KADUNA STATE POLICY ON FOOD AND NUTRITION

2017

Planning and Budget Commission
No. 16, Muhammadu Buhari Way,
Kaduna.

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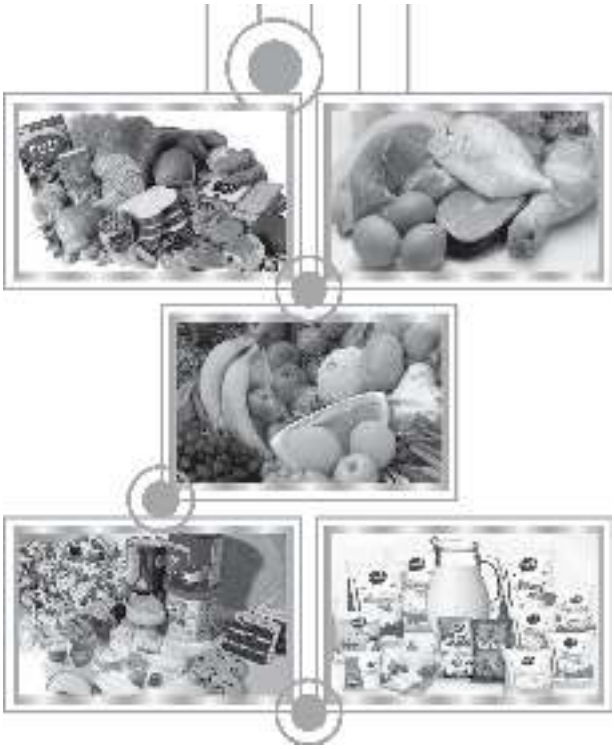

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TABLE OF CONTENTS

ABBREVIATIONS / ACRONYMS	iii - v
FOREWORD	vi - vii
PREFACE	viii - ix
CHAPTER ONE: Introduction	1
1.1 Background	1 - 2
1.2 Food and Nutrition Situation	2 - 8
1.3 Guiding Principles of the Policy	9
CHAPTER TWO: Vision, Goal and Objectives of the Food and Nutrition Policy	10
2.1 Vision Statement	10
2.2 Goal	10
2.3 Objectives	10
2.4 Targets	11
CHAPTER THREE: Strategies	12 - 21
CHAPTER FOUR: Institutional Arrangement, Legal Framework and Financing	22 - 29
CHAPTER FIVE: Monitoring and Evaluation	30 - 33
Glossary of Terms	34 - 35

ABBREVIATIONS/ACRONYMS

AIDS	-	Acquired Immune Deficiency Syndrome
ARV	-	Anti-retroviral
BCC	-	Behaviour Change Communication
BMI	-	Body Mass Index
BMS	-	Breast Milk Substitute
CAADP	-	Comprehensive African Agriculture Development Programme
CBOs	-	Community-Based Organizations
CMAM	-	Community Management of Acute Malnutrition
CSOs	-	Civil Society Organizations
CS-SUNN	-	Civil Society-Scaling Up Nutrition in Nigeria
DFID	-	Department for International Development
ENA	-	Essential Nutrition Actions
FAO	-	Food and Agriculture Organization
FBOs	-	Faith Based Organizations
FMOH	-	Federal Ministry of Health
GARPR	-	Global Aids Response Country Progress Report, Nigeria
HIV	-	Human Immunodeficiency Virus
ICN	-	International Conference on Nutrition
IDA	-	Iron Deficiency Anaemia
IDD	-	Iodine Deficiency Disorder
IFPRI	-	International Food Policy Research Institute
IMAM	-	Integrated Management of Acute Malnutrition
IMNCH	-	Integrated Maternal Newborn and Child Health
ITP	-	In Patient Therapeutic Program
IUGR	-	Intra-Uterine Growth Retardation
IYCF	-	Infant and Young Child Feeding

LBNS	-	Liquid Based Nutrient Supplement
LGA	-	Local Government Area
LGCFN	-	Local Government Committee on Food and Nutrition
LO-ORS	-	Low Osmolarity Oral Rehydration Solution
MAM	-	Moderate Acute Malnutrition
MBNP	-	Ministry of Budget and National Planning
MDAs	-	Ministries Departments and Agencies
MDGs	-	Millennium Development Goals
M & E	-	Monitoring and Evaluation
MICS	-	Multiple Indicator Cluster Survey
MNDC	-	Micronutrient Deficiency Control
PBC	-	Planning and Budget Commission, Kaduna
MoAF	-	Ministry of Agriculture and Forestry, Kaduna
NAFDAC	-	National Agency for Food and Drug Administration and Control
NBS	-	National Bureau of Statistics
NCFN	-	National Committee on Food and Nutrition
NDHS	-	Nigeria Demographic and Health Survey
NFA	-	National Fortification Alliance
NFCNS	-	Nigeria Food Consumption and Nutrition Survey
NFSP	-	National Food Security Programme
NGOs	-	Non - Governmental Organizations
NCN	-	National Council on Nutrition
NNN	-	National Nutrition Network
NPC	-	National Planning Commission
NPHCDA	-	National Primary Health Care Development Agency
NSHDP	-	National Strategic Health Development Plan
OTP	-	Out Patient Therapeutic Program
OVC	-	Orphan and Vulnerable Children

PATH	-	Programme for Appropriate Technology in Health
PLWHA	-	People Living With HIV/AIDS
RRA	-	Rapid Rural Appraisal
RUTF	-	Ready to Use Therapeutic Foods
SAM	-	Severe Acute Malnutrition
SBCC	-	Social and Behavioral Change Communication
SCI	-	Save the Children International
SCFN	-	State Committee on Food and Nutrition
SDGs	-	Sustainable Development Goals
SMART	-	Standardized Monitoring Assessment of Relief and Transitions
SMoHH	-	State Ministry of Health and Human Services
SUN	-	Scaling up Nutrition
UN	-	United Nations
UNICEF	-	United Nations Children's Fund
USI	-	Universal Salt Iodization
USI-TF	-	Universal Salt Iodization Task Force
VAD	-	Vitamin A Deficiency
VP	-	Vice President
WHA	-	World Health Assembly
WHO	-	World Health Organization

FOREWORD

Food is a critical aspect of human development of any nation. Numerous studies have shown the relationship between proper nourishment for children in the first 1000 days of their lives and their cognitive development in the long run.

Malnutrition and nutrition-related issues continue to be one of the major health concerns in Nigeria and Kaduna in particular, putting at risk our ability to achieve the dividends of our youthful demographic. In recognition of this, the present administration declared a state of emergency on malnutrition in order to address the severe acute malnutrition affecting various vulnerable groups in the state. Malnutrition manifests itself mainly as undernutrition, over nutrition and micronutrient deficiencies. However, there is close relationship between malnutrition and under-development which ahs continued to be emphasized, particularly at the various international summits aimed at improving the welfare of women and children.

An important conclusion that emerged from these discussions and in particular, from the 2014 International Conference on Nutrition (ICN2), held in Rome, was that nutritional well-being of all people is a pre-condition for development and a key objective of progress in human development.

Indeed, 'zero hunger' has been globally agreed as the second goal in the United Nations Sustainable Development Goals (SDGs). Therefore, a good government has to focus its effort in addressing the issue of malnutrition as an important goal of development.

I am pleased that the factors, which have led to the persistent and sometimes, worsening malnutrition and poor health of our people, have been identified and documented. Malnutrition contributes to

poor health, aggravates diseases, reduces productivity and compounds poverty and its after effects.

