ORIE Nutrition Research in Northern Nigeria

Qualitative Evaluation of the WINNN Programme

Summary report

Operations Research and Impact Evaluation

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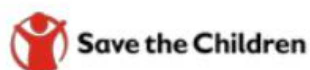

Introduction

Operations Research and Impact Evaluation (ORIE) is led by Oxford Policy Management (OPM) in conjunction with three other UK-based institutions, the London School of Hygiene and Tropical Medicine (LSHTM), the Institute of Development Studies (IDS) and Save the Children UK (SCUK), and four Nigerian partners, the University of Ibadan, Kaduna Polytechnic, Ahmadu Bello University at Zaria (ABU), and the Food Basket Foundation International (FBFI).

ORIE is funded by the Department for International Development of the UK Government and implemented in collaboration with the Government of Nigeria.

Working to Improve Nutrition in Northern Nigeria (WINNN) is a six-year (2011–2017) Department for International Development (DFID)-funded programme to improve maternal, newborn and child nutrition in northern Nigeria. WINNN is implemented by Save the Children International, Action Against Hunger and the UN Children's Fund (UNICEF). WINNN supports government work on nutrition in five states (Jigawa, Katsina, Kebbi, Zamfara and Yobe), and to a lesser extent at the federal level. It is focused on four intervention areas:

- Micronutrient supplementation (Output 1);
- Infant and young child feeding (IYCF) interventions (Output 2);
- A Community-based management of acute malnutrition (CMAM) programme (Output 3); and
- Strengthening nutrition coordination and planning at the state and national levels (Output 4).

This summary report presents the key findings of the qualitative evaluation of the WINNN programme. The qualitative evaluation assesses WINNN's contributions to change in the governance contexts for nutrition interventions, including civil society and community engagement. The focus includes: government commitment and public funding; coordination mechanisms; the institutionalisation of service delivery models; and community engagement in nutrition service delivery.

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This research was carried out by the ORIE consortium. The ORIE project is managed by Patrick Ward at OPM. For further information on this report, please email psu.ORIE@opml.co.uk or see the website: http://www.heart-resources.org/tag/orie/
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Evaluation method

The research is conducted at federal level and within four of the WINNN states (Jigawa, Katsina, Kebbi and Zamfara), including two local government areas (LGAs) in each state. At endline, some limited research has also been pursued in the fifth WINNN state – Yobe.

The data are collected from various stakeholder groups, including government officials, health workers, community volunteers (CVs), community leaders, civil society organisations (CSOs), WINNN and other development partners (DPs). The interview data are then triangulated. The analysis also draws on Operations Research and Impact Evaluation (ORIE) and WINNN quantitative data to assess programme outcomes, as well as WINNN qualitative research with caregivers at community level.

The baseline research was undertaken in July–October 2013, and the midline research was done in October 2014. The endline research was undertaken in June–August 2016, with follow-up on specific issues in December 2016.

There are some limitations to the qualitative evaluation. First, due to the DFID-scheduled contracting of ORIE, the baseline was undertaken one year after WINNN commenced, while the endline was conducted one year before WINNN ended. **This evaluation therefore reports on progress one year before the end of the WINNN programme**. Second, the qualitative evaluation is very large in scope, which limits the depth of analysis for each output area.

Evaluation findings

The evaluation findings presented below are based on research undertaken from June to December 2016. It should be noted that further progress may have been achieved since December 2016. The findings are organised by the four WINNN workstreams.

1. Government commitment, coordination and planning

WINNN was expected to promote government commitment and public funding for nutrition, and to strengthen nutrition policy, plans and coordination. This would support the institutionalisation and sustainability of nutrition work. WINNN has met or exceeded its targets for 2016, namely: '*functional nutrition coordination bodies in four states*'; '*development of nutrition action plans in four states*'; and '*funded nutrition budget lines in four states that are least partially released*'.

Context: In addition to WINNN, several DPs have supported the Government of Nigeria to strengthen nutrition sector governance.[1] WINNN has worked effectively with these DPs, through government-led committees and DP forums. Several factors affected progress with nutrition sector governance. The large drop in the price of oil in 2015 contributed to an adverse fiscal situation in Nigeria, which has affected public financing for nutrition. The political transition in 2015 also affected work to build government commitment, while the insecurity in north-east Nigeria has been a mitigating factor in Yobe.

