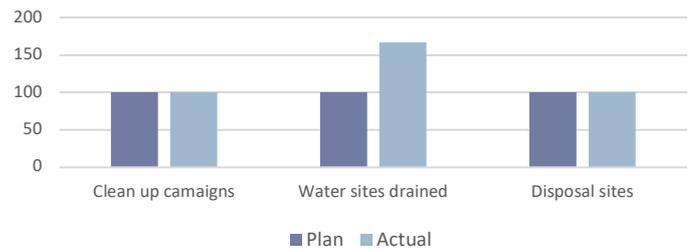
The interventions designed under the three subsectors of nutrition that included infant and child feeding behavior change, management of MAM and SAM and training of HCVs and NCVs. The necessary IEC materials are prepared and produced and made available at the nutrition centers for use by NCVs and the formed mother support groups, who received a series of training packages in about 10 training rounds in which about 230 of the nutrition cadre has participated, to forward messages on nutrition, supplementary and breast feeding messages at wider community level.

Survey of malnutrition of children is carried by Mubadiroon organization and nutrition centers are accordingly opened in 7 locations for treatment of MAM and SAM, with support from WFP and UNICEF, which provided the food rations and drugs.

In general, implementation is achieved as planned and the number of targeted beneficiaries expected to benefit from the sector is in line with the actual number of beneficiaries with observable increase in the number of those who benefited from the MAM treatment.



Nutrition center in Sengeita village
Figure 2-3, Implementation of environmental health interventions



2.3 Progress along water sanitation and hygiene

The three main intervention that included cleanup campaigns, drainage of water sites and waste disposal sites are well delivered and conform to the planned interventions. In addition, home visits are conducted by the trained CHPs and fecal coliform tests on water are regularly performed. All necessary hygiene materials and tools are distributed to beneficiaries adequately.

In ED, the project WASH activities are implemented in Yassin town, Kelakely Mojo village and Selya village by the project local partner AAO. Where one water yard was repaired including water tanks, water pipe network, water points and separation of human water points from that used for animal drinking, in addition to training of water committee members (9) on management of water sources and other (14) members on hygiene promotion.

In overall, the number of beneficiaries who benefited from the WASH interventions has very much exceeded targets with a percentage that is almost double of that targeted, this may be due to the fact that most of the water sources constructed are shared with neighboring villages and nomads, whose numbers often exceed the villages' population, which put more pressure on use of the sources and consequently increases water source management and maintenance burdens on the direct beneficiaries.

Refer to annex 1, project outputs, for details of the different interventions implemented and the number of beneficiaries for each intervention and for annex 2, for materials and equipment supplied.

3. THE EVALUATION INDICATORS

Concerning the overall interventions, about 50% of the beneficiaries affirmed their high benefit from the project, 35% indicated that the benefit is less than their expectation and the remaining consider their benefit intangible. Accordingly, similar proportions of the beneficiaries rated the relevance of the intervention to their needs, as highly relevant, 45%, relevant 40% and not relevant 15%. The fact that 85% of the beneficiaries affirmed relevance and benefit from the project, which is considered a realistic and healthy indicator, as projects are not always expected to meet beneficiaries expectation with a 100% consensus. Thus the 85% is encouraging and reflect the high value of the intervention to the majority of the beneficiaries in addressing their actual needs. While the reasons behind the dissatisfaction of the remaining 15%, could be attributed to a number of factors, most likely beyond the project domain of control, such as their personal interest to get more support or they didn't encounter a health problem that made it necessary for them to visit a health facility during the project time.

3.1 Health indicators

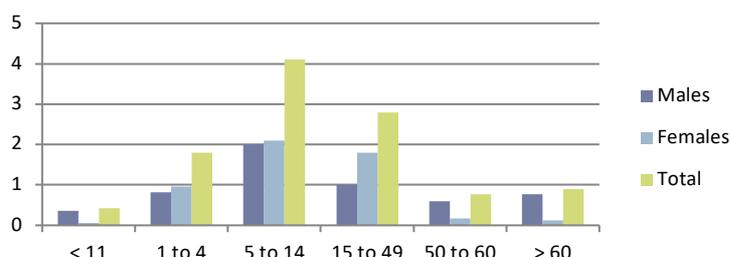
Table 3-1, incidence of diseases among communities by age category

Age category	No ill	%
< 11 months	7	0.42
1 to 4 years	30	1.8
5 to 14 years	69	4.1
15 to 49 years	48	2.9
50 to 60 years	13	0.77
> 60 years	15	0.9
Total	182	10.98

It worth mentioning that, the communities survey didn't obtain the distribution of population surveyed by age, but obtained the total number of persons surveyed, which is 1,688 persons. Therefore, instead of using the number of persons in the age category when calculating percentages, which would have been more informative, the total number of the surveyed population is used as a base for calculating percentages.

