COVERAGE MONITORING NETWORK

COMMUNITY ASSESSMENT FOR COMMUNITY BASED MANAGEMENT OF ACUTE MALNUTRITION, HAGADERA REFUGEE CAMP, DADAAB, KENYA, MARCH 18 TO APRIL 1, 2015

INTERNATIONAL RESCUE COMMITTEE

UNITED NATIONS HIGH COMMISSIONER FOR REFUGEES

WORLD FOOD PROGRAMME

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COVERAGE MONITORING NETWORK

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Coverage Monitoring Network (CMN) is an inter-agency initiative led by Action against Hunger (ACF), Concern Worldwide, International Medical Corps and Helen Keller International. The project aims to increase and improve CMAM coverage and to monitor it globally through the promotion of quality coverage assessment tools, capacity building and information sharing. The CMN was launched in July 2012 with support from the European Commission Directorate-General for Humanitarian Aid and Civil Protection (ECHO) and USAID's Office of Foreign Disaster Assistance (OFDA).

The opinions expressed herein are those of the author and do not necessarily reflect the views of the USAID or ECHO

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Melaku M. Dessie, Community Mobilization Advisor from International Medical Corps/ CMN project in collaboration with collaboration with UNHCR, WFP and IRC led this community assessment. The UNHCR and WFP teams facilitated the process and provided administration and logistic support in the field.

ABBREVIATIONS

ACF	Action Contre La Faim
BSC	Balanced Scorecard
BSFP	Blanket Supplementary Feeding Program
CHP	Community –based Health Program
CHW	Community Health Worker
CMAM	Community-Based Management Of Acute Malnutrition
CMN	Coverage Monitoring Network
FGD	Focus Group Discussion
IYCF	Infant And Young Child Feeding
IRC	International Rescue Committee
KII	Key Informant Interview
MAM	Moderate Acute Malnutrition
MUAC	Mid Upper Arm Circumference
OTP	Outpatient Therapeutic Program
RUTF	Ready-To Use Therapeutic Food
RUSF	Ready-To-Use Supplementary Food
SAM	Severe Acute Malnutrition
SC	Stabilization Center
SQUEAC	Semi-Quantitative Evaluation Of Access And Coverage
SSI	Semi-Structured Interview
TBA	Traditional Birth Attendant
TSFP	Targeted Supplementary Feeding Program
UNHCR	United Nations Higher Commissioner for Refugees
WASH	Water , Sanitation and Hygiene
WFP	World Food Program

TABLE OF CONTENTS

TABLES AND FIGURE

EXECUTIVE SUMMARY

UNHCR and WFP in Kenya in coordination with the Coverage Monitoring Network (CMN) conducted a community assessment for Community-Based Management of Acute Malnutrition (CMAM) program in Hagadera Refugee camp, Dadaab. This community assessment was carried as part of Semi-Quantitative Evaluation of Access and Coverage (SQUEAC) for CMAM program from March 18 to April 1, 2015 which is supported by UNHCR and WFP and implemented by IRC. The main objective was to understand and analyze the program context to identify existing systems, resources, community structures and cultural factors in order to design a community mobilization strategy that fits with and builds on local resources to improve access and use of the CMAM service.

Hagadera refugee camp has an impressive network of refugee leadership structures and community-based groups, such as section and block leaders, Community Health Committee (CHC), Mother to Mother Support Groups (MTMSGs). The section and block leaders are the gatekeepers of the communities and expressed their commitment to support the community mobilization for CMAM program. The refugee leaders meeting with partners, and subsequently dissemination of information to the refugees is among effective communication channels in the camp.

Most refugee informants appeared to have good awareness about malnutrition and appreciated the CMAM service quite well. However, men, sheiks and block leaders were found relatively less aware about malnutrition. Most of the community informants mentioned that they used a CMAM service. However, significant community members indicated they seek solution from Sheik (pray) for sick child, showing the level of influence the Sheikhs have on management of childhood illnesses.

The availability of RUTF and RUSF and free charge CMAM service within close proximity were distinct enablers for the caretakers to access and use CMAM services. Decentralization of the OTP and TSFP services at four health posts improved refugees' physical access to the service in the camp. Additionally, presence and support of the different stakeholders (WFP, UNHCR IRC and ACF) was also mentioned as an enabler for provision of good CMAM services. Moreover**,** outreach activities for CMAM through CHWs as part of integrated community-based health program (CHP) was a good component of the program and contributed to early case finding and referral, minimized defaulter, sensitization and consequently improve the refugee health seeking and access to treatment of acute malnutrition.

In contrast, inadequate counseling of caretakers at health facilities was cited as top barrier for the program. The caretakers received the RUTF and RUSF without proper counseling on why they need it and how to use it. As the result, the sharing and selling of the RUTF and RUSF is the major challenge in the camp. Additional barrier mentioned for not accessing CMAM service encompassed inadequate integration of community mobilization for CMAM into existing community-based initiatives-such as MTMSGs, WASH and CHC etc. Therefore, the partners in Hagadera camp should strengthen community mobilization activities for a CMAM program by prioritising nutrition into existing CHP, and capitalizing on existing refugee structures, and extensive network of community-based groups such as MTMSGs, CHC. To be successful, the community mobilization to increase access and uptake of the CMAM services should also be implemented in tandem with strategies to improve CMAM service quality at health facility level.

I. INTRODUCTION

Hagadera refugee camp was established in 1992 and is the third oldest and largest camp in the Dadaab refugee complex in the North-Eastern Province of Kenya. As of March 2015, Hagadera camp was home for more than 106, 926 refugees, mainly from Somalia (97 %)[1]. UNHCR first established the Dadaab complex as a temporary solution more than 20 years ago after Somalia descended into a civil war that continues to this day. Two camps were established in 2011 to accommodate more refugees as the drought and continuing violence between Somali Government forces and Al-Shabaab militants.

The camp has one of the biggest markets in the region. However, the livelihood activities of the refugees are limited and mostly depend on food aid from WFP. WFP through Norwegian Refugee Council distributes food rations twice a month. There is one food distribution point, where refugees collect food and non-food items through a biometric check system. These food rations ensure a daily intake of 2,100 kilocalories per person per day, which is the global standard. According to the nutrition survey conducted in 2014shows critical malnutrition levels with the prevalence of Global Acute Malnutrition (GAM) (WHZ<-2 and/or edema) was 8.1 and the severe acute malnutrition (SAM) prevalence was 0.8 the refugee camp.