National level

At **baseline (2013)**, Nigeria had signed up to the Scaling-up Nutrition movement, which had energised support for nutrition in the Federal Ministries of Health (FMoH) and Agriculture. However, no federal public funds had been allocated to nutrition at baseline. An inter-sectoral National Committee on Food and Nutrition (NCFN) had been established, but it was not functional in 2013.

The evaluation finds **strong progress in nutrition sector coordination and planning at national level**. WINNN played a key role in supporting the Ministry of Budget and National Planning (MBNP) to revitalise the NCFN, through ongoing technical support and advocacy. The NCFN is now functional and has established a budget to enable its coordination work. WINNN also supported the MBNP to revise the National Policy on Food and Nutrition, which was approved in 2016. The policy is an important milestone that provides a framework for nutrition work across sectors. WINNN also contributed to development of a National Strategic Plan of Action for Nutrition (NSPAN) for the health sector, as well as various guidelines for nutrition-specific interventions. These strategies were developed within task forces of the Nutrition Partners Forum, which is led by FMoH.

Several non-health sectors (particularly agriculture and education) have now incorporated nutrition into their policy and work since the baseline. Working with other DPs, WINNN also promoted the inclusion of nutrition into the National Health Policy, as well as into national initiatives such as Zero Hunger and Saving One Million Lives. Taken together, this is starting to provide a broadly

[1] This includes the World Bank, the EU's ECHO project, USAID's SPRING project, FHI 360, Hellen Keller International, GAIN, the Food and Agriculture Organization, and the Dangote Foundation. The WINNN implementing partners also have additional sources of funding to support nutrition sector governance. For example, Save the Children implements the Gates Advocacy project (funded by the Gates Foundation) in three of the WINNN states and UNICEF receives a grant from the Children's Investment Fund Foundation (CIFF) to support CMAM-related services and governance in 12 states (including all five WINNN states).

conducive policy framework for nutrition work. The challenge now is to get these policies and plans implemented at state level, and in this regard the key challenge is public funding.

Compared to baseline, there is now **increased political support for** nutrition at federal level, particularly in the health sector, MBNP and the Senate. WINNN contributed to this achievement through advocacy, supporting high-level dialogue, and raising the profile of malnutrition through increased media reporting. The insecurity and internally displaced persons in north-eastern Nigeria have also increased government attention to child malnutrition. The litmus test for political commitment is public financing. **Federal funding for nutrition has increased from a low base (see State level** (WINNN focal states)

There has been **strong progress in nutrition sector coordination in the focal states.** At baseline, there were no functional nutrition coordination mechanisms, and no nutrition policies or plans in the focal states. Supported by WINNN advocacy and technical support, three of the states (Katsina, Zamfara and Jigawa) now have functional state committees on food and nutrition (SCFNs). In these states, the SCFNs have spearheaded advocacy for public financing. In Kebbi, the SCFN is operational but does not meet quarterly. In Yobe, slower progress has been affected by the context of insecurity but the state did approve the creation of an SCFN in 2016. **All five states domesticated the national nutrition policy in 2016, and each have developed costed nutrition plans of action** supported by WINNN. The plans were finalised in two states (Katsina and Kebbi) in 2016. In the main, the plans provide coherent multi-sectoral strategies.

There is **strengthened political support for nutrition in the focal states**. This is evidenced by increased political engagement in most of the states, the approval of nutrition policies and plans, and improved public funding. WINNN contributed to this achievement, working with other DPs and senior state officials. The key advocacy moments were similar across states: high-level meetings with governors, retreats for legislators, the use of data and photos to provide evidence of malnutrition, and taking political leaders to CMAM programme sites. The demonstration effect of WINNN and other DP nutrition services has also built the profile of nutrition work, as has WINNN's work to promote media reporting, engage the wives of the governors, and build an advocacy platform through the SCFNs.