The

figure 3-1, Population morbidity by age by sex %



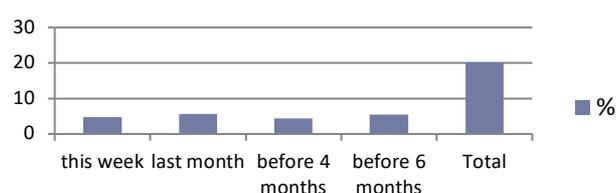
incidence of illness among the communities is depicted in the table 3-1 to the left, where the occurrence of illness and seeking of medical treatment during the past three months is reported by 10.9% of the population surveyed. The least incidence of illness recorded is among children less than 5 and highest among adolescents 5 to 14 years, this is well anticipated in the light of the relative higher immunity of the children and on the other side, the mobility of the higher age category that make them more subject to communicable diseases, as depicted in the table above.

It is also observable that, when illness is analyzed by sex, figure 3-1 above, males tend to be more subject to illness than females for < 11 months age, and ages above 50 years, illness is more likely among males than females. For the population in the middle age, both sexes tend to have similar percentages of being ill. Refer to figure to the right and for details refer to annexed table 6.2.1 Incidence of illness among target population by age by sex

The analysis of type of the disease also by age category shows that, malaria is the most common type of the disease among all age categories, in addition to diarrhea and chest infections. Details by type of disease by age category are shown in annexed analysis tables.

The frequency of visits to health facilities for treatment shows that about 22% of the beneficiaries had visited health facilities for treatment. This percentage is evenly distributed over the visits intervals with a mean percentage of about 5% for each interval. This frequency of visits to health facilities reflects both the need for the health facility and the tendency of the ill to seek the medical treatment which became available for them. For more details on frequency of visits to health facility by age refer to annexed tables 6.2.3, Population distribution by last time of health facility visit by age

Figure 3-2, Frequency of visits to the health facilities %



3.2 Nutrition indicators

About 10.4% of the households in Kass reported having one of the family members being treated or undergoing treatment from mal nutrition last year. The table below shows that the number of persons who received treatment or undergoing treatment, which is almost confined to the age category 11 months to 4 years.

Table 3.2.1 Numbers of family members treated or undergoing malnutrition treatment

Age category	Less than 11 months	1-4 years	5-14 years	15-49 years PLW	50-60 years	More than 60 years
Number treated last year or undergoing treatment	8	19	4	3	0	0

3.3 Reproductive health indicators

The rate of pregnancy equals 6%, or 60 per 1,000 populations. Though this is much greater than the average global birth rate of 18.5¹ per 1,000 populations, but, it is less than the Sudan average estimate of 72² per 1,000 for women in the age category 15 -19 years. Though the birth rate is not one of the project indicators, but may reveal several factors of concern to CARE in the fields of general health and reproductive health which CARE is addressing, and thus may inform its future programming, with regard to women health and family planning issues.

As figure 3.3.1 to the right indicates, pregnant women tend to seek consultation in the last month of the pregnancy, which leaves women at high pregnancy risks and suggests that more awareness on reproductive health need to be created among women. The health center is the most likely the place where women go to for consultation as indicated by 88.2% of the women. Here, the role of the midwives emerges as 70% of the consultation is carried by them, 24% by medical doctors and 6% by medical assistants. About 77% of the pregnant women stated having received the clean delivery tool kit.



Considering the place of birth of the last child, 58.1% of the women delivered at home, while 29% and 12.9% delivered at hospitals and HCs respectively. The high rate of at home delivery suggests the presence of trained CHWs who are accessible, which is confirmed by the percentage of deliveries of 84% by the trained birth attendants (midwives) at home as well as health facility.

Delivery of the baby health care is shown in the table below and reflects that about half the born babies had received PNC in the first three days of delivery and that one fourth of the born babies didn't receive any postnatal care.

