

# Famine Monitoring System – August 2021 Monthly Bulletin

## Cadre Harmonisé Task Force on Inaccessible Areas



### KEY TAKEAWAYS

- Findings from the FMS revealed concerning consumption patterns in inaccessible areas as more than one in every two households (63 percent) struggled to have sufficient food intake and 80 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;
- More than two in every three households relied on either crisis (23 percent) or emergency (56 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 20.1 percent and Severe Acute Malnutrition (SAM) at 7.3 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;
- Detailed analysis among newly arrived population with good quality and adequate sample size showed severe consumption deficits and concerning SAM rates (18.1 & 15.4 percent) in Bama and Damboa LGAs, whereas near Extremely Critical (Phase 5) GAM rates were found in Bama, Damboa, Madagli, Konduga, Gwoza and Kukawa;
- The Crude and Under-five Mortality Rates were; 4.09 and 7.13 deaths/10,000/day respectively, both of which reduced to CMR of 2.39 and U5MR of 3.58 respectively after exclusion of data from Gwoza which had quality issues and was exceptionally high. 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.<sup>1</sup> 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.

### 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.

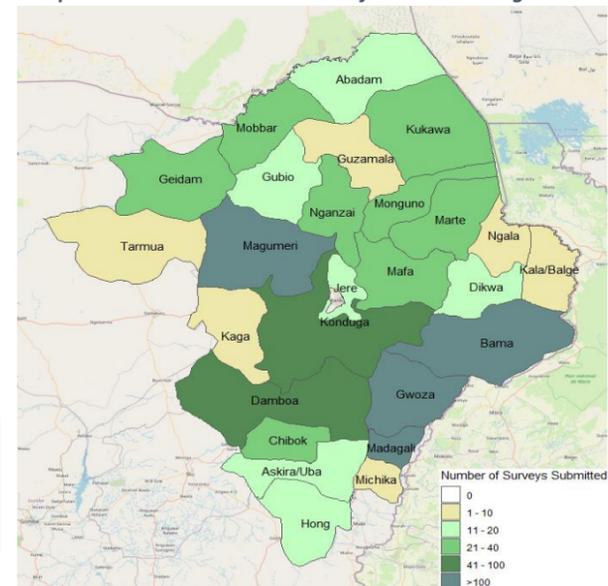
Primary data was jointly collected by partners in many accessible towns of Borno, Adamawa and Yobe States where there are new arrivals coming from the inaccessible areas with the support of the DTM from SEMA and IOM. Well-structured questionnaire was deployed by trained enumerators in collecting the 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. Between the months of 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 5<sup>th</sup> June, to 31st August, 2021.

<sup>1</sup> 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)

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 ( $\leq 10$  percent), which was reflective in severe food consumption deficits, extremely limited diversity of diets and pervasive use of food-based ration control with wild food foraging remaining a major food source in these areas. However, higher-level indicators (acute malnutrition and mortality) were insufficient to confirm famine conditions in these areas. Therefore, it 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.

Map 1: Inaccessible Areas Covered from June to August 2021



## RESULTS

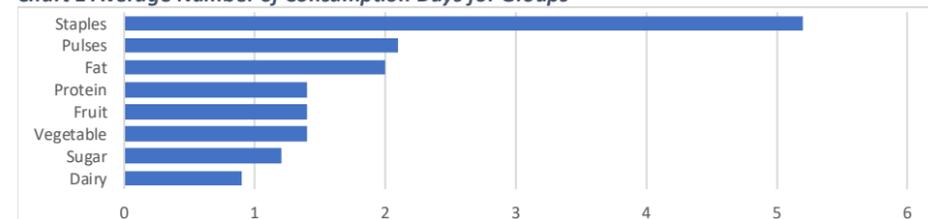
### Outcomes – Food Security

#### 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. More than one in every two households (63 percent) did not have sufficient food intake (*poor + borderline food consumption*), with 38 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, Damboa and Madagali LGA, all of which had a relatively higher level of confidence interval given their sample, showed quite concerning findings, with 88 percent, 93 percent and 92 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 (69 percent), Damboa (85 percent) and Madagali (62 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 consumption of staples in Damboa was particularly worrisome where the average number of days reported for consumption of this critical food group stood at 1.5 days. The extremely limited diversity of diets in these inaccessible areas mainly explains the limited consumption patterns and is also 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 Average Number of Consumption Days for Groups



