

THE FEDERAL REPUBLIC OF SOMALIA
SOMALIA NATIONAL BUREAU OF STATISTICS

THE SOCIO-DEMOGRAPHIC SURVEY 2026



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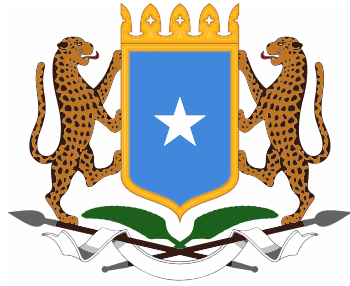
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The Federal Republic of Somalia
Somalia National Bureau of Statistics (SNBS)

THE SOCIO- DEMOGRAPHIC SURVEY 2026



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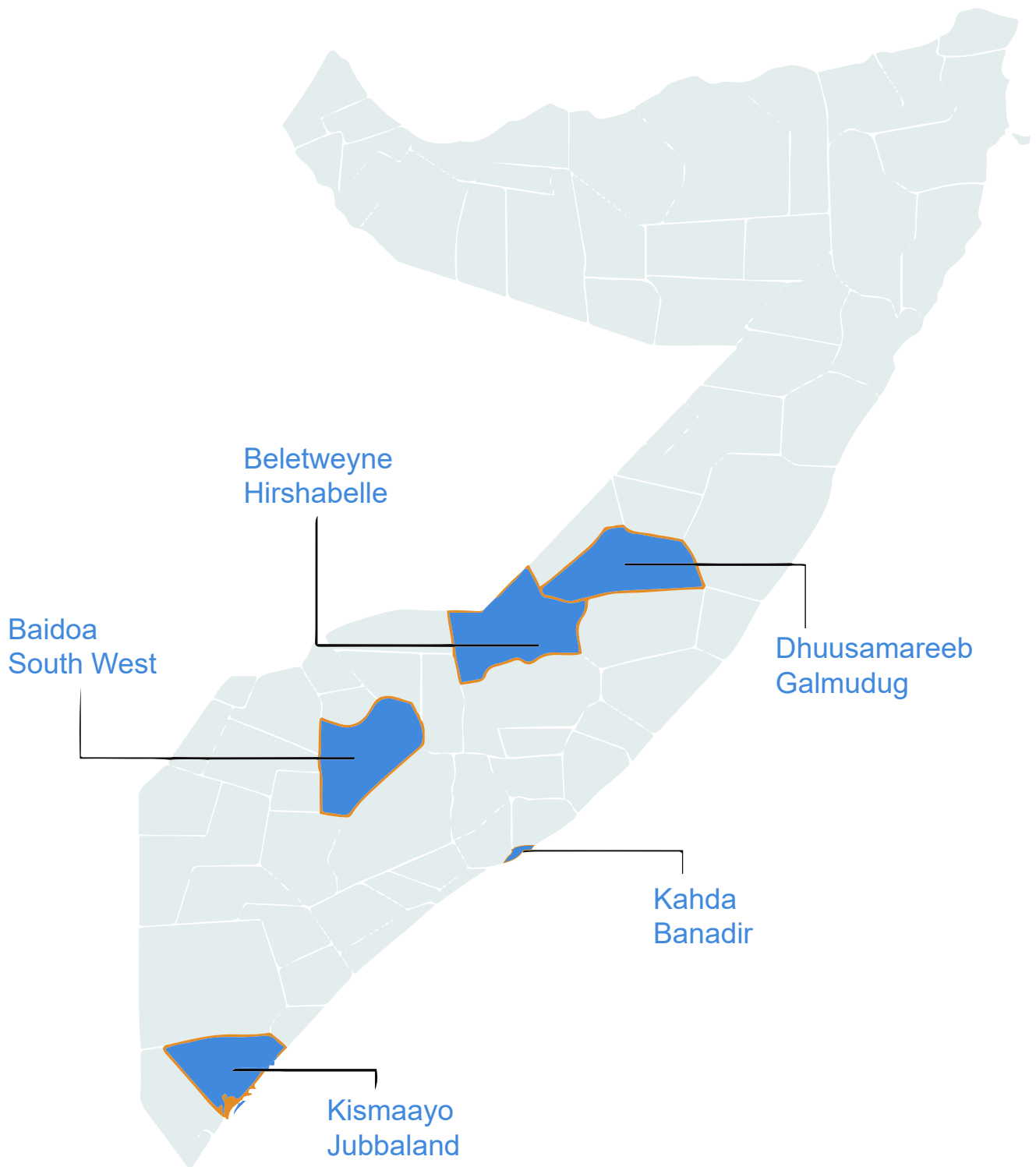


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THE SOCIO- DEMOGRAPHIC SURVEY 2026



Map somalia



Preface

It is with great pride that I present the Socio-Demographic Survey 2026, an undertaking that marks a real advance in Somalia's nationally led effort to build a modern and dependable statistical system. As Director General of the Somali National Bureau of Statistics (SNBS), I am pleased to report that this survey combined geospatial modeling to estimate population in five selected districts. The use of geospatial modeling to estimate population strengthens our evidence base while strengthening our statistical approaches for future endeavors.

My deepest appreciation goes to the field enumerators and supervisors who gathered this data across five districts — Kaxda, Dhuusamareeb, Baidoa, Beledweyne and Kismayo — often under difficult logistical and security conditions. Their diligence and resolve are the bedrock on which everything that follows is built. I am grateful, too, to the SNBS statisticians, demographers and geospatial analysts whose expertise steered the survey from its design through to its analysis.

To our partner the United Nations Population Fund (UNFPA), I offer sincere thanks for the technical guidance and steady collaboration that accompanied every phase of this work, and to the Gates Foundation for the financial support that brought it to fruition. Their investment reflects a shared and long-term commitment to strengthening the foundations of Somali statistics.

This survey also breaks new ground in how it was conducted. For the first time at this scale, fieldwork was managed through a live data-collection dashboard, allowing enumeration to be monitored and quality-assured in real time as it unfolded. Together with the wider use of geospatial and digital tools, this points clearly to the future of statistical practice in Somalia — more transparent, more responsive and more rigorous.

The findings shed light on population dynamics, living conditions, health, education and access to basic services. They offer timely evidence to guide planning under the National Transformation Plan (NTP) and to track progress toward the Sustainable Development Goals (SDGs), at both national and subnational levels. No less importantly, the exercise lays essential groundwork for a future comprehensive national census.

Looking ahead, the Somali National Bureau of Statistics will continue to broaden and refine this work, building toward fuller national coverage and ever more credible, timely and policy-relevant statistics. That a survey of such complexity could be delivered at all is a credit to the many hands behind it — government institutions, the Federal Member States, technical agencies, development partners and committed professionals — and a measure of what we can achieve as that partnership deepens.



Dr. Abdisalam Abdirahman Mohamed

Director General
Somalia National Bureau of Statistics

Acknowledgements

The Somalia Socio-Demographic Survey 2026 came together through the effort of a great many people, and the Somali National Bureau of Statistics (SNBS) is glad to set down its thanks to each of them here. Our first acknowledgement belongs to the Bureau's leadership, whose clarity of purpose saw the survey through from its earliest planning to its final pages. Dr Abdisalam Abdirahman Mohamed, Director General, and Mr Abdirahman Omar Dahir, Deputy Director General, offered the direction and careful supervision that a task of this magnitude demanded; their lasting dedication to building up the national statistical system is reflected in the soundness and authority of this report.

What follows in these pages was made possible by a committed SNBS technical team, whose skill and close coordination shaped every stage of the work, from design and preparation, through the fieldwork itself, to the processing and interpretation of the data. We record our warm thanks to Mr Abdishakur Awil Hassan (Survey Coordinator, GIS Specialist and Technical Lead); Mr Said Abdillahi (Director of Social and Population Statistics); Dr Abdi Mohamud Ali (Senior Statistician); Mr Kamal Ahmed (Advocacy and Communication Specialist); Mr Abdirazak Abdullahi Karie (Demographer); Mr Abdirahman Omar Ali (Population and Data Analyst); Mr Abdinasir Ali Dahir (Senior Demographer); Mr Ahmed Abdullahi Farah and Mr Abukar Abdulle Elmi (GIS Technicians); Mr Mohamed Ali Ibar (ICT Technician); Ms Shukri Yusuf Salad (Finance and Administration Specialist); and Mr Mohamed Mohamud Mohamed (Administration and Logistics Officer), Eng. Mohamed Abukar Omar (Report Designer & Infographics Specialist). The care they brought to their work, often in trying circumstances, is what gave this exercise its accuracy and its depth.

SNBS is thankful to the United Nations Population Fund (UNFPA), whose leadership and close partnership accompanied the survey from start to finish. The counsel of its senior staff and the technical strength of its team did much to sharpen the way the exercise was designed, carried out and analysed. We are especially grateful to Dr Mary Otieno (Former Representative), Mr Judicael ELIDJE (Representative) Mr Francis Anyansi (Deputy Country Representative), Ms Mariam Alwi (Head of Population and Development) and Mr Felix Mulama (Senior Demographer), and to the broader UNFPA technical and operations teams whose ready assistance kept the work moving.

A number of individuals also left a distinct mark on this survey, and we thank them by name. Umikaltuma Mohamed carried out the early groundwork and cartography on which the data collection later rested. Asma Ali lent her support to the project during her tenure with the Gates Foundation, and Ms Zena Lyaga gave her time to the editing and preparation of the report, sharpening its language and lending it consistency.

Likewise, the Somali National Bureau of Statistics (SNBS) extends its sincere appreciation to the Gates Foundation for its vital financial and technical support. Their belief in this initiative and its potential to improve the lives of Somali communities was instrumental in turning this groundbreaking pilot project into a reality. We are also deeply grateful for the invaluable technical cooperation, expertise, and resources provided by our international and regional partners. This milestone was achieved through a strong collaborative effort alongside the United Nations Population Fund (UNFPA), WorldPop, the Foreign, Commonwealth & Development Office (FCDO), the Office for National Statistics (ONS), the National Institute of Statistics of Rwanda (NISR), and the Kenya National Bureau of Statistics (KNBS).

No survey of this kind stands or falls anywhere but in the field, and SNBS is especially beholden to the enumerators and supervisors whose persistence, often in demanding settings, secured dependable data across Kaxda, Dhuusamareeb, Baidoa, Beledweyne and Kismayo. Most of all, we thank the households who opened their doors to the survey; the hours they gave and the details they shared are what every result in this report ultimately rests upon.

Lastly, SNBS records its deep appreciation to the Gates Foundation, the survey's lead donor, whose generosity made the Somalia Socio-Demographic Survey 2026 possible and, beyond that, has helped lay firmer ground for evidence-led, data-driven development in Somalia in the years ahead.

A survey of this scale draws on the contributions of many more individuals and institutions than can be listed in these pages. To all of them, named and unnamed alike, SNBS remains sincerely grateful.

Acronyms

ANC	Antenatal Care
ARI	Acute Respiratory Infection
ASDR	Age-Specific Death Rate
BCG	Bacillus Calmette–Guérin Vaccine
CBR	Crude Birth Rate
CDR	Crude Death Rate
CHW	Community Health Worker
DHS	Demographic and Health Survey
EA	Enumeration Area
FCDO	Foreign, Commonwealth & Development Office
FGM/C	Female Genital Mutilation/Cutting
GAR	Gross Attendance Ratio
GDP	Gross Domestic Product
GFR	General Fertility Rate
GIS	Geographic Information System
GPI	Gender Parity Index
LFPR	Labour Force Participation Rate
NAR	Net Attendance Ratio
ONS	Office for National Statistics
PNC	Postnatal Care
PPS	Probability Proportional to Size
PreEA	Pre-Enumeration Area
SDS	Socio-Demographic Survey
SDGs	Sustainable Development Goals
SNBS	Somalia National Bureau of Statistics
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
ToT	Training of Trainers
UNFPA	United Nations Population Fund
WHO	World Health Organization

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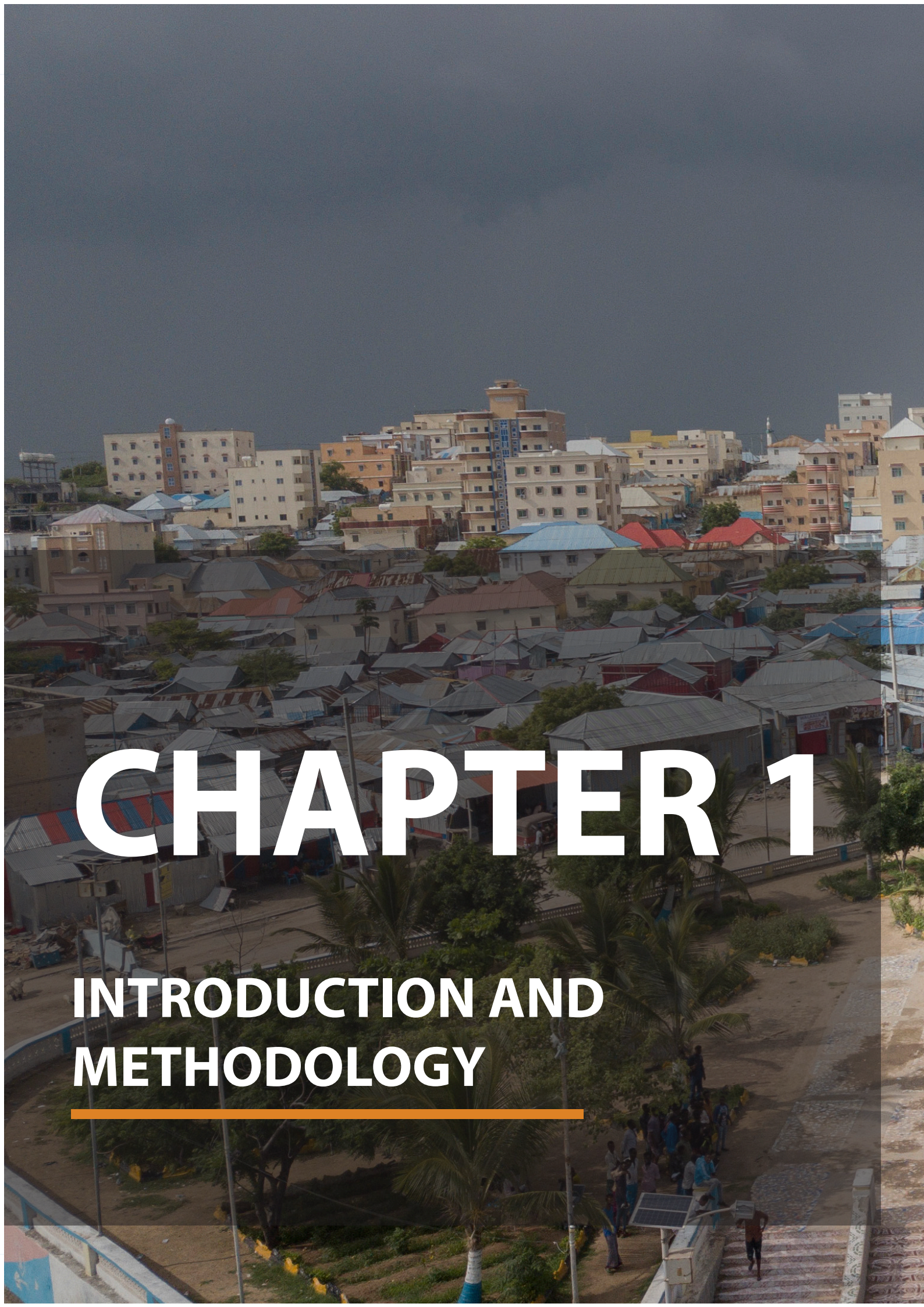
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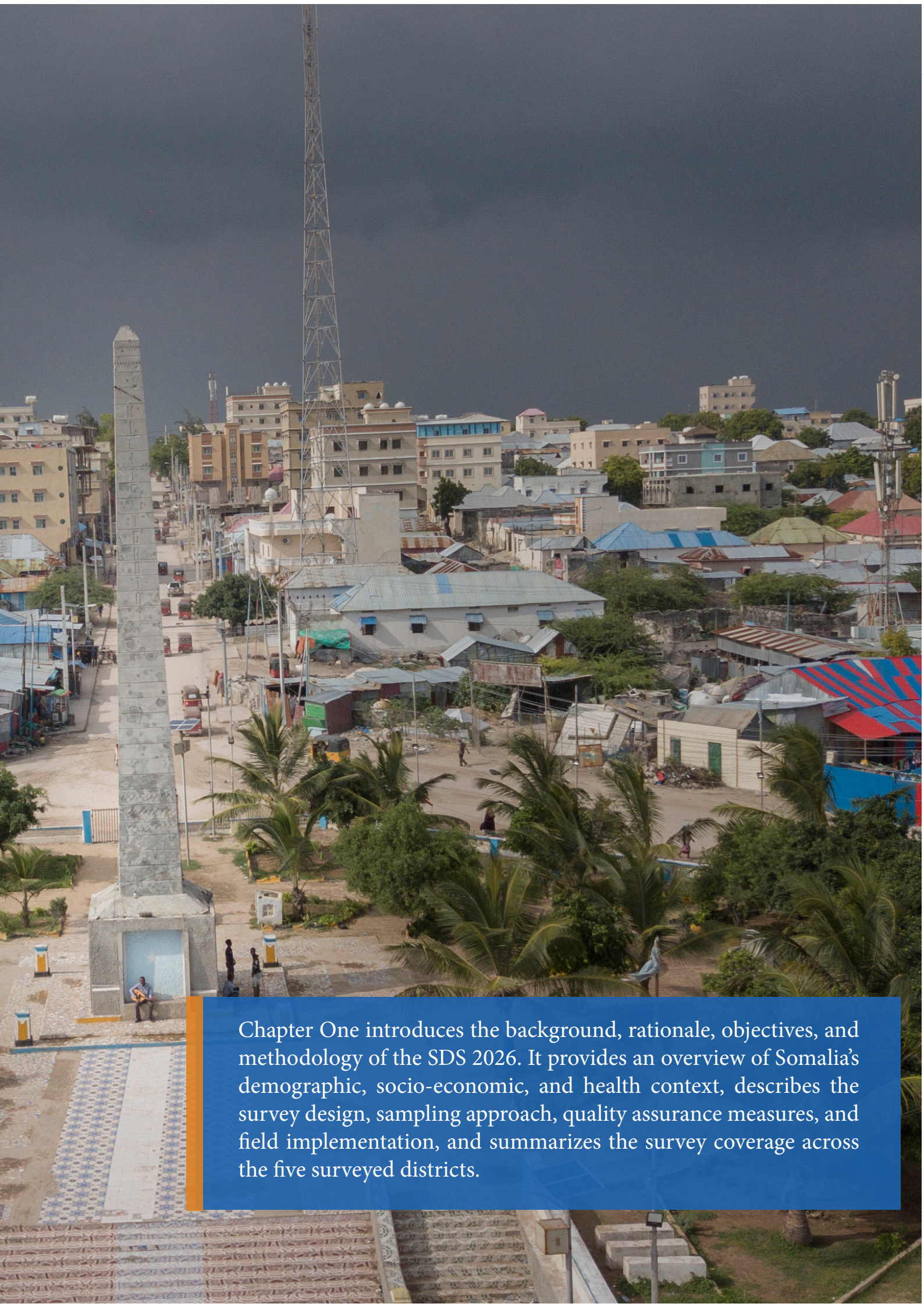
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CHAPTER 1

INTRODUCTION AND METHODOLOGY



Chapter One introduces the background, rationale, objectives, and methodology of the SDS 2026. It provides an overview of Somalia's demographic, socio-economic, and health context, describes the survey design, sampling approach, quality assurance measures, and field implementation, and summarizes the survey coverage across the five surveyed districts.

