



# Humanitarian Situation Update – March, 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 44.4 percent of the surveyed households struggled to have sufficient food intake and nearly 64.8 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;*
- *44.8 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 19.1 percent and Severe Acute Malnutrition (SAM) at 6.2 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 1.56 deaths/10,000 persons/day for CMR and 3.62 deaths /10,000 under-fives/day. Magumeri, Chibok, Marte and Abadam LGAs had the highest U5MR of 5.32, 4.54 and 4.12 deaths/10,000 children under 5years/day, respectively; while Bama and Chibok LGAs had the highest CMR of 1.91 and 1.92 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.

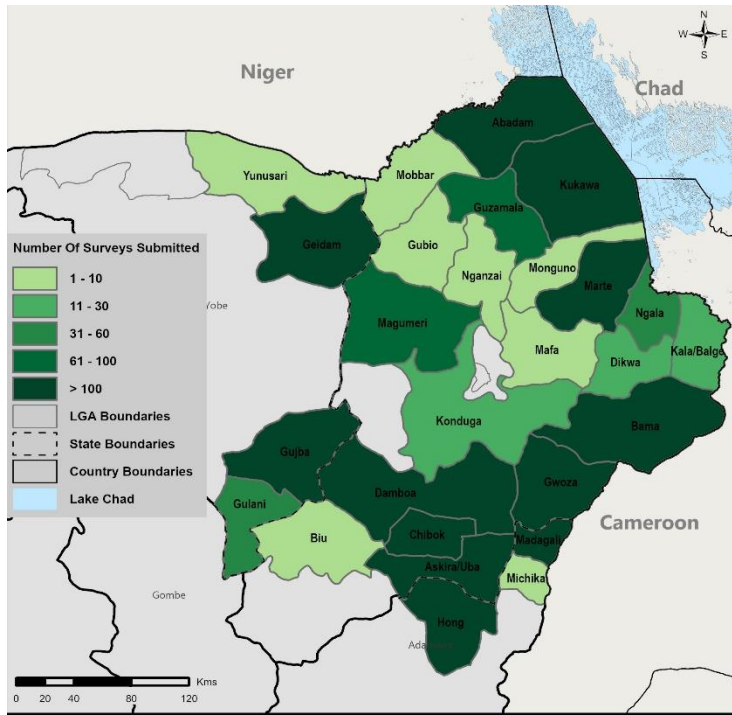
Several cycles of the Cadre Harmonisé (CH) analysis unveiled the problem situation of populations in some inaccessible areas. From the results of March 2023 CH analysis in which 3,207,298 and 4,250,397 persons for the (Mar – May) and (June – August 2023) periods, respectively, were classified in phase 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)

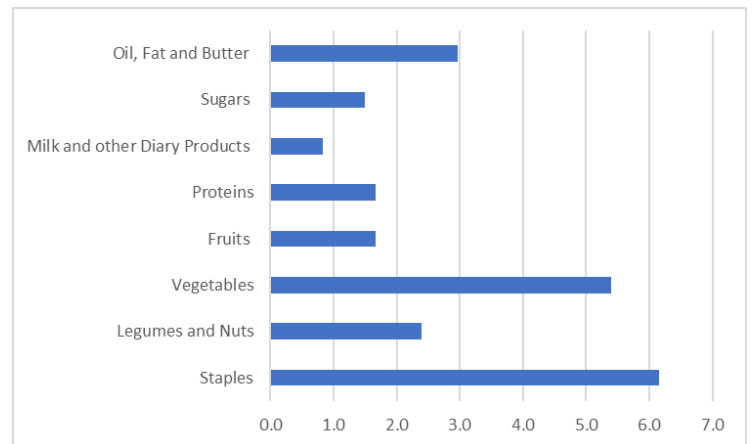
The food consumption for the HSM is measured in three dimensions in line with the provision of the CH version 2.0 – food consumption score (FCS), reduced coping strategy index (rCSI) and Household Hunger Scale (HHS).

