



Famine Monitoring System – July, 2021 Monthly Bulletin

Cadre Harmonisé Task Force on Inaccessible Areas



KEY TAKEAWAYS

- Findings from the FMS revealed concerning consumption patterns in inaccessible areas as more than one in every two households (61 percent) struggled to have sufficient food intake and 83 percent experienced 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 (26 percent) or emergency (51 percent) coping strategies to meet their food needs, which heightens economic vulnerability due to the negative impact on future productivity of the most affected households;
- The levels of acute malnutrition among new arrivals from the inaccessible areas is Critical (Phase 4 IPC Acute Malnutrition Classification) with the overall Global Acute Malnutrition (GAM) rates standing at 20.0 percent and Severe Acute Malnutrition (SAM) at 6.2 percent. This high level of acute malnutrition indicates an extremely stressed population including food insecurity, poor sanitation and hygiene and health conditions which are the key underlying causes of acute malnutrition;
- Detailed analysis among newly arrived population with good quality and adequate sample size showed severe consumption deficits and concerning SAM rates (18.1 percent) in Bama LGA, whereas near Extremely Critical (Phase 5) GAM rates were found in Gwoza, Magumeri Konduga and Kukawa;
- The elevated levels of consumption gaps, malnutrition and pervasive usage of emergency coping strategies, is largely underscored by 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 take render some areas totally or partially inaccessible to humanitarian response agencies/partners. The protracted nature of this conflict in Northeast has made the humanitarian crisis much more complicated, and, rendering parts of Borno, Adamawa and Yobe State inaccessible.¹ 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 probable situation of populations in some inaccessible areas. From the results of March, 2021 CH analysis in which 746,846 and 881,261 persons for current (March – May) and projected (June – August) period, respectively, were

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 an alert 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 will also inform the upcoming October, 2021 Cadre Harmonisé analysis and classification in different phases of food security and malnutrition of these 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 collection 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.

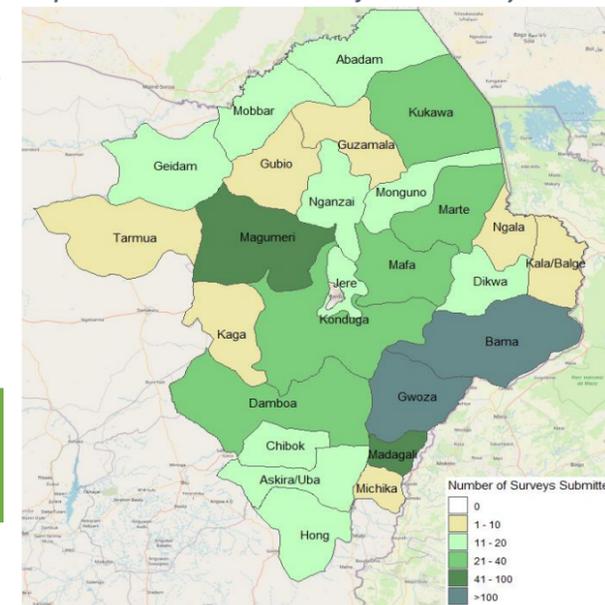
Primary data was jointly collected by partners in many accessible towns of Borno, Adamawa and Yobe States where there are new arrivals coming from the inaccessible areas with the support of the DTM from SEMA and IOM. Well-structured questionnaire was deployed by trained enumerators in collecting the 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 were employed in selecting the recent new arrivals (within the last 30 days) who were the primary target. During the month of June 2021, a total of **750 sampled households** (from 26 LGAs) were interviewed with comprehensive nutrition screening for **about 800** children 6 to 59 months old at the reception centres. The period of data collection for lasted from 5th June, to 31st July, 2021.

¹ Areas designated in North-east Nigeria as all areas where humanitarian cannot access to provide assistance to affected populations, and where populations cannot access humanitarian to receive assistance either. The Nigeria Access Working Group has also defined 9 more formal criteria to designate inaccessible areas (internal document)

classified in phase 3 – 4 of acute food and nutrition insecurity across the inaccessible areas of the BAY states. 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). 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 development outside the CH analysis cycle.