Table 3.3.2 Time of receiving postnatal care after delivery

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	three day	15	48.4	48.4	48.4
	first week	7	22.6	22.6	71.0
	Month	1	3.2	3.2	74.2
	no care	8	25.8	25.8	100.0
	Total	31	100.0	100.0	

3.4 WASH indicators

About 71.2% of the IDPs and rural communities' households indicated having access to clean water source. And 84.5% reported use of public or private latrines. The high percentages here are attributable to the hygiene promotion awareness delivered by the project and in which almost 70% of the beneficiaries have participated.

In light of the high benefit the beneficiaries realized, about one third of them want the project to continue with the same activities, however, the remaining two thirds want the project to tap new areas such as more nutrition centers and water resources, which represent the top priority for target IDPs and host communities, in addition to health education and waste management and distribution of none food items, which are in the domain of the project activities and reflect the interest of the communities for the project to continue with the WASH activities.

¹ https://en.wikipedia.org/wiki/Birth_rate

² Health nutrition and population statistics, World Bank, 2017

4. CONCLUSION AND RECOMMENDATIONS

The effects associated with the three sectors the project addressed overlaps and complement each other, which intern maximized the resultant impacts and effectiveness in achieving expected results. The fact that the lifesaving assistance is provided within a within a capacity building prospective, in which community members and volunteer capacities are improved through participation and on job training would enable the communities sustain the benefits achieved.

Effectiveness of the interventions in furthered by the participation opportunities the project has created for the community and health workers /volunteers, who are motivated to contribute to serve their communities, as well as formation and training of the community-based committees has established solid base at community level that can contribute and work to address their communities' issues on their own initiatives.

- The interventions of the project are relevant to the actual needs of the IDPs and vulnerable communities and have induced tangible improvements in their livelihoods, as a result of improved health, and hence development of the human capital which is one of the livelihood pillars. Beneficiaries expressed their satisfaction with the project and valued the benefits they realized. However, considering the large area of the region and the hardships the population experienced over many years, and the acceptance the project met at community and official levels, is encouraging to continue the project activities to new locations and consolidate the effects of the assistance so far extended.
- The provision of clean water emerged as the most important output for the communities, however, more water resources are needed, and the project is highly recommended to continue support to the water sector, while, considering changing fuel water pumps or supplementing it with solar system for water pumping to increase the availability of water during the time of shortage or lack of the fuel. Also it is suggested to investigate the feasibility of use of water yards instead of water pumps.
- In some locations, in specific Yassin locality, more efforts are needed to expand the health sector interventions and establish HC and services in Yassin village, including training of volunteers on hygiene promotion and equip them with collection tools of solid waste and may be introduction of IGAs, if possible.
- Further training for consolidation of gained capacities will be necessary to ensure the sustainability of the benefits from the services provided.
- Some incremental increase in cash or in kind of trained CHW benefit would be a catalyst for their continuity to maintain their activities., as well as to continue to conduct awareness raising workshops. In this context, support of small businesses or IGA will be welcomed by the volunteers and community members.
- The least benefit emerged is with the latrines to most IDPs, when compared with the benefits from the health, nutrition and water interventions.
- The difficulty of transport means for garbage disposal need to be further supported to attain maximum benefit from the WASH activities. This should also consider design of special type of latrines suitable for people with disabilities.

