COVERAGE MONITORING NETWORK

# COMMUNITY ASSESSMENT REPORT, CMAM PROGRAM PANYIJIAR COUNTY IN UNITY STATE, SOUTH SUDAN JANUARY 14-28, 2015

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## RECOMMENDED CITATION:

Melaku M. Dessie, Community Assessment for Community-Based Management of Acute Malnutrition Program in Panyijiar County, Unity State, South Sudan. CMN: Washington D.C, January 2015.

Coverage Monitoring Network (CMN) is an inter-agency initiative led by Action against Hunger (ACF), Concern Worldwide, International Medical Corps and Helen Keller International. The project aims to increase and improve CMAM coverage and to monitor it globally through the promotion of quality coverage assessment tools, capacity building and information sharing. The CMN was launched in July 2012 with support from the European Commission Directorate-General for Humanitarian Aid and Civil Protection (ECHO) and USAID's Office of Foreign Disaster Assistance (OFDA).

The opinions expressed herein are those of the authors and do not necessarily reflect the views of the USAID or ECHO

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# ACKNOWLEDGEMENTS

I would like to thank all who contributed to this community assessment for Community-Based Management of Acute Malnutrition (CMAM) program in Panyijiar County, Unity State in South Sudan. My special appreciation extends to the health authorities and staff, data enumerators, community leaders and members of Panyijiar County for their hospitality, time and cooperation. Particular gratefulness is noted for Jeff Kalalu, Irene Makura, and James Gatluak from International Rescue Committee (IRC), and the Panyijiar County Health Department (CHD) Director, Mr. Stephen Gatliath and the Nutrition Officer Mr. Michael Gatwich Puk, the Relief and Recovery Agency (RRA) in South Sudan, who extended their support throughout the assessment.

Many thanks to Caroline Abla from International Medical Corps, Sophie Woodhead from Coverage Monitoring Network (CMN) and Lovely Amin from Concern Worldwide, for their valuable support. Lastly, but not the least I would like to thank Coverage Monitoring Networks (CMN's) funders, ECHO and USAID for funding the CMN project. This CMN project made it possible to conduct this community assessment and to train IRC nutrition professionals in Panyijiar County of South Sudan in undertaking community assessment and design community mobilization for CMAM program.

Melaku M. Dessie, Community Mobilization Advisor from International Medical Corps/ CMN project in collaboration with IRC staff and the Panyijiar CHD led this assessment. The IRC support from DFID also facilitated the process by providing administration and logistic support in the field.

# ABBREVIATIONS

| | |
|---|---|
| CBD | Community-Based Distributor |
| CHD | County Health Department |
| CMAM | Community-Based Management Of Acute Malnutrition |
| CMN | Coverage Monitoring Network |
| CNV | Community Nutrition Volunteer |
| CNW | Community Nutrition Worker |
| FGD | Focus Group Discussion |
| IYCF | Infant And Young Child Feeding |
| KII | Key Informant Interview |
| MAM | Moderate Acute Malnutrition |
| MCG | Mother Care Group |
| MUAC | Mid Upper Arm Circumference |
| PHCC | Primary Health Care Center |
| PHCU | Primary Health Care Unit |
| OTP | Outpatient Therapeutic Program |
| RRA | Relief and Recovery Agency |
| RUTF | Ready-To Use Therapeutic Food |
| RUSF | Ready-To-Use Supplementary Food |
| SAM | Severe Acute Malnutrition |
| SC | Stabilization Center |
| SQUEAC | Semi-Quantitative Evaluation Of Access And Coverage |
| SSI | Semi-Structured Interview |
| TBA | Traditional Birth Attendant |
| TH | Traditional Healer |
| TSFP | Targeted Supplementary Feeding Program |
| VHC | Village Health Committee |

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# EXECUTIVE SUMMARY

The International Rescue Committee (IRC) in South Sudan in coordination with Coverage Monitoring Network (CMN) conducted a community assessment for Community-Based Management of Acute Malnutrition (CMAM) program in Panyijiar County, Unity State. The community assessment was carried out using the Semi-Quantitative Evaluation of Access and Coverage (SQUEAC) methodology from January 14 to 28, 2015 as part of IRC's CMAM coverage assessment. The main objective was to understand and analyze the program context to identify existing systems, resources, community structures and cultural factors in order to design a community mobilization strategy that fits with and builds on local resources to improve access and use of the CMAM services.

Community meeting is a key communication method used to disseminate information in the area. Community announcement via microphone and Village Health Committee (VHC), and announcement after church services by priest or pastor as well as informal information exchange at market and traditional rallies cited as effective communication channels by community informants. Existing of extensive networks of community committees and volunteers are impressive. Community figures, including chief of the village, headman, women representative, religious leaders in the area, are the gate keepers of the communities and expressed commitment to support the community mobilization in the locality, however they could.

Several factors, as, active involvement of chiefs of the villages in CMAM program and supporting community mobilization have been identified along the assessment as boosters for the communities to access to CMAM services. Good community mobilization activities through community nutrition volunteers (CNVs) contributed to improved early case finding and referral and minimized defaulter. Community-Based Distributors' (CBDs) opportunistic case finding and referral as part of integrated community case management (ICCM) augmented case finding and referral effort, particularly in the villages that are not reached by CNVs.

On the other hand, this assessment revealed that the communities in Panyijiar County still faces a range of barriers to access and use of CMAM services. This ranges from long distance to CMAM delivery points and stock out of Ready-to- Use Therapeutic/Supplementary Food (RUTF/RUSF) to the high opportunity cost of caretakers and the history of pervious rejection. It's necessary to address these barriers through active involvement of community figures in and implementation of good community mobilization for CMAM, including community sensitization about CMAM target group and malnutrition.

Strengthen community mobilization activities by capitalizing on the extensive network of trained community volunteers and existing community committees will improve early case finding and referral, minimize defaulter and consequently improve the coverage and outcome of treatment of acute malnutrition. Community mobilization to increase access to CMAM services should be implemented in tandem with strategies to improve CMAM services quality. This includes improve CMAM RUTF/RUSF supply chain and provide close supportive supervision and technical support. Piloting and scaling up community-based CMAM delivery through ICCM by trained CBDs could bring the CMAM services further closer to communities.

