



# Humanitarian Situation Update – April, 2023 Bulletin

## Cadre Harmonisé Task Force on Inaccessible Areas



### KEY TAKEAWAYS

- *The findings from the HSM showed concerning food consumption deficits and limited diversity of diets in the inaccessible areas surveyed. About 45.6 percent of the surveyed households struggled to have sufficient food intake and nearly 68.5 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;*
- *37.1 percent of the households relied on crisis 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 serious (Phase 4 IPC Acute Malnutrition Classification) with the overall Global Acute Malnutrition (GAM) rates of 20.9 percent and Severe Acute Malnutrition (SAM) at 8.2 percent. The high levels of acute malnutrition indicate an extremely stressed population in relation to 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 good quality and adequate sample size showed extremely critical (Phase 5) in two of the areas analyzed and Critical (Phase 4) in three of the areas analysed. According to the HSM results, a sizeable proportion of the children (6-59 months) are suffering from stunting and underweight. This is characteristic of a chronically stressed situation of poor nutrition and persistent infection.*
- *Overall, both crude and under five mortality rates (CMR and U5MR) were above the emergency threshold of 1 deaths/10,000 population/day and 2 death/10,000 children <5yr/day, respectively; with values of 1.78 deaths/10,000 persons/day for CMR and 3.36 deaths /10,000 under-fives/day. Gwoza, Chibok, Marte and Bama LGAs had the highest U5MR of 4.56, 3.80, 3.35 and 3.01 deaths/10,000 children under 5years/day, respectively; while Bama and Chibok LGAs had the highest CMR of 1.88 and 1.95 deaths/10,000 persons/day, respectively.*
- *The elevated levels of consumption gaps, malnutrition, mortality, and unsustainable usage of emergency coping strategies, is largely driven by the limited availability of food stocks, restricted access to functional markets and poor water, health and sanitation services, which might heighten morbidity risk, and, impact more negatively on households' ability to engage in labour for food or resource gathering.*

To address information gaps facing humanitarian response in Northeast Nigeria and, inform humanitarian actors on the demographics of the population in inaccessible areas, identify their needs, access to services and movement intentions, there have been joint efforts by various stakeholders' to proffer solutions and fill the information gaps.

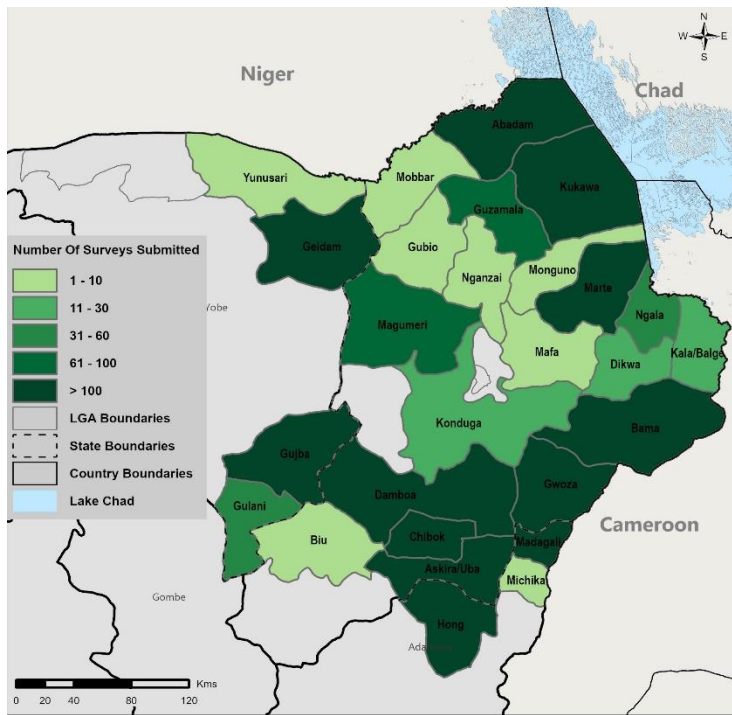
Several cycles of the Cadre Harmonisé (CH) analysis unveiled the problem situation of populations in some inaccessible areas. From the results of March 2023 CH analysis in which 3,207,298 and 4,250,397 persons for the (Mar – May) and (June – August 2023) periods, respectively, were classified in phase 3 – 5 of acute food and nutrition insecurity across the three states of Borno, Adamawa and Yobe, large proportion of this populations are located in both the totally and partially inaccessible areas of these BAY states. The final results from the Mar, 2023 CH round further reveal presence of 300,807 people in CH Emergency (phase 4) in Mar to May, 2023, with high risk of further deterioration to almost 522,366 in Emergency at the peak of the lean season next year (June to August, 2023).

Majority of the 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 ( $\leq 10$  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 is necessary to sustain 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, 2023). Thus, the Task Force on Inaccessible Areas, working in liaison with the various partners, developed 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 requiring scale up of data collection prior to CH analyses workshops and using real time analysis for flagging areas with increased risk of severe outcomes during the CH projected period. Therefore, the Humanitarian Situation 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 of food and nutrition security when unexpected events develop outside the CH analysis cycle.

