Snapshot on OCG operations in Nigeria's Borno State – November 2016

Médecins Sans Frontières (MSF) is an international, independent, medical humanitarian organisation that delivers emergency aid to people affected by armed conflict, epidemics, natural disasters and exclusion from healthcare. MSF offers assistance to people based on need, irrespective of race, religion, gender or political affiliation.

MSF Switzerland has been working in the camps housing Nigerian refugees in Niger and Cameroon for several years and started operations in Nigeria's Borno state in July 2016: first in the IDP camp of Banki (July) and later expanding its operations to the towns of Gambaru and Ngala (beginning of October).

Activities include: mass screening of children under 5 for and treatment of malnutrition; measles vaccination; support to the existing MoH teams with drugs, equipment and staff; organization of medical references for secondary care; general distribution of food rations, as well as NFIs (mosquito nets, jerry cans and soap); and water and sanitation works.

The IDP camp of **Banki** was established by the Nigerian authorities after they retook the town from Boko Haram in September 2015. The population, coming mostly from neighbouring villages and with a ratio of around 38% men compared to 62% women, is currently **at 20'000 to 25'000 people.** A team of only 6 MoH community health workers are operating the camp's health post. IDPs in Banki are not allowed to move out of the camp and are thus completely dependent on outside help for access to food, water and healthcare.	The IDP camp of **Ngala** was established end of 2015 after heavy fighting between the Nigerian army and Boko Haram in the area. The current population of the camp, coming various LGAs in Borno, lies **between 50'000 and 65'000 people**. Only two nurses from the Nigerian Red Cross are conducting consultations inside the camp. IDPs in Ngala are allowed to move in and out of the camp while observing a curfew put in place by the army. Most remain completely dependent on outside help for access to food, water and healthcare.	**Gambaru** town saw several deadly attacks of Boko Haram throughout 2014 and 2015 and was announced as retaken by the Nigerian army in September 2015. The town's current population is estimated at **70'000 to 80'000 people.** The town's only health centre is destroyed and there's currently only one nurse working from time to time. People in Gambaru can come and go but the town has been cut off from major trade with other towns in Borno state (such as Maiduguri) and with Cameroon for a year.

High mortality from preventable diseases and malnutrition

In all three locations, MSF medical personnel comes in support to the MoH teams already present on the ground, who lack the proper space and equipment to conduct consultations and are struggling to cope with the high number of patients. During our visits, MSF observed extremely high mortality rates and malnutrition.

BANKI

- In a July 2016 rapid mortality survey covering the period going from January to July 2016, MSF found a Crude Mortality Rate (CMR) of 4.16 deaths for 10'000 people per day and a mortality rate for children under 5 of 6.2 deaths for 10'000/day. **Both figures are well above emergency thresholds and attest to the impact of the conflict on people's lives and the unacceptable living conditions in the camp.**
- An initial assessment in July 2016 also showed a **prevalence of Severe Acute Malnutrition (SAM) of 14,3% among children under 5**.
- The situation drastically improved following the start of MSF's activities in the camp: in September 2016, MSF proceeded to conduct a second mortality survey covering the period running from July 20th to September 16th. The results highlighted a mortality rate of 5.6 deaths per 10'000 children under 5 per day and a CMR of 3. Followed, in October 2016 by a third mortality survey covering the period from September 16th to October 28th, which concluded to a CMR of 0.6 deaths per 10'000/day and 1.7 for children under 5.

- MSF teams have used so far 7'506 vaccine doses for measles; 13'019 chemical prevention doses for malaria; conducted 633 consultations for SAM and 812 for MAM, and more than 1'300 in general OPD.
- MSF teams installed 2 generators (operating 7 water pumps) and 6 water tanks of 3000L each; equipped 3 boreholes with pumps; created the health post's waste management zone and are building 120 latrines.

NGALA

- MSF vaccinated 7'060 children under 5 against measles, distributing Vitamin A and Abendazole to each one.
- In the 150 medical consultations conducted by MSF teams, the main illnesses observed were malaria (38%), followed by respiratory tract infections (17.5%) and diarrhoea (13.6%).
- An October 2016 MSF screening of 7'163 children under 5 showed a **prevalence of 8.5% of SAM and 14.3% of MAM (GAM of 22.9%), describing an untenable situation for the camp's population**.
- To increase access to water (up from less than 1L/person/day), MSF installed 6 solar pumps.

