



Photos courtesy of the David and Lucile Packard Foundation (left and center) and Oluseyi Akintola (right)

NIGERIA

SERVICE PROVISION ASSESSMENT OF NUTRITION SERVICES AND SUPPORT

Federal Capital Territory, Nigeria

JANUARY 2011



USAID
FROM THE AMERICAN PEOPLE

www.iycn.org

IYCN USAID's Infant
& Young Child
Nutrition Project

This document was produced through support provided by the United States Agency for International Development, under the terms of Cooperative Agreement No. GPO-A-00-06-00008-00. The opinions herein are those of the author(s) and do not necessarily reflect the views of the United States Agency for International Development.

IYCN is implemented by PATH in collaboration with CARE;
the Manoff Group; and University Research Co., LLC.

455 Massachusetts Avenue NW, Suite 1000
Washington, DC 20001 USA
Tel: (202) 822-0033
Fax: (202) 457-1466
Email: info@iycn.org
Web: www.iycn.org

Acknowledgments

The Infant & Young Child Nutrition (IYCN) Project is grateful to a number of people who made this report possible. We thank Dr. Victor Ajieroh, the principal investigator, and his research team. We also thank the Federal Ministry of Health, Department of Public Health of the Federal Capital Territory Administration, for significant contributions to the assessment. Additionally, we thank representatives from a variety of government agencies and other organizations as well as facility managers and health workers for taking the time to present their insights during the interviews. Finally, we are very grateful to the mothers and pregnant women who generously shared their insights and experiences during the exit interviews.

Contents

Acknowledgments	ii
Acronyms	vi
Executive summary.....	1
Introduction.....	7
Methodology	9
1. Data collection.....	9
2. Location and selection of facilities.....	10
3. Recruitment of study participants	11
4. Ethics	11
Observations and findings.....	13
1. National-level stakeholders and coordination of nutrition and related activities in Nigeria.....	13
1.1 Nutrition Division of the FMOH	13
1.2 Major NASCP nutrition activities and relationship with the FMOH Nutrition Division.....	14
1.3 Nutrition coordination.....	14
1.4 National-level contributions to supervisory and monitoring functions/visits.....	15
1.5 Policy framework and guidelines for national stakeholders in implementing nutrition programs.....	16
1.6 Nutrition-related tools at the national level	16
1.7 Perspectives of national stakeholders for filling gaps in infant and nutrition services in Nigeria.....	16
2. State or FCT-level stakeholders and nutrition and related programming.....	17
2.1 FCTA Public Health Department.....	17
2.2 FCT-supported community outreach to improve health and nutrition	18
2.3 Nutrition monitoring and supervision at the state/FCT level.....	18
2.4 Coordination of nutrition and related activities at the state/FCT level.....	19
2.5 Perspectives of state-level stakeholders on filling gaps in nutrition services in the FCT	19
3. Area council contributions to nutrition-related services.....	20
3.1 Key nutrition and related activities in the area councils	20

3.2 Perspectives of area-council-level stakeholders on filling gaps in nutrition services in the FCT	21
4. Facility-level nutrition services.....	22
4.1 Overview of health facilities	22
4.2 Infant feeding and counseling in HIV and non-HIV contexts at the facilities	23
4.3 System of identifying infants lost to follow-up.....	26
4.4 Community outreach activities.....	27
4.5 Home visits.....	27
4.6 Awareness campaigns	27
4.7 Support groups	28
4.8 Community meetings	28
5. Nutrition training and supervision for health workers.....	28
6. Perspectives of health workers and facility managers on filling gaps in infant, young child, and maternal nutrition services	29
6.1 Improving the nutrition counseling environment	29
6.2 Increasing the number of qualified staff and training in nutrition for all service providers	29
6.3 Nutrition education and BCC to improve maternal nutrition	30
6.4 Use of broader measures to address hunger and poverty in target communities and project areas	30
7. Client perspectives on nutrition service delivery from exit interviews with mothers ...	30
8. OVC services at national, FCT, and area council levels.....	31
8.1 National-level stakeholders and coordination of OVC and nutrition-related activities in Nigeria.....	31
8.2 Supervision of OVC services.....	32
8.3 Overview of food and nutrition services in the context of OVC programming in Nigeria.....	32
8.4 Highlights of OVC operations in the FCT.....	33
8.5 Christian Aid.....	34
8.6 Winrock.....	35
8.7 CACA	37
8.8 Opportunities to improve food and nutrition services for OVC	39
Key directions, conclusions, and recommendations	40
1. Status of nutrition-related activities in Nigeria.....	40
2. Key recommendations	42

Annex 1. List of persons interviewed45

Acronyms

AIM	AIDS Impact Mitigation
AMAC	Abuja Municipal Area Council
ASWHAN	Association of Women Living with HIV/AIDS in Nigeria
BCC	behavior change communication
BFHI	Baby-Friendly Hospitals Initiative
BMS	breastmilk substitute
CACA	Catholic Action Committee on AIDS
CBO	community-based organization
CHEW	community health extension worker
CIDA	Canadian International Development Agency
CMAM	community-based management of acute malnutrition
CRS	Catholic Relief Services
FACA	FCT Action Committee on AIDS
FCT	Federal Capital Territory
FCTA	Federal Capital Territory Authority
FHI/GHAIN	Family Health International Global HIV/AIDS Initiative Nigeria
FMOH	Federal Ministry of Health
IEC	information, education, and communication
IYCN	Infant & Young Child Nutrition Project (USAID's flagship project)
LGA	local government area
M&E	monitoring and evaluation
MARKETS	Maximizing Agricultural Revenue and Key Enterprises in Targeted Sites Project
MCH	maternal and child health
MNDC	micronutrient deficiency control
MWASD	Ministry of Women Affairs and Social Development
NASCP	National HIV/AIDS and STD Control Program
NCFN	National Committee on Food and Nutrition
NGO	nongovernmental organization
NIS	Nutrition Information System
OVC	orphans and vulnerable children
PEPFAR	President's Emergency Plan for AIDS Relief
PHD	Public Health Department

PLHA	people living with HIV/AIDS
PMTCT	prevention of mother-to-child transmission of HIV
RAPAC	Redeemed Aid Program Action Committee
SOP	standard of practice
UNICEF	United Nations Children's Fund
USAID	US Agency for International Development
WHO	World Health Organization

Executive summary

The Infant & Young Child Nutrition (IYCN) Project is the flagship project on infant and young child nutrition of the US Agency for International Development (USAID). Begun in 2006, the five-year project aims to improve nutrition for mothers, infants, and young children and prevent the transmission of HIV to infants and children. IYCN builds on 25 years of USAID leadership in maternal, infant, and young child nutrition. Our focus is on proven interventions that are effective during pregnancy through the first two years of life. In Nigeria, IYCN provides technical assistance to the Federal Ministry of Health to strengthen services for postnatal infant nutrition in programs for prevention of mother-to-child transmission (PMTCT) of HIV that are supported by the President's Emergency Plan for AIDS Relief. As part of this support, IYCN aims to improve the quality of nutrition service delivery, particularly infant feeding counseling and support.

IYCN conducted this service provision assessment to examine support for maternal, infant, and young child nutrition services provided by federal, state, and local governments in Nigeria. In addition, the study assesses nutrition services provided by select health facilities and orphans and vulnerable children (OVC) partners in the Abuja Municipal Area Council (AMAC) and the Kwali Area Council of the Federal Capital Territory (FCT), Abuja.

The objectives of the assessment were to:

1. Describe existing PMTCT, OVC, and nutrition services targeting women and children at both primary and secondary health care levels.
2. Examine state and local government technical capacity and supervisory support for nutrition services at PMTCT sites and through OVC partners.
3. Assess the quality of nutrition counseling and support provided at PMTCT sites and OVC clinics.
4. Examine the process of how nutrition services are currently delivered at PMTCT sites and provide suggestions for improvement.
5. Understand the current level of nutrition support (beyond provision of food) provided by OVC partners and provide suggestions for integrating and strengthening nutrition messages into their current programs.
6. Identify gaps in nutrition support services at the community, facility, and governmental levels and provide suggestions for improvement.

IYCN selected two of the six area councils in the FCT for study: the AMAC, which is urban, and the Kwali Area Council, which is comparatively rural. The AMAC-based study collected data from Asokoro General Hospital and the Sisters of Nativity Primary Healthcare Centre in Jikwoyi. The Kwali Area Council study collected data from Kwali General Hospital and the Yangoji Primary Healthcare Centre.

All OVC programs studied in this assessment were associated with AMAC. The OVC services studied were those supported by the Catholic Relief Services and Family Health International Global HIV/AIDS Initiative Nigeria (FHI/GHAIN) through the Catholic Action Committee on AIDS (CACA) in Durumi, the Winrock-supported OVC services through the Redeemed Aid Program Action Committee (RAPAC), and the Christian Aid-supported OVC

services through the Association of Women Living with HIV/AIDS in Nigeria (ASWHAN)/Unique Aid.

The IYCN team used five methods to collect data: structured and semistructured interviews with health workers, facility managers, and government officials; exit interviews with mothers; facility counseling observations; focus group discussions and in-depth interviews with mothers and caregivers at health facilities; and semistructured interviews with community-based OVC care providers. Some of the interviews involved national-, FCT-, and area council-level officers. Subjects were drawn from the Nutrition Division of the Federal Ministry of Health (FMOH), the Ministry of Women Affairs and Social Development (MWASD), the Health and Human Services Secretariat/FCT Authority Public Health Department, PMTCT and nutrition units, the National AIDS and STD Control Program (NASCP), and local area councils in Abuja and Kwali. Interviews of these stakeholders helped provide national perspectives on the key concerns of the study and allowed the exploration of linkages across the three tiers of government: federal, Federal Capital Development Authority, and area councils. These interviews also highlighted opportunities for intervention and collaboration at the national level as well as the state and area council levels.

Key conclusions

Although a wide range of stakeholders are involved in the implementation and coordination of nutrition-related activities in Nigeria at various levels, there are strong indications of a long absence of leadership in the field of infant and young child feeding programs. While overall coordination of nutrition activities in Nigeria lies structurally with the National Committee on Food and Nutrition (NCFN), PMTCT and nutrition-related activities are coordinated by NASCP and the Nutrition Division of the Federal Ministry of Health. The Federal Capital Territory Authority (FCTA) coordinates all state activities in the FCT, but there are no indications of functional multisectoral structures for nutrition coordination at the area councils.

Infant and young child feeding counseling

Across all the facilities, the antenatal care and some of the key contact points in the PMTCT and maternal and child health (MCH) services process present ample opportunity to provide infant and young child feeding and maternal nutrition counseling. Counseling currently provided to mothers varies across facilities and in many cases does not reflect current guidelines. Most of the advice given to mothers at the facilities studied corresponded to the 2001 WHO guidelines related to infant feeding in the context of HIV. Complementary feeding counseling receives significantly less attention than breastfeeding counseling. There are limited resources for providing on-site cooking demonstrations that would be helpful in teaching mothers how to appropriately prepare foods at home.

The overall counseling environment in most facilities is less than satisfactory. Group counseling or health talks for HIV-negative women are generally the norm. Having updated, technically correct and engaging individual and small-group counseling materials; take-home materials for mothers and caregivers; cooking demonstration tools; and detached, dedicated, and conducive counseling spaces would greatly improve infant and young child feeding counseling in some of the facilities.

PMTCT sites: Identifying infants lost to follow-up

Most follow-up actions seem to be linked to missed scheduled immunizations. Facilities seem to have good systems for following up with HIV-positive mothers who miss an appointment (these mothers are contacted by phone and sometimes visited by home-care nurses, neighbors, or support group members). However, there are no apparent systems for identifying or tracking infants of HIV-negative mothers who are lost to follow-up (with the exception of missed immunization visits). Home visits for HIV-positive mothers are common at most facilities. Such visits encourage clients to return for services.

Training and nutrition communication

Currently, the availability and use of relevant behavior change communication (BCC) materials are quite low across the facilities, and the available materials lack up-to-date information. Thus, BCC materials present an important opportunity for intervention. Training of health staff on nutrition counseling, education, and BCC is inadequate in terms of intensity, duration, frequency, and appropriateness of training contents. Also, there is a need for more qualified staff, including nutritionists and dietitians, nurses, doctors, community health extension professionals, and social workers. It is important for the nutrition teams at the federal, FCTA and area council levels to become more involved in nutrition issues relevant to HIV and OVC.

Maternal nutrition

Maternal nutrition is a neglected aspect of the nutrition program, with facilities providing only limited services. There are no targeted initiatives to improve maternal nutrition. It is important to stress that infant and young child nutrition begins with the mother. Thus, maternal health and nutrition conditions are important influencing factors that deserve attention.

Supervisory and monitoring functions

Supervision and monitoring of nutrition programs are not widely done at any level of the health system. NASCP, the Nutrition Division of the FMOH, relevant FCTA departments, and the area council nutrition and health coordinators indicated significant constraints to carrying out their supervisory and monitoring and evaluation (M&E) functions. Key challenges include funding difficulties and the lack of appropriate tools for M&E and supervision. Supervision and M&E tools and processes at the national, state, and local government levels need to be clarified and strengthened.

Funding

Financial and programmatic support for promoting good complementary feeding practices is limited. Significant funding gaps remain, though a range of international development partners provide both financial and technical support to these agencies for training, development, and dissemination of information, education, and communication (IEC) materials. Government funding is usually inadequate and arrives late.

Community outreach

Forums for health talks and discussions are important tools for community outreach because they provide opportunities to provide infant and young child feeding information in different contexts. Home visits, when conducted, complement messages passed through health talks,

and they help enforce compliance with counseling, as well as encourage more community members to access health services.

OVC services

Although OVC services are implemented in an integrated manner, the Food and Nutrition Service recognizes that many households caring for OVC lack access to nutritionally adequate foods and are chronically food insecure. Nutritional counseling and support from OVC organizations appears to be limited. There are not enough nutritionists in OVC programs and service systems in Nigeria. Involving more nutritionists in OVC programs is critical to improving the quality and content of food and nutrition services within the OVC program. The food and nutrition components of OVC services in Nigeria have been identified as a huge area of need that requires significant attention.

