



COVERAGE MONITORING NETWORK



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SOUTH SUDAN: COUNTRY PROFILE

COMPILATION OF RESULTS, ANALYSIS AND EXPERIENCES FROM COVERAGE
ASSESSMENTS OF CMAM PROGRAMMES

Foreword

Since the first SQUEAC survey conducted in South Sudan in 2010, the CMN (*Coverage Monitoring Network*) is strongly committed to consolidate local capacities for elaborating such investigations around the coverage of CMAM programmes. Moreover, the CMN supports capacity building for monitoring and analysis of data and qualitative information that is obtained through the implementation of the programmes. It is through this systematic and deep analysis that the CMN, along with other partners from all levels, contributes to the strengthening of CMAM programmes and to the improvement of their quality.

This Country Profile is a compilation of statistical data collected throughout the 17 assessments conducted in South Sudan and directly or indirectly supported by the CMN. On top of this quantitative analysis, the profile runs a full qualitative analysis of the complementary information that was gathered during the assessments. Therefore, this document intends to explore community dynamics, people's perception of the programme and their relationship with CMAM performance. It is an attempt to continue an open discussion on recommendations and lessons learned that could throttle a full scale-up of CMAM services along with a strengthening of their quality.

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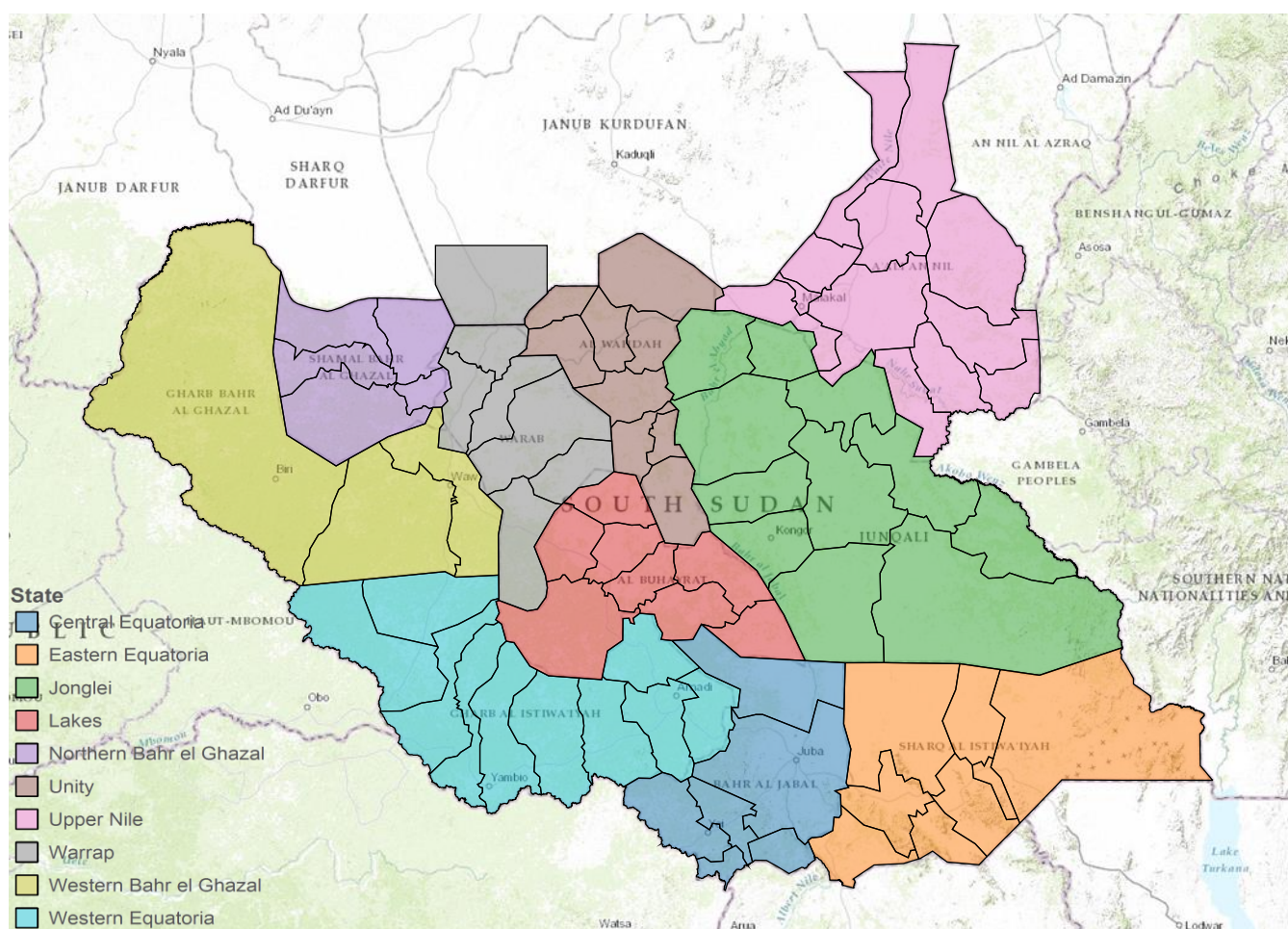
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GEOGRAPHICAL COVERAGE INDICATORS

Geographical coverage

Community-Based Management of Acute Malnutrition (CMAM) was first deployed in South Sudan before independence, with some of the oldest programmes existing since before 2010. Scaling up of CMAM programmes began quite soon, especially considering the humanitarian crisis that the country has recently faced, but the most significant part of this increase has only happened recently. CMAM programmes have been adapted to cover specific Health Units, which most times coincide geographically with the country's 86 counties that constitute the 10 states.

MAP 1 – ADMINISTRATIVE MAP OF SOUTH SUDAN



Geographical coverage (trends and changes through time)

Although the scale up of CMAM in South Sudan started along with independence, the most significant increases in service provision have taken place recently, between 2014 and 2015. The total number of operational OTPs in early 2014 was 258, and it quickly increased to 351 in December 2014. By March 2015, over a hundred additional sites were opened, reaching 462. In June of that same year, 2015 sites were fully operational.

This massive transformation in scale still faces a problematic environment that doesn't enable CMAM services to work at their full capacity. During the first half of 2015, nutrition services were fully suspended in three states due to conflict (Unity, Upper Nile and Jonglei states, which are also the region with the highest burden of SAM and GAM —see the annexes). Such contextual factors are extremely relevant not only to explain the daily challenges faced by CMAM partners, but also the environment in which coordinated scale up of services with the commitment of state and international actors is expected to take place.

INDIRECT COVERAGE AND NATIONAL PERFORMANCE INDICATORS

Indirect Coverage Estimates

Calculations of indirect coverage take into consideration the total admissions to CMAM programmes during a predefined period (usually one year), and compare them to burden figures of SAM. The latter are the result of a simple calculation made with the prevalence rate obtained through SMART surveys and an incidence factor of 1.6 used to estimate the total caseload of SAM over a year.

SMART surveys in South Sudan take place regularly at county level. This is in itself a great source of constant information on the evolution of SAM and GAM prevalence in specific areas. Data on admissions to CMAM broken down by county are however difficult to find, making the comparison and the ultimate calculation of indirect coverage very difficult.

Nevertheless, it can be estimated that with:

- a critical SAM prevalence rate of 4.5% nationwide (calculated by the 15th round of SMART surveys in March 2015);
- a national population of 11,694,649 people, as estimated by the National Bureau of Statistics for mid-2015;
- a share of the population composed of children between 6 and 59 months of 16% as estimated by the NBS;
- and with annual admissions for the year to June 2015 of 124,923 cases...

The estimated indirect coverage is of 57.1%.

Such a figure says little about regional and local contexts. As shown in the annex, the differences in prevalence of SAM and GAM across states is very significant, and different local security risks pose a challenge to constant and sustained admissions to CMAM programmes.

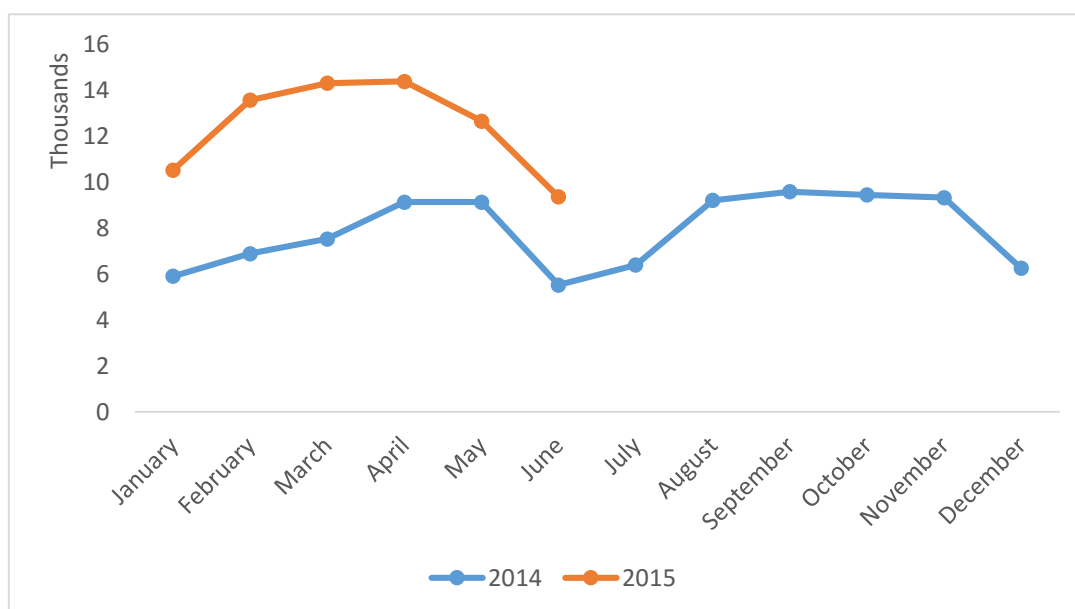
Admissions through time

It is hard to obtain older data on admissions to CMAM services in South Sudan, be them at OTP or Stabilisation Centre level. The trends for 2014 and the first half of 2015 could perhaps give an initial view on the effect of seasonality over admissions. However, we should recall that the number of active OTPs has increased steadily during 2014 and the first half of 2015.

Yet the total admissions during 2015 do not fully reflect the doubling of OTP sites since the beginning of 2014. Even more so, an additional 40 OTPs had been opened between March and June 2015, and yet admissions seemed to decline.

As reported above, increasing violence in some states of the country has severely limited the capacity of actors to provide local populations with CMAM services over a longer period. Admissions are the first indicator to drop when an interruption in the service takes place. In the case of South Sudan, the sharp decline in admissions over the second quarter of 2015 is probably explained by the socio-political context despite the increasing number of OTPs available.

