Community Mobilization Assessment Report
Damaturu and Fune LGAs, Yobe State

Nigeria
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ABBREVIATIONS

<table>
<thead>
<tr>
<th>ACF</th>
<th>Action Contre la Faim</th>
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<tr>
<td>CMAM</td>
<td>Community based Management of Acute Malnutrition</td>
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<td>CBOs</td>
<td>Community Based Organization</td>
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<td>CV</td>
<td>Community volunteer</td>
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<td>LGA</td>
<td>Local Government Area</td>
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<td>MoH</td>
<td>Ministry of Health</td>
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<td>MUAC</td>
<td>Mid Upper Arm Circumference</td>
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<td>NGO</td>
<td>Non Government Organization</td>
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<tr>
<td>OTP</td>
<td>Outpatient Therapeutic Programme</td>
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<tr>
<td>RSCA</td>
<td>Rapid Socio Cultural Assessment</td>
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<td>RUTF</td>
<td>Ready to Use Therapeutic Food</td>
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<td>SAM</td>
<td>Severe Acute Malnutrition</td>
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<td>YBC</td>
<td>Yobe Broadcasting Corporation</td>
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EXECUTIVE SUMMARY

OBJECTIVES

General Objective

To collect and compile information about communities covered by the CMAM program for the development of a comprehensive community mobilization strategy.

Specific objectives

- To conduct a rapid socio-cultural assessment (RCSA), including at least the following parameters:
  - Identify main stakeholders in the community and their relationship within the socio-political, spiritual, religious, economic and health sectors
  - Identify community organization and groups
  - Identify formal and informal channels of communication
  - Identify health attitude and health seeking behavior
  - Identify key features of the community that directly or indirectly could affect the planning and implementation of OTP
  - Look at social organization.
  - Identify social solidarity mechanisms
- To identify contextual barriers to access and address possible solution
- To develop a community mobilization strategy based on RCSA findings’ report and in consultation with stakeholders.

INTRODUCTION

Nigeria is ranked as the third country with the highest absolute number of children under five in need of treatment for severe acute malnutrition\(^1\). The estimated caseload presented by UNICEF is of over 800,000 children at risk in Northern Nigeria alone\(^2\). There is ongoing need for nutritional treatment to be integrated into routine services due to the endemic nature of malnutrition in Northern Nigeria\(^3\).

Community-based Management of Acute Malnutrition (CMAM) first started in Nigeria in April 2009, when two pilot projects were setup in Kebbi and Gombe states, with support from UNICEF and technical expertise from Valid International. Within each state, a total of three Local Government Areas (LGAs) were targetted. Since then, treatment has been extended to an additional 8 states, with the same coverage of three LGAs for each state. CMAM activities are integrated into

\(^1\) ACF Strategic Plan 2010-2015, WHO Global Database on Child Growth and Malnutrition;“The Lancet’s Series on Maternal and Child Undernutrition.
\(^2\) As cited in ‘Commission Decision on the financing of humanitarian actions in West Africa from the 10th European Development Fund’. European Commission, 2010
routine health services of the targetted LGAs and led by the State Ministry of Health (SMOH) or State Primary Health Care Development Agency (SPHCDA).

ACF started to support Yobe State and two LGAs in the integration of CMAM activities in January 2011. During the first phase the community based activities has focused on overall sensitisation and selection/training of community volunteers. In order to strengthen the CMAM community component, a rapid socio cultural assessment was conducted jointly with the first phase of community activities. This will provide the opportunity to further adapt the community approach to the local context.

The first section of the report presents an analysis of context for Fune and Damaturu LGAs. The second section shares the community mobilisation activities in place and discusses key issues that have to be addressed, with a series of recommendations to support a more comprehensive community mobilisation approach to support CMAM.

1. **UNDERSTANDING THE CONTEXT: RAPID SOCIO-CULTURAL ASSESSMENT**

‘Understanding the local community and the operating context is a prerequisite for any successful development or humanitarian intervention. An appreciation of the social organization, key community figures, the ways in which messages are transmitted, typical health seeking behavior and the support mechanisms people use in times of difficulty, is vital in designing a programme responsive to need’.

A rapid socio-cultural assessment was carried out in Damaturu and Fune LGAs in Yobe State. The assessment was mainly focused on the CMAM coverage area in the two LGAs.

1.1. **LGA Structure**

1.1.1. **Geographical and physical layout**

Yobe State is located in the North Eastern part of Nigeria and is divided into 17 Local Government Areas (LGA), with Damaturu LGA as the State capital and Fune LGA the largest LGA in the State. The area is generally a Sahel savannah zone with insignificant tree cover and patches of grass and sand. It exhibits tropical dry season climatic conditions, with rainfall for only 3 - 4 months from June to September. These dry seasons are windy and hot with temperature going up to 40˚C. The wind is dry and dusty (Harmattan) as it originates from Sahara desert where there are a limited number of large water bodies and thus the wind carries sand particles, giving the Harmattan its sandy nature. Areas in the north of the LGAs (particularly Fune) are semi deserts, with even less vegetation than the middle belt.

LGAs are the main administrative areas after the State. They are further divided into political wards, which is the smallest unit with administrative boundaries. Traditionally, however, the LGA is divided into districts which are further divided into villages. Districts’ boundaries are not necessarily the same the political ward boundaries. Villages are formed on the basis of lifestyle (social activities), livelihoods, the population, market places and water sources. The villages are divided into smaller units called settlements/wards. These are formed for two main reasons which are; growth of the

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5 There are traditional wards also referred to as settlements. Then there is a political ward with administrative boundaries.
villages and differences in lifestyle and livelihood within one village such that it is difficult for one leader to lead. These are then separated to make different settlements with a unique lifestyle and/or livelihood. The settlements are permanent and/or temporary structures but all these settlements are cluster settlements grouped together in relation to ethnicity and lifestyle. There are also linear types of settlements along the main highways. There is no specific number of settlements that form a village as the numbers of settlements under a village vary from village to village.

The settlements are the smallest units of residence grouped together to create a community. The settlements vary in size with the smallest settlements having 10 households while the largest are reported to have more than 50 households. There are both permanent and temporary settlements distributed all over the LGA. These settlements are indicative of the lifestyle of the group settled there. Settlements located along the main highway from Damaturu to Potiskum and those around the political ward centre towns are permanent structures. The structures are characterized by brick houses plastered with either cement or mud. There are several mosques in these settlements as the communities are dominated by Muslims. Churches are mainly found the Damagum and Damaturu. The permanent settlements have a much more reliable source of water and transport among others, as compared to settlements on the outskirts of the towns.

