IPC Integrated Food Security Phase Classification
Evidence and Standards for Better Food Security and Nutrition Decisions

SOMALIA

AS DROUGHT CONDITIONS WORSEN, 4.4 MILLION SOMALIS WILL FACE HIGH LEVELS OF ACUTE FOOD INSECURITY; 1.7 MILLION CHILDREN LIKELY TO SUFFER FROM ACUTE MALNUTRITION

IPC ACUTE FOOD INSECURITY AND ACUTE MALNUTRITION ANALYSIS
JANUARY - JUNE 2025
Published on 24 February 2025

CURRENT SITUATION : JANUARY - MARCH 2025

3.4 M

17 % of the analysed population

People facing high levels of acute food insecurity (IPC Phase 3 or above)

IN NEED OF URGENT ACTION

Phase 5	0 People in Catastrophe
Phase 4	442,000 People in Emergency
Phase 3	2,954,000 People in Crisis
Phase 2	6,526,000 People in Stressed
Phase 1	9,358,000 People in food security

PROJECTED SITUATION: APRIL - JUNE 2025

4.4 M

23 % of the analysed population

People facing high levels of acute food insecurity (IPC Phase 3 or above)

IN NEED OF URGENT ACTION

Phase 5	0 People in Catastrophe
Phase 4	741,000 People in Emergency
Phase 3	3,649,000 People in Crisis
Phase 2	6,947,000 People in Stressed
Phase 1	7,945,000 People in food security

ACUTE MALNUTRITION: JANUARY - DECEMBER 2025

1.7M
cases of children aged 6-59 months acutely malnourished

IN NEED OF TREATMENT

Severe Acute Malnutrition (SAM)	466,000
Moderate Acute Malnutrition (MAM)	1,257,000

Overview

The food security situation in Somalia remains precarious: the below average rainfall between October and December 2024 led to a substantial reduction in crop production in agropastoral and riverine livelihoods, and faster pasture and water depletion in pastoral areas. Localized floods in riverine areas in Hiraan, Middle Shabelle and Middle Juba, and insecurity and conflict in central and southern Somalia and some parts of northern regions caused population displacement, disrupted livelihood activities and market access. Therefore, between January to March 2025, 3.4 million people are experiencing high levels of acute food insecurity (IPC Phase 3 or above), representing almost 17 percent of the population analysed. This includes more than 2.9 million people (15 percent of the population) in IPC AFI Phase 3 (Crisis), and around 442 000 people (2 percent of the population) experiencing worse conditions in IPC AFI Phase 4 (Emergency). Out of the 119 areas analysed, 45 are classified in IPC AFI Phase 3 (Crisis) while 72 appears in IPC Phase 2 (Stressed).

Key Drivers of Acute Food Insecurity

Poor rainfall: Below average 2024 Deyr season (October-December) rainfall affected agropastoral areas; additional impact expected due to anticipated below average 2025 Gu season (April-June) rainfall.

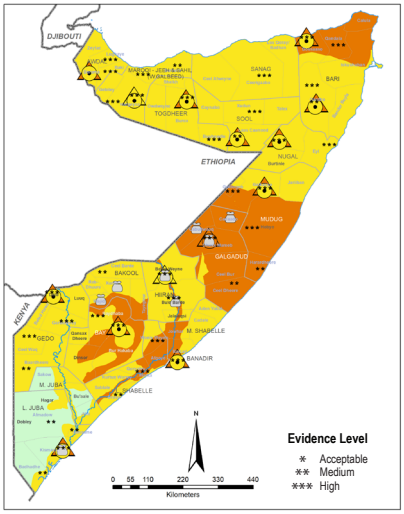
Flooding: Riverine floods caused population displacement and crop losses in some southern parts of Somalia during 2024 Deyr season and localized flooding expected to cause additional damage during 2025 Gu..

Conflict and insecurity: Persistent conflict and insecurity likely to result in population displacement, disrupt market access and functionality, hinder households' access to livelihood opportunities, and humanitarian assistance.

High food prices: Both local and imported food prices are expected to trend above the five-year averages due to the poor Deyr harvest, limited carryover stocks and high shipping costs.

Diseases and poor health access: Low access to adequate water, sanitation, hygiene, immunization and other health services contributes to increased disease and malnutrition.

Current Acute Food Insecurity (Jan - Mar 2025)



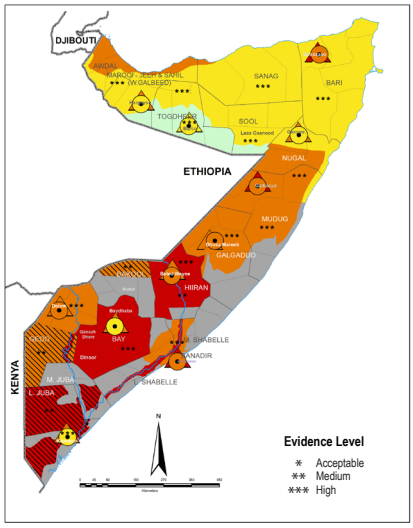
Key for the Map
IPC Acute Food Insecurity Phase Classification

- 1 - Minimal
- 2 - Stressed
- 3 - Crisis
- 4 - Emergency
- 5 - Famine

Map Symbols
- Urban settlement classification
- IDPs/other settlements classification

Area receives significant humanitarian food assistance
(accounted for in Phase classification)
- > 25% of households meet 25-50% of caloric needs through assistance
- > 25% of households meet > 50% of caloric needs through assistance

Current Acute Malnutrition (Jan - Mar 2025)



Key for the Map
IPC Acute Malnutrition Phase Classification

- 1 - Acceptable
- 2 - Alert
- 3 - Serious
- 4 - Critical
- 5 - Extremely critical
- Phase classification based on MUAC
- Areas with inadequate evidence

Map Symbols
- Urban settlement classification
- IDPs/other settlements classification

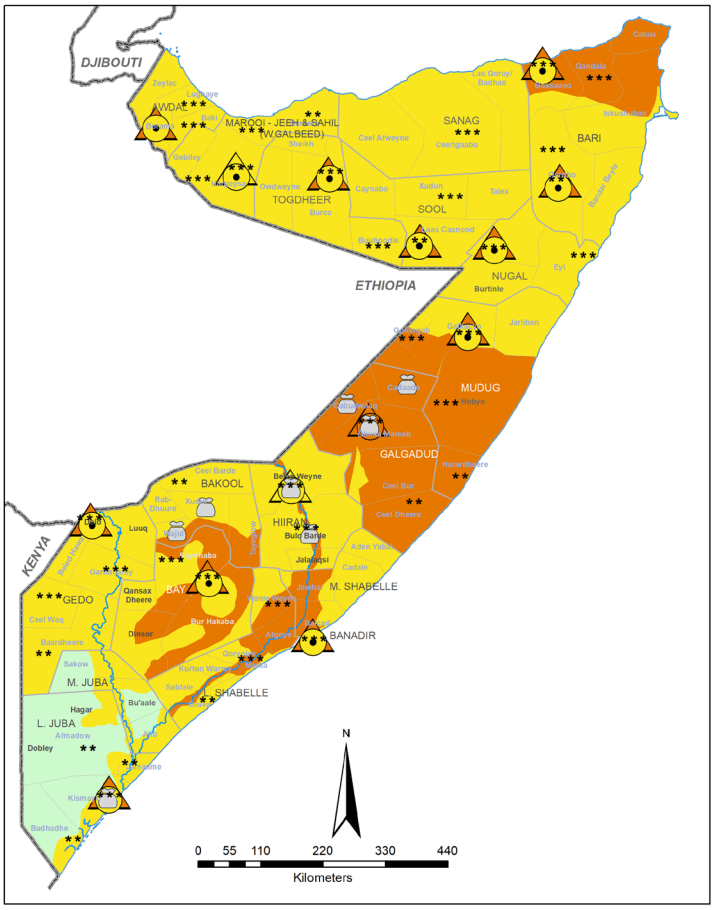
The most affected households are those with low agricultural production that have exhausted their food stocks, IDPs, poor pastoralists who own few animals and earned below-average income from livestock. These households are found throughout the country but are most represented in the areas classified in crisis (IPC Phase 3). These households should be supported with urgent humanitarian food assistance aimed at saving lives, reducing food consumption deficits and protecting livelihoods. In comparison to the same period last year, when approximately 4 million people were classified in IPC Phase 3 or above (Crisis or worse), the current figure of 3.4 million people represents a 15 percent reduction. This is attributed to relatively better rainfall over the past two seasons with a positive impact on livelihoods and continued humanitarian assistance, albeit at a reduced level.

Between April and June 2025, Gu season rainfall is likely to be below normal. However, if appropriate measures are not taken, food security situation is expected to further worsen in this projected period due to high food prices, conflict and civil insecurity, as well as localized flooding. Consequently, the number of people facing IIPC Phase 3 or above (Crisis or worse) is expected to increase to 4.4 million (23 percent of the population) during April to June 2025. During this period, for urban IDPs in Dhusmareeb (Galgaduud) and urban populations in abudwaaq, Cadaado, Ceel Buur and Ceel Dheer (Galgaduud), the food security situation is expected to deteriorate from IPC Phase 3 (Crisis) to IPC Phase 4 (Emergency).

In terms of acute malnutrition, between January and December 2025, an estimated 1.7 million children aged 6–59 months are expected to suffer from acute malnutrition (GAM). This includes approximately 466 000 children likely to be severely malnourished (SAM). Most of the acutely malnourished children are concentrated in southern Somalia. Compared to the same season last year, the current estimates represent 4 percent increase in GAM and a 9 percent increase in SAM.

In terms of severity, among the 45 areas analysed – across rural, urban, and IDP population groups – 11 are classified in IPC AMN Phase 4 (Critical), 21 in Phase 3 (Serious) and 12 in Phase 2 (Alert) for the January to March 2025 period. For the projection period from April to June 2025, conditions are expected to deteriorate, with the number of areas in Phase 4 increasing to 15 and several areas shifting from Phase 2 to Phase 3.

ACUTE FOOD INSECURITY CURRENT MAP AND POPULATION TABLE (JANUARY - MARCH 2025)



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Area receives significant humanitarian food assistance
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- > 25% of households meet 25-50% of caloric needs through assistance
- > 25% of households meet > 50% of caloric needs through assistance

Evidence Level

- * Acceptable
- ** Medium
- *** High

Population table for the current period: January - March 2025

Region	Total population analysed	Phase 1	Phase 2	Phase 3	Phase 4	Phase 5
		#people	#people	#people	#people	#people
Awdal	655,893	369,860	204,750	72,650	8,600	-
Bakool	560,266	288,120	159,510	102,460	10,200	-
Banadir	3,262,132	1,698,780	944,780	542,660	75,910	-
Bari	1,270,552	551,280	472,200	205,960	41,090	-
Bay	1,286,786	588,490	377,070	282,080	39,160	-
Galgaduud	837,918	163,420	376,220	225,840	72,460	-
Gedo	1,005,923	597,100	283,700	106,570	18,560	-
Hiraan	520,516	262,600	182,670	56,330	18,940	-
Lower Juba	1,194,276	714,530	321,230	139,120	19,370	-
Lower Shabelle	1,642,667	828,730	502,920	288,230	22,790	-
Middle Juba	443,506	292,420	112,150	38,940	-	-
Middle Shabelle	1,044,873	500,080	355,110	176,470	13,210	-
Mudug	1,516,035	476,590	688,810	286,520	64,100	-
Nugaal	651,465	297,850	261,630	91,960	-	-
Sanaag	442,034	194,200	176,840	68,170	2,820	-
Sool	566,052	224,390	258,710	78,400	4,500	-
Togdheer	887,449	436,320	363,080	75,040	13,050	-
Woqooyi Galbeed	1,492,507	873,700	484,780	116,350	17,670	-
Grand Total	**19,280,850**	**9,358,460**	**6,526,160**	**2,953,750**	**442,430**	-

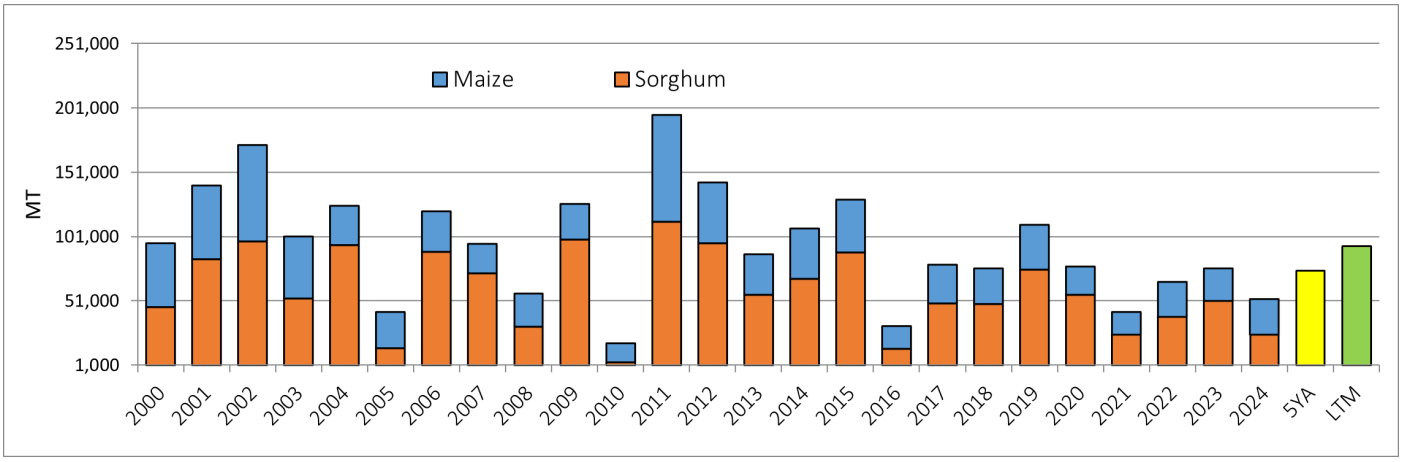
Note: A population in Phase 3+ does not necessarily reflect the full population in need of urgent action. This is because some households may be in Phase 2 or even 1 but only because of receipt of assistance, and thus, they may be in need of continued action.

ACUTE FOOD INSECURITY CURRENT SITUATION OVERVIEW AND KEY DRIVERS (JANUARY-MARCH 2025)

The January 2025 Somalia IPC Acute Food Insecurity (AFI) analysis was based on food security, nutrition and mortality assessments conducted by the Food Security and Nutrition Analysis Unit (FSNAU) of FAO in collaboration with government institutions, local universities, UN agencies, NGOs and technical partners. between November and December 2024 and additional data on contributing factors from diverse sources. Accordingly, approximately 3.4 million Somalis are experiencing high levels of acute food insecurity (IPC Phase 3 or above) between January and March 2025. Humanitarian assistance is needed to prevent the worsening of food security and nutrition outcomes in the country. An additional 6.5 million people are Stressed (IPC Phase 2), bringing the total number of people experiencing food insecurity (IPC Phase 2 or above) to 9.9 million.

Several regions are facing significant challenges leading to acute food insecurity between January and March 2025. These include, Northeast East Golis, all central livelihoods (Hawd, Addun, Coastal Deeh pastoral, and cowpea belt agro-pastoral), Hiran riverine, Shabelle gravity irrigation and Sorghum high potential agropastoral Bay and Bakool agro-pastoral (Low potential). These areas are classified as being in Crisis (IPC Phase 3), experiencing significant food consumption gaps, high levels of malnutrition, or resorting to emergency coping strategies to meet minimum food needs. While most of the pastoral and agro-pastoral areas in the north and south remain classified as Stressed (IPC Phase 2), they have minimally adequate food consumption but may need to employ non-sustainable strategies to meet other essential needs. These areas include: Guban, West Golis, East Golis, of Northern Inland Pastoral, Hawd Pastoral, Togdher, and Waqoyi Galbeed Agro-pastoral of the Northwest. Coastal Deeh, Hawd, Addun, and Northern Inland Pastoral of the Northeast and Hawd of Hiran, Bakool, Hiran, Gedo, and Middle Juba Southern Agro-pastoral, Bay, Bakool, Hiran, and Central Southern Inland Pastoral, Bay, Bakool, Gedo, and Middle Juba High Potential Agro-pastoral, agro pastoral Rain-fed Maize of Juba and Lower Shabell and Cowpea Belt Agro-pastoral in Shabelle and Hiran. In the same period, the southern inland pastoral livelihoods of the Juba regions are classified as Minimal (IPC Phase 1), indicating a food-secure situation during the current analysis period. The situation for Internally Displaced People (IDPs) in Somalia remains critical. Many settlements are classified as being in Crisis (IPC Phase 3), indicating acute food insecurity and an urgent need for assistance. Urban populations, while slightly better off, still face significant challenges, including high food prices, limited livelihood opportunities and conflict in some areas. Most urban areas are classified as Stressed (IPC Phase 2). Exceptions are urban populations in Galgadud, Sanaag and Xudur (Bakook) classified as being in Crisis (IPC Phase 3), reflecting the ongoing struggle to meet basic food needs.

