

# SQUEAC REPORT

## MORNEI & RONGATAZ, DARFUR: SUDAN

Lovely Amin, October 2012



COVERAGE MONITORING NETWORK



Humanitarian Aid  
and Civil Protection



# ACKNOWLEDGEMENTS

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I would like to thank the Khartoum team of Concern Worldwide for the support provided throughout the mission as well as the Concern Geneina and Concern Mornei team for their warm welcome and active participation.

I would also like to convey a special thanks to Lubaba Hussen, Halla Elhifni Ahmed and Mustafa Abdalla for assisting me during the SQUEAC capacity building training and the survey. I am grateful to all participants of the SQUEAC training, the survey that includes the MoH and Concern staff for their active participations and the late night work throughout the entire exercise. My gratitude also goes out to the various members of the community: mothers of children with acute malnutrition, Community Volunteers (CVs), Sheiks, Traditional Birth Attendants (TBAs) and Traditional healers as well as the health staff of the visited health centres.

The photo on the cover page was taken from the Mornei camp while conducting KII with Sheik Azen Adam Hussien. The child in the photo is one of his 12 children. Sheik Azen was proud that none of his children needed to be admitted to the CMAM programme. He gave us permission to take the photo of his child and to use it for the report, if needed. We also received permission from those whose photographs were taken during the assessment for use in this report.

# EXECUTIVE SUMMARY

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Community based Managements of Acute Malnutrition (CMAM) was adopted in Sudan as a National protocol to treat SAM cases in 2010. Since then the CMAM approach has been implemented in 9 different states out of 17 in Sudan, to treat children with acute malnutrition.

The programme identified a few barriers that may have hindering effects on the programme coverage. For example, no analysis was done as to why there were high caseloads in inpatient care (18%). Also poor record keeping on the support that CV's receive and support they require can have an effect on the programme coverage, early case findings and referrals.

Data from 'wide area survey' estimated the point coverage in 59% (Credible Interval 49.1% - 68.1). The SQUEAC exercise was permitted to identify barriers to access services to the CMAM programme. To address those barriers and to understand the dynamism of the barriers the programme team may need to explore further on key elements that become barriers. For example, it was not very clear during the assessment how active are the Community Volunteers on case findings. In coming months, the CWW and MoH team need undertake some action to determine if the number of CVs is adequate and active.

The team needs explore further the 'barriers' that was identified in order to take measures on how to remove or minimize them. During the 'weighting' exercise, of positive and negative elements it was apparent that the importance of each 'barrier' and 'booster' varied among the teams weighting exercise. This can be explained by the different perception about the 'barriers' within the nutrition team in Geneina. Also further discussions with specific key stakeholders (mother of SAM cases) could clarify their perception and knowledge of the programme and the "gravity" of certain negative elements that came from the 'wide area survey'.

# CONTENTS

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<b>EXECUTIVE SUMMARY</b> -----	<b>2</b>
<b>ABBREVIATIONS</b> -----	<b>7</b>
<b>1. INTRODUCTION</b> -----	<b>8</b>
1.1 CONTEXT OF WEST DARFUR-----	8
1.2 LIMITATION-----	10
<b>2. PURPOSE</b> -----	<b>11</b>
2.1 SPECIFIC OBJECTIVES-----	11
2.2 EXPECTED OUTPUTS-----	11
2.3 DURATION OF THE ASSESSMENT-----	11
2.4 PARTICIPANTS-----	11
<b>3. METHODOLOGY</b> -----	<b>12</b>
3.1 STAGE 1-----	12
3.2 STAGE 2-----	15
3.3 STAGE 3-----	16
<b>4. RESULTS</b> -----	<b>18</b>
4.1 STAGE 1-----	18
4.1.1 PROGRAMME ROUTINE DATA ANALYSIS-----	18
4.1.2 QUALITATIVE DATA COLLECTION AND FINDINGS-----	26
4.2 STAGE 2 SMALL AREA SURVEY-----	29
4.2.1 FINDINGS OF SMALL AREA SURVEYS-----	30
4.3 STAGE 3 WIDE AREA SURVEY-----	30
4.3.1 FINDINGS OF WIDE AREA SURVEY-----	31
4.3.2 COVERAGE ESTIMATION-----	32
4.3.3 PROGRAMME EFFECTIVENESS-----	34
4.3.4 THE BARRIERS AFFECTING THE COVERAGE-----	34
<b>5. DISCUSSION</b> -----	<b>36</b>
5.1 PROGRAMME ROUTINE DATA-----	36
<b>6. CONCLUSION</b> -----	<b>38</b>
<b>7. RECOMMENDATIONS</b> -----	<b>39</b>
7.1 SPECIFIC RECOMMENDATIONS-----	39
7.2 ACTION PLAN-----	41
<b>ANNEXES</b> -----	<b>42</b>
ANNEX 1: SCHEDULE OF SQUEAC TRAINING AND ASSESSMENT	
ANNEX 2: LIST OF PARTICIPANTS	
ANNEX 3: X-MIND	
ANNEX 4: SQUEAC SURVEY QUESTIONNAIRES	
ANNEX 5: MORNEI TOWN & CAMP MAP	
ANNEX 6: SQUEAC QUESTIONNAIRES FOR CONTEXTUAL DATA COLLECTION	

# Abbreviations

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CVs	Community based Volunteers
CI	Credible Interval
CMAM	Community Management of Acute Malnutrition
CMN	Coverage Monitoring Network
FGD	Focus Group Discussion
GAM	Global Acute Malnutrition
HAC	Humanitarian Aid Commission
IDP	Internally Displaced people
IGA	Income Generating Activities
KII	Key Informant Interviews
LoS	Length of Stay
MAM	Moderate Acute Malnutrition
MOH	Ministry Of Health
MUAC	Mid Upper Arm Circumference
OTP	Outpatient Therapeutic Programme
RUTF	Ready to Use Therapeutic Food
SAM	Severe Acute Malnutrition
SC	Stabilisation Centre
SSI	Semi Structure Interview
SQUEAC	Semi Quantitative Evaluation of Access and Coverage
TBA	Traditional Birth Attendants
UNICEF	United Nations Children's Fund
WFP	World Food Program
WHO	World Health Organisation

# 1. INTRODUCTION

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## 1.1 CONTEXT OF WEST DARFUR

Darfur is one of the 17 states in Sudan and West Darfur is one of the five comprising the Darfur region. The state covers an area of 79,460 km<sup>2</sup> with an estimated population of approximately 1,007,000 (2006).<sup>1</sup> It borders with North and South Darfur to the east, while the west and the north borders with the Chadian prefectures. West Darfur has been the site of much of the ongoing Darfur conflict.

Concern Worldwide, Sudan has been implementing a nutrition programme in Geneina, Mornei, Umshalaya, Selea and Kulbus, areas of West Darfur State since August 2004 in response to the conflict in the region. The programme currently addresses malnutrition along with other needs namely food security through the Community Management of Acute Malnutrition (CMAM). The CMAM programmes intervene with nutritional activities for children (6-59 months) who are acutely malnourished both in moderate and severe forms and pregnant and lactating women. The programme provides targeted supplementary feeding for moderately malnourished children under five, pregnant and lactating women. An Outpatient Therapeutic Programme (OTP) for severely malnourished children without medical complication. The programme also supports MoH to run inpatient care for severely malnourished children with medical complications. It also raises awareness on malnutrition and its treatment through community outreach activities.

The Coverage assessment conducted in Morne & Rongataz which is one of Concern's programme areas. The area is spread across Krenick and Azoom localities; with its population living predominantly in and around three peri-urban centres namely Mornei, Rongataz and Umshalaya. A combined estimated population of these three areas are approximately 156,000<sup>2</sup>.

In Mornei and Rongataz, the displaced households who migrated in the area during the conflict are now recouped sufficient livelihood assets to engage in diverse livelihoods strategies. However, Concern's Contextual Analysis recognised that continued vulnerability and inequalities experiencing by some particular segments of the community/ population, which are mainly women and children under five years of age.

A number of nutritional surveys have been conducted in Mornei & Rongataz IDP camp since 2004 to monitor the nutritional status of children age between 6-59 months (see graph 1). The most recent one was carried out in July 2012 by Concern worldwide together with SMoH and Humanitarian Aid Commission (HAC). The survey indicated in Mornei and Rongataz IDP camp the prevalence of Severe Acute Malnutrition (SAM) was 2.5% (C.I. 1.5- 4.4) and Global Acute Malnutrition (GAM) was 17.4% (C.I. 14.2- 21.0), based on WHO 2005<sup>3</sup>.

The prevalence of GAM is high, following WHO classification which is above the emergency threshold (15%)<sup>4</sup>. However the graph below shows the results based on the NCH standards.

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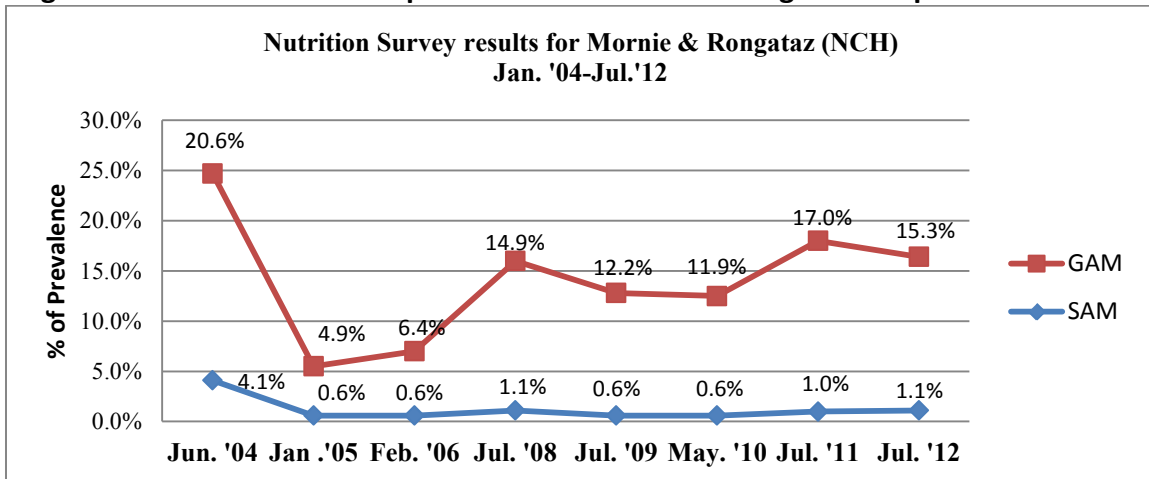
<sup>1</sup> [www.encyclopedia.wikipedia.org/wiki/West\\_Darfur](http://www.encyclopedia.wikipedia.org/wiki/West_Darfur).

<sup>2</sup> Source Humanitarian Aid Commission Mornei office, registration conducted in 2007

<sup>3</sup> Concern Worldwide SMoH and HAC, preliminary results of nutrition survey, July 2012

<sup>4</sup> WHO malnutrition classification: GAM >15% is above emergency threshold

**Figure: 1 Trend of SAM GAM prevalence in Mornei & Rongataz camp**



Source: Concern nutrition survey reports

From 2010, the MoH Sudan adopted CMAM as national guidelines for the treatment of acute malnutrition<sup>5</sup>. The CMAM manual for Sudan addresses the community-based management of severe acute malnutrition (SAM) in children from 6-59 months and includes community outreach, Outpatient care Programme (OTP) and Inpatient Care for the management of SAM. In the interim manual the community-based management of moderate acute malnutrition (MAM) is not included. In the next stage, it will be added to the manual to complete the overall CMAM approach. For the time being, the manual will use the acronym CMAM while only community-based management of SAM is covered through OTP and inpatient care. However, there are separate national SFP guidelines was developed by the Federal Ministry of Health in conjunction with World Food Programme.

Since the adoption of the 2010 CMAM approach as a National protocol to treat SAM cases; MoH, and national and international NGOs in 9 out of the 17 states in Sudan are implementing CMAM approach<sup>6</sup>.

In Mornei and Rongataz CWW is primarily responsible of the CMAM programme with progressive integration plan to government health facilities. However, the Mornei hospital implement the inpatient care for SAM cases with medical complication with technical and material support from UNICEF and Concern.

As part of the programme implementation activities, assessing the coverage of the programme has been planned. Therefore, a coverage assessment and capacity building training on coverage assessment method has been commissioned to the Coverage Monitoring Network (CMN), an alliance programme to which CWW is a member.

