ACUTE NEEDS ANALYSIS

SOMALIA

Acute Needs Analysis | July-Dec 2025

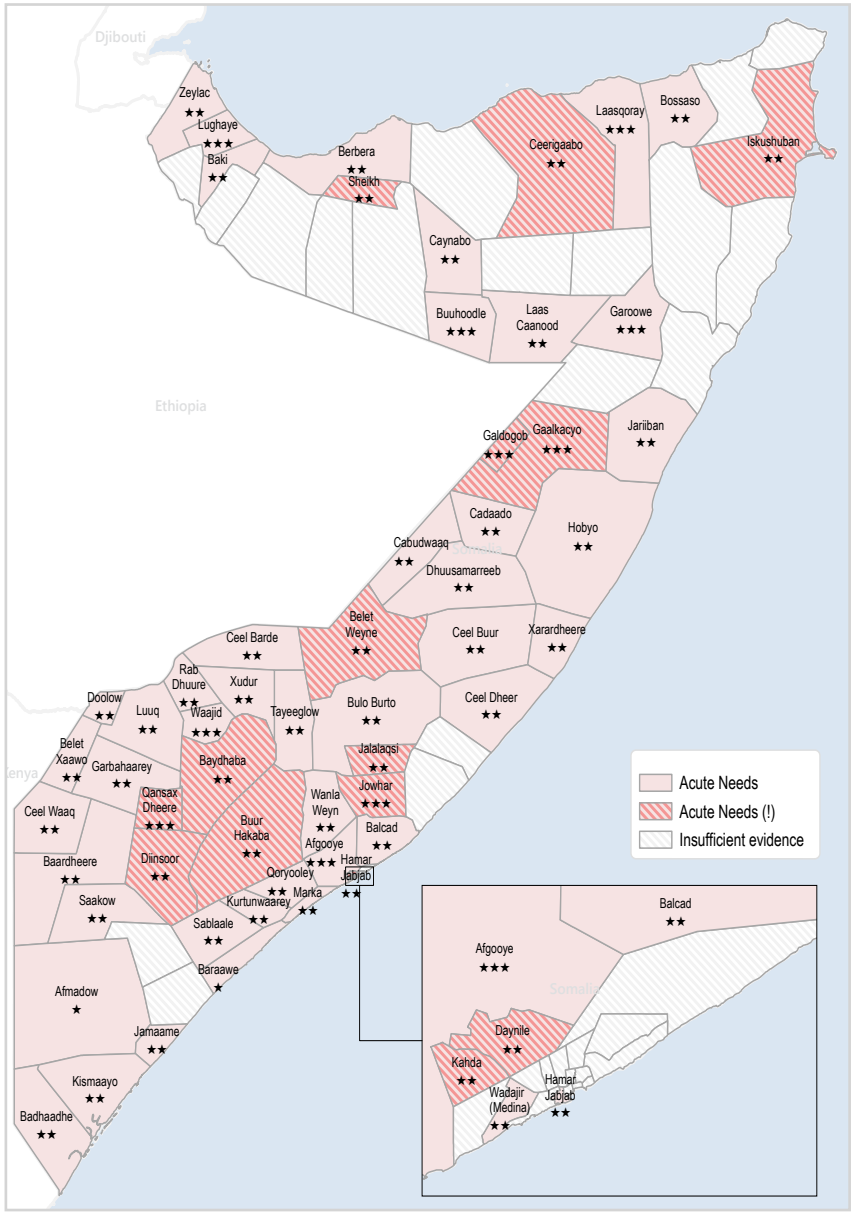
WHAT IS THE ACUTE NEEDS ANALYSIS?

The **2025 Acute Needs Analysis (ANA)** seeks to support needs-based humanitarian prioritisation by **identifying populations facing the most acute, life-threatening needs.** The analysis uses a standardised framework to consolidate a wide range of evidence and develops findings that are **comparable within and across crises**.

The ANA focuses on **intersectoral drivers of mortality to assess the risk of emergency mortality.** The ANA considers the impact of violence and insecurity on (access to) critical services. However, due to the complexity of anticipating conflict dynamics and impacts, **it does not include risk of direct trauma deaths**, nor does it provide a full picture of all humanitarian needs or community priorities.