The recent adoption of the National Policy on Food and Nutrition by the Kaduna State Government is another major landmark in the efforts of the present administration towards addressing the problem of malnutrition, which has been most devastating among young children, pregnant and lactating mothers. The policy has been adopted to add value and strengthen the synergy among sectors and other initiatives of Government and Partners. It is expected that all other policies that have any bearing on food and nutrition should be updated in line with this policy.

With the approval of the policy by the State Executive Council (SEC), I therefore recommend effective implementation of this policy to achieve the objective of ensuring optimal nutritional status of people in Kaduna State.

The government will continue to acknowledge the assistance provided by donor agencies in the execution of the State Food and Nutrition Policy.

Muhammad Sani Abdullahi
Commissioner, Planning and Budget
Kaduna State

PREFACE

Malnutrition remains a key health challenge in developing economies. Irrespective of level, individual or community, it impacts negatively on the well-being of the people, draining human resources, thus hindering adequate economic development with enormous costs in human, social and economic terms.

Over the years, Kaduna State has undergone some social and economic transformations that have resulted in the improvement of the citizens standards of health and food consumption. These transformations have impacted on reducing poverty, social exclusion and consequently on hunger and malnutrition. In realization of food security and access to adequate basic health services as prerequisites for good nutrition, Kaduna State Government of Nigeria is strongly committed to reducing hunger and malnutrition, using a multi-sectoral and multi-disciplinary programme approach including various interventions at the community, local and state as well as the national level.

The adopted policy provides an overarching framework, covering the multiple dimensions of food and nutrition improvement. The policy adds value and strengthen synergy among sectors and other initiatives of government and partners. It recognizes the need for public and private sector involvement, and that hunger eradication and nutrition improvement is a shared responsibility of all persons. The policy also aim to address the problems of malnutrition and extreme hunger across different levels of the society ranging from the individual, household and communities, thus contributing to the overall development. A holistic approach is envisioned for the implementation of this Policy, which shall involve sectoral Ministries, institutions of higher learning, the private sector, individuals, families, communities, Community-Based Organizations (CBOs), Non-Governmental Organizations (NGOs), Faith -Based Organizations (FBOs), Civil Society Organizations (CSOs), Media, Professional Associations and the International Agencies.

The adoption of this Policy allows the enactment of guiding principles and pertinent strategic options for efficient implementation of nutrition interventions to address malnutrition in Kaduna State.

I wish to appeal to State Government Ministries, Departments and Agencies, Local Governments Councils, International Development Partners, Civil Society Organizations and all other stakeholders, to work closely with the State Planning and Budget Commission, Kaduna State Emergency Nutrition Action Plan (KADENAP), Ministry of Health and Human Services, Kaduna State Primary Health Care Development Agency, Ministry of Agriculture and Forestry, Ministry of Education, Science and Technology, Ministry of Women Affairs and Social Development, Ministry of Water Resources, and Ministry of Local Government and Chieftaincy Affairs, to implement the Kaduna state Food and Nutrition Policy.

The commission wishes to appreciate the support accorded by the development partners towards the realization of this policy on food and nutrition in the state. We, therefore, reiterate Government's firm commitment to implementing this Food and Nutrition Policy.

Mahmoud Nuhu Yamusa
Permanent Secretary
Planning and Budget Commission,
Kaduna State

Chapter 1
Introduction

1.1 Background

The Kaduna State Food and Nutrition Policy is a document that draws from the framework of the National policy in addressing the problems of food and nutrition insecurity in the State, from the individual, household, community and up to the state level. It guides the identification, design, and implementation of intervention activities across different relevant sectors. Nutrition is a multi-sectoral and multi-disciplinary issue involving various sectors including health, agriculture, education, science and technology, social development, trade, economy, media and industry. In recognition of this, various sectors in Kaduna State have adopted/adapted National policies and strategies to address the nutrition perspectives of their mandates. These documents include:

i. The National Health Policy and Guidelines;
ii. The National Agricultural Policy;
iii. The Agricultural Transformation Agenda;
iv. Science, Technology, and Innovation Policy;
v. National Policy on Education;
vi. National Policy on School Health;
vii. National Policy on Infant and Young Child Feeding (IYCF);
viii. Early Child Care and Development;
ix. National Population Policy;
x. National Policy on HIV/AIDS and OVCs;
xi. National Policy on Non-Communicable Diseases;
xii. National Policy On Gender Mainstreaming;
xiii. National Policy on Security;
xiv. National Policy on Food Safety and its Implementation Strategy and
xv. National Policy on Adolescent Health and Development in Nigeria.

Despite these policies, strategies and programmes, the multi-sectoral and multi-disciplinary nature of nutrition makes the coordination of food

and nutrition activities a challenge. A quick look at history lane, in 1990 a National Committee on Food and Nutrition (NCFN) was established and domiciled in the then Federal Ministry of Science and Technology, to, among other things, coordinate food and nutrition actions and formulate a National Food and Nutrition Policy, with a National Plan of Action. The phasing-out of that ministry in 1993 led to the transfer of NCFN to the Federal Ministry of Health (FMOH). In 1994, the NCFN and emerging programmes were relocated to the National Planning Commission (NPC) now known as Ministry of Budget and National Planning (MB&NP) because of its unique position as the government agency responsible for coordination and monitoring of all national policies and programmes, including budgetary processes, as well as all technical assistance in the country. In Kaduna State, the establishment of the KDSCFN was a response to the General Staff Headquarters, State House letter dated 16th July, 1997. States were all requested 'to put in motion the machinery for the establishment of the State Committees on Food and Nutrition' this was to ensure that the problem of Food and Nutrition are better attended to at the grassroots where they are more prevalent. In 2000, membership of the State Committee on Food and Nutrition was approved by the State Executive Council through Memo No. SM (99) and inaugurated on 21st June, 2001 with the following membership;

Honorable Commissioner, Ministry of Economic Planning	-	Chairman,
Honorable Commissioner, Ministry of Agriculture	-	Member,
Secretary to the State Government	-	Member
Permanent Secretary, Ministry of Health	-	Member
Permanent Secretary, Ministry of Water Resources	-	Member
Permanent Secretary, Ministry of Education	-	Member
Permanent Secretary, Ministry of Information	-	Member
Permanent Secretary, Ministry of Women Affairs & Social Development	-	Member
Permanent Secretary, Ministry for Rural & Community Development	-	Member
Program Manager, KADP	-	Member
Department of Community Medicine, ABU, Zaria	-	Member
Department of Pediatrics, ABUTH, Kaduna	-	Member
Department of Nutrition, Kaduna Polytechnic	-	Member

UNICEF Zonal Office, Kaduna	-	Member
World Health Organization (WHO)	-	Member
Agriculture Project Monitoring and Evaluation Unit (APMEU)		Member
Country Associate Network (CANET)	-	Member
Home Economics Association of Nigeria (HEAN) HGO	-	Member
Nutrition Society of Nigeria	-	Member
Director, International Cooperation, MoEP, Kaduna	-	Secretary

In Nigeria, the first National Food and Nutrition Policy was developed through a multi-stakeholder process and produced by the NPC in 2001. However, this policy had little or no effect in bringing about improvement in the nutrition situation in Nigeria due to the fact that the policy and the plan of action arising from it were not adequately implemented. This has been due largely to poor funding as well as ineffective coordination and monitoring of the policy implementation and non-adaptation of the policy by the states of the federation.

Emerging concerns in the science, practice and programming of food and nutrition activities informed the review of the national policy and adaptation by the states. Some of these emerging critical issues include nutrition in the first one thousand days of life, nutrition during emergencies and upsurge in the prevalence of diet-related non-communicable diseases.

