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1. Introduction

The nutrition response plan in Nigeria will be implemented by different organization working in nutrition in the Northeast and will be covering activities in three states of Adamawa, Borno and Yobe. The response plan is a living document to be regularly adjusted based on the evolving situation on the ground. The sector secretariat will endeavour to review the document on a quarterly basis and targets will be adjusted in line with the humanitarian response planning cycle in June 2017. The response builds up on the nutrition sector strategy in the humanitarian response plan in 2017. The response plan also aims at articulating the various needs and responses of the affected population in Host community IDP both formal and informal camps and those in the newly liberated areas.

The nutrition sector response plan will be covering the year 2017 and will be complimenting the current nutrition partners response plans specifically the WFP, UNICEF and partner’s scale-up plan and the recently developed minimum nutrition package. The nutrition response strategy plan also aims to create collaborations with other sector to identify and implement actions that will synergize the interventions with other sectors of WASH. Health food security, education and protection. The document will outline the collective sector targets actions needed to be taken by partners and the roles of the coordination secretariat 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 intends to ensure linkages with early recovery approached of the state and the federal governments.

2. Background Situation analysis

a) Affected areas: Pre-Emergency

Pre-crisis conditions show that the social and economic indicators in Nigeria are very low, and those in the NE region generally the poorest. The country stands 152 of 187 in the Human Development Index which is below the average for Sub Saharan Africa. Nationally, 46 percent of the population is below the poverty line while in the NE, the figure is 70 percent—this figure increased between 2012 and 2013. Access to education is very low with 53 percent of children being out of school in the region. Even for those who attend school 72 percent of students are unable to read after completion of grade 6. Borno state has the lowest rates of any State in the country; only 35 percent of female and 46 percent of male adolescents are literate (compared to 98 percent for both genders in Imo State in the southeast). Under-5 mortality rates in the North East are as high as 160 deaths per 1,000. The region also lags behind the rest of the country in terms of nutrition, vaccination coverage, and antenatal care (RPBA, 2016).

From 1990 to 1999 the prevalence of stunting among children had decreased from 43 percent to 36 percent. In contrast wasting had increased from 9 percent to 16 percent over the same period. As a result of this, Nigeria did not meet the World Summit goal to reduce the prevalence of severe and moderate malnutrition among children under five by half between 1990 and the year 2000 (UNICEF, 2002; Federal Office of Statistics, 1992).

According to the MICS (1999), national stunting prevalence among children under 5 in 1999 were at 32 percent and severe stunting prevalence at 18 percent. Zonal comparisons of the distribution of stunting revealed that stunting prevalence was higher in the North Eastern states at 46 percent compared to the South West at 22 percent (UNICEF, 2002).

An analysis of the changes in stunting prevalence in Nigeria between 1996 and 2008 disaggregated by wealth showed that there was almost no change in stunting prevalence from 2003 to 2008. This is consistent with an unchanging
degree of inequality during the same period of time. Trends disaggregated by urban/rural status in Nigeria show that in 2003, the prevalence of stunting was higher in rural populations compared to urban areas; this trend remained unchanged by 2008 (Black et al., 2013). Consistently high figures for malnutrition among the focus population suggest chronic food insecurity in the region and/or repeated illness (National Population Commission, 2000). In 2008, Nigeria was one of 14 countries that accounts for 80 percent of the worlds stunted children (UNICEF, 2013).

b) Affected areas: Post Emergency

One million children under five years of age die every year in Nigeria—35 percent of these deaths are attributable to malnutrition. Nigeria therefore, is among the six countries that account for half of all child deaths from malnutrition globally (Summary of Child Survival Partnership. The Lancet Undernutrition Series, 2013). In 2016, the median of GAM is within the critical threshold (between 10 percent and 15 percent) in Borno and Yobe state, whereas it is within the stressed threshold (between 5 percent and 10 percent) in Adamawa state. Although acute malnutrition prevalen ce (SAM) levels approach critical threshold, they show an overall stability in trends compared to previous years. However, stunting prevalence is up to 40 percent in the North East and affects almost half of the children in Northern Nigeria (FAO, 2016; NBS/ FMoH/UNICEF, 2015).