# I. INTRODUCTION

Panyijiar County is located in the Nile Valley of the southern tip of Unity State and one of the counties of Unity state of South Sudan. It is composed of 10 Payams and 36 Bomas (the smallest local government administration unit). Each Boma is further divided into villages. The villages are formed along marital links, clans and higher land to protect themselves from swamps and flooding. Most of the population has settled in the villages composed of a cluster of households. The county has an estimated population of 58,375 people[1] for 2015. As of February 2014, an estimated 45,000 people were displaced from the neighboring states because of protracted civil war since December 2013 were reported from the county.

Nuer is the only predominant ethnic group in the county. Nuer language is the language spoken by the population. The majority of the inhabitants are Christians. The livelihood of the community depends habitually on rearing animals with some subsistence farming. During the lean season, the communities depend mainly on the wild food collection, seasonal fishing, selling grass, fire wood and local poles as well as support from relatives.

Despite having been less directly affected by the conflict, Panyijiar County has hosted many of those displaced by the fighting in neighboring counties and states, increasing the burden on host communities. The crisis limited suppliers from accessing markets, which resulted in limited food supplies that normally are transported from Malakal, Bentiu, Bor and parts of Juba. This has led to expensive food prices, leaving households unable to buy even basic food and supplies. To try to cope with this, many of the households completely depend on food aid from the World Food Program and forced to coping strategies including gathering wild nuts and tubers. The malnutrition situation in the Panyijiar County has generally remained high, and the April 2014 IRC Integrated Nutritional Anthropometry and Mortality SMART Survey shows critical malnutrition levels with the prevalence of Global Acute Malnutrition (GAM) (WHZ<-2 and/or edema) was 32.8%, and the severe acute malnutrition (SAM) prevalence was 10.8% for the county.

IRC has been implementing primary health care and the ICCM in Panyijiar County since 1995. Currently, there are three operational primary health care units (PHCUs) in Pachar, Tiap and Morgok and one primary health care Centre (PHCC) located in Ganyliel Payam. These facilities together with monthly outreaches and weekly two mobile clinics (since April 2014) have been providing both curative and preventive health services for the county. The IRC also recently rolled out CMAM program in December 2013. CMAM services are provided at 9 OTP/TSFP delivery points and 1 Stabilization Center (SC) in the area. The iCCM aims to provide home-based treatment of diarrhea, malaria and pneumonia in children under five through 264 CBDs (1 CBD per 50 households). Since August 2014, IRC has trained CBDs on Mid Upper Arm Circumference (MUAC) measurement for identifying children with acute malnutrition as part of the iCCM program.

1 General population in catchment areas (2008 census with 2.85% annual growth)

# II. ASSESSMENT OBJECTIVES, METHOD AND TOOLS

This community assessment aimed at:

1) Assessing community knowledge, beliefs and practices in relation to acute malnutrition and illness;
2) Understanding community structures, leadership and actors, including appropriate communication channels and community volunteer networks that can be used for community mobilization;
3) Assessing factors that influence the community decision to access and use CMAM services;
4) Identifying strengths and weaknesses in the current community mobilization activities for, and opportunities and threats to, future collaboration with the CMAM program;
5) Improving the community mobilization strategy to improve access and use of the CMAM services;
6) Building capacity of the Panyijiar CHD and IRC staff in undertaking community mobilization assessment and designing a community mobilization strategy for the CMAM program.

This assessment was carried out in Great Ganyliel Payam[2] covering six out of ten Payams of (due to inaccessibility) of Panyijiar County, Unity state using the SQUEAC methodology from January 14 to 28, 2015 as part of the IRC's CMAM program coverage assessment. A comprehensive mixed-method approach was employed, including primary qualitative data collection, mainly through key-informant interview (KII), semi-structured interview (SSI), focus group discussion (FGD) and observation of the health facilities.

Data was collected in three stages in line with the SQUEAC methodology. In the first stage of the SQUEAC, 8 villages (4 far and 4 close to the health facility), which are covering six Payams and different Bomas of the Greater Ganyiel Payam, were purposefully selected. A total of 34 KIIs and 24 FGDs was conducted with community figures (political, religious and traditional leaders, traditional birth attendant, and traditional healer), mothers and fathers of children less than five years old and CMAM program beneficiaries. KIIs were also conducted with community volunteers and outreach workers, health and nutrition workers at eight health facilities. Moreover, KIIs were carried out with IRC project staff and Panyijiar CHD Director. At 3rd stages of the SQUEAC, the team administered SSI with 119 caretakers of children with SAM or MAM, who were not admitted into the CMAM program in order to explore their barriers to access to the care.

A two-day training was provided to data enumerators on community mobilization assessment and qualitative data collection methods. The CMN team closely supervised the data collection process in order to ensure data quality. The data were interpreted and analyzed with program staff and data enumerators in the field. Based on the assessment findings and recommendations, the assessment team developed a community mobilization strategy and an action plan for CMAM program that should be implemented jointly by IRC and Panyijiar CHD.

The CMN team held a debriefing meeting with IRC senior technical staff to share the assessment findings and recommendations. Additionally, the IRC nutrition team presented the preliminary findings and recommendations to South Sudan to nutrition information working group in Juba, South Sudan.

2 Six Payams( Ganyiel, Pachar, Pachak, Pachinjok, Tiap and Thornuom ) – is also referred as Greater Ganyiel Payam

# III. FINDINGS AND DICUSSION

## 3.1. COMMUNITY STRUCTURES AND LEADERSHIP

Panyijiar County is under the controlled by South Sudan Opposition Army, while the political leadership structure and key persons did not change. The county has a Commissioner who was appointed directly by the President of South Sudan before the current civil war. The County Commissioner continues to play his role in the opposition-controlled county. Each Payam has a Payam Administrator who directly reports to the County Commissioner.

