**A review of the humanitarian nutrition response in North-East Nigeria**

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**NORTH-EAST NIGERIA**

**What we know:** Rapid response to nutrition crises must balance the demands of rapid scale up to meet urgent needs and support for existing systems and capacities; coordination is critical to achieving this.

**What this article adds:** The Maximising the Quality of Scaling Up Nutrition Plus (MQSUN+) programme undertook a review of the emergency nutrition response in North-East Nigeria (December 2018 to March 2019) to document strengths and challenges and inform future directions. Nutrition Sector scale-up is largely centred on wasting treatment. Successes included strong government leadership, the roll-out of training programmes, the provision of surge capacity for wasting treatment and rapid scale-up of ready-to-use therapeutic food (RUTF) provision. Challenges included the duplication of operations and bilateral funding streams, inadequate programming to support infant and young child feeding (IYCF) and mothers and infants under six months of age at nutritional risk, reliance on external support and technical assistance, challenges in community-based management of acute malnutrition (CMAM) data management and reporting and challenges with RUTF tracking and forecasting. The recommendations have informed the three-year Nutrition Sector strategy developed in 2020.

**Background**

Since 2009, the Boko Haram insurgency has caused mass population displacement throughout North-East (NE) Nigeria. In 2016, previously inaccessible locations were granted humanitarian access for the first time in years. Communities were subsequently found to be facing a critical level of food insecurity, resulting in the Ministry of Health (MoH) declaring a “State of Nutrition Emergency” in June 2016 (International Organization for Migration, 2018). This prompted a rapid international response to prevent a famine that was extremely challenging to scale. In 2016, there were few non-governmental organisations (NGOs) supporting nutrition services and many of those present were unable to operate in insecure locations. To help address this, the United Nations Children’s Fund (UNICEF) engaged a consultancy firm to staff and supervise nutrition services to fill identified gaps in government staffing to scale up priority services such as the treatment of severe wasting. Since then, the Nutrition Sector has continued to scale-up service provision. By 2019, the number of children admitted to outpatient therapeutic programme (OTP) services reached over 250,000, likely averting a large scale nutrition disaster (UNICEF 2019a).
However, the prevalence of global acute malnutrition (GAM) and severe acute malnutrition (SAM) has remained at around 7% to 12% and 0.6% to 1.5% respectively (Figure 1a). This suggests that the response has been successful in scaling up treatment but has made less progress in scaling up effective services for preventing malnutrition and reducing the overall caseload (UNICEF 2019b).

The Nutrition Sector has significantly increased the number and quality of in-patient care facilities in the worst-affected state of Borno. Combining classroom training with on-the-job training and mentorship through the establishment, in 2017, of a Centre of Excellence in the University of Maiduguri Teaching Hospital likely helped to increase the number of functional stabilisation clinics from 19 in 2018 to 26 by early 2019 (Nigeria Nutrition Sector Partners 2018; Nutrition in Emergencies Sector Working Group 2019).

Hiring staff through a management company to provide services in the absence of NGO partners and government staff enabled rapid scale-up of out-patient nutrition services in challenging circumstances. Through this arrangement, consultant health staff were hired to quickly fill gaps where government services were available and NGOs were unable to quickly mobilise. Doing so likely averted a major crisis as staff were able to rapidly deploy and provide services.

Partners often duplicated operations in certain areas and did not necessarily coordinate amongst themselves. Borno State, for example, saw 214% more OTP admissions than forecasted in 2018 (UNICEF 2019a). This was despite surveys not indicating an increase in malnutrition and population movements being insufficient to explain this increase in admissions (UNICEF 2019a). Instead, in some cases, beneficiaries had accessed multiple sites and received duplicate rations due to a lack of sufficient coordination between partners. Site visits revealed that partner-managed “outreach” OTP clinics were often set up close to health facilities with existing treatment programmes.

There were issues with coordination and rationalisation, in part due to the inability of the Nutrition Sector to gain oversight on bilateral funding agreements. The pooled funding mechanism, the Nigeria Humanitarian Fund, was new and not widely used. As a result, many partners made agreements bilaterally with donors, informing the Nutrition Sector of the package of activities and locations of operation after receiving funding confirmation. As donors are based in Abuja and coordination meetings take place in Borno State, donors are often not present for the discussions. This limited the Nutrition Sector to donors.