The urgent need to scale up high-impact and cost-effective nutrition interventions, amplified by Nigeria's recent sign up with the Scaling Up Nutrition (SUN) movement in 2011 further justifies the need for the review of the national policy and adaptation by the states were the policy will be implemented.

1.2 Food and Nutrition Situation in Kaduna State

Nationally, almost seven million children under the age of five die every year, (World Health Organisation (WHO). September 2012. Children: reducing mortality Fact sheet 178). Undernutrition accounts for about 50% of all deaths among these children. Stunting, severe wasting, and Intra-Uterine Growth Retardation (IUGR) are the major contributors to child mortality, accounting for about two million deaths of under-fives

annually. Undernutrition is also the number one cause of morbidity for all age groups, accounting for 11% of the disease burden. With regard to maternal mortality, iron deficiency is 7.8%. Malnutrition and nutrition related diseases continue to be problems of public health importance in Kaduna State with the under-five mortality rate of 169/1000 live births. Malnutrition is the underlying cause of 50% of these deaths, (UNICEF. (2011). At a glance: Nigeria)

In addition to a lack of basic protein and energy, the immediate causes of undernutrition are a lack of micronutrients such as vitamin A, iodine, iron, and zinc. Almost 7.8% of women are anemic and 18% are iodine deficient, while close to 24% of under-fives are vitamin A deficient (VAD) and 20% are zinc deficient (Micronutrient Initiative. (2013), Nigeria Country Profile).

1.2.1 Poverty Situation in Kaduna

Nigeria has abundant natural and human resource endowment yet poverty has remained pervasive, multifaceted and chronic. Given the most recent data available, it is estimated that approximately 39% of Nigerians live below the poverty line (MDG 2013 report). Kaduna State is considered a lower-middle-income state. It is estimated that 61% of the population live on less than a dollar a day and 69% live below the relative poverty line, which is set slightly higher at 1.25 dollars per day (66,802 NGN per year). The proportion of Kaduna State living below the relative poverty line has increased significantly from just 27% of the population in 1980. Poverty is not equally distributed; it is higher in rural areas than urban. The degree of inequity among the population is also increasing.

1.2.2 Food Security

Insufficient food causes hunger and malnutrition. Malnutrition is the most serious consequence of food insecurity. The nature and extent of hunger and food insecurity in Nigeria are of public health concern. Available data showed that total average household expenditure on food for the period between 2009 and 2010 was about 65% (NBS, 2012). Nigeria was ranked 38th out of 76 on the 2014 Global Hunger Index (IFPRI, 2014).

According to Kaduna State Bureau of Statistics 2016 Household survey, 6.3 percent of households reportedly find it difficult satisfying their need

for food. While 35.6 percent said they have no problem feeding. 33.8 percent sometimes had problem but not always, a slightly higher percentage of households 8.5 percent in Urban areas always had problem satisfying need for food more than those in Rural areas presented as 5.8 percent, thus Rural areas have higher percentage of households (36.0percent) that sometimes find it difficult.

45.8 percent of households with size 1-2 never had problem satisfying their food while 6.8 percent of households with more than 6 members complain of always having problem satisfying their food need, 7.9 percent of households with 5-6 members often had problem with food.

In Nigeria, agricultural production has remained small-scale at subsistence level and largely dependent on rainfall while in Kaduna State it is the main stay of the economy and major source of livelihood, the sector remains the largest employer of labour which is key contributor to wealth, income and poverty alleviation. Majority of the people of the state actively engaged in farming as small-scale farmers. Cash and food crops are cultivated and the produce includes: yam, cotton, groundnut, tobacco, maize, beans. Guinea corn, millet, ginger, rice and cassava. The potential for livestock and fisheries is high in the state and can be promoted to increase the contribution to the overall growth of the economy. It is estimated that about 80% of the population engage in small and medium scale farming, about 60% of Kaduna State citizens are self-employed, 27% are employed by private enterprises while the remaining 13% are engaged in the public sector. Agriculture and related activities provide employment for 50% of the citizens yet, the level of malnutrition is on the increase.

1.2.3 Nutrition Situation

Malnutrition and nutrition-related morbidity continue to be of public health concern in Nigeria, Kaduna not being an exception. Malnutrition is widespread in the entire country, although the scale and scope varies between regions and across urban-rural divide. Malnutrition manifests mainly as undernutrition, over-nutrition and micronutrients (minerals and vitamins) deficiencies. Malnutrition appears to be on the increase in Kaduna State, recent surveys indicated the state is most affected

especially in the LGAs in the northern part sharing borders with the sahelian states and the locations affected by increase in insecurity.

Malnutrition and nutrition related diseases continue to be problems of public health importance in Kaduna State with the under-five mortality rate of 169/1000 live births. Malnutrition is the underlying cause of 50% of these deaths.

In Kaduna State, only 5% of children 0-59 months receive the minimum acceptable diet, the lowest in Nigeria and exclusive breastfeeding rate is 19.3% and 60.8% children 6-59 months received high impact Vitamin A supplement (NNHS 2014). Multi Indicator Cluster Survey (MICS 2011) data indicated 176, 754 (11.9%) of children 0-59 months have moderate acute malnutrition while 69, 165 (4.5%) have severe acute malnutrition. Nigeria Demographic and Health Survey (NDHS 2013) indicated about 38.6% of the children under-five in the state are stunted suffering from chronic malnutrition. The same survey in 2015 indicated a deteriorating situation with 834, 351 (52.1%) children under 5 stunted.

Undernutrition reduces economic advancement of nations by at least 8% due to direct productivity losses and losses due to poorer cognition and reduced schooling (Horton and Steckel, 2013). Thus, such countries will be unable to break out of poverty and sustain economic advances without ensuring that their populations are adequately nourished on a sustainable basis. This poor state of child nutrition in Nigeria is an indication of inadequate dietary intake, inadequate care of women and children as well as inadequate access to health care and living in an unhealthy environment. About 19.3% of new-borns in Kaduna receive breast milk within one hour of birth (NNHS 2013) whilst the exclusive breastfeeding rate is 8.4% (NDHS, 2013). During the transition period from 6 to 9 months, when a child is expected to receive a mix of breast milk and complementary food, only 5% of children 6-23months were fed in accordance with infant and young child feeding recommendations the lowest in Nigeria (NNHS, 2014).

Although under-nutrition is a problem throughout the country and Kaduna State, with the rural areas most disproportionately affected for

many reasons, including distance from markets, limited health and education resources, as well as access to sanitary water and refuse disposal facilities.

In addition to high rates of under nutrition, Kaduna State is witnessing an alarming rise in the incidence of Diet-Related Non Communicable Diseases (DRNCD). The 2008 NDHS reported that 19% of women were overweight or obese, with the frequency increasing with age, education, and wealth. Diabetes is predicted to cause 52% of mortality in Kaduna state by 2015 Globalization, urbanization, lifestyle transition, socio-cultural factors, and poor maternal, foetal and infant nutrition are all major causes of the increase in DRNCD.

Underlying these problems of malnutrition are number of issues such as poor maternal nutrition, sub-optimal infant and young child feeding (IYCF) practices, inadequate health services, and limited access to nutritious foods. According to the 2013 NDHS, breastfeeding is a common practice in Kaduna state, yet only 8.4% of children less than six months of age are exclusively breastfed. WHO recommended that infants should not be given water, juices, other milks, or complementary foods until six months of age, yet 48% of Kaduna State infants less than six months of age receive complementary foods.