Map 1: Inaccessible Areas Covered from June to July 2021



RESULTS

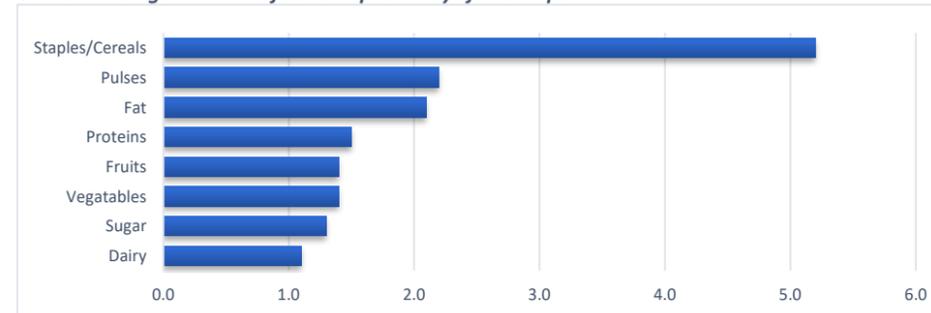
Outcomes – Food Security

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 continued to show concerning food consumption deficits and limited diversity of diets in the inaccessible areas surveyed. More than one in every two households (61 percent) did not have sufficient food intake (*poor + borderline food consumption*), with 39 percent of such households reporting severe food consumption deficit. This indicates potential widespread consumption gaps in inaccessible areas and as well infers that the FCS stands at emergency level (CH Phase 4), the highest possible classification in the FCS categorization. While the global findings were consistent in some of the areas at indicative levels, Bama, Damboa and Madagali LGA, all of which had a relatively higher level of confidence interval given their sample, showed quite concerning findings, with 88 percent, 83 percent and 87 percent of the surveyed households respectively reporting inadequate diets in their places of origin. The proportion of households with severe consumption deficits (*poor food consumption*) stood out in Bama (72 percent) and Damboa (67 percent). 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 would continue to have 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): The pronounced usage of food based coping strategies to bridge food gaps within the surveyed households persisted in July 2021. About half of all surveyed households that reported mean reduced coping strategy index (rCSI) scores greater than 19, which is the most severe categorization according to the CH guidelines (CH Phase 3). Like June 2021, households in inaccessible areas in Bama LGA continued to make significant contribution to the global average as 80 percent of households had rCSI score 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 Bama where households typically adopt such strategies for almost five out of seven days for all food based coping strategies except for the category: “*borrow food or reliance on help from friends and relatives*” (3.3 days) 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.