1.1 BACKGROUND

Country Context



1.1.1 Geography and Climate

Somalia, situated in the Horn of Africa, covers an estimated area of 637,657 km² and features a landscape predominantly made up of plateaus, plains, and highlands. It has the longest coastline in Africa, extending over 3,333 km from the Gulf of Aden down to the Indian Ocean. The country shares borders with Djibouti to the northwest, Ethiopia to the west, and Kenya to the southwest. Somalia experiences a tropical hot climate, characterized by minimal seasonal changes and daily temperatures ranging from 30°C to 40°C. It receives low annual rainfall and has four seasons: Gu' (spring) and Deyr (autumn) are the rainy seasons, while Xagaa (summer) and Jiilaal (winter) are the dry seasons. In recent years, however, changing and unpredictable climate patterns have led to recurring floods and droughts throughout the country.

The Socio-Demographic Survey (SDS) covers five high-priority districts: Kahda Banadir, Dhuusamarreb in Galmudug State, Baidoa in Southwest, Kismayo in Jubbaland State and Beletweyne in Hirshabelle State. These locations were selected to represent the diversity of Somali life, including urban, rural, nomadic, and displaced populations, ensuring that the survey reflects the socio-economic and demographic landscape of the entire population.

District Profile: Kahda (Banadir Region)

Kahda District, located on the outskirts of Mogadishu, serves as a vital indicator of Somalia's rapid urban expansion and the complex challenges of modern displacement. As a primary destination for those fleeing environmental shocks and conflict, it hosts a high concentration of internally displaced persons (IDPs) alongside low-income urban households. Many of these residents live in informal settlements with limited access to essential services, such as water, sanitation, health, and education. Consequently, Kahda provides critical insights into the intersection of urban poverty, displacement dynamics, and population vulnerability. The district is defined by a significant youth bulge, with children under the age of 18 making up 60 percent of the population, the highest proportion recorded in the survey. This young demographic, combined with the survey's largest average household size of 6.0 persons, places extraordinary demand on local infrastructure and social services. While the socio-economic landscape reflects a resilient population, it remains highly vulnerable to systemic shocks.

District Profile: Baidoa (Southwest State)

Baidoa District serves as a major administrative and economic hub for Southwest State and stands as one of Somalia's most critical urban centers. Due to its strategic importance, the district has absorbed a vast number of displaced households fleeing drought, conflict, and food insecurity from surrounding districts and regions. This influx has positioned Baidoa at the heart of humanitarian operations, service provision, and recovery efforts, making reliable district-level data indispensable for informed urban planning and development monitoring. The influx of displaced populations alongside low-income urban households has created significant pressure on local infrastructure. Many residents live in informal settlements with limited access to basic services such as water, sanitation, health, and education.

District Profile: Kismayo (Jubaland State)

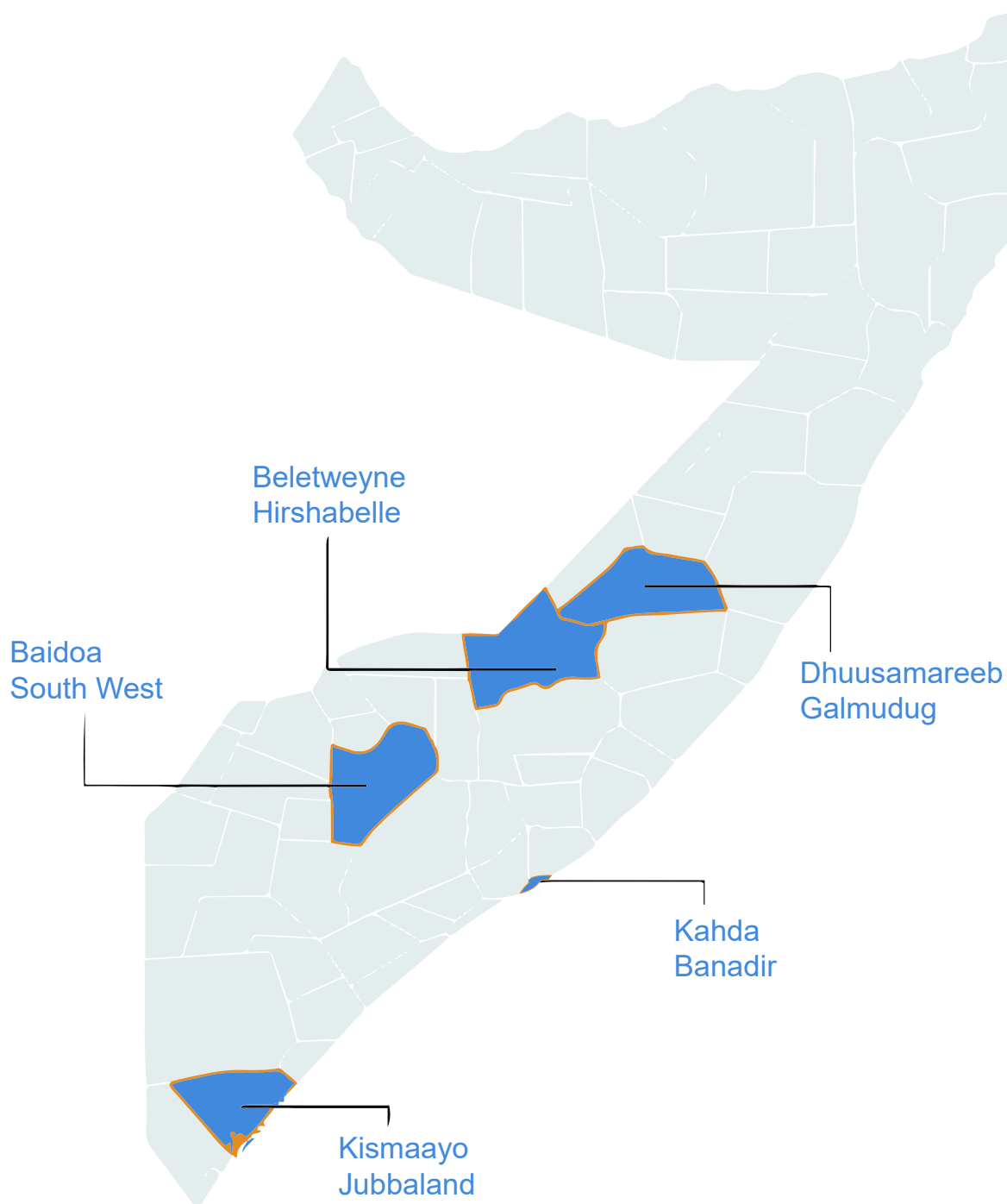
Kismayo District is a major coastal city and port that functions as a key economic center in southern Somalia, serving as a vital hub for trade, fisheries, and cross-border movement. Its strategic location and economic role make it particularly important for understanding urban development, livelihoods, and population mobility. The district hosts sizable internally displaced persons (IDP) populations in and around the city. Displacement dynamics in Kismayo have shifted dramatically in recent years, with a near-total collapse of intention to return to nomadic life; between 2022 and 2025, the intent of nomadic households to return to their places of origin dropped drastically. This trend is likely driven by extreme drought and the loss of livestock, making traditional livelihoods increasingly undesirable. The influx of displaced populations alongside low-income urban households has created significant pressure on local infrastructure.

District Profile: Dhusamareeb (Galmudug State)

Dhusamareeb District, the capital of Galmudug State and administrative seat of the Galmudug region, serves as a key political and strategic hub of central Somalia. The district encompasses a diverse demographic landscape, which represents a wide variety of livelihood systems and mobility patterns. Given its political significance and growing population, Dhusamareeb is a critical district for assessing governance structures, service delivery, and evolving socio-demographic conditions. Despite these strengths, the district faces significant structural and environmental challenges; susceptible to climate-conflict cycles, where recurring droughts intensify clan competition over essential resources like water and pasture. Furthermore, a heavy economic burden persists; with a severe unemployment among the youth population.

District Profile: Beletweyne (Hirshabelle State)

Beletweyne District, located in Hirshabelle State along the Shabelle River, is an important commercial and administrative center in central Somalia. The district includes urban neighborhoods, peri-urban settlements, riverine communities, and areas affected by recurrent displacement and climate-related shocks, particularly flooding and drought. Its position as a transport corridor and trading hub, together with its exposure to humanitarian pressures, makes Beletweyne especially significant for understanding population movement, livelihood vulnerability, service delivery, and the interaction between environmental risk and socio-economic conditions.

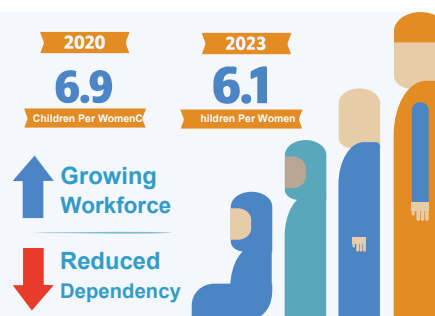


1.1.2 Health Situation

Significant efforts have been made to improve maternal and child health, and reproductive health. This includes the National Reproductive Health Strategy and a Maternal and Child Health Care Law. Despite efforts by Somali authorities to improve maternal and child health, Somalia

continues to experience alarmingly high maternal and child mortality rates. Maternal mortality decreased slightly from 732 to 692 per 100,000 live births between 2015 and 2020¹, and further to 563 per 100,000 in 2023, according to the World Bank estimates.

Fertility: Somalia continues to experience one of the highest fertility rates in the world, although it has declined modestly from 6.9 children per woman in 2020 to 6.1 in 2023². Greater investment in voluntary family planning services is therefore critical, as it will help accelerate fertility decline, strengthen economic growth, and reduce the dependency ratio by increasing the share of the working-age population.



Mortality: Mortality rates indicate more female deaths than male, particularly among women aged 15 to 49, with a death rate of 7.58 per 1,000 population. The overall adult male mortality rate was reported at 373 per 1,000 in 2022³.



Under-five mortality: Somalia's under-five mortality rate is among the highest globally, at 106 deaths per 1,000 live births in 2021, significantly exceeding both the global average (38 per 1,000) and that of high-income countries (5 per 1,000)⁴.



Disability Inclusion: Somalia has made notable progress in advancing disability rights by developing a comprehensive and inclusive national disability law in close partnership with stakeholders from the Somali disability community; the legislation is now in its final stages of adoption. The country formally recognised persons with disabilities as a vulnerable population in its Humanitarian Response Plan for 2020, highlighting the significant barriers they face in accessing public services. According to the most recent official data, approximately 11.7 percent⁵ of adults in Somalia are living with a disability.

Disability Inclusion

11.7%
of people living
with a disability

Progress on
disability rights



¹ Somali Health and Demographic survey.
² World Bank / United Nations World Population Prospects 2024 Revision (latest available data as of 2026)
³ World Bank / United Nations World Population Prospects 2024 Revision (latest available data as of 2026)
⁴ UN IGME, 2023
⁵ Somalia National Bureau of Statistics, National Disability Report 2024

1.1.3 Socio-Economic Dynamics

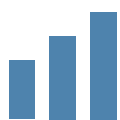
Since the end of the Transitional Federal Government in 2012, Somalia has experienced modest economic recovery with GDP reaching approximately USD 11.97 billion in 2024 and a growth rate of 4.1 percent, following 4.2 percent growth in 2023. The GDP per capita rose to USD 737 in 2024, up from 694 in 2023. Despite this progress, GDP per capita remains low (about USD 737), reflecting widespread poverty and limited improvements in household welfare.

Livelihood systems in Somalia are highly diverse and closely tied to geography and mobility patterns. Pastoralism and agro-pastoralism remain dominant in rural areas, supporting a large share of the population through livestock production and seasonal migration; while urban populations rely on informal trade, small businesses, and wage labor. Rapid urbanization and the expansion of internally displaced persons (IDP) settlements—particularly in districts such as Kahda, Baidoa, and Kismayo—have increased reliance on fragile and informal income sources.

Remittances play a critical role in sustaining household consumption and supporting economic stability. Financial inflows from the Somali diaspora are estimated to exceed official development assistance and constitute a significant share of national income. These

transfers serve as a vital safety net, enabling households to meet basic needs, invest in education and health, and cope with economic shocks. At the macroeconomic level, remittances contribute to foreign exchange stability and help finance the country's trade deficit. Despite these positive contributions, the economy remains highly vulnerable to external and internal shocks. Recurrent droughts and floods continue to disrupt livelihoods and drive displacement, while insecurity, weak infrastructure, and heavy dependence on imports constrain sustainable growth.

From a population and health perspective, Somalia continues to face significant challenges. Fertility rates remain among the highest globally, contributing to rapid population growth and a high dependency ratio. Maternal and child health indicators, although improving gradually, remain among the weakest worldwide, with high maternal mortality and under-five mortality rates. Access to essential health services is uneven, particularly in rural, nomadic, and displaced populations. At the same time, increasing recognition of vulnerable groups, including persons with disabilities, reflects ongoing efforts to promote inclusive development and equitable access to services.



USD 11.97^b

GDP (2024)



4.1%

Growth rate (2024)



USD 737

Per capita GDP
(2024)

1.2 Survey Rationale and Objectives

1.2.1 Rationale

The integration of demographic data into policy and planning contexts is vital for informed decision-making. While challenges exist, advancements in data collection and analysis methods, along with a focus on equity and privacy, can enhance the effectiveness of policies aimed at improving community outcomes.

Demographic data plays a crucial role in policy and planning across various sectors. It involves the use of statistics describing populations and their characteristics, including age, gender, race, ethnicity, education level, income, occupation, marital status, household size, and geographic location. More nuanced factors like disability status, immigration status, and technology used at home are also considered. Governments, corporations, and non-government organizations utilize this data to understand population characteristics for policy development and economic market research.

The Socio-Demographic Survey 2026 provides comprehensive data for five districts—Kahda, Baidoa, Kismayo, Beletweyne, and Dhusamareeb—revealing key population indicators and capturing the diverse socio-economic and demographic realities across these districts.

1.2.2 Survey Objectives

The main objective of the survey is to collect up-to-date, reliable socio-demographic data, specifically on population size, age and sex distribution, household size and composition, education, maternal and child health, and disability, to inform evidence-based programming and decision-making in the target districts. To achieve this, the survey collected accurate data on household composition and individual demographic characteristics; estimated fertility and mortality; analyzed child immunization and the health status of children under five years; examined antenatal care (ANC), delivery, and postnatal care (PNC) practices and

assessed the availability and accessibility of public services. In addition, the survey aimed to collect data for population estimates modelling. However, the scope of this report does not include the modelling of disaggregated population estimates; these will be presented in a separate, dedicated report.

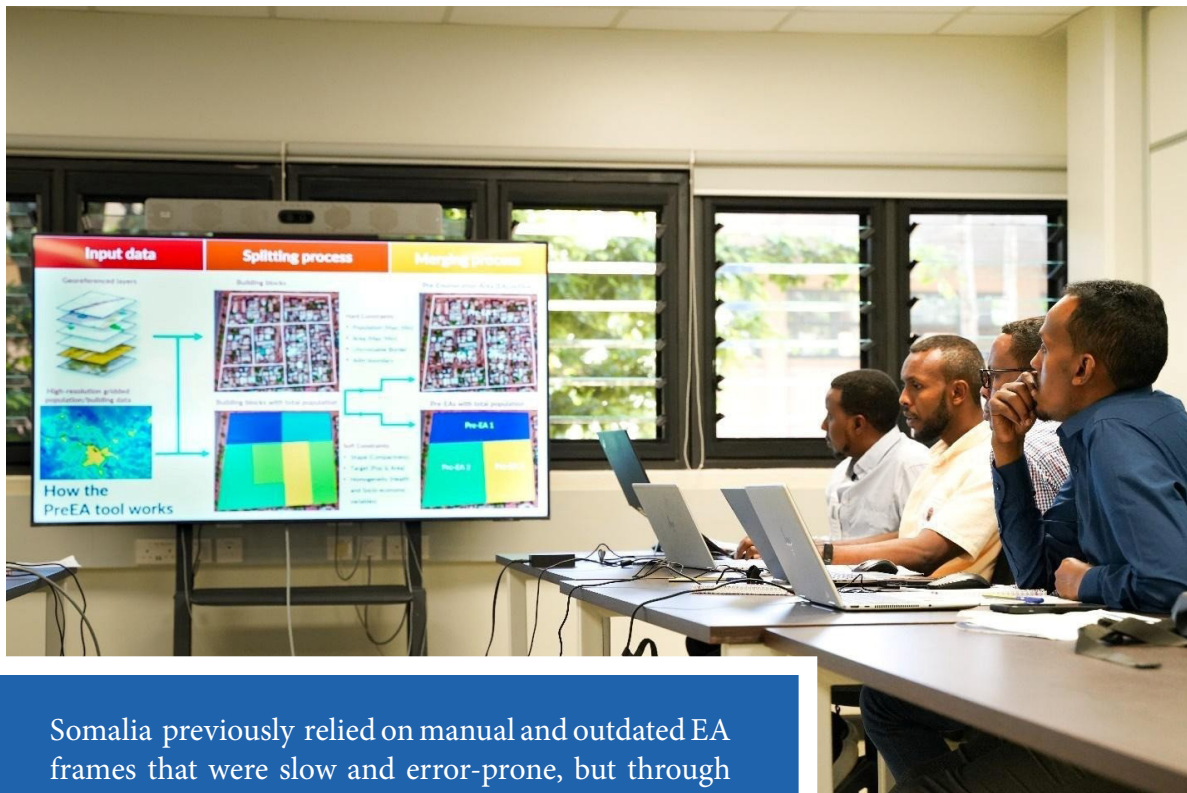
1.2.3 Methodology

Development of the Pre-EAs frame

Somalia has traditionally relied on manual methods to digitise sample frames, a process that was labour-intensive, time-consuming, and not as efficient. In some cases, existing Enumeration Areas (EAs) were incomplete, outdated, or entirely missing. Additionally, many EAs were based on outdated demographic and geographic information that no longer reflected current dynamics. The absence of a comprehensive and up-to-date EA framework weakens the statistical reliability of large-scale surveys as they are more likely to record errors and data inconsistencies.