Nutritional screening in the three states shows a higher prevalence of SAM in camp settings at 3.9 percent compared to an overall 3.2 percent in Borno and 2.9 percent in Yobe state (HNO, 2015). Trend analysis of seven Nutrition and Health Surveys using SMART methodology conducted between 2010 and 2014 show increases in Global Acute Malnutrition (GAM) rates in Borno state, indicating chronic malnutrition acute malnutrition (GAM) does not necessarily indicate chronic malnutrition in the northern states. GAM prevalence among children under 5 years in Borno State increased from 6 percent in 2010 to 11.5 percent in 2015. The peak in malnutrition prevalence however was observed in 2012 when GAM prevalence was 13.8 percent (NBS/FMoH/UNICEF, 2010-2015). In the same time period, there was little change in the prevalence of GAM for Yobe state (Myatt, 2015).

When comparing pre and post conflict GAM estimates MICS estimates suggest a similar trend. An increase in GAM and SAM prevalence was observed in Borno state between 2007 and 2011 GAM prevalence rose from 14 percent to 19 percent, and SAM prevalence rose from 5 percent to 6 percent during the time period. However for both Adamawa and Yobe states GAM and SAM prevalence decreased between 2007 and 2011; in Adamawa State GAM dropped from 10 percent to 6 percent whereas in Yobe state GAM dropped from 16 percent to 15 percent. Similarly, SAM rates also decreased from 4 percent to 1 percent in Adamawa state, and 7 percent to 5 percent in Yobe state (UNICEF/MICS, 2007; UNICEF/MICS, 2011).

MICS data suggests that from 2007 to 2011 the coverage of vitamin A supplementation increased; the reported vitamin A coverage increased from 22 percent to 68 percent in Adamawa state, from 21 percent to 33 percent in Borno state, and 18 percent to 51 percent in Yobe state. Conversely, NNHS/SMART data suggests that from 2010, there was a decrease in vitamin A supplementation. In 2010 the prevalence of vitamin A supplementation in Borno and Yobe states were 76 percent and 53 percent respectively but by 2015, the coverage prevalence had dropped to 14 percent in Borno State, and 8 percent in Yobe state. Similarly, Vitamin A coverage in Adamawa state in 2014 was reported at 61 percent, and decreased to 33 percent by 2015 (NBS/FMoH/UNICEF, 2015). Analogous to this, deworming coverage in Yobe state was 13 percent and decreased to 0.09 percent by 2015. In Borno state during the same time period, deworming coverage fell from 25percent in 2012, to 6 percent in 2015 (NBS/FMoH/UNICEF, 2010-2015).
c) Key drivers of the crisis, Pre-Emergency

Exclusive breastfeeding rates fall considerably short of the World summit goal of all women exclusively breastfeeding for the first four to six months of life and the national goal of all women exclusively breastfeeding for the first six months of life. In 1990, NDHS estimated exclusive breastfeeding rates to 2 percent, this rose to 13 percent (history since birth) in 1999 when assessed during the MICSB (Federal Office of Statistics, 1992; UNICEF, 2002).

Micronutrient deficiencies contribute to ‘silent hunger’, in 1999 vitamin A supplementation was low; according to MICS (1999) approximately 75 percent of children under five years did not receive Vitamin A supplementation in the 24 months prior to the survey being taken with only 20 percent of children under 5 reported that they did received Vitamin A supplementation during the recall period (UNICEF, 2002).

The coverage of nutrition services prior to the crisis was minimal and limited to the few areas where the health system had the required capital and human resources to integrate nutrition into the services they delivered (RPBA,2016).

d) Key drivers of the crisis: Post-Emergency

Food availability declines towards the lean season (mentions the months from- to), those households that are affected by the conflict, flooding, and dry spells will experience below average crop production which may result in a depletion of stocks at an earlier rate than normal (FAO/CH, 2015). Conversely, the main harvest period is between October and December is linked with availability of foodstuffs at household and community level and therefore a reduction GAM/SAM and admission into therapeutic feeding programs (Corbett and Binns, 2013).

There is lack low uptake of preventive nutrition interventions such as infant and young child feeding practices in the affected states. The practice of exclusive breastfeeding for the first six months, initiation of breastfeeding within one hour of birth, continued breastfeeding at two years of age, consumption of iron rich food and dietary diversity is low in the affected states; exclusive breastfeeding in Borno is at 12 percent, is 2.7 percent in Yobe state. The prevalence of careers practicing minimum dietary diversity in 2012 was 29.4 percent in Borno state and 15.6 percent in Yobe state (NBS/UNICEF, 2012).

