KEY TAKEAWAYS

- *Findings from the FMS revealed concerning consumption patterns in inaccessible areas as more than half of all sampled households (56 percent) struggled to have sufficient food intake and 67 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;*
- *Majority of households (84 percent) relied on either crisis (26 percent) or emergency (58 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 20.7 percent and Severe Acute Malnutrition (SAM) at 4.9 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 (15 percent) in Bama LGA, whereas near Extremely Critical (Phase 5) GAM rates were found in Gwoza, Magumeri 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

One of the fallouts of the insurgency in the North East States of Borno, Adamawa and Yobe is that some areas have been totally or partially inaccessible to humanitarian response agencies/partners. The continuation of conflict in Northeast Nigeria has created a complex humanitarian crisis, 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, efforts have been made by various stakeholders.

Several cycles of the Cadre Harmonisé (CH) analysis mirrored into the situation of populations in some inaccessible areas. Following the outcome of March, 2021 CH analysis in which 746,846 and 881,261 persons for current (March – May) and projected (June – August)

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) led by 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 on the alert in case issue of famine emerges. The FMS uses a methodology that combines both food and nutrition security monitoring strategies to picture and 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 Nigeria. 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 from many accessible towns of Borno, Adamawa and Yobe States where there are new arrivals coming from 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 discussion (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, 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 ***360 sampled households*** (from 23 LGAs) were interviewed with comprehensive nutrition screening for ***420*** children 6 to 59 months old at the reception centres. The period of data collection for lasted from 5th to 30th June, 2021.

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[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)*

period, respectively, were 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 consumption pattern in a smaller 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 closely monitor 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. As a result, the Famine Monitoring System aims 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 in June 2021 FMS and IOM's ETT Arrival Data
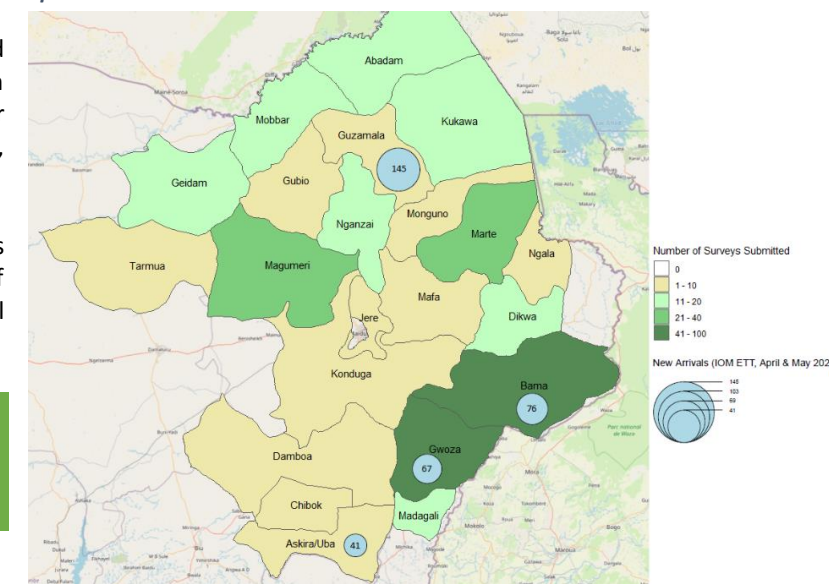
RESULTS
Outcomes – Food Security

