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ENDLINE EVALUATION REPORT

THE EMERGENCY MOBILE HEALTH, NUTRITION & PROTECTION PROJECT IN EASTERN EQUATORIA, SOUTH SUDAN

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The Emergency Mobile Health, Nutrition & Protection Project in Eastern Equatoria, South Sudan.

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LIST OF ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
BHI	Boma Health Initiative
CHD	County Health Department
CMAM	Community-Based Management of Acute Malnutrition
CSO	Civil Society Organisation
EE	Eastern Equatoria
EPI	Expanded Programme on Immunisation
FGDs	Focus Group Discussions
HHP	Home Health Promoter
IDP	Internally Displaced Person
GoU	Government of Uganda
ICCM	Integrated Community Case Management
ICM	International Confederation of Midwives.
IMCI	Integrated Management of Childhood Illness
IP	Implementing Partner
KIIs	Key Informant Interviews
M&E	Monitoring and Evaluation
NGO	Non-Governmental Organisation
OECD	The Organisation for Economic Co-operation and Development
OFDA	Office of Foreign Disaster Assistance
OTP	Outpatient Therapeutic Program
PHC	Primary Health Care
PHCU	Primary Health Care Unit
PHCC	Primary Health Care Center
PLW	Pregnant and Lactating Women
PNC	Postnatal Care
PSS	Psychosocial Support
SAM	Severe Acute Malnutrition
SDG(s)	Sustainable Development Goal(s)
S(GBV)	Sexual and Gender Based Violence)
SRH	Sexual and Reproductive Health
TBA	Traditional Birth Attendant
UN	United Nations
UNICEF	United Nations Children's Fund
UNFP	United Nations Population Fund
USAID	United States Agency for International Development
UNHCR	United Nations High Commissioner for Refugees
WASH	Water, Sanitation and Hygiene
WB	World Bank
WHO	World Health Organization

EXECUTIVE SUMMARY

This report is presented by Adroit Consult International following a successful evaluation of the Emergency Mobile Health, Nutrition & Protection Project in Eastern Equatoria, South Sudan. This main objective of the endline evaluation was to provide information on the impact of the 3 year integrated Health, Nutrition and Gender Based Violence (GBV) project and also measure results at the outcome and impact levels. The evaluation was conducted with project stakeholders such as; Community leaders, Households of beneficiaries, Individual women and men, Children under five, Health workers, Government officials, CSO/NGO partners among others, and covered the areas of Lopa Lafon and Ikotos. The evaluation reached a total of 287 respondents in project implementation areas.

The data collection took a total of 6-7 days with activities taking place in each of the locations concurrently. The evaluation also utilized literature from the project, as well as published documentation on the area of implementation. Quantitative data collection as carried out using Kobo Collect Online platform and exported into Microsoft Excel for cleaning and coding. Data was then analysed using SPSS 20. Qualitative data collection was carried out using hardcopy questionnaires and analysed with thematic analysis related with findings from the other evaluation data sources. The report provides a detailed analysis of evaluation findings. Some of the key impacts of the project noted included; Increased access to quality primary Health Care and clinical support in Torit, Ikotos, Lopa Lafon Counties; Increased access to ANC and PNC for women; Improved Knowledge and Perception of the Community Towards HealthCare and nutrition; Improved access to immunization vaccines ; Changes in nutrition Statistics; Visibility of CARE International; Increased skills and livelihoods for staff employed under the project; and Case fatality rates for communicable diseases. The table below shows information on key indicators assessed during this endline evaluation;

Indicator	**Value**
Health	
Percentage of respondents that had accessed services from the mobile health clinic in the past six months	96.9%
Average distance from homes to the mobile clinic	4.86km
Percentage of respondents shared that another household member accessed services from the mobile clinic in the past six months.	90.2%
Case fatality rates for communicable diseases	0.29%
Percentage of community members who can recall target health education messages	95.1%
Percentage of respondents with knowledge on the main causes of communicable diseases	79.2%

Percentage of respondents with knowledge on the main symptoms of communicable diseases	78.7%
Percentage of respondents with knowledge on the main treatment of communicable diseases	69%
Percentage of respondents who mentioned that the mobile clinic they visited had all the necessary services and facilities to offer them support	88.5%
Percentage of respondents who were given priority at the mobile clinic	93.9%
Percentage of respondents aware of referral facilities for health services in their community	78.0%
Percentage of women who saw anyone for ANC in their last pregnancy	93.0%
The average number of times respondents visited a health facility for ANC	4
Percentage of women who gave birth from home	43.0%
Percentage deliveries assisted by Skilled Medical personnel	38.4
Percentage of respondents that received a visit from a trained health worker within 3 days after giving birth	63.1%.
Percentage of respondents who reported to have ever taken their children to a health facility when ill	81.9%
Percentage of respondents who shared that one of their children (the first child) received any vaccinations to prevent him/her from getting diseases, including vaccinations received in a campaign or immunization day or Child Health Day with CH card.	78.8%
Percentage of members in the household diagnosed with a communicable disease in the past one year	89.9%
Nutrition	
percentage of infants 0-<6 mo. who are exclusively breastfed	62.7%
Number and percentage of children 6-<23 mo. receiving foods daily in 4 food groups	18.6%
Percentage of respondents receiving behavior change interventions to improve infant and young child feeding practices	70.4%
Protection	
Percentage of the respondents that they received information on GBV, Gender equality and protection in the last 6 months	85.4%
Percentage of respondents interviewed who were aware of any women and girls' rights	88.2%
Percentage of respondents that reported that a female household member experienced GBV in the past six months	56.4%
Percentage of respondents that reported that a member of their community experienced GBV in the past six months	68.6%
Percentage of respondents that reported participation in project implementation through one or more of the Care accountability mechanisms	63.8%
Percentage of people reporting improvement in their feelings of wellbeing and ability to cope at the end of the program (Custom)	91.1%

In conclusion, the evaluation noted that despite the support offered by the project, communicable diseases still remain a main cause of morbidity and mortality within the area. In addition, the contextual challenges as were identified at the start of the project still persisted at the end of the project such as; inaccessibility of roads, poor communication network, limited number of static health facilities among others, leading to a high risk of reduction of the status of impact caused by the project. Findings from this evaluation also noted that the community still had a poor attitude towards gender equality, due to the high importance allocated to cultures and limited change in attitudes. Recommendations were thus provided, some of which included future interventions targeting provision of services in Conflict management, capacity building of Community health workers of Boma Health workers, involvement of community leaders among others. Areas of continued advocacy such as; regular update of data by the government, especially with on ground health indicators; increased number of agencies and partners operating within project target locations, especially those supporting livelihood and WASH interventions and; allocation of resources by government to support construction of static health facilities were also recommended.

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1.0 INTRODUCTION

Adroit Consult International presents this Final Endline Evaluation Report to CARE South Sudan following a successful completion of the assignment for Provision of Consultancy Services for End line Evaluation of Emergency Mobile Health, Nutrition & Protection in Eastern Equatoria, South Sudan.

1.1 Background of the project

CARE is a humanitarian NGO 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. CARE's operations in South Sudan dates back to the early 1980s, focusing on emergency and disaster relief to the conflict affected populations. Currently, CARE works in a number of states in South Sudan. These include; Unity, Jonglei, Eastern Equatoria, Upper Nile, Central Equatoria, Western Equatoria, and Wester Bahar El Gazal, addressing both humanitarian and recovery/development needs. In development/recovery programming, CARE South Sudan focuses on four broad areas namely Gender and Protection, Food security and Livelihoods, Nutrition and Health.

About the project

This was an integrated Health, Nutrition and Gender Based Violence (GBV) project. CARE South Sudan's approach to this project is through utilizing mobile clinics and strengthening of community capacity by targeting the most vulnerable populations in remote, hard-to-reach areas with high concentrations of IDPs, Returnees and vulnerable host populations. The mobile teams provide Maternal and Child Health integrated Community-Based Management of Acute Malnutrition (CMAM), Curative Services for communicable diseases and GBV response and referral. Moreover, the mobile teams also work with Home Health Promoters who provide Integrated Community Case Management (ICCM) services- Treatment of Malaria, Pneumonia and Diarrhea and Screening and Referral for Malnutrition. CARE engages women, girls, boys, men, community leaders, and people with disabilities to ensure that activities do not undermine the communities' ability to rebuild and develop resilience strategies. The intervention is designed as a short-term emergency response to the disruption in public health services, and the deterioration of the nutrition status of the conflict-affected population in former Eastern Equatoria state after the July 2016 crisis. The mobile outreach services to remote areas are designed to complement and supplement health and nutrition services currently provided through static health facilities and Outpatient Therapeutic Program (OTP) sites by Government and other NGO/UN actors.

