Nigeria Nutrition in Emergency
Sector Strategic Response Plan
2017-2018
Contents
1. Introduction ....................................................................................................................................................... 2
2. Current Nutrition and food security situation............................................................................................. 3
   a) Nutrition situation ........................................................................................................................................ 3
   b) Food security situation ................................................................................................................................ 5
3. Nutrition sector response plan - Strategic intent........................................................................................ 6
4. Overview of the people in need of nutrition Interventions ....................................................................... 6
7. Targeting criteria ............................................................................................................................................... 7
8. Guiding Principles .............................................................................................................................................. 8
9. Implementation strategies .............................................................................................................................. 8
   a) Provision of quality care for treatment and management of acute malnutrition ............................... 9
      i) Increasing the coverage of services treating SAM with and without medical complications ... 9
      ii) Building nutrition technical capacity of sector partners and government counterparts ...... 10
   b) Strengthening community capacity and linkages to enhance early identification of malnutrition and referral to facilities and participate in the promotion and support of optimal infant and young child feeding practices ................................................................. 11
   c) Prevention and protection of vulnerable groups, against the deterioration of nutrition status and mainstream gender and protection ................................................................. 12
      i) Strengthen implementation of IYCF programming ........................................................................... 12
      ii) Optimize blanket supplementary feeding program (BSFP) .............................................................. 13
      iii) Enhance coverage of micronutrient deficiency control ................................................................. 14
   d) Strengthen nutrition surveillance and screening systems to monitor the nutrition situation .... 15
      i) Strengthen nutrition surveillance and routine screening ................................................................. 15
      ii) Monitoring and analysis of the nutrition situation ............................................................................ 16
   e) Strengthening nutrition sector coordination and partner’s engagement within and across the sectors and enhancing accountability to the affected population ................................................................. 17
      i) Inter sectorial Coordination ................................................................................................................. 17
      ii) Accountability to Affected Populations .............................................................................................. 17
1. Introduction

The nutrition sector emergency response plan for North Eastern Nigeria will be implemented by different organizations working in nutrition and covers activities in Adamawa, Borno and Yobe states. The sector response plan is a living document which will be regularly adjusted based on the evolving situation on the ground. The Nutrition in Emergencies sector will endeavour to review the document bi-annually and targets will be adjusted in line with the humanitarian response planning cycle in June 2017. This document builds upon and further details the nutrition sector strategy outlined in the humanitarian response plan 2017. This response plan aims at articulating the various needs and responses to the affected population in Host community, Internally Displaced Persons (IDP) camps in both formal and informal settings, and populations in the newly liberated areas.

The nutrition sector response plan covers the period of July 2017- June 2018 and encompasses the current nutrition partners’ response plans; specifically the joint WFP, UNICEF and partners’ scale-up plan, in line with the agreed minimum nutrition package. The nutrition sector response plan also details the collaboration between the nutrition sector and cross cutting sectors such as WASH, Health, Food Security, Education, and Protection. The document outlines the collective sector targets, actions to be taken by sector partners, and the roles and responsibilities of the coordination team to realize full scale-up to reach the 2017 targets. The proposed activities and approaches are in line with the overarching government-led response and intend to ensure linkages with early recovery approaches of the federal and state governments.
2. Current Nutrition and food security situation

a) Nutrition situation

The overall nutrition situation in the North Eastern Nigeria (Adamawa, Borno, and Yobe) has remained precarious, the results of a surveillance established by the sector and funded by UNICEF unveiled GAM exceeded the WHO crisis classification threshold for “serious” (10%) in 5 domains: Central Borno, MMC/Jere, Northern Yobe, Central Yobe, and Southern Yobe. Prevalence of GAM was highest in Northern Yobe both as assessed by weight-for-height and/or oedema (14.3%), and as assessed by MUAC (10.5%).

Both crude and under-five mortality rates were highest in Central Yobe, 0.63 (0.39-1.01 95% CI) and 2.06 (1.24-3.38 95% CI), respectively. The under-five mortality rate in Central Yobe exceeds the emergency threshold of 2 deaths in children under five / 10,000 children under five / day.