In the past, programs provided food to many caretakers. This practice is being reviewed and has been irregular. The current emphasis is on promoting food security and improved nutrition through community-driven efforts geared at creating workable structures that would enable OVC households to meet their food and nutritional needs on a sustainable basis.

Key recommendations

Policy and guidelines

Review, update, and disseminate harmonized guidelines on infant and young child feeding in the context of HIV and on nutrition for OVC.

Training and nutrition communication

- Build the capacity of all categories of health workers to counsel on infant feeding options in HIV and non-HIV contexts through more training and supervision.
- Adapt, interpret, and communicate policies and guidelines on infant and young child nutrition to health workers in user-friendly formats to help them capture the key issues faster and enable them to pass this information on to their clients.
- Revive the Baby-Friendly Hospitals Initiative (BFHI) through reorientation workshops and meetings on the ten steps to successful breastfeeding and produce large quantities of relevant IEC materials on the ten steps to successful breastfeeding in major local languages.
- Revitalize efforts to address and improve complementary feeding practices.
- Develop and disseminate appropriate monitoring tools, supervisory checklists, and reporting forms that adequately capture infant, young child, and maternal nutrition activities and services.
- Strengthen growth monitoring and promotion activities through training, establishing functional nutrition centers, and providing materials such as posters, pamphlets, weighing scales, length boards, and height-measuring devices.

Advocacy

- Support the FCTA's nutrition unit to become properly positioned and strengthened to collaborate effectively with the PMTCT and HIV/AIDS-control teams to address and improve their provision of infant-feeding counseling.

- Help replicate the collaboration between the FMOH Nutrition Division and PMTCT agencies from the federal level down to the state and area council levels. This change would give nutritionists at the lower tiers a significant voice and role in implementing the national consensus and related policies and guidelines on infant feeding and counseling in PMTCT and HIV, as well as in other related activities.
- Take advantage of the monthly FCT-wide public-private partnership and the nongovernmental organization (NGO) forum to influence decisions, share materials, create awareness, and coordinate and collaborate on activities, and mobilize support for FCT-wide and national-level initiatives.

Supervision

Strengthen supervision and monitoring roles at all levels of government.

Integrated Community Outreach

- Support the integration of nutrition messages into community outreach programs and ensure that these programs are engaging and effective.
- Strengthen community outreach to encourage mothers to seek health services more regularly to benefit from health talks and nutrition messages at the facility level.
- Support broader developmental measures that will address hunger and poverty in communities through the linkage of agriculture, health, and nutrition. Promoting home gardens through training in the development of home gardens and seed distribution, as well as offering other household economic strengthening measures, might be alternatives to handing out foodstuffs and supplements.

Integrated OVC services and programs

- Make useful contributions to the ongoing review of the national OVC standards of practice and other relevant policy documents. This process should bring on board current thinking on how best to make the food and nutrition service component more effective in the overall OVC services framework.
- Engage the Nutrition Division at the federal level and nutrition units at FCTA and area councils in OVC programs to contribute to improving the food and nutrition services in OVC programs in general.
- Integrate nutrition education and counseling into household economic strengthening programs such as Savings and Loan Association meetings, and psychosocial support activities such as youth and kids club meetings, as well as other support group meetings.
- Build the skills of OVC partners and their affiliate organizations in the areas of nutrition in the context of HIV, infant feeding counseling, and nutrition in terms of knowledge updates, comprehensive and effective communication, nutrition assessment, growth monitoring and promotion, and supervision skills.
- Provide more support to caregivers by strengthening existing support groups in the areas of counseling, economic strengthening, and household food supplementation.
- Support dietary diversification initiatives by providing seedlings and farm implements, as well as training, to promote home gardening and household food security.

- Facilitate education and counseling on nutrition and infant and young child feeding that is targeted at improving maternal and child nutrition.
- Improve the quality and suitability of food supplements that are customized to meet the needs of infants and young children through research on local food needs and preferences of the target groups.
- Improve the system of tracking OVC lost to follow-up through more robust service delivery systems that effectively integrate the various service components while promoting faster communication, improved monitoring and reporting systems, more responsive coordination, and increased community involvement.
- Strengthen community-based support systems and support groups for nutrition services in PMTCT, MCH, and OVC.
- Train and retrain all categories of health workers in PMTCT, MCH, and OVC services.
- Develop BCC strategies and IEC materials for PMTCT, MCH, and OVC.

Introduction

The Infant & Young Child Nutrition (IYCN) Project is the flagship project on infant and young child nutrition of the US Agency for International Development (USAID). Begun in 2006, the five-year project aims to improve nutrition for mothers, infants, and young children and prevent the transmission of HIV to infants and children. IYCN builds on 25 years of USAID leadership in maternal, infant, and young child nutrition. Our focus is on proven interventions that are effective during pregnancy through the first two years of life. In Nigeria, IYCN provides technical assistance to the Federal Ministry of Health to strengthen services for postnatal infant nutrition in programs for prevention of mother-to-child transmission (PMTCT) of HIV that are supported by the President's Emergency Plan for AIDS Relief (PEPFAR). As part of this support, IYCN aims to improve the quality of nutrition service delivery, particularly infant feeding counseling and support.

IYCN conducted this assessment to examine nutrition services and support for infants, young children, and mothers at PMTCT sites and through orphans and vulnerable children (OVC) partners in the Federal Capital Territory (FCT) of Nigeria. To illuminate the national landscape for PMTCT, OVC, and nutrition services and assess gaps in nutrition service delivery, IYCN conducted interviews with federal- and state-level Ministry of Health staff and other appropriate government stakeholders, as well as members of local area councils. The results are assisting IYCN and other nutrition stakeholders to improve processes that support nutrition services for infants, young children, and mothers from the state level to the community level.

The objectives of the assessment were to:

- Describe existing PMTCT, OVC, and nutrition services targeting women and children at both primary and secondary health care levels.
- Examine state and local government technical capacity and supervisory support for nutrition services at PMTCT sites and through OVC partners.
- Assess the quality of nutrition counseling and support provided at PMTCT sites and OVC clinics.
- Examine the process of how nutrition services are currently delivered at PMTCT sites and provide suggestions for improvement.
- Understand the current level of nutrition support (beyond provision of food) provided by OVC partners and provide suggestions for integrating and strengthening nutrition messages into their current programs.
- Identify gaps in nutrition support services at the community, facility, and governmental levels and provide suggestions for improvement.

The FCT, located at approximately the geographic center of Nigeria, was established in 1976 and assumed the full status of a national capital city in 1991. It is bounded to the north and northwest by Niger State, to the northeast by Kaduna State, to the east and south by Nassarawa State, and to the southwest by Kogi State. Its total landmass of about 7,315km² is located in a region of savannah vegetation. Although it was once sparsely populated, the FCT is now the fastest-growing area in the country, with a growth rate of 9.3 percent and an

estimated population of 1.41 million (2006 census). Its residents include people of all Nigerian ethnicities.¹

The FCT has state status with six area councils that are the equivalent of local government areas (LGAs) in other states. The area councils are Abaji, Abuja Municipal Area Council, Bwari, Gwagwalada, Kuje, and Kwali.

The health care delivery system in the FCT reflects a national pattern in Nigeria. The federal government funds public tertiary health institutions, the states—such as the FCT—fund the public secondary health facilities, and area councils are responsible for the primary health care centers. The primary health care centers are expected to meet the health care needs of 70 percent of the population, and the secondary facilities—run by the states—meet the needs of 20 percent of the population. The remaining 10 percent consists of those needing specialized care. These people are attended to at the public tertiary facilities. Unfortunately, as is the case in other states across the federation, the public primary health care facilities are the weakest and least functional of the entire system, putting undue pressure of patronage on the higher levels.¹

¹ United Nations Children's Fund (UNICEF). *The Mapping of PMTCT Services in the Federal Capital Territory of Nigeria*. Abuja, Nigeria: UNICEF; October 2009.

Methodology

1. Data collection

The IYCN team used five methods to collect data: structured and semistructured interviews with health workers, facility managers, and government officials; exit interviews with mothers; facility counseling observations; focus group discussions and in-depth interviews with mothers and caregivers at health facilities; and semistructured interviews with community-based OVC care providers. Verbal consent was obtained from all participants by explaining the purpose of the assessment and why they were included in the assessment. The methods are described in more detail below.

Semistructured interviews

The team interviewed the following participants:

- Staff members from the Nutrition Division of the Federal Ministry of Health (FMOH) (one interview).
- Federal Ministry of Women's Affairs and Social Development (MWASD) representative (one interview).
- Representatives of the Health Services Secretariat/Federal Capital Territory Authority (FCTA) Public Health Directorate for Nutrition:
 - PMTCT (one interview).
 - OVC (one interview).
- National AIDS and STD Control Programme (NASCP) PMTCT officer (one interview).
- Local area council members from the Abuja Municipal Area Council (AMAC) and Kwali (two interviews).
- Facility managers from PMTCT sites (four interviews).
- Health workers from PMTCT sites (four interviews).
- Managers of OVC programs:
 - Catholic Relief Services (CRS) (one interview).
 - Christian Aid (one interview).
 - Winrock/AIDS Impact Mitigation (AIM) (one interview).
 - Family Health International Global HIV/AIDS Initiative in Nigeria (FHI/GHAIN) (one interview).
- Manager of PMTCT programs in FHI/GHAIN (one interview).
- Manager of Nutrition Program in FHI/GHAIN (one interview).
- Officers of the main OVC-supporting subgrantees/community-based organizations (CBOs) providing support to OVC at the community level:
 - Catholic Action Committee on AIDS (CACA) (CRS-supported) (one interview).
 - CACA (FHI/GHAIN-supported) (one interview).

- Unique Aid Foundation/ Association of Women Living with HIV and AIDS (ASWHAN) (Christian Aid–supported) (one interview).
- Redeemed AIDS Program Action Committee (RAPAC) (Winrock-supported) (one interview).

Project staff completed 26 semistructured interviews. All were conducted in English using the appropriate interview guide. Interviewers took notes.

Interviews with key national stakeholders such as the Nutrition Division of the FMOH, the NASCP, and the MWASD helped provide national perspectives on the key concerns of the study and allowed exploration of linkages across the three tiers of government: federal, FCTA and area councils. These interviews highlighted opportunities for intervention and collaboration at the national level as well as at the state and area council levels. Questions also focused on understanding the current level of technical support and supervision provided to PMTCT and OVC sites by stakeholders, as well as their understanding of areas where improvement is needed.

For facility and OVC program managers, the interviews covered a range of topics related to nutrition services, including availability and use of treatment protocols, job aids, and nutrition assessment equipment; nutrition programs in place; community outreach programs; flow of client services; supervisory support received; and opportunities for improved integration of nutritional messages into programs and services. For facility and OVC workers, questions focused on the support they provide and opportunities to integrate nutrition messages into their work.

Exit interviews and counseling observations

Exit interviews were conducted with pregnant women or postpartum women with children less than 24 months of age who had just received infant feeding counseling. The questions focused on nutrition messages received, responsiveness of the health worker, quality of counseling, and client satisfaction. There were 12 exit interviews in all.

A random sample of counseling sessions was observed using a structured observation checklist for the following groups:

- Pregnant women receiving infant feeding counseling.
- Women with children less than 24 months of age receiving infant feeding counseling.

Observations assessed general counseling skills as well as the accuracy and completeness of the information provided to the mother. There were seven observations in all: six individual counseling sessions and one group counseling session (health talk).

2. Location and selection of facilities

IYCN selected two of the six area councils in the FCT, with the aim of assessing a sufficient range of services in the two area councils. In addition, the idea was to gain a sufficient depth of information in each area.

Initially, AMAC and Bwari Area Councils were selected because of the reasonable coexistence and concentration of PMTCT, nutrition, and OVC services in facilities and communities in the area councils. The Bwari Area Council had some facilities where all three

services could be studied. However, in consultation with the Health and Human Services Secretariat of the FCTA, AMAC was chosen as a major urban area council, while Kwali was chosen as a relatively rural area council and Bwari was omitted from the study. FCTA felt that areas relatively lacking in services—such as the Kwali Area Council—should be studied instead of area councils that already had relatively well-developed services in PMTCT, OVC, and nutrition. In AMAC, the Asokoro General Hospital was selected as a secondary hospital and Sisters of Nativity Primary Healthcare Centre in Jikwoyi as the primary facility. These two facilities in AMAC provide PMTCT and nutrition-related services.

In Kwali Area Council, IYCN staff studied the Kwali General Hospital and the Yangoji Primary Healthcare Centre. Both facilities provide PMTCT and nutrition services, though Yangoji provides more maternal and child health services than nutrition services.

Because of the absence of OVC programs in Kwali, IYCN studied only OVC programs in AMAC. The programs were those supported by the following donors:

- CRS and FHI/GHAIN through CACA in Durumi.
- Winrock-supported OVC services through RAPAC.
- Christian Aid–supported OVC services through ASWHAN/Unique Aid in two communities in Karu.

3. Recruitment of study participants

Semistructured interviews

The study coordinator—in collaboration with the IYCN country coordinator—identified participants for the semistructured interviews in advance of the study. IYCN staff contacted participants by letter and then scheduled interviews during a follow-up telephone call. Project staff obtained verbal consent before the start of each semistructured interview.

Counseling observations

After selecting one or two health workers providing infant feeding counseling that day, the study coordinator observed a convenience sample of seven infant feeding counseling sessions—six individual counseling sessions and one group counseling session (health talk). Both the health worker and the mother receiving counseling gave verbal consent prior to the counseling session.

Exit interviews

For the exit interviews, IYCN staff randomly selected women exiting the appropriate services. This randomization depended upon the number of women receiving services at each facility during a specified time period but generally ranged between every third to every fifth woman exiting the services. Women were asked if they would like to participate. If they refused, the interviewer moved on to the next woman leaving the appropriate counseling area. The interviewer obtained verbal consent prior to the start of each interview. A total of 12 women were interviewed.