**Reduced Coping Strategy Index (rCSI):** The pronounced usage of food based coping strategies to bridge food gaps within the surveyed households persisted in August 2021. About half (49 percent) of all surveyed 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). Households in inaccessible areas in Bama and Konduga LGAs made a significant contribution to the global average as 77 percent and 68 percent of households respectively had 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. The frequency of adoption of these strategies was relatively higher in Bama where households typically adopt such strategies for more than four out of seven days for all food based coping strategies except for the category: *“borrow food or reliance on help from friends and relatives”* (3 days) which suggests limited access to this coping measure and invariably widespread vulnerability in this location. 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 more than four in every five households (80 percent) experienced crisis or higher levels (CH Phase 3 and above) of food deprivation and hunger according to the CH analysis guidelines. Specifically, 5.9 percent and 4.9 percent of households reported emergency and catastrophe/famine levels of HHS respectively, suggesting severe consumption deficit and pervasive incidence of hunger episodes in these affected households. Based on the metrics presented, HHS for inaccessible areas of BAY States was classified as CH Phase 3 (crisis), albeit Bama was classified in CH Phase 5 (catastrophe/famine) because more than 20 percent (21 percent) of the surveyed households fell within the catastrophe/famine category. This suggests worrisome HHS trends and significant food deprivation and widespread hunger especially in the highlighted LGAs in the catastrophe/famine 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 79 percent of the surveyed households used either crisis (23 percent) or emergency (56 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, 50 percent sent family members to beg, 7 percent engaged in illegal income activities and 6 percent sold their assets – particularly land and house, whereas in the crisis category, 42 percent of households spent their savings and 24 percent withdrew their children from school. Usage of these coping strategies, most especially those in the emergency category, was relatively pronounced in Damboa (69 percent), Bama (58 percent), Konduga (52 percent), Gwoza (47 percent) and Madagali (42 percent). 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

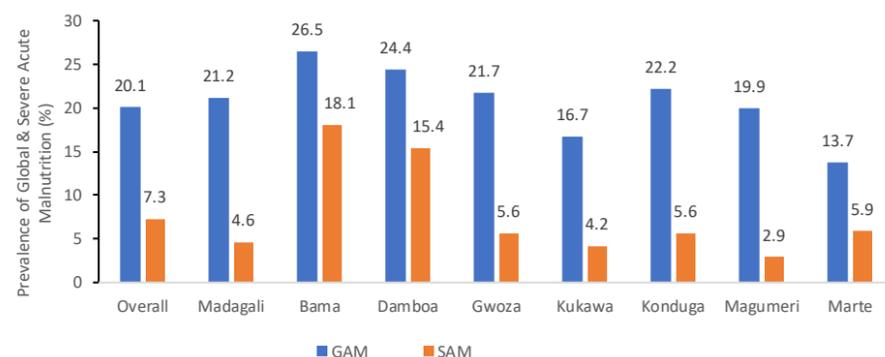
### Malnutrition

**Global Acute Malnutrition (GAM)** is determined by taking the weight, height and MUAC measurement for children 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.

**Global Acute Malnutrition (GAM):** According to the FMS findings, the levels of acute malnutrition among new arrivals from inaccessible areas is **Critical** (Phase 4 IPC Acute Malnutrition Classification) The overall Global Acute Malnutrition (GAM) rates were 20.1% and Severe Acute Malnutrition (SAM) at 7.3%. The high levels of acute malnutrition indicate an extremely stressed population including food insecurity, poor sanitation and hygiene and health conditions, the key underlying causes of acute malnutrition.

Detailed analysis among arrival population with good quality and adequate sample size showed **Critical** (Phase 4) GAM rates in Magumeri, Madagali, Bama, Damboa, Gwoza, Konduga and Kukawa. Bama and Damboa LGAs have extremely high rates of severe acute malnutrition (18.1% and 15.4% respectively) indicating continued extreme population stresses e.g extreme food shortages and high prevalence of morbidity.

