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| crslogo**CRS Sudan Progra****Terms of Reference (TOR)****Baseline Survey for:** Integrated Health, Nutrition and WASH Project in Central Darfur ***(Moafa II Project)*****Duration: December 10, 2020 – January 10, 2021** |

Catholic Relief Services (CRS) - Sudan Country Program seeks a consultant to lead a baseline survey and production of baseline report for its USAID-BHA funded project, *Moafa II: Integrated Health, Nutrition and WASH Project in Central Darfur.* This project, which began on November 1, 2020, is a follow-on project after the successful implementation of *Moafa I: Integrated Health, Nutrition and WASH Project in Central Darfur*, also funded by USAID-BHA.

This consultancy will be conducted from **December 10, 2020 – January 10, 2021**

1. **Baseline Overview**

The baseline report is a requirement of the Moafa II project. The baseline report will describe the current conditions (before the start of the project) of the project area against which progress can be measured or comparisons made to show the effects and outcomes of the project in the final project evaluation report. The baseline report will include quantitative baseline data for each indicator; numerical performance targets by indicator; as well as brief narrative description of the prevailing situation and the needs that the project will address. CRS is engaging the consultant to design and conduct the baseline survey, analyze and interpret the findings, and draft the baseline report.

*Baseline survey:*

The Moafa II project is a continuation of the prior Moafa I project. In the Moafa II project, CRS will continue working in existing Moafa I locations as well as add six new catchment areas. For the baseline survey, the consultant will use existing data from current CRS project locations as well as collect data from new project locations (six new catchment areas).

For the current CRS locations, the results of Moafa I final evaluation will be considered as baseline values for Moafa II. However, for the six new catchment areas, the consultant will conduct a full baseline survey will be conducted. Following this study, the aggregate baseline values for Moafa II villages will be derived using weighted estimates of both Moafa I old villages’ final evaluation values and Moafa II new villages’ baseline values with proportion of beneficiary HHs in old villages and new villages as weights.

This baseline survey will strictly abide by the highest standards of the COVID-19 safety regulations and guidance mentioned below, making the necessary adjustments in the original approaches, methodology, and tools at each stage of the baseline (e.g. training of enumerators, data collection, data validation, etc.). The same Moafa I baseline (BL) and final evaluation (FE) sampling design, precision and FANTA population-based sample size calculation formula is used to calculate the sample size for Moafa II. This allows for comparability of this BL and FE results.

The consultant will analyze and interpret the findings of the baseline survey (existing data and newly collected data); s/he will share these findings with CRS

*Baseline Report:*

Following the conduct of the baseline survey, the consultant will draft the baseline report. CRS will provide the template for this report following contract signature.

**2. Objective of the Baseline**The baseline study of the BHA-funded *MOAFA II project* activities is designed to collect individual and household-related data (disaggregated by sex and by status whether IDPs, returnees, or host communities) for key logframe outcome and impact indicators listed in Annex 2 below.

Overall, the objectives of the study are as follows:

* Determine the baseline values for key project outcome indicators, validate or modify project indicator target setting;
* Investigate the proposed assumptions within logframe and provide feasible recommendations for adjusting them, as required;
* Analyze household’s current livelihood, nutrition and hygiene behaviors and access to health and nutrition services;

**3. Background: Project Objectives and Goals**

*Moafa II* will seek to improve the nutrition, water, sanitation, and hygiene (WASH), and health status of 337,038 project beneficiaries (including 157,321 IDPs and returnees) in conflict-affected areas of Jebel Marra and Um Dukhun, Central Darfur State, Sudan. The project will build on the solid foundation of multiple BHA-funded interventions in Jebel Marra (since 2016) Um Dukhun (since 2019). The response will extend to newly accessible village clusters in these localities and harder to reach villages within the current clusters. The program will engage in emergency health, nutrition, WASH, and humanitarian coordination to help communities rebound from displacement and conflict.

CRS has been at the forefront of efforts to address urgent health, nutrition, and WASH needs among highly vulnerable populations of Central Darfur since 2004. CRS was among the first agencies to establish operations in Jebel Marra as these communities became accessible, sometimes after more than a decade of isolation, in both government- and armed group-held areas. Through *Moafa I*, CRS has rehabilitated and equipped health facilities (HF), sanitation infrastructures, and waste disposal systems, as well as trained and equipped line ministry staff, local management committees, and community resource persons. Now, at the outset of *Moafa II*, new parts of Jebel Marra are becoming accessible for humanitarian intervention, while emergency and development needs of the population continue to strain current government and civil society resources. The two current most pressing programmatic needs in Central Darfur are 1) health, nutrition, and WASH in areas becoming accessible for the first time, and 2) consolidating structures and systems through support for ongoing services to sustain the gains made with previous OFDA funding.

In addition to these, a critical new issue evolving over recent months is the risk of COVID-19, which presents an immediate threat to the health of both project beneficiaries and staff. While COVID-19 poses a range of medical, economic, social, and political threats to the population, transmission can be stemmed through a strengthened health system, community engagement, prevention through appropriately controlled messaging (hand washing and social distancing), and attention to community and household (HH) hygiene.

**Goal**: Conflict-affected communities in Central Darfur have improved nutrition, WASH and health status

**Strategic Objectives:**

* 1. Targeted communities have increased use of primary health services;
	2. PLW and CU5 in target communities have reduced levels of malnutrition;
	3. Target communities have improved public health and access to WASH facilities, services and materials;
	4. Humanitarian actors promote effective principled action through coordinated efforts and information sharing.

These four strategic objectives were to be achieved through the following outputs:

* Rehabilitate and support HFs and community networks at the frontline of SBCC and case referrals;
* Provide access to screening and referral for PLW and CU5 with severe and moderate acute malnutrition (SAM and MAM);
* Supporting HHs to adopt good nutrition practices including consumption of animal protein through provision of poultry;
* Provide WASH facilities, services and materials to enable HHs to consume safe drinking water, use improved sanitation facilities, and adopt hygiene practices that diminish personal, public, and environmental health risks; and,
* Provide leadership and support to humanitarian coordination and information management.

**5. Project Targeted Population**

In *Moafa II* project*,* 337,038 individuals will be targeted including 103,204 returnees and 84,260 IDPs. The main criteria for targeting will be the vulnerability of HHs among populations of IDPs, returnees, and host communities. Interventions will contribute to social cohesion and empower vulnerable and marginalized groups. CRS’ health and nutrition programs directly target women (specifically PLW) caretakers of acutely malnourished CU5. The breakdown of the population targeted can be seen in the attached annex: *Annex 1: Baseline-Indicator Value-Population Tables*

# **6. Required Baseline Methodology and Tools**

Considering the second wave of COVID-19 pandemic, as mentioned above, this baseline study will be adapted to, strictly, follow COVID-19 guidance. This might entail change in approaches during data collection; like using secondary sources to collect data for some indicators, maintain social distance and number of participants in FGDs.

**6.1: The Moafa II baseline methodology will be comprised of both secondary and primary (quantitative and qualitative) data sources:**

**6.1.1: Secondary data:**

* ***Literature Review***: Conduct a literature review of all relevant secondary sources (including a review of all Moafa II project materials and Moafa I final report report) and any other relevant CRS, BHA documents on thematic areas of the Moafa project and records of the health centers, including:
	+ Moafa I documents: final evaluation, final report findings, and relevant Moafa I project records (patients and nutrition registers). These will give the baseline picture for the current CRS areas (13 areas), including both quantitative and qualitative information.
	+ Relevant Moafa I project records (patients and nutrition registers) as source of data for many Moafa II Logframe indicators.
	+ The Ministry of Health, with support from UNICEF, INGOs and other UN agencies, conducted -in 2019- the Simple Special Survey (S3M) for the whole country; therefore, S3M could constitute a source for additional health and nutrition data.

**6.1.2: Primary data:**

* ***Quantitative Data Collection***: The consultant will lead a household survey to collect quantitative data. CRS will provide the consultant with the quantitative data tools, which will be based on the Moafa I survey design, and the sample size for data collection. CRS will determine the sample size using the new population targets as a sampling frame. The survey tools (questionnaire and accompanying databases), survey manuals, and any other related guidance will be similar to Moafa I.

The consultant will prepare a detailed plan for this data collection as well as prepare a data tabulation and analysis plan for collected data. The consultant will then lead the data collection and management, training of survey teams, and relevant analysis for compilation of baseline survey report. The household survey, inclusive of queries for relevant logframe indicators, is included in Annex #2. The survey approach will rely on probability cluster sampling (See Section 6.2 for further information on Sampling for Quantitative Data Collection), and to permit for valid statistical comparisons, a representative sample size must be used. All data must be sex-disaggregated, as per the BHA indicators’ definition and disaggregation (Annex #1).