To overcome these challenges, SNBS partnered with UNFPA and WorldPop with funding from the Gates Foundation and contributions from FCDO. This collaboration aimed to enhance the development of a contiguous frame and data collection effort at the lowest level in Somalia. In this regard, UNFPA hosted an eight-day training on the PreEA tool facilitated by WorldPop in Nairobi, Kenya, from March 5th to 14th, 2025. The workshop successfully empowered SNBS personnel with the knowledge and skills to effectively utilize the PreEA tool. This has also been cascaded into the FMS level.

The collaborative effort through the Socio-Demographic survey involved creating Pre-Enumeration Areas in five strategically selected districts across Somalia's five regions. Using WorldPop's PreEA Tool, the team successfully created a digitised sample frame with well-defined EAs for



Somalia previously relied on manual and outdated EA frames that were slow and error-prone, but through a partnership between SNBS, UNFPA, WorldPop, the Gates Foundation, and FCDO, a modern PreEA framework was introduced, empowering SNBS staff with training and enabling digitization of dwelling structures nationwide.





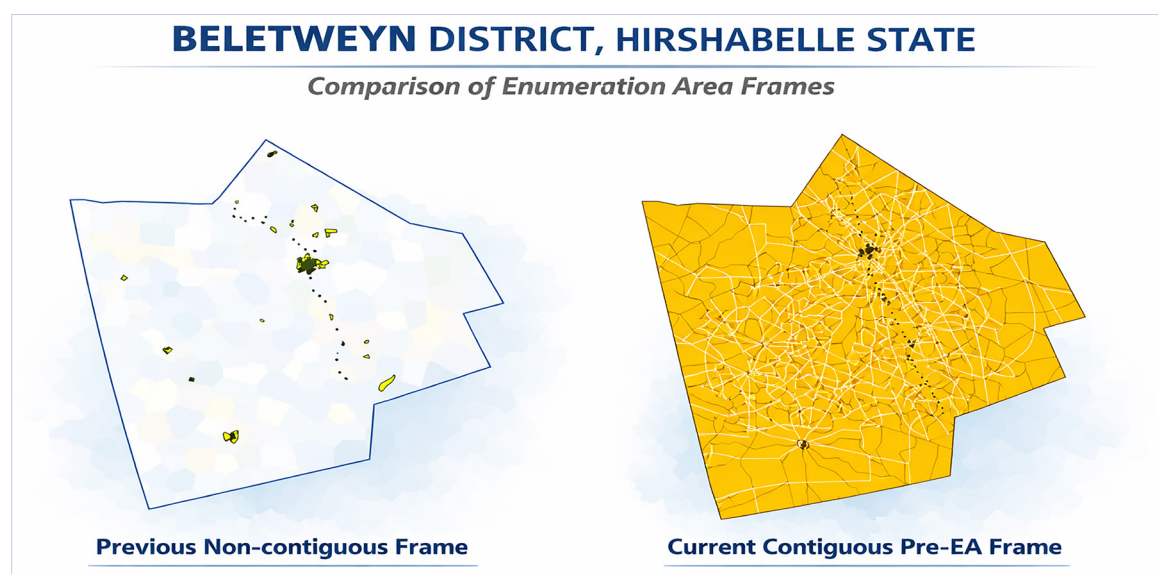
The main objective of this survey is to collect reliable socio-demographic data to guide evidence-based decision-making. It covers population size, education, disability, household composition, and estimated fertility and mortality rates. Additionally, the research analyzes child immunization, under-five health, and maternal healthcare practices. It also assesses the general availability and accessibility of public services within the target districts. While data was gathered for population modeling, those specific estimates will be presented in a separate report.

the selected districts. This tool facilitated a more efficient and precise mapping process, ensuring that the EAs were based on current contiguous frames based on the latest satellite imagery facilitated by Gates Foundation and WHO. This delineation process was crucial for establishing a more accurate and functional sampling frame.

$$n_{Households} = \frac{deff \times z^2 \times r \times (1 - r)}{(RME \times r)^2} \times \frac{1}{pb} \times \frac{1}{RR}$$

- » $r=0.107$ is the predicted value of the key indicator (children fully immunized).
- » $deff=1.2$ is the design effect, accounting for the loss of statistical efficiency due to cluster sampling.

Figure 1.1 Comparison of the previous Non-contiguous sampling frame and the current contiguous sampling frame developed using the PreEA Tool.



In addition to the generated Pre-EAs, accessibility of the EAs was updated based on contextualised verifications across the different districts. This has tremendously helped the sampling process to exclude any EAs that are not accessible.

There is significant variation in accessibility across the project's districts. For example, the Kahda district in Banadir is fully accessible, while the Baidoa district has limited accessibility, which is mostly concentrated in Baidoa city and its surroundings.

Survey Design and Sampling

The household sample size was calculated using the standard formula for estimating a proportion (or indicator) in a complex survey design, which incorporates a design effect to account for clustering. The specific formula used is:

- » $z=1.96$ is the z-score corresponding to a 95% confidence level.
- » $RME=0.05$ is the desired relative margin of error, meaning the survey aims for a 5% relative precision around the predicted indicator (i.e., a confidence interval of $\pm 5\%$ of 0.107).
- » $pb=0.245$ is the proportion of the target population (women 15-49) in the total population, used to expand the sample from the target group to the general population.
- » $RR=0.990$ is the household response rate, which inflates the sample to account for non-response.

Applying these parameters yields a sample size adequately powered to reliably capture the critical sub-population of immunizable and zero-dose children. To ensure representativeness the sample was evenly distributed across the five priority districts.

The sample was generated and equally allocated to each of the five priority districts as shown in the table below.

Table 1.1 Sample Size Determination and Allocation

Input values							Output values				
	Predicted value of indicator	Design effect	Relative margin of error at 95% CI	Proportion of target/ base pop in total pop	Average household size	HH response (completion) rate	Number of HHs to be selected (Sample Size)	Confidence limits (at 95%v CI)		Standard error	Estimate HH per EA
District	r	deff	RME	pb	Ave-Size	RR	n	Lower	Upper	Se	
Kismayo	0.107	1.2	0.05	0.245	6.7	0.99	9,860	0.102	0.112	0.00268	100
Dhuusamareeb	0.107	1.2	0.05	0.245	6.7	0.99	9,860	0.102	0.112	0.00268	100
Kahda	0.107	1.2	0.05	0.245	6.7	0.99	9,860	0.102	0.112	0.00268	100
Beletweyne	0.107	1.2	0.05	0.245	6.7	0.99	9,860	0.102	0.112	0.00268	100
Baidoa	0.107	1.2	0.05	0.245	6.7	0.99	9,860	0.102	0.112	0.00268	100
Sample size							49,302				500

EA sample selection and domain allocation

An average of 100 households per EA was estimated. To obtain the estimated 49,302 households 500 EAs were required. Using equal allocation criteria, 100 EAs were targeted per district. From a statistical perspective, equal allocation ensures comparability of estimates across districts, enabling robust sub-national analysis of key socio-demographic indicators. By maintaining a consistent sample size in each district, the design minimizes variability in precision across domains and allows for balanced estimation of indicators, including the identification of vulnerable populations

and service gaps. This is particularly important in heterogeneous contexts such as Somalia, where district-level differences in access to services and demographic characteristics are significant.

Aiming to generate demographic data disaggregated by population size, age, sex, and residence, and produced for five key districts, the survey employed simulated sampling methods with expert support from WorldPop. The objectives of the simulation were to select 500 EAs across the 5 districts that are representative of the different strata (Urban, Rural, and IDPs), to increase the predictability of population counts, and decrease bias.

Thus, the WorldPop carried out six different simulation scenarios:

- Scenario 1** – Simple Random Sampling (500 EAs, no constraints).
- Scenario 2** - Simple Random Equal Sample per District.
- Scenario 3** - In each district, select 100 Simulation Scenarios EAs, distributed by stratum population size (rural, urban, IDP).
- Scenario 4** - Select EAs using stratified sampling, ensuring representation across all district and stratum combinations (5 districts × 3 strata = 15 combinations), proportional to population size.
- Scenario 5** – Nomadic Allocation: Allocate 170 EAs to nomadic areas. The remaining 330 EAs are assigned to other district stratum combinations based on population size.
- Scenario 6** – Probability of Selection (PPS) proportional to stratum.

Scenario 3 was selected as the most applicable option. This scenario allocates 100 EAs per district distributed proportionally across strata (urban, rural, and IDP) based on population size. It provides an optimal balance between statistical robustness, representativeness, and operational feasibility.



The sampling was done in three phases:

- » **Phase 1:** Initial phase. In this phase, the 500 samples are drawn from the Enumeration Areas (EAs) and a Bayesian Spatial Statistical model is trained. The output from this phase is a population density and covariates (Geospatial Variables)
- » **Phase 2:** Repeated Simulation Draws. To capture the Bayesian model's variability and robustness, this phase runs the simulation 5,000 times.
- » **Phase 3:** Scenario analysis. Repeat phases 1 & 2 for the 6 sampling scenarios.

Out of these six scenarios and multiple discussions, the team selected scenario 3 due to its practicality and applicability to the contextualised situation in Somalia. The following table illustrates the number of EAs in each district from the frame, along with crucial information on the sampled EAs, the covered EAs, and the number of structures and households in each district.

Table 1.2 Sampling Summary

District	PreEA Generated	Selected Sample	Covered EAs	Structures	Households
Kahda	261	101	101	12,124	9,073
Dhusamareeb	521	100	110	8,269	5,335
Baidoa	2,243	98	118	17,324	11,926
Belet weyne	1,323	101	114	10,348	6,877
Kismayo	2,094	100	110	10,625	9,972
Total	6,444	500	553	58,690	43,183

Data quality assurance

The survey implemented several quality assurance measures to maintain the integrity, reliability, and accuracy of the collected data. Below are the measures employed to ensure quality.

Formation of a Technical Working Group

A consultative approach was central to the decision-making process throughout the Socio-demographic Survey to ensure the survey was robust, accurate and culturally relevant. The project adopted a highly collaborative model in all the key aspects such as methodology, instruments, fieldwork, tabulation plans, and

data access were developed through extensive discussions and collaboration; were made jointly by the Somali National Bureau of Statistics and international partners (such as UNFPA, the Gates Foundation, WorldPop, ONS, and FCDO) formed two specialized Technical Working Groups to guide the project from start to finish.

The Cartographic Technical Working Group (Mapping Team)

The Cartographic Technical Working Group was key to ensure a comprehensive, collaborative geospatial approach for the survey, that is relevant to the local context. The team focused on the “where.” By pooling expertise from various partners, they developed a map-based strategy tailored specifically to Somalia's unique geography and local conditions. This ensured the survey data is geographically accurate and truly reflected the reality on the ground.

The Questionnaire Development Working Group

This team focused on the “what.” They were responsible for designing, testing, and refining the survey questions. Their goal was to ensure the information collected is standardized, high-quality, and deeply relevant to the needs of the Somali population.

By subjecting these strategies to rigorous review by both internal and external experts, the project ensured that every step—from fieldwork and data collection to final reporting—was built on a foundation of consensus, quality, and technical precision.

Survey Team Capacity Building

A Customised ESRI GIS/Cartography Training was conducted in Nairobi, Kenya, benefiting six team members. This training equipped them with essential skills in digital cartography, spatial data management, and map production. These capabilities are essential for delineation and verification of the Enumeration Areas (EAs) and overall survey planning.

To further strengthen national geospatial capabilities, five technical staff participated in a WorldPop led Master Training of Trainers (ToT) in Nairobi from the 5th to 14th March 2025. This program concentrated on the Automatic Pre-Enumeration Areas Tool in QGIS, equipping the team members with the specialized skills to automate EA demarcation using advanced geospatial tools. This strengthened the national capacity to produce updated and accurate sample frames using modern GIS methodologies.

Between the 8th-21st July, 2025, 12 supervisors and technical leads participated in a national-level Training of Trainers (ToT) workshop in Mogadishu. The training focused on SDS and field verification, equipping project leadership to cascade operational protocols to field teams and ensure rigorous oversight of pre-enumeration verification activities prior to deployment.

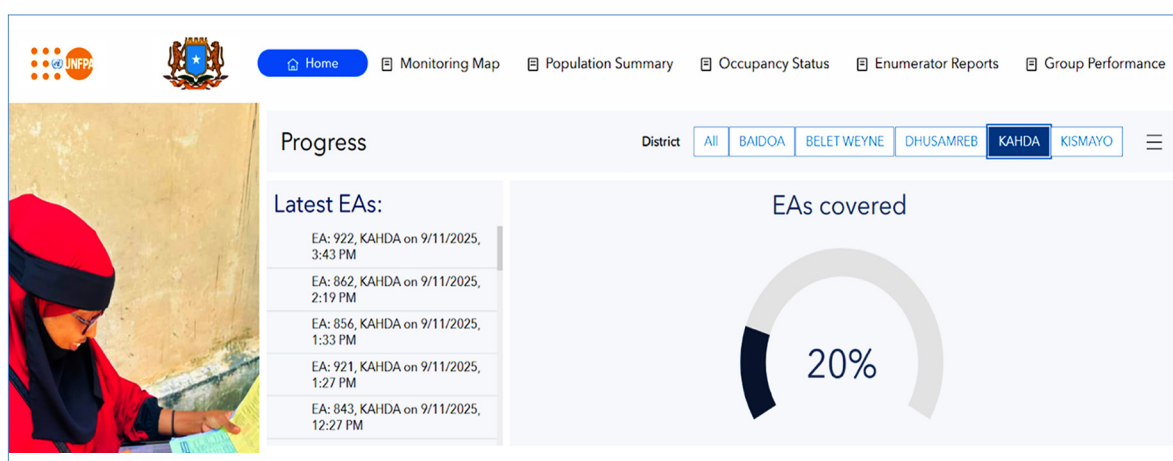
State-level training for enumerators and supervisors, was conducted in conjunction with the field data collection. Each district employed a standardized team composition consisting of 32 enumerators, 4 GIS supervisors, one state coordinator, and one technical staff member.



Real-Time Dashboard Monitoring

For the first time in the history of Somalia and SNBS survey operations, the project introduced a live dashboard to monitor data collection in real time as an integral component of data quality assurance during this socio-demographic survey. This innovation marked a significant shift from traditional post-collection data review to a real-time, system-based quality management approach. The dashboard was designed to provide continuous visibility of field and data processing activities, enabling supervisors and technical teams to spot and correct data issues instantly as they happened in the field. Real-time dashboard gave the supervisors continuous live visibility into the surveys progress including:

- » Tracking progress and enumerator Performance.
- » Real-time GPS points tracking of data collection locations to ensure teams were surveying the correct areas.
- » On-the-spot population summaries, breaking down age and gender structures by district.
- » Real-time documentation of occupancy status and non-response.



Monitoring dashboard

With a dedicated Dashboard monitoring team, the fieldwork monitoring activities took place during and after the fieldwork. During the fieldwork, the monitoring team closely followed GPS points from the monitoring map to help enumerators stay within the assigned EA boundaries. After the fieldwork, the Dashboard monitoring team released the day's report per district. In the evening, the technical team did some preliminary data analysis and provided feedback to supervisors and enumerators to improve the next day's field work.

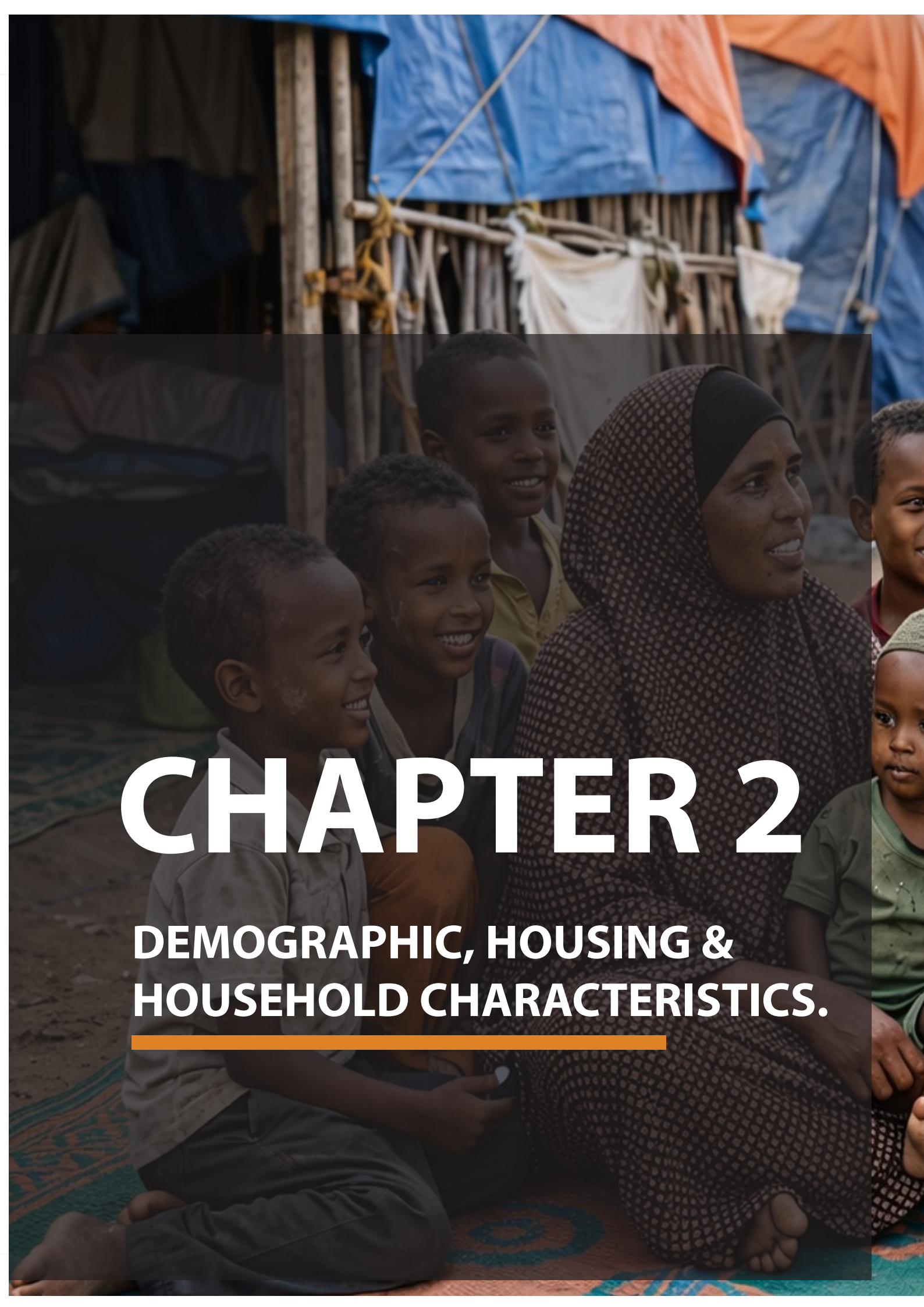
1.3 Coverage

Table 1.3 summarizes the household coverage and response rates for the survey. The findings indicate excellent coverage, with interviews completed in 42,666 of the 43,206 households visited, yielding an overall response rate of 98.8 percent. At the district level, response rates were consistently high, ranging from 96 percent in Dhusamareeb to 99.4 percent in both Kahda and Baidoa. Across

residence strata, performance was equally robust: rural areas achieved a 99.4 percent response rate, urban areas 98.1 percent, IDP settlements 99.8 percent, and nomadic settlements at 100 percent. These completion rates reflect effective field coordination, strong community trust, and well-adapted strategies for reaching mobile and vulnerable groups, all of which significantly strengthen the representativeness and credibility of the survey data.

