Nutrition and Mortality Monitoring in IDP Populations

Report on Round 6 – April 2023

Results issued: 31/04/2023
Final report: 19/05/2023

Photo taken by the Concern Worldwide data collection team in a camp for newly arrived IDP in Daynille, Mogadishu

Executive Summary

This is the sixth report from the 2022/2023 Nutrition and Mortality Motioning System project. Between April 3rd and April 20th, 2023, data was collected from 1,410 IDP households in 14 sites/camps in Khada and Daynille in the Afgooye Corridor, Baidoa, Galkayo, and Dollow. Data collection for this round was conducted and funded by the Caafimaad Plus consortium.

Overall, there has been continued progress in the health and nutrition situation within the sentinel sites covered in Round 6, although there are still areas with very high level of acute malnutrition, and the humanitarian response has still not achieved Sphere Standards in key interventions. We also draw attention to an outbreak of measles in Kahda, the deterioration of the nutritional situation in Dollow, and a worrying worsening of drinking water availability in Baidoa.

Of the 1,201 Mothers and Caregivers that were interviewed, 70% belonged to the Digil and Mirifle clan and 64% reported only speaking Maay. A recent report from REACH and Clear Global and has highlighted the ways in which language-based exclusion may impact on IDP populations in Somalia and these NMS data illustrate the size of the population that may be affected.

There have been changes in the water sources reported from different areas, with a general decrease in the utilisation of tankers. Tanker usage fell markedly in Baidoa, where only 35% now report this as the main source of water. The increasing reliance on wells or springs in *Baidoa* is associated with a *worrying situation*, with 29% of households now reporting that there is always an inadequate supply of drinking water. This deteriorating trend deserves urgent attention from agencies in the WASH sector to explore reasons and solutions. In *Dinsoor*, the adequacy of water supply has also gotten worse, with over 35% reporting that drinking water is always or often inadequate. Open defecation in the field was reported by some households in all areas except Galkayo, and the situation has deteriorated in both Baidoa and Dollow.

The trend in the prevalence or GAM by MUAC indicates that the nutritional situation is, in general, improving, following an uptick in round 5. However, as with other data presented in this report, caution is needed in interpreting the trend due to the smaller number of sites that were included in the round 6 data collection.

Coverage of health record cards has improved but still only half of children possess one. Measles vaccination coverage has improved and overall coverage is now at 81%, but still short of the 90% threshold at which campaigns would no longer be required. There was a continuing slow fall the in overall two-week period prevalence of suspected measles. However, a *marked increase was reported from Kahda*, where the prevalence increased by 11 percentage points. It *is recommended that urgent steps are taken to investigate the current status of this suspected outbreak* and ensure adequate health care and outreach activities are available.

The period prevalence of Acute Watery Diarrhoea (AWD) increased in most areas, as was expected due to the heavy Gu rains. The increases reported here are consistent with the increase in cholera cases reported by WHO.

In Round 6 we observed a stable Crude Death Rate (CDR) and a slight decrease in the Under-Five Death Rate (U5DR) compared to Round 5. Both CDR and U5DR remain below emergency thresholds.

Recommendations

1. Despite some improvements in programme performance indicators, the persistence of high levels of acute malnutrition in some areas and sites indicates a continued humanitarian response is still required to deal with the health and nutrition situation in IDP populations. The outlook for the next few months remains uncertain with the reported increase in cholera, possible escalation in conflict within southern Somalia, and global food price volatility.

2. Action to further strengthen WASH services is still required to ensure adequate access to potable water and reduce the use of open field defecation. This is particularly urgent in Baidoa and Dinsoor.

3. Efforts to strengthen treatment services for acute malnutrition should continue to try and improve the coverage of selective feeding programmes.

4. Vaccination coverage continues to slowly improve but still remains below Sphere Standards and further action should be taken to improve coverage, including the implementation of on-demand and campaign vaccination services. Sphere standards require that at least 95 per cent of newcomers to a settlement aged between six months and 15 years are vaccinated.

Contents

Introduction

This is the sixth report from the Nutrition and Mortality Monitoring System (NMS) 2022/2023 project, that was set up to track the health and nutrition situation of IDP populations in southern Somalia.

The drought-related emergency continues to impact Somalia with long-term impacts on the nutrition and health status of the population. The NMS sentinel site data collection has provided regular updates about the situation of vulnerable groups in purposively selected locations in Banadir, Baidoa, Dinsoor and Galkayo, Kismayo, and Dollow. In the Round 6 data collection that we report here, the number of surveillance sites was reduced due to the partial ending of donor funding. The NMS data collection for this round was conducted and funded by the Caafimaad Plus consortium, led by Action Against Hunger, in partnership with Evidence for Change (e4c).

Methods
Sampling

The Nutrition and Mortality Monitoring System (NMS) approach[1] was used to collect data from a purposively selected sample of IDP sites/camps. Details of the sampling and data collection methods can be found in the Round 1 report.[2]

In Round 6, sampling was continued in sites/camps that had been previously sampled in Round 5. However, the number of sites included in this round decreased from 31 to 14, due to the partial ending of donor funding. Details of the sample achieved is given in Table 1.

Team training

Hybrid trainings were conducted by e4c consultants with support from health and nutrition officers from Caafimaad Plus members. The Team training was conducted either face-to-face or remotely via video link.

One-day refresher training for community health workers (CHW), enumerators, and supervisors who had been involved in previous data collection rounds were conducted. During the training, an overview of different types of malnutrition, a virtual demonstration of MUAC measurements, the assessment of oedema, and the identification of suspected measles were provided. The data collection process was also piloted, In preparation for round 6, 4 online training sessions and 1 f2f training session were conducted, during which training was provided for 68 data collectors from 5 partner organisations.

Data collection

Data was collected at household level by trained CHW and enumerators. The questionnaire was developed by e4c after consultation with BRCiS and Caafimaad Plus, and other experts working on Somalia. It was developed in English and then translated into Somali. The data collection form was piloted and revised based on the feedback from teams during the training sessions. It was coded in ODK and data was uploaded to the ONA Systems server. Data collectors used mobile phones or tablets running the Android operating system.

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[1] Seal, A. J., et al. (2021). "Use of verbal autopsy for establishing causes of child mortality in camps for internally displaced people in Mogadishu, Somalia: a population-based, prospective, cohort study." Lancet Glob Health 9(9): e1286-e1295.
[2] https://reliefweb.int/report/somalia/nutrition-and-mortality-monitoring-idp-populations-report-round-1-july-2022-report-issued-15082022

As summarised in Table 1, in Round 6 data collection took place between 3rd and 20th of April 2023. Teams were comprised of two CHW or enumerators, one of which conducted the interviews and one who performed the MUAC measurements. Data collection took approximately 10 minutes for each household and teams averaged 10 households per day.

The questionnaire included questions on household demographics, area of origin and clan affiliation, date of arrival in the IDP site, spoken dialects/languages, household WASH, possession of child-health record cards, vaccination status, morbidity, and mortality. Questions on morbidity included symptoms of measles and acute watery diarrhoea (AWD) experienced during the last 2 weeks. MUAC measurements were taken on children 6-59 months in duplicate and, in the event that the difference in measurements was greater than 0.5 cm, a third measure was taken and the mean of the two measurements with the best agreement was used.

Data management

MUAC measurements and questionnaire data, collected by the CHW and enumerators, were entered into an ODK data form on mobile phones or tablets running the Android operating system. Data was uploaded to a server run by ONA Data after forms were finalised, and an internet connection was available. The data files were then downloaded from the ONA server in .csv format and loaded into Excel and R for data quality checks, cleaning, and analysis. Unique IDs for each household and individual were created during data collection using a unique household identifier number and sequential individual ID numbers within each household. To avoid the creation of duplicate ID numbers a paper 'cluster control sheet' was used to monitor the collection of data by each team. To find households that had been previously interviewed, household identifiers were uploaded to the digital devices so that the household identify could be confirmed at the start of each interview.

Data analysis

Data analysis was performed in R. Tree charts and graphs were created in Excel. Sparkline mini graphs were prepared in Excel and added to tables to aid visualisation. The prevalence of GAM and SAM by MUAC was calculated taking in to account the prevalence of nutritional oedema.

The under-five and crude death rates were measured using the recall period since the previous interview. Household members that joined, left, or died within the recall period contributed half of the recall period to the rate denominator. To cross-check that the date of death fell within the recall period follow-up questions were asked to confirm the number of weeks since the death occurred, and whether the location of the death was consistent with the household's date of arrival in the IDP camp. These were used during analysis to exclude any deaths that occurred outside of the recall period, or deaths that had occurred in a location outside of the IDP camp after the household reported arriving in the camp.

