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FOOD AND NUTRITION  
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**Community Outreach for Community-  
Based Management of Acute  
Malnutrition in Sudan: A Review of  
Experiences and the Development of a  
Strategy**

Vivienne Forsythe, Rania Sharawy,  
Selwa Sorkatti, Salma Awad Albalula,  
Eman Hassan, Hedwig Deconinck,  
Diane De Bernardo, and Ali Nasr El Badawi

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## Table of Contents

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<b>Abbreviations and Acronyms .....</b>	<b>i</b>
<b>Acknowledgments .....</b>	<b>iii</b>
<b>Purpose of the Community Outreach Review .....</b>	<b>iv</b>
<b>PART 1. COMMUNITY OUTREACH REVIEW .....</b>	<b>1</b>
<b>1. National Situation Analysis of Community Health Initiatives and Other Community-Based Activities .....</b>	<b>1</b>
1.1 Method .....	1
1.2 Community-Based Health Initiatives .....	1
1.2.1 Community-Based Initiative/FMOH and State Ministries of Health .....	1
1.2.2 Community-Based Maternal and Newborn Care Project .....	3
1.2.3 Community Integrated Management of Childhood Illness .....	3
1.2.4 Community Malaria Initiative .....	4
1.2.5 Expanded Program on Immunization Volunteer Initiative .....	5
1.2.6 Child-Friendly Community-Based Initiative .....	6
1.2.7 World Bank Community Development Fund .....	6
1.3 Other NGO and FMOH/SMOH Community-Based Structures and Activities .....	6
1.3.1 NGO-Supported Community Outreach Workers .....	6
1.3.2 Sudanese Red Crescent .....	6
1.3.3 Nutrition Educators .....	6
1.3.4 Community Health Task Force .....	7
1.3.5 Community Health Workers and Health Promoters .....	7
<b>2. Community Outreach Assessment, North Darfur State .....</b>	<b>8</b>
2.1 Method .....	8
2.1.1 Briefing and Orientation on CMAM Programs and Community Outreach Activities ...	8
2.1.2 Review of Community Outreach Activities .....	8
2.1.3 Participatory Learning Workshop .....	9
2.2 Assessment Limitations .....	9
2.3 Findings .....	9
2.4 Discussion and Recommendations .....	12
2.4.1 Role of Community Leaders .....	12
2.4.2 Strategies for Active Case-Finding .....	13
2.4.3 Follow-Up Home Visits .....	14
2.4.4 Traditional Practices to Treat Acute Malnutrition .....	14
2.4.5 Health and Nutrition Education .....	15
2.4.6 Effectiveness of Outreach Work .....	16
2.4.7 Supervision of Outreach Work .....	16
2.4.8 Training of Outreach Staff .....	17
2.4.9 Staff Salary Scales and Responsibilities .....	17
2.4.10 SMOH and UNICEF Support for Expansion of CMAM Services in El Fasher .....	17
<b>3. Community Outreach Assessment in Shimal el Delta Locality, Kassala State .....</b>	<b>19</b>
3.1 Method .....	19
3.1.1 Activities at the State Level .....	19
3.1.2 Activities at the Locality Level .....	19
3.2 Assessment Limitations .....	20
3.3 Findings at the State Level .....	20
3.3.1 Population Groups .....	20
3.3.2 Malnutrition Rates .....	20
3.3.3 Infant and Young Child Feeding and Care Practices .....	20
3.3.4 Organizations Working in Health and Nutrition in Kassala State .....	21

3.4	Findings at the Locality Level: Shimal el Delta .....	22
3.4.1	Community Knowledge, Beliefs, and Practices about Childhood Malnutrition and Ill Health .....	22
3.4.2	Treatment of Acute Malnutrition and Other Childhood Illnesses .....	23
3.4.3	Factors That Influence Treatment of Acute Malnutrition and Other Childhood Illnesses .....	24
3.4.4	Infant and Young Child Feeding Practices.....	25
3.4.5	Administrative Structures, Community Leadership, Community Structures, and Commitment to Establishing CMAM .....	25
3.4.6	Organizations Supporting Health, Nutrition, and Development in the Locality .....	27
3.4.7	Community Health Outreach Workers in the Locality .....	28
3.4.8	Employed Health Staff with a Defined Role in Community Outreach as Part of Routine Work.....	29
3.4.9	Methods of Information Dissemination.....	30
3.4.10	Recommendations for the CMAM Community Outreach Strategy in Shimal el Delta Locality, Kassala State .....	30
3.4.11	Organizations Supporting Health and Nutrition and Development in the Locality ....	31
3.4.12	Community Health Outreach Workers in the Locality .....	31
3.4.13	Screening and Active Case-Finding.....	34
3.4.14	Supervision of Outreach Work .....	34
3.4.15	Locality-Level Training Requirements for Community Participation and Involvement in CMAM .....	34
3.4.16	Plan for Community Sensitization .....	34
<b>4.</b>	<b>Community Outreach Assessment in Al Minar Center, Mayo, Khartoum .....</b>	<b>35</b>
4.1	Method .....	35
4.2	Findings and Recommendations.....	35
4.2.1	Outreach Workers and Volunteers.....	35
4.2.2	Home Visits for Screening and Referral.....	35
4.2.3	CMAM Referral Process .....	36
4.2.4	Home Visits for Children Being Treated for SAM.....	36
4.2.5	Records and Reports .....	36
4.2.6	Analysis of Beneficiary Referral Pathway .....	37
4.2.7	Coverage of CMAM Services in Mayo Farm.....	37
4.2.8	Use of Services by Children Living outside the Catchment Area .....	37
4.2.9	CHP/Volunteer Supervision .....	37
4.2.10	CHP Training.....	37
4.2.11	Use of Traditional Healers to Treat Malnutrition .....	37
4.2.12	Role of Community Leaders in CMAM Services.....	37
<b>PART 2. COMMUNITY OUTREACH STRATEGY .....</b>		<b>39</b>
<b>1.</b>	<b>Method.....</b>	<b>39</b>
<b>2.</b>	<b>Community Outreach Strategy Formulation.....</b>	<b>39</b>
	Step 1: Conduct a Community Assessment.....	40
	Objectives of the Community Assessment.....	40
	The Assessment Team.....	40
	At the State and Community Levels .....	41
	Organization of the Community Assessment .....	42
	Validating Information .....	43
	Reporting and Presenting the Information from the Community Assessment .....	43
	Step 2: Formulate a Community Outreach Strategy .....	44
	CMAM Community Focal Persons .....	44
	Linking with Community Mechanisms .....	44
	Planning for Community Participation .....	45
	Developing Standardized Information Messages on CMAM.....	45
	Planning for Community Outreach Activities .....	45

Step 3: Conduct Training on Community Outreach for CMAM .....	48
The CMAM Support Team and Trainers .....	48
Training at Various Levels .....	49
Methods .....	49
Step 4: Implement Community Participation and Outreach Activities .....	50
Community Participation and Outreach Activities and Responsible Persons .....	50
Step 5: Conduct Supervision and Monitoring and Reporting on Community Outreach Activities..	50
Supportive Supervision of CMAM.....	51
Monitoring and Reporting of CMAM Community Outreach Activities.....	52
Assessing Coverage.....	53
<b>Annex 1. Community Assessment Questionnaire and Tools.....</b>	<b>54</b>
<b>Annex 2. Community Outreach Messages .....</b>	<b>56</b>
<b>Annex 3. Referral Slip Community Screening.....</b>	<b>60</b>
<b>Annex 4. Community Outreach Reports.....</b>	<b>61</b>
<b>Annex 5. Checklist Home Visits .....</b>	<b>63</b>
<b>Annex 6. Health and Nutrition Education Messages .....</b>	<b>64</b>
<b>Annex 7. Terms of Reference for the Technical Working Group for Community Outreach for CMAM.....</b>	<b>67</b>
<b>Annex 8. Overall Approach to the Community Outreach Assessment for Community- Based Management of Acute Malnutrition.....</b>	<b>71</b>
<b>Annex 9. Methodology of the Community Assessment for North Darfur State .....</b>	<b>77</b>
<b>Annex 10. Methodology of the Community Assessment for Kassala State .....</b>	<b>86</b>

## Abbreviations and Acronyms

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ACF	Action contre la Faim
ACSI	Accelerated Child Survival Initiative
AUW	Ahfad University for Women
BHU	basic health unit
CBI	Community-Based Initiative
CBO	community-based organization
CDC	community development committee
CFCI	Child-Friendly Community-Based Initiative
CHP	community health promoter
CHV	community health volunteer
CHW	community health worker
C-IMCI	Community Integrated Management of Childhood Illness
CMAM	Community-Based Management of Acute Malnutrition
CMI	Community Malaria Initiative
CMNBC	Community-Based Maternal and Newborn Care
COW	community outreach worker
CR	cluster representative
ENP	Essential Nutrition Package
EPI	Expanded Program on Immunization
FGD	focus group discussion
FMOH	Federal Ministry of Health
GAM	global acute malnutrition
ICRC	International Committee of the Red Cross
IDP	internally displaced person
IFAD	International Fund for Agricultural Development
IMCI	Integrated Management of Childhood Illness
IYCF	infant and young child feeding
KII	key informant interview
km	kilometer(s)
M&R	monitoring and reporting
MCA	malaria community assistant
mm	millimeter(s)
MUAC	mid-upper arm circumference
NAC	National Advisory Committee
NGO	nongovernmental organization
NNP	National Nutrition Program
OPT	outpatient treatment
PHC	primary health care
PHCU	primary health care unit
RH	Reproductive Health
RI	Relief International
RUTF	ready-to-use therapeutic food
SABA	Sudanese Association for Breastfeeding Actions
SAM	severe acute malnutrition
SDG	Sudanese <i>gineh</i> (national currency)
SBCC	social and behavior change communication
SFP	supplementary feeding program
SMOH	state ministry of health
SRC	Sudanese Red Crescent
SWOT	strengths, weaknesses, opportunities, and threats
TB	tuberculosis
TBA	traditional birth attendant
TWG	technical working group

U.N.	United Nations
UNHCR	United Nations High Commissioner for Refugees
VMW	village midwife
WFH	weight-for-height
WFP	World Food Programme
WB/CDF	World Bank Community Development Fund

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## Purpose of the Community Outreach Review

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The purpose of this review is to inform the development of a community outreach strategy for Community-Based Management of Acute Malnutrition (CMAM) in Sudan as services are established across the country. Many community health initiatives, supported by a variety of actors and agencies, operate across the 15 states of north Sudan. The CMAM community outreach strategy must build on and strengthen the existing community-based health initiatives.

This review does not examine community-based health initiatives supported by the state ministries of health, but rather focuses on the various community-based initiatives endorsed and supported by the Federal Ministry of Health and those supported by some of the major agencies that operate in more than one state. The review covers community-based health staff and volunteers as well as facility-based health staff who have a defined role and/or responsibility in community participation and outreach (see **Box 1**).

The review encompasses the following tasks, described in **Part 1** of this report:

1. National situation analysis of community health initiatives and other community-based activities
2. Community outreach assessment for North Darfur State
3. Community outreach assessment for Kassala State
4. CMAM-related community outreach assessment for Khartoum State

A national community outreach strategy was drafted based on the analysis of these experiences and is presented in **Part 2** of this report.

### **Box 1. CMAM Community Outreach Terminology**

**Community participation or involvement** refers to the community's active involvement in planning, implementing, and monitoring CMAM services.

**Community outreach** is the overarching term for community assessment, community participation or involvement, community screening for early case-finding and referral of children with severe acute malnutrition, home visits to follow up with problem cases, and health and nutrition education.

**Community outreach worker** is used as an umbrella term for various state ministries of health and nongovernmental organization staff involved in extension work (e.g., community health workers) and for volunteers involved in community outreach activities.

## **PART 1. COMMUNITY OUTREACH REVIEW**

### **1. National Situation Analysis of Community Health Initiatives and Other Community-Based Activities**

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This situation analysis details the community health initiatives being implemented in Sudan.

#### **1.1 Method**

1. Review of key documents, including policies, plans, strategies, reports, and evaluations. (Note: All reasonable efforts were made to review source documents [e.g., external reviews/evaluations] that explore beneficiaries' perceptions of the projects).
2. Meetings with key individuals responsible for the various initiatives:
  - Community-Based Initiative (CBI)
  - Community Health Worker (CHW) Project
  - Reproductive Health (RH) Community-Based Maternal and Newborn Care (CMNBC) Project
  - Integrated Management of Childhood Illness (IMCI) – Community IMCI (C-IMCI)
  - Community Malaria Initiative (CMI)
  - Expanded Program on Immunization (EPI) Volunteer Initiative
  - Child-Friendly Community-Based Initiative (CFCI)
  - World Bank Community Development Fund (WB/CDF)
3. Through the meetings, the team:
  - Explored the current and planned coverage of policies, strategies, and initiatives
  - Identified successful community outreach projects and initiatives and explored factors contributing to this success
  - Analyzed strengths, weaknesses, opportunities, and threats (SWOT) of the initiative's organizational and institutional aspects
  - Identified how and where CMAM activities might link with various initiatives, as appropriate

#### **1.2 Community-Based Health Initiatives**

##### **1.2.1 Community-Based Initiative/FMOH and State Ministries of Health**

The CBI, a national initiative supported by the Federal Ministry of Health (FMOH) and the state ministries of health (SMOHs), is housed in the Health Systems Strengthening Department of the Primary Health Care Directorate. It was established in 1997 as the Basic Development Needs Project and initiated in two areas. The CBI is charged with improving the quality of health by increasing family income through small-scale household income-generating projects that are managed by the community. It has expanded over the past 10 years and now operates in 12 states (all except the three Darfur states), 22–27 localities (out of 134 localities), and 104 communities. An evaluation was conducted in 2008; however, the results of the evaluation were not available at the time of this review.

When a CBI is launched, a needs assessment is conducted, priorities are identified, and a plan is developed. Some CBIs have been set up and supported exclusively by the SMOH/CBI structure, while others have been set up by the FMOH in partnership with other organizations, which provide additional support to the SMOH/CBI.

State-level coordinators, usually from the SMOH team, are appointed to take responsibility for CBI in addition to their core duties; coordinators have been appointed in 11 of the 12 states. At the locality level, representatives from various sectors (e.g., health, water, agriculture) make up technical support teams for CBI.

At the community level, a community development committee (CDC) is elected to support CBI. Ideally, these committees should have male and female members, but in reality they are predominately male. At the community level, 2 cluster representatives (CRs) or family representatives (volunteers) are elected for each cluster of 10–20 households. CRs conduct health promotion and referral for all primary health care (PHC) components and keep basic records. Ideally, one male and one female CR would be elected in each area, but the majority of CRs are female.

State and locality health staff members are trained in the CBI approach. CDCs are trained in development and leadership skills, and CRs are trained in health promotion in relation to all PHC components.

The activity levels and effectiveness of the various CBIs vary considerably across the country. Interviewees cited the CBIs being conducted in River Nile, White Nile, North Kordofan, and South Kordofan states as being successful; some of these initiatives were established many years ago, others more recently.

According to the FMOH, an ideal CBI has these characteristics:

- Trained, functional CDCs and CRs
- Periodic needs assessment surveys
- An annual plan
- Regular collection of information
- Involvement of women in CDCs
- Community commitment and interest
- Ongoing supervision and mentoring of CDC and CRs
- Political commitment at locality and state level

**Table 1** lists the strengths and weaknesses of the CBI, according to the FMOH.

**Table 1. Community-Based Initiative Strengths and Weaknesses**

<b>Strengths</b>	<b>Weaknesses</b>
<ul style="list-style-type: none"> <li>• Community involvement</li> <li>• Linkages among community, localities, and states</li> <li>• Volunteer ethos</li> <li>• Community awareness (including in the traditionally more insular communities) of needs and rights, leading to proactive seeking of CBI support</li> <li>• CBI with FMOH structure and support</li> <li>• Partnerships with other community-based initiatives and organizations</li> </ul>	<ul style="list-style-type: none"> <li>• Poor supervision in some places</li> <li>• High CR turnover (female CRs leave when they get married)</li> <li>• Language barriers (need to train in different languages)</li> <li>• Limited female representation on CDCs</li> <li>• Variable functionality of CDCs despite well-defined role</li> <li>• Lack of integration with key FMOH interventions (e.g., C-IMCI, CMI, CFCI)</li> </ul>

Because many agencies are supporting the CBI with little or no coordination, collaboration, or communication, a partnership workshop was held in 2008 to bring together key agencies supporting community development, including UNICEF's CFCI and the United Nations (U.N.) Integrated Community and Rural Development Initiative. During the workshop, participants agreed on the need for much greater collaboration and resolved to work together to develop and adapt tools to facilitate integrated cross-sector community work and develop a joint plan for strategic expansion of the work. Participants agreed that collaborative interventions should be established in five areas to develop a model for integrated community development work. The proposed areas were Blue Nile, South Kordofan, Northern State, and two of the Darfur states (to be determined). A steering committee and several technical working groups were established to move the partnership consortium's work forward.

Shendi University was appointed as a focal institution for CBI training in community development and leadership. An 8-day training course was conducted in 2010 with trainers from other universities and other partner agencies for participants from FMOH Environmental Health and Tuberculosis (TB) Control Sections; the SMOHs (CBI state coordinators); and two national nongovernmental organizations (NGOs), OMAM and Youth Free from Malaria.

The CBI plans to expand activities to cover 96 of 134 localities over the next 2 years, reaching 60 percent coverage. In each locality, the CBI will be initiated in four villages. To do this, CBI will work closely with the two national NGOs as main partners to expand activities across the country. OMAM, which was established in June 2008, will appoint a coordinator in all states and each CBI locality. The role of the long-established Youth Free from Malaria is not yet clear.

The CBI will work with the FMOH's Environmental Health and TB Control Sections to support respective activities. The TB Control Section will orient and train volunteers for TB follow-up in all localities, while the Environmental Health Section will set up initial projects in two localities and six communities. The CBI will also work with other partners, including UNICEF, the World Bank, the International Fund for Agricultural Development (IFAD), and Nile Petroleum.

### **1.2.2 Community-Based Maternal and Newborn Care Project**

The RH Program is planning to initiate a CMNBC Project in Blue Nile and North Kordofan. Currently, the RH Program's policy is to train village midwives (VMWs) to take over provision of delivery services in the community from traditional birth attendants (TBAs). VMW coverage (number of localities with operational VMWs in place) is now 52 percent. VMWs are responsible for routine home visits after delivery, which are done daily for the first week after delivery, then once at 15, 30, and 40 days. Existing TBAs are being trained in health promotion, recognition of danger signs in pregnancy, and referral for emergency obstetric services.

A comprehensive CMNBC Project will be established in each state and will include:

- Provision of neonatal services by health providers (medical assistants or CHWs)
- Provision of maternal health services by VMWs
- Community-based referral using TBAs (if VMWs are not available, TBAs will also be trained in emergency obstetric skills)
- Social mobilization (e.g., community dialogue, establishment of community groups, celebration of national health days)
- Implementation of a social and behavior change communication (SBCC) strategy using CHPs to conduct home visits and focus group discussions at the community level (home visits will be made at least monthly throughout women's pregnancy and their infants' first year of life; health promotion will cover basic health education on such topics as key family practices, e.g., danger signs in pregnancy and postpartum, family planning, and neonatal care)

### **1.2.3 Community Integrated Management of Childhood Illness**

C-IMCI involves four levels: community, health facility, school, and mass media. The community component started in 2002, has gradually expanded, and is now being implemented in 15 states, 55 localities, and 126 communities. The FMOH/IMCI Section plans to expand C-IMCI activities over the next few years to reach 70 percent coverage (100 of 143 localities), with at least one "model community" providing C-IMCI in each locality. The "model community" will have an adequate number of trained, functional community health promoters (CHPs) for the population size.

Focal C-IMCI coordinators have been appointed in all states and localities. These coordinators have other responsibilities along with C-IMCI.

When a locality is selected for C-IMCI, a workshop is held at the locality level to select the community for implementation. Selection criteria include:

- High population
- High population of children under 5
- High morbidity in children under 5
- Health problems in the community
- Health facility implementing IMCI
- Trained community health volunteers (CHVs) in the locality

The community selects volunteers to be appointed as CHPs; each volunteer is responsible for 10–15 families. The selection criteria are literacy and residence within the community. Larger communities might have up to 40 trained, functional CHPs. The CHPs, most of whom are female, attend a 6-day course on promotion of the nine C-IMCI key family practices.<sup>1</sup> Following training, the CHPs are expected to make routine visits to each family at least once a month and more often if required. These visits are documented in monthly reports.

In each community, the CHPs select a leader to collect their monthly reports and submit them to the health facility. The CHPs are supervised by the health facility's medical assistant, along with the locality's focal C-IMCI coordinator, where such an officer exists. The medical assistant and/or focal C-IMCI coordinator holds monthly review meetings.

As yet, C-IMCI has not been evaluated, although a post-intervention Knowledge, Attitudes, and Practices survey was conducted in Gezira State (report was not available at the time of this review).

According to FMOH C-IMCI staff, the keys to a successful C-IMCI program are community commitment to the concept and its supporting activities and establishing C-IMCI focal points at the state and locality levels. **Table 2** lists key strengths and weaknesses of the C-IMCI program, according to the FMOH.

**Table 2. C-IMCI Key Strengths and Weaknesses**

<b>Strengths</b>	<b>Weaknesses</b>
<ul style="list-style-type: none"> <li>• Training materials</li> <li>• Training methodologies</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of supervision</li> <li>• Lack of sustainable support for CHPs</li> </ul>

### 1.2.4 Community Malaria Initiative

The CMI's aim is to provide home-based treatment of malaria for communities that are out of the reach of health facilities. It started as an initial program in one locality in South Kordofan State in 2006, with 20 volunteer malaria community assistants (MCAs) trained in community-based management of malaria. An evaluation carried out in 2007 recommended scaling up the initiative across the country. Now, the CMI operates in three more states—Kassala, North Kordofan, and Gedarf—and a total of four localities. An additional 150 community members have been trained so far.

The plan is to expand CMI across 12 Global Fund-supported states over the next 5 years (excluding Khartoum, River Nile, and Northern State). The number of localities and/or communities to be covered is not yet confirmed. The expansion might involve integrating other services in some places as appropriate, but the focus will remain on malaria prevention and treatment.

A state-level field supervisor and locality-level field assistants have been appointed in each state to support the project. These officials are full-time members of the PHC team who receive incentives for doing additional work for the CMI.

<sup>1</sup> The nine C-IMCI key family practices are: 1) exclusive breastfeeding; 2) complementary feeding; 3) adequate micronutrient intake, particularly of vitamin A and iron; 4) safe hygiene for disposal of feces and hand washing after defecation and before preparing meals or feeding children; 5) immunization; 6) use of insecticide-treated bednets; 7) feeding of the sick child; 8) recognizing danger signs and when to seek care from appropriate providers; and 9) antenatal care for pregnant women.

Under the CMI, MCAs/CHWs are selected based on nomination by community leaders, village residency, education, and literacy. While both men and women can be MCAs/CHWs, all volunteers except one were male.

In Gedarif, Kassala, and South Kordofan, MCAs/CHWs attended a 7-day training course on:

- Malaria control/SBCC
- Identification and treatment of uncomplicated malaria (for children, adults, and pregnant women)
- Identification of severe/complicated malaria and pre-referral treatment

After the training, the training team (national- and state-level officials) supervises the MCAs/CHWs and holds three monthly supervisory meetings.

In North Kordofan, the SMOH/Malaria Section collaborated with the IMCI Section to train MCAs/CHWs in malaria control and treatment as well as in treatment of pneumonia and otitis media. These MCAs/CHWs have other jobs; their CMI positions are considered voluntary. Drugs are provided for free, but there is a charge of 1 Sudanese *gineh* (SDG) for each consultation, which is considered a small compensation for the MCAs/CHWs so that they can travel to meetings and cover other job-related costs.

**Table 3** lists the CMI's strengths and weaknesses, according to staff.

**Table 3. CMI Strengths and Weaknesses**

<b>Strengths</b>	<b>Weaknesses</b>
<ul style="list-style-type: none"> <li>• Volunteer ethos—eagerness to serve (along with other main jobs)</li> <li>• Community encouragement of volunteers</li> <li>• Positive experience with integrating services in North Kordofan</li> <li>• Shared experience among states during training</li> <li>• Strong political will at all levels</li> </ul>	<ul style="list-style-type: none"> <li>• Volunteers might exceed their responsibilities and compromise other duties or quality</li> <li>• Delays in transporting drugs from state to locality to community (negative consequences)</li> <li>• Lack of sustainable funding for the project</li> </ul>

### 1.2.5 Expanded Program on Immunization Volunteer Initiative

The EPI employs paid vaccinators who are responsible for routine immunization of children and pregnant women in health facilities (static centers) and outreach sites linked to the health facilities, as well as through mobile teams sent to isolated areas. In some states vaccinators receive additional training, essentially on preventive nutrition, to conduct growth monitoring and nutrition education. The graduates of this training are considered integrated PHC cadres. This effort was initiated in some states with success, and the FMOH plans to bring it to scale.

The EPI routinely uses volunteers for polio and measles campaigns. Nationwide, the FMOH might use up to 40,000 volunteers for a campaign. These volunteers are selected from their own communities, ethnicities, and/or cultural backgrounds to facilitate communication to support outreach activities. They are recommended by local traditional leaders, but EPI managers at locality/administrative level make the final selection. EPI volunteers are trained for 1 day in communication skills and technical skills related to immunization. They work for 3 days and receive an allowance for meals and a daily incentive.

