# Nigeria Nutrition in Emergencies
## Sector Strategy and Response Plan
### 2020-2022

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1 | INTRODUCTION

The Nutrition in Emergency Sector Working Group in North East Nigeria Cluster is a mechanism which aims to ensure effective emergency nutrition programming in the “BAY” states of Borno, Adamawa and Yobe. The sector is led by the Federal Ministry of Health with UNICEF acting as co-lead. Monthly coordination meetings for the overall response take place in Abuja and in Maiduguri with state-level coordination meetings also taking place in Yobe and Adamawa.

The Response Plan, along with the Work-Plan and Operational Toolkit outlines a comprehensive, contextualised common nutrition response strategy for the years 2020-2022. The Operational Toolkits provide more in-depth recommendations on how to operationalise the strategy objectives, outlining phased milestone to enable the Sector to track progress against the workplan.

The overall aim of this process is to strengthen the coordination between all actors (government, donors, UN agencies, as well as local and international NGOs), ensuring a more timely, efficient, consistent and effective response.

The Response Plan and Operational Toolkit were produced through consultation with Nutrition Sector partners (partners listed in annex and takes into account recommendations from sector reviews, consultative workshops and individual meetings. It is intended and the Response Plan, Work-Plan and Operational Toolkit are “live documents”, which will be amended regularly in line with changes to the context as well as to national and international guidance. The response plan will be updated annually or where the situation changes significantly.

The response plan was developed in consultation with the nutrition sector partners included in annex 1.

In light of the COVID 19 pandemic, this response plan will need to be updated as the situation develops and the impact on the response is understood.

2 | SITUATION OVERVIEW

Humanitarian Situation Overview of North-East Nigeria

Ten years of conflict as a result of the armed insurgency in the north-eastern states of Borno, Adamawa and Yobe (BAY states) has resulted in the third largest population of displaced people in Africa. The conflict has exacerbated pre-existing issues of underdevelopment, increasing socio-economic vulnerability, inequality, and food insecurity. Deterioration of access to basic services, exacerbation of chronic underdevelopment as a result of the protracted crisis have all contributed to high dependence on humanitarian assistance.

In 2016, parts of Borno were granted humanitarian access for the first time in several years. Situation assessments from newly accessible areas indicated that affected communities, who had previously had very limited access to assistance, faced a critical level of food insecurity, resulting in the Ministry of Health declaring a “State of Nutrition Emergency” in June 2016. The international community, in support of the Government of Nigeria, rapidly scaled up humanitarian assistance following this declaration, preventing the expected famine in this year.

As of January 2020 a total of 7.9 million people – more than half of the population - were in need of humanitarian assistance, a 9% increase on the previous year. Borno state is the most affected by the conflict and remains the central focus of the humanitarian response. The state saw an upsurge in insecurity in 2019 in the centre and north of the state driving much of the increase in humanitarian need.

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1 Reference MQSUN plus, notes of workshops etc
2 WFP Nigeria Situation Report 01 2016—unpublished material.
3 HNO 2020
4 Humanitarian Needs Overview 2020
In addition, affected areas in the north-east states border the Sahel, a region which continues to be seriously affected by conflict and insecurity while also being prone to natural crises such as droughts and floods. The continued crises faced in the North-East are illustrated below.

**Figure 1. Multiple Crises in the North-East**

- **Displacement:**
  Large numbers of IDPs living in camps, garrison towns and host communities.
  Frequent spikes in new arrivals and secondary displacement.

- **Extreme Flooding:**
  Lengthy rainy season spanning July to October. Rainy season floods and torrential rains affect around 60% of the total population, frequently destroying farmland and exacerbating challenges with inadequate shelters and WASH facilities, particularly in IDP camps.

- **Frequent disease outbreaks.**
  Malaria is endemic and routine vaccinations have been interrupted for several years. Poor quality shelters and low levels of sanitation also contribute to frequent outbreaks.

- **Limited provision of basic services:**
  Severely limited provision of basic health, education and access to justice in conflict-affected locations. Pre-existing fragility in the health system, with sub-optimal investments on human resources.

- **High levels of malnutrition** with an estimated 10% of children across the states suffering from acute malnutrition.

Although famine was averted in 2016/2017 malnutrition rates in the north-east states have remained consistently high with approximately 10% of children 6-59 months acutely malnourished, 1-2% severely so (see trend analysis is annex 2), representing a “Severe” situation in this time period and indicating that although, the response is successfully preventing large spikes in malnutrition, reducing overall rates in these areas has been a challenge.

Analysis of the current situation in January 2020 through Integrated Phased Classification (IPC)/ Cadre Harmonise (CH) exercise classified:
- 22 Local Government Areas (LGAs), out of a total of 62 where data could be collected, as Phase 3 (Serious)
- The remaining 40 are at Phase 2 (Alert).
- This represents 921,618 children expected to suffer from acute malnutrition during the year.

According to the IPC AMN classification Phase 3 requires the scaling up of treatment for affected populations. Phase 2 indicates the situation is progressively deteriorating and requires the strengthening of the existing response.

It is recommended that all infants begin breastfeeding immediately after delivery and are provided with no other food or liquids (exclusive breastfeeding) for the first 6 months of life. This is especially important in developing countries and humanitarian contexts as there are no safe alternatives and the immune protection provided through breastmilk is essential and life-saving in the context of poor sanitation and disease outbreaks. It is also recommended that all children 6-23 months receive at least four food groups per day as well as breastmilk to ensure they receive adequate nutrients to prevent growth faltering and malnutrition. However, although some progress has been made in the north east on IYCF indicators, as shown in Annex 2, feeding practices are extremely poor with just 0.5% of children 6-23 months in Borno receiving a minimum acceptable diet.

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5 Humanitarian Needs Overview 2020
6 Integrated Phased Classification 2020
7 IPC Acute Malnutrition 2020
As part of the IPC assessment underlying causes were ranked in terms of their contribution to malnutrition in different locations in the north-east with those believed to be contributing factors ranked as “major” or “minor”. Data on trends from surveys in the north-east are included in Annex 2.

Projected future situation
The situation for 2020 is expected to deteriorate in many locations with an expectation that the most of the LGAs in Borno will move into the “Serious” category. Looking further ahead into the three years covered by this strategy, there is little indication that the security situation will improve which is likely to have implications for many of the underlying causes of malnutrition (explained in greater detail below). Added to this, this likelihood of a natural disaster in a 3-year period is high in this context, which risks driving the malnutrition rate higher if an effective nutrition response is not ensured.

Factors driving malnutrition
Malnutrition is a result of a number of interconnecting factors, with underlying causes such as food insecurity, poor care of women and children as well as low levels of sanitation and health care driving inadequate intake of nutrients and disease, ultimately leading to malnutrition and/or death and disability. The way these factors interconnect is visually represented in Annex 3.

Underlying factors identified as major contributing factors in 90% or more locations where data were available were:
- Minimum Dietary Diversity in children with children receiving a very few nutritious food items;
- Minimum Meal Frequency – children not being fed frequently enough;
- Exclusive breastfeeding – children under 6 month not being fed breastmilk alone;
- Continued breastfeeding – children not breastfed up to 2 years;
- Introduction of foods – children introduced to food at the wrong age;
- Early initiation – breastfeeding not initiated immediately after birth.

All of the major factors identified are related to infant and young child feeding practices.

Risks of malnutrition and poor feeding practices
Not only does the situation drive increases in malnutrition and affect feeding practices, but where children are malnourished or sub-optimally fed, they are at significantly higher risk of death, even outside of an emergency situation. Lancet papers focusing on nutrition have estimated the following risk factors:

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8 IPC Acute Malnutrition 2020
9 IPC Acute Malnutrition 2020
3 | OPERATIONAL OVERVIEW

Successes to date

The sector has had significant success, particularly in the speed and magnitude of the scale up of services to treat Severe Acute Malnutrition. Successes for the sector include:

- Rapid scale up of nutrition services took place with the priority focus on the treatment of Severe Acute Malnutrition which likely averted a major crisis;
- Additionally, a strong focus on inpatient care in Borno state led to a significant increase in the number of inpatient care centres;
- The sector has a large number of partners. Surge deployments also provided training and recommendations for an IYCF-E response;
- Supplies of RUTF have been stable (only one major stock out was experienced, in 2018, due to congestion in Lagos port);
- UNICEF has provided ongoing support to the Nutrition Sector with a dedicated Sector Coordinator and Information Management Officer;
- Regular, well-attended coordination meetings;
- A sentinel surveillance system has been established;
- Although there have been shortfalls in funding, nutrition continues to be one of the better funded sectors.

