

TECHNICAL PROTOCOL

FOR

Standardized Monitoring and Assessment of Relief and Transitions (SMART) Survey in Akoka County Upper Nile State, South Sudan

Submitted by

REACH Initiative



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1. BACKGROUND

1.1 Introduction

South Sudan, the world's youngest country having gained independence from Sudan in 2011, has faced recurrent conflict, displacement, climatic shocks, disrupted livelihoods, and chronically high levels of acute food insecurity and malnutrition since the onset of the civil conflict in 2013. Although the signing of the Revitalized Peace Agreement in 2018 improved humanitarian access in several parts of the country, the humanitarian situation remains fragile and continues to deteriorate in many areas due to conflict, economic instability, flooding, disease outbreaks, and large-scale displacement¹. According to the most recent IPC Projection Update (April–July 2026), approximately 7.8 million people, representing 55 percent of the analyzed population in South Sudan, are projected to face IPC Acute Food Insecurity (AFI) Phase 3 or above (Crisis or worse), including 73,000 people in IPC Phase 5 (Catastrophe). Additionally, approximately 2.2 million children aged 6–59 months are estimated to be acutely malnourished and in need of treatment between July 2025 and June 2026. Furthermore, around 1.2 million pregnant and breastfeeding women are estimated to require treatment for acute malnutrition, highlighting the increasing burden on an already overstretched health and nutrition system².

Akoka County is located in Upper Nile State and was historically administered under Baliet County prior to recent administrative changes. The county lies within the eastern flood plains livelihood zone and is characterized by livelihoods mainly dependent on subsistence agriculture, fishing, livestock rearing, and small-scale trade. Sorghum, maize, pumpkin, and cowpeas are among the major crops cultivated, while livestock ownership and fishing remain important livelihood and food sources for many households. Similar to other counties in Upper Nile State, Akoka has experienced repeated shocks related to flooding, insecurity, displacement, disruption of markets and trade routes, and limited humanitarian access, all of which have negatively affected household food security and nutrition outcomes³.

The humanitarian and nutrition situation in Upper Nile State has further deteriorated due to escalating conflict, displacement, flooding, disease outbreaks, market disruptions, and reduced humanitarian operational capacity. The IPC projection update indicates that Upper Nile State is among the most severely affected states in South Sudan, with approximately 66 percent of the analysed population projected to face IPC Phase 3 or above between April and July 2026. Conflict and insecurity across Upper Nile have disrupted livelihoods, restricted humanitarian access, reduced access to health and nutrition services, and contributed to rising food prices and poor market functionality. Additionally, flooding and poor WASH conditions continue to aggravate disease outbreaks including cholera, malaria, diarrhoea, and acute respiratory infections, which are key underlying drivers of acute malnutrition⁴.

According to the IPC Acute Malnutrition (AMN) Projection Update for April–June 2026, Akoka County is currently classified in IPC AMN Phase 5 (Extremely Critical), indicating one of the most severe nutrition situations in the country. The county is among the identified acute malnutrition hotspot areas alongside Baliet, Luakpiny/Nasir, Ulang, Rubkona, Fangak, and Akobo counties. The IPC update further indicates that Akoka deteriorated further within IPC AMN Phase 5 compared to the previous IPC analysis. The reported

