Humanitarian Response in Northeast Nigeria:
FHI 360’S Integrated Approach
<table>
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<tr>
<th>Acronym</th>
<th>Description</th>
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<tr>
<td>ANC</td>
<td>Antenatal care</td>
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<td>ART</td>
<td>Antiretroviral therapy</td>
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<td>CHEW</td>
<td>Community health extension worker</td>
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<td>CV</td>
<td>Community volunteer</td>
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<td>EWARS</td>
<td>Early Warning Alert and Response System</td>
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<td>GBV</td>
<td>Gender-based violence</td>
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<td>HEV</td>
<td>Hepatitis-E Virus</td>
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<td>IDP</td>
<td>Internally displaced person</td>
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<td>IPC</td>
<td>Infection prevention and control</td>
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<td>IYCF</td>
<td>Infant and young child feeding</td>
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<td>LGA</td>
<td>Local government area</td>
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<td>Primary healthcare</td>
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<td>Prevention of mother to child transmission</td>
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<td>Psychosocial support</td>
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<td>Ready-to-use therapeutic food</td>
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<td>SAM</td>
<td>Severe acute malnutrition</td>
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<td>SC</td>
<td>Stabilization center</td>
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<td>SRH</td>
<td>Sexual and reproductive health</td>
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Introduction

Since 2009, the population living in northeast Nigeria, which is currently 24.5 million people, have been directly or indirectly affected by the Boko Haram conflict. With swaths of populated land largely inaccessible until government action in late 2016, northeast Nigeria has been beset with violence, decimation of livelihoods, rampant political instability and disrupted services. More than 20,000 people have been killed and an estimated seven million need humanitarian assistance. Northeast Nigeria hosts 1.7 million internally displaced persons (IDPs) with 1.3 million residing in Borno State alone. Healthcare and water supply infrastructure were destroyed, skilled healthcare workers were displaced through migration or disability and many were killed. Health commodities/medical supplies are largely absent or in short supply, due to insecure logistics and transportation systems. The conflict has rendered WASH, health, nutrition, protection and HIV/AIDS management services inadequate to serve the current needs. Having implemented PEPFAR/USAID-funded TB/HIV/AIDS projects in Borno state before 2009, FHI 360 witnessed first-hand the havoc wreaked and recognized the critical need for lifesaving interventions to restore functioning health and other service systems.

FHI 360 has been present in all 36 states of Nigeria since 1986 and was therefore well-positioned to increase operations into newly liberated LGAs and deliver urgently needed support. This document showcases response activities in 2017, namely to:

- Examine the evolution and adaptation of FHI 360’s response in Northeast Nigeria
- Provide critical lessons learned that can be adapted to other humanitarian response contexts
In collaboration with government agencies, and international and local partners, we expand access to HIV/AIDS, tuberculosis, malaria and reproductive health services; strengthen health care delivery systems; improve water, sanitation and hygiene conditions; provide services for survivors of gender-based violence; increase food security; and improve education for children.

FHI 360 has been present in Northeast Nigeria for the last 15 years, including 10 years in Borno state. We have maintained offices in Adamawa, Borno, Bauchi and Yobe states since before the insurgency, to present. Of the 685 FHI 360 staff in Nigeria, nearly 165 are in Northeast Nigeria, and 116 in Borno State alone. The Borno state office implemented six projects over 2017 funded by OFDA, USAID, Shell Nigeria Exploration and Petroleum Company Ltd. (SNEPCo), UNHCR UNFPA and The Global Fund. Below is a summary of FHI 360’s 2017 programs in the northeast:

**Integrated Humanitarian Assistance to Northeast Nigeria (IHANN)** – funded by the Office of U.S. Foreign Disaster Assistance (OFDA) between January 2017-March 2019. IHANN targets more than 150,000 IDPs to contribute to reduced morbidity and mortality and improved wellbeing of conflict-affected and displaced Nigerians in three affected LGAs across Borno State (Dikwa, Ngala and Bama). IHANN delivers targeted interventions that are designed to meet the most pressing needs of IDPs in primary/reproductive healthcare, nutrition, gender-based violence protection and water, sanitation and hygiene.

**Integrated Humanitarian Assistance Project for IDPs in Dikwa (IHAP)** – funded by the Shell Nigeria Exploration and Petroleum Company (SNEPCo) between January 2017-December 2018. IHAP targets 50,000 IDPs in an area of Dikwa currently not covered by the IHANN project. IHAP has established a primary health facility in Bulabulin, rehabilitated a solar-powered borehole and established a safe space for psychosocial support and case management for survivors of GBV. Additionally, IHAP provides support for infant and young child feeding practice (IYCF) in Dikwa.