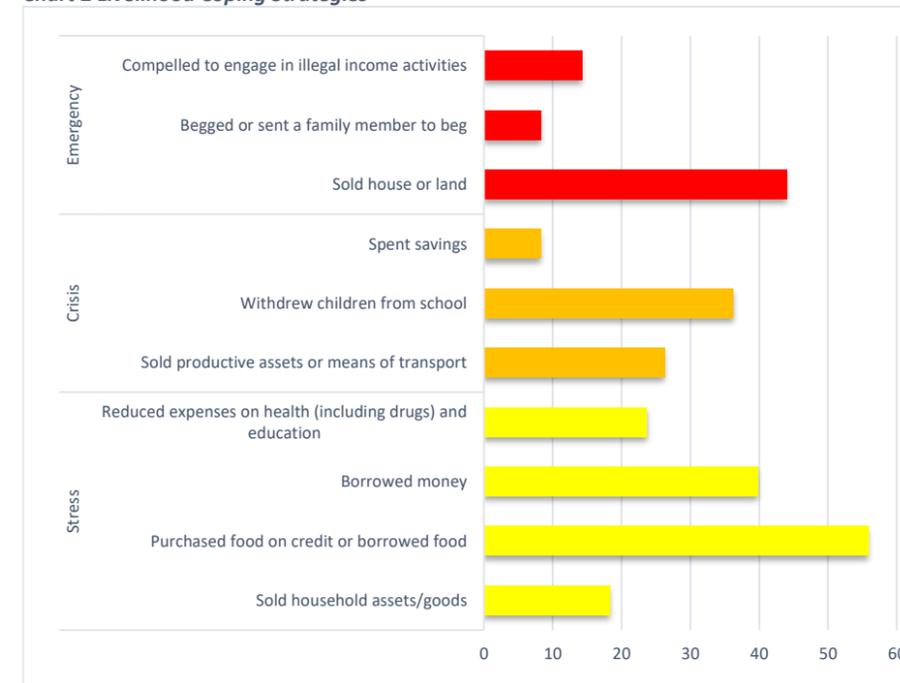
Household Hunger Scale (HHS): Findings from the HHS, which is a perception-based measure of food deprivation and experience of hunger in the surveyed households, showed that more than four in every five households (83 percent) experienced crisis or higher levels (CH Phase 3 and above) of food deprivation and hunger according to the CH analysis guidelines. Specifically, 7.2 percent and 7.5 percent of households reported emergency and catastrophe/famine levels of HHS respectively, suggesting severe consumption deficit and pervasive incidence of hunger episodes in these affected households. Based on the metrics presented, HHS for inaccessible areas of BAY States was classified as CH Phase 3 (crisis), albeit Bama (27 percent) and Dikwa (20 percent) were classified in CH Phase 5 (catastrophe/famine) because more than 20 percent of the surveyed households fell within the catastrophe/famine category. This suggests worrisome HHS trends and significant food deprivation and widespread hunger especially in the highlighted LGAs 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 77 percent of the surveyed households used either crisis (26 percent) or emergency (51 percent) 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, 40 percent sent family members to beg, 8 percent engaged in illegal income activities and 8 percent sold their assets – particularly land and house, whereas in the crisis category, 36 percent of households spent their savings and 26 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

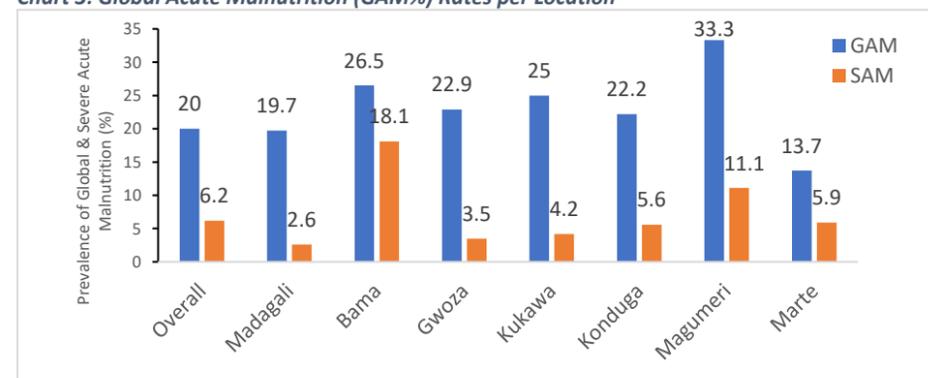
Malnutrition

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 is **Critical (Phase 4 IPC Acute Malnutrition Classification)** The overall Global Acute Malnutrition (GAM) rates were 20.0% and Severe Acute Malnutrition (SAM) at 6.2%. The high levels of acute malnutrition indicate an extremely stressed population including food insecurity, poor sanitation and hygiene and health conditions, the key underlying causes of acute malnutrition.

Detailed analysis among arrival population with good quality and adequate sample size showed **Extremely Critical (Phase 5)** GAM rates in Magumeri while Bama, Gwoza, Konduga and Kukawa are almost in the **Extremely Critical (Phase 5)**. Among inaccessible population in Bama LGA, the rates of severe acute malnutrition (18.1%) indicated recent and extreme population stresses e.g. food shortage or disease outbreak.