The traditional leadership comes from the same clan and community in each village. A chief of the village is selected by the community and represents the communities at the Boma level. The chief of the village is an influential traditional leader and has overall control over the activities in the village. Headman is also among influential traditional leaders and report to a chief of the village in the villages. There is a women's representative at each level of political and traditional leadership structures. The religious leaders (a catholic priest and protestant pastor), who lead the worship in the church, are also equally important community figures in the area.

The involvement of the chief of the village in the CMAM program helped to gain full access to the target community and to get their support to community mobilization for CMAM in the area. However, other community figures (Sub-chief, headman, women representative, religious leaders etc) need equally to be involved in community mobilization for CMAM program. They can help with mobilizing the community and support the community mobilization, such as identify and follow-up malnutrition cases, provide referrals, communicating the purpose of CMAM and address the problem of caregivers.

Similarly, traditional healers (TH) are also among the community figures and highly respected by the community and are believed to have the spiritual power to cure illnesses in the area. They are also the point of contact for some families seeking treatment for sick children, including acute malnutrition. During this assessment, it is observed that TH caretakers sought CMAM services for their sick child. Nonetheless, the THs are not involved in supporting community mobilization in Panyijiar. So this is a good opportunity to engage the TH in the community mobilization, as such communicating the outcome of CMAM services, and opportunity case finding and referral should be employed.

Women are the main childcare providers and handle the day-to-day family activities and needs. Women also mostly handle all activities outside of the home. The community practice polygamy, whereby one man can marry as many women as possible in Panyijiar County. The number of wives, children and cattle are frequently used as measures of a man's wealth. According to their culture, women have rank or standard of respect within the household according to the seniority, and respect gained from the husband.

In Panyijiar County, as in many communities in south Sudan, mothers are responsible for childcare and taking their children to the health facility for medical care. The mother of the child only needs her husband's permission to take a child to the traditional healers as there is need to pay money for the TH's services. But the fact that men's participation in the CMAM program is limited this contributes to barriers

for caretakers to access CMAM services. As men are the decision makers in the household, engaging men in CMAM program is required in order to ensure maximum possible support to women hence empowering women caretakers and improving their access and use of the CMAM services.

## 3.2. COMMUNITY GROUPS AND VOLUNTEERS

IRC established Water Management and Community Protection Committees. Panyijiar has also Teacher-Parents association and Village Health Committee (VHC). VHC is a community volunteer network supporting health initiatives in the community. The community in consultation with the village heads selects them. IRC engages the VHC, which supports health service delivery and functions as a bridge between health facilities and communities.

IRC also supports 60 Mother Care Groups made up of pregnant and lactating women (PLW) who meet weekly with health workers to discuss about infant and young child feeding practices and cooking demonstration at health facility.

There are 264 Community-Based Distributors (CBDs) - one CBD per 50 households, who are trained to provide home-based treatment for malaria, diarrhea and pneumonia in children under five years. The CBDs were also trained on screening and referral for severe acute malnutrition (SAM) in August 2014 and most of them received MUAC tape and are referring children with SAM in the area to the health facility.

IRC recruited and trained 65 CNVs (60 female and 5 male) for CMAM program in the area. These volunteers were trained to do community mobilization. They work in the communities and conduct home visits follow up, case finding and referral, one to one health and nutrition education. They are expected to work much longer hours and cover more than five villages. However, the health and nutrition staff indicated that the CNVs' motivation declined recently due to lack of incentives, particularly after the introduction of incentives to hygiene promoters.

The extensive networks of community committees and volunteers are impressive and will greatly facilitate the community mobilization for and management of CMAM services. However, the lack of formal integration between community mobilization for CMAM program and these community groups and community –based initiatives must be addressed.

## 3.3. ORGANIZATIONS SUPPORTING HEALTH AND NUTRITION IN PANYIJIAR COUNTY

Few international non- governmental organizations are supporting the health and nutrition activities in Panyijiar County (Table 1). IRC recently initiated and supported the local representative of South Sudan Relief and Recovery Agency (RRA) to lead the coordination among the partners. The RRA is supposed to coordinates the partnership and leads monthly coordination meetings but the meetings are not held regularly.

Table 1: Organizations Supporting Health and Nutrition Programs and their Role in Panyijiar County

| Organization | Role | Coverage |
|---|---|---|
| IRC | Health systems strengthening, CMAM, iCCM livelihood and food security, child protection, WASH | County level |
| Mercy corps | Food security and livelihood | County level |
| German Agro Action | Food security, food aid | County level |

## 3.4. COMMUNICATION CHANNELS

There are numerous formal and informal communication channels used to disseminate information within the community in the area. The strengths and weaknesses of each channel (how effective the channels are in reaching the target community and the number of people they can reach) were assessed and ranked (see table 2).

Table 2: Formal and Informal Communication Channels Matrix in Panyijiar County

| Communication Channels | women | Community | Perceived effectiveness |
|---|---|---|---|
| Formal Communication Channel | | | |
| Community meeting | | X | High |
| Announcement after church services | | X | High |
| Community announcement via microphone | | X | High |
| Announcement at School | | X | Low |
| Community sensitization via CNVs and CBDs | | X | Medium |
| Announcement via Village Health Committee | | X | High |
| Announcement via Water management committee | | X | Medium |
| Informal Communication Channel | | | |
| Traditional rallies ( April-May and Dec-Feb) | | x | High |
| Information exchange at Market | | x | High |
| Information exchange at Water point | x | | low |
| Information exchange at Food distribution site | | x | High |
| Information exchange during social ceremonies, such as child naming, wedding | | x | low |
| Information exchange during funeral ceremony | | x | High |

Monthly community meeting is a key communication method used in Panyijiar County. Both men and women attend community meetings at the village level. Community leaders (Chief and headman) convey important messages during community meetings. Community announcement through microphone and VHC, and announcement after church services by priests or pastors as well as informal information exchange at market, food distribution day and traditional rallies cited by community informants an effective communication channels. In addition, the community mentioned that they received key health and nutrition messages from community nutrition volunteers. Existence of these effective communication channels in the area are a great opportunities for the CMAM program, but the use of these effective communication channels for community sensitization about CMAM and malnutrition is to be maximized.