**Strengthening Integrated Delivery of HIV/AIDS Services (SIDHAS)** – funded by PEPFAR through USAID. FHI 360 leads a consortium to sustain integration of HIV/AIDS and other related services by building Nigeria’s capacity to deliver sustainable, high-quality, comprehensive prevention, treatment, care and related services in 13 states across Nigeria. In the northeast, SIDHAS works to increase access to HIV services primarily through health facilities at all levels of the health system. In response to the needs of persons displaced by the ongoing conflict, SIDHAS now provides services to IDP populations within Maiduguri and in Adamawa state.

**United Nations High Commissioner for Refugees Internally Displaced People Protection (UNIPP)** – funded by UNFPA. IRMH’s goal is to meet the most urgent reproductive health (RH) needs of over 120,000 conflict-affected under-served adolescents, youth and women through gender sensitive, rights based approaches within host communities and IDP camps in northeast Nigeria. Activities included making advocacy to stakeholders, community sensitization/mobilization, capacity building for sexual and reproductive health (SRH) conducting outreaches and provision of equipment in supported facilities.

**Northeast Initiative for HIV (NEI)** – funded by Global Fund. NEI improves the quality of life for the infected and affected, providing Nigerians with universal access to high quality, patient-centered prevention, diagnosis, and treatment services for TB and HIV. NEI targets 50,000 in the northeast with HIV testing services and plans to initiate 5,000 persons living with HIV on ART in Dikwa, Ngala and Banki; thus integrating services with the IHANN and IHAP projects. NEI began in October 2017 and is health facility-based with a strong IDP mobilization/outreach component.

**Integrated Reproductive and Maternal Health (IRMH)** – funded by UNFPA. IRMH’s goal is to meet the most urgent reproductive health (RH) needs of over 120,000 conflict-affected under-served adolescents, youth and women through gender sensitive, rights based approaches within host communities and IDP camps in northeast Nigeria. Activities included making advocacy to stakeholders, community sensitization/mobilization, capacity building for sexual and reproductive health (SRH), conducting outreaches and provision of equipment in supported facilities.

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**History and Program Evolution with Insurgency**

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From HIV/AIDS Management to Humanitarian Response

For the SIDHAS project, everything evolved based on need and in response to the situation. Due to the insurgency, the health system, including physical structures and supply chain systems, were disrupted. People previously accessing ART services through SIDHAS were displaced; health facilities and whole communities became inaccessible and clients could no longer gain access to life-saving treatment, care and support services. Sexual violence and sexual exploitation escalated during conflict, further fueling HIV transmission. At the peak of the conflict in 2015, only two out of 13 supported facilities in Borno were accessible.

As IDP camps became established in the metropolis, it became imperative for SIDHAS to assess availability of services in the camps and to identify people living with HIV and AIDS (PLWHA) previously enrolled into SIDHAS-supported ART services.

The assessment revealed that only five of the 15 recognized camps in MMC and Jere LGA had some form of non-standardized HIV/AIDS services. Furthermore, none of the camps had services for ARV refill or comprehensive HIV/AIDS treatment and care services. With support from USAID, these services were established in the camps. Dr. Yusuf Ahmadu, FHI 360’s Senior Technical Officer for PCT, added: “The main concept was to find previously known HIV positive clients who had been displaced and restart them on treatment. It then evolved as we began testing and enrolling new clients who needed services in the IDP camps.”

FHI 360 already had strong collaboration with the GoN and they were pleased to see effort by SIDHAS to provide support to displaced persons. The project formed two mobile teams to provide comprehensive ART services in 15 IDP camps. Each team consists of two doctors, two pharmacists, four nurses/midwives and two laboratory scientists. “In the camps, we further coordinated with IDP camp clinic management to identify displaced health workers, based within the camps, who could be trained to conduct HIV testing,” added Mansa Adamu, FHI 360’s Borno State Program Manager.

General healthcare was already being provided in IDP camps, thus SIDHAS integrated the HIV/AIDS components into general health services using a client-initiated approach. To guard against stigma and maintain confidentiality, the services are provided in a house where privacy is maintained. The mobile team is co-located in clinics in the IDP camps with other partners. In addition, SIDHAS-trained community volunteers to inform IDPs about the activities of the SIDHAS team and location within the camp where service could be accessed.

