COVERAGE MONITORING NETWORK

WRAP UP WORKSHOP REPORT SOUTH SUDAN

25TH FEBRUARY 2016

VENUE: TM LION HOTEL, JUBA

Table of contents:

Contents

1. Context 3
2. Introduction 4
2.1 Objectives of the Wrap Up workshop 4
2.2 Agenda 4
3. Outputs of the workshop 5
3.1 Workshop opening 5
3.2 Presentation of country profile 5
3.3 Presentations by partners 6
3.4 CMN's analysis of action plan implementation and group discussions 8
3.5 Coverage assessment methodologies 12
3.6 National priorities to scale up access and coverage 13
4.1 Annex 1: Coverage Wrap up workshop – attendance list 20
4.2 Annex 2: Terms of reference for workshop 21

1. Context

The Coverage Monitoring Network (CMN) is an inter-agency program implemented by ACF-UK and its partners Concern Worldwide, Helen Keller International and International Medical Corps. The first phase of the CMN was launched in July 2012 for an implementation period of 18 months, with the support of the European Commission Directorate-General for Humanitarian Aid and Civil Protection (ECHO) and USAID's Office of Foreign Disaster Assistance (OFDA). The project aimed to improve nutrition programs through the promotion of quality coverage assessment tools, capacity building and information sharing in 9 priority countries in Africa and Asia (including South Sudan, Kenya, Ethiopia, Niger, Burkina Faso, Mali, Chad, DRC and Pakistan).

Following the success of the first phase of the CMN project, the CMN entered its second phase in June 2014. During the second phase, the CMN continued to provide technical support to nutrition programmes but introduced four significant changes to the way it operates:

1. **Enhanced quality engagement**. Closer and more sustained engagement with programs and partners is considered key to successfully influence programmatic and organizational dynamics.
2. **Development of consolidated, simplified and standardized tools**.
3. Enhanced support for **clearer and actionable recommendations** for boosting coverage.
4. Provision of additional support and guidance to **address key barriers to access**.

The objectives and results of CMN Phase II are:

General Objective.

Contribute to a reduction in malnutrition-related mortality and morbidity

Specific Objective.

Improved capacity of selected nutrition programs to develop and implement actions to increase access and coverage:

Result 1. Improved integration of coverage assessment tools by nutrition programs

Result 2. Increased availability of actionable recommendations for improving coverage of nutrition programs

Result 3. Increased availability and utilization of lessons learned, best practices and information to improving program coverage

2. Introduction

As the CMN project will be drawing to a close at the end of March 2016, in coordination with the South Sudanese Ministry of Health and Nutrition Cluster/NIWG[1], the CMN organized a one-day "lessons learned" workshop in Juba to consolidate available tools and experiences from coverage assessments in South Sudan and to further the progress made so far to improve the access and reach of CMAM programs. The workshop objectives and agenda were in line with the Terms of reference which was developed jointly by the CMN, the MoH and the NIWG. The full ToR is available in Annex 2.

2.1 Objectives of the Wrap Up workshop

Principle objective:

To improve access to and uptake of SAM and MAM treatment programs in South Sudan

Specific objectives:

- To share the findings and recommendations coming from coverage assessments in South Sudan over recent years.
- To share and document examples of how the evidence and data generated by recent coverage assessments (including SQUEAC assessments and the CBSC-CE) are being used by programs,
- To share and document activities being undertaken in different contexts to overcome barriers to access and to identify best practices in key contexts.
- To discuss and agree the next steps needed to improve programming in order to improve access and uptake of services to treat SAM and MAM.

2.2 Agenda

Highlights from the one day agenda included:

- Update on the progress of Developing a framework for coverage in country
- Presentation of country profile: including mapping of coverage assessments, overview of trends in programme data and community profile
- Transforming coverage results into action: experiences, challenges and best practices Introduction to the topic
- Presentation of activities to overcome barriers to access in different contexts Introduction to the topic
- Group work to discuss and identify options for national priorities regarding access and coverage
- Overview of materials and tools developed by the CMN during CMN Phase 2.