### 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 humanitarian crisis in the North East much more complicated, and, rendering parts of Borno, Adamawa and Yobe State inaccessible.



Map 1: Inaccessible Areas Covered from June to November, 2022

## RESULTS

### Outcomes – Food Security

#### Food Consumption (FCS, rCSI and HHS)

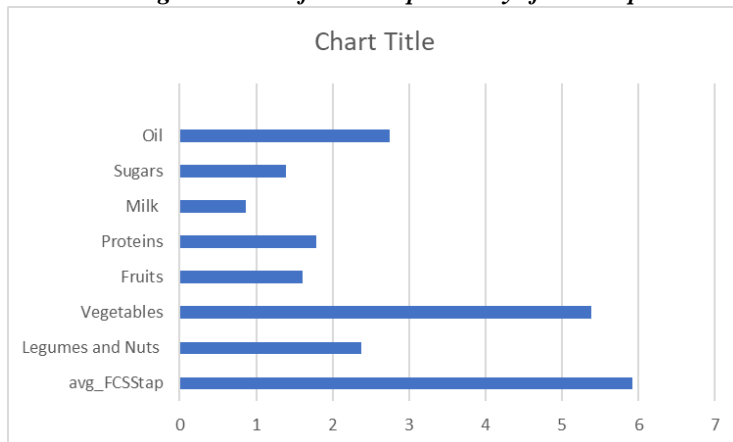
The food consumption for the HSM is measured in three dimensions in line with the provision of the CH version 2.0 – food consumption score (FCS), reduced coping strategy index (rCSI), and Household Hunger Scale (HHS).

Following the harvest of crops from the past growing season, some households in hard-to-reach areas would likely have some stocks of staple food items while others continue to face food consumption gaps and less diverse diets, owing to several factors including poor access to markets, limited access to own produced stocks due to constrained access to agricultural inputs, coupled with the fragile security environment. The findings from the HSM shows concerning food consumption gaps and limited diversity of diets in several of the inaccessible areas surveyed. Overall, 45.6% percent of households faced inadequate food intake (poor and borderline food consumption score) during the last 30 days spent in their inaccessible places of origin of which 13.1 percent of such households were reportedly affected by poor food consumption while 32.5 percent were affected by borderline food consumption. This implies that the FCS is at the stressed level (CH Phase 2) with most households having minimally adequate food consumption but cannot afford some basic non-food expenditures without engaging in irreversible coping strategies. The food security situation remains generally unchanged as compared to March 2023 when the FCS was classified as Critical.

While the global findings on the proportion of households with inadequate food consumption are lower than some of the areas at indicative levels, Askira/UBA, Bama, Chibok, Damboa, Guzamala, and Kukawa LGAs, which have a relatively higher level of confidence interval given their sample size, showed quite concerning findings as 69.3, 64.4, 62.3, 90.3, 53.4, and 54.9 percent respectively of most surveyed households had inadequate diets (poor + borderline food consumption) in their places of origin.

Regarding the diversity of diets, overall, households consumed cereals for 6 out of 7 days and vegetables for 5 out of 7 days on average, fat for 3 out of 7 days. All other food groups (pulses, proteins, sugar, and fruits) were consumed for two days or less in every typical seven-day period with milk and dairy being the least consumed food item. In Hong, Madagali, Michika, Abadam, Biu, Gubio, Guzamala, Gwoza, Konduga, Magumeri, Marte, Mobbar, Monguno, Ngala, Geidam, Gujba, and Gulani. where most households had inadequate food consumption, on average households consumed cereals for 6 to 7 days on average. The concentration on the consumption of one major food item in these inaccessible areas is indicative of significant macro and micronutrient deficiency, which has implications for the health, well-being, and economic productivity of the people trapped in these areas.

Chart 1: Average Number of Consumption Days for Groups



### Reduced Coping Strategy Index (rCSI)

The reduced coping strategy index which is an indicator of household food access calculates the frequency and severity of five standard food consumption behaviors into a score to determine the magnitude of food access challenges. A high score in the reduced coping strategy index reflects severe use of food-based coping strategies and the prevalence of considerable food access challenges in the household. Some 37.1 percent of households reported reduced coping strategy index (rCSI) scores equal or greater than 6.3, which is the most severe categorization according to the CH guidelines (CH Phase 3). In general, households in Biu, Mobbar, Magumeri, Ngala, Nnganzai, Gaidam, Gujba, Gulani LGAs contributed significantly to the global average as 71.4, 100, 69.5, 81.6, 100, 86.6, 69.2 and 65.2 percent of households respectively were in CH Phase 3, with an rCSI score equal or greater than 19, considering the relative a relatively higher level of confidence interval given their sample size. 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 Mobbar, Nnganzai, and Gaidam where households utilized all the five standard food consumption behaviors for at least 3 of seven days which suggests widespread vulnerability in these locations. 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 (68.5 percent) experienced crisis or higher levels (CH Phase 3 and above) of food deprivation and hunger according to the CH analysis guidelines. Specifically, 6.5 and 3.5 percent of households were affected by emergency and catastrophe/famine levels of HHS respectively

while 58.5 percent report crisis level of HHS. Based on the metrics presented, HHS for inaccessible areas of BAY States was classified as CH Phase 3 (crisis). This suggests worrisome HHS trends and significant food deprivation as well as incidence of hunger especially in most LGAs which are in Crisis CH phase classification.

