german humanitarian assistance
DEUTSCHE HUMANITÄRE HILFE

World Vision

Final Evaluation Report

Emergency aid for Ebola and conflict-affected children and communities in North Kivu Programme GFFO

Field: March 8 to 15, 2022
Report writing: March 17, 2022

World Vision DRC

World Vision

i. Table of Contents

1 Executive summary 2

1.1 Brief description of the project 2

1.2 Objectives of the evaluation 2

1.3 Evaluation Methodology 2

1.4 Main results and recommendation 3

2 Introduction (Background) 10

3 Methodology 12

3.1 The quantitative approach 12

3.2 The qualitative approach 13

3.3 Desk review or document review 14

3.4 Details of Data Collection and Analysis 14

4 Limits 15

5 Results, analysis, and conclusions 16

5.1 Nutrition 16

5.2 Protection 17

5.3 Accountability 26

6 Synergy and added value of the Chapeau approach 28

7 Summary of the evaluation of the main results of the project according to the classic criteria 30

8 Conclusion 36

9 Recommendations 38

10 Lesson Learnd 39

11 Appendix 40

ii. Affirmation

With the exception of references to other authors and publications, the elements of the final evaluation report described in this document are original work undertaken by the consultant contracted by World Vision DRC. This report is designed to present the findings of the final evaluation of the **Emergency Assistance to Children and Communities Affected by Ebola and Conflict in North Kivu** project, in accordance with the requirements of World Vision's system of learning through evaluation, accountability, and planning.

This evaluation aims to capture the level and final status of the project in terms of the completion of project indicators, the change brought about by the project interventions in terms of improving the well-being of targeted communities, addressing all its quality dimensions including relevance, effectiveness, efficiency and impact or sustainability. The primary quantitative and qualitative data collected and analyzed throughout the evaluation process will be used exclusively for programmatic purposes and will serve as a measure of effectiveness and lessons learned to improve future interventions. This report will likely be a piece of community property that World Vision will retain as a manager on behalf of those communities and ensure dissemination of results to stakeholders.

The information in this final evaluation report does not reflect the views of WVDRC but rather external perspectives on the implementation of the project that resulted from this consultancy.

DRC North-Kivu
17-03-2022

iv Acronyms

ACRONYM	MEANING
MEAL	Monitoring, Evaluation, Accountability and Learning
DRC	Democratic Republic of Congo
CHW	Community Health Workers
EVD	Ebola Virus Disease
WV	World Vision
FGD	Focus Group Discussion
KII	Key Informant Interview
GFFO	German Federal Foreign Office
BMZ	Bundesministerium für wirtschaftliche Zusammenarbeit und Entwicklung (engl. Federal Ministry for Economic Cooperation and Development)
M&E	Monitoring & Evaluation
RECOPE	Community Child Protection Network
BCZS	Central Zone Health Office
ECZS	Health Zone Management Team
ZS	Health Zone
AS	Health Area
ENA	Emergency Nutrition Assessment
IT	Registered Nurse
SPSS	Statistical Package for Social Sciences
CFS	Children friendly Spaces
CMAM	Community Based Management of Acute Malnutrition
TVET	Technical and Vocational Education and Training
S4T	Saving for Transformation
MPH	Master of Public Health
TDR	Terms of Reference
WVG	Word Vision Germany
MUAC	Mid-Upper Arm Circumference
IMCI	Integrated Management of Acute Malnutrition
PRONANUT	National Nutrition Program
SMART	Standardized monitoring and assessment on relief and transitions
WHO	World Health Organization
UNS	Supplementary Nutrition Unit
UNTA	Ambulatory Therapeutic Nutrition Unit
UNTI	Intensive Therapeutic Nutrition Unit
HH	Household
SWOT	Strengths, Weaknesses, Opportunities, and Threats
AAR	After Action Review
FOSA	Sanitary Training
SNIS	National Health Information System
PM	Project Manager
ITT	Indicator Tracking Table
PAM	World Food Program
SC	Stabilization Center
OTP	Outpatient Therapeutic Program
ToC	Theory of Change

1 Executive summary

1.1 Brief description of the project

In Oicha, Malabako and Vuhovi, the project "Emergency Assistance for Children and Communities Affected by Ebola and Conflict in North Kivu" funded by the German Federal Foreign Office (GFFO) through WV Germany for an operational duration of 20 months, addresses the humanitarian protection needs of children and youth. As such, the project has contributed to improving the social, emotional, cognitive, and spiritual well-being, need for protection, and development of children affected by conflict and the Ebola epidemic (as well as other possible future pandemics such as COVID-19). In addition, armed conflict and the Ebola outbreak have also deeply troubled the intervention area. This project also addressed humanitarian needs that were exacerbated by the Ebola situation, such as the treatment of severe acute malnutrition in children under 5 and their mothers. This project thus filled the nutritional gaps left by the shift in focus of humanitarian actors on Ebola. It attempted to reduce child mortality and morbidity, including adherence to community-based management protocols for acute malnutrition and prevention of malnutrition.

1.2 Objectives of the evaluation

The overall objective of this final evaluation was to systematically and objectively assess the implementation of the "Emergency Assistance to Children and Communities Affected by Ebola and Conflict in North Kivu" project by identifying the rate of completion, the strengths and weaknesses that characterized its implementation, and by determining the results according to basic quality criteria including relevance, efficiency, effectiveness, impact and sustainability. Specifically, it focused on, but was not limited to, the following objectives:

- Collect final data to measure the progress of the German Federal Foreign Office (GFFO)-funded project "Emergency Assistance for Children and Communities Affected by Ebola and Conflict in North Kivu" against the outcomes.
- Analyze the results achieved by the project as it nears completion;
- Measure the effects of the hat approach on the beneficiary community;
- Identify success factors and improvement factors on all aspects of the project;
- Analyze the degree of ownership of the project activities by the beneficiaries and the local community;
- Identify persistent needs that could be supported in future projects;
- Verify/evaluate progress based on the recommendations of the baseline assessment;
- Identify the relevant elements for launching a new phase of activities;
- Make general recommendations based on the lessons learned from the entire evaluation process.

1.3 Evaluation Methodology

This evaluation was based on a mixed methodology, relying essentially on three main approaches, namely the qualitative approach, the quantitative approach and the documentary review/Desk review. A representative sample of households was selected using a randomized systematic survey with probability proportional to the size of the health zone. A total of 561 households were visited in the Mabalako, Oicha and Vuhovi health zones.

In total, a team of 15 people supported the study, including 12 interviewers, 6 female interviewers and 3 supervisors. Field data collection took place over seven days during the period of March 8-15, 2022, following a full day of training and pretesting in Beni.

1.4 Main results and recommendation

The following tables show the results of the indicators (OUTCOMES and OUTPUT) of the GFFO project that were included in this final evaluation:

Table 1 OUTCOMES measured under the quantitative approach

Code Indicator	Indicators by expected outcome	Targets	Base value (Baseline)	Final value (Endline)	% completion
1.2.1	% Of children and their caregivers who report improvement in their psychosocial well-being following attending CFSs.	75%	N/A	40%	53%
1.2.2	% Of youth who remain disengaged from armed forces or armed groups at the end of the project	100% (180)	N/A	99,4% (179)	99,4%
1.3.2	Of children and community members (disaggregated by age and gender) declaring positive protection environment improvement	75%	16%	44,2 %	58,9%
1.3.3	% Of community members who understand the role of RECOPE	80%	30%	54%	48,7%
1.3.4	% Of community members who know the members of RECOPE	80%	16%	64%	80%
1.3.5	% Of participants actively saving with their cohort	75%	N/A	92%	122,7%
1.3.6	% Of children and parents/guardians reporting an improvement in their wellbeing as a direct result of addressing their child protection needs through case management	100%	N/A	82,4%	82,4%
2.4.2	% Of households targeted by distributions who consume at least 2 meals per day	75%	N/A	87%	116%
2.4.3	% Of target households reporting being satisfied with NFI selection	90%	N/A	96%	106,7%
2.4.1.1	% Of target households that received full support.	100%	N/A	TBD	

Table 2 OUTPUT through desk review and direct observation techniques

Code Indicator	Indicators by expected outcome	Target value (Target)	Final value (Endline)	% completion nt
1.2.1.1	# Of CFS which are functional	5	5	100%
1.2.1.2	# Of children attending CFSs each week (disaggregated by gender, age and disability)	1.250	8.808 (G:4262 and F:4546)	704,6%
1.2.2.1	# Of youth (separated by age and gender) who attended/completed basic non-formal literacy and numeracy classes.	180	179	99,4%
1.2.2.2	# Of centers that are functional	3	3	100%
1.2.2.3	# Of young people reporting that they have increased their knowledge of local protection issues (carried out via FGD)	180	179	99,4%
1.3.1.3	# Of the mitigation plans that will be implemented	3	3	100%
1.3.1.4	# Of radio spots produced for community sensitization on protection issues.	360	1.740	483,3%
1.3.1.5	# Of beneficiaries registered in the savings groups	360	323	89,7%
1.3.1.6	Average savings per member - before project start and at project end	135$	48$	35,6%
1.3.1.7	# Of RECOPE volunteers who have been actively engaged in their roles and responsibilities throughout the project.	75%	70%	93,3%
1.3.2.1	# Of children of closed cases who are satisfied with the services received through case management	75	N/A	-
	# CFS Staffs trained	55	55	100%
	# of CFS established	5	5	100%
1.2.1.3	# Volunteers who provide services at the CFS level according to the established program.	55	55	100%
1.2.1.3	# Children trained on existing tools for early warning.	1.250	1,599 (Boys: 698 and Girl: 901)	127,9%
1.2.1.5	# Organized Group conversations about relevant topics disaggregated by topic.	800	687	87,9%
1.2.1.6.a	# Group counselling sessions organized by psychologist to accompany traumatized children.	1.600	3.213	200,8%
1.2.1.6.b	# Children reached by creative and recreational activities organized using World Vision's "catalog activities" for children and youth.	1.600	8.546 (Boys 4146 and Girls 4400)	534,1%
1.2.2.1	# of youth (segregated by age and gender) who attended/ finished basic non-formal literacy / numeracy classes	180	179	99,4%
1.2.2.2	# Of TVET which are functional	3	3	100%

