World Health Organization

HEALTH CLUSTER

*Federal Republic of Somalia*

Date: 04 March 2026

# Public Health Situation Analysis (PHSA)

| Typologies of emergency | Main health threats | WHO grade | Security Risks[1] | INFORM Risk Index (2025)[2] |
|---|---|---|---|---|
| Drought<br>Conflict<br>Food security<br>Displacement<br>Floods | Malnutrition<br>Cholera and acute watery diarrhoea (AWD)<br>Maternal and Child Health<br>Measles<br>Respiratory Infections<br>Poliovirus type 2 (cVDPV2)<br>Malaria<br>Dengue | Protracted 3 | Across Somalia, the graded security risks are as follows:<br>**Armed Conflict:** High<br>**Terrorism:** High<br>**Crime:** Substantial<br>**Civil Unrest:** Substantial<br>**Hazards:** Moderate | **Somalia: 8.9** (Very High)<br>**Global Risk Ranking:** 1 out of 191 countries |

## Summary of Crisis and Key Findings

In 2025, needs were driven by the complex interaction of climate shocks, prolonged conflict and insecurity, large-scale displacement, chronic fragility, and public health threats. Severe funding reductions reshaped the humanitarian response. By mid-year, humanitarian partners were forced to revise the Humanitarian Needs and Response Plan (HNRP) targets from 4.6 million earlier in the year to 1.3 million people by July 2025, forcing difficult prioritization decisions and leaving many affected populations without assistance.[3]

Somalia's humanitarian landscape is heavily impacted by the ongoing spread of disease outbreaks of AWD/Cholera, Diphtheria, and Measles. The country is currently battling these three concurrent outbreaks which present significant public health risks and underscoring the urgent need for reinforced surveillance systems and a unified, well-resourced response effort. [4]

Between February–March 2026, a staggering 6.5 million people in Somalia are estimated to be facing high levels of acute food insecurity—nearly double the population classified in IPC Acute Food Insecurity (AFI) Phase 3 or above (Crisis or worse) in August 2025. This includes more than 2 million people in IPC AFI Phase 4 (Emergency).[5] An estimated 1.84 million children aged 6-59 months are projected to be acutely malnourished, including 483 000 children expected to face severe acute malnutrition.[6]

More broadly, Somalia has an estimated population of 19.4 million.[7] Poverty is widespread, with seven out of ten Somalis living on less than USD 1.90 a day. Recurrent climate-induced shocks, insecurity, protracted conflicts, environmental degradation, limited investments, and poor infrastructure continue to impact food systems, hindering availability and access to nutritious foods and adequate nutrient intake.[8]

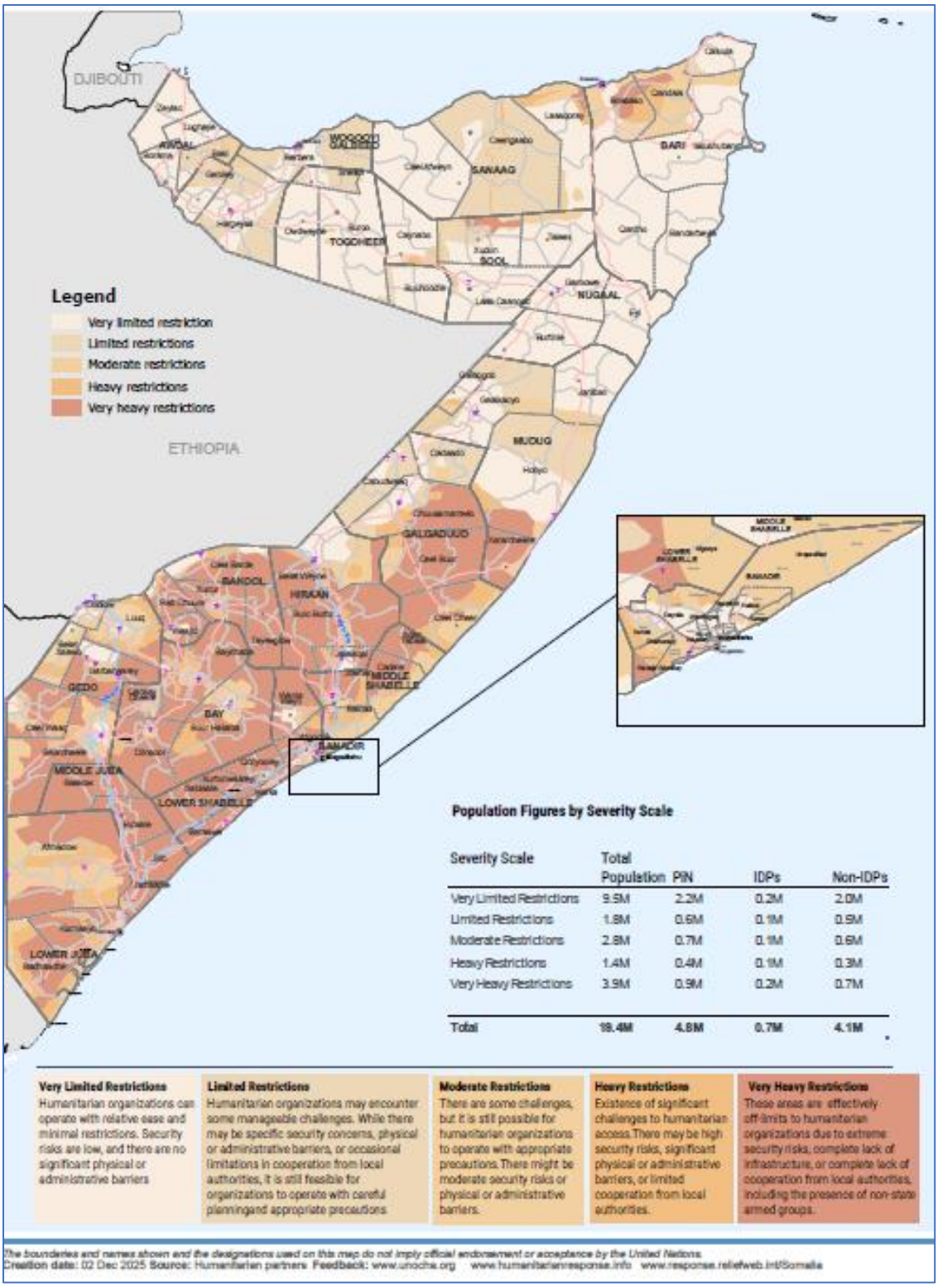


*Figure 1 Accessibility by Districts in Somalia (HNRP 2026)*

## Humanitarian Profile

**PEOPLE IN NEED 2026**[9]

**PiN**: 4.8 million people

**Target**: 2.4 million people

**HEALTH NEEDS 2026**[10]

**PiN**: 5.4 million people

**Target**: 2.4 million people

**DISPLACEMENT**

With an estimated 3.5 **million internally displaced people (IDP)**, Somalia has one of the highest IDP populations in the world.[11]

### *Humanitarian Response To Date*

The Federal Government of Somalia, the United Nations and humanitarian partners launched the 2026 Humanitarian Needs and Response Plan (HNRP), with funding requirements of US$852 million to assist 2.4 million people who need lifesaving humanitarian and protection assistance in Somalia.[12]

