



COVERAGE MONITORING NETWORK

# IMPROVING COVERAGE: LESSONS LEARNED FROM THE CMN

APRIL 2016

## **Foreword**

The CMN is an inter-agency initiative established in 2012 in order to improve nutrition programmes through the promotion of quality coverage assessment tools, capacity building and information sharing. The CMN offers trainings and workshops on the various coverage methods, as well as guidance on how to overcome the barriers identified. Furthermore, the CMN provides many online resources and toolkits to assist in the implementation of coverage assessments.

The present document compiles learning outcomes produced by the CMN team and by CMAM programmes supported in the nine priority countries for the CMN. It explores specific experiences on coverage of CMAM through case studies and best practices. It also gathers information from recommendations made to address identified barriers, and frames the findings within the Bottleneck Analysis approach.

Total recognition goes to all the organisations, from local NGOs to international partners and donors, which have closely worked with the CMN. The CMN wish to thank all organisations for their partnership, collaboration and support. Without their help, this and other learning outputs would not have been possible. Needless to say, we wish to extend our recognition to local communities and their members who informed on the most significant elements around the quality of programmes for Community-based Management of Acute Malnutrition.

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## INTRODUCTION

Following the CMN's core objectives and in line with the findings made in its first phase of implementation, this compilation of learning outputs addresses three core areas of interest that have an effect on coverage of SAM treatment services: a) **awareness** of malnutrition and the functioning of SAM treatment programmes; b) **community engagement** and community ownership of central elements of SAM treatment; and c) **quality of care** and co-ordinated supply of CMAM services in nine priority countries.

**As a result, the Phase II of the CMN concentrated on gathering learnings and experiences around particular actions taken to address those core areas.** Collecting evidence of the effectiveness of actions taken meant strengthening the monitoring of individual programmes' performance, and also identifying best practices and recommendations that had a proven effect on improving access to treatment, focussing especially on rolling out community mobilisation activities and strengthening the quality of care.

In this document, lessons and other learning outcomes on actions which can be taken to address the three core areas have been identified through a series of mechanisms, ranging from the coverage assessments conducted in the nine priority countries, to specific case studies addressing questions related to coverage of CMAM. Most learnings were evaluated and systematised by the CMN team through feedback loops with programme staff in the field and with CMN's staff.

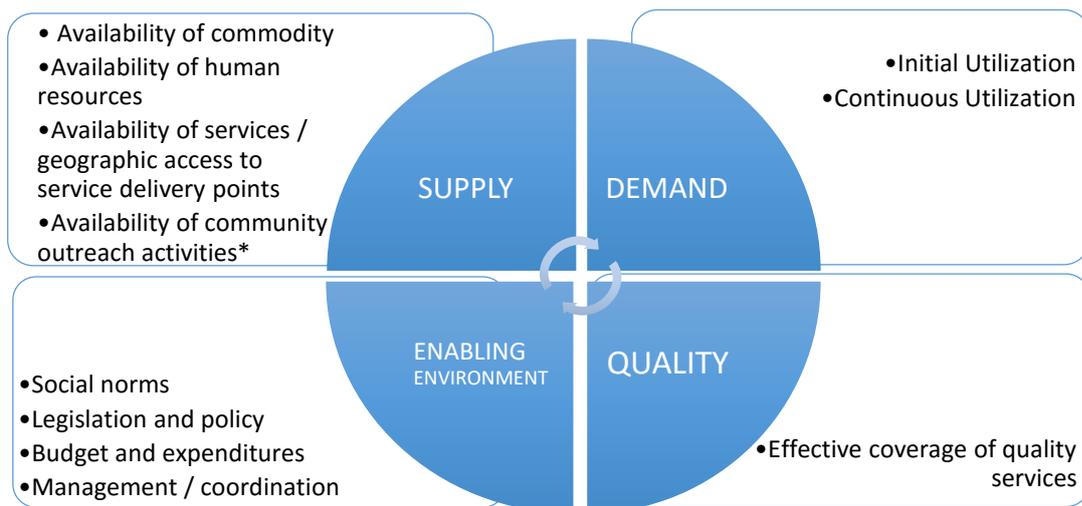
The analysis and systematisation of **learnings** involved building templates and guidelines for their collection, structuring databases for their classification and organisation, and producing documents, blog posts and interactive graphs and dashboards for their dissemination.

This document is structured according to the determinants of coverage. As per the adapted health system strengthening framework based on the Tanahashi model, there are four domains influencing effective service coverage: **the enabling environment, supply, demand and quality**<sup>1</sup>. This framework has already been applied to assess CMAM programmes' strengths and barriers in the bottleneck analysis approach. It follows that recommendations, solutions and learnings found from the programmes themselves can be classified according to the same determinants (see the diagram below).

A separate document, "Learnings from the CMN's support of coverage assessments and context-specific action plans", reviews the design and implementation of 45 action plans supported by the CMN during Phase II and assesses the impact that these action plans had on the coverage of programmes. Based on the findings, a separate set of key learnings are derived relating to coverage monitoring and action plan design and implementation.

