



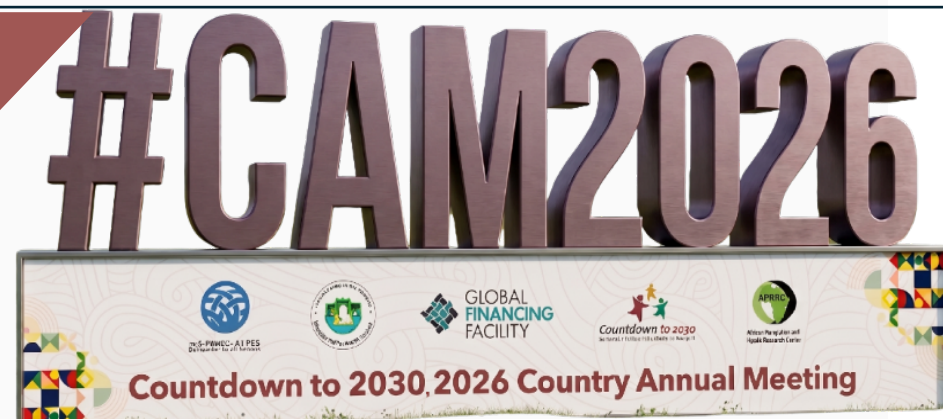
2026

SOMALIA SYNTHESIS REPORT

Analysis of Reproductive, Maternal, Newborn, Child and Adolescent Health Indicators for 2022-2025



Countdown to 2030 in partnership with Somalia's Ministry of Health, Global Financing Facility, WHO, WAHO & UNICEF



Team Members

Osman Hassan Osman, Dr. Abdulkadir Wehliye Afrah, Abdullahi A. Ali, Ahmad Mohamud Hussein, Rornald Kananura, Peter Kaberia, Abdikarim Ali Omar

KEY FINDINGS

1. Health Facility Data Quality Assessment: Numerators and Denominators

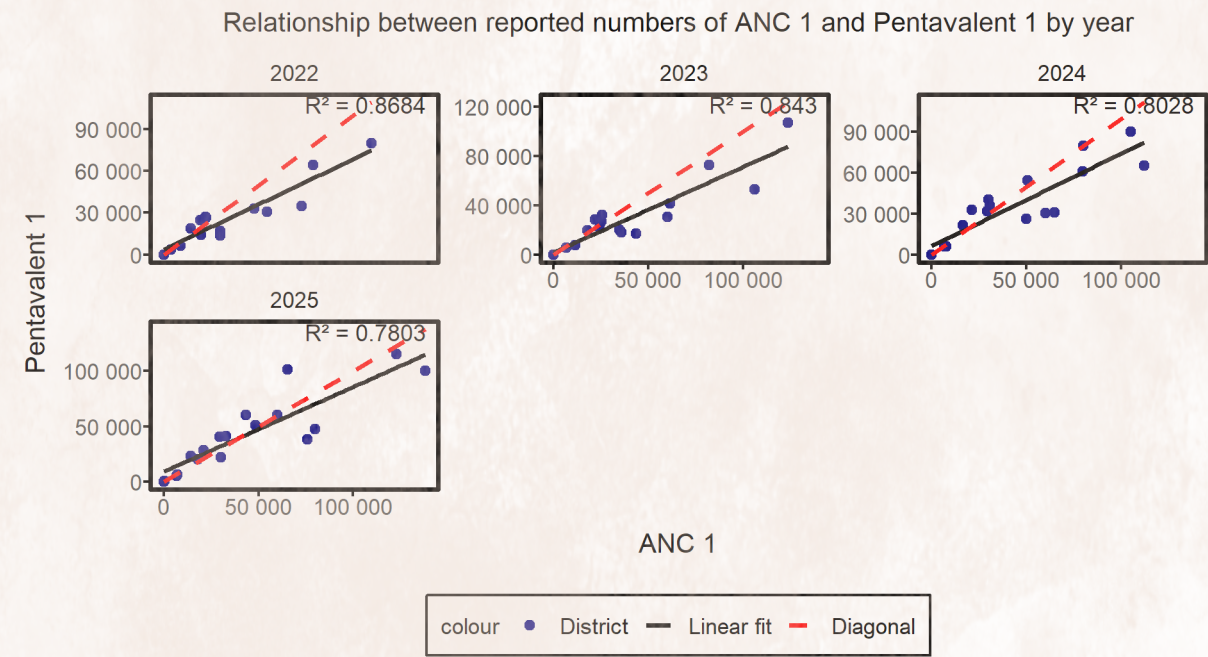
NUMERATORS: Routinely reported health facility data are an important data source for health indicators. The data are reported by health facilities on events such as immunizations given, or live births attended. As with any data, quality is an issue. Data are assessed for completeness of reporting by health facilities, extreme outliers and internal consistency. Appropriate adjustments are made to the data before use to compute statistics.

Summary of reported health facility data quality, DHIS2, 2022-2025

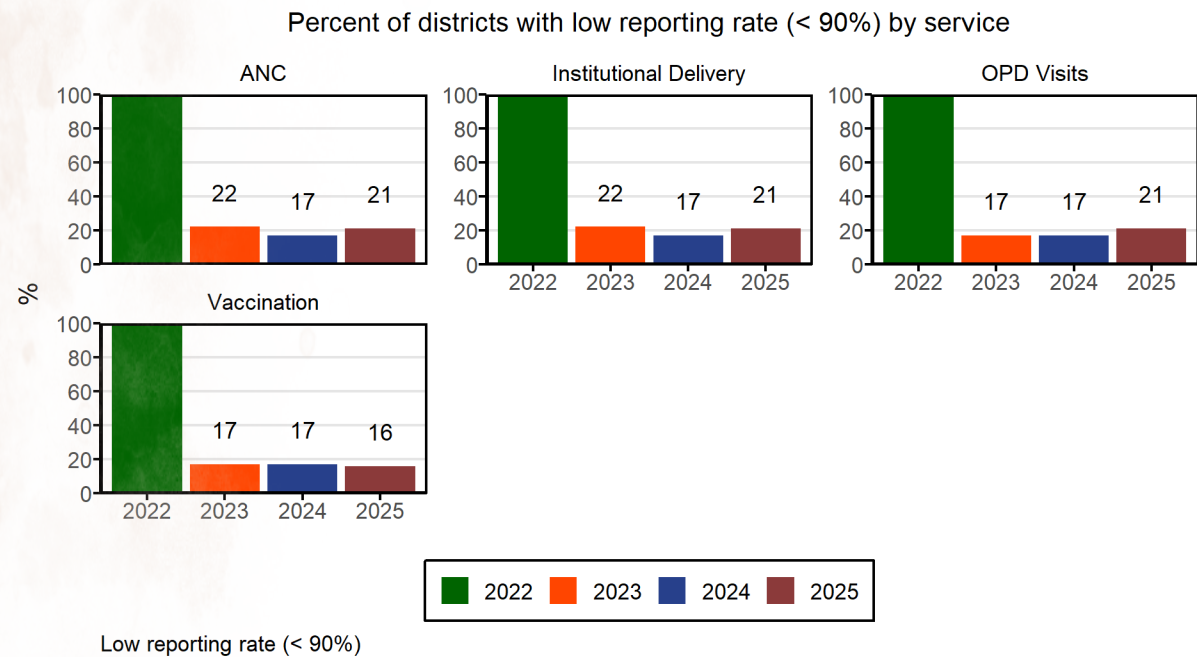
Data Quality Metrics		2022	2023	2024	2025
1. Completeness of monthly facility reporting (mean of ANC, delivery, immunization)					
1a	% of expected monthly facility reports (national)	64	82	82	85
1b	% of districts with completeness of facility reporting >= 90	0	81	83	80
1c	% of districts with no missing values for the 4 forms	46	73	74	76
2. Extreme outliers (mean of ANC, delivery, immunization)					
2a	% of monthly values that are not extreme outliers (national)	94	100	100	97
2b	% of districts with no extreme outliers in the year	74	90	83	70
3. Consistency of annual reporting					
3a	Ratio ANC1 / Penta1	1.30	1.35	1.20	1.02
3b	Ratio Penta1 / Penta3	1.17	1.15	1.16	1.11
3c	% district with ANC1/Penta1 in expected range	38	38	31	28
3d	% district with Penta1/Penta3 in expected range	100	100	100	89
4	Annual data quality score	59	81	79	75

Between 2022 and 2025, the quality of routine health facility data in DHIS2 improved substantially. The annual data quality score increased from 59 in 2022 to 81 in 2023, before declining slightly to 79 in 2024 and 75 in 2025. National reporting completeness improved from 64% in 2022 to 85% in 2025, while the proportion of districts achieving at least 90% reporting completeness increased from 0% to 80%. Data consistency also improved, with the ANC1/Penta1 ratio approaching the expected value (1.02 in 2025) and the Penta1/Penta3 ratio improving to 1.11, indicating better alignment between maternal and immunization reporting. However, the proportion of districts with the expected ANC1/Penta1 ratio declined from 38% in 2023 to 28% in 2025, and districts with no extreme outliers decreased from 90% to 70%, indicating persistent district-level data quality challenges. The strong correlation between ANC1 and Penta1 reporting, together with the reduction in low-reporting districts across ANC, institutional delivery, OPD, and vaccination services, demonstrates overall strengthening of the routine health information system. Continued supportive supervision, routine data quality assessments, and targeted interventions are needed to address remaining reporting inconsistencies and further improve data quality in lower-performing districts.