Somalia faces an intensifying humanitarian crisis driven by prolonged drought, conflict, and recurrent disease outbreaks. In 2026, 4.8 million people are estimated to need humanitarian assistance —a reduction of 20% compared to 2025 that reflects stricter needs definition align with the humanitarian reset rather than improved conditions.[13]

The United Nations World Food Programme (WFP) sounded the alarm in February 2026 that its life-saving emergency food and nutrition assistance in Somalia is at imminent risk of grinding to a halt without new immediate funding commitments.[14] WFP faces a severe funding shortfall that has forced it to reduce the number of people receiving emergency food assistance from 2.2 million in early 2025 to just over 600 000. This means WFP is currently supporting only one in every seven people in need of food assistance to survive.[15]

An estimated 1.84 million children aged 6-59 months are projected to be acutely malnourished, including 483 000 children expected to face severe acute malnutrition.[16] The situation is expected to worsen due to increased disease incidence during the rainy season and reduced access to treatment services following the closure of 125 severe acute malnutrition sites and 360 moderate acute malnutrition sites due to funding shortages.[17]

In 2025, humanitarian funding for Somalia declined sharply at a time when needs continued to rise. Significant reductions in funding from major donors substantially constrained the resources available for humanitarian programming, resulting in difficult prioritization decisions and scale-downs across several sectors.[18] These funding cuts had a direct impact on service delivery, particularly in high-need and hard-to-reach areas, limiting the ability of humanitarian actors to sustain life-saving interventions and respond adequately to escalating needs among vulnerable children and families.[19]

By December 2025, HNRP funding stood at approximately 27%.[20] Drought conditions started to worsen by November , which led the Federal Government of Somalia and various states to officially declare a drought emergency on November 10, 2025, with La Nina–linked forecasts indicating drier and hotter-than-normal conditions extending into the 2026 Jilaal season.[21]

### *Climate Events, including Drought*

Drought conditions have intensified across Somalia leading to widespread water scarcity, crop failure, livestock losses, and displacements. In many areas, community coping mechanisms are getting exhausted. According to authorities, 4.61 million people are affected by the drought, including more than 490 730 displaced persons.[22]

The situation has worsened following the failure of the 2025 Karan rains (July–September) in the north and the Deyr (Oct-Dec) rains nationwide. Northern regions have now endured a fourth consecutive failed rainy season, with rainfall levels 60 percent below average—the driest conditions recorded since 1981. Extreme heat (35–40 °C) accelerates water loss, leaving rangelands parched and water points depleted. Widespread water infrastructure failures have driven water prices in Puntland to $12–15 per 200-liter barrel.[23]

A total of 80% of berkads in Puntland have dried up, in Hirshabelle, 50 boreholes require urgent rehabilitation; These disruptions are significantly inflating water costs and compounding public health risks. Crop failure affects up to 85% of farmland, reducing sorghum and maize yields by 20–30%.[24]

The combined effects of severe drought, ongoing conflict, and soaring food prices—including imported cereals and water— have pushed Somalia's food insecurity to crisis levels. Livestock deaths and widespread pastoral movements underscore the collapse of traditional livelihoods and deepening vulnerability.[25]

Climate-related shocks, mainly drought and flooding, were the most significant drivers of humanitarian needs in 2025 marked by a damaging pattern of climatic extremes.[26] The Gu season (April-June) brought localized but severe flooding particularly in riverine and low-lying areas and densely populated urban centers like Mogadishu.[27] The failed Deyr seasonal rains (October–December) resulted in one of the driest year-end periods on record, culminating in the declaration of a national drought emergency in November 2025. Water prices surged, with the cost of a 200-liter water barrel increasing by up to 35% in areas such as Gedo and Bay.[28]

Flooding in May 2025 displaced over 84 000 people, destroyed shelters and sanitation facilities, contaminated water sources, and disrupted access to health and nutrition services. While Gu rains temporarily improved water availability and pasture conditions in parts of southern and central Somalia, northern regions, including Puntland, Somaliland, and contested areas of Sool and Sanaag, remained in persistent drought conditions.[29]

### *Food Security*

The latest released Integrated Food Security Phase Classification (IPC) analysis shows that food insecurity and malnutrition rates in Somalia are expected to rapidly deteriorate by the end of March 2026, with 6.5 million people facing high levels of hunger and more than 1.8 million children affected by acute malnutrition.[30] This is nearly double the population classified in IPC Acute Food Insecurity (AFI) Phase 3 or above (Crisis or worse) in August 2025. This includes more than 2 million people in IPC AFI Phase 4 (Emergency).[31]

This alarming deterioration is driven by worsening drought, rising food prices, and insecurity across central, southern, and parts of northern Somalia. The situation is compounded by declining humanitarian assistance.[32] Rainfall from April–June is likely to be near normal in most areas and above-normal in some northern areas. This will likely lead to only a modest improvement in overall food security, with 5.5 million people expected to be in IPC AFI Phase 3 or above.[33]

Recent food security analyses signal a marked deterioration in household conditions during Feb Mar 2026, reflecting cumulative drought impacts, water shortages, livestock losses, and weakened coping capacity.[34] Rural agricultural and pastoral communities are among the most affected, facing severe livestock losses,

crop failure and water shortages. In pastoral areas, earlier improvements in pasture have been lost as low rainfall and unusually high temperatures have desiccated soil and grazing land. Water points have dried up, rangelands are depleted, and livestock conditions are deteriorating rapidly, severely undermining livestock productivity, milk production, household nutrition and income. In many areas, community coping mechanisms have been exhausted.[35]

### *Displacement*

Displacement remained both a driver and consequence of vulnerability. An estimated 3.5 million people remained displaced in 2025, the majority living in overcrowded IDP settlements with limited access to basic services.[36] New displacements were primarily driven by drought (52%) and conflict (44%), with flooding acting as a significant secondary driver. Overcrowded living conditions heightened risks of disease outbreaks, particularly during the Gu flooding period.[37]

### *Conflict and Humanitarian Access*

Conflict and insecurity continued to shape both humanitarian needs and response delivery. Armed violence linked to Al-Shabaab and localized clan conflicts over land, water, and political influence persisted across multiple regions. The transition of the African Union mission and uncertainty around its future funding further contributed to operational volatility. Large parts of Middle Shabelle, Hiraan, and Galgaduud remained under heavy access restrictions, limiting assistance for an estimated 3.7 million people. While overall humanitarian access incidents declined by 26% year-on-year from (243 to 179), incidents related to military operations and inter-clan violence increased, particularly in Gedo and Middle Shabelle, disrupting aid delivery to vulnerable populations.[38]

### *Vulnerable Groups*

**Women and Girls:** Women and girls in Somalia are exposed to various gender-based violations, coupled with the lack of a comprehensive legal framework that protects the rights of women and girls in Somalia.[39] A new assessment shows that women in Somalia are carrying the heaviest burden of the ongoing drought, providing food, care, and stability for their families, yet their voices remain largely absent from decisions that shape their lives.[40]

Historically, women in Somalia have played a supportive economic role, mainly focusing on childcare and small-scale activities such as milk processing. Meanwhile, the traditional livelihoods of men in pastoralism and farming have collapsed, creating rising stress, unemployment and pressure around youth migration. The loss of income and social status has increased the psychosocial strain on men, contributing to domestic tension and an increased risk of intimate partner violence.[41]

**Children:** Vulnerable groups, including women, children, are especially impacted by the ongoing conflicts in Somalia. The situation remains highly volatile, with a significant risk for further escalation. Children are particularly at risk for restrictions on movement and forced recruitment into clan militias, as tensions between the clans remain unresolved.[42]