UNHCR through IRC also provides primary and secondary health care at four health posts and one hospital respectively. Additionally, IRC with support from WFP and UNHCR implement the nutrition programs in Hagadera camp. The nutrition programs includes the targeted supplementary feeding program (TSFP) to children 6 to 59 months of moderate acute malnutrition (MAM) with PlumpySup, Outpatient Therapeutic Program (OTP) for children 6 to 59 months of severe acute malnutrition (SAM) with Plumpynut and Stabilization Center (SC) for SAM cases with medical complication.

Infant and Young Child Feeding (IYCF) program is also being implemented in the camp to promote best IYCF practices such as breastfeeding and optimal complementary feeding in the camp. Mother-to-mother support groups (MTMSGs) are established in the camp and supported by IRC which funded by UNHCR. Cooking demonstrations are organized twice a month to improve caregivers' skills and knowledge of nutrition, provide practical approach to preferred food and ensure hygiene practices are maintained during food preparation. ACF also provides technical support to IRC and partners in IYCF in the camp.

[1] Hagadera Camp Profile _Dadaab Refugee Camps. http://data.unhcr.org/horn-of-africa/settlement.php?id=10&country=110&region=3

II. ASSESSMENT OBJECTIVES, METHOD AND TOOLS

This community assessment was carried out in Hagadera Refugee camp, Dadaab in Kenya from March 18 to April 1, 2015 as part of the UNHCR's and WFP's CMAM program coverage assessment. The community assessment aimed at:

1) Assessing community knowledge, beliefs and practices in relation to childhood acute malnutrition and illness;
2) Understanding community structures and actors, including appropriate communication channels and community volunteer networks that can be used for community mobilization;
3) Assessing contextual factors that influence the community decision to access and use CMAM;
4) Identifying strengths and weaknesses in the current community mobilization activities for, and opportunities and threats to the future collaboration with the community mobilization program;
5) Evaluating and strengthening a current community mobilization strategy to improve access and use of the CMAM services;
6) Building capacity of the UNHCR, WFP, IRC and partners' staff members in undertaking community assessment and designing a community mobilization strategy for CMAM program

A mixed-method approach employed combining qualitative techniques (in-depth, open-ended Focus group discussion, key-informant and semi-structured interviewing, observations), and analysis of secondary CMAM program monitoring data. Balanced scorecard was also piloted to measure organization's performance, capacity and needs in community mobilization for CMAM program

Data were collected in three stages in line with the SQUEAC methodology. In the first stage of the SQUEAC, 8 sections, which are covered different sections of the camp, were purposefully selected. A total of 41 key-informant interviews(KIIs) and 30 focus group discussions were conducted with refugee figures and leaders, media professional, MTMSGs, mothers and fathers of children five years old or less and CMAM program beneficiaries. KIIs were also conducted with Community Health Committee (CHC) members, community health workers, and nutrition and health workers from four clinics. Furthermore, KIIs were carried out with the UNHCR, WFP, IRC and ACF project staff members. At third stages of the SQUEAC, the team administered 61 semi-structured interviews with caretakers of children with SAM (16) and MAM (47), who were not admitted into the CMAM program in order to assess their barriers to access to the care.

A two-day training was provided to 20 training participants from UNHCR, WFP and five partners in community mobilization and assessment, including qualitative data collection methods. The trained participants collected the data as part of the training. The CMN team closely supervised the data collection process in order to ensure data quality. The data were interpreted and analyzed with program staff and training participants in the field. Based on the assessment findings and recommendations, the assessment team developed a community mobilization action plan for CMAM program that should be implemented jointly by UNHCR, WFP, IRC and ACF.

The CMN team held a debriefing meeting to senior technical staff members from the regional and country WFP and UNHCR offices and ACF to share the assessment findings and recommendations.

III. FINDINGS AND DICUSSION

3.1. COMMUNITY STRUCTURES AND GROUPS

Hagadera refugee camp is structured in 13sections and 143 blocks with two elected leaders (one male, one female) representing each block and each section (26 section leaders, 260 block leaders). The camp population has also elected an overall chairman and chairlady. In addition to these leaders, minorities (nationality or tribal groups), have also elected leaders. These leaders are responsible for the safety and security of the refugee, providing advice and managing disputes. They work closely with the UN agencies and partners, and disseminate information and mobilizing the refugees for campaigns, such as health and nutrition related services.

The clan leaders are also influential persons in the camp and preserve the customs and cultural norms of the refugee. Sheik is top religious leader and is highly respected by the community. Sheik leads the worship at mosques and makes important announcements after prayer time. They are in direct contact with the men in these communities five times a day at prayer time and can also reach men with various messages. Similarly, pastor is a top religious leader for minority Christian in Hagadera camp.

Hagadera refugee camp has various committees, which are established and supported the UN agencies and partners, such as Food Committee, WASH Committee and CHC. In Hagadera, each block has its own CHC (12 members) and serves as bridge between the refugees and health facilities and partners. The selected representatives from each block-CHC make main CHC, which consists of 22 members, including youth refugee. The CHC meet IRC's health team every monthly and voice community concern, problems and any emerging health problems. IRC with UNHCR also established and supports 352 MTMSGs made up of pregnant and lactating women (PLW) who meet weekly with lead mother to discuss about infant and young child feeding practices.

IRC recruited and trained 143 CHWs for the community-based health and nutrition program in the camp. The CHWs responsible health and nutrition promotion, disease surveillance, case finding and referral for nutrition, immunization and safe motherhood services. However, the CHWs' work emphasis for safe motherhood, immunization diseases surveillance but less attention to nutrition, particularly case finding and referral.

The refugees engaged in providing peer counseling, several committees such as sanitation committees, coordinating public health campaigns, promotion of community media and the involvement of refugee staff in delivering health and shelter services. The involvement of the section and block leaders and CHC in health and nutrition program helped to gain full access to the target community and to secure their support to community mobilization for CMAM in the camp. However, other community figures, particularly sheiks, traditional healers, traders and private practitioners' involvement in community mobilization for CMAM program is correspondingly important in the Hagadera refugee camp. They can help with mobilizing the community and support the community mobilization, such as opportunistic malnutrition case finding, provide referrals, and communicating the purpose of CMAM after prayer time.

