REPORT OF THE NUTRITION RESEARCH DISSEMINATION AND STAKEHOLDER ENGAGEMENT EVENT

1st to 2nd March 2016, Abuja, Nigeria

1 Background

Malnutrition is at critical levels in Northern Nigeria. Interventions, including those supported by the UK Department for International Development (DFID) in partnership with the Government of Nigeria, through the Working to Improve Nutrition in Northern Nigeria (WINNN) Programme, are vital for preventing and treating malnutrition.

On 1st and 2nd March 2016, over 150 stakeholders met to discuss how to tackle undernutrition in Northern Nigeria, including staff from State and Federal Government, international development partners, civil society organisations (CSOs) and academic institutions. The meeting was convened in Abuja in partnership with the Federal Ministry for Budget and National Planning (FMBNP), the Federal Ministry of Health (FMoH), and the National Primary Health Care Development Agency (NPHCDA). The meeting reviewed the implications of new research findings by the independent operations research and impact evaluation (ORIE) component project of WINNN. This report summarises the researches presented; key issues discussed; and commitments made during the event.

2 Situation of malnutrition and its consequences

Malnutrition is a critical problem in Northern Nigeria. Rates of stunting (58 per cent), underweight (41 per cent) and wasting (16 per cent) among children are all at “Very High” levels according to WHO standards; these rates are much worse than elsewhere in Nigeria.

In the short term, these critical levels of malnutrition contribute to the high rates of child and maternal mortality in Northern Nigeria. In the long term, they result in impaired learning ability, lower IQ levels, lower employment levels, reduced economic development and GDP.

3 WINNN and ORIE

The WINNN programme works in five states in Northern Nigeria (Katsina, Kebbi, Jigawa, Yobe and Zamfara) to improve nutrition through the management of severe acute malnutrition, promoting better feeding for infants and young children, and ensuring infants, young children and pregnant women receive essential nutrients. WINNN works to build the capacity of state and local government areas (LGAs) to implement nutrition interventions as routine services through existing primary health care structures.

The ORIE project works alongside WINNN to identify the scale, causes and underlying factors of malnutrition, providing evidence that aims to help improve service provision, programme quality and impact and support evidence-based advocacy to leverage domestic resources for tackling malnutrition. Some of the recent key results from ORIE’s work, including midline qualitative analysis, gender analysis, and operations research, presented at the event are summarised in this document (full reports are available on the DFID HEART website[1]).

[1] http://www.heart-resources.org/tag/orie/

4 WINNN interventions

WINNN supports three nutrition specific interventions: Maternal and Newborn Child Health Weeks (MNCHW), Infant and Young Child Feeding (IYCF) and Community Based Management of Severe Acute Malnutrition (CMAM). WINNN also advocates for greater involvement and resource allocation for improving nutrition by federal, state and local government authorities, greater collaboration between those government departments which can make effective nutrition sensitive interventions and greater community involvement. ORIE supports WINNN by providing data for improving the efficiency of the three nutrition specific interventions and for advocacy for increased resources for tackling malnutrition.

Key accomplishments of WINNN to date include: reaching over eight million children with vitamin A supplementation, counselling close to half a million women on appropriate IYCF, treating 171,947 children for severe acute malnutrition (SAM), and supporting the creation of a budget line for nutrition in all five WINNN states.

5 Overview of the event

This stakeholder dissemination event built on the event of two years ago, held in Abuja in April 2014, at which the baseline findings from the ORIE qualitative and quantitative baseline analyses; year one gender review; and first round of operations research were shared.[2]

During day one of the 2016 workshop, findings from the midline qualitative evaluation; the economic evaluation, based on WINNN's spending over four years; and findings from the third annual gender review of ORIE research findings, were shared. The first day ended with a panel discussion on priorities and challenges for nutrition action. During the second day, the latest round of ORIE operations research findings, and findings from an ORIE survey of facilities providing CMAM services, were presented. The operations research conducted over the last year sought to: understand barriers to exclusive breastfeeding; test IYCF messages and understand challenges mothers might face in implementing these messages; and understand the barriers that prevent women from using antenatal care (ANC). The second day ended with participants joining state or federal level groups to discuss and agree actions that individuals would take during the six months immediately after the event to further tackle malnutrition, based on the findings and implications of the research evidence shared.

Day One:

6 Gender-related findings from ORIE studies and implications for nutrition programmes and policies

The ORIE gender workstream works annually to synthesise gender-related findings from across ORIE studies and suggest implications for nutrition programmes and policies like those supported by WINNN in Northern Nigeria and the Government of Nigeria (GoN). A gendered approach is important to allow WINNN and the GoN to better understand how family and gender roles and relations impact nutritional status in Northern Nigeria.