Table 1 project Summary Information

Project Name	Emergency Mobile Health, Nutrition and Protection
Project Location	Eastern Equatoria State Torit, Ikotos, Lopa Lafon Counties
Project Goal and Outcomes	• Respond to the humanitarian needs created or exacerbated by the July 2016 crisis, by providing essential health and GBV response/prevention services, as well as life-saving nutrition support for IDP and host community in South Sudan, focusing on women, girls, children under five and PLW. • Increase access to quality primary health Care and clinical support in Eastern Equatoria State • Increased access to lifesaving treatment for the management of acute malnutrition in children, pregnant and lactating women • Vulnerable IDP and host community women and girls have increased access to life-saving protection, health, case management, psychosocial support (PSS) services, and improved multi-sectoral and community-based protection.
Target Population and beneficiaries.	• Total Number of People Affected in the Target Area: **407,899** • Total Number of People Targeted (Individuals): **103,024 (61,170 females and 41,854 males)** • Total Number of IDPs Targeted (Individuals) as subset of above: **44,793 (24,500 females and 20, 293 males)**
Estimated life of Project	One Year (1st August, 2019 to 31st, July, 2020)

2.0 METHODOLOGY

This section provides a description of the approaches and methods used in conducting the endline evaluation.

2.1 Description of our Methodology to the Endline Evaluation

The evaluation used a descriptive cross-sectional study design using both qualitative and quantitative methods of data collection i.e. Literature review, Key Informant Interviews, household interviews, Focus Group Discussions, and Observation. It was conducted in the three counties of Lopa Lafon, Torit and Ikotos in the Eastern Equatoria State of South Sudan where the project activities were implemented. The activities focused on soliciting responses from relevant stakeholders such as; *project staff, Community leaders, Women &Youth leaders, Households of beneficiaries, Individual women & men, Children under five, Health workers, Government officials, and CSO/NGO partners among others.*

Both Random and Non-random methods (Simple Random Sampling and Purposive Sampling) were used to determine the sample of respondents to participate in the evaluation. Respondents for the qualitative interviews were selected purposively based on their experience and knowledge in the key project sectors. Simple Random Sampling method was used to determine the sample size of respondents to participate in the individual interviews. The Tarro Yamane (1967) formula was used to calculate the sample size of 382 using a proposed population of 55,309 as provided in the TOR. The sample was distributed proportionally across the different counties based on the population sizes to ensure representation. The reached sample size was 287 as shown in **Table 2** below.

Table 2 Distribution of the sample size

Eastern Equatoria State.	**Total Population**	**Number of House Holds[1]**	**Number of Respondents reached**
Counties			
Lopa Lafon	106,161	17,659	139
Ikotos	846,49	16,760	148
Total	**906,161**	**54,670**	**287**

[1]**Source:** *Data from Sudan's fifth national population and Housing census 2008.*

The same locations as visited in 2018 and 2019 during the project evaluations conducted in those years were also targeted as Enumeration Areas for this evaluation, in order to assess the impact changes resulting from the project interventions by comparing the situation.

A total of 12 enumerators were recruited, trained and oriented on the project and on research methods, as well as the content of the questionnaire. The data collection took a total of 6-7 days with activities taking place in each of the locations concurrently. The evaluation also utilized literature from the project, as well as published documentation on the area of implementation. Quantitative data collection was carried out using Kobo Collect Online platform and exported into Microsoft Excel for cleaning and coding. Data was then analysed using SPSS 20. Qualitative data collection was carried out using hardcopy questionnaires and analysed with thematic analysis related with findings from the other evaluation data sources. A number of ethical considerations were put into place, including but not limited to; seeking of consent from the RRC to carry out work in South Sudan and conduct the research. Beneficiary consent was also sought, and they were informed of the confidentiality within the research.

2.2 Limitations during the Endline Evaluation

The evaluation faced limitations in terms of the geographical set up, security condition as well as contextual challenges including but not limited to;

1. Poor road and communication network limited accessibility of some of the project implementation sites,
2. The data collection took place during farming season whereby many respondents were not at their homes to be interviewed.
3. The Research team was also affected by the sparse settlement whereby respondents' homes were far apart and in the mountanioius villages, which made the movement tiresome. Proper mobilization by the Care International team ensured that this challenge was mitigated.
4. The evaluation was also carried out following complete closure of the project and some of the mobile teams had left the areas of implementation. Many staff under the project had also already left the organization.

Limitations due to COVID-19 and Standard Operating Procedures (SOPs) followed

The Coronaviruses are a family of viruses that can cause illnesses such as the common cold, severe acute respiratory syndrome (SARS) and Middle East respiratory syndrome (MERS). In 2019, a new coronavirus was identified (COVID-19) after a disease outbreak in Wuhan China. The virus has since then spread all over the world, causing a pandemic, that led to the declaration of a public health emergency by the World Health Organization (WHO) on January 20th.

As a preventative measure, different governments around the world, including the Ugandan and South Sudan governments issued a number of guidelines to combat the spread of the virus. In addition, the WHO recommended hygiene and social distancing as a means of combatting the spread of the coronavirus. In addition to this the two countries, Uganda and South Sudan had their borders closed, and air travel banned to contain the spread of the disease. As such, our research team was required to follow SOPs issued by the respective governments, some of which included;

1. Obtaining the necessary permission and approvals from the RRC and other country officials to enable the data collection exercise take place
2. Preliminary and Inception meetings in preparation for the assignment phases were conducted online using Zoom platform.
3. Data Collection was carried out using a mobile tool (Kobo Collect) and exported directly from the field to the server. As such, there was limited transfer of data collection equipment from one person to another.
4. Training and supervisison of Research Assistants was conducted remotely and digitally by the consultant with onground support from Care International, South Sudan.
5. Social distancing was maintained during interviews and Focus Group Discussions
6. Protective materials were used by the field team. These included Masks, Sanitisers, water and soap

3.0 RESULTS AND FINDINGS

3.1 Objectives of the endline evaluation

This end line evaluation provides information on the impact of the 2 year integrated Health, Nutrition and Gender Based Violence (GBV) project in three key project sectors as per the indicators provided in the project M&E plan. It also measures results at the outcome and impact levels and is calibrated to specific vulnerabilities and resilience capacities relevant to the context. Specifically, the evaluation was to;

a) To assess and determine the impact of the project on the health and nutritional status in the targeted areas for the last 3 years;
b) To test the beneficiary knowledge, attitude and practices on health, nutrition and protection;
c) To provide data to CARE and partners to inform future programming;

Table 3 Objectives of the endline evaluation

Specific Objective	Key areas of Focus
To assess and determine the impact of the project on the health and nutritional status in the targeted areas for the last 3 years.	The evaluation looked at the direct or indirect, intended/ unintended, and the positive and negative change brought in the lives of the household and community at large. Areas of focus on included; 1. The key positive and negative changes brought to the individual, community and region, how the project changed the levels of peoples socio-economic factors such as nutrition status, ability to make healthy choices, community safety, peoples' attitudes and awareness levels towards health , how stakeholder perceptions have been changed; 2. The key political, social, economic and environmental changes brought by the project and the changes the project caused to the implementing agency To assess impact, we also looked at the achievements of the project outcomes and overall goal. Some key evaluation questions included; What are the health and nutritional changes as measured at the baseline evaluation? What are the major health and nutritional changes in the values of indicators in the project log frame?
To test the beneficiary knowledge, attitude and practices on health, nutrition and protection;	We also assessed the Knowledge, Attitudes and Practices of different groups. We looked at KAP, on key project aspects such as quality primary health Care, clinical support, lifesaving treatment for the management of acute malnutrition in children, pregnant and lactating women, life-saving protection, health, case management, psychosocial support (PSS) services, and multi-sectoral support
To provide data to CARE and partners to inform future programming	This evaluation has also provided data inform of a well-documented report to support future programming. We have assessed the integration of gender, accountability, disability, resilience, child protection and engagement with local administration and religious leaders in the project, the best practices and gaps that can be improved for future programming.

3.2 Presentation and discussion of results

The results of the evaluation are presented in accordance with the specific objectives above. The report then provides a conclusion and recommendations based on the findings from 2018- 2020.

POSITIVE & NEGATIVE IMPACTS ON HEALTH AND NUTRITION

Left: A group photo taken in Lohomiling village during a field visit in Lopa Lafon County in February 2020.

1. *Increased access to quality primary Health Care and clinical support in Torit, Ikotos, Lopa Lafon Counties*

According to a September 2016 CARE rapid needs assessment, it was estimated that over 40% of the population in Torit, Ikwoto and Lopa/Lafon needed health systems and clinical support due to their displacement to remote and hard-to-reach locations/ cut off from basic services due to insecurity.[1] In addition to this, health centers that were closest to these communities were found to be at least 36.25km[2] away from households and the level of service availability and service readiness was very low especially in PHCCs and PHCUs as manifested by inadequate infrastructure, limited equipment, and insufficient supplies of drugs and commodities.[3] Key Informant Interviews conducted during this evaluation also revealed similar findings;

> "The Government has established structures of health systems on ground such as PHCC, PHCU. This however does not cover all the villages and this used to make other community members move a long distant accessing health services" **Government Official.**

Through the mobile clinic, the project managed to serve a greater population of people in distant and hard to reach areas. This led to increased proximity of the community to health and medical support services. Majority (96.9%) of the respondents shared that they had accessed services from the mobile health clinic in the past six months and the average distance from their homes to the mobile clinic was found to be 4.86km. The services for which they accessed theses clinics included; medicines/ drugs, health & nutrition education and referrals among others. The findings of this evaluation noted that the health support not only reached individuals but also other household members. Majority (90.2%) shared that another household member accessed services from the mobile clinic in the past six months.

