FACTSHEET

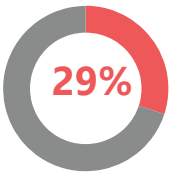
Somalia Health and Nutrition Brief: Multi-Sectoral Needs Assessment (MSNA)

February, 2024
Somalia

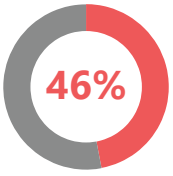
Key Messages

- Findings indicate that a lack of nearby health facilities, high treatment costs, lack of specific services and transport costs were critical barriers to accessing healthcare services. Insecurity and climatic shocks (i.e. flooding, high temperatures), coupled with scaled down funding, could increase the influence of these barriers on households and subsequently drive higher health needs in the medium-long term.
- The availability of skilled birth attendants (SBAs) remained a critical challenge. Many women still gave birth at home without the help of qualified medical professionals due to a combination of high delivery costs, a lack of functional health facilities nearby, lack of transportation and a preference for at-home birth.
- Suboptimal child feeding practices were pervasive. A significant proportion of households were not providing enough nutritious food, which can exacerbate existing cases of malnutrition and potentially lead to new cases.

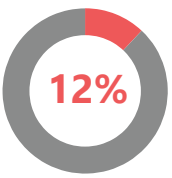
Key Findings



of individuals in the assessed households were reportedly unable to access healthcare assistance when they felt that they needed it.



of deliveries in the assessed households with women aged 15 years - 49 years who gave birth in the two years prior to data collection were assisted by non-skilled birth attendants.



of children less than six months old in the assessed households with children aged 0 - 6 months had been exclusively breastfed.

CONTEXT & RATIONALE

The healthcare system in Somalia has been significantly impacted by ongoing conflict and political instability, resulting in a profound disruption of essential health and nutrition services.[1] The occurrence of climatic shocks including the lack of rain/drought followed by severe flooding have further exacerbated the healthcare gaps. Access to healthcare is very limited- and less than 20% of the health facilities are fully operational.[2] As a result, the country has some of the lowest health and well-being indicators globally.[3] Somalia has one of the highest maternal mortality rates in the world, with 692 deaths per 100,000 live births due to pregnancy or birth-related complications.[4] According to 2024 Humanitarian Needs Response Plan (HRNP), an estimated 6.9 million people need humanitarian assistance.[5] Healthcare needs may be driven by gaps in humanitarian assistance, food insecurity and child malnutrition. According to the latest 2023 Deyr IPC analysis in Somalia, between January and March 2024, more than 4 million people are facing high levels of acute food insecurity (IPC AFI Phase 3 or above). Additionally, an estimated 1.7 million children aged 6 – 59 months are expected to suffer from acute malnutrition and require an urgent need for nutrition services.[6]

Assessment Overview

The overall objective of this analysis is to contribute to the implementation of 2024 Humanitarian Needs and Response Plan (HNRP) in Somalia by providing updated nation-wide, district-level, multi-sectoral analysis of the severity of needs among the crisis-affected populations to contribute to a more targeted, evidence-based

Methodology

The 2023 MSNA was conducted at household level with a total of 10,336 face-to-face interviews covering 59 accessible and semi-accessible districts out of the 74 districts of Somalia. However, due to targets not being reached in some districts, overall findings should be considered indicative only.

Targeted population groups:-

- Host Community population (non-displaced households)
- Internally displaced population (Protracted IDPs and New IDPs) , based on their length of displacement in their current location.*

Data collection took place from June 11th to August 4th, 2023. For more information, please refer to the Terms of Reference.

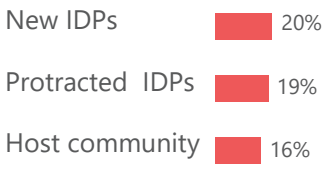
* **Protracted IDPs**:- households residing in their current location of displacement for more than 12 months. **New IDPs:**- households residing in their current location of displacement for 12 months or less.

Healthcare

Healthcare Needs

17% of individuals in the assessed households reportedly had a health problem that required healthcare in the 3 months prior to data collection.