Breastfeeding practices were assessed as a measure of infant and young child feeding (IYCF). Survey results suggest that the proportion of children who continued breastfeeding at one year (assessed among children aged 12-15 months) was over 90% in all three states, but then steadily declined; continued breastfeeding at two years (assessed among children aged 20-23 months) ranged from 31.1-40.9% by state.

Prevalence of acute malnutrition among all women of reproductive age (15-49 years) was assessed by mid-upper arm circumference. As with children, prevalence of acute malnutrition in women (≤ 221 mm) was highest in Northern Yobe. By state, prevalence of severe acute malnutrition (MUAC < 214 mm) was highest among women of reproductive age in Yobe (9.6%) followed by Borno (4.9%) and Adamawa (3.3%). Only about half of the women surveyed in the three states are achieving minimum dietary diversity for women of reproductive age (MDD-W)—50.1% in Adamawa, 42.1% in Borno and 43.3% in Yobe.

A rapid SMART assessment conducted in April 2016 in the LGAs of MMC and Jere revealed a GAM rate of 19.1% and SAM rate of 3.1% (April 2016). Nutrition assessments undertaken in April-June 2016 in some LGAs in Borno state confirm the existence of pockets with extremely high acute malnutrition rates in Konduga LGA with GAM 16.4% and SAM 5.0%, Kaga LGA with GAM 13.0 % and SAM 3.4% and Monguno LGA with GAM 27.3% and SAM 8.7%. Population based MUAC screening for children under the age of five conducted in the newly liberated areas have also indicated a dire situation in Bama, Dikwa and Biu among other location in Borno state.

The nutrition situation in the North East has further been aggravated by high food insecurity, sub optimal infant and young children feeding practices such as untargeted/uncontrolled infant formula distribution,

negative coping strategies, increasing spread of endemic diseases, low coverage of programs targeting children with moderate acute malnutrition, limited dietary diversity, loss of livelihoods, disruption of access to quality water and optimal sanitation, population displacement and destruction of housing, compromising the privacy necessary for breastfeeding; and the poor and deteriorating health care system.

**Fig 2 Nutrition survey results with call outs for data published from October 2016 to January 2017**

*Sources: UNICEF, MSF, State Ministry of Health (SMoH), ACF, FEWS NET*
b) Food security situation

The Emergency Food Security Assessment (EFSA) conducted by WFP in March 2017 shows that about 45 percent of the surveyed households are food insecure in the three Northern states of Nigeria, among them 8 percent are severely food insecure. Households in Borno State are most affected by food insecurity. The highest prevalence of households suffering from moderate and severe food insecurity were in the following Senatorial Zones: Borno Central (67 percent), Borno North (64 percent) and Borno South (61 percent). However, due to insecurity some LGAs in Borno North were not accessible for the enumerators and the food security situation may be more severe in those areas. The severe food insecurity rate for displaced households in Borno is greater than 20 percent compared to 9 percent for host households. Displacement is a key determinant of food insecurity and the majority of food insecure households are using asset depleting coping strategies. Around 27 percent of the host communities have hosted IDPs in the past 3 months. The highest asset depleting coping strategies rate is found in Borno Central and Borno South. The main reason for displacement is insecurity and IDPs feel that the security situation in the area where they have moved to is better with less threat to their safety/family’s safety.

Agricultural activities, which is the main source of income and food for households, are severely affected by the security situation. One third of the surveyed households does not have access to land for cultivation. Those who have access to land were not able to cultivate due to insecurity and did not practice agriculture this season. Households that do not have access to land are most affected by food insecurity, with 13% of them found to be severely food insecure against 5% of households with access to land. Insecurity has been cited as the main constraint to practice agriculture. Around 50% of the households that cultivated during the last agricultural campaign estimate that this year’s harvest is less than the average harvest in a normal year (before the insurgency). The production of the most cultivated cereal, millet, dropped drastically since the beginning of the insurgency.