The Coverage Monitoring Network (CMN) Project is a joint initiative by ACF, Save the Children, International Medical Corps, Concern Worldwide, Helen Keller International and Valid International. The programme is funded by ECHO and OFDA. This project aims to increase and improve coverage monitoring of CMAM programme globally and build capacities of

<sup>5</sup> Government of Sudan Federal Ministry of Health, Interim Manual Community-Based Management of Severe Acute Malnutrition, Version 1.0

<sup>6</sup> Rural Kassala CMAM program Coverage survey and training using SQUEAC tools & SAM causal analysis

national and international nutrition professionals; in particular across West, Central, East & Southern African countries where CMAM approach is used to treat acute malnutrition. It also aims to identify, analyse and share lessons learned to improve the CMAM policy and practice across the areas with a high prevalence of acute malnutrition. The project will mainly focus on building skills in Semi Qualitative Evaluation of Access and Coverage (SQEAC) methodology.

To assess the CMAM (OTP) coverage of Mornei and Rongataz, a Semi-Quantitative Evaluation of Access and Coverage (SQEAC) method has been used. The main objective of the SQEAC method is to improve the routine monitoring activities by identifying potential barriers to access service. The findings intend to facilitate an optimum coverage of the OTP service. A team of nutrition professional of MoH and Concern and UNICEF were trained in the SQEAC methodology to build the local capacity and to continue with the coverage monitoring in coming months and years.

## 1.2 LIMITATIONS

Travelling outside of Khartoum requires a travel permit, this process took one week. This reason delayed the consultant to reach the project area. Due to this, the time available for training and assessment was limited. Insecurity also played a vital role in the access of the assessment area as well as to spend enough time there. Therefore the time did not allow the collecting all necessary data and analysis of the data with the team to make comparisons and triangulations.



## 2. PURPOSE OF THE ASSESSMENT

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The overall purpose of the mission was to provide training and build capacity on the SQUEAC method for the Geneina based MoH, Concern and UNICEF staff. At the same time support the team to conduct a coverage assessment of the programme area in Mornei and Rongataz IDP camp with a view to determine the coverage, strengthen the routine programme monitoring and increase the programme coverage.

### 2.1 SPECIFIC OBJECTIVES

- To train Darfur nutrition staff of CWW, MoH and UNICEF on the latest SQUEAC coverage survey methodology as well as on preparation, planning, implementation, analysis and reporting, in order for the team to be autonomous in carrying out future coverage surveys.
- To assess the coverage of the ongoing nutrition programme (OTP and SC) implemented by MoH and Concern in Mornei and Rongataz IDP camps.
- To identify the distribution of adequate and inadequate coverage of the different catchment areas (sectors) with acceptable accuracy
- To identify the key barriers to access to the OTP and to the SC services by collecting and analyzing qualitative and quantitative data using various sources and methods.

### 2.2 EXPECTED OUTPUT

- Concern, MoH and UNICEF nutrition team in Geneina trained on coverage assessment and all preparation, planning, implementation, analysis and reporting techniques.
- Produce a comprehensive report including findings and recommendations, which identifies challenges and opportunities in the current approach.

### 2.3 DURATION OF THE ASSESSMENT & THE TRAINING

October 4<sup>th</sup> to October 12<sup>th</sup> (annex 1)

### 2.4 PARTICIPANTS

A total of 12 staff were trained in the SQUEAC method. of which, seven were from CWW Darfur, four from the Ministry of Health, Geneina, and one staff from UNICEF Geneina (annex 2)

## 3. METHODOLOGY

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The Semi-Quantitative Evaluation of Access and Coverage (SQUEAC)<sup>7</sup> tool was developed to provide an efficient and accurate method for identifying existing barriers to access services and assessing coverage in an emergency as well as non-emergency context. This approach places a relatively low demand on logistical, financial and human resources to provide detailed information. Regarding the coverage estimation, areas of low and high coverage to be detected and the principle factors preventing higher coverage in targeted areas are to be identified. It is the hope that the programme will be able to implement this method in a medium to long-term programme that integrated with MoH in a sustainable manner rather than a short-lived, NGO funded programme. Methods previously available such as the Central Systematic Area Sampling (CSAS) create a far larger demand on resources and therefore, cannot be viably integrated into MoH run programmes in the long-term. The SQUEAC method was used to assess the CMAM programme in Mornei and Rongataz IDP camp, a 3 stages screening/assessment model:

- **Stage 1**, analysis of qualitative (contextual data) and quantitative (prog. routine data)
- **Stage 2**, conducting a 'Small area survey'
- **Stage 3**, conducting a 'Wide area survey'

### 3.1 STAGE 1

#### **Quantitative and qualitative data analysis to understand barriers/boosters to coverage**

At this stage, existing programme routine data which have previously been collected and compiled are gathered and analysed. In addition to the routine programme data qualitative data was collected by the teams from the CMAM programme areas. The data (both qualitative and quantitative) were collected by using various methods and sources.

The method and sources used were focus group discussions (FGD) with MoH, Concern staff and mothers/caretaker of children admitted to OTP. Semi structured questionnaires were used for key informant interviews (KII) with Sheiks (Sector leaders of IDP camp), Traditional Healers and Traditional Birth Attendants (TBA). Based on the findings from routine data analysis and information gathered from communities, areas with low and high coverage were identified and a hypothesis was developed. Reasons for poor coverage/coverage failure were identified by conducting a 'small area survey' (stage 2).

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<sup>7</sup> Mark Myatt, Daniel Jones, Ephrem Emru, Saul Guerrero, Lionella Fieschi. SQUEAC & SLEAC: Low resource methods for evaluating access and coverage in selective feeding programs.

**Figure: 2 MindMap, SQUEAC, Mornei**



Information that were collected from different sources through various methods was plotted on the 'Mindmap' (Figure -2) to verify, the information was gathered through the triangulation process. That information was later transferred to the X-Mind (annex 3). Information from the Mind map were weighed and scored by separating the positive and negative elements that pushed coverage up or down. The scoring was done by the assessment team, based on the weight of each element, they have used a scale from 1- 5 to score the positive/negative elements (table 1).

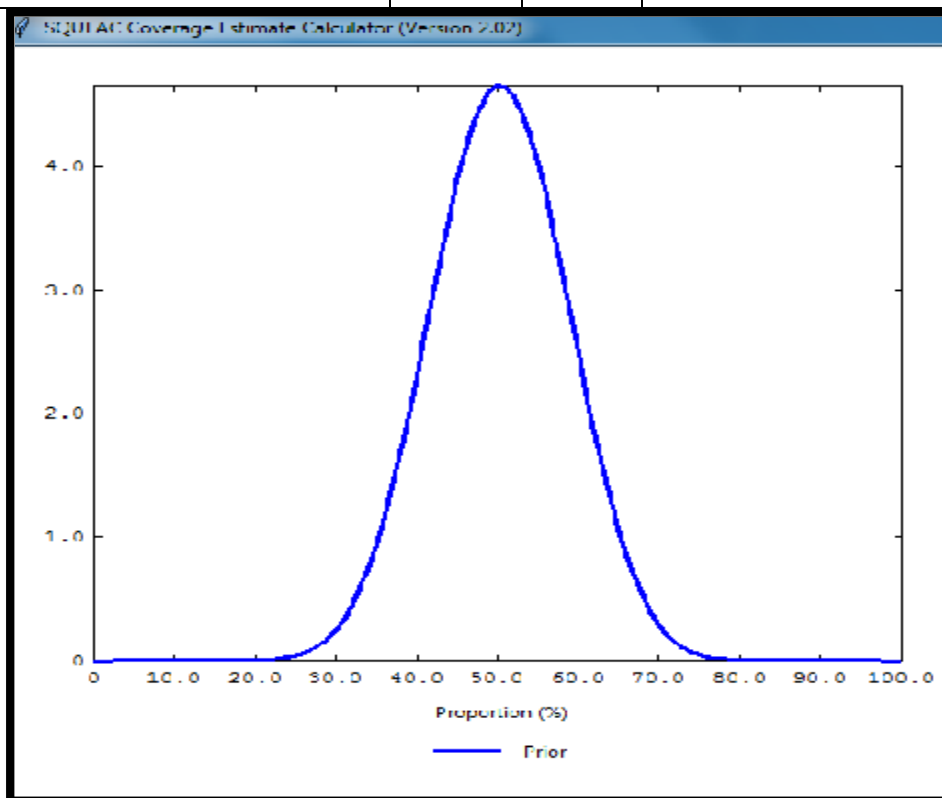
The team scored them separately and it was expected that the scoring differed from group to group as there were different perceptions. However, after a long discussion the final scoring for each element was agreed on and assigned. The average scores for each category were added to "build up" from zero (i.e. lowest possible coverage) and to "knock down" from 100% (i.e. highest possible coverage). The average from all these were estimates then the upper and lower expected values around coverage were then estimated.

The 'Prior' generally set using the prior information to make an informed guess about the most likely coverage value and express it as a probability density. The 'Prior' was calculated using findings from the small area survey and information gathered through 'Mind map'. The Prior was then described using the probability density Alpha prior = 17.4 and Beta prior = 17.2 using Bayesian SQUEAC software.

Based on the programme routine data, qualitative information and findings from the Small area survey; the team decided to calculate the sample size for the 'Wide area survey, (3<sup>rd</sup> Stage) assuming that the coverage is likely to be within 50% (figure under table 1).

**Table: 1 Scoring of Mind map & setting the 'Prior' by BayesianSQUEAC**

Negative	Values	Values	Positive
Staff Dealings	1	3	Staff Dealings
Supply shortage	2	4	Distance
Poor community participation	1	3	Good follow up
Non active volunteer, in some area	1	3	Good RUTF Med supply
Poor screening	2	3	Security
Seasonal activities – increase defaulter rate	2	3	Close community
Poor Defaulter follow up	1	5	Community Awareness
Traditional beliefs	1	3	Early Referral
Refuge to be admitted to SC	2	3	Active Volunteers/follow up
Staff shortage for Concern	1	3	Short LoS in the programme
MoH Staff get no feedback on their work	1	4	Good relation with other health partners
		3	Good supervision
		2	Tradition not effecting
<b>Total</b>	<b>15</b>	<b>42</b>	
	<b>15+0</b>	<b>100-42</b>	
Added to Minimum Coverage (0%)	15	58	Subtracted from Maximum Coverage (100%)
	15+58= 73/2		
	<b>36.5</b>		
<b>Alpha value</b>	<b>17.4</b>	<b>17.2</b>	<b>Beta Value</b>



## 3.2 STAGE 2 'SMALL AREA SURVEY'

The hypothesis that was formulated in stage one was tested by conducting a small area survey. Small survey communities and sub-communities were selected purposely, using the programme admission data; which indicated areas with high and low coverage (table 2). Sample sizes were not calculated in advance for this survey. Four survey teams sampled from four neighbouring communities in a single day, two from high and two from low coverage areas. The survey sample size was the number of SAM children found by the surveyors. The data was collected using active and adaptive case-finding methods. Questionnaires were developed to record the cases (SAM), both current cases and recovering cases were translated into Arabic (annex 4). A separate questionnaire was used for the cases of mothers/caretaker that were not attending the programme to find out the reasons for not attending to the programme.

**ACTIVE:** The method actively searched for cases rather than just expecting cases to be found in a sample.

**ADAPTIVE:** The method used based on information found during case-finding exercises to be informed and improve the search for case finding exercise.

### **Case Definition**

The case definition used by the Mornei coverage survey was defined as “a child matching the admission criteria of the programme”. The admission criteria of the Sudan CMAM programme included children age between 6 and 59 months with at least one of the following criteria:.

1. A Mid Upper Arm Circumference (MUAC) of <11.5 cm
2. <-3 Zscore, WHO 2005
3. Bilateral pitting oedema

However for the SQUEAC assessment, local term was used for case (SAM) finding. No pictorial image was used as that is not culturally appropriate for Mornei & Rongataz IDP camps.

### **Local names for malnutrition in Mornei and Rongataz IDP camp**

Marasmus is known as 'Deif'

Oedema is known as 'Worem'

In this survey, the criterion of Z-score was not considered to identify cases. Z-score is a criterion generally used at Nutrition centre level. Also in regular screening by the CVs to identify acute malnutrition cases Z-score has not been used. Therefore, only a MUAC of <11.5 cm and the presence of bilateral pitting oedema were considered in the case definition for SQUEAC assessment.

The overall programme coverage was estimated using the BayesianSQUEAC technique. This technique includes an estimation of the prior (prediction of coverage before conducting a wide area survey) and the likelihood (calculate a small sample size for 'wide area survey').