Proportion of individuals in the assessed households with a health problem who needed healthcare in the 3 months prior to data collection, by population group



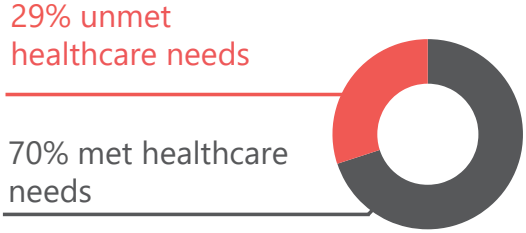
The majority (54%) of individuals assessed households with healthcare needs sought consultation or drugs for acute illnesses in the three months prior to data collection. Additionally, there was a demand for preventative check-ups and consultations or medications for chronic illnesses, such as hypertension and diabetes.

Proportion of most reported healthcare needs, by population group*

Population group	Consultation or drugs for acute illness	Preventative consultation / check-up	Consultation or drugs for chronic illness
Host community	51%	36%	10%
Protracted IDPs	57%	34%	12%
New IDPs	57%	39%	10%

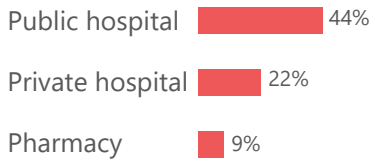
Unmet Healthcare Needs

Overall, 29% (on average 2 out of 7) of the individuals who reportedly had a healthcare need in the three months prior to data collection could not get healthcare assistance when they felt they needed it.**



Health Seeking Behaviours

Three most reported health facilities that individuals went to for healthcare services, by % of individuals with a healthcare need in the 3 months



Three most reported health facilities that individuals in assessed households went to for healthcare services, by population group

Population group	Host community	Protracted IDPs	New IDPs
Public hospital	41%	47%	45%
Private hospital	25%	20%	15%
Pharmacy	8%	9%	11%

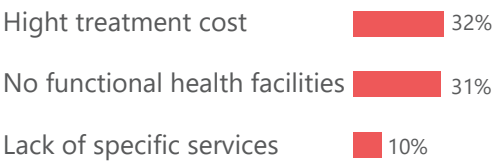
Access to Healthcare Services

Barriers to healthcare services

64% of assessed households reported at least one barrier to healthcare access in the three months prior to data collection

Survey findings suggest that a lack of functional healthcare facilities was the most prominent barrier to accessing healthcare services. The most commonly reported barriers were no functional healthcare facility (40%) high treatment cost (20%) followed by and lack of specific services (14%).

Three most commonly reported barriers to healthcare services by % of assessed households*



** Responses could be more than 100% as it was a select multiple question.*

*** Due to rounding up, findings on this FS may not amount exactly to 100%*

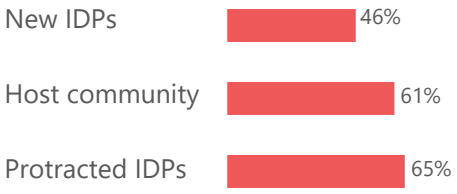
Women of Childbearing Age (WCBA)

19% of women (15 - 49 years of age) in the assessed households with women 15 - 49 years of age had a pregnancy that ended in the two years prior to data collection.

Antenatal Care Visits (ANC)

Overall, 61% of WCBAs who completed their pregnancies during the two years prior to data collection reported at least one ANC visit.

Proportion of WCBAs which reported at least one ANC visit, by population group



Delivery

Proportion of place of delivery, by % of WCBAs who reportedly gave birth in the two years prior to data collection

Skilled Birth Attendance (SBA)[7]

53% of all WCBA deliveries were assisted by skilled birth attendants.

Nearly half (43%) of the deliveries were conducted by Traditional Birth Attendants (TBAs). This can lead to delays in recognizing and managing obstetric emergencies, which in turn increases the risk of maternal and neonatal morbidity and mortality.

Proportion of WCBAs who gave birth in the two years prior to data collection, attended by professional medical staff

Birth attendants	Host community	Protracted IDPs	New IDPs
Skilled Health Worker	52%	50%	66%
Traditional (non skilled)	44%	44%	33%

Proportion oof birth attendant type, by % of WCBAs who gave birth in the two years prior to data collection

Two-thirds (66%) of WCBAs who reportedly did not give birth in a health facility reported that the primary obstacle to facility-based delivery was lack of a functional health facility. This was followed by no means of transportation (22%), high delivery costs (15%) and preference for home delivery (10%).

