Famine Monitoring System – December 2021 Monthly Bulletin

Cadre Harmonisé Task Force on Inaccessible Areas

FMARD
FEDERAL MINISTRY OF AGRICULTURE AND RURAL DEVELOPMENT

KEY TAKEAWAYS

- *The findings from the FMS showed concerning food consumption deficits and limited diversity of diets in the inaccessible areas surveyed. More than one in every two households (62.9 percent) struggled to have sufficient food intake and nearly 80 percent experienced a crisis or higher levels (CH Phase 3 and above) of food deprivation and hunger, further evidenced in the pervasive use of food-based coping strategies;*
- *More than two in every three households relied on either crisis (17.6 percent) or emergency (48.1 percent) coping strategies to meet their food needs, which heightens economic vulnerability due to the negative impact on the future productivity of the most affected households;*
- *The levels of acute malnutrition among new arrivals from the inaccessible areas are Critical (Phase 4 IPC Acute Malnutrition Classification) with the overall Global Acute Malnutrition (GAM) rates 22.0% and Severe Acute Malnutrition (SAM) at 9.0%. The high levels of acute malnutrition indicate an extremely stressed population including food insecurity, poor water, and sanitation access, and poor health conditions as the key underlying causes of acute malnutrition;*
- *The levels of acute malnutrition among new arrivals from the inaccessible areas are Critical (Phase 4 IPC Acute Malnutrition Classification) with the overall Global Acute Malnutrition (GAM) rates 22.9% and Severe Acute Malnutrition (SAM) at 8.10%. The high levels of acute malnutrition indicate an extremely stressed population including food insecurity, poor water, and sanitation access, and poor health conditions as the key underlying causes of acute malnutrition;*
- *Detailed analysis among new arrival population with adequate sample size showed Critical (Phase 4) GAM rates in Bama and Kukawa LGAs while Extremely Critical (Phase 5) in Damboa LGA. According to the FMS nearly half of the children are stunted (41.5%) and 28.8% underweight. The high stunting and underweight is a clear indication of a population that is chronically stressed with poor nutrition and repeated infection;*
- *Overall, both crude and underfive mortality rates were above the emergency threshold of 1 death/10,000 population/day and 2 deaths/10,000 population/day respectively with values of 3.02 deaths/10,000 persons/day for CMR and 3.82 deaths /10,000 under-fives/day. Analysis of the data for the 4 LGAs (Kukawa, Madagali, Magumeri, and Gwoza) with the highest number of people reveals that both CMR and U5MR are highest in Gwoza 5.43 deaths/10,000 persons/day and 10.10 deaths/10,000 under-fives/day.*
- *The elevated levels of consumption gaps, malnutrition, mortality, and pervasive usage of emergency coping strategies, is largely underscored by the limited availability of food stocks, restricted access to functional markets and water, health and sanitation services, which might heighten morbidity risk and impact households' ability to engage in labour for food or resource gathering.*

INTRODUCTION

The insurgency in the North East States of Borno, Adamawa and Yobe continues to render some areas totally or partially inaccessible to humanitarian response agencies/partners. The protracted nature of this conflict has made the

Famine Monitoring System (FMS) for Inaccessible Areas

The Famine Monitoring System (FMS) is an approach put in place by the Food Security Sector and Nutrition Sector (both having their operational bases in the North East) under the leadership of the Nigerian Government, for tracking the trend of acute food and nutrition security situation in such areas that had been analyzed to be in the emergency (phase 4) so as to be able to develop and issue alerts in case famine emerges. The FMS uses a methodology that combines both food and nutrition security monitoring strategies to assess the situation and then raise necessary alert, as the case may be. The FMS is basically conceptualized to support the Cadre Harmonisé analysis of the inaccessible areas in the BAY States.

The general objective of FMS is to provide a comprehensive information about the food security and nutritional situation of the population in inaccessible areas of Northeast BAY States. The FMS also informs the Cadre Harmonisé analyses and classification in different phases of food security and malnutrition of the inaccessible areas. The specific objectives of the FMS entails data collection through monthly monitoring in support of better classification of inaccessible areas between rounds of CH analysis with focus on:

- understanding the risk of a population to face severe, acute catastrophic or famine-like conditions;
- understanding the degree of livelihood change, including capacity to engage in traditional and emergency livelihoods, etc;
- understanding food consumption outcomes through the use of proxy information on Household Hunger Scale (HHS) and Food Consumption Score (FCS);
- understanding availability of health and nutrition services, including household and individual access to services by collecting information on functionality of nutrition/health services;
- understanding how households cope (including the severity of coping measures) during periods of hunger, thirst, morbidity or malnutrition in such areas of interest;
- understanding the malnutrition situation in such areas of interest through the collection of information on GAM prevalence (for children 6-59 months) in reception centres and other new arrival terminals; and
- understanding changes in crude and U5 mortality rates and indicative causes in such areas of interest.