**Disabilities:** People with disabilities face attitudinal, institutional, communication and physical barriers to accessing humanitarian assistance, basic services and income opportunities, and to engaging in decision-making on need priorities and how to address them. Applying the global estimate of 15% yields a population of around 1.2 million people living with disabilities in the country, although the actual number is certainly higher due to the impact of years of conflict.[43]

**Older People:** Older people are 4% of the People in Need (PiN) in Somalia in 2024.[44] Older people's vulnerabilities stem from lack of opportunities, services and exclusion. There is also growing feminisation of the older population as women outlive men, leaving many widowed older women.[45]

**People with noncommunicable diseases (NCDs):** Disasters affect people with NCDs, including loss of medicines, interruption of regular medical treatment and damage to hospitals.[46] Patients suffering from non-communicable diseases e.g. respiratory, cardiovascular diseases, cancer and diabetes are among vulnerable groups in critical conditions, who face different problems following flooding.[47] Long-term health issues such as spread of communicable diseases and compromised access to health care facilities cause more problems than acute injuries.[48]

## Health Status and Threats

**Population mortality**: The leading causes of death in Somalia (2019, per 100 000 population) are lower respiratory infections, diarrhoeal diseases, tuberculosis, preterm birth complications and stroke.[49]

Notably, drought related mortality estimates conducted in Somalia indicates that the drought crisis caused an estimated 43 000 deaths in 2022 (half of which estimated to have occurred in children under 5), more severe than the 2017-2018 drought.[50] An overview of mortality indicators can be viewed in the below table:

| MORTALITY INDICATORS | Somalia | Year | Source |
|---|---|---|---|
| Life expectancy at birth[51] | 56 | 2022 | World Bank |
| Crude mortality rate (per 100,000 people)[52] | 0.24 | 2025 | World Bank |
| Infant mortality rate (deaths < 1 year per 100,000 births) [53] | 68 | 2025 | UNICEF |
| Child mortality rate (deaths < 5 years per 100,0 births) | 104 | 2025 | UNICEF |

**Vaccination coverage:** Vaccination coverage in Somalia remains below targets, significantly negatively impacting the country's efforts to control vaccine preventable diseases. Despite the introduction of various immunization strategies, challenges such as insecurity, logistical barriers, and limited healthcare infrastructure hinder vaccination campaigns.

Somalia is among the countries with the highest number of zero-dose children in the world, and is grappling with outbreaks of vaccine preventable diseases mainly measles, diphtheria and Vaccine Derived Polio virus, simultaneously exposing neonates, infants, toddlers, preschoolers, and school-aged children to pathogens that are preventable through routine child immunization.[54] According to recent estimates, 70% of children are fully vaccinated an increase of 28% between 2012 to 2024, with steady improvements registered across all antigens since 2019.[55]

Additionally, ongoing humanitarian crises and displacements disrupt access to immunization services, particularly in rural and conflict-affected areas. Efforts by the Somali Federal Ministry of Health, in collaboration with international organizations, aim to improve vaccination rates through community outreach, mobile clinics, and awareness campaigns. However, sustained investment and coordination are essential to ensure that all children in Somalia are protected against vaccine-preventable diseases and to build a resilient healthcare system capable of delivering comprehensive immunization services.

Few families reported refusal to vaccinate their children due to fear and distrust towards vaccinations (5-7%) highlighting the potential to expand immunization services. Most reported reasons for not having received any vaccination, among the proportion of children of vaccination age, was no functional vaccination services available nearby and no means to pay for transport to go to nearest vaccination service.

| VACCINATION COVERAGE DATA | Somalia | Year |
|---|---|---|
| DTP-containing vaccine, 1st dose | 83% | 2024 |
| DTP-containing vaccine, 3rd dose | 76% | 2024 |
| Polio, 3rd dose | 75% | 2024 |
| Measles-containing vaccine, 1st dose (MCV1) | 71% | 2024 |

## Overview of Key Disease Risks

| Somalia: Key Health Risks In Coming Months | | |
|---|---|---|
| **Public health risk** | **Level of risk*** ** | **Rationale** |
| **Malnutrition** | | In 2026, between February–March, a staggering 6.5 million people in Somalia are estimated to be facing high levels of acute food insecurity—nearly double the population classified in IPC Acute Food Insecurity (AFI) Phase 3 or above (Crisis or worse) in August 2025. [56] Global acute malnutrition (GAM) in Somalia has risen for two consecutive years. From January–December 2026, an estimated 1.84 million cases of children aged 6–59 months are expected to suffer acute malnutrition, including 483 000 severe cases that require urgent treatment.[57] |
| **Cholera and acute watery diarrhoea (AWD)** | | Cholera outbreaks are common among displaced communities especially during seasonal April-June (Gu rains) and October-December (Dyer rains). There is usually no break in the cholera transmission cycle due to overlapping seasons with hot spot districts being in the basins of rivers Juba and Shabelle. AWD/cholera surged during the Gu season, particularly in flood-affected areas with poor WASH conditions, with over 8900 cases and nine deaths reported by the end of 2025, of which 60% were children below five years.[58] |
| **Maternal and Child Health** | | Somalia is still one of the most dangerous places for women to give birth, with a maternal mortality ratio of 621 deaths per 100 000 live births, which is among the highest in the world. This figure is well above the sustainable development goal (SDG) target of less than 70 per 100 000 live births.[59] The reproductive health status of the people in Somalia has been severely affected by the persistent insecurity due to decreased and challenged access to services, worsening during conflict, floods and drought which cause displacement. |
| **Measles** | | Measles transmission remained widespread, with 7582 cases, predominantly among children under five. Severe funding gaps constrained service delivery, further limiting access to life-saving health and nutrition interventions. [60] Measles case load in Somalia has remained high due to a high proportion of zero dose children among displaced and nomadic communities which have limited access to vaccination and other primary health care services. |
| **Respiratory Infections** | | Lower respiratory infections are still the leading cause of deaths in Somalia[61] Care-seeking for children under age five with acute respiratory infections (ARI) in Somalia increased to 22.5% in 2019, up from 13% in 2006.[62] |
| **Poliovirus type 2 (cVDPV2)** | | Due to a high population mobility and cross border movement between Kenya, Djibouti and Ethiopia, Somalia remains at a high risk of vaccine derived Polio outbreak which is prevalent in neighboring countries. |
| **Malaria** | | Somalia recorded a 59% increase in malaria case load from 8080 cases in 2024 to 12847 cases in 2025. The reported increase in case load was attributed to increased mosquito vector density mainly in Puntland and |