[1] National Information Working Group

- Group work to discuss and identify next steps to improve access and uptake of CMAM programs

3. Outputs of the workshop

A total of 25 participants took part in the workshop, including MoH staff, CMN representatives, Nutrition Cluster/NIWG staff and representatives from 19 different implementing agencies. A full list of participants and their contact details is available in Annex 1.

3.1 Workshop opening

The Director Nutrition in the MoH opened the workshop, emphasizing the need to conduct nutrition assessments in a holistic manner as well as to build the capacity of the MoH to enable them to technically review and monitor coverage assessments in the country. The Nutrition Cluster gave a presentation on the current situation of SAM in country demonstrating the impact of the recent crises on the caseload of SAM. They emphasised that the areas affected by the crises have a very high prevalence of GAM. Nutrition activities in Unity state have been greatly affected by the heightened conflict. Response has been scattered, reactive and sometimes inconsistent due to insecurity, logistics as well as a lack of staff in specific areas. Also a lack of predictability has impacted upon the response.

3.2 Presentation of country profile

The CMN presented a country profile with updated mapping of coverage assessment and trends of program data. Between 2010 and January 2016, 17 SQUEAC assessments were conducted in ten different counties of South Sudan, mostly in the North-West. So far, no SLEAC assessment has taken place, so there has been no attempt to estimate coverage for multiple counties or for regions. Out of 17 SQUEACs conducted, 15 have assessed the coverage of SAM programs and two have done so for MAM programs (Twic and Panyijiar Counties). Both MAM programs were analyzed together with the SAM services in those areas. Out of 17, three did not estimate a final coverage value due to methodological problems (i.e, did not accomplish the necessary sample size for the survey) or because the scope of the research advised against doing so due to security concerns. These surveys focused instead on the qualitative information gathered during previous phases.

Overall the coverage of SAM treatment across a variety of different settings was below the minimum Sphere Standard for coverage. The average Met need (combination of coverage estimate and average cure rate for period assessed) at county level was 34.9% while 54% was achieved in camp settings. While, the number of active OTPs increased steadily during 2014 and the first half of 2015 (doubling in the period), the total admissions during 2015 did not reflect this. Admissions are the first indicator to drop when an interruption in the service takes place. In the case of South Sudan, the sharp decline in admissions over the second quarter of 2015 can probably be explained by the socio-political context.

With little available data from previous years and break downs month by month, it is hard to get a clear idea of the evolution of the performance rate of CMAM programs in South Sudan. Data recorded by the

Nutrition Cluster and UNICEF is available in quarterly reports, but it is aggregated for a specific period of time.

Latest figures available, published by the Cluster in June 2015, indicate that at the national level the CMAM programme has performed well with 88% of cases cured and 8.4% defaulting. Both indicators fall within the SPHERE standards for what constitutes acceptable performance.

However, it worth exploring the data quality assurance mechanisms put in place by partners and the clusters. The quantitative data collection, as well as comparison with the reports, registration, and cards at the field level could be a good way of double-checking the validity and the overall quality of the data by comparing it to field-level assessments (SQUEAC evaluations, mostly). Another element that could be investigated in more detail is the dynamic of change across time of these performance indicators. This can be useful especially when comparing available information on service interruptions with the performance of the program. Also, because it would give a clearer idea on whether geographic scaling up of CMAM in South Sudan has come together with an improvement of performance.

3.3 Presentations by partners

The implementing partners also presented their lesson learned experiences on implementation of the action plan to overcome of the barriers identified during the coverage assessment in order to improve the access to treatment of CMAM. A full presentation of the training is available in the following link https://www.dropbox.com/sh/br90lg2ecs8wxda/AACxb9YkKFuPbunj2-YVZuIBa?dl=0
Accordingly, GOAL presented their experience from the SQUEAC conducted in Agok, Abyei Administrative Area (AAA) Warrap State in June 2015. The barriers of the program in implementation of the action plan include:

- FM Radio was done but not adequately in terms of reaching many people and advert time was limited.
- Promoting “Wal Ador” using traditional drumming and dancing was not done as community members needed incentives.
- It was not possible to roll out Care Group circles to other Payams due to shortage of staff and inaccessibility to other areas.
- Mapping CHNV distribution, recruiting and training additional community village based nutrition volunteers on CMAM was partially done due to funding gap
- Improving referral between OTP and TSFP programs and sharing information on performance indicators was not done because ACF left the area and no agency is on the ground running TSFP in Abyei/Twic County.
- Supporting CHD to roll out ICCM was also not done due to lack of national guideline on ICCM as

well as funding gap for the activity.