On the outskirts of the political ward centres there are mixed permanent and temporary structures. There are less people settled outside the main towns. These are less developed area with a lot of unused land. These areas are spacious and suitable for animal rearing or large scale farming. The areas are mainly characterized by houses made of wood or dried millet stalk. Most Fulani and Karekare tribes live in these areas because there is enough land to support their livelihood that is animal rearing and large scale farmers have their land in these areas with most of them residing in that area or in towns near their farms. Most farmers residing in towns, however, have small temporary structures close to the farms where they can stay during the planting and harvesting season.

a. Fune LGA
Fune Local Government was created in 1976 in Borno State and is one of the oldest LGA in the State. The Local Government headquarter is Damagum which is situated west of the State capital. The LGA share border with Jakusko, Nangere (North west), Potiskum and Fika (West), Tarmuwa, Damaturu and Gujba LGA (South west). Fune has a total population of 355,240 based on 2006 census. The LGA is divided into thirteen (13) political wards namely Alagarno, Borno Kichi, Damagum A, Damagum B, Daura A, Daura B, Jajere, Kollere/ Kafaje, Mashio, Marmari/ Gudugurka, Ngelzarma A and Ngelzarma B (See Annex 1). The village to settlement structure in Fune is not well defined as in Damaturu, some settlements are not under any particular village and some villages have not been subdivided into settlements.

b. Damaturu LGA
Damaturu Local Government was created in 1976 Borno State. With the creation of Yobe State in 1991 it became the State capital. It shares borders with Borno State to the East, Fune LGA to the West, Tarmuwa LGA to the North and Gujba LGA to the south. The local government has a population of 100,995 according to 2006 census. The population of the LGA is unevenly distributed with Damaturu town being the most populated area. Damaturu is divided into eleven (11) political wards namely Njiwaji/Gwange, Nayinawa, Damakasu, Murfakalam, Kallalawa/Gabai,

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6 A household is a group of people living together. Most households were seen to compose of a husband, his wives and children. eg brothers living together.
Sasawa/Kabaru, Bindigari/Pawari, Gambir/Moduri, Kukareta, Damaturu, central and Maisandari. The LGA has four districts namely Shehuri, Maisandari, Sasawa and Bulaburin. These four districts are further divided into 28 villages and the numerous settlements (See Annex 2). Damaturu town still uses the traditional leadership despite having modern type of settlements.

1.1.2. Ethnic identity and distribution

The lingua franca for the Northern part of Nigeria is Hausa. However the LGAs have a number of different ethnic groups settled together. These groups include the Fulani, Karekare, Kanuri, Ngizim and the Ngamo which are more dominant than the others. There are many different tribes in Nigeria reported to be over 250 different ethnic groups. Therefore the ethnic groups mentioned above are not the only groups found in the two local governments but the predominant groups. Despite Hausa being the Lingua franca for the area, most women in the rural communities do not understand it. They can only speak their native language. Men may not be fluent in Hausa, they can communicate with it, as they move to different places in search of work. The Fulani and Kanuri tribes are historically the predominate groups for this area and to date there is a significant number of Fulani people in Fune and Kanuri in Damaturu. (See Annex 3)

The Fulani ethnic groups are nomads and they move from one place to the other in search of pastures and water for their animals. Some will move the whole family and return after the rains. The other groups, only the younger (mostly male) members of the families are the ones who migrate with the animals and the older members stay behind with the young children (toddlers) and farm. Hence the nomads will return to the original settlements after the rains. With the development of the LGAs nomadic tribes (Fulani and Karekare) have moved out of the towns as these places are becoming more crowded. Not all nomadic tribes live in the outskirts of the towns. Some have changed their lifestyle and livelihoods and depend solely on farming or businesses. The more business orientated Kanuri, Ngizim and Ngamo prefer to settle within or around the towns.

The different ethnic groups are easily identified through dressing especially among women. The women all over Nigeria are very explicit in the way they dress as this reflects their culture, which strongly involves women decorating themselves. The way each tribe decorates themselves is usually unique to that group. Due to the development of the towns more women have their hands and legs painted with Henna by professional people, but this was originally done by the Kanuri and Fulani, who still have their own traditional painting done to their hands and legs.

Fulani tribe has curly hair and the women keep their hair long and braided sideways to the ears. Their outfits, which are made from colorful printed material usually with green, yellow and red, have beads on them for decoration. They also put beaded necklaces and head gear. The Fulani children can be identified from their unique hairstyles. The male children’s heads are shaved leaving small patches of hair, in a particular pattern around the head. The female children have the front of their hair cut almost half way and the remaining hair plaited. Most Fulani are very light skinned and small in stature.

The Kanuri women are identified by the nose ring they have. These rings are a cultural symbol for them and are made of gold. Originally it was meant to show ones status in the community. However, non gold rings are sold in the markets such that anyone who wants one will have it. Not all Kanuri women have these nose rings though. They also have their two front teeth colored in red.

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7Nomadic groups prefer to stay in spacious places to accommodate the large numbers of animals they rear and for their animals to have a grazing space.
as makeup. They use bangles on their arms and legs called *kari*. Their nails are painted halfway with black or red. The material they use to make their outfits is usually blue and red in color.

Most ethnic groups in the LGAs have however, adopted the Hausa way of dressing, which for women are colorful designs, long skirts and a scarf over the shoulders.

The man wear printed attire or long robes (*kulbu*) with a matching pair of trousers and a hat (*zanna*). It is difficult to differentiate men into their respective tribes as they all dress almost the same. The Fulani are, however, distinct in their dressing from the Hausa/Kanuri type of dressing. Fulani men are characterized by long robes or simply a shirt and trouser with head tie often covering the ears and a scarf around their neck almost always. They also carry with them long sticks, (as they are shepherds) knives, bow and arrows for protection as they are always in the bush.

Men and women from the Hausa and Kanuri tribe can also be identified by tribal marks on their faces. The Hausa tribe has six marks while the Kanuri has nine marks on the face. These marks started in the days of slave trade when people used to be kidnapped. In case one was kidnapped it was easy to identify them, communicate in a language they could understand and possibly take them back to their families. To date some families are still marking their children’s faces though the numbers are going down.

People living together in a settlement are usually related (forefathers and their descendents). Rarely do you meet with people not related at all (even by intermarriages) living together. There are very few settlements with more than one tribe. These are usually composed of the original tribe and a nomadic tribe settling on the outskirts of the settlement. These settle together because of the mutual benefits. The nomadic tribe will get grain from the permanent residence and feed stocks for their animals as these are usually farmers. The farmers on the other hand get manure from the animals and animal products (milk, meat and hide). The leaders of the settlements (Bulama - Hausa and Jauro - Fulani) are always from the tribe that originates from that particular settlement. These positions are traditional positions passed from one generation to the other in the same families.

The elders encourage their people to marry within the same ethnic group or religion. Due the development of the LGA and the growth of the economy, many young men move to the large city centres in search of jobs. There they can marry women from a different tribe than their own but almost always from the same religion. Some women after the death of their husbands will go to live with their parents and bring with them their children from another ethnic group. These cases are rare and will not influence the leadership structure which is a reliable source of showing the original ethnic group in that area.

1.1.3. *Socio-political organization*

There are three main distinct type of recognized leadership in communities. There are traditional, religious and political leaders. Traditional leaders are not elected to power as these thrones run in the family. However like any other person they have political preference and will try to influence their communities one way or the other to follow their preferred parties.

The religious leaders are the *Imams*. Fune and Damaturu are Muslim communities hence there are numerous mosques and a handful of churches most of which are in Damagum and Damaturu town. The religious leaders are very important to the community as religion shapes the people’s systems of values and belief. Religion is important in defining cultural and social behaviours and norms in a particular place, e.g. attitude towards education, gender roles etc.

The political leaders are elected into power and they have to campaign for votes to be in their positions.
The traditional leaders’ positions are cultural and well respected positions in the community. The hierarchy starts from the Emir, District head (Hakim), Village head (Lawan), and finally the Settlement leader - Bulama/Jauro (See Annex 4 and Annex 5).

The Emir is a high title of nobility or office, used throughout the Muslim world. They are also known as the Royal fathers and are the most respected traditional leaders in the community. Eleven Emirs reign in Yobe State. There are two Emir(s) for Fune LGA and one Emir for Damaturu LGA. While these traditional leaders hold few constitutional powers, ‘no politician is wise to seek office without his blessing,’ showing how powerful and influential these people are. Emirs play a vital advisory role to the LGA on matters relating to peace and security as well as the promotion and preservation of the culture and tradition of the people of the LGA and state at large. They are also used by the government as the vanguard in mobilization of the people to embrace and support its programs and policies towards the overall development of the state. The Emir has his committee which is composed of his brothers and sons. From this committee comes the Emir’s successor. The Waziri is the committee’s secretary selected by the Emir himself. The Waziri represents the Emir in his absence.

