A multi-year Humanitarian Response Plan (HRP) has been initiated which provides the overarching framework for a humanitarian response in north-east Nigeria for three years (2019-2021). Within Borno, Adamawa and Yobe states, the plan will focus on the needs of 6.2 million of the most vulnerable women, men, girls and boys. The Humanitarian Needs Overview will remain an annual exercise to ensure that changes in the context are adequately analysed and duly reflected. Strategic objectives, targets and indicators will remain the same for the duration of the plan, with annual updates on needs, activities and financial requirements. Health Sector will require US$ 73.7 million to reach 5.3 million people across three states during 2019.

Cholera cases are on decline as a result of timely and robust support from Health and WASH partners and changes in the weather patterns. Till November, over 3,472 cholera cases have been reported across Borno (947), Adamawa (2050) and Yobe (474) states. In Borno State, densely populated areas of Maiduguri and Jere LGAs have reported high numbers of cholera cases. Other LGAs like Mobbar, Gwoza, Ngala, Kala-Balge and Bama have also been affected due to poor water and sanitation conditions and lack of awareness in the communities.

The humanitarian access situation remains challenging in the north-east. Ongoing hostilities in the northern part of Borno State has led to disruption and downsizing of humanitarian operations in several locations like Rann. Humanitarian partners are still assessing the operational environment but have started upsising in many secure areas to ensure lifesaving humanitarian assistance reached people in need.

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*Total number of IDPs in Adamawa, Borno and Yobe States by IOM DTM XXII
**MoH/WHO Borno HeRAMS September/October 2017
***Number of health interventions provided by reporting HRP partners as of December 2017.
****Cumulative number of medical consultations at the IDP camps from 2018 Epidemiological Week 1 - 47
*****The number of alerts change from week to week.
A new multi-year planning approach in north-east Nigeria (HRP 2019-2021): Recognizing that north-east Nigeria is now a complex and protracted crisis with both acute and chronic needs, a more strategic plan and holistic response is required. As a result, there is a need to shift to a multi-year Humanitarian Response Plan, which provides the framework for planning and coordinating the delivery of humanitarian assistance that can also catalyze early recovery and long-term development. The multi-year plan facilitates increased engagement with development partners to address underlying structural drivers of the crisis, all in support of the recognized capacity of the Government of Nigeria to own and lead the response. The multi-year plan provides the overarching framework for a humanitarian response in north-east Nigeria for three years from 2019 to 2021. Within Borno, Adamawa and Yobe states, the 2019 plan will focus on the needs of 6.2 million of the most vulnerable women, men, girls and boys. The Humanitarian Needs Overview will remain an annual exercise to ensure that changes in the context are adequately analyzed and duly reflected. Strategic objectives, targets and indicators will remain the same for the duration of the plan, with annual updates on needs, activities and financial requirements. The plan will adopt an approach to promote the convergence of the efforts of the humanitarian actors and development partners to address needs of conflict and displacement affected communities. This will require innovative multi-sectoral programming models that support the transition to a stronger government role over time.

Summary of health needs (HRP 2019): In north-east Nigeria, 5.3 million people need life-saving and essential health care services. The crisis has had a major impact on the health care system. In hard-to-reach and newly accessible areas, communities face serious challenges in accessing health services due to various reasons, including lack of medical staff, unavailability of drugs and supplies, security barriers, transportation issues and damaged/destroyed health facilities. Critical gaps also remain in functional primary and secondary health services. The north-east remains highly endemic for diarrheal diseases due to seasonal patterns, lack of access to potable water and sanitation infrastructure, and vulnerabilities as a result of continuous displacement and low access to essential healthcare. New influxes of IDPs, refugees and returnees into overcrowded and under-serviced camps and settlements also exacerbate the risk of disease outbreaks. Affected populations, particularly women and children, are increasingly susceptible to disease outbreaks, especially cholera. GBV is also widespread in the region, amplified both by the conflict, in which sexual violence is rampant, and by the conditions in IDP camps and informal settlements, including inadequate WASH facilities, lack of safe access to firewood, and restrictions on freedom of movement in and out of camps. Mental health and psycho-social (MHPSS) services are also limited in many areas while specialized psychiatric treatment services are only available at the Federal Neuro-Psychiatric Hospital in Maiduguri.