International Rescue Committee conducted a SQUEAC assessment in Panyijar County in January 2015 and in Aweil South March 2015. The barriers in implementation of the action plan included:

- Sites for mobile sites identified however funds for roll out of mobile services yet to be secured.
- No SC in Aweil South, referrals to Aweil town are expensive for the family and IRC and discourages mothers to seek treatment when referred for SC.
- Stock out of nutrition supplies continue to affect coverage
- Reporting requirements from different donors and stakeholders take too much time for staff from the actual implementation (DHIS, NIS, WFP FORM 3,4; Supplies report UNICEF...)
- Capacity of staff and volunteers low hence more effort and resources required for follow up.
- A number of different community volunteers cadres in the community all supporting health initiatives
- Insecurity in Panyijar that distributed activities for 6 weeks in May
- Limited access to health facilities due to flooding and insecurity

International Medical Corps conducted a SQUEAC assessment in Akobo-East county in December 2014 and Kaya Refugee camp in Maban County August 2015. The barriers faced by the program in implementation of the action plan included:

- Insecurity (Conflict between different tribes).
- Regular migration in the operational area.
- Delay in procurement of construction material.
- Supply Pipeline breakage.
- Restriction to communication materials such as (GPS, Satellite phone)

In order to address the barriers to implementation, the partners also drew the following recommendations and lessons based on their county context:

GOAL in Agok, (Warrap State)

- Selection and training of more community nutrition volunteers based in each villages as a contact point for case finding, defaulter and sensitization of community members on CMAM

Program

- Mobile OTP team should be composed of many health staff and should reach all villages which are far from OTP centres
- Strengthen the capacity of Government officials to implement SQUEAC assessments to identity the program weakness and advice on improvement measures accordingly.

IRC in Panyjiar and Aweil South

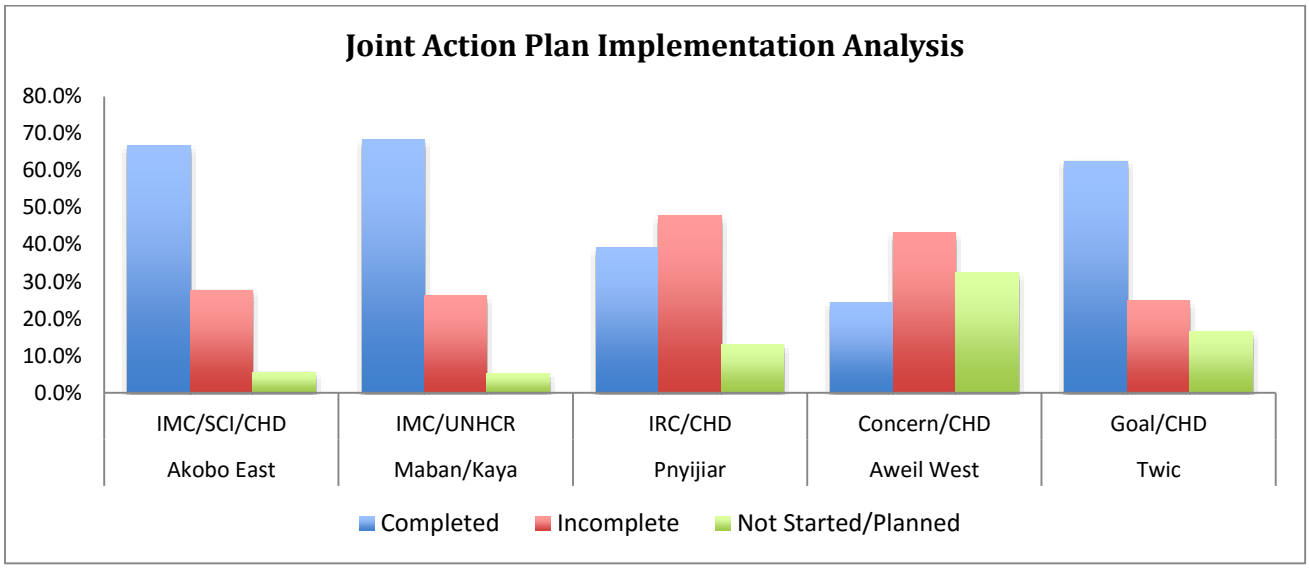
- Harmonize reporting formats at national level to reduce the time spend on compiling reports
- Provision of comprehensive IMAM services in each county (i.e. SC, OTP, TSFP)
- Harmonizing data collection tools at national level (admission cards and registers)
- Implementing partners to secure a buffer stock of RUTF to minimize stock outs
- Harmonize community volunteers roles at county/state/ national level and collectively utilize the available thinly spread resources to have an impact on health outcomes.
- It is paramount to lobby for nutrition sensitive interventions especially in the more conflict stable counties of NBeG to improve nutrition status of the community
- Pre-positioning of nutrition supplies in health facilities and engaging community members for the safe keeping of supplies