¹ <https://www.worldbank.org/en/country/southsudan/overview>

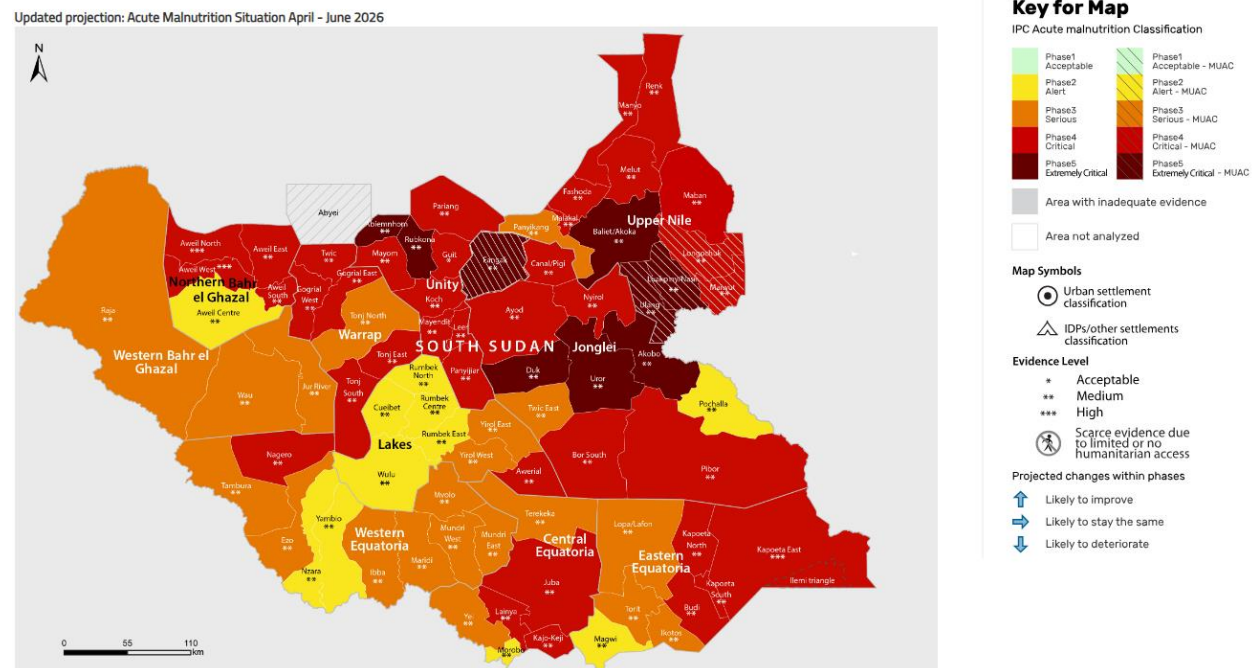
² [South Sudan IPC Update Report \(April to July 2026\), May 2026](#)

³ [CSRF South Sudan County Profile](#)

⁴ [South Sudan IPC Update, May 2026](#)

Global Acute Malnutrition (GAM) prevalence for Akoka was estimated at 27.8 percent based on Weight-for-Height Z-score (WHZ), significantly above the WHO emergency threshold of 15 percent. Akoka is also classified in IPC AFI Phase 4 (Emergency), reflecting severe food consumption gaps and heightened vulnerability among the population⁵.

Figure 1: South Sudan IPC-AMN Projection Update From April - June 2026



The IPC analysis identified several major drivers contributing to the worsening nutrition situation in Akoka and surrounding Upper Nile counties, including conflict and displacement, severe food consumption gaps, disruption of humanitarian assistance, limited access to health and nutrition services, high disease burden, poor sanitation and hygiene conditions, flooding, and prolonged market disruptions. The report also highlighted that humanitarian assistance and nutrition interventions in Akoka and neighboring counties have faced interruptions due to insecurity and access constraints, affecting the continuity of critical nutrition treatment and preventive services such as blanket supplementary feeding programs and therapeutic feeding services.

REACH Initiative, present in South Sudan since 2012, has been conducting assessments and providing evidence-based information to support humanitarian planning and response across the country. Since 2019, REACH has actively engaged with the Nutrition Information Working Group (NIWG), supporting IPC Acute Malnutrition analysis, SMART survey implementation, protocol reviews, and nutrition information management. Standardized Monitoring and Assessment of Relief and Transitions (SMART) surveys are widely recognized methodologies for generating representative and reliable nutrition and mortality data in emergency and development contexts. Given the critical nutrition situation and existing information gaps in Akoka County, REACH Initiative plans to conduct a SMART survey to assess the current nutrition situation

⁵ Ibid

and contributing factors among the population, including food security, health, WASH, and IYCF indicators, to support evidence-based humanitarian response planning and prioritization in the county.

1.2 Survey Justification

Akoka County has emerged as one of the highest-priority nutrition hotspot areas in South Sudan based on the latest IPC Acute Malnutrition Projection Update (April–June 2026), which classified the county in IPC AMN Phase 5 (Extremely Critical). The county is experiencing severe and worsening acute malnutrition outcomes driven by conflict, displacement, severe food insecurity, disease outbreaks, flooding, disrupted livelihoods, poor WASH conditions, and reduced access to health and nutrition services. The latest IPC analysis estimated a Global Acute Malnutrition (GAM) prevalence of 27.8 (19.3 – 38.2, 95% CI) percent (WHZ), significantly above the WHO emergency threshold, highlighting a severe public health concern requiring urgent humanitarian attention and evidence-based response planning⁶.

