# OPERATION UPDATE

## Nigeria| Acute malnutrition

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| **Emergency appeal №: MDRNG042**<br>**Emergency appeal launched: 26/05/2025**<br>**Operational Strategy published: 08/06/2025** | **Glide №: FA-2025-000077-NGA** |
| **No cost extension Operation update**<br>**Date of issue: 08/06/2026** | **Timeframe covered by this update:**<br>From **25/06/2025 to 30/04/2026** |
| **Operation timeframe:** 12 months<br>(26/05/2025 – 25/05/2026)<br>**NCE proposed timeframe: 6 months**<br>(26/05/2026 - 30/11/2026) | **Number of people being assisted:** 1,000,000 |
| **Funding requirements (CHF):**<br>CHF 2.5 million through the IFRC Emergency Appeal<br>CHF 5 million Federation-wide | **DREF amount initially allocated:**<br>CHF 1 million |

*To date, this Emergency Appeal, which seeks **CHF 2,500,000,** is **32%** funded. Further funding contributions are needed to enable the Nigerian Red Cross Society, with the support of the IFRC, to continue with the response efforts by providing humanitarian assistance and protecting the vulnerable people affected by malnutrition. The request for six months no cost extension is to enable the NRCS implement remaining activities and utilise the funds balance to reach out to the affected communities. The remaining funds will support implementation of activities in the same geographical targeted areas considering the fact that most states have recorded more cases of Malnutrition than the time this operation started, this extension request is timely for the current nutrition situation in the target states.*


*NRCS volunteer showing a caregiver how to use the Mid Upper Arm Circumference (MUAC) tape during house-to-house screening for children 6-59 months. Photo: Aduratomi Bolade/IFRC*

# A. SITUATION ANALYSIS

## Description of the crisis

Since April 2025, when the Nigerian government declared a national emergency on food security, signaling alarm over the country's rapidly deteriorating nutrition, the situation has not experienced remarkable progress compared to recent nutrition trends.

The funding cuts experienced from the preceding year to date and recurrent crisis in middle east have continued to represent a dangerous convergence of multiple systemic shocks. Years of prolonged conflict, including the ongoing insurgency in the northeast and escalating banditry in the northwest and north-central crisis, have displaced over 3 million Nigerians, destroyed agricultural livelihoods, and severely restricted humanitarian access. These security challenges intersect with increasingly severe climate shocks – flash floods and dry spells have given way to prolonged droughts, creating a vicious cycle of crop failures and livestock losses. The microeconomic fallouts since the 2024 fuel subsidy removal and the recent 30% fuel increase due to the middle-east crisis and fuel pipeline disruption has further compounded the crisis for food and nutrition outcomes. Similarly, the 4-5% national health budget allocation reflects health underinvestment amidst rising population and disease burden: this further crippled already overstretched health systems.

What makes this emergency particularly dire is the breakdown of critical systems meant to protect vulnerable populations. As of late 2024 and till date, only 20% of Nigeria's 34,000 primary healthcare centers were fully functioning. Because of this, access to acute malnutrition treatment remains a major challenge, with less than 20% of Severe Acute Malnutrition (SAM) cases accessing integrated management of acute malnutrition services. Health services are overwhelmed, and the number of functional Outpatient Therapeutic Programmes (OTPs) is limited due to resource shortages. The data paints an alarming picture: over 1 million children are at risk of severe acute malnutrition with stunting rates exceeding 60% in the worst-affected regions.

Recently, the Cadre Harmonisé analyses for Nigeria corroborate the picture painted by the IPC Acute Malnutrition assessment: large swathes of northern Nigeria particularly in the **Northeast, Northwest, and North central zones** are classified in **Phase 3 (Crisis) and Phase 4 (Emergency)**, with pockets at risk of further deterioration during the lean season (high acute malnutrition period _ May-September). These classifications reflect the combined effects of **persistent insecurity, displacement, climate shocks, disease burden, and constrained access to health and nutrition services**, all of which are driving elevated levels of wasting, stunting, and food consumption deficits. Moreso, there has been a record of malnutrition surge from the administrative field implementations in Zamfara, Katsina and Sokoto

As a result, chronic malnutrition, affecting over 53% of children under five, has emerged not only as a health emergency but a human capital crisis, impairing cognitive development and perpetuating intergenerational poverty. Livelihoods remain precarious due to insecurity, extortion, and degraded ecosystems, with many farmers and herders forced to abandon their means of income. As a result, this has led to a collapse of rural value chains, rising food prices, and increasing youth unemployment, particularly among women and marginalized groups.

A significant number of children under 5 years in Nigeria are facing high global malnutrition (GAM) rates as per the assessment undertaken by UNICEF between Sept and Dec 2025. The assessment projects the situation to deteriorate across all regions in the second projection period (May to September 2026), in line with the peak malnutrition season. This indicates a dire situation for the year 2026, calling for concerted efforts to protect communities from the harms of negative coping mechanisms, and further being driven to destitution. The IPC reports covering states in North-East, North-West and Benue in North-Central Nigeria revealed that over 6.4M children aged 6-59 months were

malnourished with SAM record of 2M and MAM record of 4.4M among children under 5 years. A comparative implementation assessment by MSF in its northeast implementation states also showed 20% increase in its 2025 malnutrition treatments trends compared to its reach in 2024. This further sounds like an alarm for redoubled efforts to curb the malnutrition mayhem and its risk factors.