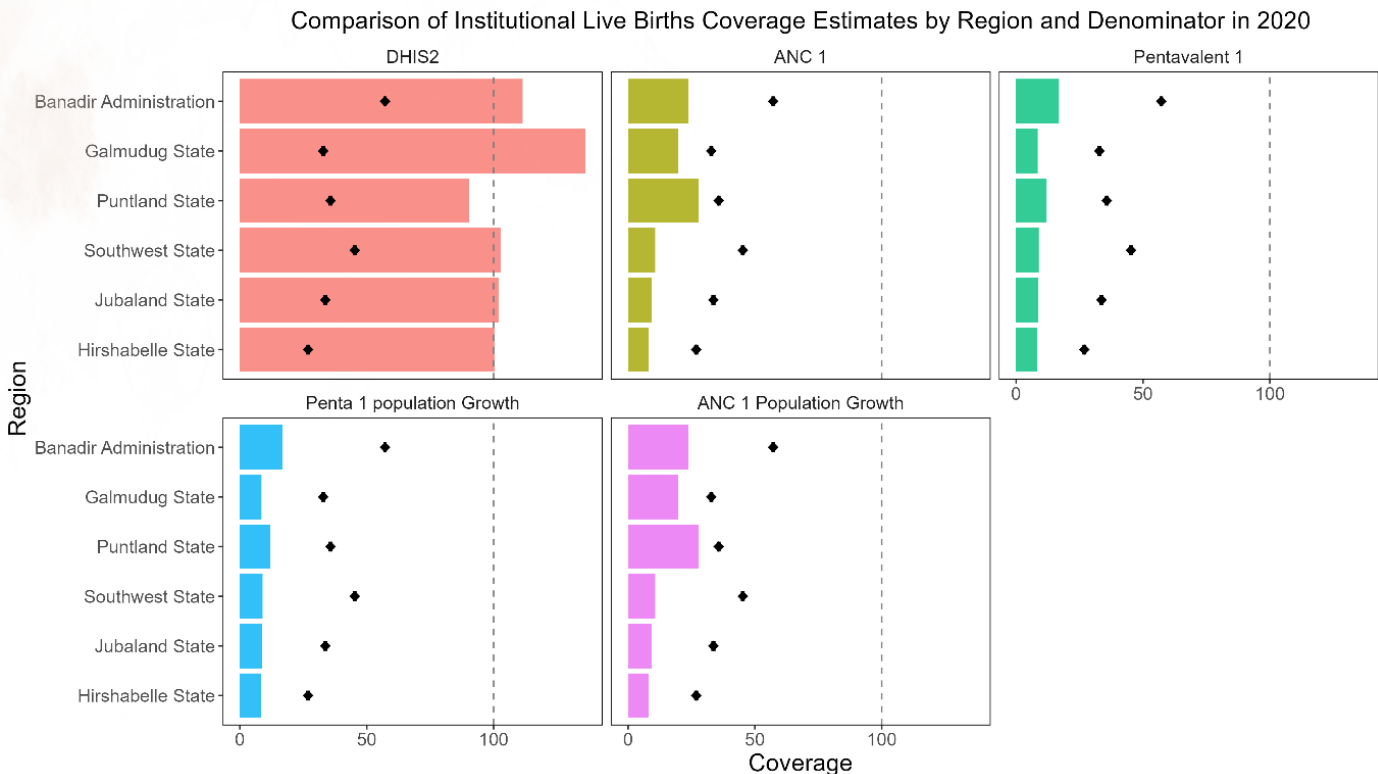
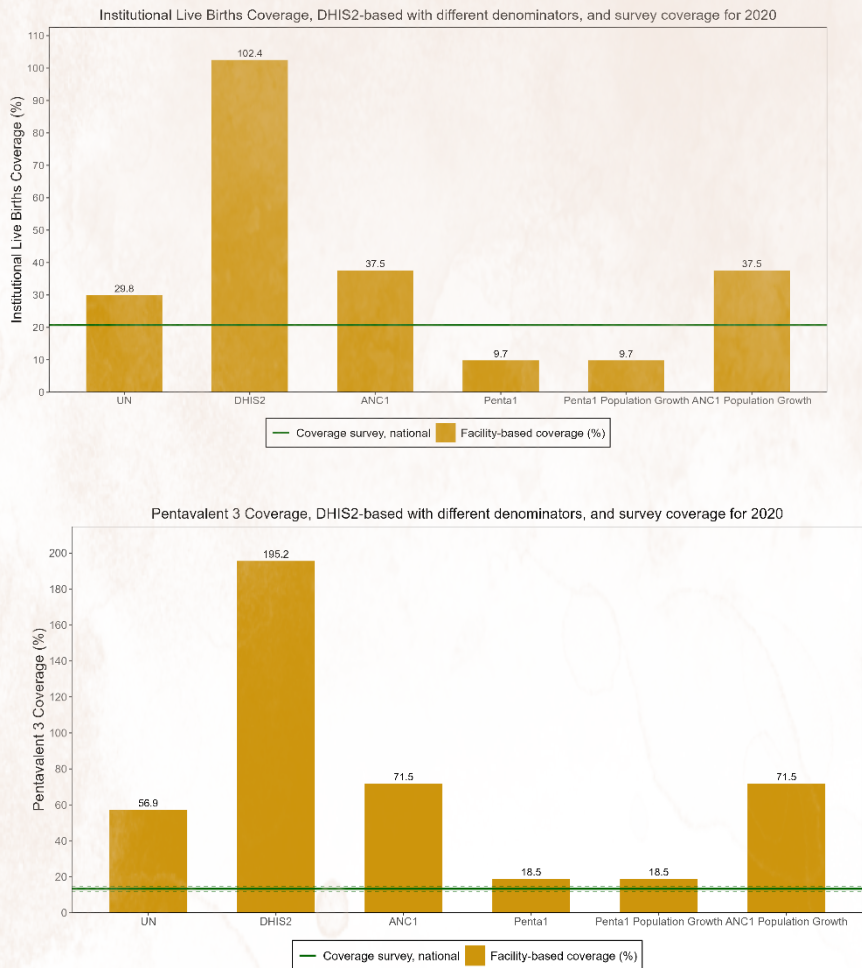
Numerator: facility data quality - example 1 Explain the observation on data quality (one bullet)



Numerator: facility data quality - example 2 Explain the observation on data quality (one bullet)



DENOMINATORS: Service coverage is defined as the population who received the service (numerator) divided by the population who need the services: (the denominator). We test four options for denominator measures using institutional live births and Pent-3 immunization coverage (Figures 2c and 2d). The quality of the population projections in DHIS2 is assessed through consistency over time and comparison with the UN projections. Two denominators are also derived using near universal service such as ANC-1 and Penta-1. The most plausible is identified for use to generate other statistics.



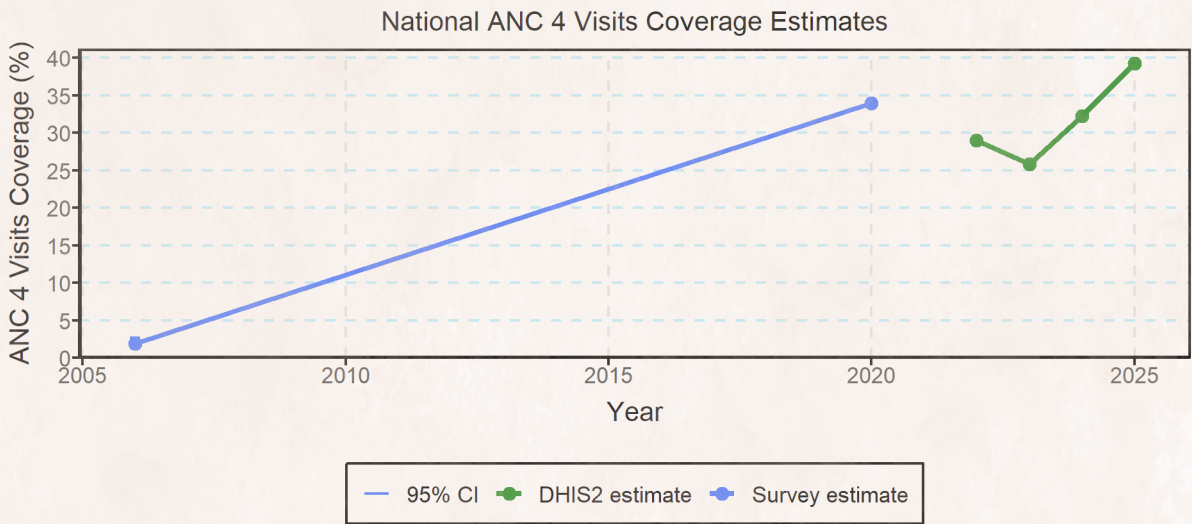
Interpretations

- DHIS2 population data performed worst for both indicators, producing implausible coverage of 102.4% for ILB and 195.2% for Penta 3, against survey values of about 21% and 13%. They should not be used for coverage estimation.
- For maternal health indicators, the ANC1-derived denominator is preferred. It gave the estimates closest to survey values at subnational level, while the Penta1-derived denominator underestimated coverage and DHIS2 overestimated it
- For vaccination indicators, the Penta1-derived denominator performed best, giving national Penta 3 coverage of 18.5%, close to the survey's 13%. UN (56.9%) and ANC1 (71.5%) overestimated coverage.
- In summary, ANC1 is recommended for maternal health and Penta1 for immunization coverage.