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 (56 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 percent of such households reporting severe food consumption deficit. This 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 LGA, which has a relatively higher level of confidence interval given its sample, showed quite concerning findings as 85 percent of the surveyed households did not have adequate diets (*poor + borderline food consumption*) in their places of origin. 71 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 six 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
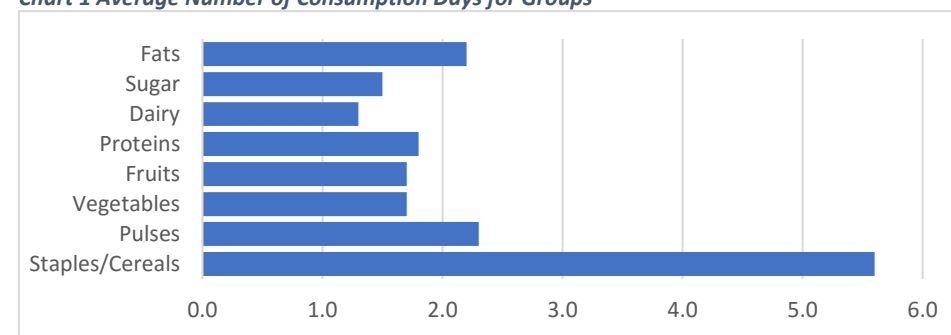
Reduced Coping Strategy Index (rCSI): Moreover, there was pronounced usage of food based coping strategies to bridge food gaps within the surveyed households. About 58 percent of households that reported mean reduced coping strategy index (rCSI) scores greater than 19, which is the most severe categorization according to the CH guidelines (CH Phase 3). Again, households in inaccessible areas in Bama LGA contributed significantly to the global average as 85 percent of households were in CH Phase 3 with an 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 an average of 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*" (3.5 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 the majority of households (67 percent) experienced crisis or higher levels (CH Phase 3 and above) of food deprivation and hunger according to the CH analysis guidelines. Specifically, 9.2 percent and 8.6 percent of households reported emergency and catastrophe/famine levels of HHS respectively, equating to almost one in every five households in inaccessible areas. Based on the metrics presented, HHS for inaccessible areas of BAY States was classified as CH Phase 3 (crisis), albeit areas such as Bama (25 percent), Dikwa (27 percent) and Mafa (25 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 84 percent of the surveyed households used either crisis (26 percent) or emergency (58 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, 50 percent sent family members to beg, 11 percent engaged in illegal income activities and 10 percent sold their assets – particularly land and house, whereas in the crisis category, 38 percent of households spent their savings and 27 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
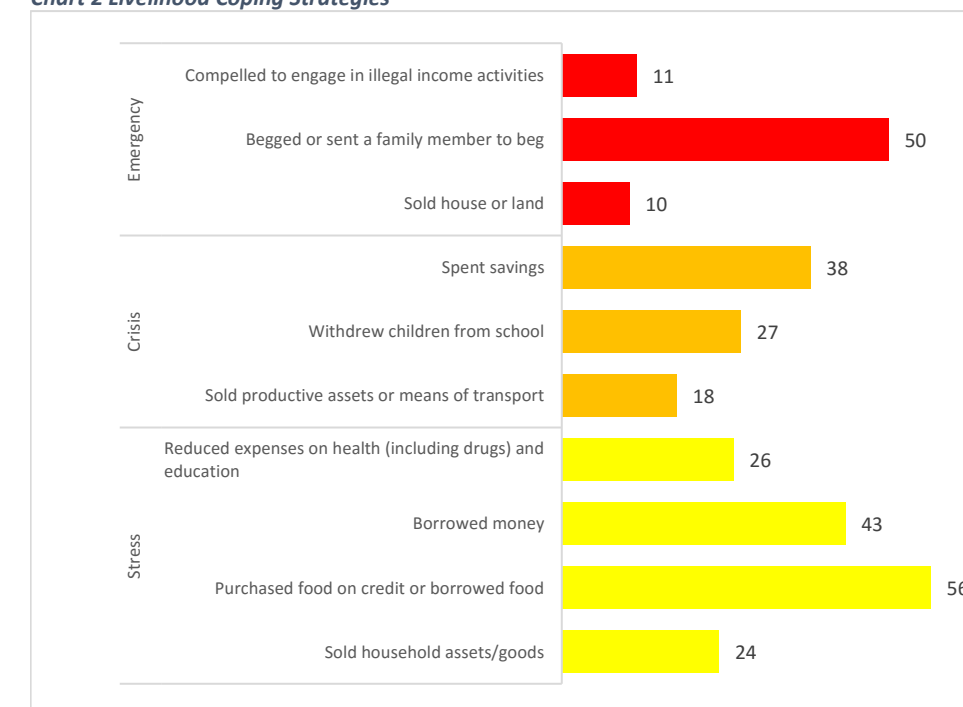
Outcomes – Nutrition

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 20.7% and Severe Acute Malnutrition (SAM) at 4.9%. 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 near *Extremely Critical* (Phase 5) GAM rates in Gwoza, Magumeri and Kukawa. Among inaccessible population in Bama LGA, the rates of severe acute malnutrition (15%) indicated recent and extreme population stresses e.g. food shortage or disease outbreak.