Findings

Nutrition Sector coordination

The Nutrition Sector benefits from strong government leadership, support from UNICEF and engagement with key stakeholders. The Nutrition Sector is coordinated through the Nutrition Sector Working Group which holds regular and well-attended meetings chaired by the Ministry of Health (MoH) with UNICEF’s support. Furthermore, although there are still shortfalls, the external funding allocated to nutrition indicates that the MoH well understands and communicates the needs of the Nutrition Sector to donors.

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Methodology

The MQSUN+ project conducted the review between December 2018 and March 2019 through a desk review of key documents (strategies, tools and policies), analysis of available datasets, observation visits to nutrition sites and key informant interviews with Nutrition Sector partners. Based on this information, the review analysed the successes and lessons learned from the response, focusing on nutrition response coordination and partner performance. Recommendations were generated for improving Nutrition Sector coordination and response in this and other fragile contexts.

1 previously UK Department for International Development (DfID)
Sector's ability to influence funding allocation, both in terms of location and the package of services and has resulted in a time-consuming rationalisation process which is unlikely to be fully completed until 2021.

**Package of services included in the response**

There was early and strong recognition of the importance of supporting infant and young child feeding in emergencies (IYCF-E) as a critical component of the response. Surge deployments from the United States Agency for International Development (USAID)-funded Technical Rapid Response Team (TRRT) and the UNICEF Rapid Response Team supported the Nutrition Sector in establishing IYCF-E programming in 2016 at the start of the response. The draft IYCF-E plan included an objective of achieving breastfeeding initiation at 60% and breastfeeding duration at 24 months by the end of the surge deployments, government, and partners the Nutrition Sector had developed a draft IYCF-E response plan with a set of minimum IYCF-E activities, IYCF-E indicators and an advocacy brief on preventing untargeted breast milk substitutes (BMS).

Despite early support, implementation of IYCF-E was not fully realised and the major focus of the response continued to be on treating severe wasting. The draft IYCF-E plan did not appear to have been endorsed or disseminated and most recommended actions had not been taken forward. Some Nutrition Sector partners established mother-to-mother support groups that provided nutrition education activities. Furthermore, IYCF-E questions were not included in rapid assessment tools, nor was a BMS monitoring system in place. Following the departure of surge deployment, the Nutrition Sector did not identify an in-country focal person with relevant technical experience to take forward recommendations from these deployments. Although UNICEF and the FCDO, along with other partners, worked to stop the flow of BMS products, they still proliferated.

**Inadequate attention was given to infants under six months of age.** The response of the Nutrition Sector and its assessments largely focused on children aged 6 to 59 months with few services in place to screen for or treat wasting in infants under six months of age. Anthropometric surveys did not include this age group and the national Community Management of Acute Malnutrition (CMAM) guidelines, until recently, did not include guidance on in-patient management of SAM in that population. The response did not include services to manage uncomplicated cases of wasting in infants under six months of age in the community. Furthermore, while criteria for referral for in-patient care were included, guidance on how they should be managed was not provided. Moreover, population-level surveys do not include children under six months; the absence of this data makes it difficult to quantify the extent of the problem.

It may be noted that this is by no means unique to NE Nigeria and, in fact, this has also been documented in Somalia (Desie 2016).

**Health systems strengthening**

**Capacity-building and sustainability**

External support, while ensuring service delivery in the short-term, risked further weakening the health system. While the surge response addressed urgent needs, it was not designed to encourage long-term sustainability and government ownership. For example, partly to ensure timely payments of government health worker salaries, top-up payments were provided to ensure continued motivation to deliver nutrition services. Furthermore, when agencies recruited to fill resource gaps, staff were recruited from the government (and paid much more), further depleting the government workforce.

Technical support to the health system beyond frontline workers was often provided in parallel to government structures and did not necessarily facilitate government ownership. Training and supervision support provided by partners was largely aimed at frontline health workers, with most partners installing supervisory staff at district level and establishing their own supervision structures for these staff. Provision of technical support and capacity-building beyond health centre-level staff was limited. While supervision activities were often performed jointly with government to enhance capacity, for efficiency’s sake tasks were also often divided, with much of the workload managed directly by someone recruited by UNICEF, the management company or NGO partners. While necessary for rapid start-up, these parallel structures risked undermining government ownership during what was ultimately a protracted response.