Table 1**), although in 2016 it remained inadequate.** The cost of implementing the NSPAN (2014–2019) is NGN 144.1 billion. The inadequate funding should be contextualised by the adverse fiscal situation since 2015. Yet there are also indications that nutrition has been seen as a 'donor-funded issue', and this was acknowledged by a senior senator in a television interview in late 2016. At the end of 2016, however, there are signs of good progress: the federal government is presently negotiating a US$ 350 million loan for nutrition from the World Bank, and the draft 2017 federal health budget includes a large allocation to the CMAM programme.

At endline there is **progress in terms of federal government coordination with the states on nutrition work**, particularly in 2016. For example, the Minister for Health held a meeting with state commissioners to promote their commitment to nutrition and federal officers toured the states to disseminate the national nutrition policy, research and statistics. Yet the inadequacy of federal funding for nutrition has prevented federal officers from more actively engaging with their technical equivalents at state level. The structure of the health sector is another mitigating factor: the FMoH does not line manage the state health ministries, departments and agencies (as is the case in all sectors), which creates a partial disconnect between the federal and state levels. At present, DPs are helping to fill this gap through their work at all levels, which is creating coherence and alignment to the policies and strategies that has been developed. The national nutrition policy provides for establishment of a National Council on Nutrition, and positions the Vice President as

its Chair. This Council, if it is created, should strengthen federal oversight and create a platform for high-level decision-making in the sector.

State level (WINNN focal states)

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Table 1: Summary of results against key evaluation indicators – governance

Situation as at December 2016	National	Zamfara	Jigawa	Katsina	Kebbi	Yobe
Political support strengthened since 2013	✓✓	✓✓	✓✓✓	✓✓✓	✓✓	✓✓
Political engagement/statements increased	✓✓✓	✓	✓✓✓	✓✓✓	✓✓✓	✓✓
Nutrition policy or plans approved	Yes	Yes	Yes	Yes	Yes	Yes
Public financing for nutrition improved	✓	✓✓	✓✓✓	✓✓✓	X	✓✓
Baseline: ad hoc release for nutrition 2013	*0*	*8.5 mil*	*11 mil*	*23 mil*	*185 mil*	*0*
State nutrition budgets 2016	*N/A*	*100 mil*	*135 mil*	*180 mil*	*100 mil*	*121 mil*
Releases for nutrition 2016	*31.8 mil***	*26.4 mil*	*21 mil*	*49 mil*	*42 mil*	*20 mil*
Additional release announced Dec 2016			*280 mil**	*200 mil**		
LGA nutrition funding established by 2016	*-*	*Yes*	*Yes*	*Yes*	*Yes*	*No*
Strengthened nutrition sector coordination	✓✓✓	✓✓✓	✓✓✓	✓✓✓	✓✓	✓
NCFN/SCFN functional & meets quarterly	Yes	Yes	Yes	Yes	progress	No
Local Committee on Food and Nutrition functional (WINNN LGAs)	NA	Yes	progress	No	No	No
Nutrition-specific coordination mechanisms	Yes	Yes	Yes	Yes	Yes	Yes
Multisector nutrition plans developed	✓✓✓	✓✓	✓✓	✓✓✓	✓✓✓	✓✓

Increased civil society engagement in sector	✓✓✓	✓✓✓	✓✓✓	✓✓✓	✓✓	✓✓✓

Key: ✓✓✓= Strong outcome; ✓✓ = moderate outcome; ✓ = low outcome; X = worsened since baseline.

All financial figures are in Nigerian Naira. * Jigawa and Katsina announced the release of these funds in December 2016, and this was publicised in the media, but WINNN has not yet received confirmation of the releases. ** The federal government release for nutrition recorded in this table includes the MBNP and FMoH only.

The growing political support for nutrition has enabled **progress with public financing for nutrition in the focal states**. This includes the creation of nutrition budget lines, increased fund allocation and releases for nutrition, and LGA monthly funding in four states (see State level (WINNN focal states)

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Table 1). WINNN contributed to this achievement through work with senior officials, facilitating decision-making spaces, and advocacy toward political leaders. The LGA nutrition funding was sustained through the political transition in Jigawa, Katsina and Zamfara – influenced by substantial advocacy from government officials, WINNN and civil society.[2] Yet there has been **more limited release of the state nutrition budgets** (see Table 1). The adverse fiscal situation has been a challenge for fund releases. Moreover, *all* fund releases are personally approved by the governors, and gaining access to them can be a challenge. Achieving fund releases for nutrition often required considerable advocacy by stakeholders with personal connections to the governors or high-level engagement from WINNN.