Barriers to health facility delivery, by population group by WCBAs who did not deliver in a health facility.*

Barriers	Host community	Protracted IDPs	New IDPs
No functional facilities	71%	52%	74%
Lack of transport	20%	27%	19%
High delivery cost	13%	20%	9%

** Responses could be more than 100% as it was a select multiple question.*

Infant and Young Child Feeding Practices (IYCF)[8]

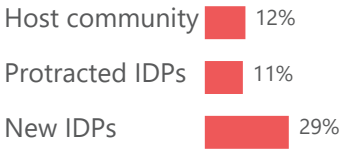
Ever Breast Feeding (EvBF)

Almost all children aged up to 23 months in the assessed households with children up to 23 months had been breastfed (100%), with minimal variation between population

Exclusive Breastfeeding (EBF)

12% of children in the assessed households with children below six months of age were exclusively breastfed. This is significantly lower than the WHO 2030 target of 70%.

Proportion of children aged 0 - 6 months who were found to be exclusively breastfed among assessed households



Continued Breast Feeding (CBF) up to 2 years

The majority of children 12-23 months (81%) in the assessed households with children in this age group had been breastfed during the first two years of life. This was significantly higher (94%) among new IDP households, as compared to the protracted IDP households (77%).

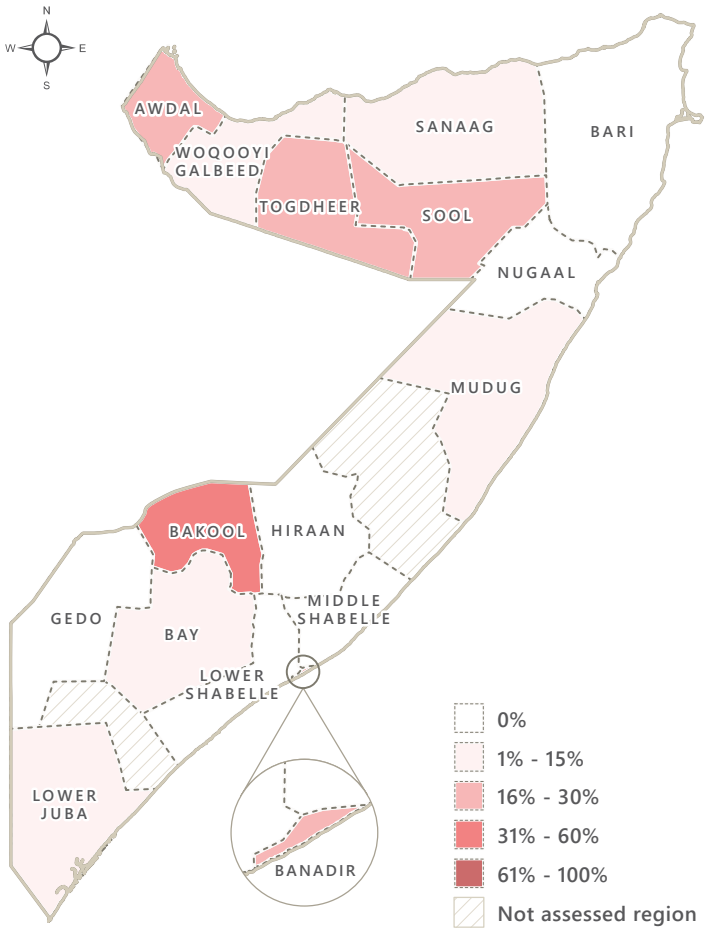
Introduction of Solid, Semi-Solid or Soft Foods for children 6-8 months (ISSSF)

More than half of children (57%) in the assessed households with children aged 6 - 8 months reported consuming solid, semi-solid or soft foods within 24 hours of data collection. This was particularly high among protracted IDP households (63%), compared to 54% of host community households and 50% of new IDPs