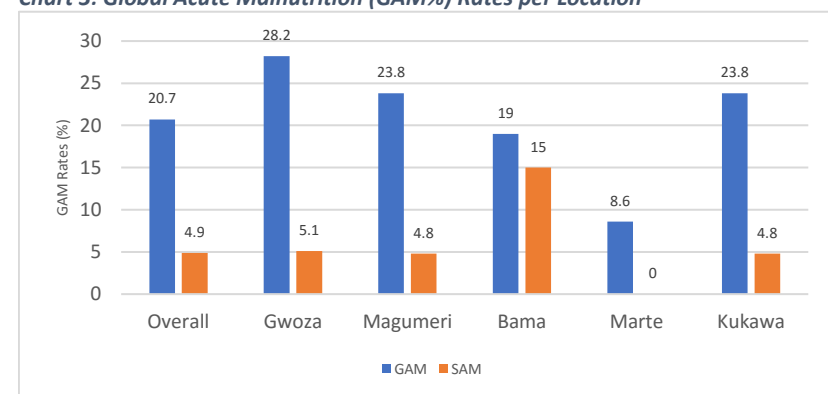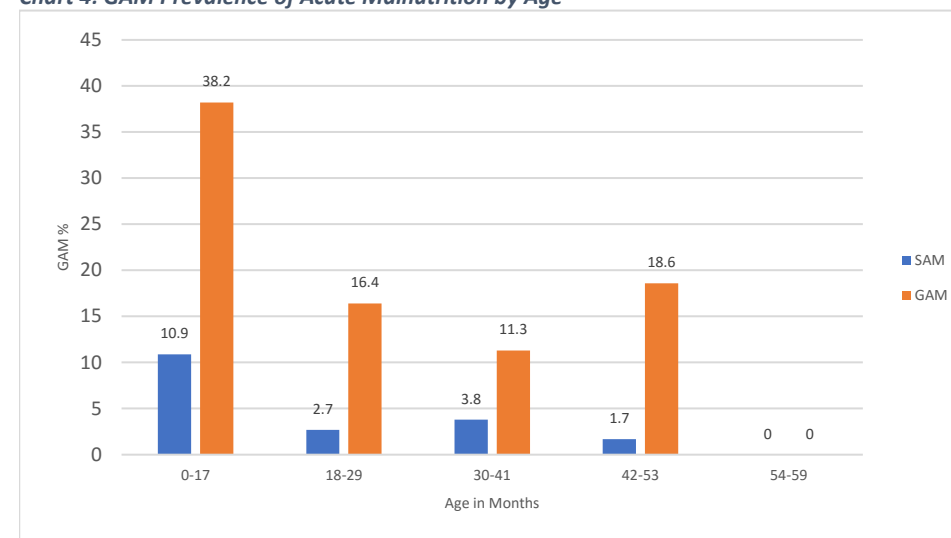*Chart 3: Global Acute Malnutrition (GAM%) Rates per Location*

Chart 4: GAM Prevalence of Acute Malnutrition by Age

The children ages 6- 17 months were four 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 5times 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.

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 an 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.

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. Armed conflict has also disrupted trade and market functionality, disrupted food commodity flow and terminated other income generating activities. Increased insurgency has cut off major trade routes creating a serious vacuum of staple food and essential non-food items. This has contributed to the atypical rise in staple prices since the evolution of COVID-19 induced economic impacts, complicated further by poor terms of trade and weak purchasing power, seriously limited most household's access to sufficient food.

The FMS survey indicates that 62 percent of respondents noted that some people have not returned to their homes of origin in the past 3 months compared to 38 percent who claimed that some people did. This indicates that the underlying drivers of displacement are yet to be resolved, and people are forced to stay in IDP camps. Data from the same survey indicates that in the months preceding their displacement, insecurity was the main shock (79 percent) followed by sickness of household member (52 percent), high food prices (49 percent) and declined income (42 percent).