These predisposing factors have continued to justify the need for dire lifesaving interventions in the current affected states. The current emergency appeal avails such an eminent opportunity within the extended project phase to contribute to mitigating the rising morbidity and mortality, especially among young children and women.

# SUMMARY OF RESPONSE

**Overview of the host National Society and ongoing response**

The Nigerian Red Cross Society (NRCS) is one of the country's largest volunteer-based organizations with over 800,000 volunteers nationwide, spread across 36 States and the Federal Capital Territory (FCT), with divisions at the Local Government Area (LGA) level and detachments at the community level. Through ongoing response, the National Society has reached 253,185 households over and above initial targets of 170,000, amounting to 149% households beyond the projected target. The appeal will enable continuation of most needed response actions while also strengthening technical capacities of the branch teams for effective and impactful implementation oof management of acute malnutrition now and in the future.

So far, Volunteers and health staff have received several training sessions on Epidemic Control for Volunteers (ECV), Community-Based Health and First Aid (CBHFA), and are well-equipped to respond to health emergencies in their domains, in collaboration with the sub-national governments. Branch health officers coordinate activities of members of the Health Action Team (HAT) and support active management of the core functions of the society at the divisions/LGAs and detachment levels, where Health Action Teams (HATs) and Mothers Clubs provide strong support to the NRCS. This structure supports the implementation of general Health and Care programmes at community levels.

Notably, the NRCS implemented a SAM Disaster Response Emergency Fund (DREF) operation in Borno, Adamawa and Yobe States (BAY States) through trained volunteers and scaled-up malnutrition screening and referral activities, promoted nutrition education, including promotion of good Infant and Young Child Feeding (IYCF) practices. Building on the Mothers' Clubs, the NRCS created Papas' Clubs, an innovation aimed at enhancing family participation in nutrition activities, while also providing similar health and nutrition services to Cameroonian refugees across seven states (Lagos, Oyo, Cross River, Benue, Taraba, Kano and Akwa Ibom) under the UNHCR health and nutrition project. Furthermore, NRCS with support from IFRC and Czech Aid funding, has implemented a project in Zamfara state, aiming to strengthen food security and resilience through nutrition, livelihoods and climate change adaptation interventions. Finally, NRCS with support from the Norwegian Red Cross is implementing a nutrition and Community health project in Benue state. This Emergency Appeal will continue leveraging the capacity, experiences and volunteer presence in the 9 targeted states (Borno, Adamawa, Yobe, Benue, Zamfara, Katsina, Sokoto, Niger and Taraba).


Mothers club meeting in Borno State & Papas club session in Adamawa States

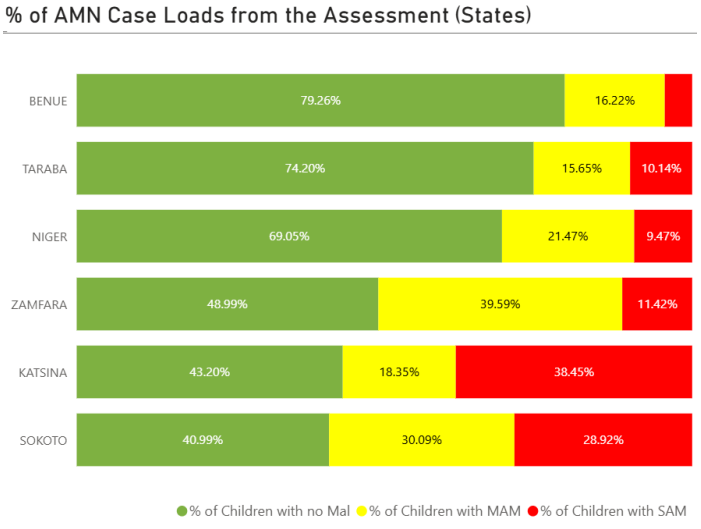
# NEEDS ANALYSIS

**Needs Assessment**

The needs analysis presented in the Operational Strategy, has been triangulated with a secondary data analysis and a needs assessment undertaken by NRCS with support from the surge team in July 2025 in Niger, Taraba, Benue, Zamfara, Katsina and Sokoto. The primary data collection for the needs assessment consisted of mass Mid-Upper Arm Circumference (MUAC) screenings, Key Informant Interviews (KIIs), Focus Group Discussions (FGDs), Household Surveys and Health Clinic Assessments. The data collection tools were reviewed by the NRCS technical leads and the surge team. The assessment was guided by evidence-based prioritization and targeting of available resources for context-specific planning and response strategies.