At the center of mobile ART interventions is camp coordination and community engagement. Mobile teams are trained to disseminate culturally and linguistically appropriate messages on HIV prevention, stigma reduction and anti-discrimination in Kanuri and Hausa. The mobile ART teams participate in camp management activities coordinated by SEMA/NEMA, IDP representatives and traditional leaders. This not only builds trust between the community and mobile ART teams but also allows for FHI 360 to learn about the most pressing needs and challenges in the camps. ART teams continuously advocate mainstreaming of HIV/AIDS awareness in camp activities and provision of basic assistance to PLWHAs to camp management.

“This aspect of the SIDHAS project has allowed us to identify IDPs who are HIV positive and availed many of them the opportunity to access care in a very comprehensive manner right at their door-steps,” commented Dr. Yusuf. He continued: “This was a very novel idea to begin with. There are no local context-specific templates for implementing comprehensive ART services in IDP camps. Our mobile ART teams have been so proactive and innovative and that has made us successful.”

Kolawole Olutunbosun, Senior Technical Officer for Care and Support for SIDHAS, provided the following statement when asked why FHI 360’s shift to this approach in the northeast was important:

“You cannot just limit your work to HIV or health. A lot of health and HIV problems are not just about health. They relate to education or other environmental factors sometimes. What FHI 360 has done in Borno is deal with humanitarian challenges whereby a basket of solutions is provided to a basket of problems; we approached problems from multiple fronts. The problem may not be HIV, it could be access to water, protection, malnutrition or anything else. The challenges in real life are not clear cut so the solutions must be tailored to respond accordingly. FHI 360 has done this in the SIDHAS program and our other humanitarian programs by remaining flexible, creative and quick to respond.”

SIDHAS built critical relationships with the GoN actors in the northeast, providing a stable foundation for FHI 360 to grow in the region. “The IDP interventions showed us that we could provide HIV/AIDS services in an emergency setting and the government recognized that we were actually providing humanitarian services,” said Adamu, “Health sector and protection sector meetings started being held in our office. This developed the skills of our staff in humanitarian response. Additionally, the mobile ART strategy’s IDP-focused approach paved the way for FHI 360 to expand into other LGAs to provide life-saving services.”
In northeast Nigeria, this translates to delivery of interventions that span multiple sectors through common service delivery points and/or community-based mechanisms. FHI 360’s health facilities provide not only direct clinical services but also health and hygiene outreach and education, support for IYCF and management of SAM, GBV medical treatment and referral to secondary health and other services. The integration of health and WASH in the clinical treatment of disease and fueling behavior change was particularly effective during the cholera and HEV outbreaks in Dikwa and Ngala, respectively.

FHI 360 has enhanced its ability to screen and make referrals for a range of nutritional, health and protection needs among IDPs and households across multiple sectors, thus improving coverage and building local capacity to encourage sustainability after the end of the project period. Consolidating service delivery points and community outreach mechanisms has relieved the burden on IDPs and vulnerable individuals and increased service-seeking behaviors.

**Integration in Action**

Henry Omara, WASH coordinator, describes the rationale behind the integrated model: “We chose this because all the issues we work with are cross-cutting. You cannot talk about preventative health, especially with malaria or diarrhea, without talking about WASH. You cannot talk about improving lives, especially women, without talking about protection. To improve people’s lives the most, we had to integrate sectors.”

Health staff in FHI 360-supported facilities receive awareness every morning to pass on to their patients. “The WASH team sends two volunteers to visit the clinic and talk about hygiene promotion. If a patient comes in with extremely dirty clothes, we will explain to them the importance of personal hygiene while referring them to the WASH team to receive a hygiene kit to help prevent the spread of disease,” said one health worker at Ngala PHC clinic.

WASH and protection activities also regularly integrate as volunteers visit safe spaces to discuss handwashing, food hygiene and other things that women may not feel comfortable sharing outside like menstrual hygiene. Omara commented: “I was amazed when I went to Ngala and saw WASH volunteers taking a woman to the safe space after she told them she was a GBV survivor.” “They not only deal with issues related to water,” he said, “but they are also trained to refer patients in need of medical care, nutritional support or GBV services to right place and at the end of the day, this is how you achieve the project goal.”