1.2.4 Health System and Disease

It is estimated that in Kaduna State, the percentage of people living with HIV/AIDS (PLWHA) is 2.2% in 2012. Administrative HIV counseling and testing in the state has shown a prevalence rate of about 1.3% in 2015. Nutrition consideration is a priority in ensuring optimal nutrition in special circumstances such as HIV/AIDS and other disease conditions.

To address health challenges in the State, a Health Sector Implementation Plan was developed which sets out realistic and achievable goals and objectives and will, as much as practicable, be the focal point of and the driving force behind all the actions and activities of the Health Sector, over the next three years.

Commendable political and executive commitments were demonstrated during the development phase of the Health Sector Implementation Plan

(SIP) with special attention to addressing malnutrition in the state. The leadership of the State, supported by the efforts, commitments and team work of all stakeholders led to the emergence of a credible Plan. This shall be strengthened and sustained over the implementation years. Stakeholders will be expected to deliver on their roles within the SIP. The path set out within the SIP will ensure the achievement of the strategic goals and objectives therein, which will in turn facilitate the realization of the Kaduna State Government Health Sector Vision of, "A State where quality health care services are available, accessible and affordable to its citizens in an equitable manner and on a sustainable basis through active participation of all individuals and communities".

1.2.5 Nutrition in Emergencies

Nutrition response to emergency situations has been limited in Nigeria. In Kaduna, the State has witnessed quite a number of factors such as farmer-herds men clashes, cattle rustling, kidnappings, floods, armed banditry, high drop out from school and high increase in food prices which cause hunger and malnutrition. As a result, basic services become over-stretched hence the need for nutrition contingency plan; women and children make up the largest percentage of vulnerable population and would therefore need urgent intervention. Thus, nutrition considerations must be incorporated into emergency preparedness as well as the emergency response and management systems in the state such as the Kaduna State Emergency Nutrition Plan of Action (KADENAP) and establishment of CMAM sites in the State.

1.2.6 Nutrition and the SDGs

Nutrition is clearly outlined along other nutrition related goals in the recent global Sustainable Development Goals (SDGs). There was little improvement in the health and nutrition status of children under five in the last decade under the MDGs in Kaduna State. It is the realisation of the need to fast track the attainment of the Sustainable Development Goals (SDGs) that prompted the Kaduna State to be the first State level Government to officially begin the implementation of the SDGs. This pronouncement was made during the visit of the United Nations Secretary General, Banki Moon to Nigeria in 2015.

1.3 Guiding Principles of the Policy

The guiding principles for implementation of this policy shall include the following:

i. Prioritizations of poverty reduction and safety nets for the poor in government budgetary allocations;
ii. Recognition of adequate food and nutrition as a human right and adopting a rights-based approach to planning, budgeting, and implementation of the policy;
iii. Gender considerations and the needs of all vulnerable groups are integral to all components of the policy;
iv. Recognition of the multi-sectoral and cross-cutting natures of food and nutrition;
v. Utilisation of partnership and the network of stakeholders in harnessing resources for the implementation of the policy;
vi. Recognition of nutrition as a developmental issue and incorporating food and nutrition considerations into development plans at all levels of government;
vii. Establishment of a viable system for guiding and coordinating food and nutrition activities undertaken in the various sectors and at various levels of the society; and
viii. Reduction of malnutrition (under nutrition and over nutrition) through Scaling Up Nutrition(SUN) strategies/ activities with high impact and low cost interventions.

Chapter 2
Vision, Goal and Objectives of the Food and Nutrition Policy

2.1 Vision Statement

A State where quality food and nutrition services are available, accessible and affordable to its citizens in an equitable manner and on a sustainable basis through active participation of all individuals and communities.

2.2 Goal

To reduce malnutrition (under and over nutrition) through scaling up nutrition activities with impact and low cost intervention..

2.3 Objectives

To achieve the goal of attaining an optimal nutritional status by the year 2025, a number of objectives and targets are articulated as follows:

i. To improve food security at the state, community and household levels;
ii. To reduce undernutrition among infants and children, adolescents and women of reproductive age;
iii. To significantly reduce micronutrient deficiency disorders, especially among the vulnerable group;
iv. To increase the knowledge of nutrition among the populace and nutrition education into formal and informal trainings;
v. To promote optimum nutrition for people in especially difficult circumstances, including PLWHA;
vi. To prevent and control chronic nutrition-related non-communicable diseases;
vii. To incorporate food and nutrition considerations into the State, Local Government, ward and community plans;
viii. To promote and strengthen Research, Monitoring and Evaluation of food and nutrition programme;
ix. To strengthen systems for providing early warning information on the food and nutrition situation; and
x. To ensure universal access to nutrition-sensitive social protection.
xi. To respond to Nutrition emergencies in collaboration with relevant agencies

2.4 Targets

i. To reduce the number of under-five children who are currently stunted by 50% in 2025
ii. To reduce low birth weight by 30% in 2025
iii. To reduce childhood wasting to less than 10% by 2025
iv. To reduce anaemia in women of reproductive age by 50% by 2025
v. To increase exclusive breastfeeding rates in the first six months to at least 50% in 2025
vi. Reduce the proportion of people who suffer hunger and malnutrition by 30% in 2025;
vii. Increase the percentage of children age six months and above who receive appropriate complementary feeding from 8.4% in 2015 to 40% in 2025;
viii. Achieve and sustain household access to iodized salt by 2025;
ix. Increase coverage of Zinc supplementation in diarrhoea management in all children needing treatment by 2025;
x. Increase the proportion of children who receive deworming tablets from 53% in 2015 to 80% by 2025;
xi. Reduce prevalence of diet-related non-communicable diseases by 25% in 2025;
xii. Increase coverage of Vitamin A supplementation from % in 2015 to 90% in 2025;
xiii. Increase by 50% households with relevant nutrition knowledge and practice that improve their nutritional status
xiv. Increase access to potable water from 40% in 2015 to 60% in 2025;
xv. Reduce the incidence of malnutrition among victims of emergencies by 50% in 2025;(generation of base line survey at program planning stage)
xvi. Mainstream nutrition objectives into social protection and safety net programmes of all MDAs linked to nutrition by 2025;
xvii. Achieve universal access of all school children in the pre- and basic school classes to school-based feeding programmes by 2025; and
xviii. To arrest the emerging increase in obesity prevalence in adolescents and adults by 2025

Chapter 3
Strategies

This chapter consists of strategies aimed at achieving the policy objectives described in the previous chapter. The strategies will employ interventions and approaches that are nutrition-specific, nutrition-sensitive, nutrition-enhancing agriculture and food systems as well as build an enabling environment for sustaining this policy.

3.1 Food and Nutrition Security

3.1.1 Ensuring Food and Nutrition Security at the State, Local Government, Ward, Community, and Household Levels

The strategic framework for achieving food and nutrition security will adopt a multi-sectoral approach to implement the state food and nutrition strategy focusing on food security, quality, and safety, consumer education, and food management. In addition, it will also focus on food production, food processing**, storage, trade, marketing and distribution, as well as consumption.**

3.1.2 Increasing Availability, Accessibility and Affordability of Food

i. Boost integrated farming (crops, livestock, apiculture and fisheries) as a means of improving food diversity and income sustainability for small-holder farmers, especially youth and women;

ii. Encourage enhanced production of priority-value chain crops, animal products, aquaculture, apiculture, ***fruits and vegetables*** across the three senatorial zones of the state;

iii. Encourage agriculture and support urban and rural women to adopt and set-up home gardening;

iv. Encourage adoption of improved and cost-effective on-farm food-storage technologies including use of silos, solar drying, fish smoking kiln, etc. by small holder farmers;

v. Encourage food safety through myco-toxins prevention during production and storage;
vi. Encourage fortification including Bio-fortification of staple food crops as a long-term means of micronutrient deficiency control (MNDC); and
vii. Encourage effective market information, food distribution and transportation systems.

