



Report on NMS Round 8

**NUTRITION AND MORTALITY
MONITORING IN IDP POPULATIONS**

December 2023

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* Photo taken by the Evidence for change (e4c) data collection team in a camp for newly arrived IDP in Afgooye Corrdior, Mogadishu.

EXECUTIVE SUMMARY

This is the eighth report from the 2022-2024 Nutrition and Mortality Monitoring System (NMS) project, which is now in its third phase. Data collection for this round was conducted and funded by the BRCiS consortium. Between 12th and 29th December, 2023, data was collected from 1,810 IDP households in 10 sites/camps in Khada and Daynille in the Afgooye Corridor, and Baidoa. These camps/sites were newly sampled and selected with the aim of determining the impact of the October-December (OND) flooding on the health and nutrition situation of newly displaced people.

The time since arrival within the 10 IDP sites/camps ranged from 1 up to 14 months, with a median of 4 months. Of the 1,542 Mothers and Caregivers that were interviewed, 77% belonged to the Digil and Mirifle clan and 55% reported only speaking Maay, while 2% reported only speaking Jido. These results reflect previous findings on newly arrived IDP populations in terms of clan identity and language usage, highlighting the need for humanitarian agencies to ensure appropriate language competencies in their staff, so that any impact of language bias and marginalisation can be minimised.

The main sources of drinking water, adequacy of drinking water, and use of defecation sites were assessed. There are marked differences by area. In Kahda, two thirds of households had access to standpipes or taps with the remainder using water from tankers. In Daynille, almost every household had access to public standpipes or taps, while in Baidoa the majority relied on wells or springs, with about 1 in 5 using water tankers.

The household experience of drinking water adequacy is generally, fairly good, with the majority in all sites never or rarely experiencing inadequate drinking water. The least favoured site is Kahda where 1 in 3 households sometimes experience inadequate supply. Open defecation in the field was reported by some households in all areas, and 56% of households in Baidoa reported defecation in the field. This finding is very concerning given the high density of many IDP sites and the high risk of water source contamination during flooding.

The trend in GAM by MUAC prevalence in all three areas lies above the 'Alert' threshold of 5% but below the 'Serious' threshold of 10%, indicating a fragile but non-emergency context. However, there is variation between camps, and within the individual camps included in Round 8, the prevalence lies above the critical 10% threshold in 2 sites, with a GAM of 15% in one camp in Baidoa. Nutrition treatment coverage for the areas included in Round 8 lies at 54% for MAM by MUAC and 68% for SAM by MUAC cases. The coverage is worse for both MAM and SAM in Kahda. The target coverage of >90% was not achieved in any area for MAM or SAM treatment.

Possession of health record cards was confirmed for 62% of all children. This coverage of health record cards is low, especially in Daynille, and is likely to be impeding the effective delivery and monitoring of essential child health and nutrition services. Measles vaccination coverage was reported for 76% of children aged 9-59 months. Coverage in all 3 areas lies below 90%, so there is a need for further strengthening of routine vaccination services. Cholera vaccination coverage in children aged 12-59 mo. was 73%.

The two-week period prevalence of suspected measles in the 3 areas combined was 1.3%, with no cases detected in Baidoa but a 2% prevalence in Daynille. It is notable that Daynille was also the area with the lowest possession of health record cards and lowest vaccination coverage. The two week period prevalence of Acute Watery Diarrhoea in children under 5 years was 3%. Crude and under-five death rates were well below emergency thresholds.

Recommendations

1. Action to improve in WASH services and eliminate the use of open field defecation are urgently required. This is especially important given the increased risk of disease outbreaks following the heavy OND rainfall.
2. Efforts to strengthen treatment services for acute malnutrition should continue to try and improve the coverage of selective feeding programmes for both MAM and SAM.
3. Vaccination coverage is below Sphere Standards and action should be taken to improve coverage by enhancing routine and campaign vaccination services.
4. In spite of the relatively good health and nutrition situation reported here, the outlook over the next few months remains concerning and emergency response capacity should be retained. The military action against Al-Shabaab by government forces, local clan militia, and international forces continues, and there has been talk of a regional conflict involving Ethiopia and Somaliland, raising the possibility of further population displacement.

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INTRODUCTION

This is the eighth 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. During the main crisis, and subsequently, 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.¹ The previous round of NMS data collection (Round 7) took place in September 2023 and focussed on sites in Khada, Daynille, Baidoa, and Kismayo. This current data collection round involved newly sampled sites in Khada, Daynille, and Baidoa and was focussed on estimating the impact of the recent floods. It was funded by the BRCiS consortium, led by NRC, and in conducted partnership with Evidence for Change (e4c).

The overall situation in southern Somalia has seen a number of changes since September, 2023. As of September 2023, over 1 million people were projected to remain or fall into IPC Acute Food Insecurity Phase 4 (Emergency) up to the end of 2023. An estimated 1.5 million children under 5 face acute malnutrition between August 2023 and July 2024, including 330,630 who are projected to become severely malnourished.² Since then there has been significant and widespread flooding associated with the El Nino and the Indian Ocean Dipole, with both flash floods, and river flooding effecting areas along the Shabelle and Juba rivers.³ Flooding has been prolonged severe in some regions. Due to the flooding and contamination of water sources there has been an increased risk of water-borne disease outbreaks such as AWD and cholera, and an associated increase in the risk of malnutrition and risk of death in vulnerable groups such as children and the elderly.

This current report details the results from camps that were purposively sampled for the first time by the NMS. The immediate objective was to find out about how the health and nutrition situation had been affected by the flooding, a shock which was layered on top of an already vulnerable situation caused by displacement and the residual effects of the 2022-2023 drought and ongoing armed conflict.

