Community Nutrition Mobilizers as a Key Mechanism to Scale Access to Nutrition Services in Northeast Nigeria

CASE STUDY • 4/6

Delivery System for Scale

NIGERIA

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Overview

This case study is part of a compendium of country-level case studies produced by the Delivery System for Scale[1] project that explore promising, context-specific approaches to scale the management of wasting treatment for children under five. In Northeast (NE) Nigeria, the Nutrition Sector has recently harmonized its approach across all implementing partners – promoting community-level engagement through Community Nutrition Mobilizers (CMNs).

The CMN approach is believed to increase coverage (i.e., through increased detection and referrals) and improve quality of care (i.e., through integration with other nutrition and health interventions and promoting adherence to treatment protocols). This case study, therefore, describes what motivated the harmonization of the CMN approach, how it was designed and implemented in practice in NE Nigeria, and where the approach stands in its current form today.

Introduction

Interest in and engagement for a harmonized community nutrition strategy in NE Nigeria began in 2017 in response to a number of emergent challenges, including:

1. A comparatively heavy concentration of implementing partners' nutrition activities in and around the longer-standing 'safe' local government areas (LGAs) rather than those areas that had more recently been declared as safe for humanitarian activities;
2. Diverse and, at times, unequitable approaches for mobilizing community-level nutrition activities across partner organizations (e.g., with some offering lucrative remuneration while others operated a volunteer system without incentives); and,
3. Consistent reporting of quarterly integrated management of acute malnutrition (IMAM) and infant/young child feeding (IYCF) below expected targets.

A taskforce, comprised of nine nutrition sector members, joined together to comprehensively review all existing community mobilization approaches across partners, assess the strengths and limitations of each approach, and then based on identified best practice, recommend a coherent and harmonized community mobilization structure to be adopted by all nutrition cluster partners.

Key Considerations for Harmonization

With the understanding that a harmonized strategy would serve to increase the coverage of IMAM and IYCF interventions, the main crosscutting priorities of the taskforce included both *sustainability* (i.e., strengthening the existing system, operating through the Ministry of Health (MOH) and/or community structures) and *effectiveness* (i.e., maximizing the use of available resources to achieve optimal results). As a result, these elements can be seen across the main components of the strategy:

- **Role Title:** The task force settled on the title of Community Nutrition Mobilizers (CNMs). The choice of 'mobilizers' as opposed to 'volunteers' was intended to better describe the nature of the work (i.e., to engage the community for update of nutrition services) and to reflect a consistent level of effort that deserves financial compensation (as compared to ad hoc, unpaid, and/or opt-in contributions of time via a volunteer system).
- **Training:** The taskforce agreed that implementing partners have a responsibility to train and facilitate the CNMs work, including through the provision of work tools, equipment, and materials (simplified for use by mobilizers with lower literacy levels through pictorial charts or tally sheets), as well as boosting CNM visibility within the community and with community leadership.
- **Qualifications:** The basic qualifications prioritized for collective recruitment of CNM positions were: 1) Over 18 years of age; 2) Self-motivated with a demonstrated commitment to community work; (3) Respected resident of and speaker of the local language in the community where services will be provided; 3) Literate to fill data tools required. Additionally, gender dimensions enabled the selection of men, where acceptable and feasible, and preference was given to candidates that were both well-settled in the community (i.e., no immediate plans to migrate for work, education, etc.) to minimize turnover and reachable phone to maximize contact with the program, where required.
- **Supervision:** The taskforce agreed that CNMs should be supervised by a state-level MOH employee or, where not feasible, an employee of a nutrition sector partner whilst still working closely with the relevant local MOH counterparts (e.g., the health facility in-charge, LGA nutritionist, etc.). be supervised by someone of higher competence and literacy level. Supervisors should be literate and geographically proximate, as each supervisor was to ensure they could locally visit and provide supportive supervision across several CNMs.
- **Roles and Responsibilities:** Primary CNM responsibilities included, but were not limited to:

1. Screening of children under five years of age for malnutrition, with referral of malnourished children to the closest IMAM center,
2. Promoting the uptake of the minimum package of essential nutrition services,
3. Maternal, infant and young child nutrition counseling and support, including organizing cooking demonstrations with locally available nutritious foods,
4. IMAM beneficiary follow-up and defaulter tracing,
5. Strengthening community feedback systems for nutrition interventions,
6. Mobilizing for outreach and health campaigns (e.g., maternal, newborn and child health week and world breastfeeding week)
7. Tracking and reporting population movements,
8. Supporting the IMAM center on follow-up days, and,
9. Support local reporting of relevant nutrition activities.