Table 1.3 Total No. of Households Visited, Households Interviewed and Household Response Rate

	Households visited	Households interviewed	Household response rate
District			
Kahda	9,094	9,036	99.4
Dhusamareeb	5,459	5,243	96.0
Baidoa	11,765	11,693	99.4
Belet weyne	6,922	6,837	98.8
Kismayo	9,966	9,857	98.9
Total	43,206	42,666	98.8
Residence			
Rural	4,123	4,100	99.4
Urban	25,209	24,718	98.1
Nomad	469	469	100.0
IDP	13,405	13,379	99.8
Total	43,206	42,666	98.8

A photograph of a woman and four children sitting on a patterned rug in front of a makeshift shelter made of sticks and tarps. The woman is wearing a brown patterned headscarf and a matching dress. The children are smiling and looking towards the right. The background shows more of the shelter and some hanging laundry.

CHAPTER 2

**DEMOGRAPHIC, HOUSING &
HOUSEHOLD CHARACTERISTICS.**



Chapter Two summarizes the population's age, sex, and marital status across districts. It reviews housing types, amenities like water, energy, and sanitation. The chapter also covers household vulnerability and displacement trends. Finally, it highlights living conditions of displaced families.

KEY FINDINGS

CHILDREN POPULATION 0-14 YEARS



52%
of the total Population

Baidoa:	55%	Dhusamareeb:	53%
Beletweyne:	51%	Kahda:	54%
Kismayo:	50%		

ADOLESCENT POPULATION 10-19 YEARS



23%
of the total Population

Baidoa:	21%	Dhusamareeb:	24%
Beletweyne:	25%	Kahda:	25%
Kismayo:	23%		

WORKING AGE POPULATION (15-64 YEARS)

46%
of the total Population



Baidoa	44%
Beletweyne	47%
Dhusamareeb	45%
Kahda	45%
Kismayo	49%

Dependency Ratio:



119 per 100
working population

ELDERLY POPULATION 65+ YEARS-



2% of the total
population

DWELLING UNIT STRUCTURES

Dwelling Structure Type



Permanent
20%



Semipermanent
52%



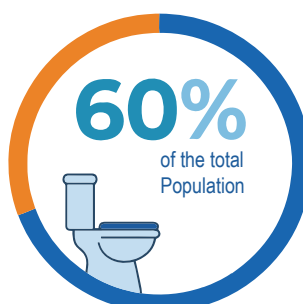
Temporary
28%

USE OF APPROPRIATE WATER TREATMENT METHODS PER DISTRICT



Baidoa	13%
Beletweyne	8%
Dhusamareeb	14%
Kahda	4%
Kismayo	5%

HOUSEHOLDS USING IMPROVED SANITATION FACILITIES



Baidoa:	32%
Beletweyne:	54%
Dhusamareeb:	78%
Kahda:	85%
Kismayo:	66%

FEMALE HEADED HOUSEHOLDS

41%

of the households



Baidoa:	51%
Beletweyne:	37%
Dhusamareeb:	46%
Kahda:	34%
Kismayo:	37%

CHILD HEADED HOUSEHOLDS

less than

1%

of the households



ORPHANHOOD



9%

Baidoa:	9%
Beletweyne:	9%
Dhusamareeb:	6%
Kahda:	8%
Kismayo:	9%

DISABILITY

8%

of households



2.1 Introduction



Chapter Two provides a comprehensive overview of the demographic profile, housing conditions, displacement dynamics and household characteristics of the population covered by the survey. It presents key findings on age and sex composition as well as marital status to provide a clear understanding of the population structure across the selected districts. The chapter further examines the distribution and types of dwelling units, while assessing access to essential amenities such as energy, water, and sanitation facilities as key indicators of household living conditions. In addition, the chapter highlights household vulnerability, displacement patterns and the living conditions of displaced populations offering important insights for humanitarian response, service provision and evidence-based planning.

2.2 Demographic Characteristics

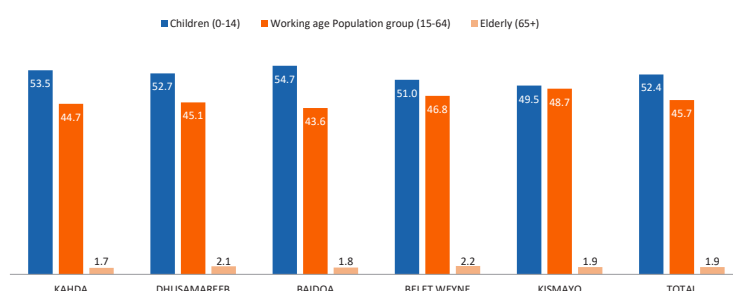
2.2.1 Age and Sex Composition

Age and sex are fundamental demographic variables that provide the basis of population classification in essential datasets such as vital statistics, censuses, and surveys. These variables are essential for understanding population dynamics including mortality, fertility, and service needs. They are also critical for informing policy formulation, health service planning, education programming, labour force analysis and broader socio-economic development strategies.

In the Somali Demographic Survey (SDS) 2026, information on the age of each household member was collected and recorded in completed years. The survey utilized both the Gregorian calendar and the Somali historical calendar to obtain dates of birth from those whose birth dates were unknown. Age calculations were then done using specially designed conversion charts, strengthening the accuracy, consistency and reliability of the data collected.

Figure 2.1 presents the percentage distribution of the household population by key demographic groups i.e. children of 0-14 years, working age population of 15-64 years and the elderly 65 years and above across the five surveyed districts.

Figure 2.1 Distribution of Key Population Groups



The findings in Figure 2.1 highlight an extensive youth bulge, with children under the age of 15 (0-14 years), accounting for 52 percent of the total household population of which 54 percent are males and 51 percent females (Figure 2.2). This youthful age structure is most pronounced in Baidoa 55 percent followed by Kahda at 54 percent while Kismayo reported the least at 50 percent. These findings point to a high child dependency burden and indicate substantial pressure on child-focused services, particularly education, health, nutrition, protection, and social support systems.

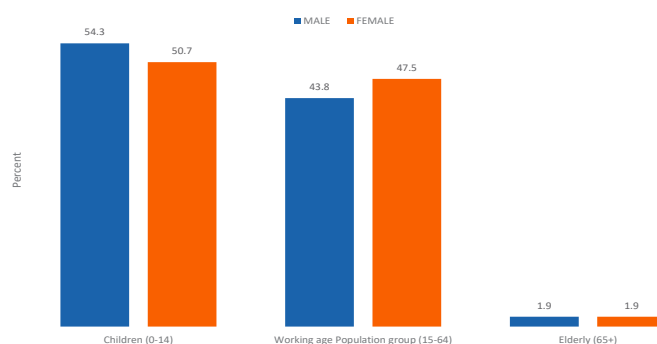
2.2.2 Elderly and the Demographic Window

At the other end of the age spectrum, the elderly population 65 years and older, is remarkably small at 2 percent across all districts (Figure 2.1). This low percentage reflects a high mortality risk and lower life expectancy. This creates a demographic window, if the massive cohort of children and adolescents is supported with quality education, skill development and job creation now, they could drive a significant demographic dividend of economic growth as they enter the workforce over the next two decades. Failure to invest in this transition, however, risks turning this youth bulge into a challenge characterized by unemployment and further instability.

2.2.3 Working-Age Population and Dependency

As presented in Figure 2.1, the working-age population 15-64 constitute 46 percent of the total population, with females comprising a larger share in this bracket - 48 percent compared to 44 percent for males (Figure 2.2). This may reflect differences in adult survival patterns, male mobility, or out-migration. At district level, Kismayo recorded the highest working-age share at 49 percent, while Baidoa has the lowest at 44 percent (Figure 2.1) reflecting a high mortality risk and a demographic window of opportunity. This structure creates a high dependency ratio, placing significant pressure on economic productivity and public services.

Figure 2.2 Distribution of Key Population Groups by Sex



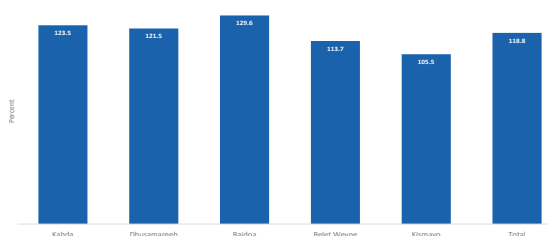
2.2.4 Dependency Ratio

The dependency ratio is a key demographic and economic indicator that measures the proportion of the dependent population (typically children aged 0–14 and elderly aged 65+) relative to the working-age population (aged 15–64), expressed as the number of dependents per 100 working-age individuals. This indicator helps in understanding the economic burden placed on the productive sector of society, as a higher dependency ratio often signals greater pressure on workers to support non-working individuals. Understanding this metric is essential for policymakers, as it influences decisions related to social welfare programs, and employment policies. Additionally, fluctuations in the dependency ratio can reflect broader societal trends such as aging populations, shifts in birth rates, and migration patterns, all of which have significant implications for future economic stability and growth.

Analysis on the SDS data, reveals a dependency ratio of 119 across the five surveyed districts, indicating that every 100 working age individuals support 119 dependents, placing a substantial economic pressure on the working age population. Baidoa, Dhusamareeb and Kahda all have dependency ratios of above 120 with Baidoa leading at 130 per 100 working age individuals. The least recorded dependency ratio is in Kismayo of 106 per 100 working population (Figure 2.3).

The elevated dependency ratio is driven primarily by a substantial youth demographic, with children aged 0–14 years comprising 52 percent of the total population (Table 2.1), an indicative of early stages of the demographic transition, defined by high fertility rates and lower life expectancy common in many fragile and conflict-affected settings, underscores a pressing need for government investment in youth-focused healthcare, education, and social services. Addressing this dependency burden is a critical prerequisite for Somalia to eventually realize a demographic dividend and foster long-term sustainable development.

Figure 2.3 Dependency Ratio by District



This high dependency ratio signals significant strain on the economically active population, potentially limiting savings, investment, and growth unless productivity rises sharply. It also amplifies risks of intergenerational poverty transmission if education, health, and skills development are under-resourced.

The large 0–14 cohort represents a future demographic dividend — if investments in quality education, vocational training, health, and job creation are scaled now, this group could drive economic growth in 15–25 years. Failure to invest risks turning the bulge into a demographic challenge (unemployment, instability, migration pressures etc).

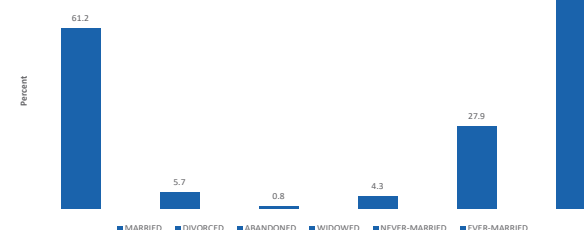
2.2.5 Working-Age Population and Dependency

This section examines marital status patterns across key demographic and social dimensions—age, sex, type of residence, and district—among the surveyed population aged 15 years and older. The analysis reveals how marriage dynamics vary by life stage, gender norms, and geographic context, providing insight into family formation, stability, and

vulnerability across the five districts.

Figure 2.4 presents the distribution of marital status for the districts combined. Overall, 61 percent of the population is currently married. The combined ever-married proportion reaches 72 percent, while 28 percent had never married. Despite the challenges of displacement and economic pressure, the rates of marital dissolution are relatively low: with only 6 percent divorced, one percent abandoned, and 4 percent widowed. These statistics suggest general marital stability, although widowhood and divorce indicate pockets of vulnerability, particularly among older adults and women.

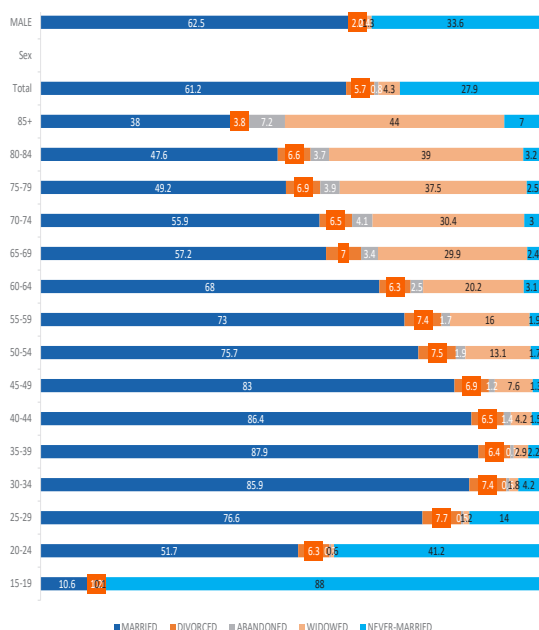
Figure 2.4: Marital Status



Marital status varies through the lifecycle as individuals move through the different stages of marital formation, stability, and dissolution over time. Figure 2.5 presents marital status across the different age groups. Among 15–19 year-olds, only 11 percent were married, while the vast majority at 88 percent have never been married. The married proportion rises sharply with age, peaking at 88 percent in the 35–39 age group. The never-married proportion declines steadily with advancing age, indicating near-universal marriage entry over the lifespan for this population. Divorce rates remain modest in younger groups but increase modestly in middle age. Widowhood becomes increasingly prominent from age 50 onward, reaching 44 percent among those aged 85 years and above.

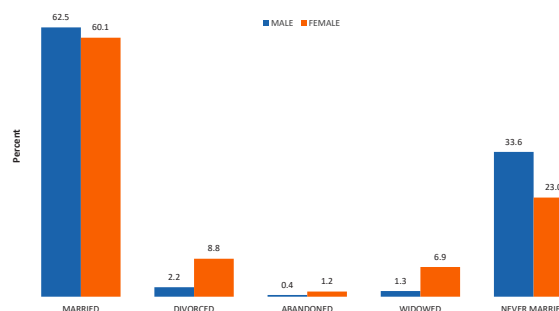
These trends point to a societal norm of eventual marriage for most individuals, with dissolution risks concentrated in later life stages, particularly for women. This pattern has important implications for household composition, dependency, social protection, and support services for older persons.

Figure 2.5 Marital Status by age



Social expectations and economic roles are often shaped by gender norms, and these influence marriage experience differently for men and women. Figure 2.6 below compares the marital status of males and females. Gender disparities in marital status were pronounced, particularly in relation to the impact of union dissolution on women. According to Figure 2.6, men reported a slightly higher proportion of currently married individuals, 63 percent compared to 60 percent of women. The most significant gender differences were observed in the rates of divorce and widowhood. Women were more than four times as likely to be divorced (9 percent) compared to men (2 percent), and seven times more likely to be widowed (7 percent compared to one percent among men). Furthermore, women recorded a substantially higher proportion of ever-married individuals at 77 percent and a lower proportion of never-married individuals at 23 percent compared to 66 percent ever married and 34 percent never married among males. The lower proportions of divorced and widowed men, combined with the relatively high proportion of currently married, suggest that men were more likely than women to remarry following union dissolution.

Figure 2.6 Marital Status by Sex



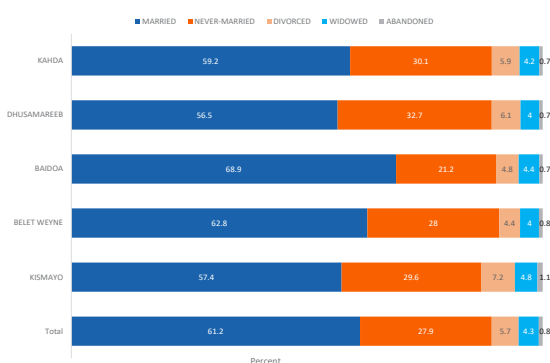
District-level patterns show important variation in marital status across the five surveyed districts. As shown in Figure 2.7, currently married individuals constitute the largest share of the population across all districts, although notable variations exist. Baidoa recorded the highest proportion of currently married individuals at 69 percent, followed by Beletweyne at 63 percent. Kahda reported 59 percent, while Kismayo and Dhuusamareeb had the lowest proportions, at 57 percent each.

The proportion of never-married individuals also varied across districts. Dhuusamareeb had the highest share of never-married persons at 33 percent, followed by Kahda and Kismayo at 30 percent each. In contrast, Baidoa recorded the lowest proportion of never-married individuals at 21 percent, reflecting its higher concentration of married and ever-married persons.

Marital dissolution remains relatively low across all districts. However, Kismayo reported the highest divorce rate at 7 percent and a slightly elevated widowhood rate of 5 percent compared to 4 percent among the rest of the districts.

These district-level differences are likely influenced by a combination of cultural practices, economic conditions, displacement dynamics, and varying degrees of urbanization, all of which shape marriage formation and union stability.

Figure 2.7 Marital Status by district

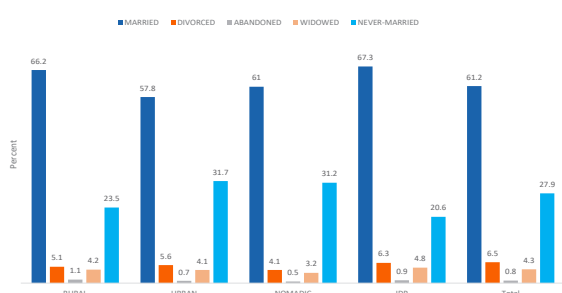


Marriage dynamics also differ by type of residence. As shown in Figure 2.8, significant variations in marital status exist across different residential groups. Rural households reported a high proportion of currently married individuals at 66 percent, 5 percent divorced and one percent abandoned. Those that had never married were 24 percent. This pattern is consistent with traditional norms that favour relatively early and stable marriages

IDP settlements exhibited the highest marriage rates, with 67 percent currently married, 6 percent divorced and one percent abandoned. Among the IDPs, 21 percent reported they had never married. This may reflect deliberate efforts by displaced families to re-establish family stability and social support networks amid displacement and uncertainty.