To assess whether conditions within IDP camps are improving or deteriorating over time, bar graphs or tables were prepared to show key indicators for each camp and how they changed between data collection rounds. If the humanitarian response is adequate a positive improvement in performance and outcome indictors is expected as the time since arrival increases.

Results

IDP Sample Characteristics

The characteristics of the samples collected in each area and IDP site are described in table 1. In total, during Round 6 data was collected from 1,410 IDP households in 14 sites. The sampled households contained 6,642 individuals. The median time since arrival within the 14 IDP sites ranged from 1.2 months

up to 40 months. The sites with the most recent arrivals were the new sites in Dayniile and Dollow, that were first included in Round 5, while the IDP sites in Galkayo contained IDPs with the longest duration of residence.

Region of Origin

Figure 1 shows the region of origin for 1,201 IDP Mothers/Carers that were interviewed in Round 6. IDPs had migrated from a range of different regions with high numbers coming from Bay, Bakool, and Lower and Middle Shabelle. Fifty-seven mothers/carers reported coming from areas other than the main Regions of Somalia.

Clan and Language

The clan affiliation of the IDP mothers/caregivers who participated in Round 6 is shown in the tree plot, in figure 2, below. Seventy percent were from the Digil and Mirifle (Rahanweyn), with 14% coming from the minority (so called 0.5) clans, and 9% form the Hawiye.

The languages spoken by Mothers/Carers are shown in Figure 3. The largest category of Mothers reported speaking only Maay (64%), with about 25% speaking Mahatiri only. Other languages that were reported included Jido. While some reported only speaking one main language, others reported speaking a range of languages in different combinations. These findings should be interpreted along with a recent report on how language barriers may exist in IDP populations within Somalia.[3] According to this report, the existence of multiple languages or dialects within Somali populations may result in communication barriers and language-based exclusion. This may contribute to marginalisation and discrimination in the targeting and provision of aid, and limit the willingness and ability of recipients to use complaints and feedback mechanisms. The report makes clear that communication between different people who speak either Maay or Mahatiri is difficult. It should be noted that while Mahatiri and Maay are both official languages of Somalia, Mahatiri is the language used in government and by the dominant clans. Therefore, the finding that 64% of the round 6 respondents reported speaking only Maay indicates that there may be a significant challenge in ensuring accountability to the affected population. The report recommends hiring staff with diverse language skills that match those of the intended beneficiaries.

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[3] How can we speak the truth if they can't understand us? Clear Global Research Report, April 2023
https://reliefweb.int/report/somalia/how-can-we-speak-truth-if-they-cant-understand-us-april-2023

Table 1: Data collection summary

| Area	Partner	IDP site	R1 Households	R1 Population	R1 HH size	R2 Households	R2 Change	R2 Population	R2 HH size	R3 Households	R3 Change	R3 Population	R3 HH size	R4 Households	R4 Change	R4 Population	R4 HH size	R5 Households	R5 Change	R5 Population	R5 HH size	R6 Households	R6 Change	R6 Population	R6 HH size	Overall Change[2] HH	Overall Change[2] Pop.	Months since arrival[1]
								Round 1 (18th Jul – 2nd Aug)					Round 2 (21st Aug – 10th Sep)					Round 3 (21st Nov – 11th Dec)					Round 4 (18th Jan – 11th Feb (2023))	Round 5 (27th Feb – 22nd Mar 2023)	Round 6 (3rd Apr – 20th Apr 2023)		
Kahda - Banadir	Action Against Hunger	Wabiyarow	198	1,092	5.5	190	-8	1079	5.7	166	-24	935	5.6	144	-22	839	5.8	137	-7	802	5.9	-	-	-	-	-61	-290	9.3 (8,10)
		Kuntuwareey	241	1,310	5.4	227	-14	1283	5.7	220	-7	1,203	5.5	192	-28	1055	5.5	174	-18	1030	5.9	-	-	-	-	-67	-280	10.1 (9,10)
		Canoole	164	680	4.1	144	-20	652	4.5	117	-27	527	4.5	75	-42	344	4.6	66	-9	328	5.0	-	-	-	-	-98	-352	10.2 (8,14)
		Al Karim	-	-	-	-		-	-	57	-	263	4.6	55	-2	299	5.4	-	-	-	-	54	-1	311	4.2	3	48	4.2 (4,5)
		Calafsuge	-	-	-	-		-	-	29	-	145	5.0	35	6	182	5.2	-	-	-	-	33	-2	181	5.5	-4	36	7.0 (6,13)
		Mahad Alle	-	-	-	-		-	-	50	-	298	6.0	42	-8	252	6.0	-	-	-	-	36	-6	230	6.4	14	-68	8.1 (7,9)
Daynille - Banadir	IRC	Durdur	-	-	-	247		1045	4.2	186	-61	898	4.8	173	-13	838	4.8	147	-26	732	-	-	-	-	-	-100	-313	8.4 (8,9)
		Horseed	-	-	-	311		1701	5.5	292	-19	1,690	5.8	247	-45	1419	5.7	230	-17	1312	-	-	-	-	-	-81	-389	7.3 (7,8)
		Furuqly	-	-	-	117		566	4.8	107	-10	579	5.4	100	-7	527	5.3	93	-7	448	-	-	-	-	-	-24	-118	9.2 (8,9)
	CWW	Qoobey	-	-	-	-		-	-	-		-	-	-		-	-	156	-	659	4.2	146	-10	682	4.7	-10	23	5.3 (5,6)
		Nimco	-	-	-	-		-	-	-		-	-	-		-	-	91	-	450	4.9	85	-6	419	4.9	-6	-31	1.2 (1,4)
		Alla Qabe	-	-	-	-		-	-	-		-	-	-		-	-	201	-	790	3.9	202	1	792	3.9	1	2	4.4 (2,8)
Baidoa City	GREDO	Bogey	109	570	5.2	79	-30	571	5.2	109	30	608	5.6	103	-6	599	5.8	74	-29	435	5.9	-	-	-	-	-35	-135	9.3 (9,10)
		Abag Dheere	122	511	4.2	110	-12	482	4.1	58	-52	289	5.0	52	-6	254	4.9	50	-2	198	4.0	-	-	-	-	-72	-313	8.3 (7,9)
		Barbaare	79	511	6.5	63	-16	497	6.4	75	12	521	6.9	67	-8	446	6.7	59	-8	396	6.7					-20	-115	11.3 (9,11)
		War Ajiin	126	754	6.0	113	-13	724	6.4	99	-14	637	6.4	96	-3	597	6.2	91	-5	570	6.3					-35	-184	10.5 (10,12)
		Garas	-	-	-	149		869	5.8	146	-3	832	5.7	138	-8	842	6.1	121	-17	774	6.4					-28	-95	8.3 (7,8)
		Lowfooraar	-	-	-	131		664	5.1	130	-1	750	5.8	130	0	750	5.8	128	-2	761	5.9					-3	97	7.2 (6,9)
	SOS	Dee	-	-	-	-		-	-	200	-	1,210	6.1	193	-7	1314	6.8	192	-1	1312	6.8	187	-5	682	6.7	-13	-528	6.5 (6,7)
		Dulmadiid	-	-	-	-		-	-	173	-	1,028	5.9	170	-3	1026	6.0	159	-11	976	6.1	147	-12	419	6.2	-26	-609	6.4 (6,7)
		Bansadiiq	-	-	-	-		-	-	230	-	1,499	6.5	206	-24	1440	7.0	193	-13	1290	6.7	183	-10	792	6.6	-47	-707	16.3 (11,22)
Dinsoor Town	GREDO	Biilale One	119	669	5.6	94	-25	623	5.5	111	17	633	5.7	112	1	648	5.8	112	0	700	6.3	-	-	-	-	-7	31	15.2 (10,17)
		Biilale Two	165	914	5.5	125	-40	864	6.0	143	18	845	5.9	143	0	855	6.0	143	0	854	6.0	-	-	-	-	-22	-60	8.6 (7,15)
		Korkaamare	95	460	4.8	80	-15	423	4.7	90	10	423	4.7	90	0	424	4.7	89	-1	422	4.7	-	-	-	-	-6	-38	9.4 (8,12)
		Tunida	73	441	6.0	64	-9	366	6.0	57	-7	351	6.2	56	-1	369	6.6	42	-14	268	6.4	-	-	-	-	-31	-173	8.3 (7,10)
		Korkaamare 3	-	-	-	-		-	-	-		-	-	146	-	731	5.0	146	0	728	5.0					0	-3	3.1 (2,4)
Galkayo	IMC	Baantu 1	-	-	-	-		-	-	36	-	258	7.2	35	-1	235	6.7	33	-2	187	5.7	32	-1	205	6.4	-4	-53	40.4 (20,64)
		Baxsan 1	-	-	-	-		-	-	77	-	560	7.3	73	-4	491	6.7	68	-5	471	6.9	58	-10	409	7.1	-19	-151	12.8 (10,28)
		Bulojawan 1	-	-	-	-		-	-	114	-	826	7.2	86	-28	671	7.8	77	-9	569	7.5	64	-13	467	7.3	-50	-359	40.2 (6, 100)
Kismayo	SC	Buulo Fatura	-	-	-	-		-	-	-		-	-	228		1516	6.6	208	-20	1337	6.4	-	-	-	-	-20	-179	7.1 (4,13)
		Dulcade	-	-	-	-		-	-	-		-	-	105		664	6.3	100	-5	626	6.3	-	-	-	-	-5	-38	10.1 (9,10)
		Gargaar	-	-	-	-		-	-	-		-	-	114		703	6.2	108	-6	692	6.4	-	-	-	-	-6	-11	16.1 (14,16)
Dollow	Trocaire	Ladan Section 12	-	-	-	-		-	-	-		-	-	-		-	-	89	-	416	4.7	87	-2	449	5.2	-2.0	33.0	7.6 (5,9)
		Kaharey Section 8	-	-	-	-		-	-	-		-	-	-		-	-	101	-	591	5.9	96	-5	604	6.3	-5.0	13.0	4.7 (3,8)
		Qurdubey Sec. 11[4]	-	-	-	-		-	-	-		-	-	-		-	-	-	-	-	-	-	-	-	-			