The following should be considered:

* + CRS will advise on the sample size needed from each location level (locality, catchment area, village). The consultant will then proceed in selecting interviewees using random selection.
	+ Phone calls with interviewees and scripting responses are to be relied upon, wherever phone coverage allows in the new area of Moafa II. Interviews could be done in more than one call to allow ample farming time for interviewees (During Moafa I final evaluation, this was not feasible due to the fact that phone subscribers in the areas of the project is very low especially among average households which might lead to bias towards well-off households).
	+ For respondents where phone surveys are not an option (e.g. no network coverage, lockdown due to COVID-19, security issues making travel too risky, etc.), there will be face-to-face data collection. Teams will conduct surveys while maintaining the social distance and other precautions (e.g. wearing face mask, conducting the survey in an outdoor space, etc.).
* **Qualitative Data Collection**: Focus Group Discussions (FGDs) and Key Informants Interviews (KII), will be used to help triangulate and explain results of the quantitative data gathered through the household survey.

For *FGDs*:

* + CRS expects 10-12 FGDs (2 per area, subgroups TBD), though the final number will be agreed upon during consultant orientation. CRS will advise on profile of KII participants.
	+ Where phone coverage allows, the FGDs may be changed into individual phone interviews. If in person, the number of the participants in FGDs will be reduced to five participants while maintaining social distance and other precautions.
	+ The length of the FGD checklists will reduced to capture the most important data that enriches areas that needed more clarification during the baseline study, and hence discussion will be shortened.
	+ Consultant will only apply PRA techniques that preserve social distance.

For *KIIs*:

* + CRS expects 10-12 KIIs (2 per area), though the final number will be agreed upon during consultant orientation. CRS will advise on profile of KII participants.
	+ KIIs will be conducted while maintaining social distancing and abiding by other COVID-19 precautions.

**6.2: Sample Size Calculation**

**6.2.1 For Quantitative Data Collection (Household Survey)**

CRS has established initial estimate sample size for this TOR, below. The final sample size will be confirmed ahead of contract signature.

For the Moafa II Project, the comparative for proportion formula suggested in “Feed the Future Population-Based Survey Sampling Guide and Calculator (2018)” is used to arrive at an overall sample size of **234** households. However, the survey will be conducted for the new villages. It is worth mentioning that the new villages weight of population represents almost 51.1% of the population. Hence, the sample size for the new villages shall be **120** households.

The project used three key indicators to get this result (the same indicators used for Moafa I baseline and final evaluation sample calculation).

* Proportion of children 6-23 months of age who receive foods from 4 or more food group”
* “Percentage of households targeted by WASH program that are collecting all water for drinking, cooking, and hygiene from improved water sources”
* “Percentage of households targeted by latrine construction/promotion program whose latrines are completed and clean”

The sample size will be calculated separately for each and then the baseline survey will take the largest sample size. Where applicable, the baseline value will be used from the Moafa I project final evaluation survey. The proposed project indicators sample size calculation is done as below with the required level of precision (only the first indicator -the 6-23-month children who receive 4 food groups- is calculated at 90% confidence level and 70% power, but standard 95% confidence level and 80% power for all other indicators).

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Where: 𝑛initial = is the initial sample size required by the surveys for each of the two time points

1. 𝛿 = 𝑃1,est − 𝑃2,𝑒st = minimum effect size to be achieved over the time frame specified by the two surveys
2. 𝑃1,est = represents a survey estimate of the true population proportion 𝑃1 at baseline [If such an estimate is not available from prior surveys, 0.5 will be used]



1. 𝑃2,𝑒st = represents a survey estimate of the true population proportion 𝑃2 at evaluation
2. 𝑧1−∝ is the value from the normal probability distribution corresponding to a confidence level 1−∝.

For 1−∝ = 0.95, the corresponding value is 𝑧0.95= 1.64.

1. 𝑧1−𝛽 is the value from the normal probability distribution corresponding to a power level of 1−𝛽.For 1−𝛽 = 0.80, the corresponding value is 𝑧 0.80 = 0.84.
2. 𝐷est is the estimated design effect (DEFF) of the survey.

**The values to calculate the sample size are included in the attached** *Annex 1: Baseline-Indicator Value-Population Tables.* There may be small revisions to this calculation prior to contract signing. It is expected to get a result that is not significantly higher or lower than the results calculated here.

# **7. Key Roles and Responsibilities**

The consultant will work closely with the CRS MEAL Manager and CRS Senior Project Officer (SPO), who will further liaise with the Moafa team (Grant Manager and Program Manager) as well as the CRS Regional Office.

*The Consultant* will lead the overall management of the baseline design and implementation as well as data analysis and report writing. This includes, but is not limited to, preparing the baseline plan; recruiting, training, supervising, and compensating the enumerators; monitoring and checking the data for quality during collection process; analyzing primary data collected as well as existing data from Moafa; interpreting overall findings; delivering findings to CRS through presentation; drafting the baseline report.

*CRS MEAL Manager and MEAL SPO* will provide the consultant with the relevant project information, existing data (MOAFA I), and data collection templates; review the baseline plan; manage approval for the baseline survey from government; conduct needed community mobilization; support recruitment of enumerators; support training logistics; provide template for baseline report.

CRS will also arrange all the needed logistics support, based on the agreed baseline plan, such as flight to Zalinegi, travel to deep field, and accommodation in Zalingei or deep field locations.

# **8.** **Timeframe**



*\*Yasir (CRS Meal Manager), Alison (Regional Advisor), Zaki (MOAFA Meal Senior Officer)*

# **9. Deliverables**

The following will be main deliverables of the baseline study. Dates are subject to slight adjustment depending on timing of contract signature with consultant.

|  |  |  |
| --- | --- | --- |
| Deliverable | Description | Deadline |
| Baseline survey plan | Consultant will prepare the baseline methodology plan. **Consultant will submit the plan for endorsement by CRS.**This plan must include the sampling framework tools and methodology, develop data collection and management strategy, human resources requirement, detailed survey implementation plan, training. The plan must also include the final data collection tools that will be used in the survey. | Dec 13, 2020 |
| Training of Data Enumerators | Consultant will train data enumerators and clerks on COVID-19 guidelines and evaluation design, sampling framework, survey tools and ethics. **Consultant will share record of training as evidence of deliverable.**\*If carrying out data collection over the phone, scripting and practice by interviewers is important; refer to: [JPAL’s best practices for conducting phone-based surveys](https://www.povertyactionlab.org/blog/3-20-20/best-practices-conducting-phone-surveys) and [60 Decibels’ remote survey toolkit](https://60decibels.com/user/pages/03.Work/_remote_survey_toolkit/60_Decibels_Remote_Survey_Toolkit_March_2020.pdf)\*Conduct household data collection visits following distancing and other safety protocols Refer to: [ID Insight’s guidance on data collection](https://www.idinsight.org/data-collection-practices-and-recommendations-for-covid-19) has helpful tips | To be agreed between consultant and CRS based on baseline survey plan |
| Fully ‘cleaned-up’ dataset in SPSS file format. | **Consultant will submit to CRS the fully ‘cleaned-up’ dataset in SPSS file format.** Different sets of cross-tabulations breaking down the results for all questions and including appropriate statistical tests so that significant differences can easily be identified. The survey team shall also share with the project team SPSS syntax file that is utilized to clean the dataset and tabulate and analyze the quantitative data. | Dec 31, 2020 |
| Presentation of baseline survey findings to CRS | **Consultant will prepare initial findings and present them to CRS, including a written summary (bullet points) and oral presentation**.The exact date/time of presentation will be agreed between CRS and consultant, before the deadline stated on the right column. | Dec 31, 2020 |
| Baseline Report  | CRS will provide consultant with a template for the baseline report. The baseline report must be in English and no more than 30 pages, excluding additional annexes of data collection tools used in the study. The report will cover the following: **The consultant will prepare the baseline report and submit to CRS. The consultant will also submit the final data collection tools used in survey and any other relevant tools created during the consultancy.** | Jan 6, 2021 |

**Annex 1: Indicator Values and Population Tables**

Please see separately attached.