In contrast, urban areas recorded the lowest proportions of the currently married at 58 percent alongside a notably higher never-married rate of 32 percent. This suggests delayed marriage, likely influenced by greater access to education, employment opportunities, and changing social norms in urban settings.

Figure 2.8 Marital Status by Type of Residence



2.3 Housing Characteristics & Dwelling Status

2.3.1 Distribution of Dwellings by Type of Dwelling & Occupancy Status

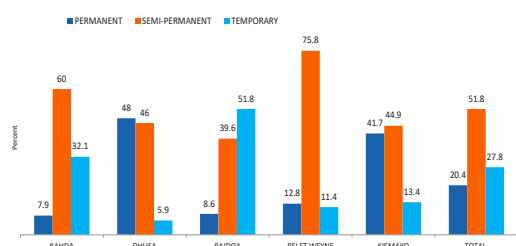
The survey provides important insights into housing conditions across the five surveyed districts (Kahda, Dhusamareeb, Baidoa, Beletweyne, Kismayo), with a focus on dwelling type and occupancy status. These indicators provide a basis for assessing housing quality, durability, stability, and household vulnerability in a context shaped by protracted displacement, conflict, climatic shocks, and rapid urbanization. For the purpose of this analysis and according to survey design, dwellings are classified into three broad categories:-

- » **Permanent:** Durable structures (e.g., concrete, brick, or stone walls; iron-sheet or concrete roofing; cement flooring), common in stable urban settings.
- » **Semi-permanent:** Intermediate structures (e.g., mud-brick, wood-framed with plaster, or bundled twigs; often with iron-sheet roofs), offering moderate durability but vulnerable to weather.
- » **Temporary:** Makeshift or emergency shelters (e.g., plastic sheeting, sticks, mats, or salvaged materials like the traditional Aqal for nomads), providing short-term cover but limited protection, privacy, or resilience.

Figure 2.9 illustrates the distribution of dwelling types across the surveyed districts. Semi-permanent dwellings predominate overall, accounting for 52 percent of housing, followed by temporary dwellings at 28 percent and permanent dwellings at 20 percent. This pattern highlights a widespread reliance on transitional and less durable housing structures across the assessed areas.

Notable variations are evident between districts. Dhusamareeb and Kismayo exhibit the highest concentrations of permanent housing at 48 percent and 42 percent respectively, suggesting relatively more established and settled communities. In contrast, Baidoa exhibits acute housing precarity, with only 9 percent permanent dwellings and 52 percent temporary structures, indicative of high displacement pressures and the prevalence of makeshift shelters in IDP-dominated areas. Kahda is characterized by a predominance of semi-permanent dwellings at 60 percent, a pattern commonly associated with peri-urban expansion around Mogadishu. Meanwhile, Beletweyne records the highest share of semi-permanent housing at 76 percent, pointing to moderately stable yet still largely non-durable living conditions.

Figure 2.9 Type of Dwelling Units by District

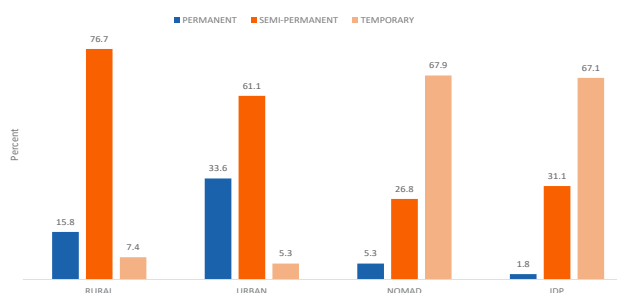


As shown in Figure 2.10, IDP and nomadic populations experienced the most precarious housing conditions, with urban residents exhibiting relatively better housing quality, reflecting incremental improvements likely associated with access to permanent building materials, infrastructure, and aid-supported upgrades.

Urban areas recorded the strongest housing conditions, with 34 percent of dwellings classified as permanent and 61 percent as semi-permanent, likely benefiting from better infrastructure, market access, and improved economic opportunities. In contrast, rural households predominantly relied on semi-permanent structures reported by 77 percent, consistent with agro-pastoral settlement patterns and local construction practices.

Nomadic households showed a high reliance on temporary dwellings reported by 68 percent, with only 5 percent living in permanent structures. This trend reflects the evolving lifestyles of nomadic populations, who are increasingly settling on the outskirts of rural communities. IDP households reported high levels of temporary shelter use at 67 percent and extremely low access to permanent housing reported by 2 percent. Overall, nomadic and IDP groups faced pronounced housing vulnerability, with makeshift shelters exposing residents to environmental hazards, insecurity, and health risks.

Figure 2.10 Type of Dwelling Units by Residence



2.3.2 Dwelling Occupancy

SDS 2026 defines occupancy as the status of a dwelling unit whether inhabited (occupied) or vacant (unoccupied) at the time of the survey. This metric is an important socio-demographic indicator in Somalia for several reasons. First, it provides a measure of housing availability and utilization, indicating whether existing housing stock is being effectively used or whether there are significant levels of vacant dwellings. Second, it helps capture population mobility and displacement patterns, particularly in the Somali context, where conflict, drought, and seasonal migration may lead to temporary or long-term abandonment of dwellings. In this regard, unoccupied structures may signal areas affected by out-migration, insecurity, or environmental stress.

As presented in Figure 2.11, overall, 77 percent of dwelling units were occupied, 13 percent were vacant, 7 percent had occupants away for extended periods.

Kismayo recorded the highest occupancy rate of 83 percent and the lowest vacancy rate of 10 percent, suggesting a relatively stable settlement pattern. In contrast, Baidoa had 73 percent dwelling units occupied and 16 percent vacant, while Beletweyne reported 73 percent were occupied and 10 percent reported the occupants were away for extended periods. This indicates higher levels of transience, possibly linked to seasonal migration, livelihood mobility, or insecurity-driven movement.

Figure 2.11 Occupancy Status of Dwelling Units by District

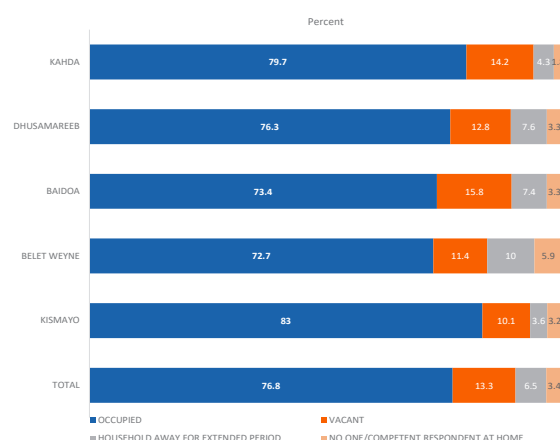
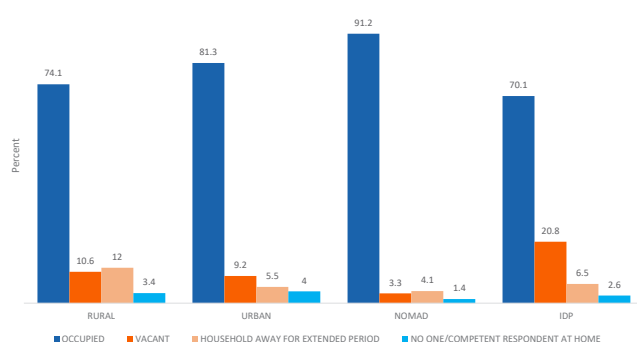


Figure 2.12 presents a comparison of dwelling units occupancy by type of residence. IDP settlements recorded the lowest occupancy rate of 70 percent and the highest vacancy rate of 21 percent, signaling frequent turnover, eviction risks, abandonment, or continued movement within displacement settings.

Urban areas recorded relatively high occupancy levels at 81 percent, while rural areas showed notable extended household absences 12 percent, likely associated with agricultural or pastoral livelihood cycles.

Figure 2.12 Occupancy Status of Dwelling Units by Type of Residence



2.3.3 Access to Housing Amenities

This section examines access to water, sanitation facilities and household energy, disaggregated by district and type of residence. This information is important for planners in ensuring citizens access services.

2.3.4 Water

As presented in Figure 2.13, overall, 85 percent of households use improved drinking water sources. However, access varies considerably across districts. Kahda leads with near-universal access to improved water sources, with 70 percent of households reporting water piped into their dwelling, yard, or plot. Beletweyne reports 95 percent use of improved water sources, with 85 percent reporting piped water access within the dwelling, yard, or plot.

Similarly, Dhusamareeb records 92 percent use of improved water sources, with 88 percent reporting piped water access to the dwelling, yard, or plot. In contrast, Kismayo at 79 percent and Baidoa at 69 percent lag behind in access to improved drinking water sources.

Figure 2.13 Source of Water for Domestic Use by District

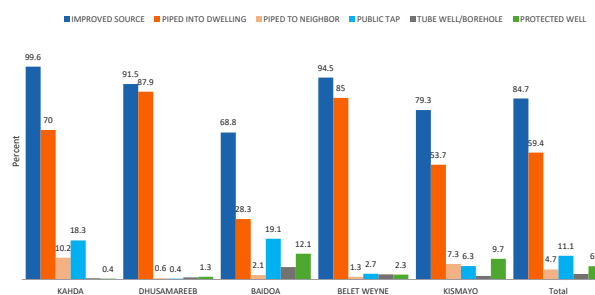


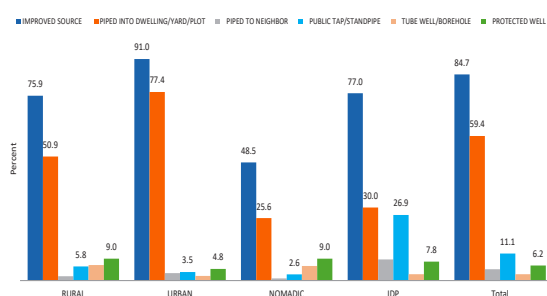
Figure 2.14 reveals substantial disparities in access to drinking water sources across residence types. Urban areas record the strongest access to improved water sources, with 91 percent of households using improved sources and 77 percent reporting water piped to their premises. Rural households report 76 percent use of improved sources, while IDP households

record 77 percent, although they depend heavily on water piped into dwelling reported by 30 percent and public taps reported by 27 percent.

Nomadic households face the greatest vulnerability, with only 49 percent using improved water sources and 26 percent reporting water is piped into their dwelling or yard.

Overall, this pattern highlights the strong relationship between residence type, infrastructure availability, and exposure to unsafe or less reliable water sources.

Figure 2.14 Source of Water for Domestic Use by Type of Residence



The analysis of water service levels and associated time burdens reveals a distinct infrastructure divide across the surveyed districts. According to Figure 2.15, approximately 80 percent of households across the five districts have water sources located directly on their premises, with Dhusamareeb and Beletweyne recording the highest proportion at 94 percent. Baidoa and Kismayo recorded proportions below the five-district average, at 62 percent and 78 percent respectively.

For households without on-site access, the time required to collect drinking water remains a significant service burden. The data indicate that 15 percent of households spend less than 30 minutes on a round trip to collect water, while 5 percent face a substantial burden of 30 minutes or longer.

At the district level, Kismayo recorded the highest proportion of households spending 30 minutes or longer collecting water at 9 percent, whereas Kahda reports the lowest

share at one percent. Baidoa, which alongside Kismayo recorded comparatively weaker on-premises water access, had 8 percent of households spending 30 minutes or more collecting water and 9 percent among the households in Kismayo, suggesting significant reliance on off-premises water sources.

These disparities highlight uneven levels of piped water infrastructure and the resulting impacts on household productivity, time use, and overall wellbeing.

Figure 2.15 Household Travel Time to Access Drinking Water

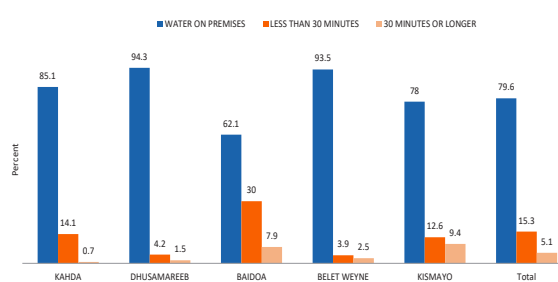


Table 2.6 presented at the end of this chapter, shows that appropriate treatment of drinking water by households is minimal at 5 percent overall. Dhusamareeb and Baidoa recorded the highest use of appropriate treatment methods at 14 percent, while Kahda recorded the least at 4 percent. Kismayo and Beletweyne recorded 5 percent and 8 percent respectively of households treating their drinking water using appropriate water treatment methods.

Boiling is the main method used in Dhusamareeb reported by 14 percent of the households, while chlorine/bleaching is the main method in Baidoa reported by 9 percent, Beletweyne by 5 percent and Kahda by 4 percent. In Kismayo equal proportions of households use either boiling or chlorine.

Overall, the low level of water treatment uptake heightens public health risks associated with unsafe or non-improved water sources, particularly in Kahda, nomadic, and IDP settings, where reliance on surface water, tanker trucks, or shared supply systems may increase exposure to contamination.

A photograph showing two people, a woman in a green shirt and a man in a green shirt, filling yellow jerrycans in a body of water. The woman is on the left, leaning over the jerrycans. The man is on the right, pouring water from a clear plastic bottle into one of the jerrycans. The water is brown and murky. In the background, there are sand dunes under a clear blue sky.

91%

of households do not treat their drinking water before use.



9.1%

9.1% of households need 30 minutes or more to get water.

2.3.5 Sanitation Facilities

Table 2.7 presented at the end of this chapter, shows that overall, 60 percent of households use improved sanitation facilities, while access to basic sanitation services—defined as improved facilities that are not shared with other households—stands at only 35 percent. This gap reflects ongoing challenges related to shared sanitation, non-improved facilities, and open defecation, which remains at 4 percent overall.

At the district level, Kahda recorded the highest utilization of improved sanitation facilities, with 85 percent of households using improved sanitation and 48 percent accessing basic sanitation services. Dhusamareeb also demonstrated strong performance, with 78 percent of households using improved sanitation facilities and 64 percent having access to basic sanitation services. In contrast, Baidoa lags behind significantly, with only 32 percent of households using improved facilities and just 10 percent accessing basic sanitation. Kismayo and Beletweyne reported 66 percent and 54 percent of households respectively having access to improved sanitation facilities and 39 percent and 33 percent using basic sanitation facilities.

Open defecation was highest in Dhusamareeb, reported by 8 percent of households, which is double the rate observed across the five districts combined. This occurred despite the high use of improved sanitation facilities, reported by 78 percent of households. Dhusamareeb also recorded the lowest proportion of households sharing sanitation facilities, at 14 percent. In contrast, Kahda and Kismayo, which reported less than one percent households practicing open defecation, also recorded the highest use of shared sanitation facilities, at 37 percent and 27 percent, respectively. These findings

highlight the important role that communal sanitation facilities can play in reducing open defecation. Meanwhile, 3 percent of households in Beletweyne and 7 percent of households in Baidoa reported practicing open defecation.

By residence type, urban households reported 66 percent use of improved sanitation facilities and 45 percent access to basic sanitation services, with only one percent reporting open defecation. Among internally displaced persons (IDP) households, 55 percent used improved sanitation facilities, but only 17 percent had access to basic sanitation services, while 4 percent practiced open defecation, indicating a strong reliance on shared sanitation facilities. Rural households reported 51 percent use of improved sanitation facilities and 36 percent access to basic sanitation services. Nomadic populations experienced the highest levels of open defecation, at 61 percent, compared to 12 percent among rural households.

Overall, high levels of open defecation and shared sanitation in IDP and nomadic settings increase disease transmission risks, underscoring the link between sanitation conditions and broader water access and infrastructure constraints.

2.3.6 Household Energy for Lighting

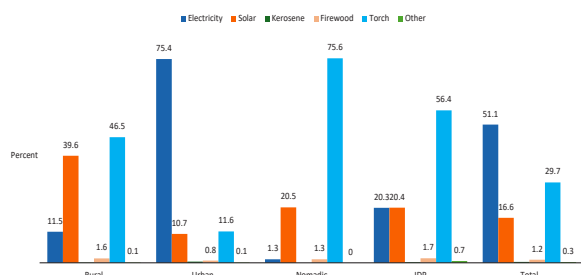
The SDS 2026 provides detailed insights into household energy use for lighting and cooking across residence types in the five districts. Figure 2.16 shows the sources of energy used by households for lighting. Overall, electricity is the leading source of household lighting energy, used by 51 percent of households. However, access is unevenly distributed across residence types. Urban households report the highest electricity use at 75 percent, likely benefiting from grid extensions, mini-grids, and stronger market access in urban centres. In contrast, electricity use is much lower among IDP households (20 percent) and rural households (12 percent), while it is almost absent among nomadic households.

Nomadic households rely heavily on torches, which account for 76 percent of lighting sources, making it the dominant energy option in these settings. Solar energy is an important alternative, used by 17 percent of households overall. Solar

use is highest among rural households at 40 percent, followed by nomadic households at 21 percent, reflecting off-grid adoption through solar lanterns and small solar systems in areas with limited grid connectivity. Kerosene use is negligible (less than one percent), indicating a clear shift away from this fuel.

The strong reliance on torches among nomadic and IDP households points to temporary and less reliable lighting arrangements, reflecting limited infrastructure, and weaker access to formal energy systems. Overall, these disparities highlight a clear urban–rural and nomadic divide: urban households have greater access to modern lighting, while rural, nomadic, and IDP households experience higher levels of energy insecurity, which may limit evening activities, education, and safety.

Figure 2.16 Main Source of Energy for Household Lighting



2.3.7 Household Energy for Cooking

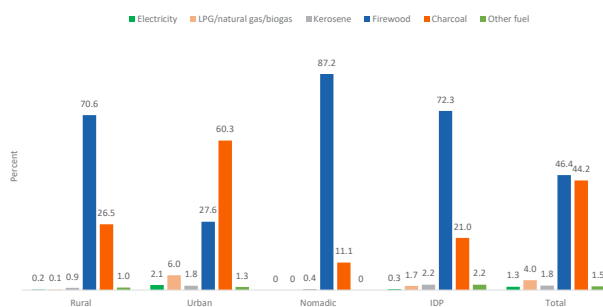
According to Figure 2.17, across the five districts, households rely mainly on charcoal and firewood for cooking at 44 percent and 46 percent respectively. Overall, only 5 percent use clean fuels such as electricity and LPG. Firewood is the dominant cooking fuel in nomadic areas used by 87 percent of the household, followed by IDP households at 72 percent and rural households at 71 percent.

Charcoal is the main cooking fuel in urban areas, used by 60 percent of households. Clean cooking options remain minimal: electricity accounts for one percent overall and reaches 2 percent in urban areas, while LPG stands at 4 percent overall and 6 percent

in urban areas, reflecting limited uptake due to cost barriers, infrastructure gaps, and supply chain constraints.

