



**End of Programme Evaluation Report for
Disaster Emergency Committee WV Relief Programme
in South Sudan – DEC Phase I and II**

Submitted to:

World Vision UK

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List of Acronyms and Abbreviations

AFOD	Action For Development
CNV	Community Nutrition Volunteers
CMAM	Community Based Management of Acute Malnutrition
DEC	Disaster Emergency Committee
FGD	Focus Group Discussion
FSL	Food Security and Livelihoods
HPF	Humanitarian Pooled Funds
IDPs	Internally Displaced Persons
IEC	Information Education Communication
IOM	International Organisation for Migration
MAM	Moderate Acute Malnutrition
MUAC	Mid-upper Arm Circumference
OTP	Out-patient Therapeutic Programme
PoC	Protection of Civilians
PLW	Pregnant and Lactating Women
RRC	Relief and Rehabilitation Committee
RUSF	Ready-to-Use Supplementary Food
RUTF	Ready-to-Use Therapeutic Food
SAM	Severe Acute Malnutrition
SC	Stabilisation Centre
SFP	Supplementary Feeding Programme
SGBV	Sexual and Gender Based Violence
SPHERE	Humanitarian Charter and Minimum Standards in Human Response
SQUEAC	Semi-quantitative Evaluation of Access and Coverage
SSP	South Sudanese Pound
TGNU	Transition Government of National Unity
TSFP	Targeted Supplementary Feeding Programme
UCT	Unconditional Cash Transfer
UNICEF	United Nations Children's Fund
UNMISS	United Nations Mission in South Sudan
WASH	Water, Sanitation and Hygiene
WFP	World Food Programme

WVSS	World Vision South Sudan
WVUK	World Vision United Kingdom

Executive Summary

Introduction

Civil war in South Sudan has degenerated into inter-ethnic violence that has displaced one in every five South Sudanese and left most of the adult population without a stable livelihood. The recent drought has further exacerbated an already precarious situation resulting in the need for humanitarian assistance to a significant affected population and the host communities.

World Vision, through the support of the Disaster Emergency Committee (DEC) has been implementing a two-phase project to support communities in Juba (Juba town) and Upper Nile (Malakal and Melut) by providing critical lifesaving support and services in nutrition, water, sanitation and hygiene (WASH) and protection activities.

Purpose of the Evaluation

The purpose of the evaluation is to assess the project's progress and results towards expected outcomes, and overall project impact, as well as adherence to the core humanitarian standards.

Methodology

The study was designed to use on Semi-Quantitative Evaluation of Access and Coverage (SQUEAC methodology). However, due to limitation of data from the health facilities the study partly employed a mix of methods including SQUEAC and cross-sectional assessment for the nutrition study. This included collection of existing data (health records) at health facilities, desk review of projects documents, Focus Group Discussions (FGDs) and Key Informant Interviews (KII). The assessment was conducted through structured and semi structured questionnaires administered to beneficiaries and non-beneficiaries.

Study Limitations

It was not possible to map trends in admissions over the project period as per SQUEAC as this data was provided cumulatively for the year rather than as monthly data. The beneficiaries surveyed within Juba county were between 0 and 2km from the health facilities to enable data to be collected within the time allowed. Lastly, nutrition related data was availed by the project rather than collected directly from the facilities; this consisted of end of project summaries rather than data per month, therefore it was not possible to use the data to create trends.

Key Findings

- CMAM coverage in Central Equatorial State Juba town, a largely urban and peri-urban area, was estimated to be: **Point Coverage1: 46.7% (37.5% - 57.0%)** while **Period Coverage2: 69.7% (61.6% - 77.3%)**. A coverage of 70% is acceptable in urban areas (SPHERE standards). In conclusion the project had sufficient coverage and efficient management of malnutrition in the targeted area.
- Cure rate was 87% which is above 75% recommended SPHERE standards. The death rate was below 1%, this is a significant improvement on the 10% recommended by the SPHERE standards. The defaulters' rate was 5% which was well within the allowable of <15% as per the SPHERE standards. The non-cure rate was at 7%, which was also well within the recommended threshold of 10% as per the SPHERE standards.

- The table below presents the main barriers on which the project must act to improve coverage as well as the boosters to the project coverage.

Barriers	Boosters
Long walking distance to health facilities coupled with poor transport network and roads	Good inter-linkage between community and health facility. Increased use of mobile clinics.
Frequent population movement	Increased awareness of OTP and MUAC by caretakers and the community members
RUTF shared amongst other HH members	Good community mobilisation (acceptance and understanding of project, including the need for recipients of RUTF to receive the complete package as intended)
Shortage of supplies	Good integration in services provided - community nutritional volunteers and health staff in clinics were screening and referring children to treatment centers
Poor health-seeking behaviour where communities do not seek health care immediately a child falls sick	Community to facility referrals facilitated by CNVs
High workload due to shortage of staff. Community Nutrition Volunteers leaving project for better livelihood opportunities.	Awareness of symptoms of malnutrition by care givers
Limited capacity of MOH staff to manage cases due to few qualified work force.	Presence of WVSS staff supporting the clinics for quality assurance and other health facility services as local staff had limited capacity to provide quality services.

Table 1: Boosters and Barriers

- There is still a gap in the practice of washing hands at critical times especially during drought when water is not easily available.
- Improved hygiene practices play a vital role in child survival. The project had a mix of both nutrition and hygiene promotion, both which helped in attaining the success of the project in Juba. However, there was no strong relationship between the two in Kor Adar.
- Continuous insecurity, resulting into population movement compounded with drought puts women and children at greater risk. The project integrated well protection and gender issues into programming empowering both women and children at risk.

Conclusions

In general, the project can be said to have attained its objectives in terms of relevance, appropriateness and effectiveness because it allowed children and women at risk of malnutrition get improved services at critical time through active case finding and referrals. Further the beneficiaries also accessed safe water, provision of sanitation services and hygiene promotion. The project also had a strong coordination framework at national level among partners that supported the government to meet the targets at national level.

The assessment also concludes that stronger collaboration between relevant ministries (Health, Agriculture, Water Resources and Irrigation, Education etc.) is necessary to ensure Government of South Sudan ownership and sustainability.

Recommendations

General

1. Further strengthen collaboration between WV and relevant South Sudan Government Ministries, this will support government capacity and sustainability of activities.
2. Document the training approaches WV-South Sudan is using to train local Sudanese staff so that project learning can be used to inform future interventions.
3. Work collaboratively with community-level volunteers, opinion leaders and communities to encourage the continued use of IEC materials and behavior change communication designed to promote positive Maternal, Infant and Young Child Nutrition and WASH practices.
4. Support the Ministry of Health to establish and maintain its own complaints and feedback mechanisms.
5. WVSS should enhance its project visibility in Kor Adar through better branding and visibility materials e.g., on water tanks.
6. Promote regular information dissemination/sharing forums to educate households on their right to access quality water services and encourage accountability of water management committees
7. Continue to actively mainstream protection and gender issues into WVSS programming.

I.0 INTRODUCTION

I.1 Project Background

South Sudan has been in a state of insecurity since violent clashes erupted in the capital Juba in December 2013, quickly spreading to other states. Over 2.3 million people have fled their homes, 1.69 million remain displaced inside the country (53.4% of whom are estimated to be children) and nearly 711,967 have sought refuge in neighboring countries. The formation of the Transitional Government of National Unity (TGNU) raised hopes of a lasting peace after the conflict but to date there are still traces of instability. Protracted conflict has severely limited food access and availability, not least through the disruption of markets and agricultural production and an economic crisis leading to hyperinflation and soaring food prices. Food insecurity is a major concern for millions of people. To cope with the situation, many families have adopted negative coping strategies such as skipping meals, reducing the amount of food eaten, and eating only one variety of food that is most affordable, such as sorghum. During the period Phase I of the project was initiated, many households with children admitted in the nutrition programme were either selling the nutrition supplies intended for the malnourished child to purchase other foods for the family or sharing the supply with other family members. The supplies for both Outpatient Therapeutic Programme (OTP) and Targeted Supplementary Feeding Programme (TSFP) were provided by UNICEF and WFP respectively. As a result, high rates of non-recovery, beyond the recommended WHO Sphere Standards were reported, particularly between Feb and June 2017.

World Vision implemented a two-phase project with funds from the Disaster Emergency Committee (DEC) with the aim *to save lives and avert the suffering of the conflict-affected children and their families in South Sudan*. The interventions focused on critical life-saving support and services in nutrition, water and sanitation hygiene, and child protection activities, which included implementation of child-friendly spaces activities. The project was implemented in two phases

Phase I: 15 March 2017 – 30 September 2017

Sector	State	District	Target number
Nutrition	Central Equatoria	Juba	14,000
Protection		Juba	8,000
WASH	Upper Nile	Melut	14,000

The locations in Juba included peri-urban settlements and IDP camps.

