Internal Impact Assessment

'Effective response to the needs of malnourished older persons in West Darfur'

October 2014

1. Overview

HelpAge International is a global network of not-for-profit organisations that helps older people claim their rights, challenge discrimination and overcome poverty, so that they can lead dignified, secure, active and healthy lives. It works with and for disadvantaged older people in the world to achieve lasting improvements in the quality of their lives. HelpAge is the only organisation globally that focuses on the needs of vulnerable older people in emergencies and takes lead action in this neglected area of humanitarian response. Our work on emergencies focuses on four core areas: health, protection, livelihoods and policy influencing.

Since 2004, HelpAge's approach has become increasingly hands-on, with a particular focus on health and nutrition. This move was driven partly by a recognition and acknowledgement of gaps in the humanitarian response towards older people, which is not always appropriately followed by concrete programme action from other agencies. While creating awareness of older people's needs among key stakeholders remains a crucial aspect of HelpAge's presence in Darfur, direct service delivery contributes to the well-being of older people and enables them and their dependents to lead dignified lives during chronic crisises.

Between 2013-14, HelpAge International in partnership with Road for Development and Rehabilitation (ROAD), with funds from the German government implemented a project entitled 'Effective response to the needs of malnourished older persons in West Darfur'. The goal of the project was to contribute to the overall recovery of vulnerable internally displaced populations. The programme activities were implemented in West Darfur in the localities of Kerenek (Kerenek and Mornie), Habila and Geneina (Kirinding II, Abuzar, Ardamata and Dorti).

The nutrition project aimed at achieving the following:

Specific Objective: To facilitate older people's access to malnutrition treatment and prevention programmes in West Darfur.

Project Indicators – Progress against Targets	
Outcome 1	Improved nutritional status for moderately malnourished older people or those at risk of malnutrition
Outputs	• At least 63.7% (against a target of 70%) of targeted older people have improved nutritional status • 81.6% (against a target of 80%) of the targeted older persons (60% of which are women) have increased skills in preparing and cooking age-appropriate foods • Annual distribution of 425 (against a target of 5,256) supplementary food baskets and 19, 512 (against a target of 20,400) complementary food baskets • 1 (against a target of 2) nutrition assessments conducted and results disseminated • Cooking demonstration sessions for at least 3,962 (against a target of 3,890) older people in social centres • 5 (against a target of 10) radio programmes aired in target area
Outcome 2	Build the capacity of ROAD, Ministry of Health staff, Older People's Committees (OPCs) and Older People's Associations (OPAs) members to identify, prepare for and mitigate nutrition problems of older people
Outputs	• 161 (against a target of 162) people from ROAD, MoH, NGOs, OPC, and OPA trained on prevention, early detection, treatment & management of malnutrition • 16 (against a target of 26) staff from partner NGO trained

2. Purpose of the Impact Assessment

The purpose of this assessment was to assess the impact of the project's intervention and the extent to which the project's specific objective and results were achieved as per the indicators set forth in the project proposal. In addition, the assessment aimed to offer strategic and operational recommendations to improve the direction, effectiveness and relevance of similar programmes in future.

3. Methodology

3.1 Methodological Approach

A cross-sectional descriptive assessment was conducted using participatory methods involving both quantitative and qualitative approaches for triangulation purposes. A desk review of relevant literature and documents was also done to strengthen the knowledge base.

3.1.1: Assessment Locations

The assessment was conducted in 7 locations in West Darfur where the nutrition project was being implemented. The target population was older men and women who had been admitted into the feeding programme.

3.2: Data Collection Tools Design and Development

Data collection tools were developed through a participatory approach. The Country Director and Darfur Programme Manager were consulted before the final data collection tools were adopted. The tools were further reviewed during training and translated by the enumerators into the local language.

3.2.1: Assessment Tools

The tools used were:

- Structured questionnaires
- Key Informant Interview (KII) guides: The tool was tailored to obtain in-depth information that could not be obtained using closed ended questionnaires
- Focus Group Discussion (FGD) guides
- Anthropometric assessment tools: MUAC tape was used to collect basic anthropometric data while oedema was checked visually

Please refer to the annexes at the end of this report for copies of the tools used.