The deteriorating nutrition situation in the NE states is mainly driven by the disruption of basic health and social services, poor infant and young child feeding practices, rising food insecurity, inadequate access to markets, decreasing access to safe water and sanitation, and declining availability of health services. Rates of diarrhoea, measles and cholera are on the rise; accentuated by childhood malnutrition, this will further exacerbate the nutrition situation. These trends are all closely linked to the ongoing conflict and displacement (HNO, 2016).

Undernutrition has been found to contribute to the high rates of disability, morbidity, and mortality in Nigeria, especially among infants and young children (NPC and UNICEF, 2001). Some groups face more severe and particular risks than others; females and children, female-or-child headed households, unaccompanied/separated children, and pregnant and lactating women (RPBA, 2016; Humanitarian Needs overview, 2016). Children suffering from SAM are nine times more likely to die than their healthy peers, and chronic malnutrition under the age of two leads to irreversible cognitive impairments that prevent affected children from reaching their full potential. Chronically malnourished children are also more likely to drop out of school, and less likely to work as adults (NBS/UNICEF, 2012).

Over 40 percent of under five children in Borno and Yobe states were found to be chronically malnourished. Chronic malnutrition affects human productivity at adulthood and eventually negatively impacts economic productivity affecting the GDP of a country. Female nutritional status affects birth outcomes, and perpetuates the inter-generational cycle of poverty and poor health. Data suggests that there has been an increase in malnutrition among women in all focus states. Although there are seasonal variations in the malnutrition status-overall increase since 2010 to 2015 (NBS/UNICEF, 2010-2015).

Current figures show that the majority of IDPs are identified in Borno (1,525,404) followed by Yobe (139,550) and Adamawa (132,626). The majority of IDPs live in host communities (92 percent) whereas 8 percent live in camps (IOM, 2016). The majority of IDPs identified were displaced as a result of the insurgency (IOM, 2016). Reports show that 56 percent of the IDP population are children, and 28 percent of these are 5 years old or younger (IOM, 2015). To be update with the latest IOM DTM.

A multi-sectoral assessment in Maiduguri which pulled samples from IDP camps (both formal and informal) as well as host communities reported that of those surveyed in Maiduguri, Borno state, there were approximately 8 percent of the children under five years old being reported by their parents as being monitored/managed for malnutrition (PUI, 2016). The assessment also highlighted that pregnant women had no access to antenatal care with anecdotal evidence that some of them even gave birth on the run, and had no access to healthcare afterwards (PUI, 2016).

Women of childbearing age are a particular vulnerable group, there has been a general increase in malnutrition prevalence among this population. When malnutrition estimates are disaggregated by lean and post-harvest season the following are noticed. Adolescent women were found to be more malnourished compared to their older counterparts. Adolescent nutritional status affects birth outcomes and perpetuates the inter-generational cycle of poverty and poor health (NBS/UNICEF, 2010-2015).
4. 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. Under five mortality rate ranged from 0.68 to 2.06 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 (≤ 221 mm) was highest in Northern Yobe. By state, prevalence of severe 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 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.

Rapid SMART assessment conducted in April 2016 in the LGA’s of MMC and Jere revealed a GAM rate of 19.1% and SAM rate of 3.1% (April 2016). Recent nutrition assessment undertaken in some LGAs in Borno state confirms the existence of pockets with extremely high malnutrition rates in Kontuga GAM 16.4%, SAM 5.0%, Kaga GAM 13.0 %, SAM 3.4% and Monguno GAM 27.3%, SAM 8.7%. Population based MUAC screening 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, absence of program 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) Current Food security situation.
5. Nutrition response Strategic intent

The nutrition response strategic plan will sustain the inter-sectoral linkages currently established, to address the underlying causes of malnutrition and to emphasize the need to have clear approaches of how nutrition activities will link with Food security, WASH, health and education. The response plan will be aiming to achieve the countries 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 the five and pregnant and breastfeeding women) focusing on infant and young child feeding in emergencies, micronutrient supplementation, and blanket supplementary feeding.