The pattern reflects a clear residence-based energy divide, with urban households relying primarily on charcoal, while rural, nomadic, and IDP households depend heavily on firewood. Overall, the near-universal dependence on solid fuels has important implications for indoor air pollution, deforestation, and gendered burdens, particularly for women and girls who are often responsible for fuel collection and cooking.

Figure 2.17 Main Source of Energy for Household Cooking



2.4 Household Characteristics

2.4.1 Household size

This section examines household size across key background characteristics, including districts and residence type, providing a clearer understanding of how demographic and socioeconomic factors influence living arrangements across urban, rural, nomadic, and IDP settings.

Table 2.8 presented at the end of this chapter, shows that the average household size across the five districts is 5.2 persons, which is lower than the national average of 6.2 persons recorded in the SHDS 2020. At the district level, Kahda records the largest average household size at 6.0 persons, while Baidoa records the smallest at 4.6 persons.

By residence type, nomadic households have the highest average household size at 6.5 persons, while rural households record the smallest average at 4.9 persons. Urban and IDP households fall in between, with average household sizes of 5.3 and 5.0 persons respectively.

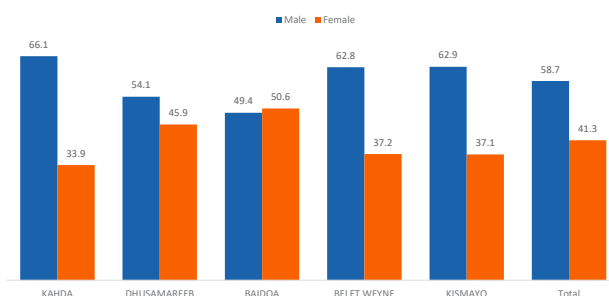
These variations suggest that household size is shaped by settlement type, mobility patterns, displacement status, and local livelihood conditions. Larger nomadic households may reflect extended family structures and shared livelihood responsibilities, while smaller household sizes in other settings may be influenced by urbanization pressures, displacement dynamics, and differing economic constraints.

2.4.2 Household Headship

Figure 2.18 presents household headship by the sex of the household head. Across the five districts, male-headed households predominate, accounting for 59 percent of all households compared to 41 percent that are female-headed. Household headship patterns vary across the surveyed districts. The highest proportion of male-headed households was recorded in Kahda, at 66 percent, followed by Kismayo and Beletweyne, each at 63 percent. Dhuusamareeb reported a lower proportion of male-headed households, at 51 percent. Baidoa was the only district where female-headed households slightly outnumbered male-headed households, with 51 percent of households headed by women compared to 49 percent headed by men.

These district-level differences suggest that household headship is shaped not only by broader gender norms, but also by localized socio-economic and demographic conditions. The relatively high female headship observed in Baidoa and Dhuusamareeb may reflect factors such as widowhood, divorce, male labour migration, displacement, or household separation. This pattern highlights the importance of considering household headship as an indicator of household structure, economic responsibility, and potential vulnerability.

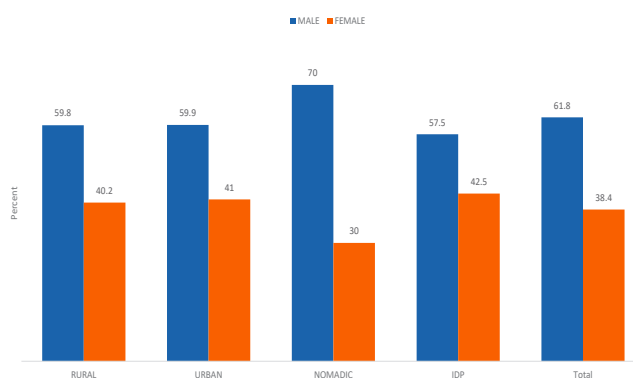
Figure 2.18 Sex of Household Heads by District



Household headship also varies by type of residence, as shown in Figure 2.19. Nomadic households recorded the highest level of male headship at 70 percent, reflecting traditional pastoralist roles in which men are often responsible for mobility, livestock management, and external household interactions. Rural and urban households also show predominantly male headship, each at 60 percent and 59 percent.

IDP households record a relatively higher level of female headship, with 43 percent of households headed by women. This may reflect the effects of displacement, household separation, widowhood, divorce, or male absence linked to migration and insecurity. These residence-based differences show how livelihood systems, mobility, displacement status, and settlement conditions shape household leadership and gendered responsibilities across the surveyed population.

Figure 2.19 Sex of Household Heads by Residence



2.4.3 Household Vulnerability

Table 2.9 presents the proportion of households exhibiting key vulnerability markers—including the presence of children under five years, persons with disabilities, elderly persons (65 years and above), female-headed households, and child-headed households—disaggregated by district and residence type. Overall, 59 percent of households include children under five years, 8 percent have a person with disability, 8 percent include elderly members, 41 percent are female-headed, and less than one percent are child-headed. Child-headed households represent an extreme form of vulnerability, often associated with orphanhood, family separation, conflict, or displacement.

District-level patterns reveal concentrated vulnerabilities across several indicators. Baidoa records relatively higher proportions across multiple vulnerability indicators, suggesting a comparatively greater vulnerability burden. Kahda has the highest share of households with children under five years (64 percent), followed closely by Baidoa at 63 percent, while Kismayo recorded the lowest share at 52 percent.

Kismayo recorded the highest proportion of households with a person with disability at 12 percent, followed by Baidoa at 8 percent, while Beletweyne recorded the lowest share at 5 percent.

These indicators point to heightened risks related to child protection, disability inclusion, elderly care, and gender inequality—particularly in IDP, nomadic, and high female-headed household settings such as Baidoa. Overall, the findings underscore the need for targeted social protection measures, cash assistance, healthcare and education outreach, and gender-responsive programming to address compounded vulnerabilities in these fragile contexts.

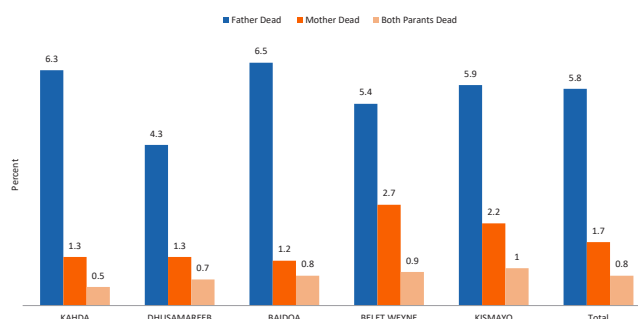
2.4.4 Orphanhood

Figure 2.20 shows the percentage distribution of children under age 18 who have experienced the loss of one or both parents. Single orphanhood—defined as children who have lost one parent—accounts for 8 percent of children under age 18 (6 percent have lost a father and 2 percent have lost a mother). Double orphanhood, referring to children who have lost both parents, is considerably less common, accounting for only one percent. Overall, approximately 9 percent of children are either single or double orphans.

District-level analysis shows that Kismayo, Baidoa, and Beletweyne record the highest levels of orphanhood, each at 9 percent, comprising around 8 percent single orphanhood and about one percent double orphanhood. Kahda follows closely with a combined orphanhood level of 8 percent, while Dhusamareeb recorded the lowest overall orphanhood level at a combined rate of 6 percent.

These patterns suggest that orphanhood remains a significant child vulnerability concern across all districts, with important implications for child protection, household dependency burdens, education continuity, psychosocial wellbeing, and the need for targeted social assistance programmes.

Figure 2.20 Distribution of Households Caring for Orphaned Children by District



2.4.5 Disability

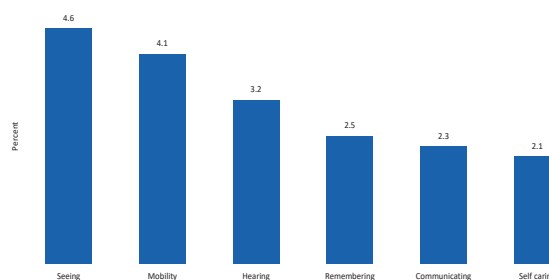
Disability is a multifaceted and non-binary experience involving physical, mental, or cognitive impairments that may limit daily activities. It is characterized by significant limitations in major life activities such as blindness, hearing loss, mobility issues, and chronic health conditions. Individuals with disabilities often encounter increased risks of poverty and social exclusion as a result of systemic, environmental, and attitudinal barriers.

According to Table 2.10 presented at the end of this chapter, the overall disability prevalence is 8 percent. Disability prevalence increases with age, rising more rapidly after age 50. Disability does not show notable gender differentials, indicating broadly similar prevalence among males and females. However, prevalence varies across districts, with Kismayo recording the highest prevalence at 12 percent and Dhuusamareeb and Beletweyne recording the lowest prevalence at 5 percent each. Kahda and Beletweyne each reported 5 percent. These patterns highlight the importance of disability-inclusive planning, particularly in health services, social protection, assistive support, and community-based outreach for households affected by disability.

2.4.6 Types of disability

Figure 2.21 summarizes the distribution of functional difficulties reported by the population. Visual impairment is the most commonly reported disability type at 5 percent, followed closely by mobility limitations at 4 percent. Hearing difficulties affect 3 percent of the population, while problems with remembering are also reported by 3 percent of respondents. Difficulties with communicating and self-care are the least common, at 2 percent each.

Figure 2.21: Distribution of Disability Types

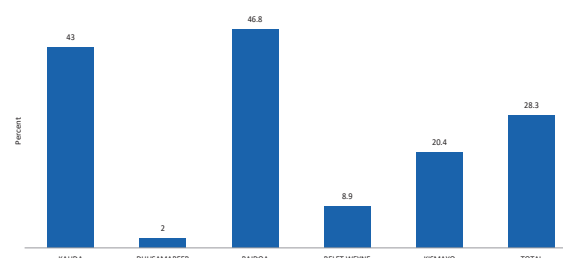


2.4.7 Displacement

Population displacement is among the most severe and protracted crises globally, driven by intersecting factors including conflict, climate shocks, insecurity, and governance fragility. According to Figure 2.22, overall, 28 percent of the households across the five districts described themselves as IDPs.

District-level data reveal considerable variation in self-reported IDP status across the surveyed districts. Baidoa recorded the highest share of households identifying as IDPs at 47 percent, followed closely by Kahda at 43 percent. Kismayo reported 20 percent, while Beletweyne recorded a relatively low IDP share at 9 percent. Dhuusamareeb recorded the lowest share, with only 2 percent of households identifying as IDPs. These differences suggest substantial variation in displacement concentration, settlement patterns, and local absorption capacity across districts.

Figure 2.22 Distribution of Households Self-Identifying as IDPs by District



As shown in Table 2.11, among those that identified as IDPs, 78 percent reside in IDP camps, which contrasts with the 3 percent in rural areas and 6 percent in urban settings.

2.4.8 Major Causes of Displacement

Table 2.12 presented at the end of this chapter reveals that displacement is primarily driven by environmental crises with drought accounting for 60 percent of all reported household displacement. This trend is most pronounced in Baidoa, where nearly 89 percent of displaced households report drought as the main reason for displacement. Armed conflict is the second most common cause, accounting for 27 percent of displacement cases overall. Conflict-related displacement is particularly prominent in Beletweyne, Dhusamareeb, and Kahda, where 58 percent, 57 percent, and 56 percent of displaced households respectively identify conflict as the primary driver of displacement.

Kismayo stands out for its high exposure to multiple displacement risks, recording the highest proportion of displacement due to floods (21 percent), followed by Beletweyne at 12 percent. This pattern is largely linked to the geographical location of both districts along Somalia's major river systems, which makes them particularly vulnerable to recurrent riverine flooding. Combined, drought and floods account for more than 69 percent of displacement across the five surveyed districts.

Overall, these findings highlight the need for displacement responses that address not only immediate humanitarian needs, but also the underlying environmental, conflict-related, and livelihood pressures that continue to drive household displacement and mobility.

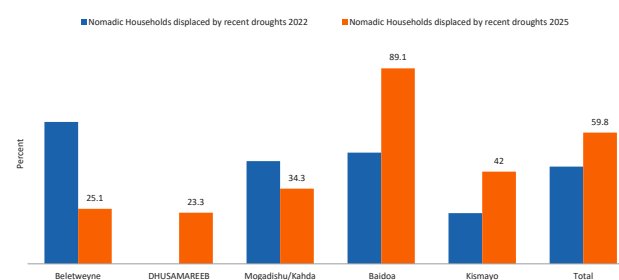
2.4.9 Drought-related Displacement

Figure 2.23 compares findings from the 2022 Survey on Nomadic Movement into IDP Camps in Mogadishu, Kismayo, Beletweyne, and Baidoa with results from the current socio-demographic survey. The findings indicate an overall increase in drought-induced displacement, rising from 44 percent of households in 2022 to 60 percent in 2025.

At the district level, Beletweyne showed a significant decline in drought-related displacement, dropping from 65 percent to 25 percent and Kahda 47 percent to 34 percent. In contrast, Kismayo recorded a notable increase from 23 percent to 42 percent, while Baidoa showed a sharp rise from 51 percent to 89 percent.

These changes could suggest shifting spatial patterns of drought impact and displacement pressure across districts over time, reflecting evolving environmental stressors and population vulnerability dynamics. They also could suggest drought-related resilience building in Beletweyne and Kahda is bearing fruit calling for further investigation into the causes of the drop for sustainability and scaling to other districts.

Figure 2.23 Trends in Drought-Related Displacement among Nomadic Households



Note: Nomadic Movement into IDP Camps 2022 is not conducted in Dhusomareeb.

2.4.10 Intention to Return

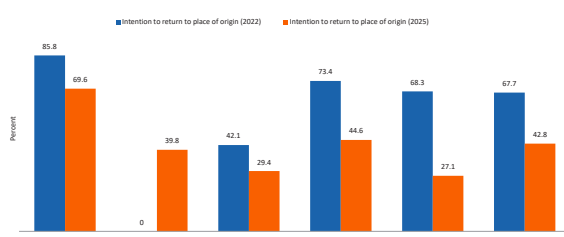
Figure 2.24 shows a substantial shift in intentions among displaced households to return to their place of origin. According to the 2022 Survey on Nomadic Movement into IDP Camps, overall intention to return among IDP households was high at 68 percent, with the strongest levels recorded in Mogadishu and Beletweyne at 86 percent and 73 percent respectively.

However, findings from the Social Demographic Survey (SDS) 2026 indicate a marked decline in return intentions, with the overall proportion dropping to 43 percent. The most significant declines are observed in Kismayo, where intention to return dropped from 68 percent to 27 percent, and in Beletweyne, from 73 percent to 45 percent.

Baidoa recorded the lowest intention to return in both periods, decreasing from 42 percent in 2022 to 29 percent in 2025. In contrast, Kahda (Mogadishu) maintains the highest intention to return in the 2025 survey at 70 percent, although this still reflects a slight decline from the 86 percent recorded in 2022.

Overall, the decline in return intentions across all districts suggests a shift in displacement dynamics, likely reflecting prolonged livelihood disruption among nomadic households, particularly during periods of severe drought when livestock losses and depletion of water resources reduce the feasibility of returning to pastoral livelihoods. It is worth noting the survey was conducted at the peak of the drought season thus influencing their perception to return.

Figure 2.24 Household Intention to Return to Place of Origin



Note: Nomadic Movement into IDP Camps 2022 is not conducted in Dhusamareeb.

2.4.11 Household Access to Information

Table 2.15 presented at the bottom of this chapter provides an overview of household access to communication technologies by district and type of residence, highlighting significant disparities in access to communication equipment. This information is critical for the designers of information and communication interventions.

The data reveals a substantial gap in access to advanced technologies such as smartphones and the internet among households across the surveyed districts. At the district level, Kahda reported nearly 90 percent mobile phone ownership, with 51 percent of households owning smartphones. Dhusamareeb and Kismayo lead in smartphone ownership, at 64 percent and 60 percent respectively. In

contrast, Baidoa exhibited a significant gap, where despite relatively high mobile phone ownership (85 percent), only 30 percent of households own smartphones.

These disparities are even more pronounced by residence type. Urban households have the highest levels of access, with 90 percent mobile phone ownership, 64 percent smartphone ownership, and 17 percent internet connectivity. In comparison, rural households lag behind, with only 35 percent smartphone access.

While internally displaced persons (IDPs) generally have better access than rural households due to proximity to urban centres, nomadic populations remain the most digitally excluded, constrained by mobility and limited infrastructure. Across all five districts, television ownership stands at 7 percent, while only 3 percent of households report owning a radio.