6.1 Differentiated gender roles within households

[2] http://www.heart-resources.org/assignment/report-winnn-orie-nutrition-stakeholders-engagement-event-29-april-2014-abuja/

Households are not single units. Thus it is important to have more nuanced data on the different gender roles within the household, including where and how each individual affects decisions around nutrition. A family-centred approach to nutrition, which seeks to understand the role of various family members, and who might be change agents for different issues, is key. For example, older women and grandmothers are the most important influences over IYCF practices such as early initiation of breastfeeding, as men are not present during the post-natal period; whereas men and husbands influence access to health care, as almost all women require their husband's permission to go to a health centre alone. Additionally, various family members are motivated by different outcomes. Mothers are motivated to exclusively breastfeed their babies when they see the baby is happy, healthy, and admired, whereas fathers are more motivated by improved health and longer term development outcomes for the child.

6.2 Female decision making

In many households men are making many major decisions alone, without consulting their wives, which means it is essential to target men as well as women with IYCF messages. Evidence from other contexts shows that increased female participation in household decisions can improve nutrition outcomes. Other research in Nigeria has found that greater female participation has a positive influence on the linear growth and immunisation status of the child. ORIE evidence found that female participation has a strong, beneficial effect on child stunting, wasting and underweight. A large age gap between the husband and wife (in ORIE baseline survey: 13.5 years on average[3]) may also contribute to reduced female decision making power in households.

6.3 Overcoming barriers

6.3.1 **Engaging men is key.** An effective way to engage men is through traditional and religious leaders. Messages which draw on Islamic teaching and the Qur'an, and which illustrate that the man is responsible for his family's health and wellbeing, can be effective. The involvement of male community volunteers has been a useful way of reaching out to men.

6.3.2 **Specific engagement strategies for adolescent mothers are necessary**. Adolescent mothers are less likely to use ANC than older mothers because they are shy, fearful, least likely to ask for their husband's permission and have lower decision making power within the household. This is a particular challenge given that they tend to have poorer health outcomes.

6.3.3 **Supply side challenges deter women from attending health clinics**. Problems on the supply side are experienced differently by men and women. Men do not want their wives to be seen by other men, due to concerns around female modesty, but there is a significant shortage of female health workers. On the other hand, women are put off by long waiting times at clinics or the possibility of being sent away if they are too early in their pregnancy.

7 Governance for nutrition

[3] http://www.heart-resources.org/assignment/orie-nigeria-quantitative-impact-evaluation-baseline-report/

The qualitative midline, conducted in 2014, sought to assess progress in the governance of nutrition work including policy, planning, co-ordination, funding and CSO community engagement. The presentation noted that while a final draft of the revised National Policy on Food and Nutrition had been agreed in 2014, the policy had not yet been ratified. As a result, states have not been able to implement and domesticate the policy. However, the profile of nutrition has improved in key ministries and agencies including NPHCDA, FMoH, and the Ministry of Agriculture (FMoA). In the FMoA, the focus is moving away from being purely growth based and nutrition is being integrated in to agricultural policies at state and national levels. In terms of Nigeria' participation in the global Scaling Up Nutrition (SUN) Movement: a civil society alliance been established and is increasingly active.

7.1 Budget for nutrition

Budget for nutrition remains a challenge and funding is largely donor dependent, raising questions about sustainability. At the federal level, there is a budget line for nutrition, but the budget is not adequate, and disbursement is unreliable. At the state level, all four states in the ORIE study – Katsina, Kebbi, Jigawa and Zamfara - now have a nutrition budget, however, like at the federal level, there are challenges with budget release, which require high level advocacy to address. State food and nutrition committees are active in all states. All four states have developed costed nutrition plans, while Jigawa and Zamfara are the only states to also have annual operational plans. All four states released ad hoc funds for MNCHW, but these were often insufficient and late, reducing time for planning, training and social mobilisation. Overall budget remains inadequate and there is a need for improved oversight and accountability systems.

7.2 IYCF

Health workers and community volunteers (CVs) are committed to IYCF work, but IYCF remains fairly low profile compared to CMAM. There are ceremonies for exclusive breastfeeding (EBF) now in all four states, however in Katsina and Kebbi these are still WINNN funded, which raises questions about ownership, commitment and sustainability.

7.3 CMAM

There are high levels of political support for CMAM, which is mainly focused on ready to use therapeutic food (RUTF) procurement. CMAM centres appear popular. However there are problems of low availability of drugs and sometimes, RUTF supplies are inadequate. Health workers feel ownership of the CMAM programmes but feel overwhelmed by the volume of people who attend on CMAM days. CVs lack funding for transport, with only Zamfara providing CVs with a travel allowance.