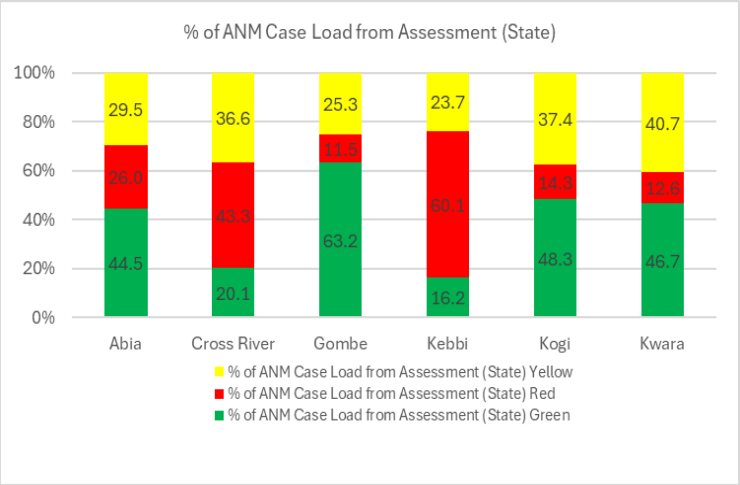
A second needs assessment was conducted in January 2026 in ten additional States (Gombe, Jigawa, Kaduna, Bauchi, Kebbi, Ogun, Kwara, Kogi, Abia and Cross River). The assessment data revealed Abia, Cross River, Gombe, Kebbi, Kogi, and Kwara with high GAM rates, referral trends, and critical service delivery gaps. This underscores the need for expansion of nutrition interventions across gaps identified areas though subject to fund availability.

**Health/Nutrition**: The data from the needs assessment conducted by the NRCS team in July 2025 showed the nutrition status of children under five screened for malnutrition, indicating an alarmingly high number of SAM and MAM cases, with precedence up to 50% in some states, as seen below. This assessment has facilitated the appeal implementation across the BAY states and the six states found with nutrition gaps. The assessment triangulated and provided a more detailed breakdown of needs and distribution of cases across the selected states and LGA's, which informed further operational planning.




The current crisis led to the immediate scale-up of Community-Based Management of Acute Malnutrition (CMAM) programs, with priority given to supporting active

OTPs with Ready to Use Therapeutic Food (RUTF) and strengthening Maternal, Infant and Young Child Nutrition (MIYCN) support to prevent further deterioration of children's nutritional status.
The second assessment conducted by the NRCS team in January 2026 indicated nutrition gaps across Abia, Cross River, Gombe, Kebbi, Kogi, and Kwara among children under five, with significant GAM rates beyond 60% for most of the accessed states. These accessed gaps as well as reports from secondary data, indicated a dire need for extension of current interventions and scale-up of both nutrition curative and preventive programs in areas of limited coverage. In the meantime, protracted gaps in the current implementation states calls for continued interventions.




Primary data collected from both analyses showed that financial access and distance to services are among the top barriers to healthcare across all assessed states. Furthermore, security barriers were identified as significant in Zamfara, Benue, Kogi, Gombe, and Cross River states. The situation is further exacerbated by compounded factors such as the freeze in donor funding, which has forced reductions in critical nutrition services just when they're needed most; a challenging lean season, which coincides with seasonal cropping shortfalls in several states due to climate shocks, as well as insecurity and displacements.

Delivering aid to these affected populations presents its own complex challenges, as the situation has largely remained the same and, in a few cases, expanded to other parts of the country, as seen in the second needs assessment conducted. Rampant banditry, inter-communal conflicts, and farmer-herder violence across multiple states have severely disrupted traditional supply chains. This necessitates careful, context-specific planning for aid delivery.

**Water, sanitation and hygiene promotion (WASH):**
The intersection of malnutrition and waterborne diseases has continued to present deadly threats that demand immediate WASH-nutrition integrated interventions. There is a bidirectional relationship between Acute Watery Diarrhea (AWD) and malnutrition, as malnutrition heightens risk and severity of AWD, while AWD can worsen malnutrition.

Priority is given to areas showing high incidences of water-related illnesses, where the vicious cycle of infection and malnutrition is most pronounced. Notably, the primary data collection found that only 12.15% of assessed households carried out any form of treatment of drinking water. Emergency WASH kits containing soap, and water purification supplies are being distributed to parents and care givers at the mothers' club, complemented by robust hygiene promotion campaigns to break disease transmission pathways.

Without these interventions, the nutritional gains from feeding programs will be undermined by preventable WASH related illnesses. Children recovering from malnutrition are particularly vulnerable to waterborne diseases, making integrated WASH-nutrition programming not just beneficial, but essential for saving lives. The window for prevention is closing fast as the rainy season progresses, and disease risks escalate.

## OPERATIONAL RISK ASSESSMENT

The operational risks remain as outlined in the Operational Strategy. A security assessment was conducted in July 2025 in six of the targeted nine states, resulting in a stronger mapping of security in the targeted states, as well as the development of standard operating procedures that include contingency plans for medical and security incidents for staff deployed to the locations which has been used throughout the implementation and is still guiding the teams activities. A detailed security assessment will also be conducted in the ten additional States, subject to availability of required funding for expansion.

# B. OPERATIONAL STRATEGY

## UPDATE ON THE STRATEGY

**Rationale for the No-Cost Extension**

Through this OU, a no-cost extension of six months is being requested to enable the Nigerian Red Cross Society, with support from IFRC, to complete ongoing priority activities, utilize the remaining appeal balance, and sustain life-saving nutrition, health, WASH, referral, and community engagement interventions in the existing targeted states during the peak malnutrition and lean season.