Continued challenges faced by the response

Across the north-east, there are substantial challenges to effective humanitarian response. Detailed analysis of these challenges is outlined in the Humanitarian Needs Overview for 2020 with the following issues of major concern to the Nutrition Sector:
Nutrition Sector Coordination Challenges

The rapid scale up of the response led to some challenges in the coordination of the response. Recognising the need to shift from initial scale up to a more strategic response, a review was commissioned in 2019. Additionally challenges were identified through consultations during the strategy development process. Key challenges include:

- Gaps and duplications in the coverage of services; with many actors operating in some locations and lack of support for service provision in other locations;
- Inconsistencies in service delivery packages offered across the Sector with different partners offering different services;
- Gaps in in routine medicines, due to both logistical (pipeline) and institutional (gaps in national pharmaceutical protocols) factors;
- Fragmented surveillance system;
- The Sector currently uses two databases, the state database as well as the Who, What, Where, When, for Whom (5W) database mandated by OCHA leading to duplication of reporting.

Projected Situation

The security situation is highly volatile and difficult to predict in this context both in terms of regaining access to areas that are cut off and maintaining access to current operational areas. As the situation currently stands, a significant or consistent improvement in the security situation in the near future does not appear likely with the possibility of further deterioration over the coming years.

Therefore, it is likely that the response will increasingly be operating services in a context where limited oversight is possible. It may also be the case that frontline staff can no longer stay in certain locations, leaving a potential gap in essential services if alternative solutions cannot be found. There are also likely to be continued and increased challenges along supply pipeline, which...
have the potential to impact on the provision of therapeutic food, medicines and equipment for nutrition programming.

The COVID 19 pandemic is expected to have a significant impact on agencies’ capacity to operate, although at the time of writing, the degree to which this will affect the NE response is not clear.¹⁰

**Nutrition**

The Integrated Phased Classification for Acute Malnutrition in January 2020 estimated that 4 out of 10 domains in the North-East were at IPC 3 “Serious” while the other 6 were at IPC 2 “Alert”.

The IPC process found reported that major contributing factors of acute malnutrition in all the analysed domains were very poor IYCF practices, both in terms of breastfeeding and food consumption (both quantity and quality) and the high prevalence of diarrhoea and malaria among the targeted populations. Other factors include insecurity, which has displaced many people and prevented the delivery of and access to humanitarian aid.

The situation is expected to deteriorate in the coming months with a total of 7 domains are projected to be in IPC Phase 3 (Serious) acute malnutrition by April 2020. This is due to the expected further deteriorating security situation, decreased food accessibility, possible outbreaks of measles and high incidences of Acute Respiratory Infections.

**4 | STRATEGIC FOCUS**

The key objectives of this strategy are to outline an approach, response plan and complementary tools that enable the Sector to provide an appropriate, adaptable, scalable, and shock-responsive approach to:

- **Prevent mortality** by ensuring that malnourished children receive timely treatment and quality services and by ensuring providing support for appropriate, safe feeding for children 0-23 months (specific focus on <6m) including those in exceptional services.

- **Prevent malnutrition** by improving access to information, counselling and services inputs to prevent malnutrition through community mobilisation and technically supporting other sectors to integrate nutrition sensitive actions into their activities.

**5 | OPERATIONAL SPECIFIC OBJECTIVES**

In order to improve the efficiency and effectiveness of the response and meet the overall objectives to prevent mortality and prevent malnutrition, the nutrition sector has identified the following priorities to improve the coordination of the response over the three-year strategy period:

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¹⁰ IPC AM 2020
SO 1  Standardisation of Nutrition Services

SO 2  Improved Coverage and Reduced Gaps in Service Provision

SO 3  Preparedness and emergency response

SO 4  Strengthened Technical Capacity

SO 5  Data Collection, Analysis and Knowledge Management for Decision-Making

SO 6  Progress on the Humanitarian Development Nexus

SO 7  Integration of Cross Cutting Themes

SO 8  Coordinated Sector Approach to Advocacy and Fundraising

SO 9  Improved Monitoring, Evaluation, Accountability and Learning
The situation varies significantly in different locations in the response. The following classifications have been made for the sector response plan to allow for a context-specific response.

### Figure 3: Context Categorisations in the North-East Response

#### Protracted Crises
- Little or no government. In some locations health services are functioning but require significant support from agencies due to limited staffing levels.
- Little or no option to cultivate food.
- Includes urban IDP camps.
- Includes host communities only when existing government services cannot manage.

#### New Emergencies
- When the current system/partner is unable to manage increased needs.
- New event or crises increases caseload of requiring additional support.
- New needs in a location without a partner.

#### Early Recovery
- Ability to access food without humanitarian assistance and livelihood activities are available.
- Government service delivery and structures are in place.
- Repatriation of IDPs to location of origin and re-establishment of services.

#### Inaccessible Areas
- Areas with no humanitarian access with people in need.
- Areas where staff have been evacuated.
- Includes those that were previously accessible or where there is a short-term loss.

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5 | CONTEXT CATEGORISATION

The situation varies significantly in different locations in the response. The following classifications have been made for the sector response plan to allow for a context-specific response.
6 | IMPLEMENTATION STRATEGY

This section outlines how the Specific Objectives will be met. For each Objective, a vision is articulated for the strategy period, ending December 2022. A short rationale is described for why the Sector has prioritised the Objective, followed by clear actions for how the Objective will be achieved, including outcome indicators. An overview of the implementation strategy can be found in annex 4.

SPECIFIC OBJECTIVE 1: STANDARDISATION OF NUTRITION SERVICES

**Vision December 2022**
- The Basic Nutrition Package is delivered in all accessible locations (with context appropriate adaptations) to minimum quality standards.
- Complementary Nutrition Service recommendations are delivered in priority locations with clear rationale for implementation in that location.
- Enhanced integration with other sectors with nutrition-sensitive activities routinely provided by other sectors.

**Rationale**
To ensure that all children, regardless of location have access to a basic package of nutrition services.

**Approach**
To meet the sector objectives and improve the standardisation of service delivery, this response plan strategy proposes:

To ensure that approaches are contextualised, the sector will maintain an overall list of locations and their context categorisation either as protracted crises, early recovery, new emergencies, or inaccessible areas. This list will allow the sector to advise partners and donors on priorities for implementation. These categories and the approach are outlined in Annex 5A (a template for this list is included in Operational Toolkit A).
**The Basic Nutrition Package (BNP)** is a set of evidence-based life-saving nutrition-specific interventions aimed at treating acute malnutrition and addressing immediate causes. The BNP should be delivered as a minimum by nutrition partners in all LGAs in protracted crises, early recovery and new emergencies. As the contexts vary significantly across the north-east, adapted implementation modalities are recommended in Annex 5B. The table below is the description of the nutrition services in the BNP that should be delivered in all accessible locations.