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<sup>1</sup> The contribution that the CMN has made to programme quality relates more to the identification of successful practices that have an effect on it, rather than direct intervention on programme structures and functioning. This is why virtually all learnings here included fall into the three other determinants, and those related to quality are more of the sort of practices and decisions that cut across all other determinants and themes.



## TYPES OF LEARNING PRODUCTS

All information comes from findings obtained at Health District level. Several learning outcomes have been produced over the two phases of the CMN, from the recommendations sections in the initial coverage reports, to the elaboration of final country profiles to compile data, findings and learnings on a broad, country-level perspective regarding the performance of CMAM programmes. The main findings intertwine with each other under broader categories (determinants and bottlenecks), allowing the reader to easily identify lessons targeting specific themes<sup>2</sup>.

These are the following sources:

- **Case Studies.** After several coverage assessments in some Health Districts, notably in Mali, Burkina Faso and other priority countries for the CMN, a central question arose: what results in a change in coverage? What activities, decisions, policies and context-specific conditions have been identified as powerful leverages to positive change in coverage—or for negative ones in such a case? This type of learning product dealt with in-depth analysis of the factors that were more likely to have an effect on changes in coverage for a specific Health District over a period of time.
- **Best Practices.** On several occasions, programme staff were the central reference points for identifying and putting in motion a series of best practices for improving coverage and programme performance. CMN staff were instrumental in collecting best practices and lessons from individual programmes, systematising them and disseminating them. All best practices collected deal with either Community Engagement or Coordination and Community Ownership.
- **Recommendations from Action Plans.** Over 500 recommendations made in more than 20 Action Plans accompanying coverage assessments were classified and compiled in a *solutions database*. Each recommendation was matched with a specific theme (for example, training and motivation of Community Volunteers) and further classified along the lines of bottlenecks and broad determinants of coverage<sup>3</sup>.

<sup>2</sup> Most learning products are available on the CMN website either in their full length or as blog posts. More information regarding each specific activity or lesson learned can thus be found online.

<sup>3</sup> Further to the database, an interactive visualisation has been published in the CMN website. It allows the reader to swiftly move from one determinant to another and discover recommended activities depending on the bottleneck they expect to address.

## KEY MESSAGES AND LEARNINGS FROM THE CMN EXPERIENCE

These are the main messages coming out of the learning from the implementation of over 200 coverage assessments and have been summarised to serve as a brief introduction to the core sections of the document. They focus mostly on **Community Engagement** and on the achievements made regarding **Country Engagement** with CMAM programmes, because these are the areas regarded as being a priority for most stakeholders and where special attention was given.

- **A change of culture among NGOs and health staff** based in country is crucial. Local communities are at the core of CMAM, and community engagement should be at the heart of all interventions; **yet resistance to community engagement is a real and large obstacle**. Opposition or lack of interest is sometimes evident within NGOs, local authorities and national governments for several reasons. As such, a shift in the overall approach is needed, so that partners and health staff can strongly engage with local communities on an equal level rather than perceiving them as being at the receiving end of a delivery chain. At the community level, gender, ethnic and class relations can appear as initial obstacles to community engagement, which makes it even more important to pay attention to such relations in order to understand how to best overcome those obstacles. Such a shift in approach can lead to a shift in practice, where partners increasingly engage with local communities for the roll-out of core parts of CMAM interventions, such as screening, referrals and community sensitisation.
- **Community Engagement is cheap**. It requires little logistical and economic resources as most of the core activities of CMAM programmes are performed by members of the beneficiary communities. Communication and outreach activities, including the engagement of mothers in screening and referral campaigns and of local leaders in public messages to raise awareness, need few human or financial resources, only strategic support from NGOs and other stakeholders.
- **Community Engagement strategies should be adapted to specific contexts**, precisely because they rely on local assets and capacities, and because they address local needs and concerns. There is no “one size fits all” approach to community engagement, and therefore careful attention must be paid to the contextual environment.
- Moreover, throughout the last few years the CMN has identified **that understanding and assessing the real level of involvement of communities is a difficult task**. This is a major challenge because it unveils shortcomings in the development and implementation of Community Engagement strategies effectively rooted in local communities. Where some plans tend to be superficial and relatively simplistic in their objectives and mechanisms, it becomes difficult to measure the true level of engagement of community actors in the development of CMAM programmes.
- A way of addressing this limitation is by boosting programmes’ human resource capacity. **Programmes should design roles for focal points for Community Engagement**. Recruitment, training and specific tasks from mobilisers should be developed by each programme in order to improve the support given to communities in the design and implementation of a Community Engagement strategy.

- Finally, and with the purpose of improving quality of services and their coverage, constant **dialogue and engagement with international donors and governments pays off.** Advocacy strategies that in some countries were rolled out since the beginning of the CMN project have paved the ground for future progress with support from UNICEF, ECHO, Ministries of Health and other large stakeholders. The CMN found it very helpful to maintain dialogues throughout all phases of the project, and to wrap-up discussions in country-wide workshops where future strategies could be collectively drafted.