- **Selection Process:** For sustainability and community acceptability, the selection process was designed to be as fair and transparent as possible by ensuring diverse involvement among local MOH staff, including the LGA nutrition focal person, together with local community leadership. Selection committees were set-up and comprised of: the chairperson of the village development committee, one representative from each local religion, the chair of the local health facility management committee, the person in-charge of the local health facility for the catchment population, a representative of the nutrition sector implementing partner supporting the area, village heads and other locally relevant leaders.
- **Working Hours:** The taskforce estimated that each CNM would dedicate approximately 3-5 hours per day across 4 days per week. This level of effort was derived in alignment with the proposed financial compensation and in consideration of the fact that most CNMs had other, pre-existing family and household commitments they were required to maintain (e.g., caregiving).
- **Household Allocations:** The guiding principle for allocation was that each CNM should be able to reach each allocated household at least once per month, within their monthly working hours. In practice, this meant that each CNM was allocated ~150 households, although for CNMs operating in areas of low population density, this allocation had to be reduced.
- **Distribution:** As a result of the household allocations, the number of CMNs per community varied with the population. The guiding principle for calculating the number of CNMs was to attain a coverage of at least 70% of households from the local area (or when covering internally displaced people, at least 90% of households from the camp area).
- **Terms of Engagement:** CNM roles were not contracted, although implementing partners were encouraged to formalize their contribution by providing them with an identity card and brief document detailing their role. Financial compensation followed a recommended monetary incentive of 15,000 Naira, which was reviewed when necessary, based on local economic and price conditions. Additionally, implementing partners had the option of providing support with transport to facilitate the work of CNMs, as well as other non-financial incentives to motivate their participation. To encourage wider behavior change within their community, implementing partners were encouraged to support CNMs to attain 'model household status' by linking them to receive support from other sectors (e.g., water, sanitation and hygiene; livelihood; health; etc.).

Implementation at Scale

After validation of the community mobilization strategy, the next step was for partners to operationalize it and work towards implementation at-scale across accessible areas of the NE region. This operationalization entailed:

1. **Evening out operational presence across the region:** This included decongesting partner presence within Maiduguri town and scaling-up nutrition services in the newly cleared, accessible LGAs. Even distribution was achieved by encouraging some partners to relocate and begin implementation towards farther LGAs. Guidance also encouraged one nutrition partner, one outpatient therapeutic program site, and one stabilization center per LGA only under exceptional circumstances (discussed and agreed with both the MOH and nutrition sector coordinator) would more be considered.
2. **Sensitizing the community and selecting CNMs:** Each partner operational in a given LGA was tasked to lead community sensitization and the process for recruitment of local CNMs, in line with the pre-agreed CNM terms of reference.

3. **Training and facilitation of CNMs:** Similarly, each partner operational in a given LGA was also responsible for training the selected CNMs and facilitating their work through the provision of necessary tools and equipment. In addition, on-the-job mentorship systems were to be set-up for continuous training and supervision systems put in-place to follow-up with CMNs on their progress and performance against monthly reporting indicators.
4. **Harmonizing reporting and integration into the nutrition information system (NIS):** At sector level, the nutrition sector harmonized minimum reporting requirements for CNMs and designed reporting tools aligned with these indicators. Collective agreement on requirements and tools from the start streamlined reporting and data analysis across partners.
5. **Adapting to new evidence-based strategies:** The structure of the CNM system has allowed for emergent adaptation and the uptake of simplifications, i.e., Family MUAC, and the minimum essential nutrition actions.
6. **Multi-faceted fundraising:** Cognizant of budgetary implications, each partner agreed to factor the CNM mobilization requirements into any new donor appeals and proposals.

With validation, nutrition coordination partners also unanimously resolved to shift into the new community mobilization structure within a 3-to-6-month period. These efforts accelerated with direction from UNICEF that the new strategy would be reflected in new Program Document contracts with UNICEF, as well as with the continuing expansion of areas safe and open for humanitarian response.

The CNM Strategy Today

As of August 2023, there are over 4,300 CNMs operational in NE Nigeria, over 3,300 of which are supported by UNICEF alone. In Borno state, recently efforts have been made to advance the approach even further through a state-wide strategy structured around community health influencers and promoter services (CHIPS). There, CNMs will be absorbed as CHIPS with the validation of the strategy and efforts are underway to ensure a smooth transition, facilitated by engagement from the MOH and community leadership from the conceptualization phase. Finally, a similar strategy is currently under consideration for adoption in the NW region to scale-up community mobilization efforts for nutrition interventions as well.

Over the coming months and years, it is expected that:

- **For treatment of SAM,** the CNM system could be leveraged if/as decisions are taken to increase implementation of community health worker-led treatment. Given that CMNs are already provide an extensive and interconnected network of individuals already familiar with and supportive of community-based nutrition-focused engagement, strengthening the CNM skillset could be more efficient and effective than creating a CHW-focused system from scratch. Additional training, resources and incentives would be essential, but given the existing workforce, this type of systems strengthening could be particularly useful for exceptional circumstances, where the system is intended to adapt on a time-limited basis with top-ups to existing resources.

- **For management of MAM,** given the new operational plan between UNICEF and WFP with priority towards increasing access to targeted supplementary feeding programs (TSFPs), the CNM approach is well-aligned with boosting coverage of these new outposts through active case finding and referral. CNMs will need, however, to be well-updated on the provision of such services and to ensure community-level sensitization on the services provided to avoid any potential confusion.
- **In inaccessible areas,** particularly those that are newly inaccessible from recent changes in the security situation, CNMs could be leveraged to ensure continuity of nutrition essential services where international humanitarian actors may be prohibited. How CNMs could be leveraged (i.e., under what conditions, with what resources, for what time period, with what responsibilities, etc.), though, remains unclear and is an emergent area for learning, if/as stakeholders engage with and empower existing CMNs in such contexts.

Finally, if/as the CNM system continues to be of interest to leverage for nutrition-related interventions at the community-level, it will be of increasing importance to ensure proper training (including through the development and use of harmonized training tools) and priority towards retention of those trained (including through the use of incentives and/or a more formalized, salary approach).

Endnotes

1 The Delivery System for Scale project was implemented from 2022-2023 by the International Rescue Committee, Action Against Hunger and Save the Children, with the support of UNICEF. The project provided technical and operational support to UNICEF country offices in high-burden countries, aiming to accelerate efforts to bring child wasting treatment to scale.