



Humanitarian Situation Update – August, 2022 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. Close to half of the surveyed households (47 percent) struggled to have sufficient food intake and nearly 64.6 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;*
- *40 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 18.3 percent and Severe Acute Malnutrition (SAM) at 6.7 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, a sizeable proportion of the children 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 2 deaths/10,000 population/day and 1 death/10,000 children <5yr/day, respectively; with values of 2.91 deaths/10,000 persons/day for CMR and 5.57 deaths /10,000 under-fives/day. Mgumeri LGA had the highest CMR of 4.32/10,000 persons/day; while Abadam had the highest U5MR of 14.43/10,000 children<5yrs/day.*
- *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.*

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.

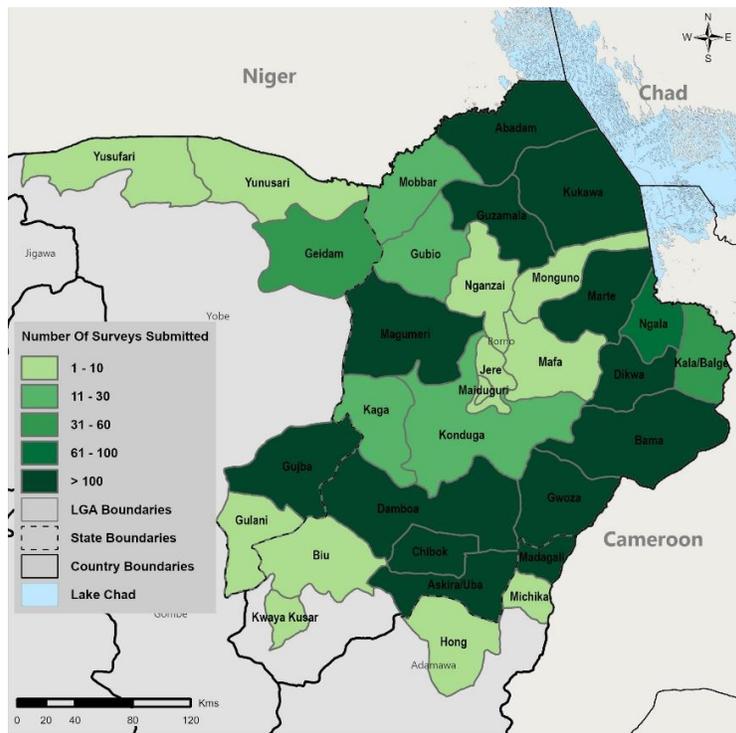
To address information gaps facing humanitarian response in Northeast Nigeria and, inform humanitarian actors on the demographics of the population in inaccessible areas, identify their needs, access to services and movement intentions, there have been joint efforts by various stakeholders' to proffer 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 2022 CH analysis in which 423,886 and 504,234 persons for the (March – May) and (June – August 2022) periods, respectively, were classified in phase 3 – 5 of acute food and nutrition insecurity across the inaccessible areas of the BAY states. The final results from the March, 2022 CH round further reveal presence of over half a million people in CH Emergency phase in March to May, 2022, with high risk of further deterioration to more than a million in Emergency at the peak of the lean season next year (June to August, 2022).

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 (≤ 10 percent), which was reflective in severe food consumption deficits, extremely limited diversity of diets and pervasive use of food-based ration control with wild food foraging remaining a major food source in these areas. However, higher-level indicators (acute malnutrition and mortality) were insufficient to confirm famine conditions in these areas. Therefore, it became necessary to undertake close monitoring of the food and nutrition security situation of the vulnerable population in these areas for emergency preparedness against possible further deterioration into famine, especially during the lean season (June-August, 2022). Thus, the Inaccessible Areas Task Force, working in liaison with the various partners, planned a real time monitoring system, including monthly data collection, for tracking the evolution of emergency needs during CH projection periods.