The protection team regularly conducts GBV safety audits where women share risks of GBV, often at water points, toilets or other facilities. The protection team takes this information to the WASH team to respond and ensure these issues are rectified. “Sometimes they may tell us that a proposed location for latrines is in a dark area or is too isolated and this puts them at risk, so we adjust our plan to ensure protection,” said Omara.

FHI 360’s protection and health teams work together through a two-way referral system. Protection staff refer cases of sexual violence to the health facilities to receive the care they need, including post-exposure-prophylaxis (PEP). Likewise, health staff refers cases of sexual violence to the safe space to ensure survivors get psychosocial support and access to other GBV response services. Tamara Obonyo, protection coordinator commented: “This type of integration not only contributes to multi-sectoral service delivery to survivors, but it also allows us to do easy follow up because we have a close relationship with the health team. We can always make sure survivors are getting the services they need at each stage of treatment.”

As community volunteers visit safe spaces to discuss hygiene promotion, midwives also visit regularly to talk about sexual/reproductive health, especially the importance of antenatal and postnatal care. Obonyo notes that “this increases knowledge and empowerment and in the end, it means more women reach services. I have personally seen how this integrated approach increases access to reproductive health services, especially with antenatal care.” When women receive such information in a safe space, many cultural factors that would cause embarrassment or shame are not present, allowing them to comfortably receive messages.

FHI 360 plays a unique role in Borno as both a development and humanitarian NGO. No other partner is conducting an integrated humanitarian program while also providing comprehensive HIV/AIDS services. Therefore, integration applies not only to sectors but also to projects. Dr. Abba Goni, project coordinator, highlights the importance of this: “The fact that the NEI project is working directly in the IDP camps is very pivotal to our operation. We know that HIV is a problem in these areas due to increased sexual violence and lack of education but before, IDP populations had almost no access to services. Now NEI staff work directly in the health facilities doing testing, counseling and treatment.”
When the IHANN team arrived to conduct its initial assessment in late 2016, 3.1 million people in northeast Nigeria needed WASH support. In Borno State alone, an estimated 758 water facilities had been destroyed, and 591 had been partially destroyed. Additionally, even in camp settings where some WASH facilities were in place, given the rapid influx into camps, humanitarian partners were unable to keep pace with the need.

“You would see such long queues of people waiting all day for water,” said Henry Omara, WASH coordinator. “People would have to fetch water from far and go home to wash clothes then come back the same day to fetch more,” he continued. This process meant that some women and children would spend several days each week just waiting for water.

While FHI 360’S WASH interventions through the IHANN and IHAP projects have strong hardware components, Omara stresses the importance of software: “There was very little water and latrines but hygiene promotion was the key intervention people needed. Without proper hygiene practices, water and latrines are not as effective. I remember seeing children filling dirty jerry cans for drinking water and children playing in drainage pits and I knew our project had to focus just as equally on hygiene promotion.

“At the same time, as we provide messages for hygiene, we have to provide them with water to wash their clothes and hands and latrines to use. You cannot tell an IDP to wash their hands without giving them water and soap.

“We noticed existing emergency latrines that were shallow, dirty and not well-maintained. Therefore, decided to provide latrine cleaning kits to keep them clean and safe for use.”
An estimated 41% of health facilities were reportedly partially or completely destroyed in 2016. Recently liberated areas and those still under Boko Haram control also lacked qualified health staff. A lack of medication, supplies, and trained health workers had increased the risk of disease and outbreaks.

Dr. Kibebu Berta, PHC coordinator gave his impression from when he arrived, “What I saw was very shocking. Dikwa and Ngala were each served by one health facility and both were overstretched. They had to turn away hundreds of patients a day because they were at capacity. This meant more cases of communicable and non-communicable disease, more complicated pregnancies, and poor referral systems for serious ailments.”

Dikwa General Hospital is receiving most of the caseload, highlighting the need to provide mobile health services/outreach, especially in places where there is not a nearby facility. “Now our health workers go out with CHEWs on a weekly basis to provide treatment and referral directly in the community; some IDPs live far from the facility and it is up to us to create awareness and bring care to them,” said Dr. Berta.