**Table 1: The Basic Nutrition Package**

<table>
<thead>
<tr>
<th>Service Delivery</th>
<th>Description</th>
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| 1. Screening of all children 0-59 months for acute malnutrition and feeding difficulties. | ● MUAC screening of children 6-59 months at least once a month (by CHW or by family MUAC coordinated with CHIPs** programme);  
● Assessment of whether there is visible wasting in children <6 months at community and health facilities;  
● All children 0-23 months receive the simple IYCF screening at health facilities/inpatient care centres/ OTPs/ Community and at all nutrition services point  
● Screening of infants for IYCF problems in the community and health facilities;  
● Referral of all SAM to the OTP (children <6m referred on to the inpatient care). |
| 2. Inpatient care) for the management of acute malnutrition with complication and in infants <6 months | ● 1 inpatient care centre per LGA as a planning guide (this may vary depending on the location of the population and needs);  
● Planning is in line with the Borno government initiative to mainstream inpatient care into the health system;  
● Service provision is led by/with the government where feasible. |
| 3. Outpatient Therapeutic Programmes (OTP)* for the management of severe acute malnutrition in the community | ● Maintain a minimum of 1 OTP per PHC (primary health centre) ward for children 6-59 months with SAM without medical complications;  
● OTPs should be implemented in Primary Health Care (PHC) where possible;  
● Maximum 1 hour walk for beneficiaries to the OTP. |
| 4. Targeted Supplementary Feeding Programme (TSFP)* for the management of moderate acute malnutrition in the community | ● TSFP integrated in OTP (based on funding and prioritisation of locations) delivered at the same site using the same staff (with extra support staff if caseload requires);  
● TSFP established for MAM in Children 6-59 months & MAM in pregnant and lactating women (PLW). |
| 5. Referral system between acute malnutrition treatment components. | ● Referrals between community, OTP, inpatient care, TSFP, and hospitals are tracked and followed-up. |
| 6. Full IYCF check | ● If the simple rapid screening indicates problems, a full mother-child assessment will be conducted by a breastfeeding counsellor/midwife including observation breastfeeding  
● Full IYCF assessment of all children <6 months at health facilities. |
| 7. Support for basic breastfeeding issues | ● Counselling and support to improve confidence, positioning, attachment, milk flow, and provide key messages  
● Support for infections, mastitis etc  
● All OTPs and inpatient care centres provide integrated technical support for IYCF difficulties. |

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8. Skilled support for challenging IYCF cases
   - Includes relactation and support for wet-nursing when required.
   - Targeted and carefully controlled artificial feeding using infant formula (case-by-case by prescription. Carefully managed and monitored to not create demand)

9. Breastmilk substitute monitoring
   - Reporting of any untargeted distributions of infant formula, milk powder or other breastmilk substitutes

10. Nutrition education, IYCF promotion
    - IYCF messaging and community level support
    - Mass messaging campaigns
    - Mother support groups, father support groups (where feasible) to discuss good child care practices to promote improve behaviours
    - Information provision about how to access services

**“Simplified Approaches” to the management of acute malnutrition should be considered as part of evidence generation.**

**Community Health influencers, promoters, and Services (CHIPS) programmes**

### Complementary Services

These recommended interventions focus on improving access to nutritious foods during pregnancy, lactation and for complementary feeding. These activities should be conducted alongside nutrition education activities to support families to access the recommended food. These activities may be led by the Nutrition Sector or the Food Security Sector.

Recommendations for these activities provided in Operational Toolkit B.

**Table 2: Complementary Services**

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<tr>
<th>Service/activity</th>
<th>Implementing Considerations</th>
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<td><strong>Blanket Supplementary Feeding Programme (BSFP)</strong></td>
<td>Blanket Supplementary Feeding Programmes (BSFP) target those most at risk of acute malnutrition to prevent deterioration of nutrition status and reduce incidence. These are often implemented during the seasons when malnutrition rates increase and target young children and pregnant and lactating women.</td>
</tr>
<tr>
<td><strong>Production of supplementary food through income-generating activities.</strong></td>
<td>A number agencies have implemented income-generating activities through production of supplementary food. This can be considered when the ingredients for the supplementary food are available.</td>
</tr>
<tr>
<td><strong>Cash and food vouchers linked to nutrition promotion</strong></td>
<td>The sector with support from CashCap and GNC will develop guidelines on cash and voucher assistance linked with improved nutrition outcomes. It is recommended that the sector provides training to those already implementing cash</td>
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Such interventions may be costly and not possible to deliver in all locations, therefore the sector should prioritise locations for these activities.

**Integrated activities to address underlying causes of nutrition:** To address the underlying causes of malnutrition, there is a need to work closely with a number of other sectors to ensure that their programmes are nutrition-sensitive. Recommendations for activities which work with or are delivered by with other sectors are included in Operational Toolkit C.

**Programmes linked to evidence generation:** A number of approaches are being tested to improve the treatment and prevention of malnutrition. It is recommended that these are considered to the evidence base along with strong research and evaluation as well as cost-effectiveness analysis. They may include the following among others:
Programmes for the treatment of acute malnutrition:

<table>
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<th>Simplified Approaches</th>
<th>Considerations</th>
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<td><strong>Simplified Approaches</strong></td>
<td>“Simplified approaches can refer to a range of modifications to the standard Community-based Management of Acute Malnutrition model, including the treatment of acute malnutrition as one continuum, with a common approach to detection and treatment of both SAM and MAM in one programme. These should be considered as to contribute to evidence generation or at a time when there is sufficient evidence for roll out.”</td>
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<td><strong>C-MAMI:</strong></td>
<td>A tool for the community-based management of acute malnutrition in infants (C-MAMI) has been developed and implemented in a number of (predominantly camp) settings. In locations where good levels of staffing and strong supervision are available, this could be considered.</td>
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<tr>
<td><strong>Multiple micronutrients</strong></td>
<td>Lack of evidence on what works to address micronutrient nutrient deficiencies. MNPs are used for home fortification to prevent micronutrient deficiencies. However ensuring their regular and correct can be challenging. Therefore this should be considered when a strategy address challenges has been designed and tested. Currently limited evidence for how to effectively programme MNPs to ensure good uptake. The sector should review previous research in Nigeria on MNPs and design methods of programming building in research and evidence generation on their use.</td>
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**Indicators**
- xx% of target facilities are implementing BNP
- At least 80% of facilities are scoring xx on standardized supervision/monitoring checklists
- 100% of Services are delivered in locations that meet the sector prioritisation criteria.
- Nutrition Sector has shared objectives/activities/indicators with at least 3 other aligned sectors

**SPECIFIC OBJECTIVE 2: IMPROVING COVERAGE AND REDUCING GAPS IN SERVICE PROVISION**

**Vision December 2022**
- One lead agency (or suitable administrative unit) who is responsible for the delivery of the Basic Nutrition Package across the whole of an LGA;
- All implementing partners and donors consult the Sector coordination and prioritisation matrix before agreeing a new project;
- A centralised system to address gaps in the medical supply chain established and used;
- No gaps in nutrition supplies including RUTF, RUSF, Super Cereal Plus or medicines across the response;
- Minimal differences in quantity of supplies used per treated child across actors.

**The Rationale**
An effective supply chain mechanism and assigning one lead agency per LGA responsible for all the Basic Nutrition Package of services will improve coordination and communication, improve the accountability of service providers as well as to increase the efficiency of the use of resources.

**The Approach**

14 Schauer, C. Experiences and lessons learned for planning and supply of micronutrient powders interventions. (2017) [https://doi.org/10.1111/mcn.12494](https://doi.org/10.1111/mcn.12494)
**Rationalisation**

The Sector will conduct a rationalisation exercise with the aim of having one lead agency responsible for all the Basic Nutrition Package of services (they can choose to sub-grant some aspects if preferred) by the end of the three-year period. This rationalisation process and suggested criteria to select the one agency per LGA is detailed in annex 6. (Template for the rationalisation exercise is detailed in Operational Toolkit D)

The sector will maintain a prioritisation matrix with prioritisation of LGAs for response based on IPC analysis. A template for the prioritisation matrix is in Operational Toolkit A. OCHA is developing a Severity Ranking Matrix for LGAs which will draw on the IPC analysis as well as other data sources and this will be used for prioritisation of nutrition activities once in place. This can act as a reference for donors and implementers to determine intervention locations.

**Supply chain**

To ensure continued service provision following national protocols, the supply chain for treatment of acute malnutrition will be strengthened. Regular training on supply management will be provided as well as the harmonisation of systems used by agencies to forecast supply needs. Given the risks of leakage involved in artificial feeding of infants, it is recommended that a lead agency procures and manages supplies for this aspect of programming.

- Identify a lead agency to manage supplies for artificial feeding of infants;
- Agree a central mechanism to procure drugs to fill gaps in the government supply chain;
- Agree a standard process for tracking and addressing gaps in the medical supply.