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, 44 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 12.2 percent of such households were reportedly affected by poor food consumption while 31.9 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 is lower than some of the areas at indicative levels, Askira/UBA, Bama, Chibok, Damboa, Guzamala, kalabalge, Magumeri, Mobbar, Monguno, Ngala and Nkanzi LGAs, which have a relatively higher level of confidence interval given their sample size, showed quite concerning

findings as 62,66,65,87,90,54,89,52,75,50,79,83percent 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 vegetable for 5 out of 7 days on average, fat for 3 out of 7 days while pulses were consumed more than 2 out of 7 days. All other food groups (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, Kaga, Abadam, Biu, Gubio, Guzamala, Gwoza, Konduga, Magumeri, Marte, Mobbar, Monguno, Gaidam, Gujba, Gulani, Yunusari and Yusufari 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 micronutrients deficiency, which has implications 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 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 39.1 percent of households reported reduced coping strategy index (rCSI) scores equal or greater than 9.8, which is the most severe categorization according to the CH guidelines (CH Phase 3). In general, households in Gubio, Guzamala, Magumeri, Marte, Mobbar, Ngala, Nkanzi, Gaidam, Gujba, Gulani Yunusari LGAs contributed significantly to the global average as 100, 67.1, 74.2, 62.6, 91.7, 68.8, 100, 87.2, 77.8, 68.6, and 66.7 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 Gubio and Nkanzi 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 (62.7 percent) experienced crisis or higher levels (CH Phase 3 and above) of food deprivation and hunger according to the CH analysis guidelines. Specifically, 39 and 2.6 percent of households were affected by emergency and catastrophe/famine levels of HHS respectively while 56.2 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 55 percent of the interviewed households using emergency livelihood-based copy strategies while 9 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, 38.2 percent sent family members to beg, whereas in the crisis category, 51.1 percent of households spent their savings and 16.7 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.

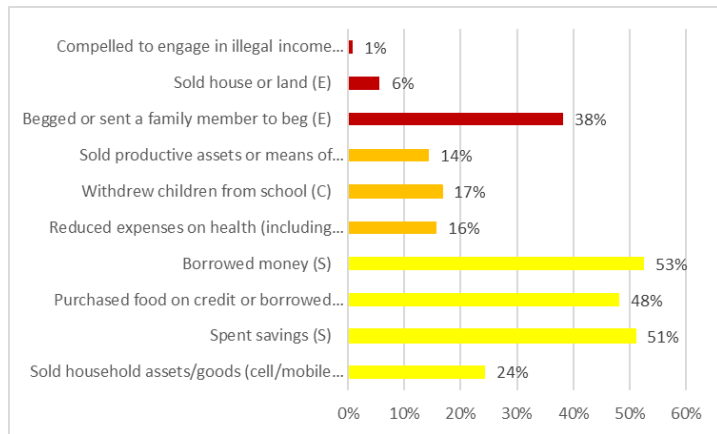


Chart 2: Livelihood Coping Strategies

### 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 18.7 percent and 5.3 percent respectively. This indicates a decrease of 0.4%-point and 0.9%-point for GAM and SAM compared to February 2023 prevalence, in which prevalence were GAM (19.1%) and SAM (6.2%) respectively. GAM prevalence was higher among boys (18.9%) compared to girls (17.7%).

According to the HSM findings, the overall levels of acute malnutrition among new arrivals from inaccessible areas for the month of March 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 post-harvest season up to the lean 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, Bama, Gwoza, Ngala, Geidam and Gujba are classified as critical (IPC AMN Phase 4).

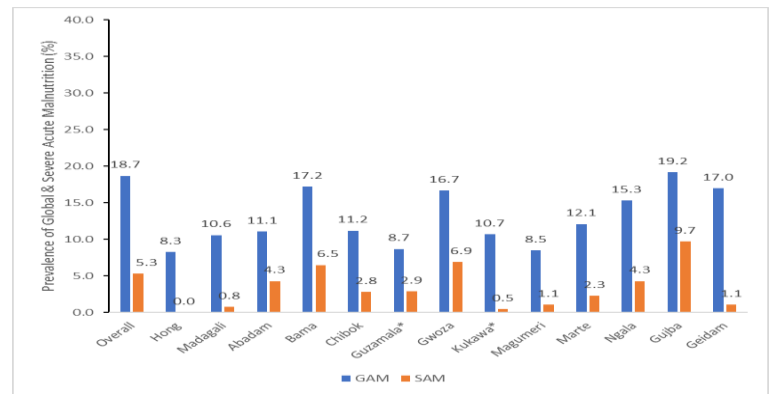


Chart 3: Global Acute Malnutrition (GAM%) Rates per Location

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.