5. SUMMARY OF COMMUNITIES FG

Locations	Limo	Alsalam IDPs camp	Gereida IDPs camp	Kalma IDPs camp	Sinegetta village	Kelakely
Population Person Households	22.000	120.000	24.000	137,000	10,000 p 2,700 hh	15,000 P 3,000 HH
No beneficiaries	15,000	6000 HH from centre 1,2 and 3 are benefiting from water and 57,806 individuals are using the health centre because people from nearby villages (kashelingo, Abgaragil – Dabat full villages) are getting treatment at this PHC	24,500 individual s this number is become less during the rainy season because of farming	All camp members and its surroundings’	na	na
Water sources	3 hand pumps and shallow wells in Limo valley, water resources are shared with others	One Submersible pump with 4 distribution points plus 3 hand pumps	is it shared with other community? From 3 submersible pump and there are 39 water distribution points in all camps supported by CIS in cooperation with WES , all community are sharing	Hamd pumps	The water source is shared with other villages around in addition to nomads’ communities in the area. <i>Water points are not functional.</i> There are some volunteers trained on health education, environmental sanitation. More than 10,000 persons and the center receives about 100-150 patients daily. Our benefit from the project interventions is 100%	two water yards, shared with Yes neighbor villages and nomads and their number exceeds village population. only one water yard is functioned now and the second repaired by CIS through AAO local organization and handover to WES (Government) not operated since repaired on July and we do not know why, we continue using the water yard that not repaired the people in village are ready to contribute in any activity lead to improve water sources and sanitation situation in the village
extent of benefit from the project	Clean water, training of water committee (10 persons), maintenance tools, training of CHVs, contributed by digging latrines, construction oh health center and provision of medicines, child nutrition and training of health cadre	Formation and training of water committee # 15 persons (5 female and 10 male) to liaise with the community and select the target beneficiaries, training of hygiene promoters committee (25 persons)	Improved our health because of practicing hygiene promotion and sanitation, benefiting from CIS workshops, cleaning tools and we disseminate the message among the community	Hand pumpd	Health center - Nutrition center - training of 6 volunteers on health education, environmental sanitation - The community built one toilet in the school.	We never benefit from the activities because the repaired water yard not operated since repaired and no other activities done in our village
Most benefit	All, but most clean water which reduced diseases and diarrhoea	Water supply and training is the most important, because water is the life and training improve our skill to continues works properly	We depend completely on CIS water supply and you know water is the most important for living	Provision of clean water and using of solar system, it improve their health	The community benefitted from the health and nutrition services that resulted in reduction of the number of mortalities among the community and improve health status.	The repairing of water yard is a good activity because it separates human from animals and this will contribute to decrease of diseases that come through contaminated water

Least benefit	Latrines which received less support	Latrines	Latrines, special we registered long time ago some disable people to get support but not done yet	Latrines for disable people		
Urgent needs	More water sources in the remote villages	lost the engine (stolen) and now the submersible pump is not working, we asked CIS to provide with new engine		To change to water storage system by using iron tanks and the current old plastic tanks causes a lot of leaking and increases the maintenance cost Changing of hand pumps to water yards	Source of electricity to the health center - Laboratory in the health center - Refrigerator in health center for drugs that need to keep in cool weather - Training to youth on different skills - Micro finance to increase the income of the our families - Provision of Improved seeds and agricultural tools	- To repair the second water yard - To extend the water pipe to the school which is near by the water yard? - Training for volunteers from the village on hygiene promotion and give them some tools for collecting solid waste - To establish health center and health services in the village - Training of the youth (males and females) on some skills that can generate income to them
Sustainability of the benefits	Have plan for good management of the water, will charge water fees and need more training for water committee members	Yes, we proposed to increase the water fee per family per month from 10 SDG to 15 SDG or more	Yes, through organizing suitable fee, and we need from CIS to conduct workshops to the community to get common understanding nad to be aware	Hand pumps	The community can maintain the benefits gained from the activity depends on ourselves and we request CIS to provide the services mentioned above to maintain the existing services	Yes we can maintain the benefits by the awareness and training
Women and youth participation	They are being involved in different committees and getting direct services but we needed mid wife training	committee members and active service deliveries	Yes, members of all committees	Yes, 90% of hygiene promoters are women including youth because they are actively works	Women benefited and instead from travel to Kass (20Km) for health services , the health center now is nearby our homes so we saved time and money and our health status improved significantly. The number of women represented in WUC, Hygiene promoters is%50	Very poor and not represented in the committees

6. SUCCESS STORIES

6.1 Empowering of women through capacity building

Aziza, originally from Senegita village, 20 km south of Kass, is 35 years old who. She is a widow, supporting 7 children. She was married when she was at secondary school and hence left the school. Her family moved to Khartoum because of the conflict, but her mother brought her with five of her children in 2009 to this camp, when they couldn't pay the rent and afford the cost of living in Khartoum, with the absence of her husband who migrated to Saudi Arabia and decided to stay with her mother in the camp. In the camp, I was hardly able to afford sending my children to school and maintain a decent livelihood for my family because of the limited work opportunities in the camp.



In 2011 CIS was looking for volunteers to be trained on hygiene promotion to assist their community, I was one of 13 members who were selected and trained. I learnt more and acquired good knowledge and skills from the training. My willingness to build my capacity, because I was unable to continue my formal education, encouraged me to have training on first aid and to participate in the vaccination campaign in IDPs camp.

I now get incentives in-kind or cash from this voluntary work, which assists me to cover my children school needs and living cost. I have a certificate and learned a lot that opened my eyes into new world and am looking for better future, particularly for all my children, of who one is now studying at the University of Sudan and am able to meet her university cost.