Defining the New Way of Working (NWoW): Recognizing that humanitarian and development actors, governments, NGOs and private sector actors have been progressively working better together to meet needs for years, the New Way of Working aims to offer a concrete path to remove unnecessary barriers to such collaboration in order to enable meaningful progress. The New Way of Working can be described, in short, as working over multiple years, based on the comparative advantage of a diverse range of actors, including those outside the...
UN system, towards collective outcomes. Wherever possible, those efforts should reinforce and strengthen the capacities that already exist at national and local levels. A collective outcome can be described as the result that development and humanitarian actors (and other relevant actors) want to have achieved at the end of 3-5 years. For example, the reduction of cholera infections in a city commonly struck by cholera from 50,000 today to zero in 2021; or the ‘legalization’ of housing of an additional 100,000 long-term IDPs in a given city and their integration into municipal services by 2021.

A collective outcome is a commonly agreed quantifiable and measureable result or impact in reducing people’s needs, risks and vulnerabilities and increasing their resilience, requiring the combined effort of different actors. A comparative advantage is the capacity and expertise of one individual, group or institution to meet needs and contribute to risk and vulnerability reduction, over the capacity of another actor. A multi-year timeframe refers to analysing, strategizing, planning and financing operations that build over several years to achieve context-specific and, at times, dynamic targets. The approach is not a “hand-over” from humanitarian to development.

Health response to Gender-Based Violence in Emergencies: The current coverage of health services for GBV survivors is low. The HeRAMS captures the availability of clinical management of rape services and the last report indicated that: CMR is fully available in 26% of health facilities, psychological follow-up (and referral) of victims of rape in 24%, emergency contraception in 22%, and post-exposure prophylaxis in 15% of the health facilities. The coverage of just CMR remains low. The HeRAMS cites the major reasons for unavailability/partial availability of these services as the lack of medical supplies (drugs and consumables) and the lack of training of health staff. While UNFPA is providing both, it is likely not enough and seems to be focused primarily on RH actors (not reaching the broader health sector). IPV and other forms of GBV are occurring in the emergency context yet health efforts are currently focused almost entirely on sexual violence.

Access to quality, confidential, age-appropriate and compassionate healthcare services is a critical and life-saving component of a multi-sectoral response to GBV in emergencies. Healthcare providers are often the first and sometimes only point of contact for GBV survivors. They are at the front line of response to GBV in emergencies and can play a significant role in identifying protection concerns, addressing physical and emotional/psychological needs, developing prevention strategies and providing referrals to other services. Healthcare services should be delivered in a confidential, non-judgmental and non-discriminatory manner that considers the survivor’s sex, age and any specific needs. Special consideration should be given for the unique needs of women, girls, boys, men, persons with disabilities, older persons, LGBTI persons and other survivor.

In order to facilitate care, survivors must have safe access to health facilities. Many survivors will not disclose violence to a health-care provider (or any other provider) due to shame, fear of blame, repercussions, social stigma and rejection from partners/families and other reasons. If health-care providers are not well trained, they may not be able to identify women and girls who have been subjected to violence. If services providers are not properly trained, equipped, skilled and knowledgeable survivors may be discouraged inadvertently from asking for help for GBV-related health problems. Survivors may fail to seek services if the provider does not ask the right questions; if the health facility does not have private spaces for consultation, protocols for provision of health care to survivors, essential medicine and supplies or confidential mechanisms for documentation and referrals; if communication materials in the facility do not make clear
the types of services that are available, and that they are available for all; or if the provider states or implies that the disclosure of GBV will not be met with respect, sympathy and confidentiality. Moreover, mandatory reporting procedures can delay or obstruct survivors from seeking potentially life-saving medical care. Mandatory reporting laws may require health service providers to report if a survivor presents which may limit access to life-saving, timely and confidential health treatment, delay care or force the survivor to pursue legal redress. Health services to survivors should be the first priority.