**Annex 2: Key Logframe Outcome and Impact Indicators**

| **Indicators with disaggregates**  | **BL value****#** | **BL value****%** | **Evaluation Result #** | **Evaluation Result %** | **Definition of indicator** | **Source of data** |
| --- | --- | --- | --- | --- | --- | --- |
| Health |  |  |  |  |  |  |
| 1. Number and percentage of pregnant women who have attended at least two comprehensive antenatal clinics
 | 3 | 1.9 |  |  | Attended: Presented to a health service delivery point and received services required for antenatal visits. Comprehensive antenatal clinics: The complete package of antenatal services as prescribed by MoH policy and delivered by a trained health care worker. WHO guidelines on the content of ANC visits include the following components: • Clinical examination, • Blood testing to detect syphilis and severe anemia (and HIV, malaria, etc. according to the epidemiological context), • Gestational age estimation, • Uterine height, USAID/OFDA Proposal Guidelines Health pg. 9 • Blood pressure, • Maternal weight and height, • Test for sexually transmitted infections (STIs), • Urine test, • Request blood type and Rh, • Tetanus toxoid administration, • Iron/folic acid supplementation, and recommendations for emergencies (WHO, 2002). | Patient registers/records from supported health facilities |
| 1. Number and percentage of newborns that received postnatal care within three days delivery

Disaggregated by: Sex | 6 | 3.8 |  |  | Received: Attended to or seen by a trained healthcare provider at a health facility, at home, or at the community-level. Postnatal care: The complete package of interventions as prescribed by MoH policy delivered by a trained healthcare worker. WHO guidelines on the content of PNC visits include the following components: • Assessment of the baby (e.g., breathing, feeding, temperature, jaundice), • Exclusive breastfeeding support, and • Cord care (WHO, 2013). | Patient registers/records from supported health facilities; CHW reports/registers |
| * Male
 | 3 | 3.4 |  |  |  |  |
| * Female
 | 3 | 4.3 |  |  |  |  |
| 1. Number and percentage of births assisted by a skilled attendant at birth

Disaggregated by: Type of birth attendant | 90 | 55.9 |  |  | Assisted by: Skilled (not traditional) Present and presiding over labor and delivery for a pregnant woman and trained/available to perform assessment and the seven signal functions of basic emergency obstetric and newborn care (BEmONC), including management of complications or recommending referral, as needed | Patient registers/records from supported health facilities; Community-based skilled attendant at birth reports/registers |
| * Midwives
 | 63 | 39.1 |  |  |  |  |
| * Doctors
 | 19 | 11.8 |  |  |  |  |
| * Nurses with midwifery and life-saving skills
 | 8 | 5 |  |  |  |  |
| Disaggregated by: Location of delivery |  |  |  |  |  |  |
| * Health facility
 | 27 | 16.8 |  |  |  |  |
| * Home
 | 63 | 39.1 |  |  |  |  |
| 1. Number and percentage of pregnant women in their third trimester who received a clean delivery kit
 | 13 | 8.1 |  |  | Third trimester: Visibly pregnant and/or weeks 27 to 40 of pregnancy. Clean Delivery Kit: Kit contents should include the following: • Soap, 110 g • Plastic draw sheet, 100cm x 100cm • Razor Blade, single-edged, disposable • Tape, umbilical, 3mm x 15mm • Cotton cloth / town, 100cm x 100cm • Gloves, examination, single use • Plastic big, snap-lock - for disposal of the placenta | Patient registers/records from supported health facilities; Distribution reports/records |
| 1. Number and percentage of community members who can recall target health education messages

Disaggregated by: Sex | 16 | 3.8 |  |  | Community members: People living within the program catchment area. Recall: May include spontaneous mention and/or aided recall. Target health education message: Information specific to particular disease prevention/treatment or health seeking behaviors that are provided to the communitySeven messages were selected for the most common diseases (Malaria and diarrhea) | Knowledge, Attitudes, and Practice (KAP) Survey administered to a representative sample of the catchment populationQuestions. C10, C11, C12 |
| * Male
 | 8 | 1.9 |  |  |  |  |
| * Female
 | 8 | 1.9 |  |  |  |  |
| Nutrition |  |  |  |  |  |  |
| 1. Percentage of infants 0 – < 06 months of age who are fed exclusively with breast milk

Disaggregated by: Sex | 2 | 3.5 |  |  | Fed exclusively: Infant is fed breast milk (including milk expressed from a wet nurse) and nothing else, not even water. ● Infants may be given ORS, drops, syrups (vitamins, minerals, medicines). ● This is based on recall of the previous day. | Survey data of mothers and caregivers of infants less than 6 months of age at the time of the interventionQuestions: D02 to D12 |
| * Male
 | 1 | 3.1 |  |  |  |  |
| * Female
 | 1 | 4 |  |  |  |  |
| 1. Proportion of children 6-23 months of age who receive foods from 4 or more food group

Disaggregated by: Sex | 6 | 20.6 |  |  | The 7 food groups used for tabulation of this indicator are: - Grains, roots and tubers - Legumes and nuts - Dairy products (milk, yogurt, cheese) - Flesh foods (meat, fish, poultry and liver/organ meats) - Eggs - Vitamin-A rich fruits and vegetables - Other fruits and vegetables. (based on previous day recall) | Survey data of mothers and caregivers of children 6-23 months of age at the time of the interventionQuestions: D02 to D12 |
| * Male
 | 3 | 19.7 |  |  |  |  |
| * Female
 | 3 | 21.5 |  |  |  |  |
| 1. a) Number of people admitted Management of Acute Malnutrition sites

Disaggregated by: Sex  | 104 | 23.5 |  |  | Admitted: the number of malnourished people that enter a treatment programRates: ● Recovery rate: Number of people who have reached the discharge criteria of success defined for the program ● Defaulter rate: Number of people who did not return for treatment two consecutive times over the number of people enrolled in the program ● Death rate: Number of people who died while registered in a community-based management of acute malnutrition program ● Relapse rate: Number of beneficiaries re-admitted to the program after having been successfully discharged as recovered within the last two months (This is a new episode of Severe Acute Malnutrition [SAM]). Length of stay: The number of days elapsed between admission and discharge. | CMAM Register (Compile data from supported health facilities and nutrition centers.)(Note: This source of data is not available in all new facilities and there is doubt of completeness/quality in the others. So, decided to collect the required data using this survey. This is for all the indicators using the source) |
| * Male
 | 64 | 15.1 |  |  |  |  |
| * Female
 | 95 | 22.4 |  |  |  |  |
| Disaggregated by: Age  |  |  |  |  |  |  |
| * Children 0<6 months
 | 16 | 10.1 |  |  |  |  |
| * Children 6<23 months
 | 46 | 28.9 |  |  |  |  |
| * Children 24-59 months
 | 15 | 9.4 |  |  |  |  |
| * Children ≥ 5
 | 30 | 18.9 |  |  |  |  |
| * Pregnant and lactating women.
 | 52 | 32.7 |  |  |  |  |
| 1. Rates of recovery
 | 126 | 79.2 |  |  |  |  |
| 1. Default
 | 6 | 3.8 |  |  |  |  |
| 1. Death
 | 4 | 2.5 |  |  |  |  |
| 1. Relapse
 | 7 | 4.4 |  |  |  |  |
| 1. D’know
 | 5 | 3.1 |  |  |  |  |
| 1. Others
 | 11 | 6.9 |  |  |  |  |
| 1. Average length of stay
 | 23 |  |  |  |  |  |
| 1. Number of animals owned per individual

Disaggregated by: Type  |  |  |  |  | This indicator counts the number of domestic animals owned by individuals who have directly benefited from USAID/OFDA-funded project interventions (not including secondary beneficiaries such as related household members or community members). Animals are defined as any non-aquatic organism reared to produce commodities, including birds, mammals, reptiles, etc. An animal is considered owned if it possessed by a person who has full claim to that animal | Survey or official government statistics specific to area of intervention**Questions: D13 to D15** |
| * Cattle and buffalo
 | 0.8 |  |  |  |  |  |
| * Camelids (e.g., camels, lamas)
 | 0.1 |  |  |  |  |  |
| * Goats and sheep
 | 2.9 |  |  |  |  |  |
| * Poultry (e.g., chickens, ducks)
 | 2.8 |  |  |  |  |  |
| * Horses, donkeys and mules
 | 1.4 |  |  |  |  |  |
| * Swine (pigs)
 | 0.0 |  |  |  |  |  |
| * Micro-stock (e.g., rabbits, guinea pigs, cane rats)
 | 0.1 |  |  |  |  |  |
| * Bees (queen or colony)
 | 0.1 |  |  |  |  |  |
| * Farmed wildlife (e.g., zebra, eland)
 | 0.0 |  |  |  |  |  |
| WASH |  |  |  |  |  |  |
| 1. Percent of households targeted by the WASH promotion program that are properly disposing of solid waste
 |  | 86 |  |  | This indicator measures the presence of proper solid waste disposal practices at household level. Proper disposal of solid waste means that households 1. Have access to appropriate hardware for disposal of solid waste; and 2. Demonstrate appropriate usage of this hardware.While “appropriate” hardware is contextual, it generally includes any household or communal refuse bin or pit which, when used properly, adequately reduces public health risks associated with vectors, flooding, and contamination of water sources. Appropriate usage means that 1. There is no unhealthy accumulation of solid waste in the living area; and 2. The hardware is operated and maintained as designed (e.g., bins have lids, waste in pits is regularly covered with soil or ash, no obvious vector issues).  | Records from statistically valid household surveysThe presence of proper household solid waste disposal practices is measured by interview and direct observation. To determine if the household’s solid waste disposal practice complies with the definition, enumerators will 1. Ask the respondent where his/her household disposes its solid waste; 2. Observe the stated disposal site and determine whether it is “appropriate” and properly operated and maintained; and 3. Assess the living area for unhealthy accumulations of solid waste.Questions: E01, E02 |
| 1. Percentage of people targeted by the hygiene promotion program who know at least three (3) of the five (5) critical times to wash hands