3.3 Sampling

3.3.1: Sample Size

A sample size of 101 older men and women respondents admitted into the feeding programme was used for the individual questionnaires.

3.3.2: Random Sampling

Simple Radom Sampling was applied based on the list of beneficiaries. Efforts were made to ensure all categories of beneficiaries were included without complicating the sampling methodology. The sample size was proportionately allocated as per the number of beneficiaries in each location.

3.4: Selection, Training and Pre-testing of Data Collection Tools

The data collection process began with the identification, selection and training of enumerators. These enumerators were recruited from the specific project implementation locations and trained for two days (13^{th} -14^{th} October 2014) to ensure that they familiarised themselves with the content of the data collection tools and understood the expected project outputs for quality data collection. Enumerators were required to have working knowledge of both English and Arabic and prior experience in data collection in the community.

The participatory training culminated in a trial demonstration of the data collection exercise amongst the enumerators. This allowed for the identification of expected challenges and assessment of the level of success of the training. There was supervision of trainees during the data collection exercise to ensure quality and consistency was maintained.

3.4.1 Translation of data collection tool

The data collection tool was translated from English to Arabic to ensure the translated and original tools collected similar information.

3.4.2: Field Work

Data collection was conducted for 2 days (20^{th}-21^{st} October 2014). Both quantitative and qualitative data collection was done concurrently in the locations to avoid logistical challenges.

3.4.3 Interview Schedules

3.4.3.1: Beneficiary Assessment

Structured questionnaires were administered to 101 beneficiaries in the 7 locations as shown in table below:

Location	**Number of respondents**
Abuzar	8
Dorti	7
Kirinding II	12
Ardamata	13
Mornei	34
Kerenek	18
Habila	9
Total	**101**

3.4.3.2: Key Informant Interviews (KII)

A total of 21 key informants were selected based on their perceived knowledge and experience of the project. Care takers, community based workers, OPC members, OPA members and local authorities were each interviewed as key informants. Further interviews were conducted with ROAD program staff with respect to their role as implementers. The aim of the interviews was to collect information on: the nature and distribution of food items and other project components, program implementation, perceived impact of activities, achievements and best practices, gaps and limitations of the activities, as well as existing opportunities for action.

3.4.3.3: Focus Group Discussions (FGD)

One FGD comprising of 10-15 older men and women was conducted in each of the project locations. The participants were chosen based on their willingness to participate and their depth of knowledge. The discussions explored views regarding the impact of the services provided by the project and their recommendations for improvement. In addition, the FGD was intended to help understand perceptions of beneficiaries as well as service providers.

3.5: Data Management and Analysis

3.5.1: Quantitative data

To ensure data quality, all structured questionnaires were first checked by supervisors at the field level and then presented to the lead supervisor for final review and coding where applicable. A data audit on a sample of the questionnaires was done by the lead evaluator to ensure quality and consistency was maintained. This also allowed for any discrepancies or errors to be addressed by the respective enumerator while still in the field.
All questionnaires were then transported to HelpAge–Geneina where data entry was carried out. Quantitative data entry was done in a computer using SPSS (statistical software). Upon completion of the data entry, further data cleaning was done to ensure that there were no additional errors generated at this stage.

3.5.2 Qualitative data

Qualitative data from KIIs and FGDs were analysed manually. Tasks included: transcription from Arabic to English by the enumerators, keying in of the information verbatim, coding, summarizing, categorizing, direct quoting and comparisons. These were finally organized as per the main themes and sub themes and then used to complement the quantitative data in the report.