Expected Outcomes

- Reduce cases of acute malnutrition among U5 children, pregnant and lactating women
- Strengthened capacity of the community to identify, assess and mitigate risks for children
- Affected populations in Kor Adar and Malakal have improved access to sufficient quantities of clean safe water that meets SPHERE Standards

Phase II: 1 October 2017 – 30 June 2018

Sector	State	District	Target number
Nutrition	Central Equatoria	Juba	15,000
Protection		Juba	10,000
WASH		Juba	6,000

Expected Outcomes

- Improved access to life-saving nutrition services, including management of SAM and MAM and Maternal, Infant and Young Child Nutrition, among children U5, pregnant and lactating women in Juba
- Strengthened capacity of the community to identify, assess and mitigate risks for children.

Expected outputs for phases 1 and 2

- Under 5 children with SAM and MAM, and pregnant and lactating women with MAM admitted to Outpatient Therapeutic Programme (OTP) and Targeted Supplementary Feeding programme (TSFP):
- Enhanced Water, Hygiene and Sanitation services in health facilities
- Optimal Infant and Young Child Feeding (IYCF) promoted to prevent under nutrition among children and women
- Increased number of children accessing safe and secure playing environment
- Improved awareness among community members on child protection, GBV issues, and referral pathways
- Sustained delivery of adequate safe water to 7000 people in Kor Adar
- Enhanced awareness of good hygiene behavior

Activities included a broad range of nutrition, WASH and protection related activities. Selected activities include as follows:

Identify cases of acute malnutrition through active and passive case finding, admit to TSFP and treat for MAM or admit to OTP and treat for SAM; set up 2 mobile sites for outreach for MAM & SAM; train CNVs on active case finding in the community through MUAC and oedema assessment,

defaulter tracing and prevention of malnutrition; conduct community and facility-based screenings for acute malnutrition; train health workers, health providers (MOH and WV SS nutrition staff), community leaders, CNVs, train Mother Support Groups and provide technical and material support/inputs to these groups to promote vegetable gardens; conduct live and interactive radio talk shows and provide pre-recorded messages to promote good nutrition, health and hygiene practices; mobilise and organise community meetings monthly to provide education in MIYCN; construct toilet facilities in training centers, health facilities, CFS and Schools; provide materials for five Child Friendly Spaces and facilitate children's activities and sport; train Child Protection committees and local leaders in GBV prevention and response, and child protection, train project staff in psychosocial support and referral of GBV cases; carry out water treatment and supply treated water to affected population in Kor Adar; carry out hygiene promotion activities, install hand washing facilities.

I.2 Evaluation purpose and objectives

The purpose of the evaluation was to assess the project's progress and results towards expected outcomes, and overall project impact, as well as adherence to the core humanitarian standards. The evaluation review was guided by the following evaluation criteria:

- a) Humanitarian response is appropriate and relevant
- b) Humanitarian response is effective and timely
- c) Humanitarian response strengthens local capacities and avoids negative effects
- d) Humanitarian response is based on communication, participation and feedback
- e) Complaints are welcomed and addressed
- f) Humanitarian response is coordinated and complementary
- g) Humanitarian actors continuously learn and improve
- h) Staff are supported to do their job effectively and are treated fairly and equitably.
- i) Resources are managed and used responsibly for their intended purpose

I.3 Scope of the Evaluation

The evaluation was conducted in Juba town, Jubek State, and Melut, Upper Nile State targeting both direct and indirect project beneficiaries. The participants in the evaluation included:

- Mothers and caregivers and children less than five years who participated or benefited from project activities (directly or indirectly)
- Community nutrition volunteers
- Mother to Mother support groups
- Child protection committee members
- Child Peace clubs
- Hygiene promoters
- Community and County leaders
- Project staff
- Nutrition, Child Protection, and WASH clusters
- Partners

2.0 METHODOLOGY

2.1 Introduction

This section highlights the methodology that was used to inform the sample, collect and analyse the data to fulfill the objectives of this evaluation. The section also highlights key research processes that guided the evaluation's implementation, data quality control and standards, as well as ethical considerations. The World Vision evaluation team reviewed Vision Quest's proposed methodology, including the suggested sample sizes as well as the data collection tools.

2.2 Sampling

In Juba town, 4 health facilities (Don Bosco, Rock City, Gurei and Munuki) were sampled out of a total of 8 facilities. The main focus of activities had been on the nutrition programme therefore in addition to visiting the facilities, observing the activities there and collecting facility-level data, the group to be sampled was households with children under 5 year and pregnant and lactating mothers who had benefited from the facility nutrition programme.

In Juba, the sampling of households was done through snowballing method. Snowball sampling consists of two steps: a) Identifying potential subjects in the population where only a few subjects can be found initially, and b) Ask those subjects to identify other subjects (and then ask *those* people to recruit). Participants should be made aware that they do not have to provide any other names. These steps are repeated until the needed sample size is reached. Since sampling was not being done at the health facilities but at home, not all households with children under 5 years were had direct records within the registries. Since the households are close together, those in the programme knew each other and further households with children under 5 are also know within this community setting. Where other beneficiaries were unknown to the households, the Community Nutrition Volunteer (CNV) guided the enumerators to specific households where there were beneficiaries. The sample target for Juba was 384, and 384 households were interviewed.

In Kor Adar, Melut, Upper Nile State, random sampling was used. Kor Adar is a single settlement comprising host communities and IDPs. All households within the settlement were beneficiaries of water supply during the prolonged drought period. Therefore, it was possible to evaluate the programme by interviewing households sampled through random sampling. Households were identified by starting from the centre of the village and tossing a pen. The direction of the pen tip was picked. The first household was visited and then subsequent households were picked by skipping two households. This was done to the outer boundary of the settlement. The process was started again the village centre. The camp office was picked as the centre of the camp. In Kor Adar the target sample was 274 and a total of 293 households were interviewed.

2.3 Data Collection

This evaluation employed qualitative and quantitative techniques of data collection. The methodologies are described below.

In Juba, a two day training was conducted to the enumerators by the consultants at World Vision offices. The aim of the training was to have common understanding on the objectives of the data collection, clear definition of various terms as translated into local dialect. This was followed by field testing of the tools to further endure clarity of responses and interpretation of the responses. Two consultants supported the enumerators and further conducted Key Informant Interviews (KIIs) while the household data and data from the Focus Group Discussions (FGDs) were collected by trained enumerators.

In Kor Adar, one consultant conducted a one and half day training conducted at Camp Chairman offices, followed by field testing of the household tools. The objective of the training was to have common understanding of the tools and the interpretation of various terms as translated into local dialect. This was followed by three days data collection. Each evening all data sheets were collected at cross checked by the team leaders for correctness and completeness before handing to the consultants. The consultant conducted KIIs and FGD with the support of an interpreter.

2.3.1 Desk Review

The consultant undertook a comprehensive desk review. Documents reviewed include: DEC Phase II 6 Month Report, DEC Phase II Output Form, DEC Phase II M&E Framework, Phase II Final Narrative Report, Project Summaries from health records facilities in Juba town (Don Bosco, Rock City, Gurei and Munuki health centres) was analysed. This included admission criteria for malnutrition, admission, OTP admissions, defaulters, length of stay.

2.3.2 Household Interviews

Vision Quest conducted structured household (HH) interviews with sampled beneficiary populations. Households were taken as a family eating from the same pot. In Juba a total of 384 households were targeted, of which 384 households were interviewed (pregnant and lactating mothers and caregivers of children below 5 years), 6 FGD and 13 KIIs (5 WVSS staff, 5 health facilities staff, UNICEF, WFP, SMOH and Concern Worldwide).

In Melut (Kor Adar settlement) a total of 274 households were targeted, while 293 households were actually interviewed, these were selected based on random sampling and 40% were host community and 60% IDPs). There were also 2 FGD (mixed gender of host and IDPs) and 8 KIIs (Community leaders and project staff).

2.3.3 SQUEAC

Vision Quest employed different tools in collecting both quantitative and qualitative data for the purpose of answering the various evaluation questions. These included the following:

Quantitative Data: mainly from **routine monitoring information** that the project had already collected including: admissions, defaulting, recovery, middle upper arm circumference (MUAC). The routine programme data helped to evaluate the general performance of CMAM services, to identify admission and performance trends and to determine if the programme adequately responds to need. It also helped point out problems in screening, admission and reporting.

Qualitative data collected from **small size beneficiary sampling** (of CMAM beneficiaries) to investigate project operations, to unravel the opinions and experiences of actors involved in CMAM and to identify any potential barriers to access. This included qualitative data collected using informal group discussions and interviews with CMAM beneficiaries.

a) **Semi-structured interviews** with key informants including project staff, clinic staff, community-based informants such as hygiene promoters, health extension workers, and CNVs, carers of children in the project, carers of children not in the project.

b. **Simple semi-structured interviews**, undertaken as part of routine programme monitoring with breastfeeding mothers.

c) **Informal group discussions** with carers of children attending project sites, relatively small groups of key informants (e.g. community leaders and religious leaders identified through volunteers and mothers at project sites) and lay informants (e.g., mothers and fathers).