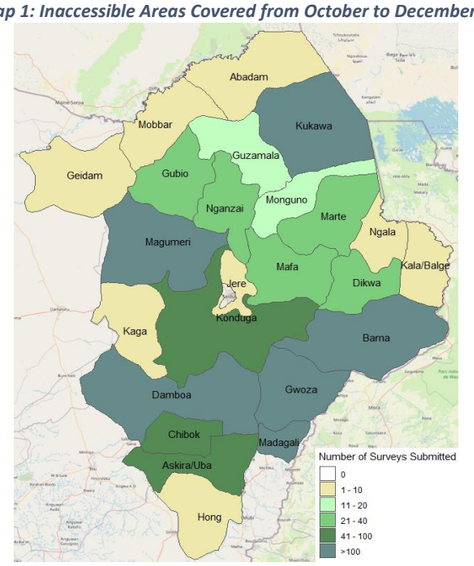
Primary data was jointly collected by partners in many accessible towns of Borno, Adamawa and Yobe States where there are new arrivals coming from the inaccessible areas with the support of the DTM from SEMA and IOM. Well-structured questionnaire was deployed by trained enumerators in collecting the information in the form of key informant interview and focused group discussions (FGD). The data collection focused more on six elements- causal factors of emergency needs, food consumption outcomes, livelihood change and coping strategies, access to life-saving services and assistance, detection of malnutrition through nutrition screenings (WHZ and MUAC), and mortality indicators as recommended by the CH analysis framework. Consideration was also given to journey duration and patterns for the new arrivals interviewed. A combination of purposive and convenient sampling techniques was employed in selecting the recent new arrivals (within the last 30 days) who were the primary target. Total number of respondents covered for this period of October to December was 1,668 ***households*** (from 23 LGAs) who were interviewed with comprehensive nutrition screening conducted for ***about 1665*** children (6 to 59 months old) at the reception centres. The period of data collection for this edition of the bulletin lasted from 1st October to 31st December, 2021.

humanitarian crisis in the North East much more complicated, and, rendering parts of Borno, Adamawa and Yobe State inaccessible. To address information gaps facing the humanitarian response in Northeast Nigeria and inform humanitarian actors on the demographics of the population in inaccessible areas, and identify their needs, access to services and movement intentions, there have been joint efforts by various stakeholders' proffer solutions.

Several cycles of the Cadre Harmonisé (CH) analysis unveiled the problem situation of populations in some inaccessible areas. From the results of October, 2021 CH analysis in which 12,936,583 and 18,030,672 persons for the (Oct – Dec) and (June – August 2022) periods, respectively, were classified in phase 3 – 4 of acute food and nutrition insecurity across the inaccessible areas of the BAY states. The preliminary results from the just concluded October, 2021 CH round further reveal presence of close to a quarter million people in CH Emergency phase in October to December 2021, with high risk of further deterioration to nearly half a million in Emergency and, over 13,000 in Catastrophe-like conditions at the peak of the lean season next year. Majority of people in Emergency and those projected to experience Catastrophe-like conditions are from the inaccessible areas. Moreover, the findings suggest a famine-like food consumption pattern among minority of the inaccessible population (≤10 percent), which was reflective in severe food consumption deficits, extremely limited diversity of diets and pervasive use of food-based ration control with wild food foraging remaining a major food source in these areas. However, higher-level indicators (acute malnutrition and mortality) were insufficient to confirm famine conditions in these areas. Therefore, it became necessary to undertake close monitoring of the food and nutrition security situation of the vulnerable population in these areas for emergency preparedness against possible further deterioration into famine, especially during the lean season (June-August, 2022). Thus, the Inaccessible Areas Task Force, working in liaison with the various partners, planned a real time monitoring system, including monthly data collection, for tracking the evolution of emergency needs during CH projection periods.