1.2.2.3	# Of youth who report that they have increased knowledge on local protection issues (done by FGD)	180	179	99,4%
	Market assessment report providing information on vocational sectors.	1	1	100%
	# WV staff and community volunteers trained on technical vocational training	56	55	98,2%
	# Operational vocational centers.	3	3	100%
	# People who benefited from TVET activities disaggregated by gender and age.	180	179	99,4%
	# Non-educated youth people aged 15-24 years who attend basic non-formal numeracy and literacy classes.	120	179	149,2%
	# Vulnerable young people who benefited from social and emotional learning activities.	180	178	98,9%
	# Young people who participate in community services actions.	180	179	99,4%
1.3.1	# of RECOPEs which function	12	12	100%
1.3.1.1	# Of community volunteers trained in their roles and responsibilities as RECOPE members	150%	144% (Men 78 Women 66)	96%
1.3.1.2	# Of advocacy meetings/ messages for improved access to services	60	123	205%
1.3.1.3	# Of mitigation plans in place	3	3	100%
	# People involved in advocacy sessions	240	149(Men 65 Women 84)	62,8%
	# Of RECOPE members involved in child protection risk analysis, mitigation plan development and dissemination.	150	156 (Men 91 Women 65)	104%
1.3.1.4	# of radio broadcasts to sensitize community stakeholders to mitigate physical and psychological harm.	240	306	127,5%
	# WV staff trained on S4T approach.	15	17	113,3%
1.3.1.5	# Community members informed about S4T.	1.230	3,504(Men 1470 Women 2034)	284,9%
	# Village Agents trained on S4T.	30	39 (Men 19 Women 20)	130%
	# of SGs trained on methodology and equipped with SGs kits.	18	18	100%
2.3.1.1	# of trained health workers in CMAM	45	67 (Men 36 Women 31)	148,9%
2.3.1.2	# of trained CHWs in CMAM	370	370 (Men 198 Women 172)	100%
2.3.1.3	# of new SAM cases with medical complications admitted to HC	99	479(Boys 207 Girls 272)	483,8%
2.3.1.4	# of new SAM/MAM cases without medical complications admitted to OTP	1.952	4.371 (Boys 1.943 Girls 2.428)	223,9%
2.3.1.5	Recovery rate (OTP / SC) % (total number of children)	85%	99%	116,5%
2.3.1.6	Dropout rate (OTP / SC) % (total number of children)	10%	2,1%	21%
2.3.1.7	Death rate (OTP / SC) % (total number of children)	3%	0,8%	26,7%

2.3.1.8	Total # of children successfully discharged (OTP / SC)	2.629	4.363 (Boys 1.933 Girls 2434)	165,9%
2.3.1.9	# of new MAM cases admitted to UNS	4.879	10.055	206,1%
2.3.1.9	# of new MAM cases rehabilitated to UNS	4.147	7.672 (Boys 3.280 Girls 4.392)	185%
	# of service providers and Volunteers (CHWs) trained on the revised Community-based Management of Acute Malnutrition (CMAM) approach.	407	437 (Men 234 Women 203)	107,4%
	# purchase and supply of UNS, OTP, SC with lifesaving inputs, drugs and treatment equipment carried out.	2	2	100%
	# of children 6-59 months of age and pregnant and lactating women screened for acute malnutrition.	5.920	13.503 (Boys 4.756 Girls 8.747)	228,1%
	# of uncomplicated moderate acute malnutrition (MAM) cases managed at UNS and severe acute malnutrition (SAM) without complications managed at the OTP.	5.920	12.287 (Boys 5.162 Girls 7.125)	207,5%
	Number of screenings realised by CHWs for acute malnutrion of children 6-59 months of age and pregnant and lactating women.	5.920	11.962	202,1%

1.4.1 Relevance of the GFFO project

- The GFFO project was in line with the child protection context and the malnutrition situation in the three health zones evaluated (Mabalako, Oicha and Vuhovi):

  "The project was very important for us because it allowed us to identify and treat children who were suffering from malnutrition, which remains a serious problem in our area, especially when there are many displaced people, and it reduced this malnutrition to a certain extent" (statement by an adult focus group participant in the Aloya health area in Mabalako).

  The objectives of the interventions were to "contribute to improving the social, emotional, cognitive, and spiritual well-being; protection needs; and development of children affected by the conflict and Ebola epidemic, as well as to fill the nutritional gaps left by the shift in focus of humanitarian actors on Ebola.

  Child protection and malnutrition are among the priorities and needs of the community members who, as a result of wars and epidemics, the psycho-social well-being, especially the protection of young people, has been threatened, thus causing the development of negative coping mechanisms, such as joining armed groups. At this end of the project, 179 young people have been socio-economically reintegrated through the learning of profitable trades, 8,808 (G: 4,262 and F: 4,546) children benefit from psychosocial support within established CFS.

  For example, in the case of protection, the initial assessment revealed a huge gap, with only 16% of respondents stating that the environment was protective for children, compared to 44.2% as revealed by the Endline at the end of the project. Furthermore, only one third or 30% of the community members understood the role of RECOPE on the one hand and on the other hand versus 39% at the end of the project and only 16% of the community members knew the RECOPE members versus 64% at the end of the project. The fact that the majority of RECOPE members are not known makes the local child protection dynamic very ineffective in the communities supported. The project has thus contributed to establishing a community-based child protection mechanism that promotes interaction between community members and local community-based

structures in charge of monitoring child protection and reporting and handling cases of abuse. Based on the above, there is no doubt that the objectives of the intervention are relevant to the priorities and needs of the target population.

- In the security context that affected all three health zones assessed, the idea of improving the psycho-social well-being of children, responding to the need for protection and development of children affected by the conflict and the Ebola epidemic, and also filling the nutritional gaps left by the change of focus of humanitarian actors on the Ebola virus was rather a salutary initiative in the community.
  The objectives and design of the intervention were therefore adapted to the context and needs of the beneficiaries.

- The activities and outcomes of the intervention were consistent with the overall goal and achievement of its objectives in that:
  - In the area of protection, the project has strengthened the capacities of RECOPE, established Child Friendly Spaces and professional centers to protect youth from negative coping mechanisms such as theft, recruitment into armed groups etc,
  - In the area of nutrition, the project has supported health centers in the detection, treatment and follow-up of cases of severe acute malnutrition (SAM) without and with complications and moderate acute malnutrition (MAM), the project has strengthened the capacities of these health centers and nutritional inputs have been provided to the complementary nutrition programs (SNF), health centers (UNTA), and hospital stabilization centers (UNTI).
    When considering the objectives of the above-mentioned interventions of the project, there is no doubt that the activities carried out and the results obtained were consistent with the goal and objectives set.

I.4.2 Effectiveness of the GFFO project

- Within the framework of this project and from an overall point of view, the intervention was implemented as planned because all the planned activities were carried out. For some activities, the project team even exceeded the targets defined in the concept note and recorded in the project's logical framework. The approach adopted for the coordination of the project made it possible to reach the project's targets, increase the level of knowledge of the people trained and reach the health zones targeted by the project. In addition, this approach allowed project stakeholders to take ownership of the project and become actively involved in its implementation in the communities. The mobilization of all the stakeholders and the population at the grassroots level allowed for the successful completion of all the project's activities.
- The achievement of most of the indicators was made possible by the work of the project team, and the existence of immense needs among the target populations. The role of the project team was decisive in the sense that the implementation of the activities was carried out by staff who were well versed in the task; despite certain shortcomings, the team was able to carry out most of the work thanks to its accumulated experience.
  Nevertheless, it must be recognized that in the health zones assessed, the need for humanitarian assistance was and remains colossal. Aid was expected by members of the community:
  "This project has not solved all our problems, which are numerous, but it has temporarily reduced the rate of malnutrition here at home. We ask that the project be extended with

school/garden field activities and interventions in the form of cash" (statement by a participant in a focus group in Mabalako in Mangodomu village).

I.4.3 Efficiency of the GFFO project

The cost (including non-monetary resources) of the inputs was justified by the degree of achievement of the results and the objective for the protection component, whereas for the nutrition component the cost was underestimated. On the other hand, the nutrition component was implemented on time with the resources available, while with the protection component there were constraints related to the security context that complicated the planning and created delays. It should be noted that there were some adaptations made during the implementation of the project following the change in the context (see evaluation summary table on page 30).

I.4.4 Impact of the GFFO project

The first effect of this project is that the knowledge transferred to project actors through training is sustainable. The community-based child protection dynamics established are continually transforming these communities into safe environments for children; the evaluation team met with RECOPE members in the communities who are able to provide information on the functioning of their community-based child protection mechanisms and their sensitization strategies as well as their role as child protection actors.

It is also worth noting the community management of malnutrition involving households, community health workers and health facilities, which is gradually improving the nutritional well-being of children. The evaluation team met with health providers trained in the Integrated Management of Acute Malnutrition (IMAM) approach, who correctly apply the protocol for managing cases of malnutrition. We have observed that the population is increasingly taking ownership of these good nutritional practices in the communities. This knowledge, added to that learned by the populations through listening to WV media programs on protection and nutrition, tends to considerably transform the behaviors and attitudes of the populations towards the well-being of children.

The project's socioeconomic reintegration of at-risk youth contributes to both peace and universal well-being by protecting them from a series of protection risks that result in the adoption of negative coping mechanisms, including joining armed groups and prostitution by young girls. The evaluation team met with young girls in the sewing and hairdressing workshops and boys in the fitting and carpentry workshops who said they were safe from all danger and who took care of themselves and their families.
Another thing that stands out when the evaluation team spoke with the project actors (RECOPE and providers at the health centers) is the will to continue the protection and nutrition actions. This willingness is a sign of a collective awareness to get involved in child protection, management, and the fight against malnutrition in the community. This in itself is a good thing for the communities. For if the actors of the project from these communities commit themselves to continue the actions of the project, there is no doubt that protection and malnutrition will be managed in a concerted manner and that the well-being of children will continue to improve progressively.