At both national and state levels, there is **increased civil society advocacy** in the nutrition sector compared to the baseline, when it was limited. Public media reporting on malnutrition has greatly increased[3] and has contributed to increasing the profile of nutrition work, and some results in

[2] For example, in Katsina the LGA monthly funding for nutrition was not released for nine months after the elections. Several DPs supported government officials in a long campaign to get the funds released. The re-establishment of the LGA monthly funding was ultimately attributed to a media campaign supported by WINNN and Gates Foundation advocacy.
[3] In 2013, there were less than 20 media articles on nutrition. In 2016, there were over 300 articles, most of which were advocacy oriented, made good use of data and included a clear message about the actions required.

public financing for nutrition. WINNN media engagement and training was a contributor to this. WINNN and other DPs have supported the establishment of a national civil society coalition (CS-SUNN), and have built capacity and networks among state-level CSOs. In some WINNN states, CSOs have pursued advocacy on nutrition financing and radio shows on malnutrition. WINNN has also engaged community leaders and local organisations in the oversight of nutrition work and facilitation of community feedback, and there is clear local ownership of this work.

2. Micronutrient supplementation through the Maternal, Newborn and Child Health Week (MNCHW) events

Working with numerous other DPs, WINNN has supported the implementation of biannual MNCHW events in its five focal states. WINNN has played a key role in supporting service planning, training, delivery and monitoring, as well as social mobilisation and advocacy for public funding and the provision of key commodities. WINNN supports the MNCHW events in all LGAs in the WINNN focal states. Some activities were more intensive in the three 'WINNN focal LGAs' per state, however, where the programme also supports the IYCF interventions and the CMAM programme.

Outcomes: The ORIE quantitative evaluation found that **WINNN had a positive and significant impact on the proportion of children receiving Vitamin A** in treatment areas, and on mothers' attendance at the MNCHW event. However, the Year 5 target for Vitamin A coverage was not reached and MNCHW event attendance remained fairly low (13%) at endline in the WINNN LGAs. While mothers' awareness of MNCHW events has increased (from 13% to 43% in the WINNN LGAs), the main reason that mothers gave for non-attendance was not having heard of the event. This points to a challenge in the social mobilisation.

There are also **contextual barriers to attendance at MNCHW events.** These include a lack of permission from husbands, which affects the generally low female use of health facility services in northern Nigeria. The significance of this factor is indicated by correlation between higher MNCHW event attendance in the WINNN LGAs in Katsina and Jigawa (Quantitative Impact Evaluation of the WINNN Programme – Volume 1: Operations Research and Impact Evaluation, 2017) and the greater proportion of women who access antenatal care (ANC) in these states compared to Kebbi and Zamfara (SMART survey 2015). The social mobilisation strategy focused largely on reaching men, which was appropriate and shows understanding of the gender context. WINNN also supported MNCHW event mobile services in hard-to-reach areas, which demonstrates attention to inclusion.

The proportion of mothers who attended the MNCHW events at endline was significantly higher in the WINNN focal LGAs (13%) compared to the control LGAs in which WINNN only supports MNCHW events (7%). This may be due to WINNN's more intensive community engagement work in its focal LGAs, and specifically in its focal communities for IYCF interventions and the CMAM programme. In its focal communities, WINNN supported strong local engagement in MNCHW event social mobilisation, which engaged multiple stakeholders and methods. This has been enabled by WINNN's ongoing work around the IYCF interventions and the CMAM programme, as well as by its engagement of community leaders and other local stakeholders in the MNCHW event planning meetings. Beyond the WINNN focal communities, the MNCHW event social mobilisation was much less expansive, relying largely on town announcers backed up by radio announcements.