The result is an evidence-based approach improving the capacity for analysis of emergency needs through identifying areas to scale up data collection prior to CH workshops and using real time analysis for flagging areas with increased risk of severe outcomes during the CH projection period. Thus, the Famine Monitoring System attempts to provide data needed to support analysis for the risk of catastrophic or famine-like conditions in hard-to-reach locations, either increasing the amount of data provided to the CH analysis process or improving the frequency of reliable data to support real time analysis of proxy outcomes when unexpected events develop outside the CH analysis cycle.

Map 1: Inaccessible Areas Covered from October to December 2021



RESULTS

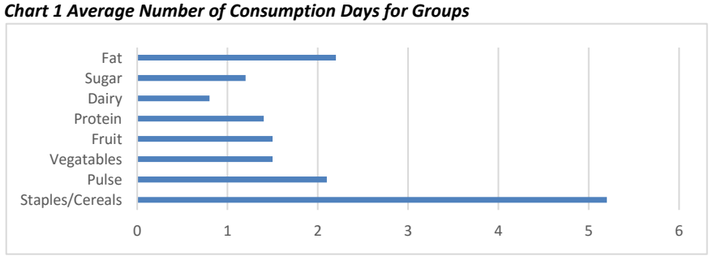
Outcomes – Food Security

Food Consumption (FCS, rCSI and HHS)

The food consumption for the FMS is measured in three dimensions in line with the provision of the CH version 2.0 – food consumption score (FCS), reduced coping strategy index (rCSI) and household hunger scale (HHS).

Food Consumption Score (FCS): The findings from the FMS showed concerning food consumption deficits and limited diversity of diets in the inaccessible areas surveyed. More than one in every two households (62.9 percent) did not have sufficient food intake (poor + borderline food consumption) in the last 30 days spent in their inaccessible places of origin, with 34.8 percent of such households reporting severe food consumption deficit. This infers that the FCS stands at the emergency level (CH Phase 4), the most severe classification in the FCS categorization. While the global findings were consistent in some of the areas at indicative levels, Bama, Damboa Madagali LGAs, which have a relatively higher level of confidence interval given their sample, showed quite concerning findings as 81.8, 81.2, and 93.0 percent respectively of the surveyed households did not have adequate diets (poor + borderline food consumption) in their places of origin. More than 20 percent of such households had poor food consumption – particularly reflecting severe consumption deficits in these areas. Regarding the diversity of diets consumed, the average daily consumption of cereals was reported at about five out of every seven days whereas all other food groups (pulses, vegetables, proteins, dairy, sugar, and fats) were consumed for two days or less in every typical seven-day period. The extremely limited diversity of diets in these inaccessible areas is indicative of significant macro and micronutrients deficiency, which has an implication for the health, wellbeing, and economic productivity of the people trapped in these areas.

Chart 1 Average Number of Consumption Days for Groups



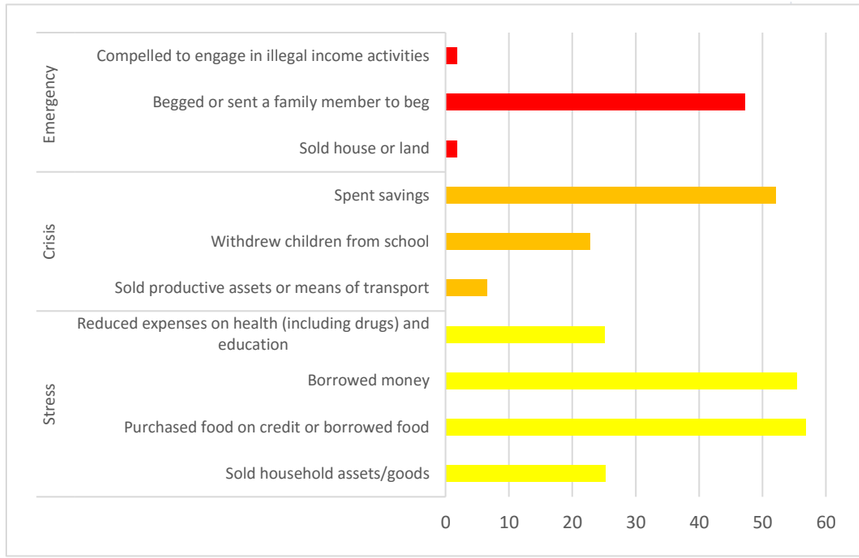
Reduced Coping Strategy Index (rCSI): Moreover, there was pronounced usage of food based coping strategies to bridge food gaps within the surveyed households. 37.8 percent of households reported reduced coping strategy index (rCSI) scores equal or greater than 19, which is the most severe categorization according to the CH guidelines (CH Phase 3). Again, households in inaccessible areas in Gubio and Mafa LGA contributed significantly to the global average as 91.2 and 77.7 percent of households respectively were in CH Phase 3 with an rCSI score equal or greater than 19. In this given context of the rCSI, households in inaccessible areas adopted multiple alimentary based coping strategies such as reliance on less preferred or less expensive food, reduction in the number of meals or portion size for an average of three days out of a typical seven-day period. The frequency of adoption of these strategies was relatively higher in Gubio where households typically adopt such strategies for an average of six out of seven days for all food based coping strategies which suggests limited access to this coping measure and invariably widespread vulnerability in this location. The pervasive use of food based coping strategies such as reduction in the number of meals and portion size has implication on nutrition, if protracted and unabated.

