



Famine Monitoring System– September 2021 Monthly Bulletin

Cadre Harmonisé Task Force on Inaccessible Areas



KEY TAKEAWAYS

- Findings from the FMS revealed concerning consumption patterns in inaccessible areas as 68 percent of the interviewed households struggled to have sufficient food intake and 25 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 in the month of September;
- More than two in every three households relied on either crisis (17 percent) or emergency (38 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 28.7 percent and Severe Acute Malnutrition (SAM) at 11.9 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;
- LGAs with the highest malnutrition rates included Bama, Konduga, Magumeri, Madagali and Gwoza, with Bama LGA continuing to record high influx of IDPs who are arriving in very poor nutrition status, with global acute malnutrition rates of above 30 percent (Extremely Critical IPC AMN classification);
- The Crude and Under-five Mortality Rates were 3.98 and 6.71 deaths/10,000/day respectively. Both crude and under-five mortality rates were above emergency thresholds and illness constituted the main cause of death. Mortality data is currently undergoing further investigation to identify and rectify quality issues during the next FMS round;
- The elevated levels of consumption gaps, malnutrition, mortality and pervasive usage of emergency coping strategies, is largely underscored by limited availability of food stocks, restricted access to functional markets and water, health and sanitation services, which might heighten morbidity risk and impact households' ability to engage in labour for food or resource gathering.

INTRODUCTION

The insurgency in the North East States of Borno, Adamawa and Yobe continues to take render some areas totally or partially inaccessible to humanitarian response agencies/partners. The protracted nature of this conflict in Northeast has made the humanitarian crisis much more complicated, and, rendering parts of Borno, Adamawa and Yobe State inaccessible.¹ To address information gaps facing the humanitarian response in Northeast Nigeria and inform humanitarian actors on the demographics of the population in inaccessible areas, and identify their needs, access to services and movement intentions, there have been joint efforts by various stakeholders proffer solutions.

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)

Famine Monitoring System (FMS) for Inaccessible Areas

The Famine Monitoring System (FMS) is an approach put in place by the Food Security Sector and Nutrition Sector (both having their operational bases in the North East) under the leadership of the Nigerian Government, for tracking the trend of acute food and nutrition security situation in such areas that had been analyzed to be in the emergency (phase 4) so as to be able to develop and issue an alert in case famine emerges. The FMS uses a methodology that combines both food and nutrition security monitoring strategies to assess the situation and then raise necessary alert, as the case may be. The FMS is basically conceptualized to support the Cadre Harmonisé analysis of the inaccessible areas in the BAY States.

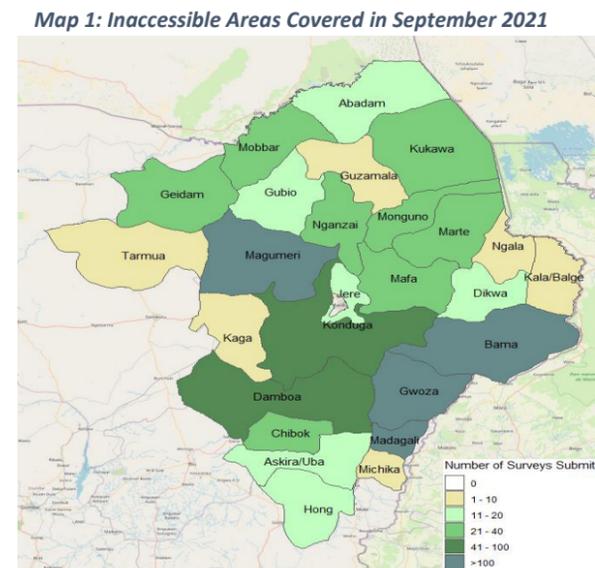
The general objective of FMS is to provide a comprehensive information about the food security and nutritional situation of the population in inaccessible areas of Northeast BAY States. The FMS will also inform the upcoming October, 2021 Cadre Harmonisé analysis and classification in different phases of food security and malnutrition of these areas. The specific objectives of the FMS entails data collection through monthly monitoring in support of better classification of inaccessible areas between rounds of CH analysis with focus on:

- understanding the risk of a population to face severe, acute catastrophic or famine-like conditions;
- understanding the degree of livelihood change, including capacity to engage in traditional and emergency livelihoods, etc;
- understanding food consumption outcomes through the use of proxy information on Household Hunger Scale (HHS) and Food Consumption Score (FCS);
- understanding availability of health and nutrition services, including household and individual access to services by collection information on functionality of nutrition/health services;
- understanding how households cope (including the severity of coping measures) during periods of hunger, thirst, morbidity or malnutrition in such areas of interest;
- understanding the malnutrition situation in such areas of interest through the collection of information on GAM prevalence (for children 6-59 months) in reception centres and other new arrival terminals; and
- understanding changes in crude and U5 mortality rates and indicative causes in such areas of interest.