Moreover, the extensive networks of community committees and leaders, and using CHWs for integrated community health and nutrition programs are impressive and would greatly facilitate community mobilization for CMAM program. However, the lack of appropriate integration community mobilizations for CMAM program into community based initiatives, such as MTMSGs must be addressed. The case finding and referral of children with acute malnutrition and sensitization about CMAM and malnutrition equally need prioritization as CHWs' work.

Women are the main childcare providers and handle the day-to-day family activities and needs in and outside house. Mothers are responsible for childcare and taking their children to the health facility for medical care. The woman does not need her husband permission to take a child to health care. However women generally needs her husband support to take care of other children at home when she takes a child to health care. But men's participation in the CMAM program is very limited and need to be addressed in order improves women caretakers' access to and use of the CMAM service.

3.2. ORGANIZATIONS SUPPORTING HEALTH AND NUTRITION IN HAGDERA COUNTY

UN agencies and non- governmental organizations are supporting the health and nutrition activities in Hagadera refugee camp (see Table 1).

Table1: Organizations supporting Health and Nutrition Programs in Hagadera Camp

Organization	Role
IRC	Provide primary and secondary health care, nutrition program
ACF	Provide technical support on IYCF
WFP	Food assistance
UNHCR	Refugee protection and assistance, camp management and coordination

Nutrition coordination meeting established to coordinate the activities and partners. UNHCR lead the coordination meeting and the partners regularly meet every month. Generally, there is fairly coordination mechanism among partners at refugee camp and Dadaab level at large.

3.3. COMMUNICATION CHANNELS

Numerous cultural appropriate and cost-effective communication channels exist in the camp that could be used for community mobilization for CMAM program (see table 2). The strengths and weaknesses of each channel (how effective are the channels in reaching the target community and how many people can they reach) was also assessed and ranked by the refugees and assessment team.

The refugee leaders meeting with partners, and subsequently dissemination of information to the refugees is effective communication channel in the camp. The men and women attend the refugees meeting and the section and block leaders and partners conveys important messages and refugees discuss to address community concerns.

Table 2: Formal and Informal Communication Channels Matrix in Hagadera Refugee camp

Communication channel	Perceived Effectiveness
Announcements at mosque by Sheik	Very effective
Public address system by partners and CHWs	Very effective
Community leaders meeting then information dissemination	Very effective
Community meeting	Very effective
Community radio (StarFM 97.1)	Effective
Role Plays	Effective
Mobile phones	Effective
Health education at facility level	Effective
Health and nutrition promotion through CHWs, CHCs, TBAs, MTMSGs	Effective
Printed materials	Less effective

During prayer time at the mosque, the sheik passes on effectively important information in the camp. In addition, formal meeting between the section and block leaders and refugees are an important forum for information exchange and decision-making. The partners also use public address system to disseminate information and reported as it reached the audience effectively in Hagadera.

IRC and partners also disseminate health and nutrition information effectively through CHWs, CHCs, traditional birth attendant (TBAs), and MTMSGs. In addition, IRC and UN agencies use regularly radio stations located in Hagadera camp and Dadaab town to dissemination health and nutrition information. However, the community radio located in the camp run only for 2 hours per day and the privately owned radio station that is located in Dadaab charges the partner significant amount of money for a single broadcast.

Using the community radio, and health and nutrition promotion through various community workers and groups (CHWs, CHCs, TBAs, and MTMSGs) is impressive. However, employing appropriate and existing various effective communication channels for community sensitization about CMAM and malnutrition needs to be maximized in the camp.

3.4. LOCAL UNDERSTATING OF CHILDHOOD ILLNESS AND MALNUTRITION

The common childhood illnesses in the camp are pneumonia, upper respiratory tract infection, diarrhea and skin diseases in descending order as ranked by the refugees. However, when asked about common childhood illnesses in the community, malnutrition wasn't mentioned, but when prompted, most of the community members were fairly familiar with different signs and forms of malnutrition, such as weakness, irritability of a child, loosen skin, wasting/thinness, loss appetite and brown hair. However, father of under five years old children and block leaders were found less aware about malnutrition. The local terms for local terms for malnutrition are *Nafaqo-daro*. The local terms both RUTF and RUSF are also *Diyar u ah inay isticmaalan cunto ku daweynta* and the CMAM is *Maamulka bulshada ee nafaqo- Xumada ba'an* in the area.

The perceived causes of malnutrition cited by most of the community members are inadequate food for children and early cessation of breastfeeding. Most of refugee informants also reported that sorghum that is commonly given, as part of general food ration is not consumed by children and by the adult refugee too. Reduced water points and less hygiene promoters who are employed by NGO and clean the area also cited as causes for malnutrition by the some of them.

3.5. TREATMENT OF ACUTE MALNUTRITION AND OTHER ILLNESS

Wide ranges of methods are used to treat malnutrition and other childhood illnesses in the Hagadera refugee camp. Most of the community informants mentioned that they used the CMAM service for the treatment of acute malnutrition. However, significant community members indicated they seek solution from Sheik (pray) and also provide milk for sick children. Some of them also indicated that they do razor cuts on the stomach to remove dirty blood that is causing the abdominal swelling in the camp.

Homemade remedies used to treat other childhood illnesses in the camp are;

- Pneumonia;
  - Burning on the chest with a hot metal rod
  - Get a glass put a piece of burning paper and put on the child's chest
  - Hot ash in a cloth is put on the child's chest
  - Malmal- gum like secretion from tree mixed water and apply on the child's chest
  - Pray by Sheik
- Diarrhea
  - Removal of false teeth
  - Homemade ORS
  - Provide sour milk or cow and camel milk to a child

INFANT AND YOUNG CHILD FEEDING (IYCF) AND CARE PRACTICES

Most the community informants, namely mothers, refugee leaders, and CHWs are aware of exclusive breastfeeding for infants up to 6 months old and introduction of complementary foods thereafter. There is fairly understanding of the importance of exclusive breastfeeding among the community. Mothers also mentioned that they have received education about IYCF at some point during ANC attendance, BSFP distribution or through CHWs and MTMSGs.

Most infants are exclusively breastfed till six months old, however some mothers who don't practice exclusive breastfeeding till six months of child age cited lack of enough breast milk as one of the factors prohibiting them. If mixed feeding is introduced before the six months, the child is given goat's milk, sugar water solution or packet milk if a family can afford. Infants born at home are often given water and sugar immediately because the community believes the mother is too weak to start breastfeeding.