| | | |
|---|---|---|
| | | Somaliland states. High levels of population movement and displacement leading to overcrowding in camps exposed these populations to insect vectors increasing the incidence of Malaria. In addition to limited access to primary health care services and lack of awareness |
| **Dengue** | | Somalia has reported dengue fever outbreaks in different districts since 2023 and continued through 2024 and 2025. In 2025, the number of dengue fever cases increased by three from 355 cases in 2024 to 1225 cases in 2025. Most cases were reported in Lascanod district of Northeast state and Banadir region. |
| **Trauma and Injury** | | More than 7700 conflict-related fatalities were recorded during the first nine months of 2025, compared with 5554 fatalities in 2024 . Inter-clan clashes and military operations against non-state armed groups, continue to restrict humanitarian access and heighten protection risks for civilians particularly women and children.[63] |
| **Diphtheria** | | From the first week of 2025 through the end of the year, 3655 diphtheria cases and 143 deaths (CFR 4%) were reported from 65 districts, with transmission continuing into 2026 as 371 cases and 11 deaths were recorded in Week 1-4 of 2026 across 30 districts.[64] |
| **Noncommunicable Diseases (NCD)** | | In 2017 the proportion of deaths attributed to communicable diseases was less than 60%, while the share of non-communicable diseases increased to nearly 40%. This indicates that Somalia is facing an epidemiological double burden, with both communicable and non-communicable diseases posing significant health challenges.[65] |
| **Mental Health Conditions** | | The mental health situation in Somalia is characterized by significant challenges, largely influenced by decades of conflict, instability, and socio-economic hardships. The most common issues in Somalia include psychosomatic complaints, depression, stress, psychosis, and substance abuse.[66] |
| **Protection Risks (including Gender Based Violence)** | | GBV in Somalia is influenced by multiple interconnected factors, including conflict and instability, displacement, poverty and economic fragility, cultural and traditional norms and practices such as Child, Early, and Forced Marriage (CEFMU) and Female Genital Mutilation (FGM), gender inequality, weak legal frameworks and justice systems, limited awareness and access to services.[67] Harmful coping mechanisms such as early marriage and sex in exchange for favours are common among women and adolescent girls to assure food security.[68] |
| **Tuberculosis (TB) and HIV (human immunodeficiency virus)** | | Somalia ranks among the 30 countries with the highest multidrug-resistant tuberculosis (MDR-TB) burden globally.[69] The prevalence of HIV is very low in the TB patients in Somalia. The HIV/TB co-infection in Somalia was not the same as in the neighboring countries. Young adults have more HIV/TB co-infection. HIV/TB co-infection is common in males. The World Bank estimated that 0.1% of Somali population had HIV/AIDS in 2021.[70] |
| **Mpox** | | No mpox cases have been reported in Somalia as of February 2026. |
| **Yellow fever** | | Countries in the region reported outbreaks of yellow fever including Kenya, affecting two counties in 2022. The vaccine has not been introduced in the routine immunization program yet. |

| | | |
|---|---|---|
| **Visceral Leishmaniasis (VL)** | | The country is endemic for visceral leishmaniasis (VL) and is regarded by WHO as one of the 14 "high burden" countries for VL.[71] |
| **Chikungunya** | | The country has previously reported confirmed cases of chikungunya. |
| **Marburg Virus Disease (MVD)** | | Given that Ethiopia has declared the Marburg Virus Disease (MVD), the situation becomes concerning for the neighbouring countries including Somalia.[72] |
| *Red: **Very high risk**. Could result in high levels of excess mortality/morbidity in the upcoming month. Orange: **High risk**. Could result in considerable levels of excess mortality/morbidity in the upcoming months. Yellow: **Moderate risk.** Could make a minor contribution to excess mortality/morbidity in the upcoming months. Green: **Low risk.** Will probably not result in excess mortality/morbidity in the upcoming months.* | | |

### *Malnutrition*

In 2026, between February–March, a staggering 6.5 million people in Somalia are estimated to be facing high levels of acute food insecurity—nearly double the population classified in IPC Acute Food Insecurity (AFI) Phase 3 or above (Crisis or worse) in August 2025.[73]Global acute malnutrition (GAM) in Somalia has risen for two consecutive years. From January–December 2026, an estimated 1.84 million cases of children aged 6–59 months are expected to suffer acute malnutrition, including 483 000 severe cases that require urgent life-saving treatment.[74]

The United Nations World Food Programme (WFP) sounded the alarm in February 2026 that it faces a severe funding shortfall that has forced it to reduce the number of people receiving emergency food assistance. Nutrition programmes have also been slashed from assisting nearly 400 000 pregnant and breastfeeding women and young children in October 2025 to just 90 000 in December.[75]

An estimated 1.84 million children aged 6-59 months are projected to be acutely malnourished, including 483 000 children expected to face severe acute malnutrition.[76] The situation is expected to worsen due to increased disease incidence during the rainy season and reduced access to treatment services following the closure of 125 severe acute malnutrition sites and 360 moderate acute malnutrition sites due to funding shortages.[77] In February 2026, IRC reported a sharp rise in acute malnutrition, increasing by nearly 42% from 2024 to 2025. The anticipated withdrawal of additional funding to health facilities threatens services in 300 more facilities in the next 2–3 months[78]

More broadly, according to UNICEF, 60% of the mothers initiate early breast feeding while on 34% practise exclusive Breast feeding up to 6 months of age. Only 14% of the children received two doses of vitamin A supplementation and only 7% consume iodised salt.

| NUTRITION INDICATORS[79] | Somalia | Source |
|---|---|---|
| Early initiation of breastfeeding | 60% | UNICEF |
| Exclusive breastfeeding (0-5 months) | 34% | UNICEF |
| Vitamin A supplementation (two dose coverage) | 14% | UNICEF |
| iodized salt consumption (>0 ppm) among all tested households | 7% | UNICEF |

### *Cholera and Acute Watery Diarrhoea (AWD)*

Cholera outbreaks are common among displaced communities especially during seasonal April-June (Gu rains) and October-December (Dyer rains). There is usually no break in the cholera transmission cycle due to overlapping seasons with hot spot districts being in the basins of rivers Juba and Shabelle. AWD/cholera surged during the Gu season, particularly in flood-affected areas with poor WASH conditions, with over 8900 cases and nine deaths reported by the end of 2025, of which 60% were children below five years.[80]

The outbreak continued with cases reported among displaced communities in Kismayo and Daynile district of Banadir in 2026. Limited access to safe water and poor sanitation are the risk factors to the AWD/cholera outbreaks in Somalia. Circulating Serotype is Vibrio cholerae, Ogawa 01.

While safe water and proper sanitation can prevent such diseases, 28% of Somali families are estimated to lack a functional sanitation facility while 34% practice open defecation and 80% lack a handwashing facility.[81] The ongoing drought situation has contributed to severe water shortages among the 120,000 displaced communities. The drought has led to drying of over 170 water sources according to the UNOCHA and this is expected to increase the risk of AWD and other water borne diseases.[82]

### *Maternal and Child Health Risks*

Somalia is still one of the most dangerous places for women to give birth, with a maternal mortality ratio of 621 deaths per 100 000 live births, which is among the highest in the world. This figure is well above the sustainable development goal (SDG) target of less than 70 per 100 000 live births.[83]

The reproductive health status of the people in Somalia has been severely affected by the persistent insecurity due to decreased and challenged access to services, worsening during conflict, floods and drought which cause displacement. There are still significant inequalities in access to opportunities for mothers and their children to live long and healthy lives based on where they live.[84]

There are still significant inequalities in access to opportunities for mothers and their children to live long and healthy lives based on where they live. Limited access and utilization of high impact interventions such as antenatal care (ANC), safe birth deliveries by skilled birth attendants and institutional delivery, and a low contraceptive prevalence rate, are believed to contribute to the high maternal mortality in Somalia. More than 80% of new-born deaths are due to prematurity, asphyxia, complications during birth, or infections such as pneumonia, diarrhea, measles and neonatal disorders.[85]

Teenage pregnancies and gender-based violence, including female genital mutilation (FGM), remain a significant issue. [86]