Primary data was jointly collected by partners in many accessible towns of Borno, Adamawa and Yobe States where there are new arrivals coming from the inaccessible areas with the support of the DTM from SEMA and IOM. Well-structured questionnaire was deployed by trained enumerators in collecting the information in the form of key informant interview and focused group discussions (FGD). The data collection focused more on six elements- causal factors of emergency needs, food consumption outcomes, livelihood change and coping strategies, access to life-saving services and assistance, detection of malnutrition through nutrition screenings (WHZ and MUAC), and mortality indicators as recommended by the CH analysis framework. Consideration was also given to journey duration and patterns for the new arrivals interviewed. A combination of purposive and convenient sampling techniques were employed in selecting the recent new arrivals (within the last 30 days) who were the primary target. Total sample of respondents covered for this month of September was **1,223**; between June and August 2021, a total of **1,301 sampled households** (from 26 LGAs) were interviewed with comprehensive nutrition screening for **about 1,494** children 6 to 59 months old at the reception centres. The period of data collection for lasted from 5th June, to 31st August, 2021.

Several cycles of the Cadre Harmonisé (CH) analysis unveiled the problem situation of populations in some inaccessible areas. From the results of March 2021 CH analysis in which 746,846 and 881,261 persons for current (March – May) and Projected (June – August) period, respectively, were classified in phase 3 – 4 of acute food and nutrition insecurity across the inaccessible areas of the BAY states. Moreover, the findings suggest a famine-like food consumption pattern among minority of the inaccessible population (≤ 10 percent), which was reflective in severe food consumption deficits, extremely limited diversity of diets and pervasive use of food-based ration control with wild food foraging remaining a major food source in these areas. However, higher-level indicators (acute malnutrition and mortality) were insufficient to confirm famine conditions in these areas. Therefore, it became necessary to undertake close monitoring of the food and nutrition security situation of the vulnerable population in these areas for emergency preparedness against possible further deterioration into famine, especially during the lean season (June-August). Thus, the Inaccessible Areas Task Force, working in liaison with the various partners, planned a real time monitoring system, including monthly data collection, for tracking the evolution of emergency needs during CH projection periods.

The result is an evidence-based approach improving the capacity for analysis of emergency needs through identifying areas to scale up data collection prior to CH workshops and using real time analysis for flagging areas with increased risk of severe outcomes during the CH projection period. Thus, the Famine Monitoring System attempts to provide data needed to support analysis for the risk of catastrophic or famine-like conditions in hard-to-reach locations, either increasing the amount of data provided to the CH analysis process or improving the frequency of reliable data to support real time analysis of proxy outcomes when unexpected events development outside the CH analysis cycle.



RESULTS

Outcomes – Food Security

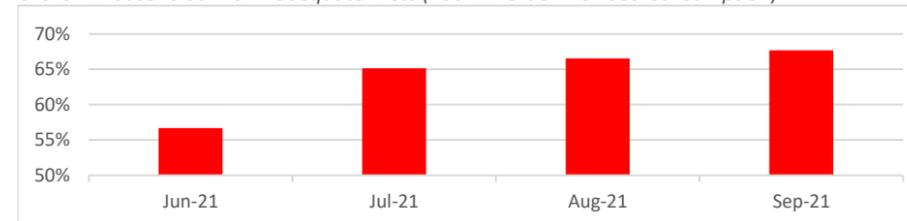
Food Consumption (FCS, rCSI and HHS)

The food consumption for the FMS is measured in three dimensions in line with the provision of the CH version 2.0 – food consumption score (FCS), reduced coping strategy index (rCSI) and household hunger scale (HHS).

Food Consumption Score (FCS): The findings from the FMS continued to show concerning food consumption deficits and limited diversity of diets in the inaccessible areas surveyed. Overall, the number of people found to be facing critical levels of food insecurity (IPC/CH Phases 4) period of from June to September 2021 have continued to increase. The proportion of households that did not have sufficient food intake (poor + borderline food consumption) were 57 percent, 65 percent, 67 percent, 68 percent in June, July, August, and September respectively (chart 1).