Household Hunger Scale (HHS): Findings from the HHS, which is a perception-based measure of food deprivation and experience of hunger in the surveyed households, showed that most households (78.6 percent) experienced crisis or higher levels (CH Phase 3 and above) of food deprivation and hunger according to the CH analysis guidelines. Specifically, 2.0 percent and 1.3 percent of households reported emergency and catastrophe/famine levels of HHS respectively. Based on the metrics presented, HHS for inaccessible areas of BAY States was classified as CH Phase 3 (crisis), albeit an area such as Gubio was classified in CH Phase 5 (catastrophe/famine) because more than 20 percent of the surveyed households fell within the catastrophe/famine category (26.5 percent). This suggests worrisome HHS trends and significant food deprivation and widespread hunger especially in the highlighted LGA in the catastrophe/famine CH phase classification.

Evolution of Livelihoods

Livelihood Coping Strategies Livelihood-based coping strategies depicts the status of households' livelihood stress and the consequential longer-term impact on future coping capability and productivity. Livelihood coping strategies are classified into the following three severity categories 'stress', 'crisis' and 'emergency', with emergency being the most severe category and is classified in CH Phase 4 (Emergency) based on the CH guideline. Overall, the livelihood coping indicator was classified in CH Phase 4 as 65.7 percent of the surveyed households used either crisis (17.6 percent) or emergency (48.1percent) coping strategies to meet their food needs during the last 30 days spent in their inaccessible areas of origin. In terms of individual strategies specifically for emergency, 45.1 percent sent family members to beg, whereas in the crisis category, 49.5 percent of households spent their savings and 21.3 percent withdrew their children from school. While reliance on these severe livelihood coping strategies (crisis and/or emergency) might alleviate the brunt of food insecurity in the short-term, their pervasive usage is particularly worrisome on the longer-term given their negative impact on future productivity of the affected households.

Chart 2 Livelihood Coping Strategies



Outcomes – Nutrition

Malnutrition

Global Acute Malnutrition (GAM) *is determined by taking the weight, height and MUAC measurement for children 6- 59 months. Acute malnutrition is most responsive to changes in diet and disease and the most dangerous form of malnutrition in terms of mortality risk.*

Global Acute Malnutrition (GAM): According to the FMS findings, the levels of acute malnutrition among new arrivals from inaccessible areas for the period October-December 2021 is **Critical** (Phase 4 IPC Acute Malnutrition Classification), with no significant change compared to the previous reporting period. The overall Global Acute Malnutrition (GAM) rates were 22.9% and Severe Acute Malnutrition (SAM) at 8.1%. The high levels of acute malnutrition indicate an extremely stressed population including food insecurity, poor water, and sanitation access, and poor health conditions as the key underlying causes of acute malnutrition.

Detailed analysis among arrival population with good quality and adequate sample size showed Critical (Phase 4) GAM rates in Bama and Kukawa LGAs, and Extremely (Phase 5) in Damboa LGA.