Also of note are the resilient interventions listed as value-added synergies that have impacted communities in general and vulnerable households in particular by providing them with the capacity to cope with shocks by meeting their immediate needs and establishing solid foundations for a better future. Among other interventions, we note the VEA approach

through which communities will inherit a healthy WASH environment, FSL activities (CfW, assistance with agricultural kits and inputs, and even training on good agricultural practices, etc.) which continuously increase the economic capacity of vulnerable households in general, enabling them to meet their survival and development needs, and those of children in particular, in terms of education, health, nutrition, protection, etc.

I.4.5 Connectivity of the GFFO project

For protection, it was found that the exit strategy was not yet in place but was being developed, while for nutrition, the availability of inputs for 3 months after project closure was planned.

In addition, the project's implementation had capitalized on collaboration with other partners or stakeholders working in the area by organizing meetings with them and participating in different humanitarian protection coordination and monthly health zone COGE meetings. However, several challenges were addressed in collaboration with other partners and or stakeholders (see evaluation summary table, page 31) and the project had attempted to find ways to address these challenges (see summary table, page 31). Furthermore, based on the project implementation strategy, the level of social and institutional ownership and sustainability of communities and government in the project area is high.

I.4.6 Sustainability of the GFFO project

It should be said that with the observations made in the field and the effects produced by the implementation of the project, we are convinced that this project will have a lasting impact on the behavior and attitudes of the community towards child protection and malnutrition.

We can cite some indices of sustainability:

- RECOPE members have been trained and therefore even without WV, they will capitalize on this knowledge in protection for the benefit of the community
- The savings groups have been established and so even without WV these groups will remain a mechanism for community empowerment.
- The young people have been trained in different trades, even without WV, the achievements of these trainings will guarantee their self-support, empowerment and will put them safe from other dangers and idleness.
- Providers have been trained on PCIMA and have taken ownership, even without WV they will continue to apply this protocol because they have adopted it.
- The community has been trained on good nutritional practices, even without WV we believe they will continue with this good practice for the fight against malnutrition.

I.4.7 Key Recommendations

With respect to the analyses included in this report, the following recommendations are made:

- **A World Vision:**

The implementation of this project has made it possible to place the population, and in particular local actors, at the heart of actions to promote inter-community dialogue for effective conflict management. In light of what this evaluation has taught us, it is worth noting that.

The results of this study showed that only 54% of the households visited recognized at least two RECOPE roles, only 42% of all households interviewed in the three health zones saw an improvement in the psychosocial well-being of their children in the community and 44.2% of community members saw a positive improvement in the child protection environment in the three health zones, It is therefore important to continue to improve the visibility of RECOPE by promoting them in the community and to continue to popularize the roles of RECOPE within the communities in order to make the interaction viable, which translates into a monitoring, reporting and referral circuit for cases of child abuse and maltreatment.

Always ensure the organization of CFS activities concurrently with TVET activities for more impact as revealed by the learning on this implementation.

- **To local partners and stakeholders involved in the implementation of the project:**

The implementation of this project has contributed to improving the social, emotional, cognitive, and spiritual well-being; the need for protection; and the development of children affected by the conflict and the Ebola epidemic. This has resulted in changes in behavior and attitudes towards children that actors must be able to increase tenfold within the communities and thus allow the project to have a real impact on the populations of the communities. To this end, RECOPE members, community and religious leaders must continue to hold consultation meetings to prevent cases of protection from emerging in the communities. Even if the frequency needs to be reviewed because of the costs involved, we believe that this activity is very important to maintain the current child protection context in the three health zones and to dissuade possible troublemakers in the communities who would like to undermine the efforts to consolidate protection.

- **To the funder:**

The context of insecurity in which the members of the communities of these three health zones live does not allow for a significant change in the protection of children, which is an ongoing process. And it is not easy with a 20-month project to have a lasting impact on the behavior of people in the communities, although it has already produced encouraging effects. This is why we call on the donor to extend the project in order to support local initiatives to promote child protection. Alternatively, share the results of this evaluation with other donors to encourage their interest in investing in the sustainability of the project's achievements.

2 Introduction (Background)

The eastern part of the DRC, and more specifically the greater North Kivu area, is one of the regions of the country most affected by armed conflicts between national and foreign rebel groups on the defensive against loyalist forces, focused on forced demobilization on the one hand, and on the other hand, armed conflicts between rebel or dissident groups that preserve partisan interests. These conflicts cause massive population displacements and consequently increase vulnerability in terms of access to the resources needed to meet immediate survival needs. To date, WFP reports approximately 26.2 million food-insecure people, 2.2 million children under 5 suffering from MAM, 1.1 million U5 suffering from SAM, with a total of 5.5 million IDPs.[1]

1 WFP, Emergency Dashboard, September 2021

Ebola has continued to have a negative impact on the precarious living conditions of the population in eastern Congo, a region already affected by conflict, poverty, lack of social services, and a health system threatened with collapse. Displaced people lack access to basic services, which not only worsens their living conditions, but is also a potential source of conflict between displaced people and host communities. The fight against Ebola and future responses to epidemics become less effective if they are not accompanied by projects that address basic humanitarian needs. General insecurity caused by a multitude of armed actors has prevented communities from reaching their fields on a regular basis, resulting in the cessation of agricultural production in targeted areas. Given their vulnerability, the resilience of the population in these health zones must be strengthened in order to prepare them for future external shocks, especially since the crown crisis is already imminent. On June 25, 2020, the Ministry of Public Health of the DRC and the WHO jointly declared the end of the 10th Ebola epidemic that affected the provinces of NORD-KIVU and ITURI. This epidemic lasted 23 long months and took 2,280 lives and contaminated more than 3,473 people. Let us note that as of 07/02/2021, there was a resurgence of the MVE which was declared in the territory of LUBERO and in the city of BUTEMBO, the end of which was declared on May 03, 2021, by the Congolese Ministry of Health.

The advent of the Covid-19 pandemic, officially declared on March 10, 2020, has unfortunately not changed the situation, with cases already emerging in the far north, specifically in the province of North Kivu, which is the second most affected province after Kinshasa out of the 26 provinces in the country in terms of diagnosed positive cases, with 8,788 cases up to January 24, 2022.[2]

In addition, as a result of wars and epidemics, psycho-social well-being, especially the protection of youth, has been threatened, leading to the development of negative coping mechanisms, such as joining armed groups. Given this problem, it is important to improve the social, emotional, cognitive, and spiritual well-being and protection needs of children affected by the conflict and Ebola epidemic.

In Oicha, Malabako and Vuhovi, the project addresses the humanitarian protection needs of children and youth. As such, the project aims to help improve the social, emotional, cognitive, and spiritual wellbeing; the need for protection and development of children affected by the conflict and the Ebola epidemic (as well as other possible future pandemics such as COVID-19) have been deeply disturbed.

This project also addresses humanitarian needs that have been exacerbated by the Ebola situation, such as the treatment of severe acute malnutrition in children under 5 and their mothers. This project will fill the nutritional gaps left by the shift in focus of humanitarian actors on Ebola. It will reduce child mortality and morbidity, including adherence to community-based management protocols for acute malnutrition and prevention of malnutrition.
This study is a final evaluation that aims to report on the changes observed in relation to the objectives defined in the theory of change.

Through this final evaluation, WV sought the following:

2 CMR, Covid-19, Epidemiological Situation Covid-19 in DRC, Covid-19/Bulletin n°672, January 24, 2022

- Final data to measure the progress of the GFFO project against the outcomes;
- Results produced by the GFFO project as it nears completion;
- The effects of the hat approach on the recipient community;
- Success factors and improvement factors on all aspects of the project;
- The degree of ownership of the GFFO project activities by the beneficiaries and the local community;
- Persistent needs that could be supported in future projects;
- Progress on Baseline Evaluation Recommendations;
- Elements relevant to the launch of a new phase of activities;
- General recommendations based on lessons learned from the entire evaluation process.

3 Methodology

In order to ensure that the information sought is properly acquired, the evaluation will be based on a mixed methodology, relying essentially on three main approaches, namely the qualitative approach, the quantitative approach, and the documentary review/Desk review.

3.1 The quantitative approach

A representative sample of households was selected based on a randomized systematic survey with probability proportional to the size of the health zone. A total of 540 households were to be visited in the health zones of Mabalako, Oicha and Vuhovi. The quantitative survey data was collected through a standard questionnaire configured in the ODK Collect mobile application and data synchronization was done on the Ona.io server. Each of the health zones visited was divided into 5 axes: North, South, East, West and Central where the interviewers started from the center of each axis to draw samples randomly based on a conventional sampling step of 5 households.

To determine the sample size, we therefore used ENA for Smart software, observing the following probabilistic precautions:

#	PRECAUTIONARY PROBABILISTIC	VALUE
1	Confidence level	95%
2	Margin of error:	5%
3	Expected prevalence:	16%[3]
4	Cluster effect	2
5	Forecasted rate of no -answer	5%

The final sample size calculated was 561 beneficiary households that were surveyed, with the size distribution shown in the table below:

HEALTH ZONE	POPULATION (Source ZS) sample	Proportion (Distribution key)	Size
OICHA	322 114	0,4766784	260
MABALAKO	218 915	0,32396	184
VUHOVI	134 718	0,1993616	117
TOTAL	**675 747**	**1**	**561**

3.2 The qualitative approach

Through functional sampling, semi-structured group and key informant interviews were also organized. A maximum of 3 FGDs per homogeneous group were organized with community members on the one hand and targeted interviews with key informants (KIIs) on the other hand. Focus group techniques and targeted interviews were used to collect data from beneficiaries and key informants in the community.