The BBQ framework- Throughout the evaluation, the data was organised, analysed and triangulated using the Barriers, Boosters and Questions (BBQs) framework. It is a tool that facilitates iterative data collection that is then categorised into one of three categories. The various data organised within the BBQ framework, when combined, helps to provide information about where coverage is likely to be satisfactory as well as where it is likely to be unsatisfactory. Additionally, the BBQ provided information about likely barriers to services access that exists within the CMAM programme.

'Barriers' are negative findings that deter from project coverage and complicate access to service. Conversely, 'boosters' contribute to a higher coverage and facilitate access. Lastly, 'questions,' are those findings elements to be further investigated, and either become a barrier or booster or remain inconclusive.

2.3.4 Key Informant Interviews

Vision Quest carried out a total of 21 KIIs, 13 with key informants in Juba town (5 WVSS staff, 5 health facility staff, and representatives from UNICEF, WFP, State Ministry of Health (MOH) and Concern Worldwide) and 8 with community leaders and project staff in Melut county, Upper Nile State. The result of these interviews contributed to the details of the communities' profile on matters concerning nutrition and WASH.

2.3.5 Focus Group Discussions

A total of six FGDs were carried out in Juba, two with caregivers, two with non-caregivers and two with CNVs. In Melut (Kor Adar settlement) there were 2 FGDs (mixed gender, host and IDPs). The FGDs were used to help provide existing perspectives about the initiatives implemented guided by the end line objectives.

2.3.6 Carrying out Field Work

Before carrying out the field work, Vision Quest in coordination with World Vision relayed information to the communities to let them know that a team was coming to visit them, this was done through Government officers and Local authorities. The enumerators were initially identified

with the support of WVSS field staff. A two-day training was conducted to ensure the subject matter was understood and common terms translated into the local language. Pre-testing of tools was done on the second day to confirm the understanding of the enumerators and contentious questions clarified accordingly. Each evening field questionnaires were collected, and consultants went through the completed questionnaires to ensure completeness. Where there were gaps, the enumerators were asked to do return to the household to complete.

2.4 Data Entry, Quality Assurance and Analysis

Quantitative data collected on paper were reviewed to check for consistencies and completeness, before coding and entering into SPSS ready for analysis. Qualitative data were asked in local language and translated to English on the questionnaire. These were then typed and uploaded into NVIVO software.

Data analysis was a rigorous process that explored descriptive statistics, specifically the frequencies, mean, sum, standard deviation and variance. Qualitative variables were coded and organised into themes and the emerging trends and patterns identified using NVIVO software, guided by the objectives and the criteria. All the findings and discussion are presented below using ratios, graphs, figures and pie charts.

2.5 Study Limitations

The following study limitations were noted:

- It was not possible to map trends in admissions over the project period as per SQUEAC as this data was provided cumulatively for the year rather than as monthly data. Data provided was in summary form and therefore would not give month-by-month health facility information.
- The beneficiaries surveyed within Juba county were between 0 and 2kilometers from the health facilities. This limitation was applied to enable data to be collected within the time allowed.
- Using the snowballing method of sampling a population means that it is not possible to determine the sampling error or make inferences about a population based on the obtained sample.
- For Kor Adar, the project had been implemented almost six months previously and some of the household members interviewed could not remember information that was requested.
- SQUEAC methodology was to be applied in Juba to collect nutrition-related data. It was indicated that health unit data was available at World Vision offices and therefore there was no need to pick 'raw' data from the facilities. However, the data availed by the project consisted of end of project summaries rather than data per month, therefore it was not possible to use the data to create trends.

3. EVALUATION FINDINGS

The data collected as indicated above was analysed resulting in the following findings.

3.1 Health and Nutrition

The programme supports nutrition and sanitation activities in 8 health units and 3 outreach stations. Four sampled facilities (Don Bosco, Rock City, Gurei and Munuki) were visited. The South Sudan Nutrition Protocol provided guidance for admissions into OTP and TSFP. For children 6 to 59 months of age with MUAC ≥ 11.5 cm and < 12.5 cm (yellow colour code) or < 11.5 cm (red colour code) with absence of bilateral pitting oedema. Children 6-59 months with grade 1 and grade 2 oedema are admitted to OTP. Grade 3 oedema is treated in SC as inpatient until the oedema subsides after which children are transferred to the OTP to continue treatment.

OTP admission criteria for children 6-59 months with SAM

- Absence of Bilateral pitting oedema + and ++

OR

- MUAC < 11.5 cm

AND/OR

- Weight-for Height/Length < -3 z-score

AND

- Good appetite (passed appetite test for RUTF)
- Clinically well and alert

ALSO

- Children discharged from SC/ITP to continue treatment for SAM
- Children transferred from TSFP if condition deteriorates to SAM without complications

Infants less than 6 months of age who have bilateral pitting oedema, are too weak or feeble to suckle effectively, with any weight loss and/or visible wasting and medical complications or general danger signs are referred to stabilisation centres for inpatient care. Pregnant and Lactating Women (PLW) with a MUAC < 23.0 cm were also admitted in the TSFP.

Overall, from the 11 nutrition sites (8 facilities and 3 outreaches), a total of 60,869 children under 5 were screened, out of which 1,689 and 110 had MAM and bilateral pitting oedema respectively. An additional 4,642 children indicated MAM. Further, a total of 29,579 PLWs were screened and 1,435 had MAM.

From the four sampled facilities a total of 8,132 children under 5 years were screened, out of which 1,239 and 30 children were identified with SAM and bilateral pitting oedema respectively. Further, a total of 3,322 PLWS were screened out of which 276 had MAM.

3.1.1 Admissions into OTP and TSFP

Figure below shows the number of children admitted into TSFP and OTP over a 15-month period (Jan 2017 – March 2018) from the sampled facilities. This gives an indication that more children were admitted into OTP and TSFP compared to the target numbers of 1000 and 1700 respectively. Don Bosco had significantly fewer admissions than the other facilities, this was thought to be since the surrounding or catchment area is sparsely populated. Don Bosco is also a community that resides in an IDP camp. The IDP population is not as big as the one within host community where the other centres are located. Populations outside of the camp are served through another Nutrition partners.

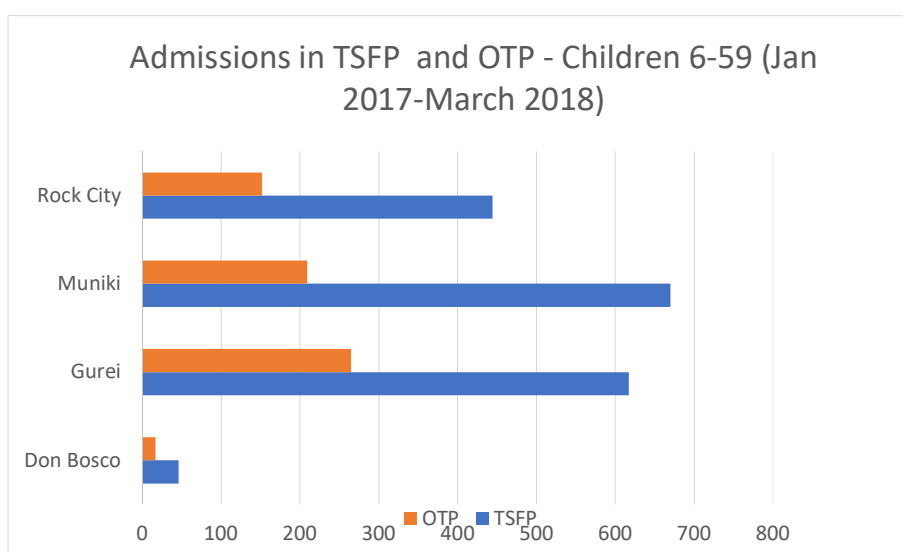


Figure 1: Admission in TSFP and OTP

The programme ensured that every health facility and community had specially selected and trained community volunteers. Their mandate includes active case finding within their communities and refer identified cases to the health facilities using referral cards as well as following up defaulters.