International Medical Corps in Akobo-East and Kaya Refugee camp

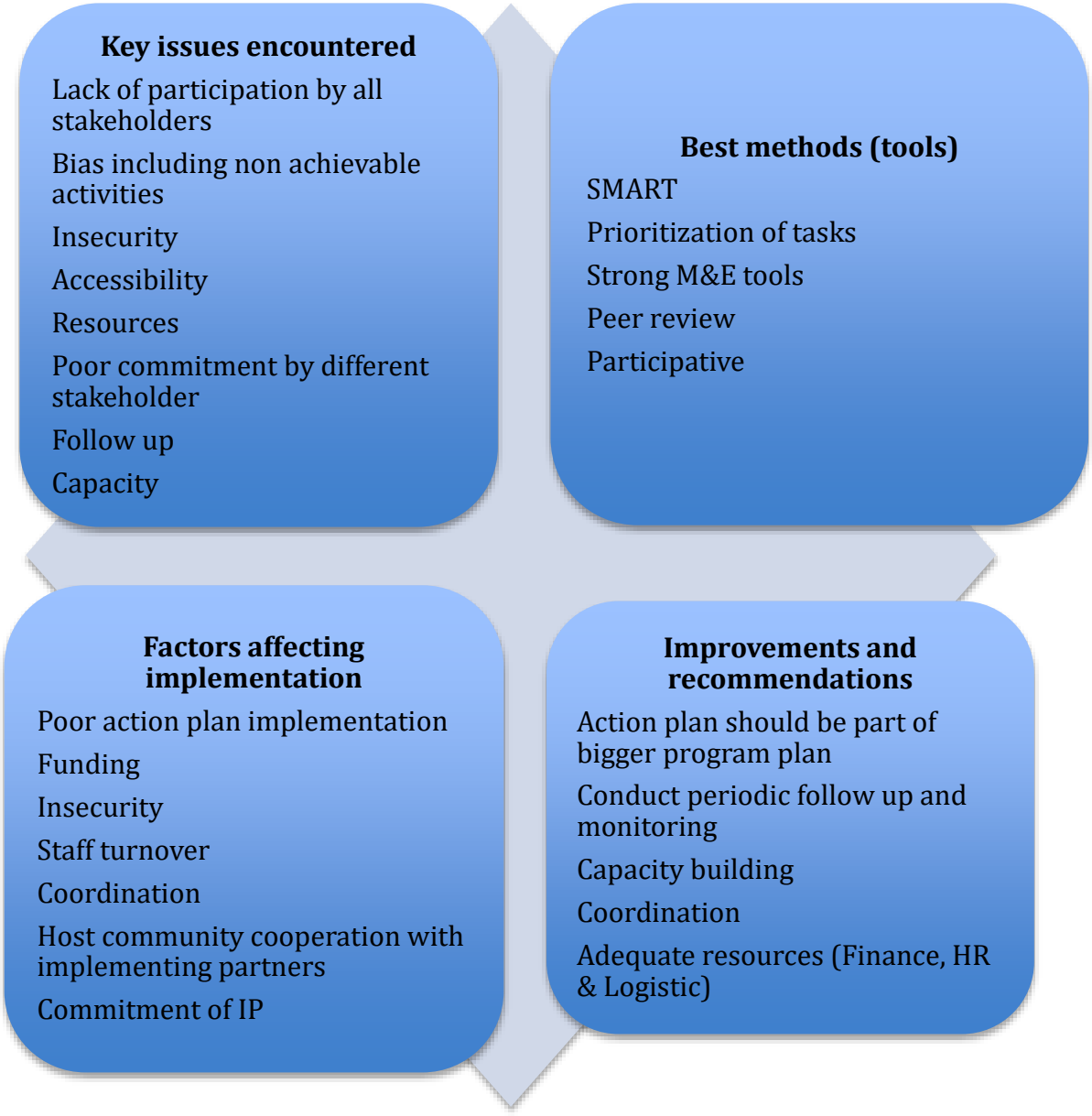
- Continue capacity building of OTP staff with refresher trainings and on-the-job coaching.
- Regular supervision and review of OTP records to check effectiveness of the program.
- Conduct follow up assessment to see the impact of Joint Action Plan and to know if program coverage is meeting with SPHERE standards.