In the reporting month, more than one in every two households (68 percent) did not have sufficient food intake (poor + borderline food consumption), with 26 percent of such households reporting severe food consumption deficit. This indicates potential widespread consumption gaps in inaccessible areas and as well infers that the FCS stands at emergency level (CH Phase 4), the highest possible classification in the FCS categorization. While the global findings were consistent in some of the areas at indicative levels, Bama, and Madagali LGA's, all of which had a relatively higher level of confidence interval given their sample, showed quite concerning findings, with 75 percent, and 86 percent of the surveyed households respectively reporting inadequate diets in their places of origin. The proportion of households with severe consumption deficits (poor food consumption) stood out in Bama (49 percent) and Madagali (57 percent). Regarding the diversity of diets consumed, the average daily consumption of cereals was reported at about five out of every seven days whereas all other food groups (pulses, vegetables, proteins, dairy, sugar, and fats) were consumed for two days or less in every typical seven-day period. The extremely limited diversity of diets in these inaccessible areas is indicative of significant macro and micronutrients deficiency, which would continue to have an implication for the health, wellbeing and economic productivity of the people trapped in these areas.

Chart 1: Households with Inadequate Diets (Poor + Borderline Food Consumption)



Reduced Coping Strategy Index (rCSI): There was pronounced usage of food based coping strategies to bridge food gaps within the surveyed households. Twenty-five (25) 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). The percentage of households in CH Phase 3 decreased in September compared to the past months (June to August). Households in inaccessible areas in Magumeri LGA contributed significantly to the global average as 55 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.

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 (63 percent) experienced crisis or higher levels (CH Phase 3 and above) of food deprivation and hunger according to the CH analysis guidelines. About three percent and two percent of households reported emergency and catastrophe/famine levels of HHS respectively. Based on the metrics presented, HHS for inaccessible areas of BAY States was classified as CH Phase 3 (crisis). The proportion of households within this range reduced compared to the previous months (June to August). These suggest very concerning HHS trends and likely food deficit in the highlighted LGAs in the emergency 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 55 percent of the surveyed households used either crisis (17 percent) or emergency (38 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, 36 percent of households sent their family members to beg, whereas in the crisis category, 31 percent of households spent their savings and 18 percent of households withdrew their children from school. . The usage of emergency coping strategies recorded in September reduced compared to previous reporting months for the FMS (June to August 2021), which peaked at the height of the lean season in August 2021. Nonetheless, reliance on emergency coping strategies in inaccessible areas remain relatively pronounced with more than one in every three households resorting to one or more of such strategies to alleviate the brunt of food insecurity in the short-term. The pervasive usage of these strategies remains worrisome given their negative impact on future productivity of the affected households on the longer term.

Chart 2 Livelihood Coping Strategies



Outcomes – Nutrition

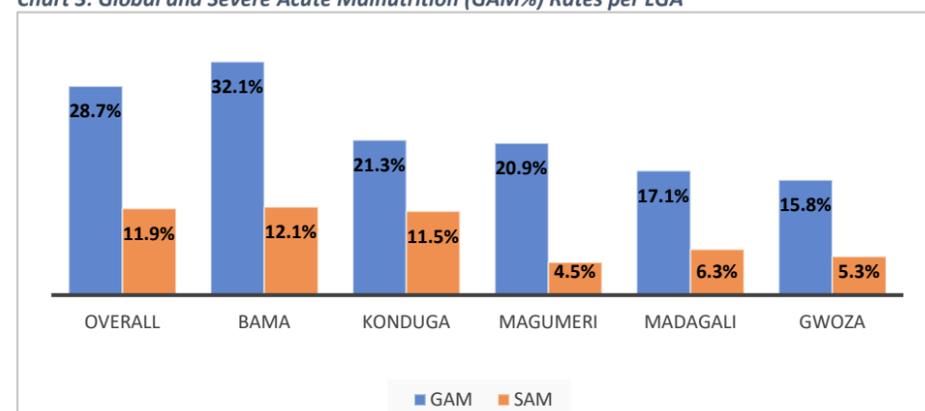
Malnutrition

The nutritional status of the new arrival IDPs from inaccessible areas in NE Nigeria continues to be very poor with significant deterioration in the month of September compared to previous data collection period. (June – August).