More than 50 percent of the surveyed households experienced shocks over the last 3 months. Food price increases and insecurity were the most common shocks, experienced by 37 percent and 30 percent of the surveyed households. These figures show that in addition to the security situation, high inflation and cost of foods has a huge impact on food security.

The most affected by food insecurity are the poorest households. Around 20% of them are severely food insecure and 60% of them do not have access to land. Households headed by a woman (10.5%) are more affected by severe food insecurity than households headed by a man (7.2 percent). According to the assessment, the main source of income for severely food insecure households is selling woods (25 percent), and begging/assistance (28.4 percent).

---

2 Borno has 3 senatorial Zones which include LGA in the North, Central, and South of the state.
3. **Nutrition sector response plan - Strategic intent**

The nutrition sector strategic response plan sustains the inter-sectoral linkages currently established, to address the underlying causes of malnutrition and to emphasize clear approaches of how nutrition activities will link with food security, WASH, health and education. The response plan aims to achieve the country’s overarching humanitarian goals of saving life and alleviating suffering through the following sector objectives:

i. Improve equitable access to quality lifesaving services for management of acute malnutrition for children (boys and girls 6-59 months) and pregnant and breastfeeding women through systematic identification, referral and treatment of acutely malnourished cases.

ii. Promote access to services preventing under-nutrition for the vulnerable groups (children under five and pregnant and caregivers of children less than 2 years of age) focusing on infant and young child feeding in emergencies, micronutrient supplementation, and blanket supplementary feeding.

4. **Overview of the people in need of nutrition Interventions**

For priority needs in the management of acute malnutrition, 70% of 450,000 severely malnourished children 6-59 months will be targeted. This will be achieved by increasing the program coverage for CMAM especially in the newly liberated areas by bringing the services closer to communities. In addition to this, sector partners will also implement preventive programmes including the treatment of MAM cases.

Routine screening during preventive and treatment programmes and collaboration with the health sector during mass immunization campaigns will allow early identification of cases for referral and treatment. Increasing the availability of services to treat severe acute malnutrition across the different states by re-establishing the inpatient management of severe acute malnutrition with medical complications will aim to reach 31,456 children 6-59 months with SAM and medical complications. Improvement of the referral systems will also be prioritised.

Prevention of acute malnutrition will be done by providing nutritious foods to 389,000 children aged 6-59 months and 192,000 pregnant and lactating women. Other preventative activities will be undertaking infant and young child feeding in emergencies to 731,332 pregnant and caregivers of children less than 2 years of age, distribution of micronutrients powder (MNP) to 561,078 children aged 6-23 months and supplementation of vitamin A and routine deworming through mass campaigns to reach 1,922,553 children aged 6-59 months, and iron folate will reach 313,465 pregnant women. The scale up of the implementation of blanket supplementary feeding for children under the age of five and pregnant and mothers of infants less than six months of age will be integrated with food assistance to food insecure households though in-kind food distribution or cash based transfers. The prevention activities will be closely linked to other sectors such as the food security sector where food distribution and cash based programing will be implemented.
7. Targeting criteria

There are several nutrition specific interventions that target children under the age of five and pregnant and lactating women. These include management of SAM and MAM, BSFP, micronutrient supplementation, infant feeding, iron folate and vitamin A supplementation among others. Children under the age of five and pregnant and lactating women are the main beneficiaries for nutrition specific interventions while general food support targets the entire household.

Different interventions can be received by the same beneficiary hence the targeting will be improved to adopt a system that will avoid double counting. The sector-specific target is the sum of the highest number of children (6-59m) and pregnant and breastfeeding women (15-49years) to be reached with the highest targeted coverage of any one intervention respectively.