Trends in Deyr Season Cereal Production in Southern Somalia (1995-2024)



The October to November 2024 Deyr rains started very late in most areas (between late October and the end of November), with intermittent dry spells. Exceptions include parts of the Northwest, Awdal, W. Galbeed regions, and parts of the Bay region, where moderate Deyr rains started on time. The Deyr 2024 rains were below-average to poor over Central and Southern Somalia, particularly in most parts of Mudug, Galgaduud, Hiraan, Middle Juba, parts of Bay, Shabelle

regions, and Gedo region, negatively affecting crop growth and development in most agro-pastoral livelihoods, as well as pasture and browse regeneration and the refilling of natural water sources. The impact of the short -lived, erratic temporal and spatial distribution of the Deyr rains being exacerbated by a hot, harsh Jilaal season (January to March 2025) due to the present La Niña conditions, which are expected to persist through February-April 2025 (59 percent chance). These conditions are likely to intensify water shortages in most of the country, increasing evaporation rates, stressing livestock and crops, and reducing soil moisture. Localized floods affected riverine areas in Hiraan, Gedo, Middle Shabelle, and Middle Juba regions, causing temporary population displacement, crop losses, and disruptions to market access.

The 2024 Dyer season crop production in southern Somalia is estimated to be 52 200 metric tons, including 7 900 metric tons of off-season harvest expected in late January/February 2025, 44 percent below long-term average (LTM) for 1995-2023. This level of poor crop production is attributed to a combination of factors including erratic rainfall patterns, extended periods of dry spells, insecurity, instances of flooding, pest infestations, and a lack of necessary farming inputs. Similarly, in the Northwest, the 2024 Gu/Karan cereal harvested in October/November 2024 is estimated to be 10 600 metric tons, 62 percent lower than the average for 2010-2023, mainly due to poor and erratic rainfall, flash floods and pests.

Despite the presence and availability of dry pasture and carryover biomass from the 2024 Gu season, the delayed and erratic onset of Deyr season rainfall in October/December 2024 has negatively impacted rangeland conditions in most of the country, deteriorating pasture, browse, and water availability in key pastoral areas, prompting livestock migration to areas with better conditions. However, some northern regions experienced average to above average rainfall. Water prices are higher compared to the five-year average and year ago, due to decreased water availability. The birth rates for all species are medium to low, contributing to average milk production and availability nationwide.

The Terms of Trade (ToT) between livestock species and cereals, as well as herd sizes, showed a slight improvement in several areas of the northwest and southern regions. This was driven by favorable conditions during the past Gu season, which contributed to herd growth and marginally improved food access, particularly for pastoral households. However, in many areas of the central and northeast regions, herd sizes remained below baseline levels, or the ToT was unfavorable, limiting the improvements in food access in those regions.

As of December 2024, prices of maize and sorghum showed mild to moderate increase compared to last Gu2024, year ago and five-year average. Limited supply from Deyr harvest, and depletion of the national cereal stocks are the main reasons on cereal prices increase. International prices of all major cereals increased in December compared to July 2024 and five-year average amid ample global supply but are still above average due to weak local currency, conflict and high transport costs. The Cost of the Minimum Expenditure Basket (CMB) has seen a moderate increase compared to the five years average.

Based on UNHCR's Protection and Return Monitoring Network (PRMN) data, approximately 313,395 people were displaced between July to December 2024, mainly due to insecurity/conflict (67 percent) and 24 percent for other reasons. Most conflict related displacements occurred in in Gedo, followed by Tog-dheer, Lower Juba, Lower Shabelle and Mudug regions.

Humanitarian assistance, including food, cash, and other forms of aid, has continued to play a crucial role in mitigating severe food security and nutrition outcomes in many regions. However, since July 2024, the provision of humanitarian food and cash assistance has been on the decline, primarily due to funding constraints. Between July and September 2024, food and cash assistance reached an average of 1.2 million people per month, but this number decreased to 0.9 million between October and December 2024. Funding shortages have already compelled humanitarian partners to scale down their response, prioritizing the most vulnerable populations in areas with the greatest need. In the context of inadequate funding, planned humanitarian food assistance will only reach 1.3 million people between January and March 2025.

Outcome Data

The Somalia 2024 Post Deyr IPC analyses was conducted through a collaborative effort involving a wide range of food security and nutrition partners. It utilised survey data from multiple sources. The Food Security and Nutrition Analysis Unit (FSNAU) carried out surveys in 15 rural livelihoods, 11 urban towns, and 11 IDP settlements, while WFP conducted eight additional assessments covering rural, urban, and IDP areas, and Save the Children International (SCI)conducted a survey in Matabaan district (Hiran). The analysis covered various food security and nutrition outcome indicators: Food Consumption Score (FCS), Household Dietary Diversity Score (HDDS), Reduced Coping Strategies Index (rCSI), Household Hunger Scale (HHS), Livelihood Coping Strategies (LCS), Global Acute Malnutrition (GAM) prevalence, Crude Death Rate (CDR), and Under-Five Death Rate (U5DR).

Based on household survey data from FSNAU, WFP and SCI, household food consumption assessment (7-day recall, FCS) revealed that:

- 11 population groups had over 20 percent of households experiencing poor food consumption, indicative of an IPC Phase 4 (Emergency). These include Northern Inland Pastoral of Northwest (49 percent) and Dhusamareeb IDPs (30 percent).
- 20 groups had 20 percent or more households with borderline food consumption, falling into an indicative Crisis situation (IPC Phase 3).
- The remaining 32 population groups had acceptable food consumption levels, indicating Minimal or Stressed (IPC Phase 1 or 2).

In Somalia, dietary diversity tends to remain somewhat stable, even in difficult periods. The Household Dietary Diversity Score (HDDS) (24-hour recall) showed:

- More than 20 percent of households in certain groups had HDDS scores of 3–4, classifying them in an indicative IPC Phase 3 (Crisis).
- 12 population groups (including East Golis Pastoral of Bari, Bossaso Urban, and Dhusamareeb Urban) reported over 30 percent of households consuming only 3–4 food groups indicative of an IPC Phase 3 (Crisis).
- The remaining 63 groups had 20 percent or more households with HDDS scores of 5 or higher, indicating Minimal or Stressed (IPC Phase 1 or 2).

The Reduced Coping Strategies Index (rCSI) (7-day recall) showed:

- 18 out of 63 population groups surveyed had 20 percent or more households employing crisis-level coping strategies (rCSI score ≥19, IPC Phase 3).
- Mataban district and Dhusamareeb IDPs had over 50 percent of households in IPC Phase 3 or worse.

The Household Hunger Scale (HHS) (30-day recall) indicated:

- Baydoa IDPs (11 percent) and Mataban district (17 percent) had households experiencing severe hunger (IPC Phase 4).
- 41 population groups had 20 percent or more households facing moderate hunger (IPC Phase 3).
- 14 groups reported slight hunger (IPC Phase 2), while 9 groups had over 80 percent of households with no hunger (IPC Phase 1).

Households employed various livelihood-based coping strategies to sustain their livelihoods:

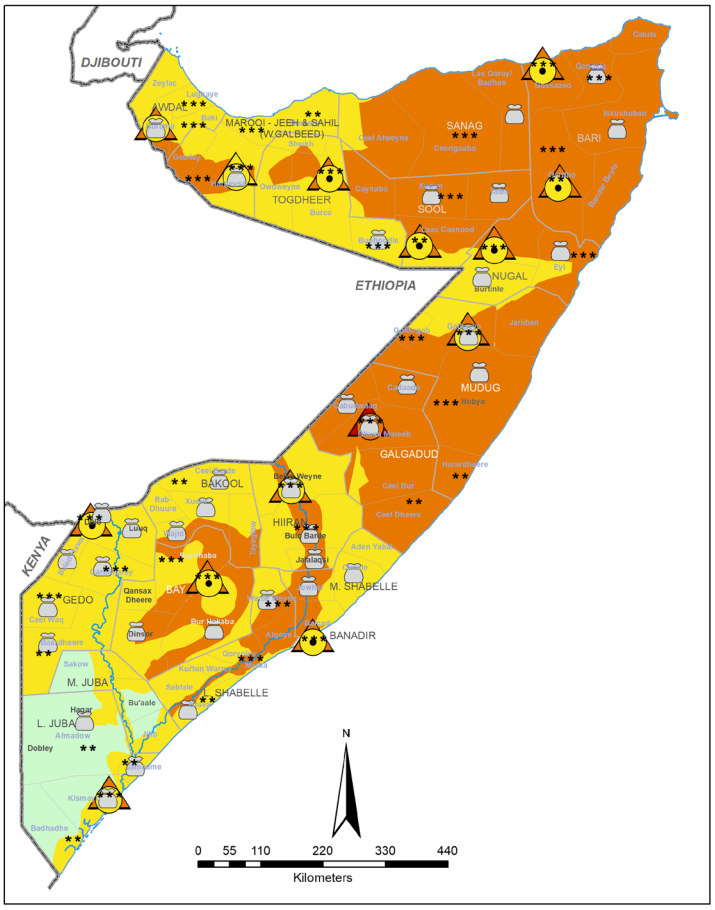
- 7 out of 63 groups had 20 percent or more households resorting to extreme depletion of assets, classifying them in Emergency (IPC Phase 4).
- 38 percent of all assessed households fell into IPC Phase 3 or worse.

Acute malnutrition (based on combined weight-for-height and MUAC measurements) was critical in several areas:

- 6 out of 38 population groups analyzed are classified as Critical (IPC Phase 4) with over 15 percent of children who are acutely malnourished: Galkacyo IDPs (Mudug), Beletweyne Rural (riverine), Shabelle Riverine, Mogadishu IDPs (Banadir) and Bay agropastoral (Bay).
- 18 population groups were in Crisis (IPC Phase 3), while only 12 were in Stressed (IPC Phase 2).

Conclusion: A significant proportion of the population in Somalia continues to experience high levels of acute food insecurity and malnutrition. Acute food insecurity and malnutrition are widespread across the country.

ACUTE FOOD INSECURITY PROJECTION MAP AND POPULATION TABLE (APRIL-JUNE 2025)



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PROJECTED SITUATION OVERVIEW (APRIL - JUNE 2025)

During the projection period from April to June 2025, a worsening of the current food security situation in the analyzed areas is anticipated, primarily due to expected below-average Gu rains. This forecast is linked to the predicted weakening of La Niña. Across Somalia, it is estimated that around 4.4 million people will face high levels of acute food insecurity (IPC Phase 3 or above). This marks a 22 percent increase compared to the previous year's Post Deyr projection period, during which approximately 3.4 million people were classified in IPC Phase 3 or above. The decline in food security is largely driven by the anticipated below-average post-Gu rainfall from April to June 2025, which could lead to poor harvests and degraded pasture and browse conditions. This stands in contrast to the previous year, when these regions benefited from above-average rainfall.

In pastoral regions, it is anticipated medium to low birth rates among small ruminants and low to medium calving in camels and cattle from April to June 2025. These births are expected to contribute to herd growth and provide access to milk, assisting poor households in meeting their essential nutritional needs. However, these households may face challenges in meeting other essential non-food needs and may have to resort to stress-coping strategies. The anticipated increase in livestock and milk sales, coupled with improved milk consumption, is expected to mitigate food shortages. Consequently, most areas are projected to remain in a Stressed (IPC Phase 2) condition.

In the Northwest and Togdher agro-pastoral areas, East Golis of Sanag, Northern Inland Pastoral, Addun, and Coastal Deeh Pastoral of the Northern regions, and Southern Agro-pastoral areas of Hiran region, livestock holdings and milk consumption remain significantly below baseline levels. The limited income from livestock and milk sales, combined with insecurity, high levels of debt, and insufficient fishing income, prevents these households from fully covering their debts or purchasing adequate food and water through credit or cash.

While food security is expected to deteriorate for poor households, it will likely move to a Crisis (IPC Phase 3) level. In most pastoral livelihood zones in the South and parts of northern regions, food security conditions remain Stressed (IPC Phase 2). Livestock herd sizes are still below baseline levels, and income from milk and livestock sales, though slightly improving, remains lower than normal. These earnings are expected to be diverted toward repaying large debts incurred during the recent drought years and covering high expenditures for water trucking (January – March 2025). However, in the Southern Inland pastoral areas of Juba, food security is projected to remain Minimal (IPC Phase 1) due to significant improvements in livestock production, reproduction, and market value.

Key Assumptions

- According to NOAA, La Niña conditions are expected to persist through February-April 2025 (59 percent chance), with a transition to ENSO-neutral conditions during March-May 2025 (60 percent chance)
- The April to June 2025 Gu rains are likely to be below average given the forecast of waning La Niña.
- Both local and imported food prices are expected to trend above the five-year averages due to the poor Deyr harvest, limited carryover stocks and high shipping costs.
- Conflict and insecurity in central, parts of northwest and southern Somalia will likely persist through June 2025.
- Social supports for poor households are expected to increase during Ramadan (March 2025) and Hajj (June 2025).
- Demand for agricultural labour will increase from March 2025 onwards when Gu season land preparation starts.
- Agricultural daily labor wages will likely remain below the five-year average, driven by reduced labor demand due to anticipated below average Gu rains.
- Due to anticipated below-average Gu season rainfall, river levels are expected to remain low but some localized flooding is expected in areas with open breakages and weak river embankments.
- Livestock body conditions will likely improve starting from late April 2025 when pasture and water conditions improve following the arrival of Gu rains.
- Low to medium livestock births are expected during the 2025 Gu season.
- Milk availability will likely decline seasonally from February to May 2025
- Despite improvement in herd sizes, household income from sales will be limited due to herd sizes being below baseline levels in most areas for some pastoral livelihood zones.
- There will likely be a seasonal increase in livestock demand and livestock prices in the lead up to and during Ramadan (March 2025) and Hajj (June 2025) festivities
- Due to severe funding constraints, food assistance will be limited and likely to reach less than 25 percent of the population each month through June 2025.

In agropastoral areas, below-average access to agricultural labor income and milk are anticipated due to the forecasted below-average April-June 2025 Gu rainfall. Cropping activities are likely to commence late due to the delayed onset of the 2025 Gu rains, as soil moisture temporarily improves labor opportunities and wage rates. Household cereal stocks from the Deyr off-season harvest will still be available in March-April 2025. Sorghum and maize prices are projected to moderately increase from January to June 2025, following low stocks and below-average 2024 Deyr production. These prices are expected to surpass both the 2024 levels and the five-year average (2019-2023). Despite staple food price fluctuations remaining above the five-year average, the anticipated temporary rise in agriculture labor opportunities and wages, along with increased livestock prices due to Hajj restocking and the Eid festival, should enhance household purchasing power. Additionally, low to medium camel and cattle births, along with medium to low births in small ruminants, will contribute to near-baseline goat herd sizes and improved milk availability.

In the Bay/Bakool Low Potential Agropastoral livelihood zone in the South, Crisis (IPC Phase 3) conditions are expected to persist. Despite below average Gu rainfall, improved agriculture labor opportunities and wage rates, limited seed supplies, and household cereal stocks for consumption, above-average staple cereal prices, will lead to sustained market purchase dependency through June 2025. High debt levels, limited access to credit for food purchases, low availability of saleable livestock due to below-baseline livestock holdings will further exacerbate the food insecurity situation.

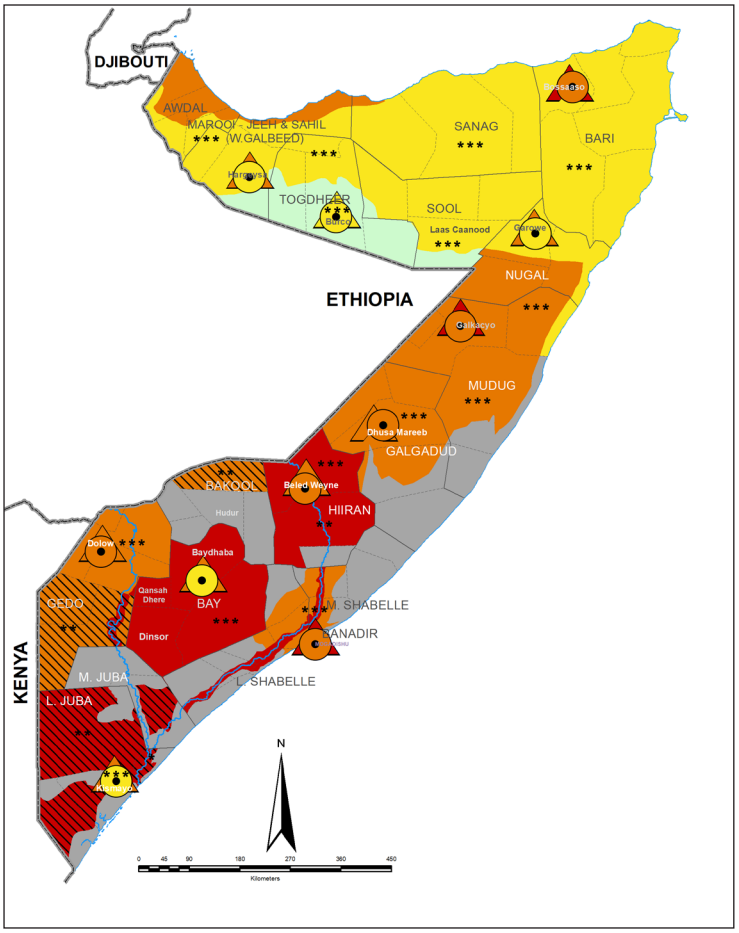
In the riverine livelihood zones of Hiraan, Gedo, Juba, and Shabelle regions, households are expected to harvest 7,900 metric tons of Deyr off-season cereal crops from March to April 2025. This harvest is likely to improve food consumption and provide some debt relief. However, due to recurrent floods and high competition for agriculture labor, the riverine livelihood zones in Shabelle regions will remain in Crisis, (IPC Phase 3). In contrast, the riverine areas in Juba and Gedo regions will likely maintain Stressed (IPC Phase 2) conditions due to successive flood recession harvests and related improved agriculture labor opportunities.