4. Ethics

The semistructured interviews focused on obtaining general information based on each interviewee's professional knowledge and experience. The names of the participants were not

collected as part of obtaining informed consent. Answers were grouped together so individual responses could not be linked to specific respondents.

Observations and findings

1. National-level stakeholders and coordination of nutrition and related activities in Nigeria

A wide range of stakeholders are involved in the implementation and coordination of nutrition-related activities in Nigeria. Overall coordination of nutrition activities in Nigeria lies structurally with the National Committee on Food and Nutrition (NCFN), which resides within the National Planning Commission under the Presidency. However, with respect to PMTCT and nutrition-related activities, the key agencies that coordinate the national response and provide overall policy direction are NASCP and the Nutrition Division of the FMOH.

NASCP coordinates the health-sector response to the HIV epidemic in Nigeria. This institution provides guidance and direction for implementing relevant policies and programs throughout the country. NASCP facilitates policy guidelines, develops curricula for different thematic areas, establishes standards for care, provides standard operating procedures and coordinates the national PMTCT response through support from implementing partners and stakeholders. On nutrition-related issues, it primarily liaises with the Nutrition Division of the FMOH.

NASCP has adapted the World Health Organization (WHO) document *Rapid Advice: Revised WHO Principles and Recommendations on Infant Feeding in the Context of HIV* (2009). It has also reviewed the draft of the *Nutrition Guidelines for People Living with HIV/AIDS*. Unfortunately, resource constraints limit the extent and speed of dissemination of documents and guidelines to the states. NASCP has written letters to state commissioners of health about nutrition recommendations from WHO, but it needs to use multiple sources to make information available in a timely manner to those who need it.

1.1 Nutrition Division of the FMOH

The Nutrition Division of the FMOH has a mandate to develop policies and guidelines for nutrition in Nigeria and to monitor and provide supportive supervision for policy implementation. The Nutrition Division works in four major areas: infant and young child nutrition, micronutrient deficiency control (MNDC), the Nutrition Information System (NIS), and nutrition in special situations (such as nutrition in HIV and community-based management of acute malnutrition [CMAM]).

The Baby-Friendly Hospitals Initiative (BFHI)—which was once a separate activity outside the Nutrition Division—is now subsumed under infant and young child nutrition as a component of the nutrition program. In this activity, trainers and health workers receive training on the ten steps to successful breastfeeding. Using a generic training manual that has yet to be adapted to the Nigerian context, the WHO integrated course on infant and young child feeding is sporadically conducted—when funds are identified—to assist health workers and service providers. Given that many mothers do not deliver at home, the Nutrition Division supports efforts at facilities to build community support groups and provide training to ensure that mothers in the community also get support for improved breastfeeding practices. The Nutrition Division participated in the 2010 celebration of World Breastfeeding Week, which had a theme of *Just 10 Steps! The Baby-Friendly Way*. It is committed to seeing how health facilities can improve their community support services.

In recent years, the Nutrition Division has provided limited support to improve complementary feeding practices. Past efforts focused on the promotion of local foods for complementary feeding as well as cooking demonstrations. The Division also aggressively pursued growth monitoring and promotion, which included the distribution of scales (using support from the United Nations Children's Fund [UNICEF]) to facilities and training of health workers.

Under the NIS, efforts are under way to develop and institutionalize a system of collecting nutrition data that will capture key anthropometric indices and infant feeding practices. The data will begin with the community and extend to facilities around communities, then to the local government areas (LGAs), then to the states and upward to the Nutrition Division at the federal level. The Nutrition Division is developing protocols to guide regular data collection and compilation at the various levels, with plans to train trainers in a combined NIS/infant and young child nutrition course in Kaduna and Bauchi States.

The MNDC program involves vitamin A supplementation campaigns. The MNDC Division is also a member of the National Fortification Alliance, where it chairs the monitoring and evaluation (M&E) subcommittee. Under the national fortification program, wheat and maize flour, vegetables, and sugar are fortified with vitamin A, and salt is iodized.

1.2 Major NASCP nutrition activities and relationship with the FMOH Nutrition Division

NASCP principally collaborates with the Nutrition Division of the FMOH in all matters that relate to nutrition. Thus, NASCP ensures that the Nutrition Division participates in all activities requiring skills and expertise in nutrition. NASCP programs are vertically planned and supported, but in the spirit of integration, NASCP should strengthen its collaboration with the Nutrition Division. NASCP also procures and distributes Plumpy'Nut[®] for severely malnourished HIV-infected children. In contributing to infant and young child feeding counseling policies and guidelines, NASCP involves the Nutrition Division. It is also involved in activities supported by the Canadian International Development Agency (CIDA) to strengthen PMTCT services in the LGAs with the highest HIV prevalence and facilitate trainings in early infant diagnosis. This CIDA-supported activity is working to strengthen M&E systems. As part of this process, NASCP has developed program-monitoring checklists, trained health workers in early infant diagnosis and infant feeding counseling, promoted community-level identification and referral of pregnant women to nutrition and family planning services, and conducted data quality assessments.

For future collaboration, the Nutrition Division looks forward to having a closer relationship with NASCP. This will enable the Nutrition Division to become involved in nutrition-related NASCP activities from the planning stage and not just at the implementation stage. Furthermore, there is a demonstrated need to supervise the implementation of policies in the states.

1.3 Nutrition coordination

At the federal level within the FMOH, the National Council on Health reviews and approves new nutrition policies or guidelines. Once approved, the policies or guidelines become binding for the states to adopt or adapt and implement. Coordination is difficult, however, because of numerous parallel structures, funding constraints, and the general inefficiency of existing structures that have mandates for nutrition coordination at various levels. Aside from

working with the Nutrition Division of the FMOH to develop relevant policies and guidelines, NASCP's direct role in coordinating nutrition-related activities in Nigeria centers on training of health care workers on infant feeding in the context of HIV. Both agencies—the Nutrition Division and NASCP—recognize that Nigeria generally develops and approves valid guidelines; however, the country encounters difficulties in implementing these guidelines to achieve the relevant Millennium Development Goals.

The NCFN has the mandate to coordinate nutrition activities across sectors. Most states have committees that address food and nutrition. However, coordination of activities across sectors and within states is limited. More support is needed to nurture these efforts.

UNICEF organizes an annual review meeting called the National Nutrition Networking Meeting. This meeting appears to be the only opportunity for nutrition actors to convene at the state level. At this meeting, UNICEF, other agencies and state implementers discuss activities and plans. Although this meeting helps to highlight major policy initiatives and their level of implementation, it leaves much more to be done in terms of supervision and effective interactions among federal agencies with supervisory functions and implementing state officers and structures. The Nutrition Division could potentially provide guidance to address these needs.

While NASCP does not work directly with health structures at the FCT level (such as the FCTA and its various departments), the Nutrition Division works closely with the FCT nutrition officer to take advantage of the proximity. Generally, the Nutrition Division provides technical assistance to states (including FCT) when they request assistance. Over time, this assistance has primarily been to facilitate training on nutrition at the state level. The Nutrition Division has trained the FCTA Public Health Directorate on the NIS. The Division sees the need to relate more with the FCTA Public Health Directorate and to request reports and conduct supervisory visits.

1.4 National-level contributions to supervisory and monitoring functions/visits

The NASCP and Nutrition Division indicated significant obstacles to carrying out their supervisory and M&E functions. Key challenges include funding difficulties and the need for nutrition to be captured in NASCP M&E checklists. NASCP is in the process of building teams and developing comprehensive M&E activities for its services. It is also involved in some CIDA-supported activities to promote community-level identification and referral of pregnant women to nutrition and family planning services. NASCP has conducted data quality assessments.

The Nutrition Division has no tools for M&E. It is crucial to support this Division to develop M&E tools in line with its core program areas; these should take into consideration the variety of agencies and institutions for which it has supervision and oversight functions. Although the Nutrition Division has a mandate to supervise state nutrition officers, it is often unable to do so because of funding challenges. M&E and supervisory visits are scarce. There are no joint work-planning activities with the state nutrition officers, and by policy provisions, the state nutrition officers do not necessarily report to the Nutrition Division. Observers have also noted that many of the state nutrition officers lack a background in nutrition. This affects the level of contribution they can make.

Although NASCP has developed some M&E tools and a supervision checklist, the Nutrition Division does not appear to have definitive tools for supervision or M&E.

1.5 Policy framework and guidelines for national stakeholders in implementing nutrition programs

Various national policy instruments define the framework of operations for stakeholders implementing nutrition and related programs in Nigeria. Some of the policy documents guiding the implementation of the nutrition programs in Nigeria that are available for the key national stakeholders are as follows:

- National Policy on Food and Nutrition 2002.
- National Policy and Guidelines on Infant and Young Child Feeding.
- National Guidelines on Nutrition for People Living with HIV/AIDS (PLHA).
- Integrated Maternal Newborn and Child Health Strategy Document.
- National Health Policy.

There are also numerous other related policies and guidelines and strategy documents. Some of the key guidelines need revision in light of the recent WHO recommendations on infant feeding options in the context of HIV.

1.6 Nutrition-related tools at the national level

The nutrition-related tools that are currently available include a number of training manuals and information, education, and communication (IEC) or behavior change communication (BCC) materials. NASCP has used nutrition training manuals for services in conjunction with the Nutrition Division. However, there are insufficient IEC/BCC materials on appropriate infant and young child feeding in the context of HIV, as well as key PMTCT messages. Many available tools are outdated, given the rapid changes in policy and international guidelines. Additionally, the program often depends on partners to provide educational tools. Infant and young child feeding messages have been incorporated to a limited extent into some integrated management of childhood illness and community program tools, including a flip chart that was recently published with support from UNICEF/Nigeria and titled *Promotion of Key Household and Community Practices for Maternal, Newborn, and Child Health*.

1.7 Perspectives of national stakeholders for filling gaps in infant and nutrition services in Nigeria

National stakeholders identified the following gaps in nutrition services that need to be addressed, particularly in the areas of health communication and relevant trainings:

- Policies and guidelines on infant and young child nutrition should be adapted, interpreted, and communicated to health workers in more user-friendly formats to help them better grasp the key issues and pass accurate information to their clients.
- Community-based knowledge of nutrition-related issues and support systems needs to be strengthened through support groups in the community. OVC programs provide significant opportunities to implement nutrition education for caregivers.
- Training and retraining nurses, community health extension workers, and community health volunteers on appropriate infant feeding practices in HIV and non-HIV contexts remains a priority. This training needs to emphasize counseling skills, particularly in relation to infant feeding in the context of HIV. Frequent changes in guidelines and protocols have caused confusion among health workers and caregivers.

- Moreover, while there have been some rapid changes in international consensus on infant feeding in HIV—which may account for the conflicting messages given to mothers by health workers over the years—there are indications that some health worker attitudes worsen the effect of these changes. These problems highlight the need for improved interpersonal communication skills. There are indications that some health workers involved with infant and young child feeding counseling tend to personalize issues and thus do not provide unbiased information. They also tend to lack the flexibility to consider the socioeconomic and cultural realities of their clients.

The two agencies do not have specific programs targeting maternal nutrition aside from providing iron and folate at the health facilities. Maternal nutrition is a neglected aspect of the nutrition program, and it is important to stress that infant and young child nutrition begins with the mother. Thus, maternal health and nutrition conditions are important influencing factors deserving attention.

2. State or FCT-level stakeholders and nutrition and related programming

The FCTA coordinates all state activities in the FCT. Key health-related agencies in the FCT include the Health and Human Services Secretariat (the equivalent of a ministry of health) and the Social Development Secretariat, which supports health objectives through social service-oriented policies and programs. Other related agencies include the FCT Action Committee on AIDS (FACA). Nutrition activities in the state or FCT are coordinated by the nutrition unit situated in the Public Health Department (PHD) of the Human and Health Services Secretariat of FCTA.

2.1 FCTA Public Health Department

The Public Health Department has a nutrition unit under its Primary Health Care Division. Key activities of the nutrition unit fall under the following areas:

- **Infant and young child nutrition:** This involves training health workers, communities, nongovernmental organizations (NGOs) and support groups on the support, protection and promotion of exclusive breastfeeding, continued breastfeeding, and complementary feeding.
- **Monitoring the utilization of micronutrients and control of micronutrient deficiencies:** This involves periodic vitamin A supplementation, routine iron and folate supplementation, and efforts to check iodine levels in salt at households, markets, and other parts of the communities.
- **Growth-monitoring activities and support for reproductive health activities:** These take place through training and promotion of maternal nutrition during pregnancy and delivery and include routine supplementation of iron and folate at the facilities. Child nutrition issues are addressed through distribution of supplements during child health weeks and other activities such as breastfeeding week, and vitamin A supplementation occurs during campaigns.

Infant and young child feeding counseling and nutritional support are provided as part of PMTCT services, and they are generally provided in HIV/AIDS control services. As of late, the Nutrition Unit of the PHD receives limited support for infant feeding in the context of HIV because infant feeding counseling in this context is specifically subsumed under the PMTCT/HIV/AIDS control service. It is important that the Nutrition Department is properly positioned and strengthened to collaborate effectively with the PMTCT and HIV/AIDS

control team to address and improve infant feeding counseling in the PMTCT and HIV/AIDS control services. Collaboration between the Nutrition Department and PMTCT agencies at the federal level needs to be replicated at the state level to give state-level nutritionists a voice and a role in the implementation of the national consensus and related policies and guidelines on infant feeding and counseling in PMTCT, HIV, and other related activities.

Through links with FACA, breastmilk substitutes (BMS) are procured and given to PLHA. Between 2004 and December 2009, FACA has been involved in distributing BMS to mothers through facilities and offering both BMS and foodstuffs to PLHA during their monthly interaction meetings. The PHD—working through the Nutrition Unit—has established cooking demonstration centers at facilities and distributed equipment to facilities at the various wards. Emphasis on the treatment of malnutrition has increased following a UNICEF survey showing high levels of malnutrition among children in the FCT. Five severe acute malnutrition treatment sites have been established and have received ready-to-use therapeutic foods. Severe acute malnutrition treatment centers have been established in the Gwagwalada, Kuje, Kwali and AMAC Area Councils (four of the six area councils). Community resource persons are trained to establish CMAM. Programs emphasize use of locally available foods to treat malnourished children.