### Evolution of Livelihoods

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 as CH Phase 4 (Emergency) based on the CH guidelines. Overall, the livelihood coping indicator was classified in CH Phase 4 with 60.6 percent of the interviewed households using emergency livelihood-based coping strategies while 8.8 percent used crisis 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, 49.8 percent sent family members to beg, whereas in the crisis category, 52.5 percent of households spent their savings and 19.5 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.

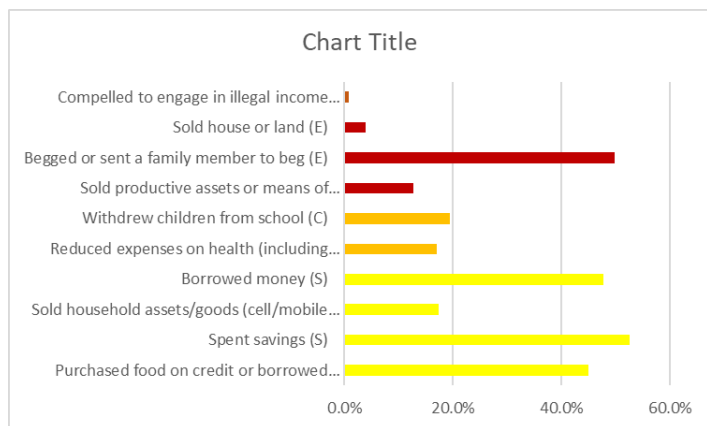


Chart 2: Livelihood Coping Strategies

### Outcomes – Nutrition Malnutrition

**Global Acute Malnutrition (GAM)** Acute malnutrition is determined by taking the weight, height and MUAC measurements for children aged 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. The overall prevalence of global acute malnutrition (GAM) and severe acute malnutrition (SAM) in the inaccessible areas across BAY states were 20.9 percent and 8.2 percent respectively. This indicates an increase of 2.2%-point and 2.9%-point for GAM and SAM compared to March 2023 prevalence, in which prevalence were GAM (18.7%) and SAM (5.3%) respectively. GAM prevalence was higher among boys (22.9%) compared to girls (19.0%). According to the HSM findings, the overall levels of acute malnutrition among new arrivals from inaccessible areas for the month of April 2023 is critical (IPC Acute Malnutrition Phase 4), which is similar compared to the previous reporting period. This is likely attributed to high stress levels among displaced households to meet food needs, high retail prices for staple foods, high food consumption gaps and morbidity, and the lack of access to improved sanitation facilities. This trend of high acute malnutrition levels is expected to continue

through the lean season (high malnutrition) up to the harvest season as the results don't indicate any seasonal variability.

Further analysis among new arrivals from LGAs with adequate representativeness for the analysis (data from ≥3 clusters) shows no LGA with extremely critical GAM rates (IPC AMN Phase 5), however, Gwoza, Guzamala, Bama, Marte, and Kukawa are classified as critical (IPC AMN Phase 4).

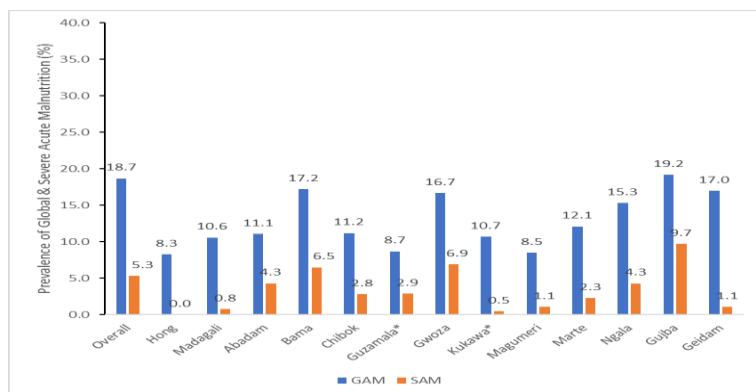


Chart 3: Global Acute Malnutrition (GAM%) Rates per Location

The prevalence of acute malnutrition was generally higher among young children (6-23months) compared to older age groups (24-59months) (Chart 4). Younger children are the most vulnerable and therefore bear the brunt of displacements, poor feeding practices, and morbidity.

