In the community-based management of acute malnutrition (CMAM), the community-component is vital and critical for the success of the CMAM program in any context.

Organizations and Ministries of Health use different terminology for the community-component of the CMAM program, including community outreach, community participation, and community sensitization among others. Community mobilization moves beyond community assessment, participation, engagement, and outreach activities towards building capacity of the community actors (individuals, leaders, group or organizations) to lead or participate in all stages and components of a CMAM program and increase community ownership, support and responsibility.

WHAT IS COMMUNITY MOBILIZATION?

Community mobilization is a capacity-building process which enables community actors to plan, carry out, monitor and evaluate activities in a participatory and sustained basis to improve health, nutrition and other needs, either through their own initiatives or stimulated by others. Community mobilization is not a campaign, nor a series of campaigns. Nor is community mobilization the same as social mobilization, advocacy, social marketing, participatory research, or non-formal or popular education. Community mobilization, however, often makes use of these strategies. Community mobilization for CMAM aims to build the capacity of community actors and obtain their commitments to support caretakers of children with acute malnutrition access and use CMAM services, and support community mobilization activities, including the work of volunteers and outreach workers’ activities.

WHY IS COMMUNITY MOBILIZATION IMPORTANT?

In recent years, the context of CMAM implementation has changed dramatically, from emergency and vertical programing into government-led programing or an “integrated” approach into the national health system. However, CMAM coverage and access remains low. A major factor contributing to this shortfall is the weakness of national health systems and nutrition programs to implement the community component of CMAM.

Community mobilization is important as it engages local community figures and actors in supporting CMAM services in order to improve the impact and coverage of these services and contribute to their cost-effectiveness, accountability, sustainability and equity (see figure 1: community mobilization project cycle).

WHO NEEDS TO MOBILIZE IN THE COMMUNITY?

To be successful, it is extremely important to gather the support of those who have the most interaction and influence with the community along with caretakers (mothers, fathers, grandmothers) of children with acute malnutrition. They include, but are not limited to:

- Political, religious and traditional leaders,
- Health care providers (nurses, doctors, and midwives),
- Traditional healers and traditional birth attendants,
- Community health workers and volunteers,
- Community groups, local non-governmental organizations, and faith based organizations,
- Media professionals and;
- Teachers, agriculture extension workers, and social workers

Figure 1: Community Mobilization Project Cycle with Inputs, Processes, Outputs and Outcomes. Adopted from Nell Gray, et al; Community Engagement (2)
Mobilizing your community to support the CMAM program may seem like a big challenge — however, if you break down the effort into phases and employ the framework for community mobilization process for the CMAM program (see figure 2), you will be able to manage it in a systematic fashion. It will guide you through the design and implementation of successful community mobilization activities for CMAM.

With community mobilization, the role of the implementing agency shifts from a more traditional service provider to that of a facilitator. The implementing agency, such as a health facility facilitating community mobilization, should guide communities through a step-by-step process.

**Figure 2: Framework for Community Mobilization Process to improve access and utilization of CMAM program**

### How to Conduct a Community Assessment?

Community assessment requires the collection of a large variety of qualitative information from community actors from the district to the beneficiary level.

- Develop the community assessment questions based on community assessment objectives.
- Identify primary actors (people who have the most interaction and influence on caretakers of children), such as traditional healer, religious leader, traditional leader; and secondary actors (such as, agricultural workers, teachers, media professional) for interviews to collect relevant data.
- Hire and provide 1-2 days training to enumerators on qualitative data collection methods. Form 6 to 8 teams (2 enumerators in each team) to collect data in 2-3 days from district to beneficiary level. Assign 10 days for training, data collection, analysis and drafting an action plan in the field.
- Collect in-depth qualitative data through key-informant interviews, focus group discussions, observations, and semi-structured interviews.
- Conduct analysis of community figures and actors; what other people or groups can participate in the community mobilization activities? What resources or support can they offer?
- Conduct contextual factors analysis; what are the barriers and boosters for caretakers to access and use the CMAM services?
- Conduct communication channel analysis; what communication channels are available in the area? The formal communication channels may include community meeting, radio, community announcer etc., and informal communication channel such as exchange of information among community members at market, water point etc.; what are the strengths and weaknesses of each channel? For example, how effective are the channels in reaching the target community? How many people can they reach?
- Conduct strengths, weaknesses, opportunities and threats (SWOT) analysis of the current community mobilization activities.
- Review CMAM service utilization and effectiveness of current community mobilization activities (i.e., number of self-referrals versus community volunteers versus other referrals, number of late referrals, or actual geographical coverage of CMAM services) using secondary program monitoring data analysis.
- Then validate the primary data findings against the findings from secondary routine program monitoring data analysis.