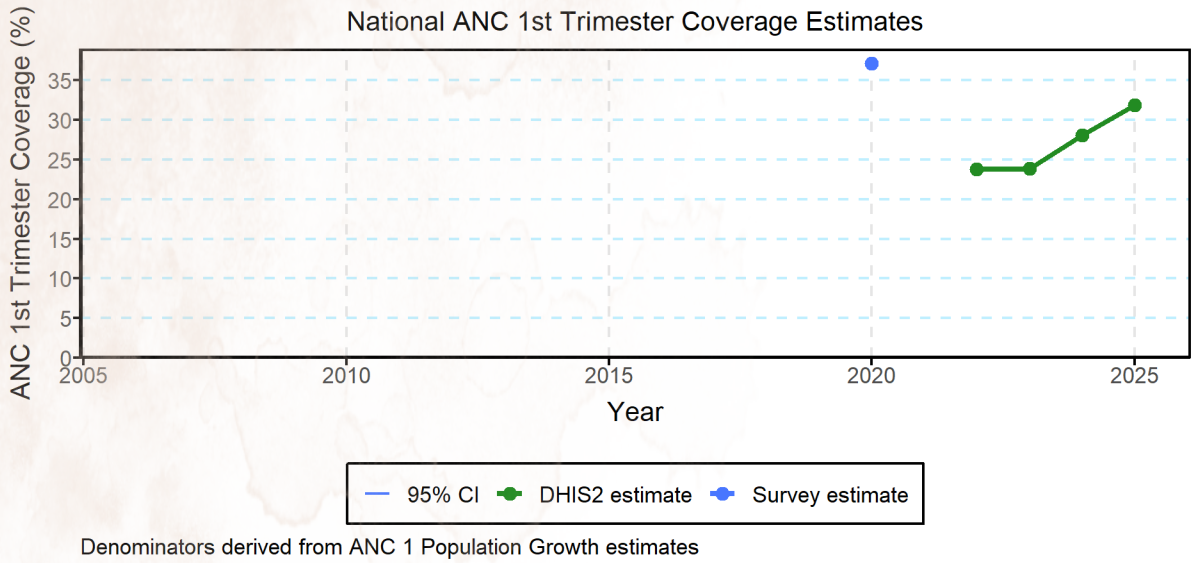
2. National Coverage Trends: Facility Data and Surveys

Antenatal care: ANC4, ANC early visit, first trimester of pregnancy

ANC 4



ANC early visit

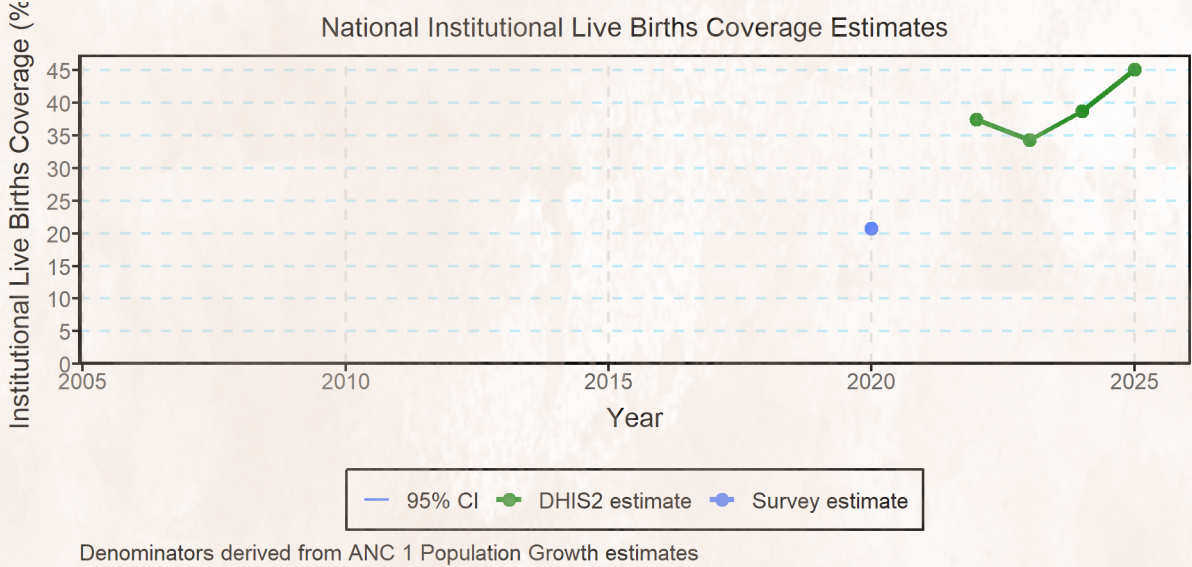


Interpretations

The national trends for antenatal care show different patterns between ANC4 coverage and ANC early first trimester visits when comparing survey estimates with DHIS2 facility data. For ANC4, the survey estimates indicate a steady increase in coverage from approximately 4% in 2006 to about 35% in 2020, suggesting substantial long-term improvements in women completing at least four antenatal care visits. The DHIS2 facility data show coverage of around 30% in 2022, a slight decline in 2023, followed by a gradual increase to nearly 40% in 2025. Although there is some fluctuation in the facility data, the overall trend is consistent with the survey findings, indicating continued progress in ANC4 service utilization over recent years.

For ANC early first trimester visits, the survey estimate for 2020 is approximately 36%, while the DHIS2 facility data report lower coverage levels of about 24% in 2023 and 2024 before increasing to around 31% in 2025. This suggests that early initiation of antenatal care remains below the survey estimate but has shown recent improvement. The difference between survey and facility estimates may reflect variations in reporting systems, data completeness, or differences in measurement methods. Overall, the trends indicate gradual progress in maternal health service utilization, with continued efforts needed to improve early ANC attendance and strengthen routine health information system reporting.

Institutional Live Births

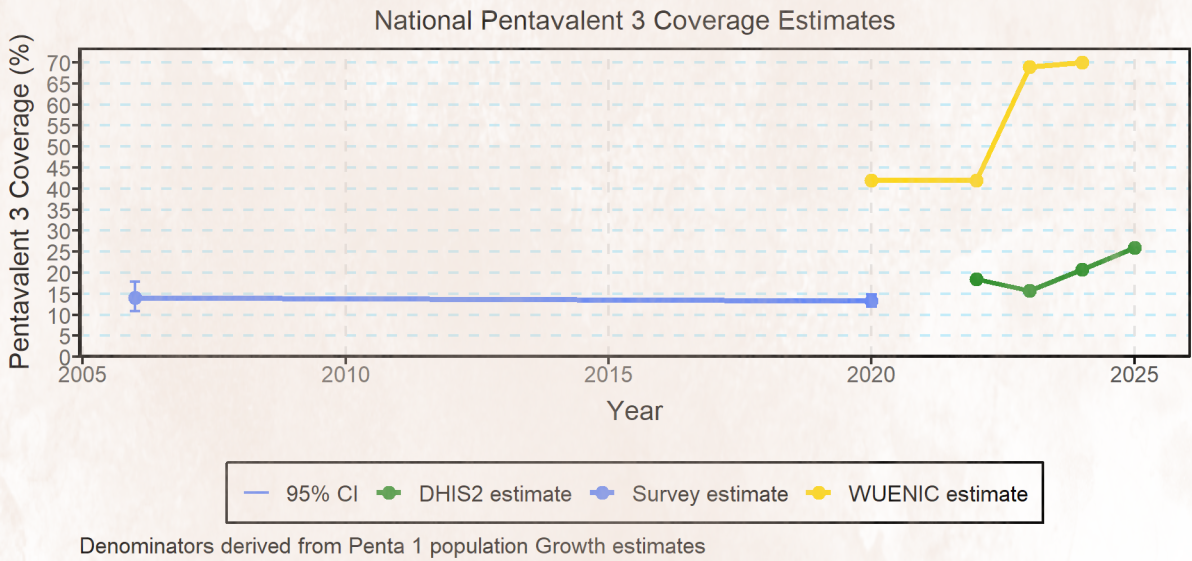


Interpretations

The national trend for institutional live births shows steady improvement in the utilization of health facilities for childbirth. The survey estimate indicates that institutional live birth coverage was approximately 21% in 2020, while DHIS2 facility data show higher coverage levels, increasing from about 37% in 2022 to 45% in 2025 despite a slight decline in 2023. This overall upward trend suggests improved access to and use of skilled delivery services.

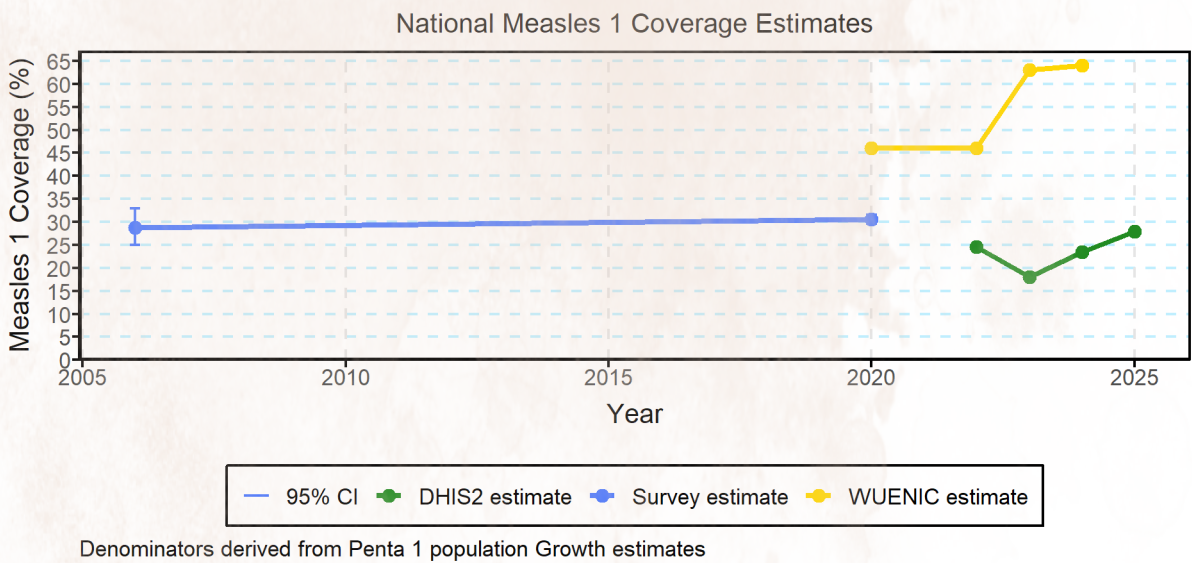
Although there is a noticeable difference between the survey and facility estimates, the increasing DHIS2 coverage reflects strengthened routine reporting and expanded maternal health service utilization. The continued rise in institutional deliveries is a positive sign for improving maternal and newborn health outcomes. However, coverage remains below desired national and global targets, indicating the need for sustained efforts to improve access to quality delivery services, strengthen routine data systems, and encourage more women to deliver in health facilities.