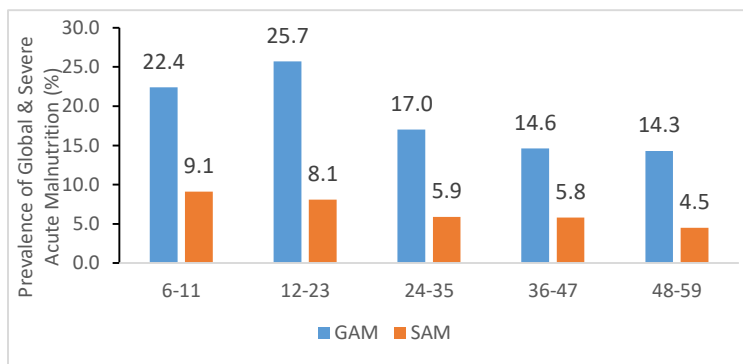


Chart 4: Prevalence of Acute Malnutrition by Age

### 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:** HSM data reveals that 45.6 percent of the children aged 6-59 months among new arrivals in BAY states were stunted while 37.8 percent were underweight. This shows a marginal decrease of about 2.6%-point for Stunting and an increase of 2.7%-point for Underweight when compared to the previous result in February 2023 where stunting was 48.2% and underweight was 35.1%. The consistently high prevalence of stunting and underweight are an indication of a protracted crisis and other synergistic drivers exacerbating hunger, disease, and malnutrition.

## Mortality

Crude Mortality Rate (CMR) and Under-Five Mortality Rate (U5MR) are measures of all-cause mortality occurring during the period. CMR is defined as the rate of death in the entire population, including both women and men and all ages. U5MR is the rate of death among children below five years of age in the population. Deaths both from conflict as well as natural causes contribute to all-cause mortality.

The overall crude and under-five mortality rates were 1.78/10,000 persons/day and 3.36/10,000 children under-5 years/day respectively. Both CMR and U5MR were above the emergency thresholds of 1 death/10,000 persons/day and 2 deaths/10,000 children under 5 years/day respectively. Bama and Chibok LGAs had the highest CMR of 1.88 and 1.95 deaths/10,000 persons/day, while Gwoza, Marte, Chibok and Bama LGAs had the highest U5MR of 4.56, 3.80, 3.35 and 3.01 deaths/10,000 children under 5 years/day. Analysis of cause and location of death reveals that majority of the death (54.0%) were because of illness and only 24.7 percent were due to injury/trauma. Majority of the death (56.2%) reportedly occurred in the place of last residence (in-accessible area) while 22.9% of the deaths occurred during migration.

### 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

Northeastern Nigeria is experiencing a protracted food and nutrition insecurity situation, mainly driven by the over ten years of armed insurgency, led by *Boko Haram* and other non-state armed groups. The insurgency has led to displacement of thousands of families, collapsing their basic livelihoods, significantly reducing their purchasing power and coping capacity, made markets dysfunctional and consequently increasing people's vulnerability to food and nutrition insecurity and unending hardship. It has led to serious vulnerabilities that negatively affect household's capacity to access food, agricultural inputs, finance, farming land, extension services, markets and other alternative agricultural livelihood options. Due to the conflict, Nigeria is now among the top 10 largest food crises in the World<sup>1</sup> and the largest food crisis in West Africa – south of the Sahara, despite its remarkable potential for food production.

Despite relative reduction of attacks on civilians, a significant number of highly vulnerable populations remain trapped in inaccessible locations, despite their urgent need for assistance. Inaccessibility limits provision of the much-needed basic social and humanitarian services to those in urgent need. Due to insecurity, market functionality and access are compromised, and people's movements are restricted, all of which continuously affect food access. Apart from insecurity, other major shocks affecting households in hard to reach areas include high food prices, reduced incomes, sickness of household members, loss of employment and restricted access to markets. Due to insecurity and socioeconomic hardship in inaccessible localities, dozens of households continue to flee their homes to seek safety and support to rebuild their livelihoods, and better services in internally displaced camps and host communities.

In April, approximately 33 percent of interviewed households reported to have witnessed some previously internally displaced persons (IDPs) returning to their communities of origin.

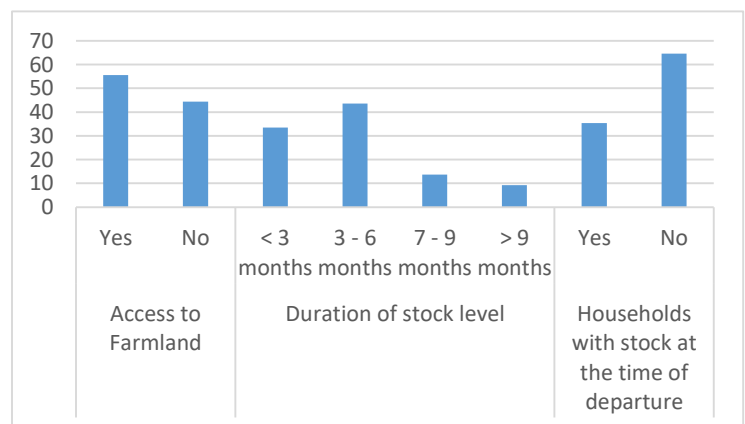
For those fleeing, the most significant shocks in the localities of origin reported were conflict reported by 78 percent of respondents, down from 85 % in March – portraying relative reduction in violence-driven insecurity. This is followed by high food prices at 52 percent which is 1 percentage less than last month, loss of employment at 45 percent – up from 32 percent in March, sickness of household members (42 percent, up from 36 percent in March), temporary relocation/displacement of the household member reported by 32 percent, and restricted access to markets at 16 percent (chart 6). The most reported severe needs among the fleeing households were food (49 percent) and Protection (29 percent).