The selection of these categories of people was based on the method of reasoned choice of participants likely to discuss the themes of the study and familiar with their respective communities. The preliminary knowledge that we have of the intervention zone has convinced us that it is possible to provide representative and in-depth information on certain determinants (protection and malnutrition) that are linked to the well-being of children in particular and the community in general. In order to conduct this qualitative study, the following collection plan was followed and respected:

	#FGD/KII	#Persons per FGD/KII	#Total People interviewed
FGD			
Children (girls and boys)	6 (3 girls and 3 boys) [3]	8	48
RECOPE members	6	8	48
Women	3	8	24
Men	3	8	24
Youth disengaged from armed groups enrolled in TVETs (girls and boys)	6 (3 girls and 3 boys)	8	48
Member of S4T	3	8	24
Project teams, PMs, and staff implementation	1	8	8
Total FGD	**28**		**136**
KII			
RECOPE representative	3	1	3
Physicians Head of area or its representative	3	1	3
IT	6	1	6

3 % of children and community members (disaggregated by age and gender) reporting a positive improvement in the protective environment, GFFO & BMZ Project Baseline Report, January 2021, P#3

HCW/Agent de Community Health	2	2	2
Total KII	**14**		**14**
Total FGDs & KIIs participants	**42**		**150**

3.3 Desk review or document review

This approach consisted on the one hand of a document review, and on the other hand allowed the evaluation team to gather statistics and other relevant information available from the implementing actors, the evaluations of other humanitarian agencies, the SNIS (National Health Information System) reports of the SAs (Health Areas) at the level of the BCZS (Central Office of the Health Zone), the validated reports on the progress of the project's activities, the up-to-date ITT (Indicator Tracking Table), the Baseline Report, etc. This approach favored the collection of secondary data related to the services provided within the SNUs (Supplementary Nutrition Unit), UNTA (Ambulatory Therapeutic Nutrition Unit) and UNTI (Nutrition Unit). This approach favored the collection of secondary data related to the services provided within the SNUs (Supplementary Nutrition Unit), ATNU (Ambulatory Therapeutic Nutrition Unit) and ITNU (Intensive Therapeutic Nutrition Unit) within the framework of the management of malnutrition but also to inform the level of completion of the project deliverables/outputs.

It should be noted that this approach was reinforced by the SWOT analysis and the administration of the After Action Review (AAR) tool to deepen the learning on implementation through structured brainstorming sessions with the teams involved in implementation but also the observation technique translated into visits to project deliverables such as TVETs, CFSs etc.

3.4 Details of Data Collection and Analysis

Epi-info 7 software was used to analyze the quantitative data. The descriptive analysis provided results on all relevant and reportable indicators in order to inform the program on the contribution of these indicators to the overall impact of the program for the benefit of the affected communities targeted by the project.

Data collection in the field was done on the basis of the administration of collection tools designed for this purpose. Each tool corresponds to each of the methodologies used.
The tools used are: the individual interview guide for interviews with key informants, the facilitation guide for focus groups, and the quantitative questionnaire for the household survey. These tools were designed by the consultant and submitted to the project team for review and validation. The tools are available in the appendix. For the interview guides, we made sure that each tool corresponded to the target person.
For the focus groups (FGDs), despite the fact that the targets were different, a single facilitation guide was designed. The questions in this guide were adapted according to the study targets, to allow for in-depth collection from all segments of the population in the study target communities, such as the beneficiary focus group guide was also used in the key informant interviews and the TVET girls and boys guide was used for TVET leaders to triangulate information. For the survey, a survey questionnaire (attached) was developed and configured on the ODK-Collect application to minimize the risk of bias often associated with quantitative data collection. This application made it possible to geo-locate the respondents

in the field and thus to ensure the effectiveness of the data collection in the field and to have instantaneous access to the data collected.

The qualitative data were collected and transcribed into a data entry matrix to identify trends.

Results were disaggregated by health zone and some of the other results were also disaggregated by gender. Statistical significance tests (t-test, chi-square, or z-test) were applied to the baseline and final evaluation results to assess the statistical significance of the changes observed between the pre- and post-intervention periods. Qualitative data were used to provide additional insight into the quantitative results through triangulation and were transcribed into a score entry matrix for analysis.

For the efficiency of the fieldwork for this final evaluation, data collection was conducted by a team of 12 balanced interviewers (6 men and 6 women) and 3 male supervisors, as well as the consultant team of 3 people, including the principal consultant and 2 assistants. Most of the interviewers had already participated in the initial evaluation and other evaluations organized by WV, bringing a good understanding of the project and data collection tools. These interviewers were recruited from the three respective health zones involved in this evaluation to maximize their contextual understanding. Data collection was preceded by a day of training: The first half of the training was devoted to talking about the GFFO project and its objectives, the importance of quality data, interviewing techniques, sampling and household selection methods, as well as a refresher on the ODK platform and the use of tablets in data collection. The second half of the training focused on explaining the tools and translating the survey questions into Swahili and local languages. After the training sessions, the interviewers tested the tools through role-playing.

The results of this assessment will be presented to stakeholders including local government, community leaders, and state partners, who may provide additional input for a more in-depth understanding of each objective and outcome.

4 Limits

The general insecurity in the project implementation area restricted travel for field data collection. Some villages initially planned were not visited and the schedule was disrupted, for example in Vuhovi.

The interviews and focus groups with the youth were not easy to conduct because they had already completed the training sessions in the various TVETs, the youth were in the process of socio-economic reintegration in their respective communities, and the children were being supervised in the CFSs. To overcome these challenges, the number of guides was doubled, and the participants began to prepare for the focus group with these youth.

The measurement of indicator #1 of outcome 2.3 "% of children of 6-59 months with weight-for-height score < -2 or MUAC < 125 mm" was not possible during this evaluation insofar as only the regulatory service of the nutrition sector in the DRC within the Ministry of Health, in particular PRONANUT, is authorized to conduct studies of the nature of taking anthropometric measurements on Congolese citizens on the national territory, including weight, height, etc., by conducting SMART surveys. The assessment of the change caused by

the interventions for this indicator was made on the basis of secondary data collected from BCZS implementation partners.

A significant delay in the implementation of CASH Transfer activities was noted due to certain constraints related to the security context in the intervention zone, so these activities were implemented just after this final evaluation of the GFFO project, which is why it was not possible in this evaluation to collect data related to Cash Transfer.

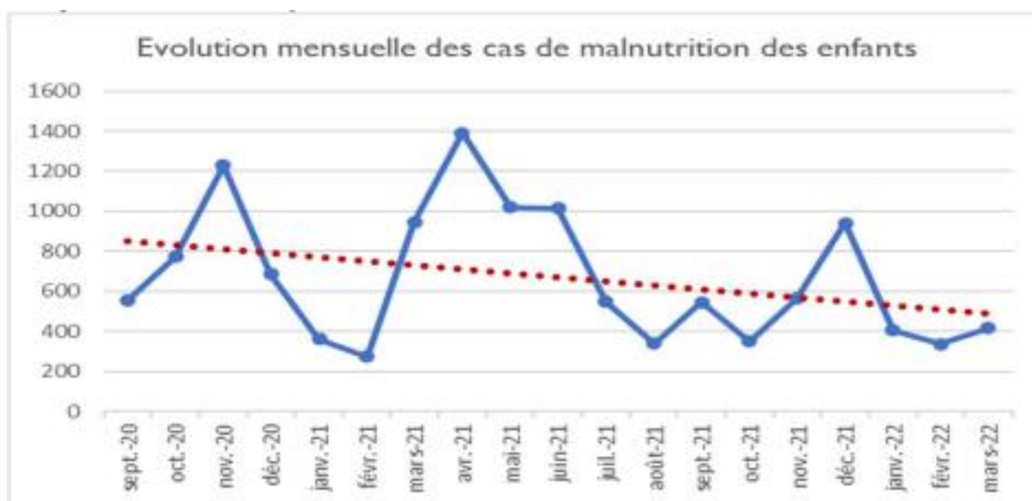
5 Results, analysis, and conclusions

5.1 Nutrition

5.1.1 General trend of malnutrition cases

The figure below illustrates the general trend of malnutrition cases in the three health zones covered by the GFFO project. The general trend is that of a downward trend during the period from August 1, 2021, to March 31, 2022. This decline can be modelled by a trend equation with a negative slope ($y = -0.6622x + 3034$) with y expressing the monthly malnutrition cases and x the period of appearance of the cases in months.
Furthermore, it would be interesting to compare this trend with data from the same previous period (August 2020 - March 2021) to see if there was a real decline or it was related to the agricultural season, but this was not possible due to lack of data from this previous period.

Graph 1 Monthly evolution of child malnutrition cases



Monthly trends in child malnutrition cases in the health zones of Mabalako, Oicha and Vuhovi, August 1, 2021, to March 31, 2022

Some of the statements made by community members in the focus groups organized in the three health zones corroborate this general downward trend in malnutrition cases:

- In Mangodomu in the Mabalako health zone, a woman said, "Even though eating three kinds of food a day was not a usual practice, it helped us decrease the rate of malnutrition.

- During the focus group in the Mabalako health zone, one man said, "There has been food assistance for malnourished children in our community, which has contributed to their good health in the community.

- In the village of Vulamba in Vuhovi, a woman said: "Obviously, we could not see malnourished children in families.

5.2 Protection

5.2.1 Description and socio-demographic characteristics of the sample

Table 3 Distribution of the samples according to the health zones

Health zones	Workforce	%
MABALAKO	184	32,8
OICHA	260	46,3
VUHOVI	117	20,9
Total	561	100,0

From this table we observe that 46.3% of respondents were in the health zone, 32.8% in the Mabalako health zone and 20.9% in the Vuhovi health zone.