Immunization: Penta 3, Measles 1



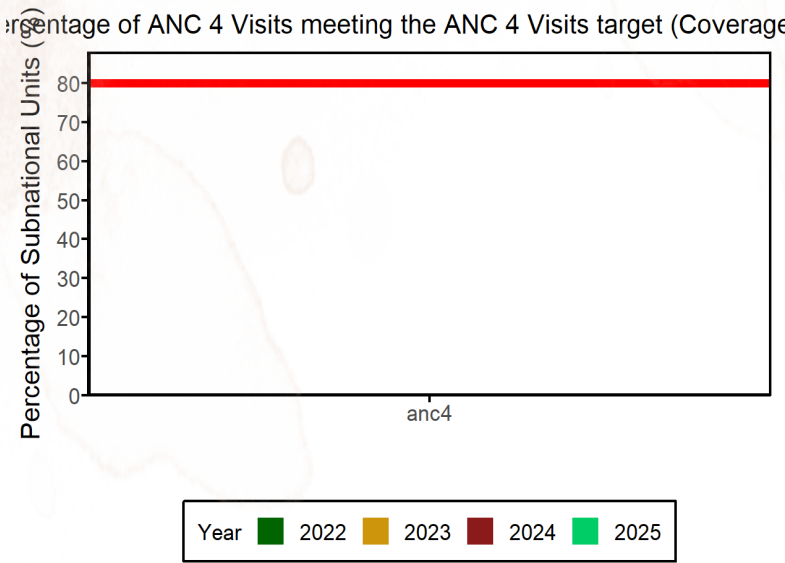
Interpretations

The national trends for Penta 3 and Measles 1 show gradual improvement in DHIS2 facility coverage between 2022 and 2025 following a slight decline in 2023. However, DHIS2 coverage remains considerably lower than both survey and WUENIC estimates. While the increasing trend indicates progress in routine immunization services and reporting, the large gap between administrative and external estimates suggests the need to strengthen data quality, reporting completeness, and vaccination service delivery. Continued efforts are required to improve immunization coverage and move closer to national and global vaccination targets.

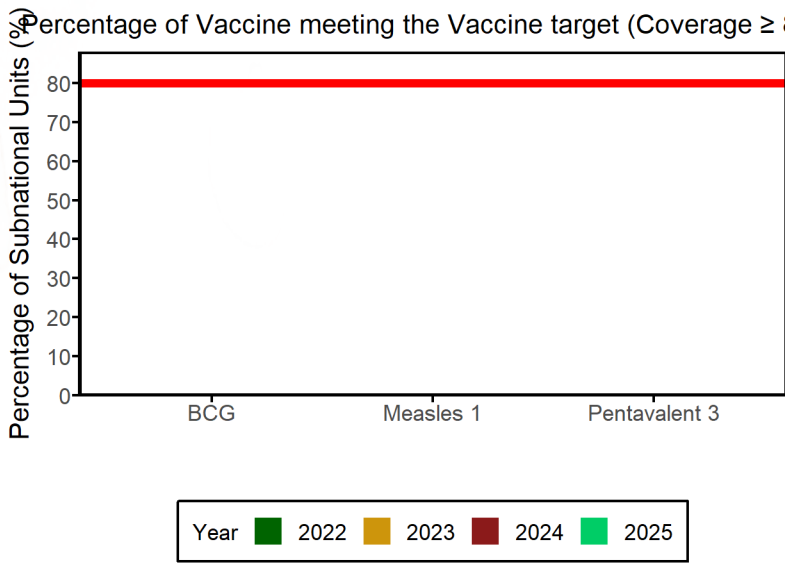


Percent of districts achieving high coverage targets

ANC 4



Child Health Indicators



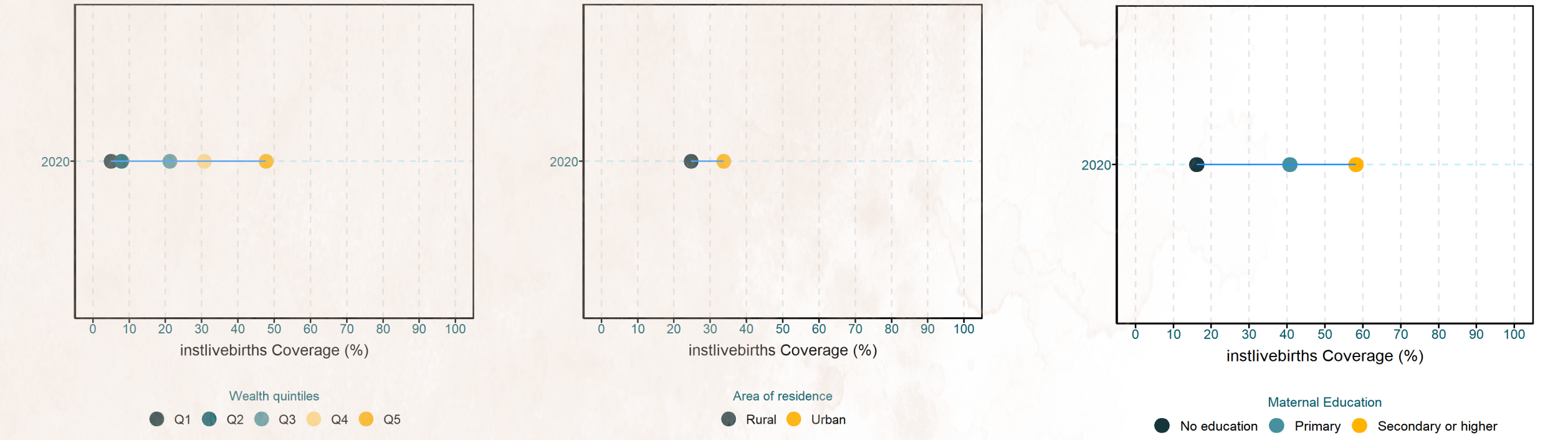
Interpretations

The chart does not provide sufficient district-level results to evaluate progress toward the coverage targets. Additional data are required to determine how many districts achieved the ANC4 and immunization targets and whether performance improved or declined between 2022 and 2025.

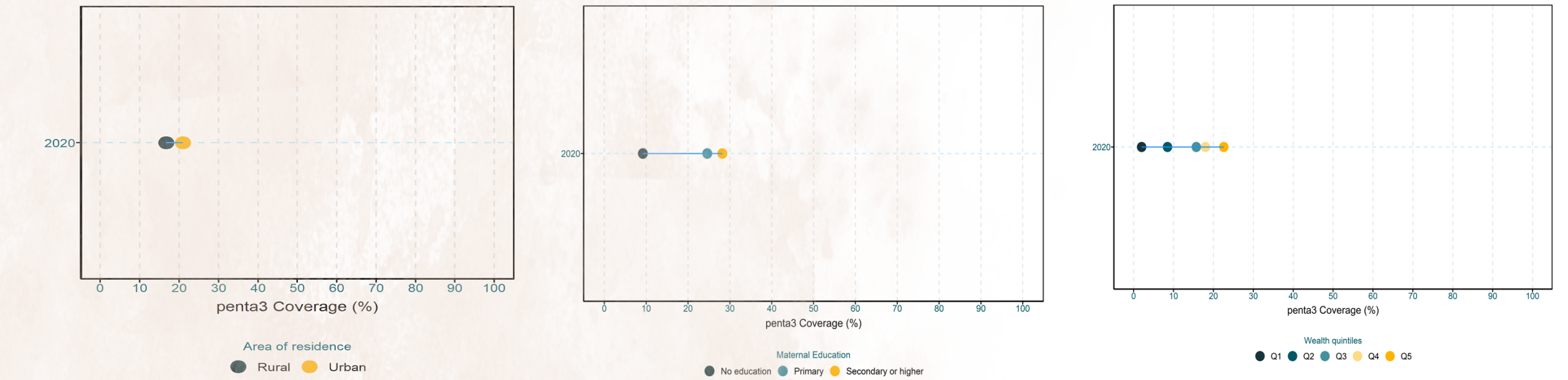
3. Equity

Equity by wealth, education, rural-urban residence (from surveys)