4.0 Results

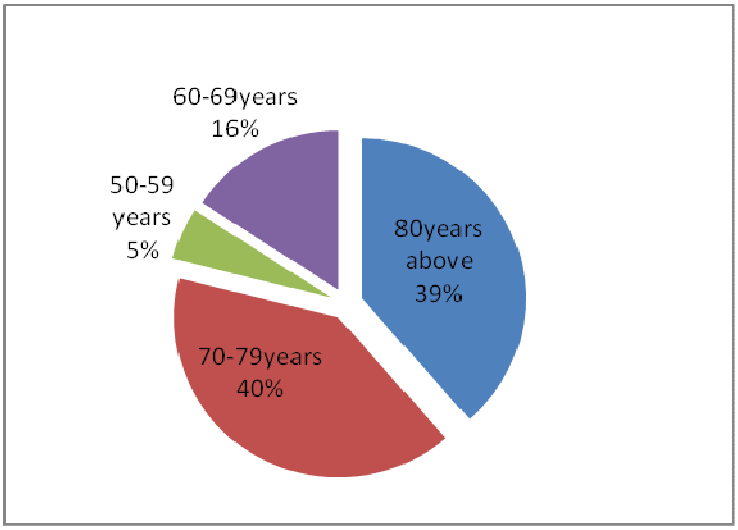
4.1 Introduction

The results of the assessment are presented below in graphs, tables and figures.

4.2 Social - Demographic Characteristics

A total of 101 respondents were interviewed: all Sudanese in nationality.

Age in years



The majority of the respondents were 70 – 79 years old (40%); the fewest respondents were in the 50-59 year old category (5%).

4.2.1 Sex

56.4% (57) of the CFP beneficiary respondents were women.

4.2.2. Domestic Status and Responsibilities

59.4% (60) of these older people were heads of households whose poor nutrition status was probably a result of the burden of care they had for their families. 53.5% (54) of the respondents reported caring for children: a factor that could lower their chances of getting adequate food for themselves. 27.7% (28) had no source of income and about 13.9% shared the food they collected. Only 28.7% (29) admitted that the food given to them was enough while the majority - 71.3% (72) - said the CFP food given was not enough for the month, and therefore 74.2% of respondents supplemented these provisions with daily family meals.

4.2.3 Nutrition Status: MUAC and Oedema Case Findings

Table 2: summarises the MUAC and Oedema rates at admission and at impact assessment

MUAC at admission (HelpAge guidelines)				
101 Respondents	<160mm - SAM	≤160mm – ≥210mm – MAM	>210mm – Normal but with clinical and social risk factors	Invalid
	1 (1.0%)	49 (48.5%)	51 (50.5 %)	0
MUAC during Impact assessment (HelpAge guidelines)				
101 Respondents	<160mm - SAM	≤160mm – ≥210mm – MAM	>210mm - Normal	Invalid
	1 (1.0%)	34 (34%)	65 (65%)	1
MUAC during Impact assessment (Sudan National Nutrition guidelines)				
57 Female	<214mm – SAM	214 – 222mm –MAM	>222mm- Normal	Invalid
	28 (49.1%) 50%	4 (7.0%) 7.1%	24 (42.1%)42.9%	1 (1.8 %)
44 Male	<224 mm – SAM	224 – 232mm –MAM	>222mm- Normal	Invalid
	28 (63.7%)	6 (13.6%)	10 (22.7%)	0
Oedema at the time of Assessment				
Yes		No		
2 (2%)		99 (98%)		

In total, 101 older people were assessed. This information was obtained from patients' ration cards. As per HelpAge's guidelines, the number of SAM cases remained the same between the baseline MUAC measurement at admission and at the time of the impact assessment. Yet there was a 10% decline in the number of MAM cases and a 27% increase in the number of normal cases with clinical and social risk factors between the two time points.

However, the table above shows that assessment of the beneficiaries' nutritional status using Sudan National guidelines indicates a higher percentage of SAM cases (both male & female). This is as a result of the higher MUAC cut-off point used by the Sudanese government.

Lastly, at the time of the impact assessment, only 2% (2) of respondents had oedema.

4.3 Food Demonstrations
48.5% (49) of the respondents described the food demonstrations sessions they attended (in terms of food preparation, serving and variety) as 'very useful' and 'relevant', 32.7% (33) said 'useful' while the rest said 'did not know'.

4.4 Hygiene Awareness Sessions
56.4% (57) of the respondents stated that the hygiene awareness sessions (in terms of food, water, personal, environmental and waste disposal hygiene) were 'very useful' in relation to the prevention of diseases like diarrhoea, 37.6% (38) said they were 'useful' while 6% did not realise the importance of these sessions.