## SECTION 1 – ENABLING ENVIRONMENT

CMAM programmes are expected to be rooted in the regional contexts where they are developed. Yet in several cases, services seem to happen in isolation of other elements of their environment, despite those elements being strong determinants to the quality and performance of CMAM. This refers to the whole political, administrative, socio-cultural and economic environment in which CMAM programmes exist but sometimes fail to operate.

Several actors are responsible for building an enabling environment that can ensure: a) better **coordination and management** of CMAM programmes in one country or region; b) more effective allocation at different levels of **budgets and resources** for CMAM; c) punctual targeting of decision makers through advocacy initiatives in order to build **legislative and policy structures** that better address a co-ordinated fight against malnutrition; d) and last but not least, comprehensive linking of CMAM –and other health interventions– within broader sets of **social norms, cultural practices** and social organisation.

### LEARNINGS

This section explores the feasibility and success of pushing for core changes in the enabling environment to improve CMAM programmes. The main learnings in this section relate to:

- **Better coordination and management** within and between NGOs to improve their outputs
- Good practices and lessons learned from **advocacy initiatives around CMAM**

#### *Coordination and Management*

National CMAM programmes and the stakeholders implementing them locally constantly work to improve the general context in which they operate, either by influencing authorities and policy-makers through advocacy activities, or by collaborating with other partners to strengthen the networks through which common projects are designed, implemented, monitored and evaluated. This enabling environment is harder to influence and depends less on programme decisions than the other determinants, but in the long run it is essential for a sustainable high performing CMAM programme.

**Coordination:** Collaboration among partners (local and international NGOs, local authorities, etc.) for joint advocacy, influencing and coordination is essential. In the absence of it, individual CMAM interventions tend to pursue different objectives and work with different systems and tools. Coordination helps homologating the essential elements of CMAM to boost its effectiveness and quality whilst allowing programmes to adapt to their specific contexts.

- Organise monthly planning meetings with stakeholders to monitor and evaluate the implementation of community outreach activities (i.e. sensitisation, screening) (Aweil West, South Sudan)
- Organise performance review meetings with local authorities (Bolosore, Ethiopia)

- Strengthen joint UNHCR, WFP and NGOs technical support and monitoring for collective action, including reinforcing local taskforce and coordination meetings (Dadaab, Kenya; Sekota, Ethiopia)
- Map out potential partners, which could assist the local population with a provision of collective transport to the nearest OTP site (Kohat, Pakistan)

**Integration into other health services:** Linked to advocacy and strategic planning, programmes should access existing mechanisms to better integrate CMAM services into wider health interventions.

- Activate a Health and Nutrition Taskforce meeting at district level to address CMAM programme and general health (Aweil South, South Sudan; Bati, Ethiopia)
- Involve community health committee (CHC) to monitor and address programme barriers (Dadaab (Hagadera Camp), Kenya)
- Combine CMAM screening and sensitisation activities with existing IYCF programmes (Paniyijar and Aweil South, South Sudan; Boloso Sore, Ethiopia)

### *Legislation and Policy*

Country-specific nutrition and health policies are driven by a multitude of factors. CMAM stakeholders should play a key role in influencing decision makers on the laws and policies that will drive the scale-up of CMAM, whilst at the same time advocating for a strengthening of states' participation and commitment.

**Advocacy:** Advocacy by international organisations can have a positive effect on the involvement of national governments.

- Whenever it is possible, improving advocacy from local and international organisations toward national government should be a priority. In Eastern Burkina Faso, the recommendation was made to sustain the effort after some organisations had already engaged in this process.

**Discharge Criteria:** When criteria are unclear, it is more likely that they will be used randomly. Organisations supporting CMAM should commit to follow existing protocols, and to propose their periodic revisions if necessary.

## SECTION 2 – SUPPLY

The CMAM model includes a community component which differentiates it from more traditional or centralised health interventions. This community component has been the driving force behind the process of local ownership and coordination needed to fully expand CMAM services at community levels.

So why is supply so important? Although CMAM is centred upon its community component, all stakeholders play a central role in delivering CMAM services. Supply is not reduced to the logistical perspective of bringing CMAM to the communities; it is a rather complex combination of processes that guarantee a constant and sustained availability of CMAM services.

Supply is a vast term that encompasses **commodity availability** for CMAM, **geographical availability** of OTPs and other delivery centres, and **human resources availability** to staff those centres and conduct **community outreach activities** in the framework of CMAM.

## LEARNINGS

Thanks to specific case studies, best practices identified and the analysis of Action Plans, a wide list of learnings has been compiled, addressing the core bottlenecks related to supply, along with the more specific topics that encompass activities, solutions and learnings.