Table 4 Socio-demographic characteristics of the surveyed households

Variables		Mabalako	Oicha	Vuhovi	Set
	N	184	260	117	***561***
Age of head of household	Average age in years	43	42	49	***44***
	Standard deviation (SD)	14	14	13	***14***
Gender of head of household	Male	37%	29%	32%	***32%***
	Woman	63%	71%	68%	***68%***
Marital status of head of household	Married	77%	76%	57%	***73%***
	Divorced/Separated	5%	5%	5%	***5%***
	Widow/Widower	13%	17%	33%	***19%***
	Single	4%	2%	5%	***3%***
Level of education of the head of the household	No	19%	22%	27%	***22%***
	Literate (Who can read and write)	9%	9%	9%	***9%***
	Primary interrupted	36%	37%	39%	***37%***
	Full primary	8%	8%	11%	***8%***
	Secondary interrupted	22%	17%	11%	***18%***
	Full secondary	5%	6%	4%	***6%***
	Higher education (Graduate, Bachelor, Master, Doctorate, ...)	1%	1%	0%	***1%***
Do you have children under 5 years of age in your household?	yes	62%	71%	52%	***64%***
Number of persons in households	Average number	7	8	6	***7***
	Standard deviation (SD)	2	3	2	***3***

The above table shows several pieces of information related to the socio-demographic situation of the households surveyed:

- 68% of the respondents were women and 32% were men
- The average age of the head of the household is 44 years (SD 14 years)
- Most of the heads of households visited are married (about 73%) and 19% are widows/widowers
- 22% of the heads of households visited have not studied, 9% are literate, 8% have a primary level, only 6% have a secondary level and only 1% have a higher level.

Average number of persons in a household is 7 (SD = 2 persons)

5.2.2 % Of children and their caregivers who report improvement in their psychosocial well-being following attending CFSs.

Table 5 Distribution of the samples according to the evaluation of the psychosocial

How much do you value your children's psychosocial well-being now?	Men	Women	Set
	%	%	%
	(n = 180)	(n = 381)	(n = 561)
He feels optimistic about the future	33%	47%	40%
Currently it feels that it does not have traumas or stresses	28%	29%	28%
Felt useful in the community	36%	45%	41%
Felt relaxed	32%	38%	35%
He/she felt interested in others	45%	50%	48%
He had energy to spend	39%	41%	40%
He solved the problems he was confronted with well	22%	28%	25%
He had a good image of me	33%	36%	35%
He/she felt close to others	49%	55%	52%
Felt confident	37%	45%	41%
He is able to make my own decisions	28%	28%	28%
He/she feels loved	62%	62%	62%
Feels interested in new things	54%	47%	50%
He/she feels joyful	63%	54%	58%
% Medium (often and all the time)	**40%**	**43%**	**42%**

From this table, we observe that the psychosocial well-being of children after the implementation of the project is appreciated by about 42% of households. We note that only 28% of the respondents find that the young people no longer have traumas and stress.
It should be noted that this measure was captured only through the quantitative survey of caregivers in surveyed households.

A youth from TVET of Kitevya in OICHA stated that:

> *"We are often optimistic about the future with the professional guidance we have received, but we are sometimes traumatized and stressed as a result of events in the past."*

A community woman in a focus group at Mangodomu in the Mabalako health zone said

> *"This project has contributed to the improvement of the social welfare of our children with this vocational training center that has taught our children some useful trades, reducing the literacy rate and also giving good behavior to our children."*

In OICHA in the health area of KITEVYA, a boy product of TVET says this,

> *"We are really calm and happy because we spend all the time in our workshop here, which makes us safe from any danger and violence in our village."*

A TVET OICHA official in the KITEVYA health area said:

> *"At the beginning these young people were traumatized and stressed sometimes, but after a series of listening and learning of the trades we have noticed a change, and they are*

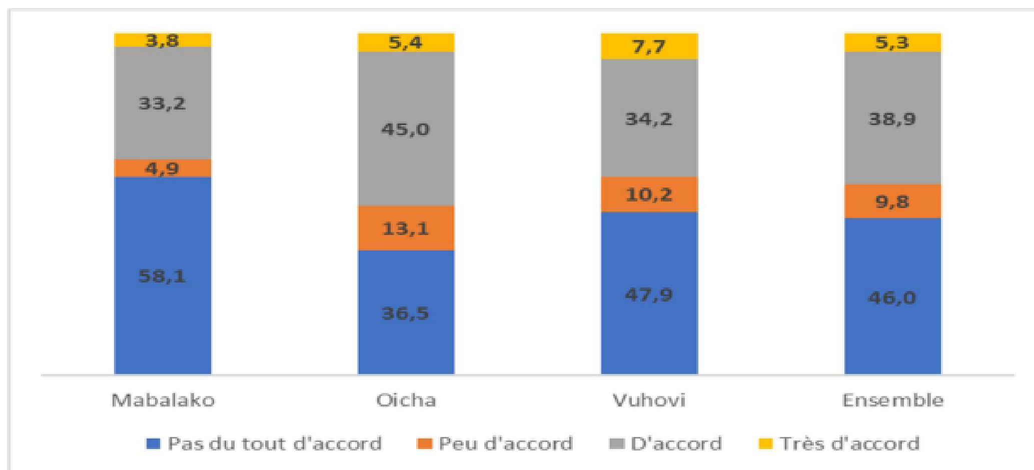
blooming by finding the smile consequently they become useful to the community with the trades that they learned".

A girl of TVET OICHA declared,

"Trauma has disappeared since we have been supervised here, we are comfortable, happy with our jobs and feel safe from any further incidents."

5.2.3 % Of children and community members (disaggregated by age and gender) declaring positive protection environment improvement

Graph 2 To what extent do you think that there is a positive improvement of the child



Only 44.2% of the parents surveyed agreed that there has been a positive improvement in the protective environment for children in their community.

Depending on the health zone, this protection is 37% in the Mabalako health zone, 50.4% in the Oicha health zone, and 41.9% in the Vuhovi health zone. However, it should be noted that this measure was captured only through the quantitative survey of those responsible for children in the surveyed households.

In a focus group of men in Bunyuka in the health zone of VUHOVI:

"The contribution is palpable in this way of protection since there was implanted a Hangar going towards the Catholic parish of Bunyuka where the children are framed and learn by their various professional trades, putting them at the shelter of all evils which can arrive to them when they wander, not schooled, with several risks of education of the street, alcoholism, the undesirable pregnancies? traumatized, soaked in the illiteracy, drug etc" (remarks of a man in Vuhovi)

A TVET boy from the ALOYA health area said:

"First, we are spared from all the wrong paths because the different trades we learn already give us another perspective on life and empowerment."

Photo of one of ninety at-risk youths benefiting from the trade apprenticeship program, performing her first markets to individuals in the community

Graph 3 Figure 3 Distribution of heads of children in surveyed households by health zone in relation to the question: "To what extent do you think your girl children are safe from danger and violence in your village?"

From the graph above, it can be seen that 45.1% of the respondents believe that the girls in their household feel safe most of the time, 34.8% believe that they are safe sometimes and 20.1% believe that they are not safe.
Note also that in the Oicha health zone, 16.9% of respondents felt that the girls in their households were not safe at all, due to several crimes such as sexual harassment, various forms of violence and other problems caused by local gangs.

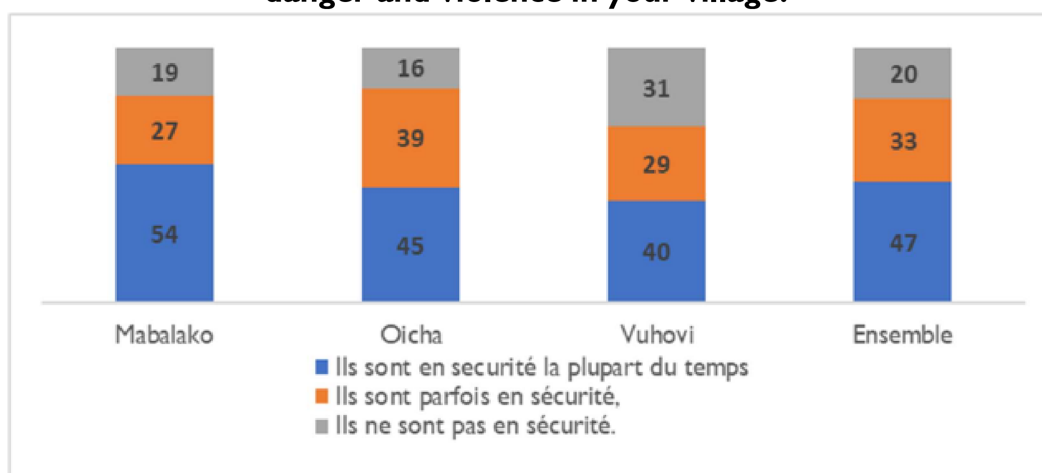
In the ALOYA health area in Mabalako, during the focus group, a girl said:

> *"We think we are safe most of the time we spend at the center, but as the insecurity persists, we don't know what to do anymore.*

A TVET manager in OICHA:

> *"We think they are all safe when they are all here at the vocational center, however our city of OICHA is an area of armed conflict where security is precarious.*

Graph 4 Distribution of heads of children in surveyed households by health zone in relation to the question, "How safe do you think your male children are from danger and violence in your village?"



From the graph above, it can be seen that 47% of the respondents believe that the boys in their household feel safe most of the time, 33% believe that they are safe sometimes, and 20% believe that they are not safe.