Living in the camp for many years is a challenge and I look for returning to my village, build a house in Kass. Am looking for an opportunity to have training on improved stoves and tailoring to start an income generating business and sustain and improve and my family living.

6.2 CIS helped to save my life

I am Hussein Ishag Suleiman; from Singetta village I have 4 wives and 16 children. I was very poor and was practicing traditional farming and have no animals. CARE organization gave me five goats under the program of livestock as a loan for two years. The goats' number has increased to 14 goats after two years and I was able to pay back the five goats to CIS, to be given to another member and kept the remaining nine goats. The number of my goats gradually increased to 26 goats in the following years. The returns I gain from the goats and goats' products sale cover well my family needs and education fees for my children.



With time am able to save some money and I bought a donkey, which helped me much in plough of my farm and increase the area I cultivate. The donkey also relived the burden of carrying and transporting water from the well off my family members.

7. Annexes

7.1 Project outputs and beneficiaries

Indicator	Target	Actual	% achieved	Comments
Sector Name Health				
Subsector Name Health Systems and Clinical Support				
<i>Indicator 1 (Number of health care facilities supported and/or rehabilitated by type (e.g., primary, secondary, tertiary))</i>	7	7	100%	
<i>Indicator 2 (Number of health care providers trained by type (e.g., doctor, nurse, community health worker, midwife, and traditional birth attendant), by sex)</i>	200	220	110%	
<i>Indicator 3 (Number of health facilities submitting weekly surveillance reports)</i>	7	7	100%	
<i>Indicator 4 Number of consultations, by sex and age, per quarter</i>	195,174	249,376	128%	
Subsector Name: Communicable Diseases				
<i>Indicator 1 Number of cases diagnosed and treated per standardized case management protocols, by sex and age (0-11 months, 1-4 years, 5-14 years, 15-49 years, 50-60 years, and 60+ years)</i>	140,000	161,463	115%	
Subsector Name Reproductive Health				
<i>Indicator 1 Number of pregnant women who have attended at least two comprehensive antenatal clinics</i>	23,000	20,642	90%	
<i>Indicator 2 Number and percentage of women and newborns that received postnatal care within three days after delivery.</i>	2,100	2,078	99%	
<i>Indicator 3 Number and percentage of pregnant women in their third trimester who received a clean delivery kit</i>	15,000	8,847	59%	
<i>Indicator 4 Number and percentage of pregnant women who deliver assisted by a skilled (not traditional) birth attendant by type (e.g., midwife, doctor, nurse) and location (e.g., facility or home).</i>	2,100	1,779	85%	
<i>Indicator 5 Number of cases of sexual violence treated.</i>	N/A	N/A		
Subsector Name Community Health Education/Behavior Change				
<i>Indicator 1 Number of CHWs trained and supported (total and per 10,000 population within project area), by sex</i>	80	154	193%	
<i>Indicator 2</i>	75	75	100%	

<i>Number and percentage of CHWs specifically engaged in public health surveillance</i>				
Indicator 3 <i>Number and percentage of community members utilizing target health education message practices.</i>	100,000	207,212	207%	
Subsector Name Medical Commodities Including Pharmaceuticals				
Indicator 1 <i>Number of supplies distributed by type (e.g., medical kits, equipment, consumables)</i>	N/A	5,376		
Indicator 2 <i>Number and percentage of health facilities, supported by USAID/OFDA, out of stock of selected essential medicines and tracer products for more than one week</i>	N/A	N/A		
Sector Name Nutrition				
Subsector Name Infant and Young Child Feeding and Behavior Change				
Indicator 1 <i>Number of people receiving behavior change interventions, by sex and age the breakdown should be for two group 15-49 & >50</i>	150,000	148,894	99%	
Indicator 2 <i>Number of people receiving behavior change interventions, by sex and age</i>	150,000	148,894	99%	
Subsector Name Management of Moderate Acute Malnutrition (MAM)				
Indicator 1 <i>Number of sites managing MAM</i>	7	7	100%	
Indicator 2 <i>Number of people admitted to MAM services, by sex and age (0-11 months, 1-4 years, 5-14 years, 15-49 years, 50-60 years, and 60+ years)</i>	7,500	10,225	136%	
Subsector Name Management of Sever Acute Malnutrition (SAM)				
Indicator 1 <i>Number of health care providers and volunteers trained in the prevention and management of SAM, by sex and age (above 15 yr)</i>	75	77	103%	
Indicator 2 <i>Number of sites established/rehabilitated for inpatient and outpatient care</i>	8	8	100%	
Indicator 3 <i>Number of people treated for SAM, by sex and age*</i>	7,500	6,034	80%	
Indicator 4 <i>Rates of admission, default, death, cure, relapse, nonresponse-transfer, and length of stay</i>	Cured=89.2%, Def=7.0% , Death=1.0%	Cured=84.0%; Def= 12.0%; Death= 0.6%		
Sector Name Water, Sanitation and Hygiene				
Subsector Name Environmental Health				
Indicator 1 <i>Number of people benefiting from solid waste management, drainage, and/or</i>	130,000	276,418	213	<i>CARE was able to reach more than targeted due to the continuation of the</i>