2.2 FCT-supported community outreach to improve health and nutrition

The PHD of the FCT—through its various units—conducts community outreach aimed at sensitizing the community to mobilize people to attend clinics. This effort is part of the overall plans to scale up PMTCT services, educate community members and organizations on various nutrition-related practices, and facilitate general health talks and nutrition education. Through the Health Education Unit of the PHD, a social mobilization team increases awareness of various units' activities. Specific activities include mobilizing communities for immunization activities; educating communities on water issue; identifying malnourished children; and observing food consumption patterns, breastfeeding practices, and the use of local foods to improve nutrition. The health education team participates in all trainings of the various PHD units and communicates nutrition and other issues to community members. The team works with unit specialists to develop joint messages and programs. Funding constraints limit outreach by area councils. By implementing integrated activities, the PHD takes advantage of the huge logistical supports to mobilize communities for immunization and to improve other PHD services, such as nutrition.

2.3 Nutrition monitoring and supervision at the state/FCT level

The standard supervision protocol is for LGAs or area councils to supervise their facilities on a weekly basis, for the state to supervise the LGAs on a monthly basis, and for the federal structures to supervise the states every quarter. The FCTA PHD usually holds monthly meetings with officers from the area councils, but lack of funds has hindered monthly supervisory visits to facilities at the area councils. Government funds are usually not available or are inadequate to support this activity. Sometimes, funds are only able to reach facilities when support is available from development partners on specific activities in designated facilities. As a result, vehicles may be grounded without repairs, and fueling or maintaining vehicles remains a significant challenge. The area councils have very serious logistic and funding constraints that limit their supervision and monitoring of the facilities under their jurisdiction.

The PHD uses the integrated supervisory checklist to supervise and monitor facilities. This list helps the different units of the department monitor some common indices collectively. The nutrition team has had support to monitor the severe acute malnutrition centers regularly. Nutritionists go to the sites, supervise and collect monthly reports, and become involved in the PHD collective supervision.

The Nutrition Unit also holds quarterly meetings with nutrition coordinators of the various area councils to assess implementation activities. The Nutrition Unit has also established a pilot Nutrition Information Surveillance System to help evaluate children reached, assessed, and counseled by any of the program components of the units.

2.4 Coordination of nutrition and related activities at the state/FCT level

The FCTA PHD contributes to efforts to coordinate the activities of different agencies working in the health facilities and sectors in the FCT through a quarterly public-private partnership and NGO forum. The meeting—chaired by the secretary of the Health and Human Services Secretariat—helps to harmonize the activities of different agencies in the FCT. The meeting also helps to prevent agencies from directly approaching facilities to implement activities without proper authorization and guidance from the PHD or the Health and Human Services Secretariat.

The forum also allows different agencies to harmonize their data collection tools. Forum leaders encourage the partners to use the government's health management information system to ensure the data collection system is used consistently. Getting additional information outside the health management information system can always be addressed on a case-by-case basis. While harmonization of guidelines and tools takes place at the federal level, the forum is a potential means of disseminating approved national guidelines and policies. The forum therefore presents the IYCN Project in Nigeria with an opportunity to influence decisions, share materials, create awareness, coordinate and collaborate on activities, and mobilize support for FCT-wide and national-level initiatives.

2.5 Perspectives of state-level stakeholders on filling gaps in nutrition services in the FCT

The following list summarizes the suggestions and recommendations of FCT-level stakeholders on improving nutrition services in the FCT:

- **Revive the BFHI:** In recent years, this laudable program for breastfeeding promotion has lost steam, resulting in the resurgence of bottle-feeding and a decrease in exclusive breastfeeding rates in the country to a current level of only 13 percent. It is important to conduct reorientation workshops and meetings on the ten steps to successful breastfeeding and revive the BFHI.
- **Develop and reproduce relevant BCC materials:** These materials should cover optimal infant feeding practices in the three main national languages of Igbo, Yoruba, and Hausa, as well as in the language of the Gwari (the largest indigenous tribe in the FCT) for distribution to all facilities.
- **Reactivate cooking demonstration centers at immunization sites and facilities:** Activities will include teaching people what foods to prepare and how to prepare them. This should be completed in coordination with the strengthening of growth monitoring and promotion activities through training and supervision of health personnel.

- **Other capacity-building efforts:** These should be targeted at developing monitoring tools such as standard PMTCT checklists and providing more training for all categories of health workers on infant feeding counseling. For efficiency, training programs could be modified such that a pool of health workers at the primary health care level are trained at their LGA headquarters, while their counterparts at secondary facilities are trained within their facilities to allow for the direct training of a larger number of health workers. Having the trainer go to where the health workers are would save money and allow more health workers to be trained.

3. Area council contributions to nutrition-related services

The two area councils studied were the AMAC and the Kwali Area Council. AMAC is predominantly cosmopolitan and is the largest of the six area councils, with 12 wards. Moreover, it has the highest population. Although it has some rural communities, it is largely urban, and much of its population has a relatively high socioeconomic status.

The Kwali Area Council consists of ten political wards. The bulk of the population is made up of farmers, traders, fishermen, hunters, migrants, and laborers. The main languages are Gbagis, Baasa, Danadana, and Hausa. The level of malnutrition is high in Kwali, especially in communities like Sadaba, Kundu, Kwaita, Daafa, and Yangoji. People living in some of these communities produce a good quantity of food, but sell much of it.

3.1 Key nutrition and related activities in the area councils

The AMAC experience—as reported by the nutrition coordinator—suggests that very limited nutrition activities are taking place in the area council. A small number of these activities are noteworthy.

3.1.1 Community outreach

AMAC conducts outreach activities in some rural communities, such as Gidan Mangoro, Karshi, and Karu. These activities include promotion of key household practices in Karshi and training of community health promoters in growth monitoring and promotion in Gidan Mangoro. These growth monitoring activities are not conducted regularly—partially because health promoters provide their services on a voluntary basis.

3.1.2 Breastfeeding and child health weeks

One of the key infant and young child activities conducted in the two area councils is the annual World Breastfeeding Week. This event includes workshops, activities to mobilize women, lectures, and competitions with prizes.

Another key activity is Child Health Week. This event includes cooking demonstrations and education of caregivers on how to breastfeed and prepare complementary feeds. The area councils have some nutrition centers equipped with facilities provided by the FCTA for cooking demonstrations. However, not all facilities are used; because many of the people in charge are not nutritionists and cooking demonstration is not a high priority for them. Limited funding also poses a challenge.

3.1.3 Nutrition coordination, monitoring and supervision at area council level

There are no indications of functional multisectoral structures for nutrition coordination at the area councils. Generally, the area council/ LGA committees on food and nutrition—an

interdepartmental structure that is approved in the National Policy on Food and Nutrition to coordinate all nutrition activities at the third tier of government—does not appear to be providing this support in the FCT.

Limited funding and poor financial status further weaken the ability of area council nutrition coordinators to implement and coordinate nutrition activities. The area councils have a small budget line for nutrition, but allocated funds are usually not released on time. These problems affect staff members' morale, resulting in reluctance to do nutrition programs.

In Kwali, supervision of facilities is done when logistically possible. Although the nutrition coordinator is supposed to visit facilities every month, this often fails to happen because the unit lacks a vehicle. Staff members are invited to refresher courses, and growth monitoring and promotion activities are monitored while identifying malnourished children in the process. In AMAC, the nutrition coordinator has implemented monitoring and supervisory activities for the past two years. This once included weekly visits to UNICEF focus communities where UNICEF activities were being implemented. This weekly visit was discontinued, however, because of funding constraints. The nutrition coordinator had been able to use monitoring visits to deliver regular health talks to the communities. Other facilities are visited occasionally to see how health talks are given during antenatal sessions. When focal persons in different facilities are being trained, nutrition coordinators can interact with them to check on circumstances in those facilities.

Generally, across the area councils, no formal monitoring tools or forms are available for monitoring and supervisory activities by the nutrition coordinators, even though the M&E units have formats for collecting and reporting facility service data and information. Growth monitoring reports from the facilities go to the M&E unit of the area council and the FCTA PHD, and copies are kept. Information generated from supervision and monitoring visits is discussed at the area council level, corrections are made where necessary, feedback is given to facilities, and reports are sent to the FCTA PHD. Financial constraints usually preclude interventions based on the monitoring visits. The FCTA PHD calls quarterly meetings of area council nutrition coordinators, who also send their monthly reports to the FCTA PHD.

3.2 Perspectives of area-council-level stakeholders on filling gaps in nutrition services in the FCT

Perspectives of area-council-level stakeholders who were interviewed about nutrition services in the FCT are summarized below:

- Training is essential. A limited number of trained nutritionists are present in the area councils. Training for health staff on nutrition counseling and education and BCC is inadequate. More caregivers need to be advised on key household practices. More training opportunities for health workers and community resource persons are needed.
- Many job aids and tools exist, but most are not available or need to be updated with the latest technical guidance. New job aids need to be developed and disseminated.
- Nutrition centers should be established in every health facility. More centers for demonstration of food preparation and nutrition counseling are needed. Additionally, many that exist now are not functioning. These centers need trained staff and materials and facilities such as weighing scales, length boards, height meters and good venues for nutrition counseling.

- Supervision of facility- and community-based services is poor because of transportation challenges (i.e., a lack of vehicles). This could be addressed through integrated supervision with other government agencies or agreements with implementing partners to accompany them on supervision visits.
- Monitoring tools, checklists, and reporting forms need to be developed, printed, and distributed. More collaboration with the FCTA PHD is considered very important.
- Key household practices related to nutrition and health need to be promoted and replicated. These practices include exclusive breastfeeding for the first six months, adequate complementary feeding with continued breastfeeding into the second year, appropriate health-seeking behaviors, and home management of common illnesses. Community members are receptive to these practices, and it is easy to find evidence of positive changes in the lives of people who follow them.
- Every ward has a health committee that undertakes local-level advocacy and community mobilization. Technical support would enable these committees to better integrate nutritional messages and support into their activities.

4. Facility-level nutrition services

4.1 Overview of health facilities

This assessment included four health facilities: two in the Kwali Area Council and two in AMAC. Kwali Area Council is more rural than AMAC, which is largely cosmopolitan. Kwali General Hospital, located at the headquarters of the area council, serves a more urban community than the Yangoji Primary Healthcare Centre, which is in a rural area. In AMAC, Asokoro General Hospital is in an urban area, and the Jikwoyi Primary Healthcare Centre is in a periurban region. AMAC facilities generally appear better staffed, better equipped, and more functional than facilities in the Kwali Area Council.

4.1.1 Yangoji Primary Healthcare Centre

The Yangoji Primary Healthcare Centre is managed by a senior community health extension worker (CHEW). Other staffers include a junior CHEW. Some retired nurse midwives work in the hospital on the new Midwives Service Scheme being coordinated by the National Primary Health Centre Development Agency. The junior CHEW spends 80 percent of her time in the community and 20 percent at the clinic. She is engaged in community mobilization and health awareness campaigns, promoting environmental hygiene and conducting home visits. The senior CHEW is involved with immunization activities, home visits, and treatment of minor ailments, as well as the general components of primary health care services and oversight over all facility functions. The facility does not currently have a physician or standard laboratory. Staff refer patients to the Kwali General Hospital for all services related to PMTCT that the facility is not equipped to handle.

4.1.2 Jikwoyi Sisters of Nativity Primary Healthcare and PMTCT Centre

The Jikwoyi Sisters of Nativity Primary Healthcare and PMTCT Centre is a faith-based facility supported by CRS. The Reverend Sister who heads the facility is a trained nurse-midwife with many years of experience, including four years of experience in PMTCT. This facility also has experienced health workers who render general nursing services and have been involved in PMTCT services for more than three years. They refer non-PMTCT HIV-positive patients to secondary facilities in the FCT—for example, Asokoro, Maitama, and Garki for highly active antiretroviral therapy and related services. Three physicians work in

this facility. Support from CRS has enabled the facility to be better organized, equipped, and staffed than other public facilities in the area.

At the Sisters of Nativity Primary Healthcare Centre, nutrition activities are handled by nurses, midwives, and CHEWs. The nurses administer supplements and foods and provide nutrition counseling, and the CHEWs assist nurses at support group meetings. The responsibilities of health workers and nurses include supplying foods such as rice, beans, and crayfish to HIV-positive mothers through their monthly community-based support group meetings; counseling mothers to eat body-building foods; and providing BMS to women who choose replacement feeding. Mothers learn how to feed their babies during immunization sessions and learn about diet and food preparation during demonstrations at the nutrition center. The center supports poor mothers with food, money, and transportation to help improve the nutritional status of their household members. At antenatal care sessions, health workers discuss nutrition issues with mothers and conduct cooking demonstrations.

4.1.3 Kwali General Hospital

At Kwali General Hospital, the main responsibility for providing nutrition services lies with professionals other than trained nutritionists. Doctors and nurses provide infant feeding counseling and advice on nutrition. They also explain the preparation of BMS and offer education on various feeding options—especially for HIV-positive mothers. The pharmacists and the social welfare workers give BMS to those opting for replacement feeding and demonstrate their use. They also provide F75 and F100 formulae for treating severely malnourished children. The general health talk during antenatal care is the main channel for passing nutrition messages to mothers. The twin challenges of poverty and lack of knowledge make behavioral modification efforts quite challenging.

4.1.4 Askokoro General Hospital

At Asokoro General Hospital, no one staff member is specifically responsible for providing nutrition services. Nurses are involved in providing nutrition counseling, education, and cooking demonstrations, and the facility has a dietician and some support staff who support nutrition counseling activities. The dietician and nutrition team do not appear to have prominent roles in nutrition activities. During antenatal care sessions, mothers receive counseling on infant feeding and nutrition. Nurses promote breastfeeding as the best feeding option for babies. Exclusive breastfeeding is stressed during the first six months of life. Nurses have reportedly been trained on infant and young child feeding. Antenatal care sessions provide opportunities to address maternal nutrition issues through general counseling and health talks. Dieticians are also invited to talk to mothers during pregnancy. Mothers are usually counseled to avoid wrong beliefs that limit their dietary diversity and food intake. Pregnant and lactating women receive advice about taking supplements such as multivitamins and minerals as appropriate.