The recent deterioration in the humanitarian situation across Upper Nile State, including escalating insecurity, displacement, market disruptions, flooding, and limited humanitarian access, has likely worsened nutrition outcomes beyond previous projections. The IPC analysis further notes that humanitarian assistance and nutrition services in Akoka and neighboring counties have been disrupted due to insecurity and operational constraints, affecting the continuity of life-saving interventions and increasing vulnerability among children and pregnant and lactating women. Concurrently, disease outbreaks including cholera⁷, malaria, diarrhoea, and acute respiratory infections continue to increase the risk of acute malnutrition and mortality among vulnerable populations⁸.

Despite the severity of the nutrition situation, there remains a significant information gap regarding the current nutritional status and contributing factors in Akoka County. Limited recent representative SMART survey data are available to adequately inform humanitarian response prioritization, programme design, targeting, and resource allocation. Furthermore, the evolving humanitarian context, population displacement, flooding, and deteriorating food security conditions necessitate updated and robust nutrition data to support operational decision-making by nutrition partners, humanitarian actors, donors, and government stakeholders.

Based on nutrition information working group (NIWG) technical guidance, Akoka county is considered to have broadly similar population, livelihood, socio-economic, and contextual characteristics to neighbouring Malakal county, particularly given their shared Upper Nile context, riverine/floodplain livelihood patterns, exposure to flooding, displacement, food insecurity, and access constraints. Therefore, in the absence of recent representative SMART data for Akoka county, the survey will use the parameters from the December 2024 Malakal SMART survey, including the observed design effect of 1 for both anthropometry and mortality. This approach was recommended by NIWG as most contextually appropriate available reference for sample size estimation, while acknowledging that final survey quality and heterogeneity will be assessed through standard SMART plausibility checks during and after data collection.

The planned SMART survey will therefore provide updated and representative information on the prevalence of acute malnutrition, mortality, morbidity, food security, WASH conditions, health indicators,