The extension is justified by the continued deterioration of the nutrition situation in the targeted states, where malnutrition needs have increased compared with the start of the operation. Recent assessments and projections indicate heightened risks during the May–September 2026 lean season, particularly among children under five and pregnant and lactating women. The extension will therefore help avoid disruption of community-based screening, referral of SAM cases to OTPs, follow-up of MAM cases through Mothers' and Papas' Clubs, supplementary feeding using available supplies, hygiene promotion, community engagement, and supportive supervision.

The no-cost extension will not involve geographic expansion. Activities will remain focused on the existing approved implementation areas, prioritizing high-burden communities and the efficient use of residual funds and available supplies. It will also provide time to consolidate gains achieved to date, maintain trained volunteer presence, strengthen coordination with government and nutrition partners, and continue resource mobilization to address remaining operational gaps.

**Location targeting, scale and activities**

All adopted strategies will remain and continue to be implemented during the appeal extension period across all 9 implementing states. The comprehensive needs assessments, alongside coordination with various external humanitarian agencies on their programming and humanitarian response gaps will also be considered as this may inform some changes to the operational planning.

Drawing on the first assessment of needs, ongoing humanitarian interventions, and available funding, NRCS has prioritized implementation activities in 9 states: Borno, Adamawa, Yobe, Niger, Benue, Sokoto, Katsina, Zamfara and Taraba. This is based on the highest needs identified and the priority to sustain activities beyond the Emergency Appeal implementation timeframe. Implementation of activities in Taraba state has just commenced in the first quarter of 2026 due to increased nutrition gaps amidst exiting humanitarian agencies' interventions.

After the decision was made not to directly establish or run OTPs but to support existing sites with supplies in consultation with other stakeholders, RUTF was procured and routinely distributed to existing OTPs being managed by government and other agencies (as there were supply pipeline breaks across existing OTPs). The support included

training of healthcare workers and some specialized volunteers to strengthen service delivery in those centres if the need was identified. This was therefore supported through other agencies and the Government. This decision was guided by two key considerations. First, the timeline of the operation and scale of available funding does not allow for the sustainable establishment and operation of new OTP sites, which require long-term investment in staffing, infrastructure, and supply chains. Secondly, sustainability and impact were promoted and best achieved by reinforcing and complementing the efforts of existing OTPs rather than duplicating services. By ensuring consistent availability of RUTF and building local human resource capacity, the programme was still contributing to ensuring access to life-saving SAM treatment while maximizing the use of limited funds and supporting a more resilient and coordinated nutrition response other stakeholders in the target areas. Indicators related to the running/oversight of OTPs within the Emergency Appeal have been updated to reflect the situation.

The needs assessment and engagement with external partners during the current implementation further provided a detailed overview of needs at the LGA level, as well as prevalence and functionality of OTPs in the targeted LGAs. This informed the decision on scope, scale and priority of interventions and supplies support at the state and LGA levels. To address identified gaps in access to nearby OTPs, NRCS also provides funding for transportation of complicated SAM cases requiring referral to stabilization centres. The needs are huge in all targeted states as far as provision of RUTF is concerned and any other malnutrition initiatives hence more resources required to cub the problem.

**Shared leadership approach**

IFRC, in support of Nigerian Red Cross Society (NRCS), channelled a proportion of funding available from the IFRC Nigeria Malnutrition Emergency Appeal to Norwegian Red Cross (NorCross) to support implementation of activities for Benue and Zamfara states. This approach builds on the existing partnership between NRCS and NorCross through its current engagement and support to and with NRCS on health interventions in Benue, and strategic interest to scale up longer term interventions in Zamfara. This is supporting the longer-term sustainability of interventions beyond the implementation timeframe of the Emergency Appeal. It also leverages the capacities, presence and interest of NorCross in the country and in the health sector in general, and underlines IFRC's commitment to the Agenda for Renewal, putting into practice the commitment to ensure appropriate support to the best placed actor for a specific action on the ground. The operational planning and strategy are well aligned with the larger framework of the Emergency Appeal.

In addition to the internal coordination between information management, PMER and health, the cell also worked externally with other Movement partners, relevant clusters and organizations to collect and analyse readily available data to challenge assumptions and build an evidence base and identified gaps which informed primary data collection and analysis.

In this reporting timeframe, maps covering needs, reach, and security were created, including a story map showcasing the malnutrition situation, a dashboard supporting analysis of the primary data collection, as well as a situational analysis snapshot in coordination with and for external communications.

Integrated with the deployment was capacity strengthening actions in agreement with NRCS, supporting the National Society in digital primary data collection tools (KOBO) and data visualization tools (Microsoft Power BI) for the response.

**Communication**

Scale-up of communications has been a key activity in the Emergency Appeal. Powerful storytelling and media production are essential for drawing urgent attention to the scale and human impact of the crisis. Through

photography, video, and interviews, communication vividly documents the situation on ground, amplifies the voices of affected communities, and showcases the life-saving work being carried out by responders.
As the emergency appeal activities continue to unfold, successes have been recorded across all aspects of the proposed interventions, one of these is presented below of a baby identified with Severe Acute Malnutrition by our team of community-based volunteers, referred to the nearest OTP site and was successfully treated from severe acute malnutrition.