3.4 CMN's analysis of action plan implementation and group discussions

Through regular follow up with partners on action plan implementation, the Coverage Monitoring Network (CMN) has analysed the implementation of the action plan of the partners. The results are as follows:



Information is currently limited on the experiences of implementing action plans to improve coverage. Thus, during the workshop, group discussions took place addressing key issues encountered, best methods (tools), factors affecting implementation, improvements and recommendations to consider. The results are as follows:



Another group discussion focused on transforming the results of coverage assessments relating to community engagement and service delivery in to actions. The results were as follows:

Community Mobilization & Sensitization	Supply	Quality of Care	M&E
• Empowering all community groups • Use of role models (governor, ministers, chief leaders, Mothers) • Use of effective tools (drama, dance) • Clear explanation of role & expectation • Communicate success to CNV (Motivation)	• Prepositioning plan to be put in place • Coordination among agencies • Developing supply SOP • Proper storage facilities to be constructed • Local systems to be put in place to address leakages • Adhering to protocols • Linkage of SAM beneficaries with GFD aid to address HH food insecurity • Sensitize & counseling caregivers to encourage RUTF as medicine not food. • Engage traditional authorities to disipline offenders (Staff)	• Offering of compherensive health care (RH, OTP,TSFP,EPI) • Adequate waiting areas (Benches, roofing) • Minimize time taken by caregivers • Create user friendly data managment tools • Use IEC materials • Conduct monthly meeting with staffs & volunters • Conduct routine training • Adequate availablity of supplies • Routine SBCC sessions with Cards	• Document reason why mothers are refusing transfer • Strengthen coordination between OTP & SFP follow up as well as community screening & Referral • Plan to have a vertical CMAM program for effective M&E • Harmonize monitoring and reporting tools • Conduct regular supportive supervision with the engagement of CHD

3.5 Coverage assessment methodologies

During Phase II CMN has developed different tools to transform coverage results into action plans through trainings and workshops, technical support as well as development of tools and resources. For example:

1. The integration of coverage assessment tools by nutrition programs

- Review and adaptation of the methodologies through
  - Active and adaptive case findings
  - Errors in LQAS at stage II of SQUEAC assessments
  - The application of Bayesian Beta-Binomial conjugate analysis
  - A new tools to assist survey implementation
  - Cases studies for MAM and SAM
- Bottleneck Analysis
  - Commodity availability
  - Human Resources availability
  - Geographic availability
  - Community mobilization activities
  - Utilization of services
  - Continuity of services
  - Quality of services
  - Online training center
  - Country level trainings

2. Increased amount of actionable recommendations

- Support programs in the measuring coverage and actionable solution to overcome the issues encountered
- Elaboration of action plans
- Support with the implementation of the action plan

3. Increased availability and utilization of lesson learned, best practices and information to improving program coverage.