Chart 3: Global Acute Malnutrition (GAM%) Rates per Location

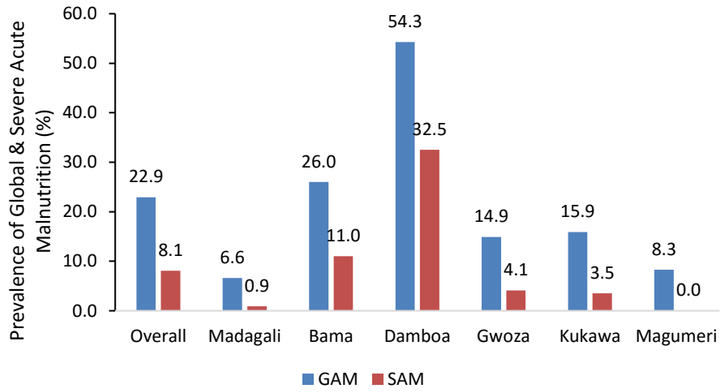
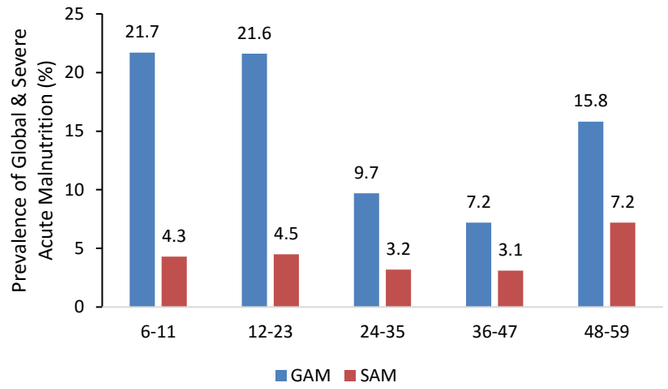


Chart 4: GAM Prevalence of Acute Malnutrition by Age



The children ages 6- 23 months were 1.5 times more likely to be acutely malnourished than older children (48 – 59 months). The younger children are more vulnerable to shocks but also an indication of poor infant and young child feeding practices especially continued breastfeeding up to two years and poor complementary feeding.

The very poor nutritional status of the inaccessible population continues to be very poor even during the harvest season, a clear indication that the population is not accessing adequate food both at the origin and arrival locations or the other underlying causes of malnutrition are persistent and don't change with seasonality.

Chronic Malnutrition

Chronic malnutrition (stunting) is determined by comparing the height and age of the children measured. Stunting is a measure of chronic malnutrition that occurs because of inadequate nutrition over a longer period. **Underweight** refers to the proportion of children with low weight-for-age

Stunting and Underweight: According to the FMS over a half of the children are stunted (41.5%) and underweight (28.8%). The high stunting and underweight rates is a clear indication of a population that is chronically stressed with poor nutrition and repeated infection. Stunted children fall sick more often, miss opportunities to learn, perform less well in school, grow up to be economically disadvantaged, and are more likely to suffer from chronic diseases. *Other nutrition sector data sources (such as the ETT screening) show that new arrivals from inaccessible areas are 5 times more likely to be acutely malnourished compared to those from accessible locations. This indicates the FMS data is highly probable and confirms the extremely poor nutritional status of the inaccessible population.*

The data on acute and chronic malnutrition must be interpreted with caution due to the overall sample size (low arrival numbers) and data quality challenges.

Mortality

Crude Mortality Rates (CMR) and **Under five Mortality Rates (U5MR)** are measures of all-cause mortality occurring during the period. Deaths both from conflict as well as natural causes contribute to all-cause mortality.

Overall, both crude and under five mortality rates were above the emergency threshold of 1 death/10,000 population/day and 2 deaths/10,000 population/day respectively with values of 3.02 deaths/10,000 persons/day for CMR and 3.82 deaths /10,000 under-fives/day.

Analysis of the data for the 4 LGAs with the highest number of people reveals that both CMR and U5MR are highest in Gwoza 5.43 deaths/10,000 persons/day and 10.10 deaths/10,000 under-fives/day.

Interpretation based on these thresholds should be done with caution considering that the adapted methods used to gather information from inaccessible areas may over-estimate mortality rates.

Note:
Data on malnutrition and mortality must be interpreted with caution, due to the overall small sample size (low arrival numbers) and data quality challenges. Only data that met the quality threshold (LGA sample size, standard deviation and confidence interval of collected data) was included in the analysis.

Contributing Factors

Hazards and Vulnerabilities

For over a decade, armed insurgency-driven insecurity has driven disproportionate levels of food and nutrition insecurity in northeastern Nigeria states of Borno, Adamawa, and Yobe. The armed conflict has driven thousands of families out of their homes, significantly eroding them of their basic livelihoods, increasing their vulnerability to food and nutrition insecurity. Despite the urgent need for assistance, most locations with vulnerable populations remain inaccessible, significantly limiting the delivery of both humanitarian and public services.