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



**Chart 4: GAM Prevalence of Acute Malnutrition by Age**



The children ages 6- 17 months were two times more likely to be acutely malnourished than older children (30 – 59 months). The younger children are more vulnerable to shocks but also an indication of poor infant and young child feeding practices especially continued breastfeeding up to two years and poor complementary feeding.

The very poor nutritional status of the inaccessible population could be attributed to data collection period (rainy / hunger peak) which is characterized by food shortage, diarrhea, and poor childcare practices due to increased workload among the farming communities. Other nutrition sector data sources (such as the ETT screening) show that new arrivals from inaccessible areas are 5 times more likely to be acutely malnourished compared to those from accessible locations. This indicates the FMS data is highly probable and confirms the extremely poor nutritional status of the inaccessible population.

### Stunting and Underweight

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: According to the FMS over a half of the children are stunted (58.2%) and underweight (42.2%). The high stunting and underweight is a clear indication of a population that is chronically stressed with poor nutrition and repeated infection. Stunted children fall sick more often, miss opportunities to learn, perform less well in school and grow up to be economically disadvantaged, and more likely to suffer from chronic diseases.

### Mortality

The Crude and Under-five Mortality Rates were; 4.09 and 7.13 deaths/10,000/day respectively. Based on the SPHERE Humanitarian Standards handbook, both the crude and under-five mortality rates were above the emergency thresholds of 1 and 2 deaths/10000/day respectively. The results indicate that the New Arrivals IDPs from inaccessible areas face a prospect of elevated mortality, approximately 3 times the average mortality rate of NE Nigeria general population. Gwoza LGA results shows very high mortality rates that could be attributed to ongoing Cholera outbreak in the area; without data from Gwoza, the crude and under-five mortality rates seem contextually plausible (CMR =2.39 and U5MR = 3.58 ). Illness was the main cause of death and it was reported by more than half of the households, followed by injuries and trauma. In general, about half of the deaths occurred in the current location however it is worth noting that in Magumeri a significant proportion of deaths (40.9%) occurred in the original settlement (pre-displacement).

Results should be interpreted with caution because thresholds do not account for the unique displacement profile of households from inaccessible areas and the adapted methods employed to gather mortality data.

#### 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 the ongoing FMS assessment 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, and most people do not feel safe/secure to return to their communities of origin. Conflict remains the most significant shock (85 percent) that affected IDPs' settlements of origin four to five months prior to their arrival, followed by sickness of household member (49 percent) and high food prices (44 percent). – see chart 6.

The majority (72 percent) of the newly displaced persons confirmed to have had access to farmland, and engaged in farming (88 percent) before they fled; however, 63 percent did not have any food stocks left in their households prior to their departure from their homes which confirms significant food scarcity in their communities of origin. Less than a third (32 percent) of the respondents concurred that the households they left behind cultivated various crops during this year's wet season, with the majority planting cowpea (47 percent) and maize (46 percent). 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 while others might have to share their harvest with the insurgents.

### Food Availability

Among the surveyed households, 63 percent in most the inaccessible LGAs reported not having stock of foods from last season's harvest. In places where sufficient samples existed, Bama (80 percent) and Damboa (89 percent) have the highest proportion of households that fell within this category. For about a third of all surveyed households that had food stock left, majority (66 percent) indicated that it would have lasted for less than 3 months, thus suggesting severe food deficit in inaccessible areas, particularly during the lean season period. Generally, land access was relatively high as about 79 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 small portion of land of about 1 hectare of less. 31 percent of households reported access to about 0.5 to 1 hectare of land being available for cultivation while another 35 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. Despite these challenges highlighted, farming continues to remain the mainstay for food availability in households with arable land access as 88 percent of such households were engaged in farming during the month that preceded their departure from places of origin.