Besides the mobile approach, the project increased access to health Care and clinical support due to the affordability aspect. Health support was provided at no cost to the community. Further review of project documents also showed that there was a notable increase in the number of community members that accessed services from the mobile clinic. 2019 recorded 31,470 at the end of the implementation period evaluated then[i], which brought an approximation of 500 consultations per week. These services were also provided free of charge to the community, thus reduction in the costs associated with transport to cover long distances to health centers.

The project further increased access in terms of quality of health support provided and accessed in the community. Majority (88.5%) of the respondents mentioned that the mobile clinic they visited had all the necessary services and facilities to offer them support. Additionally, 93.9% reported that when they visited the clinic, they were given priority.

[1] SARA Report 2017
[2] Project baseline Report
[3] SARA Report 2017

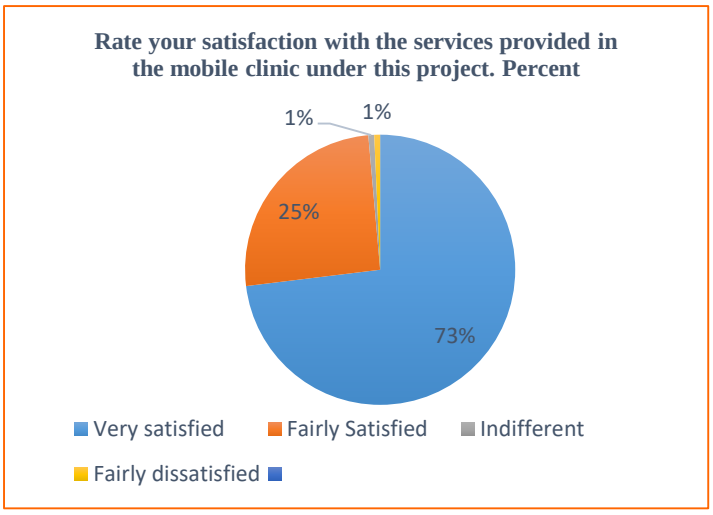

Figure 1 Satisfaction with services at the mobile health clinic

Top: A mobile clinic taking place in Ikwoto in 2019

"I remember a patient was sick and could not be treated for 2 hours. There was no improvement. The mobile clinic referred the patient to Ikwoto PHCC for medical treatment"
Respondent during household survey

Furthermore, access has been increased due to the high number of referrals to static health centres facilitated by the mobile clinics. In addition to this, the percentage of respondents who reported that they were aware of referral facilities for health services increased from 2019 (62.6%) to 2020 (78%). Interaction with the respondents from the PHCC also revealed that in addition to the referral, Care also provided an ambulance to facilitate the movement of patients to better health facilities. Findings from the evaluation however revealed logistical challenges which may reduce the impact of the referral system. The capacity of referral centres were not built to a greater extent to take up transportation of referred victims. In addition to this, communication and poor road network still remains a challenge in most of the locations, making it hard for information to reach. The impacts of the exit of the project are already starting to become visible, as reported by some of the Key informants interacted with.

> "With the absence of Care, we will face some challenges. We have poor referral mechanism due to lack of standing ambulance in the county. 2 days ago in Imuluha in Imehejek Payam, a mother died during labour because there was no transport means for referral," **Key Informant, Static Health Facility, Imehejek**

2. Increased access to ANC and PNC for women

In 2018, the percentage of respondents that sought support for ANC was 62%.[4] The project survey conducted that year attributed the low attendance to limited access to health facilities and made recommendations for the intervention to ensure that the mothers are made aware, the advantages of antenatal Care. The project response through Mother to Mother support groups and mobile clinics equipped with staff enabled mothers to recognize this need and led to increased attendance of ANC. As of 2019, the percentage of women who sought ANC increased to 83% and as per this evaluation in 2020, 93% of the respondents reported receiving ANC. The project also recruited skilled midwives to provide ANC in the mobile clinics, which led to an increase in percentage of persons accessing ANC from midwives/ nurses. The findings of this evaluation reveal that a majority (91.1%) of the respondents that shared that they received ANC from the nurse/ midwife mentioned that they received this support from the Mobile Clinic.

Based on the findings of this evaluation, the access to ANC was also increased due to the empowerment of Community Health teams to provide mobile health support thus guaranteeing a possibility of sustainability of project initiatives. The project exit was replaced by the BHI of the government, and **Figure 2** shows the increased participation of community Health Workers support, a potential indicator of continuity of access to ANC services beyond project exit.

[4] Field data, Emergency Health, Nutrition and GBV Response Assistance Survey in Torit East, Ikwotos, Lafon and Lopa, South Sudan (November, 2018).

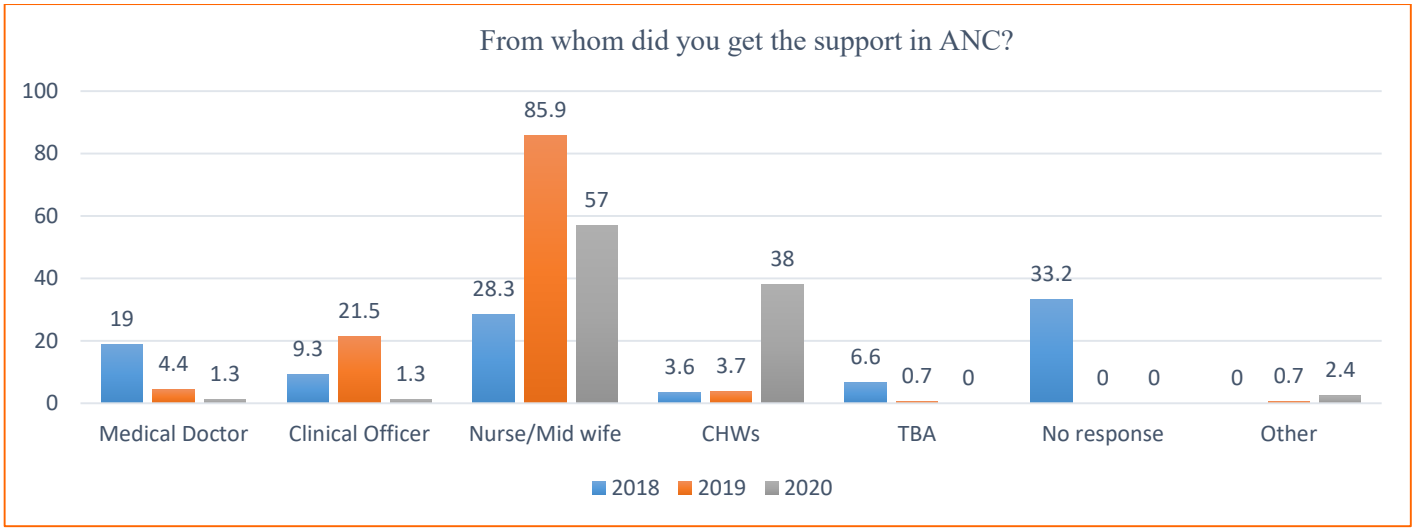

Figure 2 Where respondents accessed ANC

In 2018, the use of TBAs was prominent in provision of ANC. These are grandmothers or young women, probably their friends trained by the elders within the community to help the mothers to deliver safely[5]. Due to their limited skill, mothers were at a high risk of unsafe delivery processes. The findings of this evaluation noted that these percentages reduced to 0% in 2020, thus reducing the possibility of these risks.

Through the increased interaction with skilled medical personnel, findings also showed an increase in skilled deliveries. The percentage of respondents who reported giving birth from home reduced from (83% as reported in 2019 to 43% in 2020) There was also a change noted in percentages of skilled medical personnel assisting delivery and a reduction in percentage of TBAs as shown in the **Table 4** below;

Table 4 Person who assisted in Delivery

Category of personnel	**2018 (%)**	**2019 (%)**	**2020 (%)**
Skilled Medical personnel (Nurses/ Midwives)	16.5	22.2	38.4
Relative/ friend	23.4	52	31.9
TBA	28	11	7.9
Community Health Worker[1]	3.6	7.1	9.7
No one	0	0	6.5
Other	8.5	7.7	5.7
No response	18.1	0	0
Total	100.0	100.0	100.0

In the table it was however noted that there were some women, (possibly those that have given birth following closure of the project) who have not received help from anyone in delivery (6.5%).[1] Similar to **Figure 2**, this table also shows the presence of community Health Workers that are assisting in the provision of health Care.

The project also increased the access of PNC to the women post-delivery. As of 2019, only 39.6% of the women interviewed reported to have received PNC from a trained personnel within 3 days after giving birth. It was noted that the mobile nature of the clinics led to some women giving birth and missing out on post-delivery support. During this evaluation, findings showed that the percentage of respondents that received a visit from a trained health worker within 3 days after giving birth increased to 63.1%.

3. Improved Knowledge and Perception of the Community Towards HealthCare and nutrition

Prior to the project, many of the communities had little to no access to medical Care. Results from the KIIs conducted show that the project has created a lot of awareness which enabled community members access health Care.