Limited access to agricultural land is another major contributing factor to the prevailing food and nutrition insecurity in the inaccessible localities as pointed out by newly arrived IDPs. While most (56 percent) of interviewed households reported having access to land for cultivation, only 28 percent confirmed to have actually cultivated. For those who had access to land, majority (66 percent) were able to access just 1 hectare or less. About 18 percent reported to have access to between 1 and 2 hectares of farmland; while only 4 percent reported to have access to more than 2 hectares.

### Note:

In the Northeast, notably in Borno state, the government continues the process of closing IDP camps and resettling IDPs. According to IOM, hundreds of thousands of IDPs have been relocated to various locations across Borno state from the closure of seven IDP camps, Bakassi, NYSC, MOGCOLIS, Teachers Village, Stadium Camp, Filin Ball Camp, and Farm Center. The resettled IDPs mainly reside among the host community in Jere, MMC, Gwoza, Monguno, and Kukawa LGAs. While other previously displaced IDPs relocated to various LGA headquarters to IDP camps as they were unable to resettle in their homesteads due to their unpredictable safety. Those who stay within camps are still accessing assistance, while those living among the host community are not receiving aid. Returnees living among the host community only received a resettlement package to help rebuild their livelihoods.

Many of these returnees are residing where humanitarians can't reach, which renders them more vulnerable to, hunger, starvation and acute malnutrition. These populations are left vulnerable to repeated attacks by Non State actors and armed opposition groups. The result is the vulnerability of returnees continues to worsen than those still in the IDPs camps.



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

<sup>1</sup> FSIN, May 2023. [The Global Report on Food Crises 2023](#)



### Most Significant Agric Shock in Inaccessible Areas

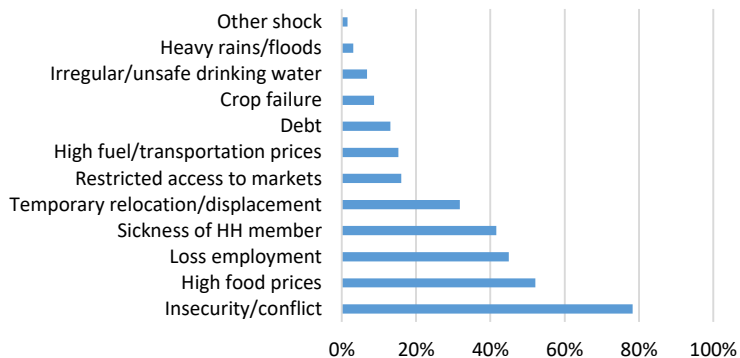


Chart 6: Most Significant Shocks before Arrival

### Food Availability

Among the assessed households, about 64.6 percent in most of the inaccessible LGAs reported not having a stock of foods from last season’s harvest. It was pronounced in places such as Geidam (97 percent), Magumeri (96.6 percent), Marte (93.2 percent), and Abadam (90.8 percent). Others who reported not having stock include Dikwa, Guzamala, Kala Balge, Mafa, Mobbar, Monguno, and Nganzai (100 percent) has the highest proportion of households that fell within this category. For about a third of all surveyed households that had food stock left, about (33.5 percent) indicated that it would have lasted for less than 3 months, thus suggesting a severe food deficit in inaccessible areas, despite the dry season harvest. Overall, land access was relatively high with about 55.6 percent of households reporting such access. However, of the (55.6 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 cultivated. 65.8 percent of households reported access to about 0.5 to 1 hectare of land being available for cultivation while 23.2 percent of households only had access to less than 0.5 hectares of farmland and 17.7 percent have access to 1 to 2 hectares of land. While only 3.6 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 27.7 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 88.7 percent of the surveyed newly arrived households. Areas with a high preponderance of households reporting non-functionality of the market are Biu (100 percent), Dikwa (100 percent), Guzamala (100 percent), Mafa (100 percent), Magumeri (100 percent), Marte (100 percent), Monguno (100 percent), Nganzai (100 percent), and Geidam (100 percent) reported a complete lack of functioning markets or sub-optimal functional markets in their places of origin, others include Abadam (95.4 percent), Askira Uba (94.5 percent), Marte (95 percent), and Kukawa (93.5 percent). Although, 86.6 percent of the households from inaccessible areas said they had access to the market in the last three months. However, insecurity (6.5 percent), and lack of money (2 percent), remained the main impediment to market access. Households from inaccessible areas acknowledged a significant increase (51 percent) and a small to moderate

increase (19.2 percent), a significant decrease (2.7 percent), and a small to moderate decrease (19.5 percent) in the prices of food commodities, which would potentially further weaken the already frail purchasing power of the inaccessible populace and consequently, deepen food insecurity vulnerability. This is particularly pertinent to note as market purchases were reported as the main source for staples in (19 percent) of interviewed households and this is high among Askira Uba LGA reported 78 percent dependence on the market, Others include Chibok (62 percent), and Michika (57 percent). Other notable sources for cereals recorded were own harvest (22 percent) which Biu LGA reported 100 percent, and labour exchange for food (22 percent). Moreover, wild food gathering (24 percent), and begging (6 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 Konduga (66 percent), Guzamala (46 percent), and Magumeri (54 percent). While begging for food is most pronounced in Damboa (41 percent), and Kala Balge (40 percent).

