ORIE Nutrition Research in Northern Nigeria

Improving micronutrient supplementation among women and children: Lessons from the WINNN programme

Key messages

- **Increasing attendance at periodic, preventative health events like MNCHWs requires intensive community engagement and mobilisation** to ensure that the target population receives the information and is convinced of the benefits of attending. Information should be targeted at both mothers and fathers.
- **Political commitment to such events, and adequate and timely public funding,** are essential to ensure effective planning, delivery, and sustainability.
- **Technical capacity among local government officials and health workers is key** to ensuring good planning and implementation and adequate supply of key commodities.
- Additional efforts are needed to ensure that micronutrient supplementation reaches the **poorest mothers, younger mothers, mothers with no formal education, and mothers living further away from health facilities.**

Northern Nigeria has a high prevalence of child malnutrition, with around 10% of children (aged 6–59 months) acutely malnourished, one-third underweight, and over 50% stunted.[1] This brief summarises learning from an intervention to improve micronutrient supplementation in five states in northern Nigeria (Jigawa, Katsina, Kebbi, Zamfara and Yobe) implemented with the support of the Working to Improve Nutrition in Northern Nigeria (WINNN) programme.[2]

In comparison with control areas, in focal areas:

15% more children received Vitamin A supplementation in last 6 months

10% more pregnant women received iron folate

WINNN supported the provision of key micronutrient supplements to pregnant women and children under the age of five, primarily through support for the bi-annual nationwide Maternal and Child Health Weeks (MNCHWs), as well as micronutrient distribution at antenatal care (ANC) services. WINNN played a key role in supporting MNCHW planning, training, delivery and monitoring, provided key commodities, and supported advocacy for public funding. It also supported more intensive social mobilisation and community engagement in three focal Local Government Areas (LGAs) in each state in which it supported community management of acute malnutrition (CMAM) services and infant and young child feeding (IYCF) counselling.