[5] Project baseline Report 2018

> "Before this CARE emergency project implementation, most people in the community preferred herbalist and witch doctors when they are sick, but now a lot of people go to the health facility to access health, nutrition and GBV services. **Key Informant, Static Health Facility, Imehejek**

Findings from this evaluation also showed an increase in percentages of people who reported to have ever taken their children to a health facility when ill from (63.5%) in 2019 to 81.9% in 2020. Improvement in perception of the community was also evident due to the increased participation in project activities through attending the mobile clinics. The evaluation conducted in 2019 also showed that Luhobohobo, one of the project sites, the community came together to construct a structure for the project mobile clinic so that activities could still go on even when it rained. This structure is still existent and enables the frequent operations of the mobile clinic. Interaction with leaders showed that the mobile clinic also attracted community members from different locations to access health Care services.

> "The community is very happy with the project implemented by CARE International. They feel like the project should continue. This project was very important and brought a lot of changes in the targeted population leading to neighbouring communities benefitting as well. Itueso boma was in Ikwoto Payam and the community from as far as Lemuleny boma under the Imotong boma also accessed services from the mobile clinic", **Key Informant, Community Leader.**

The KAP of the community towards health and other health practices greatly improved due to the project. As explained later in the report, majority of the respondents were aware of the main causes, signs & symptoms, treatment and prevention of communicable diseases, mostly malaria and AWD. In addition to this, findings also revealed that 88.6% of the respondents who are mothers slept under a treated mosquito net at their homes.

4. Improved access to immunization vaccines

Some of the major causes of morbidity, disability, and mortality in children are preventable by vaccines. In 2018, 59.3% of the respondents shared that one of their children received any vaccinations to prevent him/her from getting diseases, including vaccinations received in a campaign or immunization day with Child Health card. This percentage has increased to 78.8%. (Without a CH Card was 17% and this was 10.1% at the time of the evaluation). Those that did not receive any vaccination are 11.1% a decrease from 18.7% recorded in 2019. Further analysis showed that the percentage of children immunized against different diseases with CH Cards increased. This is an indicator of access to vaccines and increase in children having CH Cards due to having been given birth to at a health facility. Furthermore, this also shows the effectiveness of awareness created by the project on importance of Child Health Cards, as due to this, respondents were taking better care of the CH Cards. The increased access to vaccines has a direct relationship on the reduction in child morbidity due to immunisable diseases. These are shown in **Table 5** below.

Table 5 Vaccination of children

	2018	**2020**
Has your child ever received a BCG vaccination against tuberculosis?		
Yes, with CH Card	56.6	78.4
Yes, without CH Card	12.9	9.4
No	25.0	11.8
Has your child ever received any vaccination drops in the mouth to protect him/her from Polio?		
Yes, with CH Card	57.7	78.7
Yes, without CH Card	20.1	10.1
No	17.0	11.1
Has your child ever received a Pentavalent vaccine?		
Yes, with CH Card	48.5	76.7
Yes, without CH Card	10.2	9.8
No	25.2	13.6
Has your child ever received a Pneumococcal vaccine?		
Yes, with CH Card	-	.3
No	-	99.7
Don't know	-	0
Has your child ever received a Measles injection?		
Yes, with CH Card	35.2	72.1

Yes, without CH Card	12.4	7.7
No	43.4	20.2
Has your child been taken for de-worming		
Yes	36.5	45.6
No	49.5	34.1
N/A	14.0	.7
Don't know		19.5
Has your child ever received Vitamin A (first dose)		
Yes	42	70.4
No	46.7	16.0
Don't know	11.3	13.6
Has your child ever received Vitamin A (Second dose)		
Yes	28.6	65.2
No	63.2	21.3
Don't know	8.2	13.6

5. *Changes in nutrition Statistics*

The project interventions improved nutrition statistics within the implementation areas. It was noted that the percentage of children with SAM reduced considerably in 2019, and those who were well nourished increased. As at the time of the evaluation, percentage of respondents who mentioned that their children were well nourished increased by 26%.

Table 6 Records of MUAC during the evaluation

MUAC children 6-59 months		**2018**	**2019**	**2020**
Percentage of red MUAC (proxy SAM)	<11cm	16.3	0.8%	7.1%
Percentage of yellow MUAC (proxy MAM)	12.5cm – 11.5cm	33.7	3.2%	16.9%
Percentage of green MUAC (Well nourished)	MUAC >12.5cm	50.0%	96%	76.0%
MUAC PLW		**2018**	**2019**	**2020**
Percentage of red MUAC (malnourished)	MUAC<23cm	-	15.8%	21.1%
Percentage of green MUAC (Well nourished)	MUAC >=23cm	-	84.2%	78.9%

Records of MUAC during the evaluation in terms of numbers			
	2018	**2019**	**202**
Number of children under 5 screened during Endline evaluation	**-**	**126**	**154**
Number children with yellow MUAC (proxy MAM)	-	4.03	26
Number of Children with Red MUAC (proxy SAM)	-	1	11
Number of PLW screened	**-**	**57**	**236**
Number of PLW MUAC <23cm	-	9	50

Despite the improvement in nutrition indicators of MUAC, the findings of the evaluation however noted an increase in SAM in 2020 among the children. Despite a slight increase in the number of children under 5 screened during the evaluation, the number of those found with SAM increased significantly from 1 to 11. Similarly, among PLWs, those that were malnourished increased.

It was noted that the increase in malnutrition was due to the possibility of non-food related causes but more related to infections by diseases. Despite the efforts by the project, communicable diseases still remain a great threat to the community. Majority (89.9%) of the respondents shared that in the past one year, someone in their household had been diagnosed with a communicable disease. Most of them mentioned malaria and AWD. In addition to this, respondents who mentioned that their children had suffered from diseases in the last two weeks remained high in 2020 as shown in **Table 7**. This is to a smaller extent attributed to the exit of the project without adequately built capacity of Boma Health Workers and Community Health Workers to continue with provision of health education and support.

Table 7 Diseases child has suffered from in the past two weeks

Diseases Child suffered from in the last two weeks	Percent of cases
Fever/malaria	64.1%
Measles	4.2%
Cough	34.5%
Diarrhea	57.5%
Skin diseases	26.5%
Other	1.7%
Eye disease	17.8%
No Illness	21.6%

The project improved the statistics on exclusive breastfeeding. The percentage of respondents who shared that their children are exclusively breastfed increased from 44.8% in 2018, to 59.3% in 2019. This percentage increased to 62.7% during the endline evaluation in 2020. Exclusive breastfeeding during the first 6 months of life prevents over 1 million deaths each year. Breast milk is the ideal food for newborns and infants. It is safe, provides babies the nutrients they need to develop and contains antibodies which help to protect babies from common childhood infections, such as pneumonia and diarrhea. Improvement in breastfeeding rates is vital to improve the health and nutrition of infants and children. Focus Group Discussions revealed that the Mother to Mother support groups established under this project played a key role in improvement in these nutrition indicators of breastfeeding.

> "Mother to mother support group that are led by mothers in the community. They have benefitted in providing education on antenatal, exclusive breast feeding, family and personal hygiene and drama to mothers to educate them," **Focus Group Discussions, Women & Girls groups**
>
> "Yes, Mother to Mother support groups, benefited us through awareness raising on personal hygiene, washing hands after visiting the latrine, breast feeding up to two years and supplementary food for children after six months. They also educated us about creating good relationship with the baby when breastfeeding," **Focus Group Discussions, Pregnant and Lactating Women**

The changes in feeding practice of children was noted in this evaluation. Only 7% of the children between 6-23 months received foods from 4 or more food groups in 2019. At the time of the evaluation, the percentage increased to 18.6%. This shows that these children have a high likelihood of consuming at least one animal-source food and at least one fruit or vegetable, in addition to a staple food (grain, root or tuber) which is good for their health and nutrition.

6. Visibility of CARE International and OFDA/ USAID the donor

The project created increased visibility for OFDA as the donor and CARE as an organization providing services in health, nutrition and protection within Eastern Equatoria. All stakeholders we interacted with where aware of the roles being played by the project in the regions of implementation. They also shared that there was high involvement. Respondents interviewed mentioned Care as the main NGO from whom they received health and medical Care, GBV and nutrition support. The Mobile Clinic Methodology was also the first to be implemented by CARE in Eastern Equatoria with funding from OFDA/ USAID. Visibility on the project was also enhanced through development of materials such as T-shirts, Caps, Lawa for mother to Mother support groups, aprons for HHPs, sign posts for mobile sites among others.

> "CARE International has had a good relationship with all the government institution and local communities. We have never heard one day that CARE international had a problem with government and other partners on the ground," **Key Informant, Director of relief and rehabilitation commission for eastern equatorial,**
>
> "This project funded by OFDA/ USAID has helped a lot and saved the lives of many people in the community where they were serving. We are still lobbying for the same project from different donors."

7. Increased skills and livelihoods for staff employed under the project

The project interventions built the skills of implementing staff both directly and indirectly. Staff were able to gain knowledge and experiences through trainings like GBV, protection and M&E. CARE International also provided employment for members of the community in terms of Community Health Workers.

> "Yes, the project had adequately addressed the barrier of unemployment through provision of jobs to the local people within a community such as CHW, HHP, GBV volunteer and mother to mother lead group," **Key Informant, Community leader, Ramula.**

Through the project, CARE enabled capacity building to the local community by training some of the members as community health workers, nutrition volunteers and GBV volunteers which they are helped in awareness raising in the community. The community was also trained directly on different ways of improving health, nutrition and protection outcomes in the community.