Despite the majority having access to farmland (73 percent), the average size of the farmland reportedly available was predominantly less than one hectare. Moreover, more than 60 percent households did not have any food stocks left in their households before fleeing their homes, while those that were left behind are projected to cultivate (53 percent) crops during this year's wet season, with the majority anticipated to harvest maize (49 percent), cowpea (49 percent), millet (38 percent) and groundnuts (36 percent). Consequent to the ongoing and protracted shocks, food security and nutrition outcomes have continued to deteriorate.

Food Availability

As expected with the onset of the lean season, more than half of households (60.3 percent) in most the inaccessible LGAs have reportedly depleted last season's harvest or have limited food stocks remaining, with disproportionately higher proportion of such households situated in Bama (87 percent). For the few households (40 percent) that reported availability of food stock at the time of departure from their places of origin, one in every two of such households (51 percent) only had stock that would have lasted for three months or less. This suggests severe food deficit in the inaccessible areas, particularly during the lean season period. In general, access to land for farming was relatively high in most areas (73 percent), albeit, with relatively lower rates reported in completely inaccessible LGAs, notably Marte (59 percent), Kukawa (58 percent) and Guza-

mala (50 percent). However, across most of the areas, the amount of land cultivated remains minimal with most households (85 percent) reporting 0.5 to 1 hectares 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 87 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)
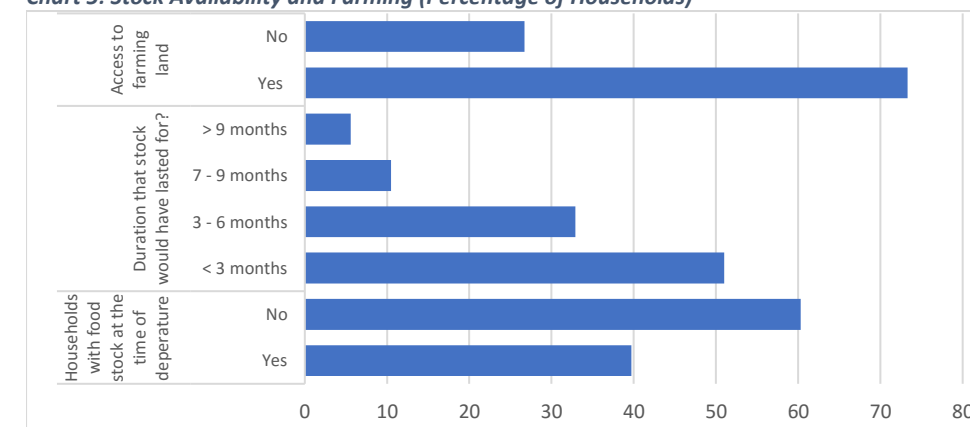
Food Access

Markets were either completely non-functional or functioning at sub-optimal levels in inaccessible areas as 60 percent of the respondents indicated that markets were not functioning in their places of origin before their departure. A higher proportion of households reported that markets were non-functional in their places of origin, most notably Magali (90 percent), Askira Uba (86 percent), Bama (85 percent), Gwoza (81 percent) and Kukawa (68 percent). However, even in the few areas with functioning markets, over 80 percent of the households reported a time could not access the market in the last 3 months before they left their place of origin. The primary constraints for market access were lack of money (12 percent) and insecurity (16 percent). Moreover, 1.1 percent of households reported market location was far and 4.4 percent reported that market were closed in the LGAs assessed. Specifically for access to major cereals, the main sources reported were own harvest (21 percent), labour exchange for food (14 percent), fishing and hunting (13 percent), gathering and wild food foraging (12 percent) and begging (9 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 one in every five households (almost 20 percent).

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 35 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 Gwoza (73 percent), Askira Uba (57 percent) and Chibok (43 percent) LGAs of Borno State. About 34 percent of the respondent new arrivals said it takes between 30mins and 1 hours to source water while 18 percent spent more than 1 hour to access water. Highest proportions of new arrivals in Monguno (67 percent) and Ngala (50 percent) spent between 1 and 3 hours to access water. The new arrivals largely do not have access to improved toilet facilities as over 95 percent of them use either ordinary pit latrine, open field or dig hole and bury their faeces. However, ordinary pit latrine is the most common toilet facility reported by the new arrivals across the LGAs, closely followed by the use of bush/open field.