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

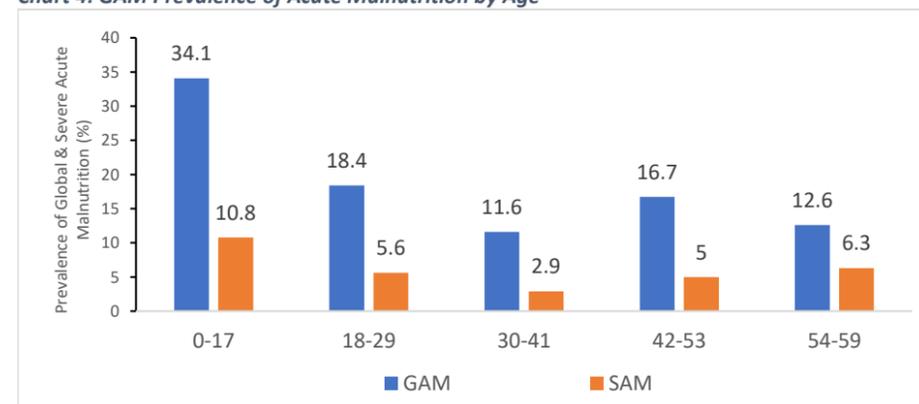


Contributing Factors

Hazards and Vulnerabilities

Protracted armed violence by non-state armed groups (NSAG) has forced hundreds of thousands of farming households out of their homes, seeking refuge in internally displaced camps, and host communities perceived to be safer. Livelihoods of many households have broken down, rendering them food insecure with high levels of severe acute and chronic malnutrition; while armed conflict has also disrupted trade and market functionality, food commodity flow and terminated other income generating activities. Increased wave of insurgency has cut off major trade routes creating a serious clog in the supply of staple food and essential non-food items. This has contributed to the abnormal rise in staple prices since the inception of COVID-19 induced economic impacts. As a result, thousands of farming households continue to flee their homes to seek shelter in internally displaced camps and host communities. Just over a third (37 percent) of respondents from the ongoing FMS assessments confirmed that some previously internally displaced persons (IDPs) have been returning to their communities of origin in the past 3-4 months while 63 percent have not witnessed any returning IDPs. This confirms that the underlying drivers of displacement are yet to be resolved, and people do not feel safe/secure to return to their communities of origin. Indeed conflict and/or insecurity was considered the most significant shock (82 percent) that affected IDPs' settlements of origin 3-4 months prior to their departure, followed by sickness of household member (51 percent) and high food prices (44 percent) – see chart 6.

Chart 4: GAM Prevalence of Acute Malnutrition by Age



The children ages 6- 17 months were three times more likely to be acutely malnourished than older children (30 – 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 could be attributed to data collection period (rainy / hunger peak) which is characterized by food shortage, diarrhea, and poor childcare practices due to increased workload among the farming communities.

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.

Despite the majority having access to farmland (72.1 percent), the average size of the farmland reportedly available was predominantly less than one hectare (73.2 percent). Moreover, more than 65.6 percent households had no food stocks left in their households before fleeing their homes, while 48.9 percent of those left behind are projected to cultivate mostly cereals and legumes (maize 52.3 percent, millet 44.4 percent, cowpea 53.3 percent and groundnut 42.3 percent) during this year's wet season. However, most of these farmers that have expressed perception to cultivate might not be able to harvest all their produce due to insurgency. Some might abandon their crops on the field while others might have to share their harvest with the insurgents. Consequently, the identified shocks, food security and nutrition outcomes have continued to deteriorate.

Food Availability

Among the surveyed households (65.6 percent) in most the inaccessible LGAs reported not having stock of foods from last season's harvest. Most of these households that do not have any food stock left at the time of departure are largely located in Marfa (92.3 percent), Chibok (88.9 percent) and Bama (83.5 percent). Bulk of the households that have food stock left said it could only last for less than 3 months (57 percent). This suggests severe food deficit in the inaccessible areas, particularly during the lean season period. Generally, access to land for farming was as high as 100 percent in Michika (Adamawa) and Tarmua (Yobe); places like Kaga and Kala balge of Borno no access at all (0 percent).