4.2 Infant feeding and counseling in HIV and non-HIV contexts at the facilities

4.2.1 General feeding of infants under six months of age

Across the studied facilities, health workers generally encourage mothers to exclusively breastfeed their children and highlight the numerous benefits. To boost milk production, breastfeeding mothers are advised to drink pap or *kunu* (watery pap made from fermented cereals). Mothers are also warned during counseling of the danger of mixed feeding (i.e., giving a child breastmilk and BMS at the same time).

4.2.2 Infant feeding in the context of HIV

The information given to HIV-positive mothers on infant feeding was found to differ significantly across the facilities. A recent FCT-wide assessment of PMTCT services indicated that the problem may not lie with infant feeding counseling but with the content and quality of nutrition counseling given to mothers.²

Three different counseling scenarios with HIV-positive women were observed in the facilities:

Scenario 1: The health worker advised HIV-positive mothers not to breastfeed at all, without any consideration of whether replacement feeding is acceptable, feasible, affordable, safe, and sustainable. These mothers were advised to give baby formula such as NAN or Lactogen to feed the child.

Scenario 2: The health worker advised HIV-positive mothers not to breastfeed, but if the client insisted on breastfeeding, she was advised to breastfeed for the shortest time possible—a maximum of three months—and was also told to avoid mixed feeding.

Scenario 3: Mothers were counseled to make an informed choice between exclusive breastfeeding for three months or exclusive replacement feeding from the very beginning.

Many of the women reported that after receiving such information, they breastfed exclusively for two to three months and then stopped breastfeeding completely. This is confirmed by an FCT-wide assessment conducted by UNICEF in 2009.² According to the assessment, formula feeding was the most common infant feeding choice of HIV-positive women in 35 percent of the facilities, and exclusive breastfeeding for up to six months was preferred by women in 27 percent of the facilities. The remaining facilities provided other unspecified options.

4.2.3 Challenges for infant feeding counseling in the context of HIV

Many mothers want health workers to make a choice for them. This makes the women vulnerable to the tendencies of some health workers to provide biased counseling. A central issue is that many mothers and families who choose replacement feeding cannot safely sustain this choice over the long term. To support mothers in their replacement feeding choice, some facilities have provided mothers with free BMS. Government and donor agencies provided support for BMS over the years until late 2009. Since then, supply has been inconsistent. Thus, this approach is not considered sustainable. Some facilities counsel women to start saving money to buy formula once they have tested positive and have chosen their feeding option. Poverty and the influence of relatives appear to have caused some mothers to change their feeding method after initiating formula to breastfeeding, which greatly increases the risk of mother-to-child transmission.

Many of the mothers end up practicing mixed feeding. One reason is not being able to stand the stigma, pressure, questions, and suspicions associated with not breastfeeding in an environment where mothers are expected to breastfeed a newborn. Many mothers breastfeed in the open but replacement feed in secret, not realizing the added risk of transmission with mixed feeding. This is an additional challenge that needs to be addressed through appropriate counseling.

² United Nations Children's Fund (UNICEF). *The Mapping of PMTCT Services in the Federal Capital Territory of Nigeria*. Abuja, Nigeria: UNICEF; October 2009.

4.2.4 Infant feeding counseling and current technical guidelines

The different messages given to mothers at the four facilities demonstrates the magnitude of the challenges associated with infant feeding counseling in the context of HIV in Nigeria. The advice currently being given to mothers across most facilities does not reflect even the 2006 WHO guidance; let alone the current international guidelines and *National Consensus Statement*. This problem is largely due to the time it takes for new guidelines to be developed, disseminated, and put into practice at the facility level. The situation is such that before international guidelines and supporting documents are adapted to the Nigerian context and disseminated, new international revisions are released. This struggle to keep pace contributes to the confusion and often promotes adherence to the older guidelines and resistance to adoption of new guidance. This is further exacerbated by the inadequate resources available for comprehensive training, regular and systematic supervision, and dissemination of updated job aids and other support materials.

4.2.5 Counseling mothers on complementary feeding

Across the facilities, mothers are generally encouraged to commence feeding their children semisolid and solid foods at six months and introduce their children to family diets as they get older, while continuing to breastfeed. Counselors encourage frequent feeding at short intervals, as well as the hygienic preparation of foods. At Yangoji, staff advise mothers to commence complementary feeding at six months, and they learn how to enrich the most common complementary food—cereal-based pap—with blended crayfish, soybeans, and groundnuts. Mothers and caregivers are also advised to adopt active and responsive feeding styles, as opposed to a forced-feeding approach. Counselors do not mention the importance of diet diversity, including the addition of vitamin A-rich foods, or of the importance of feeding during and after illness.

4.2.6 Nutrition counseling and bottlenecks identified at various points in the PMTCT process

Tables 1 through 3 show the nutrition activities that take place across the various service points in the PMTCT service process in facilities. The tables also highlight the major bottlenecks at every stage in the service process.

Table 1. Nutrition counseling and bottlenecks identified at various points in the PMTCT process at Kwali General Hospital.

Service Points	Nutrition Activities	Bottlenecks
Antenatal care	Infant feeding counseling	Lack sufficient nurses
Pretest counseling	Infant feeding counseling	Lack conducive space for one-on-one counseling; some opt out
Voluntary counseling and testing	Infant feeding counseling	Kits not available
Counseling	Infant feeding counseling, use of cups and spoons to demonstrate, also use BMS	Some don't come back; lack relevant posters, lack conducive counseling space
Labor and delivery	Infant feeding counseling	Lack conducive counseling space; lack enough doctors and nurses
Postnatal (6 weeks)	Age-appropriate infant feeding counseling; follow-up on practices and decisions	Lack conducive counseling space; lack enough doctors and nurses
Postnatal (10 weeks)	Infant feeding counseling; follow-up on practices and decisions appropriate for age	Lack conducive counseling space; lack enough doctors and nurses

Table 2. Nutrition counseling and bottlenecks identified at various points in the PMTCT process at Sisters of Nativity Hospital, Jikwoyi.

Service Points	Nutrition Activities	Bottlenecks
Antenatal care/pretest counseling	The antenatal care booklet is used; it advises mothers on dietary diversity and adequacy	Some are unwilling to undergo the HIV test (though most accept). Partners are not sufficiently supportive
Posttest counseling	Infant feeding counseling	Mothers have difficulty with choosing not to breastfeed, as people associate the choice of not breastfeeding with HIV status

Table 3. Nutrition counseling and bottlenecks identified at various points in the PMTCT process at Asokoro General Hospital.

Service Points	Nutrition Activities	Bottlenecks
Antenatal care	Health talks are given and nutrition messages are passed on through this mechanism	None specifically identified
Pretest counseling	Health talks are given	Given the opt-out policy, some opt out of test after this counseling
Posttest counseling	Infant feeding counseling	None specifically identified
Postnatal (6 weeks)	Pediatric session takes over, with follow-up activities on infant feeding options: exclusive breastfeeding and replacement feeding	None specifically identified
Postnatal (10 weeks)	Pediatric session takes over, with follow-up activities on infant feeding options: exclusive breastfeeding and replacement feeding	None specifically identified
6 months	Complementary feeding issues are addressed	None specifically identified

4.3 System of identifying infants lost to follow-up

In general, facilities seem to have an established system for following up infants who miss immunization visits, as well as for HIV-positive mothers and/or their infants who miss appointments. Facilities make efforts to have complete addresses and telephone numbers for each client.

For PMTCT services, facilities use registers or other patient records to identify clients who have missed appointments. This is usually completed during reporting time, and appropriate follow-up is carried out. For some sites (such as Asokoro General Hospital), the cards of persons treated are counted (usually each day) to ascertain the number of persons who attended their follow-up clinics compared to the number of appointments made for the day. Home-care nurses then visit the mothers or call them on the phone.

At Sisters of Nativity, facility staff try to get to know the HIV-positive mothers personally. The regular support group meetings also help in following up. The facility calls mothers on the phone when they miss their appointments and encourages them to return to the clinic.

Defaulters are traced to the communities, and their neighbors or other community members help in tracing them or giving useful information about their whereabouts. The facility reports that keeping mothers' detailed addresses helps in tracing them and that establishing a personal relationship between mothers and staff helps to maintain contact.

For HIV-positive mothers, support groups play a crucial role in helping mothers adhere to treatment regimens and keep scheduled appointments. In addition, the group meetings provide a link between the facilities and the mothers and facilitate tracking mother/baby pairs lost to follow-up.

4.4 Community outreach activities

The major community outreach activities implemented by the facilities are home visits, awareness campaigns, support group meetings, child health days, and community meetings. Health workers are already using these opportunities to conduct nutrition and health education activities as well as infant feeding counseling in the context of HIV. The frequency of these activities differs across health facilities. Overall, this outreach needs to be strengthened and expanded to further promote nutrition.

4.5 Home visits

At Kwali General Hospital, health workers make monthly home visits to clients within the catchment areas to track defaulters. In Asokoro, health workers principally make home visits to check up on clients, encourage them to go to their clinic appointments, reinforce hygienic practices, and encourage adherence to the drug regimens and infant-feeding options they have committed to. At the Yangoji Primary Healthcare Centre, the service providers use home visits to discuss the types of foods available in their areas and households and how to make the most of these. This involves demonstrating cooking methods and encouraging the consumption of bodybuilding foods available in their communities. Home visits are conducted weekly, and discussions are geared toward promoting improved nutrition, immunization, and environmental and personal hygiene.

In Jikwoyi, health workers make irregular visits to the homes of PMTCT patients. During these visits, patients receive care, their homes are inspected, and mothers receive counseling on feeding themselves and their children. Some clients do not want to be visited in their homes because they do not want others to know about their HIV status. Staff shortages also affect the regularity of this activity.

4.6 Awareness campaigns

Awareness campaigns include community-wide talks on nutrition and health issues at places such as town halls and marketplaces. At Kwali, this occurs twice monthly in marketplaces and involves educating parents on nutrition and on the need to come to the hospital. Details of infant and young child feeding have not generally been communicated through this particular channel, although it represents an opportunity to do so. The primary health care center in Yangoji does not conduct awareness campaigns. At Jikwoyi, awareness campaigns are held twice monthly and emphasize encouraging community members to learn their sero-status and use voluntary counseling and testing services. Asokoro Hospital does not conduct such awareness campaigns.

4.7 Support groups

The findings of this assessment indicate that support groups facilitated by these facilities are predominantly targeted at HIV-positive mothers.

At Kwali General Hospital, mother support groups are conducted only for HIV-positive mothers, and financial support for this activity has declined. At Asokoro, support groups for HIV-positive mothers are held monthly. In these groups, mothers discuss infant and young child nutrition, use of water guards to promote water hygiene, consumption of nutritious foods, and other health issues. At Jikwoyi Primary Healthcare Centre, support groups for HIV-positive women feature monthly meetings during which mothers pray and discuss challenges and issues that disturb them, as well as encourage themselves. Health workers distribute food rations, when available, and counsel women on infant and young child feeding and maternal nutrition. They also give general health talks and provide support to women who are being stigmatized. Members lead the support group meetings, and clinic staff provide technical input and clarifications.

4.8 Community meetings

The primary health care facilities have community meetings to discuss issues affecting the facilities, as well as issues related to outbreaks of diseases and other community-wide interests. At Yangoji Primary Healthcare Centre, issues that are mostly discussed include the National Immunization Days and other mobilization strategies to improve immunization. This meeting is held monthly. The Jikwoyi Primary Healthcare Centre does not participate in other community meetings outside the mothers support group meetings.

5. Nutrition training and supervision for health workers

The assessment shows that many health workers in PMTCT services have had very limited training on nutrition in general and on infant and young child nutrition in particular—especially in the past few years. For those who have been trained, the length of training has ranged from one to five days. Previous trainings tended to focus more on the management of malnutrition than on prevention.

Generally, the common practice among facility staff is for persons who attend training to conduct step-down training for those who did not. If this practice is expected to continue and be successful, staff need appropriate guidance and materials to effectively train other health workers.

To enhance the quality of nutrition assessment, counseling, and support, especially in the area of infant and young child nutrition, training needs to be more systematic in terms of length and regularity.

Supervisory support from FCTA and other authorities and agencies

The timing and content of supervision varied widely across the four sites. In general, all facilities reported irregular supervisory visits from the FCTA. This is understandable for the primary care facilities, which are generally overseen by the local area councils. The facilities do receive more frequent supervision from other groups or agencies as detailed below:

Kwali General Hospital

- **Health and Human Services Secretariat:** This agency visits periodically to see how activities are carried out in different sections of the hospital using a structured checklist. Kwali also submits monthly reports to this agency.
- **International partners:** The hospital also enjoys supervisory visits and support from international partners such as FHI/GHAIN and Community Participation for Action in the Social Sector (when the latter project was still being implemented). FHI/GHAIN visits about once every two months, and monthly reports are shared.

Yangoji Primary Healthcare Centre

- Area council and NGOs provide supervision, though details of these visits are unclear.

Jikwoyi Sisters of Nativity

- **CRS:** CRS is the main support body for this facility and visits approximately once a month. This group uses checklists and conducts interviews in the course of supervision, which is centered on PMTCT-related issues.. The center also sends monthly reports.
- **CACA:** This group also provides oversight functions from time to time.
- **Manos Unidas:** This is a Spanish agency that also supports these activities. The facility sends reports to this agency twice a year. Supervisory trips include some impromptu supervisory sessions and checks of facility data records and registers.

Asokoro Hospital

- No agencies are reported to provide any regular supervision.

6. Perspectives of health workers and facility managers on filling gaps in infant, young child, and maternal nutrition services

Facility managers and health workers made various recommendations on how to fill gaps in infant, young child, and maternal nutrition services in the FCT.

6.1 Improving the nutrition counseling environment

Some facilities lack adequate space to provide private, individual counseling. Facilities also lack space to demonstrate feeding practices, such as preparation of complementary food. With adequate financial support, facilities could expand upon or renovate existing space. If financial support is not available, each facility should carefully review its current use of space and look for opportunities to use unoccupied space for counseling at certain times of day.