Institutional Live Births



Pentavalent 3rd Dose

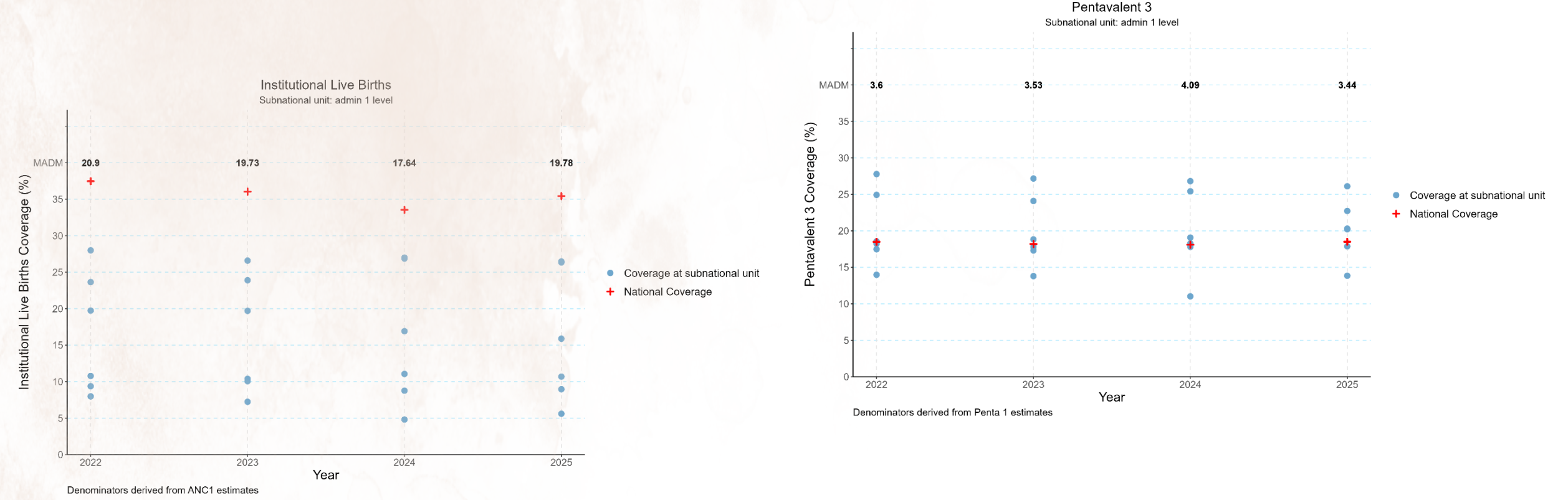


Interpretations

Both institutional delivery and child immunization coverage remain low overall, with modest equity gaps. For births, systemic health system limitations are the main barrier, while for immunization, socioeconomic status—especially maternal education and household wealth—has a stronger influence. Improving health system capacity, reducing economic barriers, and strengthening education and awareness are essential to achieve equitable and higher coverage across maternal and child health services.

InstituionalLive Births

Pentavalent 3rd Dose



- Institutional Live Births coverage remained low and largely stagnant, with national coverage at 33.5–37.5% over the period. Subnational inequality was high, with MADM between 17.6 and 20.9 percentage points. National coverage exceeded every regional estimate in all years, which is not possible if it is computed from these same regions. It may include areas not shown, or be calculated differently, and should be verified because it inflates the MADM.
- Penta 3 coverage (Penta1-derived denominator) was also low but stable at about 18% nationally. Inequality was much lower, with MADM between 3.4 and 4.1, and regional coverage clustered between 14% and 28%. Hirshabelle State seems to be lagging, falling to about 11% in 2024.
- Overall, inequality is persistent and there's need to inspect the data further.

4. Institutional mortality

Institutional Mortality trends (iMMR, iSBR)



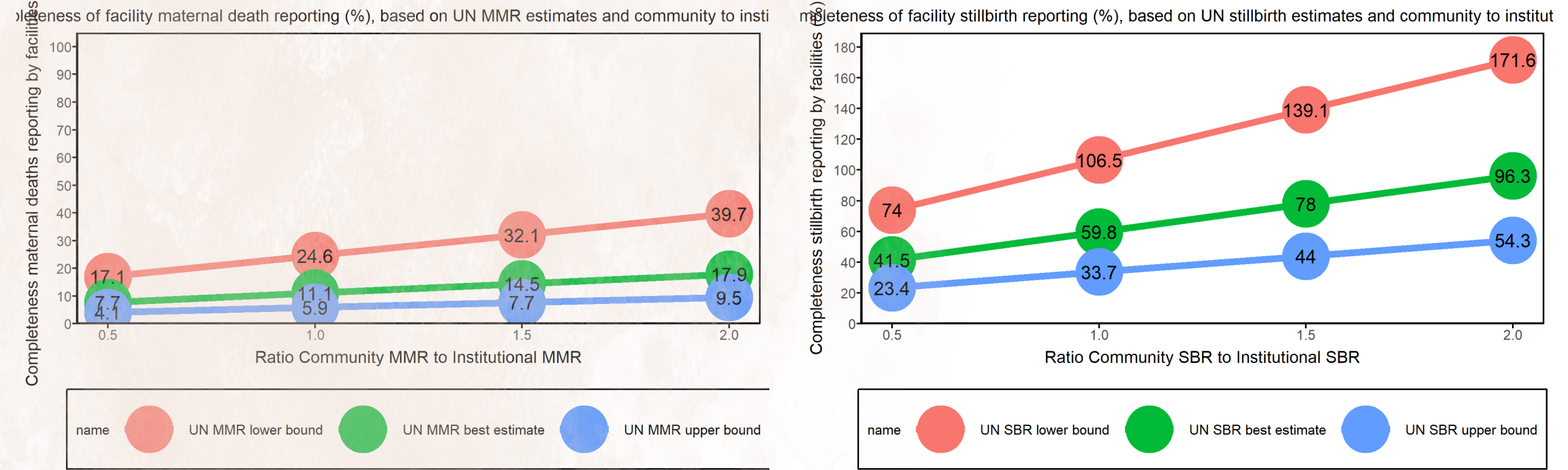
Interpretations

The national institutional maternal mortality ratio (MMR) increased from 68.4 per 100,000 live births in 2022 to 73.2 in 2023, reaching a peak of 83.1 in 2024, before declining substantially to 51.0 in 2025. Considerable regional variation was observed throughout the study period, with some regions consistently reporting much higher facility-based MMR than the national average. The decline in 2025 may indicate improvements in maternal health outcomes, reporting practices, or changes in case mix, although the marked regional disparities suggest persistent inequalities in maternal health services and outcomes across Somalia.

The national institutional stillbirth rate (SBR) declined from 27.1 per 1,000 births in 2022 to 18.6 in 2023, increased slightly to 20.1 in 2024, and decreased again to 17.0 in 2025. Despite the overall downward trend, substantial regional variation persisted, with several regions consistently reporting considerably higher stillbirth rates than the national average. These findings suggest gradual improvement in facility-based perinatal outcomes over time while highlighting ongoing geographical disparities that warrant targeted interventions to improve maternal and newborn care across regions.

Data quality metrics

Estimated completeness of facility maternal death and stillbirth reporting



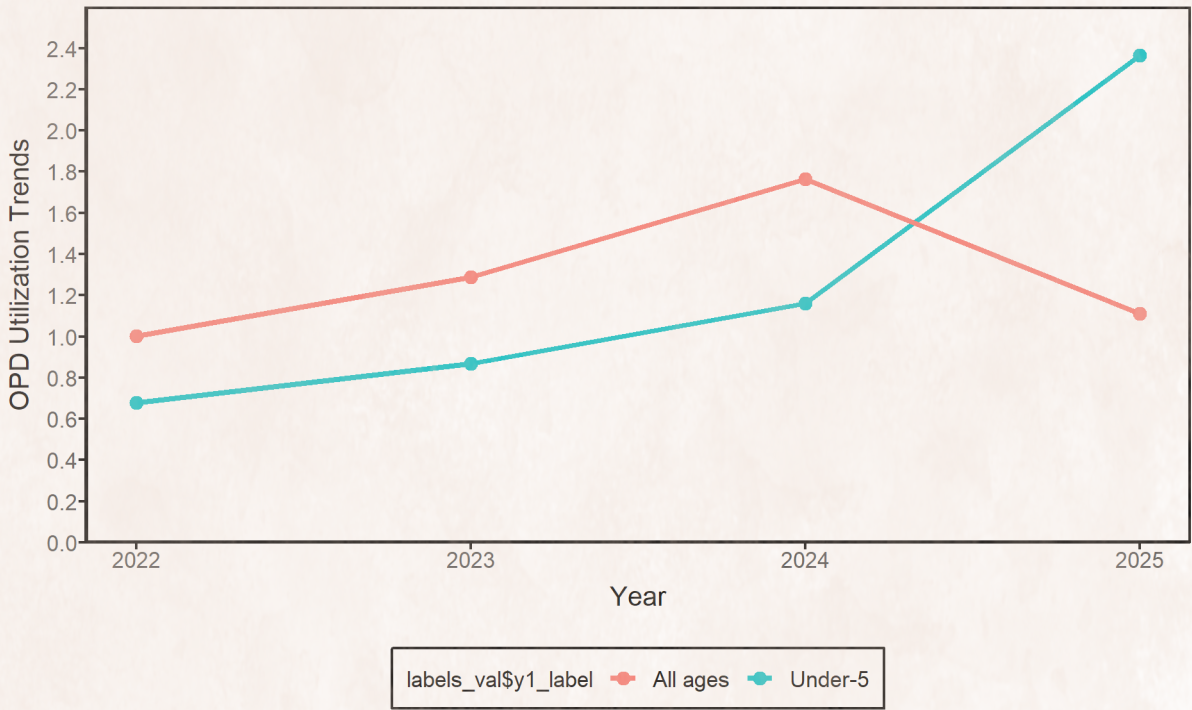
Interpretations

- Facility maternal death reporting completeness increased steadily as the ratio of community maternal mortality to institutional maternal mortality increased. Based on the UN best estimate, completeness rose from 7.7% at a ratio of 0.5 to 17.9% at a ratio of 2.0. Using the UN lower-bound estimate, completeness increased from 17.1% to 39.7%, whereas the UN upper-bound estimate increased from 4.1% to 9.5%. Overall, these findings indicate that facility reporting captures only a small proportion of expected maternal deaths, even under the most optimistic assumptions, suggesting substantial underreporting and highlighting the need to strengthen maternal death surveillance and reporting systems.
- While Completeness of Facility Stillbirth Reporting also increased with higher community-to-institutional stillbirth ratios. Under the UN best estimate, completeness increased from 41.5% at a ratio of 0.5 to 96.3% at a ratio of 2.0. The UN lower-bound estimate exceeded 100% at higher ratios, increasing from 74.0% to 171.6%, indicating possible overestimation due to denominator uncertainty. In contrast, the UN upper-bound estimate increased from 23.4% to 54.3%. Overall, stillbirth reporting was substantially more complete than maternal death reporting, although the wide variation across denominator assumptions underscores the importance of using accurate denominator estimates for reliable assessment of reporting completeness