According to UNHCR, there are approximately 3.9 million Internally Displaced Persons (IDPs) in Somalia. These individuals face significant challenges as most are poor, possess limited working skills, and have few livelihood assets. Furthermore, they face minimal communal support and heavily dependent on humanitarian food aid. Given the reduction in humanitarian food aid, a substantial portion of IDPs, both in rural and urban areas, will encounter moderate to large food consumption gaps. This situation will also affect the urban poor across Somalia during the projection period.

Most of the main Internally Displaced Persons (IDP) settlements are projected to sustain Crisis (IPC Phase 3) conditions. However, the situation in the Dhusa-Mareeb IDP is more severe. Successive years of drought have severely impacted rural livelihoods, and ongoing conflict has displaced both rural and urban households. As a result, Dhusa-Mareeb is classified to be in an Emergency state (IPC Phase 4), characterized by substantial food consumption gaps. While the majority of IDPs will remain in Crisis (IPC Phase 3), there are exceptions. The rural IDPs in the certain regions such as Middle Shabelle (Jowhar, Balcad, Adale), Hiran (Bulo-Burti, Jalalaqsi), W. Galbeed (Hargeisa, Berbera, Gabiley), and Nugal (Eyl, Jariban), are classified as Stressed (IPC Phase 2), with conditions similar to those in the nearest rural livelihoods.

Despite high food prices, competition for income-earning opportunities, and a high unemployment rate, most urban livelihoods are classified as Stressed (IPC Phase 2). However, there are exceptions: Urban areas in Sanaag (Ceel Afweyn, Cerigavo, Las-Qoray) and Hudur are classified in Crisis (IPC Phase 3). Urban areas in Galgadud (Ceel Bur, Ceel Dheer, Cadaado, Cabudwaq) are classified in Emergency (IPC Phase 4), primarily due to insecurity, high food prices, and limited income-earning opportunities.

ACUTE MALNUTRITION CURRENT MAP (JANUARY-MARCH 2025)



Key for the Map

IPC Acute Malnutrition Phase Classification

- 1 - Acceptable
- 2 - Alert
- 3 - Serious
- 4 - Critical
- 5 - Extremely critical
- Phase classification based on MUAC
- Areas with inadequate evidence
- Areas not analysed

Map Symbols

- Urban settlement classification
- IDPs/other settlements classification

Evidence Level

- * Acceptable
- ** Medium
- *** High

Acute Malnutrition burden table (January - December 2025)

Region	No. of Children 6-59 months	No. of Children (6-59 Months) in Need of Treatment		
		Moderate Acute Malnutrition (MAM)	Severer Acute Malnutrition (SAM)	Global Malnutrition (GAM)
Awdal	131,179	31,490	12,520	44,010
Bakool	112,053	42,880	36,680	79,560
Banadir	652,426	217,770	69,170	286,940
Bari	254,110	71,970	23,770	95,740
Bay	257,357	104,050	91,250	195,300
Galgaduud	167,584	61,230	14,960	76,190
Gedo	201,185	53,970	12,760	66,730
Hiraan	104,103	47,860	11,210	59,070
Mudug	303,207	116,520	26,460	142,980
Nugaal	130,293	41,220	13,060	54,280
Sanaag	88,407	23,800	10,580	34,380
Sool	113,210	28,410	12,060	40,470
Togdheer	177,490	31,720	11,440	43,160
W. Galbeed	298,501	64,240	24,200	88,440
M. Shabelle	208,975	76,280	22,330	98,610
L. Shabelle	328,533	131,960	42,730	174,690
M. Juba	88,701	28,810	7,100	35,910
L. Juba	238,855	82,930	24,160	107,090
TOTAL	**3,856,170**	**1,257,110**	**466,440**	**1,723,550**

The expected number of cases of acute malnutrition (total acute malnutrition burden) was the product of multiplying the population of children under five by the prevalence of acute malnutrition and the respective incidence correction factor (3.6 for severe acute malnutrition-SAM and 2.6 for moderate acute malnutrition -MAM). Somalia's total population in 2025 is estimated at 19,280,850, with children under five comprising 20 percent of this total. On the prevalence, the combined GAM and SAM from the results of the SMART nutrition survey carried out in November and December 2024 was used. As a result of continuous demand from nutrition implementing agencies for estimates of the number of malnourished children disaggregated by regions or districts, when in fact, the current FSNAU food security and nutrition assessments are conducted at the livelihood (rural) level and for discrete population groups (IDP and Urban), a combination of real estimate value and proxy prevalence techniques has been used to provide the nationwide absolute number of acutely malnourished children. If the prevalence of acute malnutrition is not available, the prevalence observed in similar livelihoods and an average median GAM prevalence is used for regions crosscut by more than one livelihood zone.

ACUTE MALNUTRITION CURRENT OVERVIEW (JANUARY-MARCH 2025)

An estimated 1.7 million children aged 6 – 59 months are expected to suffer from acute malnutrition and need urgent treatment between January and December 2025. This includes approximately 466 000 cases of children likely to suffer from SAM, and 1.2 million of children facing MAM. Notably, around 64 percent of the total acute malnutrition burden is concentrated in southern Somalia. Compared to the same season of last year, the expected burden represents a 1 percent reduction in GAM but a 9 percent increase in SAM.

Regarding the severity of the acute malnutrition situation, between January and March 2025, out of the forty-five analysed areas, eleven are classified in IPC AMN Phase 4 (Critical). These include IDPs in Bossaso (Bari), Galkacyo (Mudug), Mogadishu (Banadir), as well as some rural areas in Beledweyne rural (riverine/agropastoral), Shabelle riverine, Bay agropastoral, and Mataban district, all of which were assessed based on Weight-for-Height z-scores. Other areas in Phase 4 include the South Gedo riverine, Juba Cattle pastoral, Juba riverine, analysed using GAM based on MUAC, and Buloburte, analysed employing the IPC AMN protocols for similar areas.

Moreover, a total of twenty-one population groups are classified in Phase 3 (Serious). This includes nine rural populations, namely Guban pastoral, Hawd pastoral of Northeast and Central, Addun pastoral, Shabelle agropastoral, Bakool Southern inland pastoral (Elberde), North Gedo pastoral – SIP, North Gedo riverine, South Gedo pastoral, and South Gedo agropastoral. Additionally, six urban populations in Bossaso, Galkacyo, Dhusamareb, Beletweyne urban/IDPs, Mogadishu, and Dolow, and six IDPs settlements, namely Hargeisa, Garowe, Dhusamareb, Baidoa, Dolow and Kismayu.

A comparative statistical analysis of the GAM prevalence based on WHZ from 2024 Post Deyr and the same season of last year indicated a significant improvement in the nutrition situation among IDPs in Burao in (Togdheer) Kismayo and Beledweyne Urban/IDPs and among the rural population areas in Howd pastoral in Northwest (Somaliland) and Hawd Pastoral Central. However, the nutrition situation among the rural population groups in Guban Pastoral (Northwest) reflect significant increases in GAM prevalence since the 2023 Deyr. Additionally, there has been consistent improvement among Baidoa IDPs since the Deyr 2022, with the GAM decreasing from 21.2 to 13.5 in 2023 to 11.2 in 2024.

Contributing Factors

Morbidity: These include high disease burden, with a total of 20 population groups recording a high morbidity prevalence (above 20 percent with the highest morbidity among rural in Howd pastoral central (38.0 percent); Bay agropastoral (36.8 percent); Juba Cattle pastoral (33.3 percent) and Hargeisa IDPs (31.9 percent) followed by Galkacyo urban (29.9 percent) and Dollow IDPs (28.9 percent). Fever, cough (proxy of Acute Respiratory Infections), and diarrhoea were the most prevalent childhood illnesses reported. Additionally, outbreaks of acute watery diarrhoea and measles have been persistently present in Southern areas. Access to health and nutrition services remains limited, with vitamin A supplementation and measles vaccination coverage remaining below 80 percent in many of the assessed areas. The lowest measles immunization coverage status was recorded at 6.4 and 8.2 percent in Shabelle agropastoral and riverine, 19.7 percent in Bay agropastoral ,19.7 percent in Mogadishu IDPs and 38 percent in Northern Inland Pastoral (Northeast), all of which heighten the risk of acute malnutrition.

Poor WASH services: Access to water, sanitation, and hygiene (WASH) facilities remains inadequate, especially among the rural population. According to the FSNAU November to December 2024 survey, the median prevalence of households accessing water from improved sources was only 28 percent, while the median prevalence of the population accessing sanitation facilities was 51.0 percent. It should be noted that the latter does not reflect access to improved sanitation facilities. Poor WASH correlates to a high prevalence of acute watery diarrhoea and frequent cholera outbreaks, adversely affecting nutrition outcomes. Furthermore, critical WASH infrastructure that got destroyed by flooding, such as water pipes and sanitation facilities continue to further hinder access to clean drinking water, exposing many communities to waterborne diseases.

Suboptimal infant and young children caring and feeding practices: Child caring practices and YCF indicators continue to remain suboptimal across the country, constituting an additional high-risk factor for acute malnutrition. According to FSNAU 2024 Post-Dayr assessment (Nov-Dec 2024), less than 10 percent of children assessed met the Minimum Acceptable Diet (MAD), while less than 50 percent met the Minimum Meal Frequency (MMF).

NUTRITION SITUATION BY POPULATION GROUPS

Rural Population

Of the estimated number of cases of children in need of treatment, 61.1 percent come from the rural populations.

Seventeen SMART surveys were conducted among the rural population. The acute malnutrition prevalence for these surveys ranged from 3.6 percent in Northwest Hawd Pastoral to 18.9 percent in Bay agropastoral. In terms of its severity, 4 out of the 17 rural areas were classified in Phase 4 (Critical). These include Beledweyne district (Riverine and agropastoral), Mataban district, Middle and Lower Shabelle Riverine and Bay agropastoral. With regard to the drivers of the observed severity, morbidity prevalence was high (≥ 20 percent) in 10 out of 17 of the rural population groups, and the highest morbidity was reported in Hawd Pastoral of Central (38 percent), Bay agropastoral (36.8 percent) followed by Addun pastoral (28 percent).Measles vaccination, Vitamin A supplementation are low in many rural livelihoods, with lowest coverage (<20 percent) among the Shabelle agropastoral and riverine and Bay agropastoral , increasing the risk of acute malnutrition.

Besides SMART surveys, six rural populations were assessed through MUAC. The prevalence of acute malnutrition based on MUAC ranged from 8.8 percent in South Gedo pastoral to 16.1 percent in Juba Riverine.

On the other hand, a Serious situation (IPC AMN Phase 3) was classified among nine rural population groups. These include Guban Pastoral in Northwest, Hawd and Addun Pastoral in Northeast and central, Shabelle agropastoral, Southern Pastoral (Elberde), North Gedo Pastoral and Riverine, South Gedo Pastoral and agropastoral. Overall morbidity prevalence remains elevated in rural populations. 12 out of 23 assessed rural population groups reported a high disease prevalence of over 20 percent, with the highest level reported in Howd pastoral central (38.0 percent); Bay agropastoral (36.8 percent); Jubba Cattle Pastoral (33.3 percent).

The coverage of health and nutrition services in rural livelihoods is inadequate, which increases the risk of acute malnutrition. In many livelihoods surveyed, measles vaccination and vitamin A supplementation rates were low, with a median coverage of 59.2 and 59.7 percent, respectively. The lowest coverage (<30 percent) for measles and Vitamin A supplementation was observed in Shabelle and Bay agropastoral.

During the projection period, the number of population groups in IPC AMN Phase 4 (Critical) is expected to increase from currently eight to eleven areas, namely: Hawd Pastoral Northeast and Central, Beledweyne, Mataban and Buloburte districts in Hiran, Bay agropastoral, Juba Riverine and Cattle Pastoral, South Gedo Riverine Bakool Southern Inland pastoral in Elberde district and Shabelle Riverine and agropastoral. IPC AMN Phase 3 (Serious) situation is expected in eleven population groups, namely: Guban Pastoral, West Golis, Northwest agropastoral, Northern inland Pastoral in Northwest, East Golis, Northern inland Pastoral in Northwest in Northeast, North Gedo riverine and Pastoral and South Gedo pastoral and agropastoral. Only two rural livelihoods, namely, Hawd pastoral of Northwest and Coastal Deeh of Northeast are likely to be at Alert during the projected period.

Deterioration is expected during the projection period in twelve areas, however, without any phase change from the current classification, except for few areas: Howd pastoral Northeast and Central, Shabelle agropastoral , and Bakool southern inland pastoral that are expected to deteriorate from the current Serious (IPC AMN Phase 3) level to Critical (IPC AMN Phase 4), and East Golis pastoral, West Golis, Northwest agropastoral , Northern inland pastoral in Northwest and Northern inland pastoral in Northeast, which are expected to deteriorate from Alert (IPC AMN Phase 2) to Serious (IPC AMN Phase 3). The Howd pastoral of Northwest in Somaliland is also expected to deteriorate from Acceptable (IPC AMN Phase 1) to Alert (IPC AMN Phase 2). This is on the assumption of expected continued food insecurity and poor child food consumption, high disease burden, limited access to health and nutrition services and safe water and sanitation aggravated by further reduction in humanitarian assistance.

In addition, the nutrition situation is expected to remain the same (IPC AMN Phase 4 or Critical) in Beledweyne Rural (riverine/agropastoral), Shabelle Riverine, Bay agropastoral, South Gedo Riverine, Matabaan, Juba Cattle Pastoral and Riverine, and Buloburte. On the other hand, the situation is expected to be sustained at Serious (IPC AMN Phase 3) in Guban Pastoral, Addun Pastoral, North Gedo pastoral, North Gedo Riverine, South Gedo Pastoral and agropastoral, while sustained at Alert (IPC AMN Phase 2) in Coastal Deeh of Northeast.

Urban Population

Nearly 16.1 percent of the estimated number of cases of children in need of treatment come from the urban population. The overall median prevalence of GAM based on WHZ among the twelve assessed urban populations in 2024 Deyr was at 10.6 percent, indicating a Serious nutrition situation, which remains similar to that observed in the same period of 2023. The severity, nonetheless, varies across. In Bosasso (Bari), Galkacyo (Mudug), Dhusamareb (Galgadud), Beletweyne, Mogadishu (Banadir) and Dolow (N Gedo), were classified in Seriou situation (IPC AMN Phase 3), while in Hargeisa (W. Galbeed), Burao (Toghdeer), Garowe (Nugaal), Baidoa (Bay), and Kismayu (L. Juba) are classified as Alert (IPC AMN Phase 2).

Morbidity prevalence was high (≥ 20 percent) in 3 out of 11 of the Urban population groups, and the highest morbidity was reported among Galkacyo Urban (29.9 percent) in (Mudug) and Hargeisa Urban in W. Galbeed (28.1 percent). Measles vaccination and Vitamin A supplementations were fairly good in most of the urban population groups, except for Urban in Beletweyne and Mogadishu that reported lowest.

For the projection period (April – June 2025), in ten areas, the acute malnutrition situation is expected to deteriorate within the same IPC AMN phases as the current classification: Hargeisa (W. Galbeed), Burao (Toghdeer), Bosasso (Bari), Garowe (Nugaal), Galkacyo (Mudug), Beletweyne, Mogadishu (Banadir), Baidoa (Bay), Dolow (N Gedo), and Kismayu (L. Juba). The deterioration is linked to reduced food access, increased food prices and disease burden during the wet season. In most other urban populations, the situation is expected to remain the same as Serious, while five are projected to be at Alert.

Internally Displaced Populations (IDPs)

The burden of acute malnutrition among IDPs represents 22.8 percent of the country estimate. The 2024 Deyr overall median prevalence of GAM based on WHZ was at 12.9 percent, corresponding to a Serious nutrition situation that is an improvement from 15.8 percent (Critical) observed in a similar period of 2023.

The most severe GAM during 2024 Deyr was observed in Galkayo (19.1 percent), Bosasso (17.9 percent), and Mogadishu (16.1 percent). In the current analysis, Bossaso in (Bari), Galkacyo (Mudug), Mogadishu (Banadir) are classified in Critical nutrition situation (IPC AMN Phase 4), while Hargeisa (W. Galbeed), Garowe (Nugaal), Dhusamareb (Galgadud) and Dolow (North Gedo), Kismayo (Lower Juba), Baidoa were classified in Serious (IPC AMN Phase 3). These findings highlight the ongoing vulnerability of IDP populations. Mother's MUAC is high among the IDPs in Dollow, Garowe, Galkacyo, and Baidoa. The high severity of acute malnutrition among the IDP population are largely attributed to inadequate food consumption in terms of both frequency and diversity, alongside persistent food insecurity where IPC AFI Phase 3 or worse persist as key risk factors. Additionally, high disease prevalence is a significant factor with 20.0 percent of the assessed IDPs' children reported to have been sick two weeks prior to the assessment. The overall disease prevalence was above 20 percent in 5 out of the ten population groups where morbidity data was collected, with the highest prevalence recorded among IDPs at 31.9, 28.9, 28.6, 27.6 and 20.9 percent in Hargeisa, Dollow, Baidoa, Galkacyo, and Mogadishu, respectively. Measles vaccination and Vitamin A supplementation are low and below the SPHERE standards (at least 95 percent), in Baidoa IDPs in Bay, and Mogadishu IDPs in Banadir, recording the lowest coverage of less than 50 percent with Mogadishu IDPs (27.9 percent), and Baidoa (49.6 percent).