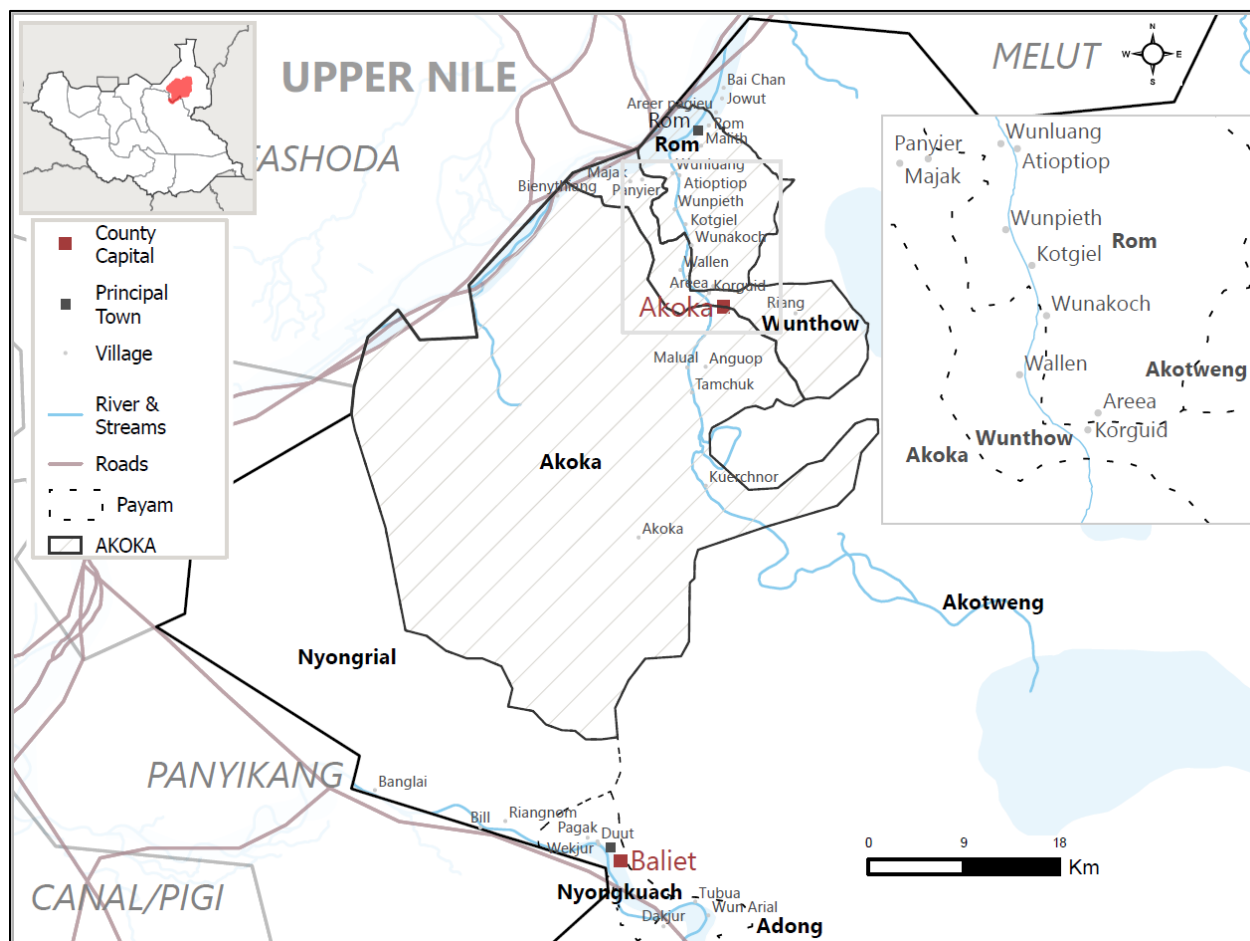
⁶ Ibid

⁷ [UNICEF, February 2026](#)

⁸ Ibid

and Infant and Young Child Feeding (IYCF) practices in Akoka County. Findings from the survey will contribute to improved humanitarian planning, targeting, prioritization, and response implementation by nutrition and multi-sectoral actors operating in Upper Nile State. The survey findings will also contribute to future IPC Acute Malnutrition analyses and support evidence-based advocacy for increased humanitarian support in one of the country's most critical nutrition hotspot areas.

Figure 2 Akoka County Reference Map



Disclaimer: Akoka County was historically administered as part of Baliet County; administrative boundaries and population estimates are subject to ongoing official verification.

1.3 Survey Objectives

General Objectives

To assess the nutrition situation and retrospective mortality rates amongst the overall population and to analyse the possible factors contributing to acute malnutrition of the community in Akoka County. In particular, the following are the specific objectives of the assessment:

Specific Objectives

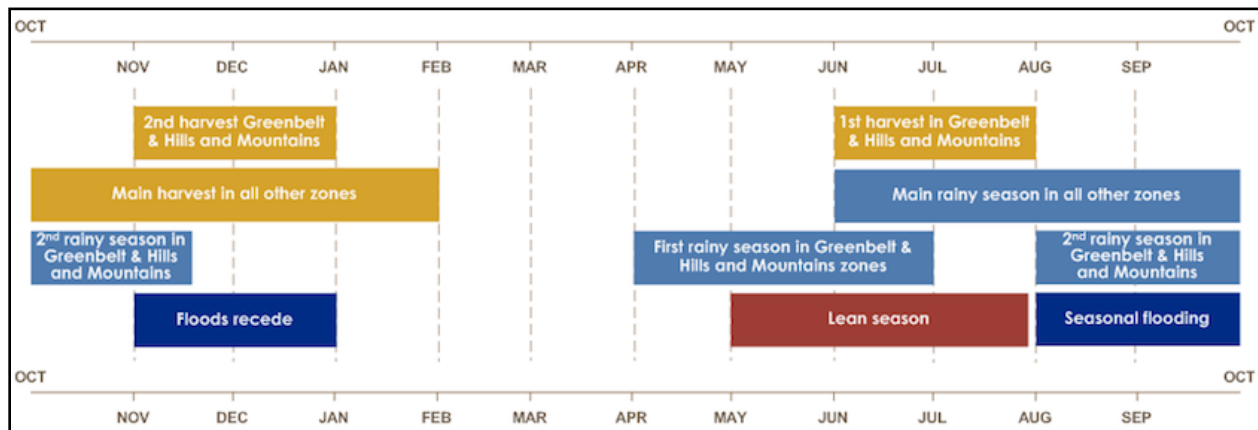
1. To estimate the prevalence of acute malnutrition, stunting and underweight among children (boys and girls) aged 6 – 59 months in Akoka County.
2. To estimate the retrospective Crude Mortality Rate (CMR) for the overall population and Under 5 Mortality Rate (U5MR) in all payams of Akoka County
3. To estimate the coverage of various immunizations in Akoka County including:
 - Vitamin A supplementation (for children 6-59 months)
 - Deworming (for children 12 to 59 months)
 - Measles vaccination coverage among children 9-59 months.
4. To assess childhood morbidity and health-seeking behaviors among households with children aged 6-59 months in Akoka County.
5. To assess the nutritional status of women of reproductive age (15-49) in Akoka County.
6. To assess IYCF Practices such as breastfeeding and complementary feeding among mothers who have children under the age of two years in Akoka County.
7. To assess the WASH situation in Akoka County (Main water source, distance/time to water source, water treatment status, access to soap, access to latrine).
8. To assess the food security and livelihoods situation in Akoka County [Food Consumption Scores (FCS), Household Hunger Scale (HHS), main livelihoods, and Livelihood Coping Strategies (LCS)].
9. To formulate practical interventions and recommendations for both emergency and long-term programs of Nutrition actors in Akoka County.