**Indicators**

- One lead agency in each agreed administrative unit responsible for oversight of all services;
- 100% of implementation locations based on the sector prioritisation matrix;
- 100% of donors require sector approval against the prioritisation matrix as a criteria for funding approval;
- Minimal variation in the quantity of nutrition supplies used per recovered child across by agencies.

**SPECIFIC OBJECTIVE 3. PREPAREDNESS AND EMERGENCY RESPONSE**

**Vision December 2022**

- New emergencies response begins within 15-30 days of a received alert;
- Pooled rapid response funding in place and used widely by actors;
- Standby teams in place and to deploy within 15 days to new emergencies;
- Access to critical services ensured during predictable crises and loss of access.

**Rationale**

In addition to ongoing crises, there will be a need to respond to new emergencies. As described in section 1, there is a high risk of natural crises, new displacements and outbreaks of diseases. There may also be changes in accessibility to affected locations. Where accessibility has been gained, there will likely be a population in high need of support.

**Approach**

- **Emergency preparedness planning.** Due to the volatile conflict dynamics and high level of vulnerability to climatic shocks, emergency preparedness planning will be conducted on a quarterly basis led by the coordination unit in close collaboration with OCHA and the Rapid Response Mechanism.
- **Rapid Response Mechanism**: Establishment of a rapid response mechanism with rapid response funds available and trained teams on stand-by to be able to initiate the response.
- **Identification of partners to host “standby teams”**. The teams will be trained and able to deploy rapidly.
Definition of “trigger” indicators for deployment and data sources to monitor for triggers. The initial deployment period will be for 30 days as surge support or to establish programmes with the possibility of extension. At a minimum, the team will include a staff member experienced in managing OTP and a technical IYCF expert. When not deployed this team may be utilised to provide training and on-the-job support to the sector.

Contingency and alternative methods to ensure service provision for periods when access is lost: if accessibility changes without warning, supply roads cut off in locations where NGO are not able to support service delivery, government and national NGOs should be encouraged to continue providing services.

Alternative monitoring options agreed such as use of photos, videos and mobile supervision checklists to verify and monitor nutrition activities. See Operational Toolkit E for supervision checklists.

Special circumstances. In exceptional circumstances such as the COVID 19 pandemic the Sector will adapt global guidance and protocols for the local context and align to the overall humanitarian response plan.

Annex 7 illustrates potential scenarios, its potential impact, and suggested response. To further develop these and to better respond to emergencies, the minimum preparedness activities should be prioritised.

Comprehensive tools for use by the Sector to further develop the risk analysis and monitoring, contingency planning and response preparedness are provided in Operational Toolkit F which guide the process and make recommendations for minimum and advanced preparedness actions for the Nutrition Sector.

### Indicators
- % of responses initiated within 15 days of alert;
- At least xx% of new emergency needs are fully funded within X days;
- xx% of sites/services continue uninterrupted;
- 100% of reports and presentations of assessment findings include recommendations on required changes to improve the response.

### SPECIFIC OBJECTIVE 4: STRENGTHENED TECHNICAL CAPACITY TO DELIVER THE NUTRITION RESPONSE

**Vision December 2022**
- All nutrition partners able to implement the basic nutrition package to minimum standards;
- Sector-wide mechanism to coordinate technical capacity development in place;
- System to manage challenging cases in place and used by partners.

**Rationale**
To ensure that the quality of preparedness, assessment and response is improved, there is a need to work collectively and collaboratively as a sector to address capacity gaps, improve technical skills and strengthen/standardise supervision across the sector.

Expected priority capacity gaps to address include: management of inpatient care facilities to treat SAM with complications; management of SAM in infants <6 months; Skilled support for breastfeeding issues, such as relactation and case management of non-breastfed infants.

**Approach**
The sector will consult with partners to understand capacity gaps to deliver the BNP with the aim of prioritising capacity-development to ensure service delivery is improved, and that all partners are able to provide the BNP by the time frame identified in the work-plan.

The Minimum Operating Standards for the BNP are outlined in Operational Toolkit G based on National Guidelines to summarise logistical, HR and supply recommendations to guide all partners on how services should be managed and to beneficiaries to outline the standard that they should expect.
Technical Working Groups. The sector will identify agencies to lead on taking forward technical areas of the response (IYCF, CMAM, IM, advocacy, gender & disability, and AAP).

Technical staff. Lead agencies will recruit technical experts in key areas to provide support and guidance to the sector.

Working group chairs will be supported by technical experts to develop agendas and to solve problems. National and global experts within the agency and the Global Nutrition Cluster GTAM initiative may be able to offer this support.

Revise the TORs for the Technical Working Groups with clear TORs and lines to technical support.

Training to be provided at different levels - from managers/supervisors to implementers. Any cascade training should be accompanied by an appropriate training package for each level and monitoring of quality.

Training tracked by the sector IMO.

Model/training sites. To support in-service training, model sites with highly skilled staff should be established. New staff can be deployed in these sites for 1-2 weeks.

Staff in the model sites should receive training on mentoring and instructions about how to arrange the in-service training.

System to manage unusual/challenging cases. Establish a system to identify and troubleshoot cases at the field level which are beyond the equipment, training or guidelines in place. See annex 8 for further explanation. This will link to support to find solutions on a case-by-case basis to ensure appropriate guidance is followed and gaps in guidance are addressed/filled.

Address capacity gaps in surveillance and surveys; develop a pool of capable local people who can train and support in assessment linked to global support mechanisms for mentoring and coaching.

Indicators

- xx% of partners who have received comprehensive training to implement the BNP.
- Lead agency(ies) and staff with technical capacity to support the sector in place.
- % of partners who are aware of and use the challenging cases mechanism.
- Number of people trained on BNP supervision protocols and tools.
- 75% of accessible locations receiving at least one supervision visit per quarter using standard checklists.

SPECIFIC OBJECTIVE 5: DATA COLLECTION, ANALYSIS AND KNOWLEDGE MANAGEMENT FOR DECISION-MAKING.

Vision December 2022

- A standardised set of assessments and protocols for analysis and communication implemented at an agreed frequency;
- Dashboards developed by the Sector are used to inform programme implementation strategy;
- The State Nutrition Database updated with relevant Nutrition in Emergency reporting indicators is adopted by all sector partners;
- A systematic data quality assurance methodology is used across the response;
- Government, donors and sector partners have access to and utilise the updated the agreed Nutrition Sector online information management platform to inform decision making.

Rationale

To improve preparedness and response in the nutrition sector and inform decision-making, it is necessary to improve the understanding of the situation, challenges through assessments, analysis and access to the information.

Approach

- The Sector will develop a coordinated surveillance system and recommend a standard set of additional assessments including qualitative assessments.
- SMART surveys will be used to assess the malnutrition rate and to track progress against key indicators. Surveys are conducted on a regular basis by UNICEF and INGOs and are coordinated through the Information Management Working Group.
- The Sector Information Working Group to map and continue to track planned assessments across the Sector and recommend priority locations and types of assessment. Partners will proactively report and the status of the
assessment. A recommended set of nutrition assessments and how they should be used is included as a reference at the end of this document in Annex 9.

- The Sector will continue to use the Humanitarian Response platform to store and share key documents. The IMO will consult Sector partners to understand the types of information that would be most useful to inform their work to whether current information provision meets these needs.
- The Sector will develop a prioritised list of deliverables in terms of analysis and visualisations (considering use of applications such as ReportHub) as well as frequency of requirement. The top priority information will be provided, depending on the resources available.
- Improved focus on ensuring reporting quality at the site levels. The Operational Toolkit H include a recommended filing system for OTPs to reduce under reporting of defaulters.

### Indicators

- A nutrition information platform in place and used widely;
- At least 80% of partners regularly report to the monthly/quarterly dashboard and sector indicators;
- At least 80% of partners are engaged in standardised data quality assurance process;
- At least 80% of partners using standardised assessment formats;
- At least 80% of all assessment results are fed back to the centralised information management platform.