**Meetings of nutrition technical working groups (TWGs) were reactive instead of proactive**

While TWG meetings were frequent with active engagement from key stakeholders, feedback from partners indicated that the focus of the TWG meetings tended to be on addressing immediate issues rather than long-term priorities such as strategic areas to address technical gaps or develop guidelines.
CMAM data management and reporting

While significant progress was made in ensuring that patient records at facility level were completed correctly, there were discrepancies. An assessment of Nigeria’s CMAM information system showed varied levels of accuracy and reliability along the reporting chain from data collection at health facilities to aggregated national data (Mezger et al., 2018). Likewise, in Kenya, there is significant under-reporting of defaulted children when using a paper-based system (5%) compared to a mobile app (42%) (Keane et al., 2018). In NE Nigeria, all OTP cards sit in one folder regardless of whether the child had been seen that week; in effect, “hiding” children who were supposed to be marked absent. While facility supervisors check monthly tallies against daily admissions, these quality checks are infrequent and often inconsistent. There are also many stages at which data is recorded, leaving multiple opportunities to introduce errors which may skew downstream interpretation and analysis (Mezger et al., 2018).

Large discrepancies were also found between partner-reported data and site-level information. For instance, this review found that 25% of all sites were reporting cure rates of 99% and above, including in locations with a transient population. The review cross-checked records in a sample of these sites and found that many children had been admitted but never discharged. These “ghost” children continued to be counted as undergoing treatment.

Under-reporting of defaulters (or possibly even deaths) appeared to be an issue across the majority of partners in the Nutrition Sector. When partners reported lower cure rates, this was flagged as an indication of poor performance. In reality, the opposite may have been true, with lower reported cure rates being a reflection of accurate reporting and effective programme management. In some cases, partners felt that honest reporting threatened funding, especially when others were not reporting correctly and, as such, there was little incentive to proactively seek out defaulters amongst patient records. As the cure rate is a key performance indicator that is routinely tracked, there is little incentive to seek out defaulters from register books and OTP cards. This results in lost opportunities to trace these children, risking recovery. Furthermore, unreported defaulters falsely elevate recovery rates. Additionally, data on the children currently enrolled on the programme may be incorrect, potentially affecting planning for staffing and procurement. More information on sources of under-reporting is provided in Box 1

Ready-to-use therapeutic food
(RUTF) supply chain

In Nigeria, UNICEF supports the government to procure and transport RUTF. The government and UNICEF each procure a portion of the supply. UNICEF is responsible for the management of forecasting, procurement, import and delivery at national level. Once imported, UNICEF transports supplies to three warehouses at subnational level. Based on requests, UNICEF then transports supplies to government-managed warehouses. This, in most cases, is the “handover point” where agencies or the government are responsible for managing the supply.2

There are successes in rapidly scaling up provision of RUTF to the entire Nutrition Sector. The UNICEF supply division in Copenhagen has recently honed its procurement procedures and diversified suppliers. As a result, UNICEF is able to negotiate reduced costs and successfully supply at a larger scale so that RUTF is successfully procured and distributed to meet increased demand/need.

Forecasting and ordering are likely not based on the most relevant data, potentially leading to overestimation or underestimation of supply needs at different points. The goal of supply chain management is to efficiently match supply with demand. As supply requests are based on numbers of children in the programme and forecasting is based on population-level survey results, there is a risk of underestimating supply needs. Underestimation of supply needs could also have occurred as a result of the MUAC discharge criteria for OTP increasing from 11.5 to 12.5 cm which led to children remaining in the programme for longer. On the other hand, defaulters lowered the average amount required for each child as they dropped out of the programme early. Additionally, as mentioned, many sites had “ghost children” which may have also resulted in overestimating supplies.

Multiple risks of bottlenecks exist throughout the RUTF supply chain. The numerous steps involved in forecasting, purchasing, ordering, delivering and supplying the product to end-users often do not link well with one another. This review found that site-level gaps in RUTF supply are not consistently tracked across partners, making it difficult to understand where breaks occurred, the reason for these and which part of the supply chain was responsible. Furthermore, significant discrepancies between forecasted amounts and supplies actually used may indicate a worse than expected nutrition situation or could signal challenges with the management of supplies at the facility level. In the absence of a mechanism to track supplies along the supply chain, including at the health facility level, on an ongoing basis, it is difficult to make a distinction between the two scenarios, identify leakages and explain discrepancies between forecasts and amounts delivered.