Staple food prices remain atypically higher than long-term averages amidst compromised household purchasing power. Dozens of households continue to flee their homes to seek safety, support and better services in internally displaced camps and host communities due to the persistent violence and socioeconomic hardship.

In December, unlike in the previous months (September-November), 41 percent of interviewed respondents reported that some previously internally displaced persons (IDPs) had returned to their communities of origin during the previous 3 or more months, compared to 42 percent in November, while 59 percent objected to having witnessed any returning IDPs. These figures significantly vary between LGAs, however, they reflect that most people (59 percent) still feel unsafe/insecure returning to their communities of origin. Conflict in localities of origin is still regarded as the most significant shock (82 percent), followed by the sickness of the household member as reported by 58 percent of the new arrivals in December compared to 54 and 53 percent in November and October, respectively. High food prices follow, reported by 47 percent of households in December, followed by loss of employment (38 percent) and temporary relocation (31 percent) – ***see chart 6***.

Limited access to agricultural land was another major contributing factor to the prevailing food security and nutrition situation within the inaccessible localities as pointed out by newly arrived IDPs. The majority of the interviewed displaced persons (46 percent) confirmed having access to between 0.5 and 1 hectare, while a whole 20 percent reported to having access to less than 0.5 hectares of farmland. Just about 6 percent could access more than 2 hectares of farmland.

Despite the generally fair harvests that commenced in September, majority of households indicated that they did not have any food stock available a few months before they fled their localities of origin, which suggests that either or both limited crop cultivation and meagre harvest. Only about 30 percent had food stocks, the majority (79 percent) of which indicated that food stocks were limited and would not last for more than 3 months while only 15 percent indicated that their food stocks would take them through 3 to 6 months.

Chart 6: Most Significant Shocks before Arrival

Food Availability

Among the assessed households, about 70.2 percent in most of the inaccessible LGAs reported not having stock of foods from last season's harvest. It was pronounced in places such as Askira/Uba (97.7 percent), Chibok (94.6 percent), and Damboa (90.9 percent). Others who reported not having stock include Guzamala, Geidam, Mobbar, Hong, and Jere each (100 percent) has the highest proportion of households that fell within this category. Of all the surveyed households that had food stock left, majority (79.3 percent) indicated that it would have lasted for less than 3 months, thus suggesting a severe food deficit in inaccessible areas despite the just concluded main harvest. Generally, land access was relatively high with about 56.5 percent of households reporting such access. However, in 56.5 percent of households with land access across most of the areas, the amount of land cultivated remains minimal with most households reporting only about 1 hectare or less was cultivated. 46.4 percent of households reported access to about 0.5 to 1 hectare of land being available for cultivation while another 19.8 percent of households only had access to less than 0.5 hectares of land. Noteworthy to highlight that only 6.4 percent of households have access to more than 2 hectares of land in these previously agrarian-dominated areas. Despite these challenges highlighted, farming continues to remain the mainstay for food availability in households with arable land access as about 92.1 percent of such households were engaged in farming during the month that preceded their departure from places of origin.

Food Access

Markets were either completely non-functional or functioning at sub-optimal levels in some of the inaccessible areas as confirmed by 84.8 percent of the surveyed newly arrived households. Areas with a high preponderance of households reporting non-functionality of the market are Kala Balge, Jere Chibok, Askira, Hong, and Abadam (100 percent), Damboa (90 percent), Dikwa (97 percent), Gwoza (94 percent), Mafa (95 percent) and Bama (93 percent) reported a complete lack of functioning market or sub-optimal functional markets in their places of origin. Although, 91 percent of the households from inaccessible areas said they had access to the market in the last three months. Insecurity (9 percent), lack of money (2 percent), and market closure (2.2 percent) remained the main challenges to market access. Households from inaccessible areas acknowledged a significant increase (54.5 percent), small to moderate decrease (11.5 percent) and small to moderate increase (9.5 percent) in prices of food commodities, which would further weaken the already frail purchasing power of the inaccessible populace and consequently, worsen vulnerability. This is particularly pertinent to note as markets were reported as the main source of cereals for close to 14 percent of the interviewed households among which Abadam reported 100 percent dependence on the market. Other notable sources for cereals recorded were own harvest (26.4 percent), labour exchange for food (20.1 percent). Moreover, wild food foraging (24.2 percent) and begging (7.3 percent) account for cereal sources in almost one in every five households in inaccessible areas, which is quite worrisome given their characteristics as extreme coping measures. The prevalence of gathering was most pronounced in Madagali (84.3 percent), and Bama (43.6 percent), While begging for food is most pronounced in Jere (33.3 percent), Hong (66.7 percent), and Askira Uba (52.3 percent).