All facilities expressed a need for supplies such as weighing scales, length boards, cooking equipment, video facilities and computers, and enhanced internet capabilities.

6.2 Increasing the number of qualified staff and training in nutrition for all service providers

There is a need for more qualified staff with adequate time to provide counseling and support. Current service providers—especially nurses—have limited time and many competing priorities. Employing persons with nutrition skills and providing more training on nutrition for service providers generally would contribute significantly to improved nutrition service delivery at the facilities.

Volunteers and community health workers should also be trained on infant and young child nutrition to help in counseling and follow-up of mothers and other clients. Seminars and workshops on development of implementation plans to improve outreach activities and to better integrate nutrition into this outreach are strongly recommended.

6.3 Nutrition education and BCC to improve maternal nutrition

Sustained BCC messaging through a variety of channels is essential to preventing undernutrition. BCC campaigns can counter widespread lack of knowledge, poor nutrition behaviors, and practices aggravated by superstitious beliefs and taboos. Appropriate and up-to-date IEC materials are needed for such campaigns. Currently, the use of relevant BCC materials is quite low across the facilities. Moreover, the available materials lack up-to-date information. Thus, BCC campaigns and IEC materials present important opportunities for intervention.

6.4 Use of broader measures to address hunger and poverty in target communities and project areas

Broader developmental measures that will address hunger and poverty in the communities will increase the ability of families to consume nutritionally adequate diets. Promoting home gardens and other household economic strengthening measures will decrease reliance on handouts of foods and supplements.

7. Client perspectives on nutrition service delivery from exit interviews with mothers

Most of the women or caregivers interviewed received group counseling because most service providers are too busy to provide individual counseling. Women who are HIV-positive are much more likely to receive individual counseling than women who are HIV-negative. One common feature of group counseling is that service providers deliver a broad range of messages for a broad category of clients. As a consequence, some of the messages a particular client receives in a group counseling session may not be applicable to her situation or context. She may receive the messages she needs at a particular moment of time, as well as other messages she may need later on. This often adds to confusion among mothers when they feed their children at home.

Exit interviews also revealed that child health cards are not always reviewed because of the unavailability of staff for individual counseling. Furthermore, workers seem to be more informed on general breastfeeding issues such as positioning and attachment than on complementary feeding messages.

Mothers provided two key suggestions for improving nutrition services:

1. Health workers need more training on infant and young child feeding to be better informed on a broader range of infant feeding issues.
2. Counseling would more be more effective if health workers used job aids during group and individual counseling.

8. OVC services at national, FCT, and area council levels

8.1 National-level stakeholders and coordination of OVC and nutrition-related activities in Nigeria

The Ministry of Women Affairs and Social Development has a division of OVC services that provides direction and coordinates the national response to OVC issues. It develops, coordinates, and supervises the implementation of policies and guidelines related to OVC. It provides clear guidelines on services in the context of community realities and how support can be leveraged from other service providers within the community. The ministry ensures that standards for service delivery are established, provides supportive supervision, and builds relevant capacities.

Relevant national policy and program instruments include the National Policy on Children and the Child Rights Act. Although there are efforts to develop a specific policy on OVC, the prevailing understanding is that the two aforementioned policy instruments have substantially taken care of key OVC-related issues in Nigeria. A national OVC Plan of Action 2006–2010 is currently being reviewed to reflect ongoing developments and emerging issues, as well as the National Guidelines and Standards of Practice (SOP) [2006–2010] for OVC.

The SOP essentially serves as the working document for service provision. It provides details and definitions for all services provided and explains how to assess needs for the services. The M&E plan has tools to help in assessing children and their needs, as OVC services are essentially needs-based. In 2008, a situation assessment and analysis on OVC in Nigeria was conducted, and a comprehensive M&E plan is currently being pilot-tested in several states of the federation. The M&E mechanism is designed to address gaps in knowledge about a broad range of issues in OVC programming in Nigeria. This mechanism is designed to capture information on OVC services from the communities where those services are being provided to the LGA (i.e., the tier of government closest to the communities, through to the states and upward to the federal level). This structure will inform the reporting system of the indicators of concern. The findings from pilot-testing of the M&E mechanisms and from the expanded implementation of this mechanism will influence reviews of the National Plan of Action and SOP. These studies and reviews take time because of the size of Nigeria and the attendant implications for a multisectoral response like the OVC program.

The various policy instruments and M&E plans help the MWASD coordinate OVC services in Nigeria. These instruments represent harmonized guidelines, common policies, and tools for various agencies to implement OVC services. Several years ago, different agencies used different protocols and guidelines, including PEPFAR guidelines. In recent years, partners have seen a need to relate with the government more than before. Deviations in use of protocols and guidelines have been minimized with the availability of various instruments and tools, the increased visibility and influence of the ministry, and the fact that some of the agencies are now revising their policies to align with current national policies and guidelines. The revised PEPFAR guidelines reflect this. When partners come to Nigeria, they involve the ministry in the early stages of project conceptualization and planning, through to the implementation phase and closeout.

In further coordinating OVC services in Nigeria, the MWASD strengthens the capacity of states and LGAs to implement OVC services. Communities are also being mobilized to recognize the guidelines and encourage community leaders and household heads to take charge of OVC services in their communities.

The MWASD, with support from UNICEF and USAID, is involved with mapping OVC services at the LGA and community levels. Although much progress has been made in strengthening capacity at the state level for OVC services, the LGA structure for OVC response is very weak. An important part of the efforts to strengthen the LGA structures is to establish LGA desk officers for OVC. Because LGAs are closest to the communities and OVC services are principally community-based, working on the LGA structure is considered imperative. The structure of civil society organizations at the LGA level could be mapped, as well as service areas in the community. Service providers in an area could be identified along with their services, while exploring opportunities to network and leverage resources. Tools have been developed for this mapping activity, and data collection has commenced at LGAs within UNICEF zones. M&E, together with these mapping activities, will release substantial amounts of data and information on OVC services in the country.

At the community level, CBOs are encouraged to form coalitions that bring them together, such as the Association of OVC NGOs. This association ensures that operating CBOs conform to national OVC guidelines. USAID is currently supporting the ministry to develop a dossier or system that will help identify the range of OVC partners implementing services across the country. This system will help identify the number of OVC services rendered in any given area and clarify how these services might complement and strengthen each other.

8.2 Supervision of OVC services

According to OVC partners, supervisory support from government agencies such as the MWASD and the FCTA is minimal and irregular. The OVC partners share their reports with the MWASD and attend trainings organized by the ministry. Some OVC partners—such as FHI/GHAIN—ensure that the MWASD endorses their activities, plans and participates in implementation, and provides guidance and direction in the course of their OVC programs.

8.3 Overview of food and nutrition services in the context of OVC programming in Nigeria

As stipulated in the SOP, the major OVC service areas include shelter, household economic strengthening, educational support, health care services, psychosocial support, child protection and legal support, and food and nutrition services. In line with the focus of this assessment, more details are provided on the food and nutrition component of the OVC program.

The Food and Nutrition Service recognizes that many households caring for OVC have inconsistent access to nutritionally adequate foods and are chronically food insecure. Interventions highlighted for implementation in the SOP include the provision of nutrient-dense and adequate food to OVC households in emergency situations and nutritional support for those exposed to HIV. Other interventions include providing nutrition education activities and improving income-generating activities for improved food security, as well as improving agricultural productivity and enhancing food quality, storage, and utilization in OVC households.

Interaction with OVC service providers showed that while all OVC services are needs-based and are provided in an integrated manner, not all components are implemented with equal efficiency, skill, and resources. The food and nutrition component of OVC services in Nigeria has been identified as an area that requires much attention. Few trained nutritionists work in the national OVC program. Skilled high-level nutrition experts that could help in providing broad direction for improving this component of OVC services have not been effectively

engaged in this program. Despite efforts by various agencies, progress is slow for reasons such as insufficient training on nutrition programming in the context of OVC and lack of financial resources to sustain the food handout approach that was adopted earlier.

Stakeholders at various levels have seen the need for a systematic reassessment of the food and nutrition component of OVC services in Nigeria. The “handout approach” that was part of the initial OVC emergency rapid response—characterized by providing food and supplements to OVC households—proved to be unsustainable. Many agencies provide needy households with these materials but cannot sustain them due to the huge costs involved.

At present, the emphasis is on community-based support for food and nutrition. Food security and improved nutrition should be promoted through community-wide efforts geared at creating workable structures that will help OVC households meet their food and nutritional needs on a sustainable basis. This also explains why the current SOP needs to be reviewed, as it gives substantial prominence to the handout approach. This is notwithstanding the fact that the SOP recognizes the need to match immediate efforts to improve nutrition by providing food to households with longer-term efforts to increase household and community food security.

8.4 Highlights of OVC operations in the FCT

At the governmental level, the Social Development Secretariat of the FCTA has adapted the National OVC Development Plan of Action for use in the FCT. It will likely be available before the end of 2010. This provides key direction for OVC programming in the FCT.

The staff of OVC partners (i.e., Christian Aid, Winrock, CRS, and FHI/GHAIN) and their affiliate organizations or subgrantee organizations have a strong appreciation for the food and nutrition component of OVC services. They have made several efforts to hire consultants and attend or implement trainings on nutrition to strengthen this component of their services. With the exception of FHI/GHAIN, the OVC partners and service providers lack trained nutritionists and need more training and guidance on nutrition, and as such run weak nutrition services. Some nutrition focal persons have had just about two trainings in nutrition over a period of three years and supplement their knowledge through personal reading.

Given the integrated nature of OVC services, ample opportunity exists to introduce or strengthen the nutrition component of OVC services through multiple channels, such as Savings and Loan Association meetings, the regular kids and youth clubs meetings, and the annual get-together meetings of these clubs. The Savings and Loan Association weekly meetings held by the Christian Aid for OVC caregivers provide opportunities for effective nutrition counseling, education, and behavioral change activities. The household economic strengthening service recognizes that some families living with OVC lack adequate economic resources to meet their children’s physical and material needs. Thus, OVC partners often implement interventions that increase the capacity of such households to cope with tough economic situations through focus activities related to microfinance, improving agricultural productivity and efficiency, imparting vocational life skills, and strengthening social safety nets. Economic-strengthening activities can potentially be integrated with nutrition and health services for OVC and their caregivers.

8.5 Christian Aid

Christian Aid provides OVC services in FCT, covering the five major OVC service areas, through its major partner, ASWHAN. One of the community-based organizations it uses to implement OVC services in the FCT is the Unique Aid Foundation.

The key OVC services provided by Christian Aid include the following:

- **Education support through block grants to schools:** Christian Aid provides materials and services to schools to offset the costs of caring for OVC over a certain period of time.
- **Economic strengthening using Savings and Loan Associations:** This involves providing business support and self-help grants to groups of OVC caretakers. Members make weekly contributions, and association members have opportunities to borrow from the pooled funds. Meetings are held on a weekly basis and involve caregivers for more than 500 OVC.
- **Psychosocial care through the kids and youth weekly meetings:** Trained facilitators train caretakers on relationship issues in the community and family. OVC also share and interact with each other during these weekly meetings.
- **Health service support provided to OVC at health care centers supported by Christian AID:** Christian Aid pays these health centers through block grants to secure the welfare of the OVC on a regular basis. Partner organizations have staff members with some background in health, who help meet the health needs of the OVC and coordinate referrals to health facilities.

8.5.1 Food and nutrition services provided by Christian Aid

Christian Aid conducts the following nutrition-related activities:

- **Training:** The agency uses nutrition consultants to train Christian Aid staff and partners to provide step-down training to community volunteers. This training emphasizes the use of locally available foods to improve the nutritional status of OVC and promote dietary diversity. However, Christian Aid has conducted only two nutrition-related trainings in the past two years.
- **Nutrition counseling:** Christian Aid staff and affiliates provide nutrition counseling and support rather than commodity-based services.
- **Facilitation of food-based provisions:** Food supplements for severely malnourished children are provided periodically through the USAID Maximizing Agricultural Revenue and Key Enterprises in Targeted Sites (MARKETS) project. Unique Aid liaises with an organization called Compassionate Heart Initiative and the MARKETS project to secure food supplements such as Richfil for children. The Unique Aid Foundation has a nutritionist who supports the initiative from time to time.

Other nutrition services include the following:

- Growth monitoring and promotion (quarterly) conducted by community health volunteers, who monitor the growth of children and provide education to caregivers.
- Cooking demonstrations, held infrequently—perhaps once a year.
- Home gardening activities at the community level encouraged through support groups.

Of all the services offered by Christian Aid, the two program areas that have perhaps contributed the most to improving the wellbeing of OVC are the economic and psychosocial support services. The loans received by caregivers help with their businesses, as well as pay school fees, improve their diets, and reduce challenges to their livelihoods. The psychosocial support is aimed at building self-esteem in children. This helps to make them feel loved, enhances their mental and retentive capacities, and improves their school performance. The nutrition component is considered particularly weak.

8.5.2 Supervisory support to Christian Aid from the FMOH and FCTA

Christian Aid receives little supervisory support from the FMOH. Contact is limited to sharing reports and attending trainings organized by the ministry. Christian Aid has not been supervised by the FCTA.

8.5.3 Follow-up of OVC in the context of food and nutrition services

Community support group meetings help in following up on OVC. Because Christian Aid services are community-based, tracking of OVC is done within the context of community-based operations. Tracking those lost to follow-up begins when they stop coming to meetings. They are then reached through community volunteers.

CBOs such as Unique Aid have facilitators and mentors who play important roles in following up on OVC. The facilitators are trained to work with the youth and kids clubs on a weekly basis. The mentors visit OVC at home and school and monitor the relationship between the OVC and their caretakers. This helps in finding out issues of child abuse, expulsion from school, and other related matters. These home and school visits also help in identifying the nutritional and health challenges of the OVC. The facilitators and mentors report any cases of absence, abuse, and other observations on the wellbeing of the OVC.