## 3.5. LOCAL UNDERSTATING OF CHILDHOOD ILLNESS AND MALNUTRITION

Common childhood illnesses are Diarrhea, Malaria, Measles, Malnutrition, Whooping Cough, Pneumonia, and eye infection in the area. The local terms are ***Pet*** for malaria, **cam** for diarrhea, ***Juak*** for Measles, ***riay*** for malnutrition, ***kilkil*** for Whooping Cough, ***yieth*** for Pneumonia, and ***banynyim*** for eye infection. Communities mentioned that diarrhea disease and pneumonia are severe forms of childhood illnesses and occur between February to May and August to December respectively. The communities also indicated that childhood malnutrition is common and high between March and July.

Most community informants were able to describe malnutrition, and could differentiate it from other diseases like malaria and diarrhea. They were also familiar with different signs and forms of malnutrition, such as wasting/ thinness, edema, big abdomen, old man's face, stunting and gray hair

The local terms for different signs and forms of malnutrition are ; **Riay,** and ***Nuan, Thuok Buany, chiew*** for wasting/thinness; ***Hnial wuot midit*** for old man face; ***Nyoy*** for stunting and ***Miem tii meri*** for gray hair. Edema and big abdomen are expressed in local term as ***pout*** and ***leng kok*** respectively. ***Dual wall nyalop mi lual*** and ***Dual wall nyalop mi yian*** are local terms for RUTF and RUSF respectively.

The perceived causes of malnutrition cited by community members were lack of cow milk, lack of food, vomiting, diarrhea and fever. Furthermore, most of the community reported that if the caretakers are lazy, the child becomes malnourished as the result of poor care and feeding practices.

Most of key informants associated the causes of malnutrition with diarrhea, which is caused as the result of "the breastfeeding mother has had sex while she should still be breastfeeding her child (up to 2 years of child's age)". Moreover, informants mentioned that if this same mother visits other families, she would bring malnutrition to the young children (< 2 years old) in that household. So it is important to ensure that community sensitization and ongoing health and nutrition promotion across the area include local terminology and clear information on the cause, signs and symptoms of a malnourished child.

Additional causes of malnutrition cited:

- If an older son in the family passes away before he is married and his younger brother does not marry a wife for him, it would causes death or illness including malnutrition in the household.
- If a family does not pay their cattle debt, it would causes death or illness including malnutrition in the household

**INFANT AND YOUNG CHILD FEEDING (IYCF) AND CARE PRACTICES**

Almost all community members stated that all infants are breastfed until two years old. Communities reported that infants are fed additional soft foods and liquids, such as cow milk and porridge anytime from 2 to 9 months indicating limited knowledge of optimal breast-feeding practices. When asked about the frequency of feeding a 12 month-old child, most mothers said they would feed the children 3 to 5 times per day.

## 3.6. TREATMENT OF ACUTE MALNUTRITION AND OTHER ILLNESS

Despite the fact that the CMAM program has recently rolled out, most communities mentioned that they seek CMAM service to treat acute malnutrition. They also indicated that they appreciated the outcome of the treatment and recognized the positive changes in children who had received treatment. During the assessment, it is observed that caretakers bring their children often to the OTP site for MUAC measurement of children and are eager to get their children admitted into the CMAM program. However, most of them lacked awareness about the purpose of CMAM program and they just want to have RUTF/RUSF as part the family food.

In contrast, traditional healing practices and homemade remedies are sometimes also used alongside CMAM services in the area.

Homemade remedies used to treat malnutrition and other childhood illness n in the communities;

- *Fresh* fish soup and cow milk to treat malnutrition
- *Reep*-leaves, *Tintin*-leave, *Niim* –leaves/steam cover, *Tiit*-steam cover to treat malaria
- Apply ash on shoulder, chest and head of child for blessing and treat any illness
- *Thuc* -grass and chewing root *to treat any cough*
- *Koop*- leaves *to treat whooping cough*

## 3.7. FACTORS INFLUENCING ACCESS TO CMAM SERVICES

The assessment shows that the communities in Panyijiar County face several barriers to access and use of CMAM services (see table 3).

Table 3: Barriers to Access to CMAM Services in Panyijiar County

| | Barrier | Concepts |
|---|---|---|
| 1 | Long distance to service delivery point | Caretakers need to walk up to 4 hours on foot to reach CMAM site, no access in remote area |
| 2 | Inaccessibility | Flooding, swamps, difficult to get transport, lack of money to pay for transport and insecurity |
| 3 | High opportunity cost of caretakers | Mother busy, sick or has workload, competing task, lack of family member support on child care , busy for looking for food |
| 4 | Long waiting hours at the service delivery point | Shortage of CNWs, CNVs and outreach supervisors, long waiting hours, overcrowding at CMAM site, |
| 5 | Shortage of RUTF/RUSF supply | stock out of RUTF/RUSF, logistic constrain, expensive labor and no timely payment to laborer , expensive airlifting of CMAM supply |
| 6 | Inadequate quality of service | Poor motivation of CNVs and CNWs, No admission card, Poor provider-client interaction |
| 7 | Some key community figures are not adequately involved in CMAM program | Lack of involvement of VHC, tradition healers, headman, religious leaders and TBA in community mobilization for CMAM program, |
| 8 | A child rejected by the program | Mother think every child is eligible to CMAM program as they presume RUTF and RUTS as food but not medicine, know rejected case too |
| 9 | Poor health facility infrastructure | No storage for RUTF and RUSF, No waiting area, No latrine, No structure for OTP/TSFP ( service is provided at somebody's house ) |

Long distance to CMAM service delivery point is a top barrier for the community to access to CMAM services in the area. Despite the fact that CMAM services are delivered through nine sites in six Payams, a significant proportion of the communities lives in scattered clusters of villages that are located up to 4 hours walking distance from the nearest CMAM site. Caretakers must visit health facilities on a weekly or bimonthly basis for their OTP or TSFP appointments respectively.