5. Curative Health Service Utilization for Sick Children

Outpatient and inpatient service utilization

OPD per person per year

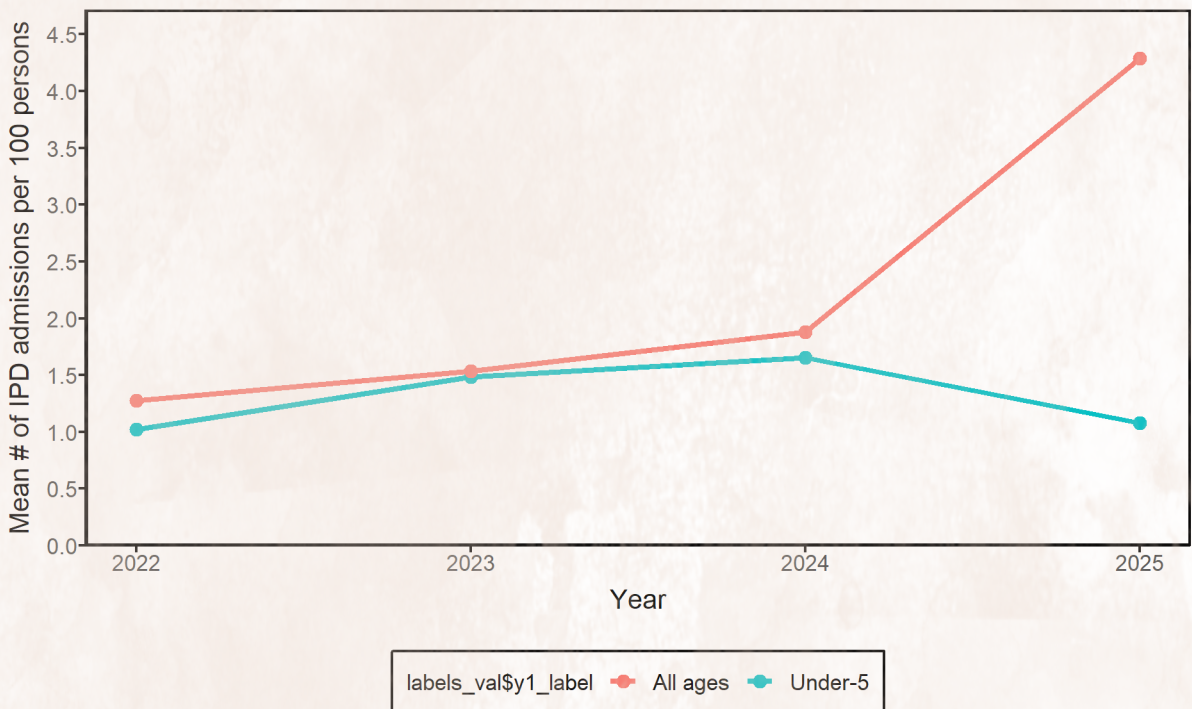


Interpretations

Outpatient department (OPD) utilization increased over the study period for both age groups, although the trends differed. Among all ages, utilization rose from 1.0 visits per person in 2022 to 1.3 in 2023 and peaked at 1.8 in 2024, before declining to 1.1 in 2025. In contrast, under-five children demonstrated a continuous increase from 0.7 visits per person in 2022 to 0.9 in 2023, 1.2 in 2024, and 2.4 in 2025. The marked increase among children under five suggests improved utilization of child health services, whereas the decline among the overall population in 2025 may reflect changes in healthcare-seeking behaviour, service availability, or reporting practices.

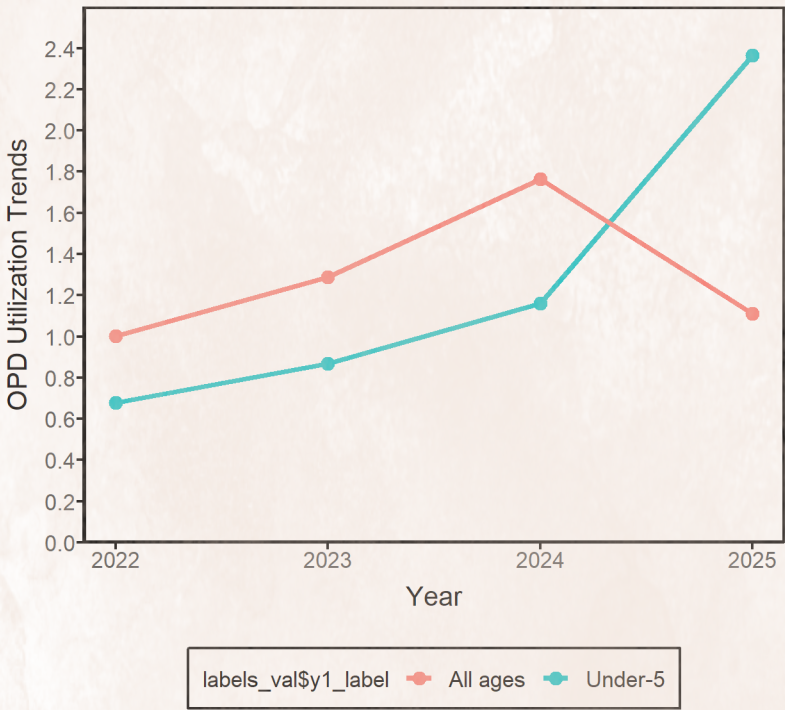
The mean number of inpatient department (IPD) admissions increased over time for both age groups, although distinct trends were observed. Among all ages, admissions rose steadily from 1.3 per 100 population in 2022 to 1.5 in 2023, 1.9 in 2024, and increased sharply to 4.3 in 2025. Among children under five years, admissions increased from 1.0 per 100 population in 2022 to 1.5 in 2023 and 1.7 in 2024, before declining to 1.1 in 2025. These findings indicate a substantial increase in inpatient service utilization among the general population, while under-five admissions remained relatively stable and declined in the final year, suggesting differences in healthcare utilization patterns between age groups.