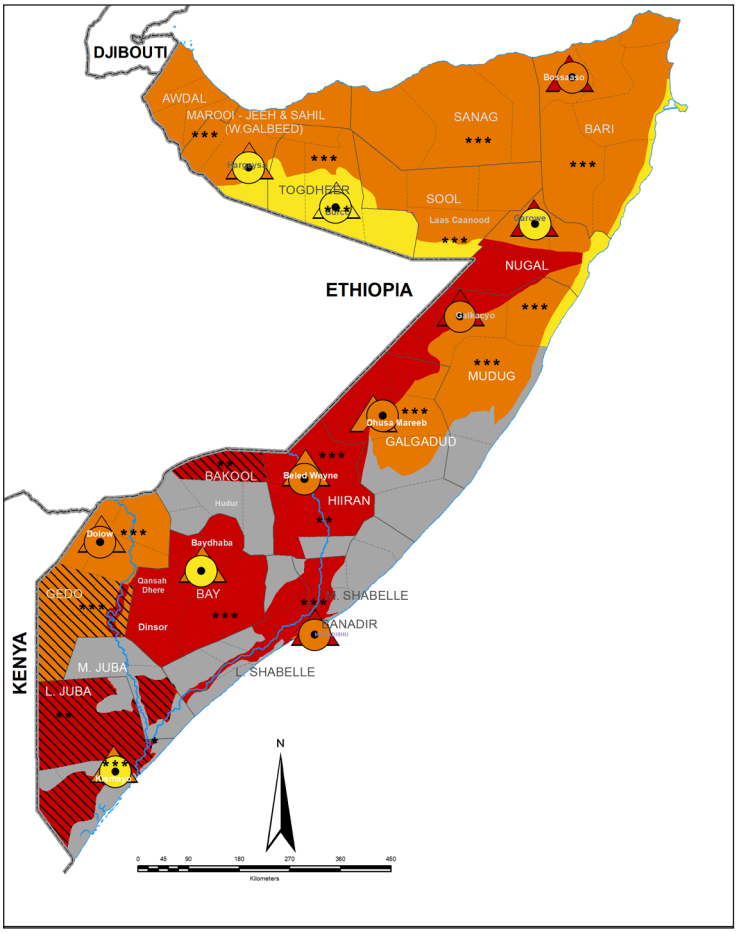
Concerning the projected situation, acute malnutrition is expected to deteriorate in nine of the ten IDP populations analyzed, however, without a change in phase. Exception are IDPs in Garowe (Nugaal), where acute malnutrition is expected to deteriorate from Serious (IPC AMN Phase 3) to a Critical (IPC AMN Phase 4) situation. The deterioration is linked to increased food prices, disease burden during the wet season and declining humanitarian assistance due to funding constraints. . Overall, Critical nutrition situation (IPC AMN Phase 4) is expected in four of the analyzed IDP populations, a Serious situation (IPC AMN Phase 3) is likely among five IDPs, while Alert nutrition situation (IPC AMN Phase 2) is likely among the Burao IDPs in Togdheer region populations from March to June 2025.

Trend of acute malnutrition in vulnerable population groups

Somalia remains highly vulnerable to acute malnutrition. Four of the thirty-seven assessed population groups through SMART surveys have shown persistently Critical (IPC AMN Phase 4) nutrition situation for at least three out of the past five Deyr seasons (2020-2024). This includes Mogadishu IDP settlements, which have remained at Critical (IPC AMN Phase 4) since 2020. Additionally, the Beletweyne IDPs, and Shabelle riverine populations have sustained Critical levels in four out of five seasons, while Galkacyo IDPs, Beledweyne urban/IDPs and North Gedo riverine have recorded Critical level in three of the five seasonal assessments.

General disease prevalence among these populations has consistently remained high (>20 percent), making morbidity one of the significant risk factors for high levels of acute malnutrition. In addition, inadequate food access is also a significant factor driving high acute malnutrition, with Acute Food insecurity in these areas largely being from IPC AFI Phase 3 (Crisis) and above, implying that households consistently face food gaps. Coverage for essential nutrition and health services such as vitamin A supplementation and measles vaccination has also been consistently low, especially among rural populations. At the same time, access to safe drinking water and sanitation facilities remains limited.

ACUTE MALNUTRITION PROJECTION MAP (APRIL-JUNE 2025)



Key for the Map

IPC Acute Malnutrition Phase Classification

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- 5 - Extremely critical
- Phase classification based on MUAC
- Areas with inadequate evidence
- Areas not analysed

Map Symbols

- Urban settlement classification
- IDPs/other settlements classification

Evidence Level

- * Acceptable
- ** Medium
- *** High

ACUTE MALNUTRITION PROJECTION OVERVIEW (APRIL-JUNE 2025)

Between April and June 2025, a period characterized by a spike in disease outbreaks and reduced food access, acute malnutrition is expected to worsen. In ten areas, namely, West Golis, in Northwest agropastoral, Northern Inland pastoral in Northwest, Hawd Pastoral in Northwest, East Golis Northwest and Northeast cross cutting, Northern Inland pastoral Northeast, Hawd pastoral of Northeast and central, Garowe IDPs, Shabelle agropastoral , and Bakool southern inland pastoral (Elberde), the situation is expected to progress towards a higher Phase than it is in the current situation. In the other 31 areas, the situation is expected to deteriorate but to remain within the same Phase as that of the current. This includes 10 areas in IPC AMN Phase 4 (Critical), namely Bossaso IDPs, Galkacyo IDPs, Beletweyne Rural (riverine/agropastoral), Shabelle Riverine, Mogadishu IDPs, Bay agropastoral, Juba Cattle Pastoral, Juba Riverine, Buloburte and Mataban district in Hiran. The other areas are likely to remain within Phase 3 and Phase 4.

The expected deterioration in the projected period is likely to be attributed to spikes of childhood illness during the Gu' period and persistent sub-optimal feeding and care practices. Access to safe drinking water and sanitation facilities is also projected to decline during the rainy season, further elevating the risk of disease. Moreover, the coverage of humanitarian and essential health and nutrition services is likely to be hampered by inaccessible roads during the wet season, exacerbating the risk of acute malnutrition. Humanitarian funding is expected to reduce, and this will likely affect health and nutrition services provided by outreach mobile. These services are essential for the provision of treatment of childhood illness (malaria, pneumonia and diarrhoea), immunization, malnutrition treatment particularly among rural communities. The projected La Niña will exacerbate the already serious malnutrition situation across the country.

Key Assumptions

- Reduce access to milk associated with below average rainfall will increase malnutrition risk among pastoralists.
- Rising food prices will reduce purchasing power and poor diets.
- Increased population displacement may overstretch access to health, nutrition, and WASH services, worsening health and nutrition outcomes.
- Low access to adequate water, sanitation, and hygiene will increase diarrheal diseases and infections, contributing to malnutrition in IDPs and rural areas.
- Low IYCF knowledge and reliance on undiversified diets will contribute to malnutrition
- Localized flooding is expected to worsen WASH conditions.
- Reduced humanitarian assistance will likely disrupt nutrition response activities.
- Higher immunization rates, through the "Big-catch up" campaign.
- Early detection and referral of acute malnutrition cases through the scaling up of mass MUAC screening.
- Expansion of integrated Community Case Management (iCCM+) in rural areas are expected to reduce morbidity and improve nutrition outcomes.

Linkages between food security and acute malnutrition

Out of the 45 analysed areas, three (South Gedo riverine, Juba riverine and Juba cattle pastoral) show a phase divergence of two or more in current classifications, with AMN generally higher phase than AFI. Eighteen areas, including nine IDPs (Mogadishu, Kismayu, Baidoa, Dallow, Galkacyo, Dhusamareb, Beletweyne, Bosasso and Garowe), seven rural livelihoods (Hawd pastoral, Addun pastoral, Shabelle riverine, Shabelle agropastoral, Beletweyne riverine, Bay agropastoral and Elberde), and two urban livelihoods (Galkayo and Dhusamareb), were classified as Phase 3 or above for both AFI and AMN. Divergence is defined as a difference of at least two or more phases between AFI and AMN classifications.

Livelihood Zones	AMN		AFI		Divergence
	Current: January – March 2025	Projection: April – June 2025	Current: January – March 2025	Projection: April – June 2025	
South Gedo riverine	4	4	2	2	2
Juba riverine	4	4	2	2	2
Juba Cattle pastoral	4	4	1	2	3

Historically, acute malnutrition has taken the higher phase for both Juba riverine, Juba cattle pastoral and South Gedo riverine. The high acute malnutrition in these areas were attributed to 1) high disease burden including recurrent outbreaks of cholera and measles, 2) limited access to humanitarian assistance, 3) inadequate nutrient intake – food consumption score, dietary diversity and meal frequency, 4) limited access to safe drinking water and sanitation, and 5) limited access to health services including outreaches and CMAM coverage.

South Gedo riverine

South Gedo riverine was classified in IPC AMN phase 4 (Critical) in the current period (January – March 2025) and expected to remain similar in the projection period (April – June 2025). The area is in southern Somalia along the Juba river; populations rely on pump irrigation and rainfall for agricultural activities. The water levels of the river depend on upstream flow from the Ethiopian highlands, which sometimes leads to flooding or reduced water volume of the river. The area has armed conflicts and locally organized violence that reduces access to the area and population. Despite favourable household outcome indicators registered in the area, hunger gaps exist among the children less than five years that imply severe nutrient deficiencies. Only 2.4 percent achieved minimum dietary diversity while 19.6 percent achieved the minimum meal frequency in 24 hours, which further negates the timely introduction to solid and semi solid foods of 67 percent of the children aged 6-8 months and results to large nutrient gaps aggravated by low continued breastfeeding at 42.7 percent, depriving the children of supplemental nutrients, and, hence, contributing to acute malnutrition.

The disease prevalence among the children is generally low, with rates below 5 percent except for malaria (10.4 percent) presenting medium risk to acute malnutrition. Immunization coverage for measles is low at 57.9 percent while vitamin A supplementation is at 58 percent. However, there was no disease outbreak reported in the area. Less than 50 percent of the households access sufficient water while only 15 percent have access to safe drinking water. Water shortage coupled with unsafe sources compromised hygiene situations and likelihood to infections and parasitic infestations such as helminths that though not considered among the childhood illnesses, still pause a threat to malnutrition among the children. Against the severe food gaps observed in the child food consumption, severe vulnerability to nutrient deficiencies and acute malnutrition is realized.

Juba cattle pastoral

The Jubba cattle pastoral zone, located in the semi-arid regions of southern Somalia, is primarily inhabited by pastoralist communities who rely on cattle for their livelihood. Livestock production is the main economic activity, providing milk, meat, and income through trade. Challenges in the area include recurrent droughts, animal diseases, and market access constraints. The population includes vulnerable groups such as IDPs who often settle with host communities. The livelihood area is classified IPC AMN Phase 4 (Critical) despite the low IPC AFI Phase 1 (Minimal) classification citing adequate animal protein and sufficient cash income to purchase food based on animal body condition and favourable market prices. However, the food dimensions at the household are not as favourable with household hunger scale (HHS) of 48 percent of the households indicative of a Phase 3 (Crisis) while food consumption score reports 20-45 percent of the household with Borderline Food Consumption (Indicative IPC Phase 3) that is an indication of food gaps at the household level. Higher vulnerability to food gaps is exhibited among the children where none of the children achieved the MDD while only 1.4 percent of the children met the MMF. The nutrient deficiency from less diversified diets and reduced number of meals among children is further aggravated by suboptimal care practices where 46 percent of the children aged 12-23 months were breastfed while about half 54 percent had been introduced to solid and semi solid foods. The hunger gaps at the household that translates to further severe undernutrition among the children has contributed to high acute malnutrition observed at Critical level. There is need to improve food availability at the household and the childcare and feeding practices to manage and prevent high acute malnutrition among the children in Juba cattle pastoral livelihood of Somalia.

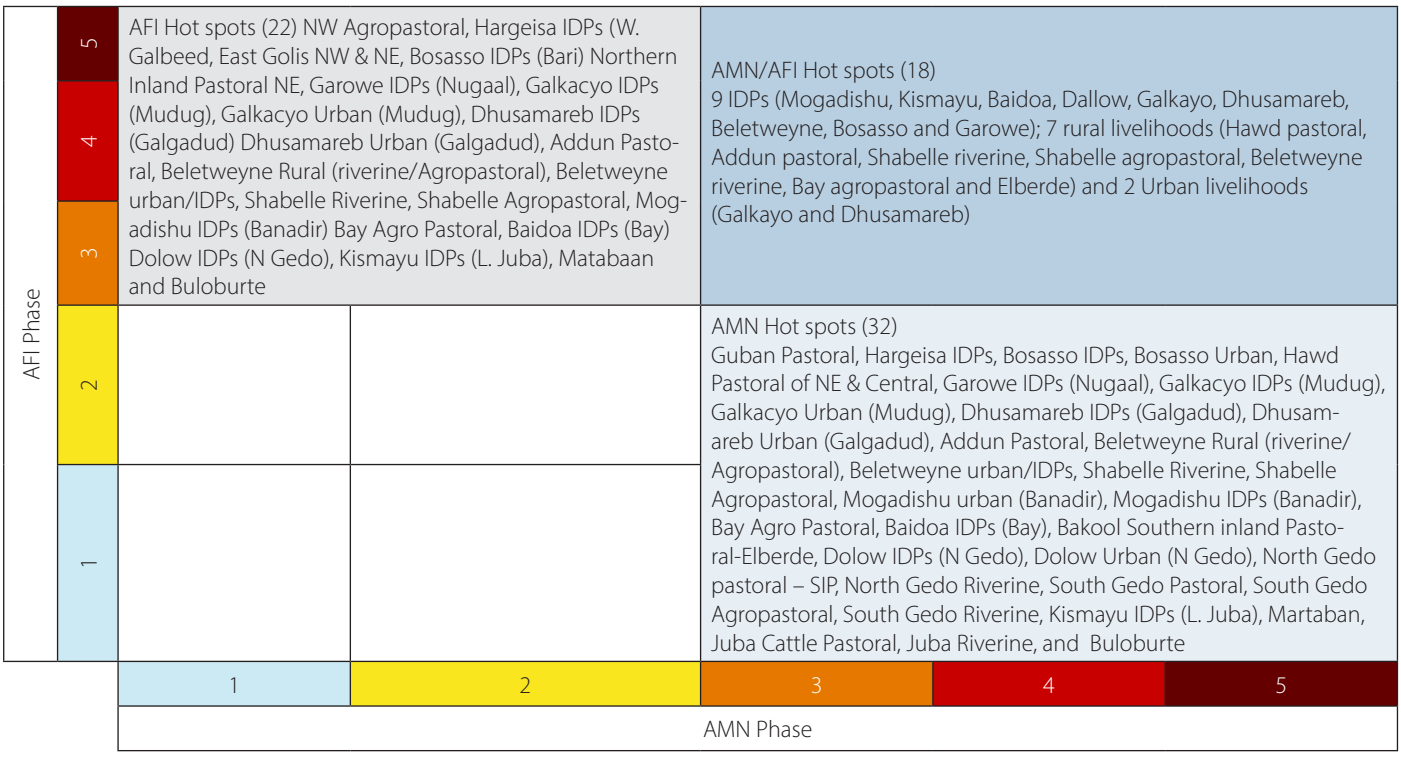
Disease increases nutrient requirements while poor nutrition increases the chances of getting ill due to compromised immunity. In Juba cattle livelihood, the main child illnesses reported were measles outbreak reported on 4.1 percent of the children, malaria at 11.7 percent and acute respiratory infection at 14.9 percent. While child immunization protective aspects prevent infection or reduces severity of illness, sub-optimal immunization coverage was realized in Juba cattle pastoral livelihood reporting measles vaccination and vitamin A supplementation at 60.5 percent and 61.9 percent respectively. This is further exacerbated by the poor access to safe water sources reported at 33 percent while only 28 percent of the households' access sanitation facilities. Widespread open defecation does not only high risk to environmental contamination, but also to risk to infection including other child illnesses like parasitic helminths that compromise nutrient availability in children that are already experiencing severe inadequacies in food consumption,

and further contributing to high acute malnutrition observed. There is need for multisectoral, integrated approach in addressing food availability at household level, child food consumption, safer water and sanitation to address acute malnutrition in Juba cattle pastoral livelihood.

Juba Riverine

The Juba riverine zone, stretching along the Juba river, supports a mix of sedentary farming and fishing communities. This zone also faces frequent flooding, which can displace communities and damage crops. Population sub-groups include agropastoralists and IDPs who have settled along the riverbanks. The AFI situation in Juba riverine is classified as stressed (Phase 2) with 10 percent of the population in Crisis (Phase 3), while acute malnutrition is classified as Critical (Phase 4), indicating higher vulnerability to acute malnutrition in the area. Despite the favourable food security overall classification, the food security dimensions report that 5 percent of the household are resorting to extreme coping strategies while 20 percent are experiencing moderate to severe hunger and further, household food stocks remain a risk factor to monitor in the area. Cumulatively, household food inadequacies exist in Juba riverine that is further exhibited by severe food deprivations among children where less diversified diets and high reduced meals are reported with MDD (17.4 percent), MMF (1.5 percent) and minimum adequate diets at 0 percent. Nutrient inadequacies are further attributed to poor feeding practices with late introduction to solid and semi solid foods to children that is reported at zero percent that exhibit severe deprivations of older children that are continuously fed on liquids that they have outgrown based on increased nutrient demands leading to acute malnutrition, while increasing vulnerability to infection that in turn aggravates acute malnutrition.

