REPORT

ENDLINE EVALUATION

PROJECT: **ACCESS PROTECTION EMPOWERMENT ACCOUNTABILITY AND LEADERSHIP (APEAL) II PROJECT**

Submitted

TO:

CARE International in Uganda
P. O. Box 7280
Union House 5thFloor, Luthuli Avenue
Kampala

BY

Brain Trust Consult Ltd
Plot 78 Kanjokya Street, Kololo
P. O. Box 21529, Kampala Uganda
Tel: +256-772-420446/ 0701 492155
E-mail: braintrustconsultants@gmail.com
paddynahabs@gmail.com

SEPTEMBER, 2021

Funded by European Union Civil Protection and Humanitarian Aid

Contents

LIST OF TABLES

LIST OF FIGURES

ACKNOWLEDGEMENTS

This is an APEAL II Endline Evaluation Report which incorporates the contribution of all Consortium members comprised of: Care International's (Lead Partner) valued stakeholders and consortium partners; International Rescue Committee (IRC), Save the Children (SCI), War Child Holland (WCH), Humanity & Inclusion (HI), WoMena Uganda, Transcultural Psychosocial Organization (TPO), Uganda Law Society (ULS), and Kabarole Research and Resource Centre (KRC).

We wish to thank the Office of the Prime Minister (OPM) for providing the needed permission with a caution to the Consultants' team on strict observance of **COVID 19 MOH SOPs** during the course of data collection and consenting to the Settlement Commandants to provide the evaluation team with the requisite support. We are equally grateful to the Kikuube and Kyegegwa Districts local government technical and political leadership.

Brain Trust Consult Ltd is grateful to Care International Staff and other Consortium Members for their valuable technical support in providing the necessary documents, clarification when needed, key contacts and logistical support that enabled successful completion of this assignment.

Our sincere appreciation goes to the individual Consultants and Research Assistants for their tireless efforts throughout the evaluation assignment.

Finally, we take this opportunity to thank **CARE INTERNATIONAL** for entrusting us with this very important assignment and for giving us an opportunity to serve.

We thank you all.

BRAIN TRUST CONSULT LTD

LIST OF ACRONYMS

APEAL	Access Protection Empowerment Accountability and Leadership
CFR	Complaints, Feedback and Reporting
CFS	Children Friendly Space
CPCs	Child Protection Committees
CRRF	Comprehensive Refugee Response Framework
DRC	Democratic Republic of Congo
EU	European Union
EVI	Extremely Vulnerable Individuals
FGDs	Focus Group Discussions
FRRM	Feedback, Reporting and Referral Mechanism
HI	Humanity and Inclusion
SGBV	Gender-Based Violence
GiE	Gender in Emergency
IEC	Information, Education and Communication
IRC	International Rescue Committee
IYCF	Infant and Young Children Feeding
KIIs	Key Informant Interviews
KRC	Kabarole Resource and Research Centre
LC	Local Council
MBAs	Mother Baby Areas
NFI	Non-Food Items
NGO	Non-Government Organizations
ODK	Open Data Kit
OPM	Office of the Prime Minister
PLW	Pregnant and Lactating Women

PSNs	Persons with Special Needs
PWDs	People with Disabilities
RRM	Resolution and Referral Mechanism
RRP	Refugee Response Plan
RWC	Refugee Welfare Committee
SCI	Save the Children International
SDG	Sustainable Development Goals
TPO	Transcultural Support organisation
UNHCR	United Nations High Commissioner for Refugees
VSLAs	Village Savings and Loans Associations
WLiE	Women Lead in Emergency

EXECUTIVE SUMMARY

The APEAL II project was a follow on project to APEAL I. The purpose of APEAL 2020 was to Enhance multi-sectoral responses by providing targeted life- saving protection, mental health, Psychosocial support and inclusive services to Congolese refugees and vulnerable host communities in Kyangwali and Kyaka II settlements. APEAL II deferred from APEAL I by; increasing the Consortium members from six (6) to nine (9) after incorporating three (3) organizations, programme scope included changes from GBV to SGBV, disability and Inclusion Services and strengthening the capacity of community structures. The community structures were strengthened to identify, respond, support and refer persons in need of MHPSS, comprehensive rehabilitation, disability and inclusion, protection and SGBV services. The Project operated in a COVID 19 environment which was not present in APEAL 1. As such, the project embedded a specific focus on COVID 19 response.

The European Civil Protection & Humanitarian Aid Operations (ECHO) funded the Project with Euro**3,462,889.15** spanning from **May 01, 2020 to April 30, 2021**.

The project targeted 40,000 beneficiaries split between Kyaka II and Kyangwali refugee settlements and distributed support to 20% of surrounding Host communities and 80% of Refugees. The APEAL II intended to achieve: Enhanced access to timely protection, SGBV, MHPSS and disability and inclusion services, Improved protection mainstreaming and strengthen the capacity of community structures, duty bearers and stakeholders, provide extra capacity in nutrition screening for young children, pregnant and lactating mothers and supportive advocacy for standards setting, and harmonized approaches to refugee protection and MHPSS at the national level.

The APEAL II project end line evaluation was conducted to assess change and impact by comparing data from before and after for APEAL Project implementation. The end line evaluation was constructed on a cross-sectional assessment of intervention focus area, the individual refugees and host community members. Qualitative and quantitative data collection methods were applied with the former utilized to obtain information on project relevance, effectiveness and outcomes from Project key stakeholders including beneficiaries through key informant interviews and focus group discussions. For quantitative method, evaluation conducted a household survey covering 515 respondents. Respondents interviewed, were drawn from Kyangwali 52.0% and Kyaka II 48% with 80.0% refugees and 20.0% host community members. The gender distribution of respondents was 56.1% female and 43.9% male.

Sexual and Gender Based Violence: The prevalence of SGBV remains high in the settlements. Whereas synergies have been put in place to sensitize masses more so in settlements, the main goal should be to further reduce SGBV in the settlements and host communities. The trajectory shows that numbers of individuals experiencing SGBV is reducing but still existing in both settlements with the highest numbers in Kyangwali 22% compared to Kyaka at 2%. Female experience SGBV at 14% is slightly higher than that of male at 12%.

The key forms of SGBV identified in the Refugee Settlements are;

(i) Emotional and psycho social abuse including Men abandoning their responsibility to family and children with 38.46 % in Kyaka II and 32.84% in Kyangwali
(ii) Physical Violence (beating, fighting, battering) by someone known (domestic) with 20.65% reported in Kyaka II and 35.45% in Kyangwali.
(iii) Sexual violence (early marriages, forced marriages)
(iv) Economic violence

Vulnerability of Respondents: Results on Extremely Vulnerable Individuals (EVI) targeted by APEAL II reverting to high-risk behaviors and negative coping strategies showed Kyaka II (5.67%) and Kyangwali (32.46%) settlement compared to baseline of 72% and 59.9% in the settlements respectively. A significant drop in Kyaka II compared to Kyangwali. This is indicative of a major milestone in APEAL II contribution in enabling conditions for EVIs to seek positive coping measures given the vulnerability magnitude that needed to be addressed in a one-year timeframe.

Feeling of Safety and Dignity: Respondents who reported to be feeling safe and dignified were 80.6%, which was higher than the 75.8% at baseline by 4.8 % difference. Those feeling safe and dignified were 75.4% (baseline=73.7%) among refugee respondents and 85.7% (baseline=89.3%) among host community members while gender disaggregated were-77.4% (baseline=75.2%) were male respondents and 77.5% (baseline=76.1%) were female respondents. The settlements' illustration was 91.9% (baseline=70.60%) in Kyaka II and 64.2% (baseline=80.7%) in Kyangwali.

Protection Mainstreaming to Non-Protection and Non SGBV Specific targets: The targeted Non-Protection and Non SGBV Specific Actors by APEAL II for incorporating protection principles in humanitarian aid are at 75% while those with activities that demonstrate principles of meaningful access, safety and dignity stands at 76.1%

Population demonstrating improved psychosocial well-being by the end of Intervention: The percentage of respondent's demonstrative of this indicator overall at end line and base line were 43.9% and 49.9% respectively; Refugee community reported 74.30%(end line) ,93.60% (baseline) and Host community 6.4%(end line), 13.40% (baseline). This is drop of 19.3% in the Refugee settlement and slight improvement of 7% in the Host communities.

Humanitarian assistance delivered in a safe, accessible, accountable and participatory manner: The percentage of respondents at end line were- 79.6% from Refugees and 71.4% from Host

Community while the baseline stood at 89.5% and 10.50% respectively designating a 9.9% dip from the Refugees with a major improvement of 60.9% from the Host Communities. Kyaka II shows 87.7% and Kyangwali 64.7% at end line.

Lessons Learned:

Humanitarian assistance is most effective if done in a consortium approach, as the varied protection needs cannot be effectively addressed by a single agency. The competency synergies and specialization that individual consortium members bring on the table are critical when handling issues of humanitarian assistance.

Modified approaches in delivering the project provided a quick fix for implementing the project in a COVID-19 context. There is need to consider adapting approaches in other Project models implemented by CARE and consortium members in respective interventions. Deeper involvement of community structures, ToTs and use of online technology are some of the innovations that are found effective.

Adherence to COVID-19 prevention guidelines by the community was slow. The community understanding of COVID disease remains shrouded with myths and misconceptions. There is need for continued efforts to promote awareness about the disease especially as vaccine roll out to all adults is forthcoming.

The merger between APEAL and SPOT consortia made it easier to implement the basic needs approach (BNA). The merger made it easier to refer beneficiaries, follow up, and close cases. This helped to eliminate many layers and cross-organizational actions in the referral process.

Delivery in partnership with refugee community participation enhances coverage, access, and integration. Use of trained refugee court interpreters greatly enhances access to justice for refugees since they can follow proceeding in a language they understand. The community-based paralegals contributed to timely and quick disposal of civil cases of minor nature.

Having a fixed point in the community where the comprehensive specialized services like rehabilitation on specific and known days increases uptake of services with improved access. This was the case with the success witnessed in providing rehabilitation services to People with Disabilities (PWDS).

Meeting the immediate needs of EVI is not an end in itself. For example, PWDs after receiving comprehensive rehabilitation services need sources of livelihood. If such are not addressed, this can make them relapse – especially those that had serious psychological challenges. This should be an area of focus in future disability inclusion and other vulnerabilities like SGB programming.

Conclusions:

Evidence has been adduced by this evaluation that APPEAL II Project strengthened Access to Protection- and MHPSS- specific and sensitive multi-sectoral life-saving assistance for

newly arrived refugees from DRC as well as their host communities, supported by more Empowered, Accountable, and inclusive Leadership structures at all levels.

Through implementation of various activities, the project managed to score 80.6% of the targeted population reporting an improved feeling of safety and dignity by the end of the intervention compared to 75.8% registered at the Baseline at the beginning. This translates into a 4.8% increase. There is still worry that once the boarders open after the COVID 19 there is going to be an overwhelming influx of persons seeking refuge in Uganda as the conflicts in DRC continues. This should keep the humanitarian actors and government on alert – as more resources will be needed to support the refugees. The next phase of interventions need to build on other programs like Emergency preparedness planning by the district to include all actors in humanitarian assistance

The Project targeted extremely vulnerable individuals (EVIs) or other persons at risk in the refugee population who have multiple vulnerabilities, complex issues or concerns that require case management to enable a response to their needs and access to services. The project managed to bring down such forms of vulnerability from 64.70% registered at Baseline to 13.4%; a 51.3% reduction, which was a remarkable achievement. The challenge remains in areas of early marriages, transactional sex and sale of humanitarian assistance items as coping mechanisms.

Due to COVID 19, effects there are a number of idle young people who are slipping back into vulnerability. Schools as protection and safe spaces are closed due to COVID 19 therefore, shutting down opportunities where young persons would find safety and also be productively engaged. There are currently few or limited livelihood activities to engage them.

Evidence from key respondents indicate that Livelihood activities and Youth Village and Savings Associations be given prominence in future interventions as they directly address poverty which is the main cause of vulnerability and SGBVs.

There was occasional conflict between organizational core roles and Consortium activities during implementation which sometimes delayed implementation. The staffs engaged by the consortium had other individual organizational roles; they were employed for in their mother organizations. Consortium advisors had other roles to attend to and multitasking caused some delays to the consortium activities.

The size of the Consortium is good in the respect of creating integration of the project and coherence. However, it has issues of efficiency especially in terms of time. There is need to split the consortium into two sub themes for task operations, between those in mainstream protection and those in Mental Health and psychosocial support with implementation coordination managed at top level.

Recommendations:

General

There is evidence that refugees are still coming in through porous borders and there is likelihood of increased refugee influx arriving in the Country after opening of boarders. There are still protection challenges faced by the existing refugees in the country. It is therefore recommended that APEAL or related interventions continue to be provided in Kyaka II and Kyangwali refugee settlements.

Specific recommendations

Implementation modality: The Project enhanced multi-sectoral responses by providing targeted lifesaving protection, mental health, psychosocial support and inclusive services to Congolese refugees and vulnerable host communities in Kyangwali and Kyaka II settlements with each agency bringing on board their specialized skills and competencies. It is therefore recommended that a similar approach be adopted in funding where possible to enhance effectiveness of programme interventions. This could however be by sub themes

The next phase of interventions need to build on other programmes like District Emergency preparedness planning to include all actors in humanitarian assistance as contingence for continued unanticipated disasters.

Further Strengthening of Community structures: is required for better community mobilization and sensitization, adherence to policies, laws and standards.

SGBV and community structures: Whereas the response to SGBV has been good and yielding results, there is still a gap in capacity of community structures on the SGBV referral system especially in emphasising the importance of timely reporting. Delay in timely reporting of cases was found a hindrance to handling of cases to logical conclusion.

Dignity - The next phase of the project may have to consider support in household shelter especially for PSNs and customer care and protection training to health service providers to improve feeling of dignity. Poor shelter at household and attitude of service providers especially health are rated top causes for feeling of undignified. Secondary, the concentration of interventions and services by humanitarian actors into refugee settlements is perceived by host community members as "not caring and dignifying" Subsequent interventions (APEAL III) need to increase ratio coverage to host communities

Vulnerability- Three key areas remain not performing well and so should attract attention of humanitarian actors for intervention to fight vulnerability in the next phase of the project or

at other earlier opportunity. The challenge remains in areas of early marriages, transactional sex and sale of humanitarian assistance items as coping mechanisms.

Safety: The feeling of safety is still less among the adolescents (11-17) compared to others like youth and adults. Subsequent efforts in similar or related project should do more targeting to adolescents with further analysis of why they still feel not as safe as the rest of the age groups. The need is more imminent in Kyangwali

Menstrual Health information & services: Mothers constitute the highest and trusted sources of information about menstrual health across the board; they should therefore be more targeted for capacity building for effective support of girl child in building knowledge and capacity confidence in menstrual management among the young women.

COVID 19: Whereas there is sufficient knowledge on COVID-19 contraction and prevention, the community understanding of COVID disease remains shrouded with myths and misconceptions. There is need for continued efforts to promote awareness about the disease especially as vaccine roll out to all adults is forthcoming.

Comprehensive support to EVI: Meeting the immediate needs of EVI is not an end in itself. EVIs supported with immediate rehabilitation, counseling, treatment should be followed by livelihood interventions or else they slip back in relapse. This should be an area of focus in future disability inclusion and other vulnerabilities.

Support to Livelihood engagements: The participation of people in VSLAs brings sustainable benefits as beneficiaries are able to find solutions to some of their livelihood related challenges. There is need to upscale livelihood interventions in new programme designs.