Stunting and Underweight

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

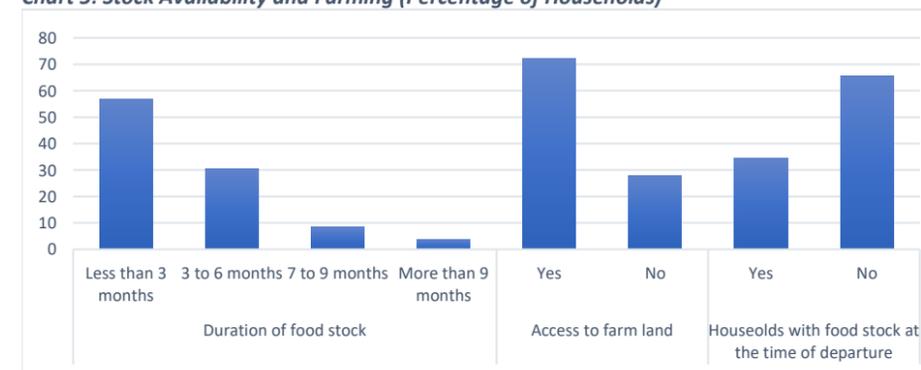
Stunting and Underweight: According to the FMS over a third of the children are stunted (38.3%) and underweight (33.9%). The high stunting and underweight is a clear indication of a population that is chronically stressed with poor nutrition and repeated infection. Stunted children fall sick more often, miss opportunities to learn, perform less well in school and grow up to be economically disadvantaged, and more likely to suffer from chronic diseases.

Note:

The data on acute malnutrition 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 the collected data) was included in the analysis. Also, for reason of data quality, mortality is not reported in this edition.

Other areas with relatively low access to land include Damboa (41.7 percent), Dikwa (46.7 percent), Jere (45.5 percent) and Mobar (50 percent). However, across most of the areas, the amount of land cultivated remains minimal with most households (73.2 percent) reporting 0.5 to 1 hectare of land being available for cultivation. Despite these challenges highlighted, farming continues to remain the mainstay for food availability in households with arable land access as 89.1 percent of such households were engaged in farming during the month that preceded their departure from places of origin.

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



Food Access

Markets were either completely non-functional as confirmed by 64.9 percent of the surveyed newly arrived households, or functioning at sub-optimal levels some of the inaccessible areas. Areas with higher preponderance of households reporting non-functionality of market are Michika and Chibok (100 percent), Hong (90.9 percent), Askira/Uba (92.3 percent) that markets were non-functional in their places of origin, most notably Magali (90 percent), Askira Uba (86 percent), and Damboa (91.7 percent). Although 81.4 percent of the households from inaccessible areas said they had access to market in the last three months, however, 13.2 percent and 10 percent of them were constrained by insecurity and lack of money, respectively; while 4 percent said the markets were closed. All the respondents (100 percent) from Kaga said their access to market is mainly constrained by insecurity. Households from inaccessible areas acknowledged small moderate (21.3 percent) to significant increase (25.1 percent) in prices of food commodities. Access to food would also be challenged by significant increase (25.1 percent) in prices of staple food commodities. Specifically, for access to major cereals, the main sources reported were own harvest (21.2 percent), market purchase (16.9 percent) and labour exchange for food (13.2 percent). Fishing and hunting are resorted to by 10.9 percent while gathering and wild food foraging is applied by 12.4 percent. The pervasive use of extreme coping measures such as wild food foraging and begging remains concerning as this accounts for the source of cereals for about 19 percent of the households.

Health and WASH

The assessment of inaccessible areas collected data bordering on water, sanitation, hygiene and health services in the inaccessible areas from where the new arrivals left. About 38.8 percent of the interviewed individuals across the inaccessible LGAs accessed water from unsafe sources (surface water {river, dam, pond, etc}, rain water, unprotected spring and tanker truck). The highest preponderance of surface water sources was reported for Askira/Uba (77 percent) and Chibok (72 percent) LGAs of Borno State. About 49 percent of the respondent new arrivals said it takes more than 30mins to access water. Highest proportions of new arrivals in Monguno (44 percent) and Kala/Balge (33 percent) spent between 1 and 3 hours to access water. Moreover, access to sanitary services is constrained in inaccessible areas as evidenced in majority of surveyed households (98 percent) that lacked access to improved toilet facilities. Ordinary pit latrine remained the most common toilet facility, closely followed by open defecation in the bush/open field.