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Table 2.1 Dependency Ratio

District	Children (0-14)	Elderly (65+)	Working (15-64)	Dependency Ratio
Kahda	53.5	1.7	44.7	123.5
Dhusamareeb	52.7	2.1	45.1	121.5
Baidoa	54.7	1.8	43.6	129.6
Belet Weyne	51	2.2	46.8	113.7
Kismayo	49.5	1.9	48.7	105.5
Total	52.4	1.9	45.7	118.8

Dependency ratio= (children (0-14 years) + elderly (65+ years))/ (working age population (15-64 years)) X100

Table 2.2 Household Population Groups by Age, Sex, and District

	Kahda			Dhusamareeb			Baidoa			Belet weyne			Kismayo			Total		
	Sex			Sex			Sex			Sex			Sex			Sex		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Children (0-14)	55.3	51.8	53.5	54.5	51.0	52.7	57.3	52.3	54.7	53.0	49.2	51.0	50.6	48.4	49.5	54.3	50.7	52.4
Working age Population group (15-64)	42.9	46.5	44.7	43.6	46.7	45.1	40.9	45.9	43.6	44.8	48.7	46.8	47.3	49.9	48.7	43.8	47.5	45.7
Elderly (65+)	1.7	1.7	1.7	1.9	2.3	2.1	1.7	1.8	1.8	2.2	2.2	2.2	2.0	1.7	1.9	1.9	1.9	1.9
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Under 18																		
Under 18	62.0	58.5	60.2	61.3	57.3	59.3	62.7	57.4	59.9	59.9	55.8	57.8	57.1	54.6	55.8	60.7	56.8	58.7
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Adolescent Population																		
Adolescent (10-19)	25.3	25.1	25.2	24.7	23.6	24.1	21.2	20.2	20.7	24.7	24.8	24.8	23.0	22.4	22.7	23.7	23.0	23.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Table 2.3 Marital Status by Age, Sex, Residence and District

Background characteristics	Marital status					
	Married	Divorced	Abandoned	Widowed	Never-married	Ever married
District						
Kahda	59.2	5.9	0.7	4.2	30.1	69.9
Dhusamareeb	56.5	6.1	0.7	4.0	32.7	67.3
Baidoa	68.9	4.8	0.7	4.4	21.2	78.8
Belet weyne	62.8	4.4	0.8	4.0	28.0	72.0
Kismayo	57.4	7.2	1.1	4.8	29.6	70.4
Total	61.2	5.7	0.8	4.3	27.9	72.1
Type of residence						
Rural	66.2	5.1	1.1	4.2	23.5	76.5
Urban	57.8	5.6	0.7	4.1	31.7	68.3
Nomadic	61.0	4.1	0.5	3.2	31.2	68.8
Idp	67.3	6.3	0.9	4.8	20.6	79.4
Total	61.2	6.5	0.8	4.3	27.9	72.1
Age group						
15-19	10.6	1.2	0.1	0.1	88.0	12.0
20-24	51.7	6.3	0.3	0.6	41.2	58.8
25-29	76.6	7.7	0.5	1.2	14.0	86.0
30-34	85.9	7.4	0.6	1.8	4.2	95.8
35-39	87.9	6.4	0.7	2.9	2.2	97.8
40-44	86.4	6.5	1.4	4.2	1.5	98.5
45-49	83.0	6.9	1.2	7.6	1.3	98.7
50-54	75.7	7.5	1.9	13.1	1.7	98.3
55-59	73.0	7.4	1.7	16.0	1.9	98.1
60-64	68.0	6.3	2.5	20.2	3.1	96.9
65-69	57.2	7.0	3.4	29.9	2.4	97.6
70-74	55.9	6.5	4.1	30.4	3.0	97.0
75-79	49.2	6.9	3.9	37.5	2.5	97.5
80-84	47.6	6.6	3.7	39.0	3.2	96.8
85+	38.0	3.8	7.2	44.0	7.0	93.0

Table 2.4 Distribution of dwelling units by type, status, district and residence

Background Characteristics	District						Residence					
	Kahda	Dhusamareeb	Baidoa	Belet Weyne	Kismayo	Total (%)	Rural	Urban	Nomad	Idp	Total (%)	Total (n)
Type of dwelling												
Permanent	7.9	48.0	8.6	12.8	41.7	20.4	15.8	33.6	5.3	1.8	20.4	10,617
Semi-permanent	60.0	46.0	39.6	75.8	44.9	51.8	76.7	61.1	26.8	31.1	51.8	26,952
Temporary	32.1	5.9	51.8	11.4	13.4	27.8	7.4	5.3	67.9	67.1	27.8	14,439
Total dwelling units	11,057	6,913	15,879	8,737	9,422	52,008	5,184	28,106	514	18,204	52,008	52,008
Dwelling status												
Occupied	79.7	76.3	73.4	72.7	83.0	76.8	74.1	81.3	91.2	70.1	76.8	39,927
Vacant	14.2	12.8	15.8	11.4	10.1	13.3	10.6	9.2	3.3	20.8	13.3	6,915
Household away for extended period	4.3	7.6	7.4	10.0	3.6	6.5	12.0	5.5	4.1	6.5	6.5	3,390
No one/competent respondent at home	1.8	3.3	3.3	5.9	3.2	3.4	3.4	4.0	1.4	2.6	3.4	1,776
Total dwelling units	11,057	6,913	15,879	8,737	9,422	52,008	5,184	28,106	514	18,204	52,008	52,008

Table 2.5a Distribution of Households by Source of Drinking Water, Time to Obtain Drinking Water by District

Source of Drinking Water	District (%)					Total
	Kahda	Dhusamareeb	Baidoa	Belet weyne	Kismayo	
Improved source	99.6	91.5	68.8	94.5	79.3	84.7
Piped into dwelling/yard/plot	70.0	87.9	28.3	85.0	53.7	59.4
Piped to neighbor*	10.2	0.6	2.1	1.3	7.3	4.7
Public tap/standpipe	18.3	0.4	19.1	2.7	6.3	11.1
Tube well/borehole	0.6	1.0	5.8	2.4	1.7	2.6
Protected well	0.4	1.3	12.1	2.3	9.7	6.2
Non-improved source	0.4	8.5	31.2	5.5	20.7	15.3
Unprotected well	0.1	1.1	7.2	0.5	4.8	3.3
Tanker truck/cart with small tank	0.0	5.5	9.2	1.5	1.6	3.8
Surface water	0.0	0.0	12.9	0.4	8.6	5.6
Time to Obtain Drinking Water (Round Trip)						
Water on premises	85.1	94.3	62.1	93.5	78.0	79.6
Less than 30 minutes	14.1	4.2	30.0	3.9	12.6	15.3
30 minutes or longer	0.7	1.5	7.9	2.5	9.4	5.1
Drinking water service						
Percentage with basic drinking water service	99.0	91.0	64.0	93.1	76.1	82.2
Percentage with limited drinking water service	0.7	0.5	4.8	1.4	3.2	2.5
Number of Households	9,014	5,252	11,686	6,778	9,710	42,440
1 Includes water piped to a neighbor and those reporting a round trip collection time of zero minutes 2 Defined as drinking water from an improved source, provided either water is on the premises or round-trip collection time is 30 minutes or lessIncludes safely managed 3 Drinking water from an improved source, provided round-trip collection time is more than 30 minutes						

Table 2.5b Source of Drinking Water, Time to Obtain Drinking Water By Residence

Characteristic	Households (Type of Residence)				
Source of Drinking Water	Rural	Urban	Nomadic	Idp	Total
Improved source 1	75.9	91.0	48.5	77.0	84.7
Piped into dwelling/yard/plot	50.9	77.4	25.6	30.0	59.4
Piped to neighbor	1.8	3.0	0.9	8.7	4.7
Public tap/standpipe	5.8	3.5	2.6	26.9	11.1
Tube well/borehole	6.4	1.9	6.0	2.6	2.6
Protected well	9.0	4.8	9.0	7.8	6.2
Non-improved source	24.1	9.0	51.5	23.0	15.3
Unprotected well	1.9	2.5	10.5	5.0	3.3
Tanker truck/cart with a small tank	6.0	1.7	32.3	6.2	3.8
Surface water	3.1	3.2	0.9	10.9	5.6
Time to Obtain Drinking Water (Round Trip)					
Water on premises	70.5	91.3	58.1	61.8	79.6
Less than 30 minutes	20.4	5.9	27.6	30.6	15.3
30 minutes or longer	9.1	2.8	14.3	7.6	5.1
Drinking water service					
Percentage with basic drinking water service 2	72.0	89.6	41.5	73.1	82.2
Percentage with limited drinking water service 3	3.9	1.4	7.1	3.9	2.5
Number of Households	4,077	24,563	468	13,332	42,440

Table 2.6 Percent distribution of households by water treatment methods, by district and residence, SDS 2026

	District				
	Kahda	Dhusamareeb	Baidoa	Belet weyne	Kismayo
What is done to make water safer to drink					
Boil	0.3	14.1	4.2	2.0	2.1
Add bleach/chlorine	3.5	0.3	8.6	5.3	2.2
Strain through a cloth	0.0	0.0	0.3	0.1	0.1
Use water filter (ceramic/sand/composite)	0.3	0.0	0.3	0.1	0.3
Solar disinfection	0.0	0.0	0.0	0.0	0.1
Let it stand and settle	0.0	0.0	0.1	0.0	0.3
Other	0.0	0.0	0.1	0.0	0.1
Do nothing	95.9	85.6	86.4	92.4	94.9
Total	100.0	100.0	100.0	100.0	100.0
Appropriate treatment method	4.1	14.4	13.4	7.5	4.8

1 Appropriate water treatment methods include boiling, bleaching, straining, filtering, and solar disinfecting.

Table 2.7 Household Sanitation Facilities by District and Residence

Type of Toilet/Latrine Facility	Population (District)					Total	Population (Type of residence)				Total
	Kahda	Dhusamareeb	Baidoa	Belet weyne	Kismayo		Rural	Urban	Nomadic	Idp	
Improved facility	84.5	78.0	32.4	53.7	65.6	60.1	51.4	65.6	3.8	54.7	60.1
Flush/pour to septic tank/sewer	12.1	8.2	1.3	4.6	1.8	5.1	2.1	7.1	0.0	2.5	5.1
Flush/pour to a pit latrine	8.2	50.8	8.6	8.2	7.9	13.5	21.8	15.9	0.0	7.1	13.5
Ventilated improved pit (VIP) latrine	9.0	0.2	0.5	0.5	0.9	2.4	0.2	1.5	0.2	4.6	2.4
Pit latrine with a slab	55.2	18.8	21.9	40.4	54.9	39.1	27.3	41.0	3.6	40.5	39.1
Non-improved facility	15.1	12.9	60.1	42.3	32.8	35.6	35.5	32.9	34.2	40.8	35.6
Flush to somewhere else	0.2	0.5	0.3	0.5	0.1	0.3	0.3	0.4	0.4	0.2	0.3
Flush/pour flush, don't know where	0.1	0.2	0.3	0.2	0.1	0.2	0.3	0.2	0.2	0.0	0.2
Pit latrine without slab/Open latrine	13.8	11.9	57.9	40.5	32.3	34.2	33.9	31.9	26.9	38.8	34.2
Others	1.1	0.4	1.6	1.0	0.2	0.9	1.0	0.4	6.6	1.7	0.9
Open Defecation	0.1	7.8	7.0	3.3	0.2	3.5	12.4	0.5	60.7	4.2	3.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Percentage with basic sanitation service 1	48.1	63.6	9.7	33.0	39.0	35.0	36.2	45.1	1.3	17.1	35.0
Percentage with limited sanitation service 2	36.5	14.4	22.6	20.7	26.6	25.1	15.2	20.5	2.6	37.6	25.1
Number of households	9,014	5,252	11,686	6,778	9,710	42,440	4,077	24,563	468	13,332	42,440

1 Defined as use of improved facilities that are not shared with other households. Includes safely managed sanitation service, which is not shown separately 2 Defined as use of improved facilities shared by 2 or more households

Table 2.8: Household Size by District and Residence

	Number of usual household members							Total (N)	Mean household size
	1	2	3	4	5	6	7+		
District									
Kahda	1.7	6.1	10.8	13.6	15.2	14.2	38.4	9,011	6.0
Dhusamareeb	3.8	8.3	12.7	13.0	15.1	11.2	35.9	5,238	5.8
Baidoa	5.3	10.7	18.1	18.6	16.9	12.2	18.3	11,685	4.6
Belet weyne	4.1	10.7	15.0	14.8	15.2	13.1	27.1	6,780	5.1
Kismayo	5.7	13.5	16.8	15.8	14.6	10.1	23.6	9,698	4.8
Total	4.3	10.0	15.1	15.6	15.5	12.2	27.4	42,412	5.2
Residence									
Rural	5.8	12.7	15.5	14.6	14.9	11.5	25.1	4,077	4.9
Urban	4.0	10.3	14.8	14.5	14.7	12.0	29.7	24,538	5.3
Nomadic	1.3	5.8	8.8	12.4	15.0	13.9	42.9	468	6.5
Idp	4.3	8.9	15.7	17.9	17.1	12.7	23.3	13,329	5.0
Total	4.3	10.0	15.1	15.6	15.5	12.2	27.4	42,412	5.2

Table 2.9: Household Vulnerability status by District and Residence Type

Background characteristic	Households with Under-five	Households with a person with disability	Households with Elderly (65+)	Female-headed Households	Child-headed Households	Number of Persons
District						
Kahda	63.7	8.1	7.9	33.9	0.2	9,035
Dhusamareeb	61.7	5.1	9.9	45.9	0.2	5,392
Baidoa	62.6	8.2	6.2	50.6	0.7	11,690
Belet weyne	54.8	5.0	8.7	37.2	0.4	6,834
Kismayo	52.1	12.1	6.8	37.1	0.3	9,852
Residence						
Rural	57.3	9.2	9.6	40.2	0.3	4,199
Urban	57.1	9.2	8.0	41.0	0.4	26,301
Nomadic	67.5	2.5	8.8	30.0		497
Idp	63.7	8.2	5.7	42.5	0.5	11,653
Total	59.1	7.9	7.6	41.3	0.4	42,650

Table 2.10 Prevalence of Disability by Background Characteristics

Background Characteristics	With disability (percent)	Without disability (percent)	Total (percent)	Total (N)
District				
Kahda	8.0	92.0	100.0	21393
Dhusamareeb	5.0	95.0	100.0	12337
Baidoa	8.0	92.0	100.0	21719
Belet weyne	5.0	95.0	100.0	14843
Kismayo	12.0	88.0	100.0	20976
Total	7.9	92.1	100.0	91265
Sex				
Male	8.0	92.0	100.0	42112
Female	8.0	92.0	100.0	49153
Total	7.9	92.1	100.0	91265
Population Aged 18+				
18-29	3.0	97.0	100.0	40294
30-39	5.0	95.0	100.0	23473
40-49	8.0	92.0	100.0	13694
50-59	16.0	84.0	100.0	6723
60-69	28.0	72.0	100.0	4026
70-79	44.0	56.0	100.0	1985
80+	62.0	38.0	100.0	1073
Total	7.9	92.1	100.0	91265

Table 2.11: Percent of Persons 18+ with Disabilities by Type of Disability, Sex, and District

Background Characteristics	Seeing	Hearing	Mobility	Remembering	Self-caring	Communicating	Total
Sex							
Male	4.5	2.9	4.0	2.4	2.0	2.2	7.9
Female	4.6	3.5	4.1	2.6	2.2	2.4	8.0
Total	4.6	3.2	4.1	2.5	2.1	2.3	7.9
District							
Kahda	4.8	3.1	4.6	2.7	2.1	2.2	7.8
Dhusamareeb	2.6	1.7	2.6	1.8	1.6	1.6	4.6
Baidoa	4.7	3.0	3.2	1.9	2.1	2.1	8.3
Belet weyne	2.9	2.0	2.8	1.5	1.5	1.6	5.2
Kismayo	6.4	5.3	6.2	4.0	2.7	3.6	11.6
Total	4.6	3.2	4.1	2.5	2.1	2.3	7.9

Table 2.12: Displacement by Type, Status, District and Residence

	District						Residence					Total (n)
	Kahda	Dhusamareeb	Baidoa	Belet-weyne	Kismayo	Total	Rural	Urban	Nomad	IDP	Total (%)	
Household considered as IDP	43.0	2.0	46.8	8.9	20.4	28.3	3.0	6.2	2.4	77.9	28.3	12077
Main reason displaced												
Armed conflict	56.4	57.3	2.9	58.3	27.1	27.4	28.5	35.0	0.0	26.3	27.4	3,306
Generalized violence	3.0	9.7	0.6	1.8	5.1	2.3	1.6	3.7	0.0	2.1	2.3	274
Drought	34.3	23.3	89.1	25.1	42.0	59.8	45.5	46.8	100.0	61.9	59.8	7,227
Floods	4.6	2.9	7.0	11.7	20.8	8.7	20.3	10.8	0.0	8.3	8.7	1,056
Forced eviction	1.1	1.9	0.4	0.7	3.1	1.1	0.8	1.8	0.0	1.0	1.1	134
Other	0.5	4.9	0.1	2.3	1.9	0.7	3.3	1.9	0.0	0.5	0.7	80
Total	3,884	103	5,471	605	2,014	12,077	123	1,528	11	10,415	12,077	12,077
Place currently staying												
IDP camp	93.9	34.0	99.0	51.1	95.3	93.8	78.9	76.7	18.2	96.5	93.8	11,325
Hosted by relative	1.2	31.1	0.1	16.4	2.2	1.9	4.9	9.8	0.0	0.7	1.9	229
Hosted by friend	0.1	1.0	0.0	1.2	0.1	0.1	0.0	0.7	9.1	0.1	0.1	17
Rented Accommodation	1.5	10.7	0.2	18.8	1.1	1.8	3.3	8.5	0.0	0.8	1.8	218
Own home	3.1	19.4	0.6	12.2	1.2	2.3	12.2	4.1	45.5	1.8	2.3	274
Other	0.2	3.9	0.0	0.3	0.0	0.1	0.8	0.2	27.3	0.1	0.1	14
Total	3,884	103	5,471	605	2,014	12,077	123	1,528	11	10,415	12,077	12,077
Where household came from												
Urban	10.4	34.0	9.5	35.5	14.7	12.2	12.2	22.4	9.1	10.7	12.2	1,472
Rural	71.9	29.1	59.7	43.0	65.2	63.5	77.2	54.7	9.1	64.6	63.5	7,664
Nomadic	5.5	28.2	3.0	7.6	12.1	5.8	5.7	7.9	81.8	5.4	5.8	699
Idp	12.2	8.7	27.7	13.9	7.9	18.6	4.9	14.9	0.0	19.3	18.6	2,242
Total	3,884	103	5,471	605	2,014	12,077	123	1,528	11	10,415	12,077	12,077
Intends to go back	69.6	39.8	29.4	44.6	27.1	42.8	27.6	34.4	72.7	44.2	42.8	5,168
Total	3,884	103	5,471	605	2,014	12,077	123	1,528	11	10,415	12,077	12,077

Table 2.13: Trends in Drought-Induced Displacement among Nomadic Households by District