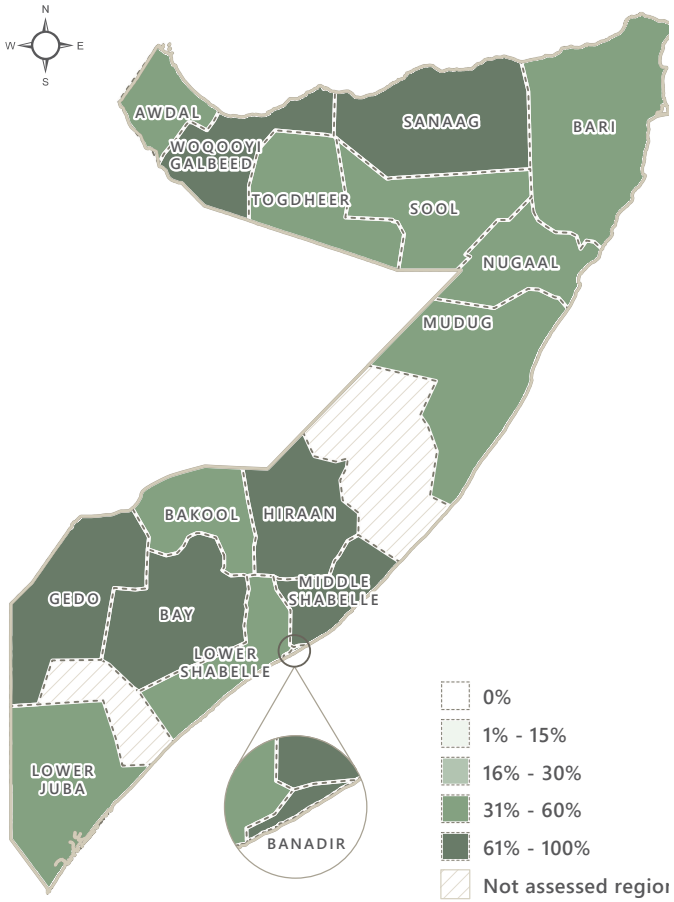
Minimum Meal Frequency (MMF)

More than half of children (59%) aged 6 to 23 months in the assessed households with children aged 6 to 23 months received a minimum of 2 meals per day - with marked differences between population groups. This was high among New IDPs (68%) and Host community (61%) compared to 55% of children aged 6 to 23 months in assessed protracted IDP households.

Map 1: Reported EBF of children aged 0 to 6 months among assessed households with children aged 0 to 6 months, by district



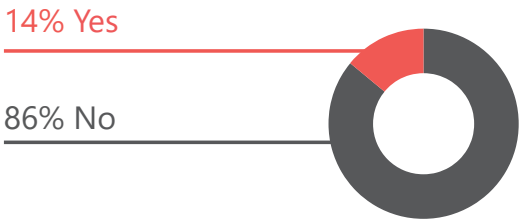
Map 2: Reported MMF of children aged 6 to 23 months among assessed households with children aged 6 to 23 months, by district



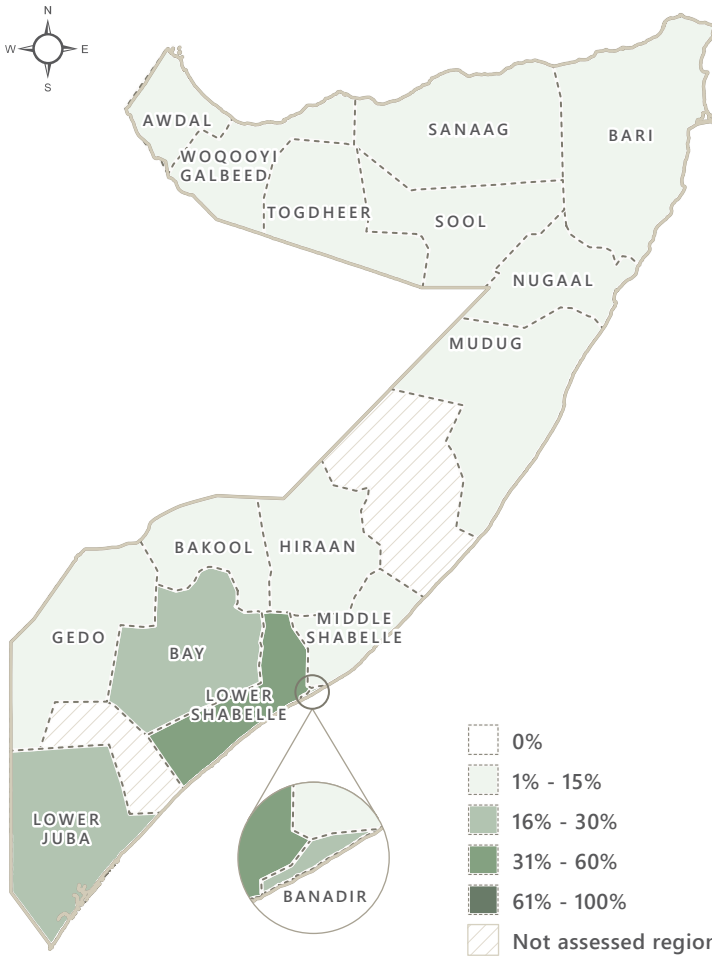
Minimum Dietary Diversity (MDD)