1.4 Survey Areas

The SMART survey will be implemented across the entire Akoka County, covering all accessible payams and communities to ensure representative data collection for both anthropometric and mortality indicators.

Survey time

Figure 3: South Sudan seasonal calendar⁹



2. METHODOLOGY

2.1 Survey Design

The survey will apply cross-sectional study design with a two-stage cluster sampling using the SMART methodology with the clusters being selected using the probability proportional to population size (PPS). Stage one sampling will involve the sampling of the clusters (the smallest geographical units, in our case villages) to be included in the survey while the second stage sampling will involve the selection of the households from the sampled clusters. The survey targeted children 6-59 months and households in assessing the nutrition and mortality indicators, respectively.

2.2 Study Population

The target population for this survey will be: 1) Children aged 6 – 59 months for the anthropometric, children 0 -23 months for Infant and Young Child Feeding practices (IYCF), and 2) General population for the Mortality, Food Security and Livelihoods (FSL) and Water, Sanitation and Hygiene (WASH) components, including in this group Pregnant and Lactating women (PLW) to investigate about child health seeking behavior components.

⁹ FEWS NET [South Sudan Famine Early Warning Systems Network \(fews.net\)](https://www.fews.net/)

Table 1: Indicators and targeted population

	Key Indicators	Targeted Population
1.	Prevalence of acute malnutrition 2-week retrospective child morbidity & health-seeking behaviour	Children 6 – 59 months
2.	Vitamin A supplementation	Children 6 – 59 months
3.	Measles coverage	Children 9 – 59 months
4.	Deworming	Children 12 – 59 months
5.	Prevalence of PLW acute malnutrition by MUAC	WRA (15 -49 years)
6.	Infant and young child feeding practices	Children 0-23 months
7.	Under-five mortality rate	Children 0-59 months
8.	Crude mortality rate	All persons (households)
9.	FSL- HHDS, FCS and RCSI	All persons (households)

2.3 Sample Size Estimation

Sample size calculation for the survey will be based on the expected prevalence of Global Acute Malnutrition (GAM) and Mortality Rate in the survey areas. The parameters used have been extracted from the previous survey reports conducted by REACH in Neighboring Malakal County in December 2024 which is neighboring populations with similar characteristics. The Anthropometric and mortality sample sizes have been calculated using Emergency Nutrition Assessment (ENA) software (January 11th, 2020, version) following SMART methodology.

2.3.1 Anthropometric Sample Size**Table 1: Sample Size (Anthropometric)**

Parameter	Akoka County	Justification
Estimated Prevalence (%)	24.5%	From Malakal SMART survey conducted by REACH in December 2024 with GAM by WHZ of 24.5% (19.9 – 29.7, 95% CI as they are neighboring counties with similar characteristics.
Desired Precision	5	Reasonable precision for expected prevalence
Design Effect	1	From Malakal SMART survey conducted by REACH in December 2024
Children to be Included	309	
Average Household Size	4.6	From Malakal SMART survey conducted by REACH in December 2024
% children Under-Five	29.5%	From Malakal SMART survey conducted by REACH in December 2024
% Non-Respondents	3%	Expected non-response
Households to be Included	261	

2.3.2 Mortality Sample Size

Table 2: Sample Size (Mortality)

Parameter	Akoka County	Justification
Estimated death rate per 10,000/day	0.48	The Neighboring Estimated CMR from the Malakal County SMART Survey was 0.48 (0.26-0.88, 95% CI)
Desired Precision	0.4	Applicable precision for CDR <1 as per the SMART guidelines.
Design Effect	1	From Malakal SMART survey
Recall Period	90	A default three-month recall period was applied; this will be adjusted once the survey starts.
Population to be Included	1394	
Average Household Size	4.6	From Malakal SMART survey conducted by REACH in December 2024
% Non-Respondents	3%	Expected non-response
Households to be Included	312	

The maximum sample size is found to be anthropometry sample size calculation, and this will be considered the final sample size, with **312 households** in Akoka County to be included in the survey.