In relation to health services and facilities, over 66 percent of the interviewed new arrivals said there were not functional accessible health and nutrition services in the locations they came from. However, majority of the individuals from Abadam and Nganzai (92 percent each), Dikwa (82 percent) and Gubio (63 percent) said there were functional and accessible health and nutrition services in the communities they arrived from. Status of health and nutrition services in settlement is such that 65 percent of the interviewed new arrivals claimed they are fully functional and free while 25 percent said the facilities in settlement and partially functional (free or paid). All the new arrival from Geidam LGA said the health and nutrition services are fully functional but are paid for. Majority (70 percent) of the individuals from the inaccessible areas spent relatively longer than time traveling to and returning from health facilities with 46 percent achieving this between 30mins and 1 hours, and about 23 percent making it in more than 1 hour or even up to half a day as in Gwoza and Geidam LGAs. In- and out-patient health services are most available in the communities of origin of interviewed new arrivals as reported by 19 percent and 14 percent respectively. Community outreach health services was confirmed by 7 percent and nutrition services (7 percent) only. There is serious lack of health services in places like Madagali (Adamawa), Bama, Ngala (Borno) and Geidam (Yobe) where only out-patient services were skeletally offered. Illness of household members is prevalent in the areas covered in this assessment as consented to by 84 percent