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C4D in Humanitarian Action

COMMUNICATION FOR DEVELOPMENT
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South Sudan cholera response 2016-2017

Engaging communities outside the reach of conventional communication and community engagement approaches

A case study

BACKGROUND

Since the eruption of the civil war in December 2013, South Sudan has been declaring cholera outbreaks every year. Recently a large-scale cholera outbreak lasted for 16 months, from 18 June 2016 to 18 December 2017.[1] This resulted in 20,438 cholera cases and 436 deaths in one third of all counties. The most affected populations included communities in landing sites and towns along the Nile River, cattle camp dwellers and populations living on islands with limited access to basic social services. These include internally displaced persons (IDPs) who were recently displaced and are currently living with inadequate access to water, sanitation and hygiene (WASH) facilities.

Cholera is a disease that can be contracted by consuming food or water contaminated with toxigenic vibrio cholerae or by accidental ingestion of contaminated faeces following direct contact with a cholera patient. Cholera is preventable as long as access to safe water, proper sanitation facilities and satisfactory hygienic conditions are ensured and sustained for the entire population.[2]

In South Sudan, only 50 per cent of the population has access to improved drinking water sources and open defecation is widespread, practised by approximately 65 per cent of the population. Open defecation has often been reported as a contributing factor to cholera outbreaks. An assessment conducted by the social mobilization sector in 2014 mentioned a high rate of open defecation in Torit County, especially along the river where people can hide behind vegetation. A 2015 Knowledge, Attitudes and Practices (KAP) survey conducted in Kajo-Keji, Torit and Magwi counties also revealed that 76 per cent (n=81) of respondents in rural settings practised open defecation.[3] Moreover, the lack of WASH facilities and soap at the household level reduces the possibility of washing hands with soap after defecation.

The already low WASH indicators have further declined with continued population displacement, particularly for those who have found refuge on islands and swampy areas along the Nile River. Drought has exacerbated the situation, leading to serious water and food shortages in the country. This has forced people, especially cattle herders, to gather around the fewer remaining water points, thus rendering them more vulnerable to the disease. Clear-looking water is not always safe to drink, as it can be contaminated with faecal particles and parasites that cannot be seen by the naked eye. Using borehole water reduces exposure to waterborne disease risks. The 2015 KAP survey, which explored the perception of water for drinking purposes, highlighted that 70 per cent (n=110) of respondents in Kajo-Keji believe that clear water is safe. The assessment further stated that the community in Torit prefers drinking river water to borehole water, which tastes salty. The survey also explored community behaviours associated with health care and showed that 18 per cent of respondents in Torit used traditional medicine and 26 per cent in Magwi urged their sick to drink less liquid.[4]

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[1] WHO Africa, 'South Sudan declares the end of its longest cholera outbreak', <www.afro.who.int/news/south-sudan-declares-end-its-longest-cholera-outbreak>, accessed April 2019.

[2] United Nation's Children's Fund/ESARO, 'Epidemiological study of cholera hotspots and epidemiological basins in the East and Southern Africa region', 16 April 2018, p. 7.

[3] UNICEF South Sudan, 'Knowledge, Attitudes and Practices Study', 2015.

[4] Ibid.

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Aside from these factors, several other behaviours intensify the risk of contracting and spreading cholera. These include: using a water source close to the place of residence, eating outside the home and using surface water regularly. Case investigations during the 2006–2017 period identified cholera transmission during funeral rituals and around affected households. Being in a facility that receives cholera cases was also noted as a high-risk factor.

Overall, during the 2016–2017 cholera outbreak, children under 19 years of age constituted nearly 60 per cent of the total cholera cases.[5] In 2017, a total of 10,964 cholera cases were treated using UNICEF supplies in supported Oral Rehydration Points (ORPs) and Cholera Treatment Units/Centre (CTU/Cs). Among these cases 18 per cent (1,864 cases) were of children under the age of 5. Twenty-eight per cent (2,910 cases) were of children between 5 and 18 years of age.

UNICEF supported vaccine management, social mobilization and training during preventive and reactive oral cholera vaccine (OCV) campaigns conducted in seven states in IDP settlements (Mingkaman, Aburoc), point of care (PoC) sites (Bor, Bentiu, Juba) and high-risk towns including those with active cholera transmission. During this time, 79 per cent (879,239) of the targeted 1,118,420 individuals above the age of 1 received the first dose

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and 43 per cent (482,848) received two doses of OCV. Of the children between the ages of 1 and 5 years who were immunized, 45 per cent were male and 55 per cent were female.

As previously mentioned, the UNICEF South Sudan Country Office (SSCO) commissioned a KAP study in 2015 covering three counties (Kadjo-Keji, Torit and Magwi) with high numbers of cholera cases, following consecutive and protracted cholera outbreaks since 2013. Based on the findings, the SSCO Communication for Development (C4D) team designed a response plan targeting areas with active cholera transmission, mainly among cattle camps. This case study showcases how SSCO C4D engaged affected populations who were outside the reach of conventional communication and community engagement approaches.