Disaggregated by: Sex |  | 25.5 |  |  | This indicator measures individuals’ knowledge of the hand washing practices which are most effective at preventing the spread of pathogens along the fecal-oral cycle. The five critical times to wash hands are defined as 1. After defecation/using the toilet; 2. Before eating; 3. After changing diapers or cleaning a child’s bottom; 4. Before preparing food; and 5. Before feeding an infant. | Records from statistically valid household surveys are preferredQuestions: E03 to E05 |
| * Male
 |  | 5.2 |  |  |  |  |
| * Female
 |  | 20.3 |  |  |  |  |
| 1. Percentage of households targeted by the hygiene promotion program who store their drinking water safely in clean containers
 | 267 | 63.0 |  |  | This indicator measures the existence of safe household water storage practices that reduce the risks of post-collection water contamination.  This indicator requires that water be stored in safe containers and that those containers be clean. A safe water storage container is defined as a drinking water storage vessel which limits the risk of contamination and prevents dipping instruments or hands from coming in contact with the water (e.g. sealed/covered buckets with spigots or narrow-necked jerry cans). The determination of whether a container is clean is based on the presence/absence of dirt, grime, sediment, or other foreign substances on the interior or exterior surfaces of the container | Records from statistically valid household surveys. The existence of safe water storage practices is measured by direct observation during the household survey.**Questions: E06** |
| 1. Percentage of households targeted by the hygiene promotion program with no evidence of feces in the living area
 |  | 80% |  |  | This indicator measures the effectiveness of hygiene promotion efforts to reduce the practice of open defecation in immediate living areas.  For this indicator, feces includes both human and animal feces  | Records from statistically valid household surveys. The presence of feces in the living area is measured by direct observation during the household survey.**Questions: E07, E08** |
| 1. Percentage of excreta disposal facilities built or rehabilitated in health facilities that are clean and functional
 |  | 80 |  |  | This indicator measures the cleanliness and operational status of all excreta disposal facilities built or rehabilitated by the program in targeted health facilities. For this indicator, an excreta disposal facility is defined as • A simple pit latrine; • A VIP latrine; or • A flush latrine (pour-flush or cistern-flush) connected to a pit, septic, or sewerClean is defined as • The absence of feces or used anal cleansing material on the slab and within a five-meter radius around the exterior of the excreta disposal facility; and • The absence of unreasonably noxious odors and excess flies which may cause users to avoid the facility. A “functional” excreta disposal facility at a health facility must 1. Be constructed of cleanable material; 2. Be supplied with water if water is required for flushing or anal cleansing; 3. Be lockable from the inside; and 4. Have a handwashing station with soap and water located no more than ten meters away | For the numerator, records from an assessment of all excreta disposal facilities during a health facility survey. For the denominator, project records.The functionality of all (100%) excreta disposal facilities built or rehabilitated by the program in health facilities should be assessed by direct observation during a cross-sectional survey no earlier than three months after building or rehabilitating.Direct observation checklists are drafted to check cleanliness of excreta disposal facilities and hand-washing stations that the project has directly build/rehabilitate or assist building/rehabilitating. This will not be collected by the HH questionnaire but rather using cross-sectional survey as recommended. |
| 1. Percentage of hand washing stations built or rehabilitated in health facilities that are functional
 |  | 47.8 |  |  | This indicator measures the operational status of all hand washing stations built or rehabilitated by the program in targeted health facilities. Handwashing facilities are generally associated with either a latrine or common area accessible to staff, patients, and caregivers. A “functional” handwashing station associated with a latrine must 1. Be located no more than 10 meters from the latrine; 2. Have both soap and water present; and 3. Appropriately manage gray waterA “functional” handwashing station associated with other common areas accessible to staff, patients, and caregivers must 1. Be in a location which makes hand washing convenient to patients, caregivers, and staff; 2. Have both soap and water present; and 3. Appropriately manage gray water. | For the numerator, records from an assessment of all handwashing stations during a health facility survey. For the denominator, project records.The functionality of all (100%) hand washing USAID/OFDA Proposal Guidelines Water, Sanitation, and Hygiene PIRS pg. 26 stations built or rehabilitated by the program in health facilities should be assessed by direct observation during a cross-sectional survey no earlier than three months after building or rehabilitating.This will not be collected by the HH questionnaire but rather using cross-sectional survey as recommended |
| 1. Percentage of households targeted by latrine construction/promotion program whose latrines are completed and clean
 |  | 37.8 |  |  | This indicator measures the program’s effectiveness in facilitating the construction of household latrines in order to prevent human excreta from being a source of contamination. Facilitation can range from direct construction by your organization (100% subsidy) to promotion of household latrines with no subsidyA latrine is defined as • A simple pit latrine; • A ventilated improved pit (VIP) latrine; or • A flush latrine (pour-flush or cistern-flush) connected to a pit, septic, or sewer. A “completed” latrine means that it is designed, located, built and maintained in a way that 1. Enables safe and convenient access to all users, and 2. Safely contains excreta so that it is not a source of contamination. For this indicator, clean is defined as 1. the absence of feces or used anal cleansing material on the slab and within a five-meter radius around the exterior of the latrine; and 2. The absence of unreasonably noxious odors and excess flies which may cause users to avoid the latrine. | If a census of targeted households is conducted, the data source for the numerator will be observation records from household visits. For the denominator, the data source will simply be an enumeration of the targeted households. If a representative, household survey is conducted, then the data source will be records from statistically valid household surveysThe enumeration of households whose latrines are completed and clean (the numerator) is measured by direct observation during a census or sample survey of households targeted by the program.**Questions: E09** |
| 1. Percentage of households targeted by WASH program that are collecting all water for drinking, cooking, and hygiene from improved water sources
 |  | **54.9** |  |  | This indicator measures the proportion of the population that is collecting water for drinking, cooking, and hygiene solely from improved water sources.  This indicator focuses only on water collected for the drinking, cooking, and hygiene needs of household members. This excludes water collected for livestock, agriculture, gardening, construction, or other livelihood generating purposes An “improved source” is one which has the potential to deliver safe water by nature of its design and construction. Specifically, for this indicator, an improved source is limited to: piped water; boreholes or tubewells; protected dug wells; protected springs; protected rainwater collection systems; packaged or delivered water; and emergency water treatment systems. | Records from interviews conducted during statistically valid household surveys are preferred. Other reliable population-based survey methods (e.g., people at water points) may be used when household surveys are not possible.Questions must be open ended, e.g.: “From which source(s) do you collect water for drinking, cooking, and hygiene?”, “Are there times when water is unavailable from these sources?”; “If yes, where do you collect water for drinking, cooking, and hygiene when it is unavailable from these sources?;” “Do you collect water for drinking, cooking, and hygiene from any other sources other than those mentioned?”**Questions: E10 to E17** |

## Annex 3: Data Collection Tools

**Identification:** [ ] [ ]  [ ] [ ]  [ ] [ ]  [ ] [ ]

***Moafa* Baseline Survey**

**(WASH, Nutrition and Health Integrated Project – Central Darfur – USAID OFDA Funded)**

**(Quantitative Households’ Survey)**

Questionnaire for Randomly Selected Households

**INTRODUCTION AND CONSENT**

| **Guidance for introducing yourself and the purpose of the interview:****Assalamualaikum!** My name is \_\_\_\_\_\_\_\_\_\_\_\_\_ and I am representing *CRS Organization.* * CRS is implementing an integrated Health Nutrition and WASH Project called (Moafa). You are one among the project beneficiaries. Now we are conducting a survey at the beginning of the project to obtain baseline information that can be used to learn about the project outcomes in meeting its objectives.
* You have been selected **by chance** for this interview. Your participation in the survey is ***voluntary***.
* The information that you (and your family) give will be ***confidential***. It will be used to prepare report but will not include any specific names. There will be no way to identify that you gave this information.
* Could you please spare some time (around 40 minutes) for the interview?