Health and WASH

Protected well is the most reported source of water (by 48.2% of respondents), especially in Abadam, Kaga, Kala/Balge, Gubio, Konduga, Kukawa, Mafa and Marte LGAs where more than 80% of respondents use protected wells as their main source of water. Surface water is the second most reported source of water (by 30.8% of respondents). In Hong (Adamawa), Askira Uba (Borno) and Chibok LGAs, respondents reported to rely almost exclusively on surface water. The third major source of water is tube well/borehole reported mainly in Monguno (94.4% of respondents) and to a lesser extent in Nganzai (62.1%), Geidam LGA in Yobe (50% of respondents) and Madagali LGA in Adamawa (50.4% of respondents). Other sources of water include piped water (reported mainly by respondents from Ngala LGA in Borno), public tap and other marginal source of water such as springs (protected or unprotected) and rainwater.

The majority of the respondents (56.1%) spend more than 30 minutes to collect water. It is worthy to note that in Geidam LGA (Yobe), Gubio and Guzamala LGAs (Borno), most respondents spend between 1 and 3 hours to collect water. In some areas of Bama, Gubio, Monguno and Nganzai LGAs (Borno State), some respondents reported spending half a day or even a whole day (as in the case of Monguno) to collect water.

A slight majority of respondent (57.5%) have access to an ordinary pit latrine. The remaining mainly go to the nearest bush or open field (27.2% of respondents), dig a hole (14.2%) or use a bucket or a hanging toilet to relieve themselves. Open defecation is mostly reported by respondents from Hong LGA in Adamawa (100% of respondents respectively), Geidam LGA in Yobe (75% of respondents), Chibok LGA (92.7% of respondents), Damboa LGA (64.2%), Gubio LGA (65.6%) and Ngala (100%). Respondents from Hong LGA in Adamawa State, Abadam, Chibok, Guzamala, Jere and Kala Balge LGAs in Borno State reported having no health facility in their LGAs. Where health facilities exist, the facility is fully functional, as reported by 51.8% of respondents and services are free of charges in most cases. To reach the health facility, 35.1% of respondent travel less than 30 minutes, 30.5% between 30 minutes and one hour whereas 33.6% travel between 1 and 3 hours.

Chart 5: Stock Availability and Farming (Percentage of Households)