Global Acute Malnutrition (GAM): The overall GAM and SAM prevalence for the month of September was 28.7% and 11.9% respectively, classified as *Critical* (Phase 4 *Integrated Phase Classification for Acute Malnutrition*). LGAs with the highest malnutrition rates included Bama, Konduga, Magumeri, Madagali and Gwoza in order of severity (**chart 3**). Bama LGA continues to record high influx of IDPs who are arriving in very poor nutrition status, with global acute malnutrition rates of above 30% (*Extremely Critical* IPC AMN classification).

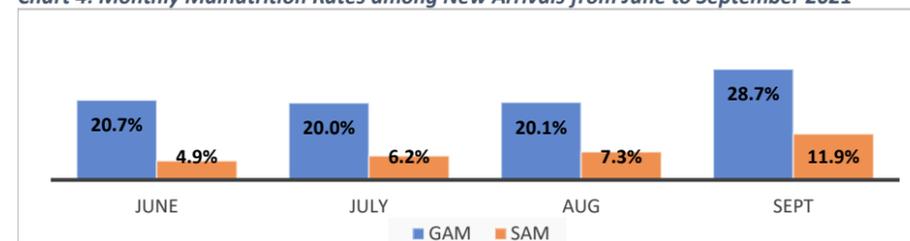
The results continue to show that acute malnutrition rates among children 6-24months is twice as high compared to children above two years.

Chart 3: Global and Severe Acute Malnutrition (GAM%) Rates per LGA



The overall increase in the acute malnutrition rates in the month of September compared to previous period of data collections (June-August), see **chart 4** below, is attributed to the influx of IDPs in Bama contributing more than half of September sample size; the persistent lean season (increased food insecurity), and continued high prevalence of morbidity especially diarrhoea/cholera. The new arrivals are also not receiving adequate humanitarian assistance including General Food Distribution (GFD) at their location of arrival.

Chart 4: Monthly Malnutrition Rates among New Arrivals from June to September 2021



Mortality

The cumulative crude and under-five mortality rates are 3.98 and 6.71 deaths/10,000 people/day respectively, both of which were above the SPHERE emergency thresholds of 1 and 2 deaths/10,000 people /day. Gubio LGA has the highest cumulative crude mortality death rates (CMR) of 10.14 deaths/10,000 people /day. Other LGAs with high CMR include Bama, Gwoza and Magumeri. The major reported cause of death is illness (79%). The scope of the assessment does not allow disaggregation of illness to specific diseases. Overall, two-thirds (66%) of all of deaths recorded among the new arrivals occurred in the place of last residence (original settlement). In Bama and Gubio, ninety percent of the deaths occurred in original settlement, while in Gwoza and Magumeri majority of deaths occurred in the current location.

The high deaths occurring in the current location is a clear indication of the inadequate humanitarian access of lifesaving services in the location of arrival including Cholera prevention and treatment.

**Interpretation based on these thresholds should be done with caution considering that the adapted methods used to gather information from inaccessible areas may overestimate mortality rates.*

The quality of data for Damboa LGA was below the minimum acceptable standard, but the nutrition status and mortality rates among the new arrivals in the LGA is most likely very critical.

Recommendations

- Humanitarian organisations to explore ways to provide lifesaving services in the inaccessible areas, where the population are facing high famine risk.
- The humanitarian response in Bama, Damboa, Magumeri, Gwoza, Konduga and Madagali be scaled-up with a focus on improving WASH, health and Food Security.
- Registration of new arrival IDPs for GFD and other humanitarian services e.g cash/voucher interventions, be accelerated in Bama, Konduga and Madagali LGAs. (IOM, WFP, FAO).
- WASH and Health Sector indicators to be incorporated into the FMS to improve the analysis of the famine risk underlying causes and context.