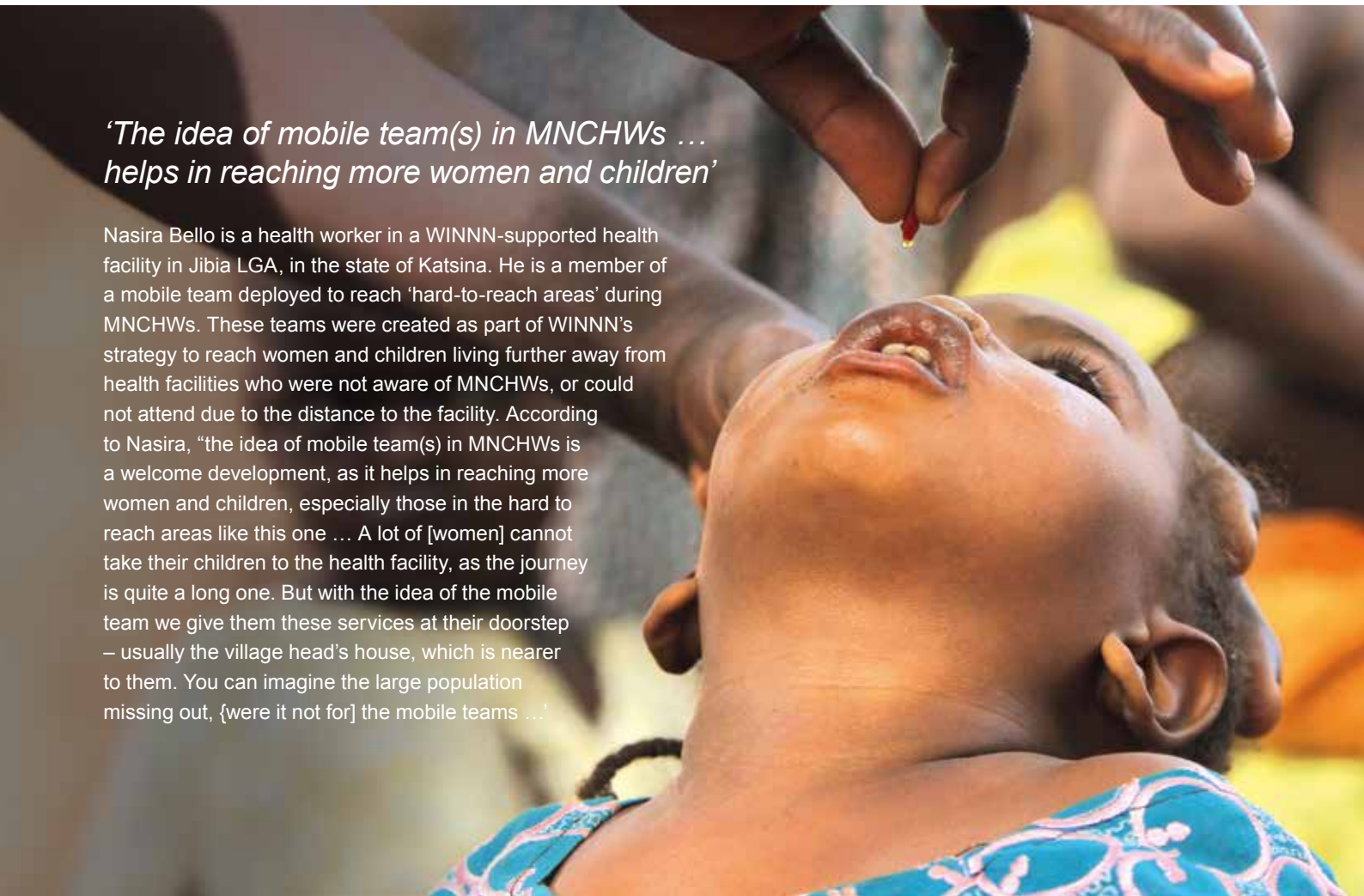
Context

The harsh social, economic and physical environments in northern Nigeria contribute to micronutrient deficiency. This includes food insecurity, poor dietary quality, high levels of infection, poor sanitation and hygiene, and limited access to clean water. Women have limited access to health care services like MNCHWs and ANC, partly due to weak female decision-making power around health care and male resistance to the use of health services. The distance and cost of travel to health facilities are also barriers for some households. Deficiencies in iron, folic acid, Vitamin A and zinc contribute to decreased immunity, increased severity of illness, anaemia, poor maternal health, impaired cognitive function, poor growth and mortality.

Key findings

As MNCHWs is not a heavily-branded campaign, it is difficult to accurately measure mothers' attendance at MNCHWs. As such, Vitamin A supplementation among children during the six months prior to the survey is a possible proxy, given that MNCHWs were the main source of distribution at endline. Survey evidence indicates that **WINNN had a significant positive impact on the proportion of children aged 6–35 months who received a Vitamin A drop in the six months prior to the survey.**

The data suggest that WINNN counteracted a general negative trend in Vitamin A supplementation between baseline and endline. The proportion of children receiving Vitamin A decreased in both the focal and control LGAs. This may have been due to the decline in Immunisation Plus Days (IPDs), at which Vitamin A was distributed house-to-house. The decline in supplementation was lower in focal than control LGAs. However, the data suggest that



'The idea of mobile team(s) in MNCHWs … helps in reaching more women and children'

Nasira Bello is a health worker in a WINNN-supported health facility in Jibia LGA, in the state of Katsina. He is a member of a mobile team deployed to reach 'hard-to-reach areas' during MNCHWs. These teams were created as part of WINNN's strategy to reach women and children living further away from health facilities who were not aware of MNCHWs, or could not attend due to the distance to the facility. According to Nasira, "the idea of mobile team(s) in MNCHWs is a welcome development, as it helps in reaching more women and children, especially those in the hard to reach areas like this one … A lot of [women] cannot take their children to the health facility, as the journey is quite a long one. But with the idea of the mobile team we give them these services at their doorstep – usually the village head's house, which is nearer to them. You can imagine the large population missing out, {were it not for] the mobile teams …'

Vitamin A supplementation – and therefore attendance at MNCHWs – remained low in the focal LGAs at endline (only 28% of children received Vitamin A drops in the six months prior to the survey). **Micronutrient supplementation among pregnant women (iron folate) was 10% higher in WINNN's focal LGAs than in control LGAs at endline.** These supplements may have been received at MNCHWs, ANC or postnatal care (PNC) services, or bought elsewhere.

What worked well?

WINNN's experience demonstrates that micronutrient supplementation can be improved through intensive community engagement and mobilisation, increased political commitment, and improved technical capacity within the primary health care system.

Intensive community engagement increased micronutrient supplementation at MNCHW. Supplementation among pregnant women and children was higher in the focal LGAs where WINNN supported the engagement of community leaders, organisations and volunteers (CVs) in CMAM and IYCF services, and involved them in MNCHW planning and social mobilisation. In other LGAs, the social mobilisation was less intensive, relying largely on radio and town announcers, some of whom did not explain the benefits of attending MNCHWs.