5.2.4 % Of community members who understand the role of RECOPE

Table 6 Distribution of samples according to the community's knowledge of RECOPE's

What is the role of this Community Child Protection Network or RECOPE in your community?	**Workforce**	**% n = 206**
To monitor cases of **child** abuse and maltreatment	129	63%
Monitor cases of **child** rights violations	123	60%
To record complaints of abuse, maltreatment, violation of children's rights in the **community**	50	24%
Referring cases of abuse, maltreatment, violation of children's rights to the appropriate legal authorities and services (Justice, care, etc.)	20	10%
Don't know	31	15%

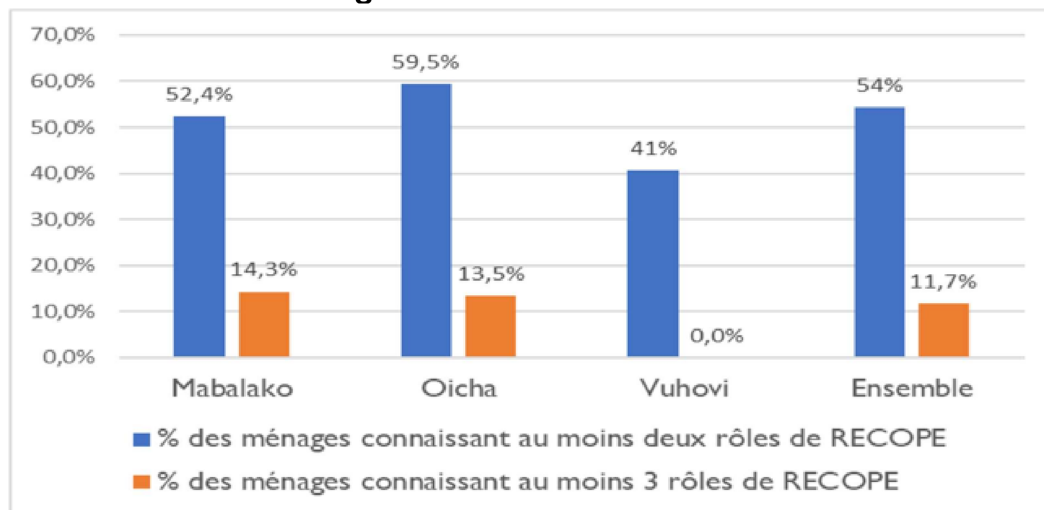
The table above shows that among the community members surveyed, monitoring cases of child abuse and maltreatment is the most well-known role in the community with 63%, followed by monitoring cases of child rights violations with 60%.

The graph below shows the percentage of community members who can quote at least two roles of RECOPE by health zone compared to those who know of at least three roles since this indicator was defined in the MEAL plan as "Percentage of Community members who can quote at least two roles of RECOPE[4]" which guided the calculation by grouping the members who quoted at least two roles of RECOPE in the numerator and in the denominator the members who are aware of the existence of a RECOPE in their community (n=206) The

[4] MEAL PLAN-ITT-GFFO-December 2021, logframe_M&E plan

results of these calculations, overall and by health zone, are shown in the following graph:

Graph 5 Distribution of samples by health zone in relation to community knowledge of at least two RECOPE roles



The graph above shows that among the community members surveyed who are aware of the existence of a RECOPE in their community, overall, 54% are aware of at least two RECOPE roles, 52.4% are aware of at least two RECOPE roles and 14.3% are aware of at least three RECOPE roles in the MABALAKO health zone.
59.5% know of at least two RECOPE roles and 13.5% know of at least three in the OICHA health zone 41% know of at least two RECOPE roles and no one knows of at least three in the VUHOVI health zone.
Community members' knowledge of at least two RECOPE roles did not differ significantly by health zone (p= 0.158).

This is the case of a man in the health area of MAMBABEKA in OICHA:

> *"RECOPE members identify cases, refer, follow up and sensitize the community on child protection."*

Women in a focus group in VUHOVI:

> *"Their role is to follow the children in our families, and to refer the cases of protection incidents that may occur in the community and moreover they are the ones who could better refer them to the structures of supervision...unfortunately that do not exist here at home as for example the orphanage at the level of the convent of the Sisters of the Congregation of the Little Sisters of Jesus which is not operational this last time.*

A woman of RECOPE of OICHA:

> *"To be known by the community and to make known what we do, we sensitize (churches, schools, community meetings) and we accompany the community in their actions of advocacy, identification of cases of incident, listening, orientation and follow-up of the activities of the community.*

During focus group discussions in some settings, the community seemed to know neither the RECOPE members nor their roles as in the health areas of Vuhovi and Vunyuka in Vulamba village, however in other health areas or villages they are known and with their

roles as well as in most of the Oicha Health Zone and Bingo village in the Mabalako Health Zone for example

In the focus group with adult women in the Vunyuka health area:

"No, we don't know about the existence of RECOPE, and don't know if the office of RECOPE is where"

"No, we don't use the Recope, because they are not better known in the community," said the 7/8 women participants.

5.2.5 % Of community members who know the members of RECOPE

Table 7 Distribution of the samples according to the community's knowledge of at least

Do you know at least one member of this Community Child Protection Network or RECOPE in your community?	Workforce	%
Yes	131	64%
No	75	36%
Total	206	100%

The table above shows that only 64% of all households interviewed in the three health zones know at least one RECOPE member in the community.

5.2.6 % Of community members who know at least one member of a RECOPE

Table 8 Distribution of samples according to whether the community can name a RECOPE member

Would you please name at least one RECOPE member from your community that you know?	Workforce	%
Yes	102	78%
No	29	22%
Total	131	100%

The table above confirms the awareness of RECOPE by community members because among the respondents who said they know at least one member of RECOPE, 78% cited at least one name of the members of the community child protection network correctly.

5.2.7 % Of children and parents/guardians reporting an improvement in their well-being as a direct result of addressing their child protection needs through case management

Table 9 Distribution of households according to whether WV interventions have helped improve the well-being of your children

Do you feel that World Vision's interventions have helped improve the well-being of your children?	Workforce	%
Yes	462	82,4
No	99	17,6
Total	561	100,0

Only 17.7% did not think that World Vision's interventions had contributed to the improvement of their children's well-being. However, it should be noted that this information was collected from all households, not just those supported by case management.

5.2.8 % Of households targeted by distributions who consume at least 2 meals per day

Table 10 Distribution of households in Oicha according to the question "Did you receive assistance/distribution of non-food items from WV?"

Have you received any non-food assistance/distribution from WV?	Workforce	%
Yes	153	59%
No	97	41%
Total	260	100%

From this table, we note that 59% of households received non-food assistance/distribution from WV.

Table 11 Distribution of households eating at least two meals a day in Oicha

Number of meals eaten per day	Workforce	%
1 meal	34	22%
2 meals	107	70%
3 meals	12	8%
Total	153	100%

The table shows that among 153 respondents who had received assistance, 78% of OICHA households eat at least two meals a day.

5.2.9 % Of target households reporting being satisfied with NFI selection

Table 12 Distribution of households according to their appreciation of the contents of the NFI kits distributed by WV

Were you satisfied with the composition/selection of the non-living/non-food NFI kit you received?	Workforce	%
Yes	149	97%
No	4	3%
Total	153	100%

The table above shows that of the 153 households that received assistance/distribution of non-food items from WV, only 4 households (or 3%) were not satisfied with the composition/selection of the contents of the NFI kit, and 97% of households were satisfied with the composition/selection of the contents of the NFI kits they received during the distribution organized by WV.

5.3 Accountability

Table 13 Distribution of households according to knowledge of a mechanism for reporting problems, making complaints, opinions, suggestions or obtaining information on World Vision's interventions within the framework of the project

Are you aware of a mechanism for reporting problems, making complaints, opinions, suggestions, or obtaining information about World Vision's interventions in the project?	Workforce	Percentage
Yes	345	61,5
No	216	38,5
Total	561	100,0

The table above shows that just over 6 out of 10 households are aware of a mechanism to report problems, make complaints, give advice, make suggestions, or obtain information about World Vision's interventions under the project.

Table 14 Distribution of households according to the answers to the question "Which mechanism do you know?"

If yes, what mechanism do you know?	Workforce	Percentage
WV agents working in the community	**26**	**7,5%**
Complaint Management Support Committee established by WV	224	64,9%
Suggestion box established in the community and WV office	31	9,0%
WV toll-free number	35	10,1%
Other to specify …	29	8,4%
Total	345	100,0%

The table above shows that of the 345 households that said they were aware of a mechanism to report problems, make complaints, give advice, make suggestions, or obtain information about World Vision's interventions under the project, only 31 of the 345 households (or 9%) were aware of the suggestion box established in the community and WV office, and more than 6 out of 10 households were aware of the complaints management support committee established by WV as a complaints mechanism.
Respondents cited other mechanisms for reporting problems, voicing complaints, opinions, suggestions, or obtaining information about World Vision's interventions in the project, such as

- Bring the complaint to the local office
- Go inform the CAD or SEPAD office
- Take the complaint to the Police Office
- Bring the complaint to the Neighbourhood Office
- Bring the complaint to the Office of the Displaced
- Go inform the agronomist.

Table 15 Distribution of households according to the knowledge of a series or any opinions, suggestions or complaints made by the community to World Vision in the framework of its activities in your community?

Do you know of any advice, suggestions, or complaints from the community to World Vision about its activities in your community?	Workforce	Percentage
Yes	105	19%
No	454	81%
Total	559	100%

The table above indicates that only 19% of respondents are aware of a series or any advice, suggestions, or complaints that the community has made to World Vision in the course of its activities in your community.

Table 16 Distribution of households according to the question: "To what extent do you agree that World Vision has taken these community comments into account to further improve the quality of its interventions?"

If yes, on a scale of 1 to 4, 1 being strongly disagree and 4 being strongly agree, to what extent do you agree that World Vision has taken these community comments into account to further improve the quality of its interventions?	Workforce	Percentage
I don't agree at all	15	14%
I do not agree	22	21%
I agree	54	51%
I fully agree	12	11%
No answer	2	2%
Total	105	100%

The table above shows that of the 105 respondents who were aware of any feedback, suggestions or complaints from the community to World Vision in the context of its activities in your community, 66% of the respondents agreed that World Vision has taken

into account this feedback from the communities to further improve the quality of its interventions.

