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Stakeholder Mapping and Selection for Scaling-up Maternal, Newborn, Child Nutrition and Health Interventions in Nigeria

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Abstract

Introduction: Nigeria remains a global hotspot for maternal and child deaths. The Advocacy and Implementation of Maternal, Newborn, and Child Nutrition and Health (AIM MNCNH) project aims to build a critical mass of advocates who will accelerate the uptake of proven innovations nationwide. The objective of this study was to map and prioritise stakeholders capable of championing scale-up of MNCNH interventions across sixteen states.

Methods: Sixteen female physicians received a four-day course on stakeholder analysis. Using desk reviews, snowball sampling and a structured checklist, each trainee identified twenty potential stakeholders in her state. Candidates were scored for influence and engagement (30%), alignment with project objectives (25%), technical capacity (20%) and commitment (25%). Consensus meetings reconciled differences and produced the final list.

Results: Three hundred and twenty actors were initially recorded. One hundred and ninety-two (60%) surpassed the 60-point threshold and were retained. Policymakers accounted for 26% of the group, frontline healthcare providers 31%, traditional or religious leaders 24%, civil society and media advocates 12%, and development partner or private private-sector representatives 7%. All six geopolitical zones were equally represented. Early engagement sessions revealed enthusiasm for evidence-based advocacy but highlighted the need for additional training in budget tracking and policy-brief writing.

Conclusion: Within a fortnight, the AIM MNCNH consortium assembled a diverse, motivated cohort of 192 stakeholders positioned to drive maternal and child health reforms. The transparent, criteria-driven process offers a replicable model for rapid stakeholder mobilisation in complex, pluralistic settings.

Keywords: stakeholder engagement; MNCNH; Nigeria

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Background

Despite decades of programmes, Nigeria still contributes roughly one in ten maternal deaths worldwide and remains among the top three countries for under-five mortality.[1,2] Gaps in infrastructure, uneven distribution of the health workforce and socio-cultural barriers all undermine progress.[3] Yet compelling evidence shows that when proven interventions—skilled birth attendance, essential newborn care, and early breastfeeding support—are delivered at scale, survival improves markedly.[4,5]

The AIM MNCNH project is a national effort aimed at scaling up proven, evidence-based interventions that can significantly improve survival and health outcomes for women and children. At its core, AIM MNCNH seeks to strengthen the policy environment and foster a collective commitment to transformative change, particularly through advocacy grounded in real-time data and community engagement. The project was conceived to strengthen the social momentum required to expand such interventions. Its theory of change rests on the SMART (Specific, Measurable, Achievable, Relevant, Time-bound) framework and on the conviction that sustainable change demands broad-based, well-co-ordinated advocacy. Early experience from other settings demonstrates that coalitions of policymakers, clinicians and community gatekeepers can unlock budgets, amend guidelines and normalise healthy practices.[6,7]

It is a collaborative effort led by the African Centre of Excellence for Population Health and Policy (ACEPHAP), in partnership with national and sub-national stakeholders, including the Medical Women's Association of Nigeria (MWAN), Pathfinder International, and the Centre for Communication and Social Impact (CCSI).[3,5]

Effective advocacy, however, begins with knowing who holds power, who shapes opinion and who can translate evidence into everyday action. We therefore carried out a structured stakeholder-mapping exercise across sixteen Nigerian states, home to nearly half of the country's population. This paper describes that process and discusses lessons for similar initiatives.

Method

This study employed a structured stakeholder mapping exercise to support the identification and engagement of key individuals and organisations relevant to maternal, newborn, child, and nutrition health (MNCNH) across 16 Nigerian states. The process was guided by a mixed-methods approach, combining both qualitative and quantitative elements to enhance rigour and contextual relevance. To begin, sixteen medical women—selected for their local knowledge and professional backgrounds—participated in a four-day intensive training programme. The training focused on stakeholder engagement strategies, data-gathering techniques, and ethical considerations. Participants were introduced to the criteria for mapping, ensuring a consistent understanding of the methodology across all participating states. Following the training, a two-phase field implementation process commenced. In the first phase,