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



## Food Access

Markets were either completely non-functional or functioning at sub-optimal levels some of the inaccessible areas as confirmed by 69 percent of the surveyed newly arrived households. More than 80 percent of households in areas with sufficient sample (Madagali, Bama, Damboa, Gwoza) reported complete lack of functioning market or sub-optimal functional markets in their places of origin, except for Konduga, where 53 percent of households lacked such access (please see digital data tables for LGA level breakdown). Although 82 percent of the households from inaccessible areas said they had access to market in the last three months, however, insecurity (11 percent), financial constraints and lack of money (8 percent) and market closure (4 percent), remained the main impediments for market access. All the respondents (100 percent) from Kaga said their access to market is mainly constrained by insecurity. Households from inaccessible areas acknowledged small to moderate increase (21 percent) and significant increase (29 percent) in prices of food commodities, which would potentially further weaken already frail purchasing power of the inaccessible populace and consequently, deepen vulnerability. This is particularly pertinent to note as markets were reported as the main source for cereals in 17 percent of interviewed households. Other notable sources for cereals recorded in the FMS were own harvest (22 percent), labour exchange for food (16 percent). Moreover, wild food foraging (13 percent) and begging (5 percent) account to 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 (51 percent), Kukawa (33 percent) and Gwoza (20 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 36 percent of the interviewed individuals across the inaccessible LGAs 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 was reported for Michika (100 percent), Damboa (80 percent) and Askira/Uba (79 percent). About 50 percent of the interviewed households indicated that it takes more than 30mins to access water, with the highest proportions of such recorded in Michika (100 percent), Abadam (75 percent), Gubio (74 percent) and Kukawa (72 percent). Moreover, access to sanitary services is constrained in inaccessible areas as evidenced in majority of surveyed households (99 percent) that lacked access to improved toilet facilities. Ordinary pit latrine remained the most common toilet facility (53 percent), closely followed by open defecation in the bush/open field which was reported in 26 percent of the interviewed households (please see digital data tables for further information).

For health services and facilities, 77 percent of the surveyed households 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 (94 percent), Bama (93 percent), Damboa and Gwoza (92 percent each) and Konduga (57 percent). Regarding the cost of access to such services in places where they are existent, 55 percent of households access for free whereas 23 percent either access for free or pay for such services. More than half (65 percent) of respondents spend more than 30 minutes to access health facilities. In- and out-patient health services are mostly available in the communities of origin of interviewed households as reported by 26 percent of households. Community outreach health services was confirmed by 6 percent while nutrition services was acknowledged by another 5 percent of the interviewed households. 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 78 percent of the surveyed households. Moreover, except for Kaga (0 percent), Michika (0 percent) and Kala Balge (33 percent), more than 50 percent of households in all assessed LGAs confirmed that one or more member of their households experienced illnesses. Children under 5 years of age were most vulnerable to illness as reported by 50 percent of the new arrivals, followed by children between five and 18 years (44 percent). Monguno has the highest prevalence (72 percent) of under 5 years illness, followed by Nganzai (70 percent); while illness of older people (60 years and above) and lactating mothers are most common in Gwoza, Monguno and Tarmuwa. Fever (74 percent) and cough/flu (44 percent) constitute the most common illness across the inaccessible areas of origin of the respondents.