- **Commodity Availability** of RUTF and other basic inputs, focussing on improving coordination among stakeholders and better involving national authorities.
- **Geographic availability** of CMAM (geographical coverage), dealing with better infrastructure, transport, mapping and innovative practices for service delivery.
- **Human resources availability** in terms of staff, especially concerning training, consolidation of CVs networks and strengthening of community outreach activities.

Moreover, **changes in the supply side** have been found to have some **effect on the levels of coverage**. Bespoke learning activities have aimed to understand the links between the improvements made by programmes regarding service delivery, and positive changes in programme coverage. Specific activities or decisions have attracted the observers' attention, who then pushed their analysis further by conducting case studies. For example, it was found that decisions to increase the number of staff, invest resources in training new Community Volunteers and deploying them more often in screening campaigns, could each help explain positive changes in coverage.

### *Commodity Availability*

The availability of RUTF and routine antibiotics is essential to service provision. Without these supplies, a programme is rendered non-functional. The negative impact of stock-out on admissions and retention of cases is implicit and has been documented through several coverage investigations. It can also have negative knock-on effects, such as affecting community perceptions of the programme, which can last much longer than the stock-break itself.

It is therefore essential to try to prevent stock-outs and, when they do occur, to mitigate the negative effects.

**Advocacy:** Strong advocacy to state authorities and international actors may be necessary to achieve correct delivery of RUTF and general improvement of OTP and SFP services.

- Advocacy to improve RUTF supply was carried out, including government and donors increased participation in RUTF delivery (Kirotshe, DRC). Follow-up assessments are required to identify the effect of advocacy on the stability of RUTF stocks.
- Target suppliers (e.g. UNICEF) with key advocacy messages to ensure a punctual and sustainable delivery of RUTF (Agadez and Tanout, Niger)

**Coordination:** Lack of collaborative agreements with other partners (international, national and local) complicates the scope of action of programmes for improving their activities and their developmental environment.

- Coordinate with PHCU partners to ensure medication for children attending OTP sites would be efficiently allocated to avoid duplication and overstock (South Sudan)
- Reposition system suggested for improving the supply chain (Ethiopia)

**Transport:** Ensuring that RUTF stocks arrive at the health facility or treatment centre can be very challenging, especially at certain times in the year when rains, migration patterns and other seasonal dynamics may have an effect on logistics operations –procurement and distribution.

- Invest in pre-position, where large stocks are stored in advance in hard-to-reach health centres (Paniyijar, South Sudan)
- Programmes can use their own resources and link with community resources to transport RUTF and medicines to health facilities (Bolosore, Ethiopia)

**Follow-Up:** Very often, meaningful follow-up of stock and supply lines does not take place.

- Programme should improve own follow-up system for supply lines (Bitkine, Chad; Mopti and Kalabancoro, Mali)

**Shift Responsibility:** The sustainability of CMAM programmes depends on an effective transfer of ownership to local communities, and national and regional health structures. This happens with regards to commodity availability, although large scale constraints are still relevant.

- Engage community leadership to guarantee and monitor steady supply of RUTF (Paniyijar, South Sudan)
- Train HF staff in RUTF supply chains to initiate transfer of responsibility (Agadez, Niger)

**Equipment & Infrastructure:** Although not strictly part of commodity availability, the capacity to host CMAM services is linked to the overall availability of services. In some places, the space in some health facilities is insufficient for hosting both services and patients seeking healthcare. There is also little equipment available to facilitate communication within the team for its screening and referral activities which can be in remote locations.

- Provide mobile teams with satellite radio & telephones (Akobo East, South Sudan)
- Rebuild OTP centres to comfortably fit all required services (Kakuma, Kenya)

### *Geographic Availability*

The relatively low number of health facilities in most contexts, combined with spread populations in rural areas, makes distance one of the most important barriers to access. On a general basis, large efforts are required to expand the infrastructural and human resources capacities of health systems in most countries, so that the number of OTPs can increase. However, individual CMAM programmes supported by single partners would find it hard to sustain, on their own, geographical scale-up of service delivery, especially concerning the creation of new OTP sites. There are nonetheless several things that individual programmes can do in order to improve their reach within their areas of intervention.

**Expansion of Service Availability:** Geographic scaling-up is expensive and complex. Alternative ways of expanding service availability are crucial, supported with strong advocacy to achieve better and more efficient decentralisation of service delivery.

- Advocate the expansion and decentralisation of CMAM services to secondary HF, beginning with a secondary health facility (Kalabancoro, Mali)

- The “C” Project, with which the CMN has frequently collaborated, has worked on a strategy to decentralise CMAM services down to village level —as long as secondary health posts or CV representation are present— in order to reduce distance and the costs related to it (Kita, Mali).

**Mapping:** Often insufficient information on geographical availability of CMAM services and community resources limits the planning capacity of programmes, both at partner and state level.

