



Risk Monitoring: Dikwa Update

Dikwa Town, Borno State, Northeast Nigeria

April 2021

CONTEXT

A series of attacks in Dikwa town between February 19th and the first week of March by non-state armed groups (NSAGs) triggered the evacuation of humanitarian actors from an area heavily dependent on life-saving assistance for food, water, and healthcare. Dikwa town, the capital of Dikwa Local Government Area (LGA), is a highly congested hub of roughly more than 100,000 people, including approximately 76,000 internally displaced people (IDPs) living in 17 camps and collective centres, and 7 host community areas.¹ In addition, an estimated 22,000 people reside outside of Dikwa town in areas inaccessible to humanitarian actors.² Prior to the escalation in violence, Dikwa town was the only ward in Dikwa LGA that was accessible to humanitarian actors.³

Updated as of April 8:

While security in Dikwa town has improved in the immediate term, surrounding areas remain highly volatile. Deteriorated humanitarian access in Dikwa takes place against a backdrop of increased targeting of humanitarians across the North East, including a recent surge of attacks against humanitarian infrastructure in Damasak, Mobbar LGA, by NSAGs.⁴

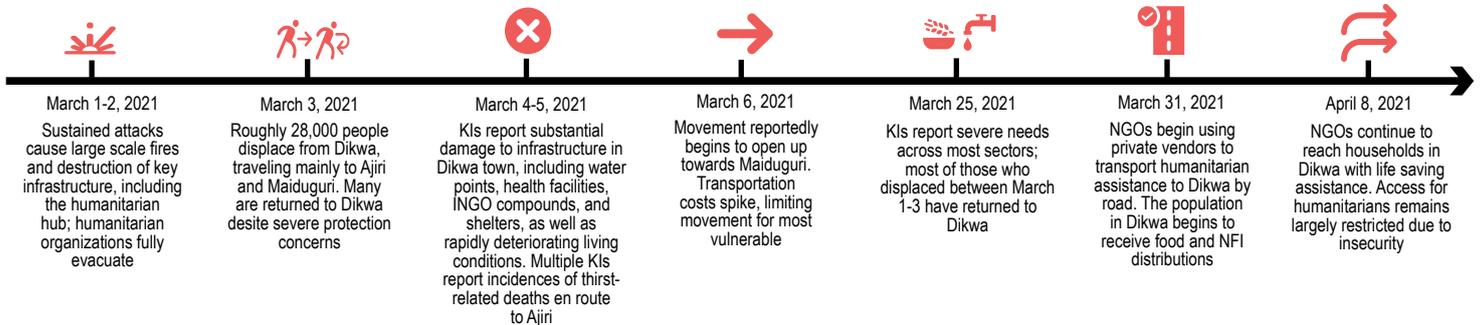
METHODOLOGY OVERVIEW

From March 4-5, REACH conducted a rapid assessment through interviews and participatory displacement mapping with 10 key informants (KIs) in Dikwa, Ajiri, and Maiduguri to better understand the current and anticipated needs subsequent to the spike in violence on March 1-2. From March 6-7, REACH continued to receive informal updates from additional KIs on the evolving situation in Dikwa and Ajiri. For this April update, REACH interviewed 7 KIs in Dikwa on March 25-26, including 3 community WASH volunteers, to get a better understanding of how access to services, and needs had changed since the evacuation of humanitarian actors. REACH continued to receive informal updates from humanitarian personnel familiar with the situation, and KIs in Dikwa, from March 26 to April 8, in order to better understand shifts in humanitarian access and service provision.

The methodology follows REACH's rapid assessment toolkit, focused on gathering information on causal factors of severe needs, including displacement patterns, asset stripping, food access, livelihood coping strategies, nutrition, and health service access. The situation continues to evolve at the time of writing and the findings of this brief are reporting on information received up until April 8. All findings are indicative only and should be triangulated.