3.1.3 Improving Food Harvesting, Processing and Preservation

i. Adopt appropriate technologies for harvesting, processing, and preservation for crops, vegetables, fisheries, apiculture and livestock;
ii. Facilitate access of small-holder farmers to technologies for improved crop harvesting, processing, and preservation; and
iii. Strengthen the capacity of agriculture extension workers for adequate dissemination of environmentally friendly agricultural technologies.

3.1.4 Improving Food Preparation and Quality

i. Encourage dietary diversity through the use of nutritionally adequate recipes using locally available ingredients for all age groups especially pregnant women and under-fives;
ii. Encourage appropriate food-preparation methods for improved nutrition as well as the consumption of hygienic and nutritious foods;
iii. Enforcement of minimum standard for food quality and safety for locally produced foods, including street-vended foods; and
iv. Fortify staple food during production, processing up to consumption level.

3.1.5 Improving Management of Food-Security Crises and Nutrition in Emergency

i. Institutionalize an efficient and effective process of securing cash backing for activities in the nutrition-costed plan

ii. Ensure government fiscal policies' support the implementation of the policy.
iii. Ensure effective nutrition activities implementation monitoring and evaluation towards outputs achievement.
iv. Ensuring the quality of the implementation of any assigned responsibilities a key performance appraisal issue for all Stakeholders involved with the nutrition related activities;
v. Exercising zero-tolerance for non-implementation or substandard execution of responsibilities assigned to any member of staff regarding nutrition.
vi. Strengthen existing Information Management Systems for food-insecurity and nutritional-vulnerability;
vii. Establish a system for timely intervention and food price stabilization during periods of food shortfalls by constituting a commodity board and fodder reserve (buffer stock) as well as community-level strategic stock/cereal banks;
viii. Identify, develop, implement and sustain programmes that would provide safety nets to protect the most vulnerable groups from negative effects of food crises as a result of natural disasters and economic policies;
ix. Develop and provide comprehensive guidelines for managing nutrition during emergencies; and
x. Facilitate effective coordination of interventions by government and other stakeholders/ development partners during emergencies.

3.1.6 School-based Strategies

i. Include nutrition education and training in the curricula of early child care, primary and secondary schools;
ii. Promote school feeding programmes in all early child care and primary schools to improve nutritional status, learning capacities and enrollment/retention of school-age children through community participation and public-private partnerships; and

iii. Encourage and support the establishment of school gardens to provide food items and also stimulate interest in farming and food production among growing children.

3.2. Enhancing Caregiving Capacity

3.2.1 Ensure Optimal Nutrition in the First 1,000 Days of Life

i. Promote nutritional care for girls of child-bearing age and pregnant women;

ii. Encourage and support early initiation of breastfeeding within thirty minutes of delivery, exclusive breastfeeding for the first six months and the continuation of breastfeeding well into the second year of life with the introduction of nutritionally adequate complementary foods at six months of age;

iii. Promote a State nutrition education programme which should target child caregivers, health workers and communities to increase awareness of the proper care and feeding of children;

iv. Encourage hand-washing, proper waste disposal and Community-led Total Sanitation (CLTS);

v. Encourage the establishments of crèches in work places having more than ten women in public and private institutions;

vi. Provide and promote IYCF counseling and support for pregnant and lactating women at the community and health-facility levels in line with the State Primary Health Care Development Agency (SPHCDA) strategies;

vii. Effectively monitor the implementation of the state regulation and the international code and all WHA resolutions on the marketing of Breast Milk Substitutes (BMS); and create accountability mechanisms for marketing of infant formulas;

viii. Advocate for extension of the existing regulation of maternity leave at all levels, including public- and private-sector institutions.

3.2.2 Caring for the Socioeconomically Disadvantaged and Nutritionally Vulnerable

i. Ensure adequate (both quantity and quality) food intake and adequate rest for pregnant and lactating women; and

ii. Encourage the use of labor-saving technologies to reduce the workload of women and create more time for child care.

3.3. Enhancing Provision of Quality Health Services

3.3.1 Reduce Morbidity and Mortality Associated with Malnutrition through Prevention and Management of Nutrition-Related Diseases;

1. *Advocate for establishment of more health centres to* increase access to and improvement of quality health care services that provide essential maternal and child nutrition care;
2. Promote the full integration of essential nutrition actions (ENA) into routine primary health care services;
3. Create an enabling environment for the local production of Ready-to Use Therapeutic Food (RUTF)
4. Provide adequate Ready-to-Use Therapeutic Food (RUTF) for the treatment of SAM
5. Promote prevention and treatment of diseases associated and linked with malnutrition
6. Provide nutrition support in special cases such as preterm and small-for-gestation babies, PLWHA, abandoned babies and orphans, etc.
7. Promote an integrated approach for the management of IMAM, CMAM, SC, ITP as a minimum package of MNCH services

3.3.3 Preventing Micronutrient Deficiencies

i. Prevention of VAD by instituting short- and long-term sustainable interventions, including bi-annual Vitamin-A supplementation to children aged 6 to 59 months during MNCH week and RI as well as promoting dietary diversification and food fortification;

ii. Control of iron-deficiency anaemia (IDA) through:

- The provision of iron-folate supplements to pregnant women.
- De-worming of children aged 12 to 59 months and school-aged children every six months.

iii. Control and prevent Iodine-Deficiency Disorders (IDD) through the enforcement of legislation on universal salt iodization (USI) at 50mg per kg salt, and through regular monitoring of salt iodine levels;

iv. Control and prevent Zinc-deficiency disorders;

v. Provide Zinc and low-osmolarity oral rehydration solution (LO-ORS) to treat diarrhea;

vi. Enforce food fortification standards in regulated food products;

vii. Enhance micronutrient consumption through encouragement of the use of micronutrient powders and lipid-based nutrient supplements (LBNS) for food enrichment at the household level; and

viii. Promote social and behavioral change communication (SBCC) to encourage appropriate food choices that favour consumption of micronutrient-rich foods through media programming and news reportage.

3.3.5 Protecting the Consumer through Improved Food Quality and Safety

i. Collaborate with appropriate agencies for the effective control of food quality and safety;

ii. Collaborate with appropriate agencies for the enforcement of food safety regulation to guarantee food safety and quality;

iii. Advocate for the detection, monitoring, and control of chemical residues in foods; and promote appropriate and safe utilization of agricultural chemicals; and

iv. Advocate for standards for nutrition labeling and advertisement of all foods, including locally prepared indigenous foods, promote compliance and strengthen consumer education

3.4. Improving Capacity to Address Food and Nutrition Insecurity Problems

3.4.1 Assessing, Analysing and Monitoring Nutrition Situations

i. Strengthen health facility based growth monitoring and introduce community-based growth monitoring to promote healthy growth, identify child growth faltering, and recommend appropriate actions;
ii. Encourage participatory approaches for communities to assess, analyse, and take appropriate actions to address food and nutrition challenges;
iii. Identify capacity/skills-gap at all levels of those involved in the planning and implementation of food and nutrition programme and activities;
iv. Build and strengthen the effective planning and managerial capacity of state and local governments to address food and nutrition problems;
v. Advocate for inclusion of nutrition courses in state owned tertiary and vocational institutions;
vi. Support regular capacity building of Nutritionists, Nutrition Desk Officers and other relevant service providers to improve their capacity for food and nutrition programme management; and
vii. Provide adequate staffing of relevant MDAs implementing sectoral nutrition programmes with skilled and qualified nutritionists.