*In Kolo Kauri community of Kaga Division, Borno branch, one of the dedicated Nigerian Red Cross volunteers carried out a follow-up visit to check on a child previously identified with Severe Acute Malnutrition (SAM) during an earlier MUAC screening. The child had been referred to the nearest health facility for treatment. On his return visit, the volunteer was delighted to find remarkable progress, the child had improved from SAM to Moderate Acute Malnutrition (MAM), showing visible signs of recovery, she was further referred to the Tom brown targeted supplementary feed program (Mothers' Club) for continued care and recovery from acute malnutrition. This moment highlights the power of consistent follow-up, community engagement, and the steadfast commitment of Red Cross volunteers to ensure that every child receives the care and attention they need to survive, recover and grow stronger.*


Other feedback from the community regarding the current implementation: https://x.com/ifrcafrica/status/2026204665310842892?s=46

# C. DETAILED OPERATIONAL REPORT

## STRATEGIC SECTORS OF INTERVENTION

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|---|---|---|---|
| | **Health & Care**<br>(*Mental Health and psychosocial support / Community Health / Medical Services)*<br><br>*PWDs (est. Pop. Indices, 10%)* | Female>18: 257,250<br>Male >18: 257,750<br><br>PWD Female ≈ 49,000<br>PWD Male ≈ 51,000 | Female<18: 232,750<br>Male < 18: 242,250 |
| **Objective:** | *Strengthening the holistic individual and community health of the population impacted through community-level interventions and health system strengthening* | | |
| | **Indicator** | **Actual** | **Target** |
| **Key indicators:** | # of volunteers trained and deployed for nutrition screening and referrals; CMAM, IYCF, CBS, and WASH | 810 | 4,500 |
| | # of community health workers trained in IYCF/OTP | 0 | 180 |

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|---|---|---|---|
| | # of children screened for acute malnutrition | 363,555 | 180,000 |
| | % of children screened and detected with SAM | 93% (25,215) of the target | 15% (27,000) of the total children screened |
| | % of children screened and detected with SAM, referred for treatment | 94% (20,320) of the target | 80% (21,600) of the SAM target |
| | % of children screened and detected with MAM | 125% (78,527) of the target | 35% (63,000) of the total children screened |
| | % of children screened and detected with MAM supported by the NRCS with supplementary feeding | 76% (38,220) of the target | 80% (50,400) of MAM target |
| | # of households reached with health and nutrition messages | 253,185 | 170,000 |
| | # of persons reached with messages on health and nutrition | 1,397,894 | 800,000 |
| | # of Mothers and Papas clubs formed (90 MC and 90 PC) | 180 | 100 |
| | % of Mothers and Papas club participants who demonstrate improved knowledge of key barriers and ways to overcome them | 0 | 0 |
| | # of pregnant and lactating women supported with micronutrient supplementation | 0 | Pending funding |
| | # of persons reached with OTP services | 0 | 0 |
| | # of Mothers clubs and Papas clubs supported to develop nutritious home gardens or poultry farm | 180 | 100 |

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|---|---|---|---|
| | # of PWD reached | 12,653 (3,966 male, 8,687 female) | N/A |

A total of 810 volunteers were engaged as compared to the 4,500 initially planned because of the limited resources mobilized and the reduction in the targeted numbers to be reached by the operation. These 810 volunteers have managed to carry out the planned activities within the limited scope of work versus the total available funding. The other reason was that the programme could not invest more in volunteer support with a limited number of activities; this had to be balanced.

In the reporting period, 810 volunteers from Borno, Adamawa, Yobe, Sokoto, Katsina, Zamfara, Niger, Benue and Taraba States were trained and deployed for the operation. The training covered Maternal, Infant and Young Child Nutrition (MIYCN) and hygiene promotion, MUAC screening, referral of children with SAM to OTPs, hygiene promotion, facilitation of Mamas and Papas Clubs, and the use of Kobo for data collection and management. The trained volunteers conduct routine door-to-door visits in the targeted communities to provide MIYCN education, hygiene promotion, and WASH messages to parents and caregivers. They also screened children aged 6–59 months using MUAC tapes and referred acutely malnourished cases and pregnant women to Mothers' Clubs, OTPs, and Primary Healthcare Centers (PHCs) for appropriate care and support. These activities are conducted 3 days a week; 2 days for house-to-house active case search and 1 day for Mother/Papas club meetings. Referral forms are used for SAM cases to facilitate referrals to OTPs, while MAM cases are documented in a dedicated MAM register for enrolment into the Tom brown TSFP with weekly growth monitoring and rescreening.

No health workers were directly trained by this emergency appeal but rather worked with those who were already trained by other agencies, including the Government.

Two inception meetings for the 9 priority States were held in Kano and Bauchi, with participation from NRCS and representatives of all 9 state Ministries of Health. This enabled the branches and state health authorities to stay informed, discuss the needs in their respective states, identify opportunities for inter-agency coordination, and develop state-level implementation plans based on available funding and the prioritization of assessments, which were conducted in July 2025.