8. Case fatality rates for communicable diseases

In the past one year, the case fatality rate for communicable diseases is shown in the table below, based on records from a static health facility.

Table 8 Case fatality rate of communicable diseases based on statisc facility records

Communicable disease	No. of cases diagnosed	Number of health facility deaths	Case fatality rate
Malaria	3736	10	0.27%
Acute watery diarrhea (AWD) and acute bloody diarrhea (ABD)	1764	2	0.11%
Respiratory Tract Infection (ART) and Acute Respiratory Infection (ARI)	1128	7	0.62%
Total	**6628**	**19**	**0.29%**

Top: CARE mobile clinic team in ambulance heading to one of the Bomas in Ikotos in 2019

KNOWLEDGE ATTITUDES & PRACTICES

9. *Knowledge, Attitudes and Practices on Health*

Communicable Diseases

Communicable diseases remain a main cause of morbidity in South Sudan. According to WHO, Malaria, diarrhea and pneumonia constituted about 77% of the total OPD diagnoses for children under five in 2018.[6] The findings from this evaluation noted that the respondents were also aware of the threats posed by these diseases. Majority (94.8%) mentioned communicable diseases as the main cause of morbidity for children less than five years old as shown in the graph.

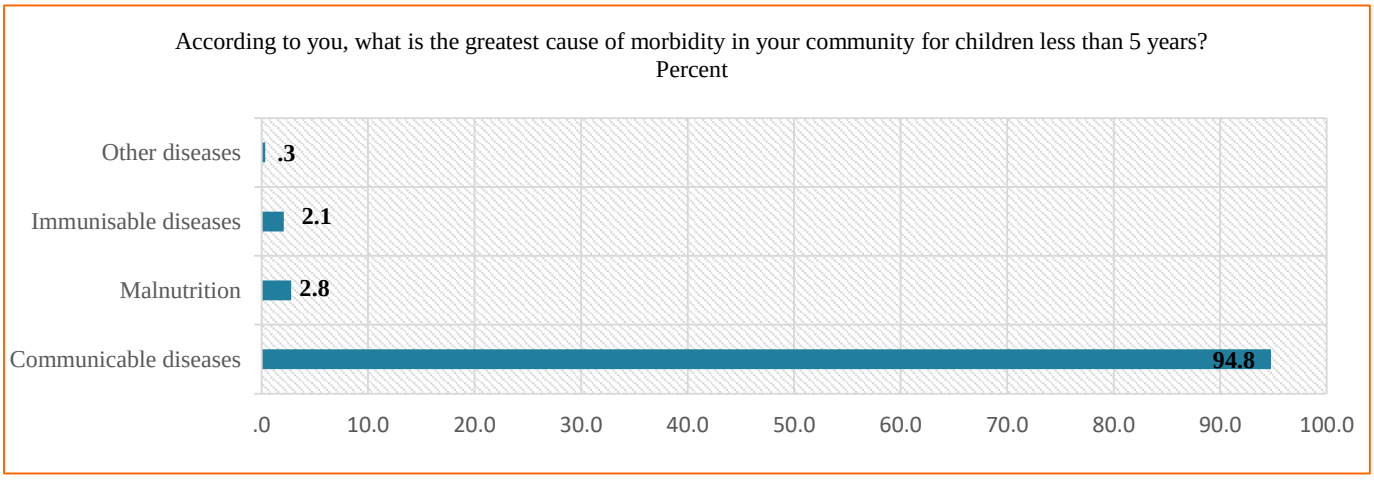

Figure 3 Main cause of morbidity according to respondents

The evaluation also sought knowledge of respondents on three diseases; malaria, diarrhea and pneumonia. Majority of the respondents (on average 79.2%) have knowledge on the main causes of communicable diseases, but were more knowledgeable about the main causes of malaria, compared to the other diseases. The explanations given as the main causes of malaria included; mosquitoes, having bushy areas around the homestead and heavy rainfall that needs to flood. Respondents also shared the main causes of Acute Watery Diarrhea to include; consuming contaminated food

[6] Country Cooperation Strategy at a glance, South Sudan, World Health Organization. https://apps.who.int/iris/bitstream/handle/10665/136881/ccsbrief_ssd_en.pdf;jsessionid=57141AD811F3742F2909035ABAEA269F?sequence=1

and drinking water, eating leftover food from the previous day, dirty environments, among others. The 56.1% of respondents that knew causes of pneumonia shared; cold weather conditions, smoking, among others.

Majority (average 78.7%) of the respondents were aware about the main symptoms of communicable diseases, with the highest level of knowledge being on Malaria. The main symptoms of malaria mentioned included: vomiting, fever, headache, general body pain and general body weaknesses. In reference to AWD, abdominal pain, watery stool, general body weakness, sunken eyes, loss of body weight were mentioned. Respondents also shared that the main symptoms of Pneumonia included; Difficulty in breathing, chest pain, cough, fever, rib pain, among others.

Respondent knowledge on treatment of the diseases was lower (69%). Knowledge on treatment methods of pneumonia was lowest (46.7%). They shared that malaria is treated by anti-malarial tablets such as Amodiaquine (ADQ), Artesunate (AS), and paracetamol, among others. Amoxicillin was mentioned as a treatment for pneumonia and ORS/ Zinc for AWD.

Table 9 Beneficiary knowledge on communicable diseases

Knowledge of the main causes	Malaria	Acute Watery Diarrhea	Pneumonia
Yes	97.2	84.3	56.1
No	2.8	15.7	43.9
Knowledge of the main symptoms	Malaria	Acute Watery Diarrhea	Pneumonia
Yes	96.5	83.3	56.4
No	3.5	16.7	43.6
Knowledge on Treatment	Malaria	Acute Watery Diarrhea	Pneumonia
Yes	78.8	80.1	46.7
No	21.3	19.9	53.3
Knowledge on Prevention & Control of the disease	Malaria	Acute Watery Diarrhea	Pneumonia
Yes	85.0	79.4	47.7
No	15.0	20.6	52.6

Respondents mentioned that to prevent malaria, one has to sleep under a mosquito net and clean/ slash around their compound. To prevent AWD, households have to avoid eating contaminated food, boil drinking water, covering food thoroughly and washing hands regularly. To prevent pneumonia, respondents shared that one has to avoid cold weather/ use warm clothing in case of cold weather, avoid smoking, dust among others.

> Majority of the respondents (78%) also have knowledge of referral mechanisms for health cases within the community. "*There was a child completely sick and CARE mobile clinic tried to treat but, is not able to treat. Due to limited medication, the child was referred to Iemeheje PHCC for medical treatment*" ***respondents, household interview***

Majority (84.7%) of respondents shared that they had ever received any target health education messages example on diseases, their prevention and health seeking behaviors (and any other targeted health education) within their community. Of these, 95.1% could recall the target health messages they received (100% of the males and 94.9% of the females) interviewed.

Knowledge, Attitudes and Practices on ANC and PNC

Respondents had some knowledge on the good practices of ANC and PNC. Majority of them (96.2%) mentioned that during the antenatal Care, they were informed or counselled about any signs of complications (danger signs) that should warn them of problems with the pregnancy. Findings also revealed that 88.6% of the respondents had and slept under a treated mosquito net at their homes. With this practice, the possibility of intense malaria transmission is reduced hence a decrease in the risk of malaria related morbidity and mortality. Male participation in ANC and PNC is moderate, as majority of the respondents mentioned that they were accompanied by their husbands/ partners to the ANC clinic.

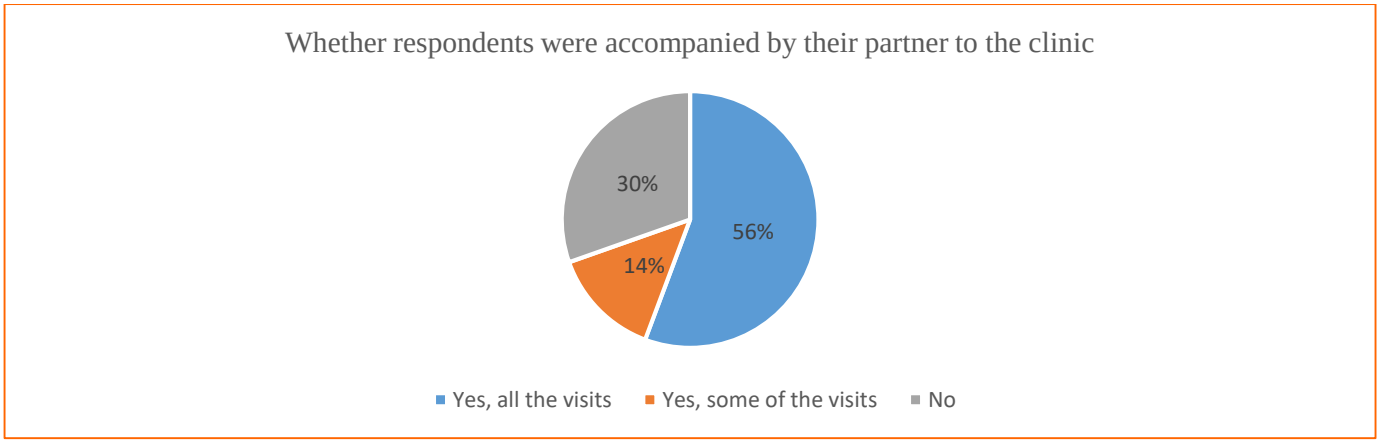

Figure 4 Whether respondents were accompanied by their partner to the clinic

The average number of times respondents visited a health facility for ANC was 4, which is the recommended number. Respondents were also seen to be aware of the times when they first started ANC as 50.6% mentioned 0-3 months. 39.2% mentioned 4-6 months and 10.1% mentioned 7-9 months. Results from this evaluation also showed that majority (93.7%) of women attended 2 or more comprehensive antenatal clinics during their last pregnancy. Majority (63.1%) also mentioned that they received a visit from a trained health worker within 3 days of giving births.