6. Priority needs.

Management of acute malnutrition targeting about 70 % of 450,000 severely malnourished children 6-59 months. This will be achieved by increase the program coverage for CMAM especially in the newly liberated areas by bringing the services close to the people affected. Routine screening and collaboration with the health sector during Mass immunization campaign to screen and treat acute malnutrition. 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 to reach 31,456 children 6-59 months.

Prevention of acute malnutrition by undertaking infant feeding in emergencies to 731,332 pregnant and breastfeeding women, distribution of micronutrients powder (MNP) to 561,078 children of 6-23 months and supplementation of Vitamin A and routine deworming through mass campaign to reach 1,922,553 for 6-59 children, and iron folate will reach 313,465 pregnant women. Scale up the implementation of Blanket supplementary feeding for children under the age of five and pregnant and breastfeeding women.

<table>
<thead>
<tr>
<th>interventions</th>
<th>Adamawa PIN</th>
<th>Adamawa Target</th>
<th>Borno PIN</th>
<th>Borno Target</th>
<th>Yobe PIN</th>
<th>Yobe Target</th>
<th>Total PIN</th>
<th>Total Target</th>
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<tr>
<td>SAM without medical complication</td>
<td>42,945</td>
<td>30,091</td>
<td>266,941</td>
<td>186,893</td>
<td>94,425</td>
<td>66,118</td>
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<td>SAM with Medical complication</td>
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<td>29,660</td>
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<td>354,521</td>
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<td>194,372</td>
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<td>180,075</td>
<td>1,044,658</td>
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</table>
7. Targeting criteria

There are several nutrition specific interventions that target children under the age of five and pregnant and lactating women. They include management of SAM and MAM, BSFP, Micro nutrient supplementation, infant feeding, Iron foliate and vitamin A supplementation among others. Children under the age of five, pregnant and lactating women are the main beneficiaries.

Different interventions can be received by the same beneficiary hence the targeting must adopt a system that will avoid chances 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, new born, 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 breastfeeding women will be targeted for the provision of infant and young child feeding counselling which promotes and supports safe and appropriate feeding practices for children aged 0-23 months during emergencies. The targeted pregnant and breastfeeding women to be reached have strategically been set at 70% to promote program integration with CMAM whereby all women presenting at OTP sites with children suffering from SAM will receive IYCF education and counselling.

8. Guiding Principles:

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 communication.

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 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 as deemed necessary.

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 objectives through the following strategic actions:

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

b) Strengthening community capacity and linkages to enhance early identification of malnutrition and referral to facilities.

c) Prevention and protection for vulnerable groups, against the deterioration of nutrition status

d) Strengthen nutrition surveillance systems to monitor the nutrition situation

e) Strengthening nutrition sector coordination and partners engagement
a) Provision of quality of care for treatment and management of acute malnutrition

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

To strengthen the partner’s capacities and improve coverage of the stabilization centres, initiative started with CERF funding in mid-2016 have seen the sector target to achieve at least 1 SC in every LGA. Collectively the sector will be aiming to deliver quality services, through strategic partnership with the state government, Sector partners the Maiduguri teaching hospital which will see the establishment of a training facility that will give practical training and experience in the management of severe acute malnutrition with medical complication to all actors in the North east and beyond.

The finalization of the training guidelines will harmonize the approaches utilized in all stabilizations centres. The sector has also set aside funds under the CERF-UFE to ensure the required routine medications and equipment’s to establish at least one stabilization centre per ward is realized in location where the SAM burden is high. Detailed geographic and functional analysis of SC will be conducted to ensure increased coverage and 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 location where inpatient services are not available.

As the availability of the services have been limiting in 2016, the community mobilization and sensitization messaging will ensure that the communities are made aware of the availability of this services and that this services are free of charge and proper communication to the caretaker to allow them 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 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 are realized and that the gaps in coverage can be addressed appropriately.

The federal and state government working closely with UNICEF and INGO/LNGO have resolved to increase tripartite partnership, 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.

### Objective: Increasing the coverage of services treating SAM with and without medical complication

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<th>ACTION PLAN</th>
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<tbody>
<tr>
<td>TASK</td>
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ii) Building nutrition technical capacity of sector partners and government counterparts.