According to the FMOH and SMOH, the EPI Volunteer Initiative's weaknesses are:

- Repeat of volunteer selection and training for each campaign
- Volunteer training that is too limited for the volunteers to conduct other tasks that could be linked with the campaigns
- Relatively high cost of work

### **1.2.6 Child-Friendly Community-Based Initiative**

The CFCI evolved in 2003 from UNICEF's Child-Friendly Village Initiative, which was established in 1993. The main goals of the CFCI approach are coordination in sectoral service delivery, community empowerment, capacity building, community mobilization, and advocacy. Output objectives are to establish CDCs; improve key indicators (full immunization coverage of children under 1, skilled birth attendants and deliveries, primary school enrolment, and access to safe drinking water); and plan, manage, and sustain social services. The CFCI operates in 9 states (Blue Nile, Gedarif, Kassala, Red Sea, North Kordofan, South Kordofan, North Darfur, South Darfur, and West Darfur), 41 localities, and 700 communities, according to the UNICEF CFCI program manager in Khartoum. The states were selected based on vulnerability as determined by a set of social indicators; vulnerable localities and communities within the states were then identified for CFCI implementation.

The CFCI works in partnership with the selected communities. A CDC and a health subcommittee are established, and CHPs are selected in each community. UNICEF trains and mentors the committees and provides some basic supplies. However, there is no formal partnership mechanism to coordinate the CFCI at the state or locality levels.

### **1.2.7 World Bank Community Development Fund**

In some localities/communities, UNICEF and CFCI collaborate with the WB/CDF. The WB/CDF might provide funding for constructing facilities and training health cadres, with UNICEF and CFCI supporting some of the ongoing costs, such as drugs and other supplies. The WB/CDF operates in Blue Nile, North and South Kordofan, and Kassala.

## **1.3 Other NGO and FMOH/SMOH Community-Based Structures and Activities**

### **1.3.1 NGO-Supported Community Outreach Workers**

Many diverse NGOs support health and nutrition workers and volunteers in all 15 states in Sudan. It is essential that these networks be fully explored at state and locality levels as part of the community outreach assessment for development of a locality-specific strategy for community outreach for CMAM.

### **1.3.2 Sudanese Red Crescent**

The Sudanese Red Crescent (SRC) has branches in all states and a considerable number of active volunteers. In 2008, 15,000 SRC volunteers were working in the Khartoum peripheries with the displaced, underserved population, and more than 2,000 SRC volunteers were working in Darfur. Some volunteers receive financial incentives for work, while some might get food for work. Other volunteers are motivated by training and certificates. SRC health activities, conducted mostly by volunteers, include community-based first aid, PHC, and preventive and environmental health activities.

### **1.3.3 Nutrition Educators**

Nutrition educators are mainly assigned to primary health care units (PHCUs) and are responsible for preventive nutrition interventions at both facility and community levels. (Some nutrition educators work in the therapeutic feeding centers at hospitals.) Nutrition educators' employment status varies: In some states, they are full-time, paid staff members; in other states, they are volunteers, but do the same job as paid staff.

In recent years, nutrition educators have been trained by state nutrition staff. However, because there were no national curriculum and training guidelines, the training's content and length varied from state to state. Now, nutrition educators will be trained on the Essential Nutrition Package (ENP), a package of priority interventions/practices for mothers, infants, and young children with a proven high public health and nutritional impact.

Developed in 2008, the components of the ENP are:

- Promotion of maternal nutrition and child spacing
- Promotion of optimal infant and young child feeding and care practices (e.g., early and exclusive breastfeeding, optimal complementary feeding)
- Growth monitoring and referral to services
- Control of micronutrient deficiencies (promoting and providing supplementation, promoting food diversity and fortification)
- Promotion of immunization
- Promotion of optimal family nutrition and dietary diversity
- Promotion of optimal hygiene and sanitation

#### **1.3.4 Community Health Task Force**

The Community Health Task Force was established within the FMOH in 2008 to explore how best to scale up community health initiatives based on experience from a malaria initial project and C-IMCI and considering the roles of CHWs and CHPs. The task force has broad membership, including representatives from a variety of FMOH departments and sections (TB, Environmental Health, Malaria, Health Promotion, Mother and Child Health, Sudan National AIDS Program, and EPI).

#### **1.3.5 Community Health Workers and Health Promoters**

From 1978 to 1983, following Sudan's 1976 adoption of the PHC approach, the FMOH established more than 2,500 PHCUs and trained 2,500 CHWs to operate from these front-line health posts. The CHWs provided basic curative services, preventative services, and health education. They also provided services for nomadic communities. However, this initiative was not sustained. Many of the facilities were built by the communities and fell into disrepair, and there was no proper system to support the CHWs.

The Community Health Task Force developed a draft concept paper on expanding the CHW cadre. Sixty percent of the population lives in rural areas but is served by only 30 percent of the health personnel. Recognizing the limited coverage of health services because of this shortage of health care providers in rural areas—and the potential to expand health services rapidly by recruiting and training CHWs (who require 7 months of training as opposed to 3 years for nurses and 5 for doctors)—the task force proposed to revitalize the CHW cadre to help achieve the Millennium Development Goals in Sudan. The proposal includes training CHWs initially in five states in north Sudan—South Kordofan, South Darfur, Blue Nile, White Nile, and Senar—in a 7-month course conducted by each state's Health Training Academy.

In addition, under the auspices of the task force, a committee was appointed to develop a concept note on CHPs in Sudan. However, this task will be done as part of a wider effort to develop a health promotion strategy under the leadership of the FMOH director of health promotion. To date, no clear position or strategy on the role of CHPs in Sudan has been developed, other than what various FMOH sections developed for their respective program focus areas.

## **2. Community Outreach Assessment, North Darfur State**

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### **2.1 Method**

A community outreach assessment was conducted in North Darfur from August 15 to August 20, 2009. Meetings were held with SMOH and UNICEF staff to collect information on current CMAM activities and to confirm the work schedule during the course of the review.

In a series of program site visits, CMAM services were observed, and discussions and interviews were held with the following informants:

- Managers and clinical staff responsible for provision of CMAM services
- Community outreach workers (COWs)
- COW supervisors
- Community leaders
- Caregivers of children currently admitted to the CMAM program
- Caregivers of children not currently undergoing CMAM treatment

Visits were made to the following program sites:

- Abu Shok Camp – inpatient care, outpatient care, and community outreach activities
- Zam Zam Camp – outpatient care and community outreach activities
- Shahid Health Center in El Fasher town – outpatient care and community outreach activities
- El Fasher – inpatient care site in El Fasher town (brief visit only)

The assessment involved three tasks:

- Briefing and orientation on CMAM programs and community outreach activities
- Review of community outreach activities
- A participatory learning workshop for managers and senior staff who support CMAM services/programs

#### **2.1.1 Briefing and Orientation on CMAM Programs and Community Outreach Activities**

The review team met with key SMOH stakeholders and key implementing partners to:

- Get a briefing/general overview of CMAM service provision, supplementary feeding programs (SFPs), outpatient treatment (OPT), and inpatient treatment
- Explore the process and time frame for planning and establishing OPT services
- Explore community outreach activities and referral systems (e.g., use of volunteers for referral to SFP and OPT, use of house-to-house and/or community-level case-finding, and links with the Accelerated Child Survival Initiative [ACSI] and child health day campaigns)

For orientation purposes, the team visited inpatient care and outpatient care sites

#### **2.1.2 Review of Community Outreach Activities**

The review team was divided in two, and each subteam visited one area. The two areas—El Fasher town and Abu Shok Camp—were purposefully selected during discussions between the review team and state stakeholders. Focus group discussions and key informant interviews were conducted at each area, with prespecified topics and probe questions for the group discussions and set questions for the key informant interviews.

Focus group discussions were held with:

- CHWs/CHVs responsible for CMAM outreach
- Male and female community representatives, except for mothers/caregivers attending services

Key informant interviews were held with:

- Outpatient staff responsible for CMAM services (joint interview with two key staff per clinic/area)
- CHW/CHV supervisors or, if there was no supervisor, the person responsible for CHWs/CHVs
- Program beneficiaries (caregivers of children attending severe acute malnutrition [SAM] treatment programs)
- Caregivers of children with SAM who are not in a program
- Caregivers of healthy children
- Community leaders (joint interview with two community leaders per area)

### 2.1.3 Participatory Learning Workshop

The review team held a workshop in North Darfur to share operational experiences of CMAM community outreach among the three Darfur states and to glean lessons learned and promising practices on CMAM community mobilization and sensitization. Participants included managers and senior staff involved in supporting CMAM services/programs in North Darfur, the SMOH, and key implementing partners. A few key individuals from South and West Darfur were also invited to share the operational experience from the programs in those states.

## 2.2 Assessment Limitations

There was not enough time to analyze data from the program sites to triangulate health facility records and reports with COW reports and records, or to analyze the effectiveness of the outreach activities.

## 2.3 Findings

The three program sites are very different in the context of CMAM implementation.

1. **Abu Shok Camp.** CMAM services here have been established for some years. The camp was originally managed by an international NGO, Action contre la Faim (ACF) but is now managed by the SMOH with UNICEF support. COWs and a COW supervisor are employed full-time.
2. **Zam Zam Camp.** The camp has two parts: Old Zam Zam, where CMAM services have been operating since the camp was established in 2006, and New Zam Zam, where CMAM services have been operating since the camp was established in 2009. The camps are managed by an international NGO, Relief International (RI). COWs and a COW supervisor are employed full-time. The community outreach activity review was conducted in Old Zam Zam, where staff reported that they are establishing the same system used in New Zam Zam. Interviews with caregivers of children attending the program were held at New Zam Zam, as outpatient care was operating there on the day of the visit.
3. **Shahid Health Center.** The center is a government facility managed by the SMOH. Outpatient care sites were established at the end of 2008. Outreach work is conducted one day a week by staff working in the health facility.

**Table 4** lists the outreach activities (screening and referral, follow-up, tracking children who default, and health and nutrition education) at the three sites.

**Table 4. Outreach Activities in North Darfur State**

	<b>Abu Shok Camp (CMAM)</b>	<b>Old Zam Zam Camp (outpatient care)</b>	<b>Shahid Health Center (outpatient care)</b>
<b>Number and gender of COWs</b>	12 COWs (predominately female), 1 supervisor	16 COWs (predominately female), 1 supervisor	7 health care providers (trained staff, 5 female and 1 male); nutritionist, nutrition educator, health visitor, 3 midwives, 1 medical assistant, no supervisor
<b>Cadre and employment status</b>	COWs paid, full-time	COWs paid, full-time	Nutritionist, health visitor, and midwives (full-time staff); conduct home visits 1 day per week
<b>Coverage of COW activity</b>	COWs work from 6 health clinics across the camps, but this does NOT cover the camp	Camp divided into sections with 100–150 houses each; COWs work in pairs to cover allocated section(s); each house visited once or sometimes twice a month	Home visits are done 1 day per week; team works together to cover area; in 7 months, the team covered 8 of 22 sections in catchment area
<b>Activity</b>	COWs screen children attending the various health clinics, using mid-upper arm circumference (MUAC) and weight-for-height (WFH) (in some clinics)	Home visits – screening and referral for CMAM, medical care and vaccinations, health and nutrition education, and follow-up of defaulters/non-responders; weekly home visits to all children under treatment Periodic community-level health education; clinic work ,such as assisting with measuring, distribution of RUTF, and health and nutrition education	Home visits – screening and referral for CMAM, medical care and vaccinations, health and nutrition education, and follow-up of defaulters/non-responders
<b>COW referral process</b>	Pre-printed referral to clinic for measurement of MUAC and WFH	Pre-printed referral to clinic	Handwritten referral to clinic (discarded at health center)
<b>Analysis of beneficiary referral</b>	Although data available, the number of beneficiaries referred by COWs is not compared with the number who self-refer	Although data are available on the patient record, the number of beneficiaries referred by COWs is not compared with the number who self-refer	Although data available on patient record, the number of beneficiaries referred by COWs is not compared with the number who self-refer
<b>Records</b>	COWs complete daily/weekly tally sheets on number of children screened and number referred to outpatient care; weekly reports are submitted to the supervisor, but there is no feedback on referrals	COWs complete daily tally sheets on number of homes visited, children screened, and referrals made; weekly reports are submitted to the supervisor, who checks referrals against facility records and gives feedback on referrals	No records of home visits made; no handwritten referrals are kept
<b>Community leader role</b>	Active in early stages of program for awareness-raising and sensitization on CMAM services and facilitation of home visits; no involvement currently	Active in early stages of program for awareness-raising and sensitization on CMAM services generally and facilitation of home visits; ongoing involvement to meet with COWs monthly; community leader name (sheik) added on referral form so the leader can be contacted if problem occurs	Active in early stages of program for awareness-raising and sensitization on CMAM services and facilitation of home visits; no involvement currently
<b>Actual coverage of CMAM services</b>	Although data available, no analysis of where beneficiaries are from	Although data available, no analysis of where beneficiaries are from	Staff report that 25% of beneficiaries come from outside the catchment area; although data available, no analysis of where beneficiaries are from within the catchment area; staff feel that services reach only a small proportion of children who need services and that many more children could/should be registered

**Table 5** lists the strengths and weaknesses of the community outreach activity in Abu Shok Camp, Old Zam Zam Camp, and the Shahid area of El Fasher town.

**Table 5. Strengths and Weaknesses of Community Outreach in North Darfur**

Strengths and Opportunities	Weaknesses and Threats
<b>Abu Shok Camp</b>	
<ul style="list-style-type: none"> <li>• COWs are highly educated and well trained.</li> <li>• Facility staff's technical knowledge and capacity are excellent.</li> <li>• Community leaders are informed about malnutrition and CMAM services and ready to facilitate further, including helping to engage traditional practitioners.</li> <li>• COWs know the traditional healers and (previously) involved them in the program.</li> <li>• Community awareness about services is good, with a high number of screening and referrals; although there also are late presentations.</li> </ul>	<ul style="list-style-type: none"> <li>• There is no active case-finding at community level. Screening is conducted by the COWs, who now base themselves in six health facilities around the camp. This will pick up children presenting as ill but misses early detection and referral, as evidenced by the presence of children presenting late for treatment (two self-referrals were admitted to inpatient care on the day of the review).</li> <li>• Follow-up of defaulters/non-responders is no longer done.</li> <li>• COWs are not formally supervised.</li> <li>• The effectiveness of the current strategy (screening from health facilities) is not compared with the previous strategy (house-to-house screening).</li> <li>• The CMAM services' actual geographical coverage has not been analyzed (i.e., mapping/listing by area where the children attending treatment live).</li> <li>• Community leaders are not involved in CMAM-related activities.</li> <li>• Staff are demotivated and unhappy with changes in employment conditions (reduced salaries) since ACF handed the program over to the SMOH.</li> <li>• COWs have no health and nutrition education materials.</li> <li>• COWs educate caregivers at outpatient care mainly on hygiene and sanitation, with little information about good nutrition, according to interviews with caregivers of children in the program.</li> </ul>

The SMOH and UNICEF staff did not know that COWs no longer conducted home visits for screening and referral or for follow-up of defaulters/non-responders. They indicated that the review team had been misinformed. However, the information about the home visits came from the COWs, the COW supervisor, the medical assistant, the doctor working at the health facility, and the beneficiaries. Of seven caregivers interviewed (three exit interviews at outpatient care and four interviews at inpatient care sites), one was a self-referral and six were referrals from two of the clinics where COWs are based.

Strengths and Opportunities	Weaknesses and Threats
<b>Old Zam Zam Camp</b>	
<ul style="list-style-type: none"> <li>• Camp is well organized with pairs of COWs responsible for a section of 100–150 houses.</li> <li>• COWs do comprehensive home visits (screening and referral for CMAM, other medical care and vaccination as required, and health and nutrition education).</li> <li>• COWs have links with and involve traditional healers in the program; some traditional healers refer children to CMAM services.</li> <li>• Community leaders are involved in outreach work; monthly meetings are held to facilitate home visits; the sheik’s name is on the referral card, so the sheik can be contacted to help with follow-up on defaulters and problem cases. (Sheiks are village leaders who are part of the regional government structure in Sudan. They allocate land to farmers and settle disputes among village groups.)</li> <li>• COWs have weekly meetings with supervisor to review referrals and other work.</li> <li>• Community awareness about CMAM services is generally good.</li> </ul>	<ul style="list-style-type: none"> <li>• The COW supervisor has many other tasks and rarely goes out to supervise COWs.</li> <li>• COWs have no health and nutrition education materials.</li> <li>• The CMAM services’ actual geographical coverage is not analyzed (i.e., mapping/listing by area where the children attending treatment live).</li> <li>• Some COWs are dissatisfied because they are paid at two rates: 300 SDG for those employed when ACF managed the program and 200 SDG for new COWs after the SMOH took over. COWs also feel they are not paid as much as COWs in other areas.</li> </ul>
<b>Shahid Health Center Area, El Fasher Town</b>	
<ul style="list-style-type: none"> <li>• Home visits are conducted by well-trained facility staff as part of routine work; quality of screening is assumed to be good, and there is some sustainability.</li> <li>• Community leaders were oriented on CMAM and involved in awareness-raising and screening when services were established (but now are no longer involved).</li> </ul>	<ul style="list-style-type: none"> <li>• The team does active case-finding only 1 day a week.</li> <li>• Use of house-to-house visits means coverage is low. In 7 months, the team covered only 8 of 22 sections in the health center’s catchment area.</li> <li>• There are no records of outreach work.</li> <li>• While there is no analysis of the impact/effectiveness of outreach work, staff member know that many children are missed because of the large number of homes and limited staff available to conduct the visits.</li> <li>• There are no health and nutrition education materials for outreach work.</li> <li>• Community leaders are not involved in CMAM-related activities.</li> <li>• Because 25% of admissions are from Zam Zam or other rural areas outside the catchment area, it is not feasible to follow up with these children if they default.</li> </ul>

## 2.4 Discussion and Recommendations

### 2.4.1 Role of Community Leaders

In Abu Shok Camp and the Shahid area, the role of community leaders in supporting CMAM is currently limited. In both areas, the community leaders were involved in the early stages of establishing the program (sensitization and awareness-raising about services) and facilitation of home visits. Currently, the community leaders are not actively involved in the program in either area. However, the community

leaders in Abu Shok stated that they know the signs and symptoms of malnutrition and the CMAM admission criteria. The leaders said that if they saw an obviously malnourished child, they would ask whether the child attended the program. If the child was not in the program, they would bring or send the child for treatment (opportunistic case-finding).

In Old Zam Zam Camp, community leaders are much more active in supporting CMAM activities, specifically outreach work. The leaders attend monthly meetings with the COWs and their supervisor to review activities and address problems. Generally, the leaders facilitate home visits through awareness-raising and sensitization in the community. The COWs register the community leader's name on the referral forms so that the leader can be contacted to assist if a beneficiary defaults, moves, or refuses treatment. The community leaders are also involved in COW selection.

**Recommendation:** Encourage the sustained, active engagement of community leaders in supporting CMAM services and facilitate this engagement beyond the planning stage. Community leaders can continue to play a key role in sensitization and awareness-raising, facilitation of screening and referrals, and ongoing monitoring and adaptation of CMAM activities, including the planning of sale up of services.

## 2.4.2 Strategies for Active Case-Finding

The areas reviewed use two different strategies for active case-finding and referral of children with SAM. In the Zam Zam camps and Shahid, home visits are used. In the Abu Shok catchment area, screening and referral are done at health facilities.

New Zam Zam's use of house-to-house visits is certainly an appropriate strategy, given that the camp was established only 6 months before this report was written. New arrivals are still going to the camp, and many don't know about CMAM services. The general situation in the camp is still very poor. COWs are available to conduct home visits. Of the five caregivers of children attending outpatient care interviewed, four were referred through a COW home visit. Three of the caregivers lived near the facility, while two lived more than half an hour's walk from the center.

Old Zam Zam's use of home visits is also appropriate and feasible. But as the situation is somewhat stabilized and the population is familiar with CMAM services, it would be possible to consider an alternative strategy, such as community-level screening by regularly gathering the population at central points for screening and referral.

In the Shahid area, screening coverage is very low because of the large number of houses and limited staff available to conduct home visits. In 7 months, the team covered only 8 of the 22 sections in the health center's catchment area. Staff members are aware that they are missing many children. "There could be many more children admitted for treatment of SAM if we were able to do more screening," one staff member said.

**Recommendation:** Consider community-level screening and referral to reach many more children. However, this would require raising community awareness before screening begins and increasing the health facility's capacity to provide CMAM services for the additional children. Therapeutic treatment would probably be needed more than one day a week.

Abu Shok Camp's facility-level screening picks up children who present to the six health facilities as ill, but it misses early detection and children who are treated by traditional practitioners. It is not clear how health facility-level screening was chosen or whether the strategy's impact has been evaluated or analyzed.

During the review, the COW supervisor said the health facility-based strategy was not covering the whole camp. The community leaders stated that although they did not have definitive proof, they felt that some children who should be admitted were being missed. Of the seven caregivers of children at the outpatient care interviewed, five were referred by COWs based in the six health facilities and two were self-referrals. What is worrisome is that the two children who were self-referrals required admission to inpatient care.

**Recommendation:** Switch the case-finding strategy to either routine community screening, in which children are periodically gathered at a central point for screening and referral, or to house-to-house screening. Integrate screening and referral into sick-child consultation procedures in the camp's six health facilities. Orient the relevant staff members from each facility in CMAM and train them to measure MUAC and refer children who meet the admission criteria for treatment.

### 2.4.3 Follow-Up Home Visits

In the Zam Zam camps, COWs make weekly follow-up home visits to *all* children registered in outpatient care to check their progress and give their mothers health education and support.

In the Shahid area, staff conduct follow-up home visits to children living in the catchment area who have defaulted or do not respond to treatment. If the children default, caregivers are encouraged to bring them back for treatment. If the children do not respond to treatment, caregivers are counseled on child feeding and care. Follow-up visits are not made to children living outside the catchment area.

In Abu Shok Camp, COWs previously made follow-up visits to children who defaulted or did not respond to treatment, but these visits have been discontinued.

**Recommendation:** COWs should make follow-up home visits to children who have defaulted or do not respond to treatment in outpatient care's catchment area. Weekly home visits for children in outpatient care are encouraged to check progress and give caregivers counseling and support.

### 2.4.4 Traditional Practices to Treat Acute Malnutrition

Across the program sites, a variety of traditional healers or family members commonly use traditional practices, such as cutting the uvula, removing teeth, applying herbs, and tying Darfur rope around children's waists. Other common practices are having children wear *hijabat*,<sup>2</sup> inhaling *bakhrat*,<sup>3</sup> and drinking *mihaiya* or *fekki* water.<sup>4</sup> In Abu Shok and Zam Zam, it was reported that edema is believed to be air under the skin, and so the skin is burned to release the air.

The common use of traditional practices to treat malnutrition delays referral for treatment at health facilities. Children might be referred only when the traditional practice is clearly not working and the children's conditions are deteriorating. In some situations, children might receive traditional and conventional treatment at the same time.

Abu Shok Camp has many traditional healers, most specializing in one practice or another, according to community leaders. The leaders believe that the use of traditional practices has decreased over the past few years but is still common. They know all the traditional healers and are willing to contact them and get

<sup>2</sup> Quranic verses are written on white paper by a man of religion. The paper is then wrapped with leather or other material and worn around the neck or the arm. Wearing these wrapped verses—*Hijabat*—is believed to protect the wearer from evil, magic, and disease.

<sup>3</sup> With *bakhrat*, Quranic verses are also written on white paper by a man of religion. The papers are then burned in fire, and the resultant smoke is inhaled by someone covered by a blanket or bed sheet. *Bakhra* is commonly used to treat people suffering from mental issues.

<sup>4</sup> In this practice, Quranic verses are written on carved, flat wood. The verses are washed out of the wood with water, which is then drunk. The resulting liquid, called *mihaiya* or *fekki* water, is also used to treat various illnesses.

them to come to a meeting to discuss the situation with the health facility. Both staff and managers wish to do this. The COWs stated that they used to discuss malnutrition with the traditional healers and ask them to help identify malnourished children to refer for treatment. However, this work has stopped, and many caregivers now take their children to traditional healers before bringing them to health facilities. This results in many late presentations when traditional healing has failed. During the review, 3 of the 50 children in the camp's inpatient care site underwent extensive skin burning by traditional practitioners.

In Old Zam Zam, community leaders, COWs, and community members all indicated that a variety of traditional practices are widely available and commonly used. However, they generally felt that traditional practices are decreasing as a result of health education, noting that "even older people are starting to change behavior." COWs reported that some people still use traditional practices for the treatment of malnutrition, but when children with malnutrition are identified during home visits, they are referred to the health facility for treatment. The caregivers are advised and usually comply and eventually bring the children in for treatment. The COWs also report that they are discussing malnutrition and CMAM services with the traditional healers and that some have started to refer malnourished children to the health facilities for medical treatment.

In New Zam Zam, according to exit interviews with five caregivers of children attending outpatient care, four caregivers said that the children had received traditional treatment for malnutrition and that the treatment(s) had continued after admission to outpatient care. Treatments given were *fekki* water and burning of the skin.

Staff members in the Shahid area were aware that traditional practices were commonly used to treat malnutrition and other childhood illnesses and said that this resulted in children presenting to the health facility late, after complications developed. The staff stated that while most people outside El Fasher town believed in traditional healing, ideas and beliefs in the town were changing to some extent, partly because of health education.

**Recommendation:** In each program area, engage strategically with traditional practitioners to develop trust among the practitioners, COWs, and health facility staff to facilitate early referral of children with SAM.

#### 2.4.5 Health and Nutrition Education

COWs in Abu Shok Camp conduct health education sessions at the six health facilities where they are based. A few COWs are based at outpatient care sites and conduct health and nutrition education during the sessions. A few of the program beneficiaries interviewed said that the health and nutrition education focuses more on hygiene and sanitation than on optimal nutrition practices. The caregivers were more knowledgeable about vaccinations than about malnutrition.

COWs in the Zam Zam camps provide health and nutrition education during home visits for screening and weekly follow-up visits. Periodically, they conduct sessions at the community level. The COWs also conduct sessions at the facility during outpatient care sessions.