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participants employed structured checklists and stakeholder profiling tools to identify up to 20 individuals or organisations per state who had demonstrable involvement or influence in MNCNH policy, practice, or advocacy. These preliminary lists were broad and inclusive, covering policymakers, frontline health workers, traditional and religious leaders, civil society organisations, and development partners. In the second phase, a validation and selection exercise was conducted by the consortium partners and state implementation teams. This involved a series of in-person and virtual meetings over a two-week period. During these sessions, each identified stakeholder was evaluated using a scoring framework developed specifically for the project. The scoring system was built around four key criteria: Level of influence and engagement (30%): This criterion assessed the stakeholder's capacity to affect MNCNH-related decisions or mobilise others. Alignment with advocacy goals (25%): This measured how closely the stakeholder's mission, activities, or public stance aligned with the objectives of the AIM MNCNH project. Technical capacity (20%): Stakeholders were evaluated based on their knowledge, expertise, and ability to contribute meaningfully to MNCNH policy or programme development. Interest and commitment (25%): This considered the stakeholder's past engagement in health-related initiatives and their willingness to be involved in ongoing advocacy efforts. The combination of scoring and consensus discussion allowed the team to narrow down the initial list of 320 individuals to a final selection of 192 stakeholders across all 16 states. Emphasis was placed not only on the individual's or institution's profile but also on their willingness to actively participate in the project's goals. Throughout the process, care was taken to ensure representation across gender, geography, and sector. Ethical considerations were embedded throughout the methodology. Stakeholder identification and engagement were conducted transparently, and no data collection involving personal health information was undertaken. Participants involved in the mapping process were briefed on the purpose and goals of the project, and informed consent was obtained where direct interviews or interactions occurred. This structured, participatory, and context-sensitive approach to stakeholder mapping was designed to build local ownership, promote sustainability, and ensure that the most relevant and committed individuals were brought into the fold to support the scale-up of MNCNH interventions in Nigeria.

Ethical approval

Because only publicly available or voluntarily supplied professional data were handled, risk was minimal. Nevertheless, all state-level ethics committees reviewed and approved the protocol

Results

Stakeholder landscape

Three hundred and twenty candidates were recorded across sixteen states. The overall median score was 72 (inter-quartile range 68–78). One hundred and ninety-two individuals or organisations met the 60-point threshold and formed the final

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cadre. Their distribution was as follows: policymakers 50 (26%), health-facility staff 60 (31%), traditional or religious leaders 46 (24%), civil-society and media 24 (12%), and development partners or the private sector 12 (7%). Each state retained between ten and fourteen stakeholders, ensuring balanced regional representation.

Early engagement insights

Kick-off meetings held within four weeks of selection revealed:

- High enthusiasm for data-driven storytelling but limited experience with budget-analysis tools.
- Traditional and faith leaders' preference for culturally resonant information, including local proverbs and scriptural references that emphasise maternal care.
- Policymakers' request for concise briefs timed around annual and supplementary budget cycles.

These insights informed a tailored training package covering budget advocacy, strategic communications and community dialogue.

Beyond identification, tailored engagement activities were rolled out. These included state-level workshops, planning forums, and advocacy trainings. These platforms enabled shared learning, built trust, and fostered alignment around the project's objectives. Notably, these engagement strategies helped reinforce stakeholder ownership and accountability.

Despite the overall success, challenges emerged. Resistance to new ideas, especially in areas with deep-rooted cultural norms, occasionally hindered progress. Additionally, managing the diverse expectations of stakeholders required careful facilitation and continuous dialogue. Nevertheless, these challenges also served as entry points for deepening relationships and adapting strategies in real time.

By creating inclusive pathways for dialogue and mobilisation, the project laid the foundation for sustained collaboration. The identification and integration of 192 key stakeholders represent a significant milestone in enhancing MNCNH outcomes through collective action and community-driven health solutions.

Discussion

Rapid, inclusive stakeholder mapping is both feasible and valuable in a context as diverse as Nigeria. Three lessons emerged.