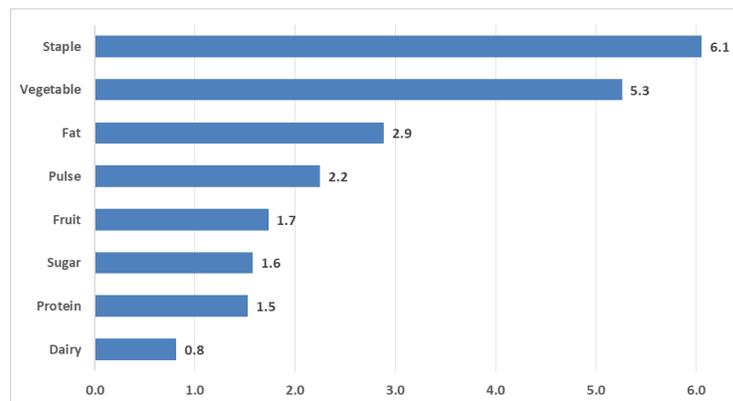
The result is an evidence-based approach improving the capacity for analysis of emergency needs through identifying areas requiring scale up of data collection prior to CH analyses workshops and using real time analysis for flagging areas with increased risk of severe outcomes during the CH projected 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.

Map 1: Inaccessible Areas Covered from March to August, 2022



out of 7 days and vegetable for 5 out of 7 days on average, while fat and pulses were consumed for 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 dairy being the least consumed food item. In Askira-Uba, Bama, Damboa and Dikwa LGAs where more than 5 in 10 households had poor food consumption, on average households consumed cereals for 5.3, 5.6, 6.0 and 4.3 days respectively out of 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



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).

As the lean season reaches its peak, households in hard-to-reach areas continue to face significant 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 deficits and limited diversity of diets in several of the inaccessible areas surveyed. Overall, nearly half of all households (47 percent) faced inadequate food intake (poor and borderline food consumption score) during the last 30 days spent in their inaccessible places of origin of which 16 percent of such households were reportedly affected by poor food consumption. This implies that the FCS is at the critical level (CH Phase 3), a severe classification in the FCS categorization.

While the global findings on the proportion of households with inadequate food consumption were consistent in some of the areas at indicative levels, Madagali, Askira/Uba, Bama, Chibok, Damboa and Dikwa LGAs, which have a relatively higher level of confidence interval given their sample size, showed quite concerning findings as 50, 72, 73, 68, 78 and 86 percent respectively of most surveyed households had inadequate diets (poor + borderline food consumption) in their places of origin. In the specific case of Dikwa, 50 percent or more of such households had poor food consumption – particularly reflecting severe consumption deficits in these areas.

Regarding the diversity of diets, overall, households consumed cereals for 6

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 40 percent of households reported reduced coping strategy index (rCSI) scores equal or greater than 19, which is the most severe categorization according to the CH guidelines (CH Phase 3). In general, households in Abadam, Damboa, Guzamala, Kukawa, Magumeri, Marte and Gujba LGAs contributed significantly to the global average as 50.6, 70.7, 74.4, 56.7, 67, 63 and 77 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 Guzamala and Marte, where households utilized all the five standard food consumption behaviors for at least 3 of seven days which suggests widespread vulnerability in this location. In other locations with relatively large sample size such as Magumeri and Gujba, households used 4 out of five standard food consumption behaviors for 3 or more days. 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):

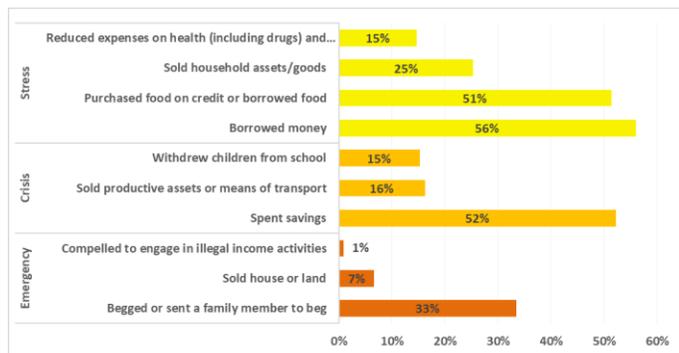
Findings from the HHS, which is a perception-based measure of food deprivation and experience of hunger in the surveyed households, showed that most households (64.6 percent) experienced crisis or higher levels (CH