Dr. Berta highlighted the importance of FHI 360’s ability to collaborate with WHO and the Borno State Government: “WHO has built our staff capacity, providing us with training on several topics including inpatient management of severe acute malnutrition. We provide them with disease surveillance statistics through the early warning and reporting system (EWARS) and we receive feedback every time there is an alert.”
After five months of implementation in Dikwa and Ngala, OFDA approached FHI 360 to expand into Banki and the nutrition sector. While FHI 360 was developing the nutrition strategy, there were an estimated 3.1 million individuals in need of food assistance, and 250,000 children were severely acutely malnourished. Undernutrition contributes to increased morbidity and mortality, impaired intellectual development, suboptimal adult work capacity, and increased risk of disease in adulthood. Moreover, malnourished children are roughly three times higher risk of mortality from common communicable diseases than if they were well-nourished. Children with SAM may be up to nine times as likely to die compared to those who are not undernourished.

Dr. Berta, who was developing the strategy, noted that in FHI 360’s operational areas, partner nutrition programs were – like health facilities – overstretched. “There were no stabilization centers (SCs) in Dikwa, Ngala or Banki so we saw this gap and decided to intervene,” he noted. FHI 360 also calculated caseloads and determined that partner outpatient therapeutic programs (OTPs), whereby parents bring their malnourished children on a regular basis to receive supplementary food, did not have the capacity to meet the need on ground. “There were not well-designed IYCF [infant and young child feeding] programs or systems in place, meaning that most pregnant and lactating women were unaware of good nutritional practices for themselves and their children,” Dr. Berta continued.

FHI 360 is now operating SCs and OTPs in Dikwa, Ngala and Banki, partnering with UNICEF to receive ready-to-use-therapeutic food (RUTF) and has treated more than 540 cases of severe acute malnutrition (SAM) with medical complications.
Protection

For IDPs coming out of Boko Haram-controlled areas or in newly liberated areas, there are urgent protection needs. Even before the height of the conflict, in 2013, an estimated 30% of women in northeast Nigeria were gender-based violence (GBV) survivors—a figure that has likely increased since the escalation of conflict.

An estimated 1.5 million girls have been affected by GBV in northeast Nigeria. The conflict and displacement puts women/girls at heightened risk of not only rape, but also forced or early marriage, sexual exploitation, and/or using sex to support family needs (i.e. in exchange for food, critical household items/relief items, etc. given the extreme level of household vulnerability).

Tamara Obonyo, describes the conditions on ground when she arrived: “There were no GBV-specific actors in any of the places we are now operating. Military operations were going on actively and girls were returning from captivity and sometimes being rejected by their families, further putting them at risk. There were no actors to provide support to these survivors who were facing stigma in their own communities. There was no post-exposure-prophylaxis (PEP) care for rape victims so we saw this as a gap that our integrated program could fill. Female-headed households were and are at exceptionally high risk, especially the younger ones. It is their responsibility to feed their children and you would see them going out in the street begging. This often leads to them engaging in sexual activity as a means of survival. It was up to us to come up with a system to provide them with positive coping mechanisms.”

FHI 360 mainstreams protection into all elements of programming. For example, the protection team holds regular sessions on sexual exploitation and abuse, referral mechanisms and GBV guiding principles for survivors targeting WASH volunteers and community health extension workers. Obonyo describes this as “a coordinated outreach for all sectoral teams that takes into consideration all risks for GBV so that anyone can refer cases to the appropriate services.”

Obonyo noted that setting up safe spaces meant women could come and share experiences and build social networks practiced before the insurgency. These groups traditionally have governance systems, bylaws and processes for electing leaders.

“Before, everyone was sitting in their own rooms in pain; they had to suffer in silence,” said Obonyo “and now they are in a place where than can talk freely, laugh, have a conversation and feel connected with women like them.”

2,200 WOMEN REACHED through GBV services
738 RECEIVED dignity kits
167 TRAINED in GBV prevention and response
140,000 COMMUNITY MEMBERS REACHED through GBV outreach and awareness activities
During the Hepatitis-E outbreak [Ngala] and the cholera outbreak [Dikwa], the bulamas and community leaders were actively engaged with us. We went out to meet them in both places and explain the situation and the risks that they faced. They were supportive and worked hard to mobilize their communities for disease prevention and control.

I remember the day after we received the first case, I went to meet with the lawan [traditional title] in Bulabulin, which was ground zero for the cholera outbreak. We discovered latrines near the first cases that were overflowing and crumbling so we surmised that this could be the cause. We engaged him [lawan] to ensure his people would not use the latrines until we could desludge and clean them and he did just that. His cooperation was essential.