Shahid staff provides health and nutrition education during home visits for screening and referral. But because the teams are supposed to cover 100 houses a day, there is little time for quality health and nutrition education in every house. The staff members also conduct education sessions during outpatient care sessions and during follow-up visits for defaulters and non-responders.

Discussions with informants from the various areas indicated some increased awareness about malnutrition and CMAM services and as well as some change of attitudes and behaviors related to nutrition practices. However, more work clearly must be done to address ongoing harmful traditional practices and poor infant feeding and care practices. The team had the following observations:

- Traditional practitioners were reportedly treating fewer cases of malnutrition in children in Abu Shok, Old Zam Zam, and the Shahid area than before the start of CMAM implementation, but the use of traditional practices continues and still causes problems. Three children had severe scars from traditional burning in the Abu Shok inpatient care site. Four out of five caregivers brought their children to traditional practitioners in New Zam Zam.
- Community members and community leaders in Old Zam Zam knew about the causes, signs, and symptoms of malnutrition and about CMAM services and optimal infant and young child feeding (IYCF) practices. In Abu Shok they were knowledgeable about malnutrition and CMAM services. In the Shahid area, they had some awareness of malnutrition and CMAM services, but their IYCF practices indicated a need for more health and nutrition education.

**Recommendation:** Source appropriate health and nutrition education materials and make them available to staff conducting outreach work. While there has clearly been progress in behavior change, it is difficult to quantify this progress. Conduct a study to determine actual knowledge, attitude, and practices regarding key behaviors affecting infant nutrition status to help prioritize future health and nutrition education.

- COWs in Abu Shok Camp complete daily tally sheets, which record the number of children screened and referrals made, the number of follow-up visits, the number of community and facility health and nutrition sessions conducted, and the number of caregivers who attended. Weekly and monthly reports are then submitted to the supervisor.
- COWs in the Zam Zam camps complete daily tally sheets of the number of home visits and referrals made. Weekly reports are then submitted to the supervisor.
- In the Shahid area, the team conducting community outreach does not record the number of homes visited or referrals made. When beneficiaries are referred for treatment, they are given a handwritten referral slip that is discarded on admission to health facility.

**Recommendation:** Shahid staff should keep records of outreach activity to help with supervision and monitoring of the CMAM program.

#### 2.4.6 Effectiveness of Outreach Work

In each area, there were data that could be used to monitor the effectiveness of outreach work. However, there was no monitoring or analysis of the COWs' effectiveness (i.e., number of self-referrals versus COW referrals, number of late referrals, or *actual* geographical coverage of CMAM services) in any of the program areas.

**Recommendation:** Available data on community outreach reports should be analyzed and used to monitor the effectiveness of outreach work.

#### 2.4.7 Supervision of Outreach Work

Supervision of outreach work is weak in each area. Even where supervisors are appointed, there is little evidence of structured COW supervision.

In Abu Shok Camp, the supervisor appears to be in regular/daily contact with the COWs. The supervisor also contacts the COWs if there are problems to address. However, the supervisor does not observe COW activity or provide feedback on COW referrals. In addition, there are no regular COW meetings.

In Old Zam Zam Camp, the supervisor reported that, because he has many other tasks in the health facility, he rarely visits or accompanies the COWs on community visits. However, he holds weekly meetings with the COWs to discuss general issues, address problems, and give feedback on referrals.

As noted earlier, COWs in Abu Shok and Zam Zam complete daily tally sheets and submit weekly and monthly reports to the supervisors.

In the Shahid area, a team of health facility staff, including the nutritionist, conducts outreach work. Some of the staff are relatively senior. The nutritionist, who is also responsible for conducting outpatient care at the health center, directs the COWs.

**Recommendation:** Strengthen supervision of outreach work, both supportive supervision of day-to-day COW activities and broader supervision and support of COWs from management, which should look at the more strategic issues, such as which strategy, approach, or outreach priorities to focus on.

#### 2.4.8 Training of Outreach Staff

COWs at the Zam Zam and Abu Shok camps received pre-employment and refresher training from RI and ACF, respectively, in basic nutrition and the specific outreach activity. Staff at the Shahid center received a 3-day orientation in CMAM, which included outreach activities. However, these training courses were not standardized. In June 2009, the SMOH and UNICEF conducted refresher training for Abu Shok COWs on general nutrition and treatment of SAM. The training did not include CMAM-related outreach activities.

**Recommendation:** Provide all staff responsible for CMAM-related outreach (including COWs and facility staff who are also responsible for outreach) with appropriate training in line with their duties.

#### 2.4.9 Staff Salary Scales and Responsibilities

NGO salary levels for COWs were very high for the cadre's qualifications/classifications and responsibilities. These salary scales are absolutely not sustainable when NGOs leave and donor funding is no longer available. ACF COWs were paid a salary of 720 SDG, but senior SMOH staff members receive less. When ACF withdrew from Abu Shok and the SMOH took over management of CMAM services there, COW salaries were reduced, along with salaries of all other health cadres working in the facility. This has caused major dissatisfaction among the staff and is one reason COWs no longer do home visits. Zam Zam Camp staff also complained that they are paid less than COWs in other areas (presumably referring to Abu Shok Camp).

**Recommendation:** Although it is not easy to reduce salaries of current staff, the SMOH and UNICEF should work toward establishing a standard salary scale for COWs and other health cadres.

#### 2.4.10 SMOH and UNICEF Support for Expansion of CMAM Services in El Fasher

The SMOH plans to expand CMAM services to additional facilities around El Fasher town and in some rural areas.

**Recommendation:** The SMOH and UNICEF should provide the required level of management support and supervision needed for CMAM services generally and for the outreach activity in the new areas and the areas where CMAM services already exist. Routine supportive supervision should be built into the operational work plan and supported with the required resources. Standardized reporting format(s) for all CMAM activities, including outreach, should be used to facilitate supervision and monitoring of work. These forms will be available in the forthcoming *Sudan Interim Manual for CMAM*.

### 3. Community Outreach Assessment in Shimal el Delta Locality, Kassala State

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In Kassala, which the FMOH selected as an Early Implementation State for scale-up of CMAM services, the assessment was done at the state and locality levels. The Kassala assessment took place August 22–26, 2009 (including travel time). The assessment team spent 1 day in Kassala town, meeting briefly with the UNICEF health program officer and program representative, and spending the rest of the day with staff in the SMOH office.

SMOH staff stated that Shimal el Delta Locality was selected for the assessment because Samaritan's Purse will establish CMAM services in Telkoot Locality. A recent Kassala survey found that malnutrition in Shimal el Delta was high: SAM prevalence was 6.8 percent and moderate acute malnutrition prevalence was 21.9 percent. After selection of Shimal el Delta Locality, the SMOH briefed the team on the various community initiatives in Kassala and helped prepare for the visit to Shimal el Delta.

#### 3.1 Method

##### 3.1.1 Activities at the State Level

The SMOH briefed the team on the state's current nutrition status. The discussions covered:

- An overview of global acute malnutrition (GAM), SAM, and areas of particular vulnerability/need
- Specific local infant and young child feeding and care practices that impair nutrition
- The state's various ethnic groups and different infant and young child feeding and care practices that impair nutrition
- Health services and IMCI coverage
- Use of health services and barriers to care
- Preventive nutrition services and coverage
- Number and allocation of nutrition educators in the state
- Number and allocation of integrated PHC workers and/or vaccinators in the state
- Therapeutic feeding programs and SFP coverage and issues
- International agencies supporting health and nutrition services
- Community involvement in health and nutrition issues in the state, including:
  - Health committees at various levels
  - Organizations engaged in health and nutrition
  - Number, mandate, and coverage of volunteers

##### 3.1.2 Activities at the Locality Level

Considerations for selection of the first locality for CMAM implementation included:

- Active community leaders who are interested in and committed to supporting the establishment of CMAM services and community outreach
- CBI or CFCI locality management structures in situ and functional
- Already trained CHWs and/or other health volunteers in the locality and potentially available to take on outreach activities
- Well-established and functioning health facilities, ideally with IMCI-trained staff
- Need for establishment of services in terms of SAM rates

After the SMOH briefing and confirmation of the selection of the first locality for implementation of CMAM services, a 2-day community assessment was conducted in Shimal el Delta to gain an understanding of:

- Community perceptions about malnutrition and treatment of malnutrition, as well as potential barriers to using CMAM services
- The community leadership structure and commitment to establishing CMAM and supporting community outreach
- COWs and volunteers operating in the locality who could be trained for community outreach

These issues were explored through consultation with health facility staff, community leaders, health committee representatives, caregivers, and volunteers in Wagar, the locality's capital, and in the Hadalya area in Shimal El Delta. The team also met with representatives of Samaritan's Purse, the NGO that manages CMAM activities in Hamash Karob Locality and that plans to establish CMAM in Telkoot Locality, and GOAL, the NGO that manages malnutrition prevention activities in Kassala, Aroma, Shimal el Delta, and Garub Kassala localities and that plans to start CMAM activities in Kassala and Aroma localities.

### 3.2 Assessment Limitations

While the consultation conducted in Shimal el Delta provided valid information, time limitations did not allow for enough interviews or discussions with informants to provide a complete picture of the situation across the locality. Thus, it is necessary to further analyze community knowledge, beliefs, and practices, and to map activities of agencies and the presence of volunteers in other parts of the locality.

**Recommendation:** Revisit Kassala State to further analyze the situation and use the information for refining the community outreach strategy when establishing CMAM services in Shimal El Delta and Kassala State.

### 3.3 Findings at the State Level

#### 3.3.1 Population Groups

Kassala State has a population of 1.8 million in 11 administrative localities. The state's peoples include the Beja (made up of Hedendawa, Beni Armi, and another subtribe), Rashida, Hausa (from Nigeria). There are also large refugee populations from Ethiopia and Eritrea who arrived in the 1980s, along with many second- and third-generation refugees. Reportedly, 62,000 internally displaced persons (IDPs) live in 12 camps due to conflict, although some are now integrating into neighboring communities.

#### 3.3.2 Malnutrition Rates

Malnutrition rates are high in Kassala State. SAM and GAM rates rose from 2.8 percent and 14.1 percent, respectively, in 2007, to 3.5 percent and 15.1 percent, respectively, according to a February 2009 survey. Lack of or erratic rain has affected access to food, which, in turn, has worsened the food security situation, and rising food prices have worsened the state's deteriorating nutritional status.

#### 3.3.3 Infant and Young Child Feeding and Care Practices

Poor infant and young child feeding and care practices contribute to malnutrition in the state. Some are practiced among all groups, while others are practiced by only one or a few groups. The 2009 survey showed that 97 percent of infants were breastfed, but only 32.8 percent were exclusively breastfed up to age 6 months. Early introduction of complementary foods is widely practiced. The Rashida tribe commonly starts to bottle-feed infants immediately after birth.

Women's poor diet during pregnancy is recognized as a major contributor to the poor nutritional status of infants and children. This poor diet might result from lack of money for food or from traditional practices. For example, Hedendawa women traditionally do not eat eggs during pregnancy so that their infant's birth weight will be lower and delivery will be easier, especially for women who have undergone pharaonic circumcision. The Hedendawa also believe that it is bad luck to have children weighed as this attracts the "evil eye."

Traditional healing practices are widely used to treat malnutrition and other childhood illnesses. These practices include cutting or burning skin, traditional medicines, and *hija* (wearing mixed clay and words

from the Quran in a small amulet to keep evil spirits away). Sometimes traditional healing practices are used along with conventional treatment. The following factors contribute to the widespread use of traditional healing practices.

- Because health care services are still not free for children under 5 years, it might be cheaper to go to traditional healers. They might require payment, but are reportedly more flexible; they might accept in-kind or late payments.
- MOH facilities might not have required drugs in stock.
- Many rural populations must travel long distances to MOH facilities and might incur costs for travel and time away from work. The Hendedawa practice of having the extended family accompany a patient for the duration of treatment means additional expense.
- MOH staff members are mainly male, which discourages some women from some communities, such as some sections of the Hendedawa, to come to the facility.
- Some people, particularly the Hendedawa, believe it is bad for women to go to a hospital, so they try other options before conventional treatment.

One of the Beja tribe's cultural traditions is drinking coffee several times a day. Families often end up spending scarce resources on coffee—along with other expensive items, such as sugar and charcoal—rather than other basic needs. This impairs food diversity and utilization/consumption for the household members, which in particular affects access to quality foods for young children.

### 3.3.4 Organizations Working in Health and Nutrition in Kassala State

A variety of United Nations and international agencies and local NGOs support health and nutrition activities in Kassala State. Several community-based organizations (CBOs) also operate in the state (see **Table 6**). The SMOH office provided a broad picture of what each organization was doing, but it was unclear in which or how many localities the agencies were working. In addition, some of the information the SMOH provided was outdated. For example, some agencies had left localities or activities had stopped. Changes in locality administrative boundaries also contributed to the information gap.

**Table 6. Organizations and Their Roles in Kassala State**

Organization	Role
Community-Based Initiative (CBI)	Operates in one community in Aroma Locality.
DELTA	Supports training of health leaders in Shimal el Delta and other localities.
Eastern Development Programme	Supports construction of health facilities and water/sanitation activities.
GOAL	Supports preventive nutrition activities in parts of Kassala, Aroma, Shimal el Delta, and Garub Kassala Localities; proposes to establish CMAM services in parts of Kassala and Aroma Localities.
International Fund for Agricultural Development (IFAD)	Concentrates on agriculture and supports training of extension workers in Kassala, Telkoot, Aroma, and Shimal el Delta Localities.
Plan Sudan	Supports PHC (health, nutrition, water) in Shimal Eel Delta and other localities.
Samaritan's Purse	Supports CMAM services in Hamash Karob Locality; plans to establish CMAM services in Telkoot Locality.
Sudanese Red Crescent (SRC)	Supports emergency health and SFPs in Kassala, Ref Helfa, Hamash Karob, Telkoot, Hasamal Gurba, and Wedalhe Localities.
Sudanese Association for Breastfeeding Actions (SABA) committees	Works in localities across the state; level and type of activity vary between states.

Organization	Role
U.S. Centers for Disease Control and Prevention, World Bank, and Government of Sudan	Support construction of health facilities, staff training, and capacity development in Kassala, Aroma, Hamash Karob, and other localities.
UNICEF	Supports CFCI activities in 70 communities in 5 localities and SMOH health and nutrition activities across the district with supplies and staff training.
United Nations High Commissioner for Refugees (UNHCR)	Is responsible for health and nutrition in refugee camps; also recently established CMAM services to replace therapeutic feeding centers in camps in Kassala, Hasamal Gurba, and Wedalhe Localities.
Well-Being Committees (under the auspices of the Women's Union Association)	Widely established across Kassala Locality, with varying activity levels.
World Food Programme (WFP)	Supports supplementary feeding across the state as well as TB patients and their families.

**Recommendation:** While planning CMAM services, identify what each agency is doing in each locality to engage them appropriately as services are established.

### 3.4 Findings at the Locality Level: Shimal el Delta

Shimal el Delta is populated almost exclusively by the Hedendawa ethnic group. While the population is predominately settled, there are also nomadic groups. These groups generally move around within the locality. In addition, the locality has IDPs, also from the Hedendawa tribe, who moved from Hamash Karob due to conflict.

The information below is based on consultations with community health committee members, other community leaders, health facility staff, groups of women in the community, and two volunteers during visits to Wagar town and Hadalya village.

#### 3.4.1 Community Knowledge, Beliefs, and Practices about Childhood Malnutrition and Ill Health

##### *Definition of Malnutrition*

There are no local terms for wasting or edema in the area. Malnutrition is generally associated with anemia (*yannatee*) and diarrhea. There did not appear to be a clear differentiation between under-5-year malnutrition and general illness in the area.

##### *Signs and Symptoms of Malnutrition*

Given this lack of definition, community awareness of the signs and symptoms of malnutrition varied. Some respondent groups knew that edema on legs and face, weight loss, and general wasting were signs and symptoms of malnutrition, while others did not.

##### *Causes of Malnutrition*

The community appeared to be fairly knowledgeable about the causes of malnutrition in infants and children. They cited bottle feeding; poor hygiene; poor dietary intake among children and pregnant women; and complications from illnesses, including vomiting and diarrhea. The community groups interviewed linked poverty with malnutrition; one person said, "People do not have the money to buy good health." The groups also saw the link between women's and children's nutritional status. "Women are not healthy, so the children are not healthy," one person explained.

**Recommendation:** Ensure that community sensitization and ongoing nutrition education across the locality include clear information on the signs and symptoms of a malnourished child.

### Box 2. Establishing CMAM in Hamash Karob Locality

Samaritan's Purse, which has worked in the Hamash Karob Locality for 8 years and which has a long-standing relationship with the community and its leaders, started implementing CMAM in May 2009. It provides treatment at a static outpatient care site at a government health facility 3 days a week and through mobile sites on 2 other days. Four sites were established, but two have closed temporarily due to local conflict. Samaritan's Purse plans to operate four mobile sites a week (two each day), visiting each location every fortnight rather than weekly.

Before starting CMAM services, Samaritan's Purse held a series of awareness-raising sessions with community leaders. In the meetings, Samaritan's Purse explained the program and asked the leaders to inform the community about the services. Because the people in Hamash Karob are very traditional and conservative, it is not easy for males to mix with females. So the sensitization process started with a male staff member engaging with male community leaders. Subsequently, female staff members also conducted awareness-raising sessions with some of the influential female community members.

All awareness-raising sessions and the subsequent CMAM training sessions were conducted orally because literacy levels are very low, even among community leaders. All the people speak the Bedowi language, and Samaritan's Purse ensured that a number of its staff spoke the language.

Samaritan's Purse employs an all-female team (nurse, nutritionist, and nutrition assistant) to carry out CMAM. The nurse is responsible for conducting medical assessments in outpatient care. An SMOH male doctor at the hospital is available if required, and mothers are happy to go to see him. Samaritan's Purse also recruited 12 Hedendawa female volunteers to help launch CMAM. Initially, these women were responsible for crowd control and general assistance in the clinic. However, the women have been given additional training and now do additional tasks, such as taking measurements and providing health education. They will likely be involved in the outreach work as it develops. The volunteers receive food for work but no financial incentive.

Community leaders were educated on signs and symptoms of malnutrition and have been referring children to the health facility or outpatient care site. The referral is based on observation only, without using MUAC. To date, children being refused admission at the site has not been a problem, because during the referral process, including when community leaders advise mothers to take the children to the site to be checked, the mothers are not guaranteed that the children will be admitted.

The program has admitted almost twice the number of projected cases, meaning that either the population figures were inaccurate or the reported SAM rate was incorrect. In the first 3 months, more than 200 children were admitted, mainly in Hamash Karob town. There was no capacity for Hamash Karob Locality to have its own inpatient care site, so children with medical complications were referred to the hospital.

The program has had a low death rate: Only two children have died so far. While the exact default rate is not known, it is considered to be low. This might be because the services are mainly provided in town, making the expected default rate lower than in rural areas, where beneficiaries have to walk long distances. So far, there have been 20 readmissions after treatment as a result of poor sanitation and increased incidence in diarrhea during the rainy season.

There is an issue with referral from outpatient care to SFPs: Children are referred, but admission to SFPs is not automatic, as the children are screened by SRC volunteers who might refuse them admission.

Samaritan's Purse plans to start CMAM services in Telkoot Locality shortly.

## 3.4.2 Treatment of Acute Malnutrition and Other Childhood Illnesses

In Shimal el Delta, management of SAM is available at the inpatient care site in the hospital. During the visit, no children were undergoing treatment there. The community mentioned a wide range of methods

used to treat malnutrition and other childhood illnesses, including home remedies and use of traditional practitioners:

Home remedies for children with malnutrition:

- Shower the child with cow or goat milk
- Give the child a cold water shower to treat fever resulting from malnutrition
- Rub black cumin on the child's arms and legs to break the spell of the "evil eye"

Food recommended for malnourished children:

- Fresh goat milk
- Fresh cow milk
- Porridge made of unfermented sorghum without oil
- Milk
- Dates
- Meat (if the family is rich)

Home remedies for other childhood illnesses:

- Massage *delka* with perfume on skin
- Massage *mehlad* on teeth
- Massage crushed *garad* with oil on skin
- Massage black cumin on arms and legs to break the spell of the "evil eye"

Food recommended for sick children include:

- Rice porridge
- *Durah* porridge
- Honey

Traditional practices used to treat both malnourished and sick children:

- Cutting or burning the child's skin
- Giving a child a *hijab*

### **3.4.3 Factors That Influence Treatment of Acute Malnutrition and Other Childhood Illnesses**

Some informants reported that in recent years attitudes had changed somewhat and conventional health services had been used more often because of awareness-raising campaigns. Nevertheless, use of traditional practitioners is still very common in the area, and traditional treatment is often sought before conventional treatment. One of the main reasons cited for this was that people are very poor and cannot afford to pay for drugs. People use traditional healers because they are more flexible about what and when they are paid.

However, cost is not the only reason people use traditional healers instead of conventional medicine. Informants said some people prefer to take children to traditional healers and will not go to conventional services unless the traditional healers instruct them to do so. By that time, the child's condition is usually deteriorating, and the healers are afraid the child will die. An NGO-managed health facility in Wagar—which provides free consultation and drugs—reported that many sick children were still presenting late, as their condition worsened after having been seen by traditional practitioners.

**Recommendations:** Given the central role that traditional healers play in first-line treatment of malnutrition and other childhood illnesses, establish relationships with them to gain their cooperation in identifying and referring children with SAM to CMAM services. This will require a sensitive approach, and it might take some time for traditional healers to trust the health facility.

Be sure the community knows that CMAM consultation, treatment, and routine medications, in line with protocol, will be provided free of charge at both inpatient and outpatient level as CMAM services are established. Include this information in sensitization messages before and in the early stages of service establishment. Reinforce the information with caregivers when children are referred for treatment.

#### 3.4.4 Infant and Young Child Feeding Practices

All infants in the area are breastfed, and it is Hedendawa practice to breastfeed until children are 2 years old. However, very few infants are exclusively breastfed for the recommended 6 months after birth. Mothers said they start giving infants additional liquids any time from birth to age 4 months and start giving soft foods at age 3–4 months. When asked about feeding a 12-month-old child, groups of mothers said they would feed the children “when they wanted to be fed,” indicating limited knowledge of optimal complementary feeding practices.

**Recommendation:** Review and strengthen current nutrition education on optimal IYCF practices at the facility and in the community to prevent SAM.

#### 3.4.5 Administrative Structures, Community Leadership, Community Structures, and Commitment to Establishing CMAM

Shimal el Delta is a new locality, recently separated from neighboring Aroma Locality. While the community organization structures did not change with the reorganization, new administrative structures were recently established at the locality level. For example, Shimal el Delta now has a locality commissioner (an appointed position) who oversees all activity in the locality and heads the locality council, a legislative body made up of elected community leaders from the locality.

The locality’s main tribe, the Hedendawa, has an overall tribal sheik as well as tribal *umdah*, who lead large central villages with about 4,000 people. The tribe has many subgroups, each of which has its own tribal sheiks and *umdahs*. There are also religious sheiks (*sheik khalwa*). The locality’s nomadic groups are part of the same community and come under the same community structures.

The locality has a CDC, also known as the Popular Committee, with 12 appointed members and 6 subcommittees (health, education, women, water, youth, and emergencies). The CDC and the subcommittees did not appear to be very active. The health subcommittee’s chairman and one of its members—who also serve as public health officer and vaccinator, respectively—were very honest about the absence of clear responsibility and a clear mandate for the subcommittee. The health subcommittee seemed to work in a reactive fashion, as directed by the SMOH office or the locality commissioner. Although the representatives participating in the assessment referred to the health committee as a locality health committee, they had only limited information about what was actually happening outside Wagar town, other than in relation to their specific technical field and position of employment as SMOH representatives. When Wagar was upgraded to a locality, it was given no additional resources and the government built on the existing infrastructure, rather than providing any new infrastructure. Wagar locality-level committees are also only in the initial stage of operations, since they new (transformed from the original Wagar town committees).

Shimal el Delta also has several other Popular Committees or village committees made up of community leaders in the villages. Some of these committees have various subcommittees, including a women’s

subcommittee and a health subcommittee. The village committees are locally established and have no formal links with locality-level committees. The composition, mandates, and activity levels of the village committees and health subcommittees were not at all clear.

Some agencies established committees in villages and areas where they support health and development. For example, CFCI committees have been established in the communities where UNICEF supports CFCI, and IFAD committees have been established in the communities where IFAD supports activities. There are no formal mechanisms to link these committees even when they operate in the same catchment area.

Hadalya village in Shimal el Delta has a village committee that was supposed to oversee the work of all the committees in the area. But respondents said that this was not happening because “there is no reporting of activity, and communication is ad hoc.” Hadalya also has a 10-member health subcommittee chaired by the medical assistant from one of the health centers. However, there is no village health plan, and the members “have been trained in planning but have not developed a plan for the area.” There were no women on the health subcommittee, and the women’s subcommittee was not functional.

Hadalya village and health subcommittee members were aware of a CFCI community in Tamatasha (within Hadalya village catchment area, 5 km from Hadalya center), but were unaware of a committee in Tamatasha or the CFCI itself. The CFCI was established in Tamatasha in 2000 and has a committee of 28 members, including 5 women, to support activities.

Community leaders in Hadalya said the *umdah*, the head of the Popular Committee, and the religious sheik are the most powerful individuals in the area and must be consulted to support awareness raising and sensitization.

Women’s involvement in the assessment was obtained through interviews with female nutrition staff, SABA volunteers, and women’s community meetings. However, women were not involved in official meetings at the commissioner’s office or at the community level. In addition, the women’s subcommittees at the locality and sub-locality levels did not appear to be functioning.

Locality representatives, including the tribal sheik, the commissioner/head of the Popular Committee and Health Committee, and community representatives in Hadalya village, expressed a commitment to support the establishment of CMAM services in the locality however they could.

The extensive networks of community committees are impressive and will greatly facilitate the establishment and management of CMAM services. However, the lack of formal linkages and communication between locality and village committees and among neighboring village committees within a catchment area must be addressed.