FIGURE 1 – TOTAL ADMISSIONS IN SOUTH SUDAN BY MONTH



Performance rates through time

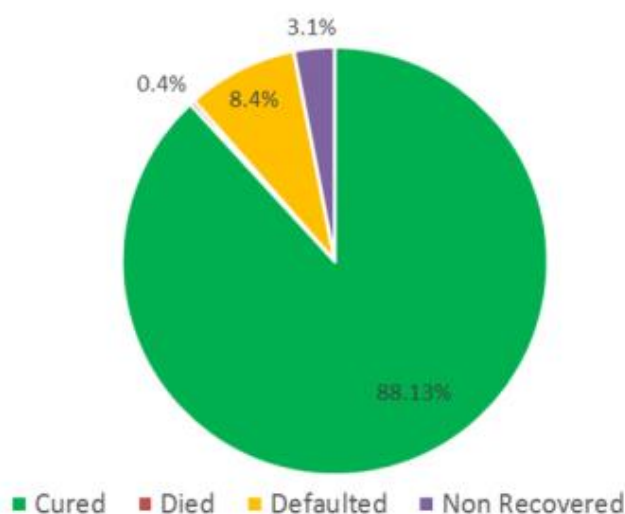
With little available data from previous years and broke down by month, it is hard to get a clear idea on the evolution of the performance rate of CMAM programmes in South Sudan. Data recorded periodically by the Nutrition Cluster and UNICEF is available in the quarterly reports, but is aggregated for a specific period of time.

Last figures available, published by the Cluster in June 2015, show a good performing programme on the national average. With 88% of cases cured and 8.4% defaulting, the average performance of the programme nationwide is outstanding. Both indicators are respectively above and below the SPHERE standards for what constitutes an acceptable performance.

However, it is worth exploring into the data quality assurance mechanisms put in place by partners and the cluster. As we will discuss in the following sections, a good way of double-checking the validity and the overall quality of the data is by comparing it to field-level assessments (SQUEAC evaluations, mostly).

Another element that could be looked into with further detail is the dynamic of change across time of these performance indicators. This can be useful especially when available information on service interruptions due to different causes can be compared to the performance of the programme. Also, because it would give a clearer idea on whether geographic scaling up of CMAM in South Sudan has come together with an improvement of performance.

FIGURE 2 - SAM TREATMENT PERFORMANCE UP TO JUNE 2015, AVERAGE FOR THE COUNTRY



DIRECT COVERAGE. DETAILS OF ASSESSMENTS

Between 2010 and January 2016, 17 SQUEAC assessments have been conducted in ten different counties of South Sudan, mostly in the North-West. So far, no SLEAC assessment has taken place, so there has not been an attempt to estimate coverage for a wider area altogether.

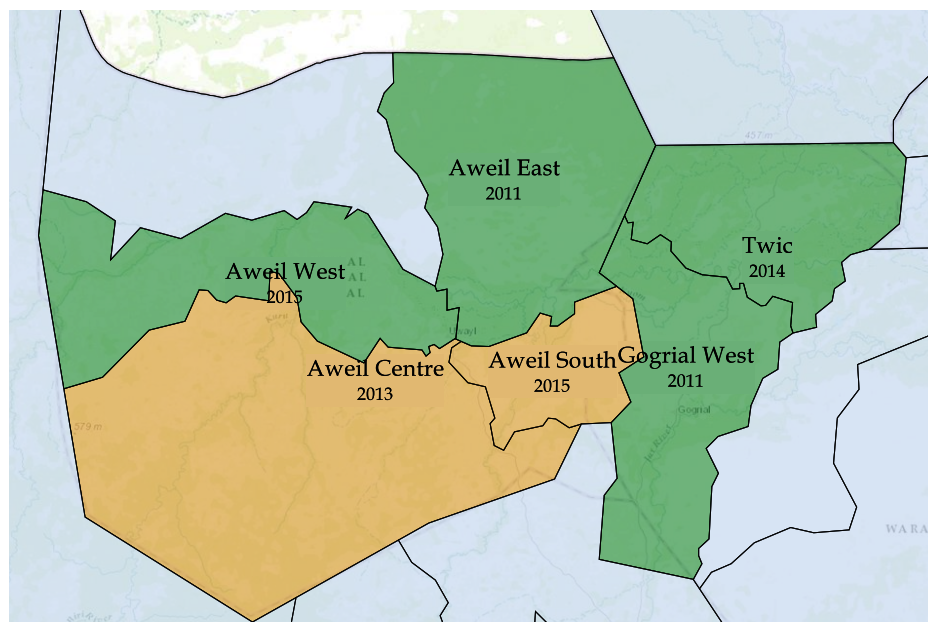
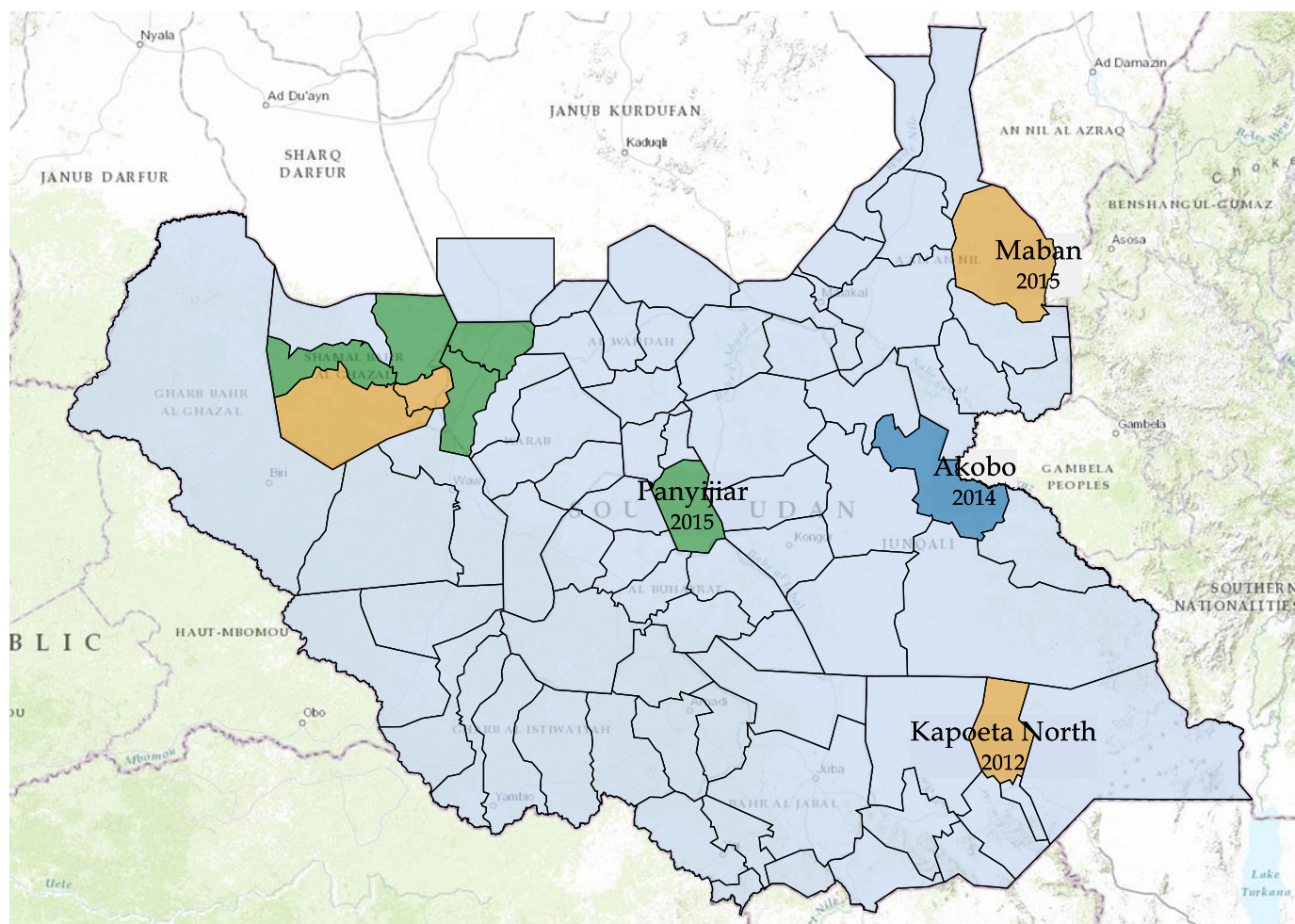
The general results of the SQUEAC assessments, specifically the final coverage estimate, **have been retroactively calculated using the Single Coverage Method**. This does not invalidate original coverage estimates, and makes it possible now to compare each SQUEAC's result with each other and across time.

Out of 17 SQUEACs conducted, 15 have studied the coverage of SAM programmes and two have done so for MAM programmes (Twic and Panyijiar Counties). Both MAM programmes were analysed together with the SAM services in those areas. Out of 17, three did not estimate a final coverage value due to methodological problems (i.e, did not accomplish the necessary sample size for the survey) or because the scope of the research advised against doing so and rather focusing on the qualitative information gathered in previous phases.

In all counties assessed, coverage has been classified with a three stage graduation, where low coverage is below 20%, moderate coverage is up to 50% and high coverage is above 50%. This classification applies to rural areas only. The **three SQUEACs done in a refugee camp (in Maban County)** are compared against another classification threshold. A low coverage is considered as being below 40%, moderate goes up to 90%, and high coverage is above that.

The following map shows all counties assessed and shows the classification of coverage of the latest SQUEAC conducted. In dark blue, Akobo County is showed as the only one where a SQUEAC has not estimated coverage yet.