Figure 1: Timeline of events

Updated as of April 8:



KEY FINDINGS

Updated as of April 8:

- Of the roughly 28,000 individuals that were displaced in the direct aftermath of the attacks in Dikwa in March, **most have returned to Dikwa town** from Ajiri and Maiduguri.⁵
- At the end of March there was a **partial resumption of humanitarian assistance**, with the distribution of food, medicine, nutrition supplements, and key NFIs in Dikwa town; however **response is largely limited** to supplies and aid prepositioned in Dikwa or transported in by contracted vendors and distributed by local staff.
- Assistance that relies heavily on technical expertise**, such as health services, shelter construction, nutrition, borehole maintenance and infrastructure repair are **facing the most significant response challenges** given the ongoing lack of access for humanitarians to travel from Maiduguri into Dikwa.
- KIs continue to report **disruption to water availability and access** in Dikwa town. According to KIs and partners, community volunteers have made basic repairs to some damaged WASH infrastructure, including to solar-powered boreholes, tap stands, and overhead tanks and while there are communal water points reported as functional, access for households to meet full daily needs remains limited.
- KIs report that hundreds of households who lost their shelters in the attacks are still **sleeping in converted public buildings such as schools or out in the open**.
- According to the March 2021 Cadre Harmonisé (CH), Dikwa LGA is classified as Crisis (CH Phase 3), with **48% of individuals facing Crisis or worse acute food insecurity** in the current period (March-May), which is expected to increase to 59% in the projection (June-August)—the primary mitigating factor for food security is a full resumption of humanitarian assistance.
- KIs in Dikwa, and health and nutrition partners reported **widespread health care needs**, which actors on the ground, primarily community-based volunteers, are reportedly unable to meet due to **lack of**



HUMANITARIAN ASSISTANCE OVERVIEW

Populations in Dikwa town are heavily dependent on non-governmental organizations (NGOs) for humanitarian food assistance and other basic services. KIs report that most residents of Dikwa town are beneficiaries of NGOs operated health care clinics, schools, water points, or various forms of shelter and livelihood assistance. Many residents also depend on humanitarian food assistance (HFA) as a primary food source.

Updated as of April 8:

More than five weeks after attacks triggered the evacuation of humanitarian actors, there is **limited resumption of humanitarian assistance** in Dikwa town, including food assistance, non-food item (NFI) kits, water, sanitation, and hygiene (WASH) support, and basic health and nutritional services. According to KIs and partners, **assistance provision is limited in both coverage and depth due to continued access constraints**. Further, KIs and CH reported **populations continue to face severe needs across many sectors**. **Dikwa town is still largely inaccessible to INGOs**, and while humanitarian actors are moving goods along roads through vendors, assistance is directly provided by local community-based volunteers with limited technical capacity. **In addition, KIs report that the discovery of an unexploded ordnance (UXO) near a humanitarian program sites will further delay the full resumption of activities**. The large scale resumption of operations is reportedly pending a security assessment and United Nations Humanitarian Air Service (UNHAS) test flight.

DISPLACEMENT & MOVEMENT RESTRICTIONS

Updated as of April 8:

Waves of displacement out of Dikwa town immediately followed the initial attacks in early March; IOM reported that approximately 28,000 individuals initially fled Dikwa town to Ajiri due to the fighting, the deteriorating humanitarian conditions in Dikwa town, and the fear of future attacks.⁶ More than 5 weeks after the initial displacement, KIs reported that **the majority of those who initially left Dikwa town for Ajiri and Maiduguri have since returned**, and the security situation is perceived to have improved in the town. Regular vehicle travel between Dikwa and Maiduguri has largely resumed and large-scale displacement by foot out of Dikwa is no longer ongoing. However, KIs reported **ongoing small-scale migration driven by poor living conditions and limited access to livelihoods in Dikwa town**.

The First Wave (March 1-3)

- Sudden-onset displacement immediately following fighting, primarily west to Ajiri or east and into the bush. IDPs were initially restricted from proceeding on the road past Ajiri - some were returned to Dikwa town by bus, while others returned voluntarily due to the lack of access to water, shelter, and food.

The Second Wave (March 4-5)

- Resource-stress driven movement in the days following initial attacks due to deteriorating conditions, including limited availability of water, rapidly decreasing food stocks, and no medical support. Those with direct or financial access to a vehicle reportedly travelled by car or truck, while others to Ajiri by foot.

The Third Wave (March 6 - March 12)

- On March 6, IDPs reportedly started gaining increased access to Maiduguri by vehicle. However, spikes in transportation prices (approx. 300% increase) and long distances to travel by foot (approx. 90 km) reportedly limited movement for more vulnerable populations.