IPD admissions

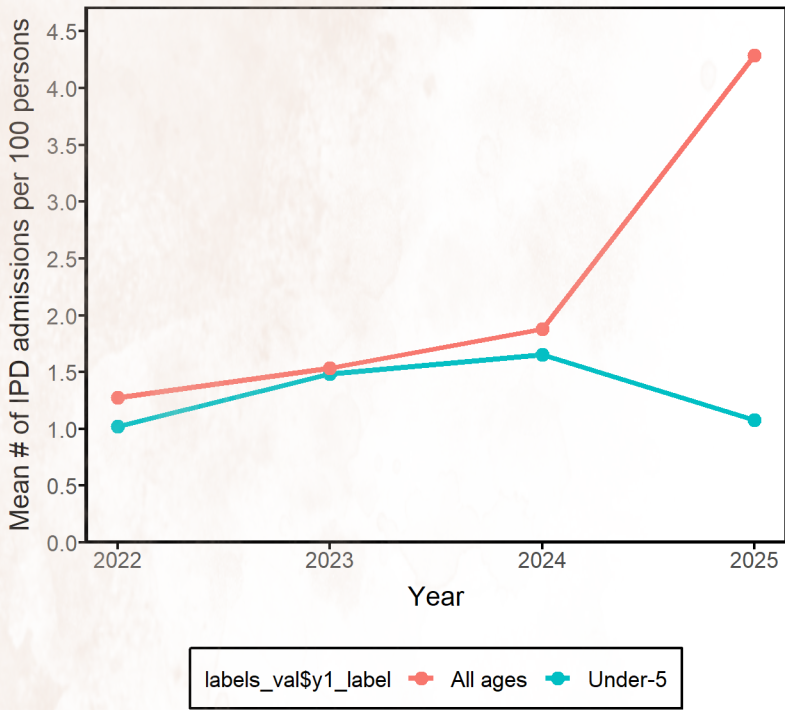


Regional/provincial service utilization

OPD per person per year



IPD admissions



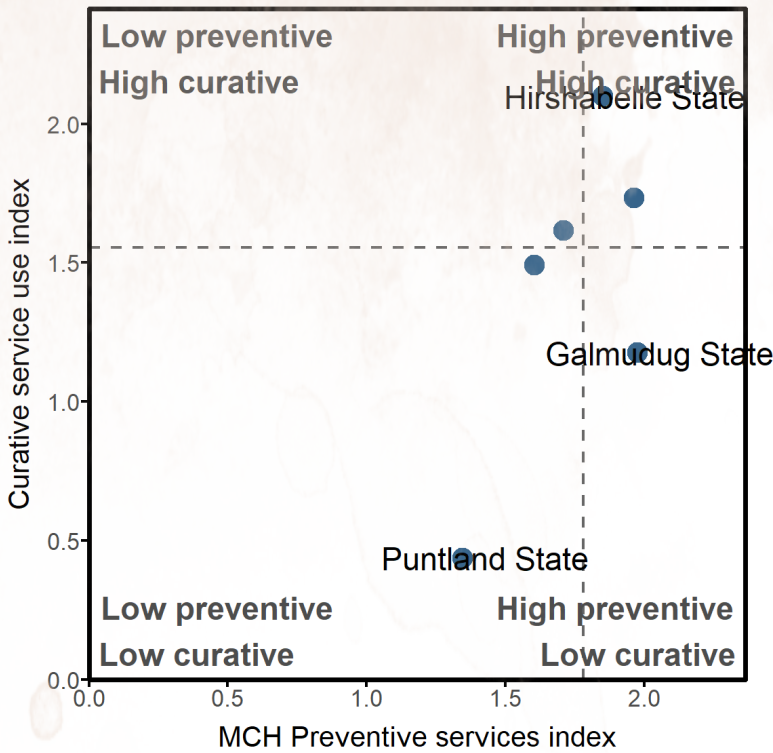
Interpretations

Outpatient department (OPD) utilization showed different trends between the general population and children under five. Among all ages, OPD visits rose from 1.0 in 2022 to 1.8 in 2024, then declined to 1.1 in 2025. In contrast, under-five children had a steady increase from 0.7 in 2022 to 2.4 in 2025, suggesting improved child health service use, while the decline among the overall population may reflect changes in healthcare-seeking behaviour, service availability, or reporting practices.

Inpatient department (IPD) admissions increased overall, from 1.3 per 100 population in 2022 to 4.3 in 2025. For under-five children, admissions rose from 1.0 in 2022 to 1.7 in 2024, but declined to 1.1 in 2025. These findings indicate substantial growth in inpatient service utilization among the general population, while under-five admissions remained relatively stable before decreasing, showing differing healthcare utilization patterns across age groups.

MCH Preventive vs Curative Index

MCH preventive index compared to curative service index, under 5



Interpretations

The Maternal and Child Health (MCH) preventive and curative service indices varied across states. Hirshabelle State recorded the highest preventive (approximately 2.0) and curative (approximately 1.7) service indices, indicating relatively strong performance in both domains. Galmudug State also demonstrated high preventive (1.8) and curative (1.6) service indices, while Puntland State exhibited a moderate preventive service index (1.4) but a substantially lower curative service index (≈ 0.4). Overall, Hirshabelle and Galmudug were positioned in the high preventive–high curative quadrant, whereas Puntland showed relatively stronger preventive than curative service performance, suggesting the need to strengthen access to curative child health services.

6. Health System Progress and Performance

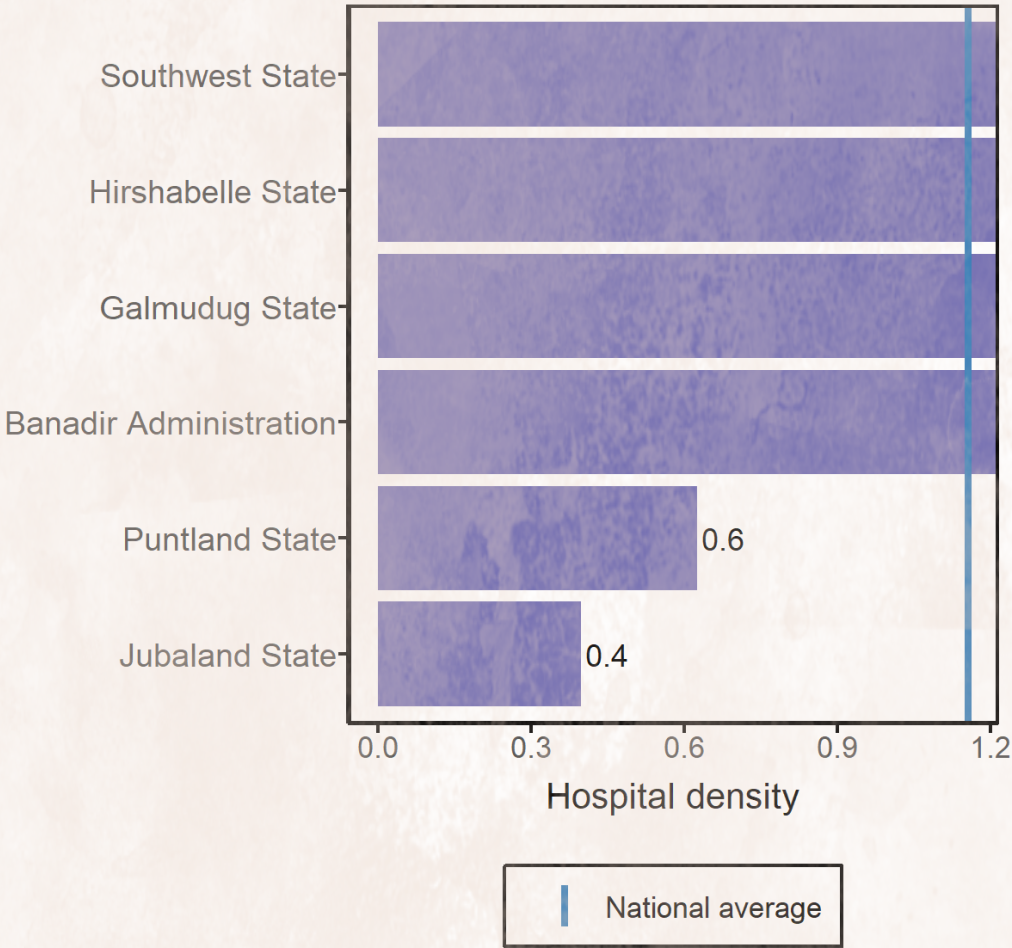
Health system inputs

2024		
Indicator	Value	Unit
Health infrastructure		
Health facility density	0.3	per 10,000
Share of facilities that are hospitals	42.0	%
Hospital density	1.2	per 100,000
Inpatient bed density	6.0	per 10,000
Health workforce		
Health workforce density	30.3	per 10,000
Skills mix ratio nurse-midwives per physician	1.0	
Role of private sector		
Share of Private facilities	424.3	%
Share of NGO facilities	111.9	%

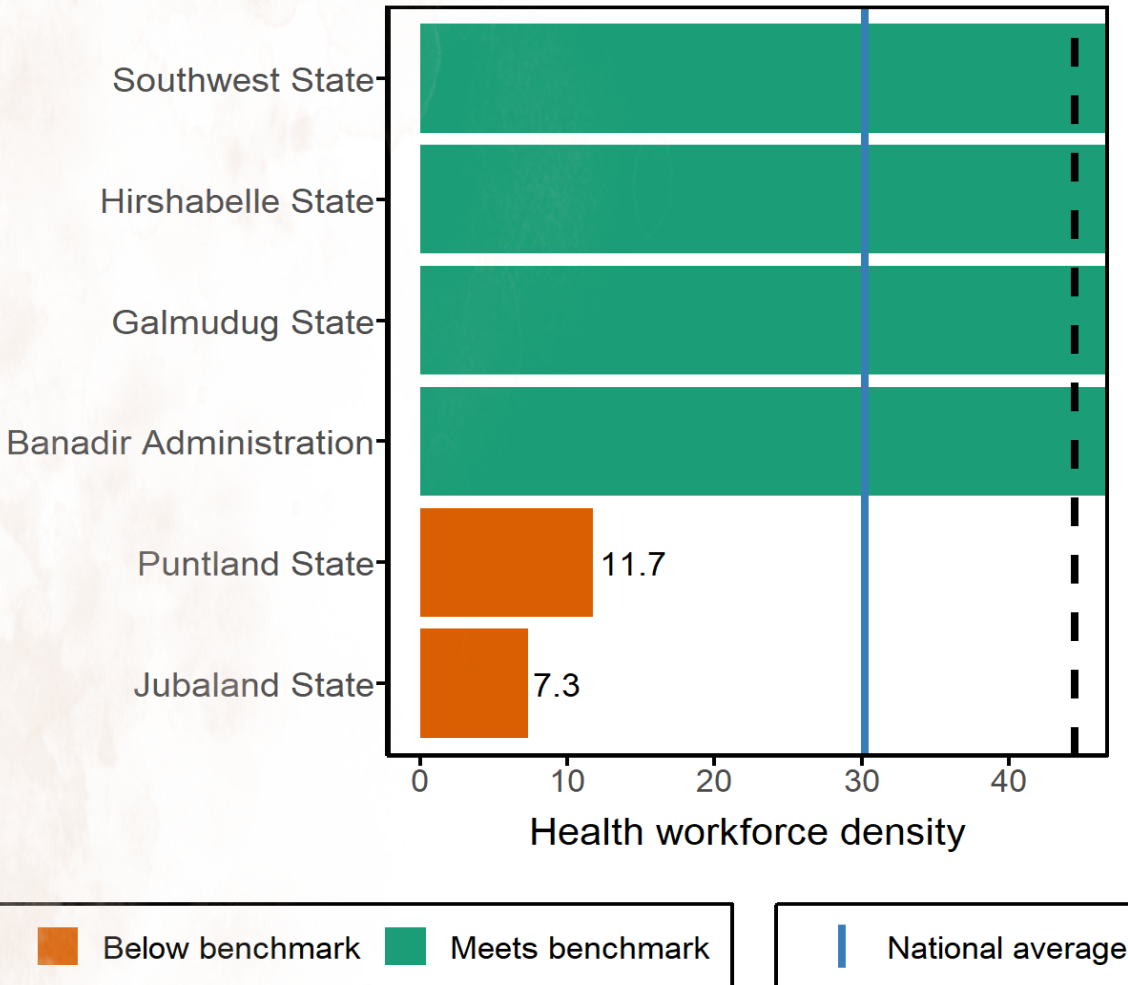
The 2024 health system indicators suggest both strengths and challenges in health service capacity. Health facility density is low at 0.3 facilities per 10,000 population, while hospital density is only 1.2 per 100,000 population, indicating limited physical access to health services. Inpatient bed density is also modest at 6.0 beds per 10,000 population, suggesting constrained capacity for inpatient care. The health workforce density of 30.3 per 10,000 population and a nurse-midwife-to-physician ratio of 1.0 indicate a relatively balanced workforce composition. However, the reported shares of private (424.3%) and NGO (111.9%) facilities exceed 100%, suggesting possible data quality or reporting errors that should be verified before interpretation and policy us