The nutrition sector with financial support of UNICEF as the sector lead agency and other partners have rolled several approached for training aimed at improving the in country capacity on 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 increased capacity in nutrition sector with emphasis on CMAM programs: Utilization of the USAID funded Technical rapid response team (TRRT), 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 will be encouraged to increase the technical capacity with specific skills in responding to complex nutrition emergencies. This 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.

### Objective: Building nutrition technical capacity of sector partners and government counterparts.

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<th>ACTION PLAN</th>
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<td>TASK</td>
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</table>
iii) Optimizing supply chain management and support logistics of nutrition commodities.

Rationalization of the supply chain management has seen PCA partnership increased, the sector in collaboration with the UNICEF ensured adequate planning of the 2017 nutrition supply requirement and UNICEF is managing the supply chain for SAM commodities for the sector. Sector partners to resume reporting on supplies requirement to the UNICEF to ensure that they will be accountable to restock and transport for the nutrition sites that they are currently implementing. To facilitate this the nutrition sector is working with UNICEF to rationalize geographical presence to avoid duplication and overlap of partners.

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

<table>
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<th>ACTION PLAN</th>
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b) Strengthening community capacity and linkages to enhance early identification of malnutrition and referral to facilities

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. Active case finding will be strengthened in 2017, with monthly exhaustive MUAC screening to be implemented by partners in their areas of operations. To deal with the outcome indicators for the management of acute malnutrition example of the high defaulter rates reported in some sites, partner will be engaging with the Community owned resource persons (CORPS) to do defaulter tracing and follow-up. The CORPS will be identified in consultation with the local community leaders to enhance accountability to the community clear roles will be outlined and with the minimal to include routine screening for active case finding. Follow –up of beneficiaries at the community, IVCF-E promotion and sensitization.
To optimize functionality of CMAM programs, increase coverage, ensure early detection of cases and timely referral and improve programs performance by following-up on problem cases and defaulters. Nutrition sector partners will continue their commitments to increasing the number of outreach sites at the backdrop of a health system functioning below capacity due to the destruction of health facilities related to the conflict. Within areas where there presence of nutrition actors is limited, efforts will be made to link up with Health and WASH sector in utilizing their community structures by training them on key outcome like MUAC screening, and maternal MUAC screening as indicated in the **Strengthen nutrition surveillance and routine screening section below.** Annex community mobilization and sensitization strategy.

| Objective: *Strengthening community capacity and linkages to enhance early identification of malnutrition and referral to facilities* |
|---|---|---|
| **TASK** | **DELIVERABLE** | **NEXT STEPS** |
| 1 | Identify existing platforms (VCMs and CVs) that can assist with community mobilisation, and active case finding. |  |
| 2 | Provide support to VCMs and CVs to mobilise and identify children through capacity development initiatives, supportive supervision, and ensuring accountability. |  |
| 3 | Ensure VCMs and CVs conduct active acute malnutrition screening targeting all children 0 – 59 months once a month. |  |
| 4 | Ensure VCMs and CVs conduct Rapid IYCF Assessments to identify children 0 – 23 months who are fed sub-optimally and refer for full IYCF assessment and services. |  |
| 5 | Where existing platforms may not be sufficient, support additional mechanisms to ensure community mobilisation and identification. |  |
| 6 | Ensure health facilities conduct passive acute malnutrition screening for all children 0-59 months. |  |
| 7 | Ensure health facilities conduct passive screening for IYCF difficulties for all children 0 – 23 months. |  |
| 8 | Ensure all children identified as SAM or MAM are referred to appropriate services (ITP/OTP or SFP). |  |
| 9 | Ensure assessments, campaigns, BSFP and other such events provide linkages and referrals to nutrition services as appropriate. |  |
| 10 | Provide support to VCMs and CVs to mobilise and identify children through capacity development initiatives, supportive supervision, and ensuring accountability. |  |
c) Prevention of protection for vulnerable groups, against the deterioration of nutrition status
   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 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 guideline to support collection of vital information on IYCF in the displaced and those in the host community annex xxx.

The sector partners are collaborating to ensure that all nutrition interventions are comprehensive and integrate IYCF to maximize presence and coverage in the conflict areas. Working closely with the protection sector to set up baby-friendly spaces especially in IDP camps monitor the IYCF and caring practices interventions and report on it on regular basis. Each point of contact between the child, parent and staff of the program will be an opportunity to promote key practices to ensure good nutrition for infants and young children. With increased food security and livelihood activities 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 group and counselling. Majority of the response is cash based programing the sector will strive to ensure that they offer conditional cash transfers that promotes optimal complementary feeding.