Indicator Performance Values Summary Sheet

Indicator		Gender		Project Location		Project target Category		Overall Baseline/End
		Male	Female	Kyaka II	Kyangwali	Refugee	Host Community	
Indicator 1: % of person's/ target population in a given context reporting an improved feeling of safety and dignity by the end of the intervention compared to at the beginning of project.	Baseline	75.2%	76.1%	70.6%	80.7%	73.7%	89.3%	75.8%
	End line	77.4%	77.5%	91.9%	64.2%	75.4%	85.7%	80.6%
	Change	2.2%	1.4%	21.3%	(-16.5%)	1.7%	(-3.6%)	4.8%
Indicator 2: % of Extremely *Vulnerable Individuals targeted by APEAL reverting* to high risk behaviors and negative coping strategies	Baseline	62.80%	65.70%	72.00%	59.90%	62.10%	87.50%	64.70%
	End line	18.58%	20.42%	5.67%	32.46%	23.9%	2.86%	13.4%
	Change	-44.22%	-45.28%	-66.33%	-27.44%	-38.2%	-84.64%	-51.3%
% of the targeted population who demonstrate improved psychosocial well-being by the end of the	Baseline	40,03%	59.7%	No values	No values	93.6%	6.4%	49.9%
	End line	52%	65%	71.1	55.7	74.3%	13.4%	43.9%

Indicator		Gender		Project Location		Project target Category		Overall Baseline/End
		Male	Female	Kyaka II	Kyangwali	Refugee	Host Community	
intervention compared to the beginning disaggregated by age, gender, refugee, and host community.	Change	11.97%	5.3%	71.1%	55.7%	-19.3%	7%	-6%
% of beneficiaries (disaggregated by age, gender, refugee, host) reporting that humanitarian assistance is delivered in a safe, accessible, accountable and participatory manner	Baseline	28.2%	71.8%			89.5%	10.5%	No value
	End line	79.7%	76.5%	87.7%	68.7%	79.6%	71.4%	75.5%
	Change	51.5%	4.7%	87.7%	68.7%	-9.9%	60.9%	75.5%
% of non-protection and non-SGBV specific actors targeted by APEAL incorporating protection principles in humanitarian aid delivery.	Baseline							57.%
	End line							75%
	Change							18%
% of humanitarian actors whose activities demonstrates principles of meaningful access, Safety and dignity	Baseline							52%
	End line	79.6%	76.7%	77.7%	71.6%	79.5%	71.4%	76.1%

Indicator		Gender		Project Location		Project target Category		Overall Baseline/End
		Male	Female	Kyaka II	Kyangwali	Refugee	Host Community	
through inclusive and people-centered approach mechanism	Change							24.1

1.0 INTRODUCTION AND BACKGROUND

1.1 Introduction

This Report follows commissioning of Brain Trust Consult Ltd by CARE International Uganda to conduct End of project evaluation of **Access Protection Empowerment Accountability and Leadership (APEAL) II**. The project was implemented in Kyegegwa and Kikuube Districts since May 2020 under a Consortium of nine (09) members with Care International Uganda. Other members of the Consortium are: International Rescue Committee (IRC), Save the Children International (SCI), War Child Holland (WCH), Humanity & Inclusion (HI), WoMena Uganda, Transcultural Psychosocial Organization (TPO), Uganda Law Society (ULS) and Kabarole Research and Resource Centre (KRC).

The report is organized in sections as follows; The Introduction and Background, Methodology, Findings, Lessons Learnt, Best Practices, Conclusions and Recommendations.

1.2 Background and Project context

Uganda has for more than a decade now been dealing with some of the world's most pressing humanitarian challenges. The country hosts over 1.43 million refugees, mostly fleeing conflict in neighboring South Sudan and the Democratic Republic of the Congo (DRC). The refugees are spread in about three Sub regions of the country in West Nile; Arua, Terego, MadiKollo, Yumbe, Koboko, Obongi, Adjumani and Lamwo in Mid North. In South west, Kyegegwa, Kikuube, Isingiro and Kamwenge. In each of these Districts, refugees are hosted in settlements.

The districts of Kyegegwa and Kikuube host Kyaka II & Kyangwali refugee settlements respectively. The two settlements hold 17.3% of the total refugee population in Uganda. Kyangwali to-date continues to receive refugee persons fleeing conflict in DRC through porous border. The continuous influx of refugees puts strain on government and humanitarian actors' resources which compounds vulnerability of persons need for protection, Sexual and Gender Based Violence (SGBV) and Mental Health & Psychosocial Support services (MHPSS) including unaccompanied children, SGBV survivors, older person and the people with disability.

The APEAL II project, was a follow on of APEAL I, which was designed to deliver an inclusive, evidence-based and People-centered Protection, Sexual and Gender-Based Violence, Mental Health and Psychosocial Support for new caseload of DRC refugees settling in Kyaka II and Kyangwali.

APEAL II differed from APEAL 1 in different ways. The Consortium members increased from six (6) (CARE, International Rescue Committee (IRC), Save the Children (SCI), Kabarole Resource and Research Centre (KRC), Uganda Law Society, and WoMena) to nine (9) incorporating more three (3) namely; Warchild Holland (WCH), Humanity & Inclusion (HI) and Transcultural Psychosocial Organization (TPO) to integrate MHPSS service provision in refugee settlements, reception, quarantine and treatment centres. Programme scope included changes from GBV to SGBV, disability and Inclusion Services and strengthening the capacity of community structures. The community structures were strengthened to identify, respond, support and refer persons in need of MHPSS, comprehensive rehabilitation, disability and inclusion, protection and SGBV services. The Project operated in a COVID 19 environment which was not present in APEAL 1. As such, the project embedded a specific focus on COVID 19 response.

The APEAL II Project was a one-year with funding of Euro **3,462,889.15** implemented between **May 01 2020** and **April 30 2021** funded by European Civil Protection & Humanitarian Aid Operations (ECHO).

The project targeted 40,000 beneficiaries in total, split between the two Refugee settlements under the study, and covering both refugees and surrounding host communities. The APEAL II project provided assistance targeting new arrivals and asylum seekers right from the refugee transit centers established closer to border entry points. The transit centers are Nyakabande, Matanda and Sebagoro located in Kisoro, Kanungu and Kikuube districts respectively. The project was implemented in the COVID 19 pandemic wave one and two with implementation flexibly adapted to COVID 19 context in compliance with Ministry of Health's standard operating procedures.

The Project provided Services including; SGBV prevention & response, protection mainstreaming, mental health & psychosocial support, disability inclusion, menstrual health management, child protection and youth/village savings & loans associations. Consortium partners actively involved beneficiaries in all project activities through community awareness, dialogue meetings and Community Feedback & Response Mechanisms (CFRM). The Project provided assistance through the following core intervention areas:

i. Protection Mainstreaming,
ii. SGBV Prevention & Response,
iii. Mental Health & Psychosocial Support,
iv. Menstrual Health Management (MHM),
v. Disability Inclusion,
vi. Child Protection and
vii. Youth/Village savings & Loans Associations (Y/VSLA)

The APEALII project intended to achieve the following results:

a) Enhanced access to timely protection, SGBV, MHPSS and disability and inclusion

services.

b) Improved protection mainstreaming and strengthen the capacity of community structures, duty bearers and stakeholders.
c) Provide extra capacity in nutrition screening for young children, pregnant and lactating women during peak influxes.
d) Advocate for support of common standards settings, and harmonized approaches to refugee protection and MHPSS at the national level.

1.3 Purpose and Evaluation objectives

The End-line Evaluation was conducted to assess change and impact by comparing data from before and after APEAL II Project implementation. The evaluation was intended to gather end of project data against all Project indicators in the log-frame to assess the extent to which planned targets at outcome and output levels were achieved. The End Line Evaluation was carried out in two refugee settlements of Kyaka II and Kyangwali in Kikuube between August 09and August 18 2021.

The objectives of the evaluation were:

1. How APEAL Project was contributing to access of Protection, disability inclusion and Mental Health and Psychosocial Support services in the short, medium and long term.
2. What unintended outcomes (positive and negative) were produced
3. Assessment of the relevance and sustainability of project outcomes, approaches, models and strategies.
4. Documentation of best practices, lessons learned as well as challenges that arose from project implementation.

1.4 Evaluation Criteria and Questions

The Endline Evaluation was tailored towards ensuring that information to deliver each of the objectives was collected had the following central questions;

Relevance:

i. To what extent the intervention objectives and design respond to beneficiaries, partners and government needs, policies and priorities, and continue to do so if circumstances change?

Effectiveness:

ii. How is APEAL Project contributing to access of Protection, disability inclusion and Mental Health and Psychosocial Support services in the short, medium and long term?
iii. To what extent were planned Outputs realized?
iv. What were the unintended outcomes (positive and negative) that were produced?

Sustainability:

v. How likely were the outcomes, approaches, models and strategies to be sustained after project closure?

Coherence:

vi. The compatibility of the intervention with other interventions in settlements, sectors and ECHO actions.

Efficiency:

vii. To what extent the intervention delivered results in an economical and timely way.

Best Practices and Lessons Learned:

viii. What practices, lessons learned as well as challenges arose from project implementation?

Recommendations:

ix. What recommendations can be made to improve performance of similar interventions in the future

1.5 Ethical Considerations

Ethical considerations were central to the evaluation exercise and observed through the following:

Informing relevant authorities: District and local authorities received advance information, with introduction of the evaluation team timely provided to prospective respondents by CARE international field team.

Explanation of the purpose of the study and obtaining consent: At individual level, the team explained the purpose of the study and sought consent before interviews to document or record the discussion.

Confidentiality: The evaluation team observed confidentiality at all times. The framing of questions was impersonal and reporting effected in such manner that in non-traceability of individual respondents while complying with the Comprehensive Refugee Response Framework, no photography of respondents carried out.

Child Protection and do no- harm principle: Informed consent of respondents participating in the evaluation was sought and where children were involved, their parents or guardians asked to consent on their behalf. The evaluation team was given training on how to treat the respondents with respect and dignity, being courteous and taken through child protection and safeguarding policies concerning respondents, children and young people. For example, as a compliance requirement, children were accompanied and kept in open spaces while engaging with adults.

Ministry of Health directives. The evaluation prioritized compliance with the Uganda Ministry of Health Standard Operating Procedures throughout the study activities. These included putting on masks, social distancing, hand washing and use of sanitizers at all times.

2.0 METHODOLOGY

The evaluation information requirements were such that both qualitative and quantitative methods of research be employed. By nature of the indicators and associated changes targeted by the project the evaluation emphasized quantitative data collection to obtain perceived changes in the targeted population. Qualitative methods were also used to complement findings generated through quantitative methods. As such, information gathering was participatory and consultative. It was a cross-sectional study where information was collected from different sources and different locations at the same period in the months of July and August 2021. The use of different methods (triangulation) that were applied reinforcing each other, was a check for reliability and validity of information.

The evaluation was a cross-sectional study where information collected from different sources and different locations at the same period of month of July-August 2021.

The methodologies adopted were based on objectives of the evaluation which were:

i. How APEAL II Project contributed to access of Protection, disability inclusion and Mental Health and Psychosocial Support services in the short, medium and long term
ii. What un intended outcomes (positive and negative) were produced
iii. Assess the relevance and sustainability of project outcomes, approaches, models and strategies.
iv. To document best practices, lessons learned as well as challenges that arose from project implementation.

As such, the following data collection methods were employed to gather data: Literature review of humanitarian standards and project related documents, Key informant interviews targeting implementing partners and Key stakeholders, Household structured interviews and Focus group discussions for beneficiaries and observation. This was done among both the refugee settlements and host communities and at various levels of leadership.

The methodology was also informed by the need to answer questions around; Relevance, Coherence, Efficiency, Effectiveness and Sustainability but focusing on delivery of project indicators.

2.1 Sampling Approach and determination of respondents

The sampling approach was both systematic random and purposeful. This was applied to both geographical and respondents' coverage.

2.1.1 Geographical Sample

The project was implemented in the two (2) Districts of Kyegegwa and Kikuube and accordingly, the consultant conducted evaluation in both. The project primarily targeted refuges and sampling for data collection was largely biased towards reaching more of refugee

but host community equally reached for comparison purposes. This was in a ratio of 80:20 in favor of Refugees.

2.1.2 Respondents selection

The respondents were selected from Consortium member areas of operation as reflected in Table 1.

Table 1: Respondent Selection and Consortium Member Coverage

		Kyangwali	Kyaka II
1	CARE	Zone A,B,D,F &Kyangwali (Kyabitaka, Kagoma, Kirokole, Maratatu, Mombasa, Kavule)	Bwiriza, Kaborogota, BukereByabakora
2	Save the Children	Maratatu, Mombasa, ,	Mukondo, Bwiriza, Kaborogota, Bukere, Itambabiniga, Byabakora
3	IRC		Bwiriza, Kaborogota, Bukere, Mukondo, Kyegegwa
4	HI	Waibuga, Kavule, Mombasa	Byabakora 2, and Bwiriza (Ndororile village)
5	KRC	Mombasa, Kavule, Maratatu and host communities of Kyangwali and Bukinda	Bwiriza, Bukere (Both refugee and host community), Kaborogota and Mukondo
6	WoMena	Kavule, Mombasa and Maratatu A, B,C,& D	Bwiriza, Byabakora, Bukere, Kaborogota, Mukondo, Sweswe
7	TPO	Zone A,B,D,F &Kyangwali (Maratatu, Mombasa, Kavule, Kirokole, Kentomi, Karonda, Kyebitaka, Kagoma,)	Bwiriza, Byabakora, Bukere, Ruyonza, Mpara, Kabweeza, Buliti B, Sweswe, Kakoni, Itambabiniga Central
8	ULS		Bwiriza, Mukondo, , Bukere, Kaborogota
9	WCH	Zone A,B,D,F &Kyangwali (Maratatu, Mombasa, Kavule, Kirokole, Kentomi, Karonda, Kyebitaka, Kagoma,)	Bwiriza, Byabakora, Bukere, Ruyonza, Mpara, Kabweeza, Buliti B, Sweswe, Kakoni, Itambabiniga Central

2.1.3 Respondents sample

i) Qualitative sample

Sampling for qualitative data targeted Key Informant Interview discussions with individual experts who had relevant knowledge and experience by virtue of their work or interaction with the APEAL project or by virtue of positions, they occupy. These included Partners -OPM, Local Governments of Kikuube and Kyegegwa, UNHCR, RWCs and APEAL II Consortium Members. Focus Group discussion were purposively selected from groups of People with disabilities, Youth participating in VSLAs, Pregnant and Lactating Women (PLWs), Role Model Men, VHTs, Girls & Women. The tools for Key Informant Interviews and Focus Group Discussions are annexed as VI & VII respectively.

ii) Quantitative sample

Structured interviews were the main source of primary quantitative data. Interviews were conducted among individuals (using Households as entry point) within the refugee settlements and targeted host communities. The tool used (Annex IV) was structured along components of SGBV Prevention & Response, Protection Mainstreaming, Mental Health & Psychosocial Support, Disability Inclusion, Menstrual Health Management (MHM), Child Protection and Youth/Village savings & Loans Associations (Y/VSLA); specifically, Children and Adolescent girls and boys (12-17), Pregnant and Lactating Women, SGBV/MHS/disability, Youth (18-30 years), adults (31-59 years) and the elderly above 60 years.

Secondary quantitative data was extracted through literature review of activity reports, monitoring reports as well as other project related documents including:

- Baseline survey report APEAL I
- Evaluation Report APEAL I
- Evaluation Report SPOT Project
- APEAL 2020 project proposal
- APEAL 2020 M&E framework
- ECHO Protection Main streaming indicators
- The Core Humanitarian Standard (CHS)
- APEAL Capacity building plan
- The Comprehensive refugee settlement guideline
- A Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings: Inter-Agency Standing Committee (IASC) Reference Group for Mental Health and Psychosocial Support in Emergency Settings, Geneva, 2017

The degree of variability of the attributes being measured necessitated need for a large quantitative sample, and therefore a sample calculation formula by Taro Yamane formula (1967) as indicated below to compute the household sample used:

$$n = \frac{N}{(1+Ne^2)} * deff * \frac{100}{r}$$

Where,

n = the required sample

N =estimate of total number of targeted population in Kyaka II and Kyangwali (ToRs project background) these were 40,000

e= level of precision or permissible error which was set at the lowest possible of 5%

a response rate (r) of 98% with design effect of 1.2

$$n = \frac{40{,}000}{1+40{,}000(0.05)^2} * 1.2 * \frac{100}{98} \approx 484$$

The sample of 484-targeted respondents was upheld however, 31 were added to cater for Non-response hence the total came to 515. This was distributed among the five categories representing adolescents, youth, PLW, PSNs (PWDs, SGBVs, MHPSS, Rape survivors and elderly. The samples were drawn from project recipients in a systematic random manner distributed among both refugee settlements and host communities in a cluster manner.

Community facilitators (Psychosocial Assistants, VHTS), who participated in the project provided useful guidance to the evaluation team in identifying households where targeted respondents were found. As per study design, 80% of respondents was drawn from refugee settlement and 20% from the host communities; gender consideration formed an integral part of respondents' categories. The summary data collection caseload is reflected in Table 2.

Table 2: Summary of the data collection caseload

Unit description	Targeted	Achieved	% coverage
Households (structured)	484	515	106%
Protection mainstreaming (structured)	8	4	50%
Key Informant interviews	26	20	77%
Focus Group Discussion (FGD)	16	12	75%

2.2 Limitations of the evaluation study

The field data collection exercise faced challenges that limited full accomplishment for;

i) Research fatigue among the communities

There are many studies, baselines, evaluations, and other assessments taking place by many agencies within the same communities. There are indications that the communities are fatigued that some now are beginning to ask for money coupled with community leaders negotiating money for introducing researchers to the communities. The community based young men and women (especially among refugees) who have some capacity to participate in data collection as Research Assistants are getting too used to these studies that they provide rehearsed answers and tailored questions that would compromise their reliability. For example, they either forge data, or would only work for two days in one survey and move to another study event in the community. The evaluation team engaged the potential RAs into a selection process and sieved out those who seemed fatigued.

ii) COVID 19 Effect on study Preparation

Evaluation exercise was commissioned as early as June 2021 however, the Government of Uganda instituted immediate COVID 19 lockdown in July 2021 and the evaluation could not proceed as planned. Subsequent partial lockdown ease in late July 2021 would only allow us ramp up onplanningprocess to bring activities up to speed with attendant effects. For example, it affected having the necessary requisite preparation for interviewing ***SGBVsurvivors***, such as prior advance communication, giving SGBV survivors opportunity to invite a companion where necessary or a counselor. It equally affected the planning process on ***assessing malnutrition levels,*** as the evaluation team could not easily access measurement tools/ equipment and challenged engagement with this group of project beneficiaries. The Ministry of Health SOPs had to be complied with, therefore the field data collection activity had to adapt by reducing FGD numbers from 12 to 06 persons that limited meeting some key informants.