The Hakim (District head) reports to the Emir and these rule the districts. Hakim is an Arabic title also refers to as a ruler, governor or judge. A Hakim can also be a wise man, a physician or generally a practitioner in herbal medicines. The Nigerian Hakim can best be described as a wise man, ruler or judge. These are there to act on behalf of the Emirs at district level. They are also the Emir’s advisors and hence can be referred to as the wise men of the communities. They are traditional leaders who are supposed to be apolitical, but their selection has a lot of political influence in it.

The Village head (Lawan) are the next in line and they report to the Hakim. The village leaders are more decentralize in the communities. They reign over a collection of settlements grouped together to form a village. Their roles are not that different from those of the Hakim, but they are in much closer contact with the community. The Lawan has his political preferences but most are aligned to the government and like any other leader, they will try to influence their communities towards their preferences. The Lawan is always from the tribe that originates from that area. For example Jajere (home of the light skinned people [Fulani] - garin jajaye) to date, even though many different tribes are living in Jajere, the village leaders are all Fulani. This can simply be explained by the fact that village leadership runs in a family.

The Bulama is the last in the hierarchy. They are the most decentralized leaders among all of the traditional leaders. They report to the Lawan and are always in direct contact with the community.

The political leadership from LGA level starts from the LGA Chairman then follows the Councilors who are politically elected to represent a political ward. (See Annex 4) There are 13 and 11 Councilors in Fune and Damaturu respectively. The boundaries of the political wards are administrative boundaries which do not have much influence on the traditional boundaries. The Councilors are not that popular in most communities as they are known to be active during campaigns mostly. There is no other elected person below the Councilor. However each political party has its committee in each settlement. These committees are composed of the settlement/ward chairman, secretary, women leader and youth leaders. This committee has different members for each party and no member from the other committee can represent the other, just because they have the same title. The political leaders go through the traditional leaders to outreach to the community, otherwise they are not accepted. The political leaders are usually originally from that particular area, known to the community or their family, to be elected into power. The Councilors usually have
meeting with the traditional leaders once or twice a month on issues concerning security or development of the communities.

1.1.4. Livelihood

Both local governments exhibit tropical dry season climatic conditions. These dry seasons are windy and hot. Due to these hot dry seasons the main crops cultivated are millet, sorghum, groundnuts and pulses; which thrive well in hot regions. Seventy-five (75%) percent of the population in Fune and Damaturu are farmers of these crops. The hot season are however favourable to the farmers as their produce does not take long to dry up and ready for the market. Sweet potatoes and vegetables are also common in the areas as there are some places near water chains where the main livelihood for the people is horticulture (parts of Bornokichi and Gudugurka).

There are a significant number of nomadic tribes in both LGAs. Therefore many of the people from the area are animal rearing. Fune is one of the biggest producers of meat in the country\(^8\) as the pre-dominant tribe are the Fulani. The farmers and those rearing animals are also traders. They have market days (See Annex 3) in most villages and some settlements. Here traders with different produces come to sell their items or they barter trade. Damaturu is mainly composed of farmers and animal rearing people. Fune on the other side is also rich in minerals in Daura A and B wards. It is the biggest producer of gypsum (used to make cement and chalk). Gemstones, sapphire and zircon are also produced in this local government.

In Damaturu town and Damagum there is a significant number of formally employed people, business people (retailers, restaurants - formal and informal) and civil servants. However most of these people are not from these LGAs, they come from other States (See Annex 6 from seasonal calendar).

1.2. Stakeholders/Key community figures

Identifying key community figures, community organizations and/or groups is necessary for the dissemination of messages to the community. These people are known and trusted to the communities. Key community figures identified are the traditional leaders, the Hakim, Lawan and the Bulama, the Imam and the women political leaders. Traditional healers were also identified to play a vital role in the community’s health as they are the ones closest to the communities than the health centres. Community groups/associations are known to exist but most of them are not functional.

1.2.1. Community leaders

The traditional leaders in the community play a vital role in the lives of their community members. There are mainly there to keep peace among community members and to represent their communities at higher levels (See Annex 5). The village leaders reign over a number of settlements grouped together to form a village. They are powerful traditional leaders whose options are highly regarded. The Lawan must be aware and give his go ahead for any activity to be done in the community. Their main role is to ensure peace in the village and solve disputes between different settlements. Community members may consult them in times of trouble for advice and assistance. They also solve community disputes referred to them by the Bulama.

The Bulama’s (settlement leader) main roles among others includes: ensuring peace, settling disputes among community members and sharing farmland. These are also the only people who are reliable and who can convince their communities to participate in any activity. If they do not accept a

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\(^8\) As collected from the community members.
specific activity to take place in their settlement, it is almost always impossible to get the community to cooperate. They are also there to represent the settlement at higher level and are the communication link between the Lawan, other higher authorities and the community. Bulamas are usually mature wise people in the community and come from royalty families. They are better off than the rest of the settlement which makes their opinion valued as they are regarded to be successful. Women Bulamas are not common (only one female leader was identified, Bulama Amina in Murfakalam). The Bulama’s assistant (Wakili) is responsible for the settlement in the absence of the leader. They are respected people as most are elders but when the Bulama is in the community the Wakili is not that active.

1.2.2. The Family

Mothers are undeniably the main caretakers of children and they are responsible for the day to day running of homes and family. Fathers, on the other hand, have to provide for the family and are the decision makers as the household heads and will decide on issues concerning the health and medical treatment their child will receive. A mother cannot bring her child to the health centre if she has not first asked for permission from her husband or if he refuses. Fathers need to understand the importance of their child receiving treatment, of using household money to buy medicines when needed and of taking the child to health centre if the mother is unable to do so.

Grandmothers play an important role in the care of children and have an interest in their welfare. They care for children in the absence of the mother and they can also assist in taking the child to the health centre. Many children receiving treatment come with their grandmothers as the mother sometimes is held up at home to take care of other duties and children. Grandmothers are also the ones who most frequently suggest recourse to traditional medicine when the child is sick. Their influence cannot be underestimated, especially given their respect, which is traditionally accorded to elders. They are closely involved in the health of their grandchildren. Their existing knowledge and skills needs to be recognized and equally enhanced through contact with the programme.

1.2.3. Religious leaders

The Imams are the religious leaders who are the worship leader in the mosque. These are highly respected ‘divinely appointed and sinless individuals’ (as seen by the community) and their opinion on anything in the community is highly respected and sought after. Originally the Imam was the traditional leader as well. After colonization people were encouraged to form their own small groups with their own leaders, who were not necessarily an Imam. To date they still play a role as traditional community leaders as they also settle disputes among people and try to keep peace. However, their main role is to teach people the Islamic way of life. Imams make important announcements for the community, usually after prayers, and the information is well received by the community members. Their contact in the community is with men as women do not go to the mosque except after Ramadan and Hajj when they are encouraged to go out of their homes. Nonetheless, key messages to men through them, about the importance of nutritional treatment can reach women very effectively, especially if it is via the husband.

1.2.4. Traditional healers

Traditional medicine is regarded as the most effective and first port of call for any type of illness as long as there is no diarrhea and vomiting. Traditional healers therefore are seen as very important people in the community. They are believed to have supernatural powers which enable them to communicate with spirits. Because of this supernatural power, traditional healers are highly respected and their views on health issues are taken seriously. Most caregivers first visit traditional
healers before going to the health centres. This is because most of the diseases are believed to be a result of evil spirits and/or witchcraft. Therefore, caregivers believe traditional healers address both the illness and the cause, while the health centre only cures the disease and does nothing address the cause.