At this time, do you want to ask me anything about the survey? May I begin the interview now? |
| --- |
| **RESPONDENT AGREES TO BE INTERVIEWED 1 →START****RESPONDENT DOES NOT AGREE TO BE INTERVIEWED 2 →Fill-up SAMPLE IDENTIFICATION→END** 20.5020 |
| Name of the interviewer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of the interviewer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | Date: [ ] [ ] -[ ] [ ] - dd mm yyyy |

|  |  |
| --- | --- |
| Locality name/code:…………..…………….. [ ] [ ]  | Name of the village/code: …………………..…………[ ] [ ]   |

**MODULE – A: Respondant’s Information**

| **NO.** | **QUESTIONS AND FILTERS** | **CODING CATEGORIES** |  **SKIP** |
| --- | --- | --- | --- |
| A01 | Who is the prime respondent?***[SINGLE RESPONSE]*** | Household Head 1Spouse 2Son/daughter 3Other household member 4 |  |
| A02 | Sex of the respondent? | Male 1Female 2 |  |
| A03 | Age of the respondent? | [ ] [ ]  Years |  |
| A04 | Sex of the HH Head? | Male 1Female 2 |  |

**MODULE - B: Household Demographics**

*[****INSTRUCTION:*** *PLEASE ASK THIS QUESTION FOR THE HOUSEHOLD MEMBERS WHO LIVES IN THE SAME HOUSE UNDER THE SAME ROOF AND TAKE MEAL TOGETHER BY COOKING IN THE SAME POT. HOUSEHOLD MEMBERS LIVE OUTSIDE FOR MORE THAN six MONTHS SHOULD BE EXCLUDED FROM NUMBER OF HOUSEHOLD MEMBER COUNTING].*

***INTRODUCTION:*** *Now I would like to ask you about the members living in this household and their sex and age groups*

|  **NO.** | **QUESTIONS AND FILTERS** | **CODING CATEGORIES** |  **SKIP** |
| --- | --- | --- | --- |
| B01 | How many persons in total in this household (including the HH Head)? | [ ] [ ]  Persons |  |
| B02 | How many household members are in the following age group by sex?***[INSTRUCTION: CHECK THE TOTAL AND VERIFY IT WITH B01. IF DIFFERENT CORRECT WITH RESPONDENT]*** |  | Male | Female |  |
| 1. 0 to 23 months
2. 24 to 59 months
 | [ ] [ ] [ ] [ ]  | [ ] [ ] [ ] [ ]  |
| 1. 5 – 14 years
 | [ ] [ ]  | [ ] [ ]  |
| 1. 15 – 49 years
 | [ ] [ ]  | [ ] [ ]  |
| 1. 50 – 64 years
 | [ ] [ ]  | [ ] [ ]  |
| 1. 65 years and above
 | [ ] [ ]  | [ ] [ ]  |
| 1. TOTAL
 | [ ] [ ]  | [ ] [ ]  |
| **NO.** | **QUESTIONS AND FILTERS** | **CODING CATEGORIES** |  **SKIP** |
| B03 | Are there pregnant women in this HH? | Yes 1No 2Don’t know 3 | **2 →B05 3→B05** |
| B04 | Please tell us how many pregnant women do have in this HH? | [ ] [ ]  women |  |
| B05 | Are there lactating women in this HH? | Yes 1No 2Don’t know 3 | **2 →B07 3→B07** |
| B06 | Please tell us how many lactating women do have in this HH? | [ ] [ ]  women |  |
| B07 | Is there any disabled person in this HH? | Yes 1No 2Don’t know 3 | **2 →C01 3→C01** |
| B08 | Please tell us how many disabled persons in this HH? | [ ] [ ]  persons |  |

**MODULE C: Health**

[**INTRODUCTION**: Now we will discuss about health and health care seeking of members in this household including of pregnant women and newborn babies, PLWS’ nutrition and community health**]**

| NO. | Question  | Answers Categories and coding | Skip |
| --- | --- | --- | --- |
| **Sub Sector: Communicable Diseases** |
| C 01 | Where do household members usually go for treatment? ***[MULTIPLE RESPONSE]*****[INSTRUCTION: DO NOT READ THE ANSWERS BUT PROBE, Anywhere else? Anywhere else?]** | **Yes=1, No=2**1. At home [ ]
2. Faki [ ]
3. Imam [ ]
4. Traditional Healer [ ]
5. Community Health Worker (Moawin) [ ]
6. Health Facility (health Center) [ ]
7. Health Facility (Hospital) [ ]
8. Other (Specify) [ ]
 |  |
| **Sub Sector: Reproductive Health** |
| C02 | Have any women in your HH given birth in last one year?  | Yes ………………………….……………………………………………. 1No …………………………………………………………………………. 2 Don’t Know …………….……………………………………………. 3 | **2→C16a** **3→C16a** |
| C03 | How many women in your HH given birth in last one year? | [ ]  women |  |
| **PLEASE ASK THE FOLLOWING QUESTIONS TO ALL WOMEN DELIVERED IN LAST ONE YEAR SEPERATELY, ONE AT A TIME** |
|  | Name of the mother  | **1st mother (Name)** | **2nd mother (Name)** |  |
| **C04** | **Pregnant and Lactating Women (PLW) Nutrition: PLEASE FILL-IN THIS SECTION IF B03 OR B05 ARE “YES”, FOR MAXIMUM TWO WOMEN WHO ARE EITHER CURRENTLY PREGNANT OR LACTATING. IF NO PLW, SKIP TO C10** |
|  | Name of PLW? | **1st Women ……………………** | **2nd Women ……………………** |  |
| **C05** | How old are you? |  [ ] [ ]  |  [ ] [ ]  |  |
| **C06** | Have you ever received education or messaging about proper feeding for a pregnant woman? | Yes 1No 2 | Yes 1No………………………….. 2 | **2→C10** |
| **C07** | Who trained you or offered the messages?Anybody else? Anybody else?***[MULTIPLE RESPONSE]*****[INSTRUCTION: DO NOT READ THE ANSWERS BUT PROBE]** | Yes=1, No=21. The midwife [ ]
2. NGO Worker [ ]
3. Neighbor [ ]
4. Moawin [ ]
5. Other specify [ ]
 | Yes=1, No=21. The midwife [ ]
2. NGO Worker [ ]
3. Neighbor [ ]
4. Moawin [ ]
5. Other specify … [ ]
 |  |
| **C08** | What types of food a pregnant woman should eat? Anything else? Anything else?***[MULTIPLE RESPONSE]*****[INSTRUCTION: DO NOT READ THE ANSWERS BUT PROBE]** | Yes=1, No=21. Cereals [ ]
2. Legumes [ ]
3. Milk and milk product [ ]
4. Fruit and vegetables [ ]
5. Tuber and root [ ]
6. Oil, butter or ghee [ ]
7. Other specify [ ]
 | Yes=1, No=21. Cereals [ ]
2. Legumes [ ]
3. Milk and milk product [ ]
4. Fruit and vegetables [ ]
5. Tuber and root [ ]
6. Oil, butter or ghee [ ]
7. Other specify [ ]
 |  |
| **C09** | How many times a pregnant woman should eat during the day  | #: …………………………………… |  |
| **Sub sector Community health: This sector covers community health, both preventive and treatment for Malaria and diarrhea** |
| C10 | Did you or any HH member receive any health education messages in last one year? | Yes ………………………….……………………………………………. 1No …………………………………………………………………………. 2  | **2 →D01**  |
| C11 | How many family members received health education messages | 1. Number of women [ ]
2. Number of men [ ]
 |  |
| C12 | What health education messages do you know/remember about prevention, treatment or health seeking behavior of Malaria and diarrhea? Any other? Any other?***[MULTIPLE RESPONSE]*****[INSTRUCTION: DO NOT READ THE ANSWERS BUT PROBE]** | **Yes=1, No=2**1. Using mosquito net [ ]
2. Cover/dry Stagnant water to break mosquito life-cycle [ ]
3. Washing hands [ ]
4. Treating water for domestic use [ ]
5. Take Oral Rehydration Salts (ORS) [ ]
6. Prepare and take Salt Sugar Solution (SSS) [ ]
7. Seeking treatment at the health facility [ ]
8. Other specify [ ]
 |  |