3.4.2 Providing a Conducive Macro-Economic Environment

i. Inclusion of nutrition objectives into MDAs' development policies, plans, and programmes;
ii. Identify macro-economic and sectoral policies in terms of their potential impact and consequences for household income, food consumption, and delivery of human services, with a view for policy modification to ameliorate adverse effects;
iii. Enhance social-sector spending and explore the potential role of the private sector; and

iv. Facilitate productive capacity through encouraging private sector engagement in food and nutrition related investment.

v. Empower the community volunteers and other relevant change agents with relevant skills for self reliance

3.4.3 Social Protection Programmes for the Vulnerable Groups

i. Expansion of existing social protection policy in all sectors with inclusion of nutrition considerations as conditions of social protection programmes to address poverty, malnutrition, and health of the most vulnerable groups;

ii. Advocate for the incorporation of state into the National Health Insurance Scheme to incorporate the Community Health Insurance health services to vulnerable groups, especially women and children; and

iii. Institutionalize social protection programmes that would provide safety nets, both short- and long-term (including distribution of food, access to interest free loans), to protect the most vulnerable groups from negative effects of macro-economic and sectoral policies on purchasing power, food consumption, and the delivery of human services.

3.5. Raising Awareness and Understanding of the Problem of Malnutrition in Kaduna State

3.5.1 Promote Advocacy, Communication and Social Mobilisation

i. Implement advocacy and social mobilisation strategy for food and nutrition

ii. Regular advocacy to policymakers at all levels for resource mobilisation for food and nutrition activities;

iii. Promote Behaviour Change Communication (BCC) for better understanding of food and nutrition security problems for improved food and nutrition practices;

iv. Design and produce harmonised, appropriate BCC materials for use and distribution at the state, and LGA levels; and

v. Promote and strengthen nutrition education for all age groups through multimedia communication approaches.

3.5.2 Promoting Healthy Lifestyles and Dietary Habits

i. Promote good dietary habits and healthy lifestyles for all age groups through appropriate social marketing and communication strategies;
ii. Design and implement appropriate community-based nutrition education programmes and develop appropriate food-based dietary guidelines for healthy living;
iii. Promote healthy eating habits to reduce the incidence of non-communicable diseases such as diabetes, hypertension, and other cardiovascular disorders, etc. (reduction of salt and sugar intake, preparation methods to reduce fat intake, etc.); and
iv. Promote regular physical exercise and periodic medical checkups for nutrition-related, non-communicable diseases.

3.5.3 Research in Nutrition

i. Promote research and development of locally available staple diets and use of under-utilised crops for improved utilisation and nutrition;
ii. Produce a complete food-composition table for locally available food and agricultural produce (raw, processed, and prepared);
iii. Promote, support, and disseminate research findings on food processing and preservation technologies for adaptation at the community and household levels;
iv. Promote research on local food fortification including bio-fortification;
v. Promote collaborative programme implementation through operations research to enhance programme outcomes; and
vi. Engage in annual conduct of food consumption and nutrition survey to track policy impact.
vii. Plan and implement Nutrition surveillance system for routine monitoring and programme development.

3.6. Resource allocation for food and nutrition Security at all levels

i. Ensure adequate implementation of the policy through sufficient budgetary allocation and timely release of funds;

ii. Strengthen the coordination capacity of the MoBP with the required resources (human, financial, and material) for effective management and coordination of the policy; and

iii. Strengthen the capacity of the MoBP to mobilise resources both internally (federal, state, LGA, NGOs, Philanthropists, etc) and externally (bi- and multilateral donors).

Chapter 4
Institutional Arrangements, Legal Framework and Financing

4.1. Preamble

The State Food and Nutrition Policy require an effective institutional arrangement to ensure a results-oriented programme implementation. Previous implementation efforts have been principally sectoral (health, agriculture, education, science and technology, social development and information, etc.), uncoordinated, inadequately funded and limited in scope and coverage.

In order to address this problem, the Kaduna State Government in line with the Federal Government policy designated the Planning and Budget Commission (PBC) as the state focal point for food and nutrition policy, programme planning, and coordination in the state. In 2001, the State Committee on Food and Nutrition was established by the State Executive Council.

4.2 Leadership, Structures, and Institutions

The implementation of the State Policy on Food and Nutrition is the responsibility of the authorities at the two levels of government (i.e. State and LGAs) in collaboration with other stakeholders, including the organised private sector, development partners, professional bodies, civil society organisations (CSOs) (i.e., Non-Governmental Organizations [NGOs], Faith Based Organizations [FBOs]), and communities.

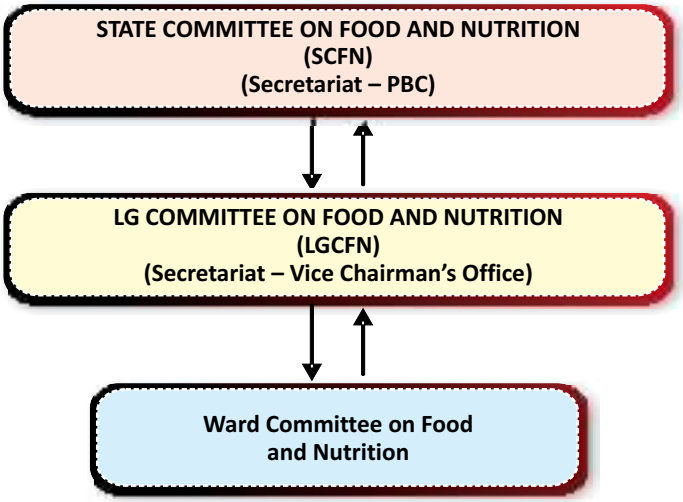
Administrative arrangements between the PBC, the SCFN, line Ministries and Local Governments will form the basis for planning and implementation of the State Food and Nutrition Policy. In this regard, local Government vice chairman's office and the PBC will be the focal points for coordination of food and nutrition programmes at state and LGA levels and will be assisted by the State Committees on Food and Nutrition (SCFN) and Local Government Committees on Food and Nutrition (LGCFN).

Implementation agencies at State and LGA levels are responsible for the implementation of specific projects and programmes relevant to the policy.

The focal points at State and LGA levels will have the responsibility of identifying and mobilising resources for executing given project or activity in a coordinated manner and paying due emphasis to the need for harmonisation and synergy within each body's geographic boundaries and authority.

The government will ensure that the various organisations are fully accountable for the resources and programme activities which are under their responsibility to guarantee the confidence of all stakeholders and partners involved as well as ensure correct and timely programme implementation.

Institutional Structure for the Coordination of Policy Implementation



4.6. Planning and Budget Commission (PBC)

The PBC will serve as the state focal point for food and nutrition policy programme planning and coordination in the state. The PBC will serve as the secretariat for the SCFN and shall coordinate with the local government Secretariats and have regular fora for interactions. The State Committee on Food and Nutrition membership will be drawn from relevant Ministries, Departments and Agencies of government as well as representatives of tertiary institutions, NGOs and private sectors dealing with food and nutrition related issues.

The PBC shall convene meetings of the SCFN and produce annual reports on progress made in food and nutrition. The Commissioner of Planning and Budget will serve as chairman of SCFN while the State Nutrition Officer serves as the Secretary. In addition, a nutrition partner's forum, state working groups, and sub-committees on food and nutrition may be established to meet regularly (at least quarterly).