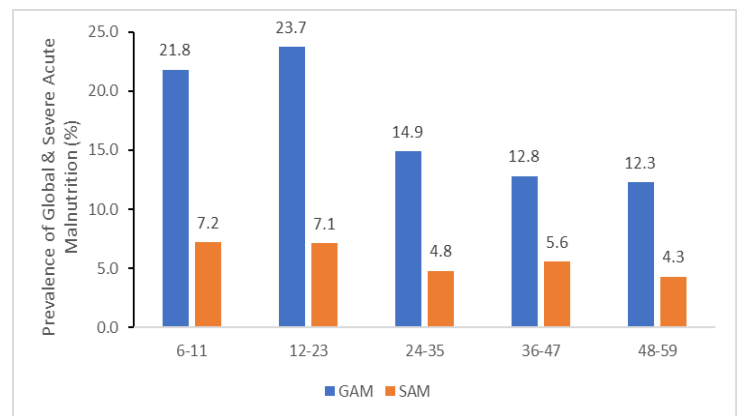


Chart 4: Prevalence of Acute Malnutrition by Age

### 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 48.2 percent of the children aged 6-59 months among new arrivals in BAY states were stunted while 35.1 percent were underweight. This shows a marginal increase of about 4.6%-point for Stunting and an increase of 1.6%-point for Underweight when compared to the previous result in February 2023 where stunting was 43.6% and underweight was 33.5%. 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 1.65/10,000 persons/day and 3.31/10,000 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 Marte, Chibok, Marte and Gwoza LGAs had the highest U5MR of 4.12, 3.91 and 3.34 deaths/10,000 children under 5 years/day. Analysis of cause and location of death reveals that majority of the death (62.6%) were because of illness and only 17.4 percent were due to injury/trauma. Majority of the death (54.0%) reportedly occurred in the place of last residence (in-accessible area) while 15.6% 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

The appalling, protracted food and nutrition insecurity situation in northeastern Nigeria states of Borno, Adamawa, and Yobe is mainly attributed to the over ten years of armed insurgency, led by *Boko Haram* and other non-state armed groups. The insurgency-driven insecurity has displaced thousands of families, collapsing their basic livelihoods, significantly reducing their purchasing power and their coping capacity, made markets dysfunctional and consequently increasing people's vulnerability to food and nutrition insecurity. Due to insecurity, 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, staple food prices have remained above average amidst economic hardship – all these factors continuously affecting food access. Other major shocks affecting households in hard to reach areas include sickness and loss of employment. 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 March, approximately 3 in ten interviewed households reported to have witnessed some previously internally displaced persons (IDPs) returning to their communities of origin.

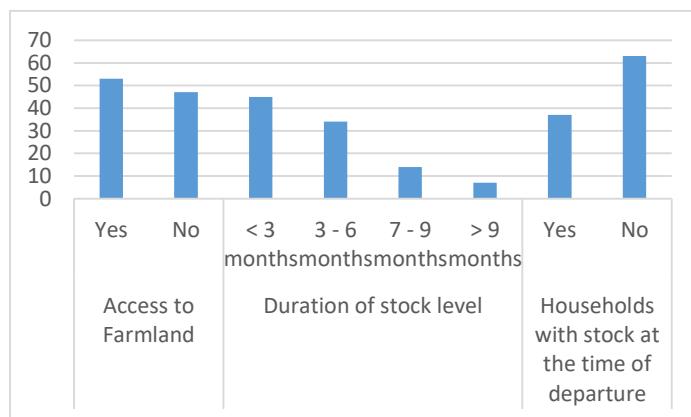
For those still fleeing, the most significant shocks in the localities of origin reported were conflict (85 percent), followed by high food prices (53 percent), sickness of household members (36 percent), temporary relocation/displacement of the household member as reported by 33 percent, and loss of employment at 32 percent as seen in chart 6. The most reported severe needs among the fleeing households were food (50 percent) and Protection (26 percent).