[1] Median and IQR

[2] Change in household number is shown since the previous data collection using red and blue bars, and the overall change in household number and population size since the first round is also given.

[3] Months since arrival is shown based on data from Round 4.

[4] A camp in Dollow, Qurdubey Section 11, was sampled for inclusion in Rounds 5 and 6 but it was not possible to gather data due to flooding of the Juba river.

Figure 1 - Region & District of Origin of IDP Mothers/Caregivers Sampled in Round 6 (*n=1,201*)[1]
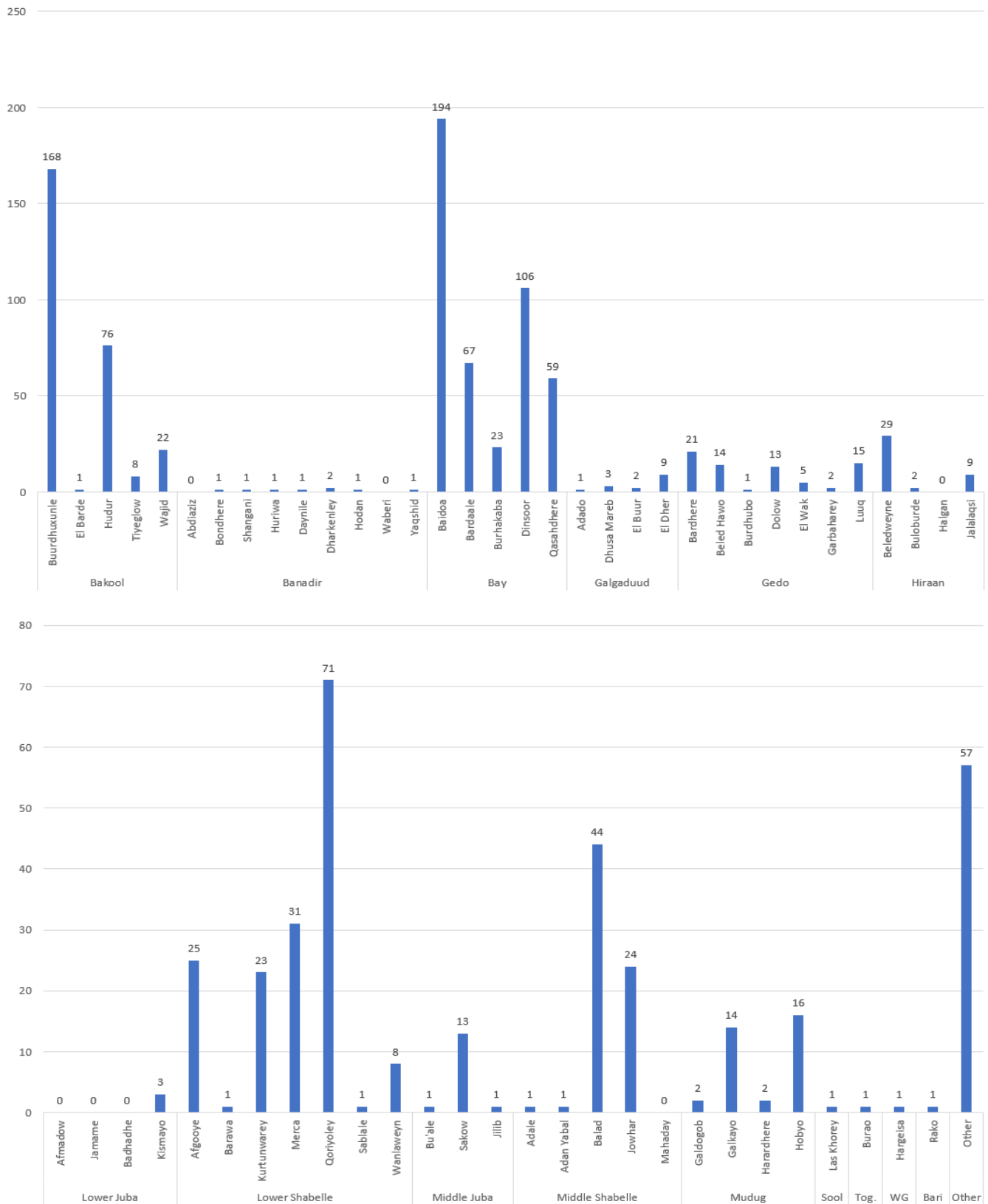
[1]WG - Woqooyi Galbeed, Tog. - Togdheer

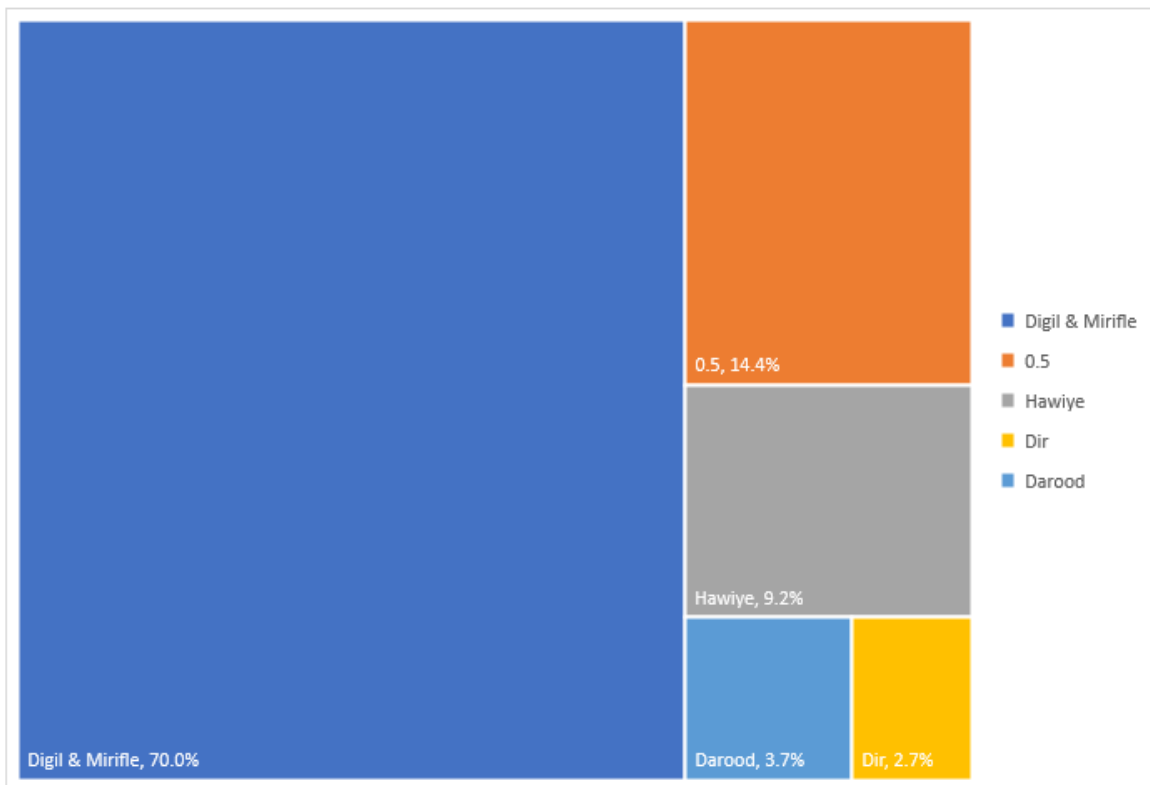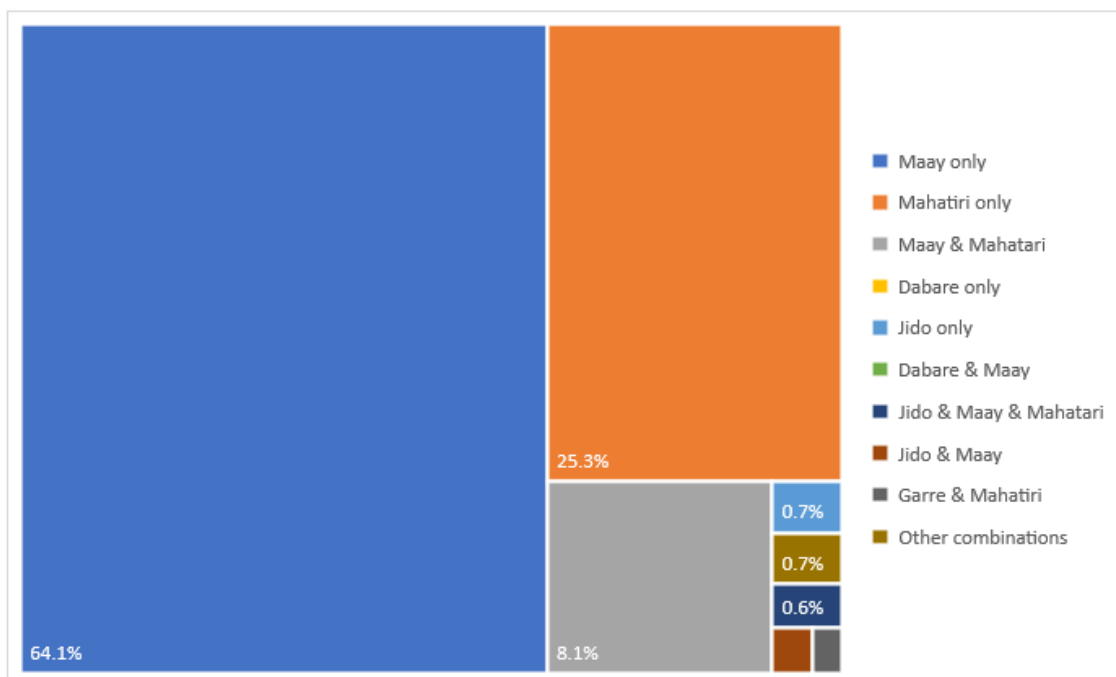**Figure 2 - Clan of IDP Mothers/Caregivers Sampled in Round 6 (n=1,201)**