(iii) Inability to measure impact

Evidence from the evaluation indicates significant reduction on EVIs reverting to high-risk behaviors and negative copings strategies to 5.67% in Kyaka II and 32.46% in Kyangwali settlements compared to baseline of 72% and 59.9% respectively. However, it was not

possible to measure impact given that APEAL II and I had only one-year timeframe each, the stakeholders and project participants could not distinctively separate the interventions of APEAL II from APEAL I and other organizations working in the refugee settlements.

3.0 FINDINGS

In this section, the findings are laid out beginning with key demographics of respondents who individually participate or utilize the APEAL II project assistance; subsequently followed by assessment and analysis of findings on the project components as implemented by the different consortium member organizations.

3.1 Background Characteristics

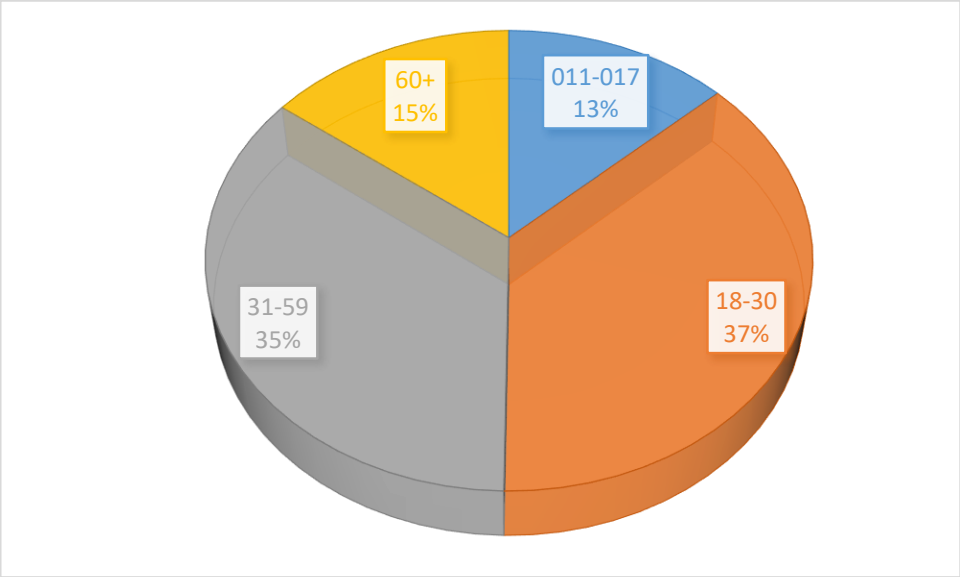
Demographic and socio-economic characteristics of respondents

The demographic characteristics of respondents that were sought included Age, Sex, level of education, disability status and nationality of origin. These characteristics are key as they influence perception and capacity of individuals to participate in development programmes including services uptake. It looks at both outputs, outcomes including stakeholders' views on process management and recommendations.

3.1.1 Age Distribution

Analysis of data reveals that Age distribution of respondents was; 11-17 years (adolescents) were 13%, 18-30 years (Youth) were 37%, 31-59 years (Adults) were 35% and 60+years (elderly) were 15%. It indicates that the majority of the respondents were aged 18-30 years while the least were those in the 11-17 year bracket. The age distribution is important as it reflects on different needs of targeted project beneficiaries, levels of project participation and vulnerability. Figure 1 shows the Age Distribution of respondents.

Figure 1: Age Distribution of Respondents

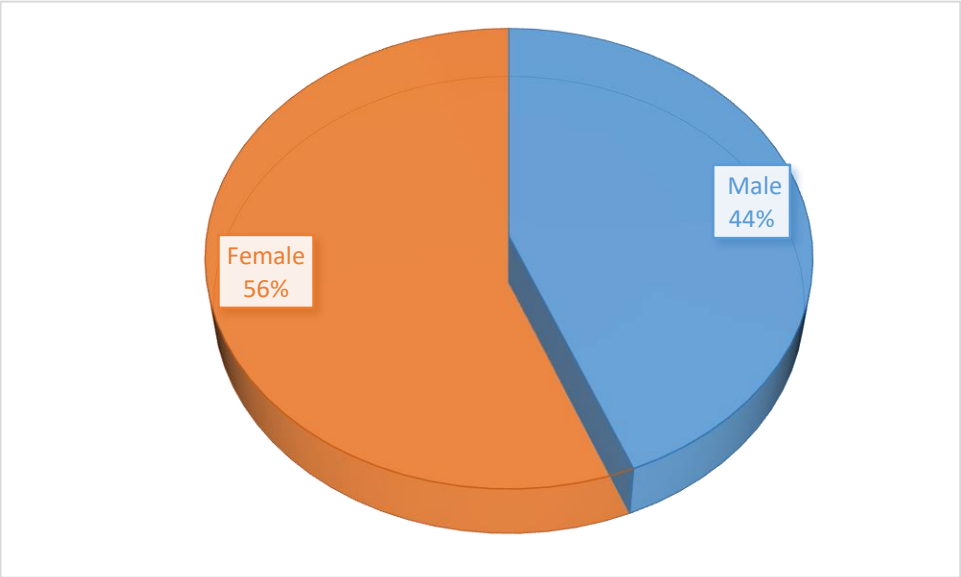


Source: Primary data

3.1.2 Sex Distribution of respondents

The sex distribution of respondents shows that 56% were females while 44% were males. Sex being one of the features used in describing an individual as either male or female, is furthermore a characteristic that has strong gender implications in terms of society expectations, needs, access to services and vulnerability amongst others while a key factor in influencing development-programming considerations. For example, the needs and behavior of males and females may vary especially as regards protection, sexual & reproductive health (SRPH) needs that are unique to one sex category such as menstrual hygiene that pertains more to females than males; and one's participation in socio-economic activities. Figure 2 presents percentage distribution of respondents by Sex.

Figure 2: Percentage Distribution of respondents by Sex



Source: Primary data

3.1.3 Sex of the respondents by settlement

Results show the interviewed population comprised of 56.1% females and 43.9% males. Samples desegregated by settlement shows that 52% of the study samples came from Kyangwali and 48% came from Kyaka II settlements. It is evident that among the interviewed population, female respondents were more than the male respondents in the two refugee settlements were as shown in Table 3.

Table 3: Showing Respondent Characteristics by Sex and Settlement (%)

Settlement	Gender/sex of Respondent		
	Male	Female	Total
Kyaka II	19.8	28.2	48.0
Kyangwali	24.1	28.0	52.0
Total	43.9	56.1	100.0

3.1.4 Nationality of Refugees

Data shows that among the 515 respondents interviewed, 410 were refugees originating from different countries. Amongst the 410 refugees, 91% were from DRC, 5.4% from Burundi while 3.4% were from Rwanda. Only 0.2% were from Somalia, as shown in Table 4.

Table 4: Origin of refugees

	Gender/sex of Respondent		
Country of Origin	Male	Female	Total
DRC	40.5	50.5	91.0
Burundi	1.7	3.7	5.4
Somalia	0.2	0.0	0.2
Rwanda	1.7	1.7	3.4
Total	44.1	55.9	100.0

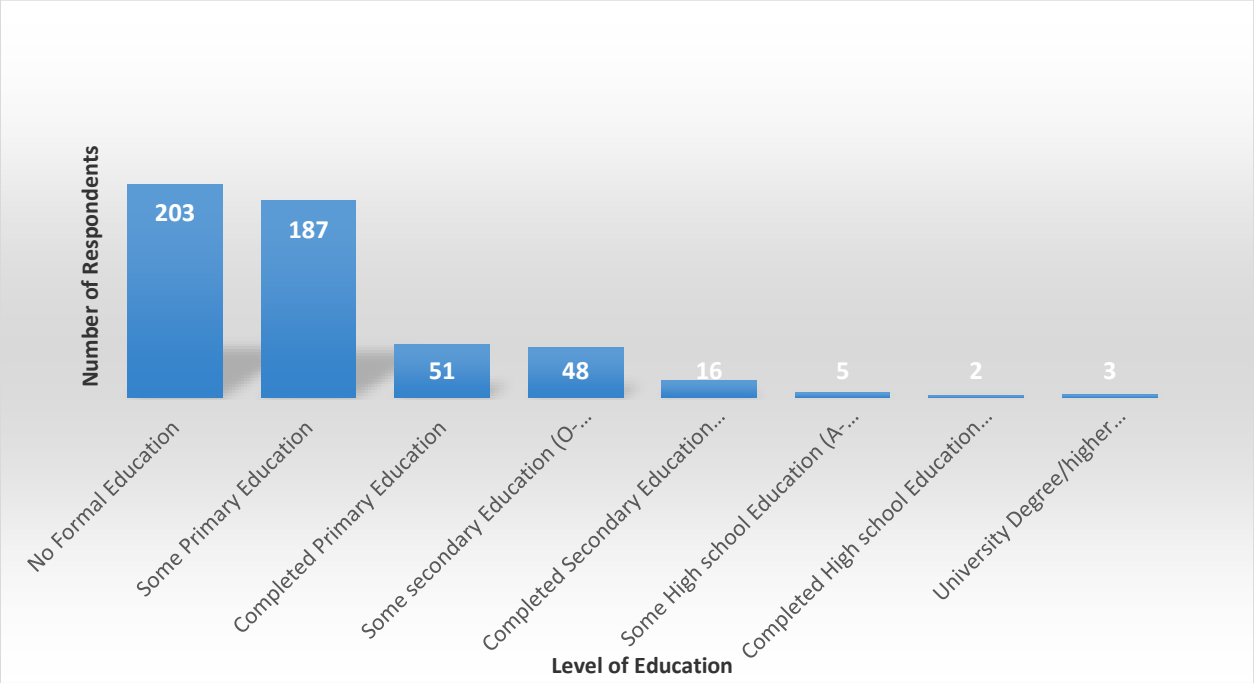
Source: Primary data

Nationality was considered a key demographic as different cultures hold different perceptions and attitudes to different practices in life including natural phenomena like right age for marriage, issues of menstrual hygiene, contraceptive use among others.

3.1.5 Level of Education

Education background reveals the literacy levels with implications on access to information especially of print materials. Education level also has effect on conceptualization of issues and decision making of uptake services. Data shows that majority of respondents have no formal education representing 39% of the interviewed population. This is followed by attained some primary with 36%. The least attained level of education is high school with 0.4%. This has implications on programming on matters that require basic level of literacy. The distribution of the respondent's education levels is shown in the figure 3.

Figure 3: Respondents' Level of Education



N=515

3.1.6 Disability Status

In order to establish the disability status as part of inclusiveness and vulnerability, respondents were asked whether they had any difficulty doing any function of daily living, such as seeing, hearing, walking, using your arms, using your hands, talking or thinking. Results indicate that N=43 (12.2%) had a disability challenge while N=310 (87.8) did not have a disability challenge. Respondents were further asked the nature of disability they had. Results show that physical disability, hearing and seeing/sight are the most common while speech was the least as shown in Table 5.

Table 5: Disability Status of respondents

Nature of impairment	Refugee	Host Community	Male	Female	Total
Physical	55.29	28.57	52.5	50.85	51.52
Hearing	45.88	21.43	45	40.68	42.42
Mental	24.71	21.43	30	20.34	24.24
Speech	14.12	0	20	6.78	12.12
seeing/sight	45.88	28.57	57.5	33.9	43.43
learning difficulty	38.82	50	37.5	42.37	40.4
Other	2.35	0	2.02	0	2.02
N=43					

Source: Primary data

3.2 Thematic evaluation findings

This section presents the core findings among the project components in terms of benchmarks on intended outcomes. It however begins with Indicator Performance Value Summary as shown in Table 6. A detailed Project Output Performance is annexed as II.

Table 6: Indicator Performance Values Summary Sheet

Indicator		Gender		Project Location		Project target Category		Overall Baseline/End line
		Male	Female	Kyaka II	Kyangwali	Refugee	Host Community	
Indicator 1: % of person's/ target population in a given context reporting an improved feeling of safety and dignity by the end of the intervention	Baseline	75.2%	76.1%	70.6%	80.7%	73.7%	89.3%	75.8%
	End line	77.4%	77.5%	91.9%	64.2%	75.4%	85.7%	80.6%
	Change	2.2%	1.4%	21.3%	(-16.5%)	1.7%	(-3.6%)	4.8%
Indicator 2: % of Extremely *Vulnerable Individuals targeted by APEAL reverting* to high risk behaviors and negative coping	Baseline	62.80%	65.70%	72.00%	59.90%	62.10%	87.50%	64.70%
	End line	18.58%	20.42%	5.67%	32.46%	23.9%	2.86%	13.4%
	Change	-44.22%	-45.28%	-66.33%	-27.44%	-38.2%	-84.64%	-51.3%
% Of the targeted population who demonstrate improved psychosocial well-being by the end of the intervention compared to the beginning disaggregated by age, gender, refugee, and host community.	Baseline	40,03%	59.7%	No values	No values	93.6%	6.4%	49.9
	End line	52%	65%	71.1	55.7	74.3%	13.4%	43.9
	Change	11.97%	5.3%	71.1%	55.7%	-19.3%	7%	-6%

Indicator		Gender		Project Location		Project target Category		Overall Baseline/End line
		Male	Female	Kyaka II	Kyangwali	Refugee	Host Community	
% of beneficiaries (disaggregated by age, gender, refugee, host) reporting that humanitarian assistance is delivered in a safe, accessible, accountable and participatory manner	Baseline	28.2%	71.8%			89.5%	10.5%	No value
	End line	79.7%	76.5%	87.7%	68.7%	79.6%	71.4%	75.5%
	Change	51.5%	4.7%	87.7%	68.7%	-9.9%	60.9%	75.5%
% of non-protection and non-SGBV specific actors targeted by APEAL incorporating protection principles in humanitarian aid delivery.	Baseline							57.%
	End line							75%
	Change							18%
% of humanitarian actors whose activities demonstrates principles of meaningful access, safety and dignity through inclusive and people-centered approach mechanism	Baseline							52%
	End line	79.6%	76.7%	77.7%	71.6%	79.5%	71.4%	76.1%
	Change							24.1%

3.2.1 Project relevance

The UNHCR has collected and collated extensive data on refugees and asylum seekers in nearly every country globally. The design of APEAL II Project and indicator development was based upon international data with internationally agreed methodology. For instance, after hard work, the 10th IAEG-SDGs meeting in Addis Ababa, in October 2019- adopted for inclusion under target 10.7 an indicator on refugees in the SDG indicator framework, which states "**Facilitate orderly, safe, regular and responsible migration and mobility of people, including through the implementation of planned and well-managed migration policies".**

Displaced and stateless people have been almost invisible in the reporting on the SDGs, which has undermined the basic premise of the 2030 Agenda and the promise to "Leave No One Behind". The specific inclusion of an indicator relating to refugees allows those advocating for their protection to be included in the discourse on sustainable development. Preventing situations, which generate forced displacement, and finding durable solutions for those already displaced is now part of meetings the SDGs. It also highlights the humanitarian-development nexus, ensuring that it is front and center in sustainable development.

The APEAL II Project was designed to respond to the Government of Uganda Policy and Action for Refugees. The Country has made self-reliance a central point of the Uganda Refugee Response in order to ease pressure on local resources and maintain the sustainability of its progressive policy. The Settlement Transformation Agenda (STA), which supports the development of refugee-hosting districts through transformative investments in infrastructure, livelihoods, peaceful coexistence initiatives and environmental protection, was integrated into the Government's development agenda under its second National Development Plan (NDP II, 2016 - 2020). Uganda implements the Comprehensive Refugee Response Framework (CRRF), which further promotes the country's progressive policy through a multi-stakeholder approach, boosting resilience and self-reliance, and expanding solutions for both refugee and host communities. The Office of Prime Minister (OPM) is the government entity responsible for coordinating and managing the refugee response and is supported by various line ministries and several development and humanitarian partners.

3.2.1.1 Alignment to Refugee Policies

Comprehensive Refugee Response Framework (CRRF)

At the heart of the CRRF and the GCR is the idea that **refugees should be included in the life dynamics of local communities from the very beginning**. When refugees gain access to education and labor markets, they can build their skills and become self-reliant, contributing to local economies and fueling the development of the communities hosting them.

Throughout the design and implementation of activities, the Consortium aligned their work to Humanitarian Assistance Principles and policies such as the Comprehensive Refugee Response Framework and the **ECHO PROTECTION MAINSTREAMING** Programming in Emergencies. Safety, dignity and inclusiveness were key tenets of project interventions.

UNHCR's Mental Health and Psychosocial support – Global Review 2013

A perspective on the Mental Health and Psycho-Social Support (MHPSS) to Persons of Concern offers a new way to look at humanitarian assistance. It calls into questioning the appropriateness, sensitivity, and empathy of humanitarian interventions and demands that humanitarian agencies support avenues for displaced people to address and heal their own trauma. That is how WCH, TPO, WOMENA and HI found their programmes appropriate in the project.