Moreover, flooding and swamps due to seasonal rain and overflow of Nile River extremely limited community's access to CMAM sites throughout the year. In Panyijiar County, each village form an island due to swamps and the communities uses local made canoe to move from village to village and health facility. However, the high cost of canoe transport and lack of money often prevents caretakers visiting the clinic.

The second major barrier cited by most community informants was that the high opportunity cost of caretakers, such as mother busy, sick or has lots of workload and competing task at household. As the result, caretakers either miss CMAM appointment or do not seek CMAM services due to lack of support from husbands and other family members to care of the remaining children and carry out other household duties at home.

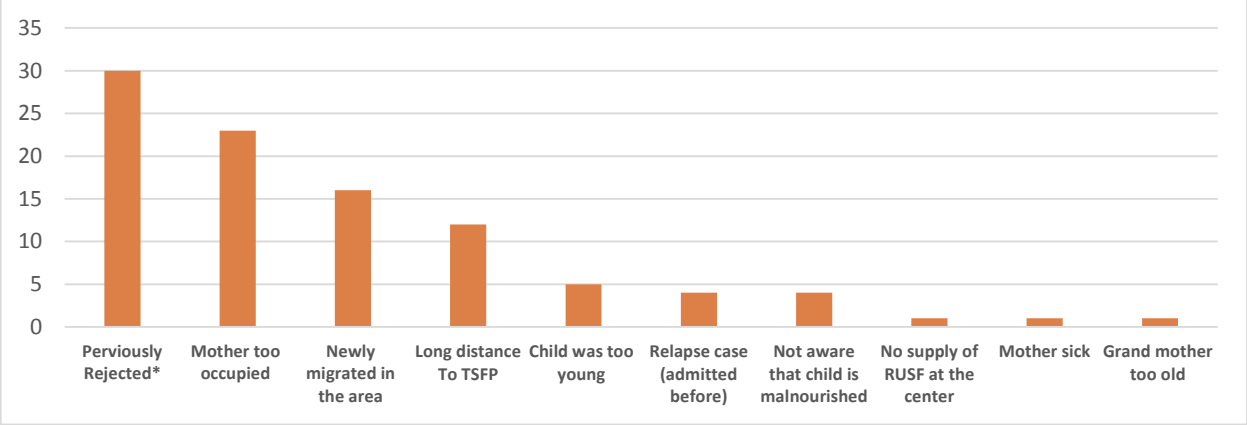
Inadequate quality of services was also part of the reported barriers that affecting the communities' access to care in Panyijiar. Frequent stock out of RUTF and RUSF is common and deleteriously affects caretaker interest to return to the health facility. This includes overcrowding and long waiting hours, lack infrastructure and poor motivation of community nutrition workers and volunteers.

Lack of adequate number of active community nutrition volunteers and supervisors in the villages was associated with inadequate home visit follow-ups, screening and referral of children with SAM/MAM, and community sensitization about CMAM and malnutrition. As such, caretakers of children in most areas are not aware CMAM target group and its purpose. As the result, caretakers often visit the CMAM sites for MUAC measurement of their children and are eager for their children to be admitted into the program. This leads overcrowding of the CMAM sites, high workload to nutrition workers and most mothers were dissatisfied that children were not eligible for admission.

Lack of some community figures (VHC, tradition healers, headman, religious leaders and TBA) involvement in CMAM program was also associated with inadequate support to community mobilization for CMAM services, such as inadequate screening and referral of children with SAM/MAM, and community sensitization about CMAM and malnutrition

In the 3rd stage of the assessment, 97 caretakers of children with MAM, but not admitted into the CMAM program, were interviewed to explore the barriers to access to CMAM. A history of previous rejection because child did not fulfill the admission criteria during screening was cited by 31 % of caretakers as a major barrier, followed by the mother's workload at household (24%) and newly migrated to the area (16.5%) as shown in Fig 1.

Fig 1: Reasons given by mothers with MAM cases for not being in CMAM program, Panyijiar County




**(did not fulfill the admission criteria before)*

The enabling factors to access and utilize treatment for acute malnutrition by the community are listed below in Table 4. The main enabling factors cited by community informants were community's appreciation of the CMAM treatment outcome, the availability and provision of free of charge CMAM services in the area. Before the start of CMAM program implementation in December 2013, the communities had to travel for two weeks on foot or 3 days by boat to the Leer County to seek the CMAM service, and required significant money for accommodation and transport. As such, the provision of CMAM service was highly welcomed by the communities and provides better access to CMAM services in the area.

The good referral system between OTP and TSFP programs and good skills of CNVs on MUAC measurement was also identified as enablers for the community to access CMAM services. Equally, good community mobilization (case finding and referral, defaulter tracing and home to home sensitization about CMAM) through CNVs and CBDs, and chiefs of the villages support for the CMAM program contributed to better access to the CMAM services by the communities.

Table 4: Boosters to access CMAM Program in Panyijiar County

| | Boosters | Concept |
|---|---|---|
| 1 | Appreciation of CMAM treatment outcome | Community appreciate child's weight gain |
| 2 | Availability of comprehensive CMAM services | OTP, TSFP and SC services provision by IRC |
| 3 | Good referral system between OTP, SC and TSFP | good referral between services |
| 4 | Provision of free CMAM service | |
| 5 | Aware the availability of CMAM services | Community knows the CMAM services availability , referral system and admission criteria |
| 6 | Community has easy access to CMAM services in some area | Nine OTP site in six Payams and some of villages are close to services |
| 7 | Good community mobilization activities in most area | Case finding and referral, defaulter tracing, sensitization, community leader's participation in CMAM. |
| 8 | Good collaboration between health and nutrition staff and the community in most area | Leaders and community support the services and workers, and provide room for storage , OTP and TSFP service provision |

## 3.8. COMMUNITY MOBILIZATION STRATEGY

The strengths and weaknesses in the current community mobilization activities for the CMAM program, and opportunities and threats to future collaboration with the CMAM program in Panyijiar County are summarized below in Table 5.