8 Economic evaluation

The ORIE economic evaluation seeks to look at the cost and cost effectiveness of WINNN programme interventions. However, key outcomes cannot yet be analysed, including the cost effectiveness of the programme and cost per beneficiary, because they require data from the yet to be implemented end-line survey and data quality assessment. The economic evaluation presentation at the event looked only at WINNN costs, and did not include key government costs such as health workers, or broader societal costs.

WINNN has spent $47.9 million over the last four years. CMAM represents the greatest percentage of those costs – 50 per cent – followed by MNCHW, IYCF, and then advocacy. WINNN is not a very capital-intensive programme – with capital representing only three per cent of overall programme costs. Most of the costs are recurrent expenditure, with a large percentage specifically spent on RUTF.

Although end line analysis is not yet available, it is important to note that significantly greater sustained resourcing commitments are needed to meet the costs for full coverage articulated in the national costed plan and estimates made by the SUN Movement.

9 Panel discussion

In the afternoon, a high level panel comprising: Dr Chris Osa Isokpunwu, Head of Nutrition, Federal Ministry of Health; Prof Andrew Tomkins, ORIE International Team Leader; Prof Taofeek Ibrahim, Vice Chancellor Al HIKMA University; Hon. Mahmud of Zamfara State House of Assembly; Alh. Kabiru Mohammed, Chairman, Zamfara State Committee for Food & Nutrition; and Prof Ngozi Nnam, President, Nutrition Society of Nigeria, discussed, based on the presented ORIE findings, priority areas for action over the following six months. Key discussion points were:

9.1 **Increased access to information, statistics, and evidence is crucial** for engagement at the state level. Effectively engaging key stakeholders and professional bodies, especially those in the health sector, requires strong and relevant evidence in order to make a convincing case for the importance of investing in nutrition. Documenting and disseminating that evidence is also essential.

9.2 **Clear messages are needed around the importance of nutrition and increased awareness that nutrition is not only about food**. The nutrition community talks to itself but does not communicate effectively to a broader audience. Nutritionists tend to discuss numbers and statistics but what really resonates with people are personal stories about individual children and families. Because the nutrition community has not done a good job of communicating messages about nutrition to a broader audience, the majority of people think nutrition is only about food and do not realise that nutrition is much more complex.

9.3 **Increasing awareness about nutrition at all levels, from the national government all the way to the individual level, is necessary**. Focusing advocacy efforts on opinion leaders, community leaders, traditional leaders and religious leaders is essential, so that they understand what nutrition is and its importance. However, awareness raising must not stop there, and efforts must be made to reach out to all members of the community.

9.4 **An aggressive behaviour change communication strategy is necessary to achieve change**. The target group for nutrition interventions must be children under five as well as pregnant and lactating women in order to break the intergenerational cycle of malnutrition. Women need to know what they should eat and what to feed their children but also correct infant feeding practices, and the importance of hygiene and seeking health care. The behaviour change communication (BCC) strategy cannot only target women but must also include fathers, husbands, grandmothers, mothers-in-law and other community members who influence child nutrition.

9.5 **Strengthen institutions.** Government institutions in Northern Nigeria need to be strengthened to enable long-term and sustained improvements in nutrition.

9.6 **Long term commitment to adequate budget allocation and disbursement is needed**. In order to achieve long term improvements in nutrition, commitment to adequate budgets and timely release of these funds is key. All of the elements articulated by panellists: better information, evidence and statistics, changed behaviours and stronger institutions, will require adequate and reliable funding.

9.7 **Gender relations, women's decision making power and female education are essential for nutritional improvements**. Children's nutrition status, female education levels, and levels of decision making power are strongly linked, with increased female education and decision making power correlated to reduced levels of child undernutrition. Improving social and economic circumstances for women, and supporting them to earn incomes, will increase their power over decision making within the household.

9.8 **Innovations and complementarity of nutrition specific and nutrition sensitive interventions**. To achieve real improvements in nutritional outcomes, nutrition specific interventions alone will not be enough. Nutrition sensitive interventions in areas such as water and sanitation and agriculture must also be integrated into efforts to improve nutrition.

Day Two:

10 **Health Facilities Survey**

Given that CMAM is one of the largest cost-drivers of the WINNN programme, the health facilities survey was administered to capture some of the complexity around CMAM costs as well as to understand some of the key accomplishments and challenges for health facilities delivering CMAM services.

10.1 **Methodology**

The survey was conducted in all WINNN LGAs. One stabilisation centre and two facilities providing outpatient care (OTPs) were visited in each LGA. Within each facility, three separate surveys were used to collect data: one for the facility, one for community volunteers, and one for caregivers. The results represent a "snap shot" of what was happening in facilities in August 2015.