of the respondent new arrivals. The least occurrence of illness among household members is reported in Guzamala (50 percent). Children under 5 years of age were most vulnerable to illness as reported by 58 percent of the new arrivals, followed by children between five and 18 years (51 percent). Illness of under 5-year old children is most common in areas of Ngala, Askira Uba, Chibok, Damboa, Konduga and Geidam; while illness of people older than 60 years and pregnant/lactating mothers is reported by 10 percent and 6 percent respectively. The most common type of illness across the areas is fever (83 percent), cough/flu (48 percent) and rashes/measles (26 percent).
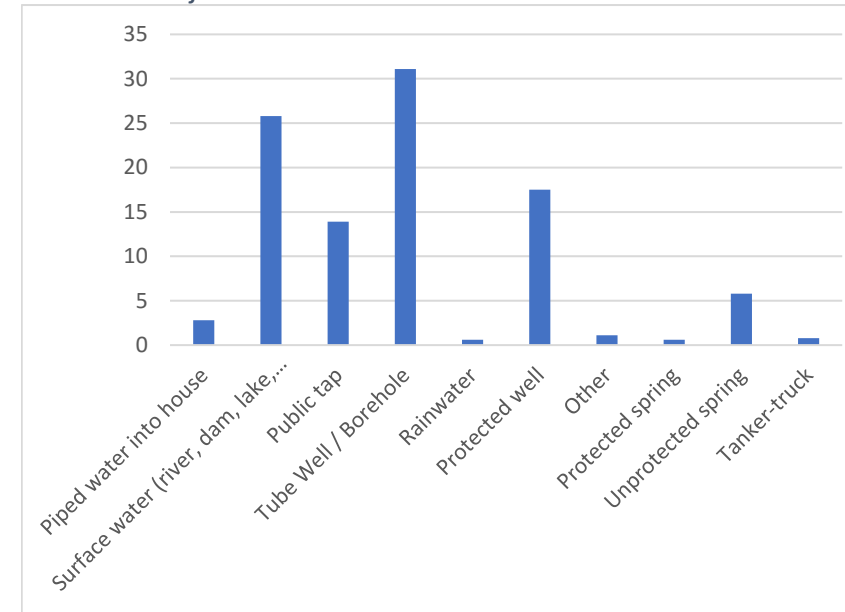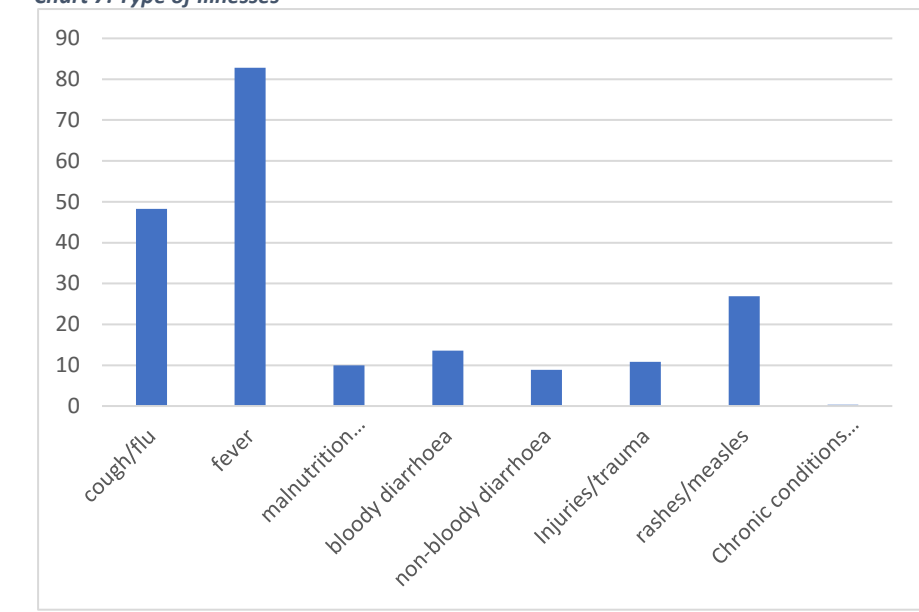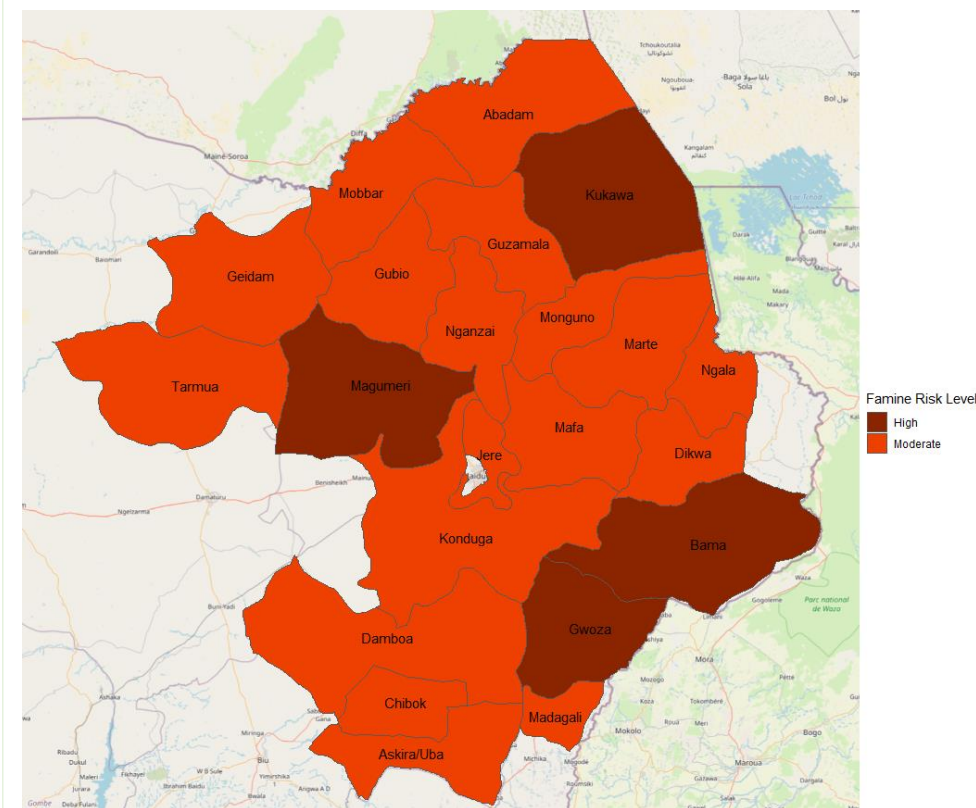
Chart 6: Source of Water

Chart 7: Type of Illnesses

Famine Risk Level – June 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, Kukawa and Magumeri – should 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;*

- *Almost all 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*

- *When these highlighted factors are combined, they heighten morbidity risk and would likely impact households' ability to engage in labor for food or resource gathering— and further deepening the vulnerability of already fragile households.*

Limitations of the FMS

- Small sample size arising from fewness of new arrivals from the inaccessible localities;
- Data quality issues due to low understanding of the instrument by field enumerators;
- Some inaccessible areas were not covered in the assessment due to lack of partners' representation/operation in such areas.