Limited access to agricultural land is another major contributing factor to the prevailing food security and nutrition situation within the inaccessible localities as pointed out by newly arrived IDPs. While most (53 percent) of interviewed households reported having access to land for cultivation, only 23 percent confirmed to have actually cultivated. For those who had access to land, majority (61 percent) were able to access just 1 hectare or less. About 16 percent reported to have access to between 1 and 2 hectares of farmland; while only 6 percent reported to have access to more than 2 hectares.

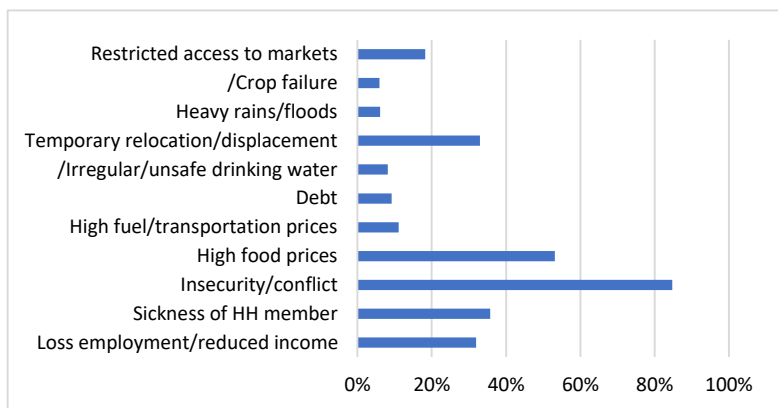
#### Note:

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)**



**Chart 6: Most Significant Shocks before Arrival**

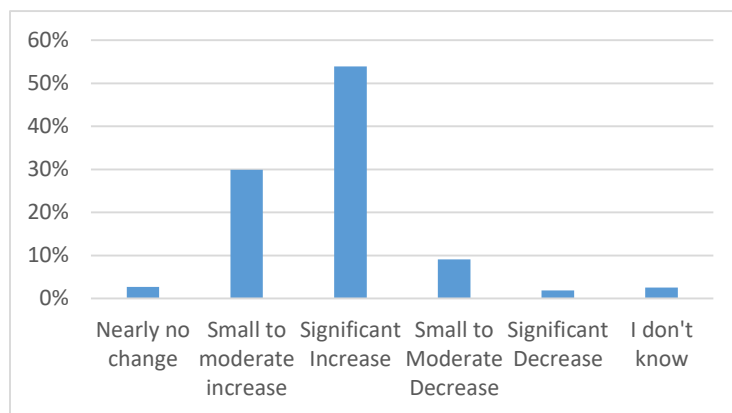
### Food Availability

Among the assessed households, about 63 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 (95 percent), Mobbar (92 percent), Damboa (88 percent), and Ngala (88 percent). Others who reported not having stock include Mafa, Nnganzai, and Yusufari, (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 (45 percent) indicated that it would have lasted for less than 3 months, thus suggesting a severe food deficit in inaccessible areas, despite the main season harvest in October and the dry season harvests in late March. Overall, land access was relatively high with about 53 percent of households reporting such access. However, of the (53 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. 61 percent of households reported access to about 0.5 to 1 hectare of land being available for cultivation while 26 percent of households only had access to less than 0.5 hectares of farmland and 16 percent have access to 1 to 2 hectares of land. While only 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 23 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 81 percent of the surveyed newly arrived households. Areas with a high preponderance of households reporting non-functionality of the market are Mafa (100 percent), Nnganzai (100 percent), and Yunusari (100 percent), reported a complete lack of functioning markets or sub-optimal functional markets in their places of origin, others include Dikwa (99 percent), Ngala (96 percent), Marte (95 percent), Damboa (93 percent), and Guzamala (93 percent). Although, 82 percent of the households from inaccessible areas said they had access to the market in the last three months. However, insecurity (12 percent), and lack of money (3 percent), remained the main impediment to market access. Households from inaccessible areas acknowledged a significant increase (54 percent) and a small to moderate increase (30 percent), a significant decrease (2 percent), and a small to moderate decrease (9 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 (30 percent) of interviewed households and this is high among Yunusari LGA reported 100 percent dependence on the market, Others include Askira Uba (79 percent), Monguno (75 percent), Gubio (67 percent), Damboa (58 percent), Chibok (58 percent), and Michika (54 percent). Other notable sources for cereals recorded were own harvest (17 percent), and labour exchange for food (18 percent). Moreover, wild food gathering (22 percent) and begging (3 percent) account for cereal sources in almost one in every five households in inaccessible areas, which is quite worrisome given their characteristics as extreme coping measures. The prevalence of gathering was most pronounced in Nnganzai (57 percent), and Guzamala (46 percent), While begging for food is most pronounced in Damboa (26 percent), and Chibok (10 percent).