Complementary foods are introduced from period within 4-6 months of child age based on the mother's milk production. Some of the food given include: porridge (CSB++) and normal GFD-CSB, mashed food: potatoes, rice, injera, tea, undiluted milk (goat's milk, camel milk, packet milk) and some fruits- based on

affordability. The community informants mentioned that the child is fed from the family pot- to allow the food to be edible the food is mashed.

When we asked about the frequency of feeding a 12 month-old child, most mothers said they would feed the children 3 times per day. Breastfeeding also continues during complementary feeding. If children are noted to have diarrhea at some point the mothers change the type of milk they are giving.

The common misconceptions about maternal and child feeding among the refugees are:

- Children are not given liver meat because the mothers believe it will delay speech in children
- During pregnancy, mothers avoid eggs and other high protein food because they believe that the baby will grow so big leading to C-section mode of delivery

3.6. FACTORS INFLUENCING ACCESS TO CMAM SERVICE

The contextual factors (boosters and barriers) that influence the caretakers' decision to access and use a CMAM services were explored and weighted in the Hagadera refugee camp as shown below in table 3.

Table 3: Weighted Boosters and Barriers to access and use CMAM services in Hagadera refugee camp

	Weighted Boosters	Score	Score	Weighted Barriers
1	RUTF and RUSF and services are free and available within close proximity	9	6	Inadequate counseling of caretakers at health facilities
2	Adequate involvement of various community actors in CMAM program	8	6	Inadequate staffing and capacity
3	Health and nutrition education at health posts and community through MTMSGs and CHWs	7	5	Inadequate community mobilization for CMAM in some areas
4	Active community mobilization, such as case finding and referral, defaulter tracing in most areas	7	5	Caretaker's competing tasks and priorities
5	Availability of well-structured community mobilization work plan	7	4	Double registration of beneficiaries
6	Integration of CMAM programs with other services	6	3	Inadequate medicines supply and delay of RUFT/SF delivery to heath posts
7	Presence of qualified national staff who provide technical supporter to refugee workers	5	3	Inadequate integration of community mobilization for CMAM into community-based initiatives, eg MTMSGs
8			3	Insecurity
9			2	Discrimination to minority at health facilities
10			1	Long distance to health posts in some area
11			1	Language barrier

The availability of RUTF and RUSF without stock out and free charge CMAM service within close proximity at health posts were distinct enablers for the caretakers to access and use CMAM services in Hagadera camp. Decentralization of the OTP and TSFP services at four posts improved refugees' physical access to the service, approximately within 10 minutes walking distance in most sections and blocks of the camp.

Presence and support of the different stakeholders (WFP, UNHCR and ACF) and community leaders was also mentioned as enabler for provision of good CMAM services and the caretakers' access to it. The husband support to women to take a child to health care, as well the block leaders' and CHCs' support to information dissemination about health and nutrition contributed to caretakers' access to and use of the CMAM services.

Additionally, good outreach activities (case finding and referral, home visit follow–up and sensitization) by CHWs contributed to timely case finding and referral cases, increased community awareness about the CMAM program and consequently the increased refugees' access to the CMAM service. Furthermore, health and nutrition education at health facilities, nutrition promotion conducted through extensive network of MTMSGs resulted good community awareness about malnutrition and seeking behavior.

Moreover, integration of nutrition into primary health care program at health facility and community level was among boosters for the caretakers to access CMAM service. CHWs conduct community mobilization for CMAM as part of community–based health program. CHWs identify and refer children with acute malnutrition when they visit the households for health education, disease surveillance and absent tracing from immunization service.

On the other notes, inadequate counseling of caretakers at health facilities was cited as top barriers for the program. The caretakers received the RUTF and RUSF without proper counseling and education on why they need it and how to use it. As the result, the sharing and selling of the RUTF and RUSF is the major challenge in the camp. Double registration of beneficiaries at multiple health posts and bring somebody's child with SAM or MAM for registration to get the RUTF and RUSF were common problem in the camp. These caused inappropriate use of RUTF and RUSF, and poor compliance to treatment that lead to poor treatment outcome. Additionally, the caretakers also associated childhood diarrheal illness with RUSF and refuse to referral from OTP to TSFP. The other possible reason for this, the TSFP service is provided monthly, which forced children who are discharged from OTP had to wait for a month to be admitted into TSFP.

Added related barrier cited by the refugee are inadequate qualified nutrition staff and capacity of refugee workers to deliver the CMAM services. Unqualified refugee workers under supervision of skilled and trained national staff delivered most of nutrition services. The lack of adequate national staff undermined the quality of nutrition services and support to refugee workers.

Additional barrier mentioned for not accessing CMAM service encompassed inadequate community mobilization activities for CMAM and integration of community mobilization for CMAM into existing community-based initiatives in Hagadera camp. Although most CHWs conduct case finding and referral, and defaulter tracing of children with acute malnutrition, MUAC screening of children, sensitization about CMAM and malnutrition and home visit follow up for problematic cases were not priority for the CHWs' works in the camp. The CHWs work more focused on diseases surveillance, immunization and safe motherhood and are overworked. Moreover, the program missed the great opportunities to integrate of community mobilization for CMAM into extensive network of existing community-based initiatives, such as MTMSGs, WASH and CHC, and involving the community leaders. This led to inadequate screening of children and referral, and community sensitization about malnutrition and CMAM service.

Another main reason for not accessing and using a CMAM service was caretakers' competing tasks and priorities. This includes the women caretakers are busy and have a lot of competing household tasks. Despite the husbands are supportive to women caretakers to health facility, neither husband nor other family members take care of children at home if mother goes to the health facility to access the CMAM services.