3.2.1.2 Involvement of beneficiaries and stakeholders

In all processes of Project Implementation, beneficiaries were involved in identification of their real needs and in development and implementation of action plans. Community structures were also involved in planning and execution of activities such as identification of vulnerable individuals and their referral, mobilization of communities for participation in community work and validation of study findings. Involvement of beneficiaries for example in needs identification led to project components like VSLA targeting youth and Menstrual health and hygiene for girls.

The evaluation found that the OPM was involved in key project activities such as vulnerability assessment but there are some perceptions that point to insufficient involvement of the OPM as stated below:

> *"The focal persons at the OPM were not adequately engaged in the identification ofbeneficiaries and whereas the RWCs could have been used I doubt that the most at risk and the most deserving were identified. It's true that no project can do any work here without engaging the RWC's; however, when this is done then the identification of the most in need without adequately engaging with OPM goes wrong. The RWC's are known to select their relatives and friends in situations where OPM is not adequately utilized"* KI*Settlement commandant*

3.2.1.3 Response to COVID 19

A COVID-19 pandemic lockdown was effected between May and August 2020 affecting activity implementation in that period including planned activities for new arrivals as entry of asylum seekers and refugees was banned.

The Project commenced COVID 19 response with a Rapid assessment of protection needs in the refugee settlements and responded by conducting outreach services of psychoeducation, awareness generation on COVID-19, psychological first aid and provision of specialized services and provision of en route kits and material assistance to refugee caseload received prior to the lockdown period in place of those who would have been received in 2020 and categorised as new arrivals. Additional PPEs were procured to protect frontline workers delivering services to the beneficiaries against COVID-19 and preventing further transmission. Child Friendly Spaces (CFS) and Mother Baby Areas (MBA's) remained closed due to COVID lockdown measures. The CFS's were used as COVID isolation centres. The project adopted COVID-19 home-based service delivery, in line with MOH SOPs, for provision of sanitizers, handwashing facilities and masks while encouraging social distancing. Figure 4 shows the project team on one of the home visit activities.

Figure 4: Project Team on one of home visits for Covid 19 prevention

According to a COVID 19 Surveillance focal person, the response and mitigation integration in the project was timely and relevant, since it came in the middle when the surge of COVID-19 was high. At the time, Government was shifting from Health-facility based care to home based care, which APEAL II provided support for health workers and laboratory personnel training on rapid testing, PPEs support to health facilities, oxygen cylinders in the Isolation centres and community sensitization using VHTs.

In order to respond to increased cases of SGBV during C19 Lockdown, Protection partners came up with SGBV adaptation strategies as follows:

❑ Capacity building of community structures to provide psychosocial first aid

❑ Partners continued online coordination meetings with the referral networks

❑ Airtime was given to the LC1s to enable immediate updating of the partners in case of a reported case

❑ Integrated SGBV and health services; established a temporary SGBV outreach at the ante-natal clinic and vaccination clinic at the hospital since pregnant women would still go for health services

❑ The presence of the SGBV referral pathway in both settlements which elaborates where to go and when.

❑ The SGBV Protection Working Group (SGBV PWG) overseen by UNHCR and a SGBV Coordination Group (SGBV CG) for APEAL Consortium within the settlements continued to work [1]remotely.

3.2.2 Project Efficiency

- Planned activities and outputs implemented within time frame
- Utilization of budget versus planned
- Cost driver's consideration

Evaluation appreciates that the project was implemented in a very unstable situation characterized by electoral campaigns, national general elections and COVID 19 pandemic and associated lockdowns. For example, in March 2021 there was a modification in the work plan to integrate COVID 19 as a protection issue. This affected the original work plan.

Nonetheless, the project consortium members achieved much of what they planned; changing approaches some from direct contact with beneficiaries to remote but also in a rush to catch up with time lost after the COVID 19 lockdown. Reacting to whether COVID 19 affected activity implementation a respondent had this to say:

> *"To a big extent yes but also considering other factors not all went as planned. Because during the APEAL II first of all there was COVID and implementation was largely through the times of this pandemic and its associated lockdowns and being the first ever lockdown, there was be a lot of fear, there was a lot of anxiety and some of the activities were done remotely. By the time we got out of the lockdown, the project was ending so many things were done in a rush just trying to catch up with the lost time; this meant that certain things, resources being spent on implementing some of the COVID SOPS away from what was originally planned. So I cannot say that we implemented according to our plan since COVID affected the project implementation"* *KI-Consortium Member*

3.2.2.1 Delivery on time

Evaluation also found out that whereas much of the planned activities were delivered but delivering them on time was a big challenge as stated *"The activities were implemented as planned, though COVID 19 affected and we had to ask for a no cost-extension and that was just for that period and some of those activities which were not done by end of December 2020." KI Consortium Member.* This was because organizations still had resources and but needed some time to be able to cover what the lock down could not allow them to do and later were able to implement what had been planned. Table 7 shows Budget Performance

[1] *Draft Report Care: Protection Concerns and Benefits of Cash Based Interventions (CBI) in Kyaka II and Kyangwali Refugee Settlements V3 page 35*

Table 7: Budget Performance

Organisation	Budget allocation (EURO)	Spent	Performance/burn rate
1. International Rescue Committee and Uganda law Society (ULS)	460,344.00	386,116.63	84%
2. SAVE THE CHILDREN INTERNATIONAL	609,799.00	551,197.41	90%
3. CARE International in Uganda, KRC and Womena	1,077,309.00	1,113,952.60	103%
4. War Child Holland and TPO Uganda	697,376.00	657,899.72	94%
5. Humanity & Inclusion	336,617.00	252,041.56	75%
6. CARE DK	54,900.00	31,500.00	57%
7. Indirect costs	226,544.15	209,489.55	92%

Overall, the project had sufficient resources compared to the work scope. This is according to most of the consortium members. However, as project time progressed, there was a feeling of financial strain because of fixed costs during COVID lockdown yet work was not moving as planned.

> *"Given the COVID situation of course, some moneys were not enough. Because you realize the target would change in some activities and the quality of things changed because if I was meant to have a training of 30 participants at one venue, because of COVID I had to split the team to train into two each with about 15 members and this means almost double the resources required because I would need to hire the hall twice, spent double the time from what was earlier alone planned, these are some of the issues. KI Consortium Member*

It was not possible to establish achievements by outputs for each consortium member since achievement was documented by result area.

3.2.2.2 Project delivery model

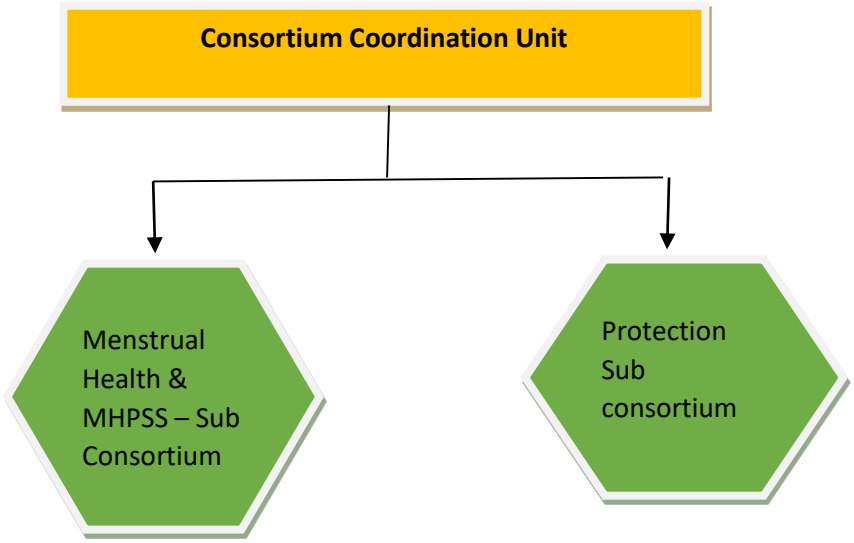
The size of the Consortium as a project delivery model is good in the respect of creating integration of the project and coherence. However, it has issues of efficiency especially in terms of timeliness in decision-making, implementation of activities and reporting.

"What I think can be improved or can be done to improve the effectiveness; the consortium should be relatively small and manageable. There should not be such a sizeable number because when I

compare with before we joined the APEAL team, we were three partners implementing another project still doing MHPSS and disability inclusion. We were just three and our work was moving on well, relatively faster, and of course, that goes with decision-making, compiling reports and it takes relatively a shorter time. This is my own take on this matter, but the Donor thinks this approach is better to harmonizing use of resources" KI- Consortium Member.

This member's view, which is shared by some members of the Consortium, is that the consortium could be split into two sub-themes, between those in mainstream protection and those in Mental Health and psychosocial support. Implementation coordination could then be managed at top level as reflected in figure 5.

Figure 5: Proposed Consortia Approach



The main function of the Consortium coordination unit would be overall coordination of the implementation plan. The thematic sub consortia would for example merge their reports before the main consortium coordination unit puts all together.

The evaluation further proposes that performance reporting could be arranged in tandem with the budgets.

3.2.3 Project coherence

Link with on-going initiatives

APEAL II was a project building on what was implemented, lessons learned from SPOT, and APEAL I projects. First, it galvanized the lessons learned and technical synergies existing among the consortium members in the humanitarian response. Secondly, at individual institutional levels, the consortium members for example CARE, Save the children; IRC, WCH and TPO have been in the global business of providing humanitarian assistance in their respective core competencies and mandates. The consortium therefore significantly contributed to the APEAL II project scopes and consolidation of assistance being provided to the refugees and host populations by the humanitarian actors.

Technical working groups conducted a situation analysis including internal and external environmental scan to align to the principles in the strategic plan to WHO principles and guidelines. The technical working groups undertook a stakeholder mapping exercise and identified the roles of each stakeholder in the strategic plan. Members also noted a specific need to harmonise training packages on PSS across the two ministries. Incorporation of COVID-19 disease prevention and response in MHPSS strategic plan and updating the mission and vision statement of the MHPS.

Relationship government efforts

The Project aligned to Government programmes for the youth including young men, women and children. Youth targeted activities implemented under APEAL II like VSLAs, vocational training skills, menstrual hygiene were coherent with already existing government efforts, this was in addition to the common programmes on Health, Water and Sanitation and community development. As such the project had several planning and coordination meetings with Government.

Internal coordination

Regarding coordination within the consortium, there were project coordination meetings, review meetings, joint monitoring visits conducted and represented by each sector among the consortium members.

> *These meeting aimed at drawing coordinated plans, sharing challenges and learnings and drawing coordinated way forward. They were meant to ensure that there is coherence in what members are implementing and efficiency" KI- Consortium Member*

3.2.4 SGBV Prevention & Response, Protection Mainstreaming

SGBV refers to any harmful act that is perpetuated against a person's will, and that is based on socially ascribed (gender) differences between males and females. The nature and extent of specific types of SGBV vary across cultures, countries, and regions.
https://www.humanitarianresponse.info/en/operations/referral-pathway-survivors-gender-based-violence

APEAL II, intervention on SGBV centered on providing timely and comprehensive SGBV case management, including legal assistance. The Key Organizations among the consortium members that were providing SGBV assistance are IRC, TPO and CARE international. A survivor-centred approach was used in addressing the different needs, providing case management services so that they feel respected, empowered and dignified.

The action also targeted communities with SGBV Information, Education and Communication (IEC) campaigns, providing gender and age 'safe spaces' for women, youth, and children. The Safe Spaces were utilized for learning, playing, socializing, recovering and building resilience. Furthermore, APEAL II, conducted sensitisation for community leaders and key authorities to be more proactive in the protection of the vulnerable/at-risk refugees. The intervention also included training of health workers

on Clinical Care for Sexual Assault Survivors (CCSAS), in order to improve the clinical care provided to survivors.

Different forms of SGBV that were targeted by the project in the current context of the emergency response:

- Physical violence: any act of physical violence that is not sexual in nature and results in pain, discomfort or injury such as domestic violence.
- Sexual violence: any form of non-consensual sexual contact, such as rape (including in the context of marriage), sexual exploitation, forced prostitution, trafficking and inappropriate touching.
- Economical violence: Denial of resources, opportunities or services, assets or livelihood opportunities, education, health or other social services.
- Psychological/emotional abuse: threats of physical or sexual violence, intimidation, humiliation, forced isolation, harassment, unwanted attention, remarks, gestures or written words of a sexual and/or menacing nature, destruction of cherished things, etc.

Under this component, a number of activities including Humanitarian assistance (cash, shelter, health care, NFIS), Skilling support, treatment of Sexual transmitted diseases for cases of infection and related first aid, Counselling and guidance, referral to the responsible Organizations and training community facilitators like Men Role Models, and VHTs.

Preliminary activities that were conducted included assessment studies to establish the level of Gender Based Violence (SGBV), vulnerability and protection. Key amongst the studies were ***Rapid Gender Analysis (RGA) April- May 2020***, by CARE; ***Access to Wash Facilities by Women & Girls – August 2020*** by WoMena Uganda. This in particular was carried out to establish the level women and girls' access WASH facilities for menstrual health management.

CARE and IRC supported 231 (228 F; 3 M) SGBV survivors to access comprehensive, timely and quality survivor-centered SGBV / protection case management services. Unaccompanied minors & separated children were also identified and provided with alternative care arrangement. The number of children supported was 275 (120 girls, 155 boys). Caseworkers, monitored their well-being for additional child protection support services and referrals and continuously supported the children25 (11 girls; 14 boys) unaccompanied children were reunified with their biological relatives within the settlement after tracing them. ***(Dec 2020 Interim Report***)

Significant strides were made on responses to SGBV cases in the APEAL II Project. For example, during the quarter Jan -March 2021 period, 63(F62 M01) new SGBV cases were reported and provided (IRC) with timely, appropriate and quality case management services and psychosocial support, using the survivor-centred approach. Out of cases handled, 13 reported Rape, 16 psychological/emotional abuse, 12 denial of resources, 21 physical assault and 01 sexual assault. Two (2) out of the 13 incidences of rape were reported within the 72-hour window period; 01 case was reported between 2 weeks to 1 month whereas the other 10 were reported beyond 1 month.

In addition, 14 out of the 63 survivors were referred for medical examination and other related specialized health services. 21 survivors who received legal assistance were supported to report their cases to police based on individual request. Fifteen (15) survivors were supported with material support in form of jerry cans, buckets, sanitary pads, wrappers, food, clothes, cooking oil and salt across for the female survivors and adult diapers for 1 male survivor.

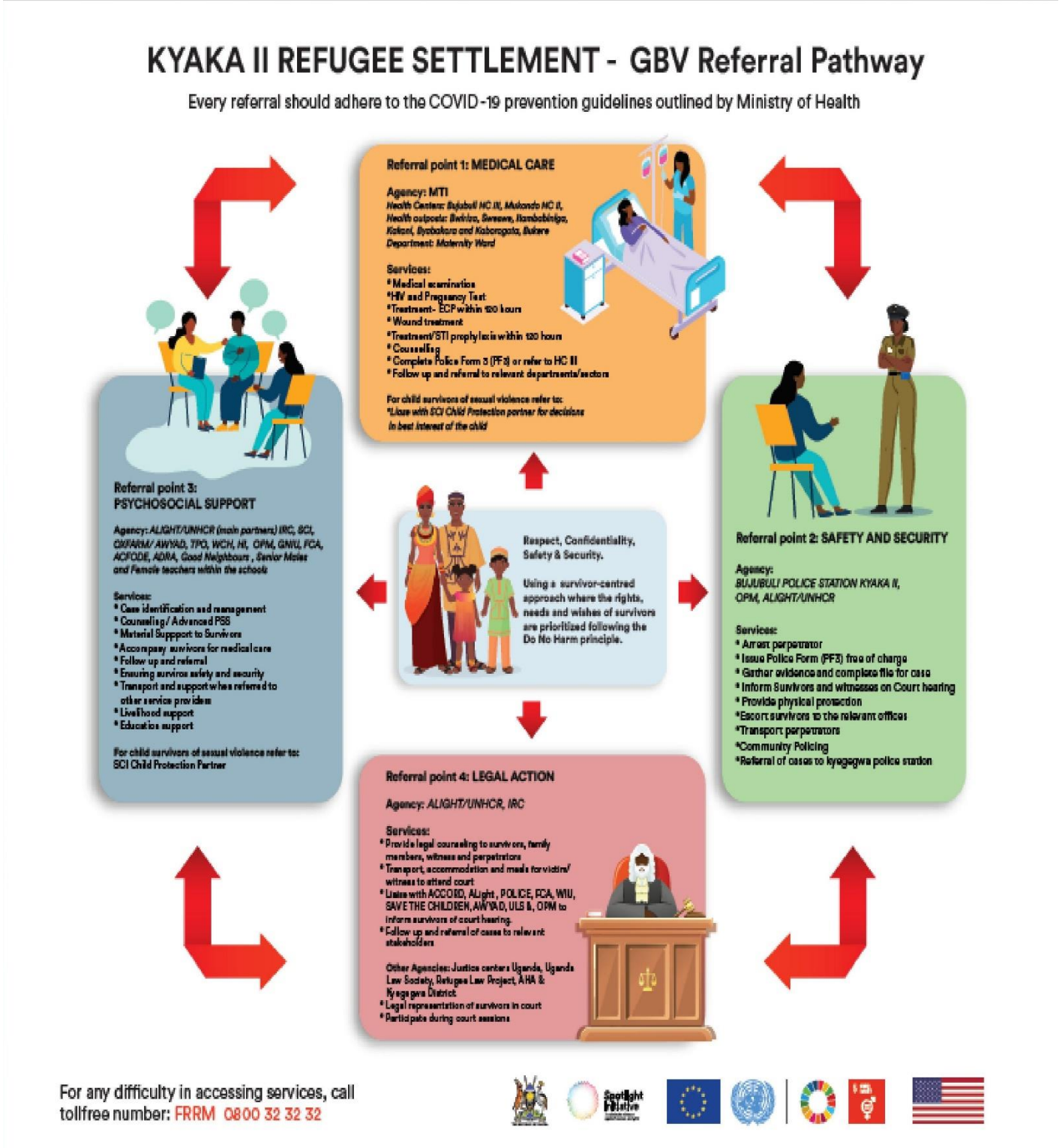
Accordingly, 42 case follow-ups were carried out, 31 survivors whose cases were closed in the previous quarters were surveyed and they reported being satisfied with services received, and there was observed improvement in their recovery status. That said,physical Violent (beating, fighting, battering) by someone known (domestic) remains the main reported form of SGBV in the two settlements of Kyangwali at 35.45% andKyaka II-20.65 percentage respectively.