Health system inputs by region/province

Hospital Density per 100,000 population



Health workforce density per 10,000 population

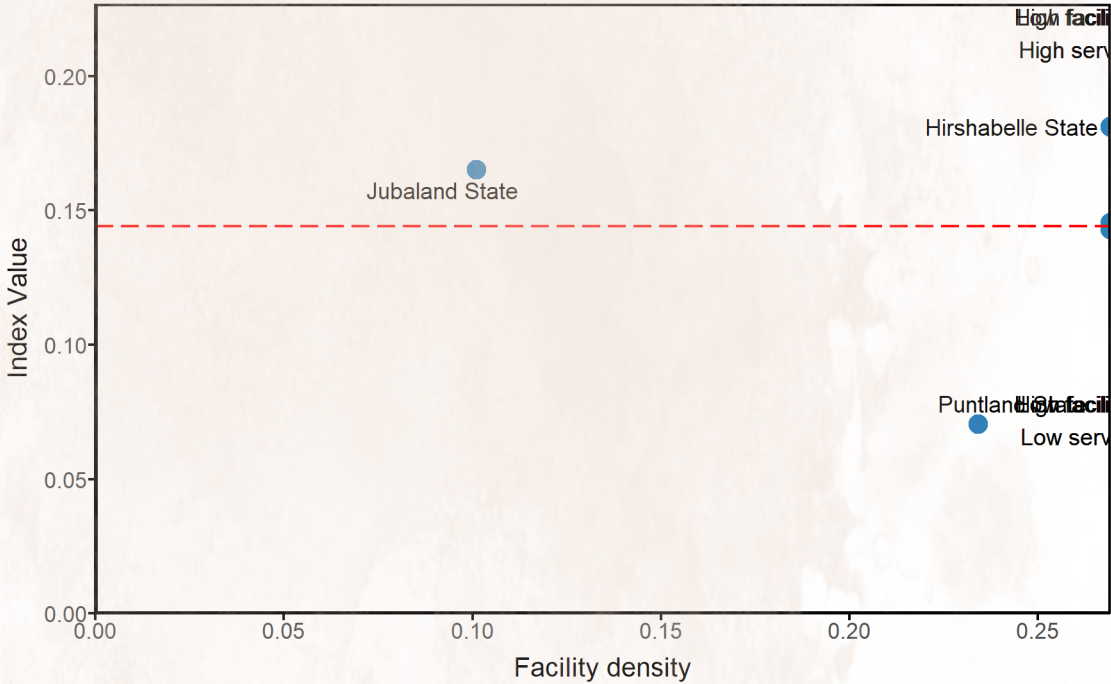


The figure reveals substantial regional inequalities in Somalia's health system inputs.

Southwest State, Hirshabelle State, Galmudug State, and Banadir Administration have the highest hospital density (approximately 1.2 hospitals per 100,000 population) and exceed the health workforce benchmark of 44.5 health workers per 10,000 population. In contrast, Puntland and Jubaland have significantly lower hospital densities (0.6 and 0.4, respectively) and workforce densities (11.7 and 7.3 per 10,000), falling well below the national average. These disparities indicate unequal access to health infrastructure and skilled personnel, emphasizing the need for targeted investments to strengthen health service capacity in underserved regions

Health system outputs by inputs at the subnational level

Facility density vs PHC Indices



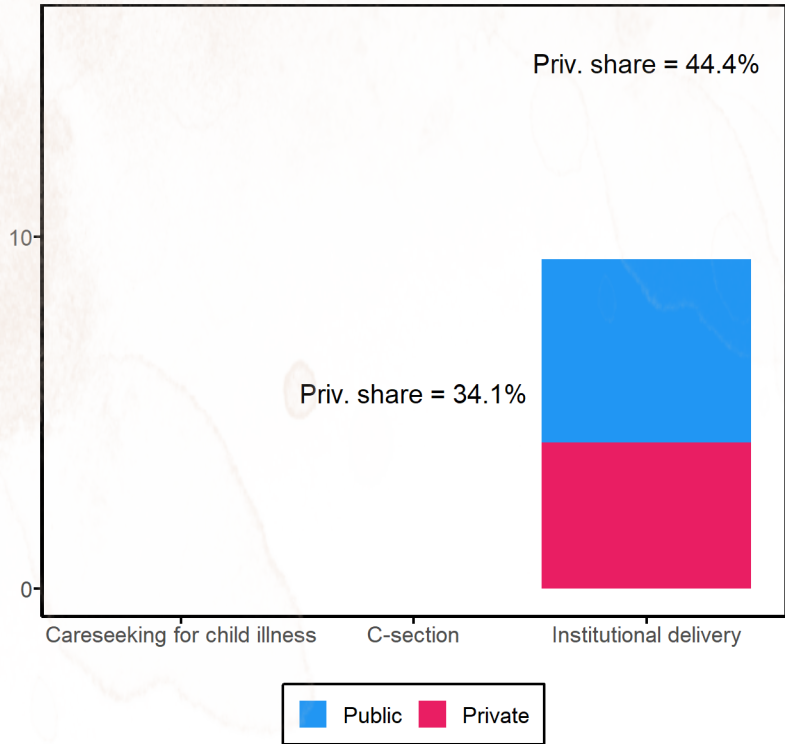
Interpretations

Southwest has most facilities (0.25) but lowest services (0.08). Jubaland has fewest facilities (0.10) but highest services (0.17).

Jubaland (1.70 efficiency ratio, 0.17 service index—most efficient). Hirshabelle (0.71 efficiency, 0.15 service index—balanced).

Puntland (0.35 efficiency, 0.08 service index). Southwest (0.32 efficiency, 0.08 service index—worst).

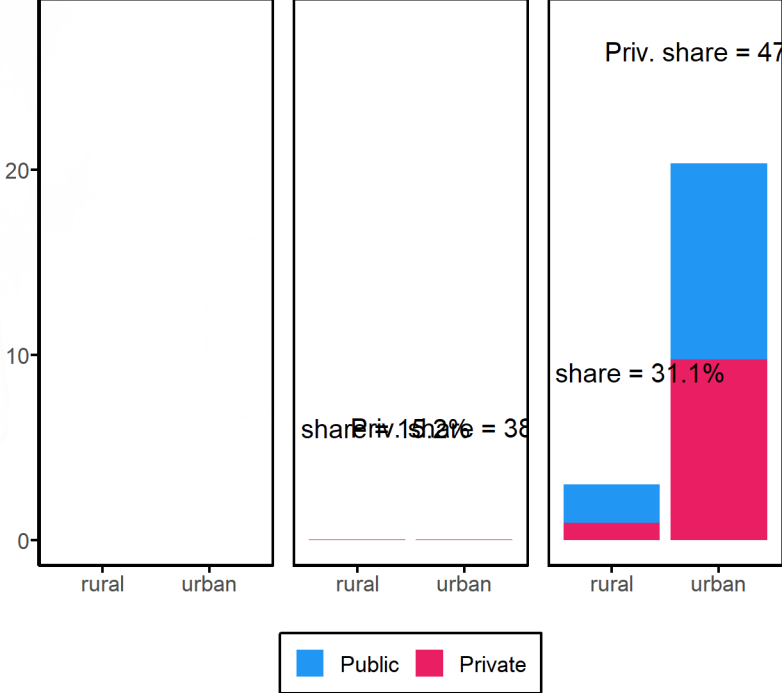
Private sector and RMNCAH services



careseeking for child illness

C-section

Institutional delivery



Interpretations

Rural-Urban Disparities: Extreme inequalities across all indicators. Careseeking, C-section, and institutional delivery show 3–10× gaps favoring urban areas. Rural populations severely underserved.

Private Sector Share: Institutional delivery has highest private share (47%), followed by careseeking (44.4%), and C-section (34.1%). Nearly half of maternal services in private sector, suggesting public sector insufficient.

Private Sector Distribution: Concentrated in urban areas. Urban private share 1.5–2.5× higher than rural (C-section: 38% urban vs. 15.1% rural; institutional delivery: 47% urban vs. 31.1% rural). Rural areas rely on weak public sector

COUNTDOWN TO 2030

COUNTRY ANNUAL MEETING

CAM 2026



JUNE 2026