A summary of maternal and new-born care health indicators is displayed below (data is the most recently available, from various years):

| MATERNAL AND NEWBORN HEALTH INDICATORS[87] | Somalia | Source |
|---|---|---|
| Postnatal care for mothers – percentage of women (aged 15-49 years) who received postnatal care within 2 days of giving birth (Female) | 11% | UNICEF |
| Antenatal care 4+ visits – percentage of women (aged 15-49 years) attended at least four times during pregnancy by any provider (Female) | 24% | UNICEF |
| Skilled birth attendant – percentage of deliveries attended by skilled health personnel (Female) | 32% | UNICEF |
| C-section rate – percentage of deliveries by caesarean section | 2% | UNICEF |

### *Measles*

Somalia reported a continuous outbreak of measles in all federal member states for the past three years. Measles transmission also remains ongoing, with 1665 suspected cases reported in week 1-4 of 2026, predominantly affecting children under five (72%) and the highest burden observed in Lower Juba, Bay, Banadir, Hiraan, and Lower Shabelle.[88] Severe funding gaps constrained service delivery, further limiting access to life-saving health and nutrition interventions.[89]

### *Respiratory Infections*

The sentinel-based surveillance for Influenza and other respiratory pathogens was started in six sentinel centers in Mogadishu(4),Garowe(1) and Hargeisa (1) in 2020. The objective of Influenza surveillance was to support timely detection and response to respiratory pathogens to prevent excess morbidity and mortality attributed to respiratory pathogens.

According to data reported from health facilities in DHIS-2 a total of 103623 cases of Influenza were reported in 2025 which represents a 30% increase in case load compared to 2024. Of the 1587 cases that were tested in the laboratories in Mogadishu and Garowe, 151 (95%) were positive for seasonal influenza while 8 (5%) were positive for SARS-COV-2. The increasing case load of influenza and other respiratory pathogens is attributed to overcrowding mainly among displaced communities, climatic changes that favor the transmission of respiratory pathogens and poor adherence to Infection Prevention and Control practices in communities.

### *Poliovirus type 2 (cVDPV2)*

For nearly a decade, the Horn of Africa has battled persistent outbreaks of variant poliovirus. The spread has been fuelled by low immunity in children, unmonitored population movements, lack of access to children living in insecure areas, variable levels of national ownership of polio eradication efforts across countries, limited cross-border coordination and delayed responses to outbreaks.

Somalia has continued to combat variant poliovirus circulation since 2017. In 2024, the virus paralyzed 7 children. No cases have been reported so far this year. During the first vaccination drive, which began in Somalia in February 2025 and concluded in Ethiopia and Kenya, the 3 countries shared real-time information on vaccination and poliovirus surveillance to ensure no pockets of under-immunized children or circulating virus were missed.[90]

Response to Polio outbreaks in Somalia is negatively impacted by the high population mobility inside Somalia and also with neighbouring countries- Kenya, Ethiopia and Djibouti, where there is an active circulation of cVDPV2 in 2025 in Ethiopia and Djibouti. The reduction in financial support for the polio program in Somalia has led to scale down of polio surveillance activities increasing the risk of potential outbreaks of Vaccine Derived Polio strains.

### *Malaria*

Somalia managed to reduce the prevalence rate of malaria from 20.1% in 2015 to 4.1% in 2023 in the most affected areas by adopting an integrated disease response[91] Somalia also has many people on the move: nomadic communities, internally displaced people, and people entering from the neighbouring countries. This tends to increase the disease prevalence, including malaria, owing to contributing factors such as overcrowded environments, limited access to health care, and lack of awareness.[92]

### *Dengue*

Somaliland, and Puntland confirmed outbreaks of dengue fever in some of the districts in 2025. Vector surveillance reports show evidence of mosquito vectors that spread dengue fever and other arbo virus infections. Due to the weak health system and poor health seeking behaviour for dengue, the likelihood of delayed detection is high. The proportion of people with limited access to proper sanitation is high and the ongoing rains and floods will increase the likelihood of mosquitoes breeding.

In addition, there is a limited capacity for vector surveillance and control, as well as limited capacity to manage complicated cases of dengue in Somalia. Somalia has reported dengue fever outbreaks in different districts since 2023. Risk factors for dengue fever include poor sanitation around homesteads especially in camps and high concentration of mosquito vectors in most districts of Somalia.

### *Trauma and Injuries*

The Somali population continue to experience traumatic events on a regular basis, 30 years of conflict and a volatile security situation, characterized by interclan conflict and attacks by non-state armed groups on both military and civilian targets continue. More than 7700 conflict-related fatalities were recorded during the first nine months of 2025, compared with 5554 fatalities in 2024 . Inter-clan clashes and military operations against non-state armed groups, continue to restrict humanitarian access and heighten protection risks for civilians particularly women and children.[93]

Road Traffic Accidents (RTA) occur frequently in Somalia, thereby making it a serious health problem. The incidence of RTAs is 20.2 100 000 population (2021).[94]

The capacity to respond to trauma, in particular to mass casualty events is extremely limited in Somalia. Systems to manage mass casualties from event to post operative care and rehabilitation are not in place. There is no coordinated ambulance service and limited pre hospital care capacity. Emergency rooms are being developed, expanded and supported though there remain huge gaps in geographical coverage and quality of care.

### *Diphtheria*

From the first week of 2025 through the end of the year, 3655 diphtheria cases and 143 deaths (CFR 4%) were reported from 65 districts, with transmission continuing into 2026 as 371 cases and 11 deaths were recorded in Week 1-4 of 2026 across 30 districts.[95]

### *Noncommunicable Diseases (NCD)*

There are rising cases of non-communicable diseases: (cardiovascular diseases, cancers, mental disorders, injuries and other chronic health conditions). In 2000, communicable diseases and reproductive/maternal/neonatal/nutritional diseases accounted for over 70% of deaths, while non-communicable diseases represented only 21%. However, by 2017, the proportion of deaths attributed to communicable diseases decreased to less than 60%, while the share of non-communicable diseases increased to nearly 40%. This indicates that Somalia is facing an epidemiological double burden, with both communicable and non-communicable diseases posing significant health challenges.[96]

In Somalia, the healthcare landscape is increasingly challenging with the silent rise of Non-Communicable Diseases (NCDs). While the fragile health system remains locked in a battle against persistent infectious diseases and outbreaks, strained by limited functionality of PHCs facilities and hospitals, chronic shortages of qualified staff and inconsistent medical supplies, the NCD burden continues to grow largely undocumented and underreported.

This situation is severely exacerbated by a sharp decline in international humanitarian funding. As resources decline, humanitarian actors are struggling to maintain even basic primary healthcare services, let alone the complex referral pathways required for chronic care. This funding gap has effectively severed the link to secondary and specialized treatment, leaving the Somali community with almost no access to the life-saving interventions needed for long-term health management.

There is a lack of epidemiological data from diverse settings on chronic NCD burden in Somalia, and the approach to primary care of people with chronic NCDs is currently often unstructured an area that needs to be strengthened while responding to the ongoing floods. The main primary care research needs are therefore firstly, epidemiological research to document the burden of chronic NCDs, and secondly, health system research to deliver the structured, programmatic, public health approach that has been proposed for the primary care of people with chronic NCDs.