The Fourth Wave (March 13 - April 8)

- KIs estimated that at least 80% of the roughly 28,000 people originally displaced from Dikwa following the attacks have returned and more continue to do so. KIs attributed these returns to the increased perceptions of security in Dikwa town with the return of military personnel and to the lack of access to basic services and livelihood opportunities in displacement locations.
- Movement between Dikwa and Maiduguri to access markets and livelihoods has reportedly increased since the initial implementation of movement restrictions following the attacks. The price of transportation has returned to the pre-shock rate of 1,500 NGN per person for vehicle travel to Maiduguri.⁷ The most vulnerable households who cannot afford transportation and have limited social networks in Maiduguri continue to have limited options for leaving Dikwa to access adequate resources or livelihoods.
- Movement beyond Dikwa east to Ngala and north to Monguno - areas where humanitarian assistance is ongoing - is perceived as unsafe due to the presence of NSAGs along roads.
- KIs reported that households are having difficulty registering in Maiduguri camps and lack financial access to housing or property in Maiduguri, resulting in challenges finding viable shelter options upon arrival. In addition, stretched resources in nearby garrison towns limits the number of viable destination options.
- IOM reported that approximately 5,000 individuals from Dikwa have settled across various parts of Jere and Maiduguri LGAs since the March 1-2 attacks, the vast majority of whom have settled in host communities. The flow of IDPs to these areas had been steady throughout the month of March.⁸
- KIs reported that IDPs have arrived from inaccessible areas of Dikwa and Marte LGAs to Dikwa town since March 2. While roughly 700 of those who arrived from Marte have since been returned to Marte LGA, the populations remaining are reportedly sleeping out in the open, and in primary schools.

NEEDS & SERVICE PROVISION

Updated as of April 8:

Towards the end of March, there was a partial resumption of humanitarian assistance with the distribution of food, medical supplies, nutritional supplements, and key NFIs to populations in Dikwa town. However, **the provision of aid has been largely limited to supplies either already prepositioned in Dikwa or transported by privately contracted vendors**. Humanitarian actors remain largely unable to access Dikwa, preventing technically trained or specialized staff from returning. Ongoing services are currently being provided by community-based volunteers with limited technical capacity. Consequently, high levels of needs remain across a number of sectors, including WASH, health care, and shelter. Below is a summary of ongoing assistance measures, service gaps and priority needs reported by KIs as of April 8.

Water, Sanitation, and Hygiene (WASH)

Updated as of April 8:

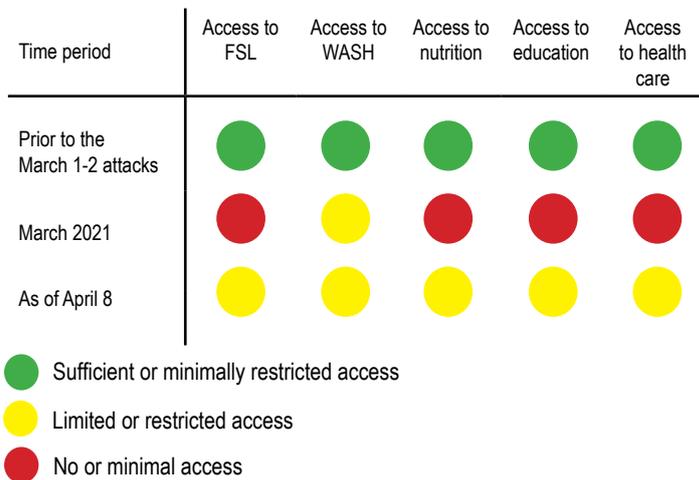
KIs continue to report a disruption of water availability and access in Dikwa town. While interviews with KIs suggest that most households are able to access minimum quantities of water for drinking, most are struggling to meet daily water needs. Further, while hygiene promotion activities are ongoing, the depletion of WASH NFIs and strain on latrine capacity are reportedly driving the deterioration of hygiene and sanitation conditions and increasing the risk of disease.

Population in Dikwa facing water shortages through availability and access constraints

While some communal water points are reportedly functional, access to water reportedly remains limited for most households, and the high demand has driven price increases at private vendors, restricting financial access for impoverished households, mainly IDPs. According to KIs and partners, community volunteers have made basic repairs to some damaged WASH infrastructure, including to solar-powered boreholes, tap stands, and overhead tanks. Additionally, KIs reported that some better-off community members have contributed to paying for operating costs, such as fuel, for generator-powered boreholes outside of camps.