- Map villages, settlements, community volunteers and key community actors by each Health Facility’s catchment area (Aweil, South Sudan)
- Map risk factors to service accessibility, including insecure areas, zones of difficult access, etc. (Dadu and Kohat, Pakistan)

The development of mapping tools and cartographic outcomes (maps) improves service delivery through logistics and better planning. It helps to understand patterns of access to programmes, especially related to distance and service availability by village. It also provides good alternatives to programme monitoring and quality assurance, whilst shifting attention to the communities themselves.

- Develop cartographic outputs to identify community members able to provide collective transport solutions, such as carts, cars, motorbikes, etc. (Dadu, Pakistan)
- Mapping the number of admissions per OTP has helped teams better coordinate mobile CMAM services in remote areas (Paniyijar, South Sudan)

Moreover, this type of data has proven to be easy to collect, and therefore should be added to routine data collection processes for periodical monitoring of CMAM programmes.

**Monitoring:** Insufficient data quality and programme performance checks are fundamental weaknesses in most CMAM programmes. Overcoming this is crucial for a better understanding of programme performance and effectiveness, allowing the identification of challenges to coverage and key priorities to improve it —especially regarding geographic availability of services.

- Conduct periodic post-distribution monitoring (PDM) of CMAM services to improve the team’s data collection and analysis skills, and improve monitoring (Dollo Ado Camp, Ethiopia)
- Train teams on data management and analysis of programme monitoring data (JPA, Maban, South Sudan)

**Seasonality:** Admission fluctuations and the general performance of CMAM programmes are strongly affected by seasonality. The rainy season can pose problems to accessibility, transport and communications, and influence population movement patterns. Seasonality must be considered when programme planning and performing context-specific studies.

- After a SLEAC research in Eastern Burkina Faso, several recommendations were put forward in order to better prepare programmes to the fluctuations caused by seasonality:
  - On the basis of a constantly updated seasonal calendar, plan ahead the distribution of stocks and alternate its frequency/quantity to ensure product availability during the whole year.
  - Take special consideration for population movement of pastoralist groups highly dependent on seasons.

**Transport and community solidarity:** Despite treatment being free of charge, most caregivers still face costs related to transport, parallel health services, etc. Reducing transport cost, either by

having programmes providing additional support or by encouraging community-based organisation, is crucial to overcoming this barrier.

- Identify key community members and resources that could be put at disposal of caregivers on OTP day (Eastern Burkina Faso; Aweil South, South Sudan; Kenieba, Mali)
- Work directly with communities to build future community financial solidarity bases, whereby the community could provide resources for transport and health interventions

### *Human Resources availability*

The key element in CMAM service delivery is the human component. On the supply side, programmes have found it difficult to significantly improve their geographic and commodity availability without simultaneously strengthening their staff capacity and, especially, a strong network of incentivised and trained Community Volunteers.

**Community Volunteer Incentives:** The lack of remuneration is often mentioned as a barrier to community volunteers' (CVs) performance. Conversely, most partners have opted against a remuneration mechanism, for fear that it could jeopardise the programme's sustainability. Although this should be context-specific decision, other non-monetary incentives are often needed to improve the quality CVs' work.

- Coordinate with other CMAM service providers to homogenise non-monetary incentives, including the distribution of t-shirts, working materials and free transport (Ethiopia)
- Organise symbolic ceremonies by communities to thank the CVs and offer certificates of appreciation (Maban Refugee Camp, South Sudan)

**Integrate CMAM community activities with other services:** CVs working in CMAM programmes would benefit from being invited to participate in other programmes' activities. Often, when CVs visit caregivers for screening they can refer children to several health programmes at the same time.

- Train CVs currently working on other projects (e.g. malaria) on CMAM protocols and MUAC measurement, so that they can refer children to multiple programmes (Kirotshe, DRC)

**Training:** Training of health staff, programme officers and, especially, community volunteers, is crucial for the sustainability of CMAM programmes and for the quality of service delivery. With the support of the CMN, most programmes have actively committed to training sessions (on the job training or by participating at large-scale Training of Trainers, often with ministerial agents). In many cases, there is an important need for the knowledge acquired to trickle down all the way to CVs.

- Train staff and CVs on community mobilisation and sensitisation activities, including prevention engagement (Agadez, Niger; Aweil South, South Sudan; Dadaab, Kenya; Kohat, Pakistan). In Fada N'gourma, Burkina Faso, the increased frequency and depth of such trainings proved to be an important factor for positive variation in coverage levels.
- Ensure periodic updates for CVs and staff to follow-up their performance and to ensure new elements (from protocol, monitoring, etc.) are properly incorporated (Bitkine, Chad; Dadaab, Kenya; Paniyijar, South Sudan)
- Modify training approaches to cover unanticipated needs:
  - Train staff in registers management (Kakuma, Kenya)
  - Familiarise CVs with local health practices and terminologies (Bitkine, Chad)

- Extend trainings to Health District Authorities and other programmes' staff (Batii, Ethiopia)
- Re-train staff on the transfer guidelines OTPs to Stabilisation Centres and treatment of non-respondents (Sekota, Ethiopia)

**Technical Support & Monitoring:** Programmes with little technical support find it difficult to design and plan strategies to overcome major challenges. Technical support implies capacity building collaboration and skills transfer and, ultimately, involves better coordination with state and international partners to improve infrastructure, logistics and communication.