More info on definitions, methods, and limitations can be found on page 6.

Area-level analytical conclusions and corresponding level of certainty, ranging from low (☆) to high (☆☆☆). More detailed findings per administrative unit can be found in Table 1 and 2 on page 7 and 8.



WHERE ARE THE MOST ACUTE NEEDS?

Somalia continues to face a complex humanitarian situation driven by climate shocks, livelihood instability, and protracted insecurity. These pressures often occur simultaneously, creating environments where households struggle to sustain minimum standards for water access, food consumption, and safe living conditions. Acute needs appear to be widespread across analysed districts, and in some locations risk of large-scale loss of life may be present but could not be confirmed with the available data. Unless otherwise stated, data cited in this report is derived from a REACH MSNA[1] conducted in late 2025 and findings refer to the analysis period of July - December 2025.

Of the ninety (90) districts of Somalia analysed for risk of excess mortality, 31 had insufficient evidence for analysis. The remaining 59 districts analysed revealed acute and potentially severely acute needs (AN), with risks to lives and livelihoods. These include Acute Needs (!) - AN(!), indicating severe deprivations where diagnostic limitations prevent ruling out pathways toward excess mortality. **A total of 14 districts were identified as AN(!), where evidence merits high concern but additional health and nutrition data is required** to assess the risk of excess loss of life. Across districts classified as AN or AN(!), the most severe conditions were observed in IDP settlements and densely populated urban areas, including in Diinsoor, Qansax Dheere, Baydhabo, and Gaalkacyo, where multiple system-level gaps converged.

Gaps in services and systems affecting survival were widespread, with evidence for food insecurity and inadequate sanitation in the majority of

1 REACH MSNA - Multi-Sectoral Needs Assessment (September-October 2025)

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14 districts were classified as AN(!) and 45 as AN, while 31 others had insufficient evidence

assessed locations, including some sub-populations experiencing IPC 4 (emergency) levels of food insecurity. Water and health systems also appeared strained in many locations, and data gaps mean these needs might be more prevelant than recorded.

The persistence of multiple overlapping system pressures and compounding system gaps suggests that conditions remain precarious, and indeed, projected malnutrition outcomes indicate deterioration due to continued drought, displacement and economic shocks.

Intersecting Pressures

Across the districts analysed, severe gaps in living conditions were widespread. Doolow district recorded some of the **most severe shelter gaps, with 95% of households (HHs) living in inadequate shelter conditions.** In Waajid, 94% of HHs reported hygiene concerns due to limited or unsafe latrine access. In Diinsoor, 81% of HHs relied on unimproved sanitation facilities, indicating widespread sanitation inadequacy. This was particularly evident in Iskushuban, where **100% of HHs reported sanitation related safety or protection concerns**, signifying complete avoidance of latrines and bathing facilities, particularly by women and girls, due to security-related risks. Combined with inadequate shelter and unimproved sanitation, these protection barriers increase exposure to environmental and public health hazards.

All (100%) of surveyed HHs in Iskushuban reported protection or safety concerns related to latrines

Limited water access further compounded these pressures and remained widespread across the districts analysed. HHs face a combination of physical barriers to water points, long travel and waiting times, and affordability constraints, which together affect their ability to maintain adequate water consumption for drinking and hygiene. In Diinsoor, **nearly all surveyed HHs (99.7%) reported physical barriers** to accessing water points, while **91% relied on unimproved water** sources for drinking and cooking.

Nearly all (99.7%) of HHs in Diinsoor district reported physical access barriers to water points

Access constraints were also reflected in the time required to collect water. In both Baardheere and Berbera districts, **100% of surveyed HHs reported travel and queue times exceeding 30 minutes** leading to heightened exposure to negative outcomes such as loss of time for other livelihoods and security risks. In addition, water affordability emerged as a major concern. The highest proportions of households spending more than 5% of their income on water[2], were recorded in Diinsoor (78%), Afgooye, Laasqoray, Daynile, and Hobyo (61%).

In total, 13 districts reported that more than 40% of households exceeded this standard threshold, indicating substantial affordability pressures and heightened vulnerability to financial shocks.