Nutrition sector partners aim to conduct vitamin A supplementation for children 6-59months in the conflict states through the biannual Maternal, Newborn, and Child Health campaign. While the goal is universal coverage, in total 80% of eligible children will be targeted for the doses of high potency vitamin A capsules. Whereas 70% of pregnant and caregivers of children under 2 will be targeted for the provision of infant and young child feeding counselling on safe and appropriate feeding practices for children aged 0-23 months. The targeted pregnant and caregivers of children under 2 be reached have strategically been set at 70% of the total number of people in need to promote program integration with CMAM whereby all women presenting at OTP sites with children suffering from SAM will systematically receive IYCF education and counselling.
8. Guiding Principles

Principles guiding the strategic response plan are:

a) Nutrition partners agree to support the development and rollout of an essential package of nutrition services.

b) Nutrition Partners agree to strive to work together to increase the quality of delivery of the essential package of nutrition services through collaboration, coordination and complementarity.

c) Nutrition partners strive to integrate their services with those of health, WASH, and food security/livelihoods and other relevant sectors in order to comprehensively address the immediate and underlying causes of malnutrition.

d) Nutrition partners engage to support capacity building of the government, communities and local partners to assist in knowledge and skill transfer for both immediate action and sustainability beyond the emergency phase.

e) Nutrition partners agree to use nationally endorsed guidelines and/or internationally supported protocols, and to support the development of national guidelines where necessary, as well as the review and updating of existing guidelines and or protocols to align with global recommendations

f) Nutrition partners engage to respect national reporting and monitoring formats and deadlines. Additionally, they strive to evaluate the impact of their programs, especially for new initiatives.

9. Implementation strategies

The nutrition response plan aims to achieve the above-mentioned principles through the following strategic actions:

a) Provision of quality care for treatment and management of acute malnutrition

b) Strengthening community capacity and linkages to enhance early identification of malnutrition and referral to facilities and participate in the promotion and support of optimal infant and young child feeding practices

c) Prevention and protection of vulnerable groups, against the deterioration of nutrition status and to mainstream gender and protection in programme delivery

d) Strengthen nutrition surveillance systems to monitor the nutrition situation

e) Strengthening nutrition sector coordination and partners engagement with and across other sectors such as Food Security, Health, WASH and Education when possible
The global approach to the strategic actions are detailed in this section with specific activities, deliverables, and responsible parties. Further details of key actions and responsibilities are detailed in the excel document.

a) Provision of quality care for treatment and management of acute malnutrition

i) Increasing the coverage of services treating SAM with and without medical complications.

To strengthen the partner’s capacities and improve coverage of the stabilization centres, the initiative that started with CERF funding in mid-2016 has helped the sector target to achieve at least one SC in every LGA. Collectively the sector will be aiming to deliver quality services, through strategic partnership with the state government, sector partners, and the Maiduguri Teaching Hospital which will establish a training facility that will give practical training and share experience in the management of severe acute malnutrition with medical complications to all actors in the Northeast and beyond.

The finalization of the training guidelines has harmonize the treatment protocols utilized in all stabilizations centres. The sector has set aside funds under the CERF-UFE to ensure the required routine medications and equipment to establish at least one stabilization centre per ward is realized with first priority in locations where the SAM burden is high. Detailed geographic and functional analysis of all operating SC
will be conducted to ensure increased coverage and to minimize duplication of activities. Emergency response will be continued to the hard-to-reach areas collaborating with other sectors like health to establish a referral pathway for those in locations where inpatient services are not available.

As the availability of the services has been limited in 2016, the community mobilization and sensitization messaging will ensure that the communities are made aware of the availability of these services and that services are free of charge as well as proper communication to the caretakers to allow them to be available for the duration of the treatment. Series of health workers’ training and mentoring are lined up to increase the capacity of health workers with the adequate skills to detect and refer as well as manage SAM with medical complications. In the 2017 HRP the sector has clearly projected the expected caseloads for SAM with medical complications; this will allow adequate follow-up on the monthly achievements, so they are realized and that the gaps in coverage can be addressed timely and appropriately.

The federal and state government working closely with UNICEF and INGO/LNGO have resolved to increase tripartite partnerships, with the roles of each partner clearly outlined to increase the coverage and quality of the outpatient treatment of acute malnutrition. The state government will be providing the health infrastructure and the health workforce, UNICEF will support with the technical capacity and supplies while the INGO will be focusing on the supporting the state with operational capacity and technical mentoring and coaching to improve quality of services.