Based on the programme routine data and qualitative information and findings from the Small area survey, the team decided to calculate the sample size for the 'Wide area survey, (3<sup>rd</sup> Stage) assuming that the coverage was likely to be within the 50% (figure under table 1).

### 3.3 STAGE 3 'WIDE AREA SURVEY'

A wide-area survey covered entire programme catchment areas. A two-stage sampling procedure was used:

**Estimation of Sample size:**

Sample size requirements were calculated (using simulation with the BayesianSQUEAC calculator) to provide a coverage estimate with a 95% credible interval of about ±10%. The minimum sample size required was calculated to be n = 63 current or recovering SAM cases. See below formula for sample estimation:

$$N = \left[ \frac{\text{Mode} \times (1 - \text{mode})}{(\text{Precision} \div 1.96^2)} - (\alpha + \beta - 2) \right]$$

$$N = \left[ \frac{0.5 \times (1 - 0.5)}{(0.1 \div 1.96^2)} - (17.4 + 17.2 - 2) \right]$$

$$N = \left[ \frac{0.5 \times (1 - 0.5) = 0.25}{(0.002603)} - 32.6 \right]$$

$$0.25 \div 0.002603 = 96.0403 - 32.6 = \mathbf{63.4}$$

Therefore, the sample size was estimated to find 63 cases (SAM) to be found by using the wide area survey.

**Sample area**

- Covering the areas of health centres that were covered by CMAM services
- Proportion of population living within the catchment of the CMAM service areas/OTP sites

To select the sectors to be included for 'wide area survey' by using quadrat stratified systematic random sampling method:

A map (annex 5) of the location showing all 5 sectors in Mornei IDP camp divided into equal sizes of a quadrant, each quadrant was 10cm by 10cm and was laid on the map that yielded 26 squares (see picture below). A separate hand drawn map was used for Rongataz IDP

camp as there was no map available for Rongataz which yielded 10 squares, using the same process.

Sectors in each square (Quadrant) were listed in the order to ensure a spatial representation of a sampling area. Sampling location of all 5 sectors in Mornei and two sectors from Rongataz were selected systematically to find 63 SAM cases.

It was estimated (from the prior estimation) that the number of sectors would be required to find 63 current or recovering SAM cases using the proportion of the population living in the survey area, percent U5 population and prevalence of SAM in the survey area from recent nutrition survey report.

Finally, active and adaptive case finding methods were used to find cases. This method allowed inclusion of all, or nearly all, current and recovering SAM cases in sampled sectors.

**Figure: 3 Map of Mornei with Quadrants**



# 4. RESULTS

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## 4.1 Stage 1 PROGRAMME ROUTINE DATA & CONTEXTUAL DATA

### *Data collection:*

Quantitative and qualitative data was collected from routine programme data and from different informants using different method in line with SQUEAC guidelines:

### 4.1.1 Programme Routine data analysis (from card & register books)

#### **Admission data**

- Admissions trend and disease calendar
- Admissions MUAC (MUAC status)
- Admission in SC vs. OTP
- Number of admission from various sectors
- Sources of referral

#### **Programme performance indicators**

- Cured
- Defaulted
- Died
- Non responded
- Transferred cases to inpatient care
- Length of stay in the programme before cured discharged

#### **Defaulter data**

- Defaulter trend and labour calendar
  - MUAC status at the time of defaulted
  - # of weeks stayed in the programme before defaulted
  - Reasons for defaulting

#### **Programme Routine data analysis**



SQUEAC utilises a programme's routine monitoring data, that are accessible and directly related to programme coverage to assess three things: i) the accuracy and appropriateness of the data related to the coverage & programme performance, ii) whether or not a programme is responding well to the demands of its context, and iii) whether there are specific areas within the programme's target area expected to have either a relatively low or high coverage.

This data is first analysed in isolation for, comparison with the changing/seasonal context of the targeted area. Then the routine data is compared to international standard



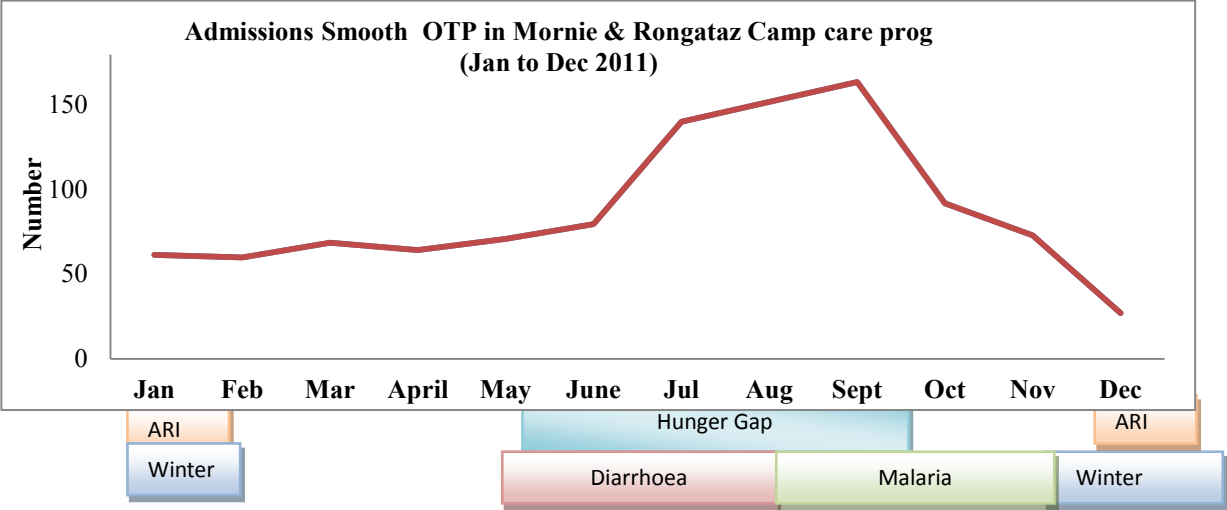
indicators (SPHERE) related to the implementation area. This is to assess the programme’s capacity to respond to changes in demand for its service.

**Admission data**

**Admissions data: Trends of diseases and hunger gap**

As indicated in the figure below (figure 4), the programme admissions follow the disease and hunger calendars of the IDP camp. According to the disease calendar, high caseloads would be expected from May/June and continue till November as shown in the figure below. The assessment was carried out in October and many children were found with red MUAC.

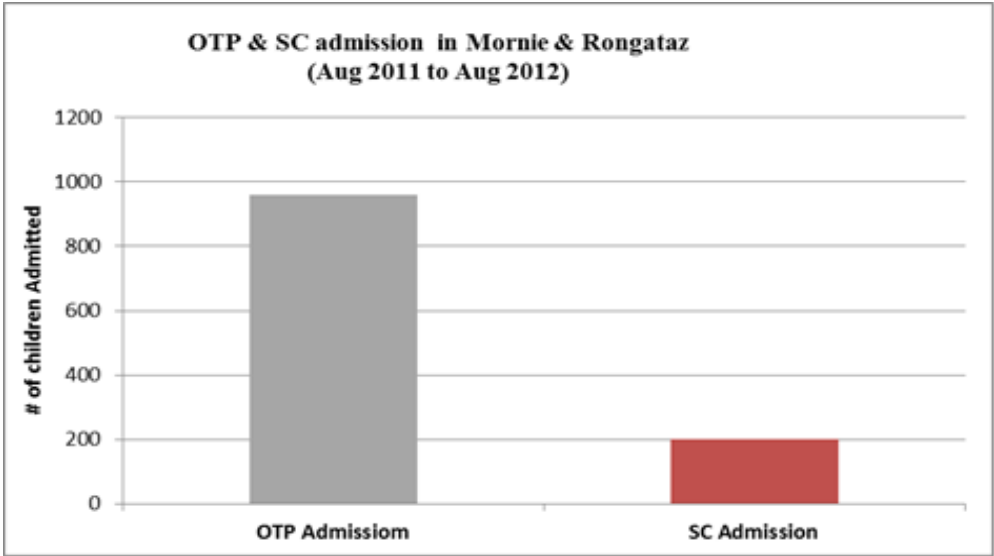
**Figure: 4 Pattern of Admission & Diseases and hunger gap Calendar**



**Admission at OTP & SC**

Figure 5 shows the number of children admitted to OTP vs. the number of children admitted to SC. The criteria to admit SAM cases in SC are with medical complications, oedema grade +++ and loss of appetite. Based on the available data about 18% SAM cases are admitted for SC to stabilise their condition before referred/returned to OTP.

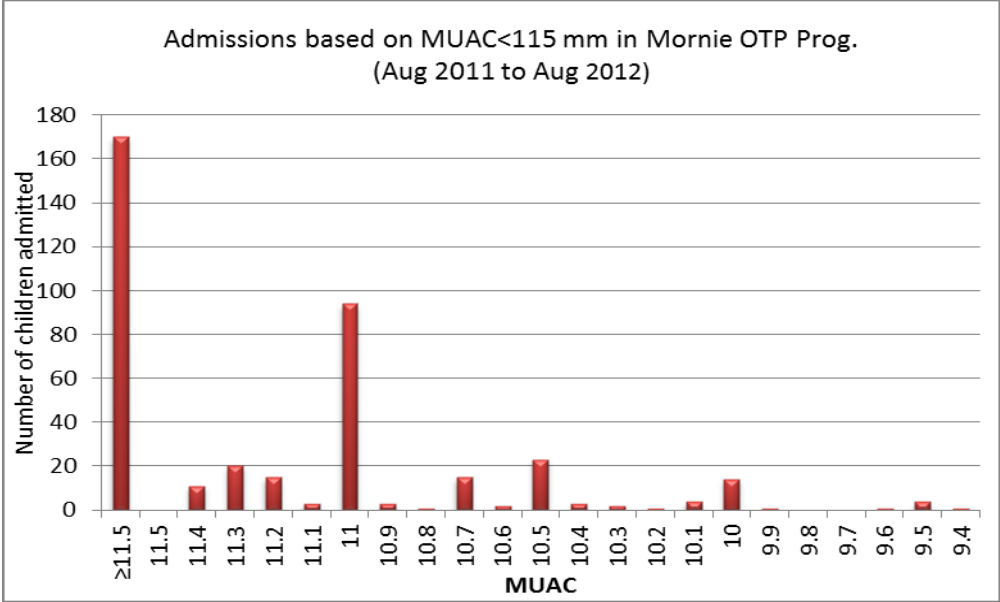
**Figure: 5 Admissions on OTP and SC**



**MUAC at the time of admission in OTP**

The measurement of MUAC at the time of the admission is part of the routine data analysis from the individual's admission card. The data compiled from August 2011 to Aug 2012 of OTP cards permits the assess of the timeliness of treatment seeking behaviours as well as the pro-activeness of the CVs on early screening and referring of cases (figure 6). Four hundred and sixty five cards were analysed. In addition to MUAC, some cases of nutritional oedema and Z-scores were recorded at admission which were then analysed separately (figure: 6).