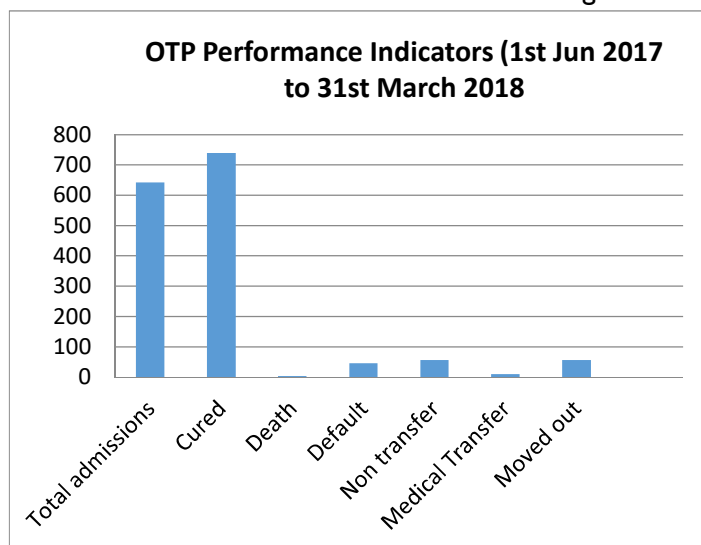


Figure 2: OTP Performance Indicators

Case finding are done at both the community level (by CNV) and at the health facilities (medical staff) through growth monitoring. PLWs are encouraged to attend mother-to-mother support groups, where awareness is created on mothers, infant and young children feeding.

The programme installed water storage, toilets and hand washing facilities at the health units. This was to help promote use of sanitation and hygiene practices at the facilities as well as at home.

The programme in partnership with the local radio station aired programmes that promoted healthy nutrition and sanitation to mothers and caregivers of infants and young children. From, the FGD with caregivers, the use of drama and songs was an effective method of passing messages due to large audience of the local radio listeners. The community loves song and drama, and during such performances, many from the audience join in the dances or sing along. Further, demonstrations on multi-store gardening as a simple technique that uses materials such as gunny bags, vehicle tires, and buckets to produce vegetables. These techniques require little space, little water, few gardening tools, and less time to produce quality results. This has been replicated by over 40 mothers.

3.1.2 Performance indicators

The **performance indicators for the 4 health facilities sampled were within the acceptable SPHERE standards from 1 June 2017 to 31 March 2018**. Data from the four health facilities from OTP between 1 June 2017 to 31 March 2018 – Don Bosco, Rock City, Gurei and Munuki were analysed and yielded the following results;

OTP performance

Target Groups for TSFP

- Children 6 to 59 months with MAM (MUAC: $\geq 11.5\text{cm}$ - $<12.5\text{cm}$; or ≥ -3 - $<-2z\text{-score}$; children discharged from OTP)
- Pregnant women from second trimester and lactating women with infants less than six months with acute malnutrition and lactating women with wasted infants less than six months (PLW) (MUAC $<23.0\text{cm}$).
- Lactating mother with infant <6 months (MUAC $<23.0\text{cm}$ or the infant is wasted)
- Other vulnerable groups with MAM

Indicator	Sphere standard	Achieved
Cure rate	> 75%	87%
Death rate	< 10%	1%
Defaulter rate	< 15%	5%
Non-cure rate	< 10%	7%

From the 4 facilities, 93% of admissions were through MUAC.

Data collected from four health facilities from SFP (6-59 months) between 1st June 2017 to 31st March 2018 – Don Bosco, Rock City, Gurei and Munuki were analysed and yielded the following results.

TSFP performance

Indicator	Sphere standard	Achieved
Cure rate	> 75%	88%
Death rate	< 10%	0%
Defaulter rate	< 15%	4%
Non-cure rate	< 10%	8%

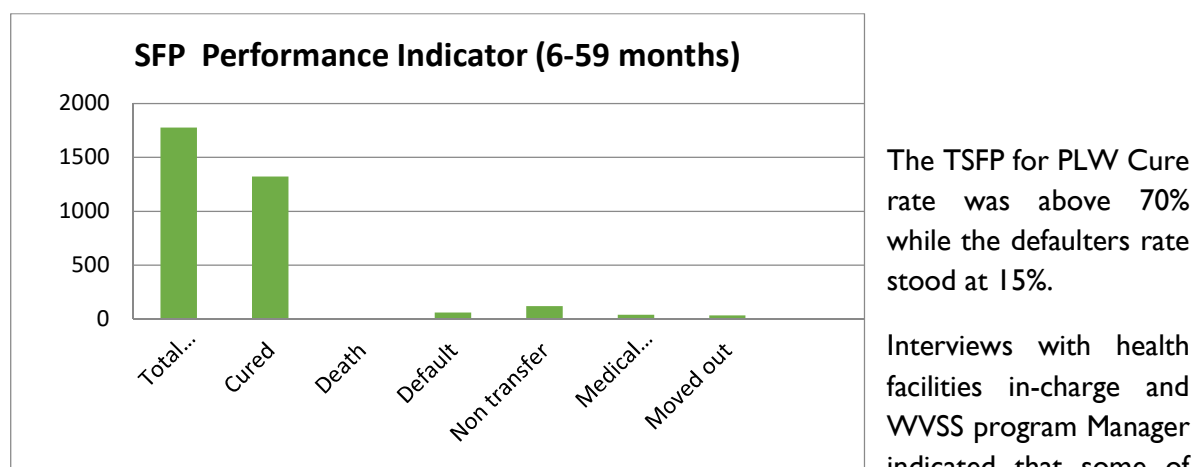


Figure 3: SFP Trend (6-59 Months)

the PLW admitted into the TSFP were sharing their supplementary feeds with the rest of the family hence leading to longer stay in the programme. FGD with caregivers confirmed that this was the case especially for very needy households, where cash was required for other competing household needs. To mitigate against this, monthly food vouchers (for 2 months) were introduced targeting all households with malnourished individuals. The voucher, valued at 5000 SSP (35 US\$), enabled families to receive a variety of food items to improve the household food and nutrition intake, and utilise the therapeutic supplies for only the malnourished individual to facilitate recovery. Further, through a different programme, WVSS targeted vulnerable households under the nutrition programme with monthly unconditional cash transfer of US\$ 45 (paid in equivalent SSP) to enable them start up business enterprises such as kitchen gardening and improve their income. The cash was given after PLW participating in FSL and entrepreneurship training.

On awareness of symptoms of malnourished children, 56% of respondents alluded to weight loss, 24% to swelling stomach, 12% to light hair and 8% to general weakness. Within the community, the common terms used for malnutrition are common disease (44%), malaria (32%), warmth disease (12%) and blood disease (12%). The majority (98%) said children get malnutrition because of poor feeding while 2% said it was due to poor care. This understanding could be attributed to the nutrition education passed through the maternal and infant nutrition messages delivered through the programme.

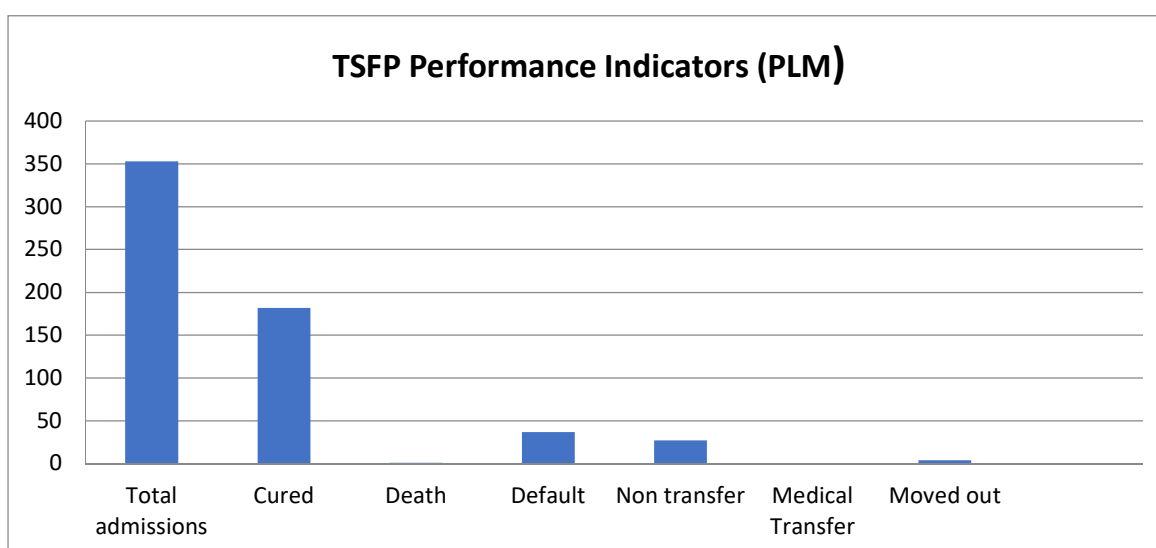


Figure 4: TSFP Trend (PLW)

All respondents were aware of CMAM services. As for source of information, 48% said it was from other sources which included neighbours, other members of households and health facilities, 18% said it was from World Vision (during community events to create awareness, and 34% said it was from health providers and volunteers. 44% of respondents indicated that CMAM is a nutrition programme, 12% said they deal with children, 6% said they did screening of children, 20% said they provided RUTF while 18% were not sure what they do. The respondents understanding about CMAM, 50% said they treat children, 24% said they save life, 24% said they offer OTP services while 2% said they help children. 94% were involved in the awareness creation while only 6% said they were not involved. On the method used to raise awareness, 31% said they were made aware during a religious event, 4% during clinic visit, 61% through home visits and 4% declined to answer.