10. Knowledge, Attitudes and Practices on Nutrition

Majority of respondents are aware of when babies should start eating solid foods in addition to breast milk, as 91.5% mentioned six months. 7.9% did not know and 0.6% mentioned other durations. Of the respondents interviewed, 90.9% of the women (0-23 months) shared that their child has been breastfed. Among these, majority shared that they did this within the first hour.

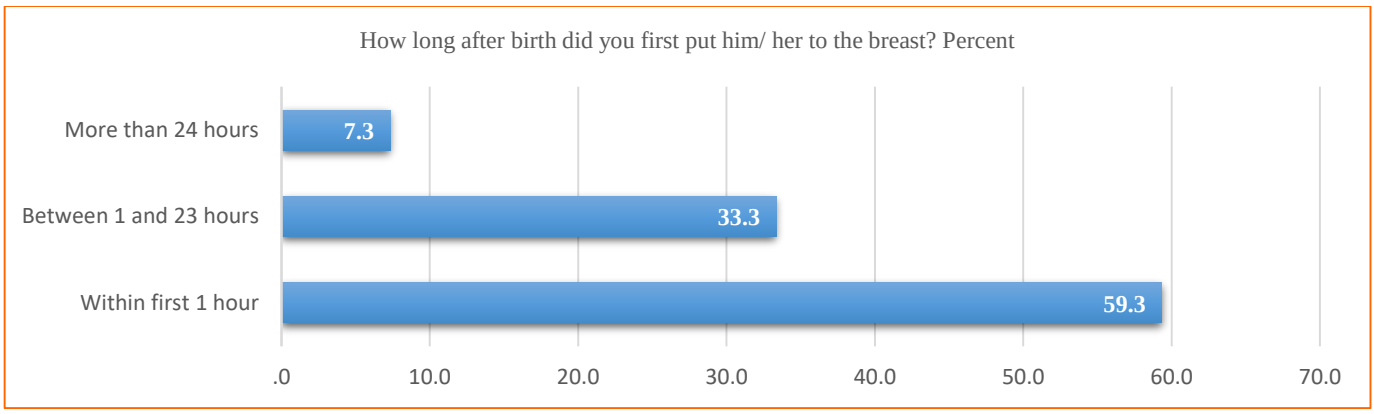

Figure 5 How long after birth respondents breast fed their children

Of the respondents interviewed, majority (91.3%) were still breastfeeding their children at the time the evaluation was conducted. A high percentage (62.7%) of the respondents exclusively breast feed their children - Including milk expressed from a wet nurse.) Infants may be given ORS, drops, syrups (vitamins, minerals, medicines. (Implications)

The results of the evaluation on KAP on nutrition are mainly attributed to the projects interventions. Majority of the respondents (70.4%) interviewed mentioned that they are receiving change interventions to improve infant and young child feeding practices (62.5% of the males and 70.6% of the females). Those that agreed shared that these interventions were mostly awareness and knowledge sharing interventions on better child breastfeeding practices, treatment and Care of the children, information on supplement feeding and provision of additional food nutrients for children. The interventions were mainly provided by CARE International, and a lower percentage shared that it was by Health Link.

The findings of the evaluation however showed that there were limited facilities or community based systems for management of SAM. Only 37.6% mentioned that these facilities existed. Those that agreed shared that they mainly provided Outpatient TF only (41.9%). Both in and out patient TF (37%) and inpatient Therapeutic feeding (21%). The findings also showed that there were limited facilities or community based systems for management of Moderate Acute Malnutrition. Only 27.9% mentioned that these facilities existed. Only 25.5% of the respondents also mentioned that there are micro-nutrient supplementation programmes (e.g. Vitamin A, Iron) in their community. Respondents were also aware of the existence of some nutrition programmes, as 33.9% mentioned existence of any. The example they gave was RUTF flour distribution. An even lower percentage (12.1%) mentioned that there is general food distribution in the community.

This evaluation collected information on a number of customary and traditional beliefs that still exist in the community with regards to breastfeeding. In an FGD, women and girls shared that Breastfeeding after three days is necessary because the milk is dirty, a mother should only eat after the umbilical code is ready; a mother should stay four days having given birth to a baby girl and three days for a boy, without bathing and drinking water; a mother moving far should hold seeds of sorghum or charcoal in her hand to avoid greeting men who might have killed people; when a woman delivers in the health facility the baby will die; In health facilities, to eat and drink water after delivery is against the culture; pregnant women are given local herbs to let her deliver without difficulties.

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The findings of the evaluation noted that respondents were aware of the incidences when it is important to wash their hands. Many of them prioritized before breastfeeding a child, before handling food and after changing a baby's nappy. The respondents however considered all the incidences outlined as important, as shown in **Table 9**

Table 10 Moments when it is important to wash hands according to respondents

Moments when it is important to wash hands	Percent of Cases
After going to the toilet/latrine	93.3%
After cleaning a baby's bottom/changing a baby's nappy?	100.0%
Before preparing/handling food	99.4%
Before feeding a child/eating	96.4%
After handling raw food	72.7%
After handling garbage	69.1%

11. Knowledge, Attitudes and Practices on protection

Majority of the respondents (85.4%) shared that they received information on GBV, Gender equality and protection in the last 6 months. Most of these (80.1%) received the information from an NGO/ Humanitarian Aid worker (Care International and Health Link), 10.6% mentioned that it was from a health worker. 7.6% from a community leader, 0.3% from religious leaders and 1.3% from teachers. The findings show that the project to a lower extent built capacity of local actors and leaders in advocating and ensuring the reduction of GBV in the community and yet as shown from **Figure 7**, they are the main actors that are approached following occurrence of cases. Respondents mentioned that information they received was about the rights of women, girls and other marginalised communities, disadvantages of sexual harassment, GBV and forced/ early marriages among others. Findings from the evaluation indicated that the average number of messages they could recall was 2.

Findings also showed that through the various activities, the project increased access to life-saving protection, health, case management, PSS and multi-sectoral protection.

Table 11 Where respondents received messages

	Percent of Cases
Awareness raising sessions in the community	87.0%
Mobile teams	73.9%
GBV Advocacy events (16 days of activism, women's day etc.)	34.8%
Visit from HHPs/ Community activists	78.3%

Majority of the respondents interviewed (88.2%) were aware of any women and girls rights. The evaluation however showed that the community had a poor attitude towards gender equality. Findings showed that these are mainly due to the cultural perspectives and patriarchal nature of the communities in these areas. Much as respondents share that a man and woman should be treated equally respondents still believe that a man has a right to own a woman he has paid dowry for.

Table 12 Attitude of the community towards gender relations

	Strongly agree	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**
I think that if a woman works she should give her money to her husband	3.8	39.4	2.4	41.1	13.2
I think that a man should have the final say in all family matters	12.2	24.4	4.2	53.7	5.6
I think that men should share the work around the house with women such as doing dishes, cleaning and cooking	13.6	36.9	13.2	22.3	13.9
I think that a woman needs her husband's permission to do paid work	7.7	35.2	9.4	39.7	8.0
I think that a woman should not refuse to have sex with her husband	29.3	41.5	8.4	17.4	3.5
I think that if a wife does something wrong her husband has the right to punish her	9.8	32.1	7.7	39.7	10.8
I think that if a man has paid bride price for his wife, he owns her	24.0	25.8	11.5	30.7	8
I think that if a man beats you it shows that he loves you	2.4	11.5	3.5	42.2	40.4
I think that people should be treated the same whether they are male or female	58.2	34.1	0.7	4.9	2.1

A high percentage (57.5%) still shared that there are harmful traditional practices that affect women and girls access to health services. Most of them mentioned that these include harmful and forced marriages among others. Due to the displacement, respondents shared that there were a number of risks boys are girls were exposed to, the highest being forced displacements.

Table 13 Risks girls and boys are exposed to due to the displacement

	Percent of Cases
Restrictions of movement for civilian like women, girls, and boys	72.1%
Destruction of infrastructure	55.4%
Discrimination of access to Resources	57.5%
Forced displacement	77.7%
Trafficking and abduction	72.5%
Increased vulnerability to physical and sexual violence	59.9%
Others specify	.7%

There are still behavioral problems among girls in the different households, as shared by 55.1% of the respondents. The mostly mentioned was increased aggression, which requires incorporation of conflict management aspects in implementation. Sexual behavior (Clunging) was also highly mentioned. The major risk of this is increased sexual behavior and resultant effects among young girls and boys of reproductive age, such as HIV/AIDs, early pregnancies, and increased chances of contracting Sexually Transmitted Diseases.