Legend:
- Digil & Mirifle
- 0.5
- Hawiye
- Dir
- Darood

Digil & Mirifle, 70.0% | 0.5, 14.4% | Hawiye, 9.2% | Darood, 3.7% | Dir, 2.7%

Figure 3 – Language of IDP Mothers/Caregivers Sampled in Round 6 (n=1,201)

Legend:
- Maay only
- Mahatiri only
- Maay & Mahatari
- Dabare only
- Jido only
- Dabare & Maay
- Jido & Maay & Mahatari
- Jido & Maay
- Garre & Mahatiri
- Other combinations

64.1% | 25.3% | 8.1% | 0.7% | 0.7% | 0.6%

WASH

The household WASH situation in the IDP camps in round 6 is shown in the figures below. In figure 4, the predominant water source is shown for each location.

Households reporting the use of water from tankers has decreased with no households now reporting this water source in Daynille, following a drop of 46 percentage points. Tanker usage also fell markedly in Baidoa, where only 35% now report this as the main source of water. However, tankers remain an important water source in Kismayo and Dollow and have also remerged in Kahda as a significant source.

The increasing reliance on wells or springs in Baidoa is associated with an increasingly worrying situation regarding the adequacy of supply. Figure 5 shows that the situation has further deteriorated since round 5 and 29% of households now report that there is always an inadequate supply of drinking water, while a further 14% reported that supply was often inadequate. *This deteriorating trend deserves urgent attention from agencies in the WASH sector to explore the reasons for this serious situation*. In Dinsoor, the adequacy of water supply has also gotten worse, with over 35% reporting that drinking water is always or often inadequate.

Open defecation in the field was reported by some households in all areas except Galkayo. As is the case with the deteriorating water supply, the proportion of households reporting that they use open defaecation continued to increase in Baidoa. The worst affected area though is Dollow, where the proportion had risen to 69% in round 6. Urgent attention to the provision of latrines is required in both Baidoa and Dollow. In other areas, the disposal of faeces remains a problem, but the trend is for an improving situation.

Trends in WASH indicators were quantitatively compared between rounds using scores calculated for drinking water inadequacy and latrine use. These are presented in Table 2. The scores illustrate the large improvements in pit latrine use in Daynille and Galkayo, as well as the fall in Dollow and Baidoa. Overall, there has been little change in the drinking water adequacy score and some improvement in the pit lateen usage.

Figure 4: Main Sources of Household Drinking Water by Area (Round 6, n=1,410)[1]
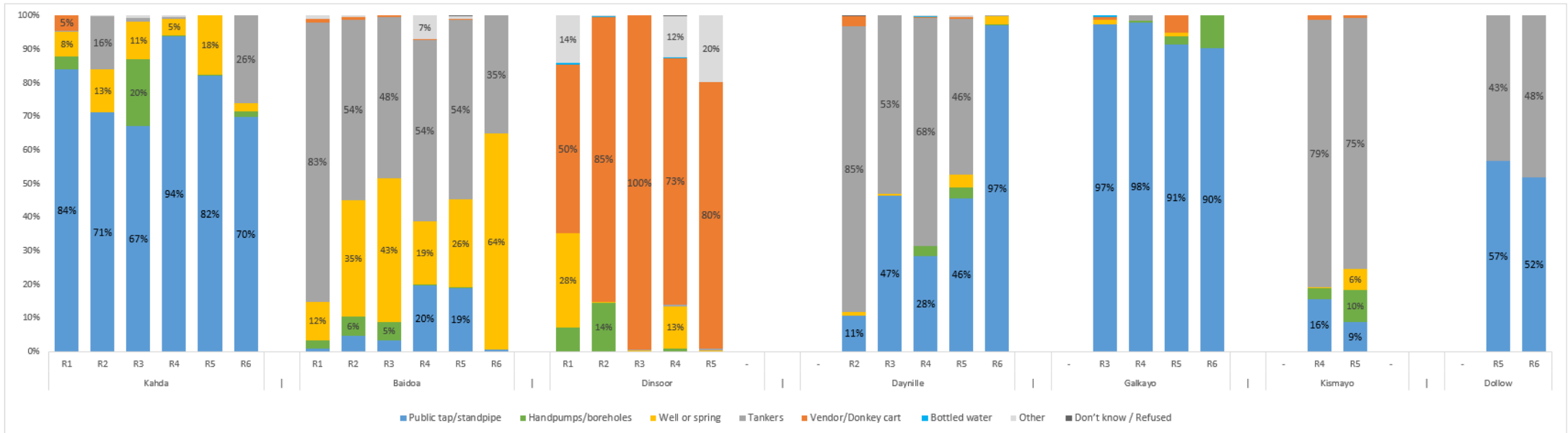
[1]Two households in Dinsoor were excluded during R3 for responding NA

Figure 5: Frequency of Inadequate Household Drinking Water by Area (Round 6, n=1,410)[1]

Legend: Never (0 times) · Rarely (1–2 times) · Sometimes (3–10 times) · Often (11-20 times) · Always (more than 20 times)
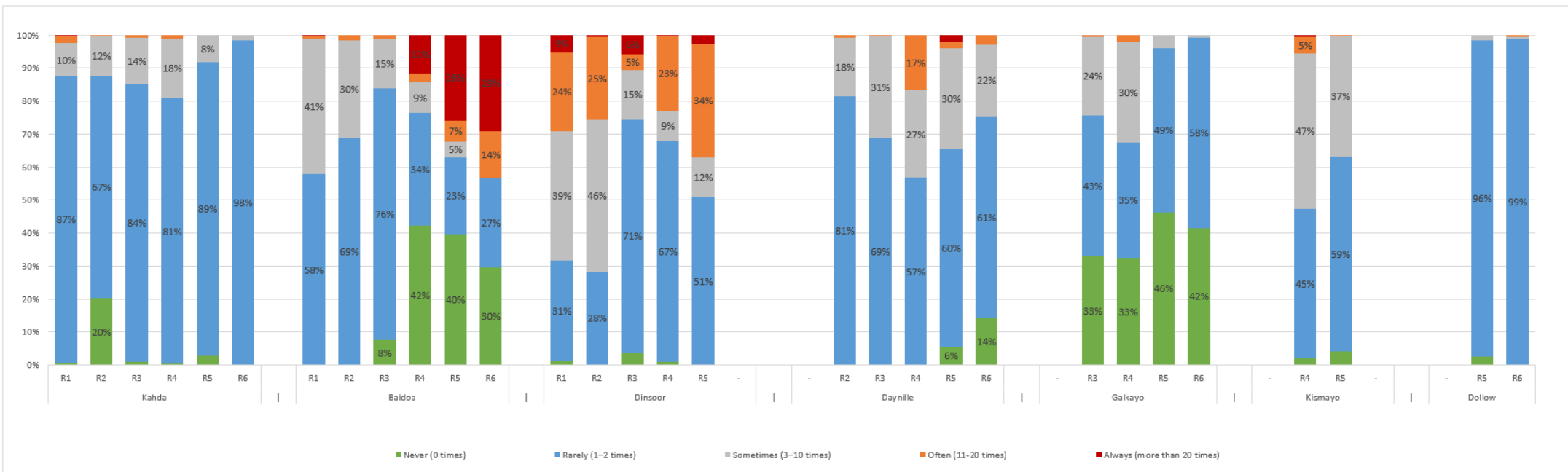
[1] Data was not available for one household in Round 5