- Publication of peer review articles
- Practical tools to overcome barriers to access
- 9 lesson learned workshops to share experiences

The Nutrition Cluster/Nutrition Information Working Group (NIWG) in collaboration with the

MoH is bears the responsibility of ownership to internalize and integrate the initiation of development of the national guideline for coverage assessment as well as the leadership to coordinate the activities and engage stakeholders regarding national priorities identified below by workshop participants regarding access and coverage to scale up CMAM programs in South-Sudan.

3.6 Next steps (way forward)

- The Nutrition cluster/NIWG recommended to develop national coverage assessment guideline
- The Nutrition cluster/NIWG in collaboration with MoH to coordinate and validate coverage survey implementation.
- The Coverage Monitoring Network (CMN) in collaboration with the nutrition cluster/NIWG to train MoH staffs on coverage assessment methodologies.
- Coverage Monitoring Network (CMN) should continue provision of remote technical support on Coverage Assessment.
- The Nutrition Cluster/NIWG to conduct mapping of capacity within partners of persons with the capacity to undertake coverage survey.

3.6 National priorities to scale up access and coverage

At the end of the workshop participants undertook Group work to discuss and identify national priorities for access and coverage in line with the 4 determinants of the Bottleneck analysis framework. The results of the discussion are summarised on pages 13-18:

Theme	Sub Theme	Problem statement	IS THIS PRIORITY RELEVANT TO South Sudan?	WHAT IS CURRENTLY BEING DONE?	WHAT SHOULD BE DONE?
Enabling Environment	Political Commitment	There is limited evidence-based understanding how to position SAM as a national priority	NO	N/A	• Scale up advocacy • Allocate appropriate budgeting design
		There are no national level wasting reduction or SAM treatment coverage targets at country level which would mirror WHA commitments	Yes	• A health & Nutrition basic health package already at the final stage • South Sudan is now part of the SUN movement	• Advocacy for donors to fund national coverage surveys at national level
		The leadership and coordination to influence national policy on SAM needs to be reinforced	Yes	• National Nutrition policy already being planned • The national IYCF policy also underway	N/A
	Financing	The inclusion of SAM treatment in national health budgets is inadequate and/or inconsistent	Yes	• There exist budget but not satisfactory	• Sustained advocacy to increase budget
	Management	The use of data/evidence for strategic and tactical decision making on SAM scale-up is limited	Yes	• Funding SMART surveys, FSNMS, IPC	• Advocate for funding to conduct a national level of surveys.

	Coordination	The lack of clear guidance and division of labour that undermine the ability to address SAM and MAM across the continuum of care in emergency and non-emergency contexts	Yes	• Development of CMAM guideline • Roll out of IYCF packages	• Strengthen the referral system • Strengthening the community engagement component
		There are limited joint initiatives between nutrition and health actors/stakeholders to support the integration of SAM into health	Yes	• More integrated approach being worked on by both the health and nutrition department at the MoH with the help of stakeholders.	N/A
Supply	Commodities	The procurement and supply of RUTF occurs outside of regular health supply chain and is unpredictable and unsustainable	Yes	• UNICEF & WFP are supplies from outside and distributing to the partners with limited involvement of MoH	• Distribution of RUTF through (government) • Establish Commodity steering committee at Boma level.
		Exploring alternative RUTF formulations at country level is made challenging by the lack of expertise in evaluating opportunities (e.g. recipes) and challenges (e.g. production)	Yes	N/A	N/A

		The understanding of key issues, challenges and barriers to inpatient treatment remains limited	NO	• Limited stabilization centres in both camp and in the host community	• Advocacy for more funding on strengthening the HF and staff
	HR	The support from health authorities, paediatricians and other senior health stakeholders in-country for SAM integration into health policy and practice (including health training curricula) is limited	No	N/A	N/A
		There are inadequate numbers of health workers in place that are adequately prepared and/or trained to deliver SAM treatment routinely	Yes	• Training schools are being established	• Additional of more health workers • Continues on job training on CMAM
		The potential contribution of community health workers to SAM treatment is not maximised	Yes	N/A	N/A