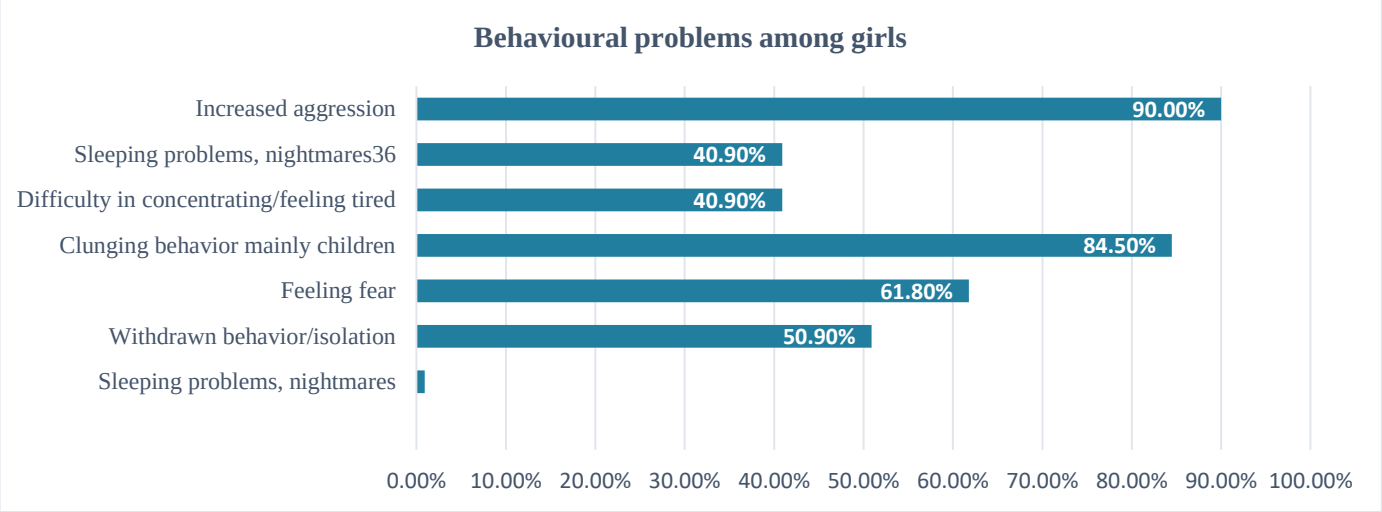

Figure 6 Behavioral problems among girls

Less than majority of the respondents (43.5%) shared that there any dysfunctional copying mechanisms adopted by boys and girls, including adolescents' boys and girls. Those that reported that these existed mentioned mainly Alcoholism, drug use, peer groups, smoking, aggressive & physical violence.

Close to half the percentage of respondents (56.4%) reported that a female household member experienced GBV in the past six months. The average number of incidences of occurrence recorded was 5 in this time period, with the highest being 26. This indicates that much as few people report to have heard of the cases, the few cases of GBV that are taking place are at a high level. Notwithstanding, the reporting rate is high within the community as 93.8% of the respondents shared that the household member reported the incidents. Findings also note that majority of cases in GBV are reported to the community leaders (57.1%), followed by humanitarian workers and family leaders.

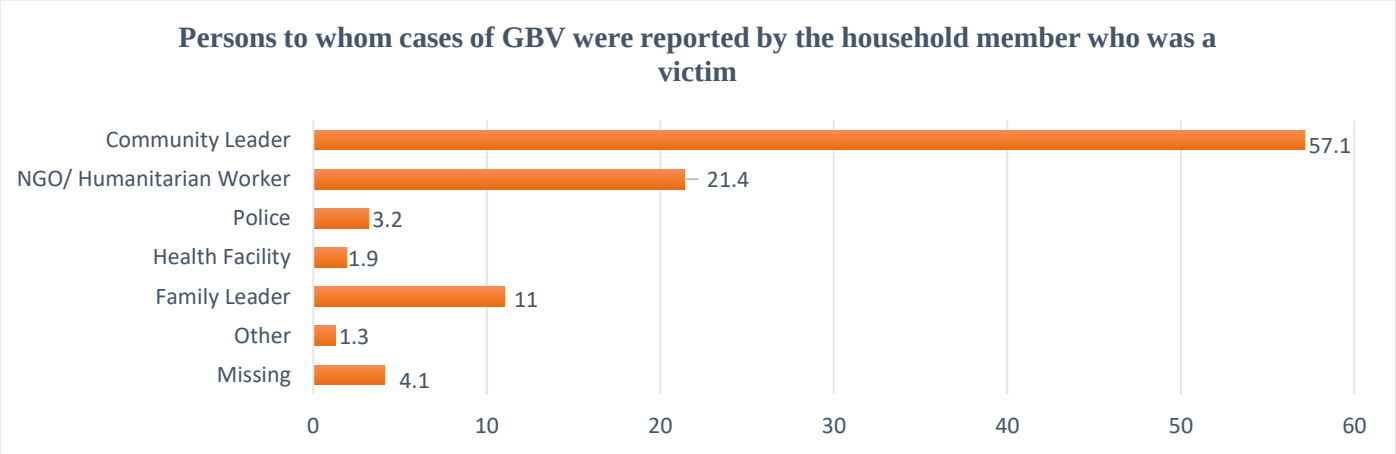

Figure 7 Persons to whom respondents' household members reported the cases

Majority of the respondents (68.6%) mentioned that they heard of a community member who experienced GBV in the past six months. The percentage was higher for Lopa/ Lafon County (74.8%) than Ikwoto (62.8%). Among these, 98% reported the cases and mainly to the community leader. The main types of GBV that still take place in the community is physical violence.

Table 14 Main types of GBV that takes place in the community

Types of GBV taking place in the community	Percent of Cases
Sexual Violence (rape, defilement, etc.)	55.3%

Physical Violence (biting, battering, etc.)	95.4%
Economic Violence (denial of food, denial of income, etc.)	42.6%
Psychological Violence (Confinement in house/home, abusing, etc.)	44.2%

The general trend of GBV in the community is mostly still constant

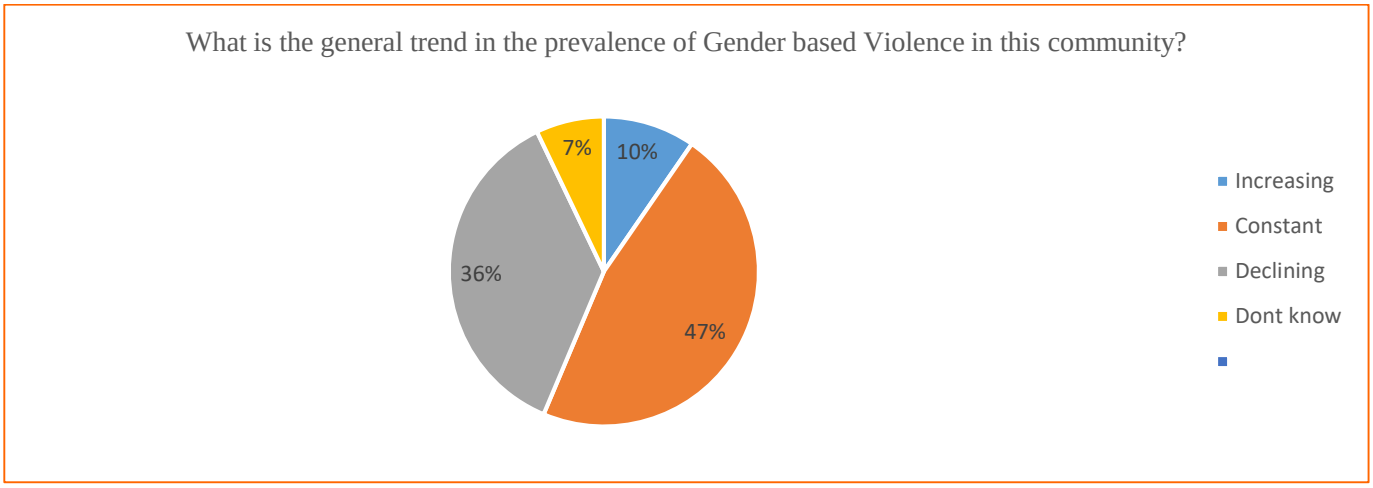

Figure 8 General trend of GBV according to respondents

In a multiple response, the main perpetrators of GBV were also reported to have been fathers/ husbands (97.5%), followed by other community members (45.7%), mothers / wives (43,1%), Relatives (36%)and others (0.5%). There is generally a good attitude towards reporting of GBV cases. Majority (81.5%) of the respondents mentioned that if they suspected that a child/ woman in their community was being abused (physically/ sexually), they would report this incident. Majority shared that they would report this to the community leader i.e. the village elder/ chief (67.5%), neighbor of friend (10.7%), relatives (4.6%), police (7.6%) and others. Only 54% of the respondents shared that there are facilities to provide GBV services within their communities. Of these, most (43.9% mentioned safety and security, 34.8% mentioned legal justice, 10.3% mentioned health support, 11.0% mentioned psychosocial support). (50% mentioned safety and security, 25% mentioned legal justice, 25% mentioned health support, 0% mentioned psychosocial support). (43.7% mentioned safety and security, 35.1% mentioned legal justice, 9.9% mentioned health support, 11.3% mentioned psychosocial support).