### SPECIFIC OBJECTIVE 6: PROGRESS ON THE HUMANITARIAN DEVELOPMENT NEXUS

#### Vision December 2022

- Greater government ownership of service delivery with a standardised approach to working with, and strengthening, government across the Sector;
- Greater delivery of activities by national actors with international NGOs supporting services beyond community mobilisation.
- Ministry of health to manage all Nutrition Sector activities including the day to day coordination.
- Improved access to the pooled funding mechanism for national actors.
- Strengthened strategic partnerships developed with national actors to enhance delivery of comprehensive nutrition service beyond community mobilisation;
- Harmonisations of pay and top up incentives across the sector.

#### Rationale

With the complexities of gaining and maintaining access in North East Nigeria, ensuring local ownership of service delivery is essential to the sustainability of nutrition services. This operational environment strengthens the case for localising the technical support provided to the government and national NGOs to deliver nutrition services, as well as direct service delivery. National NGOs typically have comparative advantages in terms of having access to insecure areas and fewer practical operational constraints in terms of service delivery.

#### Approach

**Health System Strengthening**

In Nigeria, the delivery of nutrition services is the responsibility of the Ministry of Health and is part of the primary health care package. Nutrition Sector coordination is also led by the MOH. To engage the government more consistently in the day-to-day coordination, the coordination team, currently hosted by UNICEF, will aim to move to government offices by the end of the strategy period (security-permitting).
Key government actors will be identified and consultations conducted to identify joint gaps and opportunities for HSS. Collaboration priorities will be agreed along with a plan for engagement of critical stakeholders with a joint timeline for actions.

The government as lead of the Sector will support the standardisation payment amounts to government workers including community based workers/volunteers. Any analysis of rates being paid to frontline staff across the Sector will also be conducted and compared to government salaries with recommendations on standardisation provided. (See operational toolkit J)

Locations where the government can manage services or where external support can be reduced will be identified with action plans for full handover or reduced support.

*Localisation* “Localisation” is a commitment made by global leaders at the World Humanitarian Summit in 2016. This commitment is to increase support and funds for local and national responders recognising that local organisations have a strong understanding of local circumstances, politics, and culture.

The Sector will increase the role of national NGOs in service deliver by:

- Conducting analysis of national NGO service delivery including national NGO engagement and feedback develop action plan based on analysis.
- Reviewing and adapting existing training resources where necessary.
- Pairing international agencies with national NGOs for mentoring support.
- Providing national NGOs with formal training as well as on-the-job training (in sites offering all the BNP services).
- In identified sites, local NGOs when their capacity is assessed to be sufficient will take over services using pooled funding or sub-grants with continued supervision from the mentor agency.

Annex 10 provides a reference table for activities for health system strengthening and localisation.

<table>
<thead>
<tr>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government fully responsible for delivery% facilities deliver the B by the government;</td>
</tr>
<tr>
<td>Total number of national organisations involved in service delivery;</td>
</tr>
<tr>
<td>Total number of facilities where activities are technically supported/delivered by national organisations;</td>
</tr>
<tr>
<td>Total number of Sector staff based in Ministry of Health offices;</td>
</tr>
<tr>
<td>% of pooled funding disbursed to national actors;</td>
</tr>
<tr>
<td>% paying salaries and incentives in line with government recommendations.</td>
</tr>
</tbody>
</table>

**SPECIFIC OBJECTIVE 7: INTEGRATION OF CROSS-CUTTING THEMES**

**Vision December 2022**

- At least xx% nutrition staff in agencies are female;
- Gender and disability questions routinely included in nutrition assessments;
- Guidance on gender and disability is in place and used by the sector.

**Rationale**

Crises can exacerbate pre-existing gender inequalities. The socially prescribed roles of women in particular can create challenges in ensuring their input into identifying humanitarian needs and potential solutions as well as accessing critical services when needed. To ensure an effective response, it is essential that gender issues are identified and responses adapted accordingly.

**Approach**
- Improve gender considerations by implementing IASC guidance including disaggregation of data.
- Gender lead agency to guide partners on how to apply IASC gender recommendations.
- Agree on standard sector-specific question for assessments on gender.
- Increase awareness of and response to barriers in gender balance in workspace by conducting barrier assessment and debriefing on solutions.
- Assess barriers to recruitment of female staff and identify potential solutions
- Set targets on gender for sector to improve.
- Target should include activities to address gender issues and the hiring of female staff.

Minimum operation standards and recommended action on integrating cross cutting issues can be found in Operational Toolkit L.

<table>
<thead>
<tr>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>• % of female nutrition staff;</td>
</tr>
<tr>
<td>• X% of nutrition assessments which integrate questions on gender as recommended by the IASC handbook;</td>
</tr>
<tr>
<td>• x% of Nutrition Sector standard operating procedures and protocols integrate best practice guidance on age and disability</td>
</tr>
<tr>
<td>• % of agencies that have conducted GBV safety audit and implemented risk mitigation measures.</td>
</tr>
</tbody>
</table>

SPECIFIC OBJECTIVE 8: COORDINATED APPROACH TO ADVOCACY, FUNDRAISING AND EXTERNAL ENGAGEMENT

**Vision December 2022**

- Coordinated advocacy across the sector
- Funding is coordinated, in line with sector priorities and covers the Basic Nutrition Package.
  Funding is transparent and timely

**Rationale**

To ensure wide support and commitment to ensuring commitment to action support an improved nutrition-situation in the north-east.

**Approach**

All new funding will consult the sector prioritisation list with donors committing to fund the full package of BNP ensuring that the entire LGA is covered (if accessible). Activities such as assessment and training will be coordinated with the Sector and provide opportunities for learning for other partners.

It is also recommended that sector-wide capacity-building needs are agreed, a lead agency identified to support the sector in meeting each of these areas and funding provided to these agencies.

A sector wide Advocacy Plan will identify key issues through consultation, prioritise points for advocacy, identify stakeholders and channels of communication. Lead actors on each advocacy priority will also be identified.

<table>
<thead>
<tr>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>• % of funding is in line with Sector priorities;</td>
</tr>
<tr>
<td>• At least xx number sector advocacy objectives are agreed.</td>
</tr>
</tbody>
</table>
SPECIFIC OBJECTIVE 9. IMPROVED MONITORING, EVALUATION, ACCOUNTABILITY AND LEARNING

**Vision December 2022**
- Minimum standards for services agreed, shared and displayed in the site;
- Standard monitoring checklists agreed;
- Validation system for supervision in place;
- Proactive AAP system in places with ongoing response to complaints.

**Rationale**
To ensure a consistent, high quality of service which meets the needs of beneficiaries there is a need to streamline and improve monitoring approaches and tools as well as methods to ensure Accountability to Affected Populations (AAP).

**The Approach**

**Monitoring**
The sector will standardise reporting tools forms and supervision checklists. A simple site level scorecard system will also be developed. In locations where access is not possible, alternative monitoring methods will be explored. Potential methods are outlined in Operational Toolkit M. The sector will track additional operational indicators as recommended in annex 11.

**Accountability to affected populations**
The sector will work with the overall response and other sector to develop AAP further and:
- Contextualise AAP strategy for the NE Response;
- Ensure that service standards are displayed and communicated to beneficiaries;
- Ensure that feedback is collected from beneficiaries during monitoring visits;
- Use verbal and audio communication and other formats to provide information about services;

A more detailed outline of how to improve AAP is included in Operational Toolkit N.

**Indicators**
- # of indicators developed by cluster in consultation with affected community;
- % of those who participated directly in decision making who are female;
- # of partners who include activities to mainstream AAP and core people-related issues in their budgets.
Annex 1: List of organisations consulted in the process

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action Against Hunger</td>
<td>International Rescue Committee IRC</td>
</tr>
<tr>
<td>Caritas</td>
<td>World Food Programme</td>
</tr>
<tr>
<td>Première Urgence Internationale</td>
<td>Food and Agriculture Organization of the United Nations</td>
</tr>
<tr>
<td>Plan International</td>
<td>UNICEF</td>
</tr>
<tr>
<td>Greencode</td>
<td>Save the Children</td>
</tr>
<tr>
<td>INTERSOS</td>
<td>FHI360</td>
</tr>
<tr>
<td>International Medical Corps</td>
<td>Mercy Corps</td>
</tr>
<tr>
<td><strong>World Health Organisation (WHO)</strong></td>
<td><strong>Borno State Primary Health Department</strong></td>
</tr>
<tr>
<td><strong>Yobe State Primary Health?</strong></td>
<td></td>
</tr>
</tbody>
</table>

Annex 2: Nutrition Trends

Figure 4. Trends in the prevalence of global acute malnutrition measured by weight-for-height and presence of bilateral pitting oedema amongst children 0 to 59 months of age in Borno, Yobe and Adamawa states.