GAMBARU

- MSF vaccinated 8'200 children under 5 against measles, distributing Vitamin A and Abendazole to each one.
- The main illnesses observed in the 171 consultations MSF did were malaria (37.9%), respiratory tract infections (16%), followed by diarrhoea (9%). MSF teams also noted the need for specialized care for pregnant women.
- MSF screened a total of 8'227 children, identifying a **prevalence of 2.1% of SAM and 6.4% of MAM (GAM of 8,5%)**. This confirms the dire situation the town's population finds itself in, in the aftermath of months of fighting between the Nigerian army and Boko Haram.

Insufficient humanitarian assistance

More than a year after the Nigerian army took control of these three locations, humanitarian assistance still falls appallingly short of responding to the people's most basic needs.

- **Access to adequate food rations (with enough micronutrients in quantity and quality) is the most immediate priority.** The rations distributed by the Nigerian authorities for several months to the IDPs in Banki and Ngala did not ensure people received enough to survive. So far, MSF distributed food rations to 17'313 families. Food is first and foremost a concern in Ngala and Gambaru, to where aid is only occasionally sent, but continued monitoring of distributions needs to be ensured in Banki.
- Water is also a major pressing concern. **The situation is most worrisome in Gambaru and Ngala, where MSF estimates people have access to less than 5L and 8L of water respectively.** In Banki, MSF efforts to increase people's access to water from less than 5L/person/day in July to 20L are ongoing (no technical assessment was ever conducted by the Borno State Agency in charge of water and sanitation works).
- Many of the diarrhoea cases we treat are linked to the **poor hygiene conditions** that remain an issue in Banki and need to be looked at in Ngala and Gambaru.
- Although MoH medical personnel is present in all three locations, the support they receive is inadequate in terms of HR, supervision, equipment, consumables and drugs.
- In terms of shelter, assessments are urgently needed in Ngala, as well as Gambaru and activities need to start in Banki.

Recommendations

→General distributions of adequate food rations to the populations have to be ensured on a regular basis and properly monitored in all three locations.

→Access to drinking water remains a priority in all three places and needs to be combined with major works to improve people's access to hygiene facilities.

→Shelter is inadequate for IDPs in Ngala and Banki camps. NFIs are needed with the arrival of colder temperatures at night.

→Existing MoH teams on the ground need to be reinforced with qualified personnel and permanent supervision. All locations also need to be supplied with drugs and therapeutic food.

→Since humanitarian assistance in those three hard to reach areas remains largely insufficient, access to humanitarian actors should be facilitated to upgrade the level of emergency aid.

→People's **freedom of movement** needs to be respected, especially considering many are held against their will in places where basic standards are not observed. Civilian administration of the camps needs to be put in place.

Annex 1

Evolution of data on malnutrition amongst children under 5 in Banki camp

The extremely high level of malnutrition among the displaced population blocked in Banki camp comes to light in the survey on nutrition MSF conducted in July 2016. When measuring the mid upper arm circumference of children under 5 years of age at the time, MSF teams found the following results:

Upper arm measurement	**n**	**% of total**	**Classification**
Children with arm circumference ≥135 mm	962	52.8%	Normal
Children with arm circumference 125-134 mm	362	19.9%	At risk
Children with arm circumference 115-124 mm	234	12.9%	MAM
Children with arm circumference <115 mm	261	14.3%	SAM
Children with oedema	1	0.1%	Kawshiorkor
Total:	1,820	100%	