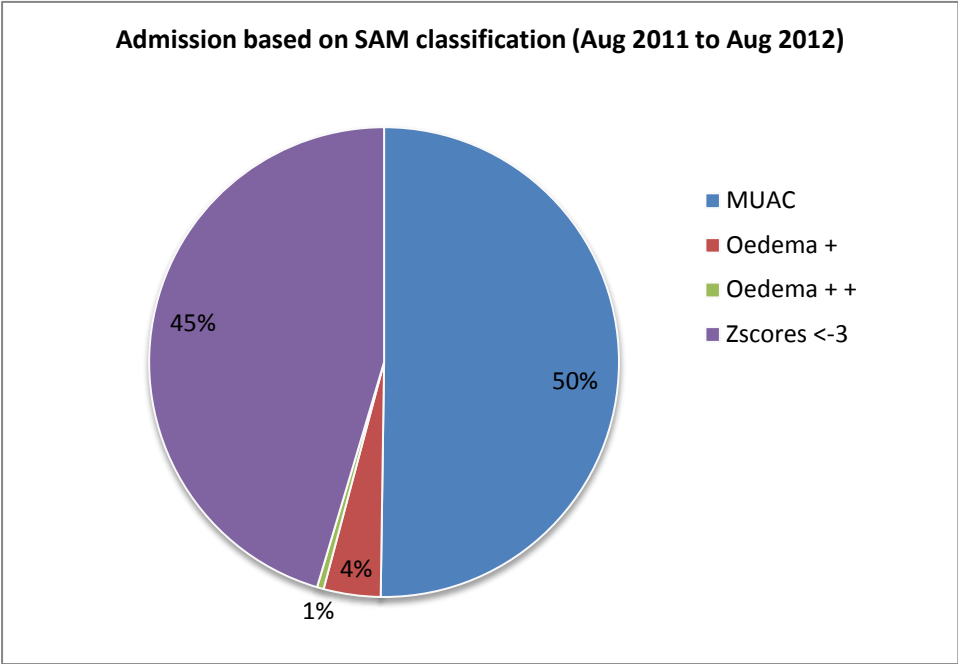
**Figure: 6 Admission based on MUAC <11.5cm**



**Status at the time of admission**

The nutritional status of children at the time of admission to OTP shows, that using the admission based on SAM classification of the Sudan CMAM guidelines; 45% of the children were admitted with MUAC of >11.5cm but fell into the category of Z-scores <-3 based on WHO 2005 standard. Children admitted with nutritional oedema were 5%, which only 1% with oedema grade +

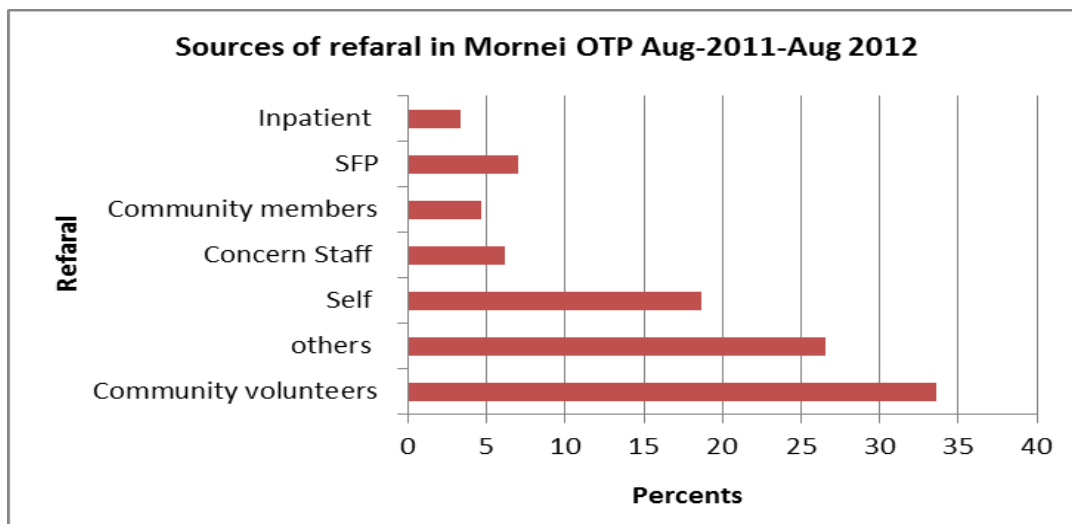
**Figure: 7 Admission based SAM classification**



**Sources of referral to OTP in Mornei**

From 465 cards 455 was found where sources of referral were recorded. More than 30% were found to be referred by the CVs, while the second highest (27%) was recorded as others without any specification (figure:8) .

**Figure:8 Referral to Mornei OTP by different sources**



**Area with high and low admission based on population under five years of age**

Areas with low and high coverage was calculated based on the number of SAM cases admitted to OTP, from the 465 OTP cards and the average U-5 population living in the area. The table below shows the areas with high or low admission, Rongataz was found to have the lowest admission, Table: 2

**Table:2 Areas with High& Low Coverage**

OTP Sites	Sectors	Admission	Low/High	U- 5 Population (% admission)
Mornei	Al Salaam	123	High	3,090 (4.0%)
	Al Jebel	99	High	1,643 (6.0%)
	Al Wadi	82	High	3,176 (2.6%)
	Imtidad Sherig	91	High	1,660 (5.5%)
	Imitidad Garib	35	Low	1,600 (2.2%)
Rongataz	Rongataz	31	Low	3,128 (1.0%)

### Programme performance indicators

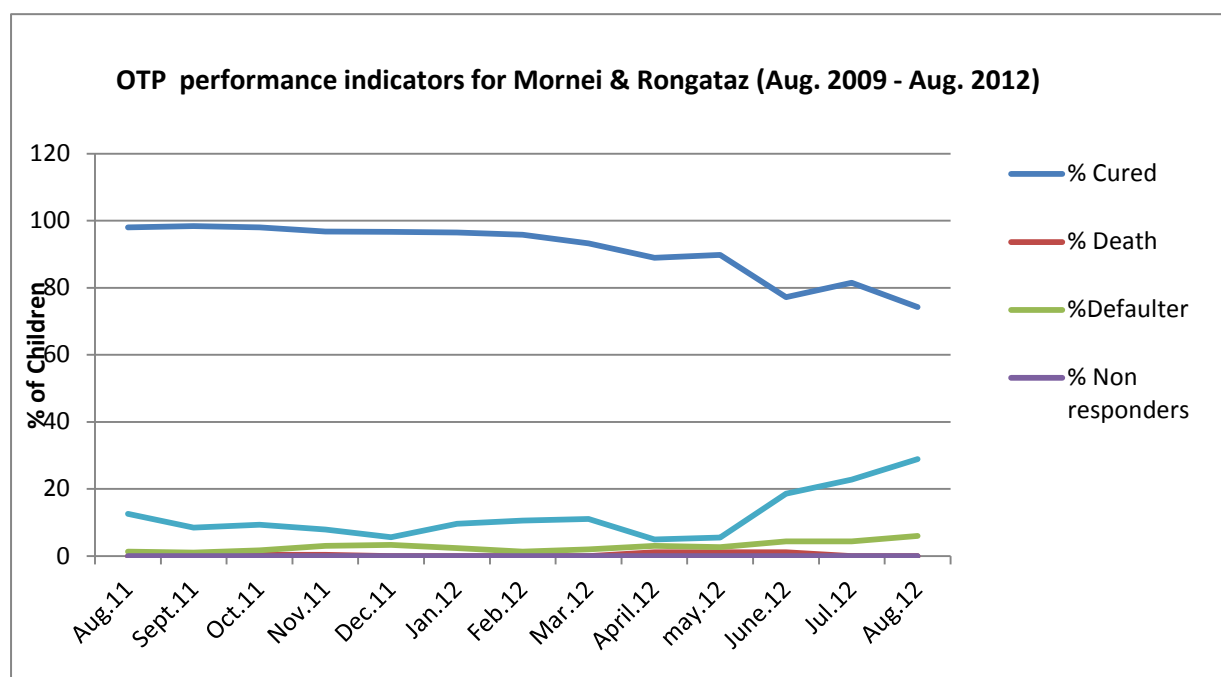
Performance Indicators:

The programme performance indicators that were set are based SPHERE standards<sup>8</sup>.

The performance indicators are the number of children exit from OTP (number of exit cured, defaulter, and death etc.) Percentages were used to assess the effectiveness over the life time of the programme compared with the standard of SPHERE. The graph below indicates the performance of the programme compared with the SPHERE standards (figure 9).

Indicators	OTP	SPHERE
Cured	92%	>75%
Defaulter	7.7%	< 15%
Death	0.3%	< 10%
Non respondent	0%	
Transfer	11.	

**Figure: 9 Programme Performance Indicators**

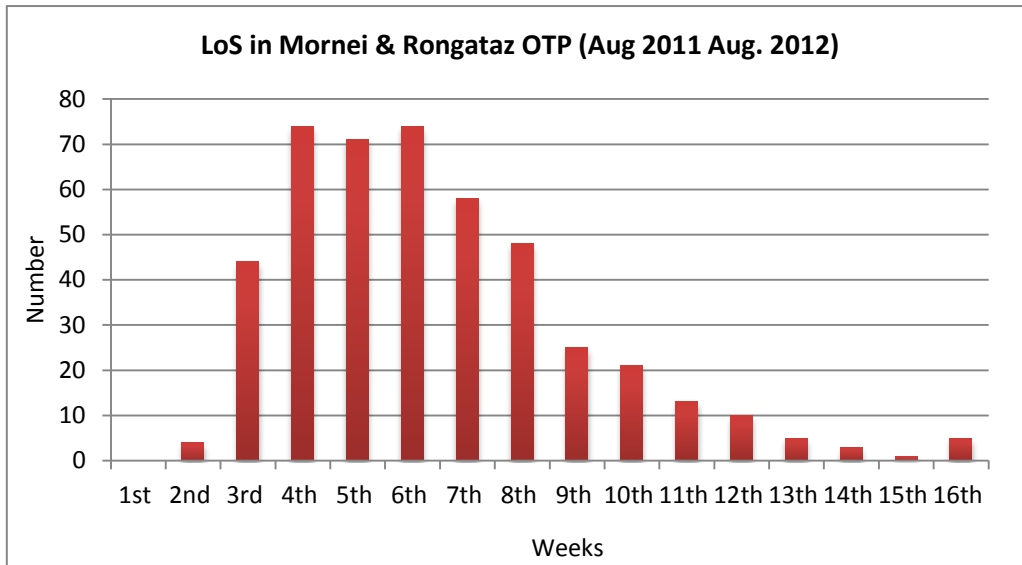


### Length of Stay (LoS)

LoS is an important performance indicator to assess the average period needed to cure a child. The median length of stay in the programme was 9 weeks. It seems that once children are in the programme, they get adequate care why the length of stay in that programme are not too long (figure 10).

<sup>8</sup> The Sphere Project Humanitarian Charter and Minimum Standards in Disaster Response, 2004

**Figure: 10 LoS in the programme before cured discharged**



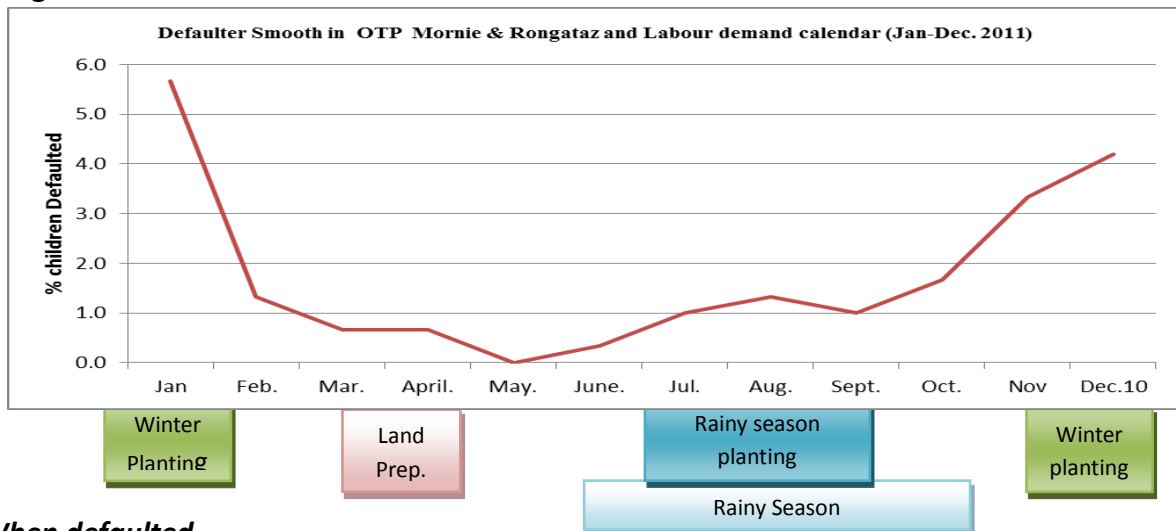
**Defaulters' data**

- MUAC status at the time of defaulted
- Number of weeks stayed in the programme before defaulted
- Reasons for defaulting

**Analysis of defaulter's data: Labour demand trends**

Defaulters are classified as uncured cases. The number of defaulters was examined to determine if it is worryingly high and if it follows the seasonal context over time. The graph indicated that the defaulter rate is very high at the time of planting, the overall rate of defaulter is about 8%, however, it is with the SPHERE standard, (<15%). See figure 11.