Partner supply usage is not optimally tracked against forecasts. Partners based their forecasts on previous admissions for existing sites and a standard caseload calculation formula (prevalence + incidence) for new sites. Furthermore, RUTF orders are placed once funding is received, suggesting that supply is based on provisional estimates of 0.9 cartons per case. When funding contracts are delayed, the current unofficial buffer of 0.1 cartons per case may not be sufficient to prevent RUTF stock-outs. In addition, while forecasting for RUTF supplies is based on weight-for-height prevalence and nutrition surveillance data, admission to wasting treatment programmes in Nigeria is based on MUAC measurements. This creates a discrepancy between forecast and actual RUTF usage. The review also found significant differences across partners in the average amount of RUTF used per child with some using double or triple that of other partners. UNICEF began calculating supply needs on behalf of partners based on the monthly number of children enrolled on the programme but amounts against original forecasts were not tracked.

Discussion and conclusions

This case study highlights the importance of standardising how to set up coordination early in a response to prevent duplication of services, ensure ownership by the government, improve data quality and management and move towards better tracking and forecasting of supplies. Crit-
Interestingly, governments should be consulted and supported by all actors, including donors, to adequately coordinate the response. If partners have secured resources for one geographic area, donors should allow the reallocation of resources to other areas if duplication occurs. Where pooled funding is not an option, the government and a cluster lead agency (e.g., a central coordination body) should prioritize geographic areas for intervention early in the response to prevent duplication and ensure services are provided in the locations where they are most needed. Donors, as part of the Nutrition Sector coordination, should consult this list prior to funding. A minimum package of services should be identified and supported by each partner delivering services. The Nutrition Sector coordination can identify capacity gaps and technically support partners to ensure delivery of the response including technically sound IYCF-E activities. While this review focused on NE Nigeria, similar issues have been documented in other emergency contexts (MQSUN+ and ENN 2018, Emergency Nutrition Network 2019, Desie 2016, UNICEF 2019c). Given the frequency of these challenges, it is important to understand why they are not addressed in new responses and what additional global efforts are needed to systematically address them.

Emergency responses often establish parallel structures that are unsustainable in the long run. In NE Nigeria, it is unlikely that any services to treat wasting would operate without technical, financial and logistical support being provided by external agencies. It is important to have guidance on how a coordinated commitment can truly support government-led services within a specific time period. Assessing health facility capacity to manage increases in case numbers could be very beneficial, not just for planning short-term surges, but to also assess the kind of support required over the medium to long term and to help prioritise where external agencies direct their technical support. An example of this in action can be found in Kenya where county-level UNICEF Nutrition Support Officers helped to strengthen the government system by building the capacity of county government nutrition officers instead of directly engaging with frontline health workers. Furthermore, as emergencies evolve into protracted, chronic crises with recurrent shocks, it is important for donors to provide longer term flexible funding to support greater integration of services (OCHA 2017). As handover to government may take several years, steps toward transition to full government delivery should be identified along with indicators to track progress. A review of humanitarian responses in Yemen and Somalia highlights similar issues and proposes the tracking of indicators for transitioning to government ownership (Global Nutrition Cluster and UNICEF Middle East and North Africa 2019).

In addition, the simplification of the CMAM approach should be explored to ultimately require less supervision and enable more streamlined data reporting. UNICEF is leading efforts to generate evidence around simplified protocols. However, more evidence is needed to evaluate the effectiveness and acceptable standards of these approaches and it will take time to build the required evidence for these to shift global and national policies and guidelines (No Wasted Lives Coalition 2020).

While these new approaches are receiving a lot of attention, less discussion is taking place around the management of standard CMAM programmes. Renewed efforts to simplify reporting, improve tools, supervision and capacity-building approaches for the existing model of CMAM could improve service delivery and support efforts to scale up coverage of services. Additionally, efforts to integrate nutrition services into government systems should take a phased whole-system approach where all levels of government are engaged in shifting responsibility for ensuring service delivery away from external actors with measurable milestones identified to track this process and to ensure that effective services are delivered and scaled up.

Recommendations from this review were incorporated into the three-year Nutrition Sector strategy developed in 2020. Recommendations to improve the NE Nigeria response have also been accepted by the Nutrition Sector including moving towards a model of one lead agency managing one local government area (LGA), requesting additional surge technical support for IYCF-E, ensuring the nutrition strategy includes a basic package of nutrition services and encouraging donors to consult the Nutrition Sector prior to making decisions on funding. Furthermore, in the new CMAM guidelines developed in 2020, in-patient care includes the management of infants under six months of age. For more information please contact Alison Donnelly at alisonjdonnelly@gmail.com and Carrie Hemminger at chemminger@path.org

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References


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