- Establish a monthly support framework, including feedback sessions and health staff-initiated prioritisation (Aweil South, South Sudan; Sekota, Ethiopia)
- In Camp context, CMAM programmes tend to seek technical support of other health interventions (malaria, cholera, etc.) and vice versa (Dadaab, Kenya).

**Shift Responsibilities:** Though not strictly a human resource approach, some programmes have pushed forward recommendations regarding the inclusion of traditional healers and, notably, mothers and caregivers into screening and follow-up activities.

- Train mothers on the usage of MUAC wristbands and community mobilisation (JPA and Maban, South Sudan). This also happens in some refugee camps, notably Dollo Ado in Ethiopia, where one of the reasons coverage increased between September 2012 and August 2013 was precisely the active engagement of mothers in screening activities.
- Train traditional healers on CMAM and use of MUAC tapes (Paniyijar, South Sudan)

## SECTION 3 – DEMAND

If on one side improving service supply has been a core goal of CMAM programmes —especially by virtue of strengthening the commitment of all stakeholders in the process—, generating demand is another essential mission. Yet “demand” is far more than identifying a need for CMAM services and promoting access to them. “Demand”, conceived as a determinant of coverage and quality, is really about community engagement, local ownership and collective mobilisation. It is therefore about awareness and action; not only about accessing services but about owning them and contributing to their improvement.

The CMN recommends that community engagement is high on the list of priorities for CMAM programmes to increase access. This section addresses some concrete points regarding strategic integration of Community Engagement into CMAM programmes and ways to shift responsibility toward communities to ensure that the *community-based* management of acute malnutrition is effectively in place.

### LEARNINGS

The assessments and studies conducted by the CMN have done more than simply estimating coverage values for CMAM programmes. They have also identified context-specific barriers that

limit access to services and that explain relatively low levels of community engagement. By the same token, several pieces of research **have confirmed that addressing the issue of community engagement is crucial for securing a sustainable and horizontal functioning of CMAM** by virtue of exalting its core element: the community side of its management.

The learnings related to programme demand are classified in four main bottlenecks, and each of them addresses several themes:

- Regarding **Community Engagement**, the main focus is on communication channels, coordination and engagement with community leaders, enhanced community-led screening and monitoring of programme activities and, crucially, on shifting responsibility and securing community ownership of the programme.
- Programme stakeholders, especially supporting NGOs and health authorities, have a lot to teach with regards to **coordination and management**, especially when it comes to the monitoring and coordination **of community engagement strategies** supported by these stakeholders.
- **Continuous utilisation**, which refers to people's awareness about the correct functioning of the programme and its sustained utilisation.

### *Community Engagement*

Service availability is only one side of the coin. Access to CMAM services should be encouraged so that demand for them is generated and sustained. To increase demand for CMAM programmes and services, it is essential to engage with community groups, leaders and individual members. Increasing community engagement will simultaneously increase CMAM programme awareness, whilst generating interest and demand.

**Communication Channels:** Community dialogues should be encouraged and become a useful platform to spread awareness about CMAM. On the other hand, lack of appropriate IEC materials and dissemination activity tools are a challenge to community engagement strengthening. That is why promoting the use of local radio systems, for example, helps spreading information about CMAM along with other health interventions. Finally, training targeting specific community groups can strongly impact overall community involvement.

- Use social mapping activities to identify the best ways to disseminate information about the CMAM programme. For instance, community members can be asked to identify influential voices in the village that could engage in a communication role (Kenieba, Mali; Dadu, Pakistan; Kohat, Pakistan)
- Support and use local radio stations to disseminate information about CMAM (Bitkine, Chad; Kalabancoro, Mali; Ouallam, Niger; Kohat, Pakistan)
- Additionally, local radio has also been used to promote infant and young child feeding practices (IYCF) together with awareness-raising for CMAM. Local radio serves to announce community mobilisation events and to share periodical messages in local languages about malnutrition (this has been specially documented in Twic, South Sudan)
- Use model families to sensitise about RUTF consumption (Tanout, Niger)

**Community Leaders:** Strong involvement of community leaders can have a positive influence on spreading messages and strengthening community mobilisation activities.

- Involve community representatives in designing a community mobilisation activities plan for CMAM, with a focus on men (East Burkina Faso; Sekota, Ethiopia)

- Organise sensitisation sessions for affluent leaders (chiefs, religious leaders) (Bitkine, Chad; Kirotshe, DRC)

**Coordination:** Several CMAM programmes face coordination challenges, including staffing, task and responsibility sharing, and accountability toward local communities.