4.5 Home Visits
63.4% (64) of the respondents reported that home visits, especially to food beneficiaries who were home-bound (i.e. taking them food rations, checking on their hygiene and other health problems) was 'very useful', 27.7% (28) stated they were 'useful' and the remaining 8.9% (9) were not well informed about the home visits.

4.6 Nutrition Assessment
According to the documentary review, the first nutrition assessment among older persons in West Darfur was completed in November 2013. A copy of the report is available at HelpAge's Geneina and Khartoum offices.

Second assessment: a SQUEAC investigation that was supposed to be done halfway through the project was not carried out. It was aimed at identifying factors and barriers influencing the coverage of the nutrition programme. However, given that this method was supposed to focus on malnourished or moderately malnourished beneficiaries receiving supplementary feeding this was no longer possible following the challenges HelpAge had with the WFP contribution for SFP baskets.

4.7 Radio Programmes
HelpAge records show that this activity started in November 2013, and in total 5 radio shows were aired on the community-based radio station. It is expected that the radio messages reached roughly 210,117 people in the localities of Mornei, Habilla, Kerenek and Geneina where HelpAge operates. Through this, older people and other members of the community were reached with information on the health and nutritional needs of older people.

4.8 Capacity Building Trainings
HelpAge's activity training report and attendance lists indicated that a total of 161 people (78 female) attended the training. Refresher training was then conducted to 20 ROAD and 7 HelpAge staff (6 female). 16 staff from partner NGOs were also trained. The two training sessions covered the following topics: finance and accounting systems, effective workload management, development of job skills, resource optimisation and modern management of voluntary work.

5.0 Discussion and Conclusions

5.1 Quantitative impact of the Supplementary and Complimentary Feeding Programme (SFP and CFP)

The desired effect of the feeding project was to improve the nutritional status of malnourished older people and those at risk of malnutrition. At least 70% of the targeted older people had their nutritional status improve during the project's duration.

Although comparison of baseline and impact assessment data did not show any difference in the number of SAM cases, MUAC measurements between the two time points showed a slight improvement but this was not significant enough to qualify for a shift from SAM to MAM (for example, for the single SAM case, the MUAC measurement at admission was 110mm and at the time of assessment it was at 110.9mm).

SAM cases were referred to the local hospital so that beneficiaries could receive appropriate treatment for the underlying causes of their malnutrition. According to their medical records, most suffered from chronic conditions like diabetes that affected their nutritional status.

There was a significant difference in the number of MAM cases between the two time points. It is worth noting that even those who remained in the range: 160mm – 210mm (MAM), the majority experienced a slight increase in their MUAC measurement over the project period, suggesting there was a general improvement in their nutritional status.

The increase in the number of normal cases was as a result of beneficiaries shifting from MAM to normal. The majority of those who were normal but with clinical and social risk factors (such as oedema, an inability to stand or immobility, extreme weakness or dehydration, living alone without family support, physical or mental disability, not strong enough to engage in any household activities, very low socio-economic status or psychologically traumatised) were discharged after mitigating the risk factors and some were linked to support groups, Food Security and Livelihoods (FSL) and other income generating activities.

5.2 Qualitative impact of the Supplementary and Complimentary Feeding Programme (SFP and CFP)

75.2% (76) of respondents reported that the food given to them improved their health while the remainder reported no improvement. The reason for no improvement among the 24.8% can be attributed to a lack of sufficient monthly food rations reported in 69.3% (70) of the respondents. To mitigate this, 74.2% (75) supplemented the food given with daily family meals, 12.9% stayed hungry, 13.9% shared food collected and 12.9% purchased food stuffs. In addition to this, 53.5% of respondents were care givers to children, further worsening their situation. 47.5% (48) of the respondents described the food given as 'very suitable' and in line with normal diets, 51.5 % (52) thought the food was 'suitable' and only 1 person couldn't provide an answer. This implied that even though the food distributed was not enough for the entire month, it was suitable and in line with normal diets.