4.7. Mandates of the PBC

The mandate of the PBC is:

i. To provide day-to-day support that will enhance the effectiveness of SCFN;
ii. To serve as the focal point for the coordination and harmonization of all food- and nutrition-related policies and programmes being implemented by various ministries and agencies into state programme consistent with the goals and aspirations outlined in this policy document;
iii. To provide a forum for exchange of views and experiences among the bodies implementing nutrition programmes in Kaduna State and, thereby foster and strengthen their respective roles in the programme;
iv. To coordinate the review, on a continuous basis, of policies and programmes with regard to their potential impact on food and nutrition issues;
v. To ensure effective implementation of the different policies and programmes by putting in place effective machinery for M&E;
vi. To maintain ongoing advocacy for food and nutrition issues;

vii. To ensure adequate financial provisions and timely release of allocated funds in the annual state budget;
viii. To liaise with international donor agencies, financial institutions, the private sector, Community-Based Organizations (CBOs) and NGOs when soliciting funds and material support to complement government resources and efforts; and ensure that development partners incorporate nutritional considerations into their development strategies across all sectors, especially food security, maternal and child health, social protection, education, agricultural research, and gender-based programmes; and
ix. To coordinate the analysis and dissemination of results of important food and nutrition studies, statistics, and data.

4.8. State Committee on Food and Nutrition (SCFN)

In order to achieve the State Food and Nutrition Policy objectives and implement its programmes, a SCFN has been established, located in the PBC to assist the PBC to assess and enhance the various policies on food and nutrition and to plan national programmes on food and nutrition matters.

Membership of the committee is drawn from relevant ministries, departments, and agencies of government as well as representatives of universities dealing with issues of food and nutrition.

4.9. Mandate of the SCFN

The SCFN has a mandate of:

i. Providing necessary technical and professional assistance and support to the Secretariat (State Planning Ministry or equivalent in the state) on food and nutrition planning and programme implementation;
ii. Ensure adequate financial provision and timely release of allocated funds in state development plans
iii. Proposing and reviewing, on a continuous basis, programmes that have a potential impact on food and nutrition issues;
iv. Ensuring that the representatives of relevant sectors on the committee undertake effective implementation of their various policies and programmes;

v. Advising on the formulation of appropriate strategies for programme M&E;
vi. Supporting the State Planning and Budget Commission (or equivalent in the state) in the maintenance of ongoing advocacy for food and nutrition issues; and
vii. Assisting the State Planning and Budget Commission (or equivalent in the state) to set up and manage a database of nutrition activities.

4.10. The SCFN Secretariat

The SCFN shall have a secretariat established in the PBC which shall be a division within the commission responsible to the chair of the SCFN in the implementation of the decisions of the SCFN as well as the day-to-day operations of the state food and nutrition programme. The division shall be fully staffed with the requisite human and material resources with the required mix of staff and competencies in nutrition, food, and M&E. In addition, the secretariat will be responsible for:

i. Servicing all statutory SCFN meetings;
ii. Establishing appropriate linkages with other departments within the PBC, and
iii. Undertaking any other duties as may be assigned by the PBC towards effective implementation of this policy.

4.14. Local Government Committee on Food and Nutrition (LGCFN)

In order to achieve the National Food and Nutrition Policy objectives and implement its programmes, a LGCFN shall be established and located in the Office of the LGA Vice Chairman. Membership of the committee will be drawn from relevant Departments and Agencies of government as well as representatives of CSOs dealing with issues of food and nutrition.

4.15. Mandate of the LGCFN

The LGCFN has a mandate of:

i. Providing necessary technical and professional assistance and support to the secretariat (Office of the LGA Vice Chairman) on food and nutrition programme implementation;
ii. Ensure adequate financial provision and timely release of allocated funds in LGAs budget

iii. Proposing and reviewing, on a continuous basis, programmes that have a potential impact on food and nutrition issues;
iv. Ensuring that the representatives of relevant sectors on the committee undertake effective implementation of their various policies and programmes;
v. Implementing appropriate strategies for programme M&E;
vi. Supporting the Office of LGA Vice Chairman in the maintenance of ongoing advocacy for food and nutrition issues;
vii. Managing and maintaining database of nutrition activities; and
viii. Coordinating nutrition programme implementation at the LGA level.

4.16. The LGCFN Secretariat

The LGCFN shall have a secretariat established in the Office of the LGA Vice Chairman who shall serve as chair of the LGCFN, and the LGA nutrition focal person shall serve as the Secretary. The Secretariat will be responsible for:

i. Servicing all statutory LGCFN meetings;
ii. Establishing appropriate linkages with other departments within the LGA; and
iii. Undertaking any other duties as may be assigned by the Office of the LGA Vice Chairman towards effective nutrition programme implementation.

4.17. Roles of Professional Bodies and Development Partners

4.17.1 Professional Bodies, CBOs, CSOs, FBOs and NGOs

To ensure proper coordination of activities and to avoid duplication of efforts, the coordinating agencies at State and Local Government levels will work closely with relevant professional bodies (including Nutrition Society of Nigeria, Dietetic Association of Nigeria, and Nigeria Institute for Food Science and Technology), NGOs, CBOs, CSOs, FBOs and local communities in pursuit of the State Food and Nutrition Policy objectives. This partnership could benefit the policy implementation through:

i. Resource mobilisation;
ii. Project implementation;
iii. Community mobilisation, participation, and ownership at the grassroots level as well as sustainability.

4.17.2 Private Sector

Apart from providing funds to accelerate growth in food supplies and to manufacture essential drugs, plant machinery, and equipment, the private sector is expected to support the food and nutrition programme effort of the government by collaborating in specific areas, including:

i. Fortification of certain identified foods with mandatory micro-nutrients such as Vitamin A, B Vitamins, Zinc and Iron;
ii. Development of low-cost nutritious complementary foods and RUTF;
iii. Promotion of nutrition education that complies with quality-control standards;
iv. Participation and support of knowledge-sharing on research findings; and
v. Adoption and transformation of research findings into commercially viable products.

In addition, the private sector would be fully involved and participate in the policy formulation/review as well as programme M&E.

4.17.3 Development Partners

Government and development partners (bilateral and multilateral agencies) have always worked closely together on food and nutrition issues in the areas of programme design, training and capacity-building, research and implementation of pilot, State and Local programmes. The government will continue to appreciate the assistance provided by donor agencies in the execution of the State Food and Nutrition Policy.
This partnership has the following benefits:

i. Resources mobilisation in the forms of grants and loans;
ii. Providing best practices to be used in refining and re-designing existing programmes, and introducing new ones; and
iii. Full participation in programme implementation and review as well as M&E.

4.18 Resource Mobilisation

Government shall regularly ensure mobilisation and timely release of resources required from budgetary allocations to fully implement the policy on food and nutrition security at all levels.

These internal resources will be complemented, as required, by external grants, loans and contributions by aforementioned organisations, and the private sector. The communities will also be expected to contribute in cash or kind as appropriate.

4.19 Sustainability and Programme Scale Up

4.19.1 National Nutrition Network (NNN):

The NNN is a platform for NCFN and SCFN to meet annually to share experiences and deliberate on annual progress, achievement, and challenges as well as chart a way forward for subsequent years. The PBC, through the SCFN, will participate in the NNN meeting with representation from the LGA, development partners and other relevant stakeholders.