- Assign one individual from existing staff as the focal person for community engagement for the CMAM programme at the Health Centre and district level (Aweil South, South Sudan)
- Establish regular contact with leaders of risk-prone areas via an existing feedback mechanism (Kohat, Pakistan)
- Engage leaders to conduct home visit follow-up for non-responder cases and selected caretakers to reduce sharing and selling of RUTF (Bolosore, Ethiopia)

**Engaging with Community Members:** Community engagement is crucial to achieve high levels of participation and guarantee local programme ownership.

- Involve teachers and school directors in sensitisation activities, including provision of materials (Aweil South, South Sudan)
- Target mobilisation campaign at fathers so that they take children to programme (East Burkina Faso; Ouallam, Niger)

**Monitoring:** Data quality and programme performance checks are fundamental weaknesses in many CMAM programmes. Proper recording of opinions, perceptions and contributions at community level makes future decision-making more accurate and evidence-based.

- Build and maintain a database for follow-up of community activities (sensitisation and screening) (Aweil South, South Sudan)
- Develop a reporting system for recording information from informal exchanges (Kohat, Pakistan)
- Monthly monitoring of programme barriers with TSFP and OTP caretakers and community leaders (Dollo Ado, Ethiopia)

Additionally, a way of involving the local population in the monitoring process is through community restitutions of coverage assessment. Along with all other investigations, coverage assessments can have the negative tendency of becoming an internal report for NGOs and donors. It should not be so. Throughout the last few years, the CMN has discovered that initiating strong dialogues with communities after an assessment has been conducted is crucial, not only for sharing final results, but also to create a better environment to involve communities in programming and delivery. By doing this, assessments get feedback from communities regarding programme quality and the level of satisfaction of beneficiaries.

- Experiences of community restitution conducted by NGOs on the field were positively appreciated by community members. It was generally a success regarding the relationship and partnership between Health Districts, NGOs and local population. This innovative way of work could increase adherence to the programme significantly.
- The CMN encourages programmes to ensure that community restitutions take place and are integrated into each coverage assessment, even as a part of their methodology.

**Screening:** Inconsistent and sporadic screening has a dramatic negative effect on admissions to the programme and on coverage so improving it is key to guarantee programme quality.

- Design, in collaboration with the MoH, monthly and quarterly mass screening campaigns, with different intensities and scopes (Aweil South, South Sudan; Ouallam, Niger)
- Coordinate screening and referral activities with other community-based organisations and public health screenings (Akobo East, South Sudan)
- Distribute MUAC tapes to mothers (Kenieba, Mali) and involve mothers of cured children in screening (East Burkina Faso). This has become a popular topic among CMAM programmes: in a national workshop in Chad the issue was presented as a solution with potentially a national scope. A case study will be conducted.

**Referral:** Inconsistent referrals negatively impact admissions, levels of awareness and community engagement.

- Improve case referral between MAM and SAM programmes (Aweil South, South Sudan)
- Improve referral between ARRA and CNCs of the children and PLW and sharing information weekly (Collo Ado, Ethiopia)
- Explore sharing screening and awareness activities with other health or WASH programmes (Dadu, Pakistan)

**Sensitisation:** Lack of attention to sensitisation activities has a dramatic effect on admissions to the programme and, therefore, on its final coverage. Tackling low awareness is more effective when combined with community-based activities and local organisations' support.

- Sensitisation stressing why rejections happen. For instance, when programme staff fail to explain admission criteria, or when Community Volunteers are unclear about referral processes, caregivers whose children have been rejected are unlikely to come back to the OTP in the future (Akobo East, South Sudan)
- Provide orientation to community figures and groups on CMAM and malnutrition and encourage them to participate in sensitisation activities (South Sudan)
- Explore use of mobile phone as part of sensitisation activities (Dadu, Pakistan)

**Shift Responsibility:** The sustainability of CMAM programmes depends on an effective transfer of ownership to local communities and national or regional health structures.

- Give MUAC tapes and sensitisation materials to traditional healers and midwives to conduct screening and referral (Bitkine, Chad)
- Encourage caregivers to inform the programme about relapse cases (Kenieba, Mali)
- Recruit mothers of cured children to conduct sensitisation activities and promote CMAM (Mopti, Mali)

Additionally, better structuring volunteers networks has proven to be a good practice for conducting Community Mobilisation activities, yet acknowledging that the functionality of such structures depends on the commitment of local executive bodies. To strengthen the volunteers' structures homogeneously, more training and support is needed, along with follow-ups and motivation mechanisms both from the government and the NGO partners.

### *Community ownership*

Commitment to community engagement strategies and practices has improved in some CMN supported CMAM programmes since the beginning of the project, and local ownership of some of the core elements of CMAM services is now considered a priority for future activities. Some organisations have managed to better integrate CMAM-related activities within existing

community-based health initiatives, allowing for a mutual reinforcement of CMAM programmes and other health initiatives in the following ways:

### ***Integration of SAM case finding and referral into community-based health initiatives***

The OTP programme in **Bati, Ethiopia**, integrated mass MUAC screening activities into a community-based health initiative called “Enhanced Outreach Strategy for Child survival Interventions” (EOS). The adoption of this initiative demonstrated that screening and referral can be done simultaneously for different health interventions, and yet it has not been done often.