**GBV and MHPSS:** Neglecting the physical and mental health implications of GBV can be a violation of medical ethics. Healthcare workers should provide necessary, life-saving care, such as post-exposure prophylaxis (PEP) for HIV; emergency contraception; treatment for sexually transmitted infections (STIs); mental health and psychosocial support; and appropriate referrals for legal and other services that can support survivors and prevent their re-victimization. When healthcare providers are not trained on the guiding principles of working with survivors, survivors may be at heightened risk of additional harm or violence from partners, family and/or community members if confidentiality, respect and safety are not adhered to. Healthcare programmes that are safe, sensitive, confidential, accessible (i.e. free of cost, location and physical access to the facility) can facilitate immediate and lifesaving care for survivors and initiate a process of recovery that results in physical and mental health benefits for individual survivors. They can also have wide-ranging benefits for families, communities and societies. Health actors should coordinate with other service providers addressing mental health and psychosocial support (MHPSS), HIV, age and environment.

**Minimum Initial Service Package (MISP):** During the acute phase of an emergency, the priority is to provide the Minimum Initial Service Package (MISP), an international standard of care that should be implemented at the onset of every emergency. The MISP is part of the Sphere Standards for essential health services and not optional. This package ensures that basic health needs are met and helps to mitigate negative long-term effects of violence on survivors. The MISP is a coordinated series of priority actions designed to prevent morbidity and mortality, particularly among women and girls. The MISP considers the prevention and management of sexual violence to be a life-saving activity that prevents illness, trauma, disability and death. As a result, the MISP meets the life-saving criteria for the Central Emergency Response Fund (CERF), making these funds available for health-care programmes. Access to health services for rape and IPV survivors has been identified as a major gap in humanitarian response; there is a critical need to ensure that established protocols for the clinical management of rape (CMR) and IPV are implemented.

**Clinical management and supplies:** Health sector partners should be equipped to provide clinical care for sexual violence, IPV, and for the consequences of other forms of GBV (e.g. HIV testing and treatment, STIs, depression, risk of suicide, injuries and pregnancy complications from IPV; increased risk of more serious IPV; health effects of early and forced sexual activity and pregnancies related to early and forced marriages; complications related to female genital mutilation/cutting; etc.). It is essential to inform communities about the benefits of, and locations of seeking care once services are established. Adequate health services are not only vital to ensuring life-saving care for women, girls and other at-risk groups, but they are also a key building block for any setting seeking to overcome the devastation of humanitarian emergency.

**Early Warning Alert and Response System (EWARS)**

- **Number of reporting sites in week 47:** A total of 163 out of 269 reporting sites (including 32 IDP camps) submitted their weekly reports. The timeliness and completeness of reporting this week were 60% and 60% respectively (target 80%).
- **Total number of consultations in week 47:** Total consultations were 36,902 marking a 3% decrease in comparison to the previous week (n=38,041).
- **Leading cause of morbidity and mortality in week 47:** Malaria (suspected n= 7,517 and confirmed n=4,797) was the leading cause of morbidity reported through EWARS, accounting for 40% of reported cases while suspected malaria was the leading cause of mortality, accounting for 28.6% of reported deaths.
- **Number of alerts in week 47**: Twenty-six (26) indicator-based alerts were generated with 85% of them verified.

**Morbidity Patterns**

- **Malaria**: In Epi week 47, 4,797 cases of confirmed malaria were reported through EWARS. Of the reported cases, 458 were from General Hospital Biu, 225 were from Herwa PHC in MMC, 157 were from Maimalari Barrack MCH in Jere, 139 were from 250 Housing Estate (Kofa) Camp Clinic in Konduga, 135 were from PHC Clinic Gwoza and 127 were from Uba General Hospital in Askira-Uba. One confirmed malaria death was reported in Askira General Hospital (1).

**Acute respiratory infection**: In Epi week 47, 5,594 cases of acute respiratory infection were reported through EWARS. Of the reported cases, 429 were from Herwa PHC in MMC, 176 were from Muna.
Garage Camp Clinic A in Jere, 169 were from PHC clinic Gwoza, 161 were from Water Board UNICEF IDP Camp Clinic in Monguno and 152 were from Monguno FSP Clinic. No death was reported.