**MODULE D: NUTRITION**

**Sub sector: Infant and Young Child Feeding in Emergencies**

[**INTRODUCTION**: Now we will talk about all the children of age under 2 years in this HH. We will discuss about their feeding practices, illness and care seeking**]**

|  |  |  |  |
| --- | --- | --- | --- |
| **D01** | How many children are U2 years in the HH? [**CONFIRM THE RESPONSE WITH B02 A.**] | a. Number of children 0-23 months: [ ]  | **0→D13** |
| **PLEASE ASK THE FOLLOWING QUESTIONS TO CAREGIVERS OF ALL CHILDREN OF AGE 0-23 MONTHS SEPERATELY, ONE AT A TIME**  |
| D02 | Name of U2  | **1st child 0-23 months [NAME]** | **2nd child 0-23 months [NAME]** | **3rd child 0-23 months [NAME]** |  |
| **D03** | Age of the child? | [ ] [ ] months | [ ] [ ] months | [ ] [ ] months |  |
| **D04** | Sex of the child? | Boy 1Girl 2 | Boy 1Girl 2 | Boy 1Girl 2 |  |
| **D05** | Did you ever breastfeed [NAME]? | Yes 1No 2 | Yes 1No 2 | Yes 1No 2 | **2→D09** |
| **D06** | How long after birth did you first put (NAME) to the breast? | 1. Days [ ] [ ]
2. Hours [ ] [ ]
3. Minutes [ ] [ ]
 | 1. Days [ ] [ ]
2. Hours [ ] [ ]
3. Minutes [ ] [ ]
 | 1. Days [ ] [ ]
2. Hours [ ] [ ]
3. Minutes [ ] [ ]
 |  |
| **D07** | In the first three days after the delivery, was (NAME) given anything to drink other than breast milk? | Yes 1No 2 | Yes 1No 2 | Yes 1No 2 |  |
| **D08** | Did **[NAME]** breastfed yesterday during the day or at night?  | Yes 1No 2 | Yes 1No 2 | Yes 1No 2 |  |
| **D09** | Did (NAME) drink anything from a spoon/cup/bottle with a nipple yesterday during the day or at night? | Yes 1No 2 | Yes 1No 2 | Yes 1No 2 |  |
| **D10** | Did (NAME) given any vitamin drops or other medicines as drops yesterday during the day or at night?  | Yes 1No 2 | Yes 1No 2 | Yes 1No 2 |  |
| **D11** | Did (NAME) given **[local name for oral rehydration solution]** yesterday during the day or at night?  | Yes 1No 2 | Yes 1No 2 | Yes 1No 2 |  |

|  |
| --- |
| Now I would like to ask you about liquids or foods that (NAME) **had yesterday** during the day or at night. I am interested in whether your child had the item I mention even if it was combined with other foods. **[INSTRUCTION: ASK ABOUT ALL FOODS/FOOD GROUPS ONE BY ONE]** |
| **D12** | 1. Plain water
 | Yes 1No 2 | Yes 1No 2 | Yes 1No 2 |
| 1. Fresh Juice or juice drinks
 | Yes 1No 2 | Yes 1No 2 | Yes 1No 2 |
| 1. Milk such as tinned, powdered, or fresh animal milk?
 | Yes 1No 2 | If yes, how many times? [ ] [ ]  | Yes 1No 2 | If yes, how many times? [ ] [ ]  | Yes 1No 2 | If yes, how many times? [ ] [ ]  |
| 1. Infant formula (e.g. leben el um, Lactogen)?
 | Yes 1No 2 | If yes, how many times? [ ] [ ]  | Yes 1No 2 | If yes, how many times? [ ] [ ]  | Yes 1No 2 | If yes, how many times? [ ] [ ]  |
| 1. Any other liquids?
 | Yes 1No 2 | If yes, how many times? [ ] [ ]  | Yes 1No 2 | If yes, how many times? [ ] [ ]  | Yes 1No 2 | If yes, how many times? [ ] [ ]  |
| 1. Yogurt?
 | Yes 1No 2 | If yes, how many times? [ ] [ ]  | Yes 1No 2 | If yes, how many times? [ ] [ ]  | Yes 1No 2 | If yes, how many times? [ ] [ ]  |
| 1. Any commercially fortified baby food like Cerelac?
 | Yes 1No 2 | Yes 1No 2 | Yes 1No 2 |
| 1. Bread, rice, noodles, porridge, or other foods made from grains?
 | Yes 1No 2 | Yes 1No 2 | Yes 1No 2 |
| 1. Pumpkin, carrots, squash or sweet potatoes that are yellow or orange inside?
 | Yes 1No 2 | Yes 1No 2 | Yes 1No 2 |
| 1. White potatoes, white yams, manioc, cassava, or any foods made from roots?
 | Yes 1No 2 | Yes 1No 2 | Yes 1No 2 |
| 1. Any dark green, leafy vegetables (eg. rudu or tamleka)
 | Yes 1No 2 | Yes 1No 2 | Yes 1No 2 |
| 1. Ripe mangoes, papayas, jackfruit or other Vitamin A rich fruits?
 | Yes 1No 2 | Yes 1No 2 | Yes 1No 2 |
| 1. Any other fruits like banana, grapes, apple, guava or other?
 | Yes 1No 2 | Yes 1No 2 | Yes 1No 2 |
| 1. Liver, kidney, heart or other organ meats?
 | Yes 1No 2 | Yes 1No 2 | Yes 1No 2 |
| 1. Any meat, such as beef, camel, lamb, goat, chicken, or duck?
 | Yes 1No 2 | Yes 1No 2 | Yes 1No 2 |
| 1. Eggs?
 | Yes 1No 2 | Yes 1No 2 | Yes 1No 2 |
| 1. Fish, seafood, shellfish?
 | Yes 1No 2 | Yes 1No 2 | Yes 1No 2 |
| 1. Any foods made from beans, peas, lentils, or nuts?
 | Yes 1No 2 | Yes 1No 2 | Yes 1No 2 |
| 1. Cheese or other food made from milk?
 | Yes 1No 2 | Yes 1No 2 | Yes 1No 2 |
| 1. Any other foods (SPECIFY)?
 | Yes 1No 2 | Yes 1No 2 | Yes 1No 2 |
| 1. How many times did (NAME) eat solid, semi-solid, or soft foods other than liquids **yesterday** during the day and at night as meal or snacks?
 | How many times?  [ ] [ ]  | How many times? [ ] [ ]  | How many times?  [ ] [ ]  |

|  |
| --- |
| **Sub sector Livestock: This section discusses ownership of livestock by type and number per HH and vet services/support received by the HH.** |
| D13 | How many animals do the HH own by type?ASK FOR EACH ANIMAL LISTED. RECORD 0 IF THE TYPE IS NOT OWNED. | 1. Cattle? [ ]
2. Camels? [ ]
3. Goats and sheep? [ ]
4. Poultry (e.g., chickens, ducks) ? [ ]
5. Horses, donkeys and mules? [ ]
6. Bees (queen or colony) ? [ ]
7. Micro-stock (e.g., rabbits) ? [ ]
8. Farmed wildlife (e.g., ghazzal) ? [ ]
9. Others (specify) ? [ ]
 |  |
| D14 | Did your household receive any livestock assistance from Community Animal Health Workers or Gov. veterinary services in last one year?  | Yes ………………………………………………………………. 1No ………………………………………………………………. 2 Don’t Know …………….……………………………………. 3 | 2 →E01 3→E01 |
| D15 | What vet services/support did they receive? Anything else? Anything else?***[MULTIPLE RESPONSE]*****[INSTRUCTION: DO NOT READ THE ANSWERS BUT PROBE]** | Yes=1, No=21. Training on poultry production, animal health and safe handling [ ]
2. Awareness on nutrition value (egg, meat) [ ]
3. Other (specify) [ ]

……………………………………………………………………………………… |  |

**MODULE – E: Access to Water, Sanitation and Hygiene**

***[INTRODUCTION:*** *Now I would like to ask you about the household access in essential services for water, sanitation, hygiene. I will ask you one by one for each of the services]*

| **NO.** | **QUESTIONS AND FILTERS** | **CODING CATEGORIES** |  **SKIP** |
| --- | --- | --- | --- |
|  | ***SUB SECTOR: Environmental Health*** |  |  |
| E01 | What Environmental Health services did your household receive in last one year? Anything else? Anything else?***[MULTIPLE RESPONSE]***[INSTRUCTION: DO NOT READ THE ANSWERS BUT PROBE] | **Yes=1, No=2**1. Solid waste Management [ ]
2. Vector control [ ]
3. Drainage system [ ]
4. Treatment of stagnant water [ ]
5. Other specify [ ]
 |  |
| E02 | What do you do with the solid waste (garbage) from your house? [SINGLE RESPONSE][INSTRUCTION: DO NOT READ THE ANSWERS BUT PROBE] | household refuse bin 1Pit within the yard 2Communal refuse bin 3Pit at the outskirts of the village 4Solid waste disposal site created by the program 5Solid waste burning site 6Just through over the wall/fence 7Take to the water stream/wadi 8Other specify 9 |  |
| **Sub-sector: Hygiene Promotion** |
| E03 | Please state all the occasions when it is most important to wash one’s hands? Any other? Any other?***Instruction:*** *Better to ask this question the mother/caregiver of children under 5 years of age. If not available, then ask the respondent.**(Multiple response possible. DO NOT read the choices but probe and mark all that)* | Yes=1, No=21. Before eating [ ]
2. Before preparing food [ ]
3. After using the latrine [ ]
4. After washing children bottoms [ ]
5. Before feeding a child [ ]
6. After eating [ ]
7. After shaking hands with others [ ]
8. When hands are dusty/dirty [ ]
9. Other specify……………………………………………………. [ ]