[5] World Health Organization and Ministry of Health, 'Situation Report #116 on Cholera in South Sudan', 2017, <www.who.int/hac/crises/ssd/sitreps/south-sudan-cholera-update-14april2017.pdf>, accessed 28 February 2018.

METHODOLOGY AND APPROACH

Sociocultural factors

South Sudan has a relatively smaller population that can read and write. Only 26.83 per cent above the age of 15 are literate and there is a substantial gender disparity: a 34.4 per cent literacy rate for males compared to 19.19 per cent for females.[6] It is important to note that because South Sudan is an oral society, people tend to appreciate receiving information from their own peers period. This very much shapes the C4D approach to promoting desired behaviour/social change.

Distinct lifestyle of pastoral communities

Pastoral communities represent a significant portion of the South Sudan population and are known to have a distinct lifestyle and social cultural practices compared to other conventional groups. Most of their camp settlements are located in scattered, isolated and remote swampy areas with very limited accessibility especially during rainy seasons. These communities frequently shift location depending on the availability of pasture and water for the animals they are tending. Due to the temporary nature of the settlements and the community's long-held traditions, the practice of open defecation is widespread. Also, a common practice is the consumption of unsafe and untreated swamp or river water which is often shared with the animals. Additionally, the culture of not burying the dead provides a conducive environment for transmission of vibrio cholera bacteria as the bodies decompose directly into the rivers and swamps that they inhabit.

This particular community has very low functional literacy, and is therefore not easily reached with the conventional risk communication and community engagement approaches. As a result, they are often missed by mainstream strategic community mobilization interventions for hygiene promotion and cholera prevention.[7] To address this, a specific cattle camp strategy was developed, and cattle camp interventions were integrated into the C4D response plan.

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[6] UNESCO, South Sudan Education and Literacy, <uis.unesco.org/country/SS>, accessed 24 April 2019.

[7] United Nation's Children's Fund, 'South Sudan Community Engagement Strategy for Cattle Camps', 2017, p. 4.

The C4D response plan

The C4D response plan focused on emergency interventions during cholera outbreaks and preparedness activities during the inter-epidemic period. The overall objective was to control and prevent cholera transmission among affected and at-risk populations – including cattle camp, IDP and fishing communities – by fostering an increased risk perception and increased knowledge of prevention and treatment of the disease.

The two key platforms used for education and risk communication were community/household engagement and mass media. Specifically, the following approaches were employed during the response:

A) INTEGRATED COMMUNITY MOBILIZATION NETWORK

The introduction of the Integrated Community Mobilization Network (ICMN) was a key strategy. It is a 2,506-member network of trained community mobilizers with a presence in six cholera-affected states working under seven implementing partners. The ICMN operates within the framework of sustained community engagement through peers and two-way conversation to engage:

- Households;
- Important players who have direct contact with households such as water vendors or food vendors, community institutions, and in spaces such as schools, health facilities, worship centres, water points and markets;
- Community platforms including traditional, religious, youth and women forums;
- Cattle camp interventions using cadres of community mobilizers from within the community and that take into account their distinct lifestyles.

Table 1 below shows the community mobilization target groups and the monthly reach.

TABLE 1: Community Mobilization Network target groups and monthly reach.

Target groups	Monthly reach
Households	Average of 160,200 households
Important players who have direct contact with households	0ver 190,000 school children 103,000 water and food vendors and clients
Community platform audiences	13,000 individuals
Cattle camp communities	Average of 35 cattle camps (reaching a total population of over 18,000)

B) LEVERAGING RADIO PLATFORMS TO STRENGTHEN RISK COMMUNICATION

Currently, there are ongoing intensive radio education and information programmes in all affected counties using the nine widely spoken local languages. Over 2.4 million people are being reached with radio programming. A total of 32 radio channels have participated, using jingles, talk shows and spots to alert listeners to the risk of cholera and to educate communities on the prevention and treatment of the disease.

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In addition, hotline services have been set up in collaboration with private mobile operator Vivacell to provide cholera counselling to callers. This has been accessed by 2,000 people to either bring attention to suspected cases or to receive cholera prevention information.

C) STANDARDIZED COMMUNICATION MATERIALS FOR COMMUNITIES, SCHOOLS AND HEALTH FACILITIES

The development of standardized communication materials and presence of long-term agreements (LTAs) with major printing companies in South Sudan were key to getting communication materials displayed in strategic places. These materials were designed to inform and mobilize communities during OCV campaigns. For example, pictorial and easily understood cholera education tools such as wall charts and booklets are being disseminated to Oral Rehydration Points (ORPs), Cholera Treatment Units/Centres (CTU/Cs), health facilities, schools and many other key locations.