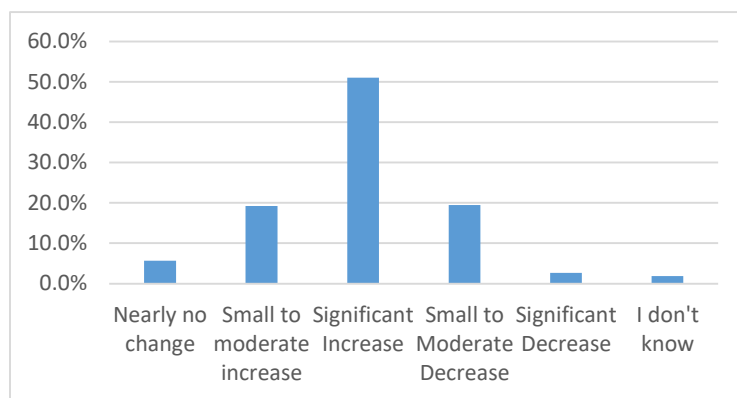


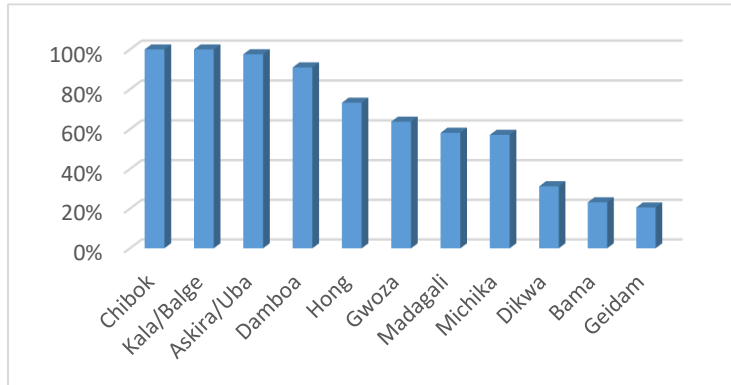
Chart 7: Changes in price

### Health and WASH

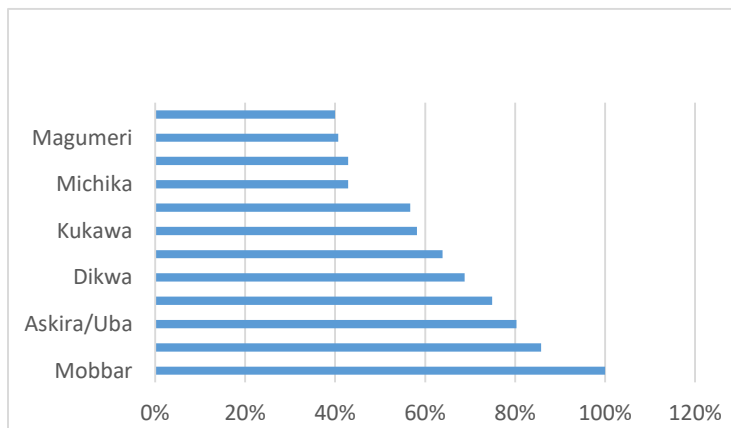
In the HSM assessment conducted in April 2023, the major source of water for the majority of households is unprotected well/spring (44%) with Kalabalge (100%), Chibok (100%), Askira/Uba (98%) and Damboa LGA (91%) among the highest. The aforementioned LGAs also have the highest number of respondents using unprotected sources. This is followed by Protected Well/Spring (33%) with Mafa (100%), Konduga (100%) and Gujba LGA (92%) among the highest. Hand pump/borehole (18%) is the third major source of water with Mobbar (100%), Abadam (58%) and Dikwa LGAA (50%) with the highest number of respondents. For Piped Water to House/neighbors’ house, only Bama (1%) reported. A source of water is through the public tap or stand (3%) with Monguno (50%) and Nganzai (33%) being the highest. Lastly surface water (2%) with Dikwa (19%), Bama (15%) and Michika LGA (14%). From the analysis, only 54% using protected sources while 46% using unprotected which shows a decrease in using protected sources (58%) and an increase in using unprotected sources (42%) compare to March 2023 data. Chibok (100%), Kalabalge (100%), Askira/Uba (98%) and Damboa (91%) are the LGAs with the highest access to unprotected water sources (Chart 8). In this regard, there is a need for water supply intervention, especially in mention LGAs to reduce the risk of water-related diseases outbreak.