The prevalence of diarrhoea (10.4 percent), Acute Respiratory Infections (ARI) (10.9 percent), and malaria (7.4 percent) were reported in the two weeks leading up to the survey. These childhood illnesses contribute to reduced food intake and impaired nutrient absorption, further exacerbating malnutrition. The child illness is reported against sub-optimal immunization coverage reports, measles (57.7 percent) and vitamin A supplementation (65.2 percent). Additionally, limited access to humanitarian assistance, due to ongoing insecurity, further hampers access to health and nutrition services. Further risk to disease is linked to widespread open defaecation where only 72 percent of the population lack access to sanitation facilities, and 67 percent lack access to safe drinking water, which increases the risk of waterborne diseases and exposure to faecal contamination, leading to high rates of diarrhoea, helminths and poor health outcomes which in turn, worsens acute malnutrition and threatens lives among the children less than 5 years. Food consumption presents the highest vulnerability both at the household and worse among the children followed by low environmental hygiene and lack of safe drinking water predisposing the children to infections and diseases that drive acute malnutrition in Juba riverine. Urgent multifaceted and multiparter integrated interventions are recommended to address acute malnutrition in this livelihood.



IDPs

There were nine IDPs that were in IPC Phase 3 and above for both AFI and AMN: Mogadishu, Kismayu, Baidoa, Dallow, Galkacyo, Dhusamareb, Beletweyne, Bosasso and Garowe. The food insecurity exhibited food gaps at the household level with household hunger score (HHS) and reduced coping strategies (rCSI) in crisis and above generally reported above 70 percent in majority of the IDP camps. The hunger gaps are supported by the poor food consumption among children aged 6-59 months where the minimum dietary diversity is generally below 5 percent with Dhusamareb and Galkacyo IDPs reporting 0 percent that is contrary to high HDDS reported in the camps that imply higher access to diversified food by adults than children in the same household. Despite fair performance in meal frequency, the very low dietary diversity implies cheap staples are continuously fed to the children contributing to severe nutrient inadequacies and acute malnutrition. The hunger gaps are attributed to continuous evictions (Mogadishu), high food prices, limited job opportunities and limited humanitarian assistance exacerbated by communal sharing as a coping strategy that negates the likely impact to beneficiary households. Low coverage of moderate acute malnutrition treatment contributes to the surge in severe acute malnutrition cases that question the logic of concentration of treatment on advanced malnutrition that is not only life threatening to the children but also requires more resources and increases the cost.

Further nutrient inadequacies are aggravated with sub-optimal care and feeding practices. Continued breastfeeding is notably low among the IDP mothers, and lowest at Dhusamareb (4.2 percent), Garowe (13 percent), Galkacyo (15 percent) and Bosasso (17 percent) despite breast milk being a crucial source of energy and nutrients for children after their first year. The proportion of children timely introduced to solid and semi solid foods remains significantly low in Kismayu (11 percent) and Dhusamareb (31.2 percent) that contribute to nutrient inadequacies and acute malnutrition. The inadequate care and feeding practices in the IDP populations is closely tied to the economic challenges resulting to many mothers leaving young children under the care of older children and seeking casual labour during the day that disrupts not only breastfeeding but also responsive caregiving. Malnourished mothers tend to struggle to produce sufficient breast milk, leading to early cessation of breastfeeding, while cultural norms often prioritize feeding older members of the household depriving the young children and further heightening malnutrition risks and contributing to acute malnutrition.

Disease not only increase nutrient requirements but also leads to reduced nutrient intake due to loss of appetite, losses based on the symptoms that further aggravate nutrient inadequacies and acute malnutrition. Among the IDP populations, cholera outbreak was reported in Mogadishu, Baidoa, Beletweyne and Hargeisa. Measles outbreak experienced in Mogadishu, Galkacyo, Beletweyne and Hargeisa. High malaria prevalence was reported in Baidoa (23.4 percent), Hargeisa (23.1 percent), Dollow (21.9 percent) and Mogadishu (18 percent). High diarrhoea prevalence of 23.8 percent while dysentery was reported in all the IDP analysis areas except for Bosasso. The high disease prevalence against poor food consumption and care practices increase vulnerability to acute malnutrition among children less than 5 years. The association between strong health system with efficient services and disease prevention and treatment underpins the need to strengthen health care among the IDP populations. Child immunizations contribute to reduced disease prevalence, frequency of infection and length of illness that if not optimally provided, contribute to further vulnerabilities to acute malnutrition among children less than 5 years. Suboptimal health services, particularly measles vaccination coverage, are reported in Mogadishu (27.2 percent), Beletweyne (44.4 percent), Baidoa (49.1 percent), Bosasso (54.7 percent) and Kismayu (56 percent) against the expected minimum of 95 percent coverage by HNO guidance (2021) for the IDP settings. Vitamin A supplementation remain highly suboptimal in most IDP setting but more severe in Mogadishu (27.9 percent), Baidoa (49.6 percent) and Dhusamareb (55.6 percent). Low immunization coverage resonates with disease outbreaks of measles and cholera reported in the IDP settings and additionally compromise benefits of immunity to other reported high prevalence child illnesses such as Malaria, and dysentery, contributing to acute malnutrition. The poor health services are attributed to constant eviction and movements experienced in Mogadishu and Baidoa that disrupt health services, reduce accessibility to health facilities, coupled with insecurities that prevent partners from keeping in truck with the services.

The inadequate living conditions and shelter fail to provide sufficient protection, and the lack of treated mosquito nets further increases their vulnerability to Malaria. Risk to infections is further aggravated by compromised hygiene in the overcrowded settlements where toilets are shared by many households and preference of use by adults while children and teenagers practice open defecation. In Kismayu IDP, only 5 percent of the households' access sanitation facilities; this poses high chances of environmental contamination that contribute to infection and high disease prevalence and acute malnutrition. Due to lack of sufficient water in the IDP settlements, there is extended use of drinking water from safe sources that face competing requirements by other domestic needs such as cooking and cleaning. This negates the

high access to safe sources of drinking water reported and increasing vulnerability to child illness and acute malnutrition. Acute malnutrition in the IDP settlements is a composite of food insecurity, poor consumption, care practices, suboptimal health services, high disease prevalence and inadequate water and sanitation facilities. This underpins the need for multisectoral integrated and timely programs, well- structured between government and partners to realize their impact on mitigating acute malnutrition in Somalia.

Rural linkages

There were seven rural areas that were in IPC Phase 3 and above for both AFI and AMN: Hawd pastoral, Addun pastoral, Shabelle riverine, Shabelle agropastoral, Beletweyne riverine, Bay agropastoral, and Elberde. All these areas reported HDDS of >90 percent, with HHS at 59 percent in Hawd pastoral, 52 percent in Addun pastoral, 49 percent in Beletweyne riverine, 33 percent in Elberde, 34 percent in Shabelle riverine, and 27 percent in Shabelle agropastoral. Food consumption scores were relatively high with less than 30 percent of the households employing reduced coping strategies. Additionally, MDD and MAD rates were below 5 percent, which indicates that children are not getting diverse nutritious foods despite households reporting good food dimensions. These shows that households report having sufficient or adequate food in terms of availability, but children within those households are still not receiving the necessary diverse and nutritious foods required for healthy growth and development, putting them at risk for malnutrition. Poor household food distribution can leave children without adequate nutrients, making them more vulnerable to malnutrition. This could be due to caregivers' lack of knowledge of the need for variety in a child's diet or how to prepare nutritious and age-appropriate meals for young children. Access to fruits and vegetables in areas such as pastoral communities may be a challenge. Further nutrient inadequacies are aggravated with sub-optimal care and feeding practices. Continued breastfeeding is notably better among Hawd and Addun pastoral (50 percent) while being lowest at Shabelle riverine (30 percent), and Shabelle agropastoral (25 percent), despite breast milk being a crucial source of energy and nutrients for children after their first year. The proportion of children introduced to solid and semi-solid foods was low in Beletweyne (26.6 percent), Hawd pastoral (36.5 percent), contributing to nutrient inadequacies and acute malnutrition. The inadequate care and feeding practices among the rural populations are as result of mothers being involved in economic activities such as taking care of livestock and farming impacting their ability to breastfeed for extended periods or timely introducing solid foods thereby disrupting responsive caregiving and heightening the risk of malnutrition among young children.

Disease not only increases nutrient requirements but also leads to reduced nutrient intake due to loss of appetite, losses based on the symptoms that further aggravate nutrient inadequacies and acute malnutrition. Malaria among young children being the most prevalent disease among Hawd (33.8 percent), Bay Agropastoral (28.3 percent) and Addun (25 percent) pastoral communities, with diarrhoea being a high-risk factor among Bay agropastoral, Shabelle riverine and Shabelle agropastoral at 16.7, 13.7 and 12.1 percent respectively. Cholera outbreaks were reported among Shabelle riverine and Beletweyne riverine with majority (60 percent) affected being young children below age of five. High disease prevalence against poor food consumption and care practices increase vulnerability to acute malnutrition among children less than 5 years. Child immunizations contribute to reduced disease prevalence, frequency of infection and length of illness that if not optimally provided contribute to further vulnerabilities to acute malnutrition among children less than 5 years. Suboptimal health services, particularly measles vaccination coverage, is reported in Shabelle agropastoral (6.4 percent), Shabelle riverine (8.2 percent), Bay agropastoral (17.5 percent), Hawd pastoral (61.3 percent). Polio coverage was also low among Shabelle agropastoral (34.7 percent), which is concerning as it may increase the risk of polio resurgence. These high disease prevalence and poor immunization coverages are highly contributed by limited access to health services in these rural areas. Access to sanitation facilities is extremely low among Shabelle riverine (53 percent), which in turn leads to high rates of open defecation, extremely low access to safe water among Beletweyne riverine (30 percent), Shabelle riverine (27 percent), all these factors increase susceptibility to diarrheal disease and thereby increasing the vulnerability to malnutrition.

Low household food assistance among rural communities, Bay Agropastoral (4 percent), Hawd (11 percent), Addun (21 percent), Elberde (28 percent), and none for Shabelle forces families to rely on already limited resources to meet their needs. Treatment coverage for moderate malnutrition in children in areas such as Addun (26 percent) and Hawd pastoral (39 percent), is likely to leave many children without necessary care to prevent their condition from progressing into severe malnutrition resulting to a surge running to about 200 percent that is more life threatening and comes with increased costs. Shocks such as droughts, flooding and insecurity among these rural communities continue in exacerbating existing vulnerabilities by disrupting access to health services and food systems and heightening the increase of malnutrition among young children.

Urban linkages

There were two urban livelihoods classified in Phase 3 for both AFI and AMN: Galkacyo and Dhusamareb. Both scales have been classified in Phase 3 in the previous Deyr season as well. The vulnerabilities have been attributed to high food prices and limited job opportunities in the urban areas. Despite very high HDDS in both livelihoods (>90 percent), the food consumption score that is a proxy indicator of household caloric availability in the previous seven days show vulnerabilities at 66 percent and 40 percent in Galkacyo and Dhusamareb respectively in crisis and above. Insufficient food intake and inconsistency in food availability at the household is further exhibited by the household hunger scale, where 74 percent and 76 percent of the households in Galkayo and Dhusamareb are in crisis and above, indicating food gaps at the household level against insignificant humanitarian support at 17 percent and 7 percent in Galkacyo and Dhusamareb respectively. Food consumption among children equally exhibit deficiencies where less than 5 percent of the children achieved the recommended five out of 8 food groups, which contrasts with the high food diversity scores-HDDS- observed at the household and implicating low access to food available to adults by children in the same household. Breastfeeding is a key supplemental component of the diet, especially among children aged 6-23 months, however, only 22.7 percent of the children in Dhusamareb were breast fed, which might have contributed to nutrient inadequacies among the children. Further, late introduction to solid and semi solid foods was observed in Dhusamareb and Galkacyo where only 23.8 and 56.2 percent of the children had a timely introduction to the foods; the liquids given over solid or semi-solid foods are less nutrient-dense, which leads to acute malnutrition. More interventions are required to target increasing access to available food at the household by children, while improving child feeding practices to manage and prevent acute malnutrition and save the young lives.

Disease prevalence was generally low, except for malaria, which poses high risk to acute malnutrition in Galkayo at 28.5 percent. Malaria further reduces nutrient intake due to loss of appetite against the increased nutrient needs. Immunization coverage for measles and Polio is quite high (>80 percent) that is attributed to the recent catch-up campaign. However, Vitamin A supplementation remains sub-optimal in Dhusamareb at 67 percent. Acute malnutrition in Galkacyo and Dhusamareb is therefore attributed mainly to food gaps at household level that is more severe among children aged less than 5 years in the same households. There is needed to address food security, intrahousehold food distribution and childcare practices to improve child consumption and reduce acute malnutrition among children.

THE ROLE OF HUMANITARIAN FOOD ASSISTANCE

Humanitarian Food Assistance (HFA) in Somalia has enabled sufficient and adequate food consumption by the most vulnerable households, mitigating loss of life and preventing the complete collapse of livelihoods. HFA in the Acute Food Insecurity (AFI) analysis includes unconditional cash, voucher and in-kind assistance for improved availability and access to food, and conditional cash transfers which promote building or rehabilitation of community assets that improve long-term food security and resilience. It also includes cash plus activities that improve availability and access to food by enabling vulnerable households to get back into production, sustain animal health, and avert further livelihood assets depletion. The Humanitarian Food Assistance (HFA) provided by food security partners covers up to 80 percent of the minimum caloric requirements. Additionally, over 70 percent of this assistance is delivered through cash and vouchers, offering recipients greater flexibility and fostering new markets for local producers and retailers.

With insufficient funding to meet the growing food insecurity needs in the country, FSC partners have undertaken prioritization of response through a combination of reducing rations/ cash transfer values and reducing the number of beneficiaries. Humanitarian partners will only target 2.5 million out of the 4.5 million people (56 percent) of the FSC people in need (PiN) in the 2025 HNRP. The planned HFA for the period January - June will reach an average of 1.4 million people translating to only 31 percent response against target. Assistance has been prioritized to the most food-insecure locations (including IDP sites) where needs are most severe, and to the most vulnerable population groups in line with the food security vulnerability framework. Vulnerable population groups such as newly displaced IDPs, households with acute malnourished children and pregnant and lactating women, protection referrals, minority and marginalized groups, and agropastoral households with high dependency burden who have repeatedly lost their crops and livestock assets have been prioritized for assistance.

In response to the growing needs and widening funding gaps, households will now receive six months of assistance and then discharged or linked with early recovery activities, while the cash and voucher transfer values have been adjusted to reflect available resources and funding levels. Vulnerable households will be provided with approximately 70 percent of the endorsed Food MEB cash transfer values translating to a national average adjusted transfer value of USD $55 per household. This precarious situation might be further exacerbated by the White House Executive Order "Reevaluating and Realigning United States Foreign Aid" signed on 20 January 2025 that directs the partial award suspension for activities under USAID/BHA awards.

During the current period (January - March 2025), HFA is reaching an average of 1.3 million people per month (38 percent of people in IPC Phase 3 and above). Extreme access challenges continue to constrain the delivery of HFA in six districts: Tayeeglow district (Bakool region), Sablaale district (Lower Shabelle region), Adan Yabaal (Middle Shabelle) and Bu'aale, Jilib and Saakow districts (Middle Juba Region) although there are significant populations in need in these areas.

For the projected period, only planned humanitarian food assistance that is either already funded or likely to be funded and is likely to be delivered has been considered. The planned HFA based on confirmed funding for the projection period (April – June 2025), will reach an average of 1.5 million per month (35 percent of people in IPC Phase 3 and above).

Humanitarian assistance plays a critical role in addressing acute malnutrition through treatment, supplementation, and prevention efforts, aiming to stabilize and improve nutrition outcomes among children under five and pregnant and lactating women (PLW). In 2024, 488,032 severely malnourished children (133 percent of PIN) and 736,994 moderately malnourished children (59 percent of PIN) received treatment. Coverage for severe acute malnutrition (SAM) treatment remained strong in urban and IDP settings but remained low in rural areas due to limited accessibility and funding constraints. Moderate acute malnutrition (MAM) supplementation was adequately covered in only 25 of the 72 targeted districts. However, several districts in Somaliland and Puntland, including Bossaso, experienced a decline in treatment and supplementation coverage due to reduced funding for operational partners. The scaling up of mass MUAC screening led to the early identification and referral of malnourished children, contributing to a reduction in SAM cases, particularly among IDPs in Baidoa.

Despite these efforts, funding shortages led to the scaling down of mobile and outreach services in rural areas, shifting the focus to facility-based nutrition services. However, the expansion of the iCCM+ approach in the coming months is expected to enhance access to nutrition services in rural and hard-to-reach areas.

Preventive nutrition-sensitive interventions remain underfunded, with low coverage of Blanket Supplementary Feeding Programs (BSFP), micronutrient supplementation, and Vitamin A supplementation. Additionally, poor quality and limited effectiveness of maternal, infant, and young child feeding (IYCF) interventions have had minimal impact on dietary behaviours.

Severe access constraints in five districts including Sablaale (Lower Shabelle) and Bu'aale, Jilib, Jaamame, and Saakow (Middle Juba), restricted service delivery, despite indications of high malnutrition levels. This is evidenced by the influx of severely malnourished children with medical complications from these districts being admitted to stabilization centers in neighbouring districts such Kismaayo.

Funding remains a major challenge, with only 60 percent of the HNRP funding secured, mostly for acute malnutrition treatment and supplementation. Minimal funding has been allocated for prevention-focused nutrition-sensitive interventions, and projections indicate a further decline, with resources primarily directed toward lifesaving nutrition services.