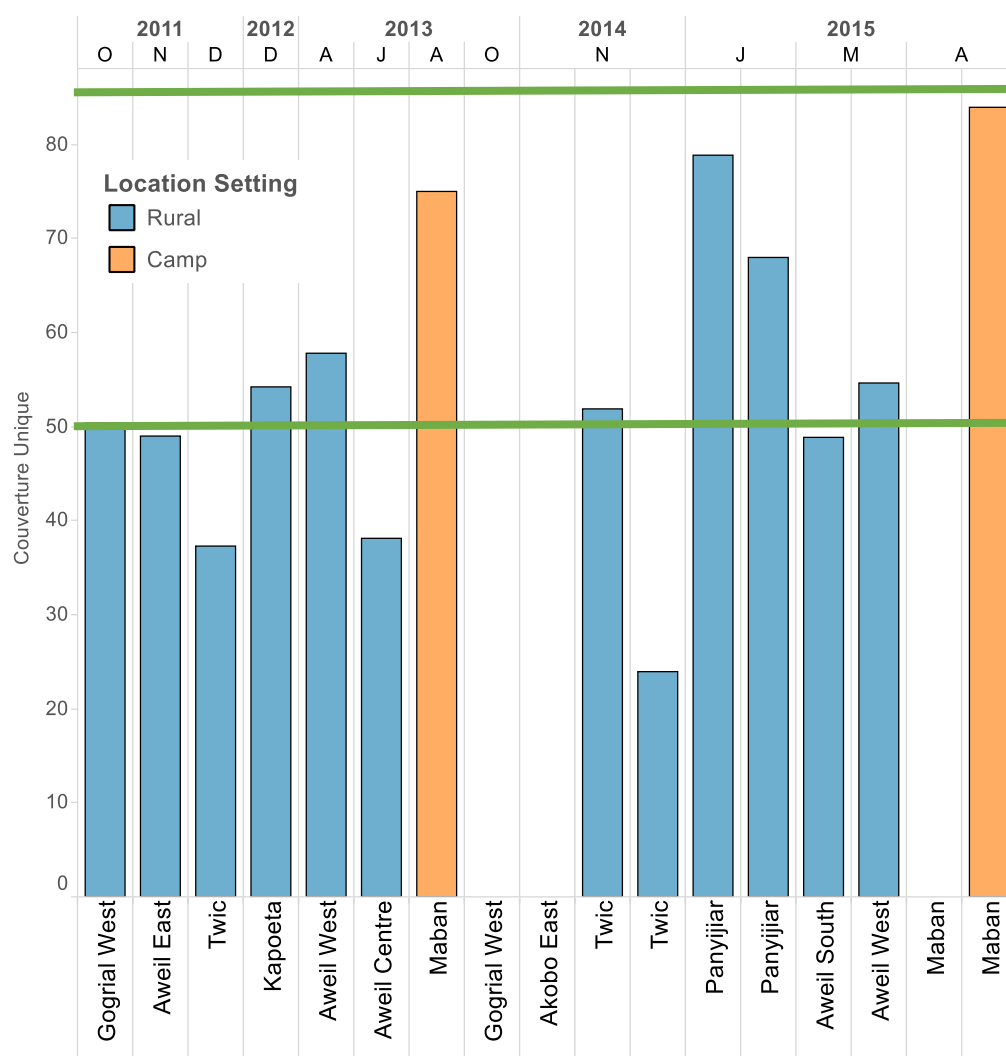
MAP 3 – COUNTIES BY THEIR CLASSIFICATION OF COVERAGE



The differences between rural and camp settings are extremely important for contextualising results of coverage. Whilst rural areas have tended to perform better than their acceptability thresholds (see the graph below for the counties of Panyijiar, Aweil East and West), the camps in Maban have fallen short of the standard.

On the other hand, no programme assessed has had a “low” result in terms of its coverage classification. So whilst the differences in coverage help us understand the regional disparities in terms of the contexts affecting the delivery of CMAM services, it is encouraging to see that collective efforts around CMAM have permitted programmes to achieve results close to the acceptability levels. There is clearly room for improvement, and the following sections will discuss in more detail the steps that can be take.

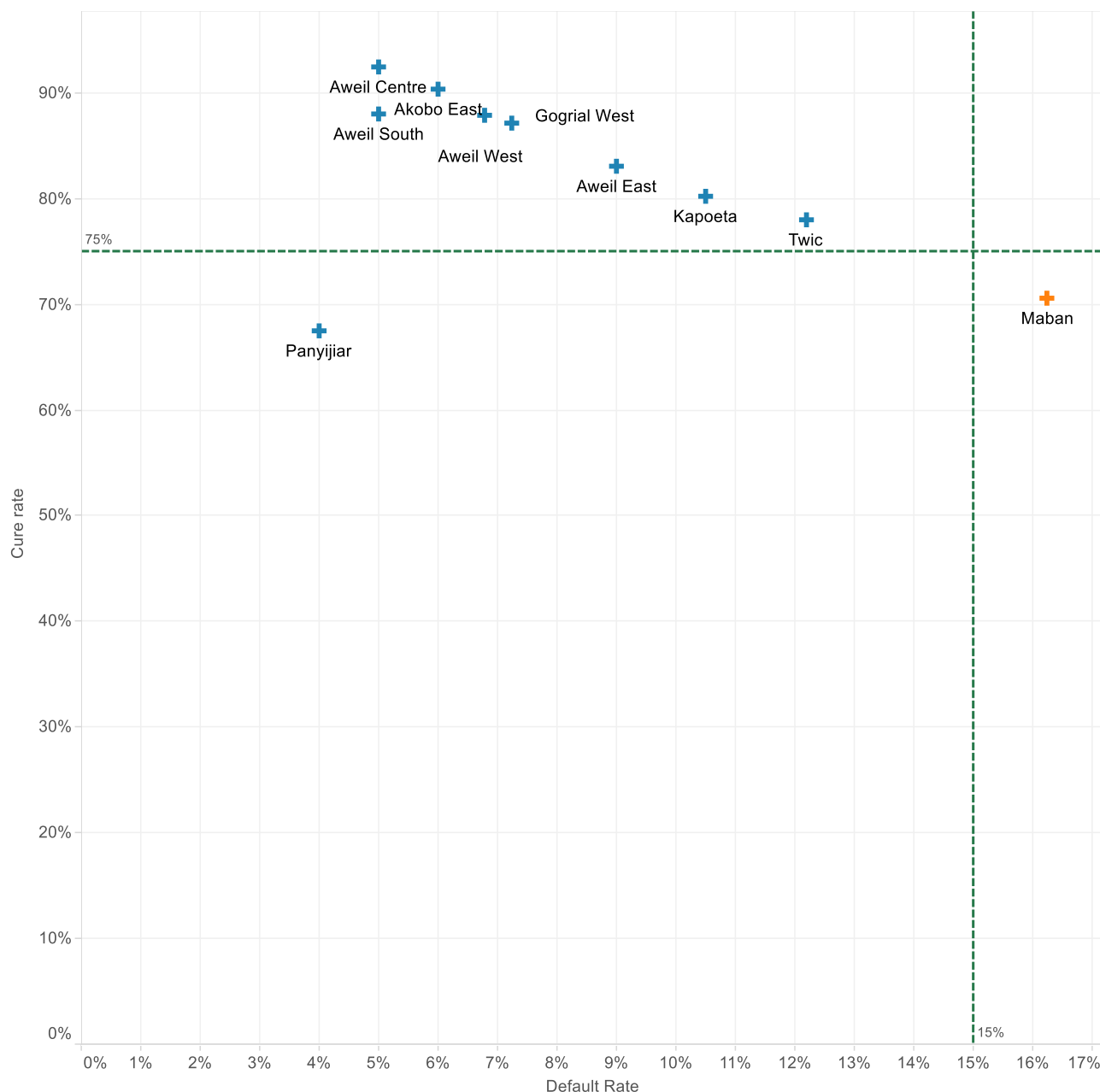
FIGURE 3 – SQUEACs IN SOUTH SUDAN BY COVERAGE AND DATE



Another key indicator of the programme’s performance, as discussed earlier, is the group of cure, default, non-respondent and death rates. SQUEACs also analyse routine data at programme level and allow

identifying these rates across time. The average value reported in the SQUEAC reports is a good proxy of the overall performance of the programme. Once again, we find that the vast majority of programmes is performing above the SPHERE standards for cure and defaulting rates, except for the Maban Camp. **This confirms the overall results presented by the cluster on programme performance.**

FIGURE 4 – COMPARISON OF CURE AND DEFAULTING RATE ACCORDING TO EACH SQUEAC



Met need

Cure rate is a powerful indicator of a programme's performance, but it tells little of its final effectiveness if is not compared to the coverage rate. CMAM programmes that have excellent cure rates —and it is the case of most Counties in the country— can also have low coverage rates, which will bring down the whole effectiveness of the programme. Consequently, coverage rates can clearly influence a programme's success. Comparing both indicators is thus useful to understand the real reach of a given programme.

FIGURE 5 – MET NEED FOLLOWING SQUEAC RESULTS



COMMUNITY PROFILE

Local social dynamics and resources, and how they are applied to CMAM

Mapping of basic social indicators

Generally, in all counties (Akobo East, TWIC, Panyijiar, and Kaya Camp) where the coverage assessment carried out in South-Sudan they have more or less the same livelihood practices and service availability. Most of the coverage assessments were done in rural settings while some of the assessment was conducted in Refugee/IDP camps. The counties livelihood ranges from agro-pastoralists who engage in both agriculture and rearing of livestock, especially cattle. Farming is conducted during the rainy season although some cultivation also occurs during summer. Vegetables are not widely cultivated as most farmers are rural rather than urban and mainly dependent on animal products. Main crops produced include sorghum, millet, maize, sesame seeds, groundnut and seasonal fishing. There are no employment opportunities in the public or private sector in most of the rural areas.

There are two main seasons in all of the county dry season and rainy/wet season, dry season from February to April rainy season from June to October. The rainy season usually results in extended extensive flooding particularly along the area of main rivers rendering many areas inaccessible and cut off from various facilities and services. Most of the areas are hard to access area and with the ongoing conflict while has created

significant challenges for the population in terms of access to basic services and goods. In most of the counties the only reliable access into the regions is by air and within the county access is only by foot and this often requires hours of walking through swamps and mud as well as jungles. Resulting in most of the counties facing multiple health, nutrition and food security challenges. During the lean season, the communities depend mainly on wild food collection, fishing, selling grass, firewood, relief distribution as well as support from relatives and friends.

In all the counties where the coverage assessment carried out the provision of primary health care and nutrition services are carried out by the county health department with the support of International Non Governmental Organization (INGOs) and Local NGOs as well as UN agencies. Among them International Medical Corps in collaboration with WFP and UNHCR provides primary health care and nutrition services to refugees in Kaya camp. While ACF, GOAL, IRC and IMC in collaboration with each county health department are providing a nutrition program includes the targeted supplementary feeding program (TSFP) to children 6 to 59 months of moderate acute malnutrition (MAM), Outpatient Therapeutic Program (OTP) for children 6 to 59 months of severe acute malnutrition (SAM), Infant and Young Child Feeding (IYCF) and community-based integrated health and nutrition program are also being implemented by to promote breastfeeding, optimal complementary feeding and positive behaviour change, and prevent malnutrition and diseases among local communities and refugees.

Population movements with children (link up with seasonal calendar if possible)

Population movements in most of counties were related with seasonal migration trend in search of water and pasture plus on going conflicts between different factions. During the hunger gap between February to May and the rate of admission is also recorded going higher in those months. Therefore there could be a relationship between peak season of childhood illness, hunger period and seasonal increase in the rate of admissions.