**Chart 7: Changes in price**

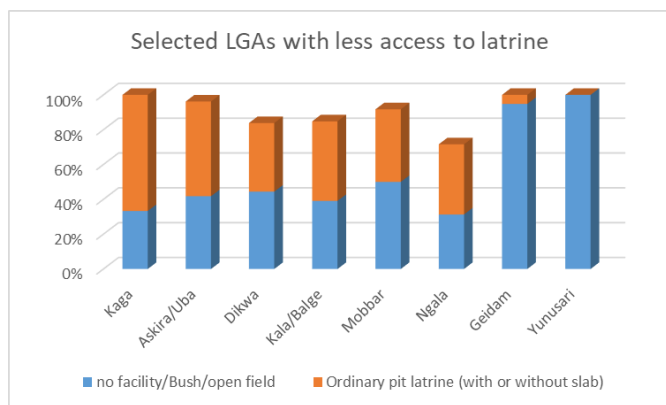
### Health and WASH

Unprotected wells/springs remain the highest source of water in the assessed area with 40% of respondents followed by protected wells/springs with 37%. Among the highest using unprotected wells/springs as a major source of water are Chibok 99% Askira/Uba 90% and Damboa 85% LGAs. While Mafa and Magumeri LGAs are most reported using protected well/springs as a source of water with 100% and 82% respectively. The third source of water is the borehole/hand pump (18%), reported mainly by respondents in Yunusari (68%), Kalabalge (52%) and Dikwa (40%) LGAs. The next is a source of water through the public tap or stand and surface water each 2%. The analysis shows little increase in using protected well/spring and hand pump/borehole compare to February 2023.

The majority of the respondent (53%) spend less than 30 minutes to collect water with 100% each in Yusufari and Mafa LGA. This shows significant improvement compare to last month's data of only 11%. This follows by respondents who spend 30 to 60 minutes (27%) to collect water with the majority in Gubio (67%) and Monguno (50%) LGAs. Water is in the vicinity account for 12% with Kaga, Dikwa and Yunusari LGAs among the highest each 33%. The least and last is 1-3 hour spending time with only 8% as against last month 29% and addition of 4+ hour (9%). The improvement may be because of borehole rehabilitation, construction, and networking.

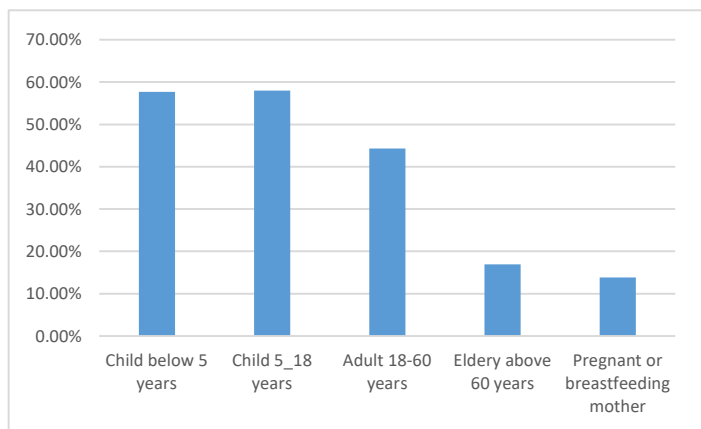
The majority of respondents (71%) has access to ordinary pit latrine (with or without slab). In Nnganzai, Yusufari and Mafa LGAs is 100% ordinary pit latrines used as a toilet facility. This is followed by the nearest bush or open field (19%) with Yunusari (100%) and Geidam (95%) LGAs being the highest, which remain

the same with February 2023 data. Dig and bury (9%) or use a bucket or a hanging toilet (2%). The result shows only a 1% increase in access to the latrine (ordinary pit latrine). But there is a significant improvement in some LGAs on open defecation compare to last month like Kalabalge (from 70% to 39%), Magumeri and (from 50% to 25%). In conclusion, there is a need for continues effective sanitation sensitization and awareness session to construct latrines and stop open defecation, especially in Yunusari and Geidam LGA.