RECOMMENDATIONS FOR ACTION

While there have been relative improvements in food security and nutrition in the country since severe drought period in 2022/2023, levels of acute food insecurity and malnutrition remain high with 3.4 million to 4.4 million people in need of urgent humanitarian assistance, and 1.7 million of cases of children that will require treatment. Moreover, investing in interventions that address underlying causes of acute food insecurity and malnutrition and strengthen household food security, health, and nutrition are important. More specific response priorities are listed below.

Response Priorities

Acute food insecurity response priorities

While there have been relative improvements in food security and nutrition in the country compared to 2024 Deyr, it is crucial not to overlook the urgent needs of those who are acutely food insecure and facing crisis or worse food insecurity conditions (IPC Phase 3 or above). Moreover, investing in sustainable solutions to strengthen household food security, health, and nutrition is crucial. More specific response priorities are listed below.

- Sustained lifesaving and life sustaining Humanitarian Assistance: Urgent funding is required to continue and sustain multi-sectoral humanitarian assistance for Food Security, Nutrition, Health, and WASH programmes. These measures are essential in preventing deterioration into more severe levels of food and nutrition insecurity for the most vulnerable populations.
- Urgent advocacy and resource mobilization: Ramp up efforts in high-level advocacy and resource mobilization to increase funding for urgent humanitarian assistance to address the urgent food security and nutrition requirements of populations classified in IPC Phase 3 and above.
- Risk based programming: Strengthen readiness, anticipatory action (AA), and early response to support vulnerable communities to mitigate, adapt and build resilience to the adverse multiple effects of climate change and recurring shocks, including drought and floods.
- Scale up Integrated programs: Implement collaborative integrated programs for Food Security, Nutrition, Health, and WASH clusters. These integrated programs should focus on disrupting the cycle of food and nutrition insecurity, especially targeting populations in IPC Phase 3 or above.
- Enhance real time monitoring of Humanitarian food security assistance, and flag major deviations from the expected assistance that could warrant rolling out an update of the IPC projection to inform decision making at all levels. If HFSA is directly impacted, it will necessitate a projection update prior to the start of the projection period.
- Improved Efficiencies in Humanitarian Assistance: Improve the targeting of humanitarian assistance to ensure it reaches those most in need, using enhanced Vulnerability-Based Targeting (VBT) and registration mechanisms to prioritize the most vulnerable population groups and geographical areas, including marginalized communities and hard to reach locations.
- Collaboration between humanitarian and development programs: Integrating humanitarian assistance and development assistance is essential to support diverse and layered livelihood-based interventions that address the underlying causes of acute food insecurity and malnutrition, promoting sustainable development, building resilience, and contributing to peace and stability in the country.
- Social Protection Programmes: Social safety nets and human capital development programmes in both urban and rural areas to address predictable needs. Scale-up shock-responsive social protection programs targeting the most vulnerable and at-risk households.

Acute malnutrition response priorities

- Adopt a Multi-Sectoral Approach for Nutrition Resilience: Nutrition programs in IPC Phase 3 or worse areas should integrate cash and voucher assistance, dietary diversification, and livelihood protection to address food insecurity and malnutrition. Promoting climate-smart agriculture will improve local food production and enhance household nutrition, reducing dependence on humanitarian aid.

- Expand iCCM+ to Improve Access to Underserved Communities: Scaling up iCCM+ services will increase nutrition outreach in hard-to-reach rural areas. Strengthening the link between outreach programs and fixed health facilities will ensure continuity of care for malnourished children and improve access to treatment in marginalized communities.
- Prevent Malnutrition Through Locally Available Nutrient-Rich Foods: Strengthening wasting prevention efforts should include research on locally available, nutrient-rich complementary foods under the "First Foods" initiative. Linking nutrition-sensitive cash and voucher assistance to these foods will help families access affordable, diverse diets, while nutrient-fortified food vouchers will support local markets and dietary diversity.
- Enhance Early Detection and Referral of Malnutrition Cases: Expanding mass MUAC and family MUAC screening will empower households and caregivers to detect malnutrition at home and ensure timely referrals. Scaling up real-time nutrition data dashboards will improve the tracking of screening coverage, referral efficiency, and treatment outcomes, leading to faster intervention and better monitoring of malnutrition trends.
- Improve WASH Services to Reduce Malnutrition Risks: Expanding WASH access for households vulnerable to acute malnutrition will reduce health risks linked to poor hygiene. Distributing WASH kits to nutrition beneficiaries will improve infection prevention, while behaviour change campaigns will promote safe water use, sanitation, and food handling to strengthen nutrition resilience.
- Promote Infant and Young Child Feeding (IYCF) Through Social Behaviour Change: Developing context-specific behaviour change programs will encourage optimal breastfeeding and complementary feeding. Integrating IYCF education with food distribution, WASH, and health services will create a holistic approach, empowering caregivers to improve feeding practices, hygiene, and healthcare-seeking behaviours for better child nutrition.
- Strengthen the Integration of Nutrition Services into Public Health Facilities: To improve service sustainability and efficiency, nutrition programs should be fully integrated into existing public health facilities. Rationalizing service delivery points will optimize coverage and resource allocation, while linking outreach services and iCCM+ interventions to fixed health facilities will ensure continuity of care and comprehensive case management.
- Digitize Nutrition Records for Real-Time Monitoring and Decision-Making: Expanding the digitization of nutrition records will improve real-time tracking, supply chain management, and service efficiency. A centralized digital platform will enhance data integration and information sharing, enabling evidence-based planning, resource allocation, and program adaptation to improve nutrition outcomes.

Situation monitoring and update

The nutrition situation remains critical and requires close monitoring, particularly during the Gu season, which has historically been the peak period for wasting in Somalia. Mass MUAC screening and nutrition and mortality surveillance systems should be strengthened, with a focus on IDP settlements, malnutrition hotspots classified as IPC AMN Phase 4, rural and hard-to-reach areas. For inaccessible locations, proxy methods should be utilized to ensure data collection and timely intervention in vulnerable communities.

Risk factors to monitor

- La Niña Development and 2025 Gu Season Performance: Track the onset and performance of the Gu rains and their impact on crop and livestock production, which may reduce access to affordable, nutritious foods and worsen WASH conditions.
- Humanitarian Assistance and Funding Levels: Monitor funding trends to assess the availability and sustainability of lifesaving interventions in nutrition, health, WASH, and food security.
- Food and Nutrition Security in Vulnerable Populations: Assess food and nutrition security among displaced populations, marginalized communities, minorities, and other at-risk groups.
- Market Prices and Economic Indicators: Track local and imported food prices, milk and water costs, livestock prices, wage labour rates, and terms-of-trade for livestock-to-cereal and labour wage-to-cereal exchanges to understand household purchasing power.
- Access and Availability of Nutrient-Rich Foods: Monitor the availability and affordability of diverse diets, including milk and other essential nutrient-rich foods, particularly in rural and pastoralist areas.

- Insecurity and Conflict Impact: Assess how conflict and insecurity affect food security, nutrition, humanitarian access, and displacement patterns.
- Flood Risk and Impact on Livelihoods: Monitor flood risks and actual impacts, particularly in riverine areas, focusing on livelihood disruptions and population displacement.
- Admission Trends for Malnutrition and Immunization Coverage: Track the admission rates of acutely malnourished children and pregnant/lactating women in treatment and feeding centers, as well as immunization and vaccination coverage.
- Disease Outbreaks and Public Health Risks: Monitor outbreaks of malaria, diarrhoea, cholera, and measles, which can exacerbate malnutrition and mortality risks.

PROCESS AND METHODOLOGY

The 2024 Post Deyr IPC analysis workshop was held concurrently in Hargeisa, Garowe and Mogadishu from 20 January to 1 February 2025 and brought together members of the IPC Core Team, the GSU support group and analysts from various backgrounds. A refresher L1 training including Analysis Platform training was organized between January 15 to 19 prior the analysis workshop. The training was conducted successfully with the participation of the FSNAU, Government, Non-Governmental Organizations and the United Nations staff). The training covered the key essential topics especially the fundamental analysis tools and guidance on using the newly introduced IPC Analysis Platform to support the AFI analysis process. The other activities conducted during this period also include data analysis, data preparation and checks as well as data uploading in AP. The IPC GSU team led and facilitated the IPC analysis process. As part of the IPC Cross-Country Learning Exchange (CCLE) programme, two experts from South Sudan TWG participated in the Acute Malnutrition analysis workshop, to facilitate the training and analysis sessions. The IPC AFI and AMN analysts were divided into three main hubs: Mogadishu, Garoowe, and Hargeisa. IPC GSU staff provided technical support and oversight across all hubs in collaboration with the in-country co-facilitators. Participants were drawn from the IPC Core Team members, including stakeholders from the government, IASC Clusters, UN agencies, NGOs and technical partners. According to IPC protocols, the analysis was assigned a high level of evidence, categorized between Medium (**) and High (***).

The classifications were done based on convergence of evidence using a wide range of household data sources including the prevalence of acute malnutrition) , food consumption scores, coping strategies, and household hunger scales. The analysis covered the periods from January to June 2025. The overall evidence level of the AMN analysis was high areas analysed using GAM by WHZ, and medium for areas analysed using GAM by MUAC.

The population estimates for the sampling units were based on the UNFPA 2014 population census and updated CCCM Detailed Site Assessments (DSA) etc. IPC acute food insecurity analysis and total acute malnutrition (burden) estimates were made based on the 2025 Somalia population (19,280,850 total) obtained from OCHA.

Variables (anthropometric and all other contextual indicators) and mortality were entered using EPI info software 7.2.5 and ENA SMART software (Jan11th 2020 version), respectively. Infant and Young Child Feeding (IYCF) indicators were analysed using RStudio software. For quality assurance, enumerators and supervisors received five days of training prior to data collection. During the fieldwork, enumerators and supervisors checked the anthropometric data set daily using ENA SMART software plausibility parameters.

Data Collection and Sources

For AMN analysis, FSNAU and partners conducted 38 surveys which were based on Standardized Monitoring and Assessment of Relief and Transitions (SMART) methodology, and 6 were assessments that used Mid Upper Arm Circumference (MUAC) as an indicator of wasting. The survey covered 26,961 children aged 6–59 months (13,397 boys and 13,564 girls) from 21,174 households. During the SMART assessments, all sampled households also provided retrospective mortality data for the 93 days prior to the assessments. The same households provided concurrent data on mortality, food security, and nutrition. Other data sources were from partners such as Nutrition cluster, ACF, REACH and WHO. The analysis was conducted for 44 analysis areas (23 rural livelihoods, 11 urban areas and 10 IDPs).

FSNAU carried out 43 household surveys (22 in rural, 11 in urban, and 10 among IDPs). Save the Children International conducted 1 additional assessment in rural areas. The various assessments generated data on food security and nutrition outcome indicators, including on Food Consumption Score (FCS), Household Dietary Diversity Score (HDDS), Reduced Coping Strategies Index (rCSI), Household Hunger Scale (HHS), Livelihood Coping Strategies (LCS), Global Acute Malnutrition (GAM) prevalence, Crude Death Rate (CDR), and Under-Five Death Rate (U5DR).

Sampling Design

Most of the 2024 Post Deyr surveys employed a two-stage cluster sampling method to ensure representative data collection. The first stage involved the selection of clusters based on probability proportional to population size (PPS), using the master list derived from the 2014 UNFPA population census and updated with detailed site assessments (DSAs). In the second stage, households within the selected clusters were chosen through simple random sampling or segmentation methods. The target population included all households in accessible, secure, and non-deserted areas.

Limitations of the analysis

While the assessment provides a strong overview of the acute food insecurity situation in Somalia, several limitations should be noted:

1. Access and Security Constraints: Some areas, particularly those affected by conflict, were inaccessible, limiting the coverage of the assessment. As a result, certain populations may be underrepresented in the analysis and the extrapolation protocol was applied using similar livelihood or adjacent neighbouring areas.

2. Data Quality and Non-response: Despite rigorous training and supervision of survey teams, challenges related to data quality and non-response rates, particularly in areas with high mobility or insecurity might increase the non-response bias.

3. Population figures discrepancies: There are significant discrepancies between PESS 2014, OCHA/IMWG, REACH/CCM Detailed Site Assessments, etc., and observations on the ground in terms of IDP population estimates. These affect the sampling process and the acute malnutrition burden estimation.

4. Assumptions in Projection: The projection period included in the analysis relies on several assumptions, including the continuation of current trends in humanitarian assistance, market access, and climatic conditions. Any significant changes in these factors may possibly change the food security and nutrition outlook.

What are the IPC, IPC Acute Food Insecurity and IPC Acute Malnutrition?

The IPC is a set of tools and procedures to classify the severity and characteristics of acute food and nutrition crises as well as chronic food insecurity based on international standards. The IPC consists of four mutually reinforcing functions, each with a set of specific protocols (tools and procedures). The core IPC parameters include consensus building, convergence of evidence, accountability, transparency and comparability. The IPC analysis aims at informing emergency response as well as medium and long-term food security policy and programming.

For the IPC, Acute Food Insecurity and Acute Malnutrition are defined as any manifestation of food insecurity or malnutrition found in a specified area at a specific point in time of a severity that threatens lives or livelihoods, or both, regardless of the causes, context or duration. The IPC Acute Food Insecurity Classification is highly susceptible to change and can occur and manifest in a population within a short amount of time, as a result of sudden changes or shocks that negatively impact the determinants of food insecurity. The IPC Acute Malnutrition Classification's focus is on identifying areas with a large proportion of children acutely malnourished preferably by measurement of Weight for Height Z-Score (WHZ) but also by Mid-Upper Arm Circumference (MUAC).

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IPC Analysis Partners:

ANNEX 1: COMPARATIVE ANALYSIS OF GAM PREVALENCE BETWEEN 2024 POST DEYR AND 2023 POST DEYR BY UNIT OF ANALYSIS

Population Group assessed	GAM prevalence (percent)		Difference (2023 Deyr vs 2022 Deyr)		Remarks
	2023 Deyr (95 percent CI)	2022 Deyr (95 percent CI)	GAM Prevalence	p-value	
Guban Pastoral	11.3 percent (8.5-14.8)	5.0 (3.1- 8.0)	6.3	0.002	Significant deterioration
West Golis	7.8 percent (5.2-11.5)	12.7 (8.9-17.7)	-4.9	0.068	Insignificant (only phase change)
NW agropastoral	7.4 percent (5.7-9.6)	9.3 (7.2-11.8)	-1.9	>0,05	Likely No Change
Hargeisa IDPs (W. Galbeed)	11.0 percent (8.3-14.3)	10.3 (8.0-13.1)	0.7	>0,05	Phase change,
Hargeisa Urban(W. Galbeed)	8.2 percent (6.0-11.3)	7.9 (5.7-10.9)	0.3	>0,05	Likely No Change
Burao IDPs (Toghdeer)	5.2 (3.7- 7.4)	11.4 (9.0-14.5)	-6.2	0.0000	Significant Improvement
Burao urban (Toghdeer)	6.5 (4.4- 9.5)	5.3 (3.9- 7.2)	1.2	>0,05	Likely No Change
Northern Inland Pastoral NW	9.1 percent (7.0-11.7)	6.1 (4.2- 8.6)	3.0	>0,05	Likely No Change
NW Hawd Pastoral	3.6 percent (2.3-5.7)	7.8 (5.6-10.7)	-4.2	0.006	Significant Improvement
East Golis (Cross cutting-NW and NE)	9.3 percent (7.0-12.2)	7.2 (5.0-10.1)	2.1	>0,05	Likely No Change
Bosasso IDPs (Bari)	17.9 (14.6-21.7)	18.0 (14.7-21.8)	-0.1	>0,05	Likely No Change
Bosasso Urban (Bari)	12.9 (9.7-17.0)	10.0 (6.6-14.9)	2.9	>0,05	Likely No Change
Northern Inland Pastoral (NE)	8.4 percent (6.3-11.0)	8.0 (5.2-12.1)	0.4	>0,05	Likely No Change
Hawd Pastoral-Central	13.4 percent (10.4-17.1)	18.0 (15.6-20.8)	-4.6	0.029	Significant Improvement
Coastal Deeh (NE)	7.1 percent (4.7-10.5)	7.6 (4.9-11.7)	-0.5	>0,05	Likely No Change
Garowe IDPs (Nugaal)	11.4 (8.5-15.1)	7.6 (5.5-10.4)	3.8	0.062	Insignificant (only phase change)
Garowe Urban (Nugaal)	6.7 (4.4-10.1)	5.1 (3.5- 7.3)	1.6	>0,05	Likely No Change
Galkacyo IDPs (Mudug)	19.1 (15.9-22.7)	18.0 (14.9-21.5)	1.1	>0,06	Likely No Change
Galkacyo Urban(Mudug)	12.6 (10.3-15.4)	12.9 (9.8-16.9)	-0.3	>0,05	Likely No Change
Dhusamareb IDPs (Galgadud)	13.1(10.3-16.4)	16.5	-3.4	0.158	Insignificant (only phase change)
Dhusamareb Urban (Galgadud)	12.1 (9.5-15.3)	8.7 (5.9-12.7)	3.4	>0,115	Insignificant (only phase change)
Addun Pastoral	13.7 percent (10.8-17.3)	14.6 (11.5-18.4)	-0.9	>0,05	Likely No Change
Beletweyne Rural (riverine)	16.4 percent (13.4-19.9)	15.5 (10.8-21.7)	0.9	>0,05	Likely No Change
Beletweyne urban/IDPs	10.9 percent (8.6-13.7)	20.3 (16.4-24.9)	-9.4	0	Significant Improvement
Shabelle Riverine	16.0(12.9-19.7)	15.9 (13.2-19.2)	0.1	>0,05	Likely No Change
Shabelle agropastoral	14.8(12.2-17.9)	15.4 (11.1-21.0)	-0.6	>0,05	Likely No Change
Mogadishu urban (Banadir)	12.1 (9.2-15.8)	13.8 (10.6-17.8)	-1.7	>0,05	Likely No Change
Mogadishu IDPs (Banadir)	16.1 (13.4-19.4)	16.2 (13.2-19.8)	-0.1	>0,05	Likely No Change