It is observed that there is increased lead-time in rape case management reportedly due to weaknesses on part of community leadership and lackadaisical attitudes towardsSGBV cases when reported by victims who felt fear, threats from community and relatives to perpetrators. Evidently there is still need for capacity strengthening to existing SGBV community structures withemphasis on the importance of timely reporting and victim protection; an observation by one the SGBV Advisors in the Consortium member organisation. Figure 6 shows a typical community sensitization session while figure 7 shows a SGBV Referral Pathway.

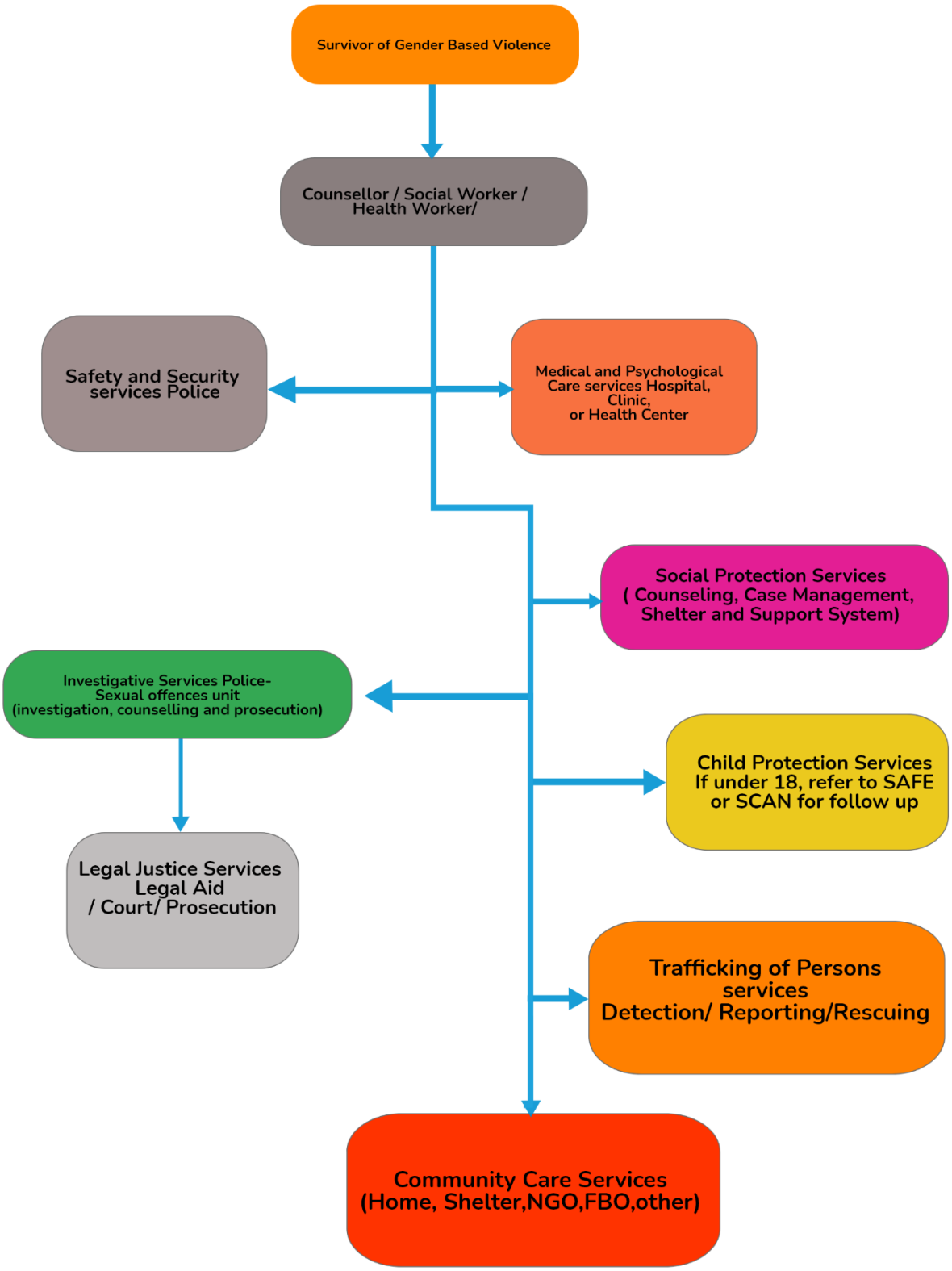
Figure 6: Conducting Legal awareness session in Mukondo

Legal officer (ULS with IRC) conducting legal awareness session in Mukondo C with the RWC structure

Figure 7: SGBV Referral Pathway



Source: Courtesy Consortium photos


Survivor of Gender Based Violence
Counsellor / Social Worker / Health Worker/
Safety and Security services Police
Medical and Psychological Care services Hospital, Clinic, or Health Center
Social Protection Services (Counseling, Case Management, Shelter and Support System)
Investigative Services Police- Sexual offences unit (investigation, counselling and prosecution)
Child Protection Services If under 18, refer to SAFE or SCAN for follow up
Legal Justice Services Legal Aid / Court/ Prosecution
Trafficking of Persons services Detection/ Reporting/Rescuing
Community Care Services (Home, Shelter,NGO,FBO,other)

The SGBV specialists from the respective consortium member organizations working with community structures, police, health workers, counselors, legal experts and counselors worked in line with OCHA SGBV guidelines and established SGBV Pathway. This traces the different service points from the SGBV survivor goes through to get comprehensive SGBV response services.

ULS activities complemented legal interventions that were done by IRC. In terms of legal representation, ULS represented refugees in criminal cases (including alleged perpetrators and other non SGBV criminal cases) and also prosecuted civil and administrative cases. According to Ugandan laws, prosecution is done by the state, however, recognizing the significant gaps in prosecution of SGBV cases for those survivors who wish to pursue legal redress, IRC addressed this gap through ULS Legal Officers and community paralegals and through the legal case management system. IRC provided legal counselling and support in accessing and engaging with the state prosecution system in cases where it was deemed the right action. There support included providing community trained Court interpreters to support trials, facilitated witnesses' attendance at trials, and engaged in discussions with the police on witness protection where required. It also engaged with OPM and UNHCR on issues of relocation and access to protection houses. IRC also conducted trainings for state actors and these trainings included a session focusing on SGBV survivors aimed at enhancing the state's capacity to be more survivor-centered. The outcomes of the interventions implemented by IRC with ULS are explained below.

3.2.4.1 Survey response on Sexual and Gender Based Violence

i) Experience of SGBV from Non-spouse

Respondents were asked if any other person other than the spouse has ever subjected them to any form of gender-based violence. Results show that Kyangwali settlement had the highest percentage of SGBV of 22.01 % compared to Kyaka of 0.81%. There was slight variation in percentage of male and female who have been subjected to SGBV i.e. 12.39% male and 11.42 % female, portraying that both female and male suffer SGBV. The SGBV experience results are shown in Table 8

Table 8: Experience of SGBV by Non-spouse by Gender and Settlement

	Gender		Settlement	
Ever been subjected to sexual violence by any other person	Male %	Female %	Kyaka %	Kyangwali %
Yes	12.39	11.42	0.81	22.01
No	87.61	88.58	99.19	77.99
Total	100	100	100	100

ii) Experience of SGBV from Spouse

Respondents were asked if they have ever been subjected to physical, sexual or psychological violence from a spouse. Results show that SGBV was slightly lower among males at 11.5% compared to females at 13.8%. Kyangwali had the highest percentage of SGBV in homes of 22.01% compared to Kyaka at 2.83% percent. This is shown in Table 9.

Table 9: SGBV Experience from a spouse by gender and settlement

	Gender		Settlement	
Ever been subjected to physical, sexual or psychological violence by a spouse	Male %	Female %	Kyaka %	Kyangwali %
Yes	11.5	13.84	2.83	22.01
No	72.12	74.39	88.66	59.33
Never married/child	16.37	11.76	8.5	18.66
Total	100	100	100	100

iii) Forms of SGBV

While trying to ascertain the forms of SGBV existing in the area, Early marriage was ranked highest at 61.95% male and 66.78% female. This was followed by forced marriage in both male and female and by settlements.

There was a marked difference on early marriage by settlement where Kyaka had 58.3% compared to Kyangwali with 70.52%.

The summary is presented in the Table 10.

Table 10: Forms of SGBV

	Gender		Settlement	
Forms of SGBV	Male	Female	Kyaka	Kyangwali
Sexual exploitation by people in authority	20.35	19.72	3.64	35.07
Forced marriage	41.15	46.71	43.32	45.15
Early marriage	61.95	66.78	58.3	70.52
Economic violence- denial of income, resources, support, etc.	17.7	17.99	8.5	26.49
Violent attacks (beating, fighting, battering) by someone unknown/not relate	20.8	17.65	11.34	26.12
Physical Violent(beating, fighting, battering) by someone known (domestic)	30.53	26.64	20.65	35.45
Sexual violent (rape and defilement) by someone unknown/not related	21.24	19.38	5.67	33.58
Sexual violent (rape and defilement) by someone known (domestic)	14.16	14.19	4.05	23.51

Threat of Violence/coercion	14.16	13.49	2.02	24.63
Emotional and psychological abuse	27.43	24.91	25.51	26.49
Men abandoning their responsibility including children	36.73	34.6	38.46	32.84
Others (please specify)	2.21	1.04	1.62	1.49

3.2.4.2 Feeling of safety and dignity

- % of the targeted population reporting an improved feeling of safety and dignity by the end of the intervention compared at the beginning (SGBV and safety)

Evaluation sought to explore the status of feeling of safety and dignity under different circumstances among the refugees and host communities. According to primary data from households, the places people felt pose risk to their safety include forest areas where they get firewood, water points, distribution points, market places and dark places. Some of the reasons given for example of feeling unsafe at water points and market places were competition for water and risk of theft of property and money respectively as shown in Table 11.

Table 11: Feeling of safety on the way to getting assistance by category

Feeling of safety at all times travelling to receive the assistance/service	Category of Respondent							
	Nationality		Gender		Age group			
	Refugee %	Host Community member %	Male %	Female %	12-17	18-30	31+	Total
Always	45.9	37.1	41.59	46.02	31	45	47	44.1
Most times	22.2	11.4	23.01	17.65	22	26	15	20
Some times	24.4	25.7	24.34	24.91	27	23	25	24.7
Subtotal positive feeling	**92.5**	**74.2**	**88.94**	**88.58**	**80**	**94**	**87**	**88.8**
No (negative)	6.6	15.2	7.52	9	12	4	11	8.35
No answer (negative)	1	10.5	3.54	2.42	7	2	1	2.9
Sub total negative feeling	**7.6**	**25.7**	**11.06**	**11.42**	**19**	**6**	**12**	**11.25**
Total (Numbers)	**410**	**105**	**226**	**289**	**67**	**188**	**260**	**515**

Respondents reporting feeling of safety among refugees and host communities were reported 92.5% and 74.2%. by gender male were at 88.6% with female at 80%. Among the age groups, 18-30 feel more improved safety, followed by 31 years and above and 17-18 (adolescents) at 80%.; with overall at 88.8%.

Several interventions and other safety measures have been put in place by police and other agencies to minimize any potential risk to girls and women. These according to individual survey respondents

include Police/patrols around the community, forming and training safety groups like Child Protection committees and model men, educating girls/women on how to report incidents and Increased number of female staff in most service centers. 40% of men and women interviewed also knew of shelter safe places for women where they may seek safety when faced with violence.

Most known actors in SGBV prevention and related interventions are CARE international, Save the children, TPO, IRC and WOMENA in ascending order as shown in Table 12

Table 12: Known Organizations supporting safe spaces establishments

Who supported establishment of these safe places	*Refugee*	*Host Community member*	*Total*
CARE international	63.2	71.4	63.8
IRC	26.0	21.4	25.6
Save the children	46.0	42.4	45.7
WCH	21.1	7.2	20.1
TPO	35.1	64.3	37.2
HI	19.5	14.3	19.1
WOMENA	24.9	21.4	24.6
KRC	7.6	21.4	8.5
ULS	0	0	0
other	12.4	0	11.6
Total	473	37	510

The APEAL II interventions are evident when the refugee were asked whether they thought violence and insecurity among girls and women had increased or reduced in the previous one year, 73.7% of refugees and 84.3% of host community indicated having observed reduced violence and insecurity especially towards girls and women.

Information was sought on insecurity in the settlements and the majority of the respondents said that they felt there was decline in feeling of insecurity in the settlement. Only 25% of males and 23% of females said they still felt insecure in their areas. Kyangwali settlement reported a slightly higher number of feeling of insecurity with 40.3% of respondents who thought there was increased insecurity compared to Kyaka where only 6.48% reported increasing insecurity as indicated in Table 13.

Table 13: Feeling of insecurity by gender and settlement

Insecurity increase	Gender/sex		Settlement	
	Male	Female	Kyaka II	Kyangwali
Yes	25.22	23.18	6.48	40.3
No	74.78	76.82	93.52	59.7

Several reasons were given attributing to improved feeling of safety and less SGBV with the communities' key of which are:

i. Girls and women are vigilant /or not to avoid insecurity
ii. Those who used to cause insecurity to women have changed
iii. The conditions for causing insecurity have changes
iv. There has been a lot of education by NGOs
v. Law enforcement against insecurity and violence has been good

3.2.4.3 Feeling of Dignity

Respondents were asked about the feeling of dignity in the society and 77.9% Male and 76.8% of female confirmed to being dignified in the society. Across the settlements, results show 98 percent in Kyaka II and 58 percent in Kyangwali. Refugees feel more dignified compared to the host community. The results are summarized in the Table 14.

Table 14: Feeling of Dignity by gender and settlement

		Feeling dignified (%)	Feeling undignified (%)
Gender of respondent	Male	77.9	22.1
	Female	76.8	23.2
Settlement	Kyaka II	98	2
	Kyangwali	58	42
Category of respondents	Refugees	98	2.0
	Host community	58	42

The evaluation sought information on what makes respondents or other people in this community feel undignified. Findings revealed multiple drivers of indignity feeling as summarized in the Table 15.

Table 15: Tenets of Indignity by gender and settlement

	Male	Female	Kyaka II	Kyangwali
i). Mistreatment and discrimination when seeking medical services	36.73	39.79	40.08	36.94
Ii). Verbal abuses and tough attitude when accessing services at the reception center	32.74	32.18	31.17	33.58
iii). Lack of access to menstrual hygiene kits for girls and women	24.78	33.91	22.67	36.57
iv). Labor exploitation when you work for very long hours and you are not paid for the day	26.11	22.49	13.77	33.58
v). Rape and other sexual abuses of girls and women	25.66	22.84	9.72	37.31
vi). Inadequate ration and PSN support (small amount /shs a month)	19.03	13.49	8.5	22.76
vi). Not knowing where to report/ respond to complaints	11.06	11.42	1.21	20.52
viii). Use of local language (Runyoro) by service providers like health centers	9.29	7.27	1.21	14.55
ix). School age going children dropping out due to school fees and other scholastics	24.78	22.15	14.98	30.97
x). Poor shelter	38.5	38.41	47.77	29.85
xi). Little food is given to other refugees outside the reception centre	11.06	13.49	4.05	20.15
xii). Serving half-cooked food at the reception centre leading to stomach pain and	6.64	3.81	0	9.7
xiv). Restricting time for accessing safe water points) between 10am – 5pm	8.41	6.92	1.62	13.06
Others, specify	3.54	1.73	4.86	0.37

Poor shelter was ranked highly among the attributes that make individuals feel undignified. This was followed by mistreatment and discrimination when seeking medical services. The project may have to consider outreach support at household shelters especially for PSNs, customer care, and protection rights training to health service providers to improve feeling of dignity.