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 protracted conflict in Northeast Nigeria continues to drive the humanitarian crisis in the three most affected states: Borno, Adamawa and Yobe, leading to disrupted livelihoods and increased vulnerability to food and nutrition insecurity, resulting from displacement of populations from their ancestral homes, loss of livelihoods assets, disruption of supply chains and collapse in delivery of public services. Humanitarian access to some of the affected communities remains elusive. As the region is experiencing the typical effects of the lean season worsened by the economic impacts of COVID-19 pandemic, staple food prices are expected to remain high. Due to the violence and socioeconomic hardship, several households continue to flee their homes to seek safety and support in internally displaced camps and host communities. As in the previous months, just over a third (37 percent) of respondents (from June to August) and 19 percent (for September only) confirmed that some previously internally displaced persons (IDPs) have been returning to their communities of origin in the past four to five months while 63 percent have not witnessed any returning IDPs. This confirms that the underlying drivers of displacement are largely unresolved, as most people feel unsafe/insecure returning to their native communities. Conflict remains the most significant shock (80 percent) for September and (85 percent) for June to August respectively, that affected IDPs' settlements of origin four to five months prior to their arrival. This is followed by sickness of household member as reported by 49 percent of the new arrivals in September compared to 44 percent for June to August 2021.

The new arrivals also mentioned high food prices (31 percent for Sept as against 44 percent for Jun-Aug). The majority (70 percent and 72 percent for Sept and Jun-Aug, respectively) of the interviewed persons confirmed having access to farmland, and engaged in farming (90 percent and 88 percent for each of Sept and Jun-Aug) before they fled. However, in Sept, 64 percent had no stock left while those that had no stock before departure during the period of Jun-Aug constituted 63 percent. This confirms significant food scarcity in their communities of origin. About 60 percent (Sept) and 53 percent (Jun-Aug) of the new arrived IDPs were of the opinion perceived the likelihood that the households left behind cultivated or would cultivate crops, during this year's wet season, with the majority planting cowpea (43 percent and 47 percent) and maize (38 percent and 46 percent) for Sept and Jun-Aug, respectively. Moreover, respondents expressed concerns that these households that cultivated might not be able to harvest all their produce due to insurgency. Some might abandon their crops on the field for fear while others might have to share their harvest with the insurgents.

Food Availability

The FMS results from June through August revealed that among the interviewed households, over 60 percent in most of the inaccessible LGAs reported not having stock of foods from last season's harvest. Households that had food stock left, though, over (60 percent) indicated that it would have lasted for less than 3 months, thus suggesting severe food deficit in inaccessible areas, June through September which is the lean period.

Overall, land access was relatively high as about 70 percent of households reporting such access, particularly in June which is the beginning of the planting season. However, almost two-third (66 percent) of households with land access only have access to a small portion of the land of about 1 hectare or less. Despite these challenges highlighted, farming continues to remain the mainstay for food availability in households with arable land access as about 90 percent of such households were engaged in farming during the month that preceded their departure from places of origin.

In the reporting month, over 70 percent of the surveyed household stock level would only last for less than 3 months. This indicates that households experienced a large food gap, its consistent in LGAs such as Marte, Mobbar, Damboa and Nganzai 100 percent each, other pronounce LGAs include Magumeri 80 percent and Madagali 96 percent. Generally, land access was relatively high as about 71.4 percent of households reporting such access, which was consistent across LGAs with sufficient samples. However, almost two-third (66 percent) of households with land access only have access to a small portion of the land of about 1 hectare or less. About 33 percent of households reported access to about 0.5 to 1 hectare of land being available for cultivation while another 33 percent of households only had access to less than 0.5 hectares of land. Noteworthy to highlight that only 4 percent of households have access to more than 2 hectares of land in these previously agrarian-dominated areas.

Food Access

The monthly (June through August) results from the FMS reports revealed that households continued to have limited access to markets in the inaccessible areas within the surveyed LGAs. Overall, the findings continued to indicate that markets were either completely non-functional or functioning at sub-optimal levels in some of the inaccessible areas as confirmed by about 70 percent of the surveyed newly arrived households as against 78% (largely from Madagali, Magumeri and Gwoza) for the month of September. Similarly, prices of staple crops are high, and households confirmed over 30 percent significant increase and over 35 percent acknowledged high price while over 20% reported small to moderate increase during the period of June to August in the inaccessible area, from the FMS findings. However, for the month of September, although 77 percent of the new arrivals said they had access to markets, they were constrained by significant price increases (37 percent) and lack of money (6 percent), thus, limiting their access to market which their primary source of staple foods. Moreover, wild food foraging (18 percent) and begging (5 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 Madagali (55 percent), Gwoza (31 percent), and Bama (19 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 33 percent and 36 percent of the interviewed individuals for Sept and Jun-Aug respectively, 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 in the month of Sept was reported for Chibok and Askira/Uba (100 percent) and Damboa (98 percent). As much as 40 percent of the newly arrived IDPs from inaccessible areas spent more than 30 minutes to access water. However, from June to August, this proportion was found to be 50 percent of the interviewed households. indicated that it takes more than 30mins to access water, with the highest proportions of such recorded in Geidam (100 percent) and Kaga (67 percent). Moreover, access to sanitary services is constrained in inaccessible areas as evidenced in majority of surveyed households (99 percent for both Sept and Jun-Aug) that lacked access to improved toilet facilities. Ordinary pit latrine remained the most common toilet facility (60 percent and 53 percent for Sept and Jun-Aug, respectively).