Chart 6: Most Significant Shocks 3-4 Months before Arrival

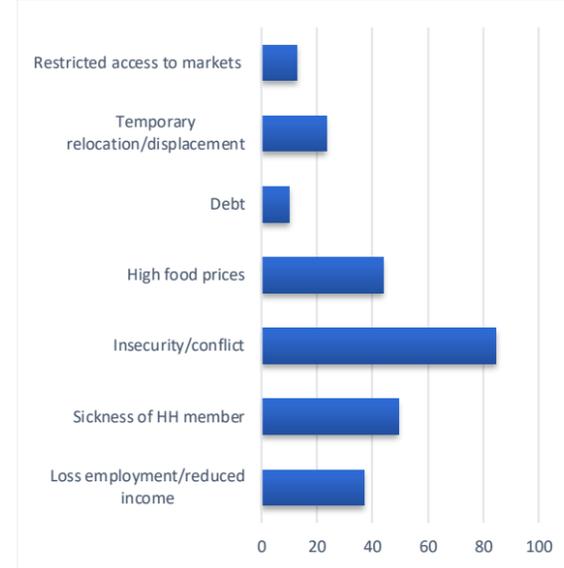


Chart 7: Changes in price

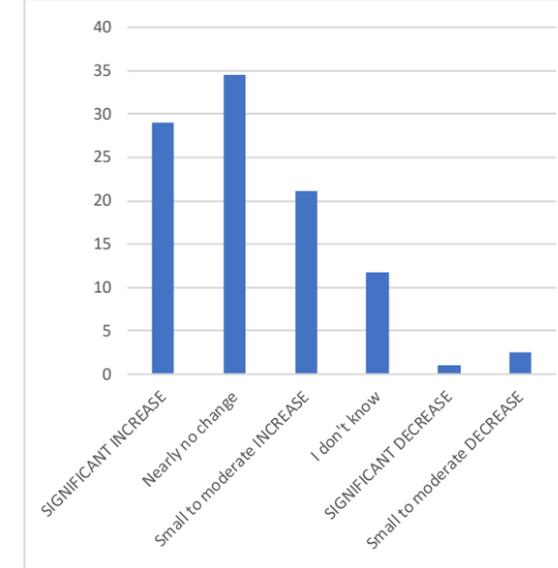
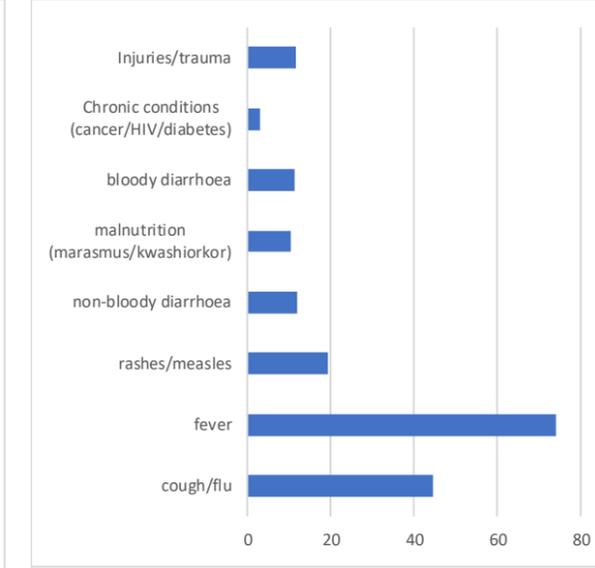
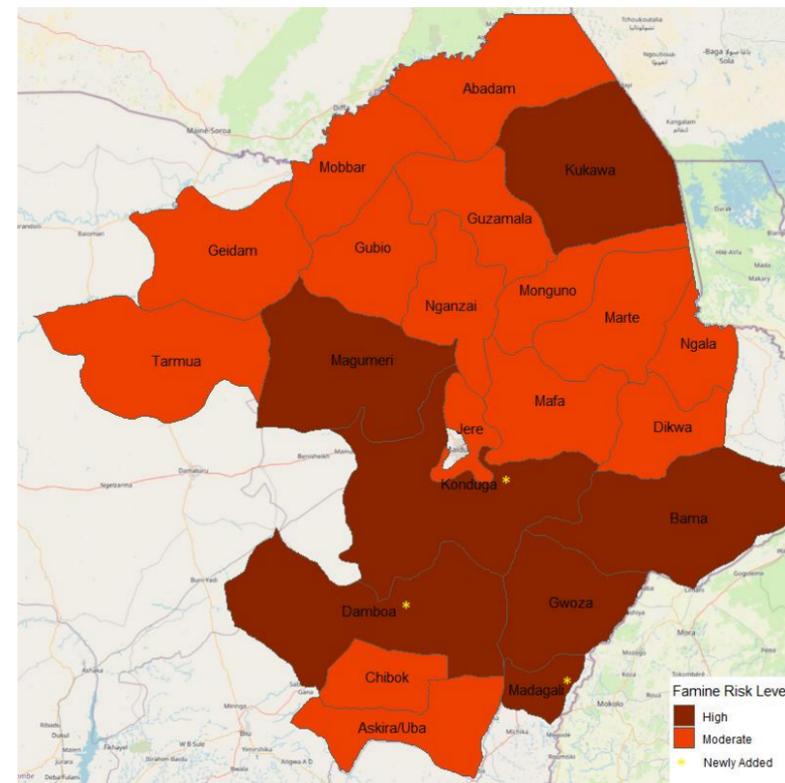


Chart 8: Type of Illnesses



Famine Risk Level – August 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

- Small sample size arising from limited number of arrivals from 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.