Abbreviations: GAM, global acute malnutrition
Table 3: Key nutrition statistics from 2016-2020

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initiation of breastfeeding within 24 hours of delivery</td>
<td>31.1%</td>
<td>36.6%</td>
<td>28.7%</td>
<td>47.4%</td>
</tr>
<tr>
<td>Exclusive breastfeeding of infants 0-5 months</td>
<td>29.1%</td>
<td>47.1%</td>
<td>45.6%</td>
<td></td>
</tr>
<tr>
<td>Minimum acceptable diet (dietary diversity) in children 6-23 months</td>
<td>0.4%</td>
<td>no data</td>
<td>1.8%</td>
<td></td>
</tr>
<tr>
<td>Not breastfed (0-5 months)</td>
<td>&lt;2%</td>
<td>&lt;2%</td>
<td>&lt;2%</td>
<td></td>
</tr>
</tbody>
</table>

Annex 3: Key drivers of malnutrition in North-East Nigeria

Adapted from the conceptual framework of undernutrition by the Nutrition Sector
Annex 4: Implementation Strategy Overview

<table>
<thead>
<tr>
<th>Sub Objective</th>
<th>Vision (at the end of three years)</th>
<th>Outcome Indicator</th>
</tr>
</thead>
</table>
| 1. Standardisation of nutrition services | V1. The Basic Nutrition Package is delivered in all accessible locations (with context appropriate adaptations) to minimum quality standards.  
V2. Complementary Nutrition Service recommendations are delivered in priority locations with clear rationale for implementation in that location.  
V3. Enhanced integration with other sectors with nutrition-sensitive activities routinely provided by other sectors. | ● xx% of target facilities are implementing BNP  
● At least 80% of facilities are scoring xx on standardized supervision/monitoring checklists  
● 100% of Services are delivered in locations that meet the sector prioritisation criteria.  
● Nutrition Sector has shared objectives/activities/indicators with at least 3 other aligned sectors |
| 2. Improving coverage and reducing gaps in service provision | V1. One lead agency (or suitable administrative unit) who is responsible for the delivery of the Basic Nutrition Package across the whole of an LGA  
V2. All implementing partners and donors consult the Sector coordination and prioritisation matrix before agreeing a new project;  
V3. A centralised system to address gaps in the medical supply chain established and used;  
V4. No gaps in nutrition supplies including RUTF, RUSF, Super Cereal Plus or medicines across the response;  
V5. Minimal differences in quantity of supplies used per treated child across actors. | ● One lead agency in each agreed administrative unit responsible for oversight of all services;  
● 100% of implementation locations based on the sector prioritisation matrix;  
● 100% of donors require sector approval against the prioritisation matrix as a criteria for funding approval;  
● Minimal variation in the quantity of nutrition supplies used per recovered child across by agencies. |
| 3. Preparedness and Emergency Response | V1. New emergencies response begins within 15-30 days of a received alert;  
V2. Pooled rapid response funding in place and used widely by actors;  
V3. Standby teams in place and to deploy within 15-60 days to new emergencies;  
V4. Access to critical services ensured during predictable crises and loss of access. | ● % of responses initiated within 15 days of alert;  
● At least xx% of new emergency needs are fully funded within X days;  
● xx% of sites/services continue uninterrupted;  
● 100% of reports and presentations of assessment findings include recommendations on required changes to improve the response. |
| 4. Strengthened technical capacity to deliver the nutrition response | V1. All nutrition partners able to implement the basic nutrition package to minimum standards;  
V2. Sector-wide mechanism to coordinate technical capacity development in place;  
V3. System to manage challenging cases in place and used by partners. | ● xx% of partners who have received comprehensive training to implement the BNP.  
● Lead agency(ies) and staff with technical capacity to support the sector in place.  
● % of partners who are aware of and use the challenging cases mechanism.  
● Number of people trained on BNP supervision protocols and tools.  
● 75% of accessible locations receiving at least one supervision visit per quarter using standard checklists. |
| 5. Data Collection, analysis and knowledge management for decision-making | V1. A standardised set of assessments and protocols for analysis and communication implemented at an agreed frequency;  
V2. Dashboards developed by the Sector are used to inform programme implementation strategy; | ● A nutrition information platform in place and used widely;  
● At least 80% of partners regularly report to the monthly/quarterly dashboard and sector indicators; |
| 6. Progress on the Humanitarian Development Nexus | V1. Greater government ownership of service delivery with a standardised approach to working with, and strengthening, government across the Sector;  
V2. Greater delivery of activities by national actors with international NGOs supporting services beyond community mobilisation.  
V3. Ministry of health to manage all Nutrition Sector activities including the day to day coordination.  
V4. Improved access to the pooled funding mechanism for national actors.  
V5. Strengthened strategic partnerships developed with national actors to enhance delivery of comprehensive nutrition service beyond community mobilisation;  
V6. Harmonisations of pay and top up incentives across the sector. | ● Government fully responsible for delivery% facilities deliver the B by the government;  
● Total number of national organisations involved in service delivery;  
● Total number of facilities where activities are technically supported/delivered by national organisations;  
● Total number of Sector staff based in Ministry of Health offices;  
● % of pooled funding disbursed to national actors;  
● % paying salaries and incentives in line with government recommendations. |
|---|---|---|
| 7. Integration of cross-cutting themes | V1. At least xx% nutrition staff in agencies are female;  
V2. Gender and disability questions routinely included in nutrition assessments;  
V3. Guidance on gender and disability is in place and used by the sector. | ● % of female nutrition staff;  
● X% of nutrition assessments which integrate questions on gender as recommended by the IASC handbook;  
● X% of Nutrition Sector standard operating procedures and protocols integrate best practice guidance on age and disability  
● % of agencies that have conducted GBV safety audit and implemented risk mitigation measures. |
| 8. Coordinated approach to advocacy, fundraising and external engagement | V1. Coordinated advocacy across the sector  
V2. Funding is coordinated, in line with sector priorities and covers the Basic Nutrition Package.  
V3. Funding is transparent and timely | ● % of funding is in line with Sector priorities;  
● At least xx number sector advocacy objectives are agreed. |
| 9. Improved monitoring, evaluation, accountability and learning | V1. Minimum standards for services agreed, shared and displayed in the site;  
V2. Standard monitoring checklists agreed;  
V3. Validation system for supervision in place;  
V4. Proactive AAP system in places with ongoing response to complaints. | ● # of indicators developed by cluster in consultation with affected community;  
● % of those who participated directly in decision making who are female;  
● # of partners who include activities to mainstream AAP and core people-related issues |
|   |   | in their budgets. |   |
### Annex 5: Specific Objective 1 Standardisation of Nutrition Services

#### 5A. Context-specific programming approach

<table>
<thead>
<tr>
<th>Context</th>
<th>Programming approach and Partnerships</th>
</tr>
</thead>
</table>
| **Protracted Crisis**        | ➢ Direct delivery by agencies where no government present.  
➢ Where government staff present, support by agency staff in the facilities, if necessary.  
➢ Where possible, integrate services into health activities.  
➢ Mobile teams considered to access to service delivery in populations in hard-to-reach areas (programmatic approach).  
➢ Improve capacity of and promote national NGOs to support more delivery of services.                                                                                                                                                                                                                                               |
| **Early Recovery**           | ➢ Partner with the government to deliver services without agency staff working at the site level.  
➢ Work with government Nutrition Focal Points to improve supervision.  
➢ Where government staff are absent, work with the government to fill the gap.  
➢ Consider temporary surge support until staff is in place.  
➢ Build capacity of government capacity to strategic planning, management and budgeting.  
➢ Improve capacity of and promote local and national NGOs to provide technical support to the government.  
➢ Cash and voucher programmes to be linked with improved nutrition outcomes.                                                                                                                                                                                                                                                      |
| **New Emergencies**          | ➢ Surge support either by the LGA lead agency if they have rapid response capacity or by a sector rapid response team.  
➢ Rapid assessment and surge response.  
➢ If partners are not able to respond, the CLA will be the provider of last resort and provide emergency services.                                                                                                                                                                                                                     |
| **Temporary loss of accessibility** | ➢ Potential response of rapid screening for acute malnutrition by mobile teams and provision of a 1-month ration.  
➢ Rapid screening and support for breastfeeding difficulties, possible referrals for challenging cases.  
➢ Where there was prior access, consider alternative methods of support and preparedness for loss of support. (See operational toolkit M for options)                                                                                                        |
Annex 5B: Approaches for each of the Basic Nutrition Package services in different contexts