### *Mental Health Conditions*

The mental health situation in Somalia is characterized by significant challenges, largely influenced by decades of conflict, instability, and socio-economic hardships. The most common issues in Somalia include psychosomatic complaints, depression, stress, psychosis, and substance abuse.[97]

However, the stress of conflict also leads to new conditions or illnesses such as post-traumatic stress disorder (PTSD), bipolar disorder, types of anxiety, and acute stress reactions. The World Health Organization (WHO) estimates that the prevalence of mental disorders among conflict-affected populations is 13%, with reports of mild forms of depression, anxiety, PTSD, bipolar disorder, and schizophrenia, while 4% still experiences moderate forms of these disorders. Generally, women, elderly people, children, and people with disabilities are disproportionately affected by mental health issues.[98]

Mental illness is generally highly stigmatized.[99] Somalis acknowledge feelings of hopelessness, despair, anxiety, and anguish as part of their symptomatology, despite not explicitly labelling such experiences and symptoms. The after-effects of trauma among Somalis have also been described in somatic terms, with emphasis on headaches and other unexplained body pains.[100]

### *Protection Risks including Gender Based Violence (GBV)*

Protection risks are detailed in the *Determinants of Health* section of the report.

### *Tuberculosis (TB) and HIV (human immunodeficiency virus)*

Somalia ranks among the 30 countries with the highest multidrug-resistant tuberculosis (MDR-TB) burden globally.[101] TB incidence has reduced from 286 cases per 100 000 population in 2010 to 246 cases per 100 000 population in 2023 – a 14% decrease over 14 years. The number of TB treatment centres in Somalia grew from just 7 centres in 1995 to 109 centres in 2023. TB cases enrolled on treatment have also gradually increased in number, from 10 469 cases per year in 2010 to 18 604 cases per year in 2023. [102]

Tuberculosis (TB) patients in Somalia often face numerous barriers to accessing timely diagnosis and appropriate treatment, which significantly contributes to worse health outcomes and the development of drug-resistant tuberculosis (DR-TB). Recurrent conflicts and drought—among other climatic hazards—in the northeast region of Somalia have led to displacement, forcing many families to live in overcrowded conditions. People also contend with a weak health care system and food insecurity, leading to poor nutrition.[103]

The prevalence of HIV is very low in the TB patients in Somalia. The HIV/TB co-infection in Somalia was not the same as in the neighboring countries. Young adults have more HIV/TB co-infection. HIV/TB co-infection is common in males. The World Bank estimated that 0.1% of Somali population had HIV/AIDS in 2021.[104] Data from UNAIDS 2021 reveal that 7700 adults and children in Somalia are HIV-positive, with more than 45% of these people being women over the age of 15. The total number of adult and child deaths related to HIV/AIDS was less than 500 people.[105] Just 62% of women with HIV in 2020 were aware that they had the virus.[106]

### *Mpox*

No mpox cases have been reported in Somalia as of February 2026.

### *Yellow fever*

Countries in the region reported outbreaks of yellow fever including Kenya, affecting two counties in 2022. The vaccine has not been introduced in the routine immunization program yet.

### *Visceral Leishmaniasis (VL)*

The country is endemic for visceral leishmaniasis (VL) and is regarded by WHO as one of the 14 “high burden” countries for VL.[107]

### *Chikungunya*

The country has previously reported confirmed cases of chikungunya.

### *Marburg Virus Disease (MVD)*

Given that Ethiopia has declared the Marburg Virus Disease (MVD), the situation becomes concerning for the neighbouring countries including Somalia.[108]

## Determinants of Health

### *Protection Risks*

According to UN Women (2022), Somalia is ranked among the highest countries in terms of gender inequality – ranked sixth globally with an index of 0.776, with 1 being totally unequal. [109] UN Women notes that the patriarchal nature of Somali society influenced by customs, and traditions, reinforces strict gender roles that disadvantage women and girls with an estimated 45% of girls getting married before the age of 18. [110]

Sexual and gender-based violence (SGBV) is widespread and likely to be under-reported. This violence can be carried out by family members, members of clan militias, al-Shabaab and the security forces. Domestic violence is the most reported form of SGBV but women may also face conflict-related violence and abuses from societal actors. Female genital mutilation (FGM) is widely practiced and socially accepted.[111] FGM has serious implications for women's health. Somalia has recorded the highest cases of FGM, with 98% of girls between the ages of 5-11 having undergone Type III, infibulation, which is the most brutal form. [112]

GBV remains one of the most prevalent human rights violations faced by women and girls in Somalia. The survey shows that over **60%** of women face physical abuse, denial of education, forced marriage, rape and sexual harassment forms of domestic violence (2020). Female-headed households being particularly vulnerable to sexual violence and abuse.[113] In 2023, there was a concerning increase in DV (domestic Violence) ranked at 52% and rape at 15%, compared to 37 percent and 11 percent, in 2022. [114]

In 2021, the United Nations reported an alarming increase in conflict-related sexual violence in Somalia. This included the use of sexual violence and forced marriage by non-state actors, as well as attacks attributed to government forces and clan militia.[115] Alongside sexual violence as a weapon of war, drought, displacement and instability exacerbate existing inequalities and vulnerabilities and undermine protection mechanisms, heightening risks of sexual and gender-based violence (SGBV). The same conflict, instability and disasters that have caused people to flee their homes also disrupt health and psychosocial support services, which are essential for survivors of SGBV.[116]

In IDP camps and host communities, aggravating factors include inadequate physical infrastructure, distance to services (water points, markets, health facilities and schools), poor lightening, and a lack of suitable WASH facilities. Harmful coping mechanisms such as early marriage and sex in exchange for favours are common among women and adolescent girls to assure food security.[117]

At least 4.3 million children require urgent aid and assistance this year. Needs are driven by inadequate clean water, sanitation, and hygiene infrastructure, conflict and disaster-induced migration, disease outbreaks, child rights violations, high prevalence of vaccine-preventable illnesses, chronic food insecurity, and complex socio-political dynamics. [118] Over 370 children recruited between January to June this year by parties to conflict, a 20% increase compared to the same period in 2023. These children are often forced to participate in hostilities, placing their lives at severe risk.[119]

GBV, including sexual violence, remains a pervasive issue. Approximately over 500 reported cases of sexual violence against children during the first half of 2024. Nearly 70% of the total GBV cases reported are persons under the age of 18 with increasing concerns of sexual violence against boys. The actual number is likely higher due to underreporting. Girls are particularly vulnerable, facing significant risks both in conflict zones and within displacement camps. [120] Somalia has the tenth highest prevalence of child marriage in the world. [121]

A summary of key protection indications is displayed in the below box (data is the most recently available, from various years):

| Child Protection Indicators[122] | Somalia | Year | Source |
|---|---|---|---|
| Percentage of women (aged 20-24 years) married or in union before age 18 | 45% | 2022 | UNICEF |
| Percentage of children (aged 5-17 years) engaged in child labour (economic activities and household chores) | n/a | 2022 | UNICEF |
| Percentage of children (aged 1-14 years) who experienced any physical punishment and/or psychological aggression by caregivers | n/a | 2022 | UNICEF |
| Percentage of girls and women (aged 15-49 years) who have undergone female genital mutilation (FGM) | 99% | 2022 | UNICEF |