WVSS intensified active case finding of malnourished cases in the communities. Community Nutrition Volunteers (CNV) were trained in active case identification of malnutrition, and through community outreach programmes and were able to conduct early detection of cases and refer to health facilities for management. The CNVs also conducted home visits to assess the utilisation of nutrition supplies, follow up on defaulter and absentee cases, and provide nutrition education to equip the caregivers with knowledge and skills to avoid relapse cases. 66% of respondents indicated that they knew someone in the villages who identifies malnourished children, while 34% said they did not know. 60% of the respondents indicated that those who identified children screened children, 34% did not know what they do, 2% said they did referrals while 4% said they did treatment of malnutrition.

To establish health seeking behavior, all respondents indicated that they take their children to hospital for treatment whenever they fell sick. However, 50% indicated that initially cost of traveling long distance affected the approach of treatment they sought while the other half claiming it was not costly to seek medical attention. However, this was captured during the implementation

and the programme intensified outreach programmes by opening three outreach posts. The opening of the 3 outposts was partly informed by congestion of two specific health facilities (Gurei and Munuki) which placed a huge workload on the health workers and longer waiting time for the mothers. The effect of opening the outposts is said to have improved access by the care givers who sought nutrition services, reduced likelihood of absenteeism given the relatively short time taken to be served by the health worker and the reduced walking distance.

A total of 92% of respondents have seen a child screened using MUAC, while 8% have not. Of those who had seen screening being done, 80% had seen a child being screened very recently, 16% recently and 4% not recently. This was evidence that the CNV were available and offering screening services within the community. 92% of respondents indicated that referrals were used a referral slip.

A total of 90% of respondents indicated that they know children who were referred by CNV and admitted into the programme at the facilities. Further, on those who were referred by CNV, 36% of the respondents indicated that they knew children who had been turned away, while 64% were not aware of children being turned away. In case they knew why some children were turned away, they indicated that this was due to loss of weight that needed monitoring (27%), to seek further medication (18%), shortage of supplies (9%) and 45% of the respondents did not know the reason.

A total of 90% of the mothers/caregivers had a negative reaction to their children being turned away for not meeting the criteria while 10% of respondents were positive about it. During the FGD with caregivers, it was indicated that there was demand for RUTF even for healthy children. Among the respondents, 32% knew of mothers who spontaneously went to the clinics without referrals and were turned away. Since their children did not meet the criteria of being admitted into the programme.

A total of 44% of the respondents said they have seen malnourished children not going for treatment. They gave the reason for not going for treatment as long distance to hospital 74%, 16% didn't know why while 10% indicated that they are afraid of going to health center.

3.1.3 Summary of barriers and boosters

The main barriers to accessing services included long walking distance to health facilities coupled with poor transport network and roads, frequent population movement due to the nature of the context, sharing of RUTF amongst other HH members, frequent stock outs causing shortage of supplies could discourage persons from honoring revisits and encourage absenteeism, poor health seeking behaviour where communities do not seek health care immediately a child falls sick. In addition, high workload due to shortage of qualified staff as well as high attrition of Community Nutrition Volunteers leaving for better livelihood opportunities after receiving training resulted in limited capacity of MOH staff to manage cases.

The boosters identified included good inter-linkage between community and health facility. awareness of OTP and MUAC by caretakers and the community members, good community mobilisation (Acceptance of programme), It was noted that there was good integration in services

provided - community based distributors and health staff in clinics were screening and referring children to treatment centers while community to facility referrals facilitated by CNVs in addition to awareness of symptoms of malnutrition by care givers played a key role in facilitating uptake of services. The improved quality of care, due to WVSS seconded staff to health facilities, is another booster.

3.2 Water and Sanitation

3.2.1 Household Drinking Water

In response to the crisis, WVSS, with DEC funds, implemented WASH projects in two areas of the country; Kor Adar in Melut County, Upper Nile State and in Juba, Central Equatoria State. The following data is from both locations and specified to which location the data refers to.

In Kor Adar, all the respondents ensure water for drinking is treated through application of chlorine (79%), settling (13%), filtering (5%) or boiling (3%) and stored in a clean and closed storage container to avoid contamination.

In Juba, plastic tanks provided convenient storage for drinking water at the health facilities. The programme supported construction and installation of 4 water tanks in 2 nutrition sites with an average 4,500 people benefitting.

In Kor Adar, 7,860 people received hand washing facilities, while 6,820 people received hand washing soap every 2 months. Further, 1,682 households received water storage containers. 98% of households indicated that they collect drinking water using containers with either narrow or wide opening with appropriate lids, ensuring safety from contamination.

In Juba, the 84% of the respondents indicated that they take water within the health facilities when they visit. The study found that 10% of respondents access drinking water from the surrounding households, while 3% don't drink water when visiting the health facilities. However, only less than 1% carry their own water while visiting the health facility.

Generally, water is stored in large containers within the household, while emphasis is put on storage of water for drinking to avoid contamination.

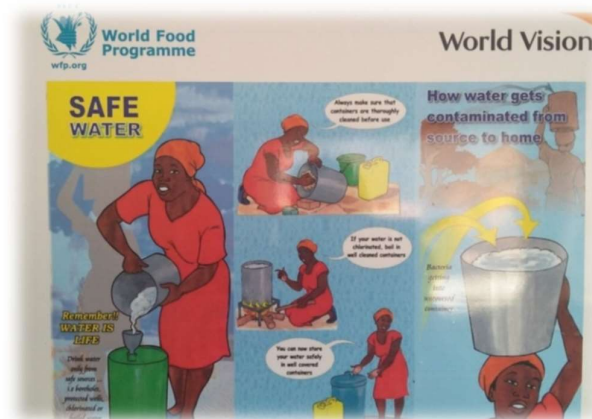
In Kor Adar, to protect drinking water from contamination, 90% of the respondents indicated that they store water in closed containers while also using special container to draw water from the storage container. 94% of the respondents acknowledged that drinking unsafe water may cause waterborne diseases such as diarrhoea. 58% practice hand washing, while 25% mentioned they wash once in a while. 89% of the respondents have access to sanitation facilities while 11% use the neighbours' facilities.

3.2.2 Health facility Sanitation

In Juba, 2 health facilities had sanitation facilities constructed, while 4 water tanks were installed in 2 OTP sites and included drinking water, and hand washing facilities. The sanitation facilities comprise of VIP latrines with separate doors for male and female and are less than 30m from the health unit block.

The facilities are in good usable state, with concrete slabs and closable doors in good condition and tolerable small. The floors were relatively clean.

In Juba, sanitation facilities at the health units are maintained by the facility management. This is contrary to Kor Adar, where there are both private and communal toilets. The private toilets are maintained by their owners, while communal toilets are maintained by the households that share the facility.



In Juba, the hand washing facilities are provided on movable stands next to the toilets. Water is filled in barrels mainly harvested from roof catchment and stored in large storage tanks. In Kor Adar, about 47% of the toilets did not have hand washing facilities.

3.2.3 Hand Washing Practices

In Juba, 42% of respondents' households are aware that not washing hands could contaminate items including water and cause waterborne diseases, while 56% understood that not washing hands can cause intestinal parasites, which in turn may cause diarrhoea especially in young children below 5 years.

In Kor Adar, 53% of respondents indicated that they have hand washing facilities near the sanitation facilities. However, 47% did not have hand washing facilities.

At the health facilities in Juba, it was observed that within the health facilities, hand washing point had water and soap, which facilitated appropriate hand washing practice. 81% of the respondents indicated that they wash their hands with water and soap while at the health facilities while 15% wash their hands with water only.

In Kor Adar, 55% of the respondents practice hand washing in at least three of the most critical hand washing times.

3.2.4 Hygiene Promotion

In Kor Adar, 70% of the respondents indicated that they know about the CHV who goes around the camp promoting good sanitation and hygiene practices.

Further, amongst the respondents, 51% have heard about hygiene and sanitation education from radio, 13% from the health unit, 31% from meetings with community health volunteers, while only 4% from the community members through word of mouth. The main messages passed included hand washing with soap during the five critical moments.

3.3 Protection

As part of the DEC project, WV set up five Child Friendly Spaces (CFS) and also conducted SGBV training for elders. Where necessary cases were referred for treatment. The CFS created a safe space for children to go in Juba. This was important because there is an increasing number of school-age children in the streets of Juba, either begging for money and food or engaging in small trades like hawking (informal selling of goods on the street). The children are identified when they attended the CFS managed by the project. These are children coming from poor backgrounds, and their parents were unable to meet their school needs. To help the children, the project provided some informal learning to the children in the CFS, where they learned simple arithmetic, alphabets, and engaged in creative activities like drawing, molding and other artwork.

The programme enhanced awareness on SGBV and child protection at facility, community and child friendly spaces for children 6 to 14 year's of age. The identified community leaders were also trained on SGBV prevention and response. Child protection committees were also trained on SGBV and child protection. This was done with the aim of creating awareness by empowering them and be able to follow-up for referrals.