The completed community assessment findings will be used to make a decision on community mobilization strategies and influence the planning, implementation and monitoring of community mobilization activities and the CMAM services at large.

### STEP TWO: FORMULATING A STRATEGY

The best way to improve community's access and use of the CMAM services is to fully engage the community in the CMAM program. There are several strategies to mobilize and involve the community in the CMAM program:
Establish a formal structure or reinforce a formal existing coordination mechanism at all levels that can effectively lead community mobilization efforts e.g., Village Health Committee, and community mobilization structure, e.g., community health workers and supervisors.

Ensure strong leadership to provide overall coordination on implementation of the community mobilization activities and facilitate a dialogue between community actors and health systems. This includes assigning focal persons for community mobilization at all levels. For example ensuring there is a community mobilization officer in district health offices.

Engage diverse community actors who are most likely to support the CMAM program, and reach out to key players that are not the “usual health providers” (agriculture workers, political leaders, religious leaders, media professionals etc.), who have significant influence in the community.

Advocate with Ministry of Health, donors and stakeholders to maintain their commitment and secure supply and support for community mobilization efforts. E.g. Village Health Committee, and community mobilization structure.

Ensure genuine community participation and shared decision making to support a sense of community actor’s commitment and ownership of the CMAM. In order to do that, establish clear roles and responsibilities for all community actors, and develop a shared decision making process.

Recruit, train and supervise community health and nutrition volunteers and outreach workers with community figures participation. Provide technical support, manage and build capacity of volunteers.

Plan and implement contextualized outreach activities depending on the availability of resources, prevalence of malnutrition, local capacity and type of CMAM program (vertical program versus an integrated CMAM service into national health systems). The outreach activities includes community sensitization, case finding and referral, home visit follow-up for defaulters and non-responders, social and behavior change communication on health, sanitation and hygiene, and nutrition issues.

Link or integrate the community mobilization activities for CMAM into existing community-based initiatives, e.g., CMAM into Integrated Community Case Management of Childhood Illness (iCCM), and Infant and Young Child Feeding Practices (IYCFP), integration of Mid Upper Arm Circumference (MUAC) into national immunization day, well-baby clinic.

Use appropriate information and communication technology to support community mobilization activities where and when it is possible. For example, community outreach workers and volunteers’ use of mobile phone for referral, follow-up, and reporting.

Monitor, report and evaluate of the activities. Decide in advance how to track the progress of the activities being implemented against the community mobilization plan. Design process, input and outcome indicators, and set targets for each indicator and data collection methods. Design reporting tools for community mobilization activities and establish feedback mechanism.

Raise resources for community mobilization. Introduce creative financing and appropriate accountability measures to encourage sustainability. Advocate for the integration of community mobilization into the local health system and its budget allocation.

Design and create the community mobilization action plan with the community actors and stakeholders in a consultative process. For example, volunteers use of mobile phone for referral, follow-up, and reporting.

STEP THREE: DEVELOPING MATERIALS AND CAPACITY BUILDING

DEVELOPING MATERIALS: adopt and/or produce information, education and communication (IEC) materials, including toolboxes, posters and flyers, and distribute these to community volunteers and outreach workers to assist in their sensitization work. The IEC materials can be distributed to community actors and figures, including religious leaders for wider distribution and use.

CAPACITY BUILDING: provide training for community volunteers and outreach workers to build their capacity before implementation of community mobilization activities. Training needs to cover malnutrition and the CMAM program and community mobilization activities. Since capacity building of outreach workers and volunteers is a process, it should be provided periodically using adult learning cycles. In areas where the literacy level of communities is very low, train community figures on word-of-mouth communication with the surrounding community and to health committees and community members.

STEP FOUR: IMPLEMENTING AND MONITORING

IMPLEMENTING: it is extremely important to invite community leaders and actors to officially launch community mobilization activities. Orientation and guidance about CMAM services should be given to community figures and volunteers during the launching ceremony. Announcing the availability of new services at the health facility encourages local communities to access care.

I. Roll out implementation of community mobilization activities in accordance with the community mobilization action plan timeline. The rollout of the community mobilization activities could be initiated by conducting case finding and referral, including a mass MUAC screening of children for acute malnutrition, where appropriate. It enables identification of children with acute malnutrition for admission to the CMAM program.