3.2.4.4 Vulnerability and Coping Strategies of Respondents

- % of Extremely *Vulnerable Individuals targeted by APEAL reverting* to high risk behaviors and negative coping

In emergency situations, Individuals in the categories of girls and boys, including unaccompanied and separated children; persons with serious health conditions; persons with special legal or physical protection needs; single women; women-headed households, older persons and persons with disabilitiesare generally considered to be at heightened risk. (*UNHCR Emergency Handbook)*

Primary data from households found that 42.9% of the respondents (451 males, 42.1 female (N=221)) had been registered with the OPM as PSNs. The categories identified were as in Table 16.

Table 16: PSNs registered with OPM

Categories of People who registered with OPM as vulnerable or PSNs in this community	Male %	Female %	Total %
a) SGBV (SV) Victim	11.06	7.27	8.93
b) Unaccompanied child or separated child (SC)	6.19	5.88	6.02
c) Child at risk (CR)	20.35	19.03	19.61
d) Woman at risk (WR)	13.72	14.53	14.17
e) Serious medical condition/Older person at risk (ER)	7.96	5.54	6.6
f) Single parent or caregiver (SP)	11.06	10.38	10.68
g) Disability (DS)	30.53	23.53	26.6
h) Family unity (FU)	10.62	8.3	9.32
i) Specific legal and physical protection needs (LP)	5.75	1.38	3.3
j) Torture victim (TR)	1.33	1.04	1.17

N=221

Interviews with respondents revealed that 27.5 and 42.9 percent of individuals had been supported by the project in Kyaka II and Kyangwali respectively to overcome vulnerability. Responses were also categorized by gender. Results show that 37.4 percent of female and 33.2 percent of male confirmed of existence of interventions to abate vulnerability. Interventions provided to reduce vulnerability include:

- ✓ Humanitarian support that offers the basic human needs of food, shelter, healthcare, water provision, protection among others.
- ✓ Psychosocial support offered to beneficiaries most of who had gone through traumatizing experiences of war and some with suicidal tendencies. They are offered physiotherapy, counselling, and rehabilitation as needed.
- ✓ Lifesaving and protection support that included SPGV, legal protection, mental, disability inclusion and nutrition
- ✓ Community structures to strengthen mobilization, build support, and participation. Existing **OCD** structures were streamlined with communication standards and given a serving period. In places without committees, election of new committees were carried out.

It was further found out that although individuals were supported to reduce on vulnerability, some individuals had slid back to resorting to more risk behaviours. Results show that among respondents interviewed 37.4% knew that there were interventions for reducing vulnerability, 20.42% knew at least a person who had been supported to overcome vulnerability and 45.34% in Kyaka II and 42.91% in Kyangwali had heard or knew a person who resorted to engaging in risky copying mechanisms. The results are shown in Table 17.

Table 17: Individuals that resorted to risky behaviors by settlement and gender

	Settlement		Sex	
	Kyaka II	Kyangwali	Male	Female
Knowledge about the project to reduce vulnerability	27.53	42.91	33.19	37.37
Individuals supported by a project but resorted to more risk behaviour	5.67	32.46	18.58	20.42
Those who know a person who is engaging in odd jobs as a copying strategy	45.34	43.28	41.59	46.37

On the coping mechanisms, results show that there are many coping strategies that individuals have been involved in. People were asked **what things girls/women or boys/men who are vulnerable in this community do to cope with the demands/challenges/needs of themselves, children, and those under their care.** On a positive note, results show that there are many people who have adopted non-risky coping strategies. These include engaging in small business in the market (petty trade), access to savings or borrow from VSLA and others depend on social capital - network of individuals to whom a participant has good relations. Data reveals that majority of individuals in Kyaka II settlement (45%) borrow from shops while the majority of people in Kyangwali settlement (41%) engage in small businesses.

There are, however, still few reported cases that resort to risky behavior as survival coping mechanisms as indicated in Table 18 and 19.

Table 18: Perceptions on Risky Survival Coping Mechanisms by Age Group

Coping strategies for vulnerability/age group	Age of Respondent				
	11-17	18-30	31-59	60+	Total
Sale of food and NFI provided through humanitarian assistance	11.94	28.72	33.89	17.5	26.6
Engage in exploitative casual labour/domestic work	10.45	11.17	15	8.75	12.04
Engage in transactional and commercial sex (prostitution, etc.)	4.48	4.79	8.33	2.5	5.63
Early marriage	26.87	19.15	21.67	11.25	19.81
Seek out for intimate/love relationship (boyfriends)	4.48	1.6	5.56	2.5	3.5
Child labour (sending children to sell in the market or do work to earn money)	16.42	20.74	16.11	15	17.67

Table 19: Risky Coping Mechanisms/Settlement & Gender

	Settlement		Gender	
Coping strategies for vulnerability/gender and Settlement	Kyaka	Kyangwali	Male	Female
a) Engage in exploitative casual labour/domestic work	7.29	16.42	14.6	10.03
b) Engage in transactional and commercial sex (prostitution, etc.)	0	10.82	7.08	4.5
c) Early marriage	7.69	30.97	22.57	17.65
d) Theft/Stealing	4.05	30.97	21.24	15.57
e) Alcohol/Drug abuse	19.84	27.24	26.99	21.11
f) Seek out for intimate/love relationship (boyfriends)	0.81	5.97	3.98	3.11
g) Child labour (sending children to sell in the market or do work to earn money	20.65	14.93	15.49	19.38

N=515

Key areas that should remain of critical attention for humanitarian actors for intervention to combat vulnerability are early marriages, forced marriages, child labour and exploitative sex.

3.2.5 Mental Health & Psychosocial Support, Disability Inclusion

The targeted population who demonstrates improved psychosocial well-being

- Percentage of the targeted population who demonstrate improved psychosocial well-being by the end of the intervention compared to the beginning disaggregated by age, gender, refugee, and host community.

War Child Holland (WCH), Humanity and Inclusion (HI) and Transcultural Psychosocial Organization (TPO) lead the humanitarian Action on Mental Health & Psycho Social Support. It harmonized their approaches and leveraged on their experiences and core competencies that offered a collaborated and consolidated MHPSS assistance in the refugee response in Uganda through the SPOT project. This is the experience they brought from SPOT project to APEAL II. Through their targeted assistance, refugees were enabled to access quality, holistic, gender-sensitive and inclusive MHPSS services that supported positive coping-mechanisms and fostered recovery from traumatic experiences that included separation from or loss of family members, abrupt displacement, physical and sexual violence.

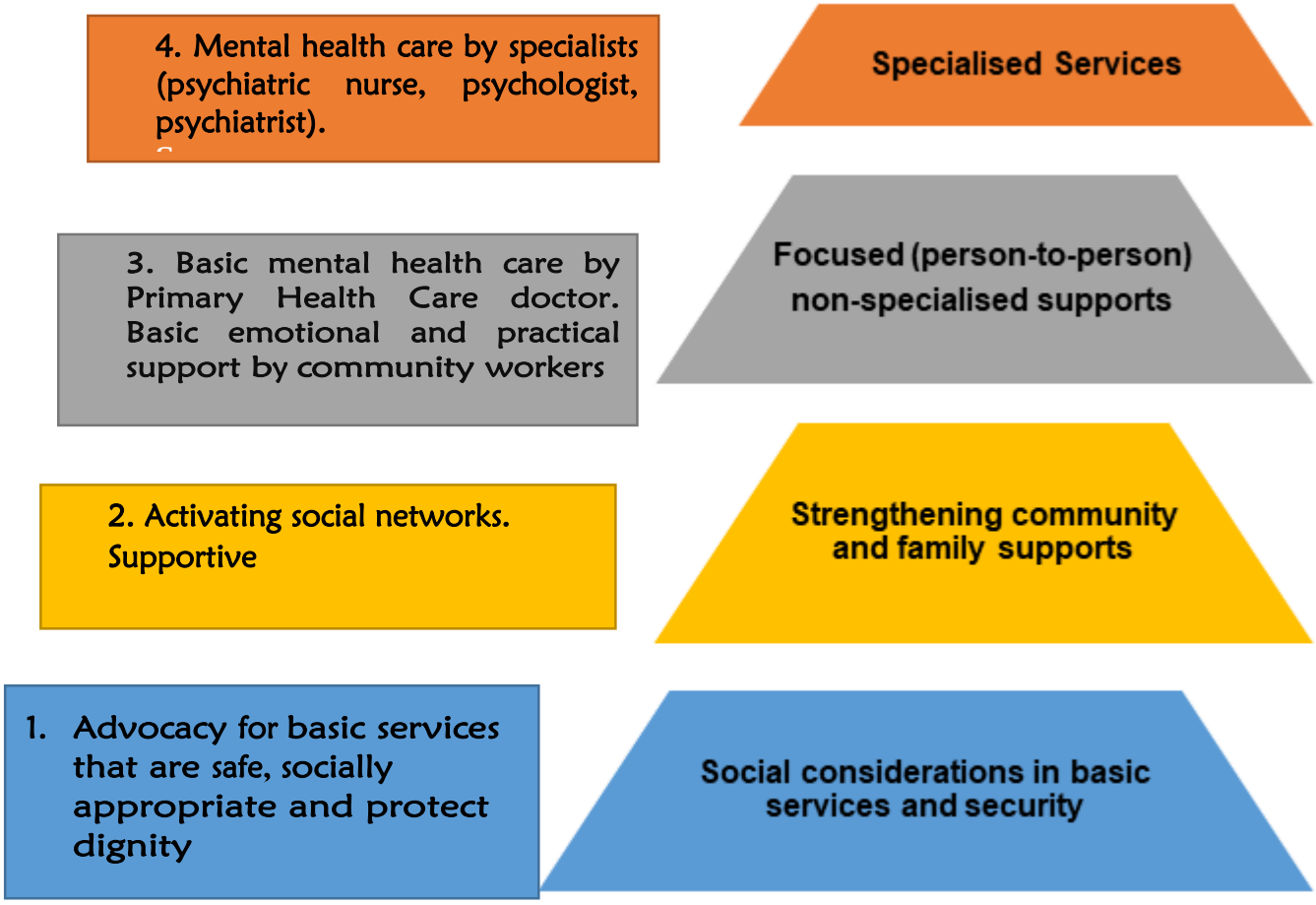
The project successfully delivered on its anticipated results of; targeted population are identified, screened and have access to quality comprehensive and specialized MHPSS services appropriate to their age, gender and disability. Equally, it helped community structures, duty bearers and stakeholders to

acquire and demonstrate the capacity to identify, support and refer persons in need of MHPSS and physical rehabilitation; and that MHPSS working group is strengthened to support harmonization, development and implementation of quality MHPSS standards adapted to Uganda humanitarian context.

3.2.6 Mental Health Pyramid of services

Mental Health and Psycho-social support services were delivered according to Mental Health and Psychosocial Support in Emergency Settings (Pyramid) guidelines (IASC). This pyramid identifies four (4) levels at which MHPSS services are delivered; Specialized services, focused (Person-to-Person Non-specialized specialized support, strengthening community and family support and Social considerations in basic services and security as shown in figure 8.

Figure 8: Mental Health and Psycho-social Support Pyramid



<u>What was done well</u>

- ✓ The project offered much needed psychosocial support for transformation on MHPSS and disability inclusion whose need was colossal among the refugees.
- ✓ MHPSS Collaborative approach; HI would offer mental health and psychosocial support needed for mild psychological distress based of health SST pyramid and individualized therapy

and those with severe distresses would be referred for treatment and services toTPO for treatment and services of psychiatric technical people (comprehensive rehabilitation services)

However as noted by a Settlement Commandant:

- The mental health and psychosocial component, he observes is not given enough funds. We do not protect the child when the mother is not okay so interventions that target children wellbeing should seriously consider mothers as well and some serious livelihood components that would improve household livelihood as a whole.
- The settlement has a huge population of over 127,000 people yet APEAL 2 only targeted 20,000 beneficiaries. This needs revision in the APEAL III
- The project coverage and targets were very small. For example, in the two sites of Kyaka and Kyangwali there were 3 psychosocial service points where the community would come to receive the services considering that Kyangwali is with 6 zones and Kyaka with 9 zones.

> *"I'm not sure whether the budget was not appropriate, because there was a huge need of people with disabilities and mental health care. This affected technical support and service provision because of a thin staff.For example, with mental health and psychosocial support we had two psychologists and four (4) psychosocial workers per settlement and those would be operating at those very fixed points so implying that even the number of beneficiaries that would be funded the services would be limited as compared to the need. Of course we would meet the target but then the target vs. the existing needs would be really small and there would be a gap*." KI Consortium Member

At household level, 15.9% of respondents interviewed (17.1 settlement, 11.4 host community) had experienced a condition that needed psycho-social support. The cases members said had suffered from are in Table 20.

Table 20: Cases of Psycho-social condition by location

Cases of Psycho-social condition survivors suffered from	1= Refugee	2=Host Community member	Total
1=Anxiety	15.71	25	17.07
2=Depression	31.43	16.67	29.27
3=Bipolar disorders	17.14	16.67	17.07
4=Psychosis	18.57	16.67	18.29
5=Developmental disorders	14.29	8.33	13.41
6=Other mental health disorders	38.57	25	36.59
7=Domestic violence	28.57	16.67	26.83

8=Rape	10	0	8.54
9=Imprisonment	11.43	0	9.76
Other	2.86	8.33	3.66
Total	**136**	**16**	**152**

The equal number (50%) of the members who suffered from these conditions sought treatment. These services were received from Community Health worker/trained counselor, General Hospital (Nurse or Doctor one-on-one), Specialist Mental Health doctor, Rehabilitation center, Referral facility and other which came to be known as traditional healers. People in settlements found Specialist mental health doctor as the most satisfying source of service compared to General hospital for host community members. Trained community counsellor was also found satisfying coming after general hospital among refugee settlements as shown in Table 21. The implication to the project is that level II (General hospital) which happens to be the most accessible needs to be strengthened in terms of care services such that it's found very satisfying.

Table 21: Level of MHPSS service provision by location

Level of MHPSS service provision people find more satisfying	Category of Respondent		
	1= Refugee	2=Host Community member	Total
1= Community Health worker/trained counsellor	17.1	0.0	14.6
2= General Hospital (Nurse or Doctor one-on- one)	28.6	66.7	34.1
3= Specialist Mental Health doctor	37.1	16.7	34.1
4= Rehabilitation center	5.7	16.7	7.3
5=referral facility	2.9	0.0	2.4
6=I dont know	2.9	0.0	2.4
8=Other personnel specify	5.7	0.0	4.9
Total	**35**	**6**	**41**

Overall 50% of the people interviewed (including those who benefited from MHPSS expressed that they had achieved a feeling of wellbeing. The disparity is in settlement vs host community where 51.4% of the refugees feel good and 41.7% of the host community. By gender, 52.9% of female feel good (wellness) and 44.8% among males.

This is a feeling of wellness across the board but still shows the majority of the population needs psychosocial services given that 50% feel are not at their wellness. A general assessment of stress levels and psycho social needs of the population may need to be conducted.

Table 22: Wellness feeling; by Location, Age group & Gender

i) By Location

I have felt cheerful and in good spirits	Category of Respondent					
	1= Refugee		2=Host Community		Total	
1= strongly agree	20.0	51.4	16.7	41.7	19.5	50
2= agree	31.4		25.0		30.5	
3=neither agree nor disagree	31.4	48.5	25.0	58.3	30.5	50
4=disagree	17.1		33.3		19.5	
Total	70		12		82	
	100		100		100	100

2. By Gender

I have felt cheerful and in good spirits	Gender/sex of Respondent					
	1. Male		2. Female		Total	
1= strongly agree	17.2	44.8	20.8	52.9	19.5	50
2= agree	27.6		32.1		30.5	
3=neither agree nor disagree	24.1	55.1	34.0	47.2	30.5	50
4=disagree	31.0		13.2		19.5	
Total	29		53		82	
	100		100		100	

3. By Age group

I have felt cheerful and in good spirits	Ages of Respondent								
	01=11=17 (%)	(%)	02=18-30	(%)	03= 31-59 (%)	(%)	04=60+ (%)	(%)	Total (%)
1= strongly agree	27.3	54.6	10.0	35.0	19.5	53.7	30.0	60	19.5
2= agree	27.3		25.0		34.2		30.0		30.5
3=neither agree nor disagree	18.2	45.5	30.0	65.0	31.7	46.3	40.0	40	30.5
4=disagree	27.3		35.0		14.6		0.0		19.5
	100		100		100		100		100
Cases	11		20		41		10		82

3.2.7 Humanitarian actors whose activities demonstrate principles of meaningful access, safety and dignity through inclusive and people-centered approach mechanism

- % of beneficiaries (disaggregated by age, gender, refugee, host community) reporting that humanitarian assistance is delivered in a safe, accessible, accountable and participatory manner (time of waiting, management of queues, respect and provision for PSNs, etc.)