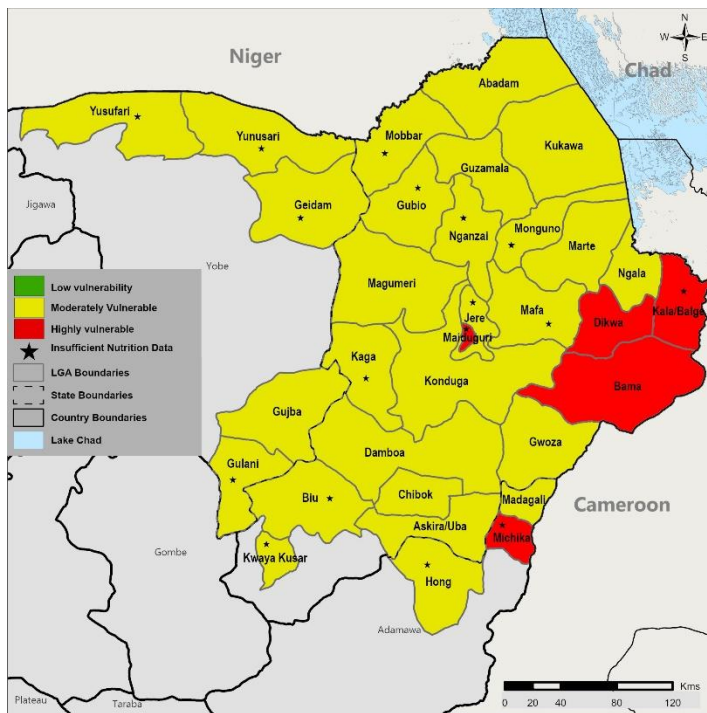


**Chart 8: Access to Toilet facilities**

The large majority of respondents (83%) said they do not have access to a health LGA where 100% of respondents reported having no access to a health facility in their respective areas. On the status of the health facility, where health facilities exist, fully functional and services are free is reported by 4% and this is mostly in Abadam (75%) while fully functional but paid (32%) within 14 LGA. The majority of the respondents said the health facilities are partially/sometimes functional (free or paid) (37%) with Abadam, Kala/Balge, Yunusari and Kagai (100% each) being the highest respondent particularly Gubio, Gwoza and Yunusari. 26% of respondents reported that there is a clinic building in their area but it lacks both personnel and supplies to operate. To reach the health facility, 24% of respondents travel less than 30 minutes, 60% between 30 minutes and one hour, 17% between 1 and 3 hours whereas the remaining 2% travel half day. Spending the whole day only reported in Geidam (2%). Fever, cough/flu and injuries/trauma were the most reported illnesses by respondents. The health service offered are Outpatient health services (21%), inpatient health services (48%), community outreach health services (43%) and Nutrition health services (13%). The majority (65%) of either the respondent or a family member suffer from illness in the last month.



**Chart 9: Who is ill**



**Map 2: Vulnerability risk level June to November, 2022**

**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.

**Note:** Please click on the link here for LGA level breakdown of the HSM results (sample size, food security and nutrition outcomes including contributing factors):

***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 **2,402** 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 October 2022 to 31st March, 2023.



|  |   |  |  |   |
|--|---|--|--|---|
|  |    |  <p>Food and Agriculture<br/>Organization of the<br/>United Nations</p> |  <p>NORWEGIAN<br/>REFUGEE COUNCIL</p>       |  |
|  |    |   |    |  |
|  |  <p>Informing<br/>more effective<br/>humanitarian action</p> |  <p>for every child</p>   |  <p>FAMINE EARLY WARNING SYSTEMS NETWORK</p> |   |