“Vulnerable groups such as women and children especially girls are able to report instances of SGBV to their schools, churches or communities” Simanga Ndebele, WVI Cash Project Manager.

97 CPC members were trained in SGBV identification and response, and child rights and advocacy. Communities and mothers in the nutrition programme were reached with protection messages on child rights and SGBV and referral pathway.

Training on psychosocial support for 29 Staff in Juba Urban programmes, communities and mothers in the nutrition programme were reached with protection messages on child rights and SGBV and referral pathway. WVSS also worked with other Protection partners to address cases of abuse in community. The project identified cases of abuse and referred for medical treatment and to other partners for case.

4.0 ADHERANCE TO CORE STANDARDS - CHS

4.1 Response is appropriate and relevant

The conflict in South Sudan continues to take toll on family livelihoods as many are forced to live in IDP camps. This negative effect has been compounded by the effect of recent drought that reduced access to food and safe water affected both host and IDPs in the camps. Through WVI with support from DEC, the host communities and IDPs were able to be supplied with clean and safe water through water trucking and sanitation and hygiene education from recruited hygiene promoters.

In Juba, the project responded to the constant population movement caused by drought and insecurity resulted in reduced household access to water, sanitation and food. Vulnerable households with children below 5 years, pregnant and lactating mothers, women and children headed households were more affected and were specifically targeted by the project. The programme as implemented by WVSS, therefore addressed the immediate needs of the population within the urban, peri-urban, host communities and IDP camps.

In Kor Adar, the project targeting was appropriate and relevant to the needs of the community. A community of about 18,000 people, with a third being IDPs, the existing resources had been stretched and made worse by the drought situation. The community was vulnerable, and the response targeted the immediate need of the community. 87% of the respondents indicated that local stream (river Yal) was their main source of water, with 95% saying the source had bad water with odor and turbid. This was confirmed by IDP women leader who said that women suffer the most by collecting river water and have to look for means of treating it.

“...the water was clean, had no funny taste and small as what we are going though now. Already the situation is growing worse since Yal is seasonal and currently not flowing. The river is highly contaminated. It is the women and children who suffer the most” Rebecca Nyambol, IDP Women Chairperson



The sanitation and hygiene promotion components ensured that at this vulnerable time, the community safely collected and stored water for cooking and drinking. 91% of the respondents reported having received water containers for both collecting and storing water. However, 98% of the respondents said that the containers for water collection are no-longer in use since they are either broken or worn out due to prolonged usage and required urgent replacement.

Consciousness on hygiene was created through concerted efforts by hygiene promoters through door to door campaigns, reducing incidences of use of contaminated water and containers.

The large population movement, reduced livelihood opportunities and weak governance structures have resulted in the rising incidences of SGBV amongst the most vulnerable of the population – children and women. Creating of CFS enabled children coming from poor backgrounds, and their parents were unable to meet their school needs, access some informal learning to the children, where they learn simple arithmetic, alphabets, and engaged in creative activities like drawing, molding and other artwork. Further, training of 68 CPC members on SGBV identification and response, psychosocial support training to 29 staff and working with protection partners helped address cases of abuse in the community. The project identified cases of abuse and referred for medical treatment and to other partners for case management. This programme was appropriate and relevant to the population due to the prevailing state of the nation.

“The population was growing with influx of IDPs and water source was overstretched. Cases of diarrhoea and other waterborne diseases were on the rise. The response helped reduce this trend. Any further delay would have been catastrophic. The camp management worked together with World Vision to ensure timely response and management of the water services.”
James Mwaito, Camp Chairperson

4.2 Response is effective and timely

In Juba, the programme was implemented at a time when most households were vulnerable, and children were at high risk. The programme enabled reversing the negative effects that would have occurred including death had the project not been implemented at the right time.

In Kor Adar, water was transported by water tankers from River Nile to Kor Adar and stored in large tanks before treated with chlorine. 98% of the respondents witnessed daily delivery and treatment of water before being released to the community. The trucks delivered water from River Nile, which was a better source. At the end of the project, water trucking stopped, and community had to revert to drawing water from River Yal. The water is still treated with chlorine but the colour and smell remains unpleasant to community. This is a clear indication of the consciousness of the community on preference of water source for drinking and cooking. As confirmed from FGD in Kor Adar, each household was able to access 60 to 100 litres (3 to 5 jerrycans) of water per day, translating to between 10 and 16 litres per person (average household has 6 people). This therefore met the minimum basic water needs of 7.5 to 15 litres per day, while addressing the water needs of both the host and the IDPs.

In Juba, 86% of respondents have accessed clean drinking water of good quality and quantity at the health centers. Further, amongst the respondents, 51% have heard about hygiene and sanitation education from radio, 13% from the health unit, 31% from meetings with community health volunteers, while only 4% from the community members through word of mouth. The main messages passed included hand washing with soap during the five critical moments. This is an indicator that health education through community volunteers, radio messages and health workers' education helped improve awareness on effects of hand washing especially to the young children in a timely manner.

4.3 Response strengthens local capacity and avoids negative effects

In Juba, the programme played an important role in strengthening capacity of the community through continuous creation of awareness through the CNV and also at the health facilities. Due to low capacity of government employed staff at the facilities, WVSS also engaged their experienced staff to support in managing the health units. However, there is continuous on-job training to build capacity of government staff. The 36 PLW were empowered through training and unconditional cash transfer (UCT) to improve their household economy by engaging in entrepreneurial activities such as vegetable production. The community in general through the open days and local radio was sensitised on various issues including sanitation, hygiene, child rights, and nutrition among others.

In Kor Adar, there was evident community participation in the project through management of the water treatment and distribution as well as carrying out hygiene promotion. The camp hygiene promoters were identified and trained on promoting appropriate sanitation and hygiene behaviour within the communities.

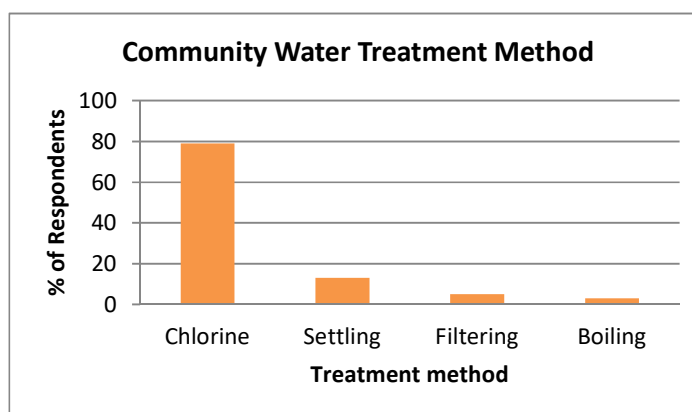


Figure 5: Community Water Treatment Methods

Different community project committees were supported with knowledge, advocacy, and awareness activities. The Water Management Committee (WMC), comprising both men and women, supported the running of water supply systems and worked with water operators to ensure communities had equal access to clean water. The Hygiene Promoter's (HP) team, made up of both men and women, disseminated WASH messages. The FGD comprised of men and women, gathered feedback about the project and participated in clean-up campaigns in the community. The campaigns helped improve the general sanitation and hygiene in the community. The entry process included mobilisation of the community through the existing camp structures. This enabled identification of key players recruited to spearhead hygiene promotion and management of the water supply system. Through their effort, door-to-door campaign helped improve general sanitation and hygiene status of the camp. As confirmed by the Community Hygiene Promoters and health facility in-charge during FGD and KII respectively, incidences of waterborne related diseases have drastically reduced. The community practices safe storage of drinking water, hand washing and safe waste disposal. There is also increased awareness of the negative effects of consuming unsafe water, not washing hands and unsafe disposal of human waste. This was confirmed with 95% of

"The camp was initially littered with faeces at every corner. With the effort of hygiene promoters, construction and use of latrines and safe disposal of faecal matter became a matter of priority. We triggered the community consciousness on contamination of water sources and the cause of diarrhoea amongst households. This had to be done to avert outbreak of epidemics such as cholera and typhoid."
Sunday Monyok, Community Hygiene Promoter

the respondents indicating awareness of negative effects of consuming unsafe water, not washing hands at critical times and unsafe disposal of human wastes.

Water points were manned by trained community water technicians. They have been trained on operation and maintenance of the system – mainly pumping of water, applying aluminum sulphate to enable settlement of dissolved solids and application of chlorine. This ensures that the system is purely managed by the community however provision of fuel and water treatment chemicals is still supported externally.



Women being the key collectors of water, it was evident from the water points that they collect water using clean containers with covers/lids. The water management committee comprising of 12 members, were trained on managing the water system. They received on-site training on how to estimate quantities of water being delivered at the site and informed of what was expected to be delivered each day in order to track and report deficiencies. The committee therefore, acts as linkage between water supply and the community

and addresses any issue concerning water supply. It was evident that as pumping and treatment continued, the community members have become aware to give the water technicians time to complete the process before collecting water.