6 Synergy and added value of the Chapeau approach

The literature review, interviews with staff and field observations identified the following synergies and added values:

- Synergy between protection and nutrition: children who benefit from CFS are also protected against acute malnutrition (regular screening of RECOs in CFS and medical care for children referred to nutritional units)
- Synergy between protection, wash, nutrition and food security components: families targeted by agricultural recovery activities, also benefiting from WASH works, the benefits of the VEA community approach are the same as those of children treated for malnutrition via the PCIMA approach.)
- Synergy between protection and food security components: Improvement of the community's economic situation with an effect on vulnerable children (Strict respect of vulnerability criteria to help vulnerable families and integration of small livestock breeding and advocacy to facilitate access to land for families who do not own any (displaced))
- Synergy between protection and food security components: Sensitization, advocacy and risk assessment on child protection for the entire community: protection main streaming in the BMZ project (Strengthen advocacy, on the participation of 50% of women in the project implementation)
- Synergy between protection and food security components: The CEPs demonstrate that there is a need to work together between IDPs and FAs and contribute to a protective environment with less discrimination, less exclusion, less exploitation of displaced children (Collaboration between IDPS and indigenous people strengthens social cohesion, and helps IDPs who do not have land to cultivate part of the land of indigenous people)
- Synergy between protection, wash, nutrition and food security components: Involvement of diversified local actors/partners (Churches, local associations and NGOs, civil society, local networks, state technical services, economic operators, health structures, local administration, media) and contribute to the coherence of the Chapeau approach in the community (Expand the supervision of young people in several activities and involve health actors for the proper management of wash facilities that will be built or rehabilitated and support to vulnerable families for economic reintegration)
- Synergy between protection, wash and food security components: Community Complaints Management Committees have also benefited from technical training to strengthen the holistic approach in the communities (Involve committee members in all children's activities (training) and ensure that some PMC members are integrated into RECOPE; Identification of infrastructure (road sections) and communities that can benefit from labor-based works and Community Complaints Management Committees participate in training on EP)
- Synergy between protection, wash and food security components: The water point management committees reassure the protection of children (During the evaluations of the water points to be rehabilitated or built, it is necessary to take into account the protection aspects; The built/rehabilitated water points respect the standards of the spheres to decrease the time of going and return of the household towards the points (max 30 min round trip and the distance ≤500m) to avoid any risk of rape in the course of way; the time of waiting to the water point decreases (max 15min making the queue))

- Synergy between protection, wash and food security components: Cash for work activities are programmed to support wash activities and benefit the most vulnerable (Discussions on prioritizing infrastructure are done in a participatory manner; roads or tracks leading to sources rehabilitated by the WASH component are prioritized among the infrastructure to be rehabilitated through Cash for Work), which rehabilitated agricultural feeder roads contribute to the evacuation of agricultural production of vulnerable households assisted in agricultural inputs to profitable markets. This road use also increases safety in the area and reduces protection incidents for both children and adults.
- BMZ's WASH interventions and this project's nutrition activities have created synergies by increasing the capacity of the health centers: improving hygiene conditions in the health centers through access to water directly benefits malnourished children and their caregivers when they receive their food supplements in the health centers
- Child protection activities had complemented each other to increase impact for those affected by focusing more on monitoring child protection cases, the project helped reduce protection risks and work toward a protective environment. The capacity building of RECOPE has enabled this network to fulfil its protection responsibilities. World Vision's savings group approach, which aimed to prevent RECOPE volunteers' priorities from shifting from protection activities to income-generating activities to ensure their families' food security, also contributed directly to the maintenance of the GFFO project's results.
- As a result of the TVET youth and children participating in CFS, their households benefited from food security and WASH activities, and some households benefited from cash, which enabled the households to improve family and child welfare.

7 Summary of the evaluation of the main results of the project according to the classic criteria

Evaluation criteria	Assessment factors	Evaluation
Relevance	Objectives versus priorities and needs	Yes, the objectives set were in line with the community's priorities and needs
	Objectives vs. context & beneficiary needs	Yes, there was a match between the objectives and the context and needs of the beneficiaries.
	Activities & results against the goal and specific objectives	Yes, the activities achieved the objectives and partially achieved the goal given the security context in the project area.
	Synergy and added value	They were identified during the implementation and evaluation of this project
	To what extent has the GFFO project reached its intended beneficiaries in terms of project objectives and outcomes?	The GFFO project reached the targeted beneficiaries in terms of objectives and results in the sense that all activities related to the objectives and results were fully achieved in terms of protection and nutrition such as: - In protection: Good targeting of the beneficiaries at the beginning, the activities carried out meet the real needs of the community and the package of activities was in adequacy with the objectives and expected results. - In nutrition: Providers trained 100% on the PCIMA approach, cure rates exceeding 100% and community awareness of the project.

Efficiency	Factors influencing the achievement of objectives	Yes, there were external and internal factors that contributed to the success of the protection component and some failures in the nutrition component: - For the protection component (Internal factors: Team competency, local leadership support within WV, national and International; capacity building of staff, online training provided to all project staff. External factors: motivation of the beneficiaries i.e. good involvement, benefits from this project, encouragement of parents of youth and children of TVET and CFS, and financial means provided by the donor) - For the Nutrition component: (Internal factors: Late supply of TPEs with short expiration date and late payment from partners. External factors: Delayed reporting by the ECZ and the mismanagement of funds allocated for the payment of RECOs and providers by the ECZ OICHA).
	How do these output-level synergies create added value at the outcome and impact level (individual, household, village, area)?	Yes, the synergies identified and listed in this report have created several value-adds: - Efficient use of resources - Households benefited from a comprehensive package of humanitarian assistance. The BMZ and GFFO projects were considered sister projects, and as such the project team made an effort to ensure that GFFO beneficiaries were also BMZ beneficiaries.
	How did the implemented emergency interventions contribute to resilience activities in the beneficiary communities?	Yes, the emergency interventions implemented have contributed immensely to resilience activities in the beneficiary communities: - Nutritional management is part of the activity package of the health facilities and the project has effectively supported this activity with inputs and should continue with or without WV inputs. - The young people who have benefited from training in different trades are already in the community with workshops in sewing, welding, carpentry...

Efficiency	Is the cost (including non-monetary resources) of the inputs justified by the degree of achievement of the outcomes and objective?	YES for the protection component while for the nutrition component, the cost of the project was minimal, the teams were able to hold on thanks to the combined efforts of other partners (One staff supervised two health zones, which was not easy)
	What are the equivalents of similar projects conducted by the WV or other agencies?	Yes, there were equivalences of similar projects during the implementation, which led to consultations and complementarities: - DRC (Danish Refugee Council) also had child friendly spaces - FEPSI's HUAMSI project intervenes in nutrition specifically for SAM cases
	Was the project implemented on time with the resources available?	Yes for nutrition, but for protection and cash transfer activities were not implemented on time, because there were constraints related to the security context that complicated planning by creating delays and therefore for protection the implementation within the timeframe was about 60%, while for cash transfer activities had not even started during the period of this evaluation because the bank that was to accompany WV in these activities of Cash drag the foot to sign the contract because of
		this insecurity in the intervention area.
	What adaptations were made during project implementation as a result of the change in context?	- For protection, based on the context and the evolution of the situation on the ground, the team adopted a case management approach as there were more and more cases of vulnerability, which required a specific intervention and also the project had provided support to the displaced which had not been planned at the beginning. - For Nutrition: for the intervention in UNS, local products were used instead of CSBI or plumpysup

Impact	Did the project cause any unintended positive or negative changes?	In all cases, the project has brought about a positive change in the beneficiaries: Protection: - The children have regained their psychosocial resilience - Children become fulfilled (Child welfare) - There was some enthusiasm in the children who had learned about the trades that are beginning to shape their future - They are already taking care of themselves and their families. They are no longer idle Nutrition - The children are cured of their malnutrition - The ownership of the project by the providers. - -Community acceptance of the project
	To what extent have women, children and especially the most vulnerable, including children living with disabilities, received positive impacts/changes in their lives and how can these changes be described?	All categories of the community have received impacts in their daily life and these changes are : - Self-care of children trained in professional centers - Knowledge gained about protection by the community - Synergy actions have affected everyone - And other changes mentioned above.
	What contribution has the project made to improving the well-being of children?	- Nutritional care is also part of the health facility package. - Supervision of children in TVET and CFS - Screening of malnutrition cases in the CFS, case follow-up and case management
	Is an appropriate exit strategy in place and implemented?	- For the protection, it is under development - For nutrition, the availability of inputs for 3 months after the
		project closure

Connectivity	How had the project implementation capitalized on collaboration with other partners or stakeholders working in the region?	- Organization of meetings with stakeholders - Participation in different humanitarian protection coordinations
	What are the challenges of working with other partners or stakeholders?	- *For protection*, some stakeholders had disproportionate expectations of the project's activity packages and budget. They thought that they could present other additional needs and expect their request to be met, which was impossible because the resources were intended primarily for the beneficiaries. - *For nutrition*, 1. The two areas are still a hotbed of malnutrition because they are home to displaced people from insecure areas. 2. The non-accessibility of the population to their field. 3. The alerts are always reported in the different corners of the zone, hence the need for a sustainable nutrition project with the integration of related nutrition packages (wash, management of certain diseases)
	How does the project attempt to address these challenges?	For protection: - Organization of dialogues with partners on certain issues - The project has proposed to the community to use the TVET sheds as classrooms until other sustainable solutions are found for nutrition: - With the GFFO & BMZ hat approach, distribution of agricultural seeds to parents and learning of agricultural techniques. - Nutritional education and cooking demonstration for women during CPS sessions
	What is the level of social and institutional ownership and sustainability of the communities and government in the project area and whether the local population will continue what has been initiated. (By	Overall, the level of ownership is high. *For protection:* This is an area of government responsibility, as WV has put in

	For example, assess the capacity of local community institutions to sustain the project after its completion?	The government has been very appreciative of WV's support in implementing a protection project in this area and continues to ask WV to do more than that and to seek other funding to do even more, hence its total involvement in the implementation. *For nutrition :* - PRONANUT, the state institution, will continue to support the health zones. - The ECZ will supervise the health facilities in this regard. - And the ITs will follow up on the RECOs in the screening and case follow-up activities in the community.
Accountability	Have you been able to organize informative meetings on project activities, progress made during implementation and response to feedback?	- For the protection component, it is an element to be improved because there was not much of it and in a formal way - For the Nutrition component: yes, there were informative meetings on project activities, progress made
	If so how many times have you done this? And with which stakeholders? What themes did you discuss?	For nutrition, the frequency was monthly. Themes developed were: the evolution of malnutrition cases, the cured, the challenges and the security situation which caused the displaced people which in turn aggravated the malnutrition situation.
	What strategy have you initiated to promote RECOPES in the GFFO intervention communities?	The strategy was as follows: - Training of RECOPE members first - In turn, they will sensitize the community through churches, radio programs, schools and community meetings.