The reporting of IYCF interventions have been poor reporting in 2016, the sector through IYCF-TWG has harmonized the reporting tools and oriented all partner during the nutrition sector meeting. The sector coordination team with support from UNICEF has plans to include IYCF in the SMS based rapid pro reporting platform. Through the IYCF TWG discussions are underway for development of radio programming to support IYCF in the local language.

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 Care group model approach and IYCF E. The GNC in collaboration with TRRT have also supported the sector with 2 deployments of IYCF-E advisor in Borno to work with partners on the scale-up. These are efforts to be harnessed coupled with the actions below to realize the much needed IYCF-E scale-up.

| Objective: Strengthen implementation of IYCF programming, |
| ACTION PLAN |
| TASK | DELIVERABLE | NEXT STEPS |
| 1 | | |
| 2 | | |
| 3 | Radio messaging on IYCF | Develop radio messages for wider broadcasting |
ii) Optimize blanket supplementary feeding program (BSFP):

The coverage of the BSFP activities are limited in a few ward of Yobe and Borno and Adamawa not covered.

The coverage of BSFP is very critical as the absence of services managing moderate acute malnutrition exerts pressure on SAM management 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 malnutrition and areas highlighted as food insecure through the cadre harmonize.

Partners conducting BSFP will integrate routine screening of all children under 5 and facilitate referrals to CMAM activities, during the mobilization for the registrations of BSFP linkages will be made with to also make referrals for IYCF-E. Further collaboration will be undertaken to ensure that there will be no duplication of micro nutrients in area where BSFP is being implemented, this will be achieved by clearly mapping the BSFP coverage and sharing programmatic data to facilitate joint collaboration.

<table>
<thead>
<tr>
<th>Objective: Optimize blanket supplementary feeding program (BSFP):</th>
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<tr>
<td>ACTION PLAN</td>
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<td>TASK</td>
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iii) Enhance coverage of micronutrient nutrients deficiency control.

There is a need to raise awareness of the importance of key micronutrient interventions and ensure they are positioned as the life-saving interventions they are. Working with State level officials to ensure other programmes are not priorities at the expense of micronutrient programme activities will be important.

Ensuring a comprehensive emergency nutrition response is essential. Integrating IYCF, CMAM and MNDC activities where appropriate, can increase the impact of the programmes and bring efficiency. 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—expect in areas where expanded criteria dictate the provision of RUTF/RUSF, or BSFP is in place—and in areas where access has been gained recently, 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 provisions of nutrition services in the health kit has been the reporting of data. Data for IDP camps has been made available, but data for PHCs has not been disseminated. The need to follow up with UNICEF health section at the CO and FO 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 continued use of iodized salt, which is part of the general rations; c) the use of fortified blended foods; d) develop IEC material on the utilization of micronutrient powders and tables.

<table>
<thead>
<tr>
<th>Objective: Enhance coverage of micronutrient nutrients deficiency control.</th>
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<tbody>
<tr>
<td>ACTION PLAN Jan 2016 – Dec 2017</td>
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<td>TASK</td>
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</table>
d) **Strengthen nutrition surveillance, screening systems to monitor the nutrition situation**

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

*Include the surveillance map round and 2*

Availability of reliable data is very critical for planning and decision making the sector will be working to strengthen routine monthly exhaustive screening for acute malnutrition, which will be aimed at ensuring that all malnourished children are referred for treatment and that the nutrition situation to the settlement is routinely monitored. The sector has developed guidelines on the rapid MUAC assessment to enhance comparability and analysis annex xx.

MUAC screening is a relatively easy skill to acquire and the sector is keen to have this skill tough to mothers who will later be issued with MUAC tapes and 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 annex xx.

The establishment of the nutrition and food security surveillance system now in its second round 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.

Partners are encouraged to conduct lower level assessment LGA rapid SMART surveys as they form the baseline of their interventions, with the recently conducted SMART survey training the capacity in country has been enhanced to undertake this assessments. The sector will also 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 project will be undertaking coverage assessment in the northeast where nutrition interventions are being implemented. With the strengthened capacity at the Nutrition information working group technical review and validation of all assessment planned will be done. Result will be analysed and shared in the Survey and assessment data base.