Human Rights awareness among the refugees and host communities has improved. Accordingly, the most known rights are Right to food (90.2%), Right to protection (87.9%), children rights (81.3%), Women rights (77.4%) and Right to Health. Least known are Right to information (58.2%), Right to property (61.2%) and Right of work detailed response is reflected in Table 26.

Table 23: Knowledge of human rights among refugees and host communities

Knowledge of human rights	Male	Female	Total	Refugees	Host Community members	Total
1. Right to protection	202	245	447	355	92	447
Percentage	90.18	85.96	87.82	87.87	87.62	87.82
2. Right to food	195	264	459	362	97	459
Percentage	87.05	92.63	90.18	89.6	92.38	90.18
3 Right to information	137	159	296	215	81	296
Percentage	61.16	55.79	58.15	53.22	77.14	58.15
4 Right to life	168	222	390	296	94	390
Percentage	75	77.89	76.62	73.27	89.52	76.62
5. Right to ownership of property	140	173	313	227	86	313
Percentage	62.5	60.7	61.49	56.19	81.9	61.49
6. Right to health	178	235	413	317	96	413
Percentage	79.46	82.46	81.14	78.47	91.43	81.14
7. Right to work	160	197	357	271	86	357
Percentage	71.43	69.12	70.14	67.08	81.9	70.14
8. Women rights	170	224	394	299	95	394
Percentage	75.89	78.6	77.41	74.01	90.48	77.41
9. Children rights	178	236	414	321	93	414
Percentage	79.46	82.81	81.34	79.46	88.57	81.34
10. Refugee rights	172	218	390	319	71	390
Percentage	76.79	76.49	76.62	78.96	67.62	76.62
11. Right to education	175	225	400	306	94	400
Percentage	78.13	78.95	78.59	75.74	89.52	78.59
Cases	224	285	509	404	105	509

Respondents were asked if humanitarian assistance was delivered in a safe, accessible, accountable manner.Satisfaction with humanitarian assistance is reflected in Table 24.

Table 24: Satisfaction with humanitarian assistance

	Category of Respondent			Gender/sex of Respondent		
Satisfied with the Humanitarian assistance/provided	Refugee (%)	Host community (%)	Total (%)	Male (%)	Female (%)	Total (%)
Always	26.3	13.3	23.7	27.9	20.4	23.7
Most times	20.5	18.1	20	16.8	22.5	20
Some times	32.7	40	34.2	34.9	33.76	34.2
Total Positives	79.5	71.4	77.9	79.6	76.66	77.9
No	19	14.3	18.1	16.4	19.4	18.1
No answer	1.5	14.3	4.1	4	4.2	4.2
Total Negatives	20.5	28.6	22.2	20.4	23.6	22.3
Total	100	100	100	100	100	100
N=515	410	105	515	226	289	515

To ascertain levels of satisfaction with humanitarian assistance, consideration was made for; always, most times and sometimes as positive, meaning people were satisfied with the way humanitarian assistance is given. Results show that 79.5% of the refugees and 71.4% of Host community members interviewed were satisfied. By gender, male 79.6% were satisfied and female 76.7%; with overall as 77.9%.

Respondents were asked if their views are listened to by Organizations and their perceptions are shown in Table 25.

Table 25:Perceptions on whether views are listened to by Organizations

Peoples' views taken into account by the organization about the assistance given	Category of Respondent (%)			Gender/ of Respondent		
	Refugee	Host community	Total	Male	Female	Total
Always	19.5	7.6	17.1	17.7	16.61	17.09
Most times	22.4	10.5	20	19.91	20.07	20
Some times	38.5	33.3	37.5	41.15	34.6	37.48
No	15.9	26.7	18.1	14.6	20.76	18.06
No answer	3.7	21.9	7.4	6.64	7.96	7.38
Total	100	100	100	100	100	100
N=515	410	105	515	226	289	515

beneficiary views were taken regarding Humanitarian assistance as a sign of participation by gender; Results show that male 78.8% and 71.3% female, by refugee vis-à-vishost community who felt their views were taken and humanitarian Assistance is implemented in a participatory and accountable manner, refugees by 80.4% and 51.4% for host communities; with overall as 74.6%.

Regarding safety and inclusion, evaluation found that the principles were adequately upheld in implementation of humanitarian assistance.

> *"I must actually say yes, because as I told you majorly these activities were capacity building but the capacity building put aside, if you look at these other activities that were done like provision of PPEs and during the IPC mentorships, the teams from CARE International would always put a lot of emphasis on consideration on PWDs … and the safety of the children"* KI DLG.

The coverage was small in Kyagwali refugee settlement. There are too many people over 90% that were not attended/or reached by the project. This is according to one officer in the office of Camp Commandant Kyangwali. There are still very grey gaps. Most of the new refugees are in Maratatu that is where much attention was put. The old refugees were not prioritized.

On respect and dignity, evaluation couldn't have a better expression than from the RWC chairperson;

> *"Care international has trained people. Before people used to crowd a lot especially as they distributed food, police would be around to ensure people are in lines and treat*

each other with respect. These days the people themselves have understood and adopted a culture that respects all. The PSNS are given the first priority like when they are receiving their food rations. Our people have learnt and are adapting to the orderly way of doing things" KI RWC 111, Chairperson

Respondents feeling of Safety while receiving assistance is shown in Table 26.

Table 26:Feeling of Safety while receiving assistance by Age Group

Overall feeling of safety in this settle	Age Group				Age of Respondent					
	01=11=17 (%)	(%)	02=18-30 (%)	(%)	03= 31-59 (%)	(%)	04= 60+ (%)	(%)	Total (%)	
1=Very unsafe	9.0	37.4	4.8	17.0	7.2	22.9	7.5	22.5	6.6	22.5
2=Unsafe	28.4		12.2		15.7		15.0		15.9	
3=Somewhat safe	40.3	62.7	39.9	83.0	33.9	77.2	36.4	77.5	37.3	77.5
4=Safe enough	11.9		36.7		36.6		37.5		33.6	
5=Very safe	10.5		6.4		6.7		3.6		6.6	
Total	67		188		180		80		515	
	100	100	100	100	100	100	100	100	100	100

The feeling of safety is still less among the adolescents (11-17) at 62.7% compared to others who are 83%, 77.2% and 75% respectively. Subsequent efforts should do more targeting to adolescents after understanding why they still feel not as safe as the rest of the age groups.

3.2.8 Non-protection and non-SGBV specific actors targeted by APEAL incorporating protection principles

- % of non-protection and non-SGBV specific actors targeted by APEAL incorporating protection principles (actors whose capacity has been targeted for protection service in Accountability, Confidentiality, Safe accessibility, Safety and security.

PROTECTIONMAINSTREAMING (PM) is the process of incorporating protection principles and promoting meaningful access, safety, and dignity in humanitarian aid. The following elements must be ensured in all humanitarian activities.

- ✓ Prioritize safety and dignity and avoid causing harm
- ✓ Meaningful access – Ensure people access assistance and services in proportion to need and with ought barriers
- ✓ Accountability: Set-up appropriate mechanisms through which affected populations can measure the adequacy of interventions, and address concerns and complaints.

- ✓ Participation and empowerment: Support the development of self-protection capacities and assist people to claim their rights

PM encompasses several cross-cutting issues in humanitarian response, such as age, gender and diversity, child protection, disability inclusion, gender-based violence, HIV/AIDS and mental health and psycho-social support. DG ECHO's approach to protection mainstreaming ensures that the specific mainstreaming requests are streamlined into one process (*DG ECHO Protection Mainstreaming tool Feb 2021)*

The background to Protection mainstreaming is that there are many actors in Humanitarian response whose basic service background in service delivery but with no background to protection principles.

CARE as lead, designed a capacity building intervention targeting institutional actors (agencies delivering assistance in NFI, Food, WASH, Health, Livelihoods, Education, Shelter and Infrastructure, Environment, Cash), APEAL staff, partner Organisations, community leaders, sectoral working groups, Local Councils and RWC representatives. Ten (10) Organisations (i.e. non-protection actors) were reached with capacity building trainings on protection mainstreaming and Gender in Emergencies (GiE). Participants in the aforementioned trainings were from MTI, Hunger Fighter Uganda, AAR Japan, CDRN, Interviews, Oxfam, UWESO, AIRD, CIDI, Alright and Windle Trust international. A total of 75 staff members from targeted institutions and groups were trained. As such these Organisations are conscious of protection principles as they implement their programmes a change occasioned by the training and other mainstreaming activities undertaken by the Project.

The APEAL II endline assessment only succeeded in collecting information from four (4) out of the Ten (10) targeted organizations (non-protection and non-SGBV actors) to mainstream protection in their refugee response plans/strategies. The Evaluation put frantic efforts to reach all the 11 but only after intervention of consortium management covered four actors, who had running refugee response programmes/projects in Kyaka II and Kyangwali settlements.

Protection Mainstreaming Training: All the four actors reported that they had staff who had ever received training on protection mainstreaming. The sampled actors reported an average of eight staff (Minimum=2 and Maximum=29) who had attended training as shown in Table 27.

Table 27: Training of Non-protection and non-SGBV specific Actors

				Rating		
	Number of Staff trained	APEAL I (Baseline) %	Endline	High	Medium	Low
Gender in Emergency (GiE)	50	70	33.3	25%	50%	25%
Protection from Sexual Exploitation and Abuse (PSEA)	50	85.7	100	75%	0%	25%
Women Lead in Emergency (WLiE)	21	42.9	50	0%	25%	50%
Feedback, Reporting and Referral Mechanism (FRRM)	50	57.1	100	50%	25%	25%
Analysis of protection risks	25	28.6	75	0%	25%	75%
Child Protection mainstreaming in Refugee Response Programming	25	42.9	75	0%	50%	50%
SGBV mainstreaming in Refugee Response Programming	50	57.1	100	25%	25%	50%

Protection Mainstreaming Actors rated their organization's refugee response plan on a five-point protection mainstreaming scale with 1 being very large and 5 being very low, and the findings are as presented in Table 28

Table 28: Protection Mainstreaming Rating Scale

	Very large	Large	Moderate	Low/ Limited	Very Low/ None
Our organization has adequate number of trained staff who demonstrate knowledge and understanding of protection mainstreaming in Refugee Response Programs	0%	50%	50%	0%	0%
Our organization has a functioning complaint and feedback mechanism accessible to all groups of workers in a confidential manner	0%	75%	25%	0%	0%
Our organization has a written protection policies/guidelines/ code of conduct (in areas of safety and dignity of beneficiaries, SGBV, child abuse) followed by all staff	25%	75%	0%	0%	0%
Our refuge response programme decisions are based on the participation of all targeted groups	50%	50%	0%	0%	0%
Our Refugee Response Programs activities/actions include to promote safety and dignity of the beneficiaries?	75%	25%	0%	0%	0%
Our Refugee Response Programs includes actions for Gender Based Violence protection of the beneficiaries	75%	25%	0%	0%	0%
Our Refugee Response Programs includes actions for Children abuse protection among the beneficiaries	50%	50%	0%	0%	0%
Our Refugee Response Programs include analysis of protection risks in context analysis	50%	50%	0%	0%	0%
Our Refugee Response Programs reflect the rights, needs and capacities of vulnerable groups in all stages of agency response	50%	50%	0%	0%	0%
Our Refugee Response Program provide humanitarian assistance and services equitably and impartially based on needs assessment and vulnerability	75%	25%	0%	0%	0%

Training for Non-protection and non-SGBV specific Actors on protection mainstreaming yielded results as reflected below:

> *"we are so much in SGBV prevention, care and support and we work with community structures; but initially our beneficiary involvement was more for sustainability not participation as a principle. After the training in protection mainstreaming, we are quite conscious of safety, dignity and participation as humanitarian principles." Beneficiary of Protections mainstreaming training*". Protection Mainstreaming Participant

3.2.9 Performance on Menstrual Health Management (MHM)

Menstrual health management project component was largely implemented by WOMENA, Save the Children, TPO and IRC., The project supported girls and women to improve access to Menstrual hygiene services including information on menstrual health hygiene and providing access to menstrual materials such as re-usable pads, menstrual cups, clean cloth and pads among others. Due to consortium interventions, such as Girl Shine, girls now are confident, have self-esteem and participate more in community activities. As part of interventions, women and girls have been educated and trained on their rights which has raised their confidence and self-esteem. "*Yes, there is increasing respect of the role of women and girls among family members and even in the community "KI RWC*

> "The perception and knowledge about menstruation has greatly changed because we no longer see it as a burden but a change that has to happen to every woman. The Girls and women now feel more secure and safe than before..." Beneficiary of MHH in Kaborogota, Kyaka II Settlement.

Regarding the level of information about menstrual health, 73% of respondents had information about menstrual health and Kyaka II had the highest percentage of knowledge compared to Kyangwali with 58 percent as shown in Table 29.

Table 29: Information about Menstrual Health

	KYAKA II	KYANGWALI	TOTAL
YES	83.72	58.33	72.89
NO	16.28	41.67	27.11

About the sources of information about menstrual health, results revealed that mothers at 72% in Kyaka and 77% in Kyangwali contribute majorly on this information. Mothers should therefore be

targeted for capacity building in supporting girl child in building knowledge and capacity confidence in menstrual management. Sources of information about Menstrual Health are shown in Table 30.

Table 30: Sources of Information about Menstrual Health

	KYAKA	KYANGWA	TOTAL
MOTHER	72.22	76.79	73.78
SISTER	16.67	33.93	22.56
FATHER	0	7.14	2.44
OTHER FAMILY RELATIVES/FAMILY MEMBERS	12.04	25	16.46
FRIEND	9.26	32.14	17.07
HUSBAND/BOYFRIEND	0	5.36	1.83
COMMUNITY HEALTH WORKER/CLINIC	38.89	12.5	29.88
NGO (SPECIFY)	16.67	8.93	14.02
MEDIA	0	7.14	2.44
DONT KNOW	2.78	0	1.83
OTHERS (SPECIFY)	2.78	3.57	3.05

On the materials used during menstruation period, reusable factory-made pads were the most used for Kyaka respondents while in Kyangwali most respondents reported use of disposable pads. Table 31 shows summary of different materials used while in menstruation period while Table 32 shows what has been learnt about menstrual health management.

Table 31: Materials used in Menstruation Periods

Materials used	*Kyaka*	*Kyangwari*	*Total*
Disposable pads (always)	44.96	47.92	46.22
Reusable factory made pads (AFRIpads, so sure, etc.)	51.16	20.83	38.22
Self-made reusable pads	0.78	16.67	7.56
Clothes/rags/fabric	7.75	26.04	15.56
Extra pair of knickers	0.78	9.38	4.44
Natural materials (grass, leaves, etc.)	0	10.42	4.44
Toilet paper	0	2.08	0.89
Cotton wool and gauze	4.65	6.25	5.33
Menstrual cup	0	5.21	2.22
Tampons	0	1.04	0.44
Nothing	0	1.04	0.44
Others (please specify)	0.78	2.08	1.33

Table 32:What has been learnt about menstrual health management

What has been learnt about menstrual management in the last 12 months	Gender/sex of Respondent		
	1. Male	2. Female	Total
00= Nothing	38	23	23
01=Right menstrual materials to use	25	11	11
02=Where to find the menstrual materials	13	4	4
03=Personal hygiene	25	57	56
04=How to use the menstrual materials	0	6	6
88=Others	0	0	0
Total	8	217	225
	100	100	100

According to respondents interviewed key learnings from the menstrual health and management interventions were *Right menstrual materials to use* (25%), *Personal hygiene (25%) and where to find menstrual materials when the need them (13%).*

The major challenges faced during menstrual periods are Menstrual management materials because there are still found too expensive (16.4%) and not affordable to many yet the materials given by NGOs are not enough. Many young women face menstrual pain (25.9%. Another concern is that 16.9% do not have soap for hygiene during menstrual days, which could lead to other hygiene related infections. The positive however is that 40.4% of the respondents indicated that they have no major challenges with menstrual management. Table 33 below summarizes all the challenges faced by females during their menstrual period.