Growth faltering is detected through the periodic weighing of children by the M&E officers during kids and youth clubs, and corrective actions are recommended. Usually, the results of the weighing serve as the basis for nutrition counseling. The officers use weighing scales, mid-upper arm circumference tapes, and registers.

8.6 Winrock

Winrock staff members have provided care and support services for about four years under the AIM project. This project covers nutrition services for children under five and includes conducting baseline surveys as a basis for providing needs-based services, liaising with the MARKETS project to provide food supplements, providing nutritional or health advice and counseling, using basic care kits to address health and nutrition challenges, distributing mosquito nets, and promoting family planning and birth spacing. RAPAC is the Winrock partner that implements OVC programs in some of the communities in the FCT. This agency has about five years of experience in issues for preschool-aged children. The major service areas of the Winrock-supported OVC programs are the provision of food and food supplements, growth monitoring and promotion, and hearth sessions (see below).

8.6.1 Food and nutrition services

Supplying food and food supplements to OVC and their caregivers is the primary area of support for Winrock. Foods such as eggs, milk, and fruits are made available to children at the Acada Learning Centres. Rice, beans, and other foods are supplied to caregivers, and Richfil supplements from the MARKETS project are provided to OVC households. Under

RAPAC, the provision of food at the Acada Learning Centre started in 2007. In addition, RAPAC hired a nutritionist to guide the feeding of children. Caregivers have also been trained on how to prepare meals using various recipes. Food supplements are provided to households on a monthly basis. In 2009, approximately 112 OVC benefited from this service. In 2010, the figure was 75.

8.6.2 Growth monitoring and promotion

Winrock completed a baseline assessment that included nutrition assessment and screening for many communities, including Idu-Karimo and Nyanya in the FCT. Monthly growth monitoring activities are targeted to children under five years. These activities also include nutrition and health counseling, referrals as needed, home visits, and provision of basic care kits to promote water sanitation and hygiene.

8.6.3 Hearth sessions

Promotion of exclusive breastfeeding and adequate complementary feeding takes place in the context of hearth sessions, which are community-based nutrition education and rehabilitation sessions. These sessions also include cooking demonstrations. Partners work with nutritionists, who provide training and technical support.

8.6.4 Other service areas

Winrock contributes to three other important service areas: economic strengthening, psychosocial support, and health services support. To facilitate economic strengthening, caregivers receive grants and training to be economically productive. OVC receive psychosocial support in the form of counseling on a one-on-one basis. In addition, clubs are organized for them with monthly meetings where they can interact with friends and have a good time. The health component of Winrock's services to OVC involves providing health talks and referring individuals who are ill to specific clinics that have an arrangement with RAPAC.

From RAPAC's point of view, the service areas that have most improved the wellbeing of OVC are those offering educational support, economic strengthening, and distribution of food.

8.6.5 Supervisory support received from the MWASD

The OVC division of the MWASD conducts supervision on a quarterly basis. Supervision includes evaluating the quality of services, checking guidelines, receiving updates on progress toward set targets in program areas, and identifying challenges in all service areas. A checklist is used for this monitoring process.

8.6.6 System of following OVC and tracking those OVC lost to follow-up in food and nutrition services

OVC are followed through home visits, where health workers monitor each child and use tools to assess the child's wellbeing. Consistent home visits are critical because most OVC are lost through relocation to other communities, death, or other crises. The project encourages caregivers to identify locations to which OVC are moving and then links them with the nearest OVC care and support service. Typically, teachers, volunteers, and RAPAC staff are all involved in following and tracking OVC. They provide feedback to RAPAC

management, who then visit the centers and work on the reports to confirm and address issues raised.

8.6.7 Referral system for nutrition and food services

For services the group does not provide, Winrock provides referrals to linked institutions. Referrals are often identified through anthropometric data obtained during growth monitoring and promotion. To support this process, community volunteers support supervision, monitoring, and tracking of OVC, as well as other related services. Some community health workers also serve as community volunteers, which increases referrals to health facilities.

8.7 CACA

CACA partners with both CRS and FHI/GHAIN in implementing its OVC programs. Thus CACA serves as a sub-grantee of FHI/GHAIN, as well as CRS.

8.7.1 FHI/GHAIN-supported CACA OVC program

The FHI/GHAIN-supported CACA OVC program began in September 2009 in the FCT. Nationally, GHAIN implements OVC programs in 14 LGAs across 9 states. Within each LGA, it works to identify and enroll all eligible OVC. As of July 2010, it had approximately 2,050 OVC meeting its eligibility criteria.

The FHI/GHAIN CACA OVC program includes nutrition education, caregiver empowerment, support for small home gardens, and enrichment of complementary foods (e.g., Tom Brown) as its major food and nutrition-related activities.

FHI/GHAIN builds capacities of CBOs and community-based volunteers for nutrition assessment and counseling. It also promotes use of locally available foods. It provides CBOs with simple processing machines to produce complementary foods, especially Tom Brown, which consists of millet, soybeans, groundnut, and maize. Tom Brown is provided free of cost to all children under five years and used to treat malnourished children over five years old.

FHI/GHAIN provides integrated nutrition and health training for its CBOs and subgrantees under the HIV/AIDS, Sexually Transmitted Diseases and Tuberculosis programming model. Its OVC programs take place in the same locations where it provides services in the prevention, control, and treatment of HIV/AIDS, sexually transmitted diseases, and tuberculosis. It uses an LGA service-delivery model that allows for substantial participatory LGA input in determining the project work plan and activities. Thus, it builds the capacities of primary health care centers and links community-based volunteers/organizations to the facilities that service their communities. Within this context, nutrition training on anthropometric assessment is provided alongside training on infant and young child feeding and production of complementary foods using locally available resources. FHI/GHAIN also plans to provide CBOs with job aids and IEC materials in different aspects of nutrition, especially on infant and young child nutrition.

FHI/GHAIN sees the household economic strengthening component of OVC services as an important area of investment that is critical to improving the nutrition and food security status of OVC. While it currently builds the knowledge of caregivers and CBOs on methods to enhance incomes and produce and use locally available foods, it plans to go beyond education to provide caregivers with actual support in terms of seeds for planting and

equipment for local food processing, as well as additional assistance such as birds for homestead poultry farms.

FHI/GHAIN's food and nutrition services are overseen by a nutritionist, a professional nurse, and a physician. Thus, FHI/GHAIN appears capable of delivering food and nutrition services more effectively than other OVC partners.

FHI/GHAIN's key nutrition indicator is the PEPFAR indicator on the number of OVC benefiting from nutrition services. Community volunteers report on a monthly basis to the CBOs, which in turn report to FHI/GHAIN. These data are used to monitor the child survival index, which assesses vulnerabilities, needs, and outcomes of OVC, thus making programmatic decisions based on the information generated.

8.7.2 CRS-supported CACA program

The CRS-supported CACA OVC program commenced in 2006 and currently has 1,800 OVC. It works in the service areas of food and nutrition, education support, psychosocial support services, and economic strengthening:

- **Economic strengthening:** CRS supports a savings and internal lending community program, where members are able to secure loans for livelihood opportunities. About 1,000 OVC caretakers are benefitting from this service.
- **Education and vocational support:** The program pays school fees and provides materials and vocational training for the OVCs—both directly and through block grants. Teachers are also trained as part of the educational support service.
- **Psychosocial support services:** Psychosocial support is provided through support group meetings, home visits and recreational activities. Children identified as being at elevated risk receive additional support.
- **Medical support:** OVC and caretakers receive multivitamins and learn how to treat minor illnesses and to maintain hygiene and sanitation. Referrals are made to health facilities when necessary. Health talks and information are also given during home visits and community support meetings.
- **Legal protection:** Through the Catholic Justice, Peace and Development Council, referrals are made in cases of child abuse, or when it is necessary to acquire birth certificates. Referrals are also made to report cases of child labor.

Support related to food and nutrition includes:

- **Food distribution:** Although food used to be supplied during monthly support group meetings, this practice has been irregular recently because of funding constraints.
- **Home gardens:** Caretakers learn how to grow foodstuffs through home gardens.
- **Training:** Counselors are trained on infant feeding counseling, exclusive breastfeeding, safe replacement feeding, appropriate complementary foods, and Plumpy'Nut[®] (when available for malnourished children).

Successful programs

From the CACA point of view, all the service areas have improved the wellbeing of OVC. Economic strengthening increases income and helps improve the self-reliance of OVC and their caretakers. Educational support is enabling many OVC to graduate from secondary

school and move to better opportunities. Through psychosocial support, trained caregivers are able to address sensitive developmental issues.

Status of food and nutrition support

The regular provision of food to OVC and their caregivers was once a key component of the CRS-supported OVC program. Now, supplies are not regularly available to caregivers. The counseling aspects of nutrition services need substantial strengthening because a limited number of service providers have the requisite skills and training to effectively conduct nutrition counseling.

Following up OVC by CACA

Community volunteers play major roles in following up OVC. Each volunteer is responsible for specific households and writes monthly reports on each household. Volunteers report on several indices, including frequency of food consumption, nutritional status, food availability, and signs of illness.

8.8 Opportunities to improve food and nutrition services for OVC

Key gaps and opportunities identified by the various OVC partners and their programs are summarized as follows:

- **Lack of nutrition professionals:** There are not enough nutritionists in the overall OVC programs and service systems in Nigeria. The Nutrition Division at the federal level, as well as nutrition units at FCTA and area councils, should all become engaged in OVC programs. This involvement would improve the food and nutrition services offered by OVC programs.
- **Training:** More training on food and nutrition-related issues in OVC programming is needed. Nutritionists are needed to train OVC project staff on proper nutrition counseling and education, as well as to demonstrate foods and appropriate feeding patterns. This training, which can be performed during support group meetings, can help ensure that OVC and caretakers meet their nutritional needs using locally available foods.
- **Nutrition education and counseling:** Given the limited nutrition skills and expertise among OVC partners and their affiliate organizations, training is needed in the areas of nutrition and HIV infant feeding counseling. Training is also needed in the areas of effective communication, nutrition assessment, growth monitoring and promotion, and supervision skills.
- **Behavior change materials:** Many organizations lack needed materials (e.g., relevant posters, counseling cards, take-home brochures, or other pamphlets on nutrition), and some do not have growth monitoring charts.
- **Integration of nutrition into economic strengthening and other OVC services:** Nutrition education and counseling could be effectively integrated into household economic strengthening programs such as the Savings and Loan Association meetings and psychosocial support activities such as support group meetings.

Key directions, conclusions, and recommendations

1. Status of nutrition-related activities in Nigeria

1.1 Various stakeholders coordinate nutrition and related activities in Nigeria

A wide range of stakeholders are involved in implementing and coordinating nutrition-related activities in Nigeria at various levels. While overall coordination of nutrition activities in Nigeria structurally lies with the National Committee on Food and Nutrition, key agencies that coordinate the national response and provide overall policy direction with respect to PMTCT and nutrition-related activities are the NASCP and the Nutrition Division of the FMOH. The FCTA coordinates all state activities in the FCT. There are no indications of functional multisectoral structures for nutrition coordination at the area councils. There are strong indications of the need to support the strengthening of leadership and coordination of activities and resources in the field of infant and young child feeding programs in Nigeria. Agencies have implemented piecemeal infant and young child nutrition activities without a sustained, coordinated, and comprehensive approach.

1.2 Infant and young child feeding counseling

Across all facilities, antenatal care and some of the key contact points in the PMTCT and maternal and child health (MCH) services present ample opportunity to provide infant and young child feeding and maternal nutrition counseling.

The different facilities studied have different levels of workers with varying levels of skills depending on the complexity and organization of operations in those facilities. Information currently being given to mothers differs across facilities, and in many cases this information does not reflect current guidelines. In general, across all the facilities, women are encouraged to exclusively breastfeed for the first six months. Counseling for HIV-positive women varies across the facilities: some facilities advise women not to breastfeed at all but to adopt replacement feeding, and others advise women who insist on breastfeeding to breastfeed—but only for a maximum of three months. Generally, the facilities lack a robust system of tracking postnatal infant feeding counseling. A system for updating key actors and service providers with the latest developments in the field of infant and young child nutrition on a timely basis is obviously needed.

1.3 Counseling on complementary feeding

Complementary feeding counseling receives significantly less attention than breastfeeding counseling. Generally, feeding semisolid and solid foods at six months is advised in health facilities, rather than the practice of introducing these foods at three months in some communities. Counseling also focuses on enriching home-prepared complementary foods, as well as on active and responsive feeding, and speaking out against force-feeding. Limited resources are available for on-site cooking demonstrations, which would teach mothers how to appropriately prepare food at home.

1.4 Counseling environment and skills

The overall counseling environment in most facilities is less than satisfactory. Group counseling (i.e., health talk) for HIV-negative women is generally the norm. Having a detached, dedicated, and conducive counseling session will greatly improve infant and young feeding counseling in some of the facilities.

1.5 Identifying infants lost to follow-up in PMTCT

Most follow-up actions seem to be linked to missed immunizations. Facilities seem to have good systems for following up with HIV-positive mothers who miss an appointment (i.e., a phone call at first and then sometimes visits by a home-based care nurse, neighbors, or the support group). No apparent systems exist for identifying or tracking infants of HIV-positive mothers who are lost to follow-up (unless for immunization visits). Home visits for HIV-positive mothers are common to encourage clients to return for services.

1.6 Training and nutrition communication

At the heart of preventing and reducing the incidence of undernutrition is a sustained BCC strategy through a variety of channels. For this, appropriate and up-to-date materials are needed. The availability and use of relevant BCC materials is quite low across the facilities, and available materials do not have current information, thus presenting an important opportunity for intervention. Training on nutrition counseling, education, and BCC is inadequate for health staff in terms of intensity, duration, frequency, and appropriateness of training content.

Few trained nutritionists work in the facilities, area councils, and relevant state departments. There is a need for more qualified staff, including nutritionists and dietitians, nurses, physicians, community health extension workers, and social workers. Nutrition teams at the federal, FCTA, and area council levels need to become more involved in nutrition issues related to HIV and OVC.

1.7 Maternal nutrition

Maternal nutrition appears to be a neglected aspect of the nutrition program, with facilities providing only limited services. There are no targeted initiatives to improve maternal nutrition. Because infant and young child nutrition begins with the mother, maternal health and nutrition are important influencing factors that deserve attention.