Figure 1 assessment planned 2017 (as of 6th March)
Objective: **Strengthen nutrition surveillance and routine screening**

**ACTION PLAN Jan 2016 – Dec 2017**

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<tr>
<th>TASK</th>
<th>DELIVERABLE</th>
<th>NEXT STEPS</th>
<th>STATUS</th>
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<tbody>
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</table>

**ii) Monitoring and analysis of the nutrition situation**

The sector secretariat in support to the state 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 meeting 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 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 training 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 partner’s achievement will be analysed per site every Month and finding discussed in the sector as a standing agenda in all coordination meeting.

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

**Objective: Monitoring and analysis of the nutrition situation**

**ACTION PLAN Jan 2016 – Dec 2017**

<table>
<thead>
<tr>
<th>TASK</th>
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<th>NEXT STEPS</th>
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</table>
### The nutrition sector M & E plan

#### Nutrition Sector Objective 1: 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.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>In need</th>
<th>Baseline</th>
<th>Target</th>
<th>Data Source/ Method(s)</th>
<th>Organisation(s) responsible for data collection</th>
<th>Frequency of reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>SAM new admissions SC (+medical complications)</td>
<td>44,924</td>
<td>0</td>
<td>31,456</td>
<td>Program Data/ 5Ws</td>
<td>NiEWG Partners</td>
<td>Monthly</td>
</tr>
<tr>
<td>SAM (OTP) new admissions</td>
<td>404,312</td>
<td>0</td>
<td>283,101</td>
<td>Program Data/ 5Ws</td>
<td>NiEWG Partners</td>
<td>Monthly</td>
</tr>
<tr>
<td>No of CMAM sites providing SAM service</td>
<td>479</td>
<td>0</td>
<td>557</td>
<td>Program Data/ 5Ws</td>
<td>NiEWG Partners</td>
<td>Quarterly/Bi-annually</td>
</tr>
<tr>
<td>SAM discharged recovered</td>
<td>n/a</td>
<td>0</td>
<td>&gt;75%</td>
<td>Program Data/ 5Ws</td>
<td>NiEWG Partners</td>
<td>Monthly</td>
</tr>
</tbody>
</table>

#### Nutrition Sector Objective 2: Promote access to services preventing under-nutrition for the vulnerable groups (children under the five and pregnant and breastfeeding women) focusing on infant and young child feeding in emergencies, micronutrient supplementation, and blanket supplementary feeding.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>In need</th>
<th>Baseline</th>
<th>Target</th>
<th>Data Source/ Method(s)</th>
<th>Organisation(s) responsible for data collection</th>
<th>Frequency of reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>BSFP coverage (children under 5)</td>
<td>2,403,109</td>
<td>0</td>
<td>314,911</td>
<td>Program Data/ 5Ws</td>
<td>NiEWG Partners</td>
<td>Monthly</td>
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<tr>
<td>BSFP coverage PLW</td>
<td>1,044,658</td>
<td>0</td>
<td>157,455</td>
<td>Program Data/ 5Ws</td>
<td>NiEWG Partners</td>
<td>Monthly</td>
</tr>
<tr>
<td>Multiple micronutrients coverage</td>
<td>801,437</td>
<td>0</td>
<td>561,078</td>
<td>Program Data/ 5Ws</td>
<td>NiEWG Partners</td>
<td>Monthly</td>
</tr>
<tr>
<td>IYCF support</td>
<td>1,044,658</td>
<td>0</td>
<td>731,332</td>
<td>Program Data/ 5Ws</td>
<td>NiEWG Partners</td>
<td>Monthly</td>
</tr>
<tr>
<td>Iron folic acid supplementation in pregnant women</td>
<td>391,747</td>
<td>0</td>
<td>313,465</td>
<td>NPHCDA campaign data</td>
<td>UNICEF/ NPHCDA</td>
<td>Bi-annually</td>
</tr>
</tbody>
</table>
e) Strengthening nutrition sector coordination and partners engagement