Evidence suggests that these costs are driving negative coping strategies. In Diinsoor, 80% of households report reducing water use for hygiene, while 85% report the same in Belet Xaawo, indicating that affordability constraints might be limiting adequate hygiene practices and increasing health risks. Overall, Diinsoor stands out as one of the most severely affected districts in terms of water access, water security, and household water consumption.

Simultaneously, HHs across many districts face significant pressures on their livelihoods and food access. Evidence suggests that these pressures may be driven by economic vulnerability and unstable income sources which exacerbate their vulnerability to shocks such as drought or flood-related crop failure. For instance, **nearly all (98%) of households in Daynile reported relying on atypical or unstable sources of income** - exchange for labour, gifts, begging - followed by 96% in Ceel Waaq and 91% in Jowhar. Such reliance on irregular livelihoods increases vulnerability to environmental and economic shocks. High food expenditure further illustrates this vulnerability, where in Jalalaqsi, **94% of households spent over 75% of total expenditure on food, followed by 81% in Luuq.** While many HHs report spending a substantial proportion (75%) of their expenditure on food, continued availability of food in markets suggests that limited economic access - lack of financial buffers - rather than widespread supply shortages, is a key constraints affecting food consumption. Evidence during the period of analysis indicates that most populations are experiencing food insecurity of IPC Phase 2 or 3, though projections predict an increase in populations in Phase 4 due to severe drought conditions. **Critically, data gaps for several food security indicators remain in some districts**, including Baki, Badhaadhe, and Hamar Jabjab. These gaps limit comparisons across locations and make it harder to assess the risk of excess mortality.

In several districts, these pressures interact simultaneously, where poor living and limited hygiene conditions increase exposure to disease, and economic constraints

2 According to The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response (4th ed., 2018, p. 108), payment for water should not exceed 3–5% of household income. Costs higher than this indicate a lack of affordability and can lead to negative coping mechanisms.

Limited financial buffers in HHs make them highly vulnerable to food access gaps following shocks.

Health/nutrition outcomes - service levels, morbidity, access - play a critical role in interpreting whether system failures are translating into excess mortality risks.

limit HHs' ability to maintain adequate food consumption. These overlapping conditions could lead to deteriorating health outcomes if unmitigated.

Mitigating Factors

Despite widespread structural pressures across food security, water access, and living conditions, available health and nutrition indicators suggest that in some districts, mitigating factors like service provision and use of coping strategies are preventing further deterioration towards excess loss of life.

Across several districts, elevated levels of acute malnutrition and reported health needs were evident, suggesting that the gaps in food, living conditions and water systems are converging to drive severe health outcomes for many populations. For instance, according to the June - September acute malnutrition IPC analysis an expected 1.85 million children were expected to suffer acute malnutrition, and large parts of the country were experiencing IPC 4 (emergency) levels of malnutrition. However, available programme indicators from severe acute malnutrition (SAM) treatment services and/or outpatient therapeutic programs (OTPs) frequently indicate low case fatality and defaulter rates - proportion of patients who begin treatment but do not complete it - well below minimum standard thresholds[3]. These suggest that where present and accessible, health and nutrition services are absorbing some pressure from deteriorating living conditions, water security and livelihood constraints.

In addition, coping strategies may be buffering against further deterioration. **Nearly all HHs in Daynile (99%) and Ceel Waaq (96%) districts rely on unstable sources of income** - such as casual labour, petty trade, remittances, or community support networks or a combination of the above - to maintain minimum levels of consumption during periods of stress. Although these coping mechanisms are often fragile and unsustainable, they may temporarily reduce the likelihood that households experience the most severe outcomes. However, many households already report significant reductions in water consumption for hygiene - up to 85% in Belet Xaawo district and 80% in Diinsoor district - high dependence on unstable income sources, and extremely high proportional expenditure on food and water. These patterns suggest that HHs' coping capacities are under significant strain, and further shocks could rapidly erode the limited mitigations that may currently exist.

While these mitigating factors may currently reduce the likelihood of the most severe outcomes from occurring, they appear increasingly fragile, as they require trade-offs and may be unsustainable in the long-term. Therefore, continued pressure on household resources, combined with ongoing drought conditions in several locations, could rapidly erode these limited buffers and increase the risk of further deterioration.

The Geography of Acute Needs

Despite common pressures evident across food security, water access, and living conditions, these constraints converge differently between distinct geographies.