Chapter 5
Monitoring and Evaluation

For successful implementation of the Food and Nutrition Policy, an effective M&E system will be established. The purpose of the M&E system will be to provide accurate, reliable, and timely information on the progress of implementation and regular reporting on the specific objectives listed in Chapter Two. This will entail intensive process of thorough assessment of existing problems, analysis of their causes and assessment of resources required to improve the nutrition situation. The information generated will be useful for future planning exercises, as well as for M&E of the success of government's efforts in addressing the problem of malnutrition in Kaduna State.

The core component of this M&E strategy will be an appropriate food and nutrition information monitoring system. The purpose of this type of information system will be to monitor food and nutrition situations in the State at regular intervals, and to answer the questions 'who are the malnourished?', 'where are they located?',' when and why are they malnourished?' A better socioeconomic description of the groups most at risk and trend analysis is essential in order to refine policies and programmes as well as timeliness of interventions that are aimed at different target groups in terms of their vulnerability.

5.2 Food and Nutrition Information System

The food and nutrition information system will rely on administrative reporting systems that already exist in certain ministries, routine data collected from all the relevant sectors as well as community-level food and nutrition information, including data from child growth monitoring and promotion programmes. Sample surveys will also be considered as well as Rapid Rural Appraisal (RRA) techniques as a possible means of obtaining information quickly. Information generated will be used to assess the food and nutrition situation as well as inform programmatic changes and amendments by programme managers to bring about improvement.

5.3 M&E System

To monitor and evaluate the nutritional impact of the State Food and Nutrition Policy and its consequent programmes, a number of known core indicators will be considered to assess whether the targets and goals are being reached. The M&E system will use the information generated through the food and nutrition information system in addition to scheduled State HH Survey, NDHS, MICS, and SMART surveys to inform decision-makers on the result achieved and the impact.

To achieve this, a database shall be created to keep accurate and relevant information through vertical and horizontal collation of data from the LGAs, state, and federal levels so that progress and changes are tracked and impact measured. The system shall use a simple M&E approach with the primary aim to enable planners at each level to collect data that shall assist them in the ongoing planning and implementation of food and nutrition programmes and activities. A feedback mechanism shall be introduced to enable "downwards" sharing of data through regular communication about the progress of food and nutrition programme and activities at state and LGA levels. The main M&E activities will include:

i. Monitoring of achievements and results component;
ii. Evaluation/impact assessment component;
iii. Implementation and Result Progress Report.

5.3.1 Objectives of the M&E:

i. Measure the progress, achievements, and performance through the strategy results framework and a set of specific indicators on food and nutrition;
ii. Provide policymakers and different stakeholders with relevant qualitative and quantitative information to enable them to:
a. Undertake the strategy performance assessment so as to make corrections for a satisfactory implementation and capitalisation on best practices;
b. Draw conclusions about the effectiveness of the achievements;
c. Increase skills in the area of quality assurance in food and nutrition strategy implementation, and use appropriate information for policy adjustment; and

d. Provide data to all stakeholders for communication with a view to creating a transparent information environment (on financial flows, inputs, results, and performance).

5.3.2 Techniques and Tools for Data Collection and Analysis

The main focus of the M&E system shall be to collect accurate, reliable and timely data on the food and nutrition programme results at prescribed intervals using appropriate tools. This will include routine data from health facilities and other relevant institutions as well as population-based data.

5.3.3 Procedures for M&E - Roles and Responsibilities of different Actors

5.3.4 Planning and Budget Commission

The PBC will have responsibility for overall M&E. The SCFN Secretariat in collaboration with the M&E office of the PBC will have responsibility for the following:

i. Providing overall coordination of the food and nutrition M&E system;
ii. Sourcing and collating M&E data from relevant ministries, departments and agencies in state, and LGAs for incorporation into the state M&E database;
iii. Working with the M&E departments of state and relevant MDAs to ensure timely submission and quality of data;
iv. Preparing yearly reports on progress of implementation and achievement of objectives as stated in the policy;
v. Identifying gaps and recommending necessary adjustments in programme implementation;
vi. Preparing and submitting state reports on food and nutrition situations at intervals as contained in the performance management plan;
vii. Engaging the State Bureau of Statistics on administration of surveys and the collection of data at specified intervals and period to document achievements of results;
viii. Facilitating capacity-building for M&E officers and personnel; and
ix. Providing data quality assurance

5.3.5 State Ministries, Departments and Agencies

In each of the Ministries, the Department of Planning, Research and Statistics will be responsible for the collation and management of M&E data and also the following:

i. Ensuring data quality and compliance with established specification;
ii. Submitting timely data and M&E report to the state M&E system;
iii. Validating the accuracy of data before submission to state M&E system.

Glossary of Terms

Adequate Diet: Food consumed that contains all the nutrients (calories, protein, fats, vitamins and minerals) in amounts and proportions required to promote growth and good health in an individual.

At-Risk Groups: Persons or segment of the population most likely to suffer from nutritional deprivation.

Baby-Friendly Hospital Initiative: A hospital-based programme that seeks to promote good breastfeeding practices by mothers (i.e. Exclusive Breastfeeding for the first six months of life).

Complementary Foods: Foods, in addition to breast milk, given to infants after six months of age.

Food: A composite of nutrients (protein, fat, carbohydrates, vitamins and minerals) consumed, digested and ultimately utilised to meet the body's needs.

Food Security: Access by all people at all times to enough food all the year round for an active, healthy life.

Food Insecurity: When a household is unable to provide adequate food for its members on a sustainable basis either due to inability to produce its own food or through food purchases.

Growth Monitoring and Promotion: A process which involves regular weighing of a child, plotting the weight on a growth chart, using the information obtained to assess how the child is growing, and then taking appropriate actions to improve or promote the health and growth of the child.

Household Food Security: The ability of a household to gain access to adequate food (both in quantity and quality) to meet its nutritional requirements for an active life throughout the year.

Intra-Uterine Growth Retardation: Gradual decline in the development of a fetus due to maternal factors such as illness or malnutrition.

Iodine-Deficiency Disorders: The spectrum of disorders resulting from inadequate iodine intake, including mental retardation, reduced growth, spontaneous abortions, still-births and physical disabilities.

Iron-Deficiency Anaemia: Reduced haemoglobin and oxygen-carrying capacity of the blood due to inadequate iron intake and/or high iron losses (e.g., blood loss), characterised by fatigue, decreased capacity to work, learning disorders, and increased complications of pregnancy.

Macronutrients: Carbohydrates, fats, and proteins, comprising the major components of most foods that supply energy and amino acids for proper growth and development.

Malnutrition: The impairment of health due to a deficiency, excess, or imbalance of nutrients. It includes **undernutrition,** which refers to a deficiency of calories and other nutrients and **overnutrition,** which refers to excess of calories and nutrients (but usually of calories).

Micronutrients: These are the vitamins and minerals present in foods and required by the body in very small quantities for proper functioning.

Night Blindness: An inability to see in the dark, due to a deficiency of Vitamin A resulting from inadequate Vitamin-A intake in the diet.

Nutrition: The end result of various processes in society (e.g., social, economic, cultural, psychological, agricultural, and health) which culminate in food being eaten by an individual and subsequently absorbed and utilised by the body for physiological processes.

Nutritional Surveillance: The process of keeping watch over the nutritional situation of a community or a population and the factors that affect it, in order to take appropriate actions that will forestall problems or lead to improvement in nutrition.

Nutritive Value: The amounts of a given nutrient in a food item that will be potentially available for use by the body.

Prenatal Mortality: Death of babies before birth.

Prevalence Rate: The percentage of individuals in a sample or population who are affected by a certain disorder or condition.

Provitamin A: A substance (beta carotene) found in plants that can be converted by the body to Vitamin A.

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