D) LOCAL MASS MOBILIZATION USING MEGAPHONES, TRADITIONAL DANCE AND DRAMA

For faster reach and larger impact, the use of radio has been complemented by traditional media and megaphone announcements at the community level. Community mobilizers also routinely engage with communities at the household level, conduct school

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orientation sessions and hold community and religious leader's meetings as well as community engagement sessions at market and water points. Local mass mobilization is also intensified using traditional drama and musical performances.

A cattle camp strategy was developed specifically focusing on the mobile population. This involved the identification and engagement of opinion leaders or 'gate keepers' among the cattle communities, working with them to track the migrant community, and ensuring their active involvement in all mobilization activities.

Other activities include the training and establishment of rapid response teams at the national, state and county level, micro-planning using social maps, and community surveillance.

Partnerships

UNICEF made significant contributions to the response by leveraging cross-sectoral synergies among the Health, C4D and WASH sectors. At the national level, UNICEF acts as co-chair for a social mobilization and communication working group. This group coordinates community engagement interventions in collaboration with the Government, key stakeholders and humanitarian clusters, and communication with community working groups to promote and sustain optimal social and behavioural outcomes. In addition, UNICEF works with 32 radio channels across the country to develop standardized key messages and communication materials, through formalized LTAs with audio production, promotion and printing services.

Monitoring and evaluation

To ensure ongoing monitoring and evaluation, several activities have been undertaken or are ongoing. A KAP study was carried out in 2016 which identified key behavioural and communication factors for consideration in C4D planning while an ICMN baseline survey collected key family knowledge and practices data of 400 households. Under the joint supportive supervision of the WASH, Health and C4D sectors, their teams conducted visits to all the supported cholera hotspots during which technical support and guidance were provided for the implementing partners and communities on effective prevention and control of the outbreak. Lastly, regular situation reports (Sitreps) using a standardized reporting format are collected, collated and shared with WHO and the National Emergency and Response Forum on a weekly basis.

RESULTS

- A total of 1,912,187 people in 362,615 households were reached in affected areas. An additional 2,173,381 people were reached with key cholera messages through the various interpersonal communication efforts, while 2.4 million people were reached through mass media.
- Of 5,640 cases of cholera, 5,468 (97 per cent) were treated in health facilities. As per patients' discharge records, most of these patients indicated that they became aware of cholera prevention and treatment strategies from house-to-house visits, community meetings and radio messages. Other reported sources of information include printed materials and the cholera hotline. Focus group discussions conducted by partners, spot interviews done during roadshows, and observations found that food vendors in Juba and other cholera hotspots exhibited positive hygienic behaviour in their business locations. Also, communities that were mobilized to clean their surroundings as part of the 'Clean Juba Campaign' ensured that communities took ownership for keeping their surroundings clean.
- As a result of the interventions, no cholera case has been reported since December 2017 through April 2019.
- Strengthening of communication activities among nomadic groups will continue and they will be reached with appropriate behaviour change messages on cholera transmission, prevention and control by using a suitable mix of communication channels. Strengthening of social mobilization and hygiene education campaigns in all the cholera affected and hotspot areas through the ICMN is ongoing, in close collaboration with community institutions such as schools, health facilities, worship centres, community media and local artists.

LESSONS LEARNT

- The strategic and integrated focus of the cholera response enabled the promotion of two-way communication interventions covering 74 out of 80 counties in all 10 states across the country. This has been further ramped up to include the promotion of child rights with a key focus on child survival, birth notification, education and hygiene promotion activities.
- Government structures are weak at the subnational level and lacking beyond the county level. As such, community interventions are heavily dependent on UNICEF that has formalized partnerships with 10 local implementing partners that operate in 77 out of 80 counties.
- ICMN as an overarching strategy was designed to engage communities and households through sustained and locally adapted communication approaches. This approach has proven relevant to the context of South Sudan where the literacy level is below 30 per cent and access to radio is only 56 per cent.
- Coordinating the ICMN through local implementing partners made it affordable and ensured minimum interruptions during emergencies.
- The 2015–2017 experiences of the evidence-based and sustained cholera outbreak response and preparedness have been leveraged in other disease prevention strategies such as the rift valley fever, malaria and Hepatitis E outbreaks that occurred in the last two years and, most recently, in the preparedness and prevention of Ebola.
- C4D plans to maximize/improve the effectiveness and efficiency of the community partnerships and engagement, not only in disease prevention but also in raising overall awareness of children's and women's rights and participation in society. This includes amplifying their voices through feedback mechanisms, ensuring community knowledge of project intentions, creating an environment where communities provide input at the outset and ensuring that community buy-in and accountability measures are in place.

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