	Geographic Access	There is an inadequate number and distribution of functioning health service delivery points (e.g. fixed and community) providing SAM treatment	Yes	• Their is very few has been done. So far donor's don't support construction of infrastructure (e.g health facilities)	• Advocate for funding of construction of health facilities. • Explore more mobile or outreach clinics.
		The ability of national health actors to adequately evaluate and structure SAM treatment scale-up is limited by basic information about the health system (e.g. # of HFs; resources; days per week)	Yes	• No baseline data on nutrition	• Advocate for national/regional assessment
Demand	Community Mobilization	Community mobilization initiatives remain limited, and when they do exist, they do not generally support health seeking behaviour on SAM	Yes	• Community engagement done only at camp setting • Care group formation • Establishment of CNV • Radio messages to health seeking behaviour	• Utilize community celebration • Use dramas, games and wal ador

		There is a limited understanding of how best to empower communities to demand SAM management services, and caregivers to diagnose, prioritise and seek treatment for SAM	Yes	• Community sensitization to create better understanding and service availability	• Increase community awareness , sensitization on malnutrition and health delivery services • Train community volunteers on screening, teaching them on triage. • Motivation strategies
DEMAND	UTILISATION	Referral pathways to SAM/MAM treatment do not currently result in consistent detection and admission of cases - Distance after referral - Inadequate detection of MAM	YES	▪ Coordination of IPs treating SAM/MAM ▪ Integrating SAM and MAM services ▪ Discourage cash incentives to volunteers	▪ Follow up to ensure SAM/MAM detection is adequately In policy documents like community strategy policy guidelines ▪ Training (OJT) of staff ▪ Enhance proper diagnosis, treatment and referral
		The opportunity cost (including transport, loss of income, official and unofficial fees, etc) associated with SAM/MAM treatment can be too expensive	YES	N/A	▪ Mobile outreach ▪ Community based sites

		The availability, quality, and consistency of SAM treatment services is irregular affecting staff –user interface and compliance with treatment regime	YES	▪ Training on CMAM ▪ Scaling up SAM treatment	N/A
QUALITY	Effective Coverage	The protocols and guidelines for SAM treatment are not applied systematically, limiting their ability to adapt to patients' needs	Yes	▪ There is an interim guideline and revision of the CMAM guideline is on going	N/A
		SAM treatment services do not meet minimum standards of care in terms of WASH, ECD and psycho-social support and broader promotion components	Yes	▪ N/A	N/A

4.1 Annex 1: Coverage Wrap up workshop – attendance list

First Name	Last Name	Position	Organisation	Email Address
Blate	Moses David	Helath and Nutrition monitoring	IOM	mblate@iom.int
Aciga	Michael Francis	M&E Manager	Help e.V	aciga@help-ev.de
Kokole	Emmanuel	Program Assisitant Health & Nutrition	Hold the Child	kokole@holdthechild.org
Arman	Mark Mussa	Nutrition Coordinator	GOAL	amusa@ss.goal.ie
Tafadzwa	Matova	M&E Coordinator	Malaria Consortium	tmatova@malariaconsortiom.org
Joyce	Ayume	IYCF - Tech Coordinator	SCI	Joyce.Akandu@savethechildren.org
Walter	Baluku	NPM	MaCDA	walterbalakun@gmail.com
Peter	Jinah	Nutrition Manager	UNKEA	peter.unkea@gmail.com
Charles	Okwany	M&E specialist	UNIDO	me@unidosouthsudan.org
Jennifer	Alt	M&E Manager	MEDAIR	mel-manager@southsudan.medair.org
Isaack	Manyama	Nutrition Cluster Coordinator	UNICEF	ssnutritioncluster.coordinator@gmail.com
Hussein Hassan	Mohammed	Deputy Nutrition Cluster Coordinator	WFP	hussein.mohammed@wfp.org
Akello	Beatrice	Health Coordinator	THESO	beatrice.akello@theso.org
Dorice	Omolo	Nutrition Surveilliance Manager	IMC	domolo@internationalmedicalcorps.org
Vilegwa	Juliet	Health and Nutrition Program Manager	CIDI	j.vilegwa@cidiss.org
Maria Leelavathi	Joseph	Country Representative	JDF	marialeelavathi@johndaufoundation.org
Nanacy	Mcgaughey	Regional Health & Nutrition advisor	IMAW.H	nancymcgaughey@ima.wh.org
Rashidi	Mbekunzuri	Nutrition Specialist	PLAN International	Rashidi.Mbekunzuri@plan-international.org
Omar	Yahya	Health Advisor	CCM	healthadvisor.ssd@ccm_italia.org
Shishay	Tsadik	Nutrition Advisor	MoH/SCI	
Patrick	Kenyi	CMAM Coordinator	MoH	kenyi.patrick@yahoo.com
Rebecca	William	Director/Nutrition	MoH	
Mesfin	Mekonnen	Nutrition Cluster Coordinator	Nutrition Cluster	memekonnen@gmail.com
Francis		M&E Coordinator	MoH	
Valarino			MoH	