Figure 3: Trend of acute respiratory infection cases by week, Borno State, week 34 2016-47 2018

- **Acute watery diarrhoea**: In Epi week 47, 973 cases were reported through EWARS. Of the reported cases, 149 were from Herwa PHC in MMC, 76 were from PHC clinic Gwoza and 61 were from Federal Training Center Camp Dalori Air Force Camp Clinic in Jere. One associated death was reported from Kida PHC Clinic in Hawul.

- **Suspected Measles**: Forty (40) suspected measles cases were reported through EWARS in week 47 from Herwa PHC in MMC (22), Dala Clinic in Jere (8), 505 Housing Estate Clinic in Jere (2), Fatima Ali Sheriff PHC in MMC (2), Muna Garage Camp Clinic ‘A’ in Jere (2), Njimtilo Health Clinic in Konduga (2), Shehu Palace PHC in MMC (1) and State Specialist Hospital in MMC (1).

- **Suspected Yellow Fever**: One (1) suspected yellow fever cases were reported through EWARS in week 47 from Pompomari Health Clinic in Konduga LGA. Three additional suspected cases were reported through IDSR* in Chibok (1), Monguno (1) and Shani (1) making a total of four suspected cases. No associated death was reported.

- **Suspected Meningitis**: There was no suspected meningitis case reported in week 47.

- **Suspected VHF**: There was no suspected VHF case reported in week 47.

- **Suspected cholera**: No case of suspected cholera was reported through EWARS in week 47.

- **Malnutrition**: 797 cases of severe acute malnutrition were reported through EWARS in week 47. Of the reported cases, 60 cases were from Kurbagayi MCH in Kwaya-Kusar, 38 were from Gajiram MCH in Nganzai, 35 cases were from Kida PHC in Hawul and 30 were from INTERSOS Health Facility in Bama.

- **Neonatal death**: No neonatal death was reported in week 47.

- **Maternal death**: Two maternal deaths were reported in MCH Miringa in Biu LGA and Uba Dispensary in Askira-Uba LGA.

*IDSR- Integrated Disease Surveillance and Response

**Alerts and Outbreaks**: Twenty-six indicator-based alerts were generated from the weekly reports submitted through EWARS in week 47. Eighty-five percent of the alerts were verified.

Regarding the ongoing cholera outbreak in Borno State, as at 25th November, a total of 6,236 with 73 associated deaths, (CFR – 1.17%). 2,390 in Jere, 1,527 in MMC, 340 in Magumeri, 34 in Kaga, 166 in Konduga, 136 in Chibok, 11 in Shani, 42 in Damboa, 1052 in Ngala, 91 in Askira-Uba, 161 in Kwaya-Kusar, 56 in Bama, 57 in Dikwa, 70 in Guzamala and 109 in Kala-Balge LGAs. No additional case reported from Magumeri, Ngala, Askira/Uba, Kaga, Chibok, Dikwa, Shani, Damboa, Kwaya-Kusar and Bama LGAs.

Out of the 196 samples collected and tested in the State using RDTs, 161 (82%) were positive while 40 (44%) of 91 samples were culture positive. Response activities such as active surveillance in affected communities, case management, house-to-house community sensitization and WASH interventions have been sustained in affected areas under the supervision of the state RRT and partners. Regular state level coordination meetings are held in the Public Health Emergency Operations Centre (PHEOC) in Maiduguri to oversee the outbreak.
**Health Sector Actions**

**INTERSOS** continues to support 5 Health facilities, 2 health posts and 1 mobile clinic and 1 stabilization center offering 24/7 services in Magumeri LGA, 1 Health facility in Ngala, 1 Health facility in Bama and 1 Health facility and mobile clinic in Dikwa LGAs of Borno State fully equipped to handle a large number of medical matters.

**a. Outpatient consultations**
The total consultations for the November are 9,874 of which U5 is 4,462 (45%) with an overall decline across all sites except Magumeri which experienced an increase. Malaria (2449 cases) and Acute Respiratory Infection (2399 cases) are the high cause of morbidity in all INTERSOS health facilities. 170 confirmed cases of Malaria were treated in Bama, Ngala and Dikwa this was slightly higher than the number encountered in September. November consultations across all of INTERSOS health facilities are found in the breakdown below

**b. Sexual and Reproductive Health**
Total ANC attendees for the month is 1,311, with 769 accounting for 1st visit and re-visit 542 of the total SRH. There is an increase of ANC attendance compared to the previous month as INTERSOS includes Hygiene Kits distribution to services offered at the Antenatal and Post-Natal Clinics.