In 2024, there was a significant rise in deaths and injuries mainly due to explosive hazards. Over 100 children were either killed or maimed as result of air strikes, explosive devices, land mines etc., with about 30% of these children were affected by unexploded ordnances (UXOs).[123] In September 2024, three explosive ordnance-related accidents were reported in the Gedo, Lower Shabelle, and Galgaduud regions, involving six individuals—two girls, three boys, and one man. Tragically, two boys were killed in these incidents, while the remaining four individuals sustained injuries.[124]

### *Access to Water and Sanitation (WASH)*

Drought conditions have intensified across Somalia leading to widespread water scarcity, crop failure, livestock losses, and displacements. In many areas, community coping mechanisms are getting exhausted. According to authorities, 4.61 million people are affected by the drought.[125] At least 171 boreholes are non-functional, and hundreds of schools have closed. Sections of Shabelle river have dried up, affecting more than 65 villages in Jowhar District and forcing communities to rely on failing shallow wells and overstretched boreholes.[126]

According to UNICEF, only 52% of the population in Somalia have access to basic water supplies while 28% of the population practise open defecation.[127] The limited access to safe water and proper sanitation is worsened by escalating drought conditions that led to drying up of water sources and displacement of communities in search of water, food and humanitarian assistance. Without access to clean water, toilets and good hygiene practices, the risk of contracting easily preventable diseases, such as diarrhoea, acute watery diarrhoea, cholera, and respiratory infections, is high.

| WASH INDICATORS[128] | Somalia | Source |
|---|---|---|
| Proportion of population using safely managed sanitation services | 16% | UNICEF |
| Proportion of population using basic sanitation services | 28% | UNICEF |
| Proportion of population using at least basic sanitation services | 44% | UNICEF |
| Proportion of population using limited sanitation services | 19% | UNICEF |

### *Education*

The school gross enrolment rate is low (32%) in primary school and drop-out rates are high and prevalent nationally.[129] The conflict has severely disrupted education in Somalia. It's estimated that more than 50% of schools in conflict-affected areas have been closed or are non-functional. As a result, approximately over 3 million children are not accessing any type of learning, lacking access to critical education and safe learning environments. Increase in out-of-school children increases the risk of exploitation including engaging in labour in hazardous environment resulting in life threatening injuries and permanent disabilities.[130]

## Health Systems Status and Local Health System Distributions

The healthcare system grapples with significant challenges in meeting the diverse health needs of its population.[131] Somalia ranks last place in terms of health security, as its morbidity and mortality levels continue to be among the worst worldwide.[132]

Somalia's fragile health system is under immense strain as poor access to safe water and drought-driven displacement have triggered an upsurge of vaccine-preventable diseases, AWD/cholera and other disease outbreaks, affecting the country's high number of 'zero-dose' children.

The health system's capacity to respond is severely hindered by chronic underfunding and logistical disruptions, leaving critical gaps in facility-based care. The combined impact of restricted access to healthcare and the rising disease burden poses an immediate threat to life, particularly for malnourished children and pregnant women in the most severely affected inter-sectoral priority areas.[133]

### Health system status & local health system disruptions

**ACCESS TO HEALTHCARE**

**95% of Somalia's health budget depends on external financing.** Funding cuts mean that 618 health facilities - 51 district hospitals, 413 health centers and 154 primary health units - will likely close their doors in 2026.[134]

**DISRUPTION TO SUPPLY CHAIN**

**Armed clashes, road blockages and insecurity** along main supply routes disrupted aid delivery.[135]

**DAMAGE TO HEALTH FACILITIES**

Armed clashes, road blockages and insecurity forced more than 20 health facilities to close following non-state armed group advances.[136]

**ATTACKS AGAINST HEALTH**

Limited recent information.

***Functionality***
Health facilities have been performing at reduced capacity due to widespread internal violence, and repetitive displacement, as well as recurrent droughts and floods. Insufficiency of health infrastructure and equipment; disrupted medical supply chain systems, inadequate staffing (as some have fled their posts due to insecurities and the limited capacity of those dedicated to their post) or lack of trained personnel; lack of supplies; and inadequate operational support to health facilities all contribute to the challenges experienced.

Humanitarian access further deteriorated in 2025, particularly in Lower Juba, Gedo, Hiraan and Banadir, where conflict, inter-clan violence and administrative impediments have limited the delivery of health services. Armed clashes, road blockages and insecurity along main supply routes disrupted aid delivery and forced more than 20 health facilities to close following non-state armed group advances. In several districts, movement restrictions delayed the deployment of medical supplies and health personnel, and these access constraints continue to undermine WHO and partner operations.

***Healthcare Workforce***
The healthcare workforce in Somalia is unevenly distributed, with a heavy focus on urban areas, leaving rural and remote communities underserved.[137] Today, for every 1000 people in Somalia, fewer than one doctor/nurse/midwife is available.[138]

***Healthcare Financing***
Healthcare financing in Somalia presents several complex issues, with a significant proportion of healthcare cost covered through out-of-pocket payments by individuals. International comparisons reveal that per capita expenditure on healthcare in Somalia is notably low.[139] Furthermore, 95% of Somalia's health budget depends on external financing. Funding cuts mean that 618 health facilities - 51 district hospitals, 413 health centres and 154 primary health units - will likely close their doors in 2026.[140]

These facilities are lifelines, especially in regions that are hard-to-reach, prone to climate shocks and report the highest rates of malnutrition. Without renewed partner investment, Somalia risks reversing critical public health gains, increasing the likelihood of large-scale disease outbreaks and preventable deaths across the country.[141]

***Health Access***
The top three reported barriers preventing households from accessing healthcare in 2023 were the absence of a functional health facility in their proximity (40%), unaffordability of treatment or medicines (20 per cent), and the lack of required medicines, treatment or services (14%).[142] With more than ten per cent of the country's health facilities reported damaged or submerged during the Deyr floods, health coverage in affected areas is expected to be even further constrained, increasing the need for mobile health services in the short term.[143]

Lack of purchasing power remains a key concern. The most vulnerable households spend more than 70% of their income on food, limiting their ability to afford services such as healthcare or education, or critical items such as mattresses and soap. Three in four households are indebted and 28% have exhausted emergency coping strategies, such as selling the last productive animal, drastically reducing future income sources and capacity to cope with shocks. Newly displaced people are most frequently forced to rely on emergency coping mechanism, including scavenging and begging for food/money (34%).[144]

**Surveillance**
Somalia adopted the Disease Surveillance and Response (IDSR) system to strengthen timely detection and response to epidemic prone diseases. IDSR Has been rolled out in 437 health facilities across Somalia, except in Somaliland. Using DHIS-2 mobile tracker, health facilities submit immediate alerts and weekly reports to the state-based surveillance officers who coordinate investigation and validation of these alerts.

***Attack on Healthcare***

There is limited recent information. The Safeguarding Health in Conflict Coalition identified 21 incidents of violence against or obstruction of health care in Somalia, including Puntland and Somaliland. Multiple security challenges continued to undermine people's access to health care throughout the country. In February 2023, violence broke out in the disputed city of Las Anod between militia of the Dhulbahante clan and the armed forces of Somaliland.[145]

## Humanitarian Health Response

Driven by persistent humanitarian shocks, specifically drought and displacement, compounded by funding decline, food insecurity and malnutrition, humanitarian conditions in Somalia are projected to deteriorate further in 2026.