To the north, **Ceerigaabo reflects a setting where chronic service deficits continue to shape daily life.** Water and sanitation pressures are severe, with 73% of HHs facing physical barriers to water points, 66% relying on unimproved water sources, and 75% reducing water used for hygiene, indicating a severely constrained WASH system. Living conditions further heighten exposure to health risks, with 79% of HHs living in inadequate shelter. Although food availability appears relatively stable and both SAM admissions and defaulter numbers (proportion of patients who begin treatment but do not complete it) have declined, these mitigating factors remain fragile. Economic pressure also remains intense, with 36% of HHs spending more than 75% of their income on food and 26% relying on unstable income sources, sustaining a vulnerability profile that appears more deep-rooted and structural than directly induced by a recent, large-scale shock.

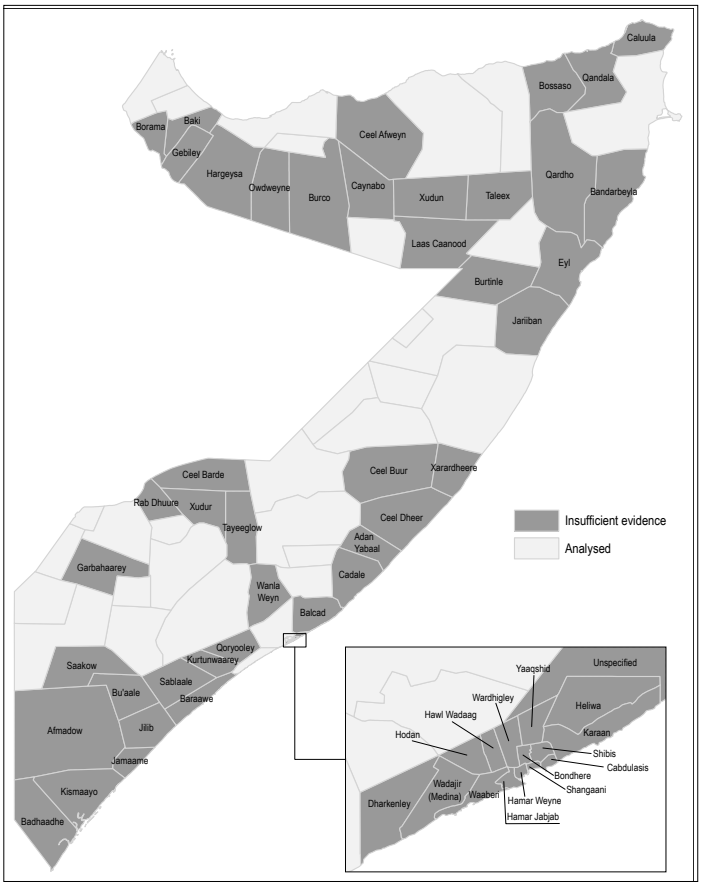
In central Somalia, **Gaalkacyo presents a distinct convergence of pressures** shaped by severe water stress, significant food and livelihood strain, and substandard shelter. Food insecurity has reached AFI-IPC Phase 3, driven by high expenditure burdens, with 45% of HHs spending ≥75% of their income on food, alongside livelihood insecurity, reflected in 74% depending on unstable income sources. Though infrastructure appears to remain generally functional, from the evidence analysed, water systems remain under strain, with 49% reducing water used for hygiene, 46% spending over 5% of income on water, and 24% facing physical access barriers. Living conditions also reinforce vulnerability, with 47% of HHs living in inadequate shelter and 39% reporting hygiene issues in latrines. Notwithstanding a GAM prevalence of 16%, mitigation capacity

3 Sphere Standard 2.2 (p. 178), minimum performance thresholds of <10% mortality and <15% default rates

seem evident, and despite a high cholera case count, no reported cholera fatalities and no deaths and declined defaulters in SC/outpatient therapeutic programmes (OTPs). Service indicators suggest some mitigating capacity may be present, but evidence gaps in health and nutrition outcomes mean it is not possible to determine with confidence whether these factors are sufficient to prevent excess mortality on a wider scale.

Families rely on coping strategies that buffer short term needs but may be increasingly unsustainable.