Despite having been less directly affected by the conflict, some of the counties have hosted many of those displaced by the fighting in neighboring counties and states, increasing the burden on host communities.

Community communication structures / role and involvement of different community actors

More or less in all counties the community communication structures or roles is based on an administrative structure and a traditional structure, which work together with the latter reporting to the former at the highest level. The administrative side is led by the County Commissioner who was supported and represent by Payam Administrators and then by Boma Administrators, while the traditional power structure are led by the Paramount Chief of the Payam. There is a chief for each boma who is represented at the village level by sub-chiefs, with all chiefs reporting to their superiors. There are eight sub-chiefs per boma and between 8-13 villages per boma. Also, Religious leaders and villages elders are respected by the community as well as Female leaders are also active and have a good insight into the health seeking practices of caregivers. In addition, Traditional healers and Traditional Birth Attendants (TBAs) are active in the villages' communication structures within the villages.

Moreover, The Witchdoctor is believed to have the spiritual power and highly respected by the community.

The Witchdoctor is the first person to be consulted by community members on important family issues and health problem. Similarly, there are traditional healers that are respected by the community and are believed to have the spiritual power to cure any illness.

In Kaya refugee camps continue to use their existing tribal authority structures, principally through sheiks that each represent a population of approximately 78 households. All refugees are Muslim and most of them speak Arabic language and their tribal language. While, in Akobo County predominantly inhabited by two ethnic groups, the Nuer (majority) and the Dinka (minority) and the community communication are mainly through payam and Boma chiefs.

The priest is the religious leader and leads the prayer at the church. An indigenous beliefs and practice leader (also referred to as the BenyBith) leads worship every Sunday under shade of big trees in the villages. The priest and BenyBith generally make important announcements after Sunday services.

Generally, various formal and informal communication channels are used to disseminate information within the community in the area. Among formal and informal communication channels used in the majority of the counties FM Radio, community meeting, church information announcer, community information announcer are perceived high effectiveness, while the informal means of communication channel drumming and dancing, community gathering at market, under tree are also perceived high effectiveness. Contrary to perceived high effectiveness of communication channels public notice at market, youth group meeting, women gathering for milling and water points, social events (weeding, birthday, funeral) are perceived low effective of communication channel used both in formal and informal means. The local FM radio also used as a major information dissemination method and the coverage of local radio program is good in the area. The community members mentioned that significant community members have access to a portable radio. The community members who do not have a portable radio also get information from other community members who get information from the radio.

Perceptions towards CMAM (different communities, ethnic groups, languages and terms, etc.)

Local terminology

In different counties the perception towards CMAM is the same. Most community informants were able to understand and describe malnutrition, and could differentiate it from other diseases like malaria and diarrhoea. They were also familiar with different signs and forms and/or signs of malnutrition, such as wasting/ thinness, oedema, big abdomen, old man's face, stunting and light color hair. However the local terminology is different from county to county due to different ethnic groups and language differences.

In Twic County, the local terms for malnutrition /wasting are Dor, Juet, Majak Odor, Dhel guop, Atook guop, Nyuet, Aci nyin lony thin. Majak Odor is the commonest term used to express malnutrition in the most areas. The odema and big abdomen are expressed in local term as Aloot and Tuei respectively. While, in Akobo East the following terms were used to identify Malnutrition – Doot/Dolcɔk, Oedema – Puotpuot, Wasting – Nuan, Big abdomen – Kuenjiay. Also, in Payniliar 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.

Symptoms, causes and effects

In all the counties where the coverage assessment took place some of the communities are able to describe the symptoms, causes and effects of malnutrition. In most communities recognized that malnutrition was a problem in the community; they knew of malnourished children and the majority cited a lack of food and illness (malaria, diarrhoea, vomiting and fever) as the cause, with some including a lack of diet diversity and insufficient breastfeeding as other contributors. However they did not necessarily view malnutrition as a disease in itself. The childhood diarrhea are severe and occur throughout the year, despite the community members were able to understand and describe malnutrition, and could differentiate it from other diseases like Malaria and Diarrhoea. However, when asked about common childhood illnesses in the community, malnutrition wasn't mentioned, but when prompted, most of the community members were familiar with different signs and forms of malnutrition, such as sunken eyes, oedema, wasting, big stomach, light color and thin hair, pale eyes, inactive and unhappy child.

The perceived causes of malnutrition cited by most of the refugee informants are diarrhea, lack of blood, inadequate food, mother unable to produce enough breast milk, early stopping of child from breastfeeding, no balance diet, lack of family planning and poor hygiene practices.

Health seeking patterns

In all counties diarrhoea, Malaria, Skin and Respiratory Infections, vomiting, Measles, Malnutrition, Whooping Coughs were the most common childhood illnesses. 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.

In TWIC county Some caregivers and community figures reported visiting traditional healers for treatment prior to attending the PHCU or OTP, which was confirmed by traditional healers themselves.

In Paynjir county despite the fact that the CMAM program has recently rolled out, most communities mentioned that they seek CMAM service to treat acute malnutrition. 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.

Some of homemade remedies used to treat malnutrition and other childhood illness 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☐o *Koop*- leaves to treat whooping cough

While in Kaya refugee camps most of the refugee informants mentioned that they sought solution from health facilities for the treatment of acute malnutrition. However, some community members indicated they seek solution from traditional healer for sick child if the treatment from health facility fails.

Community Mobilisation Assessments conducted

CMN supported partner to conduct a community assessment in Kaya Refugee camp, Maban County, TWIC county and Pynijar county in South Sudan during the CMN phase II project. The main assessment objective was to understand and analysis the program dynamics to identify community systems, resources, structures and cultural factors in order to strengthen the current community engagement strategy that fits with and builds on local resources to improve access and uptake of CMAM services.

The primary objectives of the community assessment were;

- 1) To assess community knowledge, beliefs and practices in relation to childhood acute malnutrition and illness;
- 2) To understand community systems, structures and actors, including appropriate communication channels that can be used for community engagement program for CMAM;
- 3) To assess contextual factors that influence the community decision to access and use CMAM service;
- 4) To identify strengths and weaknesses in the current community engagement activities for, and opportunities and threats to the future collaboration with the community engagement program;
- 5) To strengthen a current community engagement strategy to improve access to the CMAM service;
- 6) To build capacity of the County Health Department and NGOs' staff in undertaking community assessment and designing a community engagement strategy for CMAM program

A mixed-method approach employed combining qualitative techniques (in-depth, open-ended Focus group discussion, key-informant and semi-structured interviewing, observations), and analysis of secondary CMAM program monitoring data.

A SWOT analysis (strengths, weaknesses, opportunities and threats) for a current community engagement program for CMAM in Kaya refugee camp, TWIC county and Pynijar was drawn. The analysis revealed that the community engagement program for CMAM program have several strengths as well as weakness and opportunities which enables to improve and strengthen the community engagement.

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 three Counties are summarized below.

Strengths

- Trained CHPs to conduct community engagement program for CMAM
- Integration of MUAC screening at triage site in the health facilities
- Involvement of sheiks in community engagement
- Well integrated outreach structure and good leadership, including CHP supervisors
- CHPs report daily
- Chiefs of the villages were oriented about the program, and involved early in the CMAM program and support the community mobilization

- There is good case finding and referral through CNVs, and CBDs. The CNVs conduct home to home visit sensitization
- Defaulter tracing is conducted by CNVs who based themselves in the community.
- Mass MUAC screening carried out at start of the program
- Community Nutrition Volunteer (CNV) who are women and base themselves in village, conduct MUAC screening in their villages and refer children to TSFP site.
- Nutrition project team us local FM radio station (Mayardit) to sensitize the community about IYCFP, optimal malnutrition and hygiene
- Active Mother to Mother support groups (MTMSG) meet weekly and discuss IYCFP and maternal and child nutrition
- Health and nutrition materials and counseling cards are available for CNWs, MTMSGs and CNVs
- Community leaders involve in selection of CNVs and informing the community about community MUAC screening

Weakness

- Inadequate involvement of community figures and women groups in community engagement
- Inadequate CHPs' report data analysis and feedback to CHPs
- Less motivation mechanism for CHPs and half day working hour
- There are no enough CNVs and their supervisors to cover all CMAM program target villages.
- Community sensitization about malnutrition and CMAM is not done at large scale at community gathering places
- CHD and community figures are not well involved in CMAM related activities at scale
- Limited integration of community mobilization for CMAM into other community based initiatives
- Poor motivation of CNVs and lack of incentives to CNVs and CBDs
- No mechanism to follow up referred cases from community to CMAM sites
- The effectiveness of CNVs activity is not analyzed
- The involvement of community leaders limited mobilizing the community for screening where the screen is conducted
- Lack of mass regular MUAC screening
- Limited integration of community mobilization for CMAM into other Community-based health and nutrition programs

Opportunities

- Music dance and Drama group
- Sheiks' leadership structure
- Presence of TBAs to act as linkage between health facility and community
- Peer referral
- Various volunteers and outreach workers such as MCG, CBDs , WASH committee, VHC
- 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
- Presence of several community meeting and gathering
- Willingness of community figures to participate in CMAM program
- Presence of several active community groups such as MTMSGs
- Presence of local FM radio station at no cost
- Willingness of community to participate in CMAM

Threats

- High staff turnover
- Insecurity (tensions between host & refugees)
- Continuous reduction in budget by donors
- Demands by the CHPs for high pay in dollar
- Inadequate capacity of county health department
- Poor motivation of volunteers (no incentives)☐
- Insecurity, flooding, hunger☐
- Poor health facilities infrastructure
- Inadequate supply and stock out of the RUTF/RUSF
- High turnover of CNWs

Community Outreach

Official status of Community Volunteers and Health Workers / Volunteers Networks

There are several different community volunteers and health workers/volunteers network in different counties supported by CHD and partners.

In the Kaya refugee camp structure there are 67 sheiks with one elected leader representing each block. These leaders with support of UNHCR and partners are responsible for block administration, safety and security of the refugee.

Community Health Promoters (CHP) for the community-based health and nutrition program in the camp. The CHPs are salaried staff paid by IMC and working half day for five days to promote optimal nutrition, promotion of health, and prevent malnutrition and diseases in the camp. International Medical Corps also established and supports 100 Mother Support Group (MSG), made up of mothers, pregnant and lactating women from neighbour-hood. Each MSG meets monthly with lead mother who is supported by CHP supervisor and discuss about infant and young child feeding practices.