The state will establish a joint team involving all actors for monitoring and supervision across the three emergency states. The sector secretariat led by the state government has embarked on strengthening Information analysis on the progress of the collective sector achievements on monthly basis, Information products will be produced to clearly show the progress gaps related to coverage of SAM services.

ii) Building nutrition technical capacity of sector partners and government counterparts.

The nutrition sector, with financial support from UNICEF and other partners, has rolled out several approaches for training aimed at improving the in-country capacity on nutrition-related programing (SMART survey methodology, IYCF-E training and Rapid pro training). The resource persons trained will cascade the training to reach more sector partners and improve service delivery. Several modalities were identified to increase capacity in the nutrition sector with emphasis on CMAM programs: Utilization of the USAID funded Technical Rapid Response Team (Tech RRT), capacity building by international NGOs, on the job training and roving capacity building teams (as part of the emergency response teams), guidance by the technical working groups (NIWG, CMAM, IYCF).

With the increased technical human resources capacity of UNICEF at the state level, other INGO partners are also increasing their technical capacity with specific skills in responding to complex nutrition emergencies. These skills will be linked with the current efforts of the federal and the state government to scale up availability of skilled health workers in the conflict affected states.

iii) Optimizing supply chain management and support logistics of nutrition commodities.

The sector, in collaboration with UNICEF and WFP, ensured adequate planning of the 2017-2018 nutrition supply requirements, managing the supply chain for SAM treatment and BSFP commodities for the sector.
Sector partners will resume reporting on supplies requirements to UNICEF and WFP to ensure that they are accountable to restock and provide transport for the nutrition sites that they are currently supporting. The nutrition sector is working with UNICEF to rationalize geographical presence to avoid duplication and overlap of partners. WFP has provided extensive training in food storage and commodities management to NEMA and SEMA, and the institutions facilitated the transport of commodities and coordination at State level. WFP through the Logistics Cluster, has installed Mobile Storage Units (MSUs) that can be used for the storage of nutrition commodities at LGA level in hard to reach or newly liberated locations.

A taskforce has been established to mitigate the misuse of nutrition commodities and has developed reporting templates and actions to be taken to minimize misuse. The sector has been in discussion with UNICEF to have the supply pipeline status updated on a monthly basis to ensure that adequate buffer stocks are available at all times in country for the emergency response, the same will be done with WFP. Close collaboration with the logistics cluster through the ISWG will be established for adequate planning for supplies storage and transportation in the newly liberated areas and areas with security restrictions when needed. Hubs creations and availability of mobile storage units (MSU) in Monguno, Ngala, Dikwa and Ngwoza will support availability of supplies in areas which are more difficult to access. A capacity building workshop on supply chain management and reporting will be conducted for operational partners.

b) Strengthening community capacity and linkages to enhance early identification of malnutrition and referral to facilities and participate in the promotion and support of optimal infant and young child feeding practices

The nutrition sector partners will prioritize the establishment of a joint elaborate community engagement approach as an important mechanism for early detection of acute malnutrition and timely referral for treatment that enhances accountability to affected populations. At the same time emphasis will be given in strengthening the community promotion and support to optimal infant and young child feeding practices. Active case finding will be strengthened in 2017-2018, with monthly exhaustive MUAC screening to be implemented by partners in their areas of operation. Also infants less than six months that are not breastfed anymore will be referred for assessment to the nearest health facility. To deal with the outcome indicators for the management of acute malnutrition, an example of which is the high defaulter rates reported in some sites, partners will be engaging with the Community Nutrition Volunteers (CNVs) to do defaulter tracing and follow-up. The CNVs will be identified in consultation with the local community leaders to enhance accountability to the community; clear roles will be outlined which will include as a minimum the necessity to conduct routine screening on a monthly basis as well as active case finding, follow-up of beneficiaries at the community level, IYCF-E promotion and sensitization.