Further south, **Kismaayo reflects a comparatively stable yet vulnerable context,** where vulnerability is shaped less by acute shocks than by continued reliance on coping strategies and external assistance. Market conditions remain somewhat positive, with Terms of Trade - % change in ToTs for staple foods improving by 23% and no recent food price spikes observed, indicating a degree of moderation in economic pressure. However, this relative market stability does not seem to have translated into improved household self-sufficiency. Around 38% of HHs rely on atypical food sources, alongside humanitarian assistance (12%) and high reliance on consumption-based coping strategies (33%), signalling dependence rather than self-sustaining resilience. Health and nutrition outcomes reinforce this pattern of mitigation. While GAM prevalence remains elevated at 15% and 101 suspected or confirmed cholera cases have been reported, the absence of reported cholera fatalities (0) and of SAM deaths and defaulters indicates that essential services may be functional and are likely limiting further deterioration especially to those able to access these services. Kismaayo thus reflects a setting where pressures are present but likely remain partially mitigated.



Map showing districts with insufficient data for preliminary RoEM analysis.

In the south-west, vulnerability presents differently across Baydhaba, Qansax Dheere, and Diinsoor. **Baydhaba reflects layered but relatively contained vulnerability;** food insecurity is most pronounced among IDPs, while most urban HHs maintain acceptable FCS (82%). Economic pressure remains significant, with 51% of HHs spending most of their income on food and 65% relying on unstable income sources, while WASH and shelter conditions also show strain, with 57% reducing water for hygiene and 57% living in inadequate shelter. Despite a GAM prevalence of 19%, the absence of reported mortality, stable treatment performance, and generally accessible health services suggest mitigation capacity that is likely limiting adverse deterioration.

In Qansax Dheere, conditions appear more fragile, shaped by worsening economic access, including a 37% decline in Terms of Trade for staple food and 33% of HHs spending ≥75% of their income on food. Water and sanitation pressures are also severe, with 52% relying on unimproved water sources, 70% reducing water use for hygiene, 58% spending above affordability thresholds, and 53% living in inadequate shelter. Although mitigation remains evident, with 91% of HHs able to access health facilities within an hour and no SAM deaths or defaulters reported, affordability remains a key constraint increasing the risk of further deterioration.

Diinsoor reflects the most acute service-related strain observed, with water system failure emerging as the dominant driver of vulnerability: 91% of HHs rely on unimproved water sources, 80% reduce water used for hygiene, 78% spend over 5% of income on water, nearly 100% face physical barriers to water points and 81% reliance on unimproved sanitation facilities. These conditions might be driving the risk of excess mortality, though more data on health/nutirion is necessary to acertain the mitigation levels of these conditions.

ESTIMATES OF MAGNITUDE

In addition to the geography of acute needs, the ANA sought to capture an estimate of the magnitude of needs to **help identify where the risk of loss of life is greatest** and ensure that small pockets of the population with very severe needs living outside of areas categorised with RoEM **are not overlooked.**

The estimate of magnitude provides **an indicative range of the number of people at risk of preventable loss of life** due to public health causes. It combines data on overlapping deprivations in food, water, and living conditions with information on health-related vulnerabilities and the mitigating capacity of health systems. The calculation method requires household-level data.