1.2.5. **Women Leaders (political representatives)**

There are women leaders (political representatives) at settlement level. These women are selected by political parties so as to encourage and mobilise fellow women in their communities on voting. They are clever and active people. Their roles have been extended to sensitize women on health issues and also development projects. Traditional leaders also work with these women to pass information. These can call women to their compounds for a meeting or go house to house with the information. In times of political campaign they group and organize women of the community for them to share food stuff and money brought by political campaigners; in turn they have become very very influential and won women’s full respect. Even in times of no political campaigns they have earned the title of women leaders.

1.3. **Community Organizations and Groups**

A number of formal community groups/associations have been identified (See Annex 7). These groups are however reported not to be functional in most communities, as they are groups of people with the same type of work. Information of the existence of these groups was collected from the health centres. In the communities they are not popular, especially among women, and people cannot identify the members of the associations/committees. Those that are functional do not have much contact with the community as the associations are mainly self help groups, such as farmers coming together to form a group to help each other in the field. Thus some groups are functional, yet not necessarily to address community challenges.

It will be important to further investigate informal community group dynamics, as they are reported to exist as support mechanisms and in coming together to achieve different activities, in a more unofficial way.

*Islamic/Koran school*

In urban settlements men and women go to Islamic school. Those who cannot afford it, go for the Koranic studies in their communities. The difference between the two schools is that the Islamic school is formal school while the Koran is the informal school done under the trees in the community. This school is very important to the Muslim community. This is where they are taught on how Islamic way of life (how to eat, use the bathroom - as there is a certain way to do this in the culture, pillars of Islam, prayers). These schools are meeting places for people and the share information there. Women in urban areas attend Islamic school while those in the rural area it is not as that common. Their children, however, go to the school and can get new information there to give to their mothers.

1.4. **Formal and Informal Channels of Communication**

1.4.1. **Communication among men**

Information is disseminated in the community through different formal and informal channels. The formal networks mainly include meetings and after prayer times; the target group of these networks is usually male. After prayers announcements/message conveying are the most effective means of communication as the *Imam* will announce the information after every prayer, on a daily basis five
times a day. The information announced can be passed to the other community members during everyday interaction and women will get the information from their husbands.

Meeting with the community leaders are held occasionally when there is need at the community leader’s palace (this is the place the community leaders have meetings and spent the day interacting with community members). Otherwise the community leaders use the town announcers to pass information to the community members. The town announcer’s message is intended to reach everyone as he goes around the community with a mega phone and pass the information. Women can get this information direct from the town announcer as he passes their compounds.

In the market on market days community members share information informally in the form of discussions. Traders in different markets are using megaphones to advertise their products these traders are also used to pass out important information during market day, as many people go to these markets. Community leaders meet at the Lawan’s palace on market day. During this time the Lawan can pass information to his Bulamas for their communities.

Men in the communities will sit together during the day and discuss on various issues. They also sit together in their community when the sun sets, at the end of each day. Here they share their meals and information. It is common in all communities to see a group of men together during the day relaxing. This is a very good way to pass information to these men and they will give the information to their wives.

1.4.2. Communication among women and/or targeted to women

Women, married women in particular, require permission (and the request has to be granted) from their husbands to go outside the compounds. They get most of their information from their husbands, friends and the women leaders (women political representatives). The women leaders as mentioned above are political representatives who are known to the community and have earned respect among fellow women as well as the men. They can call for a meeting with the women and they will meet in her compound. They are used by the community leaders and the health system to educate women on health and hygiene matters in the community.

Women will also depend on this information from the town announcer as they can hear it straight from him as he moves past their compounds. They also share among themselves informally (as they share gossip) as they do their everyday chores and visit each other with permission from their husbands. The ones with most information are the petty traders within the communities. These women sell small items in the communities (spices, groundnut cake, roasted groundnuts etc) and they are well known to everyone in the community, because of the popularity and that trading requires them to be very interactive they get information easier and spread it to their fellow women.

Women also get information from their children who spent most of the time playing outside the compound or from Islamic/Koran school.

1.4.3. Community events

Community events such as weddings, naming, marriage ceremonies and funerals are where most women meet and discuss on different issues. These ceremonies get women together in one compound and they spend time together celebrating, sharing information and gossiping. Marriage and naming ceremonies are very popular in the communities and women may spend days in one compound before and after the ceremony. They also move in groups from one location to the other to attend to these ceremonies and they can stay up to one month moving from one location to the other attending ceremonies for their relatives. Town announcers also take advantage of these
ceremonies to pass on important information as community members also gather on the day of the ceremony.

Community meetings are not that popular and if they are held they are always targeting men. The community leaders call for these meetings when necessary.

1.4.4. Health centre and services

Women also get information from the health centre when they go for routine immunization. The health workers also go for outreach immunizations on a monthly basis and they are in contact with many caregivers and they can disseminate messages to the caregivers.

1.4.5. The media

Some people have access to portable radios and they are mainly listening to BBC Hausa, because the frequency for this station is accessible even in remote areas. A local radio station Yobe Broadcasting Corporation is also popular among people in the community.

The use of mobile phones to transmit messages has been observed to be very popular and effective. This is so because the people communicating with this form of communication are most likely related or friends and therefore the sources of information are trusted.

1.5. Support Mechanisms

Women in the community (from different households) help each other in preparing their harvest for storage. They come together to form a group and they move from one compound to the next processing the food. Neighbors can also help each other in taking care of the children when their mother has travelled. Women can also bring their neighbor’s or friend’s child to the health centre to receive treatment when the child’s mother is not well or has travelled.

It is the responsibility of the man in the family to farm, so when he is unwell and it is known to the community other men join hands and cultivate his farm for his family. Despite illness men usually form groups during the rainy season and help each other in their farms. This will ease each man’s workload and it is faster.

Settlements, through their leaders, help each other financially when the other settlement is in need. Members of the settlement will contribute what they can to the community leader who passes it on to the other leader in need. Communities also help each other with manpower or join together to build mosque, schools, dispensaries and boreholes when the government provides materials.

A key support mechanism to the poorest population is zakhat, one of the five key pillars of Islam. This is a welfare contriibution and it is the responsibility of the community to collect as well as fairly distribute the zakhat.

Community members contribute to each others’ ceremonies or when a family has a new born baby community members contribute money or food for the family as gifts.

1.6. Health Seeking Behavior

The local culture encourages early marriages and family planning is not a priority for most of the families. Women will try to please their husbands and get is favor by having more children than the other wives, when there is more than one wife in a household. Women usually do not have any form
of education except a few who attended Islamic school. This lack of education and limited number of sensitization practices has had a negative impact on the caring practices for the children. Most illnesses are believed to be caused by evil spirits. This means that for all illnesses, as long as there is no diarrhea and vomiting the first place they go to is the traditional healers’ households. If the medication given by the traditional healer does not work then they will go to the health centre. However, most mothers testify that the traditional medicine works almost all the time. Hospital care is their second choice after traditional medicine.

Malnutrition to the community members is not recognized as a distinct easily recognizable condition. The causes are the only ones recognized as problems. The belief in the community is that malnutrition is not a disease that can be treated at health centres with modern medication, which is natural, considering that previous to CMAM activities there was not RUTF or other type of medical treatment available. Only traditional healers and the messages from the Quran can heal the disease. The causes of malnutrition identified from the community members include:

- Poverty (hunger - *yunwe*),
- *Shanziki* (witchcraft),
- Ignorance (giving an unbalanced diet and not feeding the child frequently or at the right time),
- Evil spirits
- When the mother breastfeeds while pregnant - *kunika* (the milk is believed to be bad for the child and causes malnutrition).