2.3.3 Number of Clusters

To determine the number of clusters required, the number of households that a team can comfortably survey in a day was estimated using the parameters found in Table 3 below:

Table 3: Number of households a team can sample in a day

Activity	Estimated Time
Departure from Office	7:30 AM
a. Daily morning briefings	15 min
b. Travel to clusters	75 min
c. Introduction and HH list development	30 min
d. Lunch break	30 min
e. Total Time from one HH to another	5 min
f. Travel back to base	75 min
Total time for HH listing, travelling and breaks (a + b + c + d + f)	225 min
Arrival back to Base	5:30 PM
Total available time in a day	10 hrs (600 minutes)
Available time for work	600 – 225 minutes = 375 minutes
Time taken to complete one questionnaire	30 minutes
Total time per household + e	35 minutes

Note: The above are only estimates based on past experience but will be updated after the pilot survey has been conducted and thus, slight changes may be expected.

Given the above, the number of households that a team can comfortably visit in a day is calculated as follows:

$$375 \text{ (min)} / 35 \text{ (min)} = 10.7 \sim \mathbf{10 \text{ HH/per day}}$$

Given the above, the number of clusters per survey area is presented in the table below:

	Akoka County
Total number of HH based on sample size calculation	312
Total number of HH to be assessed per day per team	10
Clusters Needed	31.2
Rounded UP	32

2.4 Sampling Procedure: Selection of Clusters

A two-stage cluster sampling design will be used to sample the survey clusters and households. In the first stage, clusters will be assigned using Probability Proportional to Size (PPS). The sampling frame for the 1st stage sampling will be the list of villages with the population estimates in each of the survey areas. The list of villages will then be entered into ENA for SMART software (version Jan 2020) and clusters assigned using probability proportional to size (PPS).

2.5 Sampling Procedure: Selection of Households and Children

Definition of household for the survey: A household (HH) will be defined as a group of people living together, who cook and eat from the same cooking pot. Polygamous families will be defined based on the same, if each wife has her own pot, even if living in the same compound, this will be treated as different households. On arrival in the selected clusters, the team leader will meet with the village elders. The team will introduce themselves, explaining the survey objectives as well as expectations from the elder.

Household selection techniques: The standard definition of a HH will be shared to aide in developing the HH listing within the cluster. One of two methods will be used for household listing: 1) A verbal listing from one or more community leaders, and, if not possible, then 2) A manual house to house listing. Twelve households will then be randomly selected from the complete list of HHs. They will each be assigned a number, and the numbers will be selected randomly using the random number generator application in Smart phones. These are the HHs that will be visited by the survey team. The village guide and community leaders will support the teams in updating the list of households.

For clusters with more than 150 HHs segmentation will be used to select one portion of the cluster that will represent the cluster. Selection of segments will be done using either PPS or simple random sampling, depending on the population sizes of the specific segments¹⁰. In the selected segment, the process of HH selection will follow the same process done in each cluster for the selection of the 10 HHs. Households will be selected using a Random Number Generator software.

In selected households, all eligible children (aged 6-59 months) will be measured, and the household questionnaire applied. Empty households and households with absent children will be re-visited and

¹⁰ As per the SMART Guidelines, if the Segments will have almost equal population sizes, then, SRS will be used; but if the population sizes will be different, then PPS method will be use

information of the outcome recorded on the cluster control form. This form will also be used to record information on empty and non-responding households.

2.6 Survey Teams, Training, Data Collection and Data Management

- **Survey Teams:** Six teams with four members (1 Team Leader/supervisor, 1 measurer, 1 assistant, 1 enumerator) in each team will be involved in the execution of the survey. At each cluster, a local guide will be employed to facilitate data collection at the household level. The survey teams will be recruited by REACH with the involvement of the local officials at Akoka County level. To the extent possible, the team members will be a mix of both males and females and will be recruited from the local communities. REACH and partner staff will supervise the team with technical support from a local NGOs called ACCRA and Health Link.
- **Training:** The survey teams will be trained for five days, with the training planned to start on June 2nd 2026. The training will cover various components including taking anthropometric measurements, sampling of households, data collection tools, digital data collection, data quality checks, and standardization exercise among other themes. The training of the enumerators will be facilitated by SMART certified staff and staff with experience conducting SMART surveys.
- **Supervision:** The overall management of the survey will be done by REACH Initiative. Maximum supervision of the survey teams will be ensured to facilitate quality data.
- **Data Entry and Management:** Data will be collected through REACH tablets using Kobo/ODK. The data collection tools will be programmed and uploaded onto the tablets which will be used by the survey teams. The teams will be uploading the collected data to a central server on a daily basis to allow the Survey Manager to review the data collected each and every day and clean the data and give the feedback every morning to the teams.