10.2 **Preliminary findings**

For collecting data on child nutritional status, mid upper arm circumference (MUAC) tapes are available at all clinics, and consistently used, but other equipment such as thermometers and scales were often not working or not available. Other infrastructure was variable, for example, most OTPs had access to an improved water source, however hygiene practices were often weak – with less than half the caregivers reporting washing their own or their child's hands – and many of the OTPs did not have reliable access to electricity. In terms of reference material, a CMAM protocol was available in most OTP centres**,** as well as IYCF materials. However less than half of mothers reported receiving IYCF counselling at that day's visit. The availability of commodities was mixed. Almost all OTPs had RUTF available, but there were often stock-outs of key drugs such as amoxicillin.

For stabilisation centres, availability of clean water and soap was a key challenge, as were stock outs of F75 and F100 therapeutic milk products.

11 IYCF recommendations and how to motivate improved IYCF practice

The ORIE operations research on IYCF recommendations and how to improve IYCF practices sought to understand if the practices that were being promoted through WINNN were realistic, and understood by mothers in Northern Nigeria. Additionally, it sought to understand if mothers were able to actually implement some of the key recommendations, including feeding children a variety of foods, increasing the frequency of feeding, and hand washing.

11.1 Findings:

11.1.1 **There is a need to come up with a meaningful concept of dietary diversity in Hausa.** There are no names in Hausa for the concepts of different IYCF food groups, such as staple foods, legumes, fruit and vegetables. Mothers do not attribute unique health benefits to a particular food group to justify why they should feed a specific food to a child, and found it challenging to sort foods by food group. Without a concept of food groups, and an understanding of the different health benefits of food from different food groups, the concept of dietary diversity is not meaningful to mothers.

11.1.2 **Dietary practices can improve based on IYCF counselling.** Mothers were able to feed their babies more legumes, eggs and other fruits and vegetables over a period of two weeks following IYCF counselling. Mothers who participated in the study, which included one IYCF session and three interactive discussions with the research team in a two-week period, reported seeing an increase in the child's appetite and energy levels, and said that their child enjoyed the new foods and handwashing practices. Mothers found resource constraints did not prevent them from practising the IYCF recommendations, knowing they could choose between foods within a food group if something was too expensive or unavailable and could choose foods that their child liked.

11.1.3 **Target fathers to make a commitment to providing a variety of foods for their children.** Fathers are responsible for household food purchases so their commitment and support for improved IYCF practices is critical.

11.1.4 **Support development of small businesses for mothers.** Mothers who had an independent source of income were confident of sustained improvements in IYCF practices; whereas other mothers identified it as a strategy to support sustained practice.

12 Exclusive breastfeeding and early initiation

The ORIE operations research on EBF sought to understand how to improve the rate of EBF, specifically which groups should be targeted and with what messages, as well as how the Hausa term for EBF is understood by the community. The research was carried out in two types of communities: those which WINNN identified as places where IYCF practices are changing quickly, as well as those communities where WINNN feels practices are slower to change.

12.1 Findings:

12.1.1 **Develop a Hausa term for EBF that better encapsulates the full meaning and consider a term for late EBF.** In those communities where IYCF practices were changing, there was a reasonable understanding that EBF meant that the child should be given no solids or herbs, but participants did not realise that dates or holy water should also not be given. In communities where practices were slower to change, people thought that EBF meant only not giving water or simply referred to promoting breastfeeding more generally. Additionally, most care givers thought that they could not transfer to EBF if the child had already been given solids, animal milk or water, so they continued these practices. Developing a term to show that you can still choose to only exclusively breastfeed your child, even if s/he has already been given other liquids or solids is therefore important. Key target groups for this are mothers as well as older female relatives including mothers-in-law and grandmothers.

12.1.2 **Strengthen messages on the water content of breastmilk.** Views expressed in the research indicated that people feared that not giving water to the child would lead to dehydration and potential death and that it was wicked to deny a child water. Key target groups for messaging on the water content of breastmilk are mothers and older female relatives.

12.1.3 **Integrate the showcasing of healthy EBF babies in IYCF advocacy.** Seeing the benefits of EBF is key for caregivers. While health workers tended to be the initial source of information on EBF, caregivers only became convinced of the benefits of EBF when they saw a healthy, chubby, exclusively breastfed baby in their community. There is also a growing acceptance of early initiation of breastfeeding, largely because women have seen that it helps with the removal of the placenta.

12.1.4 **Increase the targeting of men and develop specific materials for this.** While men are not present in the post-natal setting, they are significant influencers in terms of introducing early solids. Once men become convinced of the benefits of EBF, they have often become advocates in the community.

12.1.5 **Develop an advocacy approach for older women.** Older female relatives have a strong influence on neonatal feeding, as mothers live with them in the post-natal period. Their influence is particularly strong over adolescent and younger mothers, who tend to have less power over neonatal decisions. There have been some difficulties changing the traditionally held beliefs of older women.