**Recommendations:** Work with and through existing community committees to plan and support CMAM services. In addition, work to reinvigorate inactive committees.

Clarify the CMAM-related responsibilities of the committees within catchment areas (committees exist at different levels in a sub-locality). Establish linkages between village committees in a catchment area and between locality and village committees.

Facilitate women’s active involvement in planning and managing CMAM services and in disseminating information. This might already have been done in areas where many women are active in community committees and in CMAM.

### 3.4.6 Organizations Supporting Health, Nutrition, and Development in the Locality

**Table 7** lists the groups supporting health and nutrition and other development activities in Shimal el Delta Locality

**Table 7. Organizations and Their Roles in Shimal el Delta Locality**

Organization	Role
<b>DELTA</b>	Supports training for health system leaders.
<b>Eastern Development Programme</b>	Has constructed health facilities and water points and has offered to provide equipment and supplies for health facilities.
<b>GOAL</b>	Works in Hangola and Shika Demin villages/areas. Five community nutrition volunteers in each area conduct home visits to screen for malnourished children. They refer moderately malnourished children and caregivers to the nutrition centers (one in each area) and attend once weekly for follow-up sessions. Children's conditions are reviewed and caregivers attend cooking demonstrations and education sessions held there. Children with SAM are referred to the inpatient care site for treatment. Kassala and Aroma inpatient care sites are closest to the operational areas.
<b>International Committee of the Red Cross (ICRC)</b>	Was operational in the locality until March 2008, supporting one health center and training three female volunteers in health education; these volunteers are still working in the communities.
<b>International Fund for Agricultural Development (IFAD)</b>	Operates in 10 areas in the locality, mainly concentrating on agriculture; has trained volunteer.
<b>Muslim Aid</b>	Supports a health unit in Wagar town; employs two staff, a medical assistant, and a VMW; provides free curative treatment for adults and children as well as reproductive health care. The midwife is responsible for delivery and routine home visits after delivery.
<b>Plan International/Sudan</b>	Has been building health posts, supporting water chlorination, and training health volunteers, but the current level of activity of the organization in the locality was not clear.
<b>Sudanese Red Crescent (SRC)</b>	Was operational in Shimal el Delta until 2008; built two health centers and trained health volunteers who are still working in the community.
<b>UNICEF</b>	Supports CFCI in Esa al Haj, Tementasha, Hangola, Sabon, Ejer, Olaib, Matataib, Saraya, Omalgar, Ath-Kalho, Mabrok, and Alkassara. CFCI supports CDC through training and mentoring and supports the basic health unit (BHU) by providing drugs and supplies. Health promoters in each area also receive training.

There was not enough time to meet with representatives of IFAD, Plan International/Sudan, the Eastern Development Programme, DELTA, or UNICEF/CFCI to get a clear picture of their current activities and locations. While SMOH staff members knew these agencies were in the locality, they did not have details on where the agencies were working or what their activities were. The locality health committee members did not have these details either.

**Recommendation:** Meet with each agency to get a clear picture of where they are, what activities they conduct, and whether they have functional community-level committees and/or extension workers. Determine whether they can play a role in community outreach for CMAM.

The presence of these agencies is a real strength for establishing CMAM services, but the lack of coordination is a weakness. While regular health and nutrition coordination meetings are held at the state level, there is no coordination mechanism at the locality level. Each group engages individually with the

commissioner's office, and there is no forum to bring these groups together to exchange information, discuss issues, or coordinate activities.

**Recommendation:** Use the establishment of CMAM services as a catalyst for locality-level coordination meetings, initially focusing on CMAM, but then moving on to cover additional health and nutrition activities. The CMAM Support Unit (established by the SMOH, UNICEF, and other NGO partners), CHWs, and other relevant SMOH staff should facilitate this effort through the locality's health committee and commissioner's office.

### 3.4.7 Community Health Outreach Workers in the Locality

**Table 8** lists the health outreach workers (employed and volunteers) currently work in Shimal el Delta Locality.

**Table 8. Health Outreach Workers by Program or Organization and Their Roles in Shimal el Delta Locality**

Health Outreach Workers	Role
<b>Community Integrated Management of Childhood Illness (C-IMCI)</b>	There are 22 C-IMCI CHPs (all female) in Shimal el Delta Locality. The C-IMCI coordinator for Shimal el Delta Locality is based in Aroma Locality. The review team was unable to meet them and, as a result, information on location, specific activities, and the supervision system was not available. CHPs conduct house-to-house health and nutrition promotion. According to the SMOH IMCI coordinator, CHP retention is very good across the state. C-IMCI is a critical community-based health outreach activity and its role in community outreach for CMAM needs to be further explored.
<b>Child-Friendly Community-Based Initiative (CFCI)</b>	CFCI is being implemented in 12 communities in Shimal el Delta Locality (Esa al Haj, Tementasha, Hangola, Sabon, Ejer, Olaib, Matataib, Saraya, Omalgar, Ath-Kalho, Mabrok, and Alkassara). CFCI volunteers have been selected in each community. In Tamatasha, both CFCI volunteers were male, while the volunteers in the other communities were all female. CFCI volunteers carry out health and nutrition promotion, vaccination awareness, and notification of diseases.
<b>Expanded Program of Immunization (EPI)</b>	There are 150 EPI volunteers in the locality, some male and some female. Two of these volunteers were previously responsible for routine Global Alliance for Vaccines and Immunization work (mobile sessions 2 days a week), but this work stopped when financial incentives were discontinued. These two volunteers are the team leaders for EPI campaign work, which is carried out periodically by the remaining volunteers. Team leaders and volunteers are paid financial incentives for attending pre-campaign training and conducting EPI campaigns for a specific number of days.
<b>GOAL</b>	Five GOAL community nutrition volunteers (all female) work in Hangola community and five in Shika Demin community. They conduct house-to-house visits, health and nutrition promotion, and screening and referral of malnourished children.
<b>International Committee of the Red Cross (ICRC)</b>	The ICRC worked in the locality until its departure in March 2009 and trained three health volunteers, who are still working in the community.
<b>International Fund for Agricultural Development (IFAD)</b>	IFAD trained female volunteers who now work in the locality.
<b>Plan International/Sudan</b>	Plan trained a number of health volunteers in the locality. The Hadalya Health Committee stated that six of these volunteers were working with them.

Health Outreach Workers	Role
<b>Sudanese Association for Breastfeeding Actions (SABA)</b>	SABA volunteers (all female) interviewed in Wagar estimated that 60 female volunteers were trained across the locality 5 or 6 years ago, but they were not sure of the current activity. In Wagar area, 5 committee members and 20 volunteers were also trained 5 or 6 years ago, but only 5 or 6 people (including committee members and volunteers) are now active. These people work in four areas, in town and in three villages, including Hadalya. SABA volunteers conduct house-to-house visits to promote optimal IYCF practices. There has been no regular work schedule, follow-up, or support from SABA over the past few years. The SABA volunteers who participated in the assessment indicated that they could screen and refer children with SAM in the areas they cover if they receive training.
<b>Sudanese Red Crescent (SRC)</b>	SRC trained health volunteers as part of an emergency response. Two female ex-SRC volunteers are now working with facility staff in Hadalya.

Other volunteers, mainly male, have been recruited to support specific activities and other public health campaigns (non-EPI) for short periods. For example, in 2008, 20 volunteers were trained to chlorinate water. Volunteers from the Youth Union helped with rubbish collection campaigns.

With the exception of EPI volunteers, most volunteers in Shimal el Delta receive no financial incentives. GOAL, CFCI, C-IMCI, and SABA volunteers are not given any kind of incentive. The amount of work that these volunteers are asked to do is not excessive, and they all have other jobs and responsibilities. The Youth Union volunteers asked for payment, and the locality administration agreed to give food as an incentive. Community leaders in Hadalya suggested that two volunteers per community be trained and paid to do awareness-raising and education. The Hadalya community leaders said NGOs usually train and give incentives to volunteers, but the work stops when funds stop. However, this is contrary to findings in discussions with GOAL and the SMOH IMCI coordinator. In fact, in Hadalya itself, a number of ex-SRC volunteers still support nutrition activities.

Shimal el Delta Locality has both male and female volunteers, which seems to work well in this conservative rural society. It would be difficult for female volunteers to work if they had to travel relatively long distances from their homes, as their culture requires that they be accompanied by a male relative. In some places and situations, male and female volunteers work in pairs, making it easier to enter houses and engage with women and caregivers, since a male volunteer cannot enter a house alone and interact with the women unless a male relative is present. C-IMCI volunteers, who are all female, also usually work in pairs.

Three female nutrition volunteers work in Shimal el Delta Locality. These volunteers were trained to do the same job as paid nutrition educators and are essentially waiting for appointment as nutrition educators. They work at the facilities and conduct home visits. They are expected to work much longer hours than the community volunteers listed above.

### **3.4.8 Employed Health Staff with a Defined Role in Community Outreach as Part of Routine Work**

#### *Nutrition Educators*

Four nutrition educators, all female, work in Wagar, Hadalya, and two other areas. These staff members conduct growth monitoring at health facilities and home visits for health and nutrition promotion. The SMOH nutrition director said the nutrition educators should spend part of 2 days every week doing home visits and make 50 visits a month (on average 7–10 home visits per week).

### *Village Midwives*

Twenty-three VMWs work in the locality, primarily performing deliveries in the community. Most babies are born at home, but complicated cases might be referred to Wagar Hospital. The VMWs conduct home visits to all mothers after delivery, daily for 1 week, then at least three more times at 15, 30, and 40 days after birth. The VMWs interviewed felt that midwives could screen and refer children with SAM in the areas they cover.

**Recommendation:** Capitalize on the extensive network of trained health volunteers and other health workers with a defined role in the community to help establish CMAM services, using them in sensitization, screening and referral of children with SAM, follow-up with defaulters and problem cases, and health and nutrition promotion.

### **3.4.9 Methods of Information Dissemination**

While an increasing number of the Hedendawa are educated, adult literacy remains low. Information should be disseminated orally in the local Bedowi language.

The main method of information dissemination in Shimal el Delta Locality is community meetings at the locality and sub-locality levels. Generally, both men and women attend community meetings. Radio is another method for information dissemination, either state commercial radio or the UNICEF-supported community radio stations in the Bedowi language. Radios have been distributed to some communities.

### **3.4.10 Recommendations for the CMAM Community Outreach Strategy in Shimal el Delta Locality, Kassala State**

#### *Community Knowledge, Beliefs, and Practices in Relation to Childhood Malnutrition and Ill Health*

- Ensure that community sensitization and ongoing nutrition education across the locality include clear information on the signs and symptoms of malnutrition in children.
- Review and strengthen education on IYCF at facility and community levels to help prevent SAM.
- Given the central role that traditional healers play in first line treatment of malnutrition and other childhood illnesses, sensitively develop linkages and establish relationships with them and gain their cooperation in identifying and referring children with SAM to CMAM services. It might take some time for traditional healers to trust health facility staff and feel comfortable engaging and cooperating in the referral of children with SAM.
- In the sensitization messages distributed before and during the early stages of establishing CMAM services, include information that CMAM consultation, therapeutic treatment, and provision of routine medications, in line with protocol, will be provided free for both inpatient and outpatient care as CMAM services are established. Reinforce this information with caregivers when children are referred for treatment. Payment for services has been a barrier to use of conventional services for treatment of sick children in the locality and must be addressed for effective establishment of CMAM services.

#### *Administrative Structures, Community Leadership, and Community Structures*

- Address the lack of formal linkages and communication from the locality to the village-level committees and among neighboring village committees within a catchment area. The extensive

networks of community-level committees are impressive, and they will greatly facilitate the establishment and management of CMAM services.

- CMAM planners should work with and through the existing community committees to plan and support CMAM services. Where committees exist but are not active, CMAM planners should proactively work to reinvigorate and strengthen them.
- Clarify the CMAM-related responsibilities of the various committees within catchment areas (committees exist at different levels in a sub-locality) and establish appropriate linkages among village committees in a catchment area and between locality and village-level committees.
- Facilitate the active involvement of women in planning and management of CMAM services and information dissemination, especially where women are not active members of community committees. Discuss and determine the responsibilities of the various committees, how they will interact, and the active involvement and engagement of women as CMAM services are being planned.

#### *Planning and Coordination of CMAM Services, including Community Activity*

- Hold locality- and sub-locality-level meetings in each catchment area to plan CMAM setup and ongoing monitoring of CMAM service implementation and community activities.
- Make support and facilitation of these activities through the locality health committee and commissioner's office the responsibility of the CMAM Support Unit, community staff, and relevant SMOH staff members, such as the responsible nutritionist and community focal person.
- Use the establishment of CMAM services as a means of instigating locality-level coordination meetings, initially focusing on CMAM but then moving on to cover additional health and nutrition activities.

#### **3.4.11 Organizations Supporting Health and Nutrition and Development in the Locality**

GOAL, UNICEF, Muslim Aid, Plan International, the Eastern Development Programme, DELTA, and IFAD support health and nutrition and other development activities in Shimal el Delta Locality. Time constraints made it impossible to meet with representatives of IFAD, Plan International, the Eastern Development Programme, DELTA, or UNICEF (CFCI focal person). Discussions with these agencies will be important to get a clear picture of exactly where each agency is based, the focus of their activities, and the presence of functional community-level committees and/or operational extension workers.

**Recommendation:** Encourage and facilitate the active engagement of these agencies in CMAM-related activities. Invite and encourage them to attend planning and coordination meetings at the locality and/or sub-locality levels).

#### **3.4.12 Community Health Outreach Workers in the Locality**

The wide range of health and nutrition outreach workers (employees and volunteers) operational and/or available in Shimal el Delta Locality include GOAL community nutrition volunteers, SABA volunteers, C-IMCI CHPs, CFCI volunteers, Plan International volunteers, ex-SRC volunteers, ex-ICRC volunteers, IFAD volunteers, and EPI volunteers. Several facility-based staff also have a defined role at the community level as part of their routine work, including nutrition educators, nutrition volunteers (who do the same job as nutrition educators but without pay), and VMWs.

The extensive network of health and nutrition volunteers and other health workers with a defined role in the community is a major advantage for establishing CMAM services. These already trained and

experienced operational staff and volunteers might be utilized in sensitization, health and nutrition promotion, screening and referral of children with SAM, and follow-up of defaulters and problem cases. More-skilled staff might be used for all tasks at the community level, while less-skilled staff might have a more limited role.

**Table 9** lists front-line health and nutrition workers and volunteers who could be involved in community outreach for CMAM in Shimal el Delta Locality. **Table 10** lists options for community outreach roles the outreach workers (employees and volunteers) and locality/community committees could play.

**Table 9. Health and Nutrition Outreach Workers Who Could Be Involved in CMAM Community Outreach in Shimal el Delta Locality**

Outreach Workers (Employees and Volunteers)	Current Community-Level Responsibility	Proximity to Cases (+ far, ++ medium, +++ close)	Number/Coverage	Able to Measure MUAC	Comments
Health visitors (midwife or nurse with 2-year training in midwifery)	Supervision of midwives, including home visits	+	1	Y	
VMWs	Post-delivery home visits as part of routine work	++	23	Y	VMWs indicated they could conduct screening and referral.
Nutritionists	Supervision of all nutrition activity in the locality, including outreach work	++	0		The nutritionist was on study leave; the vaccination officer was acting as nutrition officer.
Paid and volunteer nutrition educators	Home visits as part of routine work	+++	7 in locality (4 employed, 3 volunteer)	Y	
C-IMCI volunteers	Home visits and health and nutrition promotion	+++	22	Y	
CFCI volunteers	Community/home visits and health and nutrition promotion	+++	# volunteers NA/covering 10 communities, each with sub-villages	Y	
Volunteers attached to village health committees (might be ex-SRC, International Red Cross, or Plan International)	Community/home visits and health and nutrition promotion	+++	NA	Y	
SABA volunteers	Community/home visits to support breastfeeding and optimal weaning	++	NA	Y	SABA volunteers said they could do screening and referral but would need significant training because their knowledge of nutrition was limited to IYCF.

Outreach Workers (Employees and Volunteers)	Current Community-Level Responsibility	Proximity to Cases (+ far, ++ medium, +++ close)	Number/Coverage	Able to Measure MUAC	Comments
GOAL nutrition screening volunteers	Community home visits for screening and referral of malnourished children	+++	10 volunteers in 2 communities with sub-villages	Y	
Plan International/Sudan health volunteers	NA	NA	NA	Y	
IFAD volunteers	NA	NA	NA	Y	
EPI volunteers	Conduct routine vaccinations and campaign activities	+	150 volunteers covering the whole area	Y	Not operating permanently. Paid incentives for days/sessions worked. Could conduct campaign-style screening and referral. if required.

NA = Not available

**Table 10. Options for Community Outreach Activities**

Role	CMAM Start-Up and Continuation Phases
Awareness-raising and sensitization	Locality council Locality development committee Community leaders Village committees (development, health, CFCI, other)
Active case-finding and referral  <i>Screening can be conducted at household or community level*</i>	Nutrition educators (employed and volunteers) Midwives Volunteers from existing functional networks, as part of ongoing routine responsibilities: Additional volunteers might be needed for areas without volunteers. They should be linked to community committees in the respective areas. <i>* It might be appropriate to provide incentives for initial rounds of screening depending on volunteers' workload/demand. Incentives should not be necessary during the continuation phase, as this work should be part of routine responsibilities. It might be appropriate to cover some costs for attending supervisory meetings.</i>
Follow-up of defaulters	All volunteers: Ideally volunteers conducting active case-finding will follow up on the defaulters they have referred. If the defaulter does not return, the case might be re-categorized as a problem case, and more highly trained staff might make another home visit.
Follow-up of problem cases: non-responders, absentees and defaulters	Nutrition educators (employed and volunteers) Selected volunteers from existing networks with more nutrition training and experience, such as the GOAL community nutrition volunteers and others trained to do follow-up visits under the supervision of the nutrition educator
Health and nutrition education	Nutrition educators (employed and volunteers) VMWs Volunteers from existing functional networks Additional volunteers working in areas that did not have volunteers

### **3.4.13 Screening and Active Case-Finding**

Screening and active case-finding can be conducted through house-to-house screening or community screening at a central location. Program staff and community representatives should determine the most appropriate method during the planning process at the locality level. For example, community screening might be appropriate for Wagar town, which is densely populated and does not have an extensive network of volunteers, or for rural villages that do not have enough volunteers for house-to-house visits and are comfortable with gathering together for such activities. In other areas, the community might be more comfortable with house visits.

In addition, screening and referral should also be linked to other health and nutrition interventions at the health facility and in the community.

### **3.4.14 Supervision of Outreach Work**

The focal person(s) for the CMAM community component at the locality level will oversee outreach work overall. This person will most likely be both the nutritionist and the C-IMCI focal person. However, the day-to-day supervision of the outreach work will be the responsibility of the supervisors of each group of staff and volunteers. Duties include:

- Supervising work and ensuring that screening and referral are conducted correctly
- Providing a link between the facility and volunteers as necessary (for example, determining whether referred children presented for treatment and informing volunteers that a defaulter needs a follow-up home visit)
- Submitting monthly reports on CMAM activities (this information can be integrated into the regular monthly report form)

The specifics of how the health facility and various volunteer cadres will be linked must be determined as services are established. This should be relatively easy when volunteers live near health facilities providing outpatient care, but more challenging when they do not.

The various supervisors will interact with the CMAM focal persons as required and will attend locality and sub-locality CMAM meetings, when appropriate.

### **3.4.15 Locality-Level Training Requirements for Community Participation and Involvement in CMAM**

A variety of orientation and training sessions on community participation should be carried out for:

- Locality-level staff
- Community representatives (committee members and other community leaders)
- Supervisors
- Health workers with community outreach roles
- Volunteers selected for CMAM-related outreach work

### **3.4.16 Plan for Community Sensitization**

After orientation and training, and before launching services and outreach activities, a CMAM community sensitization plan should be developed and implemented across the locality to promote understanding about malnutrition, the components of CMAM (inpatient care, outpatient care, supplementary feeding, and community outreach), the targeted beneficiaries for services, admission criteria, and locations of the services. This plan will be developed primarily through a series of community meetings held at the locality and sub-locality levels. The feasibility of using radio (commercial or community) for information dissemination also should be considered.

## 4. Community Outreach Assessment in Al Minar Center, Mayo, Khartoum

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Al Minar Center, which is managed by Al Minor (a Sudanese NGO), is situated in the Mayo area of Khartoum. The center provides outpatient care management of SAM without medical complications 3 days a week. The review of community outreach activities for CMAM at Al Minar Center was conducted in August 2009 as part of a wider learning review of community outreach for CMAM in Sudan. The review was also used to pretest questions that would be used in the Darfur review.

### 4.1 Method

After conducting a brief overview of the CMAM services provided, the review team held discussions with a CHP, a nutrition educator who supports the CHP, and the center coordinator. Three exit interviews were held with the caregivers of three children who were registered in outpatient care.

### 4.2 Findings and Recommendations

Key findings involving CMAM-related outreach activities are summarized below. Recommendations and suggestions are shown in boxes.

#### 4.2.1 Outreach Workers and Volunteers

Three CHPs, all female, are attached to the program. Al Minar has a women's empowerment policy, and, in this conservative culture, male strangers are not allowed to visit a woman in the home without a male relative of the woman being present.

The CHPs work 3 days a week and are paid 250 SDG a month. The expectation is that they will conduct home visits for 3 hours and then go to the center to assist with outpatient care (measurements, distribution, and health education).

#### 4.2.2 Home Visits for Screening and Referral

CHPs work together to cover the catchment area, Mayo Farm, for screening and referral. Each CHP should cover 10 new houses a day. The CHPs move from area to area, sometimes targeting a specific area if it has many children presenting with SAM or has many newcomers.

During screening and referral visits, the CHPs measure MUAC only if a child looks malnourished. They make referrals to outpatient care and/or to immunization, as required, in the neighboring clinic and provide health and nutrition education. If children are not at home at the time of the visit, the CHP arranges to revisit.

If caregivers refuse to take children for treatment, the CHPs talk to other family members and neighbors to encourage them to take the children. The caregivers can usually be persuaded. (The main reasons caregivers refuse to go for services are lack of time because of other children, pregnancy, or lack of money to pay for services, which, in fact, are free.)

The CHPs said that they covered the whole area, but there are no data or reports to support this. With about 4,000 houses in the catchment area, it would take almost a year to cover the area. The CHPs themselves said that there were not enough of them to do house-to-house visits throughout the catchment area and another area where many more children should be admitted to the program. While the CHPs are mandated to conduct health and nutrition education during the home visits, they do not have any health and nutrition education materials.

**Recommendations:**

Change the case-finding strategy to arrange for children to come to central points around the catchment area for screening and referral, thus allowing many more children to be screened. This would dramatically increase the number of referrals to the center, although the center's capacity to deal with the increased workload would need to be addressed.

Increase the number of days a week the center operates or open additional centers across the catchment area.

Involve community leaders in community-level screening to inform the community about upcoming screening sessions and ensure that all children under 5 are brought for screening.

Make appropriate health and nutrition education materials available for CHPs to use for outreach work.

**4.2.3 CMAM Referral Process**

Because there is no SFP in the area, CHPs refer children only to the outpatient care. The CHPs use MUAC for screening, with a cut-off of 108 mm. WFH (less than -2 z-score) is used for admission.

CHPs give caregivers handwritten referrals with the MUAC measurements to take to the facility and advise caregivers to take their children for check-ups at the clinic. They should know that if WFH is not less than -2 z-score, the child might not be admitted. CHPs and nutrition educators reported no problems with rejected referrals.

If a child's WFH is borderline but s/he is clearly ill and the family is very poor, the center might make an exception and admit the child to outpatient care.

During distribution of ready-to-use therapeutic food (RUTF), the nutritionist might give clothes, soap, and hygiene education to caregivers of children whose hygiene is notably poor.

**4.2.4 Home Visits for Children Being Treated for SAM**

If children who live in Mayo Farm are not referred for treatment by a CHP, a CHP is supposed to make a first home visit after admission to see the house and its conditions. However, this is not possible when admission numbers rise because of the seasonal hunger gap period. CHPs make follow-up home visits for children in the program if the children have edema, are active TB cases (TB treatment is provided at nearby Angola Hospital), do not respond to treatment, are absent, or default. No home visits are made for children who come for treatment but live outside the catchment area.

CHPs assist with measuring children in outpatient care, providing RUTF, and conducting health and nutrition education. They interact with staff regarding referrals, defaulters, and non-responders.

**4.2.5 Records and Reports**

It was reported that each CHP has a notebook/register to record each home visit (including date of visit, location of house, children screened, and referrals to outpatient care and immunization). One CHP register was reviewed during the visit. While it was reported that each CHP uses the same system, one of the CHPs present that day did not have a register book at the center to verify this. Monthly reports are submitted to the nutrition educator and then to the AI Minar coordinator, but they were not available to review because files were in the AI Minar main office.

#### 4.2.6 Analysis of Beneficiary Referral Pathway

Although data were available from center records, the number of children from the catchment area who are referred by CHPs was not compared with the number who self-refers. During the visit, the three caregivers of children attending outpatient care who were interviewed had all self-referred to the center. Two lived close by; one lived farther away.

#### 4.2.7 Coverage of CMAM Services in Mayo Farm

Geographical coverage of the children registered for CMAM services was not analyzed even though data were available from center records. Staff reported that there was no problem with distance for the population in Mayo Farm, but acknowledged that most of the children admitted live relatively close to the center.

#### 4.2.8 Use of Services by Children Living outside the Catchment Area

Again, although data were available from center records, the number of children utilizing services who lived outside the catchment area was not analyzed. Staff reported that many children come through self-referral from outside the catchment area. Children who come from a long distance are asked to return every two weeks for follow-up and RUTF.

##### **Recommendation:**

Analyze center records to get an idea of the coverage of CHP activities, actual coverage of CMAM services in the catchment area, and the percentage of children registered for outpatient care who come from outside the catchment area.