¹ Nutrition and Mortality Monitoring System (NMS) - Synthesis Report (July 2022- April 2023) <https://reliefweb.int/report/somalia/nutrition-and-mortality-monitoring-system-nms-synthesis-report-july-2022-april-2023>

² IPC Somalia: Acute Malnutrition Situation for August - September 2023 and Projection for October - December 2023 <https://www.ipcinfo.org/ipc-country-analysis/details-map/en/c/1156564/?iso3=SOM>

³ SWALIM, Deyr 2023 Climate Outlook And Its Implication On Livelihoods And Programming Over Somalia https://www.faoswalim.org/resources/site_files/DEYR_2023_climate_outlook_and_impacts_on_livelihoods.pdf

Sampling

The Nutrition and Mortality Monitoring System (NMS) approach⁴ 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.⁵

In Round 8, sampling of a new set of IDP camps/sites was conducted. The number of sites included in the current round was 10, and 3 areas were included. Kismayo and Dollo are also important aggregation sites for displaced populations in southern Somalia, and their inclusion is planned for future data collection rounds as and when partners and funding is available. Data collection took place between 12th and 29th December, 2023. 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 BRCiS members. The Team training was conducted either face-to-face or remotely via video link.

A two-day refresher training for community health workers (CHWs), 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. Role plays and mock interviews were also conducted to enhance enumerators' understanding of the data collection tool and their fluency in conducting the interviews.

Data collection

Data was collected at household level by trained CHWs 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.

Teams were comprised of two CHWs 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 15 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

⁴ 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.

⁵ <https://reliefweb.int/report/somalia/nutrition-and-mortality-monitoring-idp-populations-report-round-1-july-2022-report-issued-15082022>

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

Data was collected using 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 identity could be confirmed at the start of each interview.

Data analysis

Data analysis was performed in R. Graphs and 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 September 16th, 2023, which was the start of Mawlid. Household members who 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. Deaths recorded in households not available for verification were still included. 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 will be prepared to show key indicators for each camp and how they change between data collection rounds. If the humanitarian response is adequate a positive improvement in performance and outcome indicators is expected as the time since arrival increases.

IDP Sample Characteristics

The characteristics of the samples collected in each area and IDP site are described in table 1. In total, during Round 8 data was collected from 1,810 IDP households in 10 sites (camps), from 3 areas. The sampled households contained 9,228 individuals. The median time since arrival within the 14 IDP sites ranged from 1 months up to 12 months.

Table 1: Data Collection Summary

Partner	Area	IDP site	Round 8 (12 th Dec - 29th Dec,			Months since arrival ¹
			Households	Population	Household size	
Action Against Hunger	Kahda - Banadir	Dudan	207	1,005	4.9	1 (1,2)
		Karinka Dheer	199	922	4.6	1 (1,2)
		Gardaan	185	827	4.5	1 (1,1)
	Daynille - Banadir	CiilTire	177	857	4.8	2 (1,2)
		BuloBarako	177	872	4.9	2 (1,4)
		Basro	196	956	4.9	3 (2,3)
CWW/ GREDO	Baidoa City	9 Mundul	111	451	4.1	4 (2,8)
		Balanbaale	258	1578	6.1	4 (2,8)
		Buulo Biyooley	99	549	5.5	12 (8,24)
		Buur Midowe	201	1211	6.0	5 (4,7)

¹Median and IQR

Figure 1 - Region & District of Origin of IDP Mothers/Caregivers Sampled in Round 8 (n=1,542)¹