During this reporting period, a total of 363,555 children have been screened across the nine States, 180 Mamas and Papas Clubs have established weekly meetings facilitated by trained community volunteers who also serve as community NRCS nutrition focal points. Key activities conducted in the Mamas and Papas club include MIYCN group counselling, hygiene promotion, Tom Brown supplementary food production, healthy cooking demonstrations, backyard gardening/poultry, and skills acquisition training.

These interventions are expected to strengthen community involvement, ownership and sustainability beyond the intervention period. Families are encouraged to take responsibility for their nutrition and overall well-being and children aged 5–59 months identified with MAM are referred to Mothers' Clubs for documentation, monitoring, and follow-up during mothers' club sessions.

A total of 25,215 SAM cases representing 7% of the total children screened for malnutrition have been identified by the volunteers in the communities, and 20,320 representing 81% of cases have been referred

to designated OTPs for treatment and follow-up. As planned to support existing OTPs with supplies, 5,000 boxes have been distributed to states based on needs (Sokoto, Zamfara, Katsina, Niger, Adamawa) to augment on shortages and supply pipeline breaks.

*Volunteers carrying out house-to-house screening for both mid upper arm circumference and Oedema*


During this reporting period, a total of 100 mothers/papas clubs have been formed, and 1,397,894 persons have been reached with nutrition (MIYCN), health (WASH) education and sensitization, including group nutrition counselling through the mothers/Papa's club meetings in the targeted communities. Also, at the mothers' club meetings, practical sessions on healthy cooking, demonstration and preparation of Tom brown supplementary food for MAM children are being conducted to teach women the right combination of food items for a relatively balanced nutrients as well as food hygiene.

Children with MAM identified by the volunteers during the house-to-house MUAC screening are referred to the mothers' club for registration, biweekly feeding, and weekly rescreening to monitor child recovery progress. Between August 2025 and March 2026, the volunteers have identified 78,527 MAM cases (22% of total children screened) out of which 38,220 (49%) children have been registered with the mothers' club for supplementary feeding. The first and second batches of Tom brown materials have been procured and distributed to communities and mothers' clubs, the first batch of commodities have been processed, and Tom brown production completed and distributed for MAM treatment, while the second batch is still in the process of production.



*Caregiver after receiving her last round of Tom Brown powder after weeks of successful feeding and growth monitoring.*

Twelve (12) Community model gardens and ten (10) poultry units have been established in Borno, Adamawa and Zamfara, serving as demonstration sites for men and women to replicate at the household level as well as sustainability outfits for community ownership. Proceeds from these initiatives will be used or sold to restock and expand the initiative to enhance family nutrition in the targeted Communities.


*Mothers' Club caregivers attending to their vegetable gardens and harvesting vegetables for household utilization*

Six (6) trained NRCS Health National Disaster Response Team (HNDRT) members are supporting the implementation of the Emergency Appeal, including step-down training of volunteers across the 8 targeted branches. The Federal and State Ministries of Health (MoH), Primary Health Care Development Agency (PHCDA), and the NRCS will continue conducting joint supportive supervision to strengthen the operational component of the appeal. This collaborative effort will enhance the quality implementation of the Appeal and strengthen coordination with relevant stakeholders.

It is important to note that the indicator on "tracking increased knowledge through Mamas and Papas Clubs" has been removed, as the club modality is based on drop-in sessions, with participants varying from week to week. Instead, the impact on the community and participants' knowledge is being captured through CEA indicators in community feedback sessions.

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|---|---|---|---|
| | **Water, Sanitation and Hygiene** | Female>18: 257,250<br>Male>18: 257,750 | Female<18: 232,750<br>Male<18: 242,250 |
| | | PWD_Female: 49,000 | PWD_Male: 51,000 |

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|---|---|
| **Objective:** | *Ensure safe drinking water, proper sanitation, and adequate hygiene awareness of the communities during the relief and recovery phases of the Emergency Operation, through community and organizational interventions* |

| | **Indicator** | **Actual** | **Target** |
|---|---|---|---|
| **Key indicators:** | # of households reached with hygiene promotion messaging, including hand hygiene demonstrations | 253,185 | 170,000 |
| | # of pregnant women reached with hygiene kits | 1,850 | 50,000 |
| | # of vulnerable households provided with hygiene kits | 2,000 | 10,000 |
| | # of households reached with water storage containers (jerry cans) | 0 | 20,000 |
| | # of households reached with multipurpose soap | 0 | 20,000 |
| | # of households reached with Aqua Tabs for water purification | 2,000 | 20,000 |
| | # of water supply units recovered | 0 | NA - Pending funding |

Most of the targets were not reached due to limited funding, as only a few states were supported in this sector. The HHs who benefitted from the distribution of 2,000 Aqua tabs and HH hygiene kits were selected based on the following selection criteria;

HH Kits and Aqua Tabs

- Families with SAM Children
- Families with MAM children
- PWDs

However, as there was a limited quantity, priority was given to parents with the highest number of SAM or MAM children (consistent attendance at the weekly meeting was the elimination criterion).