They also believe that malnutrition is a result of the following:
- Mother being adulterous during pregnancy,
- Kwashiorkor comes to a child born from a mother who was swollen during pregnancy and pregnant mothers eating sand will give birth to malnourished children.
- A pregnant woman is not allowed to walk by a dead donkey’s body as the child she gives birth to will be malnourished.
- Mothers with too many young children will have their hands full all day and care for the young ones is limited.
- Diseases such as malaria and yellow fever will cause wasting and swelling.
- Most mothers complain that they do not have sufficient breast milk.
- There is also poor access to treatment (health facilities not adequately equipped).

Herbal medicines from traditional healers are the most common treatment used for malnutrition and these herbs are put in water used to bathe the child or the medicine is burnt and the child has to inhale the smoke. Traditional healers also heat a needle in fire and pinch the skin above the buttocks of a child with marasmus, and then pierce the skin with the hot needle. When fluids come out of the child’s body, they believe the disease is gone. Other traditional remedies include slaughtering animals and the stomach contents of the animal are rubbed on the child’s body. Caregivers will testify that most of these remedies do not work if the mother of the child has not exposed some evil she committed, otherwise it will work. Oil is believed to add to the illness so when a child is sick with malnutrition they will not give food with oil as it will cause death. When the situation becomes very serious, then will the child be taken to the hospital, where they get nutritional advice and medication for other identified illnesses. Some of the cases are brought to the health centre too late even after the start of the CMAM programme.
Generally the infant and young child feeding practices being used are very improper. Mothers do not know the importance of breast feeding and they do not take time to feed their children. Some tribes like the Fulani do not encourage mothers to breastfeed. Since they have a lot of cattle they give animal milk. The first milk with colostrums is believed to be not pure and dirty hence it is not given to the child. The only reason a mother will continue breastfeeding is because she is not pregnant otherwise there is absolutely no need for the baby to receive breast milk in its life. No one practices exclusive breastfeeding for the first six months. As the area is a hot region they believe a child will not be able to survive without water. Watery porridge then follows after a few days of birth. Solid family foods will be introduced at around four months. The hygiene in the communities is very poor and the food is also prepared in that environment. This leaves the babies vulnerable to food poisoning or developing other stomach infections and hence diarrhea.

Moreover, the water and sanitation coverage for the Damaturu & Funé LGAs is observed to be extremely low, contributing to the poor hygiene of communities and households. The water table is very low hence water sources are few and where there is water, it is far down in the wells. The wells are not protected and in the dry season they dry up or the water is far deep down and difficult to fetch. During these times, communities use donkeys with ropes to help pull the water from wells. Most settlements in more rural areas may have one well serving the whole community. Two or more settlements/wards in the urban settlements may share a water source. Therefore, in the towns, residences depend on water that is sold in 20/containers by vendors. Some health facilities also buy water from these vendors as they usually have a water system, but it is not functional.

Most public places like the health centres and schools do not have toilets. When they do, they are rarely well maintained. In the communities the situation is worse. Most households use the bush and they do not have proper sanitation facilities. There are dirty ways from inside compounds that flow to the outside areas (which are sand), where children play without much supervision. There are also no proper waste disposal facilities, leading the environment to be littered and dirty. Diarrhea is a very common disease among children and adults. These sanitation and hygiene situations need to be addressed for the community to enjoy the right to a life with dignity and good health.

1.7. Barriers to access

1.7.1. Proximity

The most common barrier to accessing health care services is distance. Since the settlement structures are clustered settlements they are spread out far from each other to allow for farming land. Most villages are very far away from the health centre taking almost one to two walking hours to the centre. The other alternative is use of an ox/donkey cart, however not all people have an ox cart and not everyone can afford to hire one as it costs at least 2000NGN. They can also use vehicles and motor bikes especially if it is market day. In the remote places one will not get the most common form of transport which is motorbike. It has to be hired at a very exorbitant price. The CMAM coverage area has been extended by beneficiaries beyond the health center coverage as some come from areas outside the planned coverage area. Hence the distances these people have to travel before reaching to the health centre are too far.

1.7.2. Physical barriers

During the rainy season the rivers are flowing with water and some cannot be easily crossed. Rivers that totally dry up in the dry season will have water with tide during the rainy season. These are not safe to cross. The road networks, on the other hand, are very bad. Transportation is not easily
accessible in the villages unless one goes to the market places or on market day when vehicles will go to the remote areas to collect items to be sold in the market.

1.7.3. Awareness of Malnutrition

As mentioned above malnutrition is not recognized as a distinct disease. Hence when a child presents signs and symptoms of the illness the caregivers will take the child to the traditional healers. Those that are taken to the hospital before the start of the programme would just get nutritional advice, which might not even be helpful and at time can be discouraging to the caregiver. As the programme is now ongoing caregivers come with their children for treatment for a few times, though when they see the child improving, they will stop coming as they feel the child is healed and they have other things to attend to.

Beliefs of the causes of malnutrition

Malnutrition is believed to result from socially unacceptable behavior or action. Hence for the family to accept treatment for malnutrition, especially men, is demeaning to them. They will prefer to go to traditional healers unknown to the community and get treatment for the children. This lack of understanding not only on malnutrition but on health aspects in general restricts the community for seeking health care.

1.7.4. Health centre services rendered

At the health centre the caregivers complain of the attitude of some health staff toward them. Some are said to be too harsh with the mothers and not giving enough information such that the mothers are scared to come back for treatment or they are not informed. There is shortage to qualified health staff in some centres and those working as volunteers are not that motivated to participate in activities. As CMAM is on going now, the number of beneficiaries in charge is too high to do all the proper procedures in one day. Mothers have to wait in long queues for the whole day on an empty stomach and this will force some mothers to go back to their homes without receiving treatment.

1.7.5. Rejection

Many caregivers come to health facilities for screening on a regular basis because they hear about the programme from other caregivers. As some of the children are not in the criteria, they are not admitted and this is relayed back to communities. Therefore, sometimes, even if a community volunteer or caregiver may notice symptoms, they may be told by other women in the community not to attend the health facility as they will not be admitted any way. ACF community mobilization teams have been working closer at the community level to strengthen screening and messaging by volunteers to caregivers in the community.
2. COMMUNITY MOBILIZATION STRATEGY

2.1. Structure of the Mobilization Team

The mobilization team is currently composed of three members namely; Community Specialist (international staff) and two Community Officers (national staff). The team worked in close collaboration with the MoH staff from State level, to health centre and the community levels.

At health centre level, after observing the gap between the community volunteers and the health centre personnel, community mobilization focal person(s) were selected at each centre by the health staff. This person(s) will be directly monitoring community mobilization activities at health centre level. They will be the communication link between the community and the health centre through the community volunteers. The limitation for this selection, however, is that when the individual(s) is not present no one is willing to carry out the activities because they have been attached to a certain person. Then again, when there is no one selected to focus on this no one is accountable for it and hence nothing at all will be done in relation to community mobilization. The community mobilization focal persons are still receiving regular on the job training on all community mobilization activities by the ACF team.

Main focus and time for the first phase of community mobilization activities was dedicated to community members (particularly the community leaders) for the collection of information for Rapid Socio-Cultural Assessment, sensitization, identification and training of community volunteers. As the RSCA was carried out simultaneously to the start up of CMAM activities, information was collected at the same time the community was being sensitized on the new malnutrition treatment available at health centres. Community volunteers have also contributed a lot to the understanding of the programme by the community. A lot still remains to be done for them to fully understand CMAM activities and hence pass accurate information to the communities.