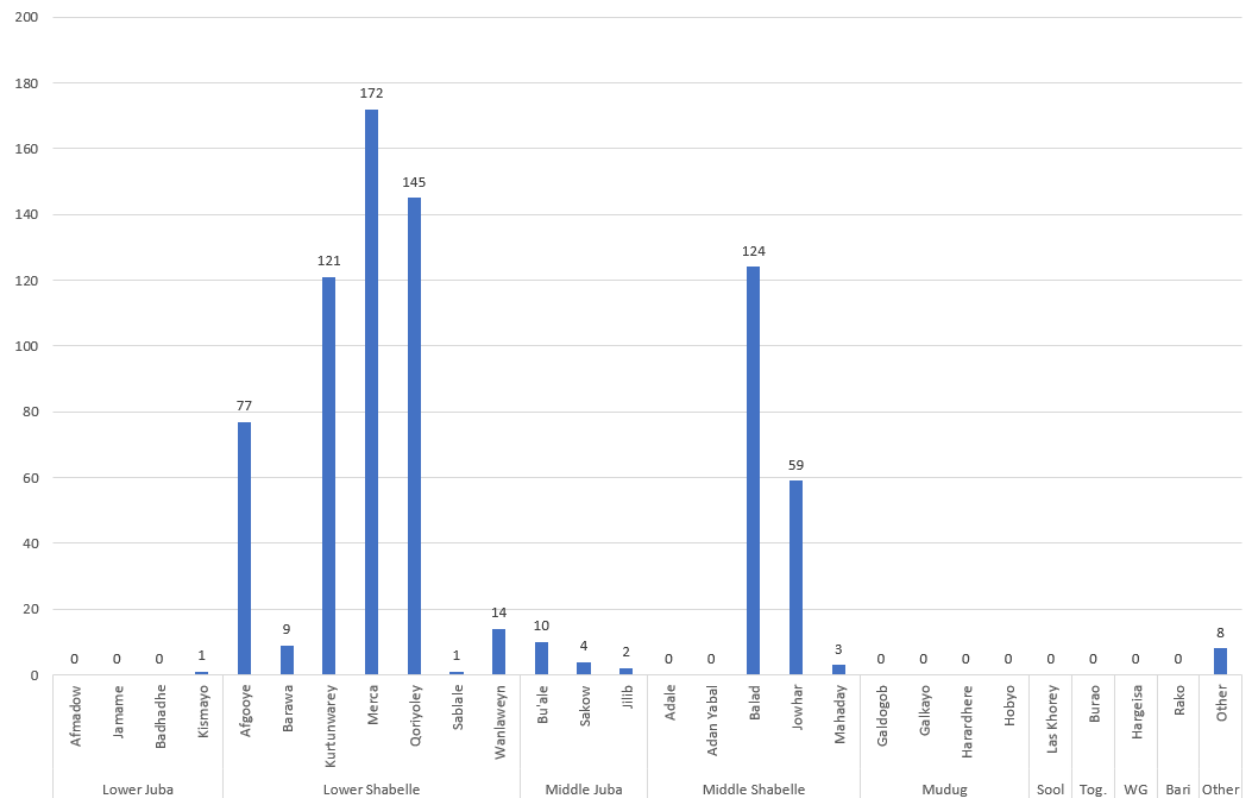
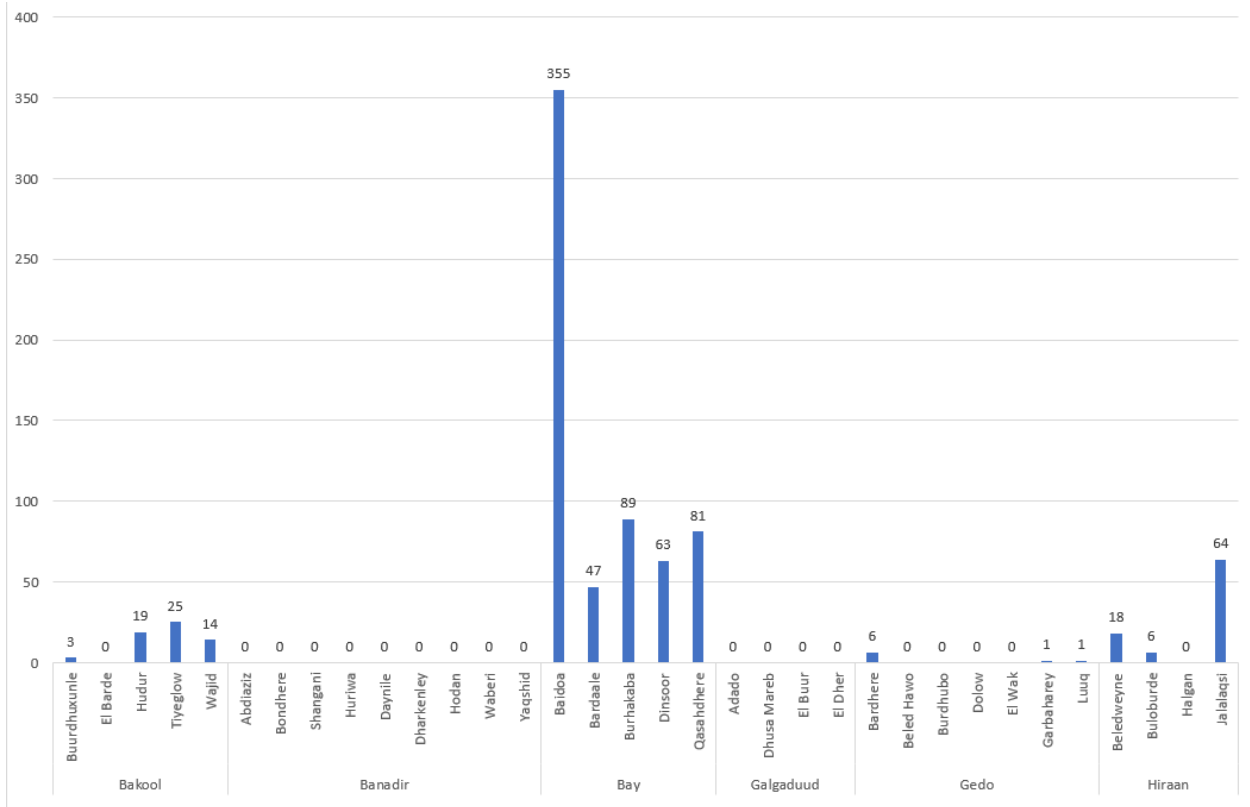


Figure 2 - Clan of IDP Mothers/Caregivers Sampled in Round 8 (n=1,542)