#### 4.2.9 CHP/Volunteer Supervision

A nutrition educator (who previously worked as a CHP) and the health coordinator supervise the CHPs, but there is no real supervision structure. Sometimes the nutrition educator and the coordinator accompany the CHPs, but this is not routine.

The nutrition educator meets with the CHPs during the outpatient care sessions, gives feedback on referrals, and provides information on absentees and defaulters. The nutrition educator has a monthly meeting with the CHPs, who also attend the general monthly meetings held by the AI Minar coordinator and attended by all center staff.

#### 4.2.10 CHP Training

The CHPs have attended several training sessions on general nutrition, screening and referral, MUAC measurement, and general health and nutrition education. These courses were held by the AI Minar MOH and Ahfad University for Women.

#### 4.2.11 Use of Traditional Healers to Treat Malnutrition

It was reported that traditional healers are not widely consulted for treatment of malnutrition in the Mayo Farm area, but that some caregivers take malnourished children to traditional healers in Damazin. In those few cases, children often come to the center later, after their condition has deteriorated.

#### 4.2.12 Role of Community Leaders in CMAM Services

AI Minar Center has links with the community leaders and could use them to gather the community for certain activities. However, the community leaders have never played any role in supporting CMAM

activities or related outreach work. **Table 11** lists the strengths and weaknesses of the center's CMAM-related outreach activities.

**Recommendation:**

The AI Minar management team should engage with and involve community leaders to support CMAM outreach activities.

**Table 11. Strengths and Weaknesses of CMAM-Related Outreach Activities, AI Minar Center**

Strengths	Weaknesses
<ul style="list-style-type: none"> <li>• Experienced CHPs do comprehensive home visits (screening/referrals for SAM and vaccination services, and health and nutrition education).</li> <li>• CHPs have good links with the health center for referral and follow-up with defaulters, non-responders, and TB cases.</li> </ul>	<ul style="list-style-type: none"> <li>• Only three part-time CHPs cover about 4,000 households.</li> <li>• The house-to-house strategy leads to inadequate coverage of screening. Staff is aware that many more children should be in the program.</li> <li>• The effectiveness of CHP activity is not monitored or analyzed.</li> <li>• The coverage of CMAM treatment is not monitored.</li> <li>• No health and nutrition education materials are available for community outreach work.</li> <li>• Community leaders are not involved in CMAM activities or outreach work.</li> </ul>

## PART 2. COMMUNITY OUTREACH STRATEGY

Community outreach strategy is developed following critical assessment and understanding of the context. The strategy outlines the parameters for CMAM, case finding, referral, and follow-up, mobilizing communities for participation and training and support of community outreach workers

### 1. Method

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Upon completion of the community assessments, a stakeholder meeting was held to define a CMAM community outreach strategy adapted to their specific context (at the locality level). This included community-based outreach activities at and/or supported from the state level.

The locality-level strategy and especially the experience from strategy implementation fed into the development of an overarching strategy for community outreach across the state as CMAM services are established. The state-level strategy will be adapted to the specific contexts of each locality as CMAM is scaled up. This was to be done through a community assessment following the process from the initial locality.

Upon completion of the national situation analysis of community health initiatives and community outreach assessments in Darfur, Kassala, and Khartoum states, the information was consolidated and fed into the development of national CMAM guidelines and training manuals and into the development of a CMAM community outreach strategy and a capacity building strategy.

### 2. Community Outreach Strategy Formulation

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Community outreach covers the community participation and outreach activities in the community, and is critical for successful CMAM implementation. The aims of community outreach for CMAM include:

- Strengthening community health committees and encouraging sustainability and ownership of services by involving the community in planning, managing, and implementing the services
- Empowering the community by increasing the knowledge of the causes, types, identification, and treatment of SAM
- Strengthening early case-finding and referral of new SAM cases and follow-up of problem cases (e.g., absentees, defaulters, non-responders to treatment)
- Promoting health and nutrition education and behavior change
- Increasing service access and utilization (coverage) for the management of SAM

Community outreach is a continuous process that involves ongoing community engagement in planning and managing CMAM activities and in supporting community outreach activity. Community engagement provides a feedback loop that enables nutrition and health care providers to understand the constraints that might hinder effective provision of care in both outpatient and inpatient care settings.

CMAM managers, coordinators, and focal persons at the state and locality levels should proactively work to engage the many relevant health and nutrition initiatives and networks already existing in Sudan in the planning and implementation of CMAM (see **Box 3**).

### Box 3. Community Health Initiatives

There are many community-based health and nutrition initiatives in operation across Sudan, supported by a wide variety of agencies (e.g., government, the United Nations, national NGOs, and international NGOs). Many of these initiatives work through committees and volunteers at the community level. In addition, certain health and nutrition staff employed at the health facility level has clearly defined roles at the community level as part of their routine job descriptions.

FMOH-supported community health initiatives include:

- CBI: 12 states, 27 localities, and 104 communities
- C-IMCI: 15 states, 55 localities, and 126 communities
- CMI: 4 states, 4 localities, and 150 community members trained
- CMNBC project (to be piloted in two states)

Health facility staff cadres with a clearly defined role in the community include nutrition educators, midwives, health visitors, assistant health visitors, nurses, CHWs (reinvigoration of cadre to be piloted in five states), vaccinators, and integrated primary health care cadres.

Major community health initiatives supported by international agencies (in more than one state) include the UNICEF CFCI (9 states, 41 localities, and 700 communities) and the WB/CDF (four states).

Major national NGOs involved at the community level and working across a number of states include the SRC (15 states) and the SABA (15 states).

The steps of community outreach for CMAM are:

- Step 1: Conduct a Community Assessment
- Step 2: Formulate a Community Outreach Strategy
- Step 3: Conduct Training on Community Outreach for CMAM
- Step 4: Implement Community Outreach Activities
- Step 5: Conduct Supervision and Monitoring and Reporting on Community Outreach Activities

### Step 1: Conduct a Community Assessment

An assessment of the community is essential to determine factors that are likely to affect the delivery of and demand for CMAM services, and to plan a strategy for community outreach. The assessment should be conducted at the locality and sub-locality community levels.

### Objectives of the Community Assessment

The objectives of the community assessment are to:

- Explore the various community actors and initiatives that already exist in the community, including formal and informal initiatives, networks, and practices
- Analyze identified strengths and weaknesses of current community initiatives and practices, and opportunities for and threats to future CMAM collaboration
- Identify the best community actors and strategy for community outreach

The outcomes of the community assessment will address factors within the community that are likely to affect the demand for the CMAM services and will influence strategies to effectively meet the demand.

### The Assessment Team

The assessment should be conducted by a team selected from the state and locality levels. The team should include nutrition staff, focal persons or coordinators for community-level activities, and other health care providers (e.g., health visitors, medical assistants, public health officers (see **Box 2** above). The team should be trained on how to conduct a community assessment prior to undertaking the activity.

A team leader with an understanding of CMAM and experience in undertaking community assessments will be required to train, guide, and mentor the team. It is anticipated that as states are establishing CMAM, external technical support will be required to initially take the position of team leader until state-level capacity for conducting community assessments has been developed.

## **At the State and Community Levels**

### *At the State Level*

A state-level review should be initially conducted to analyze the situation and to select the localities and/or communities to be engaged.

Methods of the state-level review include:

- Meeting with representatives from the SMOH, NGOs, and CBOs to understand and analyze the local context in terms of patterns of malnutrition and health seeking behaviors, community coherence, and the existence of community networks and potential partners/allies in supporting CMAM activities
- Reviewing key reference documents for the state, localities, and communities, e.g., knowledge, attitudes, and practice surveys; other health and nutrition surveys; and food security reports
- Selecting the locality and communities for the assessment (not all communities in a locality will be assessed); a map of the locality that could be hand-drawn should be available before starting the assessment with key communities (urban areas or villages) with populated areas and health facilities plotted on it
- Where a locality is homogenous, selecting a representative sample of communities and generalizing the findings; where a locality is heterogeneous, selecting a purposive sample of communities from each group and highlighting specific differences between the groups

### *At the Community Level*

The community assessment will identify community structures and systems, including:

- Key community figures and their respective roles and responsibilities
- Various community groups and organizations, and if/how these groups link together to coordinate activities
- Formal and informal channels of communication and the relative effectiveness of these channels
- Existing health, nutrition, and livelihood initiatives
- Various ethnic groups and specific vulnerable groups

The community assessment will also identify health and nutrition and acute malnutrition knowledge, attitudes, and practices, specifically:

- Understanding acute malnutrition, its causes, and the magnitude of the problem
- The various local terms used for malnutrition
- Common treatments currently used for acute malnutrition
- Health and nutrition care and feeding practices, and health seeking behaviors

The community assessment should build on information from the state-level review and the secondary data that have been made available. The time required will vary depending on the size of the catchment area and its homogeneity and the size of the team. At least 2 days should be allocated for a catchment area, with one inpatient care site and a few outpatient care sites to allow adequate time to meet with the relevant groups and individuals.

The community assessment will be conducted using qualitative research methods and tools, including:

- **Focus group discussions (FGDs).** FGDs are used to get an understanding of community perceptions about various issues. Small groups of individuals are brought together to discuss

specific topics. The interaction between participants is analyzed and a record is made of individual opinions and collective ideas.

FGDs should have 5–15 participants selected on the basis of age, gender, ethnicity, religion, and political or group affiliation to form a group with either a similar set of experiences or with different experiences. FGDs might be conducted with, for example, caregivers of small children with SAM in therapeutic care or using health services at the health facility, a mixture of community members either utilizing health services or not, existing volunteers, representatives of various CBOs, groups of community leaders, and community committees.

- **Key Informant Interviews (KIIs).** KIIs can provide a more comprehensive picture of the situation or issue/topic. They can be conducted with, e.g., health care providers at the health facility, traditional healers, community leaders, volunteer supervisors, and community health committee members. KIIs are usually held with individual informants. However, in some situations, it is appropriate to hold an interview with two informants together (e.g., interview two members of health committee together).

A series of semi-structured interviews might be held with key individuals from the health facility and the community. Semi-structured interviews will use a predetermined interview guide outlining a list of topics to address and questions to ask. The interviewer(s) can use this guide flexibly: The order and wording of questions might be different from informant to informant, and the interviewer(s) might follow topics and new leads as they arise in the discussion, allowing the informant(s) to raise (related) issues of concern. However, all the topics and questions should be covered in each interview.

- **Observation.** Observation of caregivers and children brought into the health facility and also at the community level can be carried out for signs of traditional practice as well as care and feeding practices.
- **Questionnaires.** A questionnaire that reflects key questions in a harmonized way should be developed for the community assessment (see **Annex 1. Community Assessment Questionnaire and Tools**).

#### Box 4. Women's Participation

Ensuring the engagement of women in the community assessment is important. They may participate as part of the general group discussion or separately in areas where this is culturally more appropriate.

A general request and/or invitation for women to attend meetings and participate in the community assessment should be discussed with community leaders and members.

### Organization of the Community Assessment

It is important to allow time for the SMOH to contact the relevant persons at the locality and community levels, schedule appointments with the relevant resource groups and individuals, and give adequate notice so that the required informants will be present the day(s) the community assessment is conducted.

In consultation with SMOH and locality representatives, the team leader will be responsible for determining the number of FGDs to conduct and with which groups and for selecting the key informants for semi-structured interviews. The team leader will also appropriately allocate team members to undertake the specific aspects of work.

## Validating Information

It is important to validate the information collected on completion of the community assessment. The information has been collected from a number of different sources and should be cross-checked. The best process for this is called triangulation. Information from one source is confirmed by information from another source; the information can then be considered accurate. Triangulation can be carried out by source (e.g., community leader and health facility staff member) or by method (e.g., semi-structured interviews and FGDs). When possible, information should be triangulated by both source and method.

## Reporting and Presenting the Information from the Community Assessment

It is important to consolidate and clearly present the information that is gathered during the community assessment to facilitate ease of understanding and use. A variety of tools can be used to simplify this process (see **Box 5**). This information can be consolidated by the assessment team and then used as the basis for stakeholder discussion and formulation of the community participation strategy for the catchment area and/or at the locality level. The information can also be consolidated as part of a consultative process with stakeholders at the catchment area and/or locality level and later used in methods to assess service access and utilization (coverage).

### Box 5. Summary of Community Assessment Tools

#### 1. Geographic community map

Plot the presence of NGOs, CBOs, community health committees, and community volunteer networks on a geographic representation of the catchment area. Add geographic and demographic information and community structures (e.g., roads, rivers, canyons, marketplaces, mosques, health facilities, water sources). Represent the information on a hand-drawn map on, for example, a flip chart.

#### 2. Matrix of community actors and their initiatives, target populations, and coverage

List NGOs, CBOs, community health committees, and community volunteer networks by community and/or assessment area in a matrix. List the various community actors with their initiatives and/or activities, target populations, and coverage.

#### 3. SWOT analysis for community participation and outreach for CMAM

Conduct a SWOT analysis consisting of the identified strengths and weaknesses of the current situation and the identified opportunities and threats for future community participation and outreach strategies and activities for CMAM. Plot the analysis on a matrix.

#### 4. Matrix of key perceptions and practices on health and nutrition

List key perceptions and practices affecting health and nutritional status and implications for community outreach strategies and activities for CMAM. Identify potential ways to appropriately address the identified key issues.

#### 5. Matrix of potential COWs for CMAM

List COWs, including various extension workers and volunteers with potential for involvement in community outreach for CMAM. Identify the strengths and weaknesses of involving these actors for community outreach for CMAM.

#### 6. Matrix of community actors selected for community participation and outreach for CMAM

List the various community actors that are identified to be used for community outreach activities and coordination/supervision, outlining respective responsibilities at start-up and during the implementation phase.

## **Step 2: Formulate a Community Outreach Strategy**

### **CMAM Community Focal Persons**

CMAM community focal persons will be identified at SMOH and locality levels. These individuals will be responsible for supporting CMAM community-level activity along with their other duties. The selection of focal persons will depend on ongoing activities and human resources in place at state and locality levels. It will be important to appoint a senior staff member at the SMOH level with experience in working with and supporting community-level activities to provide the required professional guidance to the locality-level focal persons. At the locality level, it might be appropriate to appoint the C-IMCI coordinator as the CMAM community focal person.

The SMOH and locality health management team will decide the strategy for community participation and outreach in CMAM in consultation with community representatives, based on the national CMAM manual and with reference to the community assessment findings. Development of the strategy will be led by the identified CMAM focal persons at the state and locality levels, who will also be responsible for supporting implementation of the strategy.

### **Linking with Community Mechanisms**

CMAM activities should be planned, monitored, and managed in consultation with and through locality and sub-locality committees, if they exist. This includes the locality- and community-level health committees and development committees that function under the auspices of the local administration. One could also consider other established committees that support the various health and development initiatives in the area, including the CBI supported by FMOH and the CFCI supported by UNICEF.

While such committees exist in some localities and sub-localities, they might not be very active or might not function at all. In such situations, CMAM can be used to reinvigorate and strengthen these committees, with CMAM coordinators or focal persons proactively seeking to work through and support them, initially to undertake CMAM-related work and then to take on responsibility for broader health and nutrition activities. Where such committees do not exist, CMAM coordinators or focal persons should work toward establishing health committees. This involves supporting the selection of committee members according to clearly defined criteria and then training and mentoring the committee.

It will be important to clarify the respective roles and responsibilities of the various committees in relation to CMAM, such as orientation, support of community outreach work (i.e., active case-finding, follow-up, health and nutrition education, and SBCC), and monitoring and reporting (M&R). It is also essential to develop mechanisms for linkages between the various committees in the catchment area, and to facilitate and support appropriate linkages and communication among the village committees, the locality health committee, and neighboring village committees.

Links with other community outreach services, programs, and initiatives need to be considered. Children with acute malnutrition are often from very poor families and/or live in a very vulnerable environment exposed to food insecurity, poor mother and child feeding and caring practices, and a poor public health environment. It is recommended that families with children with acute malnutrition are targeted by wider community initiatives that improve their home environment and promote access to an improved quality diet. These initiatives are likely to be linked with the various committees that are operating in the catchment area(s); the committees can therefore facilitate the linkages and referrals.

Through the mapping exercise (see **Step 1**), community health, nutrition, or livelihoods services or initiatives that exist in the area and might be complementary to CMAM should be identified. It is recommended that community outreach coordinators/focal persons establish links with such services and develop mechanisms for referring mothers, caregivers, and/or households with children with acute malnutrition to these initiatives.

## Planning for Community Participation

Community participation is an ongoing activity, starting from the early stages of planning for the establishment of services, to inform the community about malnutrition, its causes, and its treatment; the CMAM components (community outreach, inpatient care, outpatient care, and supplementary feeding); sites; and admission and discharge criteria.

As CMAM implementation gets under way, a process of ongoing dialogue between the community and CMAM service managers/providers should be established where activity can be reviewed, stories of success can be shared, positive behavior change can be encouraged, problems and concerns can be addressed, and the community can be involved in decision making on operational strategies. As part of this process, meetings should be scheduled regularly to maintain contact with the community and address CMAM-related issues. The local media (radio and television) could be used to inform the community about CMAM services to complement and support other community participation activities (see the next section on standardized messages).

Community participation involves dialogue between health managers and key community representatives (refer to **Step 1**) who will then engage with and inform the wider community. It will be important to ensure that the key community representatives with standing and power in the community are identified and fully involved in the participation activity. It is also important to ensure the involvement of women in the participation activity. This could be organized through the locality and village committees women's subcommittees, through the Women's Union, or through alternative women's groups that might have been identified during the community assessment.

Ultimately, community participation raises awareness about malnutrition and CMAM; promotes understanding of the various CMAM components, admission and discharge criteria, and sites where services are available; and lays the foundation for ownership. It also prevents misunderstandings that can arise around CMAM, which can subsequently cause barriers to access, such as the following.

- CMAM might attract many children who are not eligible for admission, and turning these people away can create ill feelings within a community and subsequently generate negative perceptions about the service, reducing service uptake.
- Large numbers of children arriving for admission during service start-up might overwhelm health care providers and cause negative feedback within the community, as caregivers of those eligible for admission waste time waiting for treatment.

## Developing Standardized Information Messages on CMAM

The use of standardized messages, adapted to different audiences, will facilitate uniform and accurate information sharing on malnutrition and its causes and treatment; the various components of CMAM; the sites; and admission and discharge criteria.

Specific messages on CMAM have been developed for different audiences in Sudan (see **Annex 2. Community Outreach Messages**). These standard messages will need to be adapted for each state/locality by inserting relevant location and health facility names and other amendments that might be deemed necessary for the various population groups in an area, such as use of simple language and the local terms for malnutrition.

## Planning for Community Outreach Activities

Community outreach for CMAM encompasses:

- a. Early and active case-finding (screening) and referral of children with SAM for treatment
- b. Follow-up home visits for problem cases
- c. Health and nutrition education and SBCC

It is essential to tailor community outreach activities to the local context in which they are being implemented (e.g., cultural norms on gender roles) and ensure that activities take full advantage of existing systems and structures and available human resources to facilitate establishment of a sustainable system providing maximum coverage of outreach services across the catchment area.

### *Early and Active Case-Finding (Screening) and Referral of Children with SAM for Treatment*

Early and active case-finding and referral of children with SAM is essential to initiate treatment before the onset of medical complications or increased risk of death. It is recommended that all children under 5 years be periodically screened for SAM.

Active case-finding and referral is carried out by a variety of health facility staff, extension workers, and volunteers, determined locally based on available human resources. All staff and volunteers who are involved in screening activities have been trained to identify children with SAM using a standard screening procedure.

#### Screening Tools

There are a variety of screening options that will cover different population groups in space and time, for example:

- House-to-house visits
- Screening organized at a central point in the community on a regular basis
- Screening organized at point activities or during cultural and socioeconomic events, such as community meetings, markets, or funerals
- Screening linked with other health and nutrition outreach interventions, such as during national campaigns, growth monitoring, or reproductive health clinics
- Screening at any contact point with the health care system
- Self-referrals, where caregivers bring children to the services on their own initiative

There are advantages and disadvantages to each screening option. A combination of screening options should be used depending on the operational context and should change as the operational context changes. The training of COWs should elaborate on the strengths and weaknesses of the different screening options.

#### **Box 6. Use of Traditional Practitioners for Case-Finding and Referral**

In Sudan, traditional practitioners are very often used for the treatment of malnourished children. In isolated rural areas, this may be the only locally available treatment. However, even where treatment for acute malnutrition exists, whether a center-based or community-based approach, many children undergo months of traditional treatment before starting therapeutic treatment, and sometimes continue with traditional treatment while undergoing therapeutic treatment. Some of these traditional practices are very harmful for the child.

The cooperation of traditional practitioners in the detection and referral of acutely malnourished children can have major impact on the service access, uptake, and outcome. However, it may not be easy to achieve. Health care providers from health facilities may not have a good relationship with traditional practitioners, making it difficult to secure the practitioners' trust. In addition, the establishment of CMAM services may be seen as a threat to the traditional practitioners' livelihood. Sensitivity and perseverance are necessary to establish links and to develop trust and ultimately the gain the cooperation of traditional practitioners in the detection and referral of acutely malnourished children for therapeutic treatment. Traditional practitioners should receive training and a MUAC tape, and be informed on how both practices can coexist and strengthen each other.

### Screening Procedure

The children are assessed for the presence of bilateral pitting edema, and MUAC is measured. Those children identified with SAM are then referred for treatment.

### Criteria for Referral

- Presence of bilateral pitting edema
- MUAC less than 115 mm for children 6–59 months
- Infants under 6 months with bilateral pitting edema and/or visible wasting are not measured, but are referred to the health facility where they are further investigated

### Referral Process

When a child meets the criteria for referral, s/he is instructed to go to the nearest CMAM site and is given a referral slip to present at the site (see **Annex 3. Referral Slip Community Screening**).

### *Follow-Up Home Visits for Problem Cases*

Children admitted to outpatient care are monitored to ensure sustained improvement in their condition, and, where appropriate, the health care provider will request that follow-up home visits be conducted.

Home visits for children with SAM are essential in the following cases.

- Where a child is absent from treatment (missed one or two visits) or has defaulted (missed three consecutive visits), home visits will be requested to gain understanding of the reason for the absence or defaulting and to encourage return to treatment. While the caregiver must be made aware of the importance of bringing the child back for treatment, it is important not to reprimand the caregiver, as this can discourage return to treatment.
- Where a child has static weight, is losing weight, is not losing edema, or has a deteriorating medical condition, the health care provider will discuss the situation with the caregiver and request a home visit to provide support to the caregiver and investigate the home environment.
- Children can still be fragile after treatment in inpatient care. The health care provider can request a home visit to strengthen support to the caregiver.
- In cases where caregivers refuse referral of children with SAM with medical complications to be treated in inpatient care, these children can be treated in outpatient care. In these cases, follow-up home visits are essential to strengthen support to the caregiver.

The COW will fill in home visit records and checklists for home visits, which are useful tools for M&R home visits (see **Annex 4. Community Outreach Reports** and **Annex 5. Checklist Home Visits**).

### The Role of COWs

Home visits for children who are absent or have defaulted from treatment can be carried out by all COWs. However, it is essential that they have been appropriately trained to identify problems and danger signs and provide the required support to the caregivers. Ideally, COWs are active case-finders who will follow up on the defaulting of children they have referred. If a child does not return, another home visit can be made by a more experienced COW to investigate the home situation and provide necessary advice and support to the parents/caregivers.

Where a health facility-based COW makes a home visit, the health care provider will interact directly with the facility-based staff member to inform on the need for a home visit. Where volunteers are being used

as COWs for home visits, the health care provider will interact with the outreach supervisor to convey a message to the relevant volunteer(s) to arrange a home visit for a problem case at risk of developing medical complications.

The locality-level CMAM focal person will have overall responsibility for supportive supervision of CMAM community outreach activities. However, day-to-day supervision of outreach activities will be the responsibility of the existing supervisors of the various COWs, including staff and volunteers.

### *Health and Nutrition Education and SBCC*

IMCI and the ENP have developed health and nutrition education materials and visual aids, and they should be made available for use in community outreach behavior change both for wider general health and nutrition promotion and specifically in relation to understanding causes of malnutrition, CMAM services, and key messages in relation to prevention and treatment of malnutrition and optimal feeding practices for malnourished children (see also **Annex 6. Health and Nutrition Education Messages**).

### The Role of COWs and Others in the Community

Health and nutrition education and SBCC should be conducted at household and community levels by nutrition educators as part of their routine work and by the various health and nutrition extension workers and COWs (staff or volunteers identified for CMAM) operating in the catchment area.

In many communities, existing COWs, including volunteer networks, already hold community health education sessions. In these cases, the CMAM-related health and nutrition education and SBCC should be conducted through these mechanisms. However, where such systems or mechanisms are not in place, the relevant supervisors (of the COWs, including volunteers) should interact with the community leaders and relevant committees to organize these sessions on a regular basis across the catchment area.

### At the Household and Community Levels

At the household level, health and nutrition education and SBCC should be conducted during routine home visits. Issues for discussion are determined based on the local context, and the individual household's environment and specific care and feeding practices.

At the community level, groups of mothers should be periodically gathered to discuss relevant health and nutrition issues. The issues for discussion are determined based on topical local health and nutrition priorities. It is essential, however, that the health and nutrition education and SBCC pays particular attention to the local context and provides an adequate focus on causes and prevention of malnutrition, and optimal care and feeding practices for malnourished children.

**Note:** The behavior change approach requires health care providers and COWs to:

1. Listen, understand, and then negotiate with individuals and communities to make positive behavior change
2. Focus on the promotion of positive, sustainable practices or actions, since creating awareness and building knowledge are not enough

## **Step 3: Conduct Training on Community Outreach for CMAM**

### **The CMAM Support Team and Trainers**

The CMAM support team (a team of CMAM experts at the FMOH supporting a similar structure at the state level) provides initial training to the CMAM focal person and community participation and outreach coordinator at the state level. A core team of trainers for CMAM should then be selected and trained within each state. This core team should be made up of staff from the state and locality levels who are

responsible for CMAM management, and will also include community outreach coordinators or focal persons from the state and locality levels.