Respondents have limited knowledge of available referral pathways to access GBV services in the community as only 30% agreed to have knowledge of any. They mentioned that cases are referred to among others, the Payam Headquarters and youth bodies within the community. With the occurrences of GBV, only 35.2% of the respondents mentioned that there are existing safe spaces and women/ girls friendly spaces in their community. These spaces have been seen to offer a range of services such as Psychological support, Human & Women's rights awareness, Games and sports activities, drama healing, and distributed of cloth, books, food, money and soap among others. Persons who have visited these safe spaces reported an impact in their feeling of wellbeing and ability to cope (91.1%)

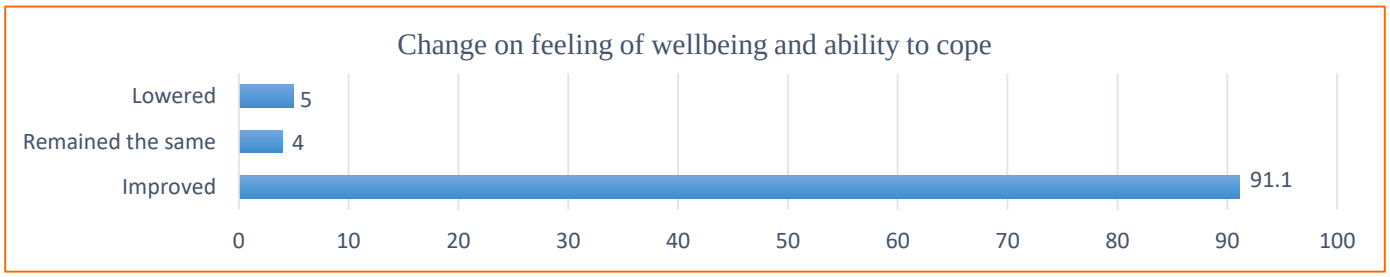

Figure 9 Change on feeling of wellbeing and ability to cope

4.0 ACCOUNTABILITY

63.8% of the community reported participation in project implementation through one or more of the Care accountability mechanisms. This indicates a reduction from the percentage reported in 2019 (70.1%).

Table 15 Involvement of respondnets in accountability mechanisms of Care

Accountability Channel	**Percent of Cases**
Regular feedback on issues addressed	69.9%
Appropriate complaint mechanisms are in place	73.2%
Effective reporting channels on project implementation	72.1%
Involvement in decision making	85.2%
Regular information sharing	70.5%
Other (specify)	1.6%

A lower percentage said they participated weekly (28%), whereas 71% said monthly 1% quarterly. Most (83.1%) of the community admitted that the mechanisms they were involved in were effective in addressing their concerns, and increment from 64.5% recorded in 2019. Respondents were asked to express their satisfaction levels with the different accountability mechanisms. VS-Very Satisfied, FS-Fairly Satisfied, VD-Very Dissatisfied, FD-Fairly Dissatisfied.

Table 16 Beneficiary satisfaction with feedback mechanisms administered

Regular feedback mechanisms		**Appropriate complaint mechanism**	
Very Satisfied	45.3%	Very Satisfied	**54.5%**
Fairly Satisfied	46.9%	Fairly Satisfied	35.1%
Indifferent	2.3%	Indifferent	6.7%
Fairly Dissatisfied	1.6%	Fairly Dissatisfied	3.0%
Very Dissatisfied	1.6%	No response	0.7
No response	2.3%		
Effective reporting channels on project implementation		**Involvement in decision making**	
Very Satisfied	**66.7%**	Very Satisfied	**57.7%**
Fairly Satisfied	25.8%	Fairly Satisfied	26.7%
Indifferent	3.8%	Indifferent	4.5%
Fairly Dissatisfied	1.5%	Fairly Dissatisfied	6.4%
Very Dissatisfied	1.5%	Very Dissatisfied	1.9%
No response	0.8%	No response	1.9%
Regular information sharing			
Very Satisfied	**73.6%**		
Fairly Satisfied	20.9%		
Indifferent	1.6%		
Fairly Dissatisfied	0.8%		
Very Dissatisfied	0.8%		
No response	2.3%		

5.0 CONCLUSION

The project made a visible impact especially in creating access to health, nutrition and protection services for the community in Eastern Equatoria. The findings of the evaluation show that despite this support, communicable diseases still remain a main cause of morbidity and mortality within the area, with a high percentage of respondents reporting having been infected in the past one year. The mobile clinic methodology employed by CARE was highly relevant and effective in leading to improvement of health and nutrition outcomes. Services were provided to individuals in some of the most remote and inaccessible areas in the county. As shown in the preliminary sections of the report, access to health, nutrition and protection information was increased. This evaluation however noted that the approach was limited in sustainability, and the project exited before adequate capacity building of Community Health Teams to continue to provide support. In addition, the contextual challenges as were identified at the start of the project still persisted at the end of the project such as; inaccessibility of roads, poor communication network, limited number of static health facilities among others, leading to a high risk of reduction of the status of impact caused by the project.

Findings from this evaluation also noted a slight decrease in MUAC of the children and PLW. Due to a positive indicators on food related causes of malnutrition, the conclusion is that these were associated with disease related risks in the area, which is evidence for the need of additional programme interventions targeting provision of health Care. The nutrition statistics also present a need for programmes targeting supplementary feeding provision as well as prevention of moderate and Severe Acute Malnutrition in Eastern Equatoria. The evaluation showed the relevance of Mother to Mother support groups and their high contribution towards improved nutrition of children and PLW.

In regard to protection, the community still has a poor attitude towards gender equality, due to the high importance allocated to cultures and limited change in attitudes. These findings showed a need for continuous capacity building initiatives that target awareness creation. The evaluation also showed that future interventions should harness the trust that the community has in the leaders, to utilize their efforts as key agents of change & sensitization. Analysis of data also revealed a high need for interventions directed towards conflict management and mitigation. Most of the behavioral characteristics and coping strategies of groups were associated with aggression and violence. This evaluation also shares key areas for continued advocacy as was identified in 2019;

1. Regular update of data by the government, especially with on ground health indicators. The team should advocate for a census to be carried out by government to provide recent statistics that guide programming.
2. Increased number of agencies, partners and within project target locations, especially those supporting livelihood and WASH interventions.
3. Allocation of resources by government to support construction of statics health facilities.

6.0 RECOMMENDATION FOR FUTURE INTERVENTIONS

- CARE should target capacity building interventions to provide support towards improving skills of BHIs to ensure continued provision of quality health services, nutrition and SGBV services.
- Future interventions should build the capacity of community leaders to provide protection services and awareness, through encouraging community led interventions.
- Within the multisectoral approach, future interventions should incorporate a WASH component since health and sanitation are directly proportional, and to have a successful health initiative, the WASH component needs to be factored in the project.
- Future interventions should incorporate conflict management implementation. This is because majority of the locations of implementation are still volatile.
- Nutrition projects are highly encouraged in Eastern equatoria.

7.0 ANNEXES

7.1 Table showing Key Informants Interviewed

Department	Person interviewed		
Government Official	**Lopa**	**Ikwoto**	**Torit**
RRC Coordinator state level			John Odongi- RRC Director
Executive director County level	Executive director Lopa County- Agustino pio		
County Health Officer	Ohisa William- County Health Officer Lopa		
County Health Officer		Lope Joseph- CHO Ikwoto	
Community leader			
Payam chiefs	Santino Itulo- Chief Lohobohobo in Imehejek		
Chief	Paul Oduwa- Community leader Lovirang	Garang Simon- Ramula community leader	
	Jikardo Okwahi- Community leader and teacher- Imuliha Iboni payam	Lugala Mark- Community leader for Iteuso	
Static health center			
Health Facility Staff	Oola william- Doctor Imehejek Hospital	Carlo Ludai- Clinical officer Ikwoto	
EPI OFFICER		Ohisa Paul- EPI Officer	
Collaborating partners			
Save the children Torit Office			Taban Justin- Nutrition coordinator, Easter Equatoria and cluster co lead
WHO Field supervisor		Phillip Oboi- WHO field supervisor for Ikwoto	Not available
Health link Lopa	Lemi Robert- Lot coordinator health link		
Community Health Workers	Jildo Uhumi- CHW Mora lopit PHCU	Mathew Lobwo- Community Health Worker	
	Argastine Owaha- Nutrition assistant save the children attached to Mora lopit		
	Arkanjelo Lowa- CHW and BHW Mora Lopit		

FGD information	**Lopa**	
	Male	**Female**
Lopa women and girls friendly space	0	10
Lohobohobo	0	9
Lohobohobo	8	0
Ikwoto FGD		
Ikwoto women and girls friendly space for girls	0	9
Ramula Mobile site for women	0	8
Iteuso Mobile site for men	8	0

[i] Project Results Framework 2018