13 **Promoting women's attendance at antenatal care.**

This ORIE operations research sought to understand who influences women's attendance at ANC and to understand what benefits of ANC are most important to beneficiaries.

13.1 **Key findings:**

Overall there was a good uptake of ANC services in most communities. In communities where attendance was lower, this was usually due to challenges in accessing ANC either because there was no health centre in the community or the centre was far away, or a woman had a previous bad experience at the clinic, including bad attitudes and behaviour of health workers and long queues.

13.1.1 **Develop a targeted advocacy strategy specifically for adolescent girls**. Adolescent girls during their first pregnancy are least likely to attend ANC due to being shy and

embarrassed about their pregnancy as well as having a fear of drugs or injections at the health centre and weaker knowledge of ANC and benefits of attending. One potential solution could be to have small group sessions for adolescent mothers where they could discuss some of their fears and receive support from their peers as well as trained health workers.

13.1.2 **Develop messages to improve women's understanding that some pregnancy problems cannot be felt by the mother and that regular monitoring is necessary**. Some women believe that health facilities are only for health problems. Older women, in particular are proud of their strength and ability to manage their pregnancy without help, thereby perceiving this to save their family the trouble and expense of paying for ANC.

13.1.3 **Targeted messages for men could explicitly encourage men to financially support their wives to attend ANC.** Men tended to focus on the positive development outcomes for the child, so focusing on these in messages could be an effective strategy for engaging men. Imams, town announcers and radio are the best way to reach men.

13.1.4 **WINNN could consider working with other donor programmes to increases access to ANC through mobile ANC clinics and health worker training.** While some of the structural and systems challenges are beyond the remit of WINNN, such as long distances to ANC clinics, WINNN could work with other programmes to introduce solutions such as mobile ANC clinics.

14 Group work

In the final session of the day, participants broke into five groups: one for each of the WINNNN States - Katsina, Kebbi, Yobe, Zamafara and Jigawa – and a Federal level group. The groups were tasked with identifying key actions that members of the group would take in the next six months, based on the evidence presented at the meeting.

All delegates committed themselves to a series of actions summarised as follows:

1. ***Share learning from the two days with key stakeholders in the WINNN states to better inform them of issues surrounding malnutrition.***
2. ***Establish and strengthen multi-sectoral coordination of nutrition interventions.***
3. ***Develop and approve costed five-year nutrition strategic plans in all the states.***
4. ***Increase activities to prevent malnutrition, including a greater focus on the promotion of infant and young child feeding practices.***
5. ***Intensify advocacy and community mobilisation to political, traditional and religious leaders for improved funding and increased uptake of nutrition interventions.***

The key prioritised actions for each group are presented below:

14.1 Federal Level

The role of the Federal level is to develop policies and guidelines which guide actions at sub-national levels. As such, those who are working at the Federal level identified the following actions as key to take forward over the next six months:

a) **Approval of the revised National Policy on Food and Nutrition.** Once the policy is approved at the national level, an implementation plan can be developed and states can domesticate the plan and develop their own costed implementation plans.
b) **High level advocacy directed at influencing people in positions of power including the President and state governors.** Advocacy directed at this level of stakeholder was felt by group members to have the greatest impact in terms of influencing key decisions such as budget allocation and disbursement.
c) **Coordination of interventions of all relevant stakeholders.** Participants also felt that coordination of all stakeholders relevant to nutrition is something that is currently weak, and felt those working at the Federal level were best placed to develop robust coordination mechanisms.
d) **A series of specific actions that will be taken by national organisations:**
    - **Civil Society Scaling Up Nutrition in Nigeria network (CS-SUNN)** – advocate for nutrition action to the National Assembly, drawing on evidence from Kebbi and elsewhere. This initiative will be highlighted in CS-SUNN's newsletter.
    - **NPHCDA** - committed to scaling up the baby friendly hospital initiative, drawing on evidence on the importance of EBF.
    - **FMoH** - committed to mobilise communities on breastfeeding.
    - **National Institute for Policy and Strategic Studies** - committed to focus on high level policy advocacy especially on issues of funding for nutrition.
    - **National Nutrition Council** - committed to developing an effective social marketing communication strategy, drawing on successful examples from other sectors including HIV.

14.2 Katsina State

The members of the group from Katsina prioritised the following actions over the next six months:

a) **Dissemination of ORIE findings** by organising a meeting with the Commissioner for Health and other key stakeholders.

b) **Advocate for adequate funding for nutrition**. The budget planning starts in August, thus budget advocacy must start before then.

c) **Promotion of IYCF**. Especially targeting Imams, grandmothers, husbands and other key community members who influence IYCF.

Additional priorities, in the longer term, include focusing efforts on improved training, and retention of health workers, particularly amongst the lowest cadres of health workforce, as a capacitated workforce is critical to be able to provide high quality, integrated nutrition services. Additionally advocacy for adequate funding for nutrition for the strategic plan, and ensuring that the nutrition budget is released, were identified as priorities.