For health services and facilities, 90 percent and 77 percent for Sept and Jun-Aug, respectively, lacked access to functional health and nutrition services in their locations of origin, which was quite consistent in most locations with sufficient sample, notably Madagali (100 percent), Bama (96 percent), Damboa (99 percent) and Konduga (89 percent). Only 13 percent of the newly arrived IDPs accessed fully functional health services for free in Sept compared to 55 percent reported in Jun-Aug. Close to 27 percent of the interviewed individuals said there was clinic building but not personnel or supplies. This is contrary to the 6 percent recorded in Jun-Aug. About 16 percent of the respondents said they pay for the health services they received. Nearly 68 percent of respondents spend more than 30 minutes to access health facilities as opposed to 65 percent obtained in Jun-Aug. In- and out-patient health services are mostly available in the communities of origin of interviewed households as reported by 13 percent and 26 percent of households, for each of Sept and Jun-Aug. Community outreach health services was confirmed by 4 percent as against 6 percent in Jun-Aug; while nutrition services was acknowledged by 0.3 percent in Sept and another 5 percent of the interviewed households in June to August 2021. There is serious lack of or only skeletal community health services in places like Bama, Gwoza, Madagali, Jere, Nganzai, Geidam and several other areas. Illness of household members is prevalent as confirmed by 59 percent compared to 78 percent of the surveyed households in Jun-Aug. Across the sampled areas, the proportion of respondents reporting illness of household members ranged from 9 percent in Jere to 100 percent in Askira/Uba, Marte and Geidam. Results show that children under 5 years of age were most vulnerable to illness as reported by 41 percent in Sept as against 50 percent of the new arrivals documented in Jun-Aug. Fever (54 percent in Sept compared to 74 percent in Jun-Aug) and cough/flu (37 percent in Sept as opposed 44 percent in Jun-Aug) constitute the most common illness in the communities of origin as reported by the new arrivals.