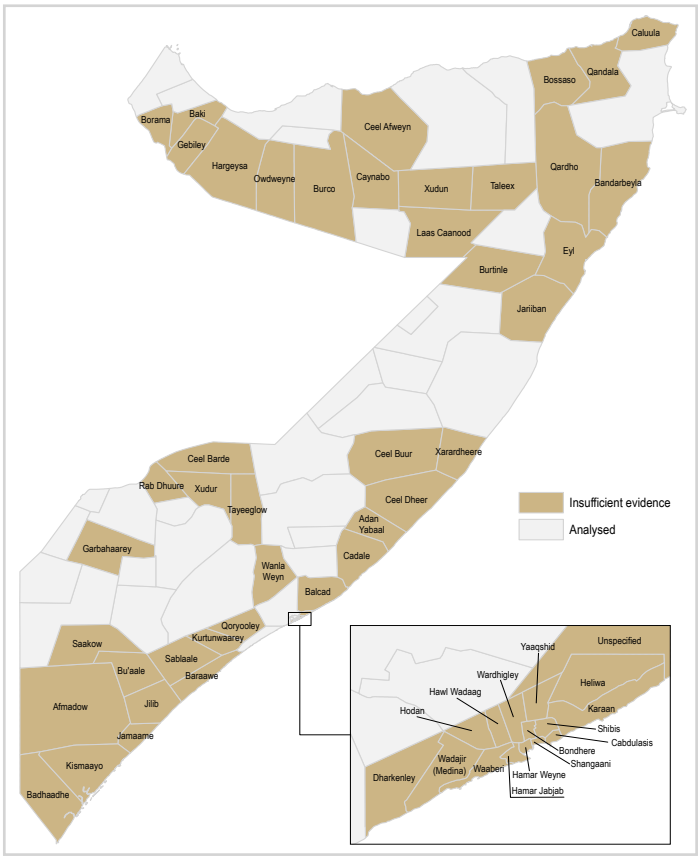
Comparing magnitude estimates with severity classifications revealed important differences between the scale and intensity of needs across districts. Several areas classified as AN(!), including Daynile, Gaalkacyo, Jowhar, and Baydhaba, stand out as both highly severe and affecting larger populations, with upper-bound estimates of those at risk reaching up to 20% of the total district population. Laasqoray recorded the highest upper-bound proportion of district population at risk, at 25%. These districts represent critical priority areas where both the depth and scale of needs are substantial.

In contrast, other AN(!) districts such as Sheikh, Iskushuban, and Jalalaqsi exhibit high proportional risk but smaller number of affected given the smaller district population. This indicates more localised yet very severe conditions. At the same time, some districts not classified as AN(!), such as Afgooye and Marka, still account for large numbers of people at risk, highlighting that substantial humanitarian burden exists beyond the most severe classifications.

Overall, these patterns demonstrate that severity and scale may not always align, and that pockets of need can be missed when looking only at area-level classifications. Furthermore, given that magnitude estimates were only available for a subset of districts, the total scale of risk is likely underestimated, particularly in data-scarce areas.

In Somalia, limitations on data availability meant that some district estimates of magnitude could not be calculated. As shown on the map below, 57 districts were without sufficient data for this part of the analysis, preventing meaningful overall conclusions.

Of the 33 districts with magnitudes estimated, constituting 44% of the total population of districts in Somalia - representing approximately 8.5 million with an estimate of 4% to 13% of estimated population appearing to be at risk of preventable loss of life due to converging acute needs and limited mitigations.



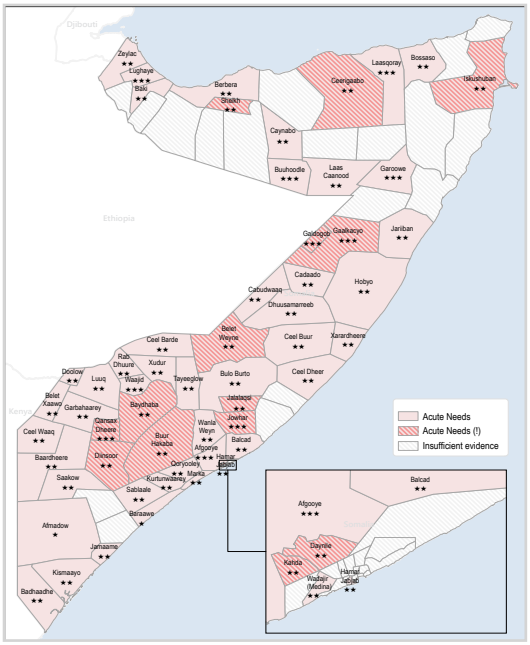
Map showing districts with insufficient data for magnitude estimates

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 or Training and Research - Operational Satellite Applications Programme (UNITAR - UNOSAT).

ANNEX 1: METHODOLOGY OVERVIEW

WHO IS NOT INCLUDED IN THE ANALYSIS?



The analysis of Risk of Excess Mortality (RoEM) is limited by missing system-level outcome data and also by the exclusion of certain districts where evidence was too sparse to assess risk confidently. On the Map, these areas appear as insufficient evidence, often places that lack sufficient reporting on mortality, disease surveillance, or household coping trends to be included in the analysis. This means that while we can identify districts showing elevated needs and multi-system strain, we cannot confirm whether conditions excluded or data-poor areas have crossed into mortality-driven emergencies.