Phase 3 and above) of food deprivation and hunger according to the CH analysis guidelines. Specifically, 1.7 percent and 1.1 percent of households reported emergency and catastrophe/famine levels of HHS respectively while 61.8 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 and significant incidence of hunger especially in the highlighted LGA in emergency 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 51 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, 33 percent sent family members to beg, whereas in the crisis category, 52 percent of households spent their savings and 15 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



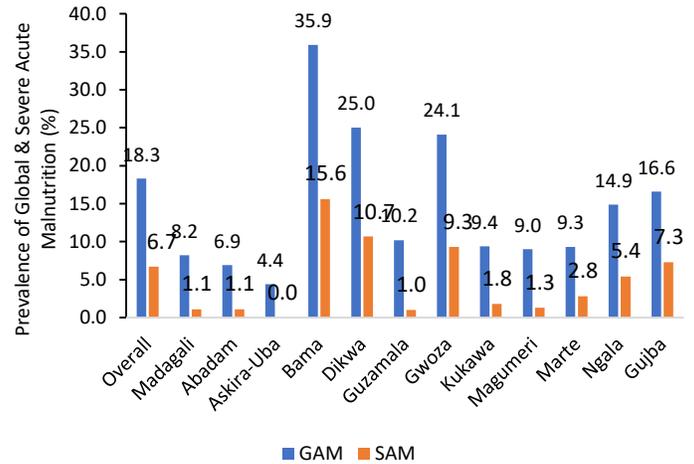
Outcomes – Nutrition Malnutrition

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 18.3 percent and 6.7 percent respectively¹. This indicates a slight increase in acute malnutrition compared to June 2022 prevalence, which were GAM (16.6 percent) and SAM (5.6 percent) respectively. GAM prevalence was higher among boys (20.5 percent) compared to girls (16.2 percent). According to the HSM findings, the overall levels of acute malnutrition among new arrivals from inaccessible areas for the month of June 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, seasonal increases in food insecurity and morbidity, and the lack of access to improved sanitation facilities. This trend of a worsening nutrition situation is expected to continue up to the end of lean season.

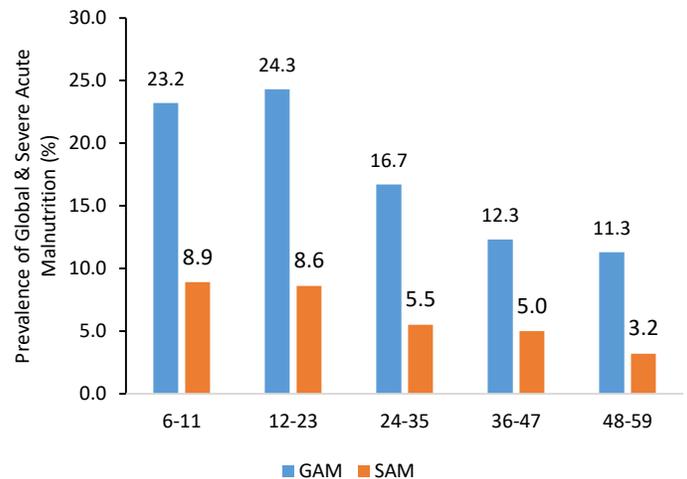
Further analysis among new arrivals from LGAs with adequate sample size showed extremely critical GAM rates (IPC AMN Phase 5) in Bama while Dikwa, Gwoza and Gujba are classified as critical (IPC AMN Phase 4).

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



¹ The overall prevalence of combined GAM (cGAM) and SAM (cSAM) were 24.2 percent and 9.5 percent respectively.