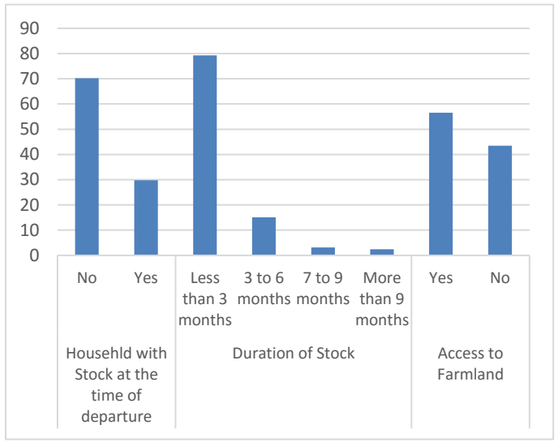


Chart 6: Most Significant Shocks 3-4 Months before Arrival

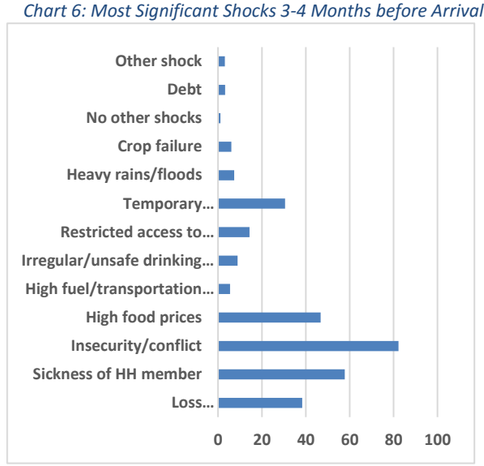
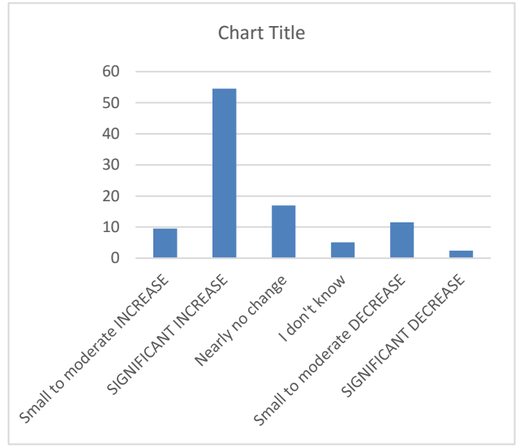
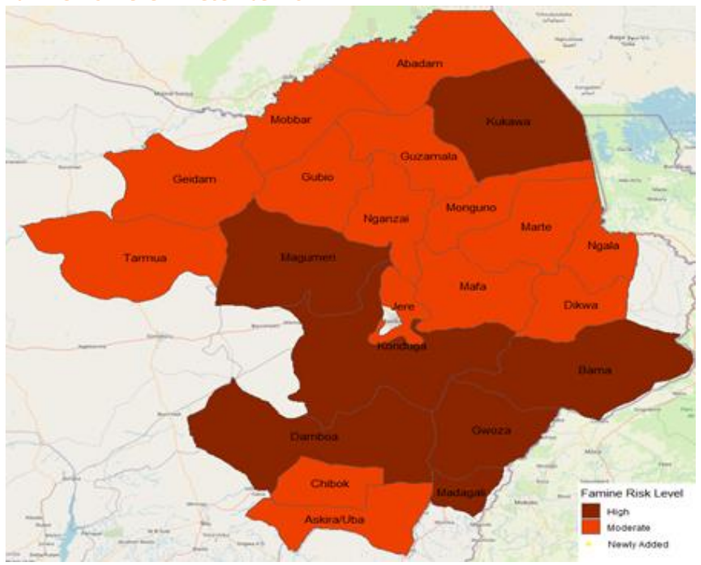


Chart 7: Chart 7: Changes in price



Famine Risk Level – December 2021



Note: Famine risk level defined based on convergence of: a) severity of food security and nutrition outcomes plus contributing factors; and b) sample size. Mortality was not considered in the convergence due to LGA level low sample sizes and quality issues. For areas adjudged "Moderate Risk", sample size was relatively small in most of them, and so, the reason for the classification. This, however, does not completely eschew the possibility of higher levels of famine risk in such areas. Thus, these results should be interpreted and utilized with some caution.

Note: Please click on the link here for LGA level breakdown of the FMS results (*sample size, food security and nutrition outcomes including contributing factors*): Data Tables for this December bulletin is available for Download Here.

Key Risk Factors to Monitor

1. *High famine risk areas – Bama, Gwoza, Damboa, Konduga, Madagali, Magumeri and Kukawa – should continue to be monitored closely considering elevated levels of food consumption gaps, malnutrition and extensive/unsustainable usage of emergency coping strategies, largely underscored by limited availability of food stocks, restricted access to functional markets and health services;*
2. *Elevated health risk within a highly food insecure, vulnerable, and inaccessible population;*
3. *FMS data indicates high morbidity rates and illnesses affecting all age groups including the productive household members. The impact of morbidity on the household expenditure, food consumption and productivity (worsened by poor to non-functionality of health facilities) require in-depth exploration and close monitoring;*
4. *Majority of the households have no access to health facility. Hence, the need to devise alternative ways through which communities could manage illnesses (i.e. 'coping strategies' for limited formal health services);*
5. *The lack of clean water and access to dignified sanitation, coupled with low hygiene awareness will likely result in increased AWD diseases, impacting under 5 children, thereby resulting in malnutrition and other negative outcomes of food and nutrition; and*
6. *The combined effect of these highlighted factors, will heighten morbidity level and, would likely impact households' ability to engage in labor-for-food or resource gathering— thereby deepening the vulnerability of the already fragile households.*

Limitations of the FMS

- Progressive reduction in sample size arising from limited number of new arrivals from the inaccessible localities;
- Limited coverage in some locations (e.g. Kaga) due to lack of partners' representation/ operations in such areas;
- Difficulty in attribution of the findings (with high degree of precision) to the entire population in the inaccessible areas.

For further enquiries, please contact:

Dr. Lawal SANI DAURA
National Coordinator, National Programme for Food Security
Daura4215@gmail.com

Leslie Parker ODONGKARA
Food Security Sector Coordinator - Nigeria
Leslie.odongkara@fao.org

Simon KARANJA
Nutrition Sector Coordinator
skaranja@unicef.org