Table 5: Strengths and Weaknesses of Community Mobilization for CMAM in Panyijiar County

| **Strengthen** | **Weaknesses** |
|---|---|
| • Chiefs of the villages were oriented about the program, and involved early in the CMAM program and support the community mobilization<br>• There is good case finding and referral through CNVs, and CBDs. The CNVs conduct home to home visit sensitization<br>• Defaulter tracing is conducted by CNVs who based themselves in the community.<br>• There is a good referral system between OTP, SC & TSFP<br>• Mass MUAC screening carried out at start of the program | • There is no enough CNVs and their supervisors to cover all CMAM program target villages. The CNVs do not have visual aid including appropriate referral form and IEC materials for their work<br>• Community sensitization about malnutrition and CMAM is not done at large scale at community gathering places<br>• Panyijiar CHD and community figures are not well involved in CMAM related activities at scale<br>• Limited integration of community mobilization for CMAM into other community based initiatives<br>• Poor motivation of CNVS and lack of incentives to CNVs and CBDs<br>• No mechanism to follow up referred cases from community to CMAM sites |
| **Opportunities** | **Threats** |
| • Various volunteers and outreach workers such as MCG, CBDs , WASH committee, VHC<br>• There are four National Immunization Days a year that target children under five years old. The health facility has also monthly outreach immunization activities that target children under 1 year old<br>• Presence of several community meeting and gathering<br>• Willingness of community figures to participate in CMAM program | • Inadequate capacity of county health department<br>• Poor motivation of volunteers (no incentives)<br>• Insecurity, flooding, hunger<br>• Poor health facilities infrastructure<br>• Inadequate supply and stock out of the RUTF/RUSF |

There is a distinct community mobilization structure for CMAM program. IRC has 65 CNVs, who are based in the communities. The CNVs, under supervision of the three community outreach supervisors, works four days a week. Generally, supervision of CNVs is good. However, the involvement of CHD staff in CMAM program, joint supportive supervision to the CMAM sites and the provision of technical support to the health workers needs to be strengthened.

**CASE FINDING AND REFERRAL STRATEGIES**

The screening of children for acute malnutrition is done at health facilities and community -level. The IRC trains the community nutrition workers to diagnose and treat childhood acute malnutrition. CNVs were also trained by IRC and have good skills in MUAC measurement. CNVs conduct the active case finding and referral in their villages and nearby villages.

In addition, 264 CBDs who are based in the villages were recently trained on MUAC measurement and most of them received MUAC tapes. CBDs currently conduct opportunistic case finding and referral of children with acute malnutrition while they do their own work of treating children for pneumonia, diarrhea and malaria. This contributed to active case finding and referral of children with acute

malnutrition. Furthermore, the IRC project team conducted two mass MUAC screenings (Dec 2013 and March 2014) in villages to identify children with SAM/MAM for newly initiated CMAM programs in the areas.

**HOME VISIT FOLLOW-UP FOR DEFAULTER AND NON- RESPONDER**

CNVs conduct home visit follow-up for defaulters and non-responders in the villages. CNWs share the profile of defaulted children to CNVs and CNVs, with the help of the chief of the village, will trace and encourage caretakers to return to the program.

**COMMUNITY SENSITIZATION**

Mother Care-group members meet health workers fortnightly and discuss at health facility to promote positive infant and young child feeding (IYCF) practices. The CNVs conduct health and nutrition promotion at household when they conduct home-to-home case finding and rarely community meeting. However, sensitization about malnutrition and CMAM needs to be conducted at community gathering places to reach the larger community.

**THE ROLE OF COMMUNITY LEADERS**

The chiefs of the villages support the CNVs and CNWs to trace the defaulters in the villages and were involved in the selection of volunteers at the start of the program. The chiefs also support the case finding by mobilizing the community, provide room for CMAM service provision, store and secure RUTF and RUSF. The chief of the villages also support the CMAM program by advising the husbands who do not allow caretakers to take the children to CMAM services and encourage the caretakers to return to the program. Involving chief of the villages as early as possible in the CMAM program lays the foundation to get support from them and for better access to the target communities.

However, other community leaders and figures involvement in CMAM program is limited in Panyijiar County. Community figures, including women representative, religious leaders, traditional healers, traditional birth attendant in the area, expressed commitment to support the community mobilization and provision of CMAM services in the locality, however they could. So the program needs to engage the community figures in supporting community mobilization for CMAM program and their possible roles is summarized below in table 6.

Table 6: Community Figures and their Potential Role in CMAM, Panyijiar County

| Community Figures | Potential Roles In Community Mobilization |
|---|---|
| Chief, Sub-chief, Headman, Women's representative | Mobilize the community and support to the volunteers' work, address caretaker's barriers to access services |
| Religious leaders | Sensitization and mobilize the community |
| Traditional healers<br>local "gods" | Sensitization, opportunistic case finding and referral<br>Community sensitization and mobilizing the community |
| Traditional birth attendant | Sensitization, opportunistic case finding and referral |
| MCG, CBDs | Sensitization, case finding and referral |
| Water Management Committee<br>Protection Committee | Sensitization and mobilize the community |

# IV. CONCLUSIONS AND RECOMMENDATIONS

The new establishment and provision of the decentralized, free of charge CMAM services seems to have a positive impact on communities' access to CMAM care in Greater Ganyliel payams. Furthermore, good community mobilization through CNVs and the integration of the case finding and referral into iCCM contributed to timely case finding and referrals and consequently the increased uptake of the CMAM service.