For this report, the findings reflect only where data was enough to analyse, and they may understate risks in places where households face severe stress but evidence is incomplete.

HOW WAS THE ANALYSIS CONDUCTED?

The ANA is a structured analysis designed to identify populations facing the most acute, life-threatening conditions resulting from a breakdown of critical systems in contexts in which mortality data is unavailable. It aims to inform big-picture humanitarian prioritisation decisions.

The analysis assesses the functionality of critical systems (health, nutrition, food, water, and living conditions), triangulated with immediate mortality drivers (acute malnutrition and morbidity). Severe deprivations in any or multiple of these public health systems are investigated further to determine whether they are severe enough to result in a Risk of Excess Mortality (RoEM).

The analysis consists of two critical phases. During the quantitative phase, preliminary "flags" are raised when emergency thresholds are exceeded across multiple indicators, based on global reference frameworks (SPHERE, WHO, IPC, etc.). Analysts then verify, triangulate, and interpret these flags with contextual evidence during the Deep-dive phase, using structured analysis techniques, to reach a final ANA category for each area or group:

- **Excess Mortality:** Timely evidence confirms mortality rates exceed the World Health Organisation (WHO) Emergency Threshold (>1 death/10,000 people/day, >2 for children under 5 years old).
- **Risk of Excess Mortality (RoEM):** Very severe gaps in multiple mortality drivers are interacting in a way that suggests excess mortality is likely occurring within the analysis timeframe, or is imminent.
- **Acute Needs (AN):** Evidence confirms very severe gaps in at least one mortality driver, but not to the extent that there is immediate concern for excess mortality.
- **No evidence of AN:** There is no evidence of very severe gaps in mortality drivers.

In some cases, (nearly) all available evidence suggests potential concern for RoEM due to multiple systems failing, but a specific data gap prevents final confirmation of RoEM. Those areas are categorised as **"Acute Needs (!)".**

DISCLAIMER

While the analysis framework and process are standardised to promote consistency and reduce cognitive biases, conclusions depend on the availability, reliability, and timeliness of data, as well as the quality of contextual interpretation. Each area is assigned an **analytical certainty score,** reflecting the degree of confidence in the conclusion (★/★★/★★★) based on the type and quality of the data and the strength of triangulation.

The ANA does not speak to community priorities and should not replace sectoral assessments, nor does it provide a comprehensive view of the full breadth and depth of intersectoral humanitarian needs.

The ANA considers the impact of violence and insecurity on access to and functionality of critical systems, and its possible cascading impacts on public health. However, due to limitations in nowcasting and anticipating conflict dynamics, **the ANA does not assess the risk of direct trauma deaths.**

The ANA in Somalia assesses the situation in the period **July-December 2025**. **Contextual changes after this time window have not been reflected in the results.**

More detailed information on the methodology and its limitations can be accessed here

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ANNEX 2: ANALYSIS CONCLUSIONS