First, gender-balanced facilitation matters. Because MWAN members are clinicians well-known in their communities, they accessed senior officials and grassroots leaders alike with relative ease, echoing research that professional women's networks often bridge otherwise disconnected spheres of influence.[8]

Second, weighting influence against commitment curbed the common tendency to rely solely on high-profile figures whose interest may wane over time. By also valuing technical capacity and demonstrated passion, the final cadre contains actors capable of both opening doors and doing the day-to-day legwork that sustains advocacy.

Third, speed need not undermine rigour. Completing the exercise in two weeks

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dispelled scepticism among partners who had anticipated protracted negotiations. The clear scoring rubric and structured, time-boxed meetings kept momentum high while preserving transparency.

The stakeholder engagement process undertaken through this initiative demonstrated the critical value of inclusivity, strategy, and community-rooted collaboration in advancing maternal and child health in Nigeria. The identification of 320 relevant actors and the systematic refinement to a final list of 192 priority stakeholders reveal not only the breadth of potential partners in the MNCNH space but also the importance of carefully matching influence with interest and expertise.

This approach mirrors findings from earlier national and global reports, which emphasise the need for stakeholder engagement to be both context-sensitive and evidence-informed to be effective in public health programming.[13] In this case, the initiative prioritised diversity in representation by including policymakers, healthcare providers, and influential community figures. Each group contributed distinct assets—policymakers influenced system-level change, health professionals offered clinical perspectives, and community leaders brought cultural legitimacy and grassroots mobilisation.[10,12,14]

A major strength of the stakeholder selection process was the emphasis on demonstrated commitment and alignment with advocacy goals. Prioritising passion and past engagement helped ensure that the selected individuals were not merely symbolic figures but rather motivated collaborators capable of catalysing change. This level of intention has been shown to be essential for long-term success in similar multisectoral health initiatives.[10.15]

The project's geographic spread across 16 states highlighted regional disparities in health infrastructure and stakeholder capacity. By engaging local actors familiar with their specific contexts, the initiative was able to customise its engagement strategies to fit each state's socio-political environment. This localisation of strategy—` as a best practice in other African and global settings—helped promote adaptability and sustainability.[1, 6, 14]

Beyond stakeholder selection, the project invested in capacity-building efforts that further strengthened its implementation base. Training sessions and interactive platforms were not only opportunities for technical knowledge sharing but also for fostering dialogue, clarifying expectations, and encouraging joint problem-solving. This participatory approach helped overcome resistance to change in certain communities and aligned stakeholders around a shared vision of improved MNCNH outcomes.[11,12]

Importantly, the mapping exercise served a dual function—not just as a planning tool, but as a catalyst for network-building. It provided a structured space for new collaborations to emerge across institutional and professional boundaries. This interconnection is crucial, as solutions to maternal and child health challenges often lie at the intersections of policy, clinical practice, and social behaviour.[5, 7, 14]

Looking ahead, the ongoing engagement of these 192 stakeholders will be critical to

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maintaining project momentum. Sustaining these relationships will require continued communication, adaptive strategies, and visible impact. Feedback loops, recognition of contributions, and periodic capacity reviews are recommended to maintain motivation and alignment.

Conclusion

Through a well-coordinated effort, the AIM MNCNH Project was able to identify and engage 192 key stakeholders across 16 Nigerian states in just two weeks. This outcome highlights the importance of planning, collaboration, and a clear understanding of the local context when working to improve maternal, newborn, child, and nutrition health outcomes.

One of the strengths of the project lay in its focus on selecting and training individuals who already had strong ties to their communities. By building on this foundation, the project was able to create a group of advocates who were not only knowledgeable but also trusted. Their involvement has helped to build momentum around MNCNH issues and set the stage for longer-term impact.

This approach shows that meaningful change is possible when local voices are involved from the beginning. It also offers useful lessons for other health initiatives looking to achieve sustainable results through inclusive and context-driven strategies.

Limitation of the Study

Our work is not without limitations. Self-reported interest can be overstated, and private-sector innovators—particularly in digital health—may be under-represented. Ongoing monitoring will address attrition and identify gaps.

Conflict of interest: None declared

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