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 44.7 percent of the children aged 6-59 months among new arrivals in BAY states were stunted while 37.2 percent were underweight. This shows a moderate increase for underweight and about 5 percent point decrease for stunting when compared to the previous result in May where stunting was 49.4 percent and underweight 38.4 percent. 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 2.91/10,000 persons/day and 5.57/10,000 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. Magumeri LGA had the highest CMR of 4.32/10,000 persons/day, while Abadam had the highest U5MR of 14.43/10,000 children under 5 years/day. Analysis of cause and location of death reveals that majority of the death (64.7 percent) were as a result of illness and only 21.5 percent were due to injury/trauma while on the other hand, majority of the death (63.9 percent) occurs in the place of last residence (in-accessible area) with only 16.5 percent of the deaths occurring during migrations.

Note:

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

CONTRIBUTING FACTORS

Hazards and Vulnerabilities

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

Staple food prices are also perceived to have remained atypically higher than long-term averages, significantly affecting access. Sickness and loss of employment are also considered major shocks affecting households in hard to reach areas. Due to the prevailing violence and socioeconomic hardship in those 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 August 2022, 40 percent of interviewed households reported to have witnessed some previously internally displaced persons (IDPs) returning to

their communities of origin, a slight decrease as compared to 44 percent in July and 46 percent in June 2022, while 60 percent did not observe any returning IDPs. The recent decrease in the rate of returning IDP household might be as a result of limited access to their usual livelihood activities, high cost of living as well as non-presence of humanitarian actors in the hard to reach areas.

In the localities of origin for those still fleeing hard to reach areas, the most significant shocks in the localities of origin reported were conflict (87 percent), followed by high food price as reported by (53 percent), sickness of household member (35 percent), loss of employment (28 percent) and temporary relocation (27 percent) as seen in chart 5.

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. Majority of the interviewed households (32 percent) were able to access just between 0.5 and 1 hectares, while 21 percent reported having access to only less than 0.5 hectares of farmland. Only, 15 percent could access more than 2 hectares, while 18 percent could access between 1 to 2 hectares of farmland.

The August 2022 data also indicates that (59 percent) of the interviewed household did not have any food stocks available a few months before they fled their localities of origin. Only about 41 percent had food stocks, the majority (50 percent) of whom had limited food stocks, which would only last for less than 3 months while 30 percent indicated that their food stocks would last for 3 to 6 months and 14 percent reported having foods that will last for 7 to 9 months.

Note:

In the Northeast, notably in Borno state, the government continues the process of closing IDP camps and resettling IDPs. According to IOM, as of January, over 103,000 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. 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 aids can't reach and they become more vulnerable to, hunger starvation and acute malnutrition. These populations are left vulnerable to repeated attack by Non State actors and armed opposition groups. The result is their vulnerability becomes even worse than those in the IDPs camps.

For those still fleeing, the most significant shocks in the localities of origin reported were conflict (84 percent), followed by high food prices (51 percent, same as in May), sickness of the household member as reported by 38 percent, loss of employment (29 percent, down from 38 percent in May) and temporary relocation (19 percent – same as in April) – **see chart 6.**

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

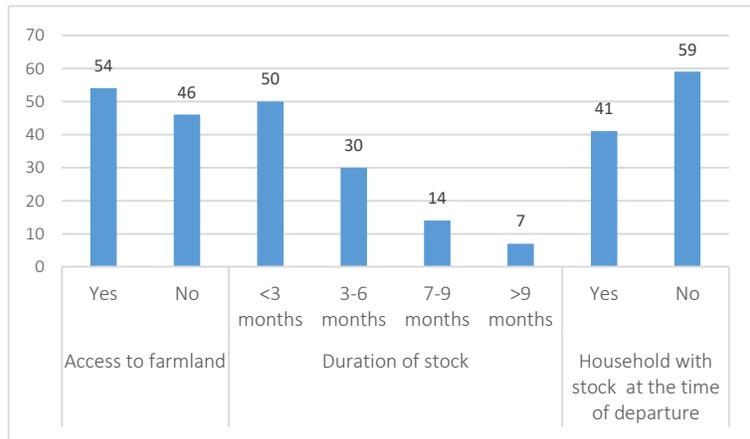
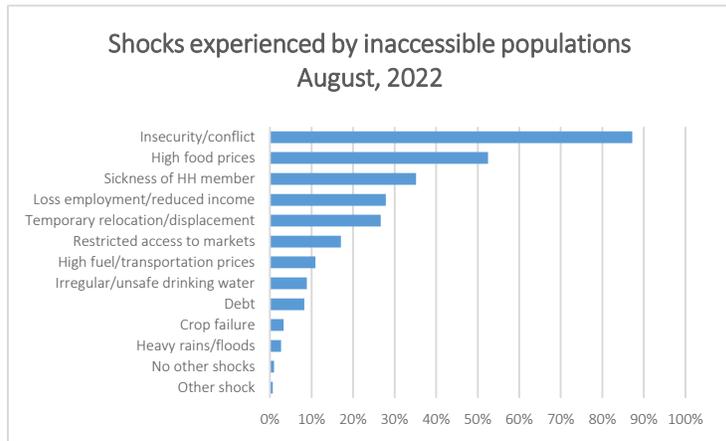