The Health Cluster's severity analysis for the 2026 HNRP estimated 5 million people will require urgent health assistance. The Health Cluster is appealing for US$ 80 million to provide life-saving health services to meet 5 million people's health needs and reach 2.4 million people with the highest needs in 2026.[146]

In January 2026, the Somalia Health Cluster partners delivered over 859 000 outpatient consultations and sustaining maternal, immunization, referral, and emergency health services that reached 311 111 people across 83 districts and 267 000 people in the 64 targeted districts (severity 3 and 4) by HNRP 2026.[147]

Despite this operational footprint, critical gaps persisting in high-severity districts (Severity 3 and 4). Partners are encouraged to scale life-saving interventions in hard-to-reach areas to stabilize essential health service delivery and prevent further deterioration in already fragile health systems. Rapid, front-loaded funding will enable prioritized expansion in the most vulnerable districts, sustain maternal and emergency services and reinforce frontline health workforce capacity. [148]

During December 2025 and January 2026, the World Health Organization (WHO) implemented a range of key interventions aimed at strengthening health service delivery and enhancing outbreak preparedness and response across Somalia. These activities focused on supporting health facilities, building the capacity of health workers, and responding to emerging public health threats.

The most recent Health Cluster Bulletin can be found here: **Somalia: Health Cluster Bulletin, January 2026**

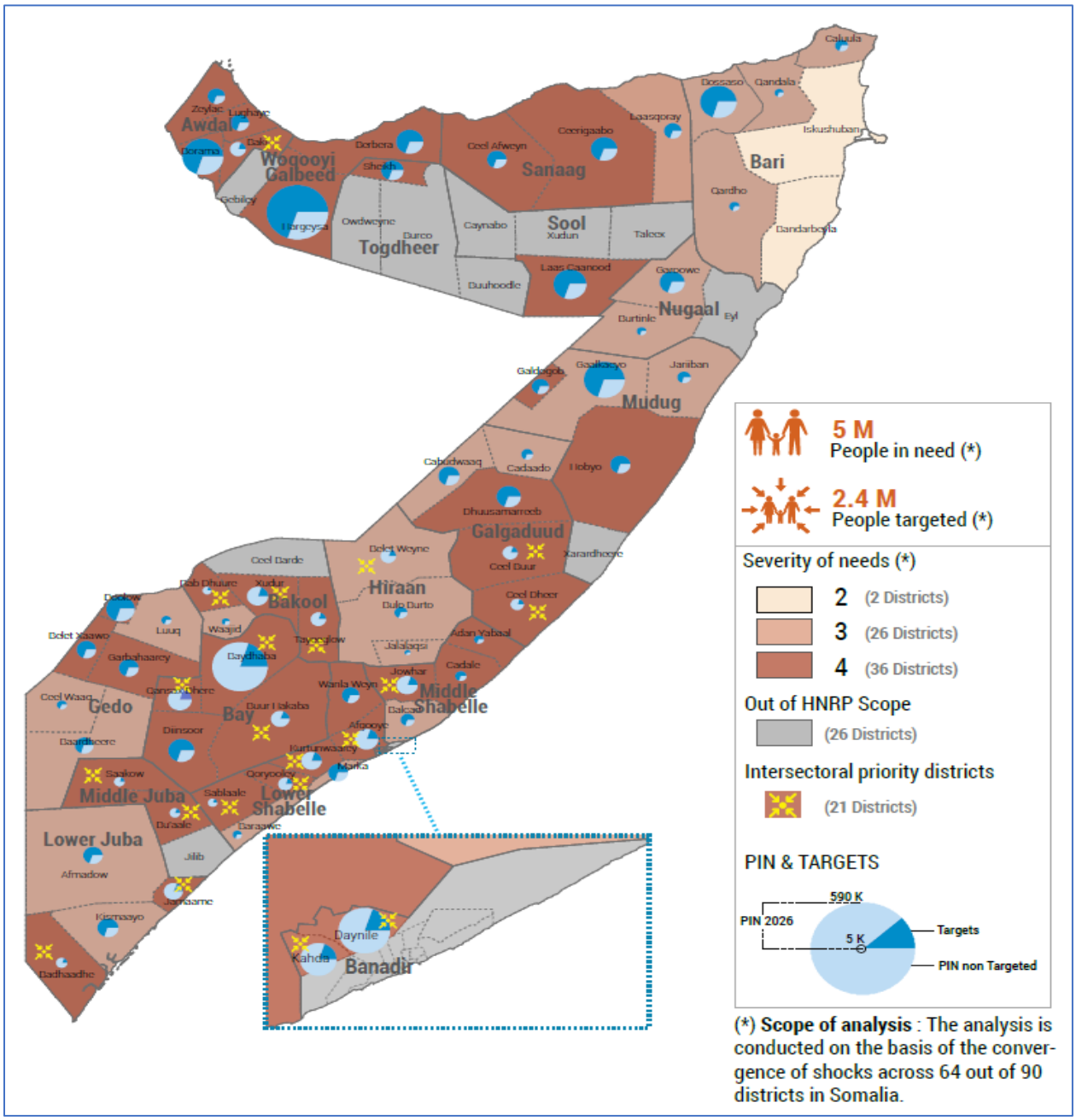


*Figure 2 Somalia Health Cluster severity, PIN 2026 and inter-sectoral severity (HNRP 2026)*

| Information gaps / recommended information sources | | |
|---|---|---|
| | **Gap** | **Recommended tools/guidance for primary data collection** |
| **Health status & threats for affected population** | Cross-border disease surveillance | • Strengthen integrated disease surveillance and response capacity<br>• Strengthen coordination of IDSR with health cluster , and regional office for technical support |
| | Mental health – incidence/prevalence /treatment data | • Integrate Mental Health services in the Primary Health care package in all health facilities |
| | Nutrition outcome indicators | • Strengthen the data collection and reporting system in states.<br>Mapping of affected areas during health crises and natural disasters such as floods and displacements |
| **Health resources & services availability** | Inter-sectoral coordination | • Joint inter-sectoral mapping and performance evaluation/ assessment at the national and regional level.<br>• Mapping of affected areas during health crises and natural disasters such as floods and displacements.<br>• Develop common geospatial data and list of health facilities. |
| | Lack of adequate information on health services availability and functionality | • Establishment of the Medical Cause of Death Certificate application to aid in collecting standard mortality data through DHIS2 using the International Classification of Diseases (ICD-11).<br>• Introducing Global SCORE assessment and digitalization of HIS to help the country better understand its current HMIS capacity and other dimensions of the health system.<br>• Developing and implementing an Electronic Logistic Management Information System (eLMIS).<br>• National data sharing and ethics guideline/protocol and national data quality assurance.<br>• National HIS enterprise architecture with specifications for IT infrastructure, connectivity, information exchange and data use.<br>• Implementation of the Electronic Immunization Registry (EIR).<br>• Scale up the implementation of IDSR to all health facilities for timely reporting and response to disease alerts<br>• Establish Event Based surveillance system as part of the IDSR<br>Implementation of Nutrition, HIV and NCD trackers.<br>• Expanded WHO Health resources Availability Monitoring System (HeRAMS) |
| | Attacks on healthcare | • Reactivate the WHO Surveillance System of Attacks on Healthcare (SSA) |

| | | |
|---|---|---|
| **Humanitarian health system performance** | Drought response information on partner's presence, reporting, and information sharing | • Update the drought response plan based on the new assessment by the health partners<br>• Strengthen coordination of the public health consequences of drought with HEALTH,WASH and other partners<br>• Establish community based surveillance system to death notification linked to drought in drought affected districts |

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