WINNN has contributed to strengthening the supply side of MNCHW events. The sampled LGA officials had good understanding and ownership of the microplanning and supervision, and

felt confident that they have developed the skills required to independently plan and deliver the MNCHW events. This, alongside WINNN's support to build forecasting capacity, has supported the fairly adequate availability of the main commodities at facility level. The main commodities are procured and delivered by WINNN. There has been less adequate availability of government-funded commodities in some LGAs, which was largely attributed to inadequate or late public financing. Government officials also reported that low and/or late public financing has reduced the time available for planning and social mobilisation, as well as limiting the extent of supervision.

All five states released public funds for the MNCHW events in 2015/16. With the exception of Kebbi, this funding has been fairly consistent since the baseline. This contrasts with a decline in public financing for the MNCHW events in Nigerian states overall during the same period.[4] In Kebbi, MNCHW events were not held between 2012 and 2014 due to a lack of support from the then-governor. This situation was turned around in late 2014, influenced by advocacy from senior officials and WINNN. Across the WINNN states, the public funding is widely seen as inadequate, however, and with the exception of Yobe and Zamfara the funding is also unbudgeted. This contributes to late releases, which is a notable challenge in all WINNN states except for Yobe, and affects some aspects of service delivery (as noted above).

3. IYCF interventions

WINNN's objective was to improve IYCF knowledge and practices in the focal LGAs, by supporting the government to integrate IYCF counselling into routine primary health care (PHC) services in target facilities, and supporting volunteer-led IYCF counselling in target communities. WINNN also aimed to strengthen the IYCF policy framework and government commitment to IYCF practices.

Outcomes: The ORIE quantitative evaluation found that WINNN's support increased (by 9%) the proportion of mothers who breastfed within 24 hours of birth in the WINNN LGAs (which reached 83% at endline). The proportion who breastfed within one hour was also higher in WINNN LGAs (38%) than control LGAs (23%) at endline. Exclusive breastfeeding (of children aged 0–5 months) increased from 9% to 20%, which may be attributable to WINNN and exceeded the programme's Year 5 target. WINNN support did not have a significant impact on child dietary diversity,[5] however, which may be due to the later start to some of the complementary feeding interventions.

At endline, 58% of mothers in the WINNN LGAs had ever received IYCF counselling. The qualitative research found that even among mothers who had gained knowledge of IYCF practices, various factors mediated its translation into practice. This includes mothers' strong fears regarding not giving water to their newborn and the influence of older female relatives over infant feeding decisions. There were also indications of challenges accessing the recommended foods for complementary feeding.

Facility-IYCF (f-IYCF) component of the IYCF interventions: **In WINNN's focal facilities, IYCF counselling is now widely provided within routine services.**[6] This achievement was underpinned by WINNN advocacy, technical support and training. The context for institutionalisation has been promoted by good support from LGA and state health officials. Yet **a key challenge for the f-IYCF component has been the inadequacy of human resources for health**. Particularly in busy CMAM facilities and ANC sites, CVs often provide education on IYCF practices, rather than health workers. The reliance on CVs for the f-IYCF component of the IYCF

[4] UNICEF (2016) Evaluation of the Maternal, Newborn and Child Health Week in Nigeria.
[5] Children (aged 6–23 months) who received food from four or more food groups.
[6] The ORIE quantitative evaluation found that 42% of mothers who attended ANC had received IYCF counselling, which suggests a moderate coverage of the f-IYCF component of the IYCF interventions at LGA level.

counselling is a challenge for the full institutionalisation of IYCF-counselling in routine PHC services.

In many of the sampled facilities, health workers explained that the f-IYCF component of the IYCF interventions is provided to large groups of women, or takes the form of very brief sessions. While the research indicated that some mothers had received in-depth counselling at a facility, others had not. In some communities, some mothers reported they had merely been told to breastfeed exclusively, with no explanation of the benefits. In some cases where the 'counselling' had been brief, caregivers said that they practised the recommendations on IYCF practices because they trust information provided at the health facility.