II. Convening community activities by holding regular community meetings with community leaders, partners and outreach workers.

III. Conducting health education activities to improve the community’s knowledge about malnutrition, and the existence and cost of the CMAM services.

MONITORING: manage and monitor community mobilization activities along with staffing, budgets, and responses of the caretakers, community figures and other stakeholders using simple excel sheets and by analyzing outreach worker reports. Conduct close monitoring of community mobilization activities to track progress and provide regular supportive supervision to outreach workers and volunteers to ensure the quality of the program. Quantify what has been done; when, where, and how it has been done; and who has been reached. Compare accomplishments with objectives and targets. It is important to identify problems and areas for adjustment as implementation proceeds.
STEP FIVE: EVALUATING, MAINTAINING OR SCALING UP

Periodically review schedules, expenditures, work performed, and outputs. Measure changes in the outputs and outcomes of community mobilization activities. Evaluate community access and CMAM coverage using secondary data analysis and/or conducting coverage assessments as necessary. Make adjustments to the action plan throughout program implementation based on regular monitoring and periodical evaluation results, and modify community mobilization interventions as necessary. Maintain, reinforce or scale up community mobilization efforts depending on the nutritional situation, program coverage, resources and changes in CMAM programming.

WHAT DID WE LEARN?

Between 2012 and 2013, the Coverage Monitoring Network (CMN) supported over 78 coverage assessments globally and identified common boosters and barriers to access CMAM services.

COMMON BARRIERS include lack of community knowledge and misinformation about the use and cost of CMAM services; lack of knowledge and misconceptions about causes and treatment of malnutrition; sociocultural factors such as lack of support from husbands; caretaker high opportunity costs (mothers busy, mothers sick, etc.); previous rejection by the program; far distance to CMAM sites; poor quality of CMAM services; long waiting time at the clinic for CMAM services; stock shortages of nutrition products; and lack/poor community participation and outreach activities.

COMMON BOOSTERS include community awareness about the signs and symptoms of severe acute malnutrition and that it is a treatable disease; effective systems in place for referral and transfer of children between CMAM services (targeted supplementary feeding programs, outpatient treatment programs and stabilization centers) and the community; key community figures actively support the program; awareness that CMAM services are available and free of charge; regular active case finding activities; MOH and NGO support to CMAM services; good coordination between CMAM actors; and community sensitization.

The assessment also shows that barriers and boosters vary to some extent not only from program to program, but also from cultural context to context. The underlying causes may range from environmental to community and household (4).

LESSON LEARNED: THE EFFECTIVENESS OF COMMUNITY MOBILIZATION ON COVERAGE

In response to increased levels of malnutrition due to the drought in 2012, World vision implemented a Community-Based Management of Acute Malnutrition (CMAM) program in all 8 municipalities in Huambo province, Angola. Community Health Workers (CHWs) were recruited with the help of community members and trained on MUAC screening. CHWs screened children in villages and referred children with severe acute malnutrition (SAM) to health facilities supported by the Ministry of Health.

In remote rural areas where villages were located far from health facilities, besides detecting and referring children with acute malnutrition, CHWs provided treatment to children with SAM without medical complications admitted into the program by providing PlumpyNut at the household level. They mobilized mothers and conducted home visits when necessary. The CHWs supervisors (also community volunteers) monitored the screening activities and reported the numbers of children screened and referred to program staff. They were provided with motorbikes to facilitate the supervision of the various CHWs of the commune and to help, when needed, in the distribution of Ready-To Use Therapeutic Food (RUTF). CHWs worked voluntarily (without pay) but received material incentives for their active participation, such as bicycles, training kits and project clothing.

As a result of this initiative, the decentralized management of acute malnutrition positively impacted on the coverage and outcomes of the CMAM programs. The Semi-Quantitative Evaluation of Access and Coverage (SQUEAC) conducted in June 2013 revealed that the period OTP coverage was 82.1% and cure rate was 87.3%. The main strengths of this initiative were the community mobilization activities including: 1) CHWs’ visits to absent mothers’ homes to avoid defaulting; 2) CHWs traveling to villages on a weekly basis to provide the RUTF instead of asking the mothers to travel to health facilities; and 3) good program coordination and collaboration with community actors, such as administrative authorities and churches.

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This note was prepared by Melaku M. Dessie, Community Mobilization Advisor from International Medical Corps/CMN, and reviewed by Caroline Abla, Director, Nutrition and Food Security Unit at International Medical Corps.

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