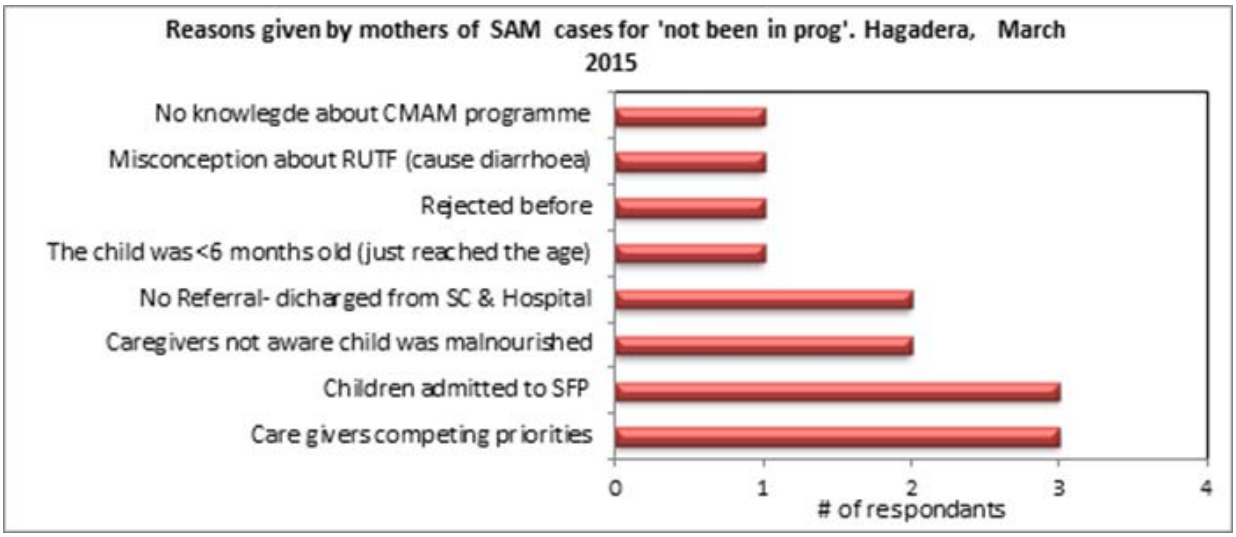
Despite no stock out of RUTF and RUSF reported in the camp, shortage antibiotics for children, particularly syrups was mentioned as barrier for the program. Delay of transport of the RUFT and RUSF from main IRC's warehouse to health posts due to lack or inappropriate of logistic arrangement caused delay of CMAM service provision and long waiting hours and overcrowding every Monday. The centralized logistic support system which serve all partners partially contributed to this

In the 3rd stage of the assessment, caretakers of children with SAM (15) and MAM (47), but not admitted into the CMAM program, were interviewed to assess their reasons for not accessing the CMAM service. Various reasons were given by caretakers as shown below in fig 1 and 2.

Mothers/care takers of SAM:

Out of the 15 mothers/caregivers of SAM cases that were 'not in programme' among those 3 mothers mentioned their workloads or competing priorities. Three children were admitted wrongly to the SFP. While others were mentioned various reasons for not attending the programme (see Figure 1).

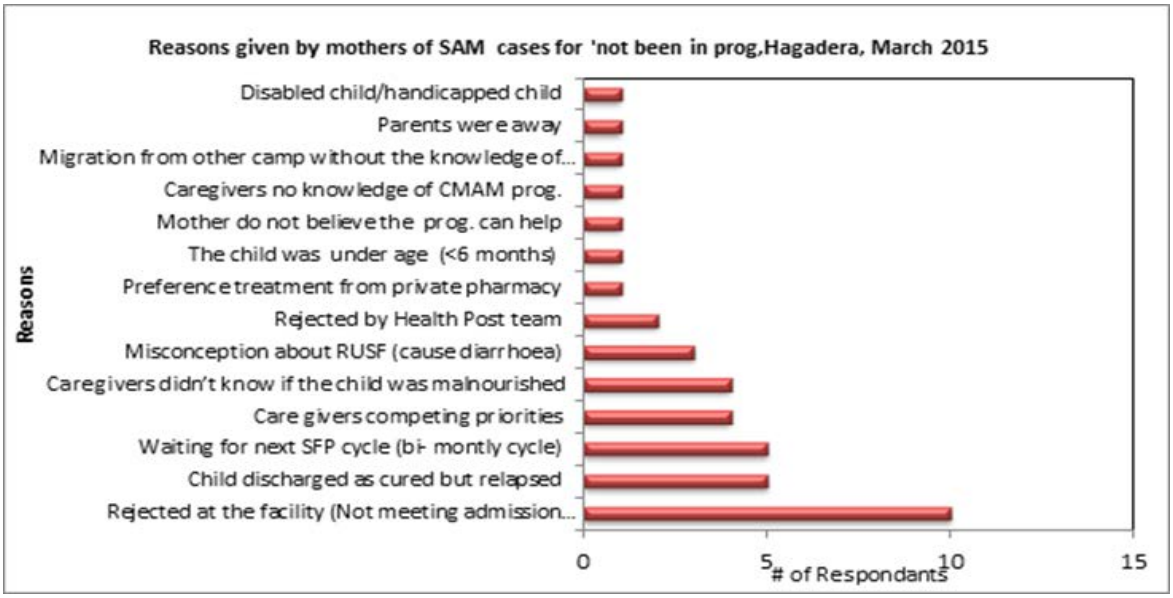
Figure 1: Reasons given by the caregivers of SAM cases for 'not in programme' Hagadera



Mothers/care takers of MAM:

Out of the 47 mothers/caregivers of MAM cases that were 'not in programme' among those majority (about 21%) that their children were rejected. While others were mentioning various reasons, including waiting for next cycle of SFP admission, relapse and caretakers; competing priories etc. (see figure 2).

Figure 2: Reasons given by the caregivers of MAM cases for 'not in programme' Hagadera



3.7. COMMUNITY MOBILIZATION STRATEGY

A SWOT analysis (strengths, weaknesses, opportunities and threats) for the current community mobilization activities for CMAM program in the Hagadera refugee camp was done and summarized below in Table 4. The analysis demonstrated that the community mobilization for CMAM program had several strengths but has also great opportunities to improve the weaknesses and gaps in community mobilization for CMAM.

The community mobilization for CMAM program integrated into Community-Based Health Program (CHP), which staffed by 143 CHWs, approximately a CHW per block that leads to 100-140 households per CHW. A CHP coordinator supervise the CHWs and support their work. The CHP has clear work plan and CHWs were well informed about their roles and objectives the program. During the assessment, it observed that the CHWs were well accepted by the community and know each household's demographic profile and the family members' health conditions in their assigned block.

CASE FINDING AND REFERRAL STRATEGIES

The screening of children for acute malnutrition is done at health facilities and community –level in the Hagadera refugee camp. The health and nutrition workers and refugee nutrition assistants are trained by the UNHCR and IRC to diagnose and treat childhood acute malnutrition without complications at health posts. If a child is suffering from SAM with medical complications then the nutrition workers will refer them to SC at the hospital located within the camp.