According to the design of the project, the type [including the quality and quantity] of food baskets was meant to meet beneficiaries' immediate food needs for survival. Much as the beneficiaries understood this, during KIIs and FGDs opinion leaders expressed a need to provide more culturally-appropriate food, for example millet rather than sorghum.

Unfortunately, some beneficiaries felt stigmatised whilst collecting food, captured by the following testimony:

"We old people - the community laugh at us because we are queuing to get food but we don't care about that, our health is more important than their words".

However it was evident from the survey feedback that the feeding programme was valued and that many respondents wanted it to continue. One 80 year old male beneficiary commented:

"We are all weak and old. We would like to continue receiving food. We cannot go and work in the market and I think that if HelpAge can provide us with more food that will go a long way."

5.3 The impact of the nutrition assessment

The nutrition assessment findings were used as a tool to advocate for the inclusion of older men and women in emergency nutrition interventions as well as to change the National Nutrition Guidelines to be in line with International Nutrition Guidelines. As a result of this advocacy the report can be found at the Federal Ministry of Health (FMOH) and is serving to guide the revision of National Nutrition documents such as the admission and discharge criteria for older people. If the revision of guidelines is successfully done, it will improve the lives of many malnourished older people who have no prior nutrition support due to exclusion from feeding programmes by the current Sudanese admission and discharge criteria.

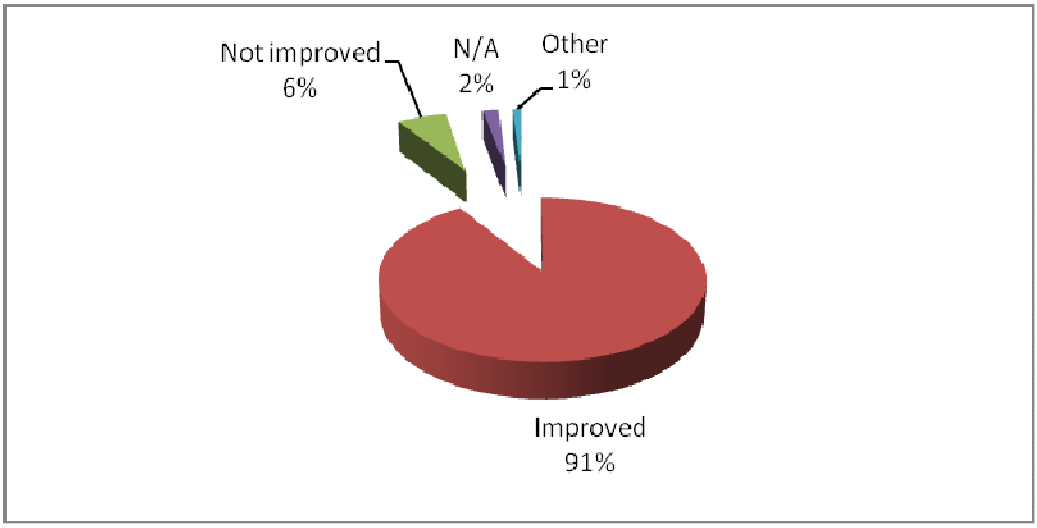
5.4 The impact of the capacity trainings

In the key informant interviews (KII) and focus group discussions (FGD), the majority of the respondents reported that the partnership between HelpAge and ROAD worked well. They felt that staff from ROAD had gained more capacity to be able to deliver nutritional services to older persons though they would still require more trainings and support to fully do this.

5.5 The overall project impact

In general, the quantitative and qualitative data collected by this assessment suggest that the project was successful in targeting and improving the nutritional status of older men and women that were moderately malnourished or at risk of developing malnutrition at the beginning of the project period.

Improvement of respondent's life attributed to this project's intervention



Overall, 91% of respondents believed that the project's intervention had improved their lives.

6.0 Recommendations

1. Sudan National Nutrition Guidelines are not in line with either HelpAge or international guidelines. HelpAge flagged the guideline discrepancy to the National Nutrition Cluster (NCC) and Federal Ministry of Health (FMOH) for revision and HelpAge is expected to follow up on this.

2. There is a need to continue and promote nutritional feeding programmes for malnourished older people and those at risk of malnutrition. This seemed to be the most preferred means of ensuring food security among this group of older people.