…………………………………………………………………. |  |
| E04 | For the occasions mentioned in E03, what do you use to wash your hands?***Instruction:*** *ask the question only for the options mentioned in E03* | **Handwashing** (Critical time)**Yes = 1** **No = 2** | **What do you use to wash hand?**1= Soap or detergent2= Ash, 3= Sand, 4=Nothing |  |
| 1. Before eating [ ] **1→**
2. Before preparing food [ ] **1→**
3. After using the latrine [ ] **1→**
4. After washing children bottoms [ ] **1→**
5. Before feeding a child [ ] **1→**
6. After eating [ ] **1→**
7. Before feeding a child [ ] **1→**
8. When hands are dusty/dirty [ ] **1→**
9. Other specify…………………………….[ ] **1→**

……………………………………………… | [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  |
| E05 | Why is it important to wash your hands? Any other? Any other?***[MULTIPLE RESPONSE]***[INSTRUCTION: DO NOT READ THE ANSWERS BUT PROBE] | **Yes=1, No=2**1. Don’t know [ ]
2. For cleanliness [ ]
3. To prevent diarrhea [ ]
4. Other specify……………………………………………………. [ ]
 |  |
| E06 | **Observe**: How do the HH stores the drinking water? | Keep water ***COVERED*** Clean in the container 1Keep water ***UNCOVERED*** Clean in the container 2Keep water ***COVERED* DIRTY** in the container 3Keep water ***UNCOVERED*** **DIRTY** in the container 4 |  |
| E07 | Observe: is there **HUMAN** feces inside or around the compound? | Yes 1No 2 |  |
| E08 | Observe: is there **ANIMAL** feces inside or around the compound? | Yes 1No 2 |  |
| **Sub-sector: Sanitation** |
| E09 | **OBSERVE** if the HH latrine is complete and cleanCompleted and clean means options A, B, C and DNote: Clean slab and around the latrine mean: 1- the absence of feces or used anal cleansing material on the slab and within a five-meter radius around the exterior of the latrine2- The absence of unreasonably noxious odors and excess flies which may cause users to avoid the latrine | **Yes=1, No=2**1. Enables safe and convenient access to all users [ ]
2. Safely contains excreta (not a source of contamination) [ ]
3. Clean slab and around the latrine [ ]
4. Absence of odor and flies [ ]
5. Household don’t have latrine [ ]
 |  |
| **Sub-sector: Water Supply** |
| E10 | From which source(s) do you collect water for drinking, cooking, and hygiene? Any other? Any other?[MULTIPLE RESPONSE][INSTRUCTION: DO NOT READ THE ANSWERS BUT PROBE] | **Yes=1, No=2**1. piped water [ ]
2. boreholes or tube wells (hand-pump) [ ]
3. protected dug wells [ ]
4. protected springs [ ]
5. protected rainwater collection systems [ ]
6. delivered/emergency water (treated) [ ]
7. Surface water (pond, river, canal) [ ]
8. Unimproved hand dug well [ ]
9. underground tank [ ]
10. From water venders (unknown sources) [ ]
11. Other (specify) [ ]
 |  |
| E11 | Are there times when water is unavailable from these sources? | Yes 1No 2 | **2 →E17**  |
| E12 | Where do you collect water for drinking, cooking, and hygiene when it is unavailable from these sources? Any other? Any other?***[MULTIPLE RESPONSE]*****[INSTRUCTION: DO NOT READ THE ANSWERS BUT PROBE]** | **Yes=1, No=2**1. piped water [ ]
2. boreholes or tube wells (hand-pump) [ ]
3. protected dug wells [ ]
4. protected springs [ ]
5. protected rainwater collection systems [ ]
6. delivered/emergency water (treated) [ ]
7. Surface water (pond, river, canal) [ ]
8. Unimproved hand dug well [ ]
9. underground tank [ ]
10. From water venders (unknown sources) [ ]
11. Other (specify) [ ]
 |  |
| E13 | How long does it take you to go there, get water, and come back in the dry season? | a. Round trip [ ] [ ] [ ] Minutes |  |
| E14 | How far is the water point from your home to fetch water in the dry season? Give some hints to get the right answer | [ ] [ ]  Km*[RECORD 00 IF LESS THAN 1 KM]* |  |
| E15 | Do you think the water source that you are using for household consumption for drinking is safe? | Yes 1No 2 |  |
| E16 | What do you usually do to make the water safer to drink? Anything else? Anything else?***[MULTIPLE RESPONSE]***[INSTRUCTION: DO NOT READ THE ANSWERS BUT PROBE] | **Yes=1, No=2**1. Do nothing [ ]
2. Use filter [ ]
3. Boil water [ ]
4. Use chlorine tablet [ ]
5. Use halogen tablet [ ]
6. Use solar disinfection process [ ]
7. Other specify…………………………………………………….[ ]
 |  |
| E17 | How much water do you collect per day (number of jerry cans of 20 liter)[Even if the HH is using small size containers, convert to 20-liter size]  |   [ ] [ ]  Jerry-cans |  |

***End of Questionnaire Thank the respondent for the information***

***Annex 3 - Checklist***

***MOAFA* Baseline Survey**

**(WASH, Nutrition and Health Integrated Project – Central Darfur – OFDA Funded)**

**(Excreta Disposal Facilities and Hand washing stations – Direct Observation checklist)**

|  |  |
| --- | --- |
| Locality: …………………………………..  | Name of the village: …………………………  |
| Name of the interviewer:…………………. | Date the facility was built: …………………….. |
| Date of the interview: …………………….. | GPS location of the Health Center: ……………… |

**Instructions:**

1. Fill-in this checklist only for facilities built or rehabilitated by the program in health facilities;
2. Your assessment should be through direct observation

**Excreta Disposal Facilities**

1. Type of the excreta disposal facilities
2. A simple pit latrine;
3. A VIP latrine; or
4. A flush latrine.
5. Check the excreta disposal Cleanliness by observing the following:
6. Do you observe feces or used anal cleansing material on the slab and within a five-meter radius around the exterior of the excreta disposal facility? YES [ ]  No: [ ]

Notes:

1. Do you observe any unreasonably noxious odors and excess flies which may cause users to avoid the facility? YES [ ]  No: [ ]

Notes:

1. Is the excreta disposal facility built from cleanable materials? YES [ ]  No: [ ]

Notes:

1. Is the facility supplied with water? Do you observe adequate quantity of water and water containers sufficient for flushing or anal cleansing YES [ ]  No: [ ]

Notes:

1. Is the facility lockable from the inside? YES [ ]  No: [ ]

Notes:

**Hand Washing Station:**

1. How far is the station from the latrine?
2. Is it located no more than 10 meters from the latrine?

YES [ ]  No: [ ]

Notes:

1. . Does it have both soap and water present? YES [ ]  No: [ ]

Notes:

1. What is the status of grey water? Is it appropriately managed? YES [ ]  No: [ ]

Notes:

1. Is the location of the station makes hand washing convenient to patients, caregivers, and staff? YES [ ]  No: [ ]

Notes:

General Remarks:

**Annex 4: FGD & KIIs Checklists**

**MOAFA Baseline Survey**

**(WASH, Nutrition and Health Integrated Project – Central Darfur – OFDA Funded)**

**(Qualitative Topical Checklists- FGD and KII)**

1. **General Instruction:**
* The group needs to be large enough to generate rich discussion but not so large that some participants are left out. The focus group should be of ***six to ten*** people led through an open discussion by a skilled moderator.
* The participants should know in advance on place, time and how long they will be engaged.
* The FGD will be conducted by a team consisting of a moderator and assistant moderator. The moderator will facilitate the FGD and assistant moderator will take note.
* Both FGD moderators need to conceptualize the TO before conducting FGD. Please ***DO NOT*** read the questions during conducting FGD.
* To conduct mini PRA make sure you have enough flip chart, vip card (rectangle and circle shape of different colors) marker of 5 colors (red, black, blue, violet, green), note book and ball point pen and markers with different colors.
1. **Basic Information:**
2. Locality : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Community : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Composition of FGD participants : Male \_\_\_\_\_\_\_ Female \_\_\_\_\_\_\_ Total \_\_\_\_\_\_\_
5. Name of the moderators 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Date of interview : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **Introduction:**

Purpose of the Group Discussion:

***INSTRUCTION:***

1. *At this stage moderator will get consent to move forward by asking “shall we start now?”*
2. *The moderator needs to be careful that it does not grow any expectation to the participants during discussion. The approach should be - we are just collecting some information that will not give any insurance of program support as an incentive to participate in the FGD. This is important to get true information from the community.*
3. *Record quotation exactly if it comes from the participants (with name of the participant who quoted) during discussion.*
4. **WASH - FGD Questions:**

**Hygiene Promotion:**

 Let the group list out the types of the Hygiene Promotion activities, they noted in the community?