- ANC attendees in Bama clinic were 180, with 104 accounting for first visit, 76 re-visit, post-natal visit: 7 and 2 deliveries.
- ANC attendees in Ngala clinic were 431, with 217 accounting for first visit while 214 accounts for re-visit, PNC visits were 62 and 6 deliveries were recorded.
- ANC attendees in Dikwa clinic had 496 clients which 363 were first visit while 133 is revisit there were 33 PNC visits and 3 deliveries.
- Magumeri had 204 ANC clients with 85 first visits while 119 revisits, 15 PNC visits and 10 deliveries.

**c. Disease surveillance**
- All of INTERSOS supported health facilities for the month of November recorded a 100% timely and complete reporting on the Early Warning and Reporting System (EWARS) platform. 2 alerts were generated on the platform but addressed accordingly. The number of confirmed Malaria cases for INTERSOS health facility in Dikwa was double the number seen over the past 3 weeks.

The team continue to strengthen referral linkages from the community to the health facility using the CHVs and details of referrals documented.

**IRC** continue to play major role in the humanitarian response to the protracted armed conflict in the three most affected state in the North East of Nigeria. Through the 30 integrated health and nutrition mobile clinic providing much needed emergency care and Health system support for 21 health facilities spread across the three states, much relieve has been brought to the internally displaced persons and their host communities. The reproductive health program works in Bakassi camp (MMC) with a comprehensive RH center, while also supporting 4 health facilities within MMC-Jere LGAs to boost RH services. The RH team is further collaborating with the Women Protection and Empowerment sector in managing Comprehensive Women Centers (CWC) in Monguno, Konduga and Gwoza, providing RH services combined with case management.

In November 2018, the IRC health team conducted a total of 35,074 consultations (13,992M, 21,082F), including 13,006 children under five and 22,068 over
five across the three NE states. Additionally, the reproductive health program reached 5,029 people, of which 4,702 were women and girls, while 327 male were treated in the STI clinic. The Comprehensive Women's Center (CWC) and supported health facilities provided first antenatal care services for 1,945 women conducting 906 skilled birth deliveries. There were also a total of 849 beneficiaries of family planning services.

Through the clinician pre-consultation daily health education, mother to mother support group sessions and community sensitization and mobilization activities of the CHVs a total of 29,873 people (11,454 M, 18,419 F) were reached with messages on Importance of immunization, Malaria prevention through environmental sanitation, use of mosquito nets, Cholera preventive and control measures, Utilization of ORS point, proper hand washing, Importance of exclusive breastfeeding and availability of STIs care at health outreach clinics., early illness danger signs in children, balance diet with the use of locally available food.

CHOLERA RESPONSE: In Borno state, although no new cholera case was recorded in Gajigana and Tungushe in Magumeri and Konduga LGAs of the state, the IRC continue to provide necessary support for the Health facilities and the community affected by the cholera outbreak. Sensitization on cholera prevention and hygiene promotion session was done in the communities and at the health facilities. In Adamawa. State, 36 cartons of Ringers Lactate Intravenous fluid (IVF), 3 cartons of suspension Erythromycin Ethylsuccinate were supplied to CTC specialist hospital Yola, while liters of fuel was given to CTC Fufore for generator use. Sensitization on cholera prevention was done for 124 Health Workers in two health facilities, FMC (M39 F14) and Specialist Hosp. Yola (M28, F43). And same sensitization activity was carried out in Yola north LGA for 420 (M 183, F 237) community members.