With UNICEF support, SMOHs and FMOH will maintain a database with information on the core team of CMAM trainers and their specific expertise (community outreach, inpatient care, outpatient care, and/or supplementary feeding).

### **Training at Various Levels**

Training for community participation in CMAM will be conducted at various levels on the following topics.

For state- and locality-level CMAM managers, coordinators, and focal persons, and health facility-level CMAM community outreach supervisors:

- CMAM orientation: basic information on the causes, types, identification, and treatment of malnutrition using the CMAM approach
- How to conduct a community assessment
- How to engage with communities for community participation and awareness-raising
- Community outreach strategies
- Practice in identifying bilateral pitting edema and using MUAC
- Health and nutrition education and SBCC
- Roles and responsibilities of CMAM health managers, community outreach coordinators, health care practitioners at outpatient care, various extension workers and volunteers responsible for outreach activity, and village committees/community representatives
- Supervising community outreach
- M&R of performance and the effectiveness of community participation and outreach
- Training for community outreach

For community-level outreach workers:

- Basic information on the causes, types, identification, and treatment of malnutrition
- Objectives and target population for the management of SAM
- Practice in identifying bilateral pitting edema and using MUAC
- Orientation on CMAM services, sites, and referral for treatment
- Community outreach strategies and issues
- Health and nutrition education and SBCC, with a particular focus on the causes and prevention of malnutrition and optimal feeding practices for malnourished children
- Community participation and how to engage with the communities and share information
- Roles and responsibilities of COWs

For community representatives:

- Basic information on the causes, types, identification, and treatment of malnutrition
- Objectives and target population for the management of SAM
- Orientation on CMAM services, sites, and referral for treatment
- Community outreach strategies and issues
- Community sensitization and awareness-raising
- Roles and responsibilities of COWs
- Roles and responsibilities of community health committees and community representatives

### **Methods**

Training will be carried out in a participatory fashion and will include in-service training and practical experience at the health facilities and in the communities. It is recommended that at least two facilitators lead the training of 15–25 participants.

Training methods include talks with visual aids, participatory lectures, plenary and group discussion, role plays, review of case studies, and observation during practicals.

Country-specific training materials will be adapted from national and international documents. Training materials will also include visual aids (including these guidelines), IMCI guidelines, and ENP training materials.

#### **Step 4: Implement Community Participation and Outreach Activities**

While **Step 2** discussed strategies in some depth, this section provides only a brief overview of implementation.

Following training of relevant staff, volunteers, and community representatives as COWs, community participation and outreach activities will be implemented in line with the strategies and plans that have been developed prior to starting CMAM services. Based on findings from supervision and M&R, the strategies and activities can be adapted as deemed appropriate in discussion with the various stakeholders.

#### **Community Participation and Outreach Activities and Responsible Persons**

Community participation activities include:

- Community orientation and discussion meetings, including feedback
- Radio messages and other multimedia or cultural strategies

Community outreach activities include:

- Early case-finding (screening) and referral of children with SAM for treatment
- Follow-up home visits for problem cases
- Health and nutrition education and SBCC

**Table 12. Community Participation and Outreach Activities and Responsible Persons**

<b>Activity</b>	<b>Responsibility</b>
Developing a community participation and outreach strategy at the state and locality levels	State and locality CMAM focal persons in consultation with community representatives
Supervising community participation and outreach activities	Locality CMAM focal person with support from the state CMAM focal person
Convening community participation activities, i.e., holding community meetings to plan community outreach and discuss issues and progress with the various stakeholders	Locality CMAM focal person with support from the state CMAM focal person; COWs; the locality council; the locality development committee; community leaders; community committees
Screening for active case-finding and referral	COWs
Following up of problem cases	COWs
Providing health and nutrition education and SBCC	COWs

#### **Step 5: Conduct Supervision and Monitoring and Reporting on Community Outreach Activities**

Supervision and M&R of community participation and outreach activities are essential components for CMAM quality assurance. M&R tools for community outreach are the home visit record, the community outreach report, and the checklist for home visits (See **Annex 4. Community Outreach Reports** and **Annex 5. Checklist Home Visits**).

## **Supportive Supervision of CMAM**

Supportive supervision of the CMAM community-level component should be conducted at the state, locality, and sub-locality levels and/or at outpatient care site catchment area levels.

### *The Role of the CMAM Community Outreach Focal Person*

At the state level, the identified CMAM community outreach focal person is responsible for supportive supervision of the locality-level CMAM community outreach focal persons. This requires:

- Regular supervisory visits to the locality to review the implementation of strategy/activities; discuss progress, problems, and issues; and provide support and direction to the CMAM community focal person
- Participating in key locality-level meetings
- Conducting periodic state level supervisory meetings in which locality CMAM community focal persons are brought together to review activities and share experiences across localities (this could be conducted as part of a wider CMAM supervisory activity)

At the locality level, the CMAM community outreach focal persons have overall responsibility for supportive supervision of CMAM community level activities, including the activities of the various community committees and the outreach activities. However, the day-to-day supportive supervision of the community outreach activities (i.e., case-finding, follow-up visits, and health and nutrition promotion and SBCC) are the responsibility of the existing supervisors of the various categories of health staff and volunteers undertaking these tasks.

Where 10 or more full-time COWs are responsible for CMAM-related work (as in a camp situation), a full-time community outreach supervisor should be appointed to support these staff (and volunteers).

### *Supportive Supervision of Community Committees*

Locality CMAM community outreach focal persons should already be meeting periodically with the community committees as part of the community participation strategy. Supportive supervision of community committee activities might be carried out as part of this process, and involves:

- Reviewing the activities undertaken
- Identifying problems or weaknesses in implementation (e.g., ineligible children arriving for admission after community participation sessions) and putting forward pragmatic solutions/recommendations to improve such activity in the future (e.g., using clear standardized messages for participation purposes)

### *Supportive Supervision of Supervisors*

Locality CMAM community outreach focal persons are responsible for supporting the various supervisors (e.g., under C-IMCI, CBI, CFCI) who are responsible for supporting CMAM-related outreach work. This support involves:

- Regular supervisory visits to the catchment areas to review strategy/activities implementation; discuss progress, problems, and issues; and provide support and direction to the various supervisors for CMAM outreach work
- Regular locality-level supervisory meetings that bring the various supervisors together to review activities and share experiences across the catchment areas (this can be conducted as part of a wider CMAM supervisory activity)

### *Supportive Supervision of Community Participation and Outreach Activities*

Where supervisors of various categories of staff and volunteers involved in community outreach activities already meet with their staff for supervisory purposes, supervision for CMAM-related community outreach can be incorporated into routine supervision. Where this is not the case (i.e., supervision is not conducted

routinely), the CMAM community outreach focal person will support the relevant supervisors to conduct CMAM-related supervision. Supervision includes:

- Observing the community outreach activities of individual staff and/or volunteers, which includes:
  - Making home visits with staff/volunteers to observe how they interact with caregivers, the accuracy of screening procedures, whether referral is according to protocol, and the quality of health and nutrition education and SBCC
  - Making community-level visits with staff/volunteers to observe how they interact with the community and the quality of health and nutrition education and SBCC

Such observation will be conducted periodically. It is likely that this is undertaken more frequently when services are newly established and when new staff/volunteers are appointed.

- Reviewing community outreach activity records. All staff/volunteers responsible for CMAM-related community outreach activities should have a notebook (or notebook section) for recording CMAM-related activities, including:
  - Each home visit made: geographical area, family name, purpose, action recommended, and outcome of visit
  - Each community-level health and nutrition education and SBCC session conducted: geographical area, topic covered, and number of beneficiaries who attended

When community-level screening is conducted, registration should be conducted, including recording the geographical area, the number of children screened, and the number of children referred for CMAM services. CMAM outreach activity registration should be reviewed by the various supervisors weekly or fortnightly to identify and address concerns (e.g., number of visits being carried out on daily basis, children wrongly referred).

### *Sub-Locality and Outpatient Care Site Catchment Area Supervisory Feedback Meetings*

Additional supervisory meetings should be held periodically, which all staff involved in CMAM-related community outreach activities (i.e., locality CMAM community outreach focal person, all supervisors, all staff/volunteers involved in community outreach, and any relevant committee members and health facility staff) would be expected to attend. These meetings provide an opportunity for the outreach work in the catchment area to be reviewed, the coverage of outreach activities to be monitored (see **Assessing Coverage**, below), success stories and positive experiences to be shared, and problems and concerns to be raised and addressed.

## **Monitoring and Reporting of CMAM Community Outreach Activities**

Monitoring of community participation and outreach activities should be conducted at the locality, sub-locality, and/or catchment area.

The minimum indicators to report on monthly or periodically are:

- Number of communities involved in community participation and outreach
- Number of COWs (including staff and volunteers) trained and active

If capacity for broader M&R of community outreach is available, the indicators to report on monthly are:

- Training
  - Number of COWs, including volunteers, trained and active
  - Number of community representatives oriented in CMAM
- Community participation
  - Number of communities involved in community participation and outreach
  - Number of community orientation meetings conducted
- Community outreach
  - Number of community-level screening sessions conducted
  - Number of children with SAM referred for treatment

- Number of community home visits for problem cases
- Number of community health and nutrition education sessions held
- Number of caregivers who received health and nutrition education
- Coverage of CMAM outreach

Monthly reports on all CMAM-related outreach activities should be submitted to the various supervisors within the normal reporting system. The various supervisors are then responsible for collating and analyzing CMAM-related activity and submitting reports to the locality or sub-locality level CMAM community outreach focal person (see **Annex 4. Community Outreach Reports**).

The indicators and means of verification listed in **Table 13** should be used.

**Table 13. Indicators and Means of Verification for CMAM Community Participation and Outreach**

<b>Activity</b>	<b>Indicator</b>	<b>Means of Verification</b>
Training	# of COWs, including volunteers, trained and active	Supervisor Report
	# of community representatives oriented in CMAM	Supervisor Report
Community Participation	# of communities involved in community participation and outreach	Supervisor Report
	# of community orientation meetings conducted	Supervisor Report
Community Outreach	# of community-level screening sessions conducted	Supervisor Report
	# of children with SAM referred for treatment	Referral Slip
	# community home visits for problem cases	Home Visit Record
	# community health and nutrition education sessions	Supervisor Report
	# caregivers who received health and nutrition education	Supervisor Report
	Coverage of CMAM outreach	Mapping

### Assessing Coverage

Coverage of community participation and outreach activities should be monitored by plotting outreach activities against a map or a list of communities/populated areas. This method helps indicate “actual” coverage of outreach activities and identify communities and/or areas that have been overlooked. If areas are found to have high levels of referrals and requests for follow-up due to default, a problem that requires investigating is indicated.

Periodic evaluations of community participation and outreach for CMAM could be carried out and would include investigating:

- The severity of acute malnutrition: demand for and offer of services
- Uptake of CMAM services, which is a good indicator of the effectiveness of community outreach activity
- Actual geographic coverage of community outreach activity
- The level of community engagement in the planning and support of community participation and outreach activities for CMAM
- The impact of health and nutrition education and SBCC

## Annex 1. Community Assessment Questionnaire and Tools

### COMMUNITY ASSESSMENT QUESTIONNAIRE

The following topics and questions should be explored in a community assessment for CMAM.

#### Topic One: Understanding Community Knowledge, Beliefs, and Practices in Relation to Childhood Acute Malnutrition and Ill Health

Subtopic	Questions
Defining acute malnutrition	<ul style="list-style-type: none"> <li>• What are the different terms used to describe acute malnutrition locally?</li> <li>• Is there a perceived difference between acute malnutrition and general illness?</li> </ul>
Signs of acute malnutrition	<ul style="list-style-type: none"> <li>• What signs are locally associated with acute malnutrition?</li> </ul>
Causes of acute malnutrition	<ul style="list-style-type: none"> <li>• What are the locally perceived causes of acute malnutrition?</li> </ul> <p><b>Note:</b> There may be many perceived causes of malnutrition. Probe for awareness about the different causes of malnutrition, including food, health and care, and cultural beliefs and practices in the community.</p>
Treatment of acute malnutrition	<p><b>Note:</b> In some areas, treatment for acute malnutrition will be available through the national health system. Where this is the case, indicate which services are available and how far away these services are (distance and/or time required to travel there).</p> <ul style="list-style-type: none"> <li>• How has the community traditionally dealt with acute malnutrition? <ul style="list-style-type: none"> <li>◦ Are home remedies with herbs used? If so, which herbs are used?</li> <li>◦ Are traditional healers used? If so, which traditional healing practices are carried out?</li> </ul> </li> <li>• Has the use of home remedies or traditional healers changed in recent years? Was there an increase or decrease in their use? Why?</li> <li>• Where conventional treatment is available through the health facilities, how does the community perceive these services? Is it happy to use the services? Do caregivers continue to use traditional healers while attending conventional treatment?</li> </ul>
Treatment of sick children	<ul style="list-style-type: none"> <li>• How does the community generally deal with a child who is sick? <ul style="list-style-type: none"> <li>◦ Are home remedies used? If so, which home remedies?</li> <li>◦ Which services do caregivers take the children to for treatment: MOH, NGO, private clinic, or traditional healer? Are traditional treatments sought and administered before children are taken to a health facility?</li> </ul> </li> <li>• What are the key factors that influence the decision on where to take a child for treatment?</li> </ul>
IYCF	<ul style="list-style-type: none"> <li>• Do most mothers breastfeed their babies under 6 months of age?</li> <li>• At what age do mothers start to give additional liquids to infants (in addition to breast milk)?</li> <li>• At what age do mothers start to give complementary soft foods? What do they give?</li> <li>• How many times per day does a mother feed a 12-month-old infant? What is the child fed?</li> </ul>

## Topic Two: Understanding Community Systems, Structures, and Organization

Subtopic	Questions
Community organization	<ul style="list-style-type: none"> <li>Explore the existence and level of activity of the various community groups in the locality, and particularly those that focus on health and women. This includes groups created by communities themselves and groups with external support from a NGO and/or the government.</li> <li>Investigate if and how these various groups link together/coordinate activities.</li> </ul>
COWs	<ul style="list-style-type: none"> <li>Explore the various health and nutrition COW and volunteer networks <b>currently active</b> in the area—the respective roles and responsibilities—and which facilities these outreach workers and volunteers are attached to and the geographical coverage of the various cadres/networks within the area (includes nutrition educators, integrated PHC cadres, vaccinators, VMWs, CHWs, C-IMCI volunteers, CBI volunteers, CFCI volunteers, COWs, and volunteers supported by any other agencies).</li> <li>Investigate commitment from unpaid volunteers in terms of hours worked per week/month.</li> </ul>
Formal and informal communication in the locality	<ul style="list-style-type: none"> <li>Explore the usual methods of disseminating information to the community in the locality, including the official methods (e.g., community meetings, through local leaders, local radio) and more informal methods (e.g., groups getting together on market day).</li> <li>Explore the perceived relative effectiveness of the various channels.</li> </ul>
Options for supporting community participation and outreach activity for CMAM	<ul style="list-style-type: none"> <li>Explore perceptions of the key individuals and groups to involve in community participation and outreach activities.</li> <li>Gather suggestions on the most appropriate groups and networks to carry out outreach activity for CMAM.</li> </ul>

## COMMUNITY ASSESSMENT TOOLS

Tool	How to use
Geographic community map	Plot the presence of NGOs, CBOs, community health committees, and community volunteer networks on a geographic representation of the catchment area. Add geographic and demographic information and community structures (e.g., roads, rivers, canyons, marketplaces, mosques, health facilities, water sources). Represent the information on a hand-drawn map on, for example, a flip chart.
Matrix of community actors and their initiatives, target populations, and coverages	List NGOs, CBOs, community health committees, and community volunteer networks by community and/or assessment area. List the various community actors with their initiatives and/or activities, target populations and coverages.
SWOT analysis for community participation and outreach for CMAM	Conduct a SWOT analysis. Plot into a matrix the identified strengths and weaknesses of the current situation and the identified opportunities and threats for future community participation and outreach strategies and activities for CMAM.
Matrix of key perceptions and practices on health and nutrition	List key perceptions and practices affecting health and nutritional status and implications for community participation and outreach strategies and activities for CMAM. Identify potential ways to appropriately address the identified key issues.
Matrix of potential COWs for CMAM	List COWs, including various extension workers and volunteers, with potential for involvement in community outreach for CMAM. Identify strengths and weaknesses of involving these actors in community outreach for CMAM.
Matrix of community actors selected for community participation and outreach for CMAM	List the various community actors that are identified to be used for community participation and outreach activities and coordination/supervision. Outline their respective responsibilities and specific functions at startup and during the implementation phase.

## **Annex 2. Community Outreach Messages**

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### **TO COMMUNITY-BASED ORGANIZATIONS**

Dear Sir/Madam,

Re: Community-Based Management of Severe Acute Malnutrition

To improve the quality and accessibility of health services, the Ministry of Health has introduced a new treatment for children under 5 with severe acute malnutrition (SAM). These children could be very thin or have swelling.

The treatment is called Community-Based Management of Severe Acute Malnutrition (CMAM). It is free and brings the treatment of children with SAM much closer to the family, making it possible for children and their mothers and/or caregivers to avoid long stays in the hospital, as was done before.

In [NAME] Locality, [NAME] State, CMAM treatment is now available in the following health facilities: [INSERT NAMES of relevant health facilities].

Children who are very thin or have swelling need to be referred to a primary health care centre, where they will receive an assessment. If a child has SAM but has good appetite and no medical complications, the child does not have to go to the hospital for treatment. Instead, the child will be given the required medicines and a weekly supply of the medical food, Plumpy'Nut<sup>®</sup>, which is taken home and fed to the child as directed. The child should attend the services at the primary health care centre weekly for follow-up and to receive the medical food.

If a child under 5 with SAM has poor appetite or has a medical complication, he or she will be admitted to the hospital for a short time until the appetite has returned or the medical complication has resolved. The child will then receive further treatment at the primary health care centre and at home. Children under 6 months who are very thin or have swelling will need specialised inpatient care in the hospital.

Health workers and volunteers within the communities have been trained to check if children need this treatment. They take an arm measurement of each child with a small tape and check if both feet are swollen. All children found to be thin or swollen are referred to the primary health care centre, where the arm measurement and swelling of feet are checked again. If the child has appetite and is clinically well, they are given treatment. Only the children who are very small or very ill will need referral to inpatient care.

If you know a child who appears to be very thin or whose feet are swollen, tell his/her parents or caregivers about this new treatment. They can ask around the neighbourhood for a health worker, volunteer, or someone else trained to take the arm measurement, or they can go directly to a health facility to have their child measured any day.

Measurement of children and referral for treatment can be carried out at the following sites: [INSERT LIST]. CMAM treatment is available in the following health facilities: [INSERT LIST].

We are confident that this new treatment will significantly improve the Locality's ability to support the recovery of malnourished children, and we look forward to your cooperation. Please do not hesitate to contact me for more information or clarification.

Yours faithfully,  
Director of Health, State Ministry of Health

## TO HEALTH FACILITIES

Dear Sir/Madam,

Re: Community-Based Management of Severe Acute Malnutrition

To improve the quality and accessibility of health services in [NAME] Locality in [NAME] State, the Ministry of Health has introduced a new treatment for children under 5 with severe acute malnutrition (SAM) (bilateral pitting oedema or severe wasting). The service is called Community-Based Management of Severe Acute Malnutrition (CMAM).

This service, which is free, brings the treatment of children with SAM much closer to the family, making it possible for children and their mothers/caregivers to avoid the long stays in hospitals or therapeutic feeding centres, which customarily has been necessary for treating malnutrition. Children under 5 will be screened in the communities and at the health facilities; they will be checked for bilateral pitting oedema and for severe wasting based on a mid-upper arm circumference (MUAC) measurement with a specially marked tape (MUAC tape). Those that require treatment will be referred for admission to the CMAM service at the health facility. Early detection of cases and referral for treatment is essential to avoid medical complications.

At the health facility, the child with SAM receives a medical evaluation. If a child with SAM has good appetite and no medical complications, he or she can be treated as an outpatient. The treatment at the primary health care centre provides antibiotic, antihelminthic, and malaria treatment; vitamin A supplementation; and a ready-to-use therapeutic food (RUTF) called Plumpy'Nut<sup>®</sup>, which the caregiver of the child with SAM takes home and feeds to the child as directed. The child will attend the health facility weekly for follow-up and to receive the therapeutic food.

If a child with SAM does not have appetite or has a medical complication, he or she will be admitted to specialised inpatient care at [NAME] hospital for a short time until the medical complication has resolved. The child will then continue treatment at home, attending the health facility weekly for follow-up and to receive the therapeutic food. Children under 6 months who are very thin or have swelling will need specialised inpatient care at [NAME] Hospital.

The Ministry of Health would like to involve a variety of health care providers, including from private clinics, to help identify children with SAM so they can be treated at an early stage. The services are currently provided in [LIST NAMES OF HEALTH FACILITIES] sites under [NAME] Locality Health Directorate, but it is hoped that the services will be extended to other health facilities in the Locality. We are therefore writing to kindly request that your health facility brief all staff members, especially those in the Outpatient Department, and have them refer children with bilateral pitting oedema and severe wasting to any of the above-mentioned health facilities for treatment.

The [NAME] Locality Nutrition Team would be pleased to provide your health facility with MUAC tapes and train your staff in identifying and treating children with bilateral pitting oedema and severe wasting.

We are confident that the CMAM services will significantly improve the Locality's ability to support the recovery of malnourished children, and we look forward to your cooperation. Please do not hesitate to contact us for more information or clarification.

Yours faithfully,  
Director of Health, State Ministry of Health

## **TO MOTHERS/CAREGIVERS WITH CHILDREN UNDER 5**

A new treatment free of charge is now available for children under 5 with severe acute malnutrition (SAM). These children are very thin or have swelling, and need a specific treatment with medicines and a medical food that will be provided at the health facility after a medical check.

Health workers and volunteers within your communities have been trained to check if your child needs this treatment. They take an arm measurement with a small tape and check if both feet are swollen. All children found to be thin or swollen are referred to the health facility, where the arm measurement and swelling of feet are checked again.

If a child with SAM has good appetite and does not have any medical complications, he or she does not have to go to hospital for treatment. Instead the health centre will treat the child with the required medicines and will provide a week's supply of special medical food, called Plumpy'Nut<sup>®</sup>, which the families of eligible children take home and feed to the child as directed. The child should attend the health facility weekly for follow-up and to receive a further supply of the medical food.

If the child with SAM has poor appetite or has developed a medical complication, he or she will be admitted to the hospital for a short time until the child's medical condition is improving. The child will then continue treatment for SAM at the health facility and at home.

Children under 6 months who are very thin or have swelling will need specialised inpatient care in [NAME] Hospital.

If you know a child who appears to be very thin or whose feet are swollen, tell his/her parents or caregivers about this new treatment. They can ask around their neighbourhood for a health worker, volunteer, or someone else trained to take the arm measurement, or they can go directly to a health facility to have their child measured any day.

Measurement of children and referral for treatment can be carried out at the following health facilities: [INSERT LIST]. CMAM treatment is available in the following health facilities: [INSERT LIST].

## **MESSAGE FOR USE ON THE RADIO AT THE STATE AND/OR LOCALITY LEVELS**

Re: New Treatment for Children with Severe Acute Malnutrition

To improve the quality and accessibility of health services, the Ministry of Health has introduced a new treatment free of charge for children under 5 with severe acute malnutrition. These children could be very thin or have swelling and need a specific treatment with medicines and a medical food.

This treatment is free and provided on an outpatient basis from a health centre for most children, making it possible for children and their mothers or caregivers to avoid the long stays in therapeutic feeding centres that customarily have been necessary for treating severe acute malnutrition.

In [NAME] State, this treatment, known as Community-Based Management of Acute Malnutrition or CMAM, will initially be started in [NAMES] Localities and then extended across the other localities.

Where the services have commenced, health workers and volunteers within the communities have been trained to check if children need this treatment. They take an arm measurement of each child with a small tape and check if both feet are swollen. All children found to be thin or swollen are referred to the health facility, where they will receive an assessment; the arm measurement and swelling of feet are checked again.

If a child has SAM but has good appetite and no medical complications, the child does not have to go to the hospital for treatment. Instead, the child will be given required medicines and a weekly supply of the medical food called Plumpy'Nut<sup>®</sup>, which is taken home and fed to the child as directed. The child should attend the health facility weekly for follow-up and to receive the medical food.

If a child with SAM has poor appetite or has a medical complication, he or she will be admitted to the hospital for a short time until the medical complication has improved. The child will then receive further treatment at the health facility and at home.

Children under 6 months who are very thin or have swelling will need specialised inpatient care in the hospital.

If you know a child who appears to be very thin or whose feet are swollen, tell his/her parents or caregivers about this new treatment. Where CMAM services are available in the Locality, the parents or caregivers can ask around the neighbourhood for a health worker, volunteer, or someone else trained to take the arm measurement, or they can go directly to a health facility to have their child measured.