To optimize functionality of CMAM programs, increase coverage, ensure early detection and timely referral of cases, and improve program performance through defaulter tracing and following-up on problem cases, nutrition sector partners will continue their commitments to increase the number of outreach sites. This is at the backdrop of a health system functioning below capacity due to the destruction of health facilities related to the conflict. Within areas where the presence of nutrition actors is limited, efforts will be made to link up with the Health and WASH sectors in utilizing their community structures by training them on key outcomes like MUAC screening, and maternal MUAC screening.
c) Prevention and protection of vulnerable groups, against the deterioration of nutrition status and mainstream gender and protection

i) Strengthen implementation of IYCF programming

During emergencies, the protection, promotion, and support of optimal infant and young child feeding practices is a priority lifesaving intervention. IYCF programming will be strengthened in the context of deteriorated food security, WASH, health, protection (GBV) situation, to prevent increased morbidity and mortality in infants and young children. As limited information has been availed during the initial rapid needs assessment in the newly liberated areas, the sector through the IYCF-TWG has developed assessment guidelines to support the collection of vital information on IYCF in the affected populations (including displaced persons and the host community).

The sector partners developed a minimum package for IYCF services that needs to be implemented at the community and health facility levels.

The sector partners are collaborating to ensure that all the nutrition interventions are comprehensive and integrate the protection, promotion and support of IYCF to maximize presence and coverage in the conflict affected areas. Through working closely with the protection sector, baby-friendly spaces are being set up especially in IDP camps to monitor the IYCF and care practice interventions and to report on a regular basis.

Each point of contact between the child, parent and staff of the program will be an opportunity to assess, provide practical support and promote key practices to ensure good nutrition for infants and young children.

With increased food security and livelihood activities across the conflict states, the sector has embarked on strategic partnerships with the actors delivering General Food Distributions to use distribution points to deliver IYCF messages and recruit for support groups and counselling. As a result of this, the majority of cash based programs will strive to ensure optimal complementary feeding is a condition for the cash transfer.

The sector agreed to focus on interventions that will help a) assess the IYCF mother and child dyad b) provide counselling support c) follow up with existing community infrastructure and d) report on the progress made. IYCF services are scaled up and will be available in: a) health facilities b) communities c) IDP camps and d) during outreach activities. With the recruitment and deployment of CNVs there will be a more aggressive IYCF campaign reaching each and every household in the northeast.

As the reporting on IYCF interventions was poor in 2016, the sector, through the IYCF-TWG, has harmonized the recording and reporting tools and oriented all partners during the nutrition sector meeting. In 2017, information will be collected through the following channels: a) mother support groups b) CNVs home visits and c) health facility based counselling services.

The sector coordination team with support from UNICEF has plans to include IYCF reporting indicators in the SMS based Rapid Pro reporting platform. The IYCF TWG agreed to step up the mass media campaign using communication materials developed for the north east and Nigeria to support IYCF in the local language. At the same time a cadre of experienced IYCF Trainers has been identified in the north east and will be tasked to facilitate capacity building activities.
The IYCF TWG has started a knowledge management exercise, with the uploading of key and relevant documentation in the humanitarian response website for Nigeria: https://www.humanitarianresponse.info/en/operations/nigeria/nutrition

At the same time the IYCF TWG initiated the process of developing a quick reference guide for field workers on how to support caregivers/mothers of infants less than six months that are not breastfed. Potential collaboration with Child Protection and WASH are under discussion and look at the convergence and services offered to improve the quality of life of the affected populations.