Training on child protection and SGBV contributed to enhancing capacity of various stakeholders at community level to handle and deal with the situations as they arise and to prevent incidents from happening. WVSS worked with other protection partners to address cases of abuse in community. The project identified cases of abuse and referred for medical treatment and to other partners for case management.

4.4 Response is based on communication, participation and feedback

At Kor Adar, the project engaged the existing community structure under the leadership of Camp Chairman and his committee, who were responsible for handling all issues arising to and from host community and well as IDPs. The chairman coordinates camp activities together with various committee and groups. This ensures that targeting is done well and the support goes to the right people/households. The project had structures which included water management committee and camp hygiene promoters. Any communication and feedback would be channeled through these structures. External communication on issues affecting the community with the government or humanitarian agencies was done through the camp chairman.

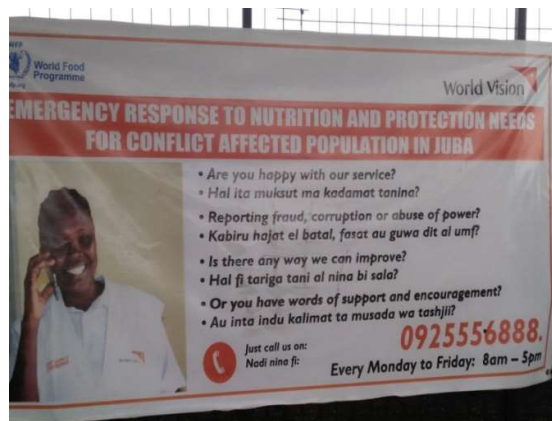
Through FGD with group of both gender, they indicated that World Vision involved the community in implementing the project. This was through community meeting and feedback given through the Camp Chairman and during open days. This ensured easy coordination in collaboration with other an organisation working at the camp (GOAL International) who provided medical services at the health unit. Water Management Committees were also engaged through their coordination efforts of the water supply delivery by monitoring daily water deliveries by the supplier and providing support on overall water management.

“World Vision South Sudan has been a strategic partner of the community. The organization has always come to our support at most critical times.” Gabriel Gift, Camp Vice Chairman

Their involvement in water management enabled proper tracking of deliveries and timely reporting of deficiencies. They were also trained on the basics of how SWATs work and different treatment procedures.

In Juba, issues of access to water and sanitation including cleanliness were handled by the health centre in-charge. Community health volunteers supported with education as well as communicating issues of interest to and from the community and World Vision.

In Malakal town and Kor Adar, the IDPs and host communities are both recipients of services provided through this grant. Vulnerable groups such as households headed by women, PLW, aged and persons with disabilities identified through Camp Committees were the first to benefit from water containers and hand washing facilities.



4.5 Complaints are welcomed and addressed

In Kor Adar, the structure available for complaints and feedback was the office of the camp chairman as confirmed by the Chairman himself or suggestion box. All complaints are taken the office and discussed with responsible committees before being forwarded to World Vision. However, there were limitations in terms of ability to read and write. Use of telephone was also limited due to not all community members being able to access mobile phones.

As confirmed during FGD with a mix of community members, for community members submitting confidential feedback, they used a trusted friend or relative who could write in Arabic/local language. Most feedback or complaints revolved around hygiene and sanitation matters. Feedback to the issues was provided in an open meeting.

In Juba, complaints were channeled through a dedicated mobile telephone line and commitment to resolve issues within a maximum of 14 days. As at end of October 2017, a total of 1453 cases

were received, of which 1445 cases reported were resolved with the others still pending at the time of reporting, meaning that they have been addressed but still waiting for confirmation from the beneficiary.

4.6 Response is coordinated and complementary

In Juba, WVSS worked in partnership with WFP and UNICEF. The supplies for both Outpatient Therapeutic Programme (OTP) and Targeted Supplementary Feeding Programme (TSFP) were provided by UNICEF and WFP respectively. UNICEF provides supplies based on an existing Programme Cooperation Agreement (PCA), while WFP does so based on a Field Level Agreement (FLA) with WVSS.

In Kor Adar, all organisations working with the community had to report to the camp chairman. He helped in coordinating all activities hence reducing instances of conflict or duplication of efforts. Every organisation has its “*area of specialisation*”. World Vision concentrated on water supply and hygiene promotion while others worked in the health, education, shelter and sanitation sectors.

In Upper Nile, the coordination of the Inter-Agency cluster at the field level is done by UN OCHA and the WASH cluster by the State Focal point. The organisation works together with other partners in identifying challenges and gaps and coming up with solutions. The coordination meetings helped identify gaps and address any concerns. Hence WVSS only ended up completing the WASH activity in Kor Adar. There were, however, no overlaps as most sites were registered by IOM to avoid duplication. Feedback from the coordination meeting by the community was helpful in improving the delivery of services, and beneficiaries are more vocal in demanding for better services.

4.7 Actors continuously learn and improve

In Juba, project information is shared through the Nutrition Information System and accessed by the Nutrition Information Working Group and SMOH. This database provides information on performance outcome indicators as well as GAM and SAM rates. Coordination and review meetings are also held monthly, and chaired by SMOH and UNICEF, provide an opportunity to share project achievements and challenges as well as lessons learned. Feedback from monitoring exercises conducted by the M&E department is used to improve service delivery. Further, during Nutrition Open Accountability days, different actors and stakeholders are invited to showcase their activities and programmes, hence helping stakeholders to learn from each other.

In the Upper Nile, cluster coordination meeting is held on monthly basis and updates provided. Discussions held at the WASH cluster to brainstorm more sustainable solutions for water challenges in Kor Adar.

4.8 Staff are supported to do their job effectively & are treated fairly and equitably

World Vision engaged staff with adequate experience, competency and language to engage the community in project implementation. The Kor Adar activities were coordinated by a field office in Melut, with support from Malakal and Juba. World Vision is generally accepted across South Sudan. Further, the government staff attached to each of the health facilities continuously benefit

from capacity building and training conducted by World Vision, working in collaboration with SMOH.

4.9 Resources are managed and used responsibly and for their intended purpose

The project worked with existing facilities, community leaders and institutions (such as the motherhood groups) and CNVs to ensure reach of advocacy and messages.

5. CONCLUSIONS

The programme was well designed, implemented and met the minimum thresholds as per the SPHERE standards, and CMAM guidelines, despite the challenging operating environment.

The project was appropriate and relevant as it responded to the immediate needs of the target communities, (host and IDP, peri-urban and urban) such as clean and safe water and ensuring access to RUTF targeted at the most vulnerable groups while supporting longer-term, sustainable development, such as through providing water harvesting systems, building WASH-related infrastructure, training and educating community members (including CNVs) in nutrition, protection, and WASH related issues, working with and supporting government facilities and staff, encouraging Mother Support Groups to grow kitchen gardens and supporting selected PLWs in Juba to start entrepreneurial activities.

The response was effective and timely. In Juba, the programme was implemented at a time when most households were vulnerable to malnutrition, children under 5 and pregnant and lactating women were at high risk and the programme avoided loss of life that would have occurred had the project not been implemented. Similarly, in Kor Adar, at a time when the population was rising due to a continuing influx of IDPs, the programme ensured that people had access to safe, clean water.

The programme played an important role in strengthening local capacity in project communities both through advocacy, messaging and training related to nutrition, sanitation and hygiene and protection but also through promotion of vegetable gardens and entrepreneurial activities, for instance, training of camp hygiene promoters, Water Management Committees and community water technicians in Kor Adar.

As well as participation through training and community mobilisation, the project communicated through community meetings, and through community members, such as CNVs in Juba.

In Kor Adar, complaints were handled through the Camp Chairman's office where they are forwarded to and discussed by the responsible committees before being forwarded to World Vision. However, low literacy levels and lack of mobile phones meant that it was difficult for some community members to write their complaints as requested and people used friends who could write. Feedback was provided in an open meeting. In Juba, complaints were channelled through a dedicated mobile telephone line; there was a commitment to resolve issues within a maximum of 14 days. As at end of October 2017, a total of 1453 cases had been received, of which 1445 cases reported had been resolved, 840 cases reported received feedback, and 51 cases had been addressed but were waiting for confirmation as to resolution from the complainant.

The project demonstrated a coordinated and complementary response through partnerships and coordination of activities, for instance with UNICEF and WFP for supply of OTP and TSFP supplies respectively and through the Inter-Agency clusters.

Project learning was shared through the Nutrition Information System and accessed by the Nutrition Information Working Group and SMOH. This database provides information on performance outcome indicators as well as proxy GAM and SAM rates. Coordination and review meetings as well as information sharing through the Nutrition Information Working Group and feedback monitoring exercises by WV SS's M&E department helped promote learning by project actors.