14.3 Kebbi State

The members of the group from Kebbi identified the following actions which they will take over the next six months:

a) **Hold regular quarterly meetings of the State Food and Nutrition Committee** to address current and emerging issues. The chairman and the secretary of the committee will be

responsible for ensuring that these meetings happen regularly. Additionally, expanding membership of the committee to include the legislature and other key stakeholders will also be a priority.

b) **Improve human resources for nutrition.** There is a need to strengthen the availability and quality of training of nutritionists and other health workers in the state. The Ministry of Education is responsible for developing more courses and improved curricula to ensure a well capacitated workforce.

c) **Awareness raising** about the importance of nutrition, using multiple channels including religious and other traditional leaders, as well as the media.

d) **Advocacy for a nutrition budget line at the LGA level.**

14.4 Jigawa State

The members of the Jigawa group identified the following actions which they will take over the next six months:

a) **Increased prioritisation of IYCF**. Key next steps for this are institutionalising the baby friendly hospital initiative at all levels to support EBF, as well as ensuring that IYCF counselling is integrated into CMAM care.

b) **Sustainable scale-up of CMAM in Jigawa LGAs**, including those which currently have no CMAM provision. One way to support the scale-up of CMAM services is to develop a "CMAM centre of excellence" to demonstrate best practices within each LGA.

14.5 Yobe State

The members of the group from Yobe identified the following actions which they will take over the next six months:

a) **High level advocacy to policymakers, religious and traditional leaders** to increase budgetary allocation and timely release of funds for nutrition.

b) **Scale up nutrition interventions from 12 LGAs to 17 LGAs** and expansion of nutrition interventions within the existing 12 LGAs with additional support from development partners.

c) **Put in place a mechanism for continuity of ownership and sustainability**, led by the Chairman of the State Food and Nutrition Committee.

d) And, within a longer timeframe, **develop a five year multi-sectoral strategic plan for nutrition**.

14.6 Zamfara State

The members of the Zamfara group identified the following actions which they will take over the next six months:

a) **Share key findings from the ORIE research** with Zamfara nutrition stakeholders using established platforms for engagement.

b) **Utilise the media,** especially health journalists, to promote IYCF.

c) **Develop an action plan to scale up IYCF** through state-wide group of at least 10 people per ward. The first element of the state-wide action plan would be an activity to educate caregivers, husbands and grandmothers on IYCF in six LGAs where CMAM activities are being implemented.

15. Next steps

The two day event provided a useful platform for engagement between critical nutrition stakeholders at Federal and State levels, and contributed to the necessary strengthening of the interface between research, policy and implementation for nutrition.

The event reinforced leadership and secured commitments to action by Federal and State government. Commitments made during the event will be monitored and supported to ensure they translate into immediate and sustained actions.

Participants highlighted the value and importance of sharing findings and recommendations from ORIE research beyond Abuja to key stakeholders at State and LGA levels. Subsequently, the Ministry of Budget and National Planning, WINNN, and ORIE will be hosting a series of dissemination meetings in the five WINNN intervention states during May and June 2016 to diffuse the learning more widely.

Annexes:

1) **Event agenda:**

Tuesday 1 March 2016

Time	Activity	Lead(s)
09.00 – 09.10	Introductions.	ORIE NTL
9.10 - 9.20	Welcome remarks	DFID Country Representative
9.20-9.30	Chairman's Opening Remarks	Hon. Minister, MB&NP
09.30 – 9.45	Goodwill messages	- Permanent Secretary, FMOH -Executive Secretary, NPHCDA - President, Nutrition Society of Nigeria
09.45 – 10:45	Setting the scene: introducing ORIE, framing the nutrition context in Northern Nigeria, and highlighting what works best to improve nutrition, including Q&A	ORIE ITL
10.45 – 11.15	**Tea Break**	**All**
11.15 – 11.45	From promises to progress: assessing Nigeria's nutrition commitments – findings from the qualitative midline evaluation, including Q&A.	Qualitative evaluation team member
11.45 – 12.15	Costing nutrition services: implications for sustainability, including Q&A.	Economic evaluation lead
12.15 – 12:45	The critical role of gender: evidence from across ORIE	ORIE gender lead
12.45 - 14.00	**Lunch**	**All**
14.00 – 15.30	Panel discussion. Using evidence for considering scaling up nutrition action in Nigeria: what next?	3-4 on panel. Head of Nutrition, FMOH ORIE ITL FGN representative(s)

		State Commissioner(s) of Health
15.30 – 15.40	Looking ahead to Day Two	WINNN NPM
15.40 – 16:00	Summing up and thanks	NPHCDA Director, CHS