UNICEF support to the integrated emergency PHC service deliveries in Borno and Yobe States: A total of 143,813 IDPs and host community members were reached with integrated PHC services in in the IDP camps and host communities in Borno and Yobe States, including 81,556 children under the age of five years. Out of a total 100,682 consultations recorded, malaria – 34,776 was the major cause of consultations, followed by ARI – 23,940; AWD – 8,327; Bloody Diarrhea in Borno State – 677, measles, also in Borno – 359, and other medical conditions – 32,603. A total of 36,460 prevention services were recorded out of which 4,863 children aged 6months-15 years were vaccinated against measles; 64,465 children and pregnant women were reached with various other antigens; 13,520 Vitamin A capsules were distributed, Albendazole tablets for deworming – 29,561 and ANC visits – 15,448, a total of 2,869 deliveries and 3,067 postnatal/home visits were recorded during the reporting period.

UNICEF supported the SMOH through SPHCDA and SPHCMB in the three states with a total of 233 NHKs – Borno - 211 and Yobe – 22 for provision of integrated emergency PHC services in the IDP camps, host communities and outreach activities in host communities. UNICEF has supported the state with 9500 pieces of LLINs to reach pregnant and lactating women and children under 5 in Ngala, Mobbar, Bama and Gwoza LGAs in Borno state.

IOM PSS mobile teams continue to provide direct Mental Health & Psychosocial Support Services to the affected population across field locations in Adamawa, Borno & Yobe States. A total of 67,781 beneficiaries (comprising of 12468 girls, 10007 boys, 31253 women and 14053 men) were reached within the month of November 2018. A total of 15365 new beneficiaries (comprising of 2508 girls, 1747 boys, 7057 women and 4053 men) were reached within the reporting month of November 2018. MHPSS activities offered to the affected population include but not limited to lay counselling, psychological first aid (PFA), FGDs and informal education, support group, recreational activities, SGBV sensitization and case follow up, small scale conflict mediation, referral to specialized services, bereavement support and psychoeducation to the caregivers and mental health patients, sensitization and livelihood
follow ups and supervision. Cholera prevention sensitization activities and campaigns are also being organized, as well as the ongoing 16 days of activism campaign organized by the teams in the camps through drama by the IDP youths. All these activities are rolled out in Borno, Adamawa, and Yobe States.

**Mental Health Referral for Specialized Mental Health Care:** 664 (21 Girls, 36 Boys, 281 Women, and 326 Men) patients in in Borno and Adamawa States were seen by the psychiatrist doctors and nurses (164 in Maiduguri, 31 in Yola and 469 in NAAs- Bama, Banki, Dikwa, Ngala, Gwoza, and Mongono). IOM have had a collaboration with hospitals offering this kind of service; in Borno, IOM is working closely with the Neuropsychiatric Hospital and a private practitioner in Adamawa-Yola. The MoU with the Federal Neuropsychiatric Hospital, Maiduguri allows for deployment of trained psychiatric nurses to hard-to-reach (NAAs) areas of Borno State for the provision of specialized mental health care services to persons identified with mental health challenges. Psychoeducation is provided to the caregivers by the psychiatric nurses as well as the mobile teams members comprising of nurses in each of the teams.

**MHPSS Coordination:** IOM is co-chairing the MHPSS sub-working group with the Borno state Ministry of Health (SMOH) as the chair, where coordination of MHPSS activities takes place, ensuring information sharing between NGOs, INGOs and humanitarian partners; observing adherence to relevant standards and guidelines and ensuring efficient use of resources among partners. As part of capacity building, workshops are organized for the national partners/institutions and NGOs to ensure sustainability of the MHPSS response in North-East Nigeria. Within the reporting month of November 2018, a monthly MHPSS SWG coordination was convened.

**PUI** have submitted a proposal for construction of two blocks, one for OPD and the other for OTP for Herwa PHCC. Staff training has been done on measles cases management and prevention as well as other topics of SRH. There is also underway, the finishing works for the new maternity and OTP blocks in Ngaranam PHC.

**WASH** need assessment for four (4) of PUI facility has been done jointly with Solidarite International to fulfill some of the gaps.