<i>vector control activities (without double-counting)</i>				<i>project into the second year.</i>
<i>Indicator 2 Number of community cleanup/debris removal activities conducted</i>	192	192	100	
<i>Indicator 3 Number of persistent standing water sites eliminated via drainage interventions</i>	6	10	167%	<i>The additional 4 were done in the second year of the modification due to gaps.</i>
<i>Indicator 4 Number of communal solid waste disposal sites created and in use</i>	10	10	100%	
Subsector Name Hygiene Promotion				
<i>Indicator 1 Number of households visited by Community Hygiene Promoters</i>		23,711		<i>No target was set.</i>
Subsector Name Sanitation Infrastructure				
<i>Indicator 1 Number of people directly benefiting from improved sanitation infrastructure program (without double-counting)</i>	1,140	15,058	258%	<i>CARE was able to reach more than targeted due to the continuation of the project into the second year and targeting additional vulnerable groups.</i>
<i>Indicator 2 Number of households with no evidence of feces in the living areas</i>				<i>Not targeted. Needs to be checked again.</i>
Subsector Name Water Supply Infrastructure				
<i>Indicator 1 Number of people directly benefitting from the water supply infrastructure program</i>	229,635	254,792	111%	
<i>Indicator 2 Percentage of test results with 0 fecal coliforms per 100 ml sample</i>	85%	93%	110%	
<i>Indicator 3 Number of tests with FRC ≤ 0.5 mg/L</i>	600	5,999	1,000%	

7.2 Analysis tables

Tables 6.2.1 Incidence of illness among target population by age by sex

1. Children < 11 months			2. 1-4 years			3. 5-14 Years		
	No	%		No	%		No	%
No ill	7	0.42	No ill	30	1.8	No ill	69	4.1
No males ill	6	0.36	No males ill	14	0.82	No males ill	33	2
No female ill	1	.06	No female ill	16	0.96	No female ill	36	2.1
Size of population surveyed	1,668		Size of population surveyed	1,668		Size of population surveyed	1,668	

4. 15-49 Years		%	5. 50-60 Years		6. 60>		%	
No ill	48	2.8	No ill	13	0.77	No ill	15	0.89
No males ill	17	1	No males ill	10	0.6	No males ill	13	0.77
No female ill	31	1.8	No female ill	3	0.17	No female ill	2	0.12
Size of population surveyed	1,668		Size of population surveyed	1,668		Size of population surveyed	1,668	

7.2.2 Prevalence of diseases by type by age category

7. <11 months			8. 1-4 years			9. 5-14 years		
	No	%		No	%		No	%
Chest	1	0.06	na	1	0.06	Chest	1	0.6
Diarrhoea	2	0.12	Anaemia	1	0.06	Diarrhoea	2	0.12
Malaria	2	0.12	Chest	5	0.30	Malaria	59	3.50
Other	2	0.12	diarrhoea	3	0.16	Other	6	0.36
Total		0.42	malaria	12	0.72	Ear pain	1	0.06
			Malnutrition	1	0.06	Total		4.64
			Other	7	0.42			
			Total		2.86			

10. 15-49 years		No	%	11. 50-60 Years		No	12. >60 years		No	%
		1	0.06	Chest infection	2	0.12	Chest infection	1	0.06	
Anaemia		1	0.06	malaria	5	0.3	Diarrhoea	1	0.06	
Chest infection		3	0.16	Other	6	0.36	Malaria	7	0.41	
Diarrhoea		5	0.3	Total		0.78	Malnutrition	2	0.12	
Malaria		25	1.5				Other	4	0.24	
Malnutrition		0	0				Total		0.89	
Other		11	0.65							
Ear pain		2	0.12							
Total			2.85							

Table 2.2.3, Population distribution by last time of health facility visit by age