Wednesday 2 March 2016

Time	**Activity**		**Lead(s)**
09.00 – 09.10	Welcome. Programme overview.		ORIE NTL
09.10 – 09.30	Overview of Day One		ORIE ITL
09.30 – 10.00	Findings from a health facility survey, including Q&A.		Economic evaluation lead
10.30 – 11.00	Complementary feeding – findings from operations research, including Q&A		Operations Research (OR) team member
11.00 – 11.30	**Break**		**All**
11.30 – 12.00	Exclusive breastfeeding and early initiation, including Q&A		OR team member
12.00 - 12.30	Promoting women's attendance at ANC, including Q&A		OR team member
12.30 - 13.30	**Lunch**		**All**
13.30 - 13.40	Introducing the group exercise		UNICEF Nutrition Chief
13:40 – 14:45	Group work: discussion on ORIE findings Questions: 1. What are the key messages from these findings? 2. What actions could/should be taken on the	Group 1: ANC	Lead: State Commissioner Facilitator: WINNN (NPM)
		Group 2: EBF	Lead: State Commissioner Facilitator: UNICEF (Nutrition Chief)
		Group 3: Religious leaders	Lead: State Commissioner

	basis of these findings?	& IYCF	Facilitator: MB&NP (Head of Nutrition)
		Group 4: Complimentary feeding	Lead: State Commissioner Facilitator: FMOH (Head of Nutrition)
14:45 – 15:15	**Break**		**All**
15:15 – 16:15	Feedback to Plenary from Group discussions: key issues, discussions points, & actions		State Commissioners (15 mins each)
16.15 – 16.45	Q&A, Summing Up		ORIE (ITL)
16.45 – 17:00	Vote of thanks & Closing		MB&NP (Director, Economic Growth)

2) Delegate list:

S/N	Name	Position & Organisation
1	Aliyu Galadima Libata	State Nutrition Officer, Kebbi
2	Hussaini Maisamari Yelusa	Rep. Permanent Secretary, Kebbi Ministry of Budget & Eco. Planning
3	Yusuf Muhammad Gunu	SCI Field Manager, Kebbi
4	Tom Barker	Senior Health & Nutrition Convenor, ORIE/IDS
5	Olufolakemi Anjorin	Program Office, Micronutrient Initiative
6	Sani Muhammed Bunza	Rep. Permanent Secretary, Kebbi Ministry of Health
7	Babangida Usman	PRO, Jigawa State House of Assembly
8	Dr. David Ojo	Director, NHORT
9	Dr. Mohammed Liman	NPM, SCI/WINNN
10	Prof. Andrew Tomkins	ORIE, International Team Leader
11	Adetunji Falana	Nutrition Officer, UNICEF
12	Kat Pittore	Nutrition Convenor. IDS/ORIE
13	Abdullah Magama	State Technical Advisor, Action Against Hunger
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150	**James Bigila**	**Media Coordinator, Save the Children**
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3) Communique:

COMMUNIQUÉ OF THE NUTRITION RESEARCH FINDINGS AND STAKEHOLDER ENGAGEMENT EVENT

Abuja, Nigeria, 1-2 March 2016 - Representatives from Federal Government, State Governments, development partners, civil society and academia met on 1st and 2nd March 2016 at the FGN-DFID-WINNN-ORIE Nutrition Research Findings and Stakeholder Engagement Event. The delegates:

Understood that, as a result of malnutrition, 58% of children under five in Katsina, Kebbi, Jigawa, Zamfara and Yobe suffer from stunting, meaning their physical and mental development have been impaired. An estimated 370,000 children with severe acute malnutrition (SAM) in these states will require lifesaving treatment this year[4]. Without such treatment, some 70,000 of these children are likely to die. Furthermore, Only 6% of children aged less than 6 months are exclusively breastfed, compared with 17% nationally.[5]

Recognised the achievements thus far of the UK Department for International Development funded Working to Improve Nutrition in Northern Nigeria (WINNN) programme in Katsina, Kebbi, Jigawa, Yobe, and Zamfara.

Commended Federal and State Government and partner commitment to addressing the challenge of malnutrition, including increased efforts to identify and treat children with SAM, running Maternal Newborn and Child Health Weeks, and procuring nutrition commodities.

Recommended that the prevention of malnutrition should be a matter addressed more widely than present, involving coordination with ministries of health; agriculture; women's affairs and social development; and water resources.

Declared that for sustained action to improve the nutrition, health and future prospects of women, adolescent girls, and children in Northern Nigeria, all levels of government should provide greater leadership and accountability, better coordination, enhanced institutional capacity, and increased and more transparent funding to scale up the lessons learned from the WINNN programme.