Figure 6: Household Defecation Site by Area (Round 6, n=1,410)

Legend: Pit latrine with slab | Pit latrine without slab | Bucket or bag | In the open field | Other

	Frequency of inadequate drinking water[1]													Use of pit patrines[2]													
	Round 1		Round 2		Round 3		Round 4		Round 5		Round 6		Change in score[3]	Round 1		Round 2		Round 3		Round 4		Round 5		Round 6		Change (% points)[3]
	N	Score	N	Score	N	Score	N	Score	N	Score	N	Score		N	%	N	%	N	%	N	%	N	%	N	%	
Kahda	596	2.1	561	1.9	646	2.1	541	2.2	366	2.1	123	2.0	-0.1	407/596	68.3%	537/561	95.7%	603/637	94.7%	480/543	88.4%	377/377	100.0%	121/123	98.4%	-1.6%
Baidoa	337	2.4	636	2.5	1289	2.3	665	2.1	644	2.6	517	2.9	+0.3	231/337	68.5%	328/636	51.6%	859/1,217	70.6%	893/1,155	77.3%	737/1,067	69.1%	325/517	62.9%	-6.2%
Dinsoor	333	3.0	409	3.4	401	2.4	542	2.5	532	2.9		-	-	144/333	43.2%	149/409	36.4%	339/401	85.0%	428/547	78.2%	423/532	79.5%	-	-	-
Daynille	-	-	673	2.2	585	2.3	520	2.6	867	2.3	433	2.1	-0.2	-	-	267/673	39.7%	174/585	29.7%	174/520	33.5%	563/918	61.3%	430/433	99.3%	+38.0%
Galkayo	-	-	-	-	227	1.9	131	2.0	95	1.6	154	1.6	0	-	-	-	-	118/227	52.0%	136/194	70.1%	166/177	93.8%	154/154	100%	+6.2%
Kismayo	-	-	-	-	-	-	438	2.6	399	2.3		-	-	-	-	-	-	-	-	398/447	89.0%	384/416	92.3%	-	-	-
Dollow	-	-	-	-	-	-	-	-	185	2.0	183	2.0	0	-	-	-	-	-	-	-	-	82/190	43.2%	47/183	31.1%	-12.1%
Combined	1,266	2.4	2,175	2.3	3,148	2.2	2,837	2.3	3,088	2.4	1,410	2.3	-0.1	782/1,266	61.8%	1,281/2,279	56.2%	2,093/3,067	68.2%	2,509/3,406	73.7%	2,732/3,677	74.3%	1087/1410	77.1%	+2.8%

[1] Drinking water inadequacy scores are calculated based on the reported frequency of inadequate supply, with a larger score indicating that there was a greater number of times in the last month when there was not adequate drinking water for the household.

[2] Use of pit latrines is calculated as the proportion of households that reported using a pit latrine, with or without a slab, as their usual defecation site.

[3] The change in score is shown for the current data collection round compared to the round immediately before it.

Acute Malnutrition

The GAM by MUAC prevalence is shown for each sentinel site area in Table 3, and the trend is illustrated in Figure 7 for those sites where prevalence data is available over at least 4 rounds of data collection. The trend in prevalence indicates that the trend towards an improving nutritional situation is continuing, following an uptick in round 5. However, as with other data presented in this report, caution is needed in interpreting the trend due to the smaller number of sites that were included in the round 6 data collection.

Figure 7: Trends in the Prevalence of GAM by MUAC in Sentinel Site Camp Areas Included in at Least 4 Data Collection Rounds

Area	Sex	Round 1				Round 2				Round 3[2]				Round 4				Round 5				Round 6				Change R5 to R6 (% points)
		N	Age (mo.)	Oedema	GAM (MUAC < 12.5 cm or oedema)	N	Age (mo.)	Oedema	GAM (MUAC < 12.5 cm or oedema)	N	Age (mo.)	Oedema	GAM (MUAC < 12.5 cm or oedema)	N	Age (mo.)	Oedema	GAM (MUAC < 12.5 cm or oedema)	N	Age (mo.)	Oedema	GAM (MUAC < 12.5 cm or oedema)	N	Age (mo.)	Oedema	GAM (MUAC < 12.5 cm or oedema)	
Kahda	All	752	31.4	4	158	21.0%	680	32.3	2	153	22.5%	813	31.7	3	136	16.7%	651	31.9	6	93	14.3%	414	32.3	1	65	15.7%	163	31.3	0	18	11.0%	-4.7%
	Male	371	31.1	3	69	18.6%	342	32.8	2	66	19.3%	384	31.7	1	64	16.7%	324	30.9	3	54	16.7%	209	31.8	1	31	14.8%	82	29.2	0	8	9.8%	
	Female	381	31.5	1	89	23.4%	338	31.7	0	87	25.7%	429	31.7	2	72	16.8%	327	33.0	3	39	11.9%	205	32.9	0	34	16.6%	81	33.3	0	10	12.3%	
Baidoa	All	423	28.4	4	120	28.4%	681	30.6	1	148	21.7%	1485	29.8	6	225	15.2%	1318	30.0	3	91	6.9%	1194	30.6	5	77	6.4%	725	31.2	4	50	6.9%	+0.5%
	Male	218	27.7	3	58	26.6%	351	30.3	1	75	21.4%	727	29.8	3	110	15.1%	651	29.9	1	42	6.5%	572	29.8	3	34	5.9%	351	30.7	3	21	6.0%	
	Female	205	29.1	1	62	30.2%	330	30.8	0	73	22.1%	758	29.9	3	115	15.2%	667	30.2	2	49	7.3%	622	31.2	2	43	6.9%	374	31.6	1	29	7.8%	
Dinsoor	All	495	29.7	1	115	23.2%	450	31.1	0	96	21.3%	436	32.8	1	77	17.7%	555	32.3	1	68	12.3%	534	32.5	2	91	17.0%	-	-	-	-	-	-
	Male	263	30.1	0	53	20.2%	245	31.6	0	47	19.2%	241	32.8	1	42	17.4%	307	32.6	1	31	10.1%	298	31.4	2	50	16.8%	-	-	-	-	-	
	Female	232	29.1	1	62	26.7%	205	30.5	0	49	23.9%	195	32.7	0	35	17.9%	248	31.9	0	37	14.9%	236	33.3	0	41	17.4%	-	-	-	-	-	
Daynille	All	-	-	-	-	-	581	29.8	10	124	21.3%	499	30.2	1	51	10.2%	418	29.5	2	26	6.2%	924	31.1	5	67	7.3%	414	31.0	3	36	8.7%	+1.4%
	Male	-	-	-	-	-	321	29.5	5	62	19.3%	282	30.0	1	27	9.6%	241	29.6	2	9	3.7%	510	31.6	3	36	7.1%	212	29.7	1	17	8.0%	
	Female	-	-	-	-	-	260	30.3	5	62	23.8%	217	30.5	0	24	11.1%	177	29.5	0	17	9.6%	414	30.7	2	31	7.5%	202	32.3	2	19	9.4%	
Galkayo	All	-	-	-	-	-	-	-	-	-	-	254	29.6	2	31	12.2%	212	30.3	5	30	14.2%	212	31.4	0	25	11.8%	162	30.4	0	15	9.3%	-2.5%
	Male	-	-	-	-	-	-	-	-	-	-	121	29.6	1	18	14.9%	98	29.1	4	17	17.3%	103	31.5	0	11	12.8%	72	29.5	0	10	13.9%	
	Female	-	-	-	-	-	-	-	-	-	-	133	29.5	1	13	9.8%	114	31.3	1	13	11.4%	109	31.2	0	14	10.7%	90	31.0	0	5	5.6%	
Kismayo	All	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	486	30.4	3	85	17.5%	461	31.7	3	50	10.8%	-	-	-	-	-	-
	Male	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	272	31.8	2	36	13.2%	267	30.3	1	22	8.2%	-	-	-	-	-	
	Female	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	214	28.7	1	49	22.9%	194	32.8	2	28	14.4%	-	-	-	-	-	
Dollow	All	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	260	29.9	0	36	13.8%	249	31.2	0	42	16.9%	+3.1%
	Male	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	135	28.6	0	13	9.6%	129	32.3	0	16	12.4%	
	Female	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	125	31.1	0	23	18.4%	120	30.1	0	26	21.7%	

[1]IPC levels of acute malnutrition: Critical-Extremely Critical (≥15.0% GAM by MUAC) 🟥
Serious-Critical (10.0 - 14.9% GAM by MUAC) 🟧
Alert-Serious (5.0 - 9.9% GAM by MUAC) 🟨
Acceptable-Alert (<5.0% GAM by MUAC) 🟩

[2]GAM prevalence figures for R3 have been updated following additional verification and data cleaning.