In camps, however, several generator-powered boreholes and hand pumps are reportedly still non-operational, requiring fuel, maintenance, or parts. IDPs in camps have limited individual or communal economic capacity to pay for fuel or maintenance. KIs reported that IDP households are traveling long distances to fetch water at various water points in town, waiting in queues for more than one hour, or spending already limited resources to purchase water at private vendors. The additional time and resources spent collecting water reduce time household members have to engage in other essential tasks, including livelihood activities.

Figure 2: Reported access to services in Dikwa town between March 1 and April 8, according to information received from KIs



Unsafe drinking source along route from Dikwa to Ajiri

KIs reported that a single stream serves as the only source of drinking water along the route from Dikwa to Ajiri. While travel by foot to Ajiri has largely stopped for now, a resumption in fighting would likely trigger another wave of large-scale displacement, posing a significant risk for those traveling. While some individuals were reportedly able to make the journey from Dikwa to Ajiri by foot without water; children were often reportedly drinking dirty surface water, which KIs reported to have caused severe sickness.

Highest WASH concerns: Households residing in camps, women, children, the elderly, and persons with disabilities

KIs unanimously reported that displaced households residing in camps and informal sites have worse access to water than members of the host community, who typically have more substantial financial resources to cope with limited access. Multiple KIs reported that women and children, particularly those that are displaced, face the most significant barriers to accessing water. Men are reportedly able to leverage physical strength and social influence to increase access to water at crowded water points, some of which have reportedly occasionally become unsafe due to violence. Vulnerable groups

such as disabled or elderly IDPs who are physically unable to travel longer distances or wait in long queues are also reported to face significant barriers to water access, some of whom KIs reported have resorted to begging as a coping strategy. Women are reportedly most in need of WASH NFIs (see below), driven in part by poor financial access to markets due to restricted access to available livelihoods such as menial labor opportunities. KIs reported that many women are coping with the decreased availability of female hygiene products by using cloth, causing unsanitary conditions.

Scarcity of key WASH NFIs

KIs unanimously reported a widespread scarcity of basic WASH NFIs, including soap, detergent, water storage containers, female hygiene products, and chlorine tablets, which were previously provided by humanitarian NGOs. A limited quantity of soap was reportedly available in markets and prices have increased substantially, with one KI reporting an increase from 80 to 150 NGN per bar at one location. Poor access to WASH NFIs and rapidly worsening conditions of public sanitation facilities (see below) are driving deteriorating hygiene conditions, increasing the risk of disease.

WASH partners reported that the disruptions to the delivery of chlorine tablets may limit the capacity to ensure clean water access in Dikwa. Multiple KIs reported a noticeable recent decline in water quality, reporting that drinking water has been “dirty,” “milky,” or “cloudy”. WASH partners note that if supplies are not able to reach Dikwa town, chlorine tablets will likely fully deplete in the coming weeks, with no reported alternative source of water treatment locally available.

Recent distributions of NFI kits have reportedly included key WASH items, such as soap, detergent, buckets, and female hygiene products, which has likely mitigated shortages and helped improve conditions. It is not clear at the time of writing, however, how many households have received kits.

Unsanitary conditions reported at public latrines, including evidence of open defecation

According to KIs, public latrines are full or nearly full in many areas, particularly camps, which depend on INGO support for desludging. Humanitarian actors reported that desludging of facilities has occurred since the attacks, however KIs reported uncertainty as to whether desludging would occur consistently in the coming weeks. Multiple KIs reported evidence of open defecation in IDP camps, driven in part by the unsanitary conditions of latrines. KIs reported they expect open defecation in camps to increase in the coming weeks as latrines fill and become unusable, increasing the risk of disease for a population with highly limited access to healthcare. Further, KIs reported that people in camps will likely increasingly travel into the bush to defecate, which poses a protection concern, especially for women, in the current security context.

Lack of technical capacity on the ground poses significant threat to WASH access

While volunteers have largely been able to manage basic maintenance of WASH infrastructure, multiple community WASH volunteers reported that they lack the necessary technical skills needed for more complex repairs. The majority of WASH staff with technical training needed for such repairs are reportedly personnel who evacuated Dikwa following the attacks. Limited technical knowledge on the ground and the lack of necessary hardware means mitigation measures for future infrastructure wear are limited. Any further deterioration of WASH infrastructure will likely pose a serious problem to already limited water and hygiene availability given the absence of humanitarian technical assistance.