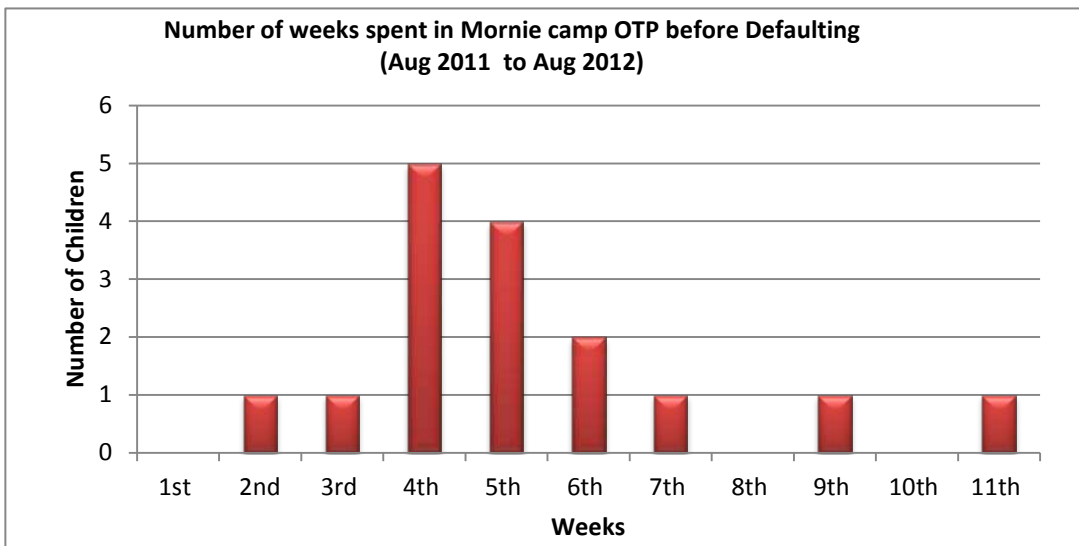
**Figure: 11 OTP Defaulter and Labour demand calendar**



**When defaulted**

Information from the 16 defaulted OTP cards found that the majority of the children defaulted from OPT after attending for a period of 4-5 weeks; 11 (78.6%) children which is worrisome. Two children defaulted after attending for 6 weeks and one child after week 7, 9 and 11 (figure 12).

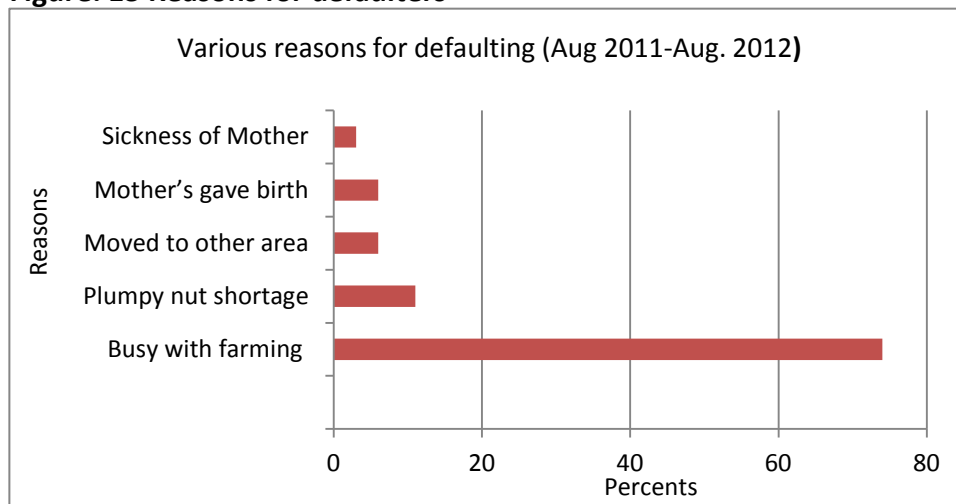
**Figure: 12 Number of weeks spent in OTP before defaulting.**



**Reasons for Defaulting**

Based on the performance indicators the defaulter rate is within SPHERE standards (7.7%). However, the reasons for default have been recorded and the primary reasons for defaulting were recorded as mothers/caretakers are busy with farm/agricultural work (more than 70%). See graph below, which is comparable with figure:13.

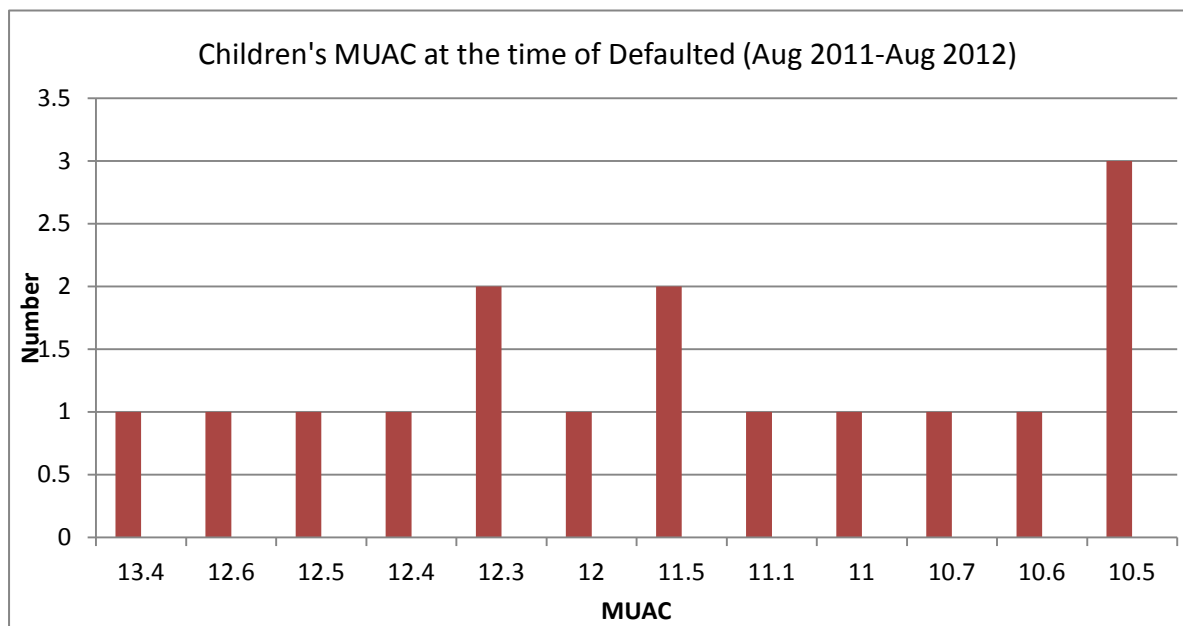
**Figure: 13 Reasons for defaulters**



**Nutritional Status at the time of Defaulted**

Thirty five children were recorded as defaulters between August 2011 to August 2012. However, information available from only 16 cards showed 3 children defaulted when their MUAC was very low (10.5cm) On the other hand, 3 children were recorded as defaulter, when their MUAC was >12.4cm (See figure 14). In addition, there were 3 children with Oedema+ who defaulted. This was worrisome (not included on the graph below).

**Figure: 14 Children Nutritional Status at the time of Defaulted:**



#### 4.1.2. QUALITATIVE DATA COLLECTION & FINDINGS

- Key Informants Interview (KII)
- Seasonal calendar (Fit to Context and Seasonality)
- Semi Structure Interview (SSI)
- Focus Group Discussions (FGDs)

The aim of collecting qualitative data is to allow more detailed development of the coverage hypotheses and an in-depth analysis of the existing information & routine programme data described in the previous section. This data also provides vital information concerning the underlying causes of low or high coverage, including key barriers and accessibility of the services. Qualitative data was collected using the following methods and sources:

#### FINDINGS FROM THE KEY INFORMANTS INTERVIEW (KII)

KII method was used with relatively homogeneous groups of key informants, that is members of the general public i.e. camp leaders (Sheiks), Traditional Birth Attendants (TBA), and Traditional healers. Who are not necessarily directly targeted by the programme?

##### **Sheiks (Camp Leaders)**

In total 6 Sheiks were interviewed from two IDP camps, Mornei and Rongataz. Five Sheiks from five sectors of Mornei and one Sheiks from one sector of Rongataz were interviewed about their perception of CMAM services in those two IDP camps. All six Sheiks have a good knowledge of the programme. When asked how they know about the programme. All of them mentioned different sources i.e. the community volunteers, the neighbours (whose children were in programme) and programme staff. They all mentioned they can recognize children with SAM, and when they see them they advise them to go to OTP. They also correctly mentioned the cause of malnutrition. They also know the work of CVs and are in regular

contact with them. There were no stigmas reported by the Sheiks that are linked with malnutrition.

### **Traditional Healers**

Five Traditional Healers four in Mornei one Rongataz were interviewed. They all are aware of the CMAM programme. All five Healers mentioned that they do not treat malnutrition. If they come across malnutrition cases, they send them to OTP or to CVs for screening. Most of them also mentioned that they know who the malnourished children are in their communities. One Healer mentioned that he never treats anybody who is less than 10 years old. Another Healer mentioned he even perform tonsil removal operation but do not treat children with malnutrition. However, according to the assessment team, who had a different view; the Healer does treat diarrhoea, fever etc. Seeking treatment from Traditional Healer may contribute to prolonged suffering which could lead to malnutrition.

### **Traditional Birth Attendant (TBA)**



KII with the TBA, Mornei, SQUEAC

Altogether six TBAs (five in Mornei and one in Rongataz) were interviewed. They all know the causes of malnutrition, which include diseases and poor feeding practices. In addition they also believe, if a mother comes from field/farm and immediately breastfeeds her child (hot breast milk), the child will develop diarrhoea. Therefore, most mothers do not breastfeed their children without washing and resting after coming from the farm. They mentioned another reason that if a mother becomes pregnant and continues to breast feed her child, this will cause malnutrition to her child.

### **Seasonal calendar**



Seasonal Calendar: in order to get a broader picture of programme performance against context, a seasonal calendar was developed including agricultural labour, disease, food availability and meteorological changes. Admissions and defaulters trends were then compared to the seasonal calendar to determine whether the programme was responding to seasonal changes and context-specific factors. Due to time constraint the calendar was developed with the SQUEAC assessment team and with the OTP staff of Mornei then compare



### **Semi Structure Interview (SSI)**

SSI was used for small and wide area surveys for the mothers/caretaker of the current cases that were not attending the programme. This requires a list of questions or ideas which was developed and used in interviewing the stakeholder of the programme (annex 6).

The qualitative data collection aimed at understanding the perception of the target population about the programmes and the programme implementers. A generic questionnaire was developed to guide the data collector to collect data from communities on their perception, care seeking behaviour and common practice of treating malnutrition etc. (annex 6). The data collectors were trained on how to interview, by avoiding leading questions and instead rely on the informants' responses to generic open questions. The data collected from this was reviewed and then checked with data gathered in subsequent groups.

### **Findings - OTP Mothers**



*FDG with the OTP Mothers in Mornei, photo by Lovely Amin*

In two groups, 30 OTP mothers were invited to participate in the FGDs. Most mothers mentioned that their children were in programme between two and six weeks and they observed good progress. The mothers/caretakers know the CVs in their areas and some of them were referred by the CVs. Most mothers were able to mention the causes and some of the signs of malnutrition correctly. From the FGD group 6% of children were found to be readmitted. All mothers were able to mention the admission criteria to OTP and SC correctly. They also mentioned that this programme helped them because RUTF bring back

appetite of the children with malnutrition, faster than any other food.

### **Findings from OTP and SC Staff**

All of the OTP and SC staff knew the admission and discharge criteria as well as the treatment protocols of OTP and SC accurately. They said that they are getting adequate training from the organisation and support from their managers to run the OTP and SC. When asked if they face any problem, they said there are many refusals to be admitted in the SC but very few refusals to the OTP. When asked 'why', they mentioned the usual reason is 24 hours stay in SC is not appreciated by most mothers/caretakers as they have other children at home. They were asked, if the programme is benefiting them and the community. They mentioned this programme reduced mortality and morbidity in their communities from malnutrition. The majority members of the communities are not seeking care/treatment from traditional healer for malnutrition. Also they have gained skills and knowledge on how to manage and treat malnutrition. The programme also created employment for them and assist them to develop social network within the communities and other health sectors.

A problem that was mentioned was that there were not enough CVs to conduct regular screening specially, during the hunger gap period.

*To improve qualities of the programme they advised:*

- to increase the number of CVs, especially, during the hunger gap to ensure early detection and referral to reduce the rate at admission in SC.
- to provide the OTP/SC staff with uniforms, so they will be easily recognised by the mothers/ caretakers.
- to ensure that programme has regular supply of RUTF, medicine and proper equipment's and supplies to prevent defaulters.
- to introduce some IGA activities for the very vulnerable mothers with malnourished children to prevent relapse and readmission.