2.2. Sensitization/Awareness

Sensitization is the first, and arguably the most important community mobilization activity in outpatient nutrition programming. There are two basic steps in sensitization; sensitization messages and sensitization strategy. The sensitization message should be short and precise but long enough to explain what the programme is about. It should include local terms that the community is familiar with. The sensitization strategy is designed to make sure that the sensitization message is disseminated far and wide in the community.

The sensitization message used was a pre-set message adapted accordingly to fit the context of Nigeria (See Annex 8). Since effective communication channels were still being identified, this message was disseminated through the community leaders (traditional and religious leaders) during leaders’ sensitization meetings. The community leaders further disseminated the message to the community during community events such as marriage, wedding ceremonies, during prayers and through the town announcers. The meetings would have been more effective if there were held on a regular basis, however, human resources and time constraints made this impossible.

Community volunteers trained also played a vital role in informing the community of the new treatment. To date they have received one training session (one day training) and they also receive regular support from the ACF team and health workers, either during community visits or
outpatient clinic days at health centres. The messages they deliver at times are not entirely correct, considering the low literacy level in relation to the time taken for training and understanding on the whole concept of CMAM, but they are helpful in introducing the treatment to the community.

As mentioned in section 1.7.3., malnutrition is not perceived as a disease in the community. Therefore there is need for sensitization messages that are understandable to the community and acceptable. Community members use strict channels of communication which must be followed for programme uptake by the community. It will take time for the community to understand the essence of the programme and hence the need for more sensitization messages and strategies to be employed to attract the attention of everyone in these communities.

**Key recommendations on Sensitization/Awareness:**

- Define an awareness strategy that will integrated the various recommendations below.
- Review, test and finalize messages to be disseminated in community according to findings.
- Develop visual materials such as posters, drama sessions, pictures, and radio messages linked to targeting community perceptions on malnutrition.
- Target key traditional, religious, and political stakeholders as well as other key stakeholders, such as petty traders and women’s leaders.
- Sensitise and collaborate closely with traditional healers, as they are the first sought for health care.
- Review community volunteer training from 1 to 2 days to strengthen practical on message delivery in their communities.
- Hold regular meeting with community leaders together with representatives from the health facilities with strong messaging on condition of severe acute malnutrition and treatment available.
- Further explore phone access in communities (among women) and ways to integrate awareness through standard messaging service (SMS).
- Further investigate informal community groups and roles they can play in support community mobilisation activities.
- Work with health facilities to ensure that they are confident in the provision of treatment and have regular RUTF supply, in order to respond to the demand from effective awareness. As previous to CMAM only advice was provided to malnutrition cases, it will be vital to strengthen health workers’ approach to cases, in reassuring caregivers that the situation has changed and that now a treatment is available.
- Identify successful cases of treatment and request caregiver & child’s support in sensitisation work, since they can convince others.

**2.3. Case Finding**

**2.3.1. Mass screening**

Mass screening was conducted for start up of CMAM activities. The mass screening was done at the health centres for a couple of weeks as the outcome from the first malnutrition treatment days was not high.

To date at some centres, caregivers still come to the centres even if they had been turned away the previous week. This illustrates a misunderstanding of the programme and target group as the caregivers just want their children to get RUTF. In addition, for some time community volunteers were not sure who to refer to the health centre as the messages passed to them were diverging.
Initially they were to refer children with SAM (red MUAC) between the ages of 6 months to 59 months. Then, for mass screening, they were informed to refer all children aged 6 months to 59 months. The mass screening also led to a higher rejection rate, which also reported to have an impact on caregiver access to treatment.

2.3.2. Active Case Finding

Community volunteers were trained on MUAC screening to be done by them at community level. It took a few weeks of follow-up to ensure quality of MUAC screening.

Due to the very high number of admissions, it is still very difficult to monitor the impact of active case finding conducted by community volunteers on the programme. The workload at the health centres on OTP day has been too high, such that no one takes time to record how many cases of new admissions were referred to the centre by community volunteers or the number of attending absentees (follow-up to prevent defaulting and not re-admitted) and returned defaulters (who are readmitted). The community volunteers do not have referral cards to give to the cases they refer. This makes it very difficult to monitor whether the cases referred by the volunteers fit the admission criteria or not. Therefore it is difficult to plan for refresher trainings that focus on the weakness of community volunteers.

As mentioned previously in the report, the programme is still starting and it is the peak hunger season for the LGAs in May thus high numbers are expected. As the number of beneficiaries reduces, and the number coming for treatment on one day are manageable, and suitable for integration then it will be more feasible for all information be recorded and all aspects monitored. At the moment there is no basis of monitoring screening activities for the community volunteers.

Key recommendations on Case Finding:

- Produce and provide referral cards to community volunteers, with their name and community, which they can collect when they visit the health facility.
- In reviewing time for community volunteer training, include a longer time period for MUAC practical to improve quality of active case finding.
- Focus on strengthening community based recognition and screening of children, instead of mass screening.

2.4. Follow-Up of Cases

According to nutritional treatment guidelines, home visits should be systematic in the following situations:

- All new cases
- Oedema persistence
- Deterioration of patient general condition
- No weight gain
- Absence/Default for 3 consecutive weeks

This is possible in contexts where there are high staffing levels or additional personnel to do so. In the context of integration of CMAM to health services it is less feasible, thus often absentee/defaulters are prioritised.

Home visits are positively viewed by beneficiaries and non beneficiaries alike. People like the individual attention of someone coming to their house, spending time with them and explaining health matters. However, due to the large number of beneficiaries in the programme and the high
rate of defaulters and absentees, these are the only categories of children being visited by ACF/MoH staff. Community volunteers may follow up on other categories of the home visiting situations but this is usually if the beneficiary is known to the community volunteer.

House to house follow up is the ideal approach, but considering the situation some cases will never be followed up. Hence an alternative option identified is meeting with community leaders and involving them in the follow up; this was tested and brought good results. During meetings the community leaders are told of the absentee/defaulter cases from their respective communities. Some children die while in charge and no one will give feedback to the health centre and they will be recorded as defaulters. During these meetings the information on specific children is gathered and recorded correctly from the community, at the same time the absentees and defaulters will return for treatment the following week. An opportunity in working through leaders can be to promote a type of ‘no defaulter settlement’ where they will be proud and promote others to work towards decreasing defaulting in their communities.

There is no proper recording of the reasons for absentees and defaulting. Some reasons have been identified but they are just the few among others that need to be addressed. Most community volunteers cannot write, hence documentation in the community impossible. The feedback community volunteers give to the health centre on absenteeism and defaulting should be recorded on each card for the child followed up. This will be useful for all health staff monitoring the programme as there will be no need for another person to explain the unrecorded information. This will also give a picture of the main reasons of not attending for treatment and these reasons can be addressed.

**Key recommendations on Follow-up:**

- Prioritise follow-up of absentees and defaulters in the given programme context.
- Strengthen linkages between the health facility (via the community mobilization focal person) and community volunteers on children who are absentees or defaulting.
- Through meetings with community leaders, address issues of defaulting and provide names of children from the different settlements, so leaders can follow-up directly that they return the following week, ensuring their recovery.
- Via health facility – community volunteer linkages, encourages feedback by volunteers to health facility staff to be recorded on OTP treatment cards.

### 2.5. Defaulting

There are very high numbers of defaulters and absentees. The main reasons identified include;

- **Caregivers having to walk long distance** to come for treatment. In one of the centres, Dubbol, there are caregivers who need three days to travel to the centre. They come from their settlement a day earlier the treatment day spend the night in another settlement close to the health centre. They will spend the whole day at the centre due to the numbers being attended to on CMAM alone, hence they will spend another night in the nearby settlement and proceed to their homes the following day. Most defaulters come from settlements of more than 2 hours walking time to the centre. Beneficiaries from these places are now being given two weeks’ ration and this has eased the burden on caregivers, but there are still high defaulter rates from these settlements.