WINNN's social mobilisation strategy was largely targeted at men. This was necessary, given that most women require their husband's permission to attend MNCHWs. The sensitisation of women to the benefits of attending MNCHW was also important. This enabled them to request their husbands' permission to attend. It was also important given that qualitative research indicated that some husbands who knew about MNCHWs but were resistant to their wives' use of health services did not tell their wives about MNCHWs.

Political commitment to implementation of the MNCHWs was critical. During 2015–16, all five WINNN states consistently released funds to support the MNCHWs. Two of the WINNN focal states also established budget lines for the MNCHWs, which promoted the timely release of funds and enabled more time for planning and social mobilisation. Established budget lines are also likely to underpin sustainability in the long run.

WINNN's technical support to officials and health workers helped to strengthen the planning and delivery of MNCHWs. LGA officials developed the skills to independently plan and implement the MNCHWs, and developed a strong sense of ownership of the events. WINNN's support to build forecasting capacity supported the adequate availability of the main commodities in most facilities.

Community feedback mechanisms strengthened local accountability. Ward Development Committees and other local organisations arranged town hall meetings in order to collect citizen feedback on MNCHWs. The meetings helped improve the quality of MNCHW services: for example, prompting remedial action at facilities which experienced commodity stock-outs.

What more needs to be done?

Greater political commitment to MNCHWs is needed in order to secure sufficient funding. The quality of planning, social mobilisation, implementation and supervision tended to be lower in states in which public funds for MNCHWs were unbudgeted, and/or funds were released late. Insecure funding was also more likely to lead to commodity stock-outs in some facilities. MNCHWs are currently largely donor-funded, which raises questions about long-term sustainability. More needs to be done to mobilise public resources to fund MNCHWs. State governments should be encouraged to increase their funding, and to access federal and donor funding sources.

Staffing at MNCHWs has been a challenge. The intense nature of campaign events like MNCHWs, and the large numbers of clients, add an additional burden to health workers' workloads. Some health workers showed a high level of commitment to the MNCHWs; others saw them as beyond their normal duties, which led to absenteeism during MNCHWs in some states. The provision of stipends to health workers strengthened motivation, but it raises expectations regarding additional payments which may be unsustainable in the long-term.

The fall in Vitamin A supplementation among children across the states represents a setback to an essential public health intervention. This appears to be largely related to the decline in distribution through IPDs. MNCHWs have not been able to compensate for this. There may be a case for reinstating some door-to-door services, which have been undertaken effectively in other countries, sometimes through the use of paid community health workers, if government is able to sustain payments to a community-based workforce.

Further work is needed to understand how attendance at MNCHWs can be increased.

According to our proxy indicator, attendance remained low even in WINNN's focal LGAs, despite intensive engagement and mobilisation. There is a need to ensure greater reach of information about the MNCHWs, and to provide convincing messages about the benefits of attending. These messages need to reach men and women. Male resistance to women's use of health services continues to be a barrier: 8% of mothers in the endline survey said they did not have their husband's permission to attend MNCHWs. WINNN's strategies to engage religious and community leaders, women's organisations, and community groups have helped, but the question remains as to whether these strategies can be taken to scale by government without WINNN support.

Additional strategies are needed to reach the poorest mothers, mothers with no formal education, and mothers living furthest away from health facilities. Survey data suggest that attendance at MNCHWs tends to be lowest among these mothers. They face particular barriers in accessing facility-based services, including a lack of cash to pay for transportation. The mobile MNCHW services supported by WINNN in some more remote areas may have helped to reduce the barriers.

Additional effort is needed to reach young mothers. Endline survey data (2016) indicate that Vitamin A supplementation in the six months prior to the survey was particularly low among children of adolescent mothers. Qualitative research found that the mobility of adolescent girls was particularly limited upon marriage, and that adolescent mothers had particularly low autonomy around childcare and health-seeking behaviours relative to their husbands and mothers-in-law.

References

[1](National Nutrition and Health Survey (NNHS) 2015. [2]WINNN is a six-year programme (2011–2017) funded by the UK Department for International Development. The Operational Research and Impact Evaluation (ORIE) project is a separate component of the programme, undertaking independent research around, and evaluation of, WINNN. The project is undertaken by a consortium led by Oxford Policy Management. This brief draws on evidence collected between 2013 and 2016.

Photos: J. Ucheh; Flint Productions /WINNN

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