In Twic, the *headman* is an influential traditional leader and has overall control over the activities in the village, including conflict resolution. Headmen traditionally consult with village's chief on issues that require their support. Female representation is generally limited to the women associations. However, women association members are frequently involved in political affairs and serve as the voice for women at Boma and village community meetings. Almost every village has a Witch Doctor – typically wears a long, orange Jubba and carries a “*spiritual stick*.” He is believed to have spiritual power and is highly respected by the community. The Witch Doctor is the first to be consulted by community members on important family issues and health problems. Traditional birth attendants (TBAs) are also among the influential community figures in the area. As in many communities, TBA is the first point of contact for most women of reproductive age in a village. TBAs have influence over the community's health-seeking behaviors.

Several community actors exist in the county including community groups and associations, which can be

used for community mobilization for the CMAM program. There are Women Associations in each of the Payams visited. Similarly, there are women groups (also referred to as MADA) in *Wunrok* and *Turalie* Payams. These women's groups are supported by GOAL and promote hygiene and adult literacy. The women associations and groups could be used platforms to reach the CMAM program target women.

Each health facility has Boma Health Committees (BHCs), which includes 5 community members and the head of the health facility, which support health service delivery and function as a bridge between health facilities and communities.

In addition, there are also various categories of community-based volunteer groups, namely: SMART group, Water User Committee, Hygiene Promotion Committee, Mother-to-Mother Support Group, Care Group, and Local Nutrition Group. Water User Committee (WUC) and Hygiene Promotion Committee (HPC)s, which include men and women as members, are the most active community volunteer groups in the area and are supported by GOAL. In most villages, WUC and HPC committees were also involved in water point management and hygiene promotion respectively. The WUC manage and repair the water points when it is broken, and fence and maintain the water points. The HPCs are generally involved in hygiene promotion.

Similarly, 75 Mother-to-Mother Support Groups (MTMSG) were established by ACF in most of the villages in four Payams. These groups meets once a week to discuss Infant and Young Child Feeding (IYCF) practices.

In Panyijiar 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.

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.

IRC engages the VHC, which supports health service delivery and functions as a bridge between health facilities and communities.

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).

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

Communication

In all counties there are various formal and informal communication channels used to disseminate

information for the community outreach works as well as to sensitize and community engagement purpose. The communication is initiated by chief of the village, religious leader and channeled through different means.

In Kaya Refugee camps, the refugee leaders (Sheiks) regularly meet with partners, and subsequently disseminate of information to the refugees in the camp is a main communication channels.

In TWIC county community leaders (Chief, headman) convey important messages during community meetings. The Boma Administrator or village chief also disseminates information to the community through information announcers. Also religious leaders are pass information after church or mosque prayer. Community gathering is also a most effective platform for dissemination of information.

The partners also use public address system to disseminate information and reported as it reached the audience effectively through home-to-home visit by CHPs and MSGs.

Sensitisation

Community sensitization about malnutrition and CMAM is carried out at community gathering sites, community meetings, and waiting area in the health facilities by different community volunteers, village chiefs, CHPs, MSG and health facility staffs. The CHPs as well as the Care groups and MSG also provide nutrition promotion at household level when they conduct home visit, and at community gathering places. The MSGs also met monthly with lead mothers fortnightly and discuss to promote positive IYCF practices in the counties. However, 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 of 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.

Screening, referral and follow up

In all counties active case finding and referral been conducted by different community volunteers. In Kaya refugee camp the CNPs conduct active case finding at household level through home-to-home visit in their assigned block and refer SAM and MAM cases to health facilities. The CHPs also involve regularly in mass MUAC screening campaign in the camp. In TWIC county active case finding and referral been conducted by community nutrition workers (CNWs) from the start of the programs. The CNWs conduct community based

MUAC screening of the children by selecting a village among several villages in one OTP/TSFP catchment areas. Also, in Panyijiar the screening of active case finding and referral is done at health facilities and communities. In addition, 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.

However, during assessment, the community informants mentioned that some of caretakers referred by CHPs from community were rejected at the health facility. This was due to the difference of the MUAC measurement between at community by CHP and the health facility by nutrition worker. This might have negative repercussions on caretakers' acceptance of referral from community and access the CMAM service.

Moreover, the geographical coverage of the community-based MUAC screening is low as the number of the community volunteers and the CMAM catchment areas are disproportional or not comparable. The CHWs also mentioned that they did not provide health and nutrition education during screening as caretaker come one by one, and leave as well.

General points of community perception of CMAM (Quality of care, sensitisation, client interface)

Generally, in all counties the community perception of CMAM program in terms of quality care, sensitization and client interface is appreciable. The community informants cited that provision of free services for malnourished children at the primary health care facility and the presence of NGOs supporting the CMAM program is a paramount for the improvement of children from malnutrition. The good referral system between OTP and TSFP programs and passive case finding at the health facility were also identified as enablers for the community to access the CMAM services. Though, it is not to optimum the good community awareness about the availability of the CMAM service and appreciation of the outcome of OTP service; and sensitization about malnutrition through local radio, CNP, CNWs and MSG were also good reasons to access the CMAM services despite geographical and flooding challenges.

Moreover, the chiefs, village leaders, sheiks also support the case finding by mobilizing the community, provide room for CMAM service provision, store and secure RUTF and RUSF. They also indicated that they do appreciate the outcome of the treatment and have recognized the positive changes in children who had received treatment. However, most of them lacked knowledge about the IMAM target groups and just want to have RUTF/RUSF as part the family food.

Despite, the integration of CMAM community volunteers with other community leaders and figures limitation. Other 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.

CAPACITY BUILDING

Trainings conducted

The CMN offers trainings and workshops on the various coverage assessment methods, as well as guidance on how to overcome the barriers identified. The CMN offers free technical support in the design, planning, implementation and analysis of coverage assessments of community based management of acute malnutrition (CMAM) programs. One of the main activities of the second phase of the project (which started in 2014) is to provide technical support in the design, implementation and analysis of coverage assessments and the formulation of community mobilization action plans.

Accordingly, the CMN in collaboration with the South Sudan NIWG/UNICEF conducted national level coverage assessment training for NGO's staff from October 19th – 23rd, 2015 in Juba. The purpose /objective of the training were -

To build the capacity of nutrition cluster partners with the skills and provide tools to implement and train others on the six core competencies of coverage assessments. With the skills they learned during the workshop, the partners would therefore be able to go on to implement coverage assessments in their own CMAM programs and cascade their knowledge to other staff in their organizations.

The Principal objective:

To provide participants with the knowledge and tools to roll out coverage assessment methodologies in their own organizations and,

Sub-objectives:

- To provide participants with an overview of the theory, practice and training techniques for the key coverage competencies (which together constitute a SQUEAC assessment)
- To train partners in SQUEAC and related techniques in coverage surveys
- To support national partners to plan for future coverage activities
- To promote participants' interest in measurement and implementation activities that improve coverage in CMAM programs.

Before the training, the CMN administered pre-questionnaire send by email to assess prior knowledge and experience among the participants with regards to coverage methodologies. The results of the questionnaires also helped the trainers to adapt the coverage training modules based on identified needs.

A total of 20 (16 Male & 4 Female) trainees or 77% of the 26 trainees attended from 10 INGO/NGO and UNICEF as well as independent consultant working in Nutrition Program in South Sudan.

To evaluate the knowledge gained by the participants, pre and post-tests were conducted. The average score of the pre-test was 50.3% and the average score of the post-test was 84%. Overall, scores increased by an average of 33.7% over the course of the training.

In order to measure the efficacy and effectiveness of the training various monitoring and evaluation methods were applied during and at the end of the training.

At the end of each day's training, participants were asked to complete daily evaluation forms, and an end of workshop evaluation was done. Each day, participants gave an overall rating for each session (scale: 1 = insufficient to 5= excellent), overall comments, and picked the most valuable learning session.

The majority (90 %) of participants mentioned that they gained new knowledge and skills during the training and that the training was useful. All participants voted that they were either "satisfied" or "extremely satisfied" with the overall training and all participants agreed that they will be able to train others or/and able to apply what they have learned in the training on CMAM program coverage assessment

BOOSTERS AND BARRIERS

Major Boosters to Access

The enabling factors (boosters) to access and utilize treatment for acute malnutrition by the community summarized

- Availability of free CMAM services
- Community appreciation of the treatment outcome
- Community awareness about the availability of CMAM service
- Involvement of Sheiks in community engagement and Existing Boma health committee (BHC)
- Good referral system

The above general common enabling factors drawn from three counties where the community assessment done identified as enablers for the community to access the CMAM services. The good referral system between OTP and TSFP programs, involvement of sheiks in community engagement was identified as enablers for the community to access to CMAM services in Kaya refugee camps as well as existing of Boma Health Committee (BHC) in rural localities. The good community awareness about the availability CMAM service and appreciation of the outcome of CMAM service is also cited in all the counties where the community assessment carried out.

Though the overall major boosters to access are more or less the same in all localities. However, the areas topography, the security situation and distance as well as availability of service delivery are factors for enablers to access to CMAM services.

The enabling factors to access and utilize CMAM services by county/payams were as follows:-

Boosters (TWIC)

- Provision of free CMAM services at PHCC and PHCU
- Good referral system between OTP and TSFP
- Peace and stability in most part of the county
- Community awareness about the availability of CMAM service
- Community figures support to CMAM program in some community
- Good supervision to TSFP site
- Existing Boma health committee (BHC)

Boosters (kaya)

- Good nutrition services
- Good outreach activities
- Short distance to TSFP
- Availability of free CMAM services
- Community appreciation of the treatment outcome
- Integration of health and nutrition services
- Good community health seeking behaviour
- Involvement of Sheiks in community engagement
- Good referral system
- Support of men to child care

Booster (Paynijiar)

- Appreciation of CMAM treatment outcome
- Availability of comprehensive CMAM services
- Good referral system between OTP, SC and TSFP
- Provision of free CMAM service
- Aware the availability of CMAM services
- Community has easy access to CMAM services in some area
- Good community mobilization activities in most area
- Good collaboration between health and nutrition staff and the community in most area

Trends and changes in Boosters to Access

In general, as all partner has difficulty on conducting a follow up assessment after the baseline assessment as such for a time being there is no any trends and changes in boosters to access to draw lesson learned. However, though there is one a follow up assessment done in TWIC county between 2011 and 2014 as there is no data on boosters were identified from the first SQUEAC assessment in year 2011, it is difficult to analysis the trends and changes in boosters to access from year 2014.