4.2 Annex 2: Terms of reference for workshop

Introduction:

The Coverage Monitoring Network (CMN) is an inter-agency project lead by Action Against Hunger and including International Medical Corps, Concern Worldwide and Helen Keller International. The project was launched in 2012 with the support of ECHO and OFDA.

The project aims to increase and improve the coverage of CMAM programmes through the promotion of quality coverage assessment tools and the sharing of lessons and good practices in 9 priority countries in Africa and Asia (including South Sudan, Kenya, Ethiopia, Niger, Burkina Faso, Mali, Chad, DRC and Pakistan).

Following the success of the first phase of the CMN project, the CMN entered its second phase in June 2014. During the second phase, the CMN field teams continued to provide direct and remote technical support to CMAM programmes with the planning and delivery of coverage assessment methodologies. The CMN field teams also helped programmes to develop context specific action plans to improve community mobilisation in their programmes. Since June 2014, the CMN team supported the CMAM programmes they had supported to implement the action plans in their programmes and have worked with programmes to consolidate best practices and lessons from their experiences.

Since June 2014, the CMN has supported directly or remotely five organisations in South Sudan to conduct coverage assessments across a total of eight counties or refugee camps. The reports for these surveys along with the reports from all previous coverage assessments are available on this page: http://www.coverage-monitoring.org/country/south-sudan/

The CMN project will be drawing to a close at the end of February 2016. The CMN would like to organise a one day workshop to share with all partners the summary of findings from the programmes it supported in South Sudan. All nutrition cluster partners are invited to attend and CMAM programmes to a one day workshop.

Objectives:

Principle objective:

To improve CMAM programming in South Sudan

Specific objectives:

- To update all partners on the implementation of action plans in the programmes supported by the CMN and to share experiences and, where possible, examples of the impact of action plans on coverage.
- To share with partners best practices and lessons from programmes in South Sudan and other CMN priority countries.
- To present and share with partners the tools and guidance developed by the CMN team to support the roll out of coverage assessment methodologies in South Sudan
- To work with cluster partners to elaborate next steps for the cluster to pursue in 2016 and beyond to roll out coverage assessments and to increase and improve the coverage of CMAM programmes.

Participants:
Ministry of Health staff, UN agencies and NGOs involved in tackling acute malnutrition through CMAM programmes.

Format of workshop:
The workshop will take place over one day. An agenda will be shared approximately one week before.
It will consist of presentations by the CMN field team and by in-country partners who have been implementing action plans at programme level in South Sudan. The workshop will also include group working sessions throughout the day.

Date and venue of workshop:
The workshop will take place on Thursday 28th January 2016 between 9am and 5pm. Venue TBC.

Expected outputs:

- The consolidation of information, results, challenges and opportunities related to improving the coverage of CMAM programmes in South Sudan in a country profile document, prepared by the CMN and shared with the cluster partners after the workshop.
- Next steps for the elaboration of a national level strategy to scale up coverage assessments and improvement to coverage of CMAM programmes.