Several factors, as, **active involvement of chief of the villages** in the CMAM program have been identified along the assessment as boosters for the community to access to CMAM services. The chiefs of the villages were engaged early in and orientated on the CMAM program. The fact that the chiefs were the ones who selected the CNVs with the community participation in their locality, supporting community mobilization by mobilizing the community for screening and encouraging a caretaker with a child that defaulted to return to the program seems to be the most important and distinctive booster in Greater Ganyliel Payams However the involvement of other community figures, particularly religious leader, TH, headman and women representatives are very limited and need to encourage.

**A good collaboration between nutrition staff and the community** is another key element of the program. The community provides their tukul and these are used as CMAM service delivery point and storage for RUTF and RUSF. The communities also secure CMAM supply and transport the CMAM supply despite the fact that the daily labourers do not receive their payment timely. These community participation greatly contributed to delivery of the CMAM services in inaccessible area.

**Good community mobilization** through CNVs is a good component of the program and contributed to early case finding and referral, minimized defaulter and consequently improve the coverage and outcome of treatment of acute malnutrition. The CNVs are voluntarily selected by the community and conduct active screening, follow-up, defaulter tracing and raise awareness about the CMAM program**.** In order to reinforce their capacity, IRC should provide continuous training and motivating them by providing a minimum transport allowance for the monthly meeting and material incentives. Opportunistic case finding and referral by CBDs of ICCM is also the paramount strategy to increase case finding and referral in the villages that are not covered by CNVs, as well as integration of community mobilization for CMAM into the existing community-based initiatives, such as ICCM.

On the other hand, this assessment also revealed the communities in Panyijiar County still faces a range of barriers to access to and use of CMAM services. This ranges from long distance to CMAM delivery points and stock out of RUTF/RUSF to the high opportunity cost of caretakers and the history of pervious rejection. To be successful, it necessary to address these barriers through active involvement of the community figures and implementation of good community mobilization for CMAM. The community figures support to the community mobilization would empower the community and enable the implementation of more accessible, culturally appropriate and community-owned CMAM service and minimize the high opportunity costs for caretakers.

The assessment revealed that self-referral of caretakers to the CMAM sites for MUAC measurement of their children is very high but the children were in fact not severely acutely malnourished and were

consequently not admitted to the CMAM program. This is because they wanted to receive the RUTF. Continued sensitization of the communities on the admission criteria could reduce self-referral as well as rejection and reinforcing community based case finding.

Current home-to-home sensitization by CNVs and health and nutrition education at health facility need to be augmented by sensitization at community gathering places through identified effective communication channels. This could improve community knowledge and practices of childhood acute malnutrition and increase health-seeking behaviour within the community.

Community mobilization to increase access to CMAM services should be implemented in tandem with strategies to improve CMAM services at health facility level. Therefore, the inadequate quality of health services needs to be addressed by close supervision and technical support and improving CMAM supply chain management. Piloting and scaling up community-based CMAM delivery through ICCM by trained CBDs could help to improve communities' access to CMAM in the inaccessible areas.

In conclusion, IRC with the support from CHD and partners need to implement the following eight essential actions in order to improve community's access and utilization of the CMAM service:

1) Strengthen community mobilization activities by capitalize on the extensive network of trained community health and nutrition volunteers and existing community committees with a defined role in the community to help CMAM services, using them in sensitization, screening and referral of children with SAM/MAM, follow-up with defaulters and problem cases, and health and nutrition promotion

2) Facilitate men and community figures' (religious leaders, traditional healers, chief and headman etc.) active involvement in addressing caretakers' barriers to access to care, supporting community mobilization, transport RUTF/RUSF from IRC office to CMAM delivery points and the construction of CMAM points. Engage strategically with traditional practitioners to develop trust among the practitioners, CNWs, and health facility staff to facilitate early referral of children with SAM or MAM.

3) Integrate community mobilization for CMAM program with existing community-based initiatives, such as ICCM, National Immunization Day in order to reach many more children at community-level screening and referral.

4) Prioritize screening and serving of children referred from the community by CNVs and/or CBDs at the health facility and reinforcing community based case finding in order to reduce the CNWs' work load and the frequency of caretakers visit to CMAM points for screening of children. However, this would require raising community awareness and involving the community figures before this initiative begins and increasing the CNVs' capacity to screen additional children.

5) Provide appropriate health and nutrition education materials, referral and reporting forms and make them available to staff conducting community mobilization work.

6) CNWs and Outreach supervisors should keep records of community mobilization activity to help with supervision and monitoring of the CMAM program. Available data on community mobilization reports should be analyzed and used to monitor the effectiveness of mobilization work.

7) Strengthen supervision of community mobilization work through supportive supervision to CNVs activities from technical officers, and provide all staff responsible for CMAM-related activities with community mobilization training in line with their duties.

8) Improve the CMAM service quality, both regular RUTF/RUSF supply, and on-job training and supportive supervision of day-to-day CNWs' activities i.e. case management and recording

Detailed recommendations are provided below in the IRC and CHD joint plan action for community mobilization for CMAM program in Table 7.

**TABLE 1: IRC AND PANYIJIAR COUNTY HEALTH DEPARTMEN JOINT PLAN OF ACTION ON COMMUNITY MOBILIZATION FOR IMAM SERVICES, MAR–DEC. 2015**