The changes in prevalence of GAM, MAM, and SAM are shown for individual camps in Figure 8. The prevalence remains above the critical 15% threshold in 8 sites according to the last data collection round that is available. In 3 of these camps the data is from Round 6, indicating that there are still a widespread number of population groups experiencing extremely high levels of acute malnutrition, despite the overall improving trend.

Figure 8: Prevalence of SAM and MAM by MUAC in Individual Camps, Round 1 to Round 5 [1,2]
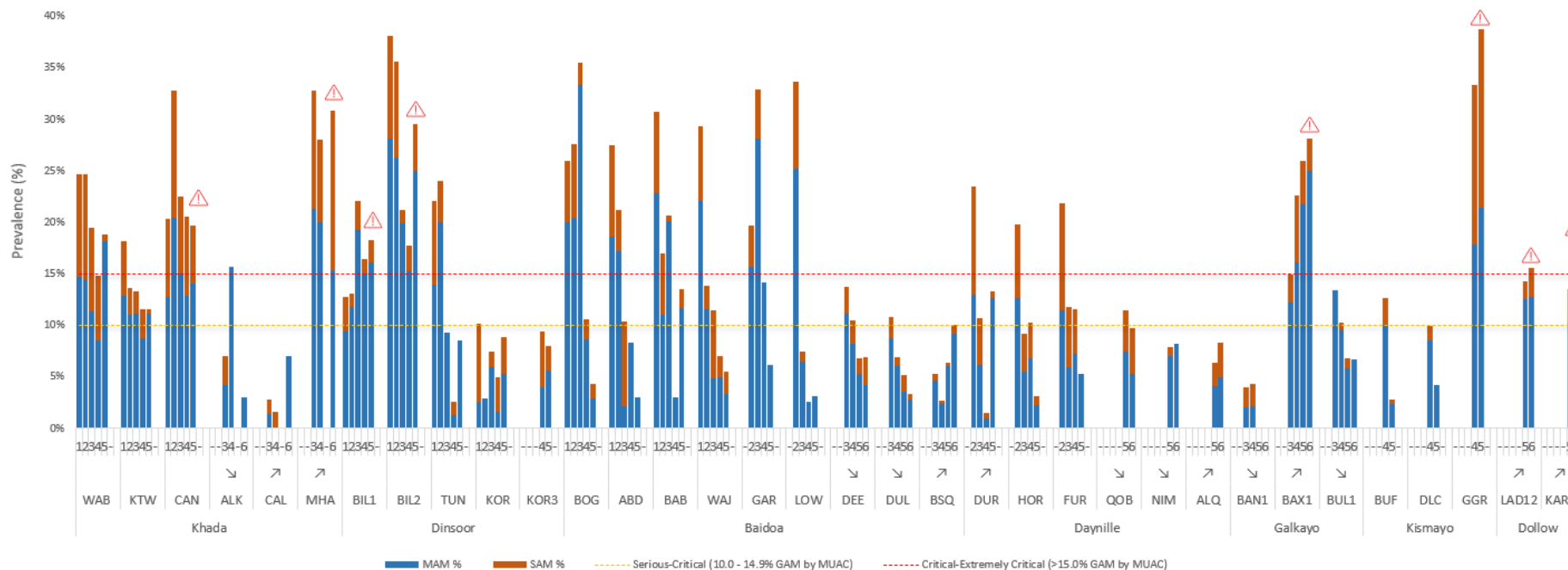
[1] An increase or decrease in prevalence since the last data collection round is indicated by an up or down arrow for the camps included in R6. A warning exclamation mark is shown when the last measured prevalence of GAM by MUAC exceeded 15%.

Camp/Site Names and Abbreviations							
Abag dheere	ABD	Biilale One	BIL1	Dee	DEE	Horseed	HOR	Mahad Alle	MHA
Al Kariim	ALK	Biilale Two	BIL2	Dulcade	DLC	Kaharey Section 8	KAR8	Nimco	NIM
Alla Qabe	ALQ	Bogey	BOG	Dulmadiid	DUL	Korkaamare	KOR	Qoobey	QOB
Baantu 1	BAN1	Bulojawan 1	BUL1	Durdur	DUR	Korkaamare Area 3	KOR3	Qurdubey Section 11	QDB11
Bansadiiq	BSQ	Buulo Fatura	BUF	Furuqly	FUR	Kuntuwareey	KTW	Tunida	TUN
Barbaare	BAB	Calafsuge	CAL	Garas	GAR	Ladan Section 12	LAD12	Wabiyarow	WAB
Baxsan 1	BAX1	Canoole	CAN	Gargaar	GGR	Lowfooraar	LOW	War Ajiin	WAJ

Coverage of nutrition treatment programs

Enrolment in Selective Feeding Programmes is described in table 4. Overall, programme coverage for the areas included in Round 6 fluctuated compared to Round 5, with an overall fall in MAM treatment coverage but an increase in SAM treatment. The target coverage of >90% has now been achieved for MAM and SAM treatment in Daynille, and was achieved in Dinsoor during the previous round. However, coverage remains below standard in the other sites.

Table 4: Coverage of Selective Feeding Programmes for Children, Aged 6-59 months, with MAM by MUAC or SAM by MUAC

| | Moderate Acute Malnutrition (MUAC < 12.5 & ≥ 11.5 cm) | | | | | | | | Severe Acute Malnutrition (MUAC < 11.5 cm or oedema) | | | | | | | |
| | Percentage and number of cases in OTP or SFP | | | | | | | | Percentage and number of cases in OTP | | | | | | | |
Area	Round 1	Round 2	Round 3	Round 4	Round 5	Round 6	Change R5 to R6	> 90% Coverage[1]	Round 1	Round 2	Round 3	Round 4	Round 5	Round 6	Change R5 to R6	> 90% Coverage[1]
Khada	74 % (75/101)	90 % (88/98)	74% (68/92)	73% (48/65)	90% (53/59)	25% (3/12)	- 65%	NO	83 % (45/57)	64 % (34/53)	77% (34/44)	64% (18/28)	50% (3/6)	67% (4/6)	+ 17%	NO
Baidoa	39 % (34/88)	42 % (47/112)	66% (124/188)	75% (59/79)	48% (30/63)	48% (19/40)	0%	NO	19 % (6/32)	46 % (16/35)	76 % (28/37)	69% (9/13)	71% (10/14)	60% (6/10)	- 11%	NO
Dinsoor	41 % (32/79)	87 % (66/76)	80% (56/70)	77% (40/52)	88% (67/76)	-	-	-	78 % (28/36)	90 % (18/20)	43 % (3/7)	44% (7/16)	100% (15/15)	-	-	-
Daynille	-	89 % (65/73)	35% (10/29)	53% (9/17)	40% (21/53)	100% (24/24)	+ 60%	YES	-	73 % (37/51)	27 % (6/22)	56% (5/9)	43% (6/14)	83% (10/12)	+ 40%	NO
Galkayo	-	-	36% (10/28)	47% (8/17)	0% (0/21)	57% (8/14)	+ 57%	NO	-	-	33 % (1/3)	50% (3/6)	25% (1/4)	100% (1/1)	+ 75%	YES
Kismayo	-	-	-	83% (48/58)	91% (29/32)	-	-	-				81% (22/27)	72% (13/18)	-	-	-
Dollow	-	-	-	-	86% (25/29)	59% (19/32)	- 27%	NO	-	-	-	-	86% (6/7)	90% (9/10)	+ 4%	NO
Combined	53 % (141/268)	74 % (266/359)	66 % (268/406)	74% (212/288)	68% (225/333)	**60%** (73/122)	- 8%	NO	63 % (79/125)	66 % (105/159)	64 % (72/113)	65% (64/99)	69% (54/78)	**77%** (30/39)	+ 8%	NO
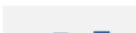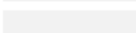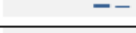
[1] https://handbook.spherestandards.org/#ch007_004_001

Vaccination and Morbidity

Possession of a child health record card was assessed for children less than 5 years of age, and all types of vaccination cards, health passports, and other record cards were counted. Overall, coverage had improved slightly but since Round 4, but there was variation between different sites. A further large improvement, building on the progress seen in round 5, was observed in Baidoa, and health record card coverage also improved by over ten percentage points in Galkayo.