Building Trust to Fight Disease Outbreaks

Dr. Kibebu Berta, PCH Coordinator

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Tamara Obonyo describes her team’s community engagement strategy: “Traditional leaders, bulamas and religious leaders are key for us. At the inception of the project, we informed the leaders – of whom the vast majority are male – about the services we provide and our linkages with other services such as legal, food distribution and health. We need their buy-in so they encourage women to come and discuss issues that affect them in a culturally appropriate way. Traditional leaders often refer sexual violence cases to the hospital and then to the safe space afterward. To me, this is a success.”

During protection outreach, the first points of contact for FHI 360 are the bulamas, who are invited to sit in all sessions and pass on messages focusing on non-stigmatization of GBV survivors and referral of sexual violence cases. There are talks in the mosques with religious leaders to discuss women’s rights and prevention of GBV. “We hold trade fairs where women can come show the things they have made in the safe space like soap, clothing and others,” Obonyo said. “This gives the women a sense of pride but also lets the community leaders see what the women are doing,” she continued.

FHI 360’s outreach work is done through trained community volunteers – or community health extension workers (CHEWs) in the case of health – to spread awareness, and educate IDPs and host communities with critical messages related to each sector. When selecting these personnel, FHI 360 explains the roles and responsibilities of the position with community leaders and they in turn recommend trusted members of the community capable of taking on such work.

“From the beginning, we focused on building a strategy that would empower the leaders and the IDPs themselves,” said Henry Omara, WASH coordinator. Traditional leaders drive the process of selecting locations for WASH facilities like latrines after FHI 360 staff explain the standards to them. After selecting locations, they are then asked what their contribution will be to the process and often they will provide labor. FHI 360 asks latrine contractors to employ the community for their unskilled labor needs. “This makes them feel empowered as they are participating directly in the project but more importantly, it gives them a sense of ownership that drives them to maintain the facilities and keep them clean,” continued Omara.

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Timothy Golfa, Dikwa Field Coordinator
Jummai Habila, a midwife in Yobe state, knows all too well the consequences the insurgency has had on the health of women and girls in northeast Nigeria. “This crisis cost many people their lives and has left thousands displaced and pushing them into extreme poverty and without access to reproductive health services like family planning, deliveries, post abortion care, post-partum care, counseling and referrals,” she said.

Habila is one of 23 health workers engaged in April 2017 by FHI 360, in collaboration with Achieving Health Nigeria Initiative (AHNi), as part of the UNFPA-funded Integrated Reproductive and Maternal Health (IRMH) Activity in Humanitarian Settings. The project was implemented in the conflict-affected states of Adamawa, Borno and Yobe states.

Because of the insurgency, healthcare infrastructure had been destroyed; skilled healthcare workers lost through migration, disabilities or death. Health commodities/medical supplies were largely absent or in short supply, due to weak logistics systems. “As health workers, we were always conscious of the threat of attacked by insurgents. However, it was fulfilling to be at the frontline of a program which has impacted so many lives,” said Abdullahi Nzika, Field Coordinator, Borno State.

IRMH’s intervention was designed to reach underserved women and girls displaced or affected by the Boko Haram Crises. Working through FHI 360 and AHNi, UNFPA engaged 10 midwives, five community health extension workers (CHEWs) and five monitoring and evaluation (M&E) assistants to deliver services in five mobile teams. These teams delivered high quality mobile outreach services such as family planning (FP) including long acting and reversible contraceptives (LARC), Sexual and reproductive health (SRH)/FP counselling was provided as part of mobile health services for people of reproductive age; with options to opt out. Health facility/mobile clinic’s capacity was built to provide RH services in eight core areas: family planning (FP), HIV testing services (HTS), screening and management of sexually transmitted infections (STIs), post abortion care, ante-natal care, clean and safe delivery services, post-natal care and clinical management of rape. By the end of November 2017, more than 120,000 individuals were reached with integrated reproductive and maternal health services across the three states.

Another one million were reached with SRH information. “Working in the NorthEast Nigeria has its challenges, but we defied all odds. We moved through rugged terrains, we pushed trapped vehicles out of the mud and we worked overtime to ensure the job gets done. I am proud to be part of the team that piloted the UNFPA IRMH Intervention project in hard to reach areas of Yobe State.” – Jummai Habila, Midwife, Yobe state.

**KEY REPRODUCTIVE HEALTH INDICATORS**

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<thead>
<tr>
<th>HIV PREVALENCE (HSS 2014)</th>
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122,756 individuals reached with SRH/FP services in Adamawa, Borno and Yobe States. Including 1,219 adolescents.