The sector has also been able to enlist the support of in country and global partners in enhancing the capacity of government in IYCF training with TOT trained on the Care Group Model and IYCF-E. The GNC in collaboration with Tech RRT have also supported the sector with 2 deployments of its IYCF-E advisor in Borno to work with partners on the scale-up. These efforts will be harnessed coupled with the actions below to realize the much needed IYCF-E scale-up.

ii) Optimize blanket supplementary feeding program (BSFP)

The coverage of BSFP is very critical as the absence of services managing moderate acute malnutrition exerts pressure on SAM management as most moderately malnourished children deteriorate to be severely malnourished if they are not reached with any intervention. The sector partners will be working with WFP to advocate for increased funding and coverage of BSFP in Yobe and Borno especially linking it to areas where high prevalence of acute malnutrition and areas highlighted as food insecure through the cadre harmonize. BSFP is linked with general food assistance through in kind food distributions or cash based transfers. The integration of both programmes promote food security in households thus limiting the consumption of BSFP commodities by the rest of the family (i.e. minimizing sharing).

Partners implementing BSFP integrate routine screening of all children under 5 and facilitate referral to CMAM activities, during the mobilization for the registration of BSFP and follow up. Linkages are also made with referrals for IYCF-E. Further collaboration will be undertaken to ensure that there will be no duplication of micronutrients powder supplementation in areas where BSFP is being implemented, this will be achieved by clearly mapping the BSFP coverage and sharing programmatic data to facilitate joint collaboration.
iii) Enhance coverage of micronutrient deficiency control

There is a need to raise awareness on the importance of key micronutrient interventions. In particular, the close collaboration with State level officials is imperative in ensuring that micronutrient programme activities continue to be prioritized as a key preventive intervention in the emergency.

Ensuring a comprehensive emergency nutrition response is essential; integration of IYCF, CMAM and Micronutrient Deficiency Control (MNDC) activities where appropriate can increase the joint impact of the programmes. Joint planning of activities should take place to identify areas and opportunities for delivery of several elements of the nutrition response in tandem. Mass screening activities are one example where micronutrient powders can be given to children with yellow MUAC—except in areas where expanded criteria dictate the provision of RUTF/RUSF, or BSFP is in place—and in those areas that have been newly liberated, VAS and deworming can also be given during such screenings.

The health kit provided to PHCs, contains vitamin A, de-worming and iron folic acid tablets. These kits are provided to priority health facilities where the need for services is greatest. A key challenge relating to the provision of nutrition services through the distributed health kits has been the reporting of data for beneficiaries reached with the respective nutrition services. Data for IDP camps has been made available, but data for PHCs has not been disseminated. There is continued need to follow up with the UNICEF health section at the Country Office and Field Office level to ensure that data are made available.
Sector partners will be encouraged to a) administer a sustained coverage of vitamin A supplementation, iron and folic acid supplementation especially to pregnant women; b) to advocate for the continued use of iodized salt, which is part of the general rations; c) the use of fortified blended foods; d) utilize already existing IEC materials on the utilization of micronutrient powders.

Coordination between BSFP and micronutrient powder supplementation is also essential; what should be done in case an MNP distribution is ongoing where BSFP will start is outlines below,

### Figure 1 Rationale for MNP implementation

**d) Strengthen nutrition surveillance and screening systems to monitor the nutrition situation**

- **i) Strengthen nutrition surveillance and routine screening**

Availability of reliable data is very critical for planning and decision making. Within the sector, concerted efforts will be made to strengthen routine monthly exhaustive screening for acute malnutrition, which aim is to ensure that all malnourished children are timely referred for treatment, and exhaustive screening data can be used to routinely monitor the nutrition situation of a particular geographic location. The sector has developed guidelines on the rapid MUAC assessment to enhance comparability and analysis.

MUAC screening is a relatively easy skill to acquire and the sector is keen to have this skill taught to mothers who will later be issued with MUAC tapes so they can screen their children and bring them to the nutrition sites for further screening and verification by health workers. Nutrition sector partners will be detailing how this approach will be undertaken in the community strategy.
The established quarterly nutrition and food security surveillance system has provided useful information for the analysis of the nutrition situation in the Cadre Harmonize analysis framework. This has also availed credible information on the projected nutrition situation allowing sector partners to plan and adjust the response adequately with the changing situation.