Unit of Analysis	Analytical Conclusion	Certainty Score
Adan Yabaal	Insufficient evidence	N/A
Afgooye	Acute Needs	☆☆☆
Afmadow	Acute Needs	☆
Baardheere	Acute Needs	☆☆
Badhaadhe	Acute Needs	☆☆
Baki	Acute Needs	☆☆
Balcad	Acute Needs	☆☆
Bandarbeyla	Insufficient evidence	N/A
Baraawe	Acute Needs	☆
Baydhaba	Acute Needs (!)	☆☆
Belet Weyne	Acute Needs (!)	☆☆
Belet Xaawo	Acute Needs	☆☆
Berbera	Acute Needs	☆☆
Bondhere	Insufficient evidence	N/A
Borama	Insufficient evidence	N/A
Bossaso	Acute Needs	☆☆
Bu'aale	Insufficient evidence	N/A
Bulo Burto	Acute Needs	☆☆
Burco	Insufficient evidence	N/A
Burtinle	Insufficient evidence	N/A
Buuhoodle	Acute Needs	☆☆☆
Buur Hakaba	Acute Needs (!)	☆☆
Cabdulasis	Insufficient evidence	N/A
Cabudwaaq	Acute Needs	☆☆
Cadaado	Acute Needs	☆☆
Cadale	Insufficient evidence	N/A
Caluula	Insufficient evidence	N/A
Caynabo	Acute Needs	☆☆
Ceel Afweyn	Insufficient evidence	N/A
Ceel Barde	Acute Needs	☆☆
Ceel Buur	Acute Needs	☆☆
Ceel Dheer	Acute Needs	☆☆
Ceel Waaq	Acute Needs	☆☆
Ceerigaabo	Acute Needs (!)	☆☆
Daynile	Acute Needs (!)	☆☆
Dharkenley	Insufficient evidence	N/A
Dhuusamarreeb	Acute Needs	☆☆
Diinsoor	Acute Needs (!)	☆☆
Doolow	Acute Needs	☆☆
Eyl	Insufficient evidence	N/A
Gaalkacyo (North&south)	Acute Needs (!)	☆☆☆
Galdogob	Acute Needs (!)	☆☆☆
Garbahaarey	Acute Needs	☆☆
Garoowe	Acute Needs	☆☆☆
Gebiley	Insufficient evidence	N/A
Hamar Jabjab	Acute Needs	☆☆
Hamar Weyne	Insufficient evidence	N/A
Hargeysa	Insufficient evidence	N/A

ANNEX 2: ANALYSIS CONCLUSIONS

Unit of Analysis	Analytical Conclusion	Certainty Score
Hawl Wadaag	Insufficient evidence	N/A
Heliwa	Insufficient evidence	N/A
Hobyo	Acute Needs	☆☆
Hodan	Insufficient evidence	N/A
Iskushuban	Acute Needs (!)	☆☆
Jalalaqsi	Acute Needs (!)	☆☆
Jamaame	Acute Needs	☆☆
Jariiban	Acute Needs	☆☆
Jilib	Insufficient evidence	N/A
Jowhar	Acute Needs (!)	☆☆☆
Kahda	Acute Needs (!)	☆☆
Karaan	Insufficient evidence	N/A
Kismaayo	Acute Needs	☆☆
Kurtunwaarey	Acute Needs	☆☆
Laas Caanood	Acute Needs	☆☆
Laasqoray	Acute Needs	☆☆☆
Lughaye	Acute Needs	☆☆☆
Luuq	Acute Needs	☆☆
Marka	Acute Needs	☆☆
Owdweyne	Insufficient evidence	N/A
Qandala	Insufficient evidence	N/A
Qansax Dheere	Acute Needs (!)	☆☆☆
Qardho	Insufficient evidence	N/A
Qoryooley	Acute Needs	☆☆
Rab Dhuure	Acute Needs	☆☆
Saakow	Acute Needs	☆☆
Sablaale	Acute Needs	☆☆
Shangaani	Insufficient evidence	N/A
Sheikh	Acute Needs (!)	☆☆
Shibis	Insufficient evidence	N/A
Taleex	Insufficient evidence	N/A
Tayeeglow	Acute Needs	☆☆
Waaberi	Insufficient evidence	N/A
Waajid	Acute Needs	☆☆☆
Wadajir (Medina)	Acute Needs	☆☆
Wanla Weyn	Acute Needs	☆☆
Wardhigley	Insufficient evidence	N/A
Xarardheere	Acute Needs	☆☆
Xudun	Insufficient evidence	N/A
Xudur	Acute Needs	☆☆
Yaaqshid	Insufficient evidence	N/A
Zeylac	Acute Needs	☆☆

ANNEX 3: LIST OF SOURCES

The 2025 ANA in Somalia draws on data from the following sources:

1. REACH MSNA 2025 PHASE 2
2. Somalia 2025 Post Gu IPC AFI Analyses Population Estimates and Classification
3. IPC post Gu partner data 2025 (WFP)
4. WFP VAM IPC Food Security Data
5. IOM DTM
6. EPI Coverage Data (Somalia Nutrition Cluster)
7. AWD/ suspected Cholera Weekly Epidemiological Report
8. Nutrition cluster dashboard SC admissions
9. FSNAU EW-EA Dashboard
10. Diseases reported_IDSR_DHIS2
11. REACH SOMALI JMMI