### **Findings from Community Volunteers**

There were 135 CVs in two camps that were reported to be active. Among those, thirty community volunteers in two groups participated in FGD. The CVs receive refresher course twice a year (every six months). They all know the admission criteria correctly and causes of malnutrition. In some sectors they conduct MUAC screening once a month and in some community twice in a month. After many years of screening, communities are now aware of malnutrition and sometime there is self-referral.

As problems, the CV in Rongataz mentioned they do not have enough MUAC band and pens to conduct the screening efficiently. The CVs from both camps mentioned the cooperation and attitude in SC toward beneficiaries are not good; therefore, so many mothers refuse to be admitted in SC. Also their incentive is not enough so some CVs stopped to work (do not know how many). They said that they like the programme and their involvement but they like to get proper incentive for their work such as uniform and certificate.

## 4.2 STAGE 2 ‘SMALL AREA SURVEY’

Small area survey was carried out to ascertain the hypothesis of areas with high and low coverage based on OTP admission from August 2011 to August 2012 comparing with U 5 population figure.

### 4.2.1 Finding of Small Area Survey

For this survey two areas with high coverage and two areas with Low coverage were selected to conduct one day survey by four teams on the 9<sup>th</sup> of October 2012.

The results of the ‘Small area survey’ revealed that the hypothesis of Low and High coverage areas is partially incomparable. Therefore, the hypothesis was rejected. See table below with the result of Small Area Survey (table 3).

**Table: 3 Area with High low and No coverage by OTP Cards**

OTP sites	Sectors	# Case found	# of case in the prog.	# of case not in the prog.	Recovering cases	Coverage High/Low based on Prog. Routine data	Results from the survey
Mornei	Al Jebel A	2	2	0	6	High	High
	Al Jabel B	3	0	3	1	High	No
Rongataz	Rongataz 1	4	2	2	5	Low	Low
	Rongataz 2	1	1	0	1	Low	High
<b>Total</b>		<b>10</b>	<b>5</b>	<b>5</b>	<b>13</b>		

The sample size for the ‘Wide area survey’ was estimated based on the results of Small area survey with the assumption the coverage should be within the 50% (SPHERE minimum standard expected coverage for rural areas >50%).

## 4.3 STAGE -3 ‘WIDE AREA SURVEY’

### 4.3.1 Findings of Wide area survey



*Team conducting ‘wide area survey, photo by lovely Amin*

The wide survey (Likelihood survey) was carried out from 10<sup>th</sup> to 12<sup>th</sup> October 2012 to estimate the programme’s likely coverage (see the methodology above section: 3). Number of cases (SAM) found during the survey, number of cases found in the programme and number of cases found not in the programme and number of recovering cases were recorded (See table:4). The reasons for the current cases (SAM) not being in the programme, were also identified using questionnaire (see graph 13).

**Table: 4 Concern Mornei OTP programme, SQUEAC Wide area survey:**

Area /Sector	QuadrantX:Y coordinate	SAM cases found	SAM cases in prog.	SAM cases not in prog.	Recovering Cases in OTP (non cases)	
1 Al-Jebel B	13	1:3	8	7	1	3
2 Al-Wadi A	24	2:5	9	5	4	1
3 Al-Salam B	5	3:2	17	9	8	0
4 Al-Salam C	10	4:3	13	7	6	12
5 Imtidad Gerib A	17	4:4	3	2	1	0
6 Imtidad Sherig B	21	5:5	2	2	0	5
7 Rongataz Centres	3 & 4		11	8	3	
<b>Total</b>			<b>63</b>	<b>40</b>	<b>23</b>	<b>21</b>

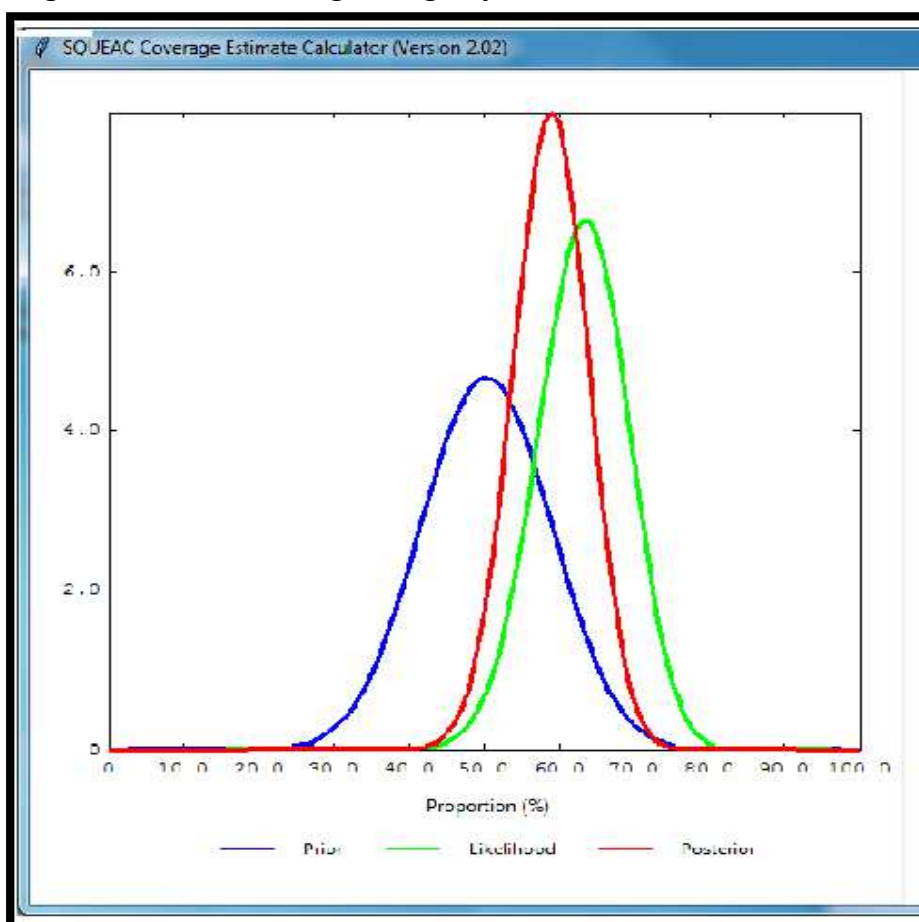
### 4.3.2 COVERAGE ESTIMATION

Data was used from the Wide area survey to estimate the coverage by using the BayesianSQUEAC calculator.

#### **Point Coverage**

To estimate the 'Point' coverage, data from the Wide area Survey was used. Estimation was made, using the BaysienSQUEAC Calculator. 'Coverage' as denominator (63) and numerator (40) was inserted to SQUEACBaysein calculator (use survey data) while same Alpha and Beta values has been ( $\alpha$  17.4  $\beta$  – 17.2) used from the pre-seted 'Prior' which was set to estimate the sample size for 'Wide area survey'. The 'Point' coverage is estimated: 59% (Credible Interval (CI) 49.1% - 68.1%), figure below 15:

**Figure: 15 Point Coverage using BaysienSQUEAC**



### 4.3.3 MAIN BARRIERS AFFECTING THE PROGRAMME

Finding from the contextual information that poor screening to identify cases by the CVs, mothers workload during planting season and periodical shortage/no RUTF supply are the main hindrance of coverage failure.

Findings of the 'Wide area survey' there were 23 SAM cases found that were not attending the OTP. A questionnaire was used to find the reasons from the mothers/caretakers of SAM cases that were not attending the OTP, as well as their perceptions about the OTP.

#### **Mothers with 'cases (SAM) that are not attending the programme:**

Among the 23 mothers/caretakers of children with severe acute malnutrition only for 19 were asked questions. Among the 23 children 4 severely acute malnourished children were found to be admitted and treated in SFP at the time of the data collection. These errors are attributable to determination/identification in children nutrition status. The team decided not ask questions to theses 4 cases as they were already in the programme. See table below (table 5) knowledge and perception of mothers/caretaker of cases (SAM) that were not in programme.

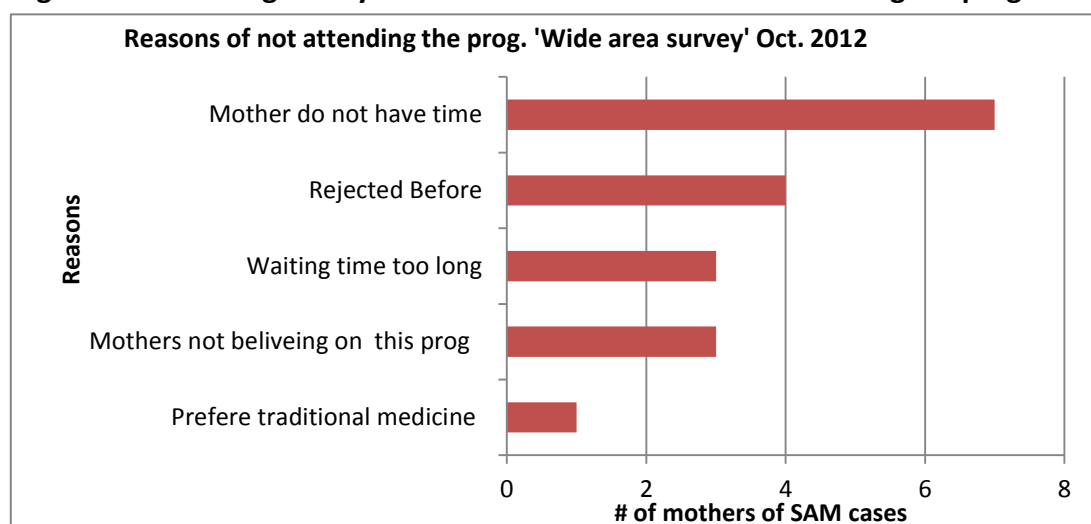
**Table: 5 Mothers/caretakers of SAM cases knowledge of the programme**

Questions (n=19)	Yes - # (%)	No -# (%)
Is your child malnourished	15 (79)	4 (21)
Do you know programme that can help your child	18 (95)	1 (5)
Was your child previously attended the programme.	9 (47)	10 (53)

#### **Reasons, that Mothers with 'cases (SAM) are not attending the programme:**

When asked, which programme can help your child, 13 of them mentioned SFP & OTP, while 5 of them mentioned OTP and while one of them did not know. All the 9 cases (SAM) that were in the programme before were relapsed between 21 days to 5 months after being cured discharged except one that defaulted. The graph showing the reasons for the current cases (SAM) not attending the programme (figure 17).

**Figure: 17 Reasons given by Mothers of SAM cases are 'not attending the programme'**



# 5. DISCUSSION

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## 5.1 PROGRAMME ROUTINE DATA FROM OTP CARDS & REGISTERS

All programme routine data were mainly collected from the 465 selected OTP cards from August 2011 to August 2012. Data on programme performance indicators was collected from the programme data base. Below are a few issues that were highlighted during the routine data analysis.

### **Admission data**

The programme admission data suggests that the coverage in Rongataz IDP camp is low and is high in Al Jebel in Mornei camp but the data from small area survey suggested the opposite. The programme admission data not always a reliable indicator of areas with high or low admission

### **Referral information**

While gathering data from the OTP cards, information on referral was found in 455 cards out of 465 cards. Although highest percentage (34%) was referred by the CVs, the detail information on screening by CVs was not available. This is one of the vital pieces of information that can be analysed to accretion the CVs performance, i.e. to find out if they are detecting the cases early enough and are being referred. The second highest cases (27%) were marked as referred by 'others' this source needs to be specified so, that in the long term this source can be strengthen.

## **Performance indicators**

### **Defaulter information**

During the period of August 2011 to August 2012 35 cards were marked as defaulters. Only 16 cards were found with defaulter information. The defaulters seem to follow the same pattern every year but there has been no discussion as to how to minimise it due to time constraint. Also, no data was available to see if they were followed up and if so, for how long before marking them as defaulter. The programme needs to identify the reasons and recognise the peak time of defaulters to have some necessary steps in place to reduce number of defaulters from programme.

There was supply breakage of RUTF in 2010 for 3 months and again in June 2012 for two weeks. The assessment did not manage to establish if that was the cause for high defaulting and low admission to OTP during that time. However, the CVs mentioned that the shortage of RUTF has contributed to refusal in reporting to OTP, when referred.

### **Community Volunteers**

Community outreach is one of the key components of the CMAM approach, where CVs are a major player. But this coverage assessment did not manage to gather much information from the CVs as there was no information/data available on their work about the OTP or SC. Also there were constraining on time and security. Therefore, it was very difficult to report, if the CVs were active or not. It is important to gather information on CV activities systematically and using the information to assist them to be more active. The wide area survey found that approximately 36% of the SAM cases were not attending the programme even though 95% of them had the knowledge about the programme. Community volunteers can motivate these mothers/caretakers to take their children to the programme.