3. There is a risk of beneficiaries becoming over-dependent on feeding programmes and thus disregarding other livelihood options. From the assessment, 55.4% collected food from the older people's social centre (OPSC) on a monthly basis and only a very small number of the respondents indicated irregular food collection. Irrespective of the fact that the centres were expected to close on Fridays and Saturdays, some of the beneficiaries still visited the OPSC on these days in anticipation of getting food. To avert this dependency tendency, there is a need to encourage beneficiaries to start engaging in income generating activities to ensure food availability at the household level.

Appendix I. Questionnaire

Assessment tools – Individual Questionnaire Interviewer

Questionnaire No----------Locality ----------Village----------

Date of Interview---------- Nationality----------

CFP Admission No----------

SFP Admission No----------

MUAC ----------

Oedema [1] Yes [No]

Household Characteristics

1. Age group of Interviewee	[1] 50-59 years [2] 60-69years [3] 70-79years [4] 80years above
2. Gender of Interviewee	[1] Male [2] Female
3. Head of family	[1] Yes [2] No
4. Are you taking care of children?	[1] Yes [2] No
5. Status	[1] Home bound [2] Non-Home bound
6. 1month prior to admission in the feeding programme, did you experience any of the following	[1]Live alone [2] Physically disabled [3] Lost family member [4] Abandoned [5] Care for orphan [6] Loss of income [7] Mental stability [8] sick (specify disease)
CFP	
7. How often do you go OPSC centre for food?	[1] Daily [2] weekly [3] monthly [4] Rarely (once in a while)
8. How many times in a month did you collect	[1] once

food from OPSC	[2] 2 times [3] 3 times [4] more than 3 times
9. Do you share the food you collect from OPSC with family members	[1] Yes [2] No
10. Is the food collected sufficient/enough for you in a month?	[1] Yes [2] No
11. If No, how do you supplement?	[1] Stay hungry [2] eat daily family meals [3] Purchase food stuff
12. Are there times that you have come to the OPSC but missed food?	[1] Yes [2] No
13. If Yes, how many times/often?	[1] Only once in a month [2] twice in 2 months [3] more than 3 times
14. Why did you miss food?	[1] The food got finished [2] Came late [3] discharged from programme [4] Other
15. Did you understand/explained for why you missed food?	[1] Yes [2] No
16. Are there days that you came to the OPSC and found it closed?	[1] Yes [2] No
17. Did you understand/explained for why it was closed?	[1] Yes [2] No
18. Approximately how many hours do you walk to reach this OPSC?	[1] 0.5 - 1 hour [2] 1 - 2 hours [3] >2 hours
19. How long do you wait before being served?	[1] Less than 1 hour [2] 1 Hour – 2 hours [3] 3- 4 hours [4] Over 4 hours
20. Is there any special treatment/care to disabled, extremely aged and weak/sick people in the queue	[1] Yes [2] No
21. Describe the food given here in terms of appropriateness and being in line with normal diets	[1] Very appropriate [2] Appropriate [3] Not Appropriate
22. In general, has the food given improved your health	[1]improved [2] Not improved
23. How did you come to learn about the food distributions	[1] Announcement in the community [2] Other community member [3] OPC/OPA [4] home visits by CHWs [5] other
24. Were you explained for/understand the	[1] Yes

project activities?	[2] No
25. Did you fully understand what you will benefit/get/receive from the OPSC?	[1] Yes [2] No
26. Given options, what means of ensuring food security would you prefer?	[1] Continue with dry food rations [2] Provide income generating activities [3] Provide cash equivalent [4]Others
27. During exit from the programme, where you explained the reason why	[1] Yes [2] No
28. When discharged from the programme, where you referred to	[1] Transfer to Hospital [2] Selected for IGA [3] Home care [4] Support group [5] None
29. Describe the usefulness and relevancy of food demonstrations in terms of food preparations, serving and variety	[1] Very useful and relevant [2] Useful and relevant]3] Not useful and relevant
30. Describe the usefulness hygiene awareness sessions that's food, water, personal, environmental and waste disposal hygiene in relation to preventing diseases like diarrhoea	[1] Very useful [2] Useful [3] Not useful
31. Describe the usefulness of home visits to the food beneficiaries especially the home – bound in relation to taking them their food rations, checking on hygiene and other health issues.	[1] Very useful [2]Useful [3] Not useful
32. Overall, has the project's intervention improved your life?	[1] Improved [2] Not improved [3] Other (specify)
Name of Team leader ----------Signature ----------	