## Annex 3. Referral Slip Community Screening

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Child's Name:

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Father's Name:

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Name of Mother/Caregiver:

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Place of Origin:

Referral Health Facility:

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Date of Outreach:

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Bilateral Pitting Oedema: Yes No

MUAC: mm

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Other Findings:

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Name of Community Outreach Worker:

Signature:

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## Annex 4. Community Outreach Reports

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### HOME VISIT RECORD

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Reason for Home Visit (circle): *Absence Defaulter Dead Non-response to treatment Other:*

Registration Number:

Date:

Site:

Community:

Locality:

Child's Name:

Age:

Sex:  Male  Female

Father's Name:

Name of Mother/Caregiver:

Address:

Date of Visit:

Findings:

Name of Community Outreach Worker:

Signature:

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## COMMUNITY OUTREACH REPORT

**Locality Name:** \_\_\_\_\_ **State Name:** \_\_\_\_\_

**Reporting Period:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Author Name and Position:** \_\_\_\_\_

<b>CATCHMENT AREA</b>	Number of children under 5:		Expected number under 5 with SAM:	
	Number of CMAM outpatient sites:		Number of CMAM inpatient sites:	
<b>TRAININGS</b>	Number of community outreach workers including volunteers trained and active:		Number of community representatives oriented:	
<b>COMMUNITY PARTICIPATION</b>	Number of communities involved in community participation and outreach:		Number of communities orientation meetings:	
<b>COMMUNITY OUTREACH</b>	Number of community level screening sessions conducted:		Number of children with SAM referred for treatment:	
	Number of community home visits for problem cases:		Number of community health and nutrition education sessions held:	
	Number of caregivers received health and nutrition education:		Coverage of CMAM:	

**SERVICE PROGRESS**

Barriers to access:

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Causes of death:

---

Reasons for defaulting:

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Reasons for non-response to treatment:

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**Reasons why areas are not covered:**

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**Success stories:**

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**Identified Problems:**

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**Planned Activities:**

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## Annex 5. Checklist Home Visits

<b>Outreach Worker's Name:</b>				
<b>Date of Visit:</b>				
<b>Child's Name:</b>				
<b>Note:</b> If problems are identified, please list any health education or advice given in the space below or on the other side of the page. Return this information to the health facility.				
<b>FEEDING</b>	Is the ration of RUTF present in the home? <i>If not, where is the ration?</i>	Yes	No	
	Is the available RUTF enough to last until the next outpatient care session?	Yes	No	
	Is the RUTF being shared or eaten only by the sick child?	Shared	Sick child only	
	Yesterday, did the sick child eat food other than RUTF? <i>If yes, what type of food?</i>	Yes	No	
	Yesterday, how often did the child receive breast milk? (for children < 2 years)			
	Yesterday, how many times did the sick child receive RUTF to eat?			
	Did someone help or encourage the sick child to eat?	Yes	No	
	What does the caregiver do if the sick child does not want to eat?			
	Is clean water available?	Yes	No	
	Is water given to the child when eating RUTF?	Yes	No	
	<b>CARING</b>	Are both parents alive and healthy?	Yes	No
	Who cares for the sick child during the day?			
		Is the sick child clean?	Yes	No
<b>HEALTH</b>	What is the household's main source of water?			
	Is there soap for washing in the house?	Yes	No	
	Do the caregiver and child wash hands and face before the child is fed?	Yes	No	
	Is food/RUTF covered and free from flies?	Yes	No	
	What action does the caregiver take when the child has diarrhoea?			
<b>FOOD SECURITY</b>	Does the household currently have food available?	Yes	No	
	What is the most important source of income for the household?			
<b>COMMENTS:</b>				

## **Annex 6. Health and Nutrition Education Messages**

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### **KEY BEHAVIOURS TO PROMOTE**

#### **Essential Nutrition Actions**

- Optimal breastfeeding during the first 6 months of life
- Optimal complementary feeding starting at 6 months with continued breastfeeding to 2 years of age and beyond
- Continued feeding when the child is ill
- Optimal nutrition care of malnourished children
- Prevention of vitamin A deficiency for women and children
- Adequate iron and folic acid intake, and the prevention and control of anaemia for women and children
- Adequate iodine intake by all members of the household
- Optimal nutrition for women

#### **Household Hygiene Actions**

- Treatment and safe storage of drinking water
- Hand washing with soap or ash at critical times: after defecation, after handling children's faeces, before preparing food, before feeding children, before eating
- Safe disposal of faeces
- Proper storage and handling of food to prevent contamination

#### **Other Care Practices**

- Antenatal care attendance, including: at least four visits, tetanus toxoid vaccine, iron/folic acid supplementation
- Full course of immunisations for all children before their first birthday
- Children and women sleeping under insecticide-treated bednets
- Recognition when a sick child needs treatment outside of the home and seeking care from appropriate providers
- Recognition of pregnancy danger signs

### **RECOMMENDED FOODS FOR INFANTS AND CHILDREN 6 MONTHS TO 5 YEARS**

Breast milk continues to be an important source of nutrients up to age 2 years of age and beyond. However, your baby needs other foods and liquids in addition to breast milk once he or she reaches 6 months.

Staple foods give your child energy. These foods include cereals (rice, wheat, maize, millet, quinoa), roots (cassava, potato), and starchy fruits (plantain, breadfruit). Staple foods do not contain enough nutrients by themselves. You also need to give animal-source and other nutritious foods.

Your child should eat a variety of foods. Feed your child different foods from the groups along with the staple foods (see **Table 1**).

**Table 1. Staple and Other Nutritious Foods**

Staple foods:	Cereals: Rice, wheat, maize, millet, quinoa Roots: cassava, potato Starchy fruits: plantain, breadfruit
Animal-source foods:	Liver, meat, chicken, fish, eggs
Milk products:	Cheese, yoghurt, curds (and milk for non-breastfed children)
Green leafy and yellow-coloured vegetables:	Spinach, broccoli, chard, sweet potatoes, carrots, pumpkin
Fruits:	Banana, orange, guava, mango, peach, papaya
Pulses:	Chickpeas, lentils, cow peas, black-eyed peas, kidney beans, lima beans
Oils and fats:	Vegetable oils, butter
Nuts and seeds:	Groundnut paste, other nut pastes, soaked or germinated seeds such as sesame, pumpkin, sunflower, melon seeds

**Recommendations for Feeding Infants 6 Months to 1 Year**

- Breastfeed as often as your baby wants and exclusively on demand.
- To initiate complementary feeding, begin offering him/her small amounts of other foods at 6 months.
- Introduce new foods one at a time.
- Wait a few days to be sure that he or she can tolerate a new food before introducing another food.
- Give him/her staple foods and a variety of animal-source and other nutritious foods.
- Increase the quantity of food as he or she grows older, while continuing to breastfeed frequently.

*For 6-8 Months*

- Start by offering 2–3 tablespoons of thick porridge or well-mashed foods 2–3 times per day.
- Increase the amount gradually to a ½ cup.
- By 8 months, give him/her small chewable items to eat with his/her fingers.
- Let him/her try to feed him/herself, but provide help.
- Avoid foods that can cause choking, such as nuts, grapes, and raw carrots.
- Give one to two snacks between meals, depending on his/her appetite.

*For 9-11 Months*

- Offer 3–4 meals per day of finely chopped or mashed foods and foods that baby can pick up, about a ½ cup's worth.
- Also give 1–2 snacks per day, depending on his/her appetite.
- Feed him/her from his/her own plate or bowl.
- Patiently help your baby eat. Talk to him/her lovingly and look into his/her eyes. Actively encourage him/her to eat, but do not force him/her.
- If he or she loses interest while eating, remove any distractions and try to keep him/her interested in the meal.
- After 6 months of age, babies could need more water, even when they drink the recommended amounts of milk. To find out if your baby is still thirsty after eating, offer him/her some water (that has been boiled and cooled).

**Recommendations for Feeding Children 1–2 Years**

- Breastfeed your child as often as he or she wants, up to 2 years of age and beyond.
- Continue to give 3–4 meals of nutritious foods, chopped or mashed if necessary, ¾–1 cup at each meal.
- Also give 1-2 snacks per day between the meals, depending on his/her appetite.

- At each meal, feed your child a staple food, along with different nutritious foods from the groups listed in **Table 1**.
- Feed him/her from his/her own plate or bowl. Continue to actively help him/her to eat.

### **Recommendations for Feeding Children 2–5 Years**

- Give three meals per day of family foods.
- Give nutritious snacks twice daily between meals.
- Offer a variety of foods, such as those listed in **Table 1**.
- If your baby refuses a new food, offer him/her “tastes” of it several times. Show that you like the food.
- Do not force him/her to eat.
- Give realistic portions, depending on his/her age, size, and activity level.
- Increase the quantity of food as he or she grows older.

## Annex 7. Terms of Reference for the Technical Working Group for Community Outreach for CMAM

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### 1. BACKGROUND

Community outreach is the cornerstone for the success of Community-Based Management of Acute Malnutrition (CMAM). Nevertheless, the Darfur review in 2008 found that community mobilization activities designed to engage communities in selective feeding programs appeared to be decreasing. This decrease in outreach has led to decreased coverage and a lack of awareness of services and of the seriousness of SAM within the community. This lack of awareness, in turn, is one of the contributing factors to children with SAM being detected late and having to be admitted to inpatient care with advanced conditions, e.g., severe bilateral pitting edema and/or severe wasting with medical complications. The review recommended that implementers set clear time frames for community mobilization activities, which should be based on innovative and culturally appropriate means of communication. Community outreach guidelines will provide a framework for CMAM implementers to follow through with this recommendation.

The FMOH has put in place community health initiatives and has established strategic mechanisms for community health outreach, such as child health weeks, in both Darfur and non-Darfur states through the Accelerated Child Survival Initiative. The FMOH has concrete strategic plans for the expansion of community health initiatives and other community nutrition interventions, including the Essential Nutrition Package (ENP). The community outreach component for CMAM will build on, link with, and integrate into the aforementioned initiatives.

There is thus a need for a more in-depth understanding of ongoing community health initiatives in Sudan and lessons learned in community outreach for CMAM from Greater Darfur. Understanding of ongoing community health initiative and lessons learned from CMAM experience in Darfur will inform the community outreach component of the operational guidelines, help define the strategy for community outreach, and help develop a concrete community outreach implementation plan for scaling up CMAM.

In discussion with FMOH/National Nutrition Program (NNP), it has been agreed that a CMAM Community Outreach Assessment be carried out—supported by the Food and Nutrition Technical Assistance II Project (FANTA-2) and in collaboration with the Federal Ministry of Health (FMOH), UNICEF, and Ahfad University for Women (AUW).

### 2. OBJECTIVES

The objectives of this community outreach assessment:

- To conduct a situation analysis on community outreach for CMAM, therapeutic feeding, and other health and nutrition extension initiatives, analyzing national experiences and lessons learned.
- To develop a draft country-specific strategy and draft work plan for scaling up community outreach for CMAM. A Sudan-specific community outreach strategy adapted to the context will build on existing outreach activities and initiatives of health and other sectors to support and strengthen each other.
- To adapt the community outreach section of the national operational guidelines for CMAM based on the findings of the community outreach situation analysis and draft strategy.
- To provide recommendations for capacity development for community outreach for CMAM in Sudan, including outlines for in-service and pre-service training curricula, facilitators' training, and adaptation of training materials and job aids based on the generic Training Guide for CMAM (FANTA et al., 2008).

### 3. METHODOLOGY

A Technical Working Group (TWG) for Community Outreach for CMAM will be established to undertake this piece of work. The TWG will be made up of individuals with relevant experience from each of the collaborating agencies: FMOH, AUW, UNICEF, and FANTA-2. The CMAM support team members will also be members of the TWG. Additional individuals from each of the collaborating agencies can be selected to participate in the assessment as a capacity building activity.

Other staff member(s) of the FMOH Nutrition Department and other UNICEF staff and consultants involved in CMAM will be involved and included in discussion as appropriate. At state level the TWG will work in collaboration with the state CMAM focal persons, Community Based Initiative (CBI) focal persons, and other staff involved in CMAM from the state health management and UNICEF teams.

Through the course of the assignment, it is expected that the TWG members will build capacity and raise awareness for community outreach for CMAM of the various stakeholders from the Government of Sudan and implementing partners by means of the various discussions and meetings. The time will be spent between Khartoum and one selected state, and will provide the opportunity for stakeholders at the federal and state level to be involved in the community outreach assessment, the development of a strategy and national operational guidelines on community outreach, and outlining training tools for community outreach for CMAM.

### 4. ACTIVITIES

Activities to be undertaken by the TWG members are as follows.

#### 4.1 National Level

- Discuss lessons learned from the desk review undertaken by the FANTA-2 consultant on community outreach for CMAM in Sudan, and globally.
- Review and finalize the Terms of Reference and work plan, and brief the National Advisory Committee (NAC) for Nutrition on the proposed activities.
- Assess community health initiatives and community organization mechanisms at the federal level, including the Reproductive Health Department initiatives. From the standpoint of which institutional and organizational elements and resources are necessary for community outreach for CMAM, perform a situation analysis. This should include a mapping and strengths, weaknesses, opportunities, and threats (SWOT) analysis of organizational and institutional aspects of current initiatives and mechanisms, through discussions with stakeholders and/or relevant partners. It should also identify institutional, organizational, and resource needs for community outreach for CMAM.
- Develop a strategy for community outreach for CMAM in Sudan based on the analysis at the federal level and operational experiences at the state level, including an implementation plan for capacity development for community outreach.
- Review and adapt the generic operational guidelines section on community outreach.
- Develop recommendations for capacity development for community outreach for CMAM in Sudan, including outlines for in-service and pre-service training curricula, training of trainers, and adaptation of training materials and job aids based on the generic Training Guide for CMAM (FANTA et al. 2008).

#### 4.2 State Level, including State Ministry of Health Focal Persons for CMAM

##### 4.2.1 Greater Darfur (State to be decided)

- Conduct a learning review of community outreach operational experience in one of the Greater Darfur States through program and community visits using focus group discussions (FGDs) and key informant interviews (KII) (with SMOH, UNICEF, NGOs, and community representatives).

- Conduct a 2-day participatory meeting with the SMOH, UNICEF, NGOs, and community representatives from the state. Key persons from the other two Darfur states will be invited to attend the meeting.

#### 4.2.2 Early Implementation Phase State (State to be decided)

- Assess current community health initiatives and community organization mechanisms at the state level: situation analysis with mapping and SWOT analysis through discussions with stakeholders and/or relevant partners, including needs identification.
- Conduct a stakeholder participatory meeting on current activities and future plans for community outreach for CMAM.
- Draft a community outreach strategy for CMAM in the selected state to feed into the overall plan for establishing CMAM services, including capacity development plans.

During the briefing session, the FMOH/NNP with the NAC for CMAM will select the specific states to be visited for assessment.

**Note:**

**Regarding the Darfur state:** issues of security, ease of movement, and access to CMAM activities are to be considered

**Regarding the Early Implementation Phase state:** the selection will be in line with the implementation plan for scaling up CMAM (draft, April 30, 2009) and could consider Kassala, Gedarif, or South Kordofan States.

## 5. Technical Working Group for Community Outreach Assessment for CMAM

**Concept development:** Hedwig Deconinck and Vivienne Forsythe (FANTA-2)

**TWG members:** Dr. Rania Sharawy, FMOH/CAH; Eman Hassan, AUW; Salma Awad Albalula, team leader, CMAM Support Team, FMOH/NNP; Selwa Sorkatti, FMOH/NNP

**Coordination for the review:** Dr. Rania Sharawy (FMOH/CAH), Vivienne Forsythe (FANTA-2)

**Coordination for the reporting:** Dr. Rania Sharawy (FMOH/CAH); Vivienne Forsythe, Hedwig Deconinck, and Ali Nasr El Badawi (FANTA-2)

## 6. Workplan

**Note:**

- It is expected that each of the institutions (i.e., FMOH, SMOH, AUW, UNICEF, NAC for CMAM, and other implementing partners) will be engaged with and will contribute to some extent in the activities carried out during the assessment. However, TWG members will be engaged in the development and consolidation of information and in the write-up of the deliverables.
- The workplan will be further developed by the TWG during the week of July 19 (electronically) and through meetings during the week of July 26, 2009.

Time frame week starting	Location	Activity	Members involved (institutions and individuals identified)	Deliverable	Comment
26 July	Khartoum				
	Khartoum	Conduct TWG meeting to finalize Terms of Reference and workplan (clarify tools and methodologies to be used, etc.) Prepare state visits Darfur	All TWG members	Terms of Reference and work plan	To be submitted to NAC for input and approval
	Khartoum	Analyze national CBI: documentary analysis, meetings, KIIs, SWOT analysis, etc.	TBD	Draft situation analysis national level	
	Khartoum	Convene meeting with NAC for briefing and input on workplan	TBD	Minutes of meeting	
2 Aug	Travel to Darfur				
	Darfur	Conduct program review in selected state: site visits, FGDs and KIIs	All TWG members	Draft report on program review in selected state	
9 Aug	Darfur	Convene Darfur participatory stakeholder meeting	All TWG members	Minutes of participatory stakeholder meeting	
	Travel to Khartoum				
	Khartoum	Consolidate learning from Darfur visit	All TWG members	Draft report extracting key learning and recommendations for best practice	
	Khartoum	Prepare EIP state visit	TBD		
16 August	Travel to EIP				
	EIP	Assess current CHI and community mechanisms Convene stakeholder participatory meeting and develop community outreach strategy for CMAM for state	TBD	Draft report on situation analysis state level Minutes of participatory stakeholder meeting and state level strategy for community outreach	
23 Aug	Khartoum	Share and analyze of information and experience Finalize reports and state-level strategy for community outreach	All TWG Members	Final draft versions of: 1. Situation analysis national and state level 2. Lessons learned in Darfur 3. Strategy for community outreach for CMAM in selected EIP state	
	Khartoum	Draft strategy and implementation plan for scale-up and strengthening of community outreach for CMAM at federal and state levels		Draft overall strategy for community outreach for CMAM, including implementation plan	
	Khartoum	Review operational manual community outreach section and adapt to Sudan context main body of manual and relevant annexes, e.g., job aids		Community outreach section of operational guidelines adapted	
	Khartoum	Review FANTA et al. training guide community outreach section and adapt to Sudan context training guide		Community outreach section of FANTA training guide adapted	
	Khartoum	Report back to NAC	TBD		
30 August	Khartoum	Conduct TWG wrap-up Confirm next steps and respective responsibility for finalization of deliverables		Minutes of key action points for follow-up and time frame	
Sept	---	Complete tasks/deliverables as assigned during assessment and wrap-up by TWG		All deliverables submitted (due dates to be determined)	

## Annex 8. Overall Approach to the Community Outreach Assessment for Community-Based Management of Acute Malnutrition

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The overall aim of this community outreach assessment is to strengthen community outreach for CMAM as services are scaled up across the country.

The assessment's specific objectives are to:

- Conduct a situation analysis on community outreach for CMAM, therapeutic feeding, and other health and nutrition extension initiatives, analyzing national experiences and lessons learned
- Develop a draft country-specific strategy and draft work plan for scaling up community outreach for CMAM. A Sudan-specific strategy adapted to the context will build on the existing outreach activities and initiatives of health and other sectors to support and strengthen one another
- Adapt the national CMAM operational guidelines' community outreach section based on the findings of the community outreach situation analysis and draft strategy
- Provide recommendations for capacity strengthening for community outreach for CMAM in Sudan, including outlines for in-service and pre-service training curricula, facilitators' training, and adaptation of training materials and job aids based on the generic *Training Guide for Community-Based Management of Acute Malnutrition* (FANTA et al., 2008).

This assessment encompasses the following tasks:

1. National-level situation analysis on community outreach
2. Community outreach assessment in North Darfur, Kassala, and Khartoum states
3. Development of a strategy for community outreach for CMAM: Consolidation of findings, incorporation of key learning into Sudan guidelines and training manuals, and development of a strategy to strengthen capacity for community outreach for CMAM in Sudan

### A. NATIONAL-LEVEL SITUATION ANALYSIS

#### Objective

To conduct a situation analysis of the community health outreach initiatives supported by the FMOH—including community organization mechanisms (under Health System Strengthening Section)—and specific initiatives supported by various programs (e.g., C-IMCI, RH program)

#### Activities

- 1) Review key documents, such as policies, plans, strategies, reports, and evaluations that explore beneficiaries' perceptions of the project (all reasonable effort will be made to review source documents [e.g., external reviews/evaluations])
- 2) Meet with key individuals responsible for the various initiatives:
  - Community-Based Initiative (CBI)
  - Community Health Worker (CHW) Project
  - Reproductive Health (RH) Community-Based Maternal and Newborn Care (CMNBC) Project
  - Integrated Management of Childhood Illness (IMCI) – Community IMCI (C-IMCI)
  - Community Malaria Initiative (CMI)
  - Expanded Program on Immunization (EPI) Volunteer Initiative
  - Child-Friendly Community-Based Initiative (CFCI)
  - World Bank Community Development Fund (WB/CDF)

Through the meetings:

- A) Explore policy and strategy and current and planned coverage for each initiative
- B) Identify successful community outreach projects/initiatives and explore the factors contributing to this success
- C) Conduct a SWOT analysis related to the organizational/institutional aspects of the initiatives
- D) Identify how/where CMAM activities can link with the initiatives as appropriate

## **B. COMMUNITY OUTREACH ASSESSMENT**

### **North Darfur State**

#### *Objective*

Draw lessons learned from operational experience of community outreach for CMAM from the various implementing agencies operating in Greater Darfur (SMOHs and implementing partners).

The assessment encompasses three tasks:

1. Briefing and orientation on CMAM program and community outreach activities
2. Review of community outreach activities for CMAM in North Darfur State
3. A participatory learning workshop on community outreach activities for CMAM in greater Darfur (all three states)

#### *Context*

Due to the difficult operational context in Darfur, CMAM programs have been severely disrupted this year. There have been many changes as NGOs have left Darfur and management of CMAM programs has been taken over by SMOHs and UNICEF.

The assessment will be held in North Darfur State over 6 days. The assessment team will comprise two staff members from FMOH (CAH Department and Nutrition Department), a staff member from AUW, and a FANTA-2 consultant.

Qualitative research methods and approaches will be used to conduct this assessment. However, it must be emphasized that this is not a program evaluation but a learning review.

### **B.1 Briefing and Orientation on CMAM Program and Community Outreach Activities**

- i) Meetings with key stakeholders in SMOHs and key implementing partners
  - Briefing/general overview of CMAM service provision, SFPs, OPT, and inpatient treatment in the state
  - Exploring the process and time frame for planning and establishing OPT services
  - Exploring community outreach activities and referral system(s) for referral to SFP and outpatient care (e.g., using volunteers to conduct case-finding house to house and/or at community level and linking with the ACSI Child Health Day campaign)
- ii) Site visits for orientation purposes
  - Inpatient care
  - Outpatient care
  - Outreach treatment centers (if they exist)

These site visits are for **general orientation and overview** of CMAM services and how the whole system works together. It will not be as necessary to go into very detailed technical protocols as it would be for a learning visit for clinical staff.

## B.2 Community Outreach Program Activity Review

The objective of this review is to examine the experience of community outreach at the operational level. This review will be conducted in two locations purposefully selected through discussions with the review team and state stakeholders (El Fasher town and Abushok Camp). The review team will be divided in two, with each subteam visiting one area. Each subteam will have a leader and, if possible, one person with CMAM experience (to fully appreciate CMAM-related nuances).

FGDs and KIIs will be conducted in each area, with prespecified topics and probe questions for group discussions and set questions for the KIIs.

**FGDs** will be held with:

- a) CHWs and CHVs responsible for CMAM outreach (*1–2 hours*)
- b) Community representatives, both male and female, but NOT mothers/caregivers attending services

**KIIs** will be held with:

- a) Outpatient staff responsible for CMAM services (joint interview with two key staff per clinic/area) (*1 hour*)
- b) CHW/CHV supervisor or, if there is no outreach supervisor, the person responsible for CHWs/CHVs (*2 hours*)
- c) Program beneficiaries (caregivers of children attending program for treatment for SAM) (*10 minutes per interview*)
- d) Community leaders (joint interview with two community leaders per area) (*1 hour*)
- e) Caregivers of children with SAM not registered in program who may be identified by CHWs/CHVs (*20 minutes per interview*)
- f) Caregivers of healthy children not in program who may be selected during the community meeting (*10 minutes per interview*)

See **Annex 9. Methodology of the Community Assessment for North Darfur State** for specific topics/area for group discussions and questions for interviews.

**Data consolidation:** Information from this process will be consolidated and key issues and findings will be highlighted.

## B.3 Participatory Learning Workshop

The objective of this workshop is to share operational experience of community mobilizations and sensitization for CMAM among the three Darfur states and to extract learning and promising practices.

A 1–2-day workshop will be held in North Darfur state. Participants will be selected from managers and senior staff involved in supporting CMAM services/programs in the state, including SMOHs and key implementing partners. A few key individuals from South and West Darfur will also be invited to attend and share the operational experience from the programs in those states.

The participatory workshop will review community outreach activities for CMAM, explore positive and negative experiences (what worked well and what didn't), and recommend promising community outreach practices for CMAM in Darfur and elsewhere in Sudan.

The TWG Review Team members will facilitate the workshop. More detailed methodology in terms of the specific group work to be done will be developed as the workshop participant profile and mix are determined.

**Note:** Some sort of CMAM services have been operating in Darfur to some degree over the past 4 years. However, given the operational context in Darfur—with major disruptions to programs over the past 12

months—we might not obtain detailed information and analysis of the assessment and set-up phase on some programs that have been established for some time.

### **Kassala State**

The assessment will be conducted by a team from Khartoum, assisted by and in collaboration with SMOH staff. The Khartoum team will include three FMOH staff (Dr. Rania Sharawy, Ms. Selwa Sorkatti, and Durria), a UNICEF CMAM Support Team member, an AUW representative, and a FANTA-2 consultant.

Based on findings from the assessment, a strategy for community outreach at the locality and state level will be developed.

## **C. DEVELOPMENT OF COMMUNITY OUTREACH STRATEGY FOR CMAM**

This sub-section describes the consolidation of situation analysis and assessments findings, incorporating key learning and providing an outline of a strategy to strengthen community outreach for CMAM in Sudan.