1.8 Supervisory and monitoring functions

Supervision and monitoring of nutrition programs is not conducted at any level of the health system. The NASCP and Nutrition Division of the FMOH indicated significant constraints to carrying out their supervisory and M&E functions. Key challenges include funding difficulties and lack of appropriate M&E and supervision tools. Supervision and monitoring tools and processes at the national, state, and local government levels need to be clarified and strengthened.

1.9 Funding

Financial and programmatic support for promoting good complementary feeding practices is limited. Significant funding gaps remain, despite the fact that a range of international development partners provide both financial and technical support to these agencies in areas of training, development, and dissemination of IEC materials. Government funding is usually inadequate and arrives late.

1.10 Community outreach

The forums for health talks and discussions during the various community outreaches provide opportunities for infant and young child feeding counseling in different contexts. Home visits complement messages disseminated through the health talks. These visits help to ensure

compliance with information given during counseling sessions and encourage more people in the community to access health services. Nutrition communication could be intensified to reach more people by increasing the frequency of these outreach activities.

1.11 OVC services

Although OVC services are implemented in an integrated manner, the Food and Nutrition Service recognizes that many households caring for OVC lack consistent access to nutritionally adequate foods and are chronically food insecure. Nutritional counseling and support received from OVC organizations appears to be limited. The food and nutrition component of OVC services in Nigeria has been identified as a major area that requires significant attention.

There are not enough nutritionists available to support OVC programs and services in Nigeria. Involving more nutritionists in OVC programs is critical to improving the quality and content of food and nutrition services within the programs. Given the limited skills of OVC partners and their affiliate organizations vis-à-vis nutrition, much training is needed in the areas of nutrition in the context of HIV and infant feeding counseling. Training is also required for comprehensive and effective communication, nutrition assessment, growth monitoring and promotion, and supervision skills.

In the past, many caretakers were provided with food. This practice is being reviewed and has been irregular. The emphasis is now on promoting food security and improved nutrition through community-wide efforts geared at creating sustainable structures that will enable OVC households to meet their food and nutritional needs.

Among HIV-positive mothers, breastfeeding is common, but exclusive breastfeeding is not. In Karimo, wet nursing still occurs among caregiver relatives and nonrelatives of orphaned children. Orphaned babies often receive infant formula, which is fed using a cup and spoon. Bottle-feeding is also common. Caregivers receive advice from sources such as nurses at health facilities, churches, community-based support groups, OVC organizations, and grandmothers.

Many OVC programs have strong community-based systems for following individual OVC and tracking those OVC who are lost to follow-up. These systems can be improved and strengthened by building more robust service delivery systems that effectively integrate the various service components, while promoting faster communication, improved monitoring and reporting systems, more responsive coordination, and increased community involvement.

Research into local food needs and preferences of the target groups is needed to inform the development of food supplements for infants and young children.

2. Key recommendations

2.1 Policy and guidelines

- Review, update, and disseminate unified guidelines on infant and young child feeding and HIV, as well as nutrition for OVC.

2.2 Training and nutrition communication

- Build the capacity of all categories of health workers to counsel on infant feeding options in both HIV and non-HIV contexts, through more training, supervision, and monitoring of service quality.

- Adapt, interpret and communicate policies and guidelines on infant and young child nutrition to health workers in more user-friendly formats to help them easily understand key issues and pass this information on to their clients.
- Revive the BFHI through reorientation workshops and meetings on the ten steps to successful breastfeeding and large-scale production of relevant IEC materials in major local languages.
- Revitalize efforts to address and improve complementary feeding practices.
- Develop and disseminate appropriate monitoring tools, checklists, and reporting forms that adequately capture infant, young child, and maternal nutrition issues.
- Strengthen growth monitoring and promotion activities through training, establishing functional nutrition centers and regularly providing materials such as food items, posters, pamphlets, weighing scales, length boards, and height meters. Additionally, ensure that environments for nutrition counseling are conducive to success.

2.3 Advocacy

- Engage the Secretary of the Health and Human Services Secretariat through the PHD in a thorough debrief on the findings of this service provision assessment in the FCT to clarify the role of the government, as well as increase advocacy for its funding and support for nutrition activities.
- Support the Nutrition Department to strengthen and properly position itself into collaborating effectively with the PMTCT and HIV/AIDS control team to address and improve infant feeding counseling in PMTCT and HIV/AIDS control services.
- Facilitate replication of the collaboration between the FMOH Nutrition Division and PMTCT agencies at the federal level down to the state and area council levels. Through this effort, nutritionists at the lower tiers can obtain a significant voice and role in the implementation of the national consensus and other policies and guidelines on infant feeding and counseling in PMTCT, HIV, and related activities.
- Take advantage of the monthly FCT-wide public-private partnership and the NGO forum to influence decisions, share materials, create awareness, coordinate and collaborate on nutrition activities, and mobilize support for FCT-wide and national-level nutrition initiatives.

2.4 Supervision

- Strengthen supervision and monitoring activities at the national, state, and local government levels.

2.5 Integrated community outreach

- To ensure the project's effectiveness, position IYCN to consistently support the integration of nutrition messages into community outreach programs.
- Strengthen community outreach to encourage mothers to attend health services more regularly to benefit more from the health talks and nutrition counseling at the facility level.
- Facilitate policy actions to provide free antenatal care services, as well as to allocate money for pregnant women to improve their dietary practices.

- Support measures that address hunger and poverty in the communities through the linkage of agriculture, health, and nutrition. Promoting home gardens and providing seeds and other household economic strengthening measures might be alternatives to handing out foodstuffs and supplements.

2.6 Integrated OVC services and programs

- Strategically involve the IYCN Project in making useful contributions to the ongoing review of the national OVC SOP and other relevant policy documents that broaden current thinking on how to make the food and nutrition service component more effective in the overall OVC services framework.
- Engage the Nutrition Division at the federal level and nutrition units in the FCTA and area councils in OVC programs to contribute to improving the food and nutrition services of OVC programs in general.
- Build the skills of OVC partners and their affiliate organizations in the areas of nutrition in the context of HIV and infant feeding counseling, as well as provide them knowledge of comprehensive and effective communication, nutrition assessment, growth monitoring and promotion, and supervision skills.
- Integrate nutrition and counseling into economic strengthening programs such as the Savings and Loan Association weekly meetings, and psychosocial support activities such as the youth and kids club meetings. Provide more support to caregivers by strengthening existing support groups in areas of counseling, economic strengthening, and household food supplementation.
- Provide seedlings and farm implements to promote home gardens and household food security, and offer education and counseling to improve dietary diversity.
- Improve the quality and suitability of food supplements that are customized to meet the needs of infants and young children, through research on local food needs and preferences of the target groups.
- Improve the system of tracking OVC lost to follow-up through more robust service delivery systems that effectively integrate the various service components while promoting faster communication, improved monitoring and reporting systems, more responsive coordination, and increased community involvement.
- Strengthen community-based support systems and support groups for nutrition services in PMTCT, MCH, and OVC.
- Develop and execute a comprehensive and systematic strategy for capacity-building and support supervision around infant and young child feeding, especially in the context of HIV, for all categories of health workers in PMTCT, MCH, and OVC services.
- Develop a comprehensive social and behavior change communication strategy; design/develop appropriate IEC/BCC materials for PMTCT, MCH, and OVC, including print materials (counseling cards, take-home brochures and other job aids), radio programming, and community mobilization activities; disseminate and train providers in their effective use; and monitor and evaluate the impact of these tools prior to updating and republishing or rebroadcasting.

Annex 1. List of persons interviewed

Name	Designation	Address
Pastor Sam Adebajo	OVC Program Manager	RAPAC FCT Field Office; Ph: 0803 294 5773
Nanya Janfa	OVC Program Officer	AIMS, Winrock, Ph: 0803 5871153
Fadere Benjamin	OVC Program Officer	AIMS, Winrock
Akpe Ushang O.	CRS OVC Program Coordinator	Catholic Action Committee on AIDS (CACA); Ph: 0803 367 0561
Amaka Jidefo	GHAIN OVC Program Coordinator	Catholic Action Committee on AIDS (CACA)
Oge Abazie	OVC Manager	CHRISTIAN AID; Ph: 0803 601 8228
Edward Ogiji	Program Officer	Unique Aid Foundation; Ph: 0703 930 9928
Jael Kwakfut	Referral Officer	FHI/GHAIN, Abuja; Ph: 08037194132
Dr. Catherine Gana	OVC Coordinator	FHI/GHAIN; Ph: 0803 596 0091
Dr. Adeola Efuntoye	OVC Care and Support Officer	FHI/GHAIN; Ph: 0803 354 7545
Gba James Tarfa	OVC Care and Support Officer	FHI/GHAIN; Ph: 0703 549 2476
Jide Adebisi	Nutritionist	FHI/GHAIN; Ph: 08022 307 9498
Patricia Suswam	Regional Team Leader, CRS OVC Program	Catholic Relief Services; Ph: 0803 960 6231
David Atamwalen	Deputy head of Health and HIV/AIDS Program Quality	Catholic Relief Services; Ph: 0803 418 4274
Dr. Yinka Falola-Anoemuah	M&E Advisor/Consultant	MSH/LMS/OVC Division, Federal Ministry of Women's Affairs; Ph: 0806 547 7269
John Duru	Program Officer	OVC Division, Federal Ministry of Women's Affairs, Federal Secretariat, Abuja; Ph: 0803 606 8357
Rose Ufomadu	Nursing Officer	Sister of Nativity Catholic Primary Healthcare Centre, Jikwoyi, AMAC
Martha Dogo	Nutrition Coordinator	Abuja Municipal Area Council, Area 10; Ph: 0703 787 7501
Yemi Nyisana	HIV/Coordinator	Abuja Municipal Area Council, Area 10; Ph: 0803 316 2076
Elizabeth Iliya Dakwoi	Nutrition Coordinator	Kwali Area Council, Kwali; Ph: 0803 693 0981
Dr. Ngige	National HIV/AIDS and STDs Control Programme	NASCP Ph: 0803 303 8090
Philomena Simon	Senior Health Community Extension Officer (SCHEW)	Yangoji Primary Healthcare Centre; Ph: 0702 609 0365
Deborah Phillip Musa	Junior Community Health Extension Officer	Yangoji Primary Healthcare Centre; Ph: 0703 559 9299
Dr Okonkwo	Chairman	Kwali General Hospital, Kwali
Dr. Fagbohun	Chief Medical Officer	Kwali General Hospital; Ph: 0803 303 8608
Mrs. Shekara	Principal Nursing Officer	Kwali Gen. Hosp; Ph: 0705 514 1583

Name	Designation	Address
Dr. Bello	Chairman	Asokoro General Hospital
Dr. Adebayo	PMTCT Coordinator	Asokoro General Hospital
Dr. Momoh	Head of Department	Public Health Department, FCTA, Area 11
Lyddah Maddo	PMTCT Officer	Public Health Department, FCTA, Area 11; Ph: 0803 604 8373
Hajiya Wasilla	Community Mobilization Officer	HIV/AIDS Control Unit, Public Health Department; Ph: 0803 613 6382
Hajiya Zainab	M&E Officer	FCT Action Committee on AIDS; Ph: 0702 461 5106
Hajiya Zubainatu	Head, HIV/AIDS Control Unit	Social Development Secretariat, Area 10, Office of the Secretary, Arts and Culture Complex; Ph: 0803 654 2507
Victoria Ikeliani	Nutrition Coordinator	Nutrition Unit; Public Health Department, FCTA, Area 11; Ph: 0803 325 3364
Clementina Okoro	Nutrition Officer	Nutrition Unit; Public Health Department, FCTA, Area 11; Ph: 0806 549 9105
Ify Mbanugo	Health Educator	Health Promotion Unit; Public Health Department, FCTA, Area 11; Ph: 0803 332 1884
Chizoba Edemba	Nutrition Officer	Nutrition Unit; Public Health Department, FCTA, Area 11; Ph: 0803 332 1884
Beatrice Eluaka	Acting Head	Nutrition Division, Federal Ministry of Health; Abuja; Ph: 0803 300 5903
Ameachina Chinelo	Prevention Officer	Catholic Action Committee on AIDS (CACA); 0805 078 0641
Tina Isiugo	Monitoring and Evaluation Officer	Catholic Action Committee on AIDS (CACA); Ph: 0802 326 4385
Ogwuchi Mary	OVC Caregiver	CACA community in Karu under St. Mary's Parish, Karu; Ph: 07066 161 8630
Dorathy Ugo	OVC Caregiver	CACA community in Karu under St. Mary's Parish, Karu; Ph: 0806 926 7625
Dorcas Rita	OVC Caregiver	CACA community in Karu under St. Mary's Parish, Karu; Ph: 0802 411 8058
Mary Abba	OVC Caregiver	CACA community in Karu under St. Mary's Parish, Karu; Ph: 0803 602 9220
Charity Madaki	OVC Caregiver	CACA community in Karu under St. Mary's Parish, Karu
Rita Ahum	OVC Caregiver	CACA community in Karu under St. Mary's Parish, Karu

Name	Designation	Address
Sanatu Zara	OVC Caregiver	Unique Aid Community in Karu
Agbadai Bawa	OVC Caregiver	Unique Aid Community in Karu
Hajana Giwa	OVC Caregiver	Unique Aid Community in Karu
Asibi Maiwazi	OVC Caregiver	Unique Aid Community in Karu
Elizabeth Ezekiel	OVC Caregiver	Unique Aid Community in Karu
Liatu Danjuma	OVC Caregiver	Unique Aid Community in Karu
Saratu Karu	OVC Caregiver	Unique Aid Community in Karu
Ladi Dogo	OVC Caregiver	Unique Aid Community in Karu
Victoria Babe	OVC Caregiver	Unique Aid Community in Karu
Elizabeth Jeghi	OVC Caregiver	Unique Aid Community in Karu
Mary Saukanmi	OVC Caregiver	Unique Aid Community in Karu
Mary Kato		Ph: 0805 561 0305