**Humanitarian situation at different centers managed by PUI are as follows:**

<table>
<thead>
<tr>
<th>Center</th>
<th>OPD Consultation</th>
<th>Immunization</th>
<th>Nutrition</th>
<th>Malaria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Herwa Peace PHC</td>
<td>3806</td>
<td>1010</td>
<td>73 new admissions for SAM cases in OTP</td>
<td>450 cases confirmed</td>
</tr>
<tr>
<td>Ngaranam PHC</td>
<td>3256</td>
<td>2038</td>
<td>132 new admissions for SAM cases in OTP</td>
<td>462 cases confirmed</td>
</tr>
<tr>
<td>Outreach teams</td>
<td>5491</td>
<td>93</td>
<td>106 new admissions for SAM cases in OTP</td>
<td>543 cases confirmed</td>
</tr>
</tbody>
</table>

**WHO/Adamawa:** In collaboration with the State Ministry of Health and Partners, the 4th cycle and last cycle for 2018 of Seasonal Malaria Chemoprevention (SMC) in 3 LGAs of Michika, Mubi North and Mubi south in Adamawa were conducted. The SMC campaign involved the administration of Sulphadoxine - Pyrimethamine and Amodiaquine (SP + AQ) to children 3 – 59 months who are most at risk of malaria during the peak transmission season. The campaign reached over 122,000 children during this cycle through house to house drug administration by over 700 personnel engaged for the campaign. The 4th cycle of SMC achieved a 99% coverage. SMC is expected to contribute to at least a 70% decline in malaria morbidity in the targeted LGAs.

WHO also continues its response to the Cholera outbreak in Yola North, Yola South, Girei and Fufore LGA of Adamawa State. This involves direct support to case management and risk communication to the response. We provided technical guidance and supplies for case management at the CTU in the State Specialist Hospital Yola. In addition, WHO has deployed the Hard to reach mobile team for active case search and risk communication in the affected communities.

**ICCM:** In the month of November 2018, 2,916 children were treated for malaria, diarrhea and Pneumonia by 123 CoRPs in 14 LGAs of the state. 2,584 of the children were screened for malnutrition using MUAC. 187
(6.4%) of the children screened had MAM and were counseled on proper nutrition, while 4 (0.1%) of them had SAM demonstrated by Red on MUAC and were referred to CMAM sites for proper management.

**HTR:** In November 2018, 32,902 clients were seen by WHO supported 20 H2R teams providing services in 20 LGAs of Adamawa state. The teams treated 11,516 persons with minor ailments and dewormed a total of 9,010 children during the month. Pregnant women were provided FANC services with 2,164 of them receiving Iron folate to boost their hemoglobin concentration while 1,284 received Sulphadoxine Pyrimethamine (SP) as IPTp for prevention of malaria in Pregnancy.

**AGUF** was in three government secondary schools, facilitated peer education on effects of drug abuse and its consequences on mental health. 374 people were reached. Sensitization on effects of drugs to youths in Sabon Pegi ward Numan LGA was conducted and 24 people were reached.

**UNFPA** continues to support the Government on coordination and service provision efforts for the Sexual and Reproductive Health/Gender Based Violence response through the SRH Sub Sector Working Group. UNFPA collaborated with Borno State Ministry of Health to conduct an obstetric fistula campaign reaching out to 18 clients. This to be maintained on a quarterly basis while increasing root cause prevention through community advocacy efforts on Child Marriage, Adolescents SRHR, and provision of basic and comprehensive SRH care. The effort to reduce burden of fistula cases in Adamawa state has continued. 118 women and girls mobilized, 63 screened and 42 repaired.

UNFPA Supported Ministry of health scale up MPDSR scale up Training to 50 secondary health facilities in order to increase MPDSR reporting and response with aims of achieving transformative goal of zero maternal mortality in alignment with SDG zero maternal mortality by 2030 and zero neonatal mortality by 2035.

**JHF** is implementing a TB Reach IDP intervention which started in July 2017 and has been scaled up for another year (2018/2019) with the involvement of four (4) additional LGAs which are Yola North, Yola South, Mubi North and Mubi South. In the 12 targeted LGAs for this intervention, 5558 persons were verbally screened for TB/HIV, 546 presumptive TB cases were identified in November including 18 under 5 presumptive childhood TB cases. Of all presumptive TB cases identified, sputum samples were collected from 448, out of which 31 all forms of TB cases were detected including 25 Bac+ and 3 under 5 Childhood TB cases. All 448 presumptive cases that submitted sputum had HCT out of which 11 were found to be HIV+. All TB and HIV cases detected are linked to treatment, care and support services.