Food Security and Livelihoods (FSL)

Updated as of April 8:⁹

According to the CH, Dikwa LGA is classified as facing Crisis (Phase 3) acute food insecurity. Humanitarian food assistance is a major factor for mitigating severe food security outcomes in Dikwa town. Consequently, the disruption of food assistance following the attacks in March was considered a substantial driver of acute food insecurity. However, in the week of March 29, general food distributions reportedly resumed in Dikwa town. As of April 4, roughly 61,561 people had reportedly received one month rations, including sorghum, cowpeas, and cooking oil.

Dikwa LGA - Cadre Harmonisé (CH) March 2021

Current (March-May 2021) Food Security Outcomes

The March 2021 CH reported that approximately 48% (57,815 ind.) of the population is experiencing Crisis (Phase 3)¹⁰ or worse levels of acute food insecurity, which is a 16% increase from the population reported in October 2020 (32%). Further, 15% (18,140) of households are currently experiencing Emergency (Phase 4)¹¹ acute food insecurity, characterised by large food consumption gaps and/or engagement in irreversible negative coping strategies and widespread livelihood disruption.

According to the CH, roughly 65% of households received food assistance and 24% of the households received livelihood assistance in February 2021. The escalation of insecurity and evacuation of humanitarian actors, suspended life-saving assistance and consequently drove increases in acute food insecurity in Dikwa. Further, financial access to food was limited by high prices of staple crops and disruption to WASH services, notably clean access to water, resulted in poor food utilization, further driving high levels of food insecurity.

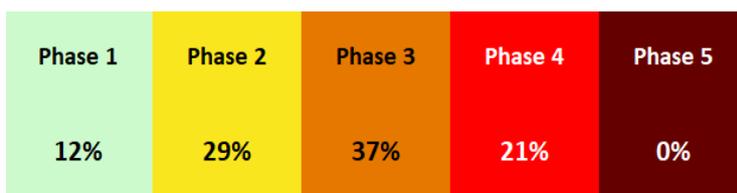
Figure 4: Population breakdown by food security classification in the current phase, March-May 2021



Projected (June to August 2021) Food Security Outcomes

From June to August, acute food insecurity is forecasted to increase by 11%, with 59% of the population (70,706 ind.) in Dikwa LGA expected to experience Crisis or worse outcomes, which is 17% higher than the October 2020 projection for June to August (42% in P3+). Further, 21% (25,450 ind.) of the population is expected to experience Emergency (Phase 4) acute food insecurity. High levels of food insecurity are likely driven by seasonal depletion of food sources in Dikwa town and surrounding areas, reliance on negative coping strategies such as asset liquidation, and increased levels of morbidity due to poor WASH conditions. The combination of these factors are also likely to drive area-level increases in malnutrition.

Figure 5: Population breakdown by food security classification in the projected phase, June-August 2021



Inaccessible Areas - CH March 2021

The March 2021 CH reported that **90% of the inaccessible population in Dikwa LGA (20,619 ind.) is experiencing Crisis or worse levels of acute food insecurity** (Phase 3 or higher), with 47% of households in inaccessible areas currently experiencing Emergency (Phase 4). In the projection period, food security in inaccessible areas of Dikwa LGA is expected to slightly deteriorate, with 95% of the population forecasted to experience Crisis or worse outcomes from June to August 2021 (CH March 2021).

Inaccessible areas are characterized by a lack of access to affected populations, resulting in the inability of humanitarian actors to provide food assistance. Therefore, inaccessible areas typically face more severe food security outcomes. Although there are a wide range of limiting factors and drivers of acute food insecurity in inaccessible areas, **these outcomes are a proxy reflection of how the withdrawal of humanitarian assistance may impact future outcomes in Dikwa town.**

Figure 6: Areas of Dikwa LGA accessible to humanitarian actors prior to March 1-2 attacks