22,707 individuals received Family Planning Services across Adamawa, Borno & Yobe State.

397 mobile medical outreach provided across LGAs Adamawa, Borno and Yobe States.

383 individuals received Sexual and Gender Based Care.

342 communities in Adamawa, Borno and Yobe States reporting SRH services through mobile outreach.

71 HCWs across Adamawa, Borno and Yobe States were trained on LARC services provision and SGBV care and counselling in supported facilities.

50 facilities receive SRH/FP services activation through provision of consumables/equipment across Adamawa, Borno and Yobe State.

“Working in the NorthEast Nigeria has its challenges, but we defied all odds. We moved through rugged terrains, we pushed trapped vehicles out of the mud and we worked overtime to ensure the job gets done. I am proud to be part of the team that piloted the UNFPA IRMH Intervention project in hard to reach areas of Yobe State.” – Jummai Habila, Midwife, Yobe state.

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An Overview of UNIPP

Given the prevailing insurgency in northeast Nigeria, prevention and response to violations against women and children remains a complex large-scale concern further complicated by culture of silence, stigma and gaps in socio-economic and psychosocial support. UNHCR, in partnership with FHI 360, implemented the delivery of protection and mixed solution for vulnerable internally displaced persons in 12 LGAs across Adamawa, Borno and Yobe States. This was targeted towards enhancing psychosocial and physical well-being of survivors by providing support access to all forms of physical and social protection through access to medical care, safe and confidential reporting systems and centers with the objectives of improving quality of registration and profiling of vulnerable IDPs in northeast Nigeria.

Profiling and Referrals in highly diverse and deserted communities in Michika LGA

With existing social strata and religious issues in Michika LGA, our success story started from the point of selecting community volunteers on an equal opportunity stance to better relate to persons of concern (POCs). Our arrival in deserted communities of Jobi, Jan, Dondomi, Kuburshawshaw and Chai communities resulted to a common saying among POCs: “we never imagined that an INGO would sit with like this; we thought nobody could cross these roads just to find out how we are faring. We are glad you know we exist.”

We realized that communities like Jobi, Jan, Dondomi, Kuburshawshaw and Chai were yet to feel the impact of humanitarian interventions. We were glad to have been able to fill the gap and provided adequate referrals. Referrals enhanced our implementation. We referred cases of malnutrition, tuberculosis, continuous bleeding after still birth and SGBV. We were able to achieve this through working in tandem with our SIDHAS supported facility and committed CV’s and staff.

Amy Gaman, Project Officer
UIPP, Adamawa State

This project has improved the life of individuals living in this community in different ways, not just based on cases being referred, also the sense of belonging and reassurance to POCs. On our part, it brought learning and resilience.

Nuraddeen Sambo

“Referrals enhanced our work and boosts the confidence POCs have on our program. We referred cases of malnutrition, tuberculosis, continuous bleeding after still birth and SGBV. We were able to achieve this through working in tandem with our SIDHAS supported facility and committed CV’s and staff.”

Building Response Capacity: Q&A with Yves Kavanagh, Associate Director, Operations and Logistics

One of the most important tools in disaster and conflict relief – logistics – determines the speed and effectiveness of a given program. Yves Kavanagh, Associate Director of Operations and Logistics for FHI 360’s West Africa and Middle East Regional Office. He discusses the process of adaptation from development to humanitarian logistics capacity.

What was the first difficulty you recognized in the environment here?
Supply chain. In an insecure setting, there is little certainty for ground transport – from drugs to consumables to water and even food. We rely on escorts to move goods and often face delays or cancellations. It’s even more challenging because we aren’t allowed to pre-position critical items like pharmaceuticals in the field because it makes our warehouses targets for theft.

How has the team responded to this?
First, we had to ensure we were always linking up to the logistics cluster and security actors to ensure safe passage and movement of critical goods. We are constantly working to build the capacity of our field teams to give us regular and accurate stock updates and requests. We don’t wait until our supplies are depleted before sending replenishment. Field teams make requests with a two-week buffer now, allowing for potential delays due to security, weather or any other factors.

When looking specifically at procurement, what have you seen as especially difficult and what have you seen change since you arrived?
Finding qualified vendors per FHI 360 policy here was very difficult. Rather than procuring from Abuja, we had to take a different approach. Our goal was to support the local markets by buying locally from Maiduguri while also making it quicker for us to get what we need. The only downside is that the market is quite small. There are only a few vendors providing the wide variety of items we need.