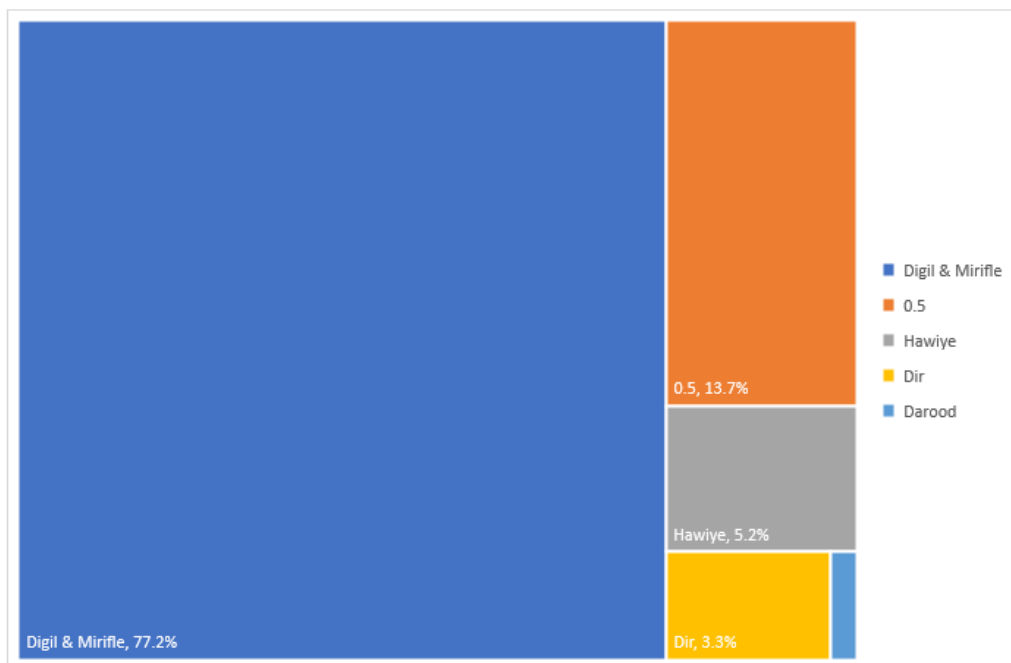
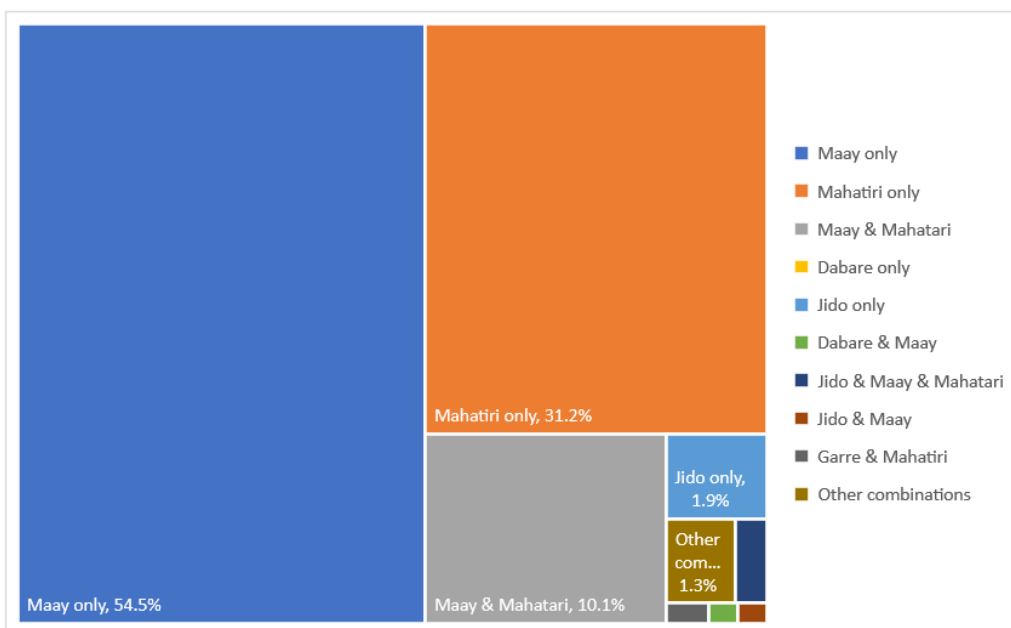


Figure 3 – Language/dialects of IDP Mothers/Caregivers Sampled in Round 8 (n=1,542)



Region of Origin

Figure 1 above shows the region of origin for the 1,542 IDP Mothers/Carers that were interviewed in Round 8. IDPs had migrated from a range of different regions with high numbers coming from Bay, Lower Shabelle, and Middle Shabelle. Eight 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 8 is shown in the tree plot, in Figure 2, above. Seventy seven percent were from the Digil and Mirifle (Rahanweyn), with 14% coming from the minority (so called 0.5) clans, and 5% from the Hawiye.

The languages spoken by Mothers/Carers are shown in Figure 3 above. The largest category of Mothers reported speaking only Maay (55%), with about 31% speaking Mahatiri only. Ten percent spoke both languages/dialects. Other languages/dialects that were reported included Jido, with 2% speaking only this language. While some reported speaking only 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. According to the report, the existence of multiple languages or dialects within Somali populations may result in communication barriers and language-based exclusion/ leading to marginalisation.⁶ Findings from this round reiterate the importance of humanitarian agencies hiring staff with diverse language skills that match those of the intended beneficiaries.

WASH

The household WASH situation in the IDP camps is presented in the figures below. In figure 4, the predominant water source is shown for each location. There are marked differences by area. While the majority were using public standpipes or taps in both Kahda and Daynille, in Kahda water tankers were reported as being the main source of drinking water for 1 in 3 households. In contrast, in Baidoa only 1 in 5 households relied on water tankers, with the majority using wells or springs.

The household experience of drinking water adequacy is illustrated in Figure 5. Adequacy is seen to be generally, fairly good, with the majority in all sites never or rarely experiencing inadequate drinking water. The least favoured site is Kahda where 1 in 3 households sometimes experience inadequate supply.

The household's use of defecation sites is shown in Figure 6. Open defecation in the field was reported by some households in all areas, and 56% of households in Baidoa reported defecation in the field. This finding is very concerning given the high density of many IDP sites and the high risk of water source contamination during flooding. A breakdown of reported defecation sites by camp is provided in the annex.

Drinking water adequacy scores and pit latrine percentage use are shown in Table 2 below. The score illustrates the overall adequacy of drinking water supply, with a low score indicating better adequacy. Under optimal conditions the drinking water adequacy score would equal 1 and pit latrine usage would be 100%.