Most children aged 6 to 23 months in the assessed households with children aged 6 to 23 months had diets that were either non-nutrient dense or less diversified diet (86%) - with notable variation between population groups. Only 4% of children aged 6 to 23 months in assessed new IDP households with children aged 6 to 23 months reportedly consumed at least 5 of the 8 defined groups, which is significantly lower than the 13% and 16% of children aged 6 to 23 months in the assessed Protracted IDP and host community households respectively.

Proportion of children aged 6 - 23 months which reportedly received the minimum five or more food



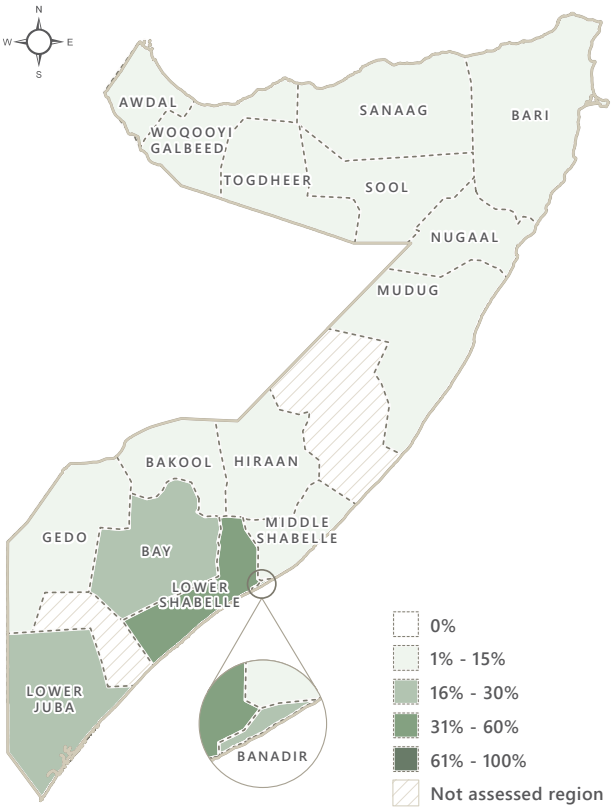
Map 3: Coverage of Minimum Dietary Diversity (MDD) among children aged 6 to 23 months, by district



Minimum Acceptable Diet (MAD)

Few children aged 6 to 23 months in the assessed households with children aged 6 to 23 months were found to have a MAD (10%)[9]. This indicates a disparity in the MAD among children aged 6 to 23 months across the three populations groups. 0% of children aged 6 to 23 months in assessed new IDP households with children aged 6 to 23 months reportedly consumed at least 5 of the 8 defined groups, which is significantly low as compared to just 9% of children aged 6 to 23 months in the assessed protracted IDP households with children aged 6 - 23 months and 10% of children aged 6 to 23 months in the assessed host community households.