CHWs were also trained by IRC and UNHCR and have good skills in MUAC measurement. CHWs conduct the active case finding at household level and referral to health posts. This contributed to active case finding and referral of children with acute malnutrition. Similarly, the CHWs identify children at risk for acute malnutrition, i.e. MUAC < 13.5 for children 6-23months old and MUAC <14.5 for older children 24-59months old, and refer to health post for second step MUAC and WFH screening by health workers. However, the caretakers

are not happy when their children do not fulfill criteria and admitted to the CMAM program. This had negative repercussions on caretakers' acceptance referral from community and access the CMAM services.

Furthermore, UNHCR with IRC and partners conducted mass MUAC screenings ever six months to identify children with SAM/MAM as part nationwide initiative called *malezi bora.*

Table 4: SWOT analysis for a Community Mobilization for CMAM program in Hagadera Refugee camp

Strengths	Weaknesses
• Good community-based health program structure, team , coordination and supervision • CHWs conduct home visits, early case finding and referral and sensitization • Intensified awareness campaigns and mass MAUC screening through routine activities such as 'malezi bora' • Targeted MUAC and WHZ screening every Saturday by CHP and nutrition teams • Health and nutrition education at health facilities • Community leaders and groups support information dissemination • Good partners coordination • IYCF promotion through MTMSGs and ACF technical support on IYCF	• Inadequate involvement of community figures and use existing community-based structures (CHC, MTMTSGs , section and block leaders etc) for community mobilization for CMAM • Inadequate prioritization of the nutrition in integrated CHP and CHWs are overworked • Low motivation of CHWs and limited of skills on community mobilization for CMAM • Limited partner technical capacity and supervision of community mobilization for CMAM • Most of MTMSGs are not active due to funding challenges?
Opportunities	**Threats**
• Several community figures and groups that can be engaged in community mobilization • Structured section and block leaders • One CHW per block • Several partners	• High turnover of staff and overload of CHWs • Host community pressure • Insecurity • Unpredictable funding • Competing activities at the community • Community leaders focus more on incentives rather than actual activities and no volunteerism

HOME VISIT FOLLOW-UP FOR DEFAULTER AND NON- RESPONDER

CHWs conduct 10-15 home visits every morning and trace absentee and defaulters while they visit homes to screen pregnant mothers, and children under one and five years old for immunization and any illness. CHWs follow-up of the children enrolled in the OTP and TSFP to assess their progress and provide counseling and support to caregivers in the health post.

COMMUNITY SENSITIZATION

Community sensitization about malnutrition and CMAM is carried out at health posts by health and refugee workers. The CHWs also conduct health and nutrition promotion at household level when they conduct home to home visit, and rarely at community meeting. However, sensitization about malnutrition and CMAM needs to be prioritized in CHP as well it should be conducted at community gathering places to reach the larger community. Furthermore, lack of job-aids and materials about CMAM and malnutrition that can be used by CHWs should be addressed. MTMSGs meet also with lead mothers fortnightly and discuss at community level to promote positive IYCF practices.

INTEGRATION OF COMMUNITY MOBILIZATION FOR CMAM INTO EXISTING COMMUNITY-BASED INITIATIVES

A community-based nutrition program, including community mobilization for CMAM program integrated into CHP in the Hagadera refugee camp. Furthermore, CHWs conduct quarterly MUAC mass screening and refer children with SAM and MAM during *malezi bora campaign.* Throughout mass screening activities, the CHWs also provide essential preventive package for children aged 6-59 months, such as deworming, Vitamin-A supplement and immunization to reduce under-5 mortality and morbidity. However, the integration of community mobilization for CMAM into exiting community-based initiatives is extremely limited. The effective integration of the community mobilization for CMAM into existing MTMSGs, WASH and CHC networks is feasible in Hagadera camp.

MONITORING, SUPERVISION AND EVALUATION OF THE COMMUNITY MOBILIZATION

Four CHWs supervisors under the supervision of CHP coordinator coordinate and support 143 CHWs in Hagadera camp. The supervision and coordination of CHP is fairly good. However, the ratio of CHW supervisor to CHWs (35) is huge to manage for one person. The CHP coordinator is overworked and has little time to support all CHWs and coordinate the activities since he also support the CHP in other camp.

The CHWs record their works and activities done on their registration book. Moreover, CHWs visit the health posts every day and sharing information to their supervisors that helped to the CHW supervisors to coordinate and monitor the activities. However, standardization of CHWs and introduce use-friendly pictorial referral forms should be addressed. Moreover, analyzing the CHWs' reports and provide feedback to CHWs is equally important in order to measure the effectiveness/impact of CJWs' work on the CMAM program (i.e., number of self- referrals versus CHWs versus other referrals, number of late referrals, or actual geographical coverage of CMAM services). UNHCR, WFP, IRC and partners conduct monthly coordination meeting and conduct joint supportive supervision to the health facility and provide technical support to the health workers.

THE ROLE OF COMMUNITY LEADERS

The section and block leaders support the community mobilization for CMAM by disseminate information. However, the involvement of other community figures, particularly sheik and traditional healers in supporting community for CMAM program is very limited. Community figures, such women representative, CHC and men expressed commitment to support the community mobilization for CMAM, however they could. So the UNHCR and partner should engage the community figures in supporting community mobilization for CMAM program and their possible roles is summarized below in table 5.