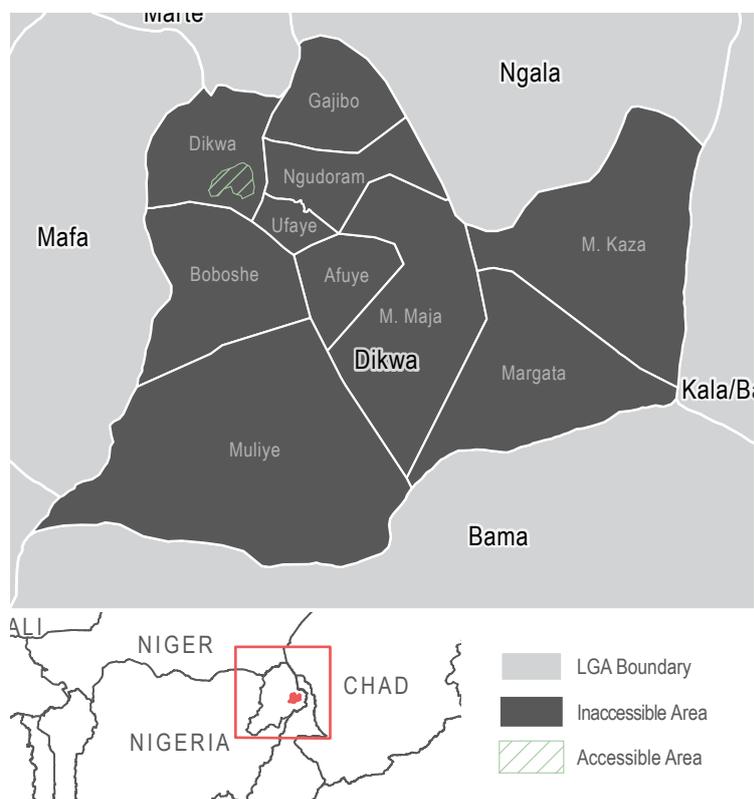


Figure 7: Assumptions to monitor food security in Dikwa LGA - June to August 2021

Assumptions (as per CH March 2021)	Effect on Food Security	Factors to Monitor
Humanitarian services are expected to resume to full operation given improved security situation	Positive	Disruption to humanitarian assistance due to insecurity or access constraints
Depletion of food stocks and increased morbidity	Negative	Food availability in markets and households, increased morbidity rates
Continuation of livestock rearing in nearby pastures	Positive	Access to nearby pastures; pasture health and availability
Improved access to farmland dependent on improved security and return of humanitarian actors	Positive	Security situation and return of humanitarian actors to Dikwa town
Improved access to drinking water and WASH services	Positive	Access to water through water trucking and borehole repair and maintenance

Shelter, NFIs, Health Care, and Nutrition

Updated as of April 8:

Critical shelter needs identified; households sleeping out in the open and in public buildings

Approximately 445 shelters were damaged or destroyed across two camps, according to an IOM report.¹² KIs reported that households whose shelters were damaged are sleeping in overcrowded public buildings, primarily schools, out in the open, or are being hosted by host community members. While shelter partners have proposed the construction of 500 new emergency shelters and the repair of 552 damaged shelters, KIs report that full-scale reconstruction and repair will be limited while access for humanitarian actors is still restricted due to the need for ground-level oversight and technical expertise. Shelter partners have begun some distribution of emergency shelter kits (ESKs) intended to support minor repairs and upgrades in the interim, and KIs reported that basic repairs are being made by households with available resources.

Some basic health services resume; specialized services remain unavailable and admissions to healthcare facilities paused

Of the ten health care centers operational in Dikwa prior to the attacks, three are currently functioning, but at limited capacity according to an IOM flash report.¹³ KIs report that community-based volunteers with limited technical capacity are providing basic health care services, such as the distribution of medicines and nutritional supplements, which is reportedly insufficient to meet the current level of need. Health facilities are reportedly not currently taking admissions, and volunteers are only working partial days. KIs report that women and children are most affected by health care gaps, particularly pregnant women, highlighted by the case of two women who are reported to have died in childbirth. Multiple KIs reported that facilities and volunteers are overwhelmed by the scale of health care needs.

Nutrition partners resume some activities, but are overstretched facing widespread critical needs

Humanitarian actors have reportedly resumed some nutrition assistance, including severe acute malnutrition (SAM) treatment services through three out-patient therapeutic feeding program (OTP) sites, and the resumption of blanket supplementary feeding programs (BSFP) targeting children under five and PLW. Partners report that on April 1, 2,330 pregnant and lactating women (PLW) and 7,338 children under two received two month rations of RUTF. Nine of the twelve OTP sites operational prior to the attacks were reportedly not functional as of April 8, including the main nutrition stabilization center, which is part of Dikwa general hospital, and was damaged in the attacks. Consequently, there are no in-patient care services for patients experiencing acute malnutrition with medical complications currently available. While sites reportedly have sufficient stocks of supplements and supplies, including RUTF, to last for two months from the time of writing, a lack of in-patient services and low numbers of specialized staff are causing sites to be overwhelmed by high needs cases.