Overall, possession of health record cards is now seen for just over half the children measured, but this is still low, and will continue to impede the delivery and monitoring of essential child health and nutrition services. In the sites monitored in round 6, coverage is particularly low in Daynille and Dollow.

Table 5: Possession of a Health Record Card in Children aged 0-59 months

Area	Round 1		Round 2		Round 3		Round 4		Round 5		Round 6		Trend	Change R5 to R6
Kahda	25.0%	199/795	34.1%	245/719	47.4%	388/818	60.1%	406/676	54.1%	235/434	50.0%	84/168		-4.1%
Baidoa	10.5%	50/476	15.1%	/729	46.7%	/1,513	53.7%	/1,360	69.7%	859/1232	87.0%	640/736		17.3%
Dinsoor	5.8%	29/497	9.0%	41/456	19.2%	85/442	16.8%	94/561	26.3%	142/540	-	-		
Daynille			10.1%	65/655	10.9%	58/531	22.8%	101/443	18.8%	180/955	24.3%	103/423		5.5%
Galkayo		-		-	67.0%	177/264	31.6%	73/231	27.1%	60/221	37.2%	63/169		10.1%
Kismayo		-		-		-	41.0%	213/520	59.7%	293/491	-	-		
Dollow		-		-		-		-	10.2%	27/265	7.5%	19/254		-2.7%
Combined	15.7%	278/1,768	18.1%	462/2,559	39.5%	1,411/3,568	42.7%	1,617/3,791	43.4%	1,796/4138	51.9%	909/1750		8.5%

Overall, measles vaccination coverage (Table 6) has continued to increase in round 6, with an increase of 15 percentage points. Within the sites covered in round 6, a marked improvement in coverage was seen on in Daynille and Dollow and the combined coverage figure has now risen to 81.4%. However, some apparent decreases were recorded in Kahda and Galkayo, which seem to be due mainly to the variation in the sample obtained in round 5 and round 6. As coverage in all Round 6 sites still lies below 90%, there is still a need for further measles vaccination campaigns (Sphere Child health standard 2.2.1: Childhood vaccine-preventable diseases).

Table 6: Measles Vaccination (MCV1) Coverage in Children aged 9-59 months
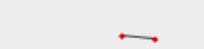
Area	Indicator	Round 1		Round 2		Round 3		Round 4		Round 5		Round 6		Trend	Change R5 to R6	90% Coverage²
Kahda	Record card	9.80%	70	18.90%	123	21.00%	157	16.50%	104	15.30%	61	24.8%	38			
	Recall	41.60%	298	46.70%	304	58.50%	437	70.30%	442	72.50%	290	55.6%	85			
	Combined	51.30%	368/717	65.60%	427/651	79.50%	594/747	86.80%	546/629	87.80%	351/400	80.4%	123/153		-7.40%	NO
Baidoa	Record card	3.20%	13	6.00%	36	23.90%	331	13.70%	172	19.00%	220	29.8%	211			
	Recall	26.90%	111	37.70%	227	39.10%	542	63.40%	794	64.90%	752	59.2%	419			
	Combined	30.00%	124/413	43.70%	263/602	63.00%	873/1386	77.10%	966/1,253	83.90%	972/1159	89.1%	630/707		5.20%	NO
Dinsoor	Record card	1.04%	5	0.00%	0	14.20%	61	13.70%	74	18.80%	99					
	Recall	20.40%	98	25.70%	96	58.50%	117	9.80%	53	15.00%	79					
	Combined	21.40%	103/481	25.90%	96/374	41.40%	178/430	23.60%	127/539	33.70%	178/528					NO
Daynille	Record card	-	-	0.50%	3	4.50%	21	3.70%	15	13.60%	122	24.2%	97			
	Recall	-	-	24.00%	133	29.40%	138	34.90%	140	35.30%	318	46.4%	186			
	Combined	-	-	24.50%	136/554	33.80%	159/470	38.70%	155/401	48.90%	440/900	70.6%	283/401		21.70%	NO
Galkayo	Record card	-	-		-	49.40%	122	37.30%	76	25.90%	51	30.2%	48			
	Recall	-	-		-	40.50%	100	42.60%	87	72.60%	143	54.1%	86			
	Combined	-	-		-	89.90%	222/247	79.90%	163/204	98.50%	194/197	84.2%	134/159		-14.30%	NO
Kismayo	Record card	-	-		-		-	23.90%	113	25.80%	116					
	Recall	-	-		-		-	33.00%	156	41.30%	186					
	Combined	-	-		-		-	56.90%	269/473	67.10%	302/450					NO
Dollow	Record card	-	-		-		-		-	7.60%	19	2.9%	7			
	Recall	-	-		-		-		-	47.60%	119	72.7%	176			
	Combined	-	-		-		-		-	55.20%	138/250	75.6%	183/242		20.40%	NO
Combined	Record card	5.50%	88	7.40%	162	21.10%	692	15.80%	554	17.70%	688	24.1%	401			
	Recall	31.00%	507	34.80%	760	40.70%	1334	47.80%	1,672	48.60%	1887	57.2%	952			
	Combined	36.90%	595/1,611	42.30%	922/2,181	61.80%	2,026/3,280	63.60%	2,226/3,499	66.30%	2,575/3,884	81.4%	1353/1662		15.10%	NO

[1] The change shown is the difference between the vaccination coverage measured in the current round and the coverage measured in the round immediately before.

[2] Sphere standards indicate the need for a measles campaign if vaccination coverage is below 90%. https://handbook.spherestandards.org/en/sphere/#ch009_004_001_001

Suspected measles infection was assessed by asking if a child had a fever *and* a rash, as well as at least one out of the other 3 symptoms (cough, coryza, or conjunctivitis).[4] There was a very slight decrease in the overall two-week period prevalence of suspected measles continuing the slow fall in incidence seen across the six rounds of data collection (Table 7). However, *a marked increase was reported from Kahda*, where the two week prevalence increased by 11 percentage points. It is recommended that urgent steps are taken to investigate the current status of the outbreak and ensure adequate health care is available for cases requiring treatment. Scaling up of outreach activities to bring vaccination coverage up to Sphere Standards is also required.

Table 7: Two Week Period Prevalence of Suspected Measles in children 6-59 mo.

Area	Round 1		Round 2		Round 3		Round 4		Round 5		Round 6		Trend	Change R5 to R6
Kahda	9.8%	78/800	4.3%	31/726	2.0%	16/791	2.0%	13/651	2.4%	10/414	12.9%	21/163		10.5%
Baidoa	6.9%	33/478	4.6%	34/734	1.7%	25/1465	0.9%	12/1,318	1.5%	18/1194	0.3%	2/725		-1.2%
Dinsoor	1.0%	5/497	0.4%	2/458	5.1%	22/434	5.4%	30/555	0.2%	1/534				
Daynille	-		4.0%	26/656	4.4%	22/496	2.6%	11/418	5.6%	52/924	2.2%	9/414		-3.4%
Galkayo	-		-		10.2%	26/255	2.8%	6/212	0.9%	2/212	1.2%	2/162		0.3%
Kismayo	-		-		-		2.9%	14/486	1.7%	8/461				
Dollow	-		-		-		-		1.5%	4/260	2.4%	6/249		0.9%
Combined	6.5%	116/1,775	3.6%	93/2,574	3.2%	111/3,441	2.4%	86/3,640	2.4%	95/3999	2.3%	40/1713		-0.1%

The coverage of Oral Cholera Vaccine in children between 12 and 59 months is shown in table 8. Overall, coverage has slightly improved since Round 5 and half the children in the sample have now been vaccinated against cholera. Marked improvements continued in Dayniile but also, but coverage also fell in Kahda due the change in the sites included in the round 6 sample.
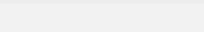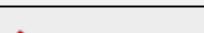
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[4] Measles Vaccine-Preventable Diseases Surveillance Standards (2018) WHO https://www.who.int/publications/m/item/vaccine-preventable-diseases-surveillance-standards-measles