Chart 9 shows that majority of the respondents (52%) spend less than 30 minutes to travel to the main source of water, wait in the queue and return with Mafa (100%), Monguno and Abadam (75%) which were the highest. Furthermore, (26%) of the respondents spent 30 minutes to 1 hour especially in Mobbar (100%), Geidam (60%) and Hong (50%) been the highest. Moreover, (11%) of the respondent have water in the vicinity with the highest

in Kalabalge (60%), Konduga (33%) and Gwoza LGA (25%). Lastly, (11%) spent 1 – 3 hours when collecting water with the highest number of respondents in Dikwa (50%), Chibok (44%) and Kalabalge LGA (40%). Considering the time to collect water, there is a slight decrease in “water in the vicinity” and “less than 30 minutes” compare to March 2023 data. There is a need for water reticulation/networking/piping and the addition of collection points and tap heads according to water supply and demand in affected LGAs to reduce the time taken in collecting water.

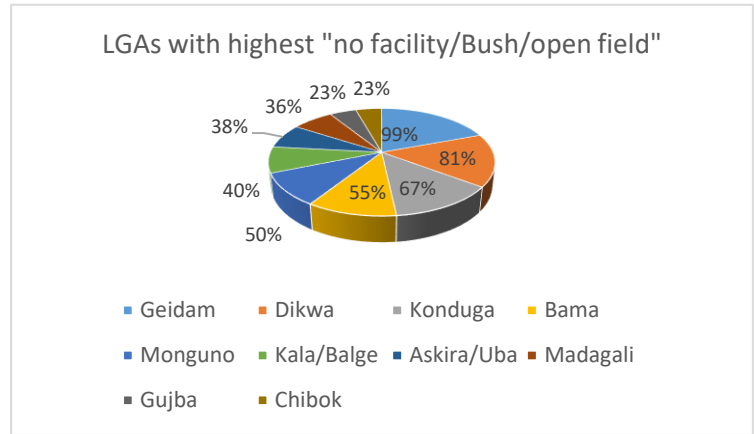


**Chart 8: Highest Use of Unprotected Water Sources by LGAs**



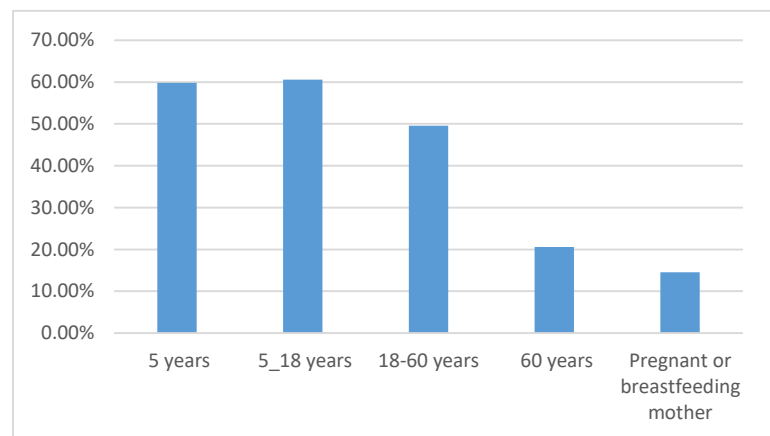
**Chart 9: Respondents spending more than 30 mins to Collect Water**

The common type of latrine used among the respondent is the ordinary pit latrine (70%) with 100% in Mafa, Nganzai, Mobbar and Michika LGA. This is followed by (22%) who do not have facility/Bush/open field with Geidam (99%), Dikwa (81%) and Konduga LGA (67%) being the highest. Dig hole and bury is (6%) with Biu, Gulani and Kalabalge at 86%, 61% and 20% respectively being the highest. The use of bucket/hanging latrines (2%) is in only five LGA with Damboa (18%), Kalabalge (5%) and Hong LGA (3%) being the highest. The flush toilet (0%) is only used in Ngala (3%), Magumeri (2%) and Damboa LGA (1%). Likewise, the access to VIP latrines (0%) is in only three LGAs of Bama, Guzamala and Kukawa LGA with 1% each as indicated in Chart 10. There is an increase in “do not have facility/Bush/open field” from 19% in March 2023 to 22% in April 2023 which pose a risk of WASH-related disease, especially at the start of the rainy season. There is a need for effective sanitation and hygiene promotion sensitization to promote the construction of latrines for safe excreta disposal.