⁶ 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>

Figure 4: Main Sources of Household Drinking Water by Area (n=1,810)

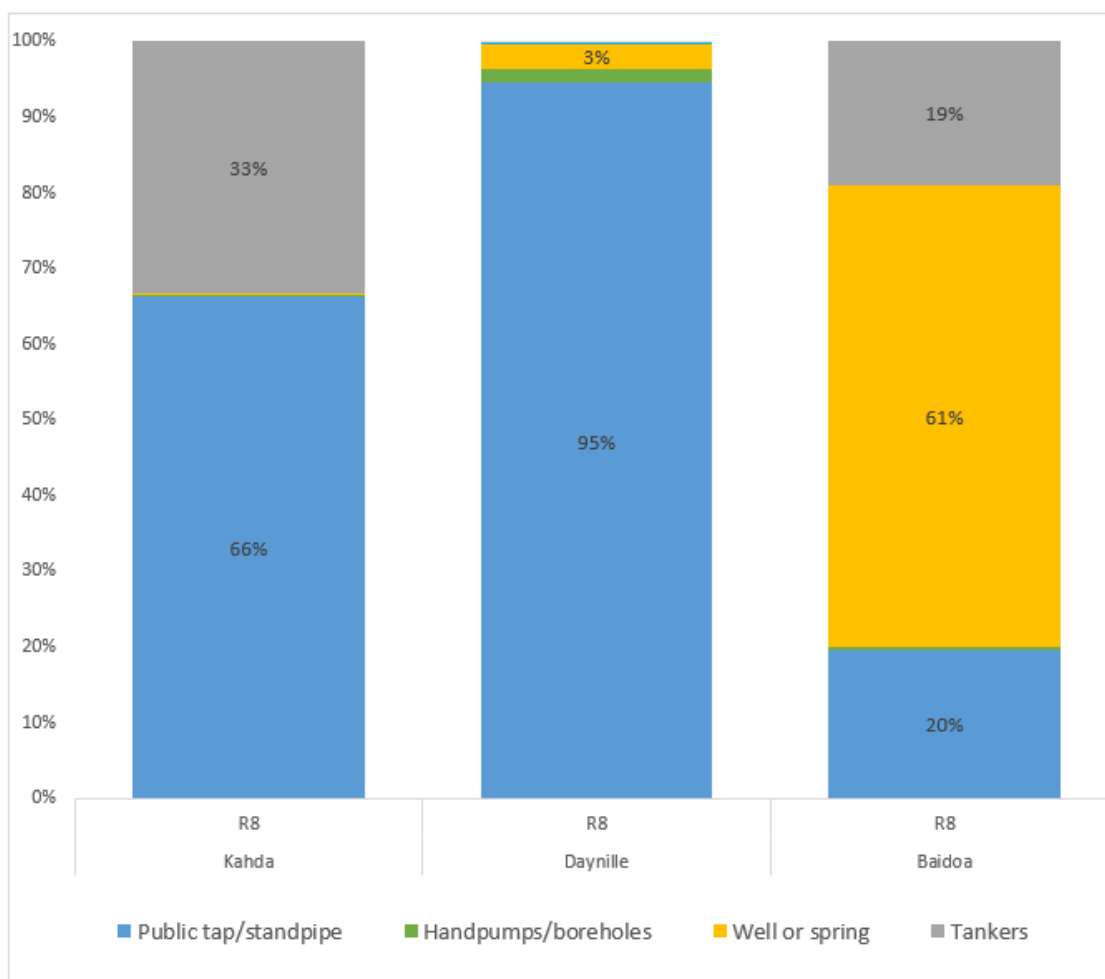


Figure 5: Frequency of Inadequate Household Drinking Water by Area (n=1,810)

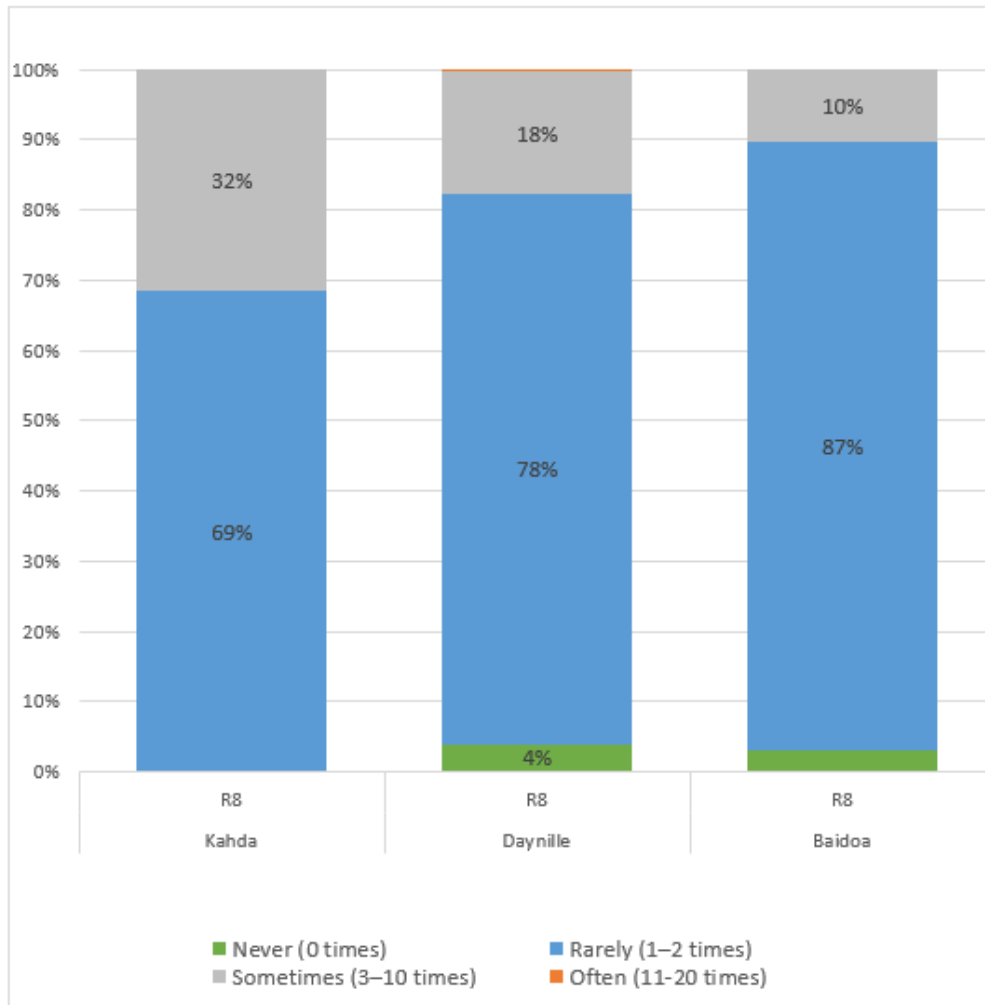


Figure 6: Household Defecation Site by Area (n=1,810)