Table 8: Oral Cholera Vaccine (OCV) Coverage in Children aged 12-59 months

Area	Indicator	Round 1		Round 2		Round 3		Round 4		Round 5		Round 6		Trend	Change R5 to R6
Kahda	Record card	7.6%	50	8.1%	48	11.5%	81	8.7%	51	5.9%	22	12.8%	19		
	Recall	26.5%	175	45.8%	273	59.3%	417	67.3%	393	71.5%	266	36.9%	55		
	Combined	34.0%	225/661	53.9%	321/596	70.8%	498/703	76.0%	444/584	77.4%	288/372	49.7%	74/149		-27.7%
Baidoa	Record card	1.8%	7	5.0%	28	20.1%	260	12.2%	144	18.4%	201	29.6%	199		
	Recall	22.0%	85	31.4%	177	29.8%	385	41.8%	494	38.2%	419	25.4%	171		
	Combined	23.8%	92/386	36.4%	205/563	49.8%	645/1294	53.9%	638/1,183	56.7%	620/1094	55.0%	370/673		-1.7%
Dinsoor	Record card	0.7%	3	0.0%	0	1.7%	7	0.6%	3	1.9%	10	-	-		
	Recall	20.4%	91	26.7%	94	26.3%	110	10.3%	54	15.8%	81	-	-		
	Combined	21.1%	94/446	26.7%	94/352	28.0%	117/418	10.9%	57/523	17.7%	91/514	-	-		
Daynille	Record card	-	-	0.8%	4	1.6%	7	2.7%	10	10.9%	92	18.1%	69		
	Recall	-	-	12.1%	63	7.5%	33	6.7%	25	33.1%	280	49.0%	187		
	Combined	-	-	12.9%	67/520	9.1%	40/441	9.4%	35/374	44.0%	372/845	67.0%	256/382		23.0%
Galkayo	Record card	-	-	-	-	20.3%	46	12.7%	24	0.5%	1	0.0%	0		
	Recall	-	-	-	-	36.7%	81	20.6%	39	0.0%	0	7.5%	11		
	Combined	-	-	-	-	55.9%	127/227	33.3%	63/189	0.5%	1/185	7.5%	11/147		7.0%
Kismayo	Record card	-	-	-	-	-	-	16.7%	75	11.4%	50	-	-		
	Recall	-	-	-	-	-	-	20.0%	90	29.7%	130	-	-		
	Combined	-	-	-	-	-	-	36.7%	165/449	41.1%	180/438	-	-		
Dollow	Record card	-	-	-	-	-	-	-	-	7.7%	18	0.0%	0		
	Recall	-	-	-	-	-	-	-	-	22.6%	53	27.9%	64		
	Combined	-	-	-	-	-	-	-	-	30.3%	71/234	27.9%	64/229		-2.4%
Combined	Record card	4.0%	60	3.9%	80	13.0%	401	9.3%	307	10.7%	394	18.2%	287		
	Recall	23.5%	351	29.9%	607	33.3%	1,026	33.2%	1095	33.3%	1229	30.9%	488		
	Combined	27.5%	411/1,493	33.8%	687/2,031	46.2%	1,427/3,083	42.5%	1,402/3,302	44.0%	1623/3682	49.1%	775/1580		5.1%

The period prevalence of Acute Watery Diarrhoea has increased in most areas, although the overall rise in period prevalence is only slight. The increase in diarrhoeal disease was expected due the heavy Gu rains that affected many areas and led to flooding in some. The increases reported here are consistent with the increase in cholera cases reported by WHO.[5]

Table 9: Two Week Period Prevalence of AWD in children 0-59 mo.

Area	Round 1		Round 2		Round 3		Round 4		Round 5		Round 6		Trend	Change R5 to R6
Kahda	21.8%	173/795	7.8%	56/719	10.4%	85/818	7.4%	50/676	3.0%	13/434	5.4%	9/168		2.4%
Baidoa	26.9%	128/476	20.0%	146/729	12.3%	186/1,513	1.9%	26/1,360	1.9%	23/1232	0.7%	5/736		-1.2%
Dinsoor	6.2%	31/497	10.7%	49/456	10.2%	45/442	5.0%	28/561	8.3%	45/540				
Daynille		-	15.0%	98/655	6.6%	35/531	5.2%	23/443	12.8%	122/955	13.0%	55/423		0.2%
Galkayo		-		-	3.8%	10/264	16.0%	37/231	0.0%	0/221	7.1%	12/169		7.1%
Kismayo		-		-		-	13.1%	68/520	5.9%	29/491				
Dollow									5.3%	14/265	10.2%	26/254		4.9%
Combined	18.8%	332/1,768	13.6%	349/2,559	10.1%	361/3,568	6.1%	232/3,791	5.9%	246/4138	6.1%	107/1750		0.2%

Mortality

The recall period used for the assessment of mortality was the time since the previous interview, which was calculated individually for each household. The shorter recall period reported for Round 6 is due to the fact that no new camps were included, so the recall period for all participants was the time since the last interview in round 5. This was, on average, just over a month for all households. We observed a stable CDR and a slight decrease in the U5DR since Round 5. Both CDR and U5DR are below emergency thresholds.

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[5] Epi Watch Epidemiological Bulletin, Week 12-13, 2023, WHO Somalia https://reliefweb.int/report/somalia/epi-watch-epidemiological-bulletin-epidemic-prone-diseases-somalia-week-12-13-2023-20-march-02-april-2023

Table 10: Crude Death Rate (CDR) and Under-five Death Rate (U5DR) in the Combined Areas

Indicator	Combined Areas						Change R5 to R6
	Round 1	Round 2	Round 3	Round 4	Round 5	Round 6	
Persons under observation	8,029	12,400	17,808	20,317	20,946	8,033	
Average recall period (days)[1]	30.4	41.8	78.6	65.3	43.3	34.8	
Person days of observation	244,082	514,878	1,388,362	1,325,871	882,524	279,166	
Total deaths reported	23	32	58	39	19	5	
Deaths in children <5 years	17	24	43	27	16	4	
Crude Death Rate[2] (CDR) deaths/10,000/day	0.9	0.6	0.4	0.3	0.2	0.2	0
Under Five Death Rate[3] (U5DR) deaths/10,000/day	3.0	2.2	1.5	1.1	0.9	0.6	-0.3

[1] The recall periods/days of exposure were set at a fixed one month (30.4 days) for each household in round 1 but were calculated for each household individually during susequent rounds. We used memorable dates to define the recall period for households that were newly recruited in each round: round - 2 Jul 9th; round 3 - the end of Mowlid, Oct 9th; round 4 - the Zobe 2 explosion on Oct 29th; and in round 5 - Jan 1st 2023. For household that had been recruited in a previous data collection round we used the date of the last interview to define the recall period. In Round 6 no new camps were included so the recall period for all participants was the time since the previous interview.

[2] Threshold levels for CDR are: 1/10,000,day = Emergency; 2/10,000/day = Out of control

[3] Threshold levels for U5DR are: 2/10,000,day = Emergency; 4/10,000/day = Out of control

Source: Humanitarian Charter and Minimum Standards in Humanitarian Response; Essential health services standard http://www.spherehandbook.org/en/essential-health-services-standard-1-prioritising-health-services/ and Interpreting and using mortality data in humanitarian emergencies, Checchi and Roberts (2005) http://odihpn.org/wp-content/uploads/2005/09/networkpaper052.pdf

Conclusions

Data from Round 6 indicates that there is a continuing improvement in the overall health and nutrition situation. The uptick that was observed in round 5 appears to have retreated. However, the results from this round need to be interpreted in the knowledge that the sample included was much smaller than the sample included in round 5. Therefore, any changes that we observe might have resulted from this change in the selection of the participants.

In addition, also see that some sites/camps still have very high levels of acute malnutrition and that the coverage and/or uptake of services is still very poor in some areas. Overall, the humanitarian response is still not meeting Sphere Standards in key interventions such as vaccination coverage. We note a high prevalence of measles cases being reported in Kahda and urge that the need for enhanced heath care provision and/or emergency vaccination is urgently explored.

As expected, the Gu rainy season has led to an uptick in diarrhoeal disease (period prevalence of AWD) although this has, so far, not resulted in a dramatic increase in cases being detected in the NMS surveillance sites, and has not yet impacted on the prevalence of malnutrition. However, Dollow is an area that requires particular attention, given the very high levels of GAM by MUAC and reports of cholera/AWD outbreaks leading to a rise in admissions in facilities. The death rates reported in Round 6 have continued to decrease, but efforts need to be strengthened and sustained to ensure the risk factors for excess mortality continue to be controlled and reduced.

As mentioned in the Round 5 report, the sanctions associated with the war in Ukraine continue to create uncertainty on global food markets and this may lead to price volatility within Somalia. The military action against Al-Shabaab by government local clan militia and international forces may be about to enter a new phase[6] and further population displacement as a result of this conflict remains possible.

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[6] https://www.garoweonline.com/en/featured/inside-hassan-sheikh-s-momentous-town-hall-meeting-in-mogadishu