FIGURE 6 – BOOSTERS IDENTIFIED AND WEIGHTED DURING FIRST AND SECOND STAGE OF SQUEAC

Awareness that SAM can be treated effectively	Regular active case finding activities with appropriate and timely referral	Key community figures actively support the program by referring children and support CHWs' activities	Adequate support (by providing training, supply) and supervision given to volunteers, health centre and program staffs by NGO and MoH	Delivery of results in term of high proportion cured, low mortality, low defaulting and short length of stay
Awareness that the treatment is free of charge	Awareness of the signs and symptoms of SAM	Good client/staff relationship	High number of self referral and peer to peer referral	Sensitisation of the community
	Effective systems in place for referral and transfer (OTP/SC/SFC/HC/CHW), including passive case finding at health centres.			
Awareness the service to treat SAM is available at the local clinic	Community access to nutrition services within the coverage area is facilitated through numerous OTP centres or mobile units	Caregivers have physical access to nutrition activities (security, no ethnic or discrimination)	Short waiting times/ efficient patient flow at program sites	Good
		Good coordination between CMAM actors	Motivation of	Supply of RUTF

Booster Type

- ☐ Awareness that the child was SAM
- ☐ Good program decision making by proper data collection
- ☐ Motivation of CHW/Volunteer
- ☐ Supply of RUTF
- ☐ Caregivers have physical access to nutrition activities (security, no ethnic or discrimination problem, women can access)
- ☐ Good coordination between CMAM actors
- ☐ Short waiting times/ efficient patient flow at program sites
- ☐ Adequate support (by providing training, supply) and supervision given to volunteers, health centre and program staffs by NGO and MoH
- ☐ Delivery of results in term of high proportion cured, low mortality, low defaulting and short length of stay
- ☐ Good client/staff relationship
- ☐ High number of self referral and peer to peer referral
- ☐ Sensitisation of the community
- ☐ Key community figures actively support the program by referring children and support CHWs' activities
- ☐ Community access to nutrition services within the coverage area is facilitated through numerous OTP centres or mobile units
- ☐ Awareness of the signs and symptoms of SAM
- ☐ Effective systems in place for referral and transfer (OTP/SC/SFC/HC/CHW), including passive case finding at health centres.
- ☐ Awareness that SAM can be treated effectively
- ☐ Awareness that the treatment is free of charge
- ☐ Awareness the service to treat SAM is available at the local clinic
- ☐ Regular active case finding activities with appropriate and timely referral

Major Barriers to Access

Barriers from the Community side

Insecurity due to civil war in South Sudan was a leading barrier to deliver the CMAM service and community access to it. Due to insecurity situation, the decentralized sites are centralized into one central site in some counties. The insecurity led high turn of staff, closure of health facilities and loss of supply during insecurity.

Also far distance to service delivery point is a major barrier for the community to access the CMAM service in the area. Besides, a 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.

Moreover, the significant proportion of the community lives in scattered clusters of villages that are situated far from the CMAM centers. Besides, wet season road conditions and lack of transportation significantly limited the community physical access to care and leads stock out of RUTF due to lack of access road to repositioning of the supply from the center to the area. Misconception on the causes of malnutrition and RUTF are also key barriers for community to access to CMAM services in the area. PlumpyNut is perceived

as food aid and not as the medicine, and the local term for PlumpyNut is “Atom” which means groundnut paste. Some of the community believes that PlumpyNut causes diarrhea.

Barriers to Service Delivery

Insecurity due to civil war in South Sudan was a leading barrier to deliver the CMAM service and community access to it. The insecurity led high turn of staff, closure of health facilities and loss of supply during insecurity incidents.

Inadequate number of CHPs, MSG lead mother and nutrition staff was identified as top barrier for CMAM program. The CHPs worked for half day for five days and limited their working hour, such as identification and referral of children of acute malnutrition.

Another barriers for not accessing CMAM services encompassed inadequate individual counselling of caretakers why they are in the CMAM program and during discharge of children, limited skills of CHP on MUAC measurement lead to the MUAC measurement result difference between at the health facility and community levels, and lack of involvement of community figures particularly tradition healers. Besides, wet season road conditions and lack of transportation significantly limited the community physical access to care and leads stock out of RUTF due to lack of access road to repositioning of the supply from the center to the area. The frequent stock out of the supplies for longer period is deleteriously affect caretaker to return back to the health facility.

In all three counties a major top barrier for the community to access to CMAM services in the area were as follows:-

Barriers (TWIC)

- Far distance to CMAM service delivery point
- Inadequate awareness about malnutrition and CMAM
- Women workload
- Inadequate outreach activities
- Inadequate of quality health services
- Insecurity and inaccessibility
- Preference of alternative treatments

Barriers (Kaya)

- Insecurity within the camp and country at large
- Inadequate incentives to CHPs, MSG & nutrition staff
- Inadequate counselling of caretakers at discharge
- Language barrier between caretakers and staff
- Staff turnover
- Long distance to OTP site
- Preference to traditional healers' treatment.

- Long waiting time at health facility
- Limited CHP's skill on MUAC screening
- Shortage of RUSF

Barriers (Paynijiar)

- Long distance to service delivery point
- Inaccessibility
- High opportunity cost of caretakers
- Long waiting hours at the service delivery point
- Shortage of RUTF/RUSF supply
- Inadequate quality of service
- Some key community figures are not adequately involved in CMAM program
- A child rejected by the program
- Poor health facility infrastructure

FIGURE 7 - BARRIERS IDENTIFIED AND WEIGHTED DURING FIRST AND SECOND STAGE OF SQUEAC

Poor outreach activities Lack of active case finding, lack of follow up defaulter, lack of motivation and/or training for CHW and/or staff, lack of sensitisation etc	Lack of awareness about malnutrition	Lack of awareness about the programme	Alternative health practitioners preferred	High opportunity costs	Insecurity
Distance	Long waiting times	Previous rejection	Carer busy Taking care of other children at home, social event such as	Seasonal barriers	
	Poor programme monitoring Mistakes in data collection, lack of follow up of registrars and cards	Stigma	treatment interface No coordination between Health Centre/ OTP or OTP/CHW or	Language barrier	
RUTF stock breaks	Population movement	Wrong admission and discharge criteria Including difficulties to follow protocol, inappropriate anthropometric measurement	training and equipment of	delivery of service Staff mean,	

Trends and changes in Barriers to Access

The trends and changes in barrier to access in the two county (TWIC and Kaya) which they have conducted baseline and follow up coverage assessment in year 2011 to 2014 for TWIC and 2013 to 2015 in Maban/Kaya Refugee camps some barriers have been repeated in 2014 assessment and some new barriers came up as well in TWIC county. The repeated barriers in TWIC county were:

- Plumpy Nut Stock out
- Over crowding
- Poor health seeking behaviour
- Insecurity

While the new barrier added during year 2014 activities were:

- Long distance to CMAM sites
- Women workload
- Inadequate outreach activities
- Inadequate awareness about CMAM and Malnutrition
- Preference of alternative treatments.

While, in Gogrial –west the trends and changes in barrier to access repeated in 2013 assessment and the barriers were: -

- Not using traditional healers to refer malnourished children
- High opportunity cost for carers
- Rejection by facility
- Shame to attend the program
- Poor access to parts of the program due to distance and flood
- Significant parts of the program area not covered by either outreach (CNVs) or community based volunteers.

The key barriers that were pointed out by previous coverage surveys were identified by the current investigation as barrier albeit some have been addressed. Most importantly, the barriers that were identified as most critical in the 2013 survey were in fact key limiters of access and coverage on the previous two surveys.

Moreover, the key barrier trends pointed out in Aweil west in 2013 and 2015 is more or less similar to the other counties:

- Poor community perception of CMAM program
- Inconsistent supply of RUTF
- Poor record keeping

While the barrier during the year 2015 were:-

- RUTF stock out
- Limited knowledge about malnutrition
- Lack of understanding of CMAM programs
- No distinction between CMAM program and other services provided at health centre
- Inaccessibility during rainy seasons
- Distance
- Plumpy-Nut being perceived as a food and being sold in the market
- Heavy workload of women,
- Stigmatization
- Inadequate of CHW networks
- Non engagement of key community figures.

Data on barriers to access

Barriers by relevance and weight

The lists of major barriers were derived from well-triangulated evidence in stage 1 and stage 2 by the assessment team. The scoring of barriers done by the assessment team based on the weight of each element

and relevance for the community to access to CMAM services in the area. Accordingly, the teams used a different rating to score each barrier. Each assessment team scored each barrier separately as it was expected that the score would differ in some extent to different context. However in this case if the scoring did differ in some extent. The final scoring for each barrier was agreed and assigned by using the average score. Accordingly, the following major barriers were weighted and scored in different context.

- Long distance to service delivery
- High opportunity cost for caretakers
- Shortage of RUTF/RUSF
- Inaccessibility/insecurity
- Inadequate outreach activities
- Preference of alternative treatment

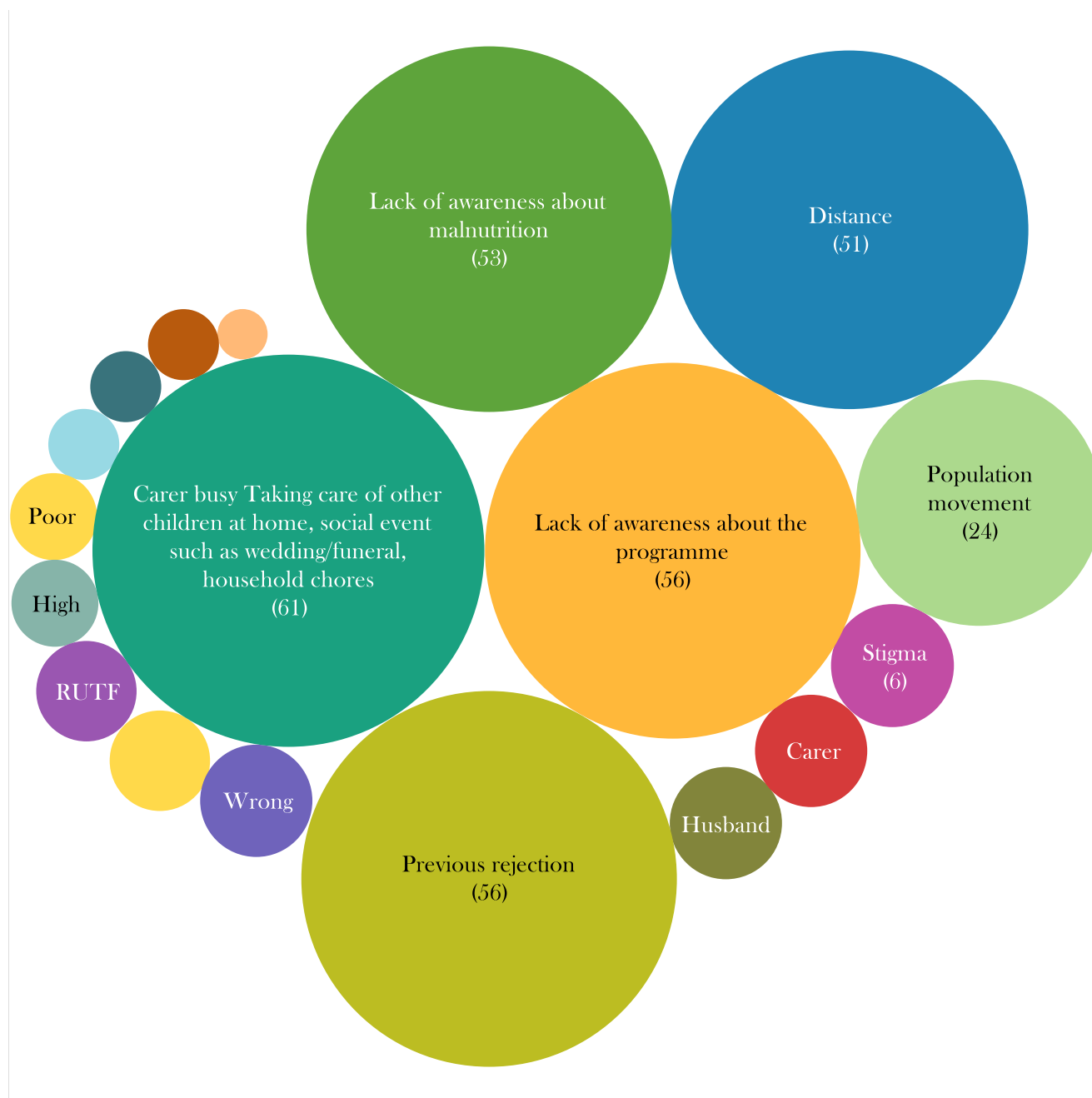
Were major barrier relevance access to service delivery weighted for rural settings, while the major barrier for the camp settings were: -