Appendix II. Key Informant Guiding Questions

1. In your opinion, how appropriate is the nutrition project in reaching targeted beneficiaries as compared to other alternatives like providing cash transfers to beneficiaries to buy the food themselves?

2. What challenges do the beneficiaries face when trying to access food from the OPSC?

3. What improvements can be made or put in place to ensure the beneficiaries get better services?

4. What alternative options should HelpAge and other stakeholders develop to ensure smooth transition from over dependence on food distributions to being self-reliant?

5. Do you think feeding programme is a dignified/appropriate way of providing to older persons at risk of malnutrition in our community?
If yes, why?
If no, why not?

6. Given same resources, what else similar or different would you implement to ensure the older persons, and other vulnerable members of the community are food secure?

7. In your opinion, to what extent does the project intervention benefit the needs and priorities of targeted groups (most vulnerable in the community?)

8. To what extent has the project achieved its objective of providing food to the most vulnerable in the community?
9. How transparent was the selection process for beneficiaries? Were the community leaders involved, community members and other stakeholders?

10. Considering the current situation in West Darfur, how relevant/useful/ suitable was the nutrition project?

11. Have there been any changes in the number of people collecting food from the sites in the last three months or 6 month? What in your opinion are the reasons for the change (increase or decrease?)

12. In your opinion, has the partnership between HelpAge and ROAD worked? If so, what has worked well?

13. If not, what has not worked well and what can be done to make it work better in future?

14. In your opinion, has ROAD gained the capacity/skills to deliver nutrition services to older persons, if so, what skills?

15. If not, what has ROAD not achieved and what can be done to improve ROAD skills in delivering nutrition services to older persons in future?

16. What general information can you tell me about nutrition intervention by HelpAge?

Appendix III. FGD Guiding Questions

1. What is your opinion regarding your nutritional status before introduction of nutrition programme by HelpAge and now? Probe: food availability, quality, affordability and accessibility.

2. What's your opinion regarding food demonstrations? probe easy to eat easy to cook food, appropriateness, effectiveness, food hygiene, serving, variety, usefulness

3. What are the significant changes that have occurred to you and your household members as a result of hygiene awareness sessions? probe hygiene behaviour change in reference to food, water, personal, waste disposal and environmental hygiene

4. Explain to us what usually happens at the OPSC centre. Probe; center organization, distribution of food at the centre, sufficiency of food at the center, storage of food at the centre, quality of food at the center, handling of vulnerable groups

5. What are some of the significant changes that have occurred to you and your household members as a result of nutrition project in your area? Probe: perception on nutritional status, expenditure on food time taken to search for food and inputs, cohesion in the family, stress and duress, undertaking daily chores, assured access to food

6. In your opinion, is the nutrition project approach appropriate to your situation? Probe: view on dignity, respect in the community and peers, time, relief on food purchase and search

7. What would wish to be done differently to improve nutrition project for the older people in your community and what do you think should be continued with?

8. Could you briefly describe to us how you were selected as beneficiaries? Probe: transparency, community involvement, feelings of some people included yet they do not deserve to be included

9. Could you briefly describe to us the process of accessing the food from the project? Probe: waiting time at service points, handling by staffs, requirements, alternatives approaches of get the food

10. In your opinion what are some of the challenges/shortfalls faced by nutrition project? Probe: What is not working well and how can it be addressed?

Appendix IV. Assessment Team

No	Description	No	Task
1	Health and Nutrition Coordinator	1	Lead
2	Programme Officer- Geneina	1	Co-lead
3	HAI staff	5	Field supervisors
4	Nutrition Officer	1	Supervisor
5	Enumerators	16	Data collectors
6	Data entry clerk	1	Data entry