### **Stabilisation Centre**

The data received from the SC in Mornei found that from August 2011 to August 2012, 201 children were admitted to SC. A very high percentage of children (18%) were admitted to SC. Based on the CMAM experience, about 10-15% cases should need inpatient care for stabilization of their condition before they are referred to OTP. However, the team informed that as there were no inpatient care facilities in Rongataz, many cases were coming from there as well as some cases were coming from outside of Mornei and Rogataz. This may have inflated the number of admissions to inpatient care for SAM. To certain the ratio of children admitted to inpatient vs. OTP from both areas Mornei nad Rongataz, data needs to be further analysed to find out where most cases were referred from. So that appropriate measures can be taken on early case findings.

Looking at the transferred data, over 11% of cases were referred to SC from OTP. It will be interesting to analyse those transfer cards to see when and why they were transferred to SC. This analysis will help to understand if in the first place, the cases were wrongly admitted in OTP or the care of OTP is not adequate for late referral etc.



## 6. CONCLUSION

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Mornie and Rongataz programme have been treating children with acute malnutrition since 2004. The programme routine data shows that the programme has admitted and has successfully treated a high number of SAM cases. The inpatient care was fully integrated to national health facilities for long term sustainability of treating SAM cases with complication. However, the OTP is physically based in Government/MoH Health Centre with some involvement of MoH but Concern is still responsible for the overall management of OTP activities.

The performance indicators (cured, death, non-responders and defaulters) are all well above their corresponding SPHERE standard. The programme needs to continue maintaining these strands as well as try to increase the coverage, hence the programme effectiveness. On the other hand, some gaps were identified on defaulter records as to why mothers defaulted and if they have been followed up.

The communities' awareness and acceptance of the programme was found to be very high. To ensure increase in accessing services, the communities' knowledge can be utilised by conducting regular community meetings and involving the community for early case findings and referral.

The 'community volunteers' strategy/community outreach strategy needs to be revisited, what is expected of them and how to improve the coverage. Experience from other country in similar situation has proven that coverage can increase but it requires partnership between all actors' such as community, MoH, NGOs and UN agencies.

Data collected in Stage 2 and Stage 3, through Small and Wide Area surveys of SQUEAC suggested that coverage is higher than 50% across both the IDP camps. If compare with rural area coverage found was good, however, if compare with camp setting (>90%) than coverage need to improve further.

The nutrition survey result shows persistence level of acute malnutrition since 2008 (graph 1). Reduction of the prevalence of SAM & MAM in Mornie and Rongataz IDP camp, can possibly be achieved through the prevention of the immediate causes such as diarrhoea, ARI, Malaria by health and hygiene education and promotion of IYCF practices.

Finally, it is anticipated that the nutrition team of CWW and UNICEF staff that attended in the assessment will be able to conduct/lead the coverage assessments in the future, using SQUEAC methods. However, the MoH staff will need to develop their skills further on this area.

## 7. RECOMMENDATIONS

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The SQUEAC exercise was permitted to identify barriers to access services to the CMAM programme. To address those barriers and to understand the dynamism of the barriers the programme team may need to explore further on key elements that become barriers. For example, it was not very clear during the assessment how active are the Community Volunteers on case findings. In coming months, the CWW and MoH team need undertake some action to determine if the number of CVs is adequate and active.

The team needs explore further the 'barriers' that was identified in order to take measures on how to remove or minimize those 'barriers'. During the 'weighting' exercise, of positive and negative elements it was apparent that the importance of each 'barrier' and 'booster' varied among the teams weighting exercise. This can be explained by the different perception about the 'barriers' within the programme team. Also further discussions with specific key stakeholders (mother of SAM cases) could clarify their perception of the programme and the "gravity" of certain negative elements that came from the 'wide area survey'.

### 7.1 SPECIFIC RECOMMENDATION

- 1) The programme need to find out how many CVs are active and how many CVs are needed (one CV per 150/200 families) to ensure effective screening and defaulter follow up on a regular basis. This can be done by revising the outreach strategy and conducting regular meeting with the CVs.
- 2) To ensure higher coverage, early case finding and timely referral, then community outreach activities need to be strengthened. Before marking the OTP/SC children as a defaulter, defaulters' children need to be followed up adequately. This can be done through developing and implementing outreach strategy by CWW/MoH.
- 3) Ensure programme routine data (not additional) are collected accurately & adequately. These data can then be used later to assess programme coverage and programme's effectiveness.
- 4) Programme need to check in a regular basis if the OTP/SC implementer strictly adhere the admission and discharge criteria at OTP, SC and SFP. Ensure all children with red MUAC (<11.5cm) are admitted to OTP to avoid children developing complication and then being admitted to SC.
- 5) CMAM approach is a community based programme, therefore, communities' involvement is pertinent to the success of this intervention. To succeed with this programmme, regular meetings with the community stakeholders need to be organised, especially, with the Sheiks. This will help to ensure that they take interest in the CVs work and in the health and wellbeing of their children.
- 6) Programme supervision and support needs to be strengthened to address programme implementation gaps that are identified and giving regular feedback to OTP, SC staff and CVs. One examples, monitoring CVs work regularly (monthly/ fortnightly), to see if CVs are fulfilling their responsibilities by conducting regular screening.

- 7) Conduct one coverage survey soon enough to practice the SQUEAC methods that they have learnt by this assessment.
- 8) Addressing immediate causes of acute malnutrition through outreach activities and health and hygiene promotion activities.
- 9) UNICEF need to ensure that RUTF and routine medicines supplies are efficient and sufficient in order to improve programme performance and avoid poor admission of SAM cases to OTP.

## 7.3 ACTION PLAN

Following are some key actions that need to take in order to eliminate or reduce the effect of the key barriers to improve the coverage.

Table: 6 Action plan for Mornei & Rongataz IDP camp, originated from SQUEAC assessment

	Issues	Time frame	Responsible Agency	Resources Needed
1	Identify how many CVs are active and how many CVs (one CV per 150/200 families) are required to fulfil the outreach activities. Supervision and support to CVs work by keeping records and provide them with regular feedback and training as a motivation to their work	On-going Starts from Dec 2012	Concern MoH	Human resources Logistic resources Training materials
2	Address the 'barrier' that has been identified during the programme assessment, in regular programme activities	Start from Jan 2013	Concern MoH	Staff's Time Logistical
3	Further invest in community participation i.e. at grass root level (Sheiks, TBAs, traditional healers) to address issues of high rate of malnutrition, high defaulters during planting seasonal variation, high caseloads at certain time of the year. This can be done by organizing periodical workshop/meeting with them.	On-going (early 2013)	Concern MoH	Logistical resources  Per Diem
4	Community outreach activities need to be revised and strengthened to ensure early identification and referral of cases As well as to ensure defaulter cases were follow up are adequate before marking them as defaulter. This can be done through developing and implementing outreach strategy by CWW/MoH.	As soon as possible	Concern MoH	Logistics
5	Increase support & supervision of OTP and SC activities to address program implementation gaps, identified in this assessment and provide regular feedback to the team.	On-going	Concern MoH	Per diem Logistical resources Stationery
6	Ensure strict adherence to admission and discharge criteria at OTP, SC. Ensure all children in red MUAC are in OTP to avoid children getting into SC with complications	On-going	Concern MoH	Per diem Logistical resources Stationery
7	Conduct one SQUEAC assessment soon enough by the team to practice what has been learnt.	Dec 2012	Concern MoH, UNICEF	Time Logistics

# ANNEXES

## ANNEX 1

### Schedule for SQUEAC Training & Assessment, Morinei & Rongataz, October 2012

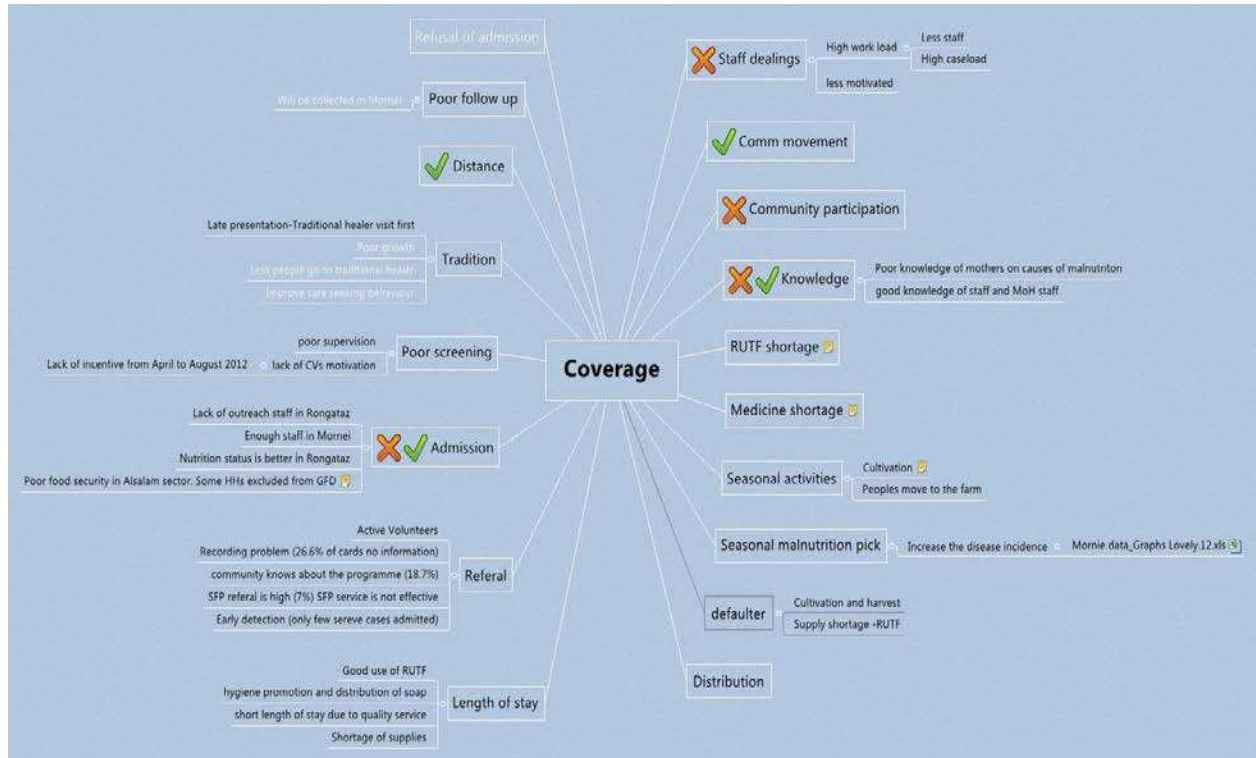
Time	Activity	Facilitator
Day 1 Wednesday 3 <sup>rd</sup> Oct	<b>PM</b> Arrived in Geneina	Lovely
Day 2-4 Thursday – Saturday 4 <sup>th</sup> to 6 <sup>th</sup> Oct 2012	<i>Class room training</i> Opening Session Introductions Schedules Overview of the SQUEAC methodology Starts up with mindmap Develop/adopt guide for FGD, KII and SSI Distribute task to the assessment team	Lovely
Day 5 Sunday 7th Oct 2012	<b>AM</b> Travel to Mornei  <b>PM</b> FGDs with OTP & SC staff in Mornei Hospital	Team
Day 6 Monday 8th Oct 2012	<b>AM</b> <i>Field Exercise</i> Collection of some Contextual Data from the field: Local leaders TBAs Traditional healer Community Volunteers  <b>PM &amp; EVENING</b> Contextual data analysis	Team
Day 7 Tuesday day 9 <sup>th</sup> Oct 2012	<b>AM</b> Conducting Small area survey  <b>PM &amp; Evening</b> Survey data analysis Sample selection for Wide area survey	Team
Day 8-10 Wednesday to Friday 10 <sup>th</sup> -12 <sup>th</sup> Oct 2012	Conducting Wide area survey	Team