Note: The above comparative analysis analysis was done using the CDC SMART calculator for two surveys

**Dhusamareb IDPs (Galgadud) is exhaustive assessment, covering all sections of the settlement and all eligible households.*

ANNEX 2: FOOD SECURITY OUTCOME INDICATORS BY POPULATION GROUP

Source	Population Group/ Livelihood Zone	Food Consumption Score			Housheold Dietary Diversity Score-HDDS			Reduced Coping Strategies-rCSI			Household Hunger Scale-HHS					Livelihood Coping				WHZ
		Acceptable	Borderline	Poor	Minimal-Stressed (>4)	Crisis (3-4)	Emergency (<3)	Minimal	Stressed	Crisis	None	Stressed	Crisis	Emergency	Catastrophe	None	Stressed	Crisis	Emergency	
FSNAU	NW Guban Pastoral (Awdal, Sanaag and W. Galbeed)	74%	10%	16%	77%	23%	0%	83%	17%	0%	99%	1%	0%	0%	0%	96%	2%	1%	0%	23.5
FSNAU	NW West Golis Pastoral (Awdal, W. Galbeed, Toghdeer, Sool and Sanaag)	81%	16%	3%	96%	4%	0%	81%	19%	0%	70%	17%	13%	0%	0%	60%	39%	1%	1%	15.6
FSNAU	NW Northwest Agro-pastoral (Awdal, W. Galbeed & Togdheer)	91%	7%	2%	99%	1%	0%	91%	8%	0%	86%	3%	10%	1%	0%	70%	13%	7%	10%	20.9
FSNAU	NW Hawd Pastoral of NW (W. Galbeed, Toghdeer and Sool)	63%	31%	6%	99%	1%	0%	64%	34%	3%	56%	29%	16%	0%	0%	60%	40%	0%	0%	24.8
FSNAU	NE Hawd Pastoral (North Mudug and Nugaal)	75%	24%	1%	96%	4%	0%	9%	80%	11%	9%	32%	55%	4%	0%	2%	35%	43%	19%	38.0
FSNAU	NE East Golis Pastoral (Bari)	55%	24%	21%	65%	35%	0%	72%	28%	0%	78%	11%	10%	0%	0%	43%	47%	8%	2%	14.4
FSNAU	Central Coastal Deeh Pastoral (Mudug and Galgadud)	84%	11%	6%	89%	11%	0%	67%	33%	0%	65%	9%	26%	0%	0%	61%	35%	2%	1%	18

Source	Population Group/ Livelihood Zone	Food Consumption Score			Housheold Dietary Diversity Score-HDDS			Reduced Coping Strategies-rCSI			Household Hunger Scale-HHS					Livelihood Coping				WHZ
		Acceptable	Borderline	Poor	Minimal-Stressed (>4)	Crisis (3-4)	Emergency (<3)	Minimal	Stressed	Crisis	None	Stressed	Crisis	Emergency	Catastrophe	None	Stressed	Crisis	Emergency	
FSNAU	Central Addun pastoral (Mudug and Galgaduud)	46%	51%	3%	93%	7%	0%	1%	88%	11%	13%	34%	48%	4%	0%	4%	8%	58%	30%	18
FSNAU	NW Northern Inland Pastoral (Sanaag and Sool)	36%	16%	49%	70%	18%	12%	51%	47%	2%	76%	7%	16%	0%	0%	51%	48%	0%	0%	22.4
FSNAU	Gedo Southern Inland Pastoral	91%	9%	0%	97%	2%	1%	10%	85%	5%	10%	27%	63%	0%	0%	3%	83%	12%	2%	27.2
FSNAU	Gedo Riverine Pump Irrigation	69%	25%	5%	98%	2%	1%	8%	81%	11%	8%	39%	53%	0%	0%	0%	64%	15%	21%	22.3
FSNAU	Shabelle Riverine Gravity Irrigation (L Shabelle & M Shabelle)	100%	0%	0%	100%	0%	0%	23%	50%	27%	28%	38%	34%	0%	0%	24%	20%	50%	5%	16.3
FSNAU	Shabelle Sorghum High Potential Agropastoral (M Shabelle and L Shabelle)	99%	1%	0%	100%	0%	0%	37%	46%	17%	41%	32%	27%	0%	0%	35%	31%	32%	2%	13.6
FSNAU	Bay-Bakool Agro-pastoral Low Potential (Bay and Bakool)	73%	25%	3%	95%	4%	1%	56%	37%	7%	63%	11%	25%	2%	0%	57%	22%	20%	1%	36.8
FSNAU	NE Northern Inland Pastoral (Bari and Nugaal)	63%	35%	2%	81%	19%	0%	80%	20%	1%	80%	9%	11%	0%	0%	77%	11%	11%	0%	14.7

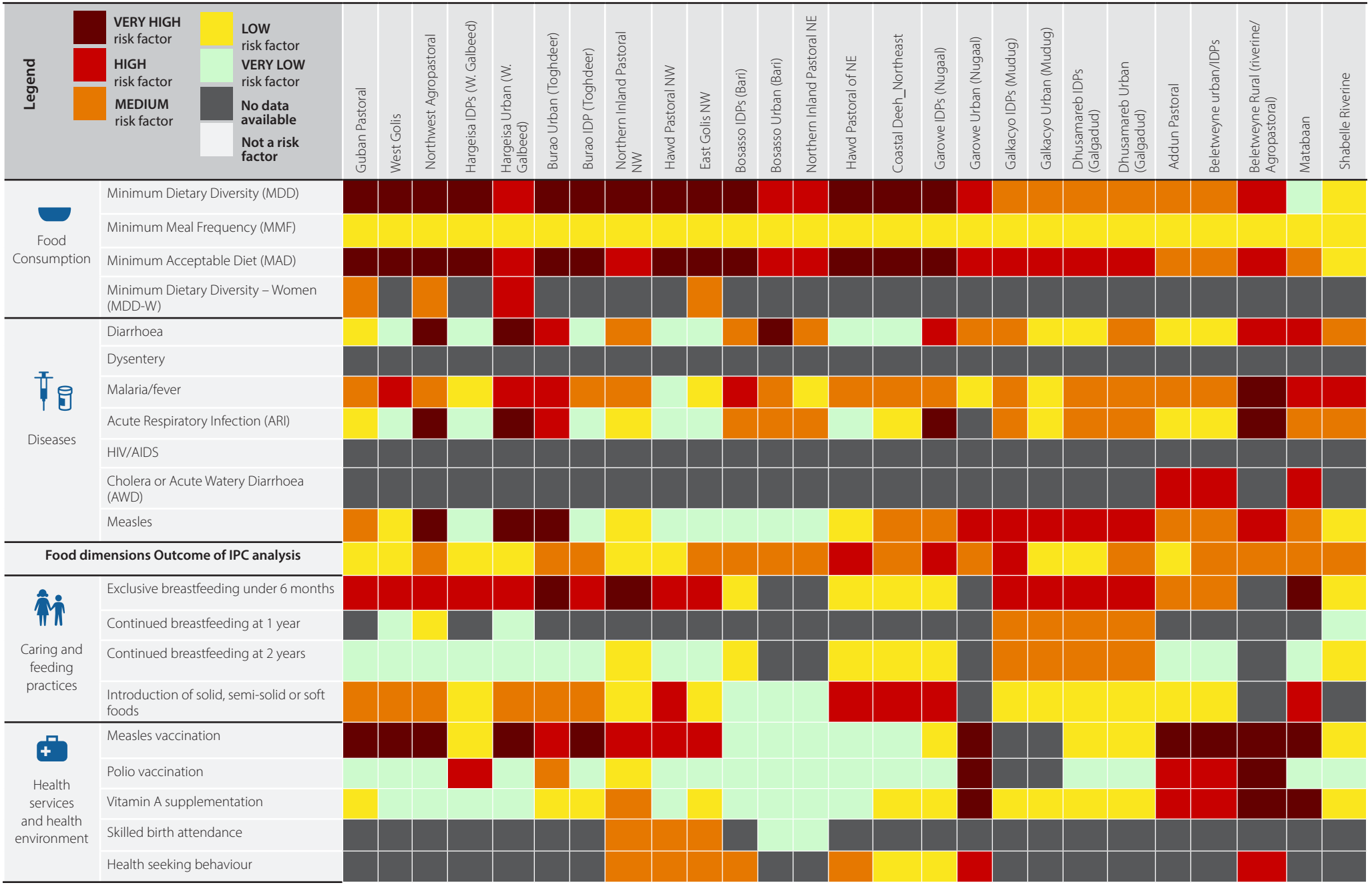
Source	Population Group/ Livelihood Zone	Food Consumption Score			Housheold Dietary Diversity Score-HDDS			Reduced Coping Strategies-rCSI			Household Hunger Scale-HHS					Livelihood Coping				WHZ
		Acceptable	Borderline	Poor	Minimal-Stressed (>4)	Crisis (3-4)	Emergency (<3)	Minimal	Stressed	Crisis	None	Stressed	Crisis	Emergency	Catastrophe	None	Stressed	Crisis	Emergency	
FSNAU	Hiraan Riverine Pump and Gravity Irrigation	95%	5%	0%	95%	5%	0%	52%	25%	22%	48%	3%	49%	0%	0%	25%	48%	19%	9%	5.5
FSNAU	Bay Urban IDPs (Baydhaba)	27%	50%	23%	85%	12%	3%	25%	27%	48%	29%	13%	48%	11%	0%	23%	21%	27%	29%	28.6
FSNAU	Bay Urban (Baydhaba)	88%	10%	3%	97%	3%	0%	60%	19%	21%	60%	11%	27%	2%	0%	59%	25%	14%	2%	15.9
FSNAU	Togdheer Urban IDPs (Burco)	53%	18%	29%	96%	4%	0%	33%	56%	11%	53%	27%	21%	0%	0%	37%	59%	4%	0%	17.5
FSNAU	Togdheer Urban (Burco)	70%	22%	8%	100%	0%	0%	62%	35%	3%	68%	25%	7%	0%	0%	63%	36%	1%	0%	16.7
FSNAU	Bari Urban IDPs (Bossaso)	22%	52%	26%	50%	49%	0%	41%	59%	0%	43%	33%	24%	0%	0%	33%	38%	28%	1%	7.1
FSNAU	Bari Urban (Bossaso)	55%	40%	5%	77%	23%	0%	68%	32%	0%	73%	17%	9%	1%	0%	50%	31%	15%	5%	2.8
FSNAU	Galgaduud Urban IDPs (Dhuusamarreeb)	35%	36%	30%	60%	36%	4%	0%	21%	79%	0%	4%	89%	7%	0%	4%	45%	41%	9%	8.2
FSNAU	Galgaduud Urban (Dhuusamarreeb)	60%	37%	3%	93%	7%	0%	6%	58%	36%	4%	21%	73%	2%	1%	13%	57%	27%	3%	16.7
FSNAU	Gedo Urban IDPs (Doolow)	63%	28%	9%	85%	14%	2%	4%	75%	20%	9%	29%	61%	1%	1%	30%	58%	11%	1%	28.9
FSNAU	Gedo Urban (Doolow)	89%	11%	1%	94%	5%	1%	18%	78%	3%	76%	23%	2%	0%	0%	6%	89%	2%	3%	16.7
FSNAU	Mudug Urban IDPs (Gaalkacyo)	45%	49%	6%	95%	5%	0%	26%	51%	23%	27%	33%	40%	0%	0%	10%	7%	51%	32%	27.6

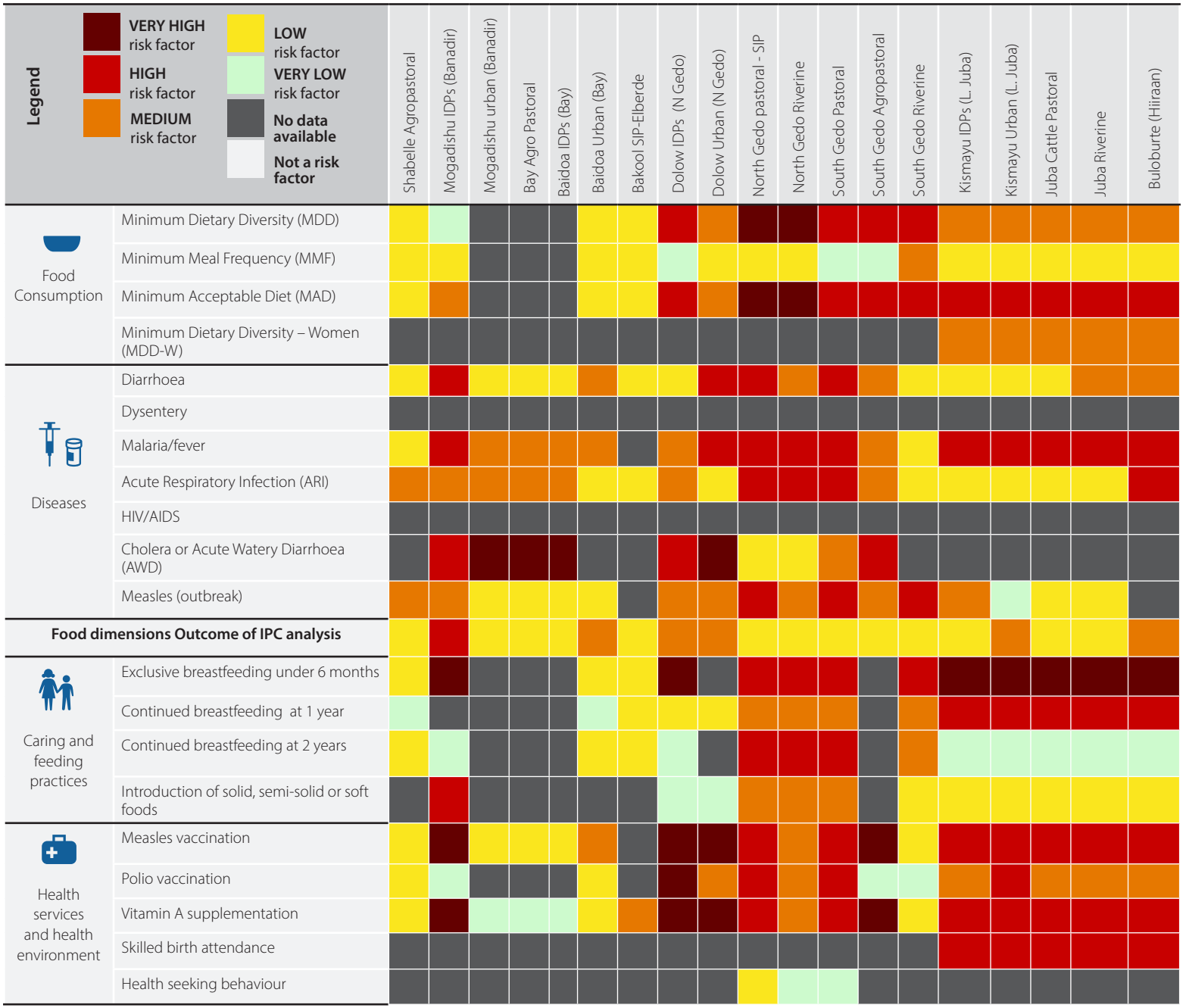
Source	Population Group/ Livelihood Zone	Food Consumption Score			Housheold Dietary Diversity Score-HDDS			Reduced Coping Strategies-rCSI			Household Hunger Scale-HHS					Livelihood Coping				WHZ
		Acceptable	Borderline	Poor	Minimal-Stressed (>4)	Crisis (3-4)	Emergency (<3)	Minimal	Stressed	Crisis	None	Stressed	Crisis	Emergency	Catastrophe	None	Stressed	Crisis	Emergency	
FSNAU	Mudug Urban (Gaalkacyo)	34%	64%	2%	98%	2%	0%	0%	96%	4%	5%	21%	74%	0%	0%	1%	16%	73%	11%	29.9
FSNAU	Nugaal Urban IDPs (Garoowe)	78%	19%	3%	91%	9%	0%	75%	25%	0%	56%	22%	22%	0%	0%	67%	21%	12%	0%	13.4
FSNAU	Nugaal Urban (Garoowe)	94%	6%	1%	95%	6%	0%	63%	37%	0%	62%	11%	28%	0%	0%	60%	38%	2%	0%	14.7
FSNAU	Lower Juba Urban IDPs (Kismaayo)	64%	33%	3%	91%	9%	0%	34%	52%	13%	30%	25%	45%	0%	0%	15%	20%	42%	22%	7.8
FSNAU	Lower Juba Urban (Kismaayo)	94%	5%	0%	95%	5%	0%	63%	32%	5%	55%	24%	21%	0%	0%	42%	13%	14%	31%	14.9
FSNAU	Banadir Urban IDPs (Mogadishu)	90%	9%	1%	97%	3%	0%	14%	51%	35%	20%	32%	48%	0%	0%	17%	48%	26%	9%	20.9
FSNAU	Banadir Urban (Mogadishu)	100%	0%	0%	100%	0%	0%	91%	9%	0%	92%	3%	5%	0%	0%	90%	3%	7%	0%	14.9
FSNAU	Woqooyi Galbeed Urban IDPs (Hargeysa)	87%	3%	10%	99%	1%	0%	89%	9%	2%	89%	6%	5%	0%	0%	83%	13%	2%	2%	31.9
FSNAU	Woqooyi Galbeed Urban (Hargeysa)	86%	8%	6%	99%	1%	0%	94%	5%	1%	92%	6%	3%	0%	0%	78%	20%	2%	0%	28.1
FSNAU	Hiraan Urban IDPs (Belet Weyne)	96%	3%	2%	95%	5%	0%	47%	52%	2%	20%	7%	73%	0%	0%	27%	70%	2%	1%	9.7
FSNAU	Hiraan Urban (Belet Weyne)	91%	8%	2%	98%	2%	0%	75%	23%	2%	69%	0%	31%	0%	0%	63%	30%	5%	3%	9.7