This table outlines how the mode of implementation of the BNP may need to be adapted for the different contexts. At the end of 3 years, it would be expected that the following could be delivered under the varying contexts:

<table>
<thead>
<tr>
<th>Service Delivery</th>
<th>Protracted Crises</th>
<th>Early Recovery</th>
<th>New Emergencies</th>
<th>Temporary loss of accessibility</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Screening</strong></td>
<td>Conducted by CHWs and CORPs</td>
<td>Conducted by CHWs and CORPs</td>
<td>Conducted by CHWs and CORPs</td>
<td>Conducted by CHWs and CORPs</td>
</tr>
<tr>
<td>Inpatient Care management of acute malnutrition with complication in infants &lt;6 months</td>
<td>Agency-led service delivery (1 per LGA)</td>
<td>Government-led service delivery (1 per LGA)</td>
<td>Referral services to an established site</td>
<td>Referral to established site</td>
</tr>
<tr>
<td>Outpatient Therapeutic Programmes (OTP) for the management of severe acute malnutrition in the community</td>
<td>Agency-led service delivery (1 per ward)</td>
<td>Government-led service delivery (1 per ward)</td>
<td>Services supported/provided by surge team</td>
<td>CHW-delivery or mobile teams</td>
</tr>
<tr>
<td>Targeted Supplementary Feeding Programme (TSFP)* for the management of moderate acute malnutrition in the community</td>
<td>Agency-led service delivery integrated with OTP (1 per ward)</td>
<td>Support to government to deliver.</td>
<td>Integrated service provision with OTP</td>
<td>CHW-delivery or mobile teams</td>
</tr>
<tr>
<td>Referral System between acute malnutrition treatment components.</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>IYCF Simple Rapid Screening</td>
<td>Screening by health workers at OTP sites and health facilities</td>
<td>Screening by health workers</td>
<td>Screening by breastfeeding counsellor on the surge team</td>
<td>Conducted by CHW or mobile team</td>
</tr>
<tr>
<td>Full IYCF check</td>
<td>Conducted by agency breastfeeding counsellor</td>
<td>Conducted by trained nurse or midwife</td>
<td>Conducted by the breastfeeding counsellor on the surge team</td>
<td>Conducted by mobile team</td>
</tr>
<tr>
<td>Support for basic breastfeeding issues</td>
<td>Provided by agency breastfeeding counsellor</td>
<td>Provided by trained nurse or midwife</td>
<td>Provided by the breastfeeding counsellor on the surge team</td>
<td>Provided by the mobile team</td>
</tr>
<tr>
<td>Skilled support for challenging IYCF cases</td>
<td>Provided by agency breastfeeding counsellor with supplies from CLA</td>
<td>Government managed with support from the Sector to manage case-by-case</td>
<td>Provided by agency breastfeeding counsellor with supplies from CLA</td>
<td>Remote technical support for case management, where feasible</td>
</tr>
<tr>
<td>Breastmilk substitute monitoring</td>
<td>By all</td>
<td>By all</td>
<td>By all</td>
<td></td>
</tr>
<tr>
<td>Nutrition Education, IYCF promotion</td>
<td>Provided through support groups and by CHWs</td>
<td>Provided through support groups and by CHWs</td>
<td>Through services and mass media</td>
<td>where feasible through CHWs and mobile teams</td>
</tr>
<tr>
<td>Infrastructure</td>
<td>At minimum, services to be delivered at semi-permanent structures</td>
<td>Within health centres</td>
<td>Could be in temporary tents</td>
<td>CHW delivery or mobile teams</td>
</tr>
</tbody>
</table>

CORPS: Community Oriented Resource Persons
Annex 6: Specific Objective 2 Improving Coverage and Reducing Gaps in Service Provision

**Rationalisation** is the process of reviewing nutrition service needs across an area, recommending a distribution of sites across the geographic areas, then and redistributing partners to reduce duplication and address gaps. Through this process, one partner will be selected based on their comparative advantage over others partner to deliver services in a given LGA.

The aim of this process is to improve coordination and communication, improve the accountability of service providers as well as to increase the efficiency of the use of resources.

**Box 1: SUGGESTED RATIONALISATION CRITERIA**
The suggested criteria provide a guideline to selecting the lead agency per LGA.

<table>
<thead>
<tr>
<th>Preference will be given to:</th>
<th>Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partner currently delivering the most services of the BNP (including by local NGO sub-grantees). Preference for partners currently implementing services that are more difficult to set up such as inpatient care centres.</td>
<td>Number of components of the BNP currently delivered</td>
</tr>
<tr>
<td>Partners operating in the most locations (ward or PHCs) within the LGA.</td>
<td>Number of locations within the LGA covered by the partner.</td>
</tr>
<tr>
<td>Partners with the most funding held (amount and duration)</td>
<td>Duration of confirmed funding held by the partner.</td>
</tr>
<tr>
<td>Partners also delivering other services in the LGA (Health, WASH, FSL)</td>
<td>Number of programmes in other sectors.</td>
</tr>
<tr>
<td>Partner with the longest presence in the LGA. Preference to those with larger investments such as infrastructure that have already been made.</td>
<td>Length of time that partners have been present in the LGA.</td>
</tr>
<tr>
<td>Partners with approval from the government and relevant authorities to operate in the LGA</td>
<td>Has approval letter from/MOU with the government/relevant authorities.</td>
</tr>
<tr>
<td>Partners with technical capacity to deliver the most components of the BNP to a high quality</td>
<td>Number of components that can be delivered based on technical capacity</td>
</tr>
<tr>
<td>Partner’s preference to operate in the LGA. This could be due to existing infrastructure and head offices.</td>
<td>Partner has an existing presence in the LGA.</td>
</tr>
</tbody>
</table>

**RECOMMENDATIONS AND NEXT STEPS**

- **Explore key challenges and risks in the rationalisation approach:** Document learning experiences from the rationalisation process to date.
- **Define the geographic area:** Using the LGA as the unit of operation is recommended. In urban and camp settings, it may be necessary to use a different measure as the unit of operation.
● **Meeting of stakeholders:** Consultation process involving the implementing partners and the government.

● **Assessment the capacity of partners to deliver services.**

● **Use a phased approach** with the less challenging LGAs moving first to one partner per LGA

● **Present gap analysis and rationalisation plan** to donors to raise awareness of the new approach and advocate that funding to partners is for an entire LGA. (Who? And Where)
## Annex 7: Specific Objective 3 Preparedness and Emergency Response