- **The number of beneficiaries at one OTP day.** The numbers are just too overwhelming considering the number of health workers who are committed to carry out the activities.
Caregivers will spend the whole at the centre with nothing to eat or drink, only to be attended at the end of the day. Due to the workload and pressure on the health workers the treatment they give to the caregivers is not proper and some have refused to come back because they are not comfortable with the treatment they receive and they feel it is not worth it.

- Misunderstanding of the treatment by caregivers. Some caregivers have refused to come back because they say RUTF causes diarrhea and hence possible death. Then appropriate information should be provided to mothers on admission day. They should be aware of the fact that RUTF can cause diarrhea in some children as they react to the treatment, but with proper medication and hygiene this will not persist.

- Attitude of caregivers on the programme. Some caregivers do not like spending all day at the health facility on a weekly basis. Therefore when they see that the child has improved they will stop coming for treatment. Sensitization of caregivers on the importance of coming for treatment until the child is discharged as cured has to be strengthened, in order to minimize the chances of relapse cases. It will also be important to explore ways to decrease waiting times in health centers.

- Attitude of husbands on the programme. Men do not like that their wives be at the health centre a full day on a weekly basis. In some cases, men have stopped their wives from coming for treatment. Some will come back when the condition has deteriorated or when the child is above admission criteria and then these cases are turned away as per national protocol (rejection - which is one of the leading factors of poor programme uptake).

- Nomadic tribes are migrating. The nomadic tribes in the community migrate to places where they can get water for their animals during the dry season. The mothers go with their young ones who are registered in the programme and they do not inform the health centre.

**Key recommendations on Defaulting:**

- Strengthen the role of community leaders is supporting tracing of defaulter through meetings.
- Increase coverage of health facilities with CMAM by identifying communities from which caregivers are walking more than 3 hours and possible health facilities that could be supported.
- In order to decrease waiting time at health facilities and allow for women to come jointly from communities, define different days in the week for specific communities, with double rations for farther communities.
- Investigate and define methods to address attitude of women and men to the programme, by working with traditional healers and religious leaders, as well as by adapting CMAM activities accordingly to decrease waiting times.
- Develop sessions on importance of treatment and follow-up targeting men.

**2.6. Summary of recommendations**

**Key recommendations on Sensitization/Awareness:**

- Define an awareness strategy that will integrated the various recommendations below.
- Review, test and finalize messages to be disseminated in community according to findings.
- Develop visual materials such as posters, drama sessions, pictures, and radio messages linked to targeting community perceptions on malnutrition.
- Target key traditional, religious, and political stakeholders as well as other key stakeholders, such as petty traders and women’s leaders.
- Sensitise and collaborate closely with traditional healers, as they are the first sought for health care.
- Review community volunteer training from 1 to 2 days to strengthen practical on message delivery in their communities.
- Hold regular meeting with community leaders together with representatives from the health facilities with strong messaging on condition of severe acute malnutrition and treatment available.
- Further explore phone access in communities (amongst women) and ways to integrate awareness through standard messaging service (SMS).
- Further investigate informal community groups and roles they can play in support community mobilisation activities.
- Work with health facilities to ensure that they are confident in the provision of treatment and have regular RTUF supply, in order to respond to the demand from effective awareness. As previous to CMAM only advice was provided to malnutrition cases, it will be vital to strengthen health workers’ approach to cases, in reassuring caregivers that the situation has changed and that now a treatment is available.
- Identify successful cases of treatment and request caregiver & child’s support in sensitisation work, since they can convince others.

**Key recommendations on Case Finding:**
- Produce and provide referral cards to community volunteers, with their name and community, which they can collect when they visit the health facility.
- In reviewing time for community volunteer training, include a longer time period for MUAC practical to improve quality of active case finding.
- Focus on strengthening community based recognition and screening of children, instead of mass screening.

**Key recommendations on Follow-up:**
- Prioritise follow-up of absentees and defaulters in the given programme context.
- Strengthen linkages between the health facility (via the community mobilization focal person) and community volunteers on children who are absentees or defaulting.
- Through meetings with community leaders, address issues of defaulting and provide names of children from the different settlements, so leaders can follow-up directly that they return the following week, ensuring their recovery.
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Investigate and define methods to address attitude of women and men to the programme, by working with traditional healers and religious leaders, as well as by adapting CMAM activities accordingly to decrease waiting times.

Develop sessions on importance of treatment and follow-up targeting men.

CONCLUSION

The conduction of the RSCA has brought together important information on communities participating in CMAM that will enable ACF to work with the State in improving community mobilization activities, as they are adapted to perception and systems existing in communities. This will look especially at ways to decrease defaulting and improve the overall understanding of CMAM services by key stakeholders and the community. It is an opportunity to further adapt the CMAM services to the needs of the communities, who are central to the intervention.
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ANNEXES
Annex 1: Map for Fune LGA
Annex 2: Map of Damaturu LGA
## Annex 3: Ethnic groups per centre, livelihoods and population

<table>
<thead>
<tr>
<th>Location</th>
<th>Ethnic groups</th>
<th>Main livelihood</th>
<th>Market day</th>
<th>Total Population/ward</th>
<th>Population (6 - 59 months)/ward</th>
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<td>Ngelzarma</td>
<td>Fulani (50%), Karekare (50%)</td>
<td>Farmers</td>
<td>Saturday</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Animal rearing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aigada</td>
<td>Ngizim, Fulani, Karekare</td>
<td>Farmers</td>
<td>Tuesday</td>
<td>15,225</td>
<td>3,045</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Animal rearing</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Self employed business people</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dubbol</td>
<td>Karekare, Ngizim, Fulani (60%)</td>
<td>Animal rearing</td>
<td>Tuesday</td>
<td>14,365</td>
<td>2,873</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Farmers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Daura</td>
<td>Kanuri</td>
<td>Farmers</td>
<td>Tuesday (Abakire)</td>
<td>Same ward as Dubbol</td>
<td></td>
</tr>
<tr>
<td>Bornokichi</td>
<td>Fulani (70%), Kanuri</td>
<td>Animal rearing</td>
<td>Saturday</td>
<td>30,015</td>
<td>6,003</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Farmers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gudugurka</td>
<td>Fulani (70%), Kanuri</td>
<td>Animal rearing</td>
<td>Saturday (Bornokichi)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Farmers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kayeri</td>
<td>Kanuri (70%), Fulani</td>
<td>Farmers</td>
<td>Friday</td>
<td>29,030</td>
<td>5,806</td>
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<td></td>
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<td>Animal rearing</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Jajere</td>
<td>Fulani</td>
<td>Animal rearing</td>
<td>Friday</td>
<td>41,355</td>
<td>8,271</td>
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<td></td>
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<td>Farmers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kollere</td>
<td>Fulani (70%), Karekare, Ngizim</td>
<td>Animal rearing</td>
<td>Thursday</td>
<td>54,995</td>
<td>10,999</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Farmers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>DAMATURU</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gwange</td>
<td>Kanuri (70%), Hausa</td>
<td>Farmers</td>
<td>Sunday</td>
<td>16,124</td>
<td>2741</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Self employed business people</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Civil servants</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Damakasu</td>
<td>Kanuri (80%)</td>
<td>Farmers</td>
<td>Damaturu town market - Sunday</td>
<td>4,968</td>
<td>845</td>
</tr>
<tr>
<td>Nayinawa</td>
<td>Kanuri (55%), Hausa, Fulani</td>
<td>Farmers</td>
<td>Sunday</td>
<td>16,415</td>
<td>2791</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Self employed business people</td>
<td></td>
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<td></td>
<td></td>
<td>Civil servants</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sasawa</td>
<td>Kanuri (70%), Fulani</td>
<td>Farmers</td>
<td>Saturday</td>
<td>5,123</td>
<td>871</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rearing of animals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Murfakalam</td>
<td>Kanuri (60%), Hausa, Fulani</td>
<td>Farmers</td>
<td>Damaturu town market - Sunday</td>
<td>6,986</td>
<td>1,188</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rearing of animals</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Kallalawa</td>
<td>Kanuri (70%), Fulani</td>
<td>Farmers</td>
<td>Damaturu town market - Sunday</td>
<td>6,541</td>
<td>1,113</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rearing of animals</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