13. >11 years			14. 1-4 years			15. 5-14 years		
	No	%		No	%		No	%
last month	2	0.12	na	2	0.12	Na	1	0.06
this week	5	0.3	before four month	1	0.06	Na	2	0.12

		last month	14	0.82	before four month	3	0.18
		> six month	3	0.18	last month	30	1.8
		this week	10	0.60	> six month	2	0.12
					this week	31	1.8

15. 5-14 years	No	%	16. 15-49 years	No	%	17. 50-60 years	No	%
na	1	0.06	na	1	0.06	Na	11	0.65
Na	2	0.12	na	4	0.24	before four month	2	0.12
before four month	3	0.18	before four month	9	0.53			
last month	30	1.8	last month	17	1			
> six month	2	0.12	> six month	2	0.12			
this week	31	1.8	this week	15	0.3			

7.3 List of FG participants

1- Limo village : Kass Locality

- 1-Mohamed Abaker Hassan(M), Chair Man Of Health Committee
- 2- Abaker Abdalla Suliman (M), Water User Committee Member
- 3- Ali Hamad (M), Water User Committee Member
- 4- Elsadig Adam Haroon (M),Hygiene Promoter
- 5- Addoum Adam Eisa (M),Water User Committee Member
- 6-Hussein Hamad Ali (M),Community
- 7- Umdai Jad Abdalla (F),Nutrition /Health Committee
- 8- Fatima Eisa (F),Health Committee

2- Elsalam IDPs camp: Beleil

- 1- Suliman Younis (M),Chair Man of Water User Committee (WUC)
- 2- Addoum Adam Ahmed (M),WUC Member
- 3-Motasim Adam Suliman (M), WUC Member
- 4-Musa Adam Bakhit (M), WUC Member
- 5- Elsadig Yahya Ismail (M),Community
- 6- Mariyam Abdalla Abaker (F), WUC Member
- 7- Harra Mohamed Ibrahim (F), WUC Member
- 8-Khadiga Yahya Ishag (F), Hygiene Promoter
- 9- Halima Ibrahim Adam (F),Hygiene Promoter
- 10- Halima Adam Daldoum (F),Hygiene Promoter
- 11- Amina Mohamed Bahreldien (F),Hygiene Promoter
- 12-Bahriya Elnour Yagoub (F),Hygiene Promoter

3-Gereida IDPs camp: Gereida Locality

- 1- Bahja Mohamed Osman (F), Community
- 2- Hawa Hamed Abdalla (F),Hygiene Promoter Committee -Chair Person
- 3- Ikhlas Brima Adam (F), Hygiene Promoter
- 4-Ikhlas Hussein Adam (F), Community
- 5-Nafesa Mohamed Adam (F), Community

- 6-Hawa Mahmoud Ahmed (F), Environment Sanitation Committee
- 7-Ikbal Mohamed Hamad (F), Community
- 8-Khaltoum Abdalla Abdalla (F), Community
- 9-Abdulmonim Ibrahim Zakaria (M), Water User Committee
- 10-Hawa Mohamed Osman Ali (F), Hygiene Promoter

4- Kalma IDPs camp: Beleil Locality

- 1-Musa Adam (M), Water User Committee Member
- 2-Jabril Abdulbanat Mohamed (M), Water User Committee Member
- 3-Zakaria Ishag Abdalla (M), Water User Committee Member
- 4- Alawia Mohamed Abaker (F), Hygiene Promoter
- 5-Zainab Yahya Ishag (F), Environment And Sanitation Committee
- 6-Kawther Abaker Arbab (F), Hygiene Promoter
- 7-Hadiya Abdulkareem Ahmed (F),Hygiene Promoter
- 8-Islam Musa Salih (F), Hygiene Promoter
- 9-Najat Omer Ahmed (F), Hygiene Promoter
- 10-Ibrahim Abaker Ali (M), Community
- 11-Souad Ishag Abdalla (F), Hygiene Promoter

5- Singetta village: Kass Locality

- 1- Ali Ibrahim Adam
- 2- Elhaj Abdalla Nour
- 3- Salih Musa Ibrahim
- 4- Ishag Mohamed Abdelrasul
- 5- Hussein Ishag Suliman
- 6- Aubakar Yagoib Suliman
- 7- Abel Rahaman Hassan Adam
- 8- Fatima Abdel Rahaman Khatir

CIS staff in Kass

- 1- Abdelrahaman - wash
- 2- Zahir haroon – Nutrition
- 3- Abakar Yahya – Health

Wash Program Manager-Eldeain

- 1. Michael Onyango

7.4 Evaluation tools

Households' questionnaire

General

Locality name

Village name

Sex of HH

Family size

Health

Were you or member of the family members treated from any of the following illnesses during the past three months?