Chart 6: Most Significant Shocks before Arrival



Food Availability

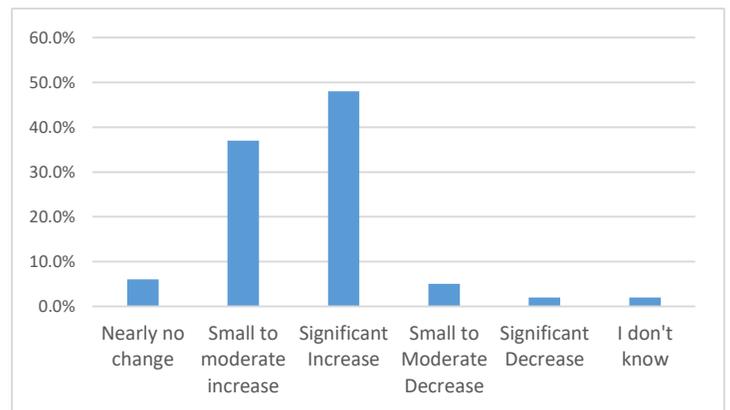
Among the assessed households, about 59 percent in most of the inaccessible LGAs reported not having stock of foods from last season’s harvest. It was pronounced in places such as Ngala (93 percent), Mobbar (91.7 percent), and Dikwa (85 percent). Others who reported not having stock include Gulani, Kwaya Kusar, Nganzai, 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, the majority (50 percent) indicated that it would have lasted for less than 3 months, thus suggesting a severe food deficit in inaccessible areas coupled with the lean season. Overall, land access was relatively high with about 54 percent of households reporting such access. However, of the (54 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. 53 percent of households reported access to about 0.5 to 1 hectare of land being available for cultivation while 18 percent of households only had access to less than 0.5 hectares of farmland and 18 percent have access to 1 to 2 hectares of land. While only 15 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 39 percent of such households were engaged in farming during the month that preceded their departure from places of origin, though the result indicates a slight decrease compared to July bulletin.

Food Access

Markets were either completely non-functional or functioning at sub-optimal levels in some of the inaccessible areas as confirmed by 74 percent of the surveyed newly arrived households. Areas with a high preponderance of households reporting non-functionality of the market are Michika (100 percent), Ngala (100 percent), Nganzai (100 percent), Gulani (100 percent), Yunusari (100 percent), Chibok (98 percent), Dikwa (92 percent), and Bama (89 percent), reported a complete lack of functioning markets or sub-optimal functional markets in their places of origin. Although, 84 percent of the households from inaccessible areas said they had access to the market in the last three months. However, insecurity (16 percent), lack of money (3 percent), and market closure (2 percent) remained the main impediment to market access. Households from inaccessible areas acknowledged a significant increase (48 percent) and small to moderate increase (37 percent), a significant decrease (2 percent), and a small to moderate decrease (5 percent) in the prices of food commodities, which would potentially further weaken the already frail purchasing power of the inaccessible populace and consequently, deepen food insecurity vulnerability. This is particularly pertinent to note as market purchases were reported as the main source for staples in (38 percent) of interviewed households and this is high among Michika, Gulani and Yunusari LGAs reported 100 percent dependence on the market. Other notable sources for cereals recorded were own harvest (10 percent), and labour exchange for food (16 percent). Moreover, wild food gathering (21 percent) and begging (2 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 Nganzai (100 percent), and Gwoza (41 percent), while begging for food is most pronounced in Mobbar (8 percent), Bama and Damboa each (6 percent).