- Insecurity within the camps.
- Inadequate incentives to CHP and Nutrition staff.
- Inadequate counseling of caretakers at discharge.
- Staff turnover.

Some of the relationship cited by the field team suggested that reasons for high defaulter rates are linked with frequent supply breakage and flooding.

The other relationship mentioned on communities misconception on the cause of malnutrition and far distance from the service delivery point significantly limits the community's access to OTP services in Twic County. These barriers enforced the community to use alternative traditional treatment for acute malnutrition.

FIGURE 8 – REASONS FOR NON-ATTENDANCE AS MENTIONED BY CAREGIVERS



Barrier Type

- Carer busy Taking care of other children at home, social event such as wedding/funeral, household chores
- Lack of awareness about the programme
- Previous rejection
- Lack of awareness about malnutrition
- Distance
- Population movement
- Stigma
- Carer sick
- Husband refusal
- Wrong admission and discharge criteria Including difficulties to follow protocol, inappropriate anthropometric measurement
- Non-respondent OTP, SC etc.
- RUTF stock breaks
- High opportunity costs
- Poor delivery of service Staff mean, asked for money, absence, no explanation given to beneficiaries, sharing RUTF, misconception of RUTF
- Insecurity
- Previous rejection of a known child
- Relapse
- Lack of money

ADDRESSING BARRIERS –RECOMMENDATIONS

Detailed Recommendations by topic

A) The main barrier to access is the population movement due to insecurity across the country

IDPs are arriving in the county as well as returnees from Ethiopian refugee camps. A clear plan needs to be made to manage this influx with the program using community structures to monitor new arrivals and include them in program activities. To do this, coordinated outreach activities are necessary, both with other IMC program and NHDF and SCI. To support this approach, CNVs need to be replaced where necessary and assigned to specific households to ensure they are able to manage the additional workload

B) Within the existing community there is a lack of understanding about why some children are rejected from the program causing discontent

Community sensitization is required to inform the community that children are rejected because they are not severely acutely malnourished. This can be done using local terms of malnutrition and with a description of a child suffering from SAM. Again, community leaders can be involved in spreading this message within the community.

C) There is evidence that traditional healers continue to treat malnutrition and caregivers seek their advice which will delay their attendance at OTP

Use healers, witchdoctors, TBA for opportunistic case finding and referral to the OTP.

D) A main barrier to access to treatment is the inconsistency of OTP days. Due to limited fuel available as a result of restricted cargo flights from Juba during the rainy season, there have been times when staff have been unable to deliver OTP or the day has changed with no warning.

As cargo delivery is a challenge for at least four months of every year, partners need to plan for fuel delivery and stockpiling so to manage it. Additionally the purchase of Motorolas or Thurayas for the boats and OTP teams will improve communication where necessary. A joint planning and coordination among partners will avoid missed OTP days for general food rations by caregivers.

E) Communities misconception on the cause of malnutrition

Sensitization about OTP (target groups, referral system and use of RUTF), causes of malnutrition and optimal breastfeeding through identified effective communication channels could improve community knowledge and practices of childhood acute malnutrition and illness, increase health-seeking behaviour within the community.

F) Far distance from the service delivery point significantly limits the community's access to OTP services

Well de-centralized and functioning primary health care system, Well-coordinated integration of community

mobilization for CMAM into existing community-based health program. Mapping the OTP service utilization and distribution and establish mobile OTP service to villages located far from OTP

G) Inadequate quality service delivery

Close supervision and technical support, improving and safeguarding the RUTF supply chain and staffing of health facilities. Piloting and scaling up community-based OTP delivery through trained community outreach workers could help to improve OTP access to the community that live in the inaccessible and remote areas.

Community mobilization to increase access to CMAM services should be implemented and review on a regular basis to improve CMAM services at health facility level. Piloting and scaling up community-based CMAM delivery through iCCM by trained CBDs could help to improve communities' access to CMAM services in the inaccessible areas.

In order to reinforce CHPs' capacity, continuous training in community engagement and communication skills, provision of appropriate job-aids and close technical support should be provided. Moreover, the monitoring of outreach program and analysis CHPs' report and provide feedback to CHPs should be strengthened.

H) Women workload

Decentralization of OTP/TSFP facilities, regular OTP days, bi-weekly distribution for those caretakers from far distance will enable to shorten the time spending in the OTP health facilities and allow enough time to chores.

Sensitization about OTP/TSFP target group, referral system and use of RUTF/RUSF and causes of malnutrition through identified effective communication channels could improve community knowledge and decrease the unnecessary travel time, rejection and decrease malnutrition incidents.

Recommendations for specific programmes/districts/regions

Programme/District 1 TWIC OTP/TSFP

The community mobilization to increase access to OTP/TSFP should be implemented in tandem with strategies to improve OTP/TSFP service. It includes increasing the OTP/TSFP centers' capacity to provide CMAM services for the additional children and improving RUTF/RUSF supply chain. Mobile OTP/TSFP and community-based OTP/TSFP delivery through trained community outreach workers could help to improve OTP/TSFP access to the community who live in the inaccessible and remote areas.

1. Integration of community mobilization for CMAM into other community-based initiatives
2. Involve the community leaders and figures in supporting community mobilization for CMAM program
3. Use social capital and local radio for sensitization for the CMAM program
4. Piloting community-based OTP delivery through trained community volunteers/outreach workers in villages located in remote and inaccessible areas
5. Strengthen coordination among partners and technical support and monitoring of OTP and mobilization activities.
6. Improve the RUTF supply chain and the quality health service

Programme/District 2 Akobo East OTP

Despite OTP staff generally have good knowledge of admission and discharge criteria. However, non-responders are not consistently given appropriate treatment by OTP staff with regards to transfer for a medical check-up and transfer back to OTP for the requisite time. Further training sessions with OTP staff to clarify the procedure is necessary.

Though the program is well established and the community generally have a good knowledge of it and about the causes of malnutrition however further sensitization is required on IYCF and the issue of 'thiang' through the work of the CNVs and with MCGs.

Of those caregivers with SAM children not in the programme, many believed treatment was only available in the county hospital so had not sought treatment due to the opportunity costs associated with doing so. This needs to be addressed during outreach activities in MCGs and during CNV home-to-home visits.

Within the existing community there is a lack of understanding about why some children are rejected from the program causing discontent. Community sensitization is required to inform the community that children are rejected because they are not severely acutely malnourished. This can be done using local terms of malnutrition and with a description of a child suffering from SAM.

Hold meetings with community leaders (elders, female leaders, religious leaders and boma chiefs) on not using traditional healers to treat malnutrition at OTP, on the meaning of rejection and on 'thiang', to be dispersed through the community

Programme/District 3 Panyijiar OTP

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 previous 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.

Programme/District 4 Kaya OTP/TSFP

1. Train CHP supervisors in supportive supervision and technical assistance to CHPs

2. Engage the community leaders and figures in supporting community engagement for CMAM
3. Analysis CHPs report to provide feedback to CHPs and use evidence for improving the community engagement program
4. Decentralize OTP service to health post and introduce a system to reduce waiting hour at health facility

CASE STUDIES. WHAT HAS BEEN DONE? WHAT HAVE WE LEARNED?

List and brief description of Case Studies undertaken

In Year 2011 and 2014 the CMN supported a coverage assessment of SAM treatment within CMAM services in TWIC county. After the first SQUEAC conducted in December 2011, a follow-up investigation took place in November 2014.

The first assessment identified a low coverage rate of **27.3%**. The second SQUEAC showed a statistically significant improvement to **47.0%** though it was below standard rate for the rural coverage rate of 50%.

The coverage increased by more than 19% in 2014 compared with the baseline coverage rate in 2011 from the SQUEAC survey.

One of the main reasons could be long duration of the programme, this programme has been running since 2007 and over time more people have become aware about the programme. So long duration of programme can be a factor for increased coverage rate. Nonetheless, during the 2014 assessment, the team did not make any direct comparison or analyse against the 2011 SQUEAC assessment results. Therefore it is not possible to come up with any tangible reason for the changes in coverage rate.

Best Practices Identified

Possible to link-up with the existing format for Best Practices

Best Practice _ ACF Twic_Radio.docx

Best Practice _ IRC Panyjiar.docx

Action Plans designed

A total of five joint action plan with a total of 114 activities were designed in five counties (Akobo east, Aweil west, Maban, Panyjiar and TWIC) in South Sudan both by partners and CHD.

National Workshops

South Sudan is one of the CMN's priority countries for 2014/15. From 17-18 October 2014, a workshop was held in Juba with members of the nutrition cluster in the country. The main objective of the workshop was to develop a country-specific action plan for scaling-up coverage assessments in South Sudan for the forthcoming years.

A total of 31 participants took part in the workshop, including CMN representatives, MoH staff, and representatives from 18 different implementing agencies.

The objectives of the workshop were threefold.