Although the nutrition and food security surveillance system provides a snapshot of the situation on a triannual basis, estimates are representative at the domain level. It is for this reason that partners are encouraged to conduct lower level assessments representative at the LGA level through SMART and rapid SMART surveys. The SMART Survey Manager Training conducted in February 2017 has increased the in-country capacity of persons that are qualified to undertake these assessments from start to finish. The sector will continuously be engaged in the multi-agency rapid needs assessment conducted in the newly accessible areas.

To ascertain the extent of the coverage of nutrition interventions, the sector in collaboration with the GNC and the Coverage Monitoring Network (CMN) partners will be undertaking coverage assessments in the North East where nutrition interventions are being implemented. With the strengthened capacity at the Nutrition Information Working Group, technical review and validation of all assessments planned will be done. Results will be analysed and shared in the survey and assessment data base and will indicate the reach of services as well as quality.

Figure 2 assessments planned for 2017 (as of 6th March)

ii) Monitoring and analysis of the nutrition situation

The sector coordination team in support of the state as the custodian of all nutrition related information will aim for:
a) Timely report submission by partners;
b) Data analysis on performance and dissemination;
c) Tracking achievement towards targets.

This will be done on a monthly basis and will be shared in the sector meetings in the 3 states and at the federal level.

The sector will also be monitoring the collective sector indicators against the HRP plan on monthly basis and a bi-annual and annual program monitoring report will be compiled by the sector secretariat. To strengthen reporting, UNICEF in collaboration with the Government has rolled out SMS reporting. Rapid pro; plans are to ensure all the emergency nutrition activities are reported on this platform. Series of trainings have been conducted and more are planned.

The partners have agreed that tracking of nutrition interventions should be done at the ward level and the sector secretariat will be analysis this information to present clearly areas where there are gaps. Progress on sector partners’ achievements will be analysed per site every month and findings discussed in the sector as a standing agenda in all coordination meetings.

The sector has committed to be providing infographics and publications, such as presence mapping and the quarterly nutrition in emergency sector bulleting.

Collectively, sector partners will be undertaking joint monitoring and supervision routinely to support the implementation of nutrition activities at the facility level, propose corrective measures and design on-job coaching and mentoring based on findings to enhance the capacity of the health workers.

**e) Strengthening nutrition sector coordination and partner’s engagement within and across the sectors and enhancing accountability to the affected population**

**i) Inter sectorial Coordination**

The nutrition sector will continue to strengthen active participation of members in all inter-sectoral coordination meetings. All the nutrition sector technical working groups have been activated and leadership is delegated to various partners with the IYCF-TWG currently chaired by the World Health Organisation; the NIWG-TWG chaired by UNICEF; and the CMAM-TWG chaired by Action Against Hunger. This is aimed at enhancing partners’ engagement and collective decision making on issues affecting the nutrition sector. The sector has also planned to undertake the Sector Coordination Performance Monitoring exercise to clearly identify areas among the six plus one core functions that require strengthening. The sector will regularly update the SCPM action plan to ensure that the cluster performs adequately on all six core cluster functions.

Federal nutrition sector meetings will be held on a monthly basis on the first Friday of every month, while in the states the meeting in Borno will be held bi-weekly, and in Yobe and Adamawa the meeting will be in held once a month.

**ii) Accountability to Affected Populations**
The nutrition sector partners will work to demonstrate their commitments to the affected population by clearly articulating within the response plan and the online project sheets clear feedback and accountability mechanisms. The sector partners will also undertake the provision of accessible and timely information on organization procedures and processes that affect them and ensure they make informed choices and facilitate dialogue.

Establishment of feedback and complaint mechanisms to actively receive and review the views of the affected population to improve the program design and vision. Partners will endeavour to ensure that feedback and complaints mechanisms are streamlined, appropriate and robust enough to deal with (communicate, receive, process, respond to and learn from any and all feedback provided) the received. Partners will create an environment which enables affected populations to play an active role in the decision-making processes that affect them through the establishment of clear guidelines and practices to engage them appropriately and ensure that the most marginalised and affected are represented and have influence. Incorporating the affected population in the supervision and monitoring of the sector partners responses regularly as an ongoing basis and reporting on the results of the process.