Age of family member	No ill	No Males	No females	Type of illness treated 1.diarrhea, 2.AIR, 3.measles, 4.sexual violence	Last time member visited the health center 1. This week, 2.last month, 3. Four months ago, 4.more than six months ago
< 11 months					
1-4 years					
5-14 years					
50-49 years					
50-60 years					
> 60 years					

Nutrition

Has any of the family members treated or undergoing treatment from mal nutrition this year?

Age of family member	No ill	No Males	No Females	Type of illness treated 1.MAM, 2.SAM	Admitted 1.Yes, 2.No	Condition 1. Cured, 2. Undergoing
< 11 months						
1-4 years						
5-14 years						
50-49 years						
50-60 years						
> 60 years						

Reproductive health

If pregnant woman in the family?

Current month of pregnancy 1. First, 2. Second, 3. Third, -----	Pregnancy month of first consultation 1. First, 2. Second, 3. Third, -----	Number of consultations	Place of consultation 1. PHC, 2. Hospital, 3. Home, four. -----	Who is consulted 1. Medical doctor, 2. MA. 3. Nurse, 4. Trained midwives, 5. Traditional not trained midwife	Clean delivery kit 1. Yes, 2. No

If, have childbirth during this year?

Place of birth 1. Home, 2. PHC, 3. Hospital, 4. -----	Birth attendant 1. Medical doctor, 2. MA. 3. Nurse, 4. Trained midwives, 5. Traditional not trained midwife	Postnatal care 1. Within 3 days, 2. Within first week, within two weeks, 4. Within a month, 5, none, 6. -----

WASH

Do you have access to clean water source?

1. Yes 2. No

Do you use your own or common improved latrine?

1. Use own 2. Use common 3. Don't use

Have you attended hygiene promotion awareness?

1. Yes 2. No

Do you want the project to continue the same activities or other activities?	1.same	2.other
If other, what activities you want the project the implement?		
How do you rate relevance of the activities to your needs?	High	moderate low not relevant
How do you assess your benefit from the project?	High	moderate low not relevant?

Line ministries checklist

MOH, PHCs, and WASH

- A. Obtain sector available statistics for the following;
 1. Number of health care centers rehabilitated and or supported, numbers and location, type of assistance
 2. Number of health cadre trained, doctors, nurses, trained midwives, traditional midwives, health workers, volunteers by sex including MAM, SAM training
 3. Frequency of health facilities reports
 4. Numbers of consultations by age by sex (0-11, 1-4, 5-14, 15-49, 50-60, 60+)
 5. Rate of morbidity by type, diarrhea, AIR, measles, -- by sex and age
 6. Number of cases diagnosed and treated by the standard case management protocol by sex and age
 7. Average attendance of pregnant women for prenatal care
 8. Post-natal care within three days after delivery
 9. Number of delivery attended by health professionals (256 birth attended by skilled health worker; 34 women in one week)
 10. Number of sites managing MAM by location, numbers admitted
 11. Number of inpatient and outpatient sites established by location
- B. Discuss
 - Project key evaluation questions and project evaluation criteria
 - Their level of involvement in planning, implementation and monitoring
 - The timing and quality of the implemented activities
 - The extent to which the activities meet the sector plan
 - The extent to which the activities meet the sector plan
 - What improvements you suggest for your sector, (the type of activities, locations targeted and methodology of the project).

Community FGD questions

- Name of village, Number of HHs, Population
- Type # and type of water source, is it shared with other community?
- # of water points functional and not functional
- Community contribution in facilities: water, sanitation
- Number of people directly benefitting from this water supply infrastructure project
- To what extent have you benefited from the activities the project implemented?
- What activities you most benefited from, how it affected your life?
- What activities you benefited least or not benefited from, and why?
- What emergency assistance you need and you think the project should have provided, but did not?
- Will you be able to maintain the benefits you gained, if yes, how, and if not why, and what you need to sustain the benefits?
- Did the women and youth benefited from the project activities, how?
- # of women represented in WUC, Hygiene promoters,
- % of respondents who mention more than three critical time hygiene messages if FGD of 15, 75% mention three
- I want to listen to the experience of one or two persons with the project, whether it is good or



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