1. To enable partners to plan, coordinate and evaluate the quality of coverage assessments
2. To jointly develop an understanding of existing technical capacities and opportunities for implementing coverage assessments in each country
3. To develop country-specific action plans for scaling-up/rolling-out coverage assessments

Presentations from the CMN focused heavily on the first objective in order to build this capacity. The second objective was achieved through interactive mapping sessions and group discussions. The third and final objective underlined the workshop and was the result of interactive sessions of objective setting, resource allocation and time-frame planning.

The Nutrition Cluster opened the workshop with a presentation on the current situation of AM in country demonstrating the impact of the recent crises on the caseload of AM. Those areas specifically affected by the crises have a very high prevalence of GAM. Nutrition activities in Unity state have been greatly affected by the conflict situation. Response is scattered, reactive and sometimes inconsistent due to insecurity, logistics as well as type of staff that should be in specific areas. Also a lack of predictability impacts upon the response. Currently the nutritional outlook of the country is a critical situation – namely the conflict-affected states are most affected. Currently there are 49 partners in country dealing with AM.

There have been a fairly limited amount of SQUEAC assessments that have taken place to date in South Sudan. Unfortunately the limited amount of coverage data makes it very difficult to conclusively analyze trends in coverage. Generally speaking however, programs are being able to achieve approximately 45% coverage in rural settings, and over 80% in camp settings

At key points during the workshop, participants were asked to think about and make note of where the priorities and gaps lie in relation to national and regional coverage assessments and local coverage assessments. They then added their notes to five thematic areas: Objectives, Timeline, Resources (financial), Capacity and Leadership.

Based on these notes from participants an action plan was developed taking in to consideration all five thematic areas. The key objectives were identified as the following:

- To get baseline information in order to identify gaps in service delivery
- To improve program performance
- To identify barriers to access
- To inform evidence based decisions/programmatic planning
- Enhance regular monitoring of nutrition program

Regardless, of the development of an action plan taken into consideration the five thematic areas and the factors affecting coverage and community mobilization session out of 10 activities planned in the action plan 7 or (70%) of the activities are not carried out.

Changes undertaken so far in service delivery

In TWIC County in general a total of 24 activities were planned and of those 62% of activities completed, 20.9% of activities were partially completed and 16.6% of activities were not started.

While in Pynijiar county a total of 23 activities were planned and of those 43.5% of activities completed fully, 43.5% of activities partially completed and 13% of activities were not started.

In Aweil West county a total of 28 activities were planned and as of August 2015 joint action plan update 14.3% of activities completed, 50.0% of activities partially completed and 35.7% activities are planned for the remaining months, however, since there is no feedback from the team we assumed that as activities not started.

According to the follow up communication on Joint Action Plan activities from Akobo-east a total of 18 activities were planned and as of October 2015 update 38.9% of activities were completed, 55.6% of activities were partially completed while 5.5% activities are not started.

Though it was difficult to gauge the changes undertaken due to lack of full update on implementing the activities in the joint action plan. However, most of the activities in the joint action plan status are partially completed. Which might indicate a change been taken in order to improve the service delivery.

- In addition, changes observable through follow-up assessments

Due to different challenges most of the partners could not able to conduct a follow-up assessments within the project life period. Thus, except in Twic County there are no any observable changes from the follow up assessments in other counties.

Ways forward

Engagements and commitments by local/regional/national authorities

The community assessment shows that the community engagement programs for CMAM through integrated community based health and nutrition program is fairly strong in Kaya refugee camp. This contributed to timely case finding and recruitment, case retention and increased refugees' awareness about the CMAM service and malnutrition. Sheiks involvement in supporting the community engagement for CMAM program helped to have access to the communities and CHPs' work. However, integration community engagement for CMAM into existing community-based initiatives, such as Mother Support Group and engaging the refugee figures would further facilitate the community engagement for CMAM in order to improve access and uptake of the CMAM service.

In Akobo east there is no clear community mobilisation strategy for the programme. However, there are well established activities that take place such as CNV activities and Mother Care groups, but yet it has not been integrated further with traditional healers (TH) and Traditional Birth Attendant (TBA).

In TWIC county several community actors, including community groups and associations exist, which can be used for community mobilization for the OTP program in Twic County. The women have formed Women Associations in all the four Payams. The women association members mobilize the community to strength peace and unity in the community. They are also involved in political affairs and represent the women at Boma and village levels. In addition, there are also various categories of community based volunteer groups, namely: SMART group, Water User Committee, Hygiene Promotion Committee, Mother To Mother Support Group, Care Group and Local Nutrition Group. SMART group is a community-based volunteer network, which exists in the four Payams. It aims to promote health, community-lead total sanitation and agriculture training. Both women and men are members of the Water User and Hygiene Promotion Committees.

In Panyijiar 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. 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.

Engagements and commitments by local partners

Though, there are commitments by local partners on engagements to programs however, most of the services are provided by INGOs with minimal support from the County Health Department.

Engagements and commitments by international partners

In Panyijiar 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 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.

In Kaya Refugee camp, International Medical Corps recruited and trained 67 Community Health Promoters (CHP) for the community-based health and nutrition program in the camp. The CHPs are salaried staff and working half day for five days to promote optimal nutrition, promotion of health, and prevent malnutrition and diseases in the camp. International Medical Corps also established and supports 100 Mother Support Group (MSG), made up of mothers, pregnant and lactating women from neighbourhood. Each MSG meets monthly with lead mother who is supported by CHP supervisor to discuss about infant and young child feeding practices.

The involvement of the sheiks in nutrition program helped to gain full access to the target community and to secure their support to community engagement for CMAM in the camp.

In TWIC county Goal has 24 CHNPs (one CHNP per health facility), who based themselves in the health facility. The CHNPs, under supervision of Community Health Officer and four Assistant Community Health and Nutrition Officers, visit the household in the village every afternoon to conduct a follow- up visit for defaulter and non-responders. In addition, there are four Care groups (15 members per group) in four villages and these are the active group in the county. There are also 4 Home Health Promoter (HHP) per health facility who based in the villages. The HHPs are only active during the epidemic control campaign and conduct health education.

In Akobo-east International Medical Corps managed Community Nutrition Volunteers (CNVs) and Mother Care Groups (MCGs) in nine bomas. In Akobo east the Ministry of Health is not active in Akobo East and all services are provided by NGOs with support from the County Health Department.

ACTION PLANS

Brief Review on Action Plans

A standard SQUEAC assessment provides programs with detailed information on the barriers caregivers face in taking their children to CMAM programs and on the treatment coverage of the program. The assessment will also result in the preparation of an action plan and recommendations for the program to implement to

address the barriers to access.

In South Sudan, between 2014 and 2015 year a total of five joint actions plan to address the barriers to access being developed by the implementing partners and their counter partners. The five joint action plans have a total of 114 activities focused on (community participation, community engagement, technical support & monitoring, capacity building and quality service delivery). As per the recent update on the joint action plan implementation by partners from four counties 39.8% of activities are fully completed, 42.5% are partially completed and 17.8% of activities are not started.

The major challenges faced during the implementing were: -

- Insecurity
- Delay of program start up
- Inaccessibility due to flooding
- Lack of funding to scale up programs
- Other priorities
- Capacity of implementing partners
- High turnover of staff

[illegible]

List of SQUEAC Assessments recently conducted in South Sudan

Date of assessment	Health District	Organisation	Link
Oct-11	Gogrial West	ACF	http://www.coverage-monitoring.org/wp-content/uploads/2015/07/Gogrial-West_-Oct-2011_-South-Sudan_-SQUEAC.pdf
Nov-11	Aweil East	ACF	http://www.coverage-monitoring.org/wp-content/uploads/2015/07/Aweil-East_-Nov-2011_-South-Sudan_-SQUEAC.pdf
Dec-11	Twic	ACF	http://www.coverage-monitoring.org/wp-content/uploads/2015/07/Twic_-December-2011_-South-Sudan_-SQUEAC.pdf
Oct-12	Aweil East	ACF	http://www.coverage-monitoring.org/wp-content/uploads/2016/03/SQUEAC-Report_Aweil-East-County-2012.10.pdf
Dec-12	Kapoeta North	Save the Children	http://www.coverage-monitoring.org/wp-content/uploads/2015/07/Kapoeta-North_-Dec-2012_-South-Sudan_-SQUEAC.pdf
Apr-13	Aweil West	Concern	http://www.coverage-monitoring.org/wp-content/uploads/2015/07/Aweil-West_-April-2013_-South-Sudan_-SQUEAC.pdf
Jul-13	Aweil Centre	Malaria Consortium	http://www.coverage-monitoring.org/wp-content/uploads/2015/07/Aweil-Centre_-July-2013_-South-Sudan_-SQUEAC.pdf
Aug-13	Maban Camp	UNHCR	http://www.coverage-monitoring.org/wp-content/uploads/2015/07/Maban-Refugee-Camp_-Aug-2013_-South-Sudan_-SQUEAC.pdf
Oct-13	Gogrial West	ACF	http://www.coverage-monitoring.org/wp-content/uploads/2015/07/Gogrial-West_-Oct-2013_-South-Sudan_-SQUEAC.pdf
Oct-14	Akobo East	IMC	http://www.coverage-monitoring.org/wp-content/uploads/2015/07/Akobo-East_-Dec-2014_-South-Sudan_-SQUEAC.pdf
Nov-14	Twic (OTP)	GOAL	http://www.coverage-monitoring.org/wp-content/uploads/2015/07/Twic-OTP-GOAL_-Nov-2014_-South-Sudan_-SQUEAC.pdf
Nov-14	Twic (SFP)	ACF	http://www.coverage-monitoring.org/wp-content/uploads/2015/07/Twic-SFP-ACF_-Nov-2014_-South-Sudan_-SQUEAC.pdf
Feb-15	Panyijar (OTP & SFP)	IRC	http://www.coverage-monitoring.org/wp-content/uploads/2015/07/Paniyijar_-Jan-2015_-South-Sudan_-SQUEAC.pdf
Feb-15	Panyijar (Community Assessment)	IRC	http://www.coverage-monitoring.org/wp-content/uploads/2015/07/Paniyijar_-Jan-2015_-South-Sudan_-Community-assessment.pdf
Mar-15	Aweil West	Concern	http://www.coverage-monitoring.org/wp-content/uploads/2015/07/Aweil-West_-March-2015_-South-Sudan_-SQUEAC.pdf
Mar-15	Aweil South	IRC	http://www.coverage-monitoring.org/wp-content/uploads/2016/02/Aweil-South-County-SQUEAC-Report_March-2015.pdf
Aug-15	Kaya (TSFP)	IMC	http://www.coverage-monitoring.org/wp-content/uploads/2015/10/Kaya-SQUEAC-Final-Report_Aug-2015_IMC.pdf