The Nutrition sector will continue to strengthen active participations of member in all intersect oral coordination meetings. All the nutrition sector technical working have been activated and leadership of the delegated to various partners with IYCF-TWG currently chaired by WHO, NIWG-TWG chaired by UNICEF and the CMAM-TWG chaired by Action against hunger. This is aimed at enhancing partner’s engagement and collective decision making on issues affecting the nutrition sector. The sector has also planned to undertake the SCPM exercise to clearly identify areas among the six plus one core functions that requires strengthening. The sector will also regularity 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 the first Friday of every month, while in the state the meeting in Borno will be held bi-weekly, In Yobe and Adamawa the meeting will be in held once a month.

| Objective: Strengthening nutrition sector coordination and partners engagement |
|---|---|---|
| ACTION PLAN Jan 2016 – Dec 2017 | DELIVERABLE | NEXT STEPS |
| TASK |  |  |
| 1 |  |  |
| 2 |  |  |
Cross cutting issues — Early recovery

Transition of Phase out strategy
Annexes

Guidance Note on MUAC Screenings

The following guidance aims to ensure the interpretability of MUAC screenings conducted in NE Nigeria. Information on the nutritional status of children is essential to the response. The attached excel spreadsheet can be used to ensure adherence to this guidance. These guidelines have been endorsed by the Ministry of Health and the Nutrition Sector.

Methods:

All of the following information is required to be submitted along with screening results (if using the standard spreadsheet please enter on the “Methods” tab). Results sent with incomplete methods information will not be validated.

1. Date(s) of the assessment
2. Organization(s) conducting the assessment
3. Location of the sites including the State, LGA, Ward, and Localities (Settlements) included
4. Information on the sites included: (1) formal IDP camp, (2) informal IDP camp, (3) within the community, (4) a combination of the above, or (5) other (to be described).
5. Method of sampling: (1) exhaustive door to door screening such that all children in the area were measured, (2) screening at a fixed post such as a clinic or CMAM program (describe what children are targeted for measurement – for example, any child that comes to clinic, those referred for enrolment in CMAM, etc.) (3) Random sampling by simple or systematic selection, (4) random sampling by another method such as EPI sampling, or (5) other (to be described).
6. Age ranges included in the assessment
7. Estimated number of eligible children in the catchment area of the assessment

Data:

Summary results should be shared with a file of raw data (MUAC values for each child measured). The raw data file should contain the following:

1. MUAC values for each child measured (preferably in millimetres).
2. Sex of the child
3. Age information – it is recognized that age information is not feasible to collect in many of the MUAC screenings. Where it is not possible to collect age in months, data should include whether each child is <87cm or ≥87 cm, (<2yrs or >2 yrs).
4. Presence of bilateral oedema (y/n) AND whether the case of oedema was verified (either by a supervisor or photograph).

Results

Given the ongoing emergency, it is expected that preliminary reports are brief however they must contain information required in Methods section above. Submission of the accompanying spreadsheet (if complete with Methods description) is sufficient for validation.

1. Results should be shared with the sector (ekormawa@unicef.org and rkmungai@unicef.org) within a week of conducting the assessment (unless justified)
2. Recommended to provide an overall proxy prevalence of SAM and GAM
3. Recommended to provide prevalence disaggregated by proxy-age (<87cm or ≥87 cm) and sex
4. The number and percent of oedema cases should be reported. Where oedema represents more than 15% of all cases of SAM, recommended to present SAM and GAM with and without oedema.
5. Recommended to report on the number of children referred to treatment and the number of children admitted into treatment following referral. The number referred is calculated on the Results spreadsheet. The number admitted should be gathered from treatment programs and added once available.

**Nutrition Minimum Package: Simplified**

1. Community mobilisation and active acute malnutrition case finding
2. Treatment of MAM in children (SFP; either blanket or targeted)
3. Treatment of SAM in children (OTP; without complications)
4. Referral of SAM (with complications) in children
5. Provision of VAS
6. Provision of MNPs
7. Monitoring of BMS distribution
8. Provision of IYCF-E package
   a. IYCF Rapid and Full Assessment
   b. IYCF Counselling (1 on 1)
   c. Skilled support to early initiation
   d. IYCF support to children in difficult circumstances
   e. Support and follow up of children 6 to 23 mos. enrolled in the CMAM program
   f. Support feeding of the infants <6 months in SC
   g. Monitoring of BMS distribution