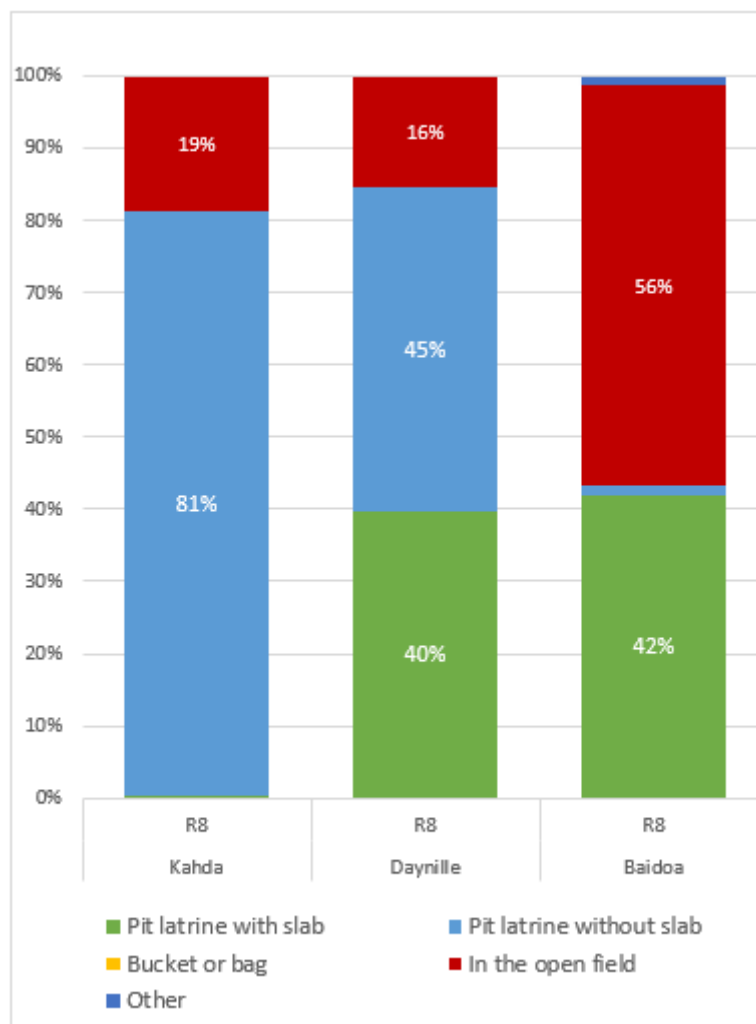


Table 2: Drinking Water Adequacy and Use of Pit Latrines

	Frequency of inadequate drinking water ¹		Pit Latrine Use (%)	
	N	Score	N	%
Kahda	591	2.3	480/ 591	81.2%
Daynille	550	2.1	465/ 550	84.5%
Baidoa	669	2.1	289/ 669	43.2%
Combined	1,810	2.2	1,234/ 1,810	68.2%

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. The score has a possible range from 1 to 5. If all households experienced adequate drinking water the score would equal 1; if all households always experienced inadequate drinking water the score would equal 5.

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 In subsequent rounds, the change in score will be 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. The prevalence in all three areas lies above the alert threshold of 5% but below the serious threshold of 10%.