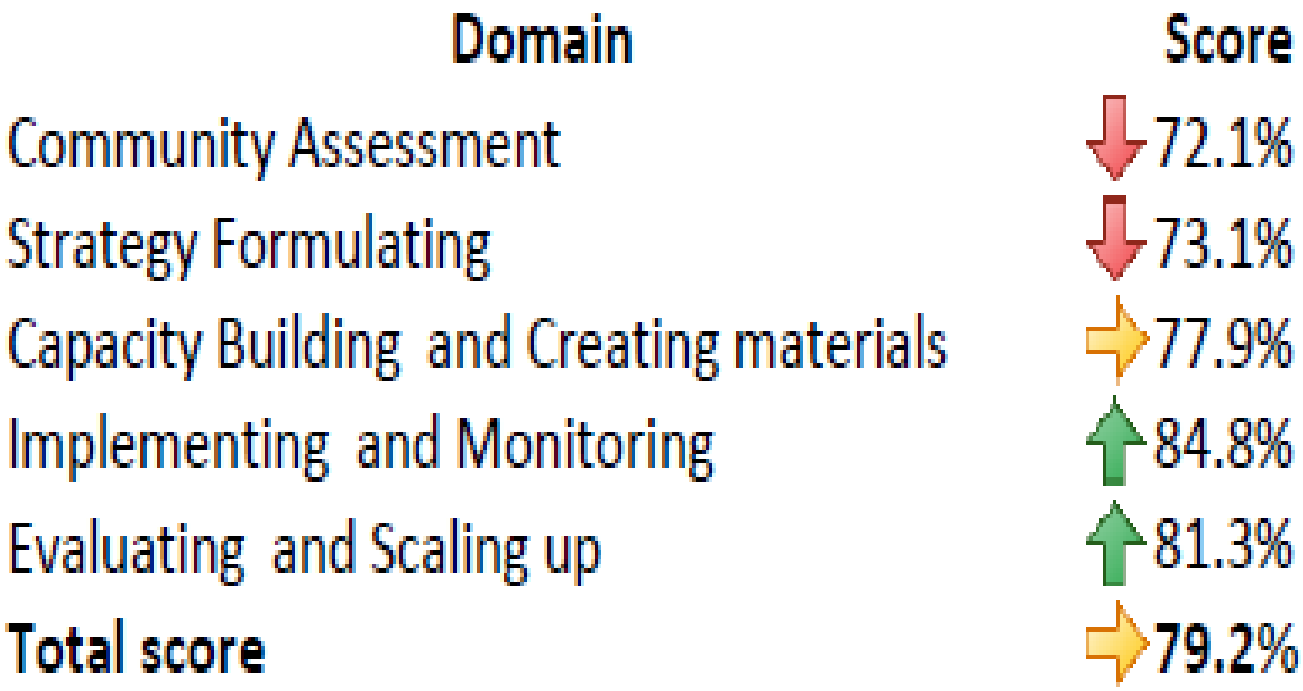
Table 5: Community Figures and their Potential Role in Community Mobilization, Hagadera camp

Community figures groups	Possible roles in community mobilization
Section and Block leaders	Community mobilization, addressing barriers
Religious Leaders , TH	Community sensitization, opportunistic case finding and referral
MTMSGs, CHC, Food committee	Community sensitization and case finding and referral

3.8. BALANCED SCORECARD

Balanced Scorecard (BSC) was piloted and employed to measure IRC's performance, technical capacity and needs in community Mobilization for CMAM program. The three teams consist of the senior nutrition coordinators from UNHCR, WFP and other partners were formed as three different facilitator groups and evaluated the IRC's community mobilization program during the assessment. The IRC's team provided answers and explanations for all questions that asked by the facilitator teams. The BSC result for Hagadera camp present below in figure three.

Figure 3: Community Mobilization BSC result, Hagadera Camp, March 2015



These results should be interpreted carefully due to several reasons including, 1) the community mobilization BSC tool was piloted for first time in Hagadera to test the tool in the field and learning exercise, and 2) during the field testing, it was observed that there were community mobilization knowledge gaps from both facilitators and IRC's teams. As the result some of the activities and domains scored high.

IV. CONCLUSIONS AND RECOMMENDATIONS

This community assessment revealed vital information, including the contextual factors for accessing and use the CMAM service.The availability of RUTF and RUSF and free charge CMAM service at decentralized health posts have been identified as most distinctive enablers for the community to access to CMAM services.Presence and support of the different stakeholders (WFP, UNHCR and ACF) technical and operational support to IRC and the team in the CMAM program is another key element of the program. The UN agencies and ACF regular supportive supervision to the IRC's nutrition workers contributed to the provision of a good quality CMAM service in the Hagadera refugee camp. However, the current technical support and training program is deficient in community mobilization and it's more focused on case management of children with acute malnutrition. The inclusion of community mobilization and health communication should be prioritized and sufficient time to be spent on community mobilization.

Outreach activities for CMAM through CHWs as part of integrated community health program is a good component of the program and contributed to early case finding and referral, minimized defaulter, sensitization and consequently improve the refugee health seeking and access to treatment of acute malnutrition. However, the CHWs are already overworked and they work with more emphasis on disease surveillance, immunization and safe motherhood but less attention to nutrition program. In order to reinforce the community mobilization for CMAM service, the UN agencies and IRC should explore other options for community mobilization strategies – such as using existing refugee section and block leaders, and refuges groups (MTMSGs, food committee, CHC etc.) who can engage and feed input from refugee to CHP and health system. The CHWs should lead and only support community mobilization efforts. Community sensitization and opportunistic case finding and referral by sheiks and traditional healers is also the paramount strategy to increase case finding and referral in the camp as well as increase refugee awareness and men and traders involvement through religious institutions.

The refugee leaders and CHC participate in supporting the community mobilization for CMAM program by disseminating information to the refugees and voice the refugee health and nutrition concerns to partners and health workers in the camp. However, the role of the community leaders and CHC in community mobilization for improving access and use of the CMAM service should be extended beyond information dissemination to encompass community sensitization, support to case finding, referral , home visit follow up, regular monitoring and addressing the bottlenecks to access to care. This expanded role could contribute to the reinforcement and strengthening of access and use of the CMAM service in the area. It would also empower the refugees and enable the implementation of more accessible, culturally appropriate and community-owned CMAM service and minimize the high opportunity costs for caretakers. Moreover, the assessment revealed that community mobilization activities have not targeted local mosques and churches and lacked the involvement of other refugee figures (sheiks, traditional healers etc.) in the community mobilization for CMAM program. It is recommended that community mobilization activities be extended to gain the support and involvement of these influential refugee figures.

On the other note, this assessment also revealed that the **sharing and selling of RUTF and RUSF** are the major problem in the camp. This includes fetching of RUTF /RUSF at multiple health posts by same

beneficiary and the double registration of children with SAM or MAM at a health post using different names and caretakers. These led misuse of the RUTF/RUSF, and poor compliance of treatment at household and consequently poor treatment outcome. Therefore, it necessary to address these barriers by encouraging the proper use of RUTF/RUSF and introducing a system to minimize double registration at health posts and to identify and minimise the cause for sale and sharing at household level. The possible use of biometric registration at health posts, and involving the block leaders and CHC to identify the actual caretakers of child with SAM or MAM could help to reduce the double registration of beneficiaries. Moreover, the refugee leaders, CHC, medical professional and traders could be involved community sensitization on proper use of RUSF/RUFT. The proper counselling of caretakers on the purpose of CMAM services should be part of the initiative. Since the CHWs visit 10-15 households per day and number of SAM and MAM cases are not more than 5 children per block, piloting and scaling up the daily follow up of use of RUTF/RUSF by CHWs (directly observed OTP at community level) would increase proper use of RUTF/RUSF and compliance to treatment.