Additionally, amongst the 2,000HHs that benefitted, menstrual hygiene kits were distributed to targeted pregnant and lactating women who met the following criteria;

- Regular antenatal attendance
- Third trimester
- Delivered at the health faculties
- Breastfeeding child/children are fully immunized for their age at the time of distribution
- Pregnant or lactating PWD

Note: The households that received the NFIs are also part of the households reached with hygiene promotion and nutrition education/messages as indicated in the table.

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|---|---|---|---|
| | **Protection, Gender and Inclusion** | Female > 18: TBD | Female < 18: TBD |
| | | Male > 18: TBD | Male < 18: TBD |

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| **Objective:** | *Communities identify the needs of the most at risk and particularly disadvantaged and marginalized groups, due to inequality, discrimination and other non-respect of their human rights and address their distinct needs* | | |
| **Key indicators:** | **Indicator** | **Actual** | **Target** |
| | # of PGI assessments conducted and reported | 1 | 1 |
| | # of volunteers trained on PSEA/SGBV | 810 | 4,500 |
| | # of unaccompanied minors registered and supported through children's safe spaces | 0 | TBD |
| | % of people suffering from protection issues identified and referred to specialized services | 0 | 100% |
| | | | |

The needs assessment conducted in July 2025 and January 2026 integrated Protection Gender and Inclusion (PGI) needs, concerns, and priorities into the questionnaire, allowing for gender analysis. The results highlighted key protection concerns and barriers reported by respondents. The top three barriers across all states were financial access, distance to health facilities, and attitudes towards health facilities. In Zamfara and Benue, safety also emerged as a significant barrier. Cultural beliefs, including gender concerns, ranked relatively low across most states, while language barriers were not identified as a major issue. During the reporting period, no referrals were made for protection issues and reasons may not be far from the ones identified during the needs assessment as highlighted above.

These findings have been incorporated into the implementation. For example, financial barriers and distance to health facilities are being addressed by availing funding for transportation to the closest functional OTPs/PHCs. Poor health-seeking behaviour is being tackled through community sensitization activities, including Mamas and Papas Clubs, door-to-door visits, focused group discussions, community meetings, and other engagement platforms. Security considerations are also factored into the implementation process as volunteers were given basic security tips during the training, including duty of care for volunteers and SAF training. OTPs are located in proxy to the targeted communities, so the allocated funds to support parents to access RUTF commodities were not requested for by the branches, hence the zero reporting.

To promote dignity, access, participation and safety under this operation, dignified and safe inclusion is being factored into all program activities considering proximity, timing, infographic sensitization, age appropriation and local language considerations.

Protection from Sexual Exploitation and Abuse (PSEA) and Sexual and Gender-Based Violence (SGBV) modules were integrated into the training carried out in 9 states for the 810 volunteers that are engaged in the operation.

# Enabling approaches

## Secretariat Services

| Objective: | *Communities in high-risk areas are prepared for and able to respond to disaster* | | |
|---|---|---|---|
| **Key indicators:** | **Indicator** | **Actual** | **Target** |
| | # of surge personnel deployed | 10 | 10 |

All ten profiles identified were deployed and completed their missions. The last mission was for the Health Coordinator who left in September and handed over the operation to the Abuja cluster and Nigeria programme team. The following profiles were deployed:

1. Head of Operations (two rotations)
2. Deputy Head of Operations
3. PMER Coordinator
4. Humanitarian Information Analyst
5. Health Coordinator
6. Communications Coordinator
7. Mapping & Data Visualization Officer
8. Supply Chain Coordinator
9. Information Management Officer

The deployments were supported by IFRC, British Red Cross, Canadian Red Cross, Kenyan Red Cross, Malawi Red Cross, Danish Red Cross and Norwegian Red Cross. Meanwhile, the operation is being managed by the Senior Health Officer of the IFRC with support from the Health Officer from the Norwegian Red Cross in providing technical support to the Nigerian Red Cross.

## Community Engagement and Accountability

| Objective: | *Communities in high-risk areas are prepared for and able to respond to disaster* | | |
|---|---|---|---|
| **Key indicators:** | **Indicator** | **Actual** | **Target** |
| | *# of staff and volunteers working on the operation who have been trained in community engagement and accountability* | 880 | 4,500 |
| | *% of queries/feedback received through established feedback mechanisms that were responded to (feedback loop closed) – Please find below, a breakdown of the feedback received and acted upon* | 100% | 80% |
| | *# of feedback received through established feedback mechanisms* | 2,029 | N/A |

| | | | |
|---|---|---|---|
| | *# of appreciations, satisfaction, encouragements received* | 1,414 | N/A |
| | *# of questions, inquiries, requests concerns handled* | 615 | N/A |
| | *% of sampled community members who say they are satisfied with the support received from RCRC through PDMs* | 0 | 80% |
| | *# of Nutrition Ambassador sessions conducted with communities* | 0 | 200 |