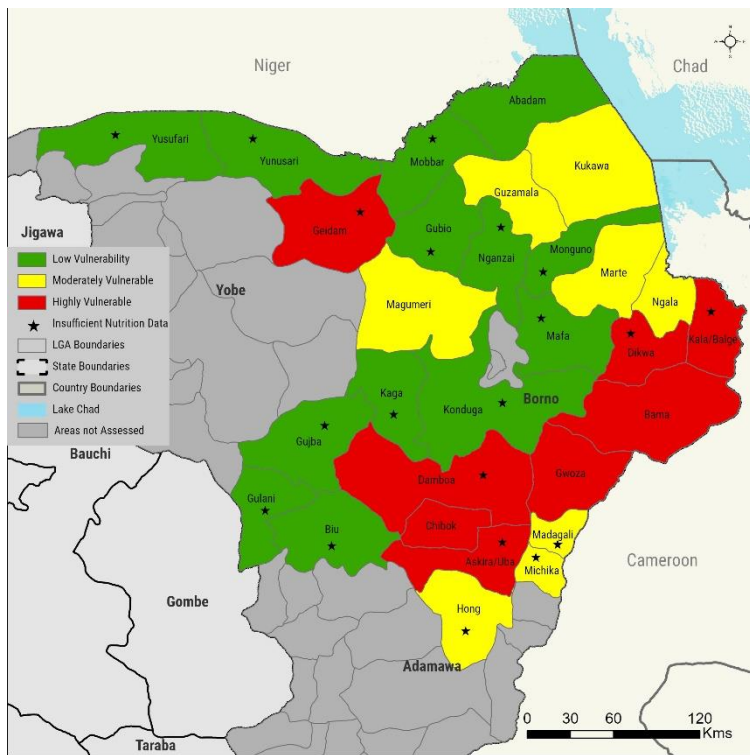


**Chart 10: Households having no toilet facility/Bush/Open field**

The large majority of respondents (89.5%) said they do not have access to a health facility, with 100% of respondents having no access to a health facility in Chibok, Dikwa, Guzamala, Kala/Balge, Konduga, Mafa, Marte, Monguno and Nganzai LGAs of Borno State. On the status of the health facility, where health facilities exist, only 3% reported fully functional facilities with free services, especially in Magumeri (50%); while fully functional facilities with paid services is reported by 9% of the respondents with Damboa having the highest proportion (30%) of respondents. Majority (46%) of the respondents said the health facilities are partially/sometimes functional (free or paid) with all (100%) of the respondents in Biu and Mobabar affirming this. Similarly, 41.2% of the respondents report that there is a clinic building but no staff or supplies to operate. This situation is worst in Geidam and Gujba where all the respondents (100%) have this view. To reach the nearest health facility, 19.3% of the respondents travel less than 30 minutes, 53.9% between 30 minutes and one hour and 25.9% between 1 and 3 hours. Responding on the type of health services provided by the clinic, 46.9%, 37.9% and 21.8% of the respondents said their clinic community outreach health services, in-patient health services and out-patient health services, respectively. Sickness of household member was reported by 71.9% of the respondents with fever, cough/flu and injuries/trauma being the most reported illnesses. These sicknesses affected mostly household members aged 5-18years (60.6%), followed by those aged 5 years (59.8%) and then 18 -60 years (49.6%) as seen in Chart 11.



**Chart 11: Who is Ill**



**Map 2: Vulnerability risk level Nov., 2022 to April, 2023**

**Key Risk Factors to Monitor**

Potential famine risk areas – Madagali, Askira-Uba, Bama, Chibok, Dikwa, Mobbar and Damboa – should be monitored closely on a continuous basis 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;

- Rising health risk within a highly food insecure, vulnerable, and inaccessible population;
- High morbidity rates and illnesses affecting all age strata including the productive household members. The impact of morbidity on the household expenditure, food consumption and productivity require in-depth exploration and close monitoring;
- Majority of the households have no access to or have difficulty accessing health facility. Hence, the need to devise alternative options for managing illnesses within the communities (i.e. ‘coping strategies’ for limited formal health services);
- The poor access to clean water and dignified sanitation, coupled with low hygiene awareness may likely result in increased AWD diseases, impacting under 5 children, thereby aggravating malnutrition and other negative outcomes of food and nutrition insecurity; and
- The combined effect of the factors highlighted above, would raise the morbidity level and, 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 HSM**

- Progressive reduction in sample size arising from limited number of new arrivals from the inaccessible localities;
- Data quality issues, especially relating to nutrition and mortality;
- Some inaccessible /Hard-to-reach localities are yet to be covered due to lack of partners’ operations in such areas.

**Note:**

Vulnerability 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.

*For further inquiries, please contact*

**Dr. Lawal SANI DAURA**

National Coordinator, National Programme for Food Security  
[Daura4215@gmail.com](mailto:Daura4215@gmail.com)

**Leslie Parker ODONGKARA**

Food Security Sector Coordinator - Nigeria  
[Leslie.odongkara@fao.org](mailto:Leslie.odongkara@fao.org)

**John Mukisa (Ph.D)**

Nutrition Sector Coordinator  
Nigeria  
[jmukisa@unicef.org](mailto:jmukisa@unicef.org)

**About the Humanitarian Situation Update for (HSU) for Inaccessible Areas**

The Humanitarian Situation Monitoring (HSM) system 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 HSM 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 HSM is basically conceptualized to support the Cadre Harmonisé analysis of the inaccessible areas in the BAY States.

The general objective of the HSM is to provide comprehensive information about the food security and nutritional situation of the population in inaccessible areas of Northeast BAY States. The HSM 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 HSM 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 employed 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 reporting period of July was **2,300** households (from 29 LGAs) who were interviewed at the reception points. The period of data collection for this edition of the bulletin lasted from 1st November 2022 to 31st April, 2023.