Current supervision of CHWs need to be augmented by strong technical assistance and supportive supervision of the CHWs by the CHP coordinator and senior nutrition and health workers. In order to reinforce CHWs capacity, IRC and UN agencies should provide continuous training to CHWs on community mobilization and communication skills, appropriate job-aids and IEC materials, and motivate them by providing material incentives and recognition of their work. Moreover, the monitoring of outreach program and analysis data and provide feedback to CHWs should be strengthened

The quality of the CMAM services is fairly good in Hagadera camp. The national and refugee nutrition staff were trained and used properly the SAM/MAM case management protocols. However, the CMAM service quality is compromised by shortage of national staff to mentor and supervise the refugee counterpart, and inadequate counselling of caretakers on use of RUTF/RUSF and CMAM service. The delay of delivery of RUTF/RUSF from main IRC warehouse to health posts also caused delay of CMAM service delivery and long waiting hours on Mondays. To be successful, the community mobilization to increase access and uptake of the CMAM services should be implemented in tandem with strategies to improve CMAM service quality at health facility level. Therefore, the gaps in quality of CMAM services need to be addressed by adequate staffing of the health posts, close supervision and technical support and improving CMAM supply chain management.

In conclusion, the following six essential recommendations need to be employed in order to improve access and use the CMAM services by the communities in the Hagadera refugee camp:

1. Strengthen community mobilization activities for a CMAM program by ensuring adequate integration and prioritization of nutrition into existing CHP , and capitalizing on the extensive community based network, such as MTMSGs, CHC , block leaders
2. Provide all partners staff responsible for CMAM-related activities with community mobilization and social and behavior change communication training in line with their duties. It includes community figures, groups and CHWs
3. Strengthen community sensitization among the caretakers on CMAM program , malnutrition and RUTF and RUSF utilization

4. Engage strategically with CHC and block leaders to monitor program barriers and address them
5. Assess the causes and introduce a system to minimize double registration and selling and sharing of RUTF/SF by the involving the refugee leaders and CHC
6. Strengthen the refugee leaders and figures involvement in supporting the community mobilization for CMAM program
7. Improve monitoring and evaluation of CMAM program, particularly the community mobilization activities

Detailed recommendations are provided below in table 6 in the joint plan action on community mobilization for CMAM program, which should be implemented by UNHCR, WFP, IRC and ACF.

UNHCR, WFP, IRC and ACF Joint Plan of Action on Community Mobilization for CMAM, April –Dec 2015

	Strategy /Activities	Performance indicator	Target	Priority/When April-Dec 2015	Responsible (Focal Person or Agency)	Applicable Internal Resources	External Resources Needed
I	**Community Mobilization**						
1	**Community participation**						
1.1	Train the community figures (sheiks, pastor, TH and section and block leaders) and groups (CHC, MTMSGs) on CMAM and malnutrition and involve them in community mobilization	# community figures and groups members trained and involved	200	April –Dec	IRC, ACF		
1.2	Involve Community health committee (CHC) to monitor the program barriers and address them	# CHC meetings held to assess and address program barriers	3	July , Sept and Dec	IRC		
1.3	Strengthen community leaders role in mobilizing the community for screening , case finding and referral, defaulter tracing , addressing selling RUTF/SF and accountable to CHWs' work	# block leaders actively involved and support	140	April-Dec	IRC		
2	**Outreach activities**						
2.1	Train CHWs on community mobilization for CMAM (case finding and referral , home visit follow–up, sensitization)	# CHWs trained and actively do community mobilization	143	July-Dec	IRC, UNHCR		
2.2	Community sensitization on use of RUTF and RUSF via radio program	# sessions on nutrition product utilization per quarter	3	April- Dec	IRC, UNHCR , WFP, ACF		
2.3	Community sensitization on CMAM and malnutrition through different community leaders and groups , and during key calendar events	# sensitization at scale conducted per year	10	April -Dec	IRC, UNHCR , WFP, ACF		
2.4	Community sensitization on CMAM and malnutrition at mosques via trained sheiks during Ramadan	# sessions conducted at mosques	50	July	IRC		
2.5	Pilot direct-observation of use of RUTF/SF at household level for problematic cases by CHWs	% CHWs conduct direct observation	50%	April –Dec	IRC, UNHCR , WFP, ACF		
3	**Technical support , Monitoring and Evaluation**						

3.1	Standardize CHW's registration book to make sure MUAC data is captured	% CHWS received revised registration book	100	May	IRC		
3.2	Continue analysis of CHWs report and data from registration book and use findings to improve community mobilization	% of CHWs received feedback monthly	75%	April –Dec	IRC		
3.3	Strengthen joint UNHCR, WFP and ACF technical support and monitoring to IRC	# joint supervision	4	April -Dec	UNHCR, WFP		
3.4	Strengthen supervision and technical support to CHWs by nutrition and health workers	% CHWs supervised by month	75%	April -Dec	IRC		
3.5	Conduct quarterly performance review of this JPA implementation	# performance review meeting held	3	June , Sept and Dec	IRC,UNHCR,WFP		
II	**SFP and OTP Services**						
1	Train OTP and SFP workers on basic counselling in nutrition program	# staff trained	42	June and Oct	IRC, ACF , UNHCR		
2	Provide counselling to caretakers on CMAM service and malnutrition at least during admission and discharge of cases, and problem cases at health posts	% caretakers received counselling	75%	April -Dec	IRC		
3	Strengthen health education on use of RUTF and RUSF at health posts	# sessions conducted /month # caretakers reached	4 1, 540	April -Dec	IRC		
4	Employ systems to minimize double registration of beneficiaries at health posts	# health posts employ system	4	June	IRC, WFP and UNHCR		
5	Strengthen screening and case finding at triage place and all contacts points at health facility	# health posts introduced triage system	4	April -Dec	IRC		
6	Provide daily SFP service for new admissions	# health posts provided SFP provide	4	June	IRC , WFP and UNHCR		