In relation to health services and facilities, 72 percent of the surveyed households lacked access to functional health and nutrition services in their locations of origin. However, majority of the individuals from Abadam and Nganzai (92 percent each), Dikwa (80 percent) and Magumeri (69 percent) reported that they had functional and accessible health and nutrition services in the communities. Regarding the cost of access to such services in places where they are existent, 61 percent of households access for free whereas 11 percent either access for free or pay for such services. About 89 percent of Magumeri households reported that the health facilities were fully functional and free, while Damboa (75 percent) had the highest proportion of respondents who said the health services were functional but paid. More than half (51 percent) of respondents spend between 30mins and 1 hours to access near health facilities. Yet it takes as much as one to four hours for 18 percent of households. In- and out-patient health services are mostly available in the communities of origin of interviewed households as reported by 29 percent of households. Community outreach health services was confirmed by 6 percent while nutrition services was acknowledged by another 6 percent of the interviewed households. There is serious lack of or only skeletal community health services in places like Gwoza, Jere, Nganzai, Geidam and several other areas. Illness of household members is prevalent as confirmed by 82 percent of the surveyed households. Children under 5 years of age were most vulnerable to illness as reported by 56 percent of the new arrivals, followed by children between five and 18 years (51 percent). Askira/Uba has the highest prevalence (77 percent) of under 5 years illness, followed by Chibok (72 percent); while illness of older people (60 years and above) and lactating mothers are most common in Tarmuwa (50 percent) and Monguno (67 percent). Fever (81 percent) and cough/flu (50 percent) constitute the most common illness across the inaccessible areas of origin of the respondents.