After the national situation analysis and the assessments in North Darfur and Kassala states (including one CMAM site in Khartoum State) are completed, the information will be consolidated, analyzed, and fed into the development of:

- The *Sudan Operational Guidelines for Community-Based Management of Acute Malnutrition's* community outreach section, which will be reviewed and adapted based on the assessment's findings
- The Generic International *Training Guide for Community-Based Management of Acute Malnutrition (CMAM)*'s community outreach section, which will be reviewed and adapted for the Sudan context, based on learning from the assessment, and linking with the reviewed operational guidelines
- A strategy for strengthening capacity for community outreach, including outlines for in-service and pre-service training curricula and facilitator training

<b>Time frame week starting (2009)</b>	<b>Location</b>	<b>Activity</b>	<b>Members involved (individuals identified)</b>	<b>Deliverable(s)</b>	<b>Persons with primary responsibility</b>	<b>Comment</b>
26 July	Khartoum					
	Khartoum	Conduct TWG meetings to finalize Terms of Reference and workplan (clarify tools and methodologies to be used, etc.)	All TWG members	Develop Terms of Reference and workplan	Forsythe lead with TWG members	To be submitted to NAC for Nutrition for input and approval
2 Aug	Khartoum	Analyze national CHI: analysis of documents; meetings; KIIs; SWOT analysis, etc.	Sharawy, Forsythe	Draft national situation analysis	Sharawy, Forsythe	
	Khartoum	Convene meeting with NAC for briefing and input on workplan	TBD	Write minutes of meeting		
	Khartoum	Coordinate with Darfur and Kassala states on visits			SN, Forsythe	
9 Aug		Consolidate national situation analysis				
		Finalize tools for Darfur review and Kassala assessment				
		Prepare logistics for trips to Darfur and Kassala			SN, UNICEF, Forsythe	
15 Aug	Travel to Darfur					
	Darfur	Conduct program review in selected state: site visits, FGDs and KIIs	Review Team: Sharawy, Sorkatti, or Durria, two AUW representatives, Forsythe	Draft report on program review in selected state	Sharawy, Forsythe	
	Darfur	Convene Darfur participatory stakeholder meeting	All TWG members	Write minutes of participatory stakeholder meeting		
19 Aug	Travel to Khartoum					
20 Aug	Khartoum	Consolidate learning from Darfur visit	Darfur review team members	Draft report extracting key learning and recommendations for promising practices		
		Adapt/fine tune Kassala assessment tool				

<b>Time frame week starting (2009)</b>	<b>Location</b>	<b>Activity</b>	<b>Members involved (individuals identified)</b>	<b>Deliverable(s)</b>	<b>Persons with primary responsibility</b>	<b>Comment</b>
22 Aug	Travel to Kassala					
23–25 Aug		Map current CHI and community mechanisms in states Conduct community assessment in selected location Convene stakeholder participatory meeting and develop community outreach strategy for CMAM for locality and state	Assessment team: Sharawy, SN, Durria, AUW representative, Forsythe	Draft report on state-level situation analysis, minutes of participatory stakeholder meeting, and state-level community outreach strategy		
26 Aug	Travel to Khartoum					
27 Aug	Khartoum	Share and analyze information and experience Finalize reports and state-level strategy for community outreach	All TWG members	Draft final versions of: –Situation analysis, national and state level –Lessons learned in Darfur –Strategy for community outreach for CMAM in selected EIP states		
30–31 Aug	Khartoum	Draft strategy and implementation plan for scale-up and strengthening of community outreach for CMAM at federal and state levels	All TWG members	Draft overall strategy for community outreach for CMAM, including implementation plan		
	Khartoum	Review operational manual's community outreach section and adapt main body of manual and relevant annexes (e.g., job aids) to Sudan context	Sharwy, Sorkatti, SN	Community outreach section of operational guidelines adapted		
	Khartoum	Review FANTA-2 et al. training guide community outreach section and adapt to Sudan context training guide	Two AUW representatives	Community outreach section of FANTA-2 training guide adapted		
	Khartoum	Report back to NAC (or on Sept 1)	TBD			
1 Sept	Khartoum	Conduct TWG wrap-up Confirm next steps and respective responsibilities for finalizing deliverables	All TWG members	Minutes of key action points for follow-up and time frame		
Sept		Complete tasks/deliverables as assigned during assessment and wrap-up by TWG		All deliverables submitted (due dates to be determined)		Electronic communication

## Annex 9. Methodology of the Community Assessment for North Darfur State

### TOPICS FOR GROUP DISCUSSION AND QUESTIONS FOR KEY INFORMANT INTERVIEWS

These tables are to be used **as a guide** for the Review Teams.

The points in the second column of the table below are issues that the review team may wish to probe on (enquire further as part of the discussion/interview), but it would be expected that many of these issues will be raised as the informant groups and individuals answer the related questions.

#### A. GROUP DISCUSSION 1: CHWs/CHVs (expected time 1.5–2 hours [maximum])

Topic	Investigate further
A.1 Observe gender mix (if all CHWs/CHVs are not present, inquire about the gender mix of those not present)	<p>Average time of employment/volunteering with CMAM program?</p> <p>Employed or volunteer status?</p> <p>How many hours work carried out per week?</p> <p>What are key issues in terms of payment of salaries and incentives and other conditions of employment/volunteering?</p>
A.2 Employment status and satisfaction with conditions	
A.3 What is the role and responsibility of CHW/CHV in relation to CMAM?	<p>Investigate which of these areas of work the CHW/CHV is responsible for:</p> <ul style="list-style-type: none"> <li>• Mobilization/sensitization</li> <li>• Screening and referral to SFP/OPT</li> <li>• Tracing of defaulters</li> <li>• Follow-up of non-responders</li> <li>• Health and nutrition at household level</li> <li>• Health and nutrition education at community level</li> <li>• Health and nutrition education at facility level (during admission and treatment days)</li> </ul> <p>Have clear messages been developed about CMAM services: aim, admission criteria, etc.?</p> <p>Do CHWs/CHVs have appropriate/adequate health and education materials?</p>
A.4 How do CHW/CHV links with health facilities for CMAM-related work?	<p>Consider in relation to:</p> <ul style="list-style-type: none"> <li>• Feedback on outcome of referrals</li> <li>• To organize default tracing or follow-up of non-responders</li> <li>• Other issues</li> </ul>
A.5 Do the CHWs/CHVs have responsibility for and/or links with other health and nutrition programs/initiatives (e.g., IYCF, IMCI, Immunization)?	List which health and nutrition initiatives CHWs/CHVs have responsibility for and/or link with and describe responsibility and linkages
A.6 Do CHWs/CHVs have additional responsibilities for and/or links with other sectors and if so what are they?	List which other sectoral initiatives CHWs/CHVs have responsibility for and/or link with and describe responsibility and linkages

Topic	Investigate further
A.7 How many villages and/or families are allocated to each CHW/CHV and what geographical distances do CHWs/CHVs have to cover?	<p>Get the range of responsibility from smallest caseload and smallest geographical area to the largest caseload and geographical area</p> <ul style="list-style-type: none"> <li>• How many villages per CHW/CHV?</li> <li>• How many households per CHW/CHV?</li> <li>• What geographical distance CHW/CHV may have to travel</li> <li>• Do CHWs/CHVs work in pairs or individually?</li> <li>• How do CHWs/CHVs travel outside of own village? Does agency provide any transport support?</li> </ul>
A.8 Within the catchment area for the health facility, are there villages/ areas left uncovered by CHWs/CHVs (or have CHWs/CHVs been allocated to all villages across the whole catchment area)? If so, where are these areas and why have they been omitted?	
A.9 How is case-finding carried out?	<p>If case-finding is carried out through home visits, inquire how often the home visits are made</p> <p>If case finding is carried out at community level, inquire:</p> <ul style="list-style-type: none"> <li>• How/where is this organized?</li> <li>• How often is community screening carried out?</li> <li>• How do you ensure that you do not miss children?</li> </ul>
A.10 What is the referral process for supplementary feeding and for outpatient treatment for SAM and does it work?	<p>Is a referral form given to caregivers? Preprinted or hand-written?</p> <p>Do clinics accept the referrals?</p> <p>Does the referral specify SFP or outpatient care?</p> <p>What advice do you give the caregivers before they go for admission?</p> <p>Is admission to OPT on MUAC or WFH?</p> <p>Is there a problem with rejection/non-admission after referral if admission on WFH?</p> <p>What are the implications of rejection/non-admission?</p> <p>Are there problems with long waiting times at health facilities?</p> <p>Are there problems with distance too far from health facility for some areas?</p> <p>Are there any other problems?</p>
A.11 How often are home visits carried out for children under treatment (including SFP and outpatient treatment for SAM)?	What criteria are used for scheduling home visits for children who are registered for SFP and for outpatient treatment?

Topic	Investigate further
A.12 How do CHWs/CHVs keep record of activities?	<p>Number of home visits,</p> <p>Number of referrals,</p> <p>Number of referrals admitted to SFP and outpatient treatment</p> <p>Number of health and nutrition education sessions conducted</p> <p>Other list</p> <p>Is the record-keeping systematic? Are all CHWs/CHVs using the same system?</p> <p>Do all CHWs/CHVs have notebooks?</p>
A.13 Are reports of CHW/CHV activity submitted to out reach supervisor?	If yes, on weekly or monthly basis?
A.14 CHW/CHV supervision	<p>Who supervises CHW/CHV activity?</p> <p>How often does the outreach supervisor make supervisory visits to individual CHWs/CHVs? Weekly, Fortnightly, Monthly, Other (specify)</p> <p>Does supervisor review and provide feedback on referrals?</p> <p>Does the supervisor hold CHW/CHV meetings? If so, how often and where are they held?</p>
A.15 What is the situation regarding the use of traditional healers for treatment of malnutrition in the community?	<p>Do the CHWs/CHVs feel that use of traditional healers for treatment of malnutrition is common in the community?</p> <p>Do caregivers bring children to facility for treatment after traditional care has been given but the child has not recovered?</p> <p>Does use of traditional healers result in late presentation of children with SAM?</p> <p>Do the CHWs/CHVs feel that use of traditional healers for treatment of malnutrition has changed over last few years? Decreased or increased?</p> <p>Do the CHWs/CHVs have links with the traditional healers? Do the traditional healers refer children for treatment?</p>
A.16 Role of community leaders in CMAM services	<p>How do community leaders support mobilization/sensitization activities?</p> <p>How do community leaders generally support CHWs/CHVs to do outreach work?</p>
A.17 CHW/CHV Training	<p>Pre-employment training (time, content, and method, and conducted by which agencies)</p> <p>In-service refresher training (frequency, time, content, and method, and conducted by which agencies)</p>
A.18 What are the main problems/challenges to sustain community outreach for CMAM?	
A.19 What are your suggestions to improve community outreach for CMAM?	

## B. GROUP DISCUSSION 2: 10–12 COMMUNITY MEMBERS, MIXTURE OF MALE AND FEMALE (Expected time 1–1.5 hours [maximum])

Topic	Investigate further
B.1 Discussion around community knowledge, beliefs, and practices in relation to malnutrition	<p>What are the terms used to describe malnutrition locally?</p> <p>What are the signs associated with malnutrition locally?</p> <p>What are the causes of malnutrition (may be many; probe for cultural beliefs in relation to malnutrition in the community)?</p> <p>Traditionally, how has the community dealt with malnutrition?</p> <ul style="list-style-type: none"> <li>- Are home remedies with herbs used?</li> <li>- Are traditional healers used?</li> </ul> <p>Has the use of home remedies or traditional healers changed in recent years? Increased or decreased and, if so, why?</p> <p><b>IYCF</b></p> <p>Do most of the mothers breastfeed their babies?</p> <p>At what age do mothers start to give additional liquids to infants?</p> <p>At what age do mothers start to give soft foods and what do they give?</p> <p>How many times a day would a mother feed a 12-month-old infant and what is it fed?</p>
B.2 Community perceptions of services for treatment of SAM	<p>Does the community understand who should come for this treatment? What are the admission criteria?</p> <p>Does the community feel that the treatment works? Does it see the children getting better?</p> <p>Is the community happy with the services provided?</p> <p>What could be done differently/better?</p> <p>Does the group know people who should bring their children to the facility for treatment and don't?</p> <p>If so, why do these people not come for treatment?</p>

## C. KEY INFORMANT INTERVIEW 1: OUTPATIENT CARE CLINIC STAFF JOINT INTERVIEW FOR TWO KEY STAFF MEMBERS RESPONSIBLE FOR CLINICAL CONSULTATION AND TREATMENT OF SAM (Expected time not more than 1 hour)

Topic	Investigate further
C.1 Name and category of health facility	
C.2 Name, category, and responsibility of staff members interviewed	
C.3 Catchment area of facility (size and population)	
C.4 Are there outreach sites for CMAM services? Yes / No	<p>If yes, how many outreach sites?</p> <p>How often are outreach sites visited for admission? Treatment and supplementary feeding?</p>

Topic	Investigate further
C.5 Is there a map of catchment area with all villages and outreach sites plotted (the map may be hand-drawn)?	
C.6 How many patients registered in outpatient care currently?	
C.7 How many outpatient care admissions per month at facility?	
C.8 Does the facility record if patient is a readmission?	If yes, how many readmissions were there in 2009 to date? What are the reasons for readmission?
C.9 How many days a week for CMAM services at facility for admission & treatment and supplementary feeding?	
C.10 How many CHWs/CHVs linked to health facility?	
C.11 How does the health facility link with CHW/CHV?	
C.12 Do some or all CHWs/CHVs attend during CMAM services at facility?	
C.13 What is the CHW/CHV role at the facility during CMAM admission & treatment and supplementary feeding days?	
C.14 What is the referral process and does it work?	
C.15 How does clinic deal with rejection/non-admission after referral from CHW/CHV?	
C.16 Are patients generally referred for treatment or do they self-present?	
C.17 Does health facility have record/analysis of number of patients referred and the number who self-presented?	If so, please indicate situation for 2009 to date: Number of CHW/CHV referrals and number self-presented
C.18 What is the <b>actual coverage</b> of services within the defined geographical target area (e.g., do patients come from furthest villages in catchment area)?	
C.19 Does health facility have record/analysis of where beneficiaries come from?	Is beneficiary location written on admission care? Has mapping of beneficiary location been conducted? Has listing of beneficiary by village name been conducted?
C.20 What are the major challenges in terms of provision of CMAM services?	
C.21 What are the major challenges in relation to sustainability of quality outreach activities?	

## D. KEY INFORMANT INTERVIEW 2: COMMUNITY OUTREACH SUPERVISOR INDIVIDUAL INTERVIEW (Expected time not more than 2 hours)

Topic	Investigate further
D.1 Is there a community outreach plan?	If there is a community outreach plan, is it being used? Please summarize key aspects of plan and indicate. If there is no specific community outreach plan, probe on approach regarding sensitization Active case-finding? Referral and follow-up of children admitted for treatment? Involvement/responsibility of community leaders?
D.2 Does outreach supervisor have map of catchment area with all villages plotted (may be hand-drawn)?	
D.3 How many villages/households do CHWs/CHVs have responsibility for (ranges from what to what)?	
D.4 What geographical distances do CHW/CHVs have to cover (ranges from what to what)?	
D.5 Is the whole health facility catchment area covered with a CHV allocated to each village/area? If not, why not?	
D.6 How were the CHWs/CHVs selected?	a) Process (who was involved in selection process, did candidates do interview or exam, etc.)? b) Criteria (gender, educational level, literacy, live with community to serve, known/trusted by community, etc.?)
D.7 What is the status of CMAM outreach workers: employed or volunteer or both?	
D.8 What is the salary or what incentives are given to volunteers?	
D.9 What are the main issues/challenges in relation to salaries/incentives?	
D.10 Training	a) What pre-employment training has been carried out (time content and method)? b) What refresher in-service training has been carried out (frequency, time, content, and method)?
D.11 How is CHW/CHV supervision and support carried out?	Frequency of supervisory visits to each CHW Informal or structured with checklist Review and feedback on outcome of referrals Are CHW review meetings conducted and if so how often?
D.12 How is CHW/CHV work monitored?	Do CHWs/CHVs submit reports of activity completed, e.g., # of home visits made, # of referrals made, etc.? Are CHW/CHV reports compiled/analyzed by supervisor? If so, are they available for review? Are reports triangulated with facility records?
D.13 How is effectiveness of CHW/CHV activity evaluated?	
D.14 What is the <b>actual</b> coverage of CHW/CHV across the defined geographical target area?	Do CHWs/CHVs make regular visits to all areas in the catchment area? Are there records of same? Have these records been analyzed (using lists or maps)?
D.15 What role do community leaders play in support for CHWs/CHVs and community outreach activities generally?	

Topic	Investigate further
D.16 What are the main issues/challenges in relation to sustainable quality outreach services?	
D.17 What are your suggestions to improve community outreach for CMAM?	

**E. KEY INFORMANT INTERVIEW 3: CAREGIVERS OF CHILDREN 6–59 MONTHS WHO HAVE BEEN ATTENDING PROGRAM FOR TREATMENT FOR SAM (Each individual interview should not take more than 10 minutes)**

**Review Team to do exit interviews as individual caregivers leave facility after weekly treatment. Purposeful selection of mothers attending facility for treatment (from different geographical areas) within defined catchment area.**

Topic	Investigate further
E.1 Where does the caregiver live?	
E.2 How far from the facility does the caregiver live? How much time does the caregiver spend getting to the facility?	
E.3 How was child identified as malnourished and admitted for services (self-presented or CHW/V referral)?	If referred by COW, please specify: <ul style="list-style-type: none"> <li>○ If screening was at community level or through home visit</li> <li>○ If screening was by MUAC of WFH</li> <li>○ If possible, when screening and referral was carried out</li> </ul>
E.4 What was the caregiver's perception of the services – before admission?	
E.5 What is the caregiver's perception of the services – since admission?	
E.6 Has a CHW/CHV made a home visit since the child was admitted to the program?	If so, when and what did they do during the visit?

**F. KEY INFORMANT INTERVIEW 4: CAREGIVERS OF CHILDREN 6–59 MONTHS WITH SAM BUT NOT REGISTERED IN PROGRAM TREATMENT (Each individual interview should not take more than 20 minutes)**

**The caregivers of these children to be identified by CHWs/CHVs.**

Topic	Investigate further
F.1 Where does the caregiver live?	
F.2 How far from the facility does the caregiver live? How much time does the caregiver spend getting to the facility?	
F.3 Does the caregiver know how long the child has been malnourished/thin/sick?	
F.4 If yes, what is the caregiver doing to treat the child currently?	

F.5 Has the mother/caregiver taken the child to a traditional healer for care?	
F.6 Has the mother done anything else to try to treat the child (e.g., home remedies, starvation – please specify)?	
F.7 Has a CHW/CHV visited the home to look for malnourished children?	If so, when did the CHV last visit? Did the CHW/CHV screen for malnutrition using MUAC? Was the child referred for treatment?
F.8 Has the child been screened by MUAC elsewhere?	If so, where and by whom was the child referred?
F.9 Why has the child not been brought to program for treatment?	

### **G. KEY INFORMANT INTERVIEW 5: CAREGIVERS OF HEALTHY CHILDREN 6–59 MONTHS INDIVIDUAL INTERVIEWS (Each individual interview should not last more than 10 minutes)**

**Interviews to be conducted after the community meeting. The caregivers may be identified during/after the community meeting.**

<b>Topic</b>	<b>Investigate further</b>
G.1 Where does the caregiver live?	
G.2 How far from the facility does the caregiver live? How much time does the caregiver spend getting to the facility?	
G.3 Has a CHW/CHV visited the house to look for malnourished children?	
G.4 When did the CHW/CHV last visit?	
G.5 Did the CHW/CHV screen the child for malnutrition using MUAC tape?	
G.6 Has the child been screened by MUAC elsewhere?	If so, specify where and by whom.

### **H. KEY INFORMANT INTERVIEW 6: COMMUNITY LEADER INTERVIEWS (Joint interview to be held with two to at most three community leaders and should not last more than 1 hour)**

<b>Topic</b>	<b>Investigate further</b>
H1. What are community leader perceptions about CMAM services?	In terms of: ○ Appropriateness of intervention? ○ Quality of services?
H2. Are there particular population groups not bringing their children to the facility for services and, if so, why do these people not come for treatment?	

Topic	Investigate further
H3. What has been community leader role and engagement in CMAM program?	<ul style="list-style-type: none"> <li>○ In early set-up phase</li> <li>○ As program has been established</li> </ul> <p>Probe on community leader responsibility in terms of sensitization/ mobilization and selection of and support for CHWs/CHVs</p>
H4. How often do community leaders meet with CHWs/CHVs and program management staff?	
H5. What are the major challenges in terms of provision of CMAM services?	
H6. What are the major challenges in relation to sustainability of quality outreach activities?	
H7. How can community leaders support outreach workers/activities?	

## Annex 10. Methodology of the Community Assessment for Kassala State

### BEFORE GOING TO THE COMMUNITY – AT STATE AND LOCALITY LEVELS

Step	Investigate Further
1. Gather information	<ul style="list-style-type: none"> <li>a. The various ethnic and social groups in the locality and the most vulnerable groups</li> <li>b. Various community systems and structures in the locality (including CBOs and informal groups)</li> </ul>
2. Confirm program for interviews/discussion at the community level	Identify key individuals/groups to engage with in community discussion

**Remember:** Discussion should be held with key community leaders, elders, and other influential individuals; community groups, including health committees and women's groups; caregivers of young children; staff from the SMOH locality office; and health clinic(s) staff.

#### A community-level participatory discussion should be held to understand:

- Local perceptions about malnutrition and possible ways to address it
- Community structures and systems and potential mechanisms for community mobilization activities

#### Methodology:

- Formal and informal interviews with 1–2 people
- Group discussion with 6–10 people
- Observation: examination of children brought to clinics for signs of traditional practice(s)

### TOPIC 1: UNDERSTANDING COMMUNITY KNOWLEDGE, BELIEFS, AND PRACTICES IN RELATION TO CHILDHOOD MALNUTRITION AND ILL HEALTH

Subtopic	Investigate Further
<b>Definition of Malnutrition</b>	<ul style="list-style-type: none"> <li>• What are the <b>different terms</b> used to describe malnutrition locally (including terms for <b>wasting</b> and <b>edema</b>)?</li> <li>• Is there a perceived difference between malnutrition and general illness?</li> </ul>
<b>Signs of Malnutrition</b>	<ul style="list-style-type: none"> <li>• What signs are associated with malnutrition locally?</li> </ul>
<b>Causes of Malnutrition</b>	<ul style="list-style-type: none"> <li>• What are the perceived causes of malnutrition? <i>There may be many perceived causes of malnutrition. Probe for awareness about the different causes of malnutrition, including food, health, and cultural beliefs/practices in the community.</i></li> </ul>
<b>Treatment of Malnutrition</b> <i>In some areas, treatment will be available through the health sector. Where this is the case, please indicate which services are available and how far away these services are (distance and/or time required to travel there).</i>	<ul style="list-style-type: none"> <li>• Traditionally, how has the community dealt with malnutrition? <ul style="list-style-type: none"> <li>○ Are home remedies with herbs used? If so, which herbs are used?</li> <li>○ Are traditional healers used? If so, which traditional healer practices are carried out?</li> </ul> </li> <li>• Has the use of home remedies or traditional healers changed in recent years, i.e., increased or decreased? If so, why has this changed?</li> </ul>
<b>Treatment of Sick Children</b>	<ul style="list-style-type: none"> <li>• Generally how does the community deal with a child who is sick? <ul style="list-style-type: none"> <li>○ Are home remedies used? If so, which home remedies?</li> <li>○ For which services do caregivers take the children for treatment?</li> </ul> </li> <li>• Who/what is used for treatment? The SMOH? An NGO? A private clinic? Traditional healers?</li> <li>• Are traditional treatments sought and administered before children are taken to a clinic?</li> <li>• What influences the decision on where to take a child for treatment?</li> </ul>

<b>Subtopic</b>	<b>Investigate Further</b>
<b>Infant and Young Child Feeding</b>	<ul style="list-style-type: none"> <li>• Do most of the mothers breastfeed their babies?</li> <li>• At what age do mothers start to give additional liquids to infants?</li> <li>• At what age do mothers start to give soft foods and what do they give?</li> <li>• How many times a day would a mother feed a 12-month-old infant, and what is it fed?</li> </ul>

## TOPIC 2: UNDERSTANDING COMMUNITY SYSTEMS, STRUCTURES, AND ORGANIZATION

<b>Subtopic</b>	<b>Investigate Further</b>
<b>Community Organization</b> <i>Include groups created by the communities themselves and groups with external support from an NGO and/or from the government.</i>	<ul style="list-style-type: none"> <li>• Outline functional community groups in the locality and particularly those with a focus on health and women</li> </ul>
<b>Formal and Informal Communication in the Locality</b>	<ul style="list-style-type: none"> <li>• What are the usual methods of information dissemination to the community in the locality (list all methods, including community meetings, through local leaders, local radio, others)?</li> <li>• What are the more informal methods of information dissemination in the locality?</li> </ul>
<b>Health and Nutrition Frontline Workers with a Role in the Community</b> <i>e.g., Nutrition Educator, Integrated Primary Health Care Cadre, Vaccinators, Volunteer Midwives, or Others</i>	<ul style="list-style-type: none"> <li>• How many of the various health and nutrition frontline workers with a role in the community are in the locality, and which health facilities are these staff employed in/appointed to?</li> <li>• What is the role and responsibility of various cadres at the community level?</li> <li>• If these staff conduct home visits, how many per week?</li> </ul>
<b>Community Outreach Workers (COWs)/Community Health Volunteers (CHVs)</b>	<ul style="list-style-type: none"> <li>• List the various health outreach workers or volunteers currently operational in the locality (and outline their current roles and responsibilities).</li> <li>• Are they paid or do they volunteer?</li> <li>• How many hours do they work/volunteer per week?</li> </ul>
<b>Suggestions for Community Mobilization for CMAM in Locality</b>	<ul style="list-style-type: none"> <li>• Potential groups and mechanisms that could be used: <ul style="list-style-type: none"> <li>○ Community organizations</li> <li>○ Communication channels</li> <li>○ COWs/CHVs</li> </ul> </li> <li>• Development and dissemination of messages</li> </ul>