In addition, nutrition partners have identified a number of concerning service gaps, including a lack of infant and young child feeding in emergency (IYCF-E) counselling, lack of micronutrient powder (MNP) supplementation and vitamin A to prevent micronutrient deficiencies. Partners also reported a lack of routine screening capacity to ensure early identification of SAM or moderate acute malnutrition (MAM) cases, all of which were active features of nutrition programming prior to the attacks.

Humanitarian actors complete distribution of vital NFIs

Multiple humanitarian actors have conducted distributions of NFIs, including basic household items and WASH NFIs, as well as emergency shelter kits. Most NFI kits were reportedly distributed to displaced households whose shelter had been damaged or destroyed in the attacks. Additional actors report that further distributions will be carried out in the coming weeks.

CONCLUSION

More than 5 weeks after an escalation in violence forced the evacuation of most humanitarian actors from Dikwa, populations are beginning to receive some assistance. Physical access for humanitarians, however, remains largely restricted due to insecurity. Further, the delivery of assistance is reliant on NGOs' ability to transport provisions through private vendors along roads, and direct delivery to beneficiaries, including the provision of services, is being carried out by local community-based volunteers. While improved security in Dikwa town and along routes from Dikwa to Maiduguri makes the delivery of assistance viable for the time being, the security situation remains highly volatile and an escalation in violence risks cutting supply routes, likely disrupting access to basic services and assistance for over 100,000 people.

The provision of assistance, including food, NFI kits, nutritional supplements, and basic health care, and the opening of movement from Dikwa to Maiduguri, are positive developments. Information gathered by REACH, however, indicates that many of the drivers of high needs are still present, particularly for IDPs, who continue to face water shortages, insecure access to food, illness, and unsanitary conditions. KIs continue to report that hundreds of households remain without access to adequate shelter, and are sleeping in collective shelters, or out in the open.

Sectors which depend heavily on specialized knowledge, including health, nutrition, borehole repair, water treatment, and shelter repair and construction,

are facing the most significant delivery challenges. In the absence of specialized personnel on the ground, the direct provision of most services, including health care, is being carried out by personnel with minimal technical knowledge, who KIs report are overwhelmed by the scale of needs and are unable to respond to severe cases. In addition, the lack of adequate livelihood opportunities and disrupted trade flows continue to impact most households' financial access to basic good and services. While conditions have likely improved following the expansion of humanitarian access, the situation in Dikwa should be followed closely. Close monitoring of the situation is critical to gain a better understanding of needs and service gaps as humanitarian accessed remains limited.

Endnotes:

1. IOM-DTM Round 34 (2020)
2. Cadre Harmonise Factsheet, Nigeria, March 2021; available online [here](#)
3. IOM-DTM North East Flash Report (February 2021)
4. "Aid Group Facilities Attacked, Set Ablaze in Northeast Nigeria" VOA, April 2021, available online [here](#)
5. Displacement figure retrieved from IOM - Flash Report, North East Nigera, Dikwa LGA, 9 March 2021; available online [here](#)
6. Ibid.
7. 1,500 NGN is the rough equivalent of 4 USD, Morningstar, April 14, 2021
8. IOM - Flash Report, North East Nigeria, Dikwa LGA, 16-25 March 2021; available online [here](#)
9. Cadre Harmonise Factsheet, Nigeria, March 2021; available online [here](#)
10. Crisis (Phase 3): Households either: have food consumption gaps that are reflected by high or above-usual acute malnutrition; or are marginally able to meet minimum food needs but only by depleting essential livelihood assets or through crisis-coping strategies.
11. Emergency (Phase 4): Households either: have large food consumption gaps which are reflected in very high acute malnutrition and excess mortality; or are able to mitigate large food consumption gaps but only by employing livelihood strategies and asset liquidation.
12. IOM - Flash Report, North East Nigeria, Dikwa LGA, 16-25 March 2021; available online [here](#)
13. Ibid.