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

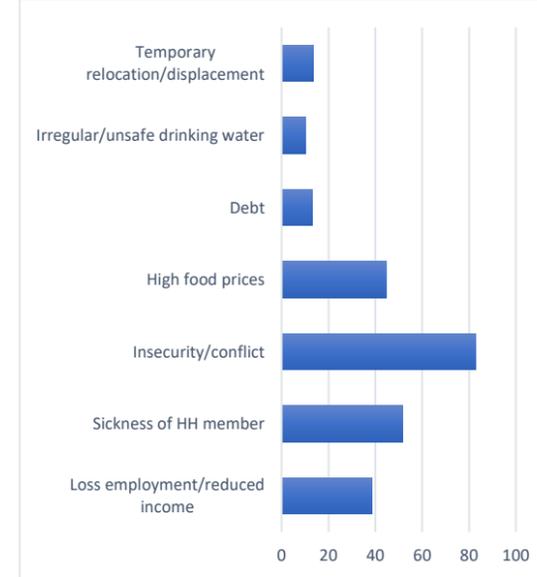


Chart 7: Changes in price

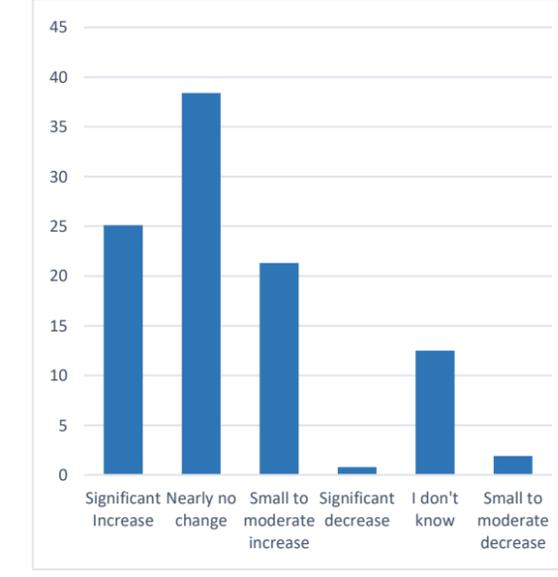
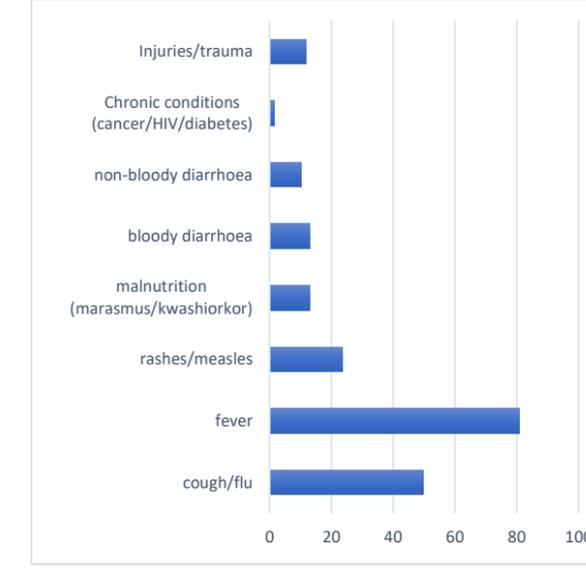
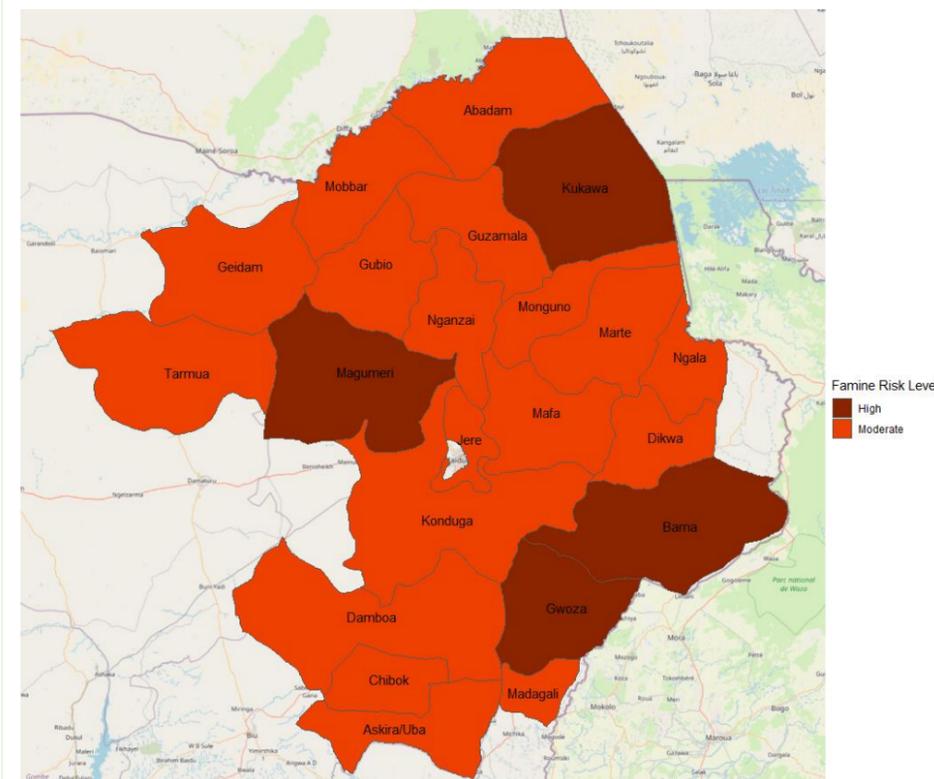


Chart 8: Type of Illnesses



Famine Risk Level – July 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. 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 available for Download Here](#)

Key Risk Factors to Monitor

- High famine risk areas – Bama, Gwoza, 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;
- Elevated health risk within a highly food insecure, vulnerable, and inaccessible population;
- 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 require in-depth exploration and close monitoring;
- Majority of the households have no access to health facility. This warrants the need to devise alternative ways through which communities could manage illnesses (i.e. 'coping strategies' for limited formal health services); and
- 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

- Small sample size arising from limited number of arrivals from inaccessible localities;
- Data quality issues due to low understanding of the instrument by field enumerators, specifically on nutrition and mortality;
- Limited coverage in some locations (e.g. Kaga) due to lack of partners' representation/operations in such areas.