**Nutrition updates**

**IRC/Adamawa:** CMAM and IYCF program activity in the four supported LGA of Adamawa state and some part of Borno state were successfully carried out. Anthropometric screening was carried out to 22,230 (11,113M, 11,117F) under 5 children, with 214 (104M, 110F) identified SAM cases and admitted into program. 1,194 (596M and 598F) MAM whom their caregivers received nutrition education and participated in community feeding sensitization seasons. Total discharges of 262 (130M and 132F) children was made, with 213 (103M and 110F) exited as cure, 2 (2M and 0F) as died and 47 (22M and 25F) defaulting clients. In the program clinics, currently 506 (251M, 255F) SAM children are on admission receiving treatment. For Stabilization centers, 28 SAM with complication were admitted. Among which 8 are cured, 19 transfer to OTP, 1 Death with no defaulters. Overall program performance for the month were 81.3% cured rate, 0.8% death rate and 17.9% default rate.

**IYCF:** The daily activity conducted in the month were routine breastfeeding related topic and issues which include early initiation of breastfeeding, exclusive breastfeeding and Good hygiene practice. The important of providing breastmilk at all time (day and night) on demand by the baby and as well rational for allowing the baby to empty first breast before switching the child to other one. 6,357 community beneficiary were
reach and benefit from the activity sessions with 1,346 pregnant mothers, 2,859 Lactating mothers, 988 old women, 583 young girls and 581 men beneficiaries were reach.

**WHO-Nutrition: Screening:** In November 2018, 19,051 children were screened for Malnutrition using MUAC by WHO supported 20 H2R teams. Of this number, 316 (1.7%) children had MAM and their caregivers were counseled on proper nutrition, while 84 (0.4%) of them had SAM as demonstrated by Red on MUAC. The SAM cases were referred to the Outpatient Therapeutic Program (OTP) centers across the state for proper management.

**Stabilization care:** WHO Supports 4 stabilization centers in the state, reports received from them showed that a total of 42 children having SAM with medical complications were managed in November 2018. 38 (90%) of the patients recovered during the month and were discharged to the OTP centers for follow up care.

**UNICEF-Nutrition:** In November, 1,644,417 children 6-59 months old were screened for acute malnutrition with MUAC. 11,824 of these children were identified as suffering from severe acute malnutrition and referred for appropriate treatment. 8,647 of the children identified with SAM were admitted into UNICEF supported outpatient therapeutic program sites for treatment. The cure rate in these treatment centers for the month of November was 92.7%, with 0.4% death rate.

For prevention of malnutrition services, 80,531 caregivers of children 0-23 months benefited from infant and young child feeding support through messaging and counselling. 14, 934 of these caregivers received such messages for the first time. At the same time, 13,714 children 6 and young child feed 23 months benefitted from infant and young child feeding support through messaging and counselling. 14, 934 of these caregivers received such messages for the first time. At the same time, 13,714 children 6-23 months received multiple micronutrient powder supplementation for treatment and prevention of micronutrient deficiencies.

### Public Health Risks and Gaps

- High risk of epidemic outbreaks especially cholera, meningitis, measles, yellow fever. The northeast region is highly endemic for malaria and cholera.
- Unpredictable security situation hampers movements of health workers, drugs and other medical supplies.
- Although health situation is improving under the NE Nigeria Health Sector 2018 Strategy, the health service delivery continues to be hampered by the breakdown of health facilities infrastructure.
- There is a serious shortage of skilled health care workers, particularly doctors, nurses and midwives, with many remaining reluctant to work inaccessible areas because of ongoing armed conflict.
- Continuous population displacements and influx of returnees and/or refugees disrupt and further challenges the health programs implementation.
- Access to secondary health care and referral services in remote areas is significantly limited.
- Unavailability of network coverage in the newly liberated areas negatively affects timely submission of health data for prompt decision-making.

### Health Sector Partners


- Health sector bulletins, updates and reports are now available at [http://health-sector.org](http://health-sector.org)

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