NB: Backup manual forms will be carried by each team as a contingency plan in any eventuality that teams face challenges with the SMART phones

2.7 Data Quality

In order to ensure optimal and high data quality, a number of measures will be put in place which includes:

- a) The survey will be done in accordance with the submitted protocol, and the following will be ensured:
 - Training of survey teams is done using standardised material as recommended by SMART Methodology
 - Undertaking of standardisation test as part of the training; taking appropriate steps thereafter based on performance of the survey teams
 - Appropriate calibration of survey equipment, during the training and on every morning before proceeding to the field for data collection
 - Plausibility checks will be conducted on a daily basis and inform the daily debriefing sessions which will be conducted every day
- b) Data will be collected through digital platform, and control checks and skip patterns will be programmed to improve the data quality.
- c) Anthropometry data will be auto analysed using ENA software anthropometry section. The same software will be used to analyse the mortality data.

2.8 Questionnaire

The survey will adopt the data collection tools which have been developed by the Global SMART Team for both anthropometric and mortality surveys. Other indicators will be collected using the modules in line with current Food Security and Nutrition Monitoring System (FSNMS) questionnaires as much as possible.

2.9 Data to be Collected

1. Anthropometry

- **Age:** Will be determined using birth/health cards/records if available and local calendar of events which will be jointly developed by local leaders and survey enumerators.
- **Sex:** Male or female
- **Weight:** Children's weights will be taken without clothes using mother and child digital weighing scales (SECA scales with precision of 100gm).
- **Height/length:** Children will be measured using the wooden UNICEF measuring boards (precision of 0.1cm). Children less than 2 years of age will be measured lying down, while those greater than or equal to 2 years of age will be measured standing up.
- **Mid-upper arm circumference:** MUAC measurements will be taken at the mid-point of the left upper arm using both the child and adult MUAC tapes (precision of 0.1cm) for children 6-59 months and for women of reproductive age between 15-49 years of age.
- **Bilateral pitting oedema:** Will be assessed by the application of normal thumb pressure on both feet for 3 seconds.

2. **Demographics and Mortality:** The following information will be collected for all current household members: age in years, sex, whether they were born, or had joined the household during the recall period. For household members that left during the recall period, will collect the age in years, sex, and whether they had joined or born into the household during the recall period. For persons who have died during the recall period, will collect age in years, sex, whether born or joined the household during the recall period, as well as estimated cause and location of death.

3. **Health Interventions Data:** Vitamin A supplementation, deworming and measles immunization data will be collected through health cards or recall.

4. **Morbidity:** Two-week retrospective morbidity data will be collected from mothers/caregivers of all children (6-59 months) included in the anthropometric survey.

5. Food Security Indicators:

- a. **Food Consumption Scores (FCS):** is an indicator of the general quantity and quality of foods being consumed in a household, based on how many days any household members have consumed 9 distinct food groups within a 7-day recall period. Households are categorized into different categories of severity based on their responses. FCS is often used as a proxy for quality of food consumed. Standard FCS thresholds are <21 for 'poor', ≥21 - ≤35 for 'borderline' and >35 for 'acceptable'.
- b. **Household Hunger Scale (HHS):** measures the perceived hunger by asking the frequency a household has experienced three common experiences associated with hunger in the past 30 days (no food in the house, slept hungry, gone whole day and night without food). HHS is often used as a proxy for quantity of food consumed. Thresholds and categories used for analysis are those used for IPC AFI in South Sudan.
- c. **Livelihood Coping Strategies (LCS)** – measures what behaviours or actions that households are taking to cope with not having enough food or resources to get food. Ten coping strategies are asked about which are categorized as Emergency, Crisis, or Stress strategies.

6. **WASH** – indicators on main water source, access to latrines, distance/time to water source, access to soap and water treatment will be asked.

2.10 Data Analysis

The anthropometric and mortality data will be analysed using ENA for SMART (Jan 2020 version). The other additional data (immunization, maternal nutrition, morbidity etc.) will be analysed using other software like R and SPSS. Various statistics will be used to summarize the data including percentages, means, and median, among others. The analysed data will be presented in both tabular and graphical presentations. The preliminary datasets will be available within 7 days after the last day of data collection upon arrival from the field, and the preliminary report within 14 days. The preliminary report will get feedback from partners and REACH, before submission to the Nutrition Information Working Group (NIWG) for validation.