| | STRATEGY/ACTIVITIES | PERFORMANCE INDICATOR | TARGET | RESPONSIBLE | TIME | PRIORITY |
|---|---|---|---|---|---|---|
| I | COMMUNITY MOBILIZATION | | | | | |
| 1 | IMPROVE COMMUNITY PARTICIPATION, COMMUNICATION AND DECISION MAKING REGARDING THE IMAM PROGRAM | | | | | |
| 1.1 | Gradually involve community figures ( chiefs, women leaders religious leaders, traditional healer), Village Health Committee (VHC) , PTA and men to support community mobilization activities in the targeted payams | # of key community figure (by category) actively involved in community mobilization | 69*7 | IRC, CHD | Mar-Dec 15 | High |
| 1.2 | Increase community leaders participation in decision making to improve performance and motivation of the community volunteers and community ownership (such as safeguard the OTP/TSFP equipment/supplies in all areas) | # of CNVs supported and oversee by community leaders | 65 | IRC, CHD | Mar-Dec 15 | High |
| 2 | STRENGTHEN OUTREACH ACTIVITIES (SENSITIZATION , CASE FINDING AND REFERRAL, HOME VISIT FOLLOW-UP etc ) | | | | | |
| 2.1 | Provide orientation to community figures on malnutrition and IMAM program and involve men to support IMAM services | # of community figures oriented and effectively involved in supporting IMAM services | 69*3 | IRC, CHD | Mar-Dec 15 | High |
| 2.2 | Increase community awareness on malnutrition and IMAM program (target groups, referrals) at community gathering places, such as market, church, community meeting, traditional "rallies", food distribution site, MCG etc | # of villages reached six times per year for community sensitization at community gathering places | 110 villages | IRC, CHD | Mar-Dec 15 | High |
| 2.3 | Provide job aid (images, counseling cards and necessary tools to CNW, CBD, MCGs facilitators and CNVs) to ensure proper dissemination of nutrition and health messages to the targeted communities | % of community volunteers who have job-aid and use counselling cards for nutrition promotion | 100% | CHD, IRC | Mar-Dec 15 | Medium |
| 2.4 | Provide refresh training to CNVs and improve their performance through provision of necessary tools and incentive on regular basis | # of CNVs perform their work and report regularly | 65 | CHD, IRC, Community leader | Mar-Dec 15 | High |
| 2.5 | Train and equip traditional healers (THs) and CBDs with MUAC to improve opportunistic case finding and referral | # of TH and CBDs trained, equipped and actively involved in identification and referral of malnourished cases | 264+138 | IRC, CHD | Mar-Dec 15 | High |
| 2.6 | Integrate case finding through MUAC screening into existing community-based initiatives or national event (national immunization day, breastfeeding day, monthly outreach immunization service, MCG, etc.) | # Integrated MUAC screening into other community based program conducted per year | 4 | IRC, CHD | Mar-Dec 15 | High |
| 2.7 | Improve follow-up of absentees/defaulters cases through home visits by CNVs and involvement of community leaders in the targeted areas | % absentees/defaulter cases traced and returned/re-admitted to program | 80% | IRC, CHD | Mar-Dec 15 | Medium |
| 2.8 | Redefine the role and responsibility of community based volunteers, harmonize their work to ensure maximum integration in the different thematic areas. | Community based worker and volunteers roles and incentive harmonized | Yes/No | IRC | Mar-Dec 15 | Medium |

| | STRATEGIES/ACTIVITIES | PERFORMANCE INDICATOR | TARGET | RESPONSIBLE | TIME | Priority |
|---|---|---|---|---|---|---|
| 3 | STRENGTHEN COORDINATION, MONITORING AND SUPPORTIVE SUPERVISION | | | | | |
| 3.1 | Re-define the community mobilization strategy based on the actual needs and available resources | community mobilization strategy redefined and implemented | 1 | IRC | May 2015 | High |
| 3.2 | Involve CHD and other actors(RRA,) in monthly nutrition and community mobilization coordination meeting | # monthly coordination meeting held in one year | 10 | IRC, CHD | Mar-Dec 15 | Medium |
| 3.3 | Conduct close supportive field supervisions and provide technical support to nutrition staff (CNW, CNVs) using a predefined checklist and ensure that feedback is provided to all regarding individual performance | # of supportive supervision conducted per health area per quarter | 3 | IRC, CHD | Mar-Dec 15 | High |
| 3.4 | Conduct quarterly joint performance review meeting on community mobilization and IMAM program | # quarterly performance review conducted | 3 | IRC , CHD | Mar-Dec 15 | Medium |
| 3.5 | Introduce appropriate reporting tools (pictorial tally sheet, reporting sheet and referral form) for CNVs, CBDs, and outreach supervisors | % of CNVs, CBDs and supervisors report weekly/monthly | 100% | IRC,CHD | Mar-Dec 15 | High |
| **II** | **STRENGTHEN OTP AND TSFP SERVICES** | | | | | |
| 1 | Provide refresher training to CNWs on IMAM services and patient-provider interaction | # of health workers trained on IMAM<br># quarterly refresh training done | 48<br>1 | IRC, CHD | Mar-Dec 15 | Medium |
| 2 | Mapping the OTP/TSFP service utilization and distribution then establish mobile IMAM service to villages located far from OTP sites, and link with CBDs for follow up | # mobile OTP/TSFP teams established and provide service | 2 | IRC, CHD | Mar-Dec 15 | Medium |
| 3 | Introduce system to reduce the crowding and workload for CNWs by providing priority for caretakers who have appointment and link service with community screening for new admission | # of OTP/TSFP sites strengthening community based case finding to improve crowd control at facility | 9 | IRC, CHD | Mar-Dec 15 | High |
| 4 | Support the training of CHD staff on supportive supervision on IMAM programming | # of CHD staff trained on supportive supervision on IMAM | 2 | IRC, CHD | Mar-Dec 15 | Medium |
| 5 | Improve OTP/TSFP supply chain by ensuring that supplies are pre-positioned in hard to reach sites in adequate amounts and developing an efficient transporting mechanism for the supplies. | % of OTP/TSFP has improved RUTF/RUSF supply chain management<br># of stock out of RUTF/RUSF/site/year | 100%<br>2 | IRC, CHD Community members | Mar-Dec 15 | High |
| 6 | Mobilize the community to construct health facilities ,stores and waiting area | # of health unit construed | 5 | IRC,CHD | Mar-Dec 15 | Medium |
| 7 | Harmonize the current reporting system (UNICEF, WFP, PSI , IRC) into a single report system or database to reduce workload and ensure appropriate reporting for IMAM program achievement | A single report system introduced | Yes/No | IRC, CHD | Mar-Dec 15 | High |
| 8 | Engage community leadership for the security of supplies in OTP/TSFP sites. | # of OTP/TSFP has security guard | 4 | IRC | Mar-Dec 15 | High |