Table 3: Prevalence of GAM by MUAC in Sentinel Site Camp Areas¹

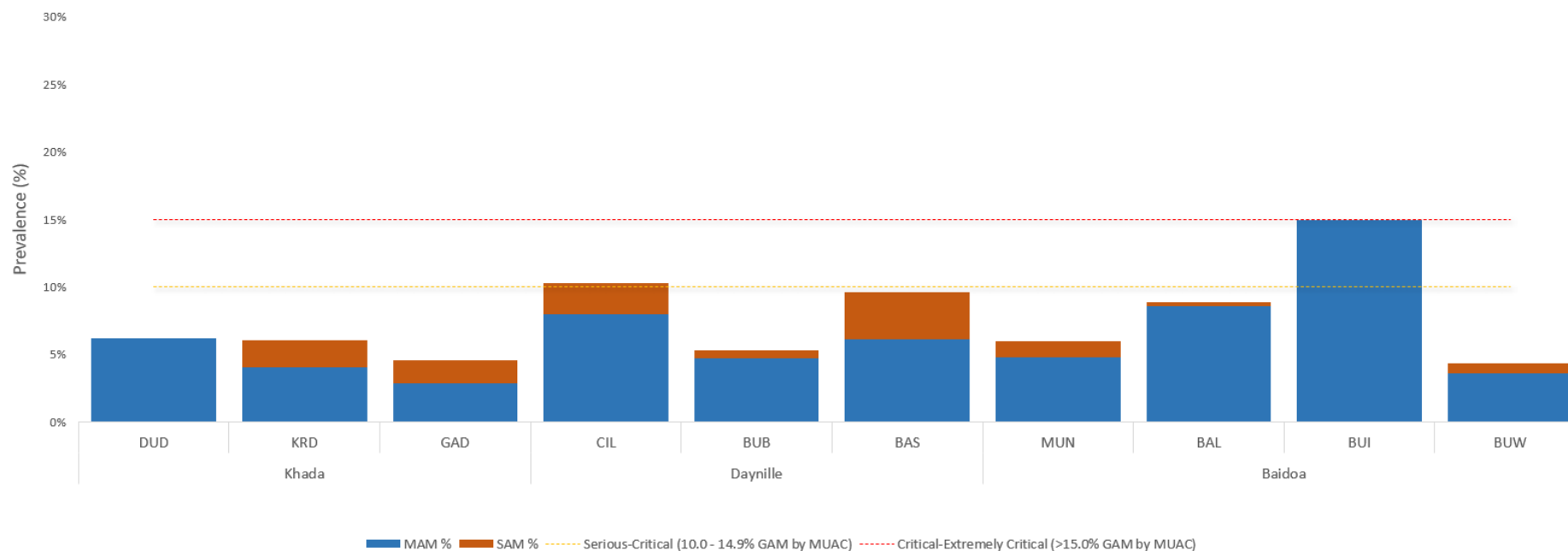
Area	Sex	Round 8				GAM (MUAC < 12.5 cm or oedema)
		N	Age (mo.)	Oedema		
Kahda	All	743	29.9	2	42	5.7%
	Male	357	29.5	2	17	4.8%
	Female	386	30.4	0	25	6.5%
Daynille	All	658	29.9	1	58	8.8%
	Male	330	29.4	0	20	6.1%
	Female	328	29.5	1	39	11.6%
Baidoa	All	615	29.4	3	50	8.1%
	Male	325	30.0	2	21	6.5%
	Female	290	29.9	1	29	10.0%

¹ IPC levels of acute malnutrition: Critical-Extremely Critical ($\geq 15.0\%$ 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)



The prevalence of GAM, MAM, and SAM by MUAC are shown for individual camps in Figure 7. Within the camps included in Round 8, the prevalence is below the critical 15% threshold in all sites. However, it exceeds the 10% serious threshold in Ciiltire camp in Daynille and Buulo Biyooley camp in Baidoa.

Figure 7: Prevalence of SAM and MAM by MUAC in Individual Camps^{1,2}



¹ An increase or decrease in prevalence since the last data collection round will be indicated by an up or down arrow. A warning exclamation mark will be shown if the last measured prevalence of GAM by MUAC exceeded 15%.

² Table of camp names and abbreviations:

Camp/Site Names and Abbreviations							
BAL	Balanbaale	BUI	Buulo Biyooley	DUD	Dudan	MUN	9 Mundul
BAS	Basro	BUW	Buur Midowe	GAD	Gadaan		
BUB	Bulo Barako	CIL	Ciiltire	KRD	Karinka Dheer		

Coverage of Nutrition Treatment Programs

Enrolment in Selective Feeding Programmes is described in table 4. Overall, programme coverage for the areas included in Round 8 lies at 54% for MAM by MUAC and 68% for SAM by MUAC cases. The coverage is worse for both MAM and SAM in Kahda. With the small sample of cases, any variation in the number being treated will have a large impact on the percentage coverage. Therefore, comparisons between sites should not be over interpreted. The target coverage of >90% was not achieved in any area for MAM or SAM treatment.

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

Area	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	
	Round 8	> 90% Coverage ¹	Round 8	> 90% Coverage ¹
Kahda	25% (8/32)	NO	50% (5/10)	NO
Daynille	67% (29/43)	NO	80% (12/15)	NO
Baidoa	62% (29/47)	NO	67% (2/3)	NO
Combined	54% (66/122)	NO	68% (19/28)	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, possession of health record cards was confirmed for 62% of all children. The coverage of health record cards is low, especially in Daynille, and this is likely to impede the effective delivery and monitoring of essential child health and nutrition services.

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

Area	Round 8	
Kahda	78.5%	601/766
Daynille	40.1%	438/675
Baidoa	64.9%	460/709
Combined	61.5%	1,323/2,150

Overall, measles vaccination coverage (Table 6) was reported for 76% of children aged 9-59 months. As coverage in 3 out of the 4 areas lie below 90%, there is still a need for further strengthening of routine vaccination services and/or 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 8		90% Coverage ²
Kahda	Record card	2.84%	20	
	Recall	74.53%	524	
	Combined	77.38%	544/703	NO
Daynille	Record card	2.64%	16	
	Recall	64.36%	390	
	Combined	67.00%	406/606	NO
Baidoa	Record card	38.31%	218	
	Recall	45.87%	261	
	Combined	84.18%	479/569	NO
Combined	Record card	13.52%	254	
	Recall	62.57%	1175	
	Combined	76.09%	1429/1878	NO

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

²Sphere 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).⁷ As shown in Table 7, the combined two-week period prevalence of suspected measles in the 3 areas was 1.3%, with no cases detected in Baidoa but a 2% prevalence in Daynille. It is notable that Daynille was also the area with the lowest possession of health record cards and lowest vaccination coverage.

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

Area	Round 8	
Kahda	2.4%	18/743
Daynille	1.2%	8/658
Baidoa	0.0%	0/615
Combined	1.3%	26/2,016

The coverage of Oral Cholera Vaccine in children between 12 and 59 months is shown in Table 8. Overall, coverage was 73%, ranging from 84% in Baidoa down to 58% in Daynille.