Chart 7: Changes in price



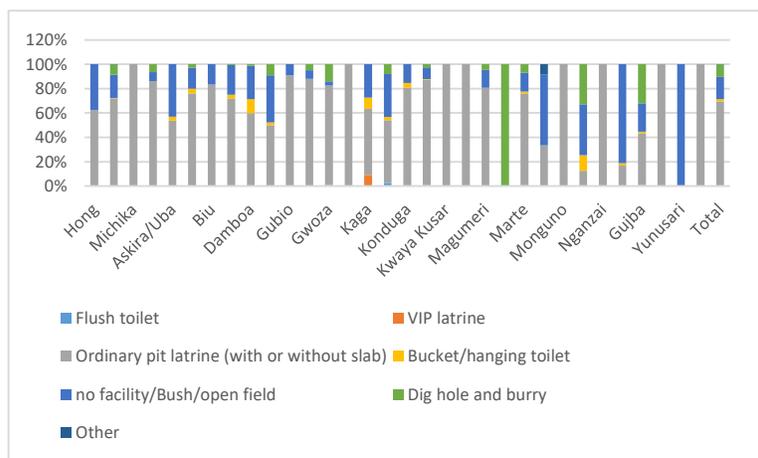
Health and WASH

Tube wells/borehole is the most reported source of water (by 39 percent of the respondents), especially in Nganzai LGA (100 percent of the respondents)

and to a lesser extent in Abadam, Kukawa, Mafa, Magumeri and Gujba LGAs where a range of 57 and 71 percent of respondents use this source of water. Protected well is the second most reported source of water (by 24 percent of respondents). All respondents in Gulani LGA (Yobe State) and a large majority (65 percent) in Kala Balge LGA (Borno State) rely on protected wells for water. The third source of water is rainwater, reported mainly by respondents in Maiduguri (Borno) and Madagali (Adamawa) (100 percent of respondents respectively), Chibok (Borno State), 82 percent of respondents), and Hong LGA (Adamawa), (57 percent of respondents). It is worth to note that beside rainwater, surface water is the second source of water for most respondents in Hong, Askira/Uba, Chibok and Damboa LGAs of Borno State. Majority of respondents (83 percent) spend more than 30 minutes to collect water. In Maiduguri, Gulani and Michika LGAs, all respondents (100 percent) spend between 1 and 3 hours to collect water. In Ngala LGA, 36 percent of respondents spend a half day to collect water. Each of Dikwa, Guzamala, Konduga, Magumeri, Marte and Mobbar LGA also reported more than 15 percent of respondents who spend a half day collecting water.

The majority of respondents (69 percent) have access to an ordinary pit latrine, the remaining go to the nearest bush or open field (18 percent of respondents), dig a hole (10 percent) or use a bucket or a hanging toilet (2 percent). mostly reported by respondents from Michika LGA in Adamawa (100 percent of respondents), Yusufari and Gulani LGAs in Yobe (100 percent of respondents), Jere, Monguno, Kwaya Kusar, Mafa, (100 percent of respondents), Guzamala (88 percent of respondents) and Kukawa (86 percent of respondents), respectively.