8 Conclusion

This report is based on the analysis of data collected in the three health zones of Mabalako, Oicha and Vuhovi where WV had implemented protection and nutrition activities funded by the German Federal Foreign Office (GFFO).
The project has found relief from the immediate protection and nutrition problems that plague the communities it accompanies, but it has also established a solid foundation for continued problem solving and resilient capacity to face the future in this context of ongoing fragility. However, the intervention area has been under a series of adversities for a long time and the needs are enormous, so that it is necessary to mobilize more funds to meet the persistent needs on the one hand and to extend the same intervention strategy, which has proven its effectiveness, to other areas of the territory characterized by the same vulnerabilities. Some points of satisfaction were found after analysis of primary quantitative and qualitative data as well as the documentary review:

- In relation to relevance:
  - The GFFO project was in line with the child protection context and the malnutrition situation in the three health zones evaluated (Mabalako, Oicha and Vuhovi)
  - The objectives and design of the intervention were therefore adapted to the context and needs of the beneficiaries.
  - The activities and results of the intervention were consistent with the objectives and their achievement,

- In relation to efficiency:
  - The intervention was implemented as planned because, apart from the cash transfer activities, all the activities planned for nutrition and protection were carried out.
  - The achievement of most of the indicators was made possible by the work of the project team, and the existence of immense needs within the target populations.
  - Nevertheless, it must be recognized that in the health zones, the need for humanitarian assistance was and remains colossal

- In relation to efficiency:
  - The cost (including non-monetary resources) of the inputs was justified by the degree of achievement of the results and the objective for the protection component, whereas for the nutrition component the cost was underestimated. On the other hand, the nutrition component was implemented on time with the resources available, while with the protection component there were constraints related to the security context that complicated planning and created delays. It should be noted that there were some adaptations made during the implementation of the project following the change in the context (see evaluation summary table on page 31)

- In relation to Impact:
  - The first effect of this project is that the knowledge transferred to project actors through training is sustainable. The community-based child protection dynamics established are continually transforming these communities into safe environments for children; the evaluation team met with RECOPE members in the communities who are able to provide information on the functioning of their community-based child protection mechanisms and their sensitization strategies as well as their role as child protection actors.

- It is also worth noting the community management of malnutrition involving households, community health workers and health facilities, which is gradually improving the nutritional well-being of children. The evaluation team met with health care providers trained in the PCIMA approach who correctly apply the protocol for the management of malnutrition cases. We have observed in the communities that more and more people are taking ownership of these notions of good nutritional practices. This knowledge, added to that learned by the populations through listening to WV media programs on protection and nutrition, tends to considerably transform the behaviors and attitudes of the populations towards the well-being of children.
- The project's socio-economic reintegration of at-risk youth contributes to both peace and universal well-being by protecting them from a series of protection risks that result in the adoption of negative coping mechanisms, such as joining armed groups and prostitution by young girls. The evaluation team met with young girls in the sewing and hairdressing workshops and boys in the fitting and carpentry workshops who said they were safe from all danger and who took care of themselves and their families.

  Another thing that stood out when the evaluation team spoke with the project actors (RECOPE and providers at the health centers) was the desire to continue the protection and nutrition actions. This willingness is a sign of a collective awareness to get involved in child protection, management, and the fight against malnutrition in the community. This in itself is a good thing for the communities. For if the actors of the project from these communities commit themselves to continue the actions of the project, there is no doubt that protection and malnutrition will be managed in a concerted manner and that the well-being of children will continue to improve progressively.
- Also of note are the resilient interventions listed as value-added synergies that have impacted communities in general and vulnerable households in particular by providing them with the capacity to cope with shocks by meeting their immediate needs and establishing solid foundations for a better future. Among other interventions, we note the VEA approach through which communities will inherit a healthy WASH environment, FSL activities (CfW, assistance with agricultural kits and inputs, and even training on good agricultural practices, etc.) which continuously increase the economic capacity of vulnerable households in general, enabling them to meet their survival and development needs, and those of children in particular, in terms of education, health, nutrition, protection, etc.

- In relation to connectivity:
  - For protection, it was found that the exit strategy was not yet in place but was being developed while for nutrition, the availability of inputs for 3 months after project closure was planned. In addition, the project implementation had capitalized on the collaboration with other partners or stakeholders working in the area by organizing meetings with them and participating in different humanitarian protection coordination and monthly COGE meetings of the health zones. However, several challenges were addressed in collaboration with other partners and or stakeholders (see evaluation summary table, page 31) and the project had attempted to find ways to address these challenges (see summary table, page 31). Furthermore, based on the project implementation strategy, the level of social and institutional ownership and sustainability of communities and government in the project area is high.

- In relation to sustainability:
  - It should be said that with the observations made in the field and the effects produced by the implementation of the project, we are convinced that this project will have a lasting impact on the behavior and attitudes of the community towards child protection and malnutrition.
    We can cite some indices of sustainability:
    - RECOPE members have been trained and therefore even without WV, they will capitalize on this knowledge in protection for the benefit of the community
    - The savings groups have been established and so even without WV these groups will remain a mechanism for community empowerment.
    - The young people have been trained in different trades, even without WV, the achievements of these trainings will guarantee their self-support, empowerment and will put them safe from other dangers and idleness.
    - Providers have been trained on PCIMA and have taken ownership, even without WV they will continue to apply this protocol because they have adopted it.
    - The community has been trained on good nutritional practices, even without WV we
  - However, in addition to these few points of satisfaction, it should be mentioned that there is still work to be done in the three health zones from the protection point of view, especially since there is still:
    - A low proportion of community members who are aware of all RECOPE roles.
    - A small proportion of the community is aware of the existence of RECOPE in the area and, as a result, not only are the members of RECOPE virtually unknown to the community, but also the very roles of RECOPE remain unknown.
    - A small proportion of the community that sees a positive improvement in the child protection environment in their community.

9 Recommendations

The recommendations we make following this evaluation are addressed first and foremost to WV, which is the sponsor of this evaluation. They are then addressed to the actors and partners in the implementation of the project and finally to the donor.

- A World Vision

The implementation of this project has made it possible to place the population, and in particular local actors, at the heart of actions to promote inter-community dialogue for effective conflict management. In light of what this evaluation has taught us, it is worth noting that

The results of this study showed that only 54% of the households visited recognized at least two RECOPE roles, only 42% of all households interviewed in the three health zones saw an improvement in the psychosocial well-being of their children in the community and 44.2% of community members saw a positive improvement in the child protection environment in the three health zones, It is therefore important to continue to improve the visibility of RECOPE

by promoting them in the community and to continue to popularize the roles of RECOPE within the communities in order to make the interaction viable, which translates into a monitoring, reporting and referral circuit for cases of child abuse and maltreatment.

To WV to always ensure the organization of CFS activities concomitantly with TVET activities for more impact as revealed by the learning on this implementation.

- To local partners and actors involved in the implementation of the project:

The implementation of this project has contributed to improving the social, emotional, cognitive, and spiritual well-being; the need for protection; and the development of children affected by the conflict and the Ebola epidemic. This has resulted in changes in behavior and attitudes towards children that actors must be able to increase tenfold within the communities and thus allow the project to have a real impact on the populations of the communities. To this end, RECOPE members, community and religious leaders must continue to hold consultation meetings to prevent cases of protection from emerging in the communities. Even if the frequency needs to be reviewed because of the costs involved, we believe that this activity is very important to maintain the current child protection context in the three health zones and to dissuade possible troublemakers in the communities who would like to undermine the efforts to consolidate protection.

- To the lessor:

The context of insecurity in which the members of the communities of these three health zones live does not allow for a significant change in the protection of children, which is an ongoing process. And it is not easy with a 20-month project to have a lasting impact on the behavior of people in the communities, although it has already produced encouraging effects. This is why we call on the donor to extend the project in order to support local initiatives to promote child protection. Alternatively, share the results of this evaluation with other donors to encourage their interest in investing in the sustainability of the project's achievements.

10 Lesson Learnd

The analysis of the data from this evaluation, the document review, and the findings from the field made it possible to understand that throughout the project, World Vision adopted an approach that allowed each person involved in the implementation of this project to feel important and to play their part fully in achieving the project's objectives. One of the lessons we learned is that when all the actors in the implementation of a project are in tune, it becomes easy to achieve the project's objectives because everyone wants to contribute. In the case of this project, it was the local partners, the ZCOs and members of the beneficiary communities who came to the fore. They conducted the activities under the watchful eye of World Vision, which provided the necessary technical support for each activity. This approach gave confidence to the community actors and allowed them to feel useful to their communities. This approach aims to enhance local capacities to find solutions to community problems in a concerted manner.

Another lesson learned from this evaluation is that the umbrella approach not only helped to address the immediate needs of community members affected by the crises, but also strengthened the resilient capacities of program participants in the face of the current context of the region through the various synergies identified during the implementation and evaluation, whose complementarity between emergency resilience interventions helped to provide a holistic response.

TVET and CFS activities would have more impact when implemented together in an intervention area, as at-risk children in CFS are referred to TVET activities at certain ages

11 Appendix

- TDR
- Evaluation Matrix
- Survey Questionnaire
- Focus group guides
- Interview guide
- Start-up report