We made it an objective to build the capacity of our vendors. If they supply incomplete documentation, we sit with them and teach them what was missing. Overtime, we have seen improvements. Nine months into the program, we’ve started seeing a difference in the way vendors interact with us. They respond faster to our solicitation requests, they abide more accurately to terms and conditions and they provide more accurate documentation. This not only expedites our financial processes but it allows vendors to get paid quickly.

What are three lessons we have learned this past year?
First, pre-planning is vital. To properly resupply field sites, we’ve learned we always need to be three steps ahead. Security concerns, changes in the environment...
or poor weather should always be considered. These are not challenges; they are data that we use to plan. We can never take an escort or a flight for granted. Therefore, we need to pre-plan.

Second, our competitive processes give us advantage when compared to sole source procurement. By competing and bidding out our needs, we widen the sea of vendors from which we can select. The result is that we receive better quality at a better price and this quality is passed on to the beneficiaries.

Finally, vendors must simply be paid on time. This builds trust and attracts better business. Maiduguri is small and information travels fast. If an NGO fails to pay a vendor on time, others will find out and the best ones won’t sign contracts with that NGO. By ensuring timely payments, and by rewarding a quality job, we give credit to our name and are likely to attract the best vendors.

Lastly, what has been the proudest moment here for you?
The opening of Banki, especially the PHC clinic was our operations team’s proudest moment, mostly due to the obstacles we overcame. Roads were often blocked and full of checkpoints. Transporting materials took a long time. Establishing a supply chain and a communication line with security actors and other partners to open a clinic was tedious but we opened just two weeks after renovations began. Within the first week of opening, we had a full medical team. During that week, one woman came to our clinic with an intestinal blockage and we coordinated with security actors to refer her to a secondary health facility in Cameroon where she could receive surgery. If not for that, she may have died. We acted quickly to save lives and it was truly rewarding to be part of that.

Fast Outbreak Response and Control: For water-related diseases such as cholera and Hepatitis-E (HEV), integrated responses, especially in WASH and health, pose one of the most effective and efficient ways to respond as FHI 360 demonstrated in 2017. HEV in Ngala was caused by existing shallow emergency latrines that were overflowing due to rain. Drainage lines became filled, latrines waste flowed into them and children played in this water, further spreading the disease. FHI 360 immediately began working with TLs to decommisison the latrines while explaining the dangers of using them to community volunteers who then passed the message to IDPs. In collaboration with Oxfam and SEMA, FHI 360 conducted intensive waste management activities in Ngala to clean drainage.

In the case of cholera and HEV, CHEWs and community volunteers worked together to do active case finding, contact tracing as well as referral to health facilities for treatment for treatment. Further integration with the protection sector allowed CHEWs and volunteers to conduct disease prevention and response sessions directly at the safe space to reach many women with messages at one time. As women are commonly caretakers who fetch water and manage household hygiene, these sessions proved especially useful.

Furthermore, FHI 360’S close relationship with the BSMoH and WHO allowed for quick mobilization of resources to respond to both outbreaks. Within one day of the first cholera case, BSMoH supplied FHI 360 with cholera beds and treatment kits to respond. WHO later prepositioned them in our facilities to ensure maximum preparedness. These relationships were pivotal in our response activities.

Integrating HIV/AIDS and Humanitarian Services: Having established itself as a major national actor in the fight against HIV/AIDS, FHI 360 is in a unique position compared to other actors in Borno state. FHI 360 is one of the few organizations in Borno running a fully-integrated health, nutrition, WASH and protection program. With leverage from SIDHAS and the Northeast Initiative for HIV (Global Fund), FHI 360 provides comprehensive HIV/AIDS management services in the humanitarian IDP context. When patients come to health facilities for any reason, they can get tested and, if positive, started on treatment immediately. Outreach staff, including CHEWs, can provide information about testing and further increase coverage. This type of integration has differentiated FHI 360 from other organizations and makes it possible to treat many health-related issues simultaneously.

Effective Community Engagement: For WASH, FHI 360 has demonstrated that engaging communities them from onset and throughout the life of the project makes them feel the facilities and project is their own. This increases ownership and the chances of sustainability. “Our CVs are selected from the camp itself and that alone makes the community feel like a part of the project,” said Henry Omara, WASH Coordinator. He continued: “We seek advice from them and it makes them participate more and the program runs more efficiently. No one fights when we distribute hygiene kits because the leaders chose the vulnerable beneficiaries.”