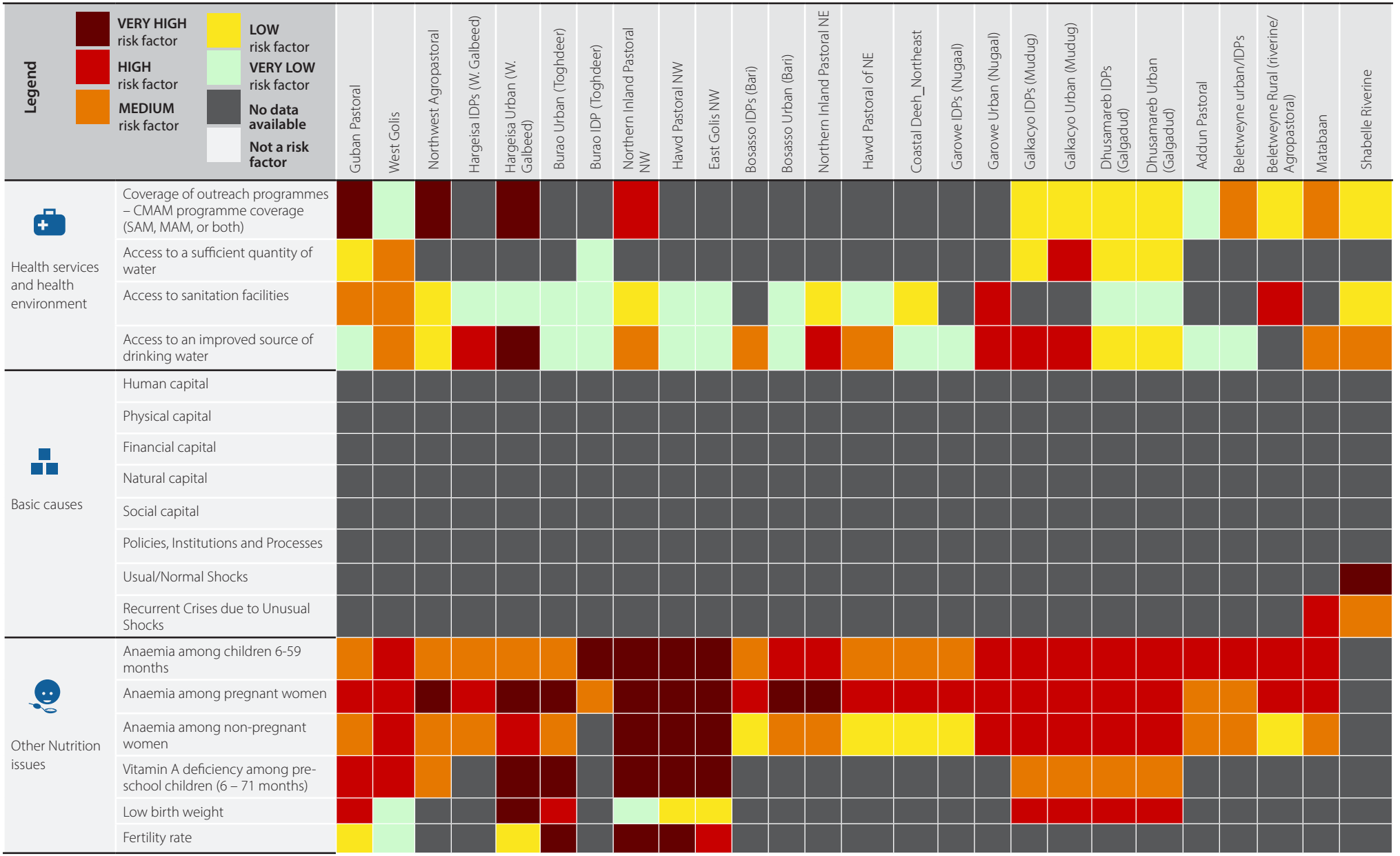
Source	Population Group/ Livelihood Zone	Food Consumption Score			Housheold Dietary Diversity Score-HDDS			Reduced Coping Strategies-rCSI			Household Hunger Scale-HHS					Livelihood Coping				WHZ
		Acceptable	Borderline	Poor	Minimal-Stressed (>4)	Crisis (3-4)	Emergency (<3)	Minimal	Stressed	Crisis	None	Stressed	Crisis	Emergency	Catastrophe	None	Stressed	Crisis	Emergency	
FSNAU	Bay-Gedo Sorghum High Potential Ag-ropastoral (Bay and Gedo)	73%	25%	3%	95%	4%	1%	56%	37%	7%	63%	11%	25%	2%	0%	57%	22%	20%	1%	
FSNAU	M Shabelle Cow-pea Belt	46%	51%	3%	93%	7%	0%	1%	88%	11%	13%	34%	48%	4%	0%	4%	8%	58%	30%	
FSNAU	Shabelles Coast-al Deeh Pastoral and Fishing (L. Shabelle & M. Shabelle)	84%	11%	6%	89%	11%	0%	67%	33%	0%	65%	9%	26%	0%	0%	61%	35%	2%	1%	
FSNAU	Hiraan Southern Agro-Pastoral							85%	14%	1%	79%	1%	20%							
FSNAU	Gedo Southern Agro-Pastoral							85%	14%	1%	79%	1%	20%							
FSNAU	Juba Southern Agro-Pastoral (M Juba and L Juba)							85%	14%	1%	79%	1%	20%							
FSNAU	Hiraan Southern Inland Pastoral	91%	9%	0%	97%	2%	1%	10%	85%	5%	10%	27%	63%	0%	0%	3%	83%	12%	2%	
FSNAU	Shabelle South-ern Inland Pas-toral (M Shabelle and L Shabelle)	91%	9%	0%	97%	2%	1%	10%	85%	5%	10%	27%	63%	0%	0%	3%	83%	12%	2%	
FSNAU	Jubas Southern Inland Pastoral (M Juba and L Juba)	91%	9%	0%	97%	2%	1%	10%	85%	5%	10%	27%	63%	0%	0%	3%	83%	12%	2%	

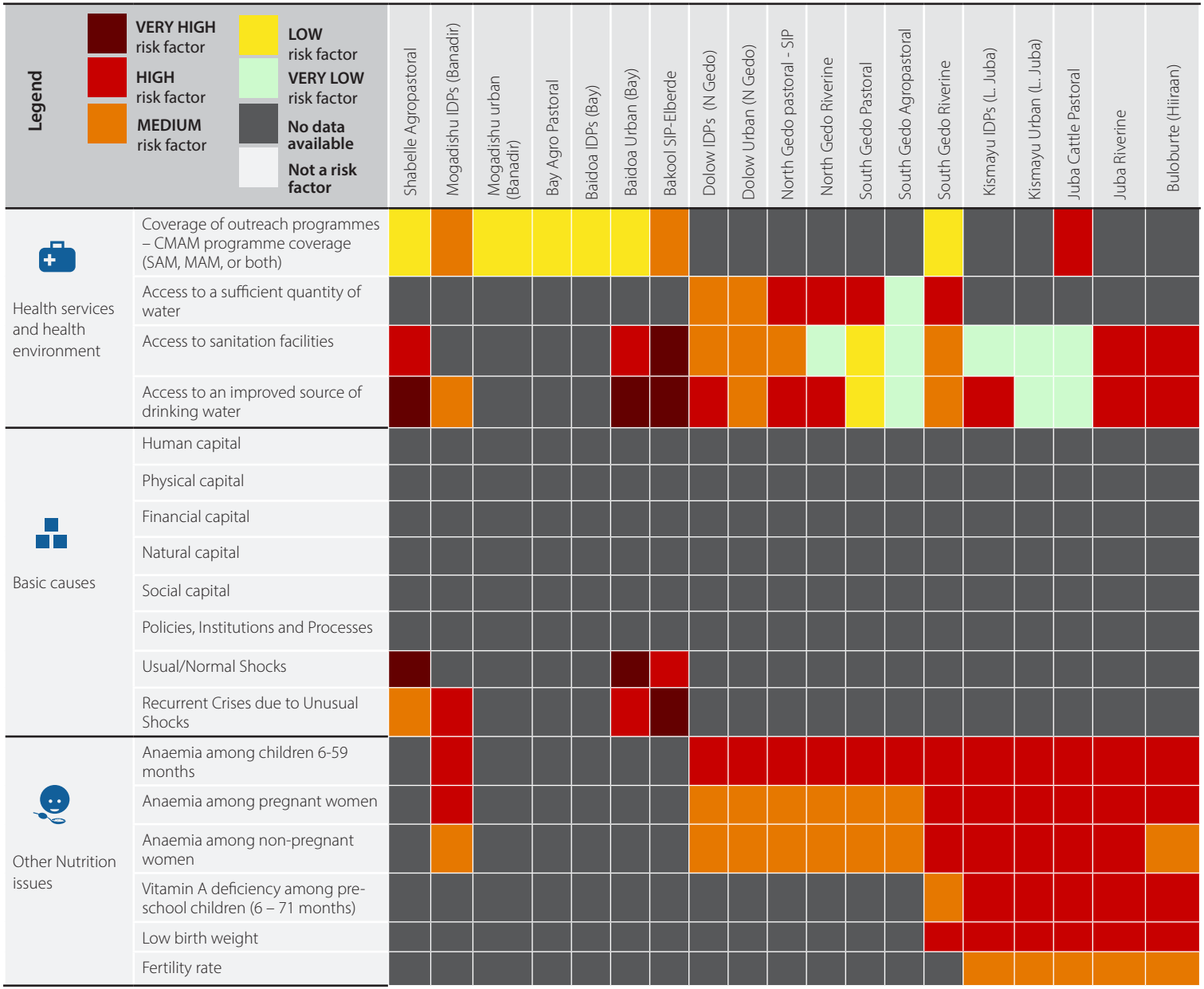
Source	Population Group/ Livelihood Zone	Food Consumption Score			Housheold Dietary Diversity Score-HDDS			Reduced Coping Strategies-rCSI			Household Hunger Scale-HHS					Livelihood Coping				WHZ
		Acceptable	Borderline	Poor	Minimal-Stressed (>4)	Crisis (3-4)	Emergency (<3)	Minimal	Stressed	Crisis	None	Stressed	Crisis	Emergency	Catastrophe	None	Stressed	Crisis	Emergency	
FSNAU	Shabelles Southern Rainfed (L Shabelle)							21%	74%	5%	14%	39%	48%							
FSNAU	Juba Sorghum High Potential Agropastoral (M Juba)	99%	1%	0%	100%	0%	0%	37%	46%	17%	41%	32%	27%	0%	0%	35%	31%	32%	2%	
FSNAU	Bakool Southern Inland Pastoral							64%	36%	0%	67%	19%	14%							
FSNAU	Juba Pastoral (M Juba and L Juba)							21%	74%	5%	14%	39%	48%							14.7
FSNAU	Gedo Southern Agro-Pastoral							85%	14%	1%	79%	1%	20%							9.2
FSNAU	Gedo Southern Inland Pastoral							92%	8%	1%	92%	1%	6%							8.8
FSNAU	Gedo Riverine Pump Irrigation							83%	15%	2%	80%	5%	15%							10
WFP	Hiran Southern Inland Pastoral	54%	31%	15%	79%	19%	2%	20%	39%	41%	41%	29%	28%	2%	0%	16%	38%	30%	17%	
WFP	Borama Urban	60%	24%	16%	81%	19%	0%	70%	20%	10%	84%	8%	7%	1%	0%	41%	41%	12%	5%	
WFP	Borama IDPs	37%	39%	24%	61%	38%	1%	59%	27%	14%	74%	15%	10%	1%	1%	36%	36%	23%	5%	
WFP	Ceerigaabo Urban	48%	33%	19%	73%	26%	1%	46%	44%	10%	68%	14%	15%	3%	1%	48%	32%	18%	3%	
WFP	Ceerigaabo IDPs	52%	24%	24%	74%	26%	0%	42%	45%	13%	72%	12%	14%	1%	1%	37%	35%	25%	3%	
WFP	Bakool Southern Agropastoral	50%	37%	13%	78%	19%	3%	7%	71%	22%	54%	24%	21%	0%	0%	11%	15%	59%	15%	
WFP	Xudur Urban	71%	20%	9%	88%	11%	1%	17%	76%	7%	71%	22%	7%	0%	0%	16%	44%	29%	11%	
WFP	Xudur IDPs	36%	43%	21%	76%	21%	3%	5%	72%	23%	55%	25%	18%	1%	1%	14%	39%	34%	14%	
SCI	Mataban SMART	42%	35%	23%				3%	36%	61%	5%	5%	52%	17%	21%					

ANNEX 3: 2024 POST DEYR LIST OF ACUTE MALNUTRITION MAJOR CONTRIBUTING FACTORS




Legend
VERY HIGH risk factor
HIGH risk factor
MEDIUM risk factor
LOW risk factor
VERY LOW risk factor
No data available
Not a risk factor
Shabelle Agropastoral
Mogadishu IDPs (Banadir)
Mogadishu urban (Banadir)
Bay Agro Pastoral
Baidoa IDPs (Bay)
Baidoa Urban (Bay)
Bakool SIP-Elberde
Dolow IDPs (N Gedo)
Dolow Urban (N Gedo)
North Gedo pastoral - SIP
North Gedo Riverine
South Gedo Pastoral
South Gedo Agropastoral
South Gedo Riverine
Kismayu IDPs (L. Juba)
Kismayu Urban (L. Juba)
Juba Cattle Pastoral
Juba Riverine
Buloburte (Hiiraan)
Food Consumption
Minimum Dietary Diversity (MDD)
Minimum Meal Frequency (MMF)
Minimum Acceptable Diet (MAD)
Minimum Dietary Diversity – Women (MDD-W)
Diseases
Diarrhoea
Dysentery
Malaria/fever
Acute Respiratory Infection (ARI)
HIV/AIDS
Cholera or Acute Watery Diarrhoea (AWD)
Measles (outbreak)
Food dimensions Outcome of IPC analysis
Caring and feeding practices
Exclusive breastfeeding under 6 months
Continued breastfeeding at 1 year
Continued breastfeeding at 2 years
Introduction of solid, semi-solid or soft foods
Health services and health environment
Measles vaccination
Polio vaccination
Vitamin A supplementation
Skilled birth attendance
Health seeking behaviour


Legend
VERY HIGH risk factor
HIGH risk factor
MEDIUM risk factor
LOW risk factor
VERY LOW risk factor
No data available
Not a risk factor
Guban Pastoral
West Golis
Northwest Agropastoral
Hargeisa IDPs (W. Galbeed)
Hargeisa Urban (W. Galbeed)
Burao Urban (Toghdeer)
Burao IDP (Toghdeer)
Northern Inland Pastoral NW
Hawd Pastoral NW
East Golis NW
Bosasso IDPs (Bari)
Bosasso Urban (Bari)
Northern Inland Pastoral NE
Hawd Pastoral of NE
Coastal Deeh_Northeast
Garowe IDPs (Nugaal)
Garowe Urban (Nugaal)
Galkacyo IDPs (Mudug)
Galkacyo Urban (Mudug)
Dhusamareb IDPs (Galgadud)
Dhusamareb Urban (Galgadud)
Addun Pastoral
Beletweyne urban/IDPs
Beletweyne Rural (riverine/ Agropastoral)
Matabaan
Shabelle Riverine
Health services and health environment
Coverage of outreach programmes – CMAM programme coverage (SAM, MAM, or both)
Access to a sufficient quantity of water
Access to sanitation facilities
Access to an improved source of drinking water
Basic causes
Human capital
Physical capital
Financial capital
Natural capital
Social capital
Policies, Institutions and Processes
Usual/Normal Shocks
Recurrent Crises due to Unusual Shocks
Other Nutrition issues
Anaemia among children 6-59 months
Anaemia among pregnant women
Anaemia among non-pregnant women
Vitamin A deficiency among pre-school children (6 – 71 months)
Low birth weight
Fertility rate


Legend
VERY HIGH risk factor
HIGH risk factor
MEDIUM risk factor
LOW risk factor
VERY LOW risk factor
No data available
Not a risk factor
Shabelle Agropastoral
Mogadishu IDPs (Banadir)
Mogadishu urban (Banadir)
Bay Agro Pastoral
Baidoa IDPs (Bay)
Baidoa Urban (Bay)
Bakool SIP-Elberde
Dolow IDPs (N Gedo)
Dolow Urban (N Gedo)
North Gedo pastoral - SIP
North Gedo Riverine
South Gedo Pastoral
South Gedo Agropastoral
South Gedo Riverine
Kismayu IDPs (L. Juba)
Kismayu Urban (L. Juba)
Juba Cattle Pastoral
Juba Riverine
Buloburte (Hiiraan)
Health services and health environment
Coverage of outreach programmes – CMAM programme coverage (SAM, MAM, or both)
Access to a sufficient quantity of water
Access to sanitation facilities
Access to an improved source of drinking water
Basic causes
Human capital
Physical capital
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