Some of the key achievements of this experience were:

- Experiences, opinions and recommendations from the communities themselves were incorporated into the planning for further integrating screening activities.
- Thanks to good advocacy toward MoH and other partners, integration of case finding and referral into other community-based programmes became possible.

In a similar fashion, the Health District of **Fada N’Gourma in Burkina Faso**, saw its coverage increase from 20 to 48% in about two years (last assessment in January 2014) thanks, among other factors, to a national homologation of the CMAM protocol that allowed official engagement with traditional healers through sensitisation activities and training to boost screening and referral sessions of SAM cases.

### ***Village authorities actively participating in delivery of CMAM services – Panyijiar, South Sudan***

In some of the most remote areas of the Panyijiar County, where government presence is limited and logistics are difficult, local leaders, religious figures and village chiefs provide essential support to the delivery of CMAM services. They provide clean and accessible locations for the OTP, secure storage for RUTF and oversee the utilisation of other supplies such as routine medicines.

Ultimately, engaging and consulting with the village Chiefs from the start of the programme lay a strong foundation to promote active participation of the community. It remains to be proved whether better access and coverage of the programme were achieved —a follow-up coverage assessment may be needed.

### ***Engagement of communities and influential leaders in CMAM – Binji and Wamakko, Nigeria***

In Northwest **Nigeria**, the two Health Districts of **Binji and Wamakko** have proven strong examples of the importance of engaging with local communities to improve the quality of CMAM: coverage was estimated at 78% (single coverage), one of the highest levels of coverage achieved by a programme in a rural setting. The key characteristics of this successful intervention were all related to community involvement:

- Engaging communities from the start of the programme, which meant that sensitisation activities were frequent;
- Meeting the different community groups in person in the village, which meant that as many stakeholders as possible could involve with CMAM;

- Discussing with them and asking their opinion of the program objectives and implementation process and addressing their concerns;
- Building on community strength such as model mothers with healthy nutrition practices;
- Using locally available nutritious foods in the cooking demonstrations at health facility and community level.

Another example is the **Burkinabe case of Fada N’gourma**, where the CMAM programme has strongly engaged with community-based organisations to expand outreach activities by relying upon additional Community Volunteers already working on other interventions. Locally based organisations may not have the capacity yet to manage the delivery of CMAM at a large scale, but have proven to be crucial players in creating an enabling environment where communities are increasingly engaged into the improvement of CMAM.

### *Coordination and Management*

Coordination with the population, state authorities and among stakeholders, is a criss-crossing determinant for both good quality service delivery and demand. This is why coordination appears as a relevant category of solutions in both areas, allowing for some overlapping and duplication. For instance, better coordination at the local level, including regular training sessions and screening campaigns, will impact service delivery through programme staff and CVs activities, whilst improving demand for services as a positive outcome of these actors’ activities. Combined, coordination-related solutions will increase coverage and thus programme demand.

**Coordination:** Specifically regarding generation of demand, insufficient collaboration agreements with other partners (international, national and local) complicates the scope of action of programmes for strengthening their sensitisation campaigns, their community engagement strategies and their constructive relation with communities.

- Collaborate with local radio stations —and support where necessary— to disseminate information about CMAM (Bitkine, Chad; Kalabancoro, Mali; Ouallam, Niger; Kohat, Pakistan)
- Design a community engagement strategy together with other CMAM stakeholders and, most importantly, with targeted communities (Bamako, Mali)

**Monitoring:** Following up demand-generating activities can be a central element of programmes’ management. Ultimately, it is about designing simple systems to monitor the performance of community engagement strategies.

- Conduct biannual performance review with partners on community engagement activities (Chad, Bitkine)
- Develop and test a monthly volunteer report format and activities (Tanout, Niger)

### *Continuous Utilisation*

In order for CMAM services to be effective, users should complete the treatment in its full length. Otherwise, defaults happen and programme effectiveness (through cure rates) diminishes. Nutrition counselling and follow-up visits will encourage continuous programme utilisation by maintaining open information channels and continuously reminding caregivers of the programme’s importance.

**Counselling:** Lack of nutrition counselling makes it even harder for caregivers to fully engage in the care process and overcome obstacles set by their environment.

- Provide and strengthen counselling to caregivers on CMAM, use of RUTF and nutritious food (Dadaab, Hagadera camp, Kenya; JPA, Maban, South Sudan)
- Follow-up on the impact of counselling activities (East Burkina Faso)

**Follow-Up:** Insufficient follow-up visits have a negative effect on default rates, and therefore on programme performance.

- Strengthen linkage between Community Health Workers (CHW) and nutrition team to enhance follow-up (Aweil South, South Sudan; Kenieba, Mali; Kakuma, Kenya)