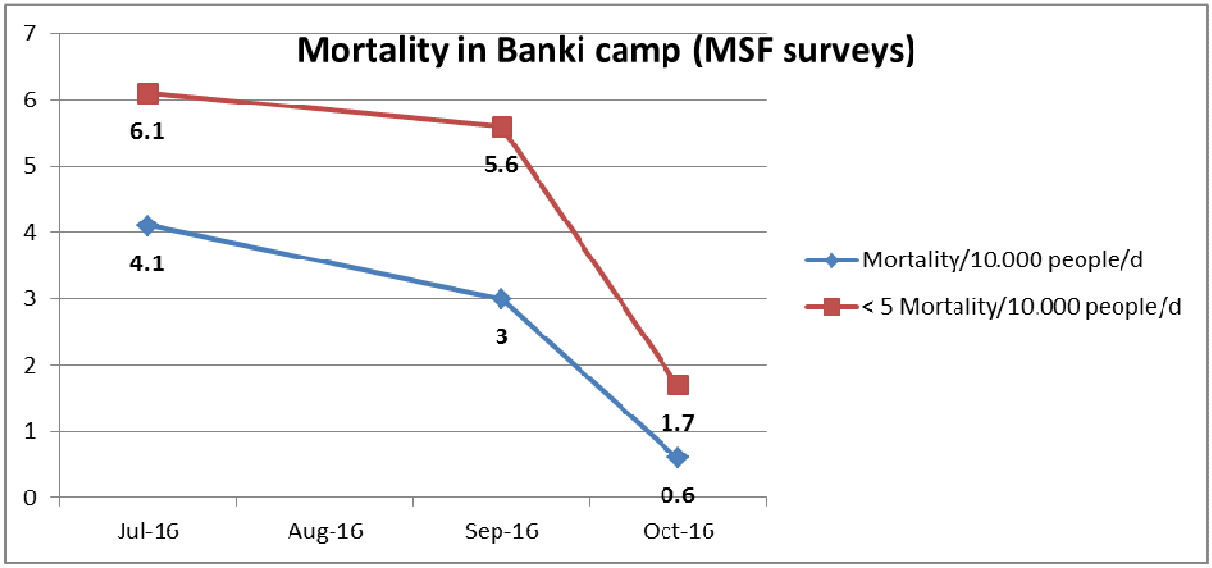
The subsequent improvement of our patient's health with the launch of MSF activities and start of regular food distributions can best be exemplified through the reduction in the number of consultations MSF teams are conducting for Severe Acute Malnutrition (out of the total consultations conducted for malnutrition).

Annex 2

Evolution of mortality amongst the general population and children under 5 in Banki camp

MSF conducted three retrospective mortality surveys in Banki camp:

- For the first survey, conducted in July 2016 and with a recall period going from January 1st to July 20th 2016, 143 households were consulted, representing 1'003 people. **The resulting rates are well above emergency thresholds.** The most frequently reported cause of death was malnutrition (30.5%), followed by diarrhoea (23.7%) and fever (23.7%).
- For the second survey, conducted in September 2016 and with a recall period going from July 20th to September 16th 2016, 675 households were consulted (representing 8'396 people). The principle causes of death reported for children under 5 years of age were malaria (40%) and diarrhoea (40%).
- The third survey was conducted in October 2016 to cover the period going from September 16th to October 28th. 898 households participated, representing 6'733 people. The main cause of death reported was malaria (50% of all deaths).



All three surveys show an abnormally high mortality rate of children under 1 year of age: they make out 54% of all registered deaths of children under 5 in September and still represent 43% in October.

Annex 3

Distributions in Banki, Ngala and Gambaru

Considering the critical status of the populations observed during our exploratory missions, where **food was mentioned at the most immediate need**, MSF launched blanket food distributions in their first visit to Banki and replicated that intervention model in Ngala and Gambaru. In Ngala and Gambaru, the dry rations consisted of 10kg of mil, 5kg of dry beans, 1L of cooking oil, 250g of salt. In Banki, they contained 25kg of mil, 5g of dry beans, 2L of cooking oil and 250kg of salt MSF coupled these with the distribution of essential NFIs: mosquito nets and soap bars in Ngala and Gambaru and soap bars and jerry-cans for Banki.

	Banki	Ngala	Gambaru
Therapeutic food (PPN and BP5)	78T (more than 400 000 packets)	42T (more than 100 500 packets)	
Dry rations	80T (2'470 rations)		240T (14'843 families)