## ANNEX 2

### Participants list, SQUEAC training and coverage assessment, Mornie, Oct 2012

	Name	Organization	Position in the organization	No of assessments/surveys involved
1	Abeker Yehiya Adam	Concern	Nut. Supervisor	10
2	Adam Zekeriya	Concern	Ex- Community Coordinator	8
3	Yassin Abdalla	SMoH	Nutritionist	6
4	Khamis Ibrahim Haroun	Concern	Ex- Community Coordinator	5
5	Bakit Mattar Juma	Concern	Ex- Community Mobiliser	3
6	Mahdi Adam Yagoub	Concern	Nutrition Worker	6
7	Amani Yousif Ibrahim	SMoH	Nutrition Officer	3
8	Halla Elhifni Ahmed	UNICEF	Nut. Surveillance Officer	
9	Maymuna Elsair Alzobir	SMoH	Nutritionist	1
10	Mustafa Abdalla	Concern	Nut. Adviser-West Darfur	12
11	Lubaba Hussen	Concern	Nutrition Programme Manager	20
12	Zeinab Ali Abdallah	MoH	Nutrition Director , Darfur	

# Coverage



## 1. Staff dealings



### 1.1 High work load

#### 1.1.1 Less staff

#### 1.1.2 High caseload

#### 1.2 Less motivated

## 2. Comm movement



## 3. Community participation



## 4. Knowledge



### 4.1 Poor knowledge of mothers on causes of malnutrition

### 4.2 good knowledge of staff and MoH staff

## 5. RUTF shortage

3 months, Oct to Dec 2010 half of the required ration

2 weeks, June 2012, from 17 to 30

2 weeks in Sep 2012 -from 16 to 30

No plumpy nut since beginning of October

## **6. Medicine shortage**

Due to the delay of budget approval, there was no medicine April to mid of SEptember funding

## **7. Seasonal activities**

### **7.1 Cultivation**

Mothers are busy in agricultural activities from July to November

### **7.2 Peoples move to the farm**

## **8. Seasonal malnutrition pick**

### **8.1 Increase the disease incidence**

#### **8.1.1 [Mornie data Graphs Lovely.12.xls](#)**

## **9. defaulter**

### **9.1 Cultivation and harvest**

### **9.2 Supply shortage -RUTF**

## **10. Distribution**

### **11. Length of stay**

#### **11.1 Good use of RUTF**

#### **11.2 hygiene promotion and distribution of soap**

#### **11.3 short length of stay due to quality service**

#### **11.4 Shortage of supplies**

## **12. Referral**

### **12.1 Active Volunteers**

### **12.2 Recording problem (26.6% of cards no information)**

### **12.3 community knows about the programme (18.7%)**

### **12.4 SFP referral is high (7%) SFP service is not effective**

### **12.5 Early detection (only few serve cases admitted)**

## **13. Admission**



### **13.1 Lack of outreach staff in Rongataz**

### **13.2 Enough staff in Mornei**

### **13.3 Nutrition status is better in Rongataz**

### **13.4 Poor food security in Al Salam sector. Some HHs excluded from GFD**

Community thinks, the distribution of new card aims to send the IDPs to thier original place (return).

## **14. Poor screening**

### **14.1 poor supervision**

### **14.2 lack of CVs motivation**

#### **14.2.1 Lack of incentive from April to August 2012**

## **15. Tradition**

### **15.1 Late presentation-Traditional healer visit first**

### **15.2 Poor growth**

### **15.3 Less people go to traditional healer**

### **15.4 Improve care seeking behavior**

## **16. Distance**



## **17. Poor follow up**

### **17.1 Will be collected in Mornei**

## **18. Refusal of admission**



ANNEX 4

SQUEAC SURVEY 2012 –Mornie Camp, Concern SUDAN  
Small/Wide area survey

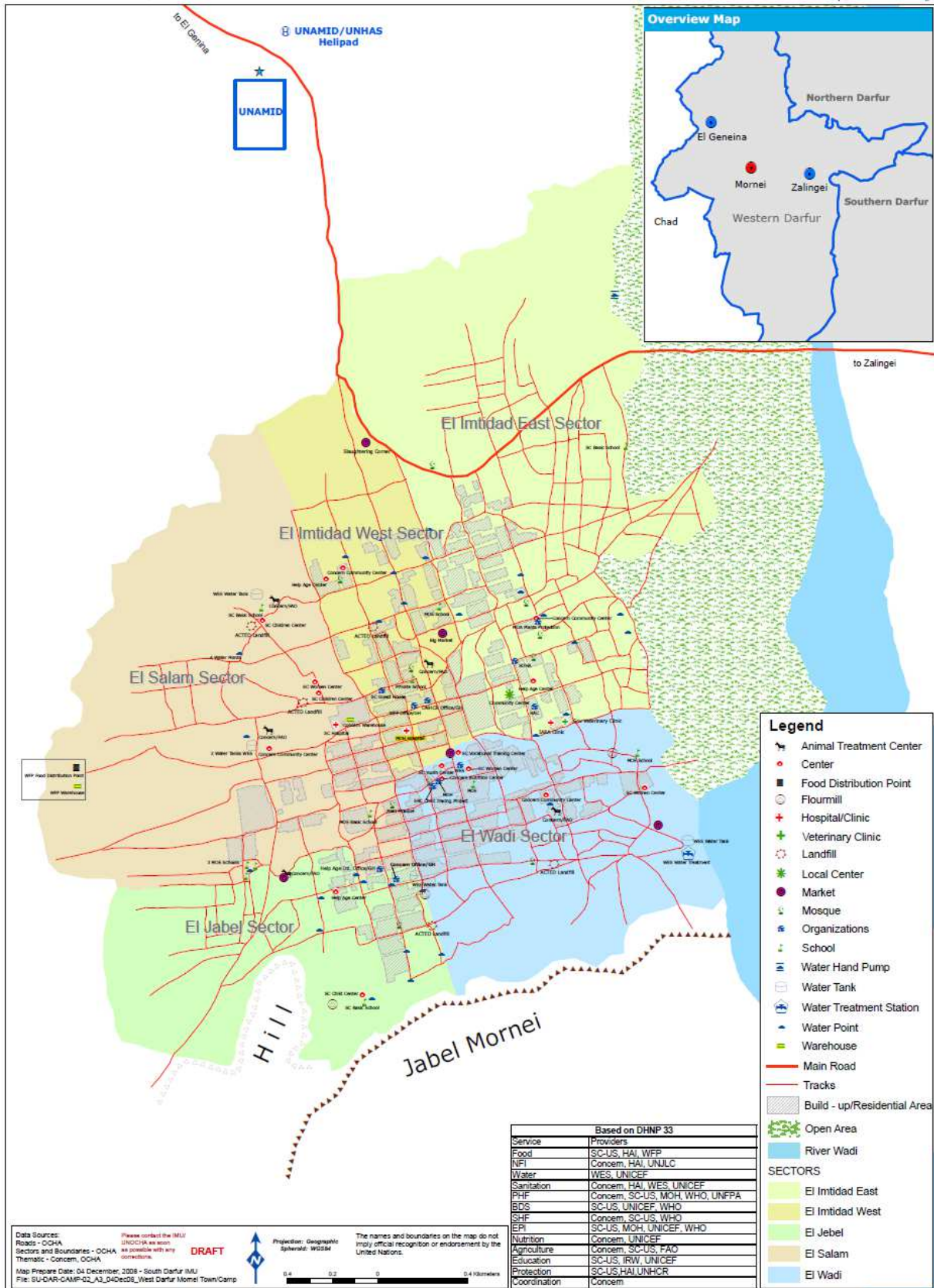
Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

#	Child's Name اسم الطفل	Father/care taker name اسم الام او راعي الطفل	Village/cam p المعسكر/ القرية	SAM cases in prog. حالات سوء تغذية شديدة في مسجل البرنامج (Yes/no) (نعم/لا)	If no, why not? اذا كانت الاجابة لا ، لماذا؟	Non cases in prog. (cases before) الطفل مسجل في البرنامج ج الان ولكن الان تحسن	Age (months) العمر بالشهو ر	Sex (M/F) النوع
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

ANNEX 5

IMU OCHA Sudan  
ochasudan@un.org  
http://ochaonline.un.org/sudan

Mornei Town and IDP Camp, West Darfur, Sudan



## ANNEX 6

### CWW, UNICEF & MoH, West Darfur CMAM programme-Guiding questions for semi structure interview with community key informants:

#### 1. Questionnaire: For Traditional Healer (Key Informant interview, one from each sectors)

Appreciation of the programme:

1. هل تعرف ان هذا البرنامج يسمى ب OTP ؟
2. اذا كانت الاجابة نعم , من الذي اخبرك بهذا ؟
3. ماذا تعرف عن سوء التغذية؟
4. هل يوجد اي حالة سوء التغذية في حيكم؟ (مجتمعكم) ؟
5. هل هنالك اطفال يعطوك لتلقي العلاج او المساعدة في العلاج منك؟
6. كيف تعالجهم او تساعدهم في العلاج ؟

#### 2. Questionnaire: For Traditional Birth Attendance -(Key Informant interview, one from each sectors)

1. ماذا تفعل للاطفال اللذين لديهم سوء تغذية
2. هل هنالك اي طفل لديه علامات سوء التغذية قمت بمعالجته ؟
3. هل تعرف البرنامج الذي يعالج الاطفال اللذين لديهم سوء تغذية شديدة او OTP (RUTF) يعطي الاطفال بسكويت خوجة ؟
4. هل قمت بتحويل اي طفل لهذا البرنامج ؟
5. هل تعرف ما الذي بسبب سوء التغذية للاطفال ؟
6. هل تعرف ام لها اطفال مصابين بسوء التغذية ولكنها رفضت الذهاب الي البرنامج

#### 3. Questionnaire: For village leader -(Key Informant interview, one from each 6 sectors)

- هل تعرف البرنامج الذي يعالج الاطفال المصابين بسوء التغذية ؟
- اذا كانت الاجابة نعم , من الشخص الذي اخبرك بهذا البرنامج ؟
- ما هو الدور الذي تساهم به لهذا البرنامج ؟
- هل هنالك اي طفل في هذا البرنامج من حيكم او قريبتكم ؟

Appreciation of the prog:

- هل لديك اي طفل في حيكم مصاب بسوء التغذية ولكن رفض الذهاب الي برنامج التغذية ؟
- ما الذي يسبب سوء التغذية للاطفال في حيكم او قريبتكم ؟

- كيف تنسق مع المتطوعين في الحي لنجاح البرنامج؟ البرنامج؟
- هل تعتقد الناس في مجتمعكم في ان الاصابة بسوء التغذية من العيب او فضية؟
- هل قمت بتحويل اي طفل مصاب بسوء التغذية ولكن اسرته تعتقد ان هذا عيب او فضيه الي البرنامج؟

**4. Questionnaire: Volunteers/ OTP Staff (Concern & MoH)-Group discussion (CVs=three groups, each with 15 participants and one with Concern staff and one with MoH staff)**

**How CMAM works:**

- ما هي مؤشرات الدخول لهذا البرنامج؟
- من هم المستفيدين من هذا البرنامج؟
- ما هي اسباب سوء التغذية؟
- هل لديك معدات و مواد كافية للعمل؟
- هل لديك أنشطة تحريك المجتمع مع السكان؟
- تاريخ اخر مسح قمت به screening
- هل هنالك اطفال كثيرين مصابين بسوء التغذية؟
- كيف تنسق مع المراكز الصحية الاخرى
- هل تجد تغية راجعة من المشرفين عن عمل البرنامج؟
- هل هنالك حالات رفض من الدخول في برنامج التغذية العلاجية الخارجية
- اذا كانت الإجابة نعم ماذا تعمل لهم؟
- ما رايك في عمل البرنامج؟
  - o من حيث الفائدة
  - o المشاكل التي تواجهك
  - o هل البرنامج يسبب لك زيادة تعب؟
- Develop seasonal calendar
- اي اقتراح لتحسين فعالية البرنامج؟

**5. OTP mothers: three group one in Rongataze and two in Mornie**

- كم الزمن الذي استغرقه هذا الطفل في البرنامج؟
- كيف تعرفت علي هذا البرنامج؟
- هل تعرف لماذا هذا الطفل دخل في البرنامج؟
- ما هو سبب المشكلة الذي حدث لهذا الطفل؟
- هل تم ادخال طفلك هذا في البرنامج من قبل (this one)
- هل تم ادخال اي واحد من اطفالك الاخرين في البرنامج؟
- اذا كانت الإجابة نعم ,لكم فترة من الزمن مكث في البرنامج؟
- هل هذا البرنامج يساعد طفلك ليكون بصحة جيدة؟
- هل قمت بتحويل اي طفل 'Dief'/Worem? اخر لديه ورم او ضعف في جسمه لهذا البرنامج؟