Chart 5: Most Significant Shocks 3-4 Months before Arrival

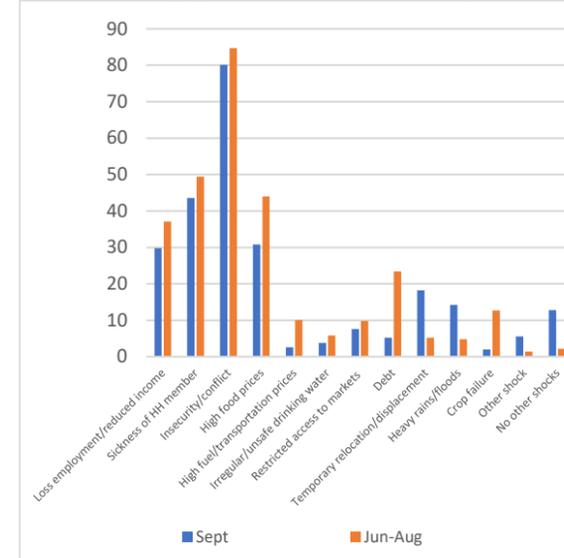


Chart 6: Changes in price

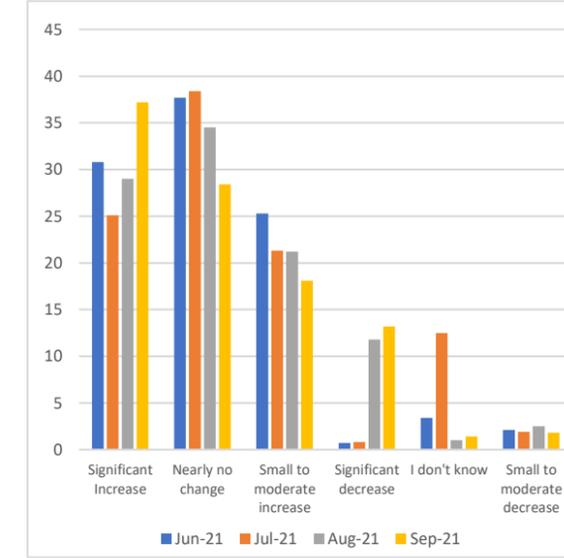
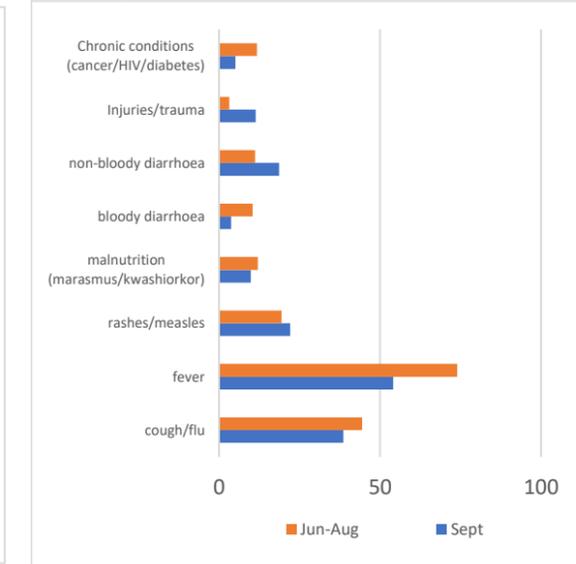
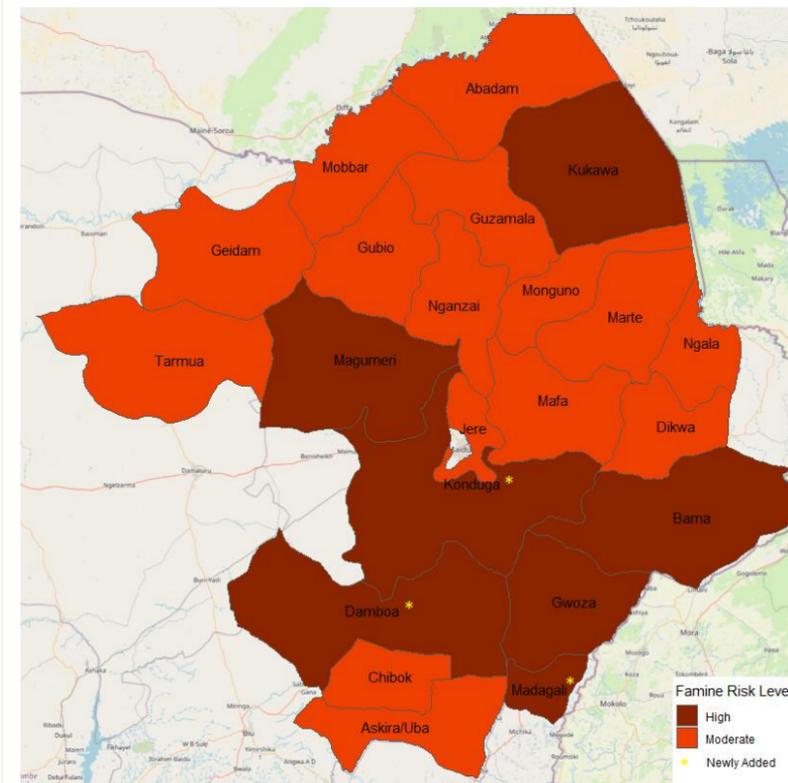


Chart 7: Type of Illnesses



Famine Risk Level – September 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. 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 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, Damboa, Konduga, Madagali, Magumeri and Kukawa – should continue to be monitored closely considering elevated levels of food consumption gaps, malnutrition and extensive/unsustainable usage of emergency coping strategies, largely underscored by limited availability of food stocks, restricted access to functional markets and health services;
- Elevated health risk within a highly food insecure, vulnerable, and inaccessible population;
- FMS data indicates high morbidity rates and illnesses affecting all age groups including the productive household members. The impact of morbidity on the household expenditure, food consumption and productivity require in-depth exploration and close monitoring;
- Majority of the households have no access to health facility. This warrants the need to devise alternative ways through which communities could manage illnesses (i.e. 'coping strategies' for limited formal health services); and
- The combined effect of these highlighted factors, will heighten morbidity level and, would likely impact households' ability to engage in labor-for-food or resource gathering— thereby deepening the vulnerability of the already fragile households.

Limitations of the FMS

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