Map 4: Minimum Acceptable Diet (MAD) among children aged 6 to 23 months, by district

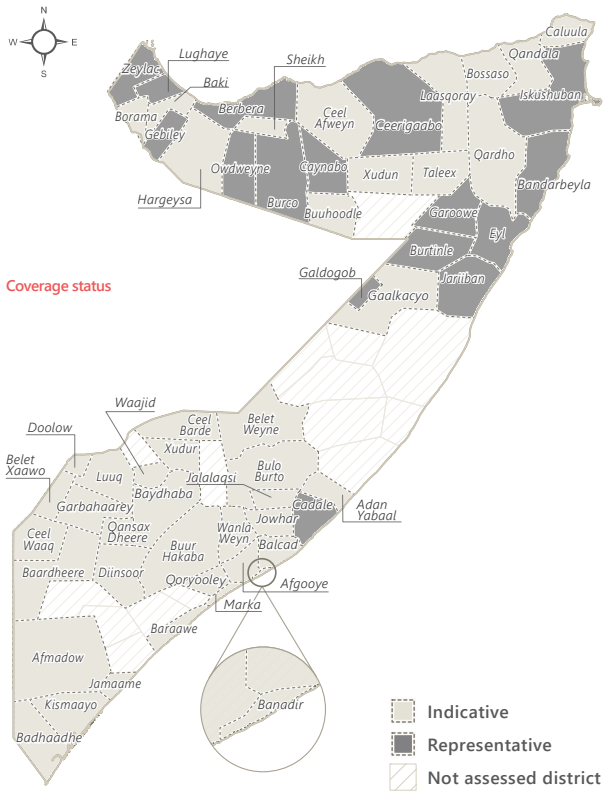


METHODOLOGY OVERVIEW

REACH 2023 MSNA in Somalia aimed to achieve wide geographical coverage through in-person household surveys. Trained REACH enumerators conducted more than 10,330 household interviews in 59 accessible or semi accessible districts, with the support from partner organizations. The assessment was designed to have representative quantitative findings. However, due to targets not being reached in some districts, overall findings should be considered indicative only. The 2023 MSNA used probability sampling to achieve representative results across population groups and districts. This involved randomly selecting respondents with equal probability for each unit in the population.

Sample size calculations for household surveys were based on probability theory to achieve the desired statistical precision. The process included stratified cluster sampling, where primary sampling units (PSUs) were randomly chosen within each stratum based on probability proportional to size (PPS). Subsequently, households were selected within the sampled sites, with the number determined by the frequency of PSU selection during the first stage of sampling. The data collection occurred between June 11th to Aug 4th, 2023. For further information, please read the TOR.

Coverage Map



ABOUT REACH

REACH Initiative facilitates the development of information tools and products that enhance the capacity of aid actors to make evidence-based decisions in emergency, recovery and development contexts. The methodologies used by REACH include primary data collection and in-depth analysis, and all activities are conducted through inter-agency aid coordination mechanisms. REACH is a joint initiative of IMPACT Initiatives, ACTED and the United Nations Institute for Training and Research - Operational Satellite Applications Programme (UNITAR-UNOSAT).

Endnotes

1 https://www.heritageinstitute.org/wp-content/uploads/2020/05/Somalia-Healthcare-System-A-Baseline-Study-and-Human-Capital-Development-Strategy.pdf
2 https://reliefweb.int/report/somalia/somalia-2024-humanitarian-needs-and-response-plan-hnrp
3 SOMALIA HEALTH CLUSTER Strategy 2023-2025 Maternal mortality is a death of a women during pregnancy or within one year of the end of pregnancy from a pregnancy complication
4 Somali Healthand Demographic Survey 2020 Somalia Humanitarian Needs Overview 2023 (February 2023).
5 https://reliefweb.int/report/somalia/somalia-2024-humanitarian-needs-and-response-plan-hnrp
6 https://fsnau.org/downloads/IPC-Somalia-Acute-Food-Insecurity-Malnutrition-Jan-Jun-2024-Report.pdf
7 The traditional birth attendant (TBA) has been defined as "a person (usually a woman) who assists the mother at childbirth and who initially acquired her skills delivering babies by herself or by working with other traditional birth attendants
8 Indicators for assessing infant and young child feeding practices: Definitions and measurement methods
9 https://www.ipcinfo.org/fileadmin/user_upload/ipcinfo/manual/IPC_Technical_Manual_3_Final.pdf