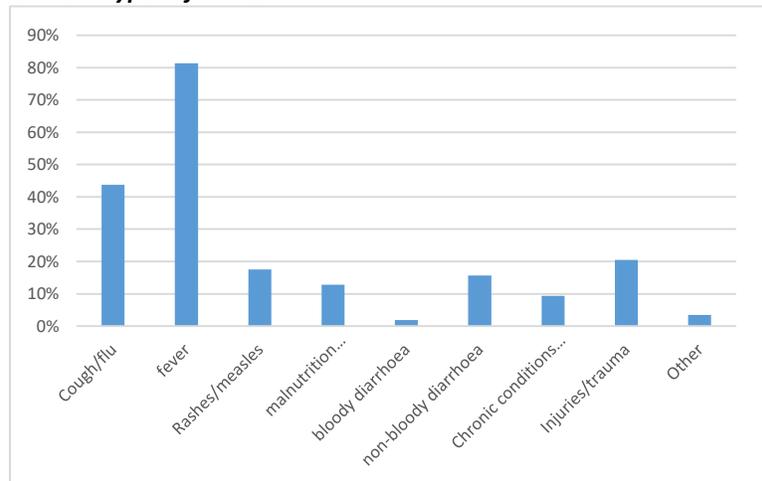
Chart 8: Toilet facilities



The large majority of respondents (77 percent) said they do not have access to a health facility. This problem seems to be most acute in Hong LGA in Adamawa State, Kwaya Kusar, Nganzai, Magumeri LGAs in Borno State as well as in Gulani LGA of Yobe State. In each of these LGAs, all (100 percent) of the respondents reported having no access to a health facility in their respective areas. Where health facilities exist, the facility is fully functional, as reported by 62 percent of respondents and services are free of charges (9 percent of respondents) or paid (53 percent of respondents). All (100 percent) of the respondents in Yusufari LGAs reported that there is a clinic building in their area but it lacks both personnel and supplies to operate. Similarly, all (100 percent) of the respondents in Kala Balge and Ngala (Borno State) and Yusufari (Yobe State) said there exists clinic but it functions only partially on free or paid conditions. To reach the health facility, 26 percent of respondents travel less than 30 minutes, 56 percent between 30 minutes and one hour whereas the remaining travel between 1 and 3 hours (17 percent) or even more (1 percent). Fever, cough/flu and injuries/trauma were the most reported

illnesses by respondents. Out-patient and community outreach health services are the most common in the surveyed localities as reported by 61 percent and 33 percent of the interviewed households, respectively. Some 61 percent of the respondents had a member of theirs suffer illness, with children under 5 years being most affected (59 percent), then followed by children between 5 and 18 years of age (55 percent). The most common illnesses reported in the survey were fever and cough as represented by 81 percent and 44 percent of the respondents, respectively.

Chart 9: Types of Illness



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.

Number of New Arrivals from Inaccessible/Hard-to-reach areas by LGA (Jan – Aug, 2022)

LGA of Arrival	INDIVIDUALS	PERCENTAGE
BAMA (Buduwa, Shehuri)	29,923	75.3%
GWOZA (Gwoza Wakane/Bulabulin, Pulka/Bokko)	4,971	12.5%
DIKWA (Dikwa)	1,856	4.7%
NGALA (Ngala)	1,512	3.8%
DAMBOA (Damboa)	301	0.8%
KALA BALGE (Rann A)	296	0.7%
GOMBI (Garkida, Gombi South)	245	0.6%
MICHIKA (Garta/Ghunchi, Madzi)	205	0.5%
MONGUNO (Monguno)	178	0.4%
SONG (Dumne, Song Gari, Song Waje)	88	0.2%
MUBI SOUTH (Gude, Lamorde)	62	0.1%
YOLA SOUTH (Namtari)	28	0.1%
HONG (Gaya)	28	0.1%
HAWUL (Kwajaffa/Hang, Puba/Vidau/Lokoja)	25	0.1%
YOLA NORTH (Jambutu)	24	0.1%
ASKIRA/UBA (Wamdeo/Giwi, Uba)	16	0.1%
Grand Total	27,554	100%

Source: IOM, Aug, 2022

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):

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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 4,384 households (from 30 LGAs) who were interviewed at the reception points. The period of data collection for this edition of the bulletin lasted from 1st March to 30th August, 2022.