Table 33:Challenges faced during Menstrual Health Management

	Kyaka	Kyangwali	Total
I don't have any challenges	52.71	23.96	40.44
Menstrual management materials are not available on the shops	6.98	23.96	14.22
menstrual management materials are too expensive to buy	8.53	27.08	16.44
menstrual management materials given at general distribution or by NGOs are not enough	14.73	19.79	16.89
Don't have enough pieces of underwear	9.3	23.96	15.56

	Kyaka	Kyangwali	Total
Don't have enough water to clean myself or menstrual management materials	0.78	19.79	8.89
Don't have enough soap to clean myself or menstrual management materials	10.85	25	16.89
Don't have privacy to change my menstrual management materials	0.78	14.58	6.67
Some Activities are restricted for cultural/ religious reasons	0	14.58	6.22
Worried people will find out am on my periods	0.78	13.54	6.22
I feel embarrassed	1.55	13.54	6.67
I feel embarrassed to buy or ask for menstrual management materials	0	5.21	2.22
I feel menstrual pain	21.71	31.25	25.78
I give/share the menstrual management materials I receive with my daughter/o	0.78	6.25	3.11
Others (please specify)	1.55	6.25	3.56

3.2.10 Youth/Village savings & Loans Associations (Y/VSLA

Livelihood activities targeting women and youth under this project, were mainly supported by and KRC. KRC had already established 100 groups under HIP 2019, with 3,500 individuals enrolled in these groups. With support from CARE, KRC under this project focused on strengthening the groups with a stronger protection lens, supporting their sustainability, and focusing on generating first-hand learning on youth and adult savings groups in the Ugandan humanitarian context. The objective of a humanitarian VSLA platform for refugees is to support self-help, quickly rebuild social capital and a support network. VSLAs support dignity and empowerment of refugee and displaced populations as the act of saving means investing in the future. They contribute to reducing high-risk behaviours used in order to access cash when needed during emergencies, e.g. during sickness, death, or other shocks. In addition to being a savings and loans platform, VSLAs are a safe place where members are able to share their stories, experiences and receive emotional and some level of psychosocial support and counselling to support healing from traumatic experiences ***(IRC Dec 2020)***

CARE and KRC reviewed the YSLA manual and incorporated entrepreneurship, life skills, visioning and protection modules. 110 adolescent girls and young women were trained on the new concepts. Another 1735 (998 F; 737 M) members of VSLA were trained on financial literacy. 181 Y/SLA vulnerable beneficiaries were referred to the Multipurpose Cash Transfer Consortium for cash assistance. Other referrals were sent to Medical Teams International for medical support, HI for disability support, WCH for psychosocial support, IRCfor legal support, andNsamizi for livelihood support

Among the sample of 515 respondents interviewed 104 representing 20% (49 males, 55 females) were participating in VLSA groups 47 from Kyaka II and 57 from Kyangwali. Table 34 shows participation in VSLAs by Gender and Settlement.

Table 34: Participation in VSLAs by Gender and settlement

Members participating in VSLAs by Gender	Gender/sex of Respondent		
	1. Male	2. Female	Total
1. Yes	49	55	104
	21.7	19.0	20.2
2. No	177	234	411
	78.3	81.0	79.8
Total	226	289	515
	100	100	100

Members participating in VSLA by Settlement	Settlement		
	1=Kyaka II	2=Kyangwali	Total
1. Yes	47	57	104
	19.0	21.3	20.2
2. No	200	211	411
	81.0	78.7	79.8
Total	247	268	515
	100	100	100

The participation of people in VSLAs came with benefits and members have as a result been able to find solutions to some of their livelihood related challenges. 60.6% said they are to meet their basic needs, 42.3% had bought domestic animals through the groups, 39.4% started small business and meeting medical bills (35.6%) as shown in Table 36. Figure 9 shows participation in income generating activities.

Table 35:Ways people have benefitted from VSLAs

Ways People have benefited from belonging to this VSLA groups	Male	Female	Total
1. Buying basic needs of HH like food, clothes	63.3	58.2	60.6
2. Paying /buying scholastic for my school going children	24.5	16.4	20.2
3. Meeting medical bills	32.7	38.2	35.6
4. Bought and is rearing animals	53.1	32.7	42.3
5. Started business	42.9	36.4	39.4
6. Other	6.1	7.3	6.7
	222.45	189.09	204.81
Cases	49	55	104

Figure 9: Participation in Income Generating Activities

Young women exhibiting materials made through the Children livelihood program during International Women's day; (Source Jan – March 2021 Quarter Report)

3.2.11 Child protection

Information was sought about knowledge of children rights in the settlements. Results show that 82percent of males and 79 percent of females were aware of the children rights existing. This information was not significantly different as desegregated by settlements. Furthermore, respondents were asked the different rights of children that exist and results show that right to education scored the highest. Results of knowledge of rights and different rights are summarized in Tables 37 and 38

Table 36: Knowledge of child rights

Knowledge of child rights	Gender		Settlement	
	Male	Female	Kyaka II	Kyangwali
Yes	81.86	79.24	86.64	74.63
No	18.14	20.76	13.36	25.37

Source: Primary data

Table 37:Types of children rights that exist

Types of children rights that exist	Male	Female	Kyaka	Kyangwali
Right to Basic needs(clothing & shelter)	75.14	71.18	75.7	70
Right to education	97.3	93.89	96.26	94.5
Right to food	95.14	96.07	96.26	95
Right to Health Care	74.59	73.8	68.22	80.5
Right to safe play	57.84	51.97	33.64	77
Right to participate	36.22	32.75	5.14	65.5
Right to be fairly treated	29.19	24.02	9.35	44.5
Right to be registered at birth	23.24	23.58	7.01	41

Source: Primary data

Respondents were asked about their perception to whether children rights are observed and 73 percent of male and 75 percent of their female counterparts confirm the existence of children rights. The results are not significantly different with settlements. Table 39 shows perception whether children rights are observed.

Table 38:Perception whether children rights are observed

	Gender		Settlement	
Perception whether children rights are observed	Male	Female	Kyaka	Kyangwali
Yes	72.57	75.09	83.4	65.3
No	27.43	24.91	16.6	34.7

Source: Primary data

Decision making is key in any operations of the family. In this regard, information was sought whether children ideas were also incorporated in decision making of homes. Results show that 72 percent of male agree which is not much different with female respondents that is 77 percent. By settlements also results show that 90 percent and 60 percent in Kyaka and Kyangwali respectively agree. Table 40 shows the results.

Table 39:whether children ideas were also incorporated in decision making of homes

	Gender		Settlement	
Children ideas to be considered while making family decisions	Male	Female	Kyaka	Kyangwali
I dont agree	7.52	8.65	3.64	12.31
somehow disagree	19.47	13.49	5.67	25.75
Somewhat agree	40.27	50.52	62.75	30.6
Mostly agree	31.86	26.3	27.94	29.48
No response	0.88	1.04	0	1.87

Source: Primary data

Since the right to education scored highly among other children rights, respondents were asked whether children are safe in school. Results show that 87 and 84 percent of male and female respectively agree that children are safe in school. The results don't differ much when desegregated by settlements. Table 41 shows the summary of the results.

Table 40:Whether children are safe in school

	Gender		Settlement	
Safety of children in school	Male	Female	Kyaka	Kyangwali
Not at all	12.83	15.22	0.81	26.49
Not very much	29.65	23.18	1.62	48.51
Somewhat yes	21.24	24.22	26.32	19.78
Yes completely	36.28	37.37	71.26	5.22

Source: Primary data

Harmful practices against children inform where synergies should be pressed for children to enjoy their rights. Information was sought about the prevailing harmful practices in the society and results show that Early marriages is the highest in both male and females and also Kyangwali settlement. Kyaka results show that child neglect was the highest. The summary is presented in Table 42 while Figure 10 shows children in action at a home based child Friendly space.

Table 41:Harmful practices against children

	Gender		Settlement	
Harmful practices against children in community	Male	Female	Kyaka	Kyangwali
None	21.68	17.65	0	0
\Early/child marriages	53.1	46.71	52.1	67.74
Child trafficking	23.89	22.15	32.93	25.4
Child labor	40.71	44.29	58.68	49.19
child neglect	47.35	46.02	63.47	54.03
early/child pregnancy	37.17	32.18	32.93	49.19
gender discrimination	18.14	18.34	5.39	34.27
Child sexual abuse (defilement and rape)	14.16	16.26	1.8	30.65
Forced marriage	17.26	15.22	5.99	29.44
Others, Specify	0	0.35	0	0.4

Source: Primary data

Figure 10: Children in Action at a Home Based Child Friendly Space

Photo Courtesy: APEAL Visibility Photos

3.2.12 Nutrition

Malnutrition in children and disengagement of mothers has an impact on a young child's development, with severe health and psychological complications. As such, APEAL II prioritized Nutrition as a key intervention area. The project conducted several trainings in promoting nutrition and good health.

Settlements receive trainings from different stakeholders where CARE International is among. Results show that indeed trainings have been rendered to the people in settlements and host communities as shown in Table 43.

Table 42:Training on proper feeding of children or balanced diet

	Gender	Settlement	
Trained on proper feeding of children or balanced diet.	Female	Kyaka II	Kyangwali
Yes	95.45	96.67	83.33
No	4.55	3.33	16.67

Source: Primary data

The survey inquired on who provides the trainings. Results show that SCIhas been the leader in providing services about nutrition with 62 percent female beneficiaries and 66 percent in Kyaka. Kyangwali results show that Kyangwali received less of the trainings as compared to Kyaka at 20 percent. The results are summarized in the Table 44.

Table 43:Trainings on Nutrition

	Gender	Settlement	
How did you receive information about proper feeding of children or balanced diet	Female	Kyaka	Kyangwali
Through a mass sensitization in the settlement	11.11	10.34	20
Health and Nutrition outreach by SCI/APEAL project	61.9	65.52	20
Community trainings by VHTs, Volunteers, Peer-peer educators, etc.	17.46	17.24	20
Counseling/training sessions at MBA	3.17	0	40
Food cooking/preparation demonstrations	1.59	1.72	0
Others (please specify)	4.76	5.17	0

Source: Primary data

It would be piecemeal to mention nutrition without mentioning what specific foods the project beneficiaries feed the children in both refugee camps and host communities. On the foods used, results show 56 percent of households feed their children on foods made from grains, roots, and tubers, including porridge and fortified baby. This is followed legumes and nuts and the least consumed foods are dairy foods at 29 percent as reflected in Table 45.

Table 44: Specific foods the project beneficiaries feed the children

Dairy Products	*29.41*
foods made from grains, roots, and tubers, including porridge, fortified baby	55.88
legumes and nuts	52.94
vitamin A-rich fruits and vegetables like Ripe mangoes, papayas	50
Any other fruits or vegetables?	50
Flesh meats and offals: Any meat, such as beef, pork, lamb, goat, chicken, du	26.47
Eggs	26.47
foods made with oil, fat, butter	50

Source: Primary data

3.3 LESSONS LEARNED

Humanitarian assistance is most effective if done in a consortium approach, as the varied protection needs cannot be effectively addressed by a single agency. The competency synergies and specialization that individual consortium members bring on the table are critical when handling issues of humanitarian assistance.

Modified approaches in delivering the project provided a quick fix for implementing the project in a COVID-19 context. There is need to consider adapting approaches in other Project models implemented by CARE and consortium members in respective interventions. Deeper involvement of community structures, ToTs and use of online technology are some of the innovations that are found effective.

Adherence to COVID-19 prevention guidelines by the community was slow. The community understanding of COVID disease remains shrouded with myths and misconceptions. There is need for continued efforts to promote awareness about the disease especially as vaccine roll out to all adults is forthcoming.

The merger between APEAL and SPOT consortia made it easier to implement the basic needs approach (BNA). The merger made it easier to refer beneficiaries, follow up, and close cases. This helped to eliminate many layers and cross-organizational actions in the referral process.

Delivery in partnership with refugee community participation enhances coverage, access, and integration. Use of trained refugee court interpreters greatly enhances access to justice for refugees since they can follow proceeding in a language they understand. The community-based paralegals contributed to timely and quick disposal of civil cases of minor nature.

Having a fixed point in the community where the comprehensive specialized services like rehabilitation on specific and known days increases uptake of services with improved access. This was the case with the success witnessed in providing rehabilitation services to People with Disabilities (PWDS).

Meeting the immediate needs of EVI is not an end in itself. For example, PWDs after receiving comprehensive rehabilitation services need sources of livelihood. If such are not addressed, this can make them relapse – especially those that had serious psychological challenges. This should be an area of focus in future disability inclusion and other vulnerabilities like SGB programming.

3.4 CONCLUSIONS

Evidence has been adduced by this evaluation that APPEAL II Project strengthened Access to Protection- and MHPSS- specific and sensitive multi-sectoral life-saving assistance for newly arrived refugees from DRC as well as their host communities, supported by more Empowered, Accountable, and inclusive Leadership structures at all levels.

Through implementation of various activities, the project managed to score 80.6% of the targeted population reporting an improved feeling of safety and dignity by the end of the intervention compared to 75.8% registered at the Baseline at the beginning. This translates into a 4.8% increase.

There is still worry that once the boarders open after the COVID 19 there is going to be an overwhelming influx of persons seeking refuge in Uganda as the conflicts in DRC continues. This should keep the humanitarian actors and government on alert – as more resources will be needed to support the refugees. The next phase of interventions need to build on other programs like Emergency preparedness planning by the district to include all actors in humanitarian assistance

The Project targeted extremely vulnerable individuals (EVIs) or other persons at risk in the refugee population who have multiple vulnerabilities, complex issues or concerns that require case management to enable a response to their needs and access to services. The project managed to bring down such forms of vulnerability from 64.70% registered at Baseline to 13.4%; a 51.3% reduction, which was a remarkable achievement. The challenge remains in areas of early marriages, transactional sex and sale of humanitarian assistance items as coping mechanisms.

Due to COVID 19, effects there are a number of idle young people who are slipping back into vulnerability. Schools as protection and safe spaces are closed due to COVID 19 therefore, shutting down opportunities where young persons would find safety and also be productively engaged. There are currently few or limited livelihood activities to engage them.

Evidence from key respondents indicate that Livelihood activities and Youth Village and Savings Associations be given prominence in future interventions as they directly address poverty which is the main cause of vulnerability and SGBVs.

There was occasional conflict between organizational core roles and Consortium activities during implementation which sometimes delayed implementation. The staffs engaged by the consortium had other individual organizational roles; they were employed for in their mother organizations. Consortium advisors had other roles to attend to and multitasking caused some delays to the consortium activities.

The size of the Consortium is good in the respect of creating integration of the project and coherence. However, it has issues of efficiency especially in terms of time. There is need to split the consortium into two sub themes for task operations, between those in mainstream protection and those in Mental Health and psychosocial support with implementation coordination managed at top level.

3.5 RECOMMENDATIONS

General

There is evidence that refugees are still coming in through porous borders and there is likelihood of increased refugee influx arriving in the Country after opening of boarders. There are still protection challenges faced by the existing refugees in the country. It is therefore recommended that APEAL or related interventions continue to be provided in Kyaka II and Kyangwali refugee settlements.

Specific recommendations

Implementation modality: The Project enhanced multi-sectoral responses by providing targeted lifesaving protection, mental health, psychosocial support and inclusive services to Congolese refugees and vulnerable host communities in Kyangwali and Kyaka II settlements with each agency bringing on board their specialized skills and competencies. It is therefore recommended that a similar approach be adopted in funding where possible to enhance effectiveness of programme interventions. This could however be by sub themes

The next phase of interventions need to build on other programmes like District Emergency preparedness planning to include all actors in humanitarian assistance as contingence for continued unanticipated disasters.

Further Strengthening of Community structures: is required for better community mobilization and sensitization, adherence to policies, laws and standards.

SGBV and community structures: Whereas the response to SGBV has been good and yielding results, there is still a gap in capacity of community structures on the SGBV referral system especially in emphasising the importance of timely reporting. Delay in timely reporting of cases was found a hindrance to handling of cases to logical conclusion.

Dignity - The next phase of the project may have to consider support in household shelter especially for PSNs and customer care and protection training to health service providers to improve feeling of dignity. Poor shelter at household and attitude of service providers especially health are rated top causes for feeling of undignified. Secondary, the concentration of interventions and services by humanitarian actors into refugee settlements is perceived by host community members as "not caring and dignifying" Subsequent interventions (APEAL III) need to increase ratio coverage to host communities

Vulnerability- Three key areas remain not performing well and so should attract attention of humanitarian actors for intervention to fight vulnerability in the next phase of the project or at other earlier opportunity. The challenge remains in areas of early marriages, transactional sex and sale of humanitarian assistance items as coping mechanisms.

Safety: The feeling of safety is still less among the adolescents (11-17) compared to others like youth and adults. Subsequent efforts in similar or related project should do more targeting to adolescents with further analysis of why they still feel not as safe as the rest of the age groups. The need is more imminent in Kyangwali

Menstrual Health information & services: Mothers constitute the highest and trusted sources of information about menstrual health across the board; they should therefore be more targeted for capacity building for effective support of girl child in building knowledge and capacity confidence in menstrual management among the young women.

COVID 19: Whereas there is sufficient knowledge on COVID-19 contraction and prevention, the community understanding of COVID disease remains shrouded with myths and misconceptions. There

is need for continued efforts to promote awareness about the disease especially as vaccine roll out to all adults is forthcoming.

Comprehensive support to EVI: Meeting the immediate needs of EVI is not an end in itself. EVIs supported with immediate rehabilitation, counseling, treatment should be followed by livelihood interventions or else they slip back in relapse. This should be an area of focus in future disability inclusion and other vulnerabilities.

Support to Livelihood engagements: The participation of people in VSLAs brings sustainable benefits as beneficiaries are able to find solutions to some of their livelihood related challenges. There is need to upscale livelihood interventions in new programme designs.

Annexes

Annex 1

Annex I. Case Narrative.docx

Annex II

Annex II. Case II COVID.docx

Annex III

Annex III output perfomance table.d

Annex IV

Annex IV HH Tool.docx

Annex V

Annex V Protection mainstreaming tool.

Annex VI

Appendix VI Qualitative interview

Annex VI

TOR_APEAL 2020 Endline Evaluation.c