***INSTRUCTION*** Let the group list the types of the hygiene activities, they observed in the community, Ask, do the group received any hygiene awareness messages before, where, who did and frequency. Let group explain the effective methods for treating a household drinking water, Let the group explain the appropriate disposal of faeces for children under U 5, Ask the group did they receive the same hygiene practice messages in two different places that including hygiene sessions, home visits and other, Ask the group, how many out of 10 persons of the community members, could receive the same hygiene education message in two different places.

1. What are the berries prevented community from adopting Hygiene promotion practices messages?

*[****INSTRUCTION:*** Ask, did they adopt received messages in their daily life, what are the changes the messages created in the community, list, ask did you faced any berries or challenges, to adopt the awareness messages. Prepare a list of challenges, Let the group explain why barriers and challenges (Social -Economic) effecting the hygiene practice in the community, Let the group discuss the difficulties and challenges. Let the group generate solution and recommendation

1. What are the factors prevent community member to adopting water treatment messages?

*[****INSTRUCTION:*** Ask the group whether they adopt the messages received, in their daily life. What changes happened to the community because of the treatment messages? Ask the group whether they faced any challenges/barriers to adopt the awareness messages. Prepare a list of challenges, and let the group explain why barriers and challenges (Social -Economic) are affecting the hand washing practice in the community Let the group to generate solution and recommendation for highlighted barriers and challenges

**Sanitation:**

1. In this community, did you noted, any of the sanitation activities conducted.

*[****INSTRUCTION:*** let the group describe these types of conducted activities, List the mentioned activities, let the group discuss each activity including accessibility, reliability, and/or affordability and quality of delivered services, (VIP) latrines and hand washing stations. Ask the group did they receive any awareness messages, concerning sanitation practice who did, where and frequency.

1. What the berries prevent community from adopting sanitation practices message?

*[****INSTRUCTION:*** Ask the group to recall some of the identified messages, ask how many out of 10 persons of the community members adopted sanitation practice messages, Ask, did they adopt received messages in their daily life, what are the changes the messages created in the community? List, ask did you faced any berries or challenges, to adopt the awareness messages? Prepare a list of challenges. Let the group explain reasons of the barriers and challenges (Social -Economic) effecting the hygiene practice in the community, let the group to discuss each challenge and generate solution and recommendation

**Environmental Health:**

1. Ask, the group, do they observe any solid waste management, activities concocted in this community.

*[***INSTRUCTION:** List the types of activities, draw a table of three columns of solid waste, drainage and vector control. Let the group sort the listed activities according the categories. Ask whether there are any cleanup/debris removal activities. Ask the group whether they received any messages regarding Environmental Health, who convey the messages, where and frequency. Let the group recall some of the received messages in this community, and let the group illustrates the types activities; focusing on accessibility, reliability, and/or affordability to services. Who delivered the services and frequency of delivery? Estimate the number of people engaged number cleanup campaigns, and ask about the quality of services delivered, on the three areas related Environmental Health

1. What are the berries prevent communities from adopting environmental health awareness messages?

*[***INSTRUCTION:** Ask, the group, whether they adopt the messages received in their daily life. What are the changes the messages created in the community? List/ask whether they faced any barriers or challenges to adopt the awareness messages. Prepare a list of challenges, Let the group explain why barriers and challenges (Social -Economic) effecting the Environmental Health practice in the community. Create a list with identified messages and ask the group to generate solutions and recommendations.

**Water Supply:**

1. Ask the group to inform you, where they are fetching water, did they observe any activities related to the water improved service activities in the area?

*[****INSTRUCTION:*** List the types of water improved service activities., who did and when, List the source of water and types of water improved service activities., who did, use PRA map exercise let the group localize the source of water, ask about the types of water sources, quantity and quality of water in each water source, Ask about the distance, seasonal availability of water in each water source

1. Try exploring the quality of water and improved services conducted in the area?

*[****INSTRUCTION:*** Let the community inform you. How does the water improvement services, affected the water quality, and/or increased water quantity available for drinking, personal hygiene, cooking, or other households uses? Ask do they have Water-User Committee established? What are the duties of WUC? Ask the group, how do they rate WUC performance? Ask the group whether they received any awareness messages on water treatment? Who conducted the awareness? Where and at what frequency? Aske the group to recall some of water treatment messages and why water treatment is important

***[End discussion giving thanks to all participants by appreciating their valuable information and time]***

**MOAFA Baseline Survey**

**(WASH, Nutrition and Health Integrated Project – Central Darfur – OFDA Funded)**

**(Qualitative Topical Checklists)**

**Nutrition**

**FGD Questions:**

1. Ask, in this community how people practice the infant and young child feeding, could you tell me do you note or hear about any of the awareness activities related Health, Nutrition and WASH sectors conducted in this community?

*[****INSTRUCTION:*** List mentioned awareness activities, ask the group, to recall of some of received messages and create a list, Draw a table of three columns, ask the group to list the received messages according to the sector: Health, Nutrition( improve infant and young child feeding practices and WASH), Ask the group who delivered the awareness messages related to improve infant and young child feeding practices, where and the frequency , ask about the importance of identified messages

1. What are the factors prevent community member from adopting awareness massages?

*[****INSTRUCTION:*** Ask do they adopt awareness message in their daily life, what are the changes the messages create in the community, list ask in your opinion what is the appropriated way of deliver awareness messages, Ask do they find any difficulties or challenges (Social - Economic – Other) to adopt received awareness messages, prepare list of challenges, Let the group generate solution and recommendation, for identified challenges.

1. In this community, which types of foods mothers are giving to the babies (0 to 5 months). Ask, what is the best food for a baby, in the age of (0 to 5 months)?

*[****INSTRUCTION:*** Create list of the answers, let the group discuss, each answer listed, From the list pick up breastfed exclusively, ask why it is important for the children 0 – 5 months. Draw a table to compare between the advantages and disadvantages of exclusive breastfeeding, ask if the group received any awareness messages on exclusive breastfeeding. Ask who did, where and frequency, Ask the group to recall some of the messages, let the group. explain appropriate and ideal breastfeeding process including duration and actions Ask, why they are important

1. What are the berries prevent community member to adopting breastfeeding messages?

 *[****INSTRUCTION:*** Ask, did they adopt received messages in their daily life, what are the changes the messages created in the community, list, ask did you faced any berries or challenges, to adopt the awareness messages. Prepare a list of challenges, Let the group explain why barriers and challenges (Social -Economic) effecting the exclusive breastfeeding in the community, Let the group to generate solution and recommendation for highlighted barriers and challenges

1. In this community usually which types of food, usually mothers give to the children 6 to 23? Ask, what is the best to the children 6 to 23?

*[***INSTRUCTION:** List the types of food and with helping the group categorized according to the 7 food groups , give the group idea about the advantages of using food from the 7 food group, [ Ask the group, did you received awareness messages on using food from the 7 groups, Ask the group to recall some of the awareness messages, Ask do the group satisfied the way of delivered messages, Ask, what are the appropriate ways of deliver the awareness messages

**7 Food Groups**

1. Grains, roots and tubers 2. - Legumes and nuts

3. Dairy products (milk, yogurt, cheese) 4. Flesh foods (meat, fish, poultry

5. liver/organ meats 6. Eggs

7. Vitamin-A rich fruits and vegetables and other fruits and vegetables

1. Are there berries prevent community member to adopt/use food from the 7 groups messages?

*[***INSTRUCTION:** Did they adopt received messages in their daily life, what are the changes the messages created in the community, list, ask did you faced any berries or challenges, to adopt the awareness messages. Prepare a list, Let the group explain why barriers and challenges (Social -Economic) effecting using food from the 7 groups in the community, Let the group to generate solution and recommendation for highlighted barriers and challenges

***[End discussion giving thanks to all participants by appreciating their valuable information and time]***