*Population adopted from the LGA projected immunization and vitamin A target population for 2011. The population figures are for the whole ward represents a greater coverage area compared to the one for the specific catchment area for a health centre.*
Annex 4a: Traditional leadership hierarchy

- Emir
  - Waziri
    - District head (hakimi)
    - District head (hakimi)
    - District head (hakimi)
      - Village head (Lawan)
        - Village head (Lawan)
        - Village head (Lawan)
          - Ward head (bulama)
          - Ward head (bulama)
          - Ward head (bulama)
            - Assistant ward head (Wakili)
Traditional leaders are not elected to power but positions are inherited from generation to generation within the same family. This is a cultural position and is well respected by the communities.

Political leaders, on the other hand have to be elected to power. The party committee is per settlement and each political party has their own committee.
# Annex 5: Roles of the community leaders

<table>
<thead>
<tr>
<th>Title</th>
<th>Roles in the community</th>
<th>Communication with the community</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Traditional leaders</strong></td>
<td></td>
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</tbody>
</table>
| Emir                | • State and LGA advisors on matters relating to the promotion and preservation of culture and tradition and to peace and security.  
• Are used by the government as the forefront mobilization team for the people to embrace government policies and programs. | Rarely. Their main communication channel is through the Hakim. | Meets with hakim twice a month or when there is need. |
| Hakim               | • Same responsibilities as above.  
• The Emir’s advisors | Meets with the Lawan regularly, can be formal or informal meetings | Meets with different Lawans on a weekly basis |
| Lawan               | • Settle disputes among community members within the village.  
• Shares farmland to village members.  
• Communication channel between the community and the Hakim (Represents village to the Hakim)  
• Advises the village on issues relating to peace and preservation of the culture | Everyday interaction with the community members and regular meeting with the Bulama. | Formal meeting with Bulamas once a week, after Friday prayer. |
| Bulama              | Same as the Lawan but at settlement level.                                              |                                                        |                                               |
| **Political leaders** |                                                                                        |                                                        |                                               |
| LGA Chairman        | Over see the LGA and is the administrative decision maker of the LGA.                   | Campaign                                              | During election time.                          |
| Councilor           | • Oversee the political wards.  
• Enable communities to help themselves and provide a vital link between the local authority and the communities which they serve. | • Monthly meetings with Lawan and Bulamas  
• Communicate through their respective ward committee.  
• Campaigns | • Once/twice a month  
• Weekly basis.  
• During elections |
| **Religious leaders** |                                                                                        |                                                        |                                               |
| Imam                | • Prayer leader  
• Adviser on issuing relating to everyday life, the Koran and disputes. | • Prayer time                                          | Daily                                         |
### Annex 6: Seasonal Calendar

<table>
<thead>
<tr>
<th>Crop Production</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
</tr>
</thead>
<tbody>
<tr>
<td>Land preparation</td>
<td></td>
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<td>Planting</td>
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<td>Weeding</td>
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<tr>
<td>Green harvest</td>
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<td>Harvest</td>
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<tr>
<td>Processing</td>
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</tbody>
</table>

| Hunger Season     |     |     |     |     |     |     |      |     |     |     |     |     |
| Hunger season peak|     |     |     |     |     |     |      |     |     |     |     |     |
| Peak staple prices|     |     |     |     |     |     |      |     |     |     |     |     |

| Livestock         |     |     |     |     |     |     |      |     |     |     |     |     |
| Livestock sale    |     |     |     |     |     |     |      |     |     |     |     |     |

| Employment        |     |     |     |     |     |     |      |     |     |     |     |     |
| Farm casual labour|     |     |     |     |     |     |      |     |     |     |     |     |
| Off-farm labour   |     |     |     |     |     |     |      |     |     |     |     |     |
| Labour migration  |     |     |     |     |     |     |      |     |     |     |     |     |
| Formal employment |     |     |     |     |     |     |      |     |     |     |     |     |

| Health            |     |     |     |     |     |     |      |     |     |     |     |     |
| Malaria           |     |     |     |     |     |     |      |     |     |     |     |     |
| Diarrhea          |     |     |     |     |     |     |      |     |     |     |     |     |
| Measles           |     |     |     |     |     |     |      |     |     |     |     |     |
| Whooping cough    |     |     |     |     |     |     |      |     |     |     |     |     |
Annex 7: Community based groups/associations

Community based groups are known to exist but the system somehow stopped functioning. There are a number of associations identified and they are as follows:

- Women Association
- Road transport unit Association
- Tailors Association
- Butchers Association
- Traditional healers Association
- Blacksmith Association
- Cattle rearers Association
- National Union of Teachers Association
- Traditional Birth Attendance Association
- Farmers Association

Most of the associations functional to date are a group of people with the same activity for example farmers, who group themselves in order to ease each other workload during the farming season. Therefore they will group themselves and plant, weed and harvest each member’s farm (one at a time) together. Besides reducing each man’s workload it is faster.
### Annex 8: Local terms for malnutrition

Local terms commonly used to describe children with malnutrition:

<table>
<thead>
<tr>
<th>Category</th>
<th>Local term</th>
<th>Concept</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wasting</td>
<td>Tamuwa</td>
<td>• Wasting is believed to be a result of excessive heat (too much exposure to the sun -rana), resulting in dehydration, hemorrhage and diarrhea.</td>
</tr>
<tr>
<td></td>
<td>Chutam rama</td>
<td>• It is also a result of witchcraft (maita)</td>
</tr>
<tr>
<td></td>
<td>Dotti (Hausa)</td>
<td>• When a mother is pregnant and she passes a place where there is a dead donkey, the child she gives birth to will be wasted.</td>
</tr>
<tr>
<td></td>
<td>Samakke</td>
<td>• A pregnant mother who is adulterous will give birth to a wasted child.</td>
</tr>
<tr>
<td></td>
<td>Waftu (Fulani)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hirna</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Kunika (KareKare)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tirana (Kanuri)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oedema</td>
<td>Ciwon kumburi</td>
<td>• Oedema is perceived to be yellow fever (shawara)</td>
</tr>
<tr>
<td></td>
<td>Bayamma</td>
<td>• Witchcraft.</td>
</tr>
<tr>
<td></td>
<td>Shawara</td>
<td>• Shortage of blood in the body causing swelling.</td>
</tr>
<tr>
<td></td>
<td>Ngonga (Fulani)</td>
<td>• Mother has oedema during pregnancy.</td>
</tr>
<tr>
<td></td>
<td>Shinkiri</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dungurm (Kanuri)</td>
<td></td>
</tr>
<tr>
<td>Big stomach</td>
<td>Nanol</td>
<td>• Mother eats sand during pregnancy.</td>
</tr>
<tr>
<td></td>
<td>Babbanciki</td>
<td>• Child eats sand and cannot digest it.</td>
</tr>
<tr>
<td></td>
<td>Sefa</td>
<td></td>
</tr>
</tbody>
</table>