2.11 Ethical Considerations

Informed consent – All households will be asked for informed consent prior to the survey. If a household does not wish to participate, they will be counted as non-response and the team will move to the next sampled household.

Keeping confidentiality of personally identifiable information (PII) – All personally identifiable information, such as names and Global Positioning System (GPS) data, will be removed from any analysis after data collection concludes and will not be shared either internally with HQ or externally with partners.

Referral – Children identified as having acute malnutrition (either by MUAC, weight for height, or oedema) will be appropriately referred to health/nutrition services by the survey team leader.

Annex 1. Survey Plan

Activity	01-Jun-26	02-Jun-26	03-Jun-26	04-Jun-26	05-Jun-26	06-Jun-26	07-Jun-26	08-Jun-26	09-Jun-26	10-Jun-26	11-Jun-26	12-Jun-26	13-Jun-26	14-Jun-26	15-Jun-26	16-Jun-26	17-Jun-26	18-Jun-26	19-Jun-26	20-Jun-26	21-Jun-26	22-Jun-26	23-Jun-26	24-Jun-26	25-Jun-26	26-Jun-26	27-Jun-26	28-Jun-26	29-Jun-26	30-Jun-26	01-Jul-26	02-Jul-26	03-Jul-26	04-Jul-26	05-Jul-26	06-Jul-26	07-Jul-26	08-Jul-26	09-Jul-26	
Travel to Malakal from Juba																																								
Field meetings (Sampling, Staffing)																																								
Training of Enumerators/Standardization test																																								
Field Test/Pilot																																								
Data Collection																																								
Data Collection "Flex Days"																																								
Debrief with Teams																																								
Discussion with Partners and agencies (SMOH, CHD, ACRA, HL)																																								
Travel From Malakal to Juba																																								
Prepare and Submit Preliminary Datasets																																								
Submit Preliminary Presentation and report																																								

Annex 2. Cluster control form

State: _____ County: _____ Payam: _____ Boma: _____ Village: _____ Cluster No.: _____ Team No.: _____								
Survey Date: / /			Team Leader: _____					
HH no	Name of HH Head	Outcome 1 = completed 2 = partly completed 3 = refused 4 = absent*	eligible children	eligible children measured	needs to be revisited Yes or No	visited Yes or No	Outcome (If necessary) 1 = completed 2 = partly completed 3 = refused	Comments
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								

Annex 3. HOUSEHOLD LISTING AND ANTHROPOMETRY

Cluster Number:		Site Name:					
Team No:		Household No:			County:		
Current household members							
Name	Sex	Age	Joined or born?	Weight (kg)	Height (cm)	MUAC (cm)	Oedema (Y/N)
Household members who have left since (____)							
Household members DIED since (____)							
				Cause Death:			
				Location Death:			
				Cause Death:			
				Location Death:			

Annex 4. FOOD CONSUMPTION LISTING

Cluster No:		Site Name:			
Team No:		Household No.		County:	
Day	Breakfast	Lunch	Dinner	Other	
[Yesterday]				☐ None ☐ Oil ☐ Sugar	☐ Salt ☐ Onions ☐ Milk
				☐ None ☐ Oil ☐ Sugar	☐ Salt ☐ Onions ☐ Milk
				☐ None ☐ Oil ☐ Sugar	☐ Salt ☐ Onions ☐ Milk
				☐ None ☐ Oil ☐ Sugar	☐ Salt ☐ Onions ☐ Milk
				☐ None ☐ Oil ☐ Sugar	☐ Salt ☐ Onions ☐ Milk
				☐ None ☐ Oil ☐ Sugar	☐ Salt ☐ Onions ☐ Milk
				☐ None ☐ Oil ☐ Sugar	☐ Salt ☐ Onions ☐ Milk

Annex 5. IYCF – 24 hours diet recall form

Cluster No:		Site Name:			
Team No:		Household No.		County:	
Day	Breakfast	Lunch	Dinner	Other	
Morning / Breakfast				☐ None ☐ Sugar ☐ Water ☐ Sweets ☐ Breastmilk	
Snacks?				☐ None ☐ Sugar ☐ Water ☐ Sweets ☐ Breastmilk	
Lunch				☐ None ☐ Sugar ☐ Water ☐ Sweets ☐ Breastmilk	
Snacks				☐ None ☐ Sugar ☐ Water ☐ Sweets ☐ Breastmilk	
Evening / Dinner				☐ None ☐ Sugar ☐ Water ☐ Sweets ☐ Breastmilk	