The community-IYCF (c-IYCF) component of the IYCF interventions has been **expansive in most of the sampled focal communities for the IYCF interventions**.[7] WINNN's strategy of asking community leaders to recruit the CVs has been key to embedding the intervention in communities. There has also been progress with implementation of mothers' support groups. Where these are well targeted and regularly convened, they have encouraged uptake of the recommendations on IYCF practices. This achievement has been buttressed by WINNN-supported training and supervision (see below). However, there are indications that many support groups include grandmothers, and some are convened with different women each time. As such, the groups are more like a broader form of community advocacy than dedicated counselling for mothers. WINNN has continued to strengthen the model, however. In 2016, the programme commenced support groups for adolescent girls and fathers and is now piloting a 'care group model' for IYCF counselling.[8]

WINNN has also supported the **development of supervision systems for the c-IYCF component of the IYCF interventions**. These link the intervention into the PHC system, thus supporting institutionalisation. In many of the sampled wards, the supervisors had provided good guidance to CVs, which strengthened their skills and provided recognition, while also promoting community interest. Some supervisors have been less active, however, and have focused more on ensuring that support groups are convened than on quality assurance. This is partly affected by the common recruitment of men into this role, who are less able to directly observe CV meetings with women.

Many of the volunteers reported that they are motivated by the visible outcomes of their work, and the WINNN-supported training, meetings, hijabs and bags. This reflects well on the WINNN support model for volunteers. However, many CVs perceive the need for financial incentives, and there were also **reports of dwindling CV motivation in some communities.** This is a concern for the longer-term sustainability of the IYCF interventions, which was a key concern of government officials.

In stark contrast to the baseline there is evidence of **growing political support for IYCF interventions** in most of the WINNN states, and three states have approved or leveraged funds for IYCF interventions scale-up. WINNN advocacy meetings and promotion of the cost-effectiveness of the IYCF interventions have been key influences, as has its work to engage the governors' wives in IYCF-related activities.

[7] WINNN supported c-IYCF component of the IYCF interventions in 10 communities per ward. This led to moderate coverage at LGA level: 32% of mothers in the WINNN LGAs had ever attended IYCF counselling in the community at endline (Quantitative Impact Evaluation of the WINNN Programme – Volume 1: Operations Research and Impact Evaluation, 2017).

[8] The care group model involves the recruitment of 'mother leaders' on each street, who provide education on IYCF practices and support to other mothers (their peers) on the street.

4. The CMAM programme

The programme objective was to support the establishment of the CMAM programme in target facilities, by working with government to develop systems and skills at LGA and facility levels, and the recruitment and training of CVs providing CMAM-related services. WINNN also works with other DPs to promote political commitment and public funding for the CMAM programme.

Outcomes: WINNN service data indicate that the programme has exceeded the Year 5 cumulative *output target* for admissions to CMAM facilities and reached the international SPHERE standards for recovery rates in all five states. SQUEAC assessments for Katsina and Kebbi show that the WINNN-supported intervention has achieved moderate coverage of around 40%, which is slightly below the SPHERE standard of 50% for rural areas. Using a different method, the ORIE quantitative evaluation found that 18% of children (aged 6–23 months) with *severe acute malnutrition* (SAM), at the time of the ORIE survey in the WINNN LGAs, had been taken to a CMAM facility for treatment. It should be noted, however, that WINNN was not expected to reach the whole LGA population with the CMAM programme.

Context: The CMAM programme interventions have been implemented within a challenging health sector context, with inadequate basic amenities at facility level and insufficient human resources for health. Moreover, the adverse fiscal situation led to the non-payment of health workers' salaries for some of 2015/16 in most of the WINNN states.

WINNN has contributed to building political support for the CMAM programme at national level and in the focal states. In addition to increased public statements about SAM, all five states allocated funds to the CMAM programme in 2016 (within the state and LGA nutrition budgets). Influenced by WINNN and other DPs, two states (Zamfara and Jigawa) have also approved some public funds to support scale-up of the CMAM programme. The advocacy approaches that worked included taking political leaders to CMAM programme sites and the use of data and photos to provide evidence of SAM and the efficacy of the CMAM programme response. There has been a challenge with the late or non-release of public funds for the CMAM programme, however, which has affected implementation (as explained below).