World Vision engaged staff with adequate experience, competency and language and supported them through the field office in Melut and through the Malakal and Juba offices. Working with existing facilities, community leaders and institutions (such as the motherhood groups) and CNVs helped to ensure cost-effectiveness and good resource management.

Protection still remains a big challenge in Juba particular and South Sudan in general. Child protection and protection of women and girls against SGBV require a multi-pronged approach by key stakeholders and the government as the key player. Children have dropped out of school due to lack of resources and low quality of teaching in school. This has been compounded by the dynamic population movement and lack of livelihoods income amongst households.

The assessment also concludes that stronger collaboration between relevant Ministries (Health, Agriculture, Water and Natural Resources, Education etc.) to ensure Government of South Sudan ownership and sustainability.

6. RECOMMENDATIONS

1. ***Further strengthen collaboration between WV and relevant South Sudan Government Ministries, this will support government capacity and sustainability of activities. –***

Health care services in South Sudan is currently provided through the Health Pooled Fund (HPF) through a consortium of donors and implemented through NGOs. In Juba health services is done by health partner Health Link. There is need for the key players in the health sector to strengthen South Sudan government healthcare management structures and enhance staff capacity, to enable the line ministry take a more active role in management of healthcare services. This will help improve and sustain quality and ownership for the people of South Sudan.

2. ***Document the training approaches WV-South Sudan is using to train local Sudanese staff so that project learning can be used to inform future interventions.***

Document the innovative training approaches adopted by WVSS to the local Sudanese staff to ensure that the lessons learnt and best practices from implementation of the project can be carried beyond the life of the current project. Approaches like on-job training and job shadowing have resulted in enhanced knowledge, attitude and skills of the local staff in delivering the services.

3. ***Work collaboratively with community-level volunteers, opinion leaders and communities to encourage the continued use of IEC materials and behavior change communication designed to promote positive Maternal, Infant and Young Child Nutrition and WASH practices.***

Since social behavior change is a product of sustained/persistent sensitisation/messaging as well as adoption/uptake of desired practices, there is need to work collaboratively with community volunteers, community members and other opinion leaders to support the continuous messaging on importance of appropriate Maternal Infant and Young Child Nutrition practices as well as WASH using appropriate IEC materials. This would ensure continued accessibility to safe drinking water, better nutrition, improved hygiene practices and sanitation facilities at household level.

4. ***Support the Ministry of Health to establish and maintain its own complaints and feedback mechanisms.*** - Support the Ministry of Health to enhance complaints and feedback mechanisms to ensure accountability by humanitarian providers and confidentiality of the beneficiaries especially for rural based programmes.

5. ***WVSS should enhance its project visibility in Kor Adar through better branding and visibility materials e.g., on water tanks.***

From field observation, there are a number of humanitarian actors in Kor Adar, WVSS should enhance its programme visibility in Kor Adar especially at large infrastructures such as the SWATS, and bulk storage tanks through better branding and visibility materials.

6. ***Promote regular information dissemination/sharing forums to educate households on their right to access quality water services and encourage accountability of water management committees.***

WVSS should ensure that water management committees at the community level maintain transparency and accountability to beneficiaries through regular information dissemination/sharing forums to both educate households on their rights to access quality water services.

7. ***Continue to actively mainstream protection and gender issues into WVSS programming.***

Integrating protection and gender issues into programming yields myriad gains. This was evident from the programme through enhanced capacity of various stakeholders at community level to handle and deal with child protection and SGBV situations as they arose and also to prevent incidents of human rights violation from happening. There is need for continuous deliberate efforts to mainstreaming these components in all future programming.

APPENDICES

Appendix I: List of Key Informants

1. Lucy Adelino - UNICEF, Juba
2. Nicholas Kenyi – WFP, Juba
3. Lubeba Hussein – Concern Worldwide, Juba
4. Gift Sibanda – Programme Manager
5. Gabriel Genge– WV UK Protection
6. Joyce Anibiei – WVI Protection Monitor, Juba
7. Eric Yunusu – WVI Food and Cash Programme Manager, Juba
8. Simanga Ndebele – WVI Cash Project Manager
9. Dan Kwenje – WVI Nutrition Coordinator, Juba
10. Martin Omoro – WVI Quality Assurance Manager, Juba
11. Damaris Wanjiku – WVI Programme Manager, Juba
12. Olga Mushakarara – WVI Quality Assurance Coordinator
13. Wilson Kipkoech – WVI Team Leader, Melut
14. Benson Ali – WVI M&E Officer, Melut
15. Amos Musembi – WVI Wash Manager, Melut
16. Rebeca Nyalbol – Kor Adar Women IDP Chairperson
17. James Mwaito – Kor Adar Settlement Chairman
18. Gabriel Gift – Kor Adar Settlement Vice Chairman
19. Ann Peters –SMOH - Health Facility In-Charge – Rock City
20. Elizabeth Athanasio – Nutrition Nurse, Gurei Health Center
21. Mary – Nutrition Assistant, Gurei Health Center

World Vision Management Response

Recommendation/Comment	Member Agency Management Response	Timeline
<p>1. Further strengthen collaboration between WV and relevant South Sudan Government Ministries, this will support government capacity and sustainability of activities.</p>	<p>One of World Vision in South Sudan's mandate is to build the capacity of Local NGOs and Government staff.</p> <p>The Nutrition Project in Juba works in close partnership with the Ministry of Health (MoH). In all the Nutrition centres/ sites there are Ministry of Health staff working hand in hand with WV Staff for capacity building and as part of the exit strategy they will eventually take over once WV leaves.</p> <p>World Vision has also been engaged in continuous capacity building of the staff. They have been trained in CMAM and MIYCN protocols and implementation through formal trainings, on the job training and mentorship. This is continuously done during site supervision visits.</p> <p>World Vision has also helped build capacity of national NGOs; these include AFOD, ART and Health Link, and all nutrition partners whose capacity is low. The capacity building is done through formal training and joint monitoring visits that serve as a good learning platform.</p>	<p>ongoing</p>
<p>2. Document the training approaches WV-South Sudan is using to train local Sudanese staff so that project learning can be used to inform future interventions.</p>	<p>Methods for on the job training included mentoring which was conducted by WV staff. WV nutrition technical staff worked closely with MoH staff, closely monitoring, guiding and mentoring local staff for the purpose of learning. Also, MoH staff were shifted from one nutrition facility to another occasionally so they engage with other</p>	<p>ongoing</p>

	staff and learn from them. Providing a platform where MoH staff get exposed during joint support supervision done every quarter by UNICEF, WFP, MoH and Nutrition partners.	
3. Work collaboratively with community-level volunteers, opinion leaders and communities to encourage the continued use of IEC materials and behavior change communication designed to promote positive Maternal, Infant and Young Child Nutrition and WASH practices.	<p>All Staff have been trained in MIYCN counselling (both group and individual) so that they are able to provide similar services at the health facility level.</p> <p>Community nutrition volunteers and mother to mother support groups trained in good MIYCN practices and are engaged in counselling at the community level. They are all equipped with Job Aids.</p> <p>Community leaders (chiefs, religious leaders, opinion leaders, women and youth leaders) trained in MIYCN so they support the initiative at community level.</p> <p>Community meetings organised monthly to educate the larger community in Nutrition, Health and Hygiene practices. Project using radio to disseminate MIYCN, Health and Hygiene messages (interactive live talk shows and pre-recorded messages)</p> <p>MIYCN counselling cards that are largely pictorial and easy to follow are used for MIYCN education</p> <p>WV also has live and recorded radio programmes where there is active interaction with communities on key nutrition, hygiene and protection related messages.</p>	Ongoing
4. Support the Ministry of Health to establish and maintain its own complaints and feedback mechanisms.	The community feedback mechanism already established in partnership with the MOH. This will however be strengthened to also	Ongoing

	<p>include other complains and response mechanisms such as suggestion boxes so the communities have a wider choice.</p> <p>Currently, the system that exists is in form of Community Help Desks and hotlines. Feedback on issues raised is provided within a period of two weeks. This will however be strengthened to provide feedback within a shorter period.</p>	
5. WVSS should enhance its project visibility in Kor Adar through better branding and visibility materials e.g., on water tanks.	This is no longer applicable. The water trucking project was only implemented for a few months to cover the time until the rainy season started.	N/A
6. Promote regular information dissemination/sharing forums to educate households on their right to access quality water services and encourage accountability of water management committees	This is no longer applicable. The water trucking project was only implemented for four months to cover the period until rainy season started.	N/A
7. Continue to actively mainstream protection and gender issues into WVSS programming.	There is already strong integration of protection into other sectors including nutrition, WASH, food security and livelihoods, and education. Protection and gender is mainstreamed into all other sectors within World Vision. There is WVSS full time staff that deals with protection/SGBV issues within the standard framework and referral pathway protocols. These include cases identified/picked through the nutrition project. The integration will be enhanced further By WVSS's campaign entitled "It takes a nation to protect the future generation".	Ongoing