The NRCS has continued engaging with key community leaders and stakeholders through community meetings (compound meetings, FGDs, and targeted advocacies), to build trust, enhance community acceptance, participation, and ownership for sustainability. 239 community entry meetings have been conducted in the targeted States where the house-to-house/mothers and papas club activities are currently ongoing. The volunteers are distributing Posters in both English and local language to the households, as well as posting them in strategic public places for public digest. A total of 15,000 IEC (10,000 in local language and 5,000 in English) materials were produced and distributed. Community feedback is also being gathered by the volunteers, using the pre-designed feedback form in the Kobo app which is transmitted to the server for analysis by the national CEA focal point majorly consisting of appreciations, inquiries and request for and about additional live saving services, and no sensitive feedback recorded. Toll-free lines are also disseminated to the households and mothers/papas club members to send private and/or sensitive feedback to inform programme messaging and communication to and with communities. A PDM for distributed commodities (NFIs) is planned within the NCE period. The tool for the exercise is being drafted by the PMER team for deployment among field participants who benefited from the distributions.

During the NCE period, Nutrition ambassadors will be identified within the respective communities. 200 Nutrition Ambassador Sessions will be organized towards the close-out of the operation as part of the sustainability plan of the project.

## Coordination and Partnerships

| **Objective:** | *Communities in high-risk areas are prepared for and able to respond to disaster* | | |
|---|---|---|---|
| **Key indicators:** | **Indicator** | **Actual** | **Target** |
| | *National Society has a membership coordination mechanism in place* | 1 | N/A |
| | *Number of government-led coordination platforms the National Society is part of* | 1 | N/A |

Coordination among the movement partners has been ongoing for this operation through the monthly health meetings with NRCS, Norwegian Red Cross, IFRC and ICRC where information on Malnutrition programme has been shared. Implementation of activities in Benue state has been done by Norwegian RC with support from all the partners. The Agreement that was signed between IFRC and Norwegian RC is ending by May 2026 and might not be extended due to limited funds to continue with direct implementation. In that case, IFRC will provide technical support to NRCS to continue the implementation in those state(s) (Benue and Zamfara).

**Supply Chain Coordination Support:**
IFRC continues to engage actors within the Logistics Cluster, conducting market analysis and actively engaging suppliers for RUTFs. In addition to the 5,000 procured in 2025; additional 1,506 boxes of RUTF were also procured in March 2026 and will be distributed to OTPs on needs basis. The NRCS Kano Branch warehouse was utilized to store RUTF and was renovated and equipped to increase and improve NRCS supply chain capacity.

**External coordination:**
In addition to engaging with the Nutrition Sector cluster, information sharing and coordination with a wide range of local and national authorities, non-governmental organizations and international organizations continue to optimize the reach of the operation while minimizing duplication of efforts.

# FUNDING

| Donor | Area of Intervention | Pledge (CHF) |
|---|---|---|
| Japanese Red Cross | Unearmarked | 27,001 |
| Canadian Red Cross | Unearmarked | 69,412 |
| ECHO | DREF Replenishment reallocated to the Emergency Appeal | 463,778 |
| Red Cross of Monaco | Unearmarked | 9,352 |
| British Red Cross | Earmarked for Mobilization Table | 212,804 |
| Turkish Red Cross | Unearmarked | 10,000 |
| Online Donations | Unearmarked | 2,551 |
| DREF Loan | DREF Loan | 1,000,000 |
| **Total funding available** | | **1,794,898** |

We extend our sincere thanks to all donors whose generous contributions to the Emergency Appeal have made the life-saving response possible. To date, this Emergency Appeal, which seeks CHF 2,500,000, is **32%** funded, excluding the loan from DREF. Total expenditure of funds received to date is 79% including the DREF loan and the request for extension is to utilize the **21**% balance of initial funds received while mobilizing more resources. Further funding contributions are urgently needed to sustain and scale up assistance to reach all those affected by the malnutrition crisis in Nigeria.

# Contact information

**For further information, specifically related to this operation please contact:**

**At the Nigerian Red Cross Society:**

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**At the IFRC:**

- Head of IFRC Abuja Country Cluster Delegation - Dr. Ghulam Muhammad Awan – email ghulam.awan@ifrc.org
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**At the IFRC Regional Disaster, Climate, and Crisis Unit:**

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**For IFRC Resource Mobilization and Pledges support:**

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**For In-Kind donations and Mobilization table support:**

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**For Performance and Accountability support:**

- Regional Head, PMER and Quality Assurance: Beatrice Okeyo; email: beatrice.okeyo@ifrc.org, phone: +254 732 404022

**Reference documents**

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Click here for:

- Previous Appeals
- Operational Strategy

# How we work

All IFRC assistance seeks to adhere to the **Code of Conduct** for the International Red Cross and Red Crescent Movement and Non-Governmental Organizations (NGO's) in Disaster Relief, the **Humanitarian Charter and Minimum Standards in Humanitarian Response (Sphere**) in delivering assistance to the most vulnerable, to **Principles of Humanitarian Action** and **IFRC policies and procedures**. The IFRC's vision is to inspire, encourage, facilitate and promote at all times all forms of humanitarian activities by National Societies, with a view to preventing and alleviating human suffering, and thereby contributing to the maintenance and promotion of human dignity and peace in the world.