In response, and in light of the new evidence shared during the event, all delegates committed themselves to a series of actions summarised as follows:

1. **Share learning from the two days with key stakeholders in the WINNN states to better inform them of issues surrounding malnutrition.**

2. **Establish and strengthen multi-sectoral coordination of nutrition interventions.**

3. **Develop and approve costed five year nutrition strategic plans in all the states.**

4. **Increased activities to prevent malnutrition, including a greater focus on the promotion of infant and young child feeding practices.**

5. **Intensify advocacy and community mobilisation to political, traditional and religious leaders for improved funding and increased uptake of nutrition interventions.**

[4] SMART Survey, Federal Government of Nigeria, 2015.

[5] MICS, FGN, 2011; NDHS, FGN, 2013.

4) **Media release:**

PRESS RELEASE

Prevention is key to reducing child malnutrition in northern Nigeria

More than half of the children in five northern states suffer severe effects of malnutrition

Abuja, 3 March 2016 – Taking action to address the root causes of child malnutrition is key to reducing the staggeringly high rate of child malnutrition in northern Nigeria, a group of experts from Federal and State Governments, development partners, civil society and academia announced in Abuja this morning.

The experts were concluding a two-day meeting to discuss the results of research on activities carried out by the Working to Improve Nutrition in Northern Nigeria (WINNN) programme in the states of Katsina, Kebbi, Jigawa, Yobe, and Zamfara.

As a result of malnutrition, 58 per cent of children under five in these states suffer from stunting, meaning their physical and mental development have been impaired. An estimated 370,000 children with severe acute malnutrition in these states will require lifesaving treatment this year. Without such treatment, some 70,000 of these children are likely to die.

While treatment for severe malnutrition remains essential and has been the focus of State Governments activities, the participants at the WINNN meeting said increased attention should be paid to prevention, which is critical to addressing the problem in the long term. Research presented at the meeting confirmed that many mothers do not understand the importance of excusive breastfeeding. Even giving water to a baby under six months old can lead to illnesses and malnutrition.

The WINNN group of experts recommended increasing activities to prevent malnutrition, such as encouraging women to attend health facilities for antenatal and postnatal care where they can be given guidance on how to best feed their children, especially the most vulnerable children under two years old. Husbands, families and community members, including traditional and religious leaders, all have a role to play, the experts agreed, and should be informed about how best to encourage and support women to breastfeed exclusively and to appropriately feed the child up to 2 years. Communities should be educated about problems with harmful traditional feeding practices that can reduce an infant's growth and development, and messages on good feeding practices should be carried on the radio, the experts agreed.

The experts also recommended that preventing malnutrition should be a matter addressed at a wider level than present, involving coordination with ministries of health; agriculture; women's affairs and social development; and water resources. They also called for greater training and deployment of health workers.

Applauding the increase in State and Federal Government and partner commitment to resolving the problem of child malnutrition over the past several years, as well as the more than US$49.7 million investment by the United Kingdom Department for International Development (DFID) in the WINNN programme since its inception in 2011, the participants at the meeting highlighted the need for all stakeholders to invest further.

They called on all levels of government to provide greater leadership, better coordination and increased transparent funding to scale up the lessons learned from the WINNN program, providing sustained action to improve the nutrition, health and future prospects of women, adolescent girls, and children in northern Nigeria.

The WINNN program, implemented by the Nigerian Government with support from UNICEF, Save the Children and Action Against Hunger, is funded by DFID and works in 3 LGAs in each of the 5 states.

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Notes to Editors:

- The Operational Research and Impact Evaluation (ORIE) project is an independent component of the UK Department for International Development (DFID) funded Working to Improve Nutrition in Northern Nigeria (WINNN) programme. ORIE is carrying out research to determine the impact of WINNN and generates important research on key evidence gaps regarding solutions to undernutrition in northern Nigeria.

- The UK Department for International Development (DFID) funded the Working to Improve Nutrition in Northern Nigeria (WINNN) programme is providing treatment of malnutrition, including Community-based Management of Acute Malnutrition (CMAM), vitamin A supplementation and deworming, and promoting improved infant and young child feeding (IYCF) practices, with the aim of benefiting 6.2 million children under five across five states (Kebbi, Katsina, Jigawa, Zamfara, Yobe) in northern Nigeria.

- The Federal Government of Nigeria signed up to the Scaling-up Nutrition (SUN) movement in 2011 and signed the Global Nutrition for Growth Compact in 2013. In doing so, it committed itself to tackling its high rates of child malnutrition. Action requires significant political commitment, government funding, effective coordination and planning at all levels and sectors, as well as civil society (CSO) and community engagement.

- More information about nutritional status and other indicators can be accessed through the Nigeria country profile revised annually by the Global Nutrition Report: http://ebrary.ifpri.org/utils/getfile/collection/p15738coll2/id/129994/filename/130205.pdf

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