CMAM-related services have been established in each of the target facilities. WINNN contributed to this achievement through advocacy, training and ongoing technical support. The **adequacy of commodity supply has improved since the midline** (2014), especially in Jigawa and Zamfara where it is now largely adequate. This achievement has been underpinned by the timely release of LGA counterpart funding, and WINNN's work to strengthen forecasting capacity and to develop coordination mechanisms. In facilities where the commodity supply has been less adequate, this has been affected by insecure LGA funding, weaker forecasting skills or late commodity requests. The consolidation of skills is a key focus for the remaining year of the programme. Influenced by WINNN, legislators have voiced commitment to institutionalising and increasing LGA funding for the CMAM programme, and to provide oversight on the use of the funds. UNICEF (partly funded by WINNN) has also successfully promoted the **incorporation of the CMAM programme into the basic costing for PHC services**, which promotes institutionalisation and aligns with wider health policy.

In regard to the quality of service provision, the ORIE facility survey found **strong observance of some CMAM programme protocols but weaker observance of others** such as oedema checks and temperature measurement. The weaknesses were partly attributed to inadequate human resources for health. In collaboration with government, WINNN has worked around this challenge by engaging CVs to support CMAM days, and 'borrowing' health workers from other facilities. This has addressed staffing needs in the short term but the facilities from which staff are seconded are

often closed for the day (once per week), which is an unintended negative outcome. WINNN has supported the development of CMAM programme supervision systems, for which there is strong local ownership. However, the non-observance of some CMAM programme protocols raises questions about rigour. Moreover, the extent of supervision is affected by understaffing at the LGA and state nutrition units, as well as insecure LGA funding.

WINNN has supported **strong community engagement** in CMAM-related service provision. The programme's approach of engaging community leaders in CMAM programme coordination meetings and the selection of CVs has promoted their ownership and support. Many CVs supporting the CMAM programme reported that they are motivated. The CVs certainly enable the provision of CMAM-related services in the context of insufficient human resources for health. Yet the large role that CVs play on CMAM days has led some to see this as their main task, which has reduced their attention to community outreach. The CVs also reported challenges with the tracking of defaulters, both because they tend to live in more distant locations and because the CVs do not receive a travel allowance. WINNN has supported the recruitment of additional CVs in a wider set of communities, and has influenced some LGAs to provide stipends for CVs. However, this funding has been inconsistent or has not yet commenced. Government officials in all five states asserted that maintaining CV motivation is a key challenge for the CMAM programme.

Key recommendations

- **Continued focus on public financing for nutrition and increased focus on strengthening accountability in the use of public nutrition funds that are released**. This includes: (a) development of more specific guidelines on the intended use of the LGA nutrition funds; (b) further strengthening of legislators' support and role in regard to expenditure oversight and institutionalising nutrition funding through legislation; and (c) further support to civil society to promote the tracking of nutrition budgets and releases.

- **Encourage and support states to access available nutrition funding from donors and national sources**. These include the US$ 500 million World Bank loan for the Saving One Million Lives initiative and the matched funding mechanism for the purchase of ready-to-use therapeutic food provided by CIFF.

- **Continue to strengthen the behavioural change strategy for the IYCF interventions**. This includes: (a) additional research on how to reduce mothers' fears about not giving water to the infant; (b) the development of separate counselling spaces for grandmothers, and continued work to strengthen and roll-out fathers' support groups; and (c) assessing the WINNN pilot of the 'care group model' for IYCF counselling and the potential for scale-up.

- **Draw on local experience and lessons from other countries to strengthen the CV model.** This includes seeking appropriate ways to sustain CV motivation and strengthen community outreach work of CVs providing CMAM-related services.

- **Explore ways to increase attendance at MNCHW events.** Further develop the social mobilisation strategies used in the WINNN focal communities, and enable non-WINNN LGAs to draw on these strategies.

- **Inaugurate the National Council on Nutrition**, chaired by Nigeria's Vice President, as set out in the approved National Nutrition Policy.

- **Seek intermediary solutions to the overriding challenge of inadequate human resources for health** in order to sustain and scale-up nutrition services with appropriate coverage and quality.