### Potential scenarios to address in the NE Nigeria Response

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Likelihood</th>
<th>Risk level</th>
<th>Impact</th>
<th>Response/minimum preparedness actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disease outbreaks</td>
<td></td>
<td></td>
<td>High risk of mortality in SAM/MAM children and NBF infants. Increase in malnutrition as a result of illness.</td>
<td>Scaled up support for nutrition to increase coverage. Scaled up technical support to address breastfeeding problems. Increased screening and referral.</td>
</tr>
<tr>
<td>Seasonal flooding</td>
<td></td>
<td></td>
<td>Road cut off, access to sites hindered.</td>
<td>Preposition stock If facilities are likely to shut, consider monthly ration for CMAM.</td>
</tr>
<tr>
<td>Large-scale drought</td>
<td></td>
<td></td>
<td>Higher number of malnourished children.</td>
<td>All partners need to prepare to scale up. Sector-wide training and advocacy with donors to begin early funding. Scaled up supervision, surge support and training of govt in early recovery areas.</td>
</tr>
<tr>
<td>Seasonal spikes in malnutrition</td>
<td></td>
<td></td>
<td>Increase in caseload. Increase in complicated cases. Services overwhelmed.</td>
<td>Surge staff and potentially temporary outreach sites to manage extra caseload. Temporary “overflow” capacity for inpatient care’s at capacity.</td>
</tr>
<tr>
<td>New areas become accessible.</td>
<td></td>
<td></td>
<td>Likely high needs amongst the population.</td>
<td>RRM/surge teams initiate services. Immediate screening and provision of SAM treatment and technical IYCF support.</td>
</tr>
<tr>
<td>Large displacement</td>
<td></td>
<td></td>
<td>Heightened risk for displaced children who are SAM/MAM or NBF Existing services overwhelmed IDP moved into a camp without existing services</td>
<td>RRM support until partner identified. Immediate screening and provision of SAM treatment and technical IYCF support.</td>
</tr>
<tr>
<td>Repatriations</td>
<td></td>
<td></td>
<td>Large number of people moving to a location without services</td>
<td>Partner identified with capacity to provide all services prior to repatriation.</td>
</tr>
</tbody>
</table>
Annex 8: Specific Objective 4 Capacity-Development Activities

Figure 5 Suggested escalation process of support to nutrition partners to manage difficult cases

Annex 9: Specific Objective 5 Data Collection, Analysis and Knowledge Management for Decision Making

Coordination of nutrition activities

SO 5 internal reference Table 7. Recommended Nutrition Assessments Activities

<table>
<thead>
<tr>
<th>Type of assessment</th>
<th>Recommendation</th>
<th>Frequency</th>
</tr>
</thead>
</table>
| Standardised Monitoring and Assessment of Relief and Transitions (SMART) | ● Use to monitor the overall nutrition situation and trends.  
  ● It is recommended that SMART surveys also include assessment of wasting in infants under 6 months and on IYCF practices and underlying causes of malnutrition. | Annual or bi-annual       |
| Coverage surveys (SQUEAC/SLEAC)                        | ● To understand the extent to which children who are acutely malnourished are being identified, admitted and treated in the programme.  
  ● To understand key barriers to accessing the programme to inform the implementation strategy.                                                                 | Annual                    |
| Data quality assessment                                | ● Recommended sector-wide exercise to understand the accuracy of data reported and recommend improvements.                                                                                                  | Annual                    |
| Rapid assessments                                      | ● Sector to use tools in Operational Toolkit  
  ● Qualitative assessment (including rapid assessments) to gather information about the programming location and inform both programming and messages provided. | For new emergencies or to assess a changing situation |
| Qualitative assessments                                | ● Focus group discussions with beneficiaries and community members to help to tailor the programme and messages to address challenges.                                                                  | Ongoing                   |
| Capacity assessments                                   | ● Assessment of health/nutrition worker capacity and training needs                                                                                                                                           | Annual                    |
| Ad Hoc or Rapid SMART                                  | ● Plans for ad hoc surveys should be coordinated with the sector to prevent duplication.                                                                                                                      | Ad hoc                    |
IYCF In depth assessment

- Qualitative assessments to understand the reasons for challenges in IYCF support needed by beneficiaries.

Ad hoc

Nutrition causal analysis

- Assessments to analyse causes of malnutrition should be integrated within programme monitoring and evaluation

Ad hoc

Access assessments

- Access assessments to be used to categorise LGAs to inform prioritisation and programme approaches within the sector.

Monthly

Annex 10: Specific Objective 6 Humanitarian Development Nexus

SO 6 Reference Table Health System Strengthening Activities

<table>
<thead>
<tr>
<th>Key areas</th>
<th>Approach / Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Partnership</strong></td>
<td>Harmonised approach to payments. It is recommended that salary top ups are only provided where staff are expected to work a) outside of normal working hours b) outside of their normal base. The amounts should be standardised for the sector and endorsed by the government. (See Operational Toolkit J)</td>
</tr>
<tr>
<td></td>
<td>Agency staff working in government centres. Agency staff should only be delivering services where the staffing levels present cannot manage the nutrition caseload. Operational Toolkit K recommends when agency staff should be used and the number budgeted per expected caseload.</td>
</tr>
<tr>
<td></td>
<td>Consider supporting temporary reassignment of government staff to respond to new emergencies</td>
</tr>
<tr>
<td></td>
<td>Restrict recruitment of government staff into NGOs and the UN with the aim of retaining government staff in the health care system. Regular assessment of the extent to which this has happened.</td>
</tr>
<tr>
<td></td>
<td>Pair of district level agency staff with nutrition focal points</td>
</tr>
<tr>
<td><strong>Capacity Enhancement</strong></td>
<td>Work to increase/improve supervision by government and move away from having parallel supervision structures.</td>
</tr>
<tr>
<td></td>
<td>Training in programme management and supervision for government. improve training packages</td>
</tr>
<tr>
<td><strong>Funding / Supply Chain</strong></td>
<td>In early recovery areas work with the government on budget allocations for both RUTF and nutrition activities.</td>
</tr>
<tr>
<td><strong>Emergency preparedness</strong></td>
<td>Support the North-East Development Commission and Federal Ministry of Humanitarian Affairs, Disaster Management and Social Development (FMHDS) to plan for new emergencies</td>
</tr>
<tr>
<td><strong>Coordination</strong></td>
<td>Nutrition sector coordination unit to be based at MOH so the government can be involved with the day to day management of the sector</td>
</tr>
</tbody>
</table>

SO 6 Reference Table Localisation Activities

<table>
<thead>
<tr>
<th>Key areas</th>
<th>Activities &amp; Approaches</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Funding</strong></td>
<td>Link with localisation sector in OCHA to manage legal finance capacity - need to go beyond community mobilisation</td>
</tr>
<tr>
<td></td>
<td>Encourage partners to build in including local NGOs in grants (Less subcontracting per localisation framework) -</td>
</tr>
<tr>
<td></td>
<td>Assess the constraints faced by local NGOs in receiving/managing funding.</td>
</tr>
<tr>
<td></td>
<td>Leverage Nigerian Humanitarian Funds to support local NGOs and government</td>
</tr>
<tr>
<td><strong>Partnerships</strong></td>
<td>Include local NGOs in consortium projects</td>
</tr>
</tbody>
</table>

16 Sector led allocation - specific funding for localisation
Capacity

• Build the capacity of local NGOs to conduct/technically support nutrition activities beyond community mobilisation through mentoring

Additional resources include: Disaster in Emergencies Preparedness Programme. Localisation in Practice. [https://reliefweb.int/sites/reliefweb.int/files/resources/Localisation-In-Practice-Full-Report-v4.pdf](https://reliefweb.int/sites/reliefweb.int/files/resources/Localisation-In-Practice-Full-Report-v4.pdf)

Annex 11: Specific Objective 10 Improved monitoring, evaluation, accountability and learning

<table>
<thead>
<tr>
<th>Box 2: Operational Indicators for the Strategy Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Coordination indicators</strong></td>
</tr>
<tr>
<td>• Days from alert to dispersal of funds</td>
</tr>
<tr>
<td>• Receipt of funds to programme establishment time</td>
</tr>
<tr>
<td><strong>Analysis presented by agency with both high and low rates flagged</strong></td>
</tr>
<tr>
<td>• Cure rate</td>
</tr>
<tr>
<td>• Default rate</td>
</tr>
<tr>
<td>• Death rate</td>
</tr>
<tr>
<td>• RUTF usage per child</td>
</tr>
<tr>
<td><strong>5W additional reporting indicators</strong></td>
</tr>
<tr>
<td>• Any stock out days yes/no</td>
</tr>
<tr>
<td>• Flags for high and low cure rate</td>
</tr>
<tr>
<td>• Non-breastfed children identified from screening</td>
</tr>
<tr>
<td><strong>Indicators for OTP and inpatient care</strong></td>
</tr>
<tr>
<td>• Average length of stay in inpatient care</td>
</tr>
<tr>
<td>• Average weight gain</td>
</tr>
</tbody>
</table>