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

Area	Indicator	Round 8
Kahda	Record card	2.4%
	Recall	75.3%
	Combined	77.7%
Daynille	Record card	1.9%
	Recall	56.0%
	Combined	57.9%
Baidoa	Record card	37.4%
	Recall	46.7%
	Combined	84.1%
Combined	Record card	12.8%
	Recall	60.4%
	Combined	73.2%

⁷ Measles Vaccine-Preventable Diseases Surveillance Standards (2018) WHO
<https://www.who.int/publications/m/item/vaccine-preventable-diseases-surveillance-standards-measles>

The data in Table 9 indicates that the two week period prevalence of Acute Watery Diarrhoea in children under 5 years was 3%. Again, a much higher prevalence was observed in Daynille than in the other areas.



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

Area	Round 8	
Kahda	2.9%	22/766
Daynille	6.5%	46/709
Baidoa	0.4%	3/675
Combined	3.3%	71/2,150

Mortality

Data on mortality is shown in Table 10. The recall period used for the assessment of mortality was the time since the beginning of the month of Mawlid (September 16th 2023), which was on average 94 days. In Round 8, we observed that both the CDR and U5DR were below the alert thresholds.

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

Indicator	Combined Areas	
	Round 8	
Persons under observation	9,190	
Average recall period (days) ¹	93.9	
Person days of observation	863,214	
Total deaths reported	37	
Deaths in children <5 years	29	
<i>Crude Death Rate² (CDR)</i> <i>deaths/10,000/day</i>	0.4	
<i>Under Five Death Rate³</i> <i>(U5DR)</i> <i>deaths/10,000/day</i>	1.4	

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 subsequent rounds. We used memorable dates to define the recall period for households that were newly recruited in each round: round 2 - 2 Jul 9th; round 3 - the end of Mawlid, 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>

CONCLUSION

Data from Round 8 indicates that while the sampled IDP population are in a fragile situation, with levels of GAM by MUAC indicating the need for continued intervention, the overall severity of the situation lies below the threshold of a serious humanitarian emergency. This observation is reinforced by the relatively low death rates recorded for both CDR and U5DR. These findings were observed in spite of the severe flooding that had affected many areas of the weeks preceding data collection.

Nonetheless, there were signs of concern with very high levels of GAM by MUAC seen in some individual camps. In addition, the full effect of the flooding and the expected increase in waterborne disease may not yet have fully impacted the population by the time of the data collection in December, 2023. As of January 2024, OCHA are reporting that the outbreaks of Acute Watery Diarrhoea (AWD) and cholera are continuing to spread in areas that were badly affected by flooding.⁸ At least 9 people died of AWD or cholera, and 474 cases were reported during the 2nd week of 2024. Therefore, the fact that we did not observe high levels of AWD morbidity during the data collection in December 2023, needs to be interpreted in the knowledge that the increase in infections may not have yet peaked.

Urgent attention to WASH services is required, as we found that open defecation was being practiced by 6 in 10 households in Baidoa, and a significant minority in other sites. Lack of latrine usage implies a high risk of water-borne disease outbreaks, especially in times of flooding. Interviews with camp residents and site inspections are urgently needed to establish the reasons for the low latrine usage, and plan remedial action.

Health indicators paint a similar picture, with levels of health record card possession and vaccination coverage being better than observed in many previous assessments of new IDP sites, but still requiring substantial improvements in order to meet international Sphere standards. In particular, measles vaccination coverage remains well below the coverage target of 90%.

The overall situation reported here is consistent with a reduction in the numbers of people in need of assistance that has been reported in the 2024 Humanitarian Needs and Response Plan.⁹ An IPC analysis is in progress and results are expected to be published within the next few weeks.

However, despite these improvements, the longer term outlook over the next few months remains concerning. The high levels of GAM reported in individual camps in Baidoa point to the continuing vulnerability of the displaced population. The military action against Al-Shabaab by government forces, local clan militia, and international forces continues. In addition, there are concerns about the possibility of a regional conflict involving Ethiopia, Somaliland, and the Federal Government of Somalia.¹⁰ These factors may, individually or in combination, lead to further displacement and challenges of population health and nutrition.

⁸ OCHA Situation Report – Highlights (24 Jan 2024) <https://reliefweb.int/country/som#digital-sitrep>

⁹ Somalia Monthly Humanitarian Update, January 2024 OCHA <https://reliefweb.int/report/somalia/somalia-monthly-humanitarian-update-january-2024>

¹⁰ 'Ethiopia's deal with Somaliland upends regional dynamics, risking strife across the Horn of Africa.' The Conversation January 13th, 2024 <https://theconversation.com/ethiopias-deal-with-somaliland-upends-regional-dynamics-risking-strife-across-the-horn-of-africa-220617>

Annex: Defecation Practices by IDP Camp/Site

Area	Camp/Site	Proportion (%)	Reported Defecation Practice	
Baidoa	9 Mundul	84.7	Pit latrine with slab	
		10.8	In the open field	
		4.5	Other	
	Balanbaale	25.2	Pit latrine with slab	
		2.7	Pit latrine without slab	
		70.9	In the open field	
		1.2	Other	
	Buulo Biyooley	100.0	Pit latrine with slab	
	Buur Midowe	11.4	Pit latrine with slab	
		0.5	Pit latrine without slab	
88.1		In the open field		
Daynille	Basro	0.5	Pit latrine with slab	
		99.5	Pit latrine without slab	
	BuloBarako	24.3	Pit latrine with slab	
		28.8	Pit latrine without slab	
		46.9	In the open field	
	CiilTire	98.3	Pit latrine with slab	
0.6		Pit latrine without slab		
		1.1	In the open field	
Kahda	Dudan	0.5	Pit latrine with slab	
		99.0	Pit latrine without slab	
			0.5	In the open field
	Gardaan	0.5	Pit latrine with slab	
		99.5	Pit latrine without slab	
	Karinka Dheer	44.7	Pit latrine without slab	
		55.3	In the open field	



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