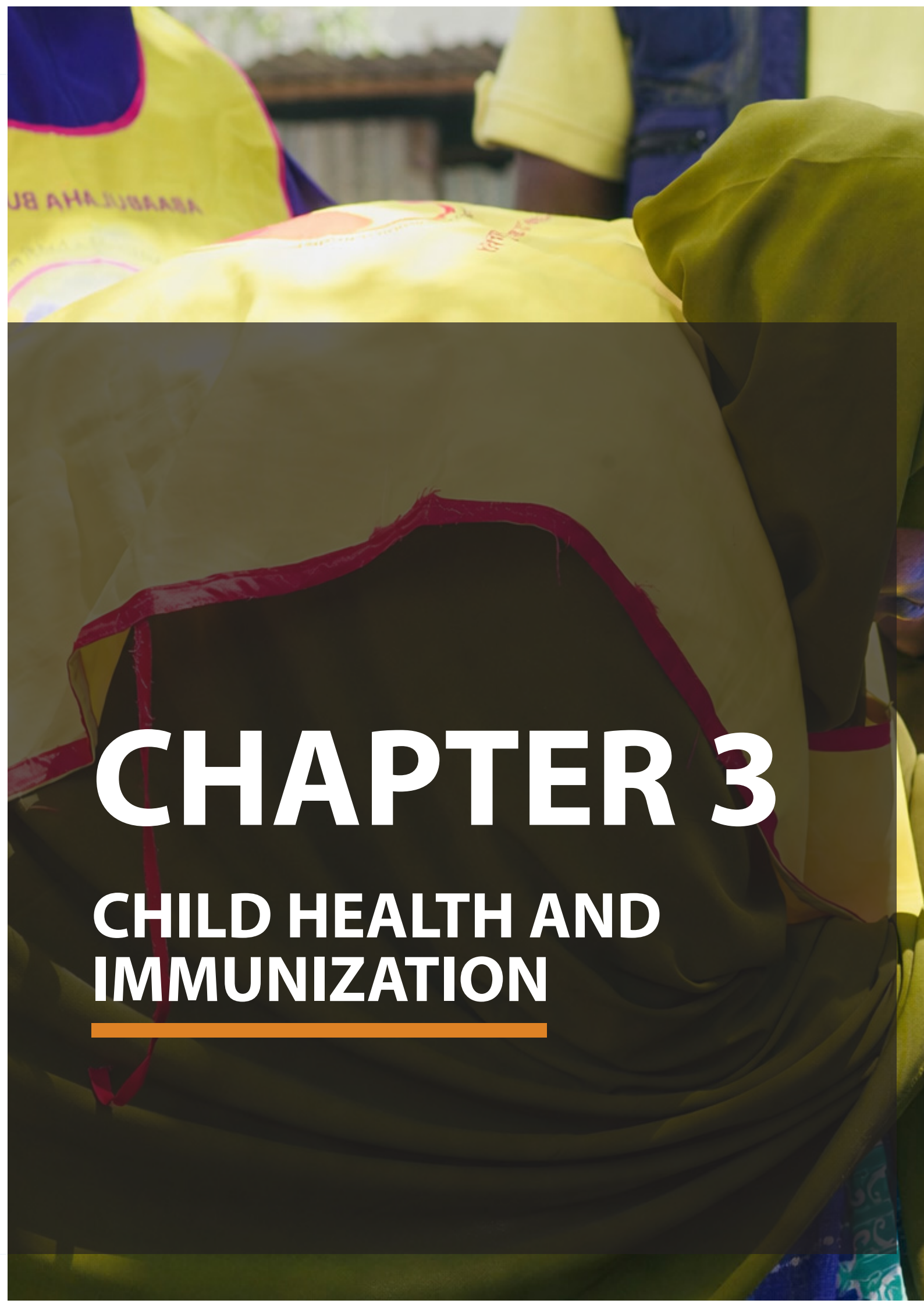
	Nomadic Households displaced by recent droughts 2022		Nomadic Households displaced by recent droughts 2025	
	Percent	Households	Percent	Households
District				
Beletweyne	64.7	3,587	25.1	152
Dhusamareeb	-	-	23.3	24
Mogadishu/Kahda	46.8	2,245	34.3	1,334
Baidoa	50.7	2,404	89.1	4,872
Kismayo	23.1	1,695	42.0	845
Total	44.3	9,931	59.8	7,227

Table 2.14 Intention of Displaced Nomadic Households to Return to Place of Origin

District	Intention to return to place of origin (2022)	Households (2022)	Intention to return to place of origin (2025)	Households (2025)
Kahda	85.8	2,245	69.6	2,704
Dhusamareeb	N/A	N/A	39.8	41
Baidoa	42.1	2,404	29.4	1,607
Belet Weyne	73.4	3,587	44.6	270
Kismayo	68.3	1,695	27.1	546
Total	67.7	9,931	42.8	5,168

Table 2.15: Household Ownership of Telecommunication Equipment by District and Type of Residence

	Household has a mobile phone	Has a smart phone	Has pc	Has internet access	Has tv	Has radio	Total (n)
District							
Kahda	90.2	50.9	7.7	13.7	12.0	0.9	8,993
Dhusamareeb	86.1	64.0	9.1	10.1	3.3	2.3	5,190
Baidoa	85.2	29.5	4.8	3.4	4.0	4.5	11,622
Belet weyne	85.0	51.2	6.0	10.5	6.2	3.8	6,733
Kismayo	87.8	59.6	10.8	21.1	9.2	3.1	9,569
Total	86.9	48.8	7.5	11.6	7.2	3.0	42,107
Type of residence							
Rural	81.0	34.5	1.8	4.9	1.1	2.4	4,052
Urban	89.6	64.0	11.8	16.8	10.6	3.5	24,304
Nomadic	79.4	15.3	0.6	1.3	0.2	4.5	462
Idp	84.1	24.3	1.6	4.3	2.9	2.3	13,289
Total	86.9	48.8	7.5	11.6	7.2	3.0	42,107



CHAPTER 3

CHILD HEALTH AND IMMUNIZATION



Chapter Three summarizes key child health and survival indicators from the SDS 2026 across the five surveyed districts. It covers neonatal health, immunization coverage, and the prevalence and management of common childhood illnesses, highlighting factors that influence child survival and well-being.

KEY FINDINGS

BIRTH WEIGHT

less than 2.5kgs at birth:

20%



ZERO-VACCINE CHILDREN:



30%

Baidoa:	36%
Beletweyne:	14%
Dhusamareeb:	26%
Kahda:	23%
Kismayo:	24%

FULLY IMMUNIZED CHILDREN:

16%



Baidoa:	11%	Dhusamareeb:	19%
Beletweyne:	7%	Kahda:	21%
Kismayo:	19%		



ORAL POLIO VACCINE BIRTH DOSE

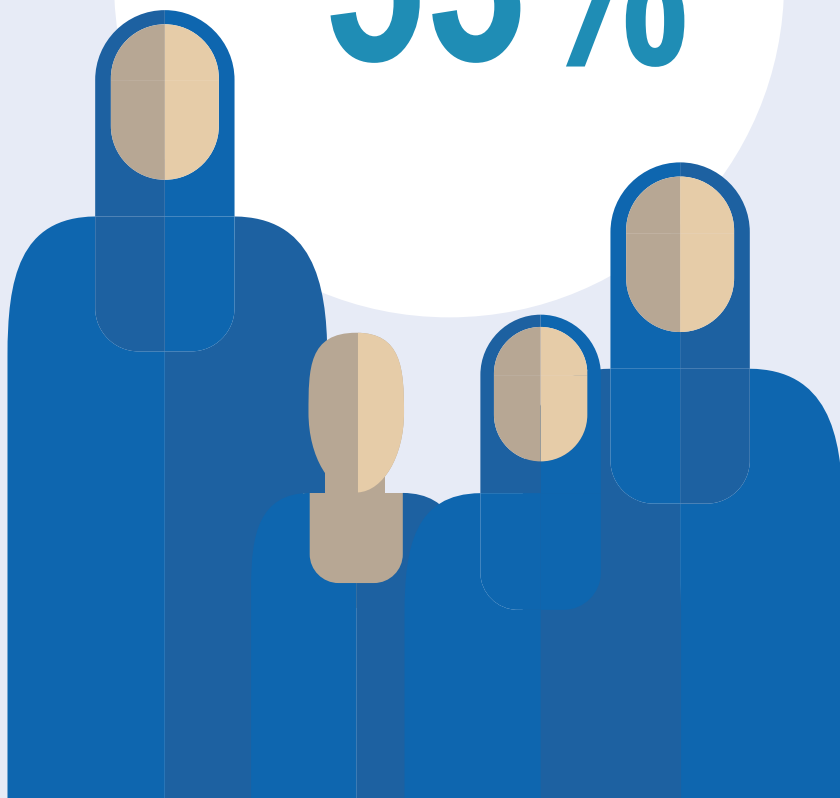
61%



Baidoa:	53%
Beletweyne:	42%
Dhusamareeb:	67%
Kahda:	70%
Kismayo:	68%

MEASLES COVERAGE

53%



BCG COVERAGE

67%

Baidoa:	62%
Beletweyne:	53%
Dhusamareeb:	71%
Kahda:	74%
Kismayo:	72%

3.1 Introduction



This chapter examines critical child health and survival indicators from the SDS 2026 across the five surveyed districts. It begins with neonatal health, as reflected in birth weight and maternal perceptions of infant size—key predictors of early vulnerability, including long-term health and mortality risk. The analysis then moves to preventive services through immunization coverage among children aged 12–23 months, followed by the prevalence and management of common childhood illnesses (acute respiratory infection, diarrhea, and fever) among children under five. These elements are closely interconnected as early biological risks, gaps in prevention, and limited response to illness often stem from the same systemic and household barriers, shaping overall child survival trajectories.

3.2 Weight and Size at Birth

Birth weight is an important indicator of neonatal health and survival. Infants weighing less than 2.5 kg are classified as having low birth weight (LBW), a condition associated with increased risk of morbidity and mortality. Table 3.1 presented at the end of this chapter shows that, across the surveyed districts 20 percent of children fall into this category. In contrast, only 10 percent of mothers reported their child as “very small” at birth, indicating a gap between measured birth weight and maternal perception. This discrepancy suggests that a proportion of low-birth-weight infants may not be recognized as vulnerable at the household level, which could potentially affect early care-seeking and newborn care practices.

Substantial geographic and residential disparities are observed. Baidoa recorded the highest prevalence of LBW at 60 percent, three times more than the average of 20 percent across the five districts, while other districts range between 11 and 15 percent. Children living in IDP settlements have a higher LBW prevalence at 25 percent, compared with 19 percent among children in urban areas and 6 percent among those in rural areas. Differences are also observed by maternal age, with 24 percent of children born to mothers under age 20 classified as LBW, compared to 20 percent among mothers aged 20–34 and 19 percent among those aged 35–49.

3.3 Immunization

3.3.1 Immunization Coverage and System Performance

Immunization is one of the most cost-effective interventions for protecting children against vaccine-preventable diseases and reducing overall under-five mortality. A child is considered fully vaccinated according to WHO standards if they have received one dose of BCG, three doses of pentavalent vaccine, at least three doses of polio vaccine, and one dose of measles vaccine. According to a WHO report, Somalia's immunization system faces a significant gap between initial vaccine contact and achieving full protection.⁷

The SDS 2026 survey assessed vaccination coverage among children aged 12–23 months. Data was collected primarily from vaccination cards when available; in cases where cards were unavailable or not observed, information was obtained from maternal or caregiver recall. As shown on Table 3.2 that is presented at the end of this chapter, across the five districts, 54 percent of children had their immunization cards available. Kismayo had the highest proportion of children between 12-23 months with immunization cards at 66 percent, while Baidoa and Beletweyne recorded the least at 44 percent.

3.3.2 Basic Immunization Coverage

Figure 3.1 presents coverage of basic immunization by district and type of residence. Coverage varies significantly across districts and population groups, reflecting inequities in both access and service delivery. It further shows that children in Beletweyne are the least likely to be fully immunized, at 7 percent, followed by Baidoa at 11 percent, while coverage in the remaining districts ranges from 19 percent each in Kismayo and Dhusamareeb to 21 percent in Kahda.

A pronounced urban–rural divide is also evident. According to the analysis, 17 percent of children in urban areas are fully immunized, compared to just 8 percent among nomadic populations and 10 percent among children in the rural areas. These disparities underscore the challenges of delivering routine immunization services to mobile and hard-to-reach communities, and the need for tailored service delivery strategies.

Figure 3.1 Basic Immunization Coverage

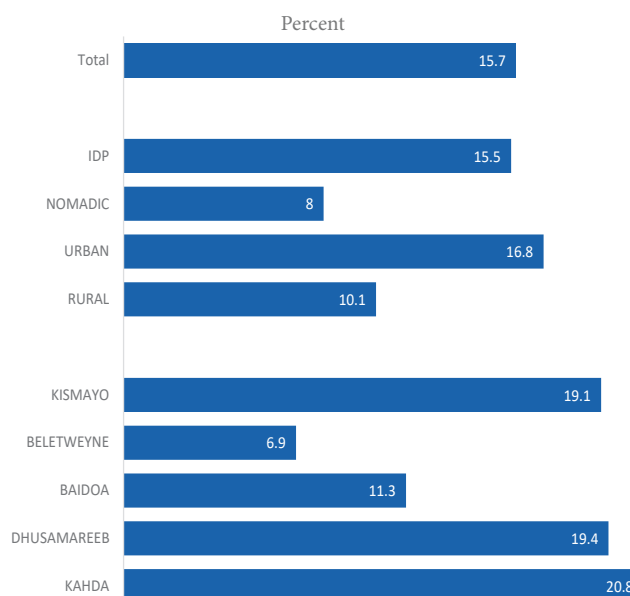
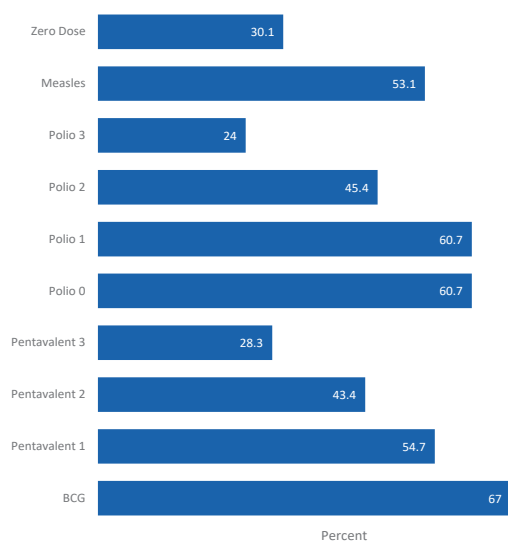


Figure 3.2 presents an analysis of immunization status of the different mandatory vaccines. The immunization landscape across the five surveyed districts reveals a system that achieves moderate eventual reach but very weak continuity of care, resulting in low levels of full protection. While a substantial proportion of children come into contact with immunization services at some point during infancy, only a small minority complete the full schedule.

According to Figure 3.2, 67 percent of children received the BCG vaccine, but only 16 percent (Figure 3.1) completed the full basic immunization schedule (BCG, three doses of pentavalent vaccine, at least three doses of polio vaccine, and one dose of measles-containing vaccine). At the same time, 30 percent of children remain “zero-dose,” having received no vaccinations at all.

⁷ <https://www.emro.who.int/somalia/news/>

Figure 3.2 Immunization Coverage



3.3.3 Initial Contact and Protection Gaps

Coverage of the Oral Polio Vaccine birth dose (OPV0) or polio 0 is 61 percent (Figure 3.2 above). Administered at birth or shortly thereafter, Polio 0 serves as a key marker of initial postnatal contact with the immunization system. While 47 percent (SDS see chapter 4) of births occur at a health facility, Polio 0 coverage exceeds this, indicating that some infants born at home are reached by vaccination services shortly after birth. Nevertheless, nearly 40 percent of newborns still miss this critical early opportunity, highlighting gaps in timely neonatal access.

According to Figure 3.2, BCG coverage, at 67 percent, reflects whether a child has ever received the vaccine and serves as an indicator of engagement with the immunization system during infancy, rather than at birth. The slightly higher BCG coverage compared with Polio 0 suggests that some children who miss the birth dose are still reached later in infancy through routine services, outreach, or campaigns. According to Table 3.2 presented at the end of this chapter, BCG coverage varies geographically, with the highest levels in Kahda at 74 percent, followed by Kismayo at 72 percent, and Dhusamareeb at 71 percent, and the lowest in Beletweyne at 53 percent.

Measles vaccination coverage stands at 53 percent, providing only partial protection and falling well below the 95 percent threshold

required for herd immunity. Coverage varies across districts, from 63 percent in Kismayo to 38 percent in Beletweyne. Gender disparities are minimal, with full immunization coverage nearly identical among boys (16 percent) and girls (15 percent), a pattern consistent across other antigens (Table 3.2).

Together, these indicators illustrate the dual challenge facing Somalia's immunization system: ensuring timely initial contact at birth and sustaining engagement through infancy to achieve full protection. Polio 0 captures access at birth, BCG reflects follow-up engagement during early life, while measles coverage at 53 percent highlights remaining gaps in population-level immunity.

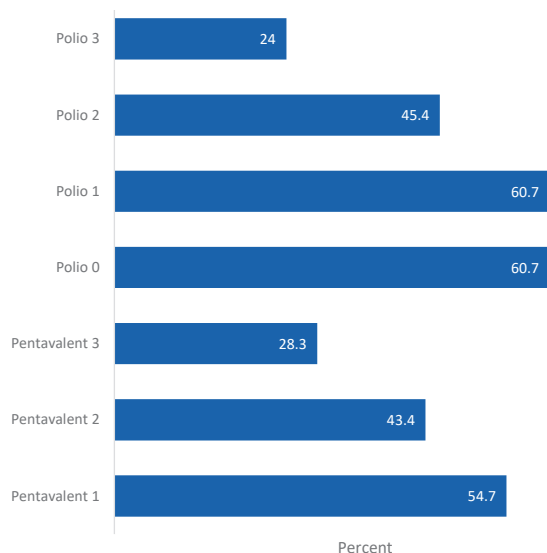
3.3.4 Immunization Retention

A critical challenge in Somalia's immunization system is the substantial dropout between initial and subsequent doses of essential vaccines. Figure 3.3 shows that while 55 percent of children receive the first dose of Pentavalent (Pentavalent 1), coverage falls sharply to 28 percent for the third dose (Pentavalent 3), representing a dropout rate of nearly 50 percent among those who start the series. A similar pattern emerges for polio vaccination: 61 percent receive the birth dose (Polio 0), yet only 24 percent complete the third dose (Polio3), highlighting steep attrition along the immunization pipeline.

District-level analysis presented in Table 3.3 presented at the bottom of this chapter, reveals marked disparities. Kahda demonstrates relatively stronger retention, with Pentavalent coverage declining from 66 percent at the first dose to 40 percent at the third. Dhusamareeb and Kismayo follow closely. In contrast, Baidoa and Beletweyne exhibit the most pronounced dropouts; Pentavalent coverage falls from 46 percent to 19 percent in Baidoa and from 36 percent to 18 percent in Beletweyne. Polio vaccination follows the same trend, with retention weakest among children in nomadic and hard-to-reach areas.

These patterns underscore the challenges of sustaining immunization coverage in settings affected by geographic, logistical, and population mobility barriers. Nomadic communities, in particular, face seasonal migration, dispersed settlements, and reliance on outreach services, all of which contribute to attrition along the vaccination pipeline.

Figure 3.3 Vaccination Retention (Pentavalent & Polio)



3.3.5 Zero-Dose Children

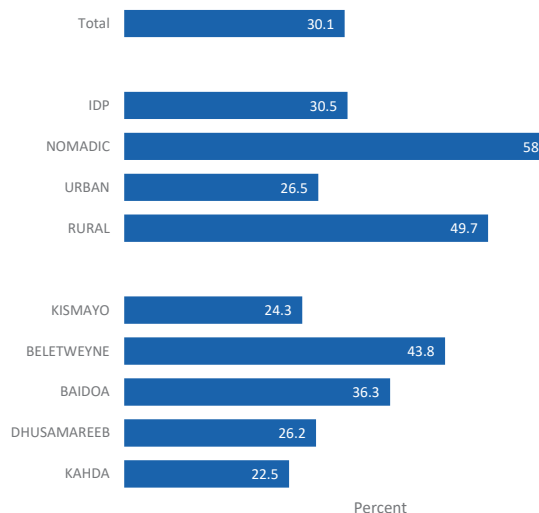
Approximately 30 percent of children in the surveyed districts are zero-dose, meaning they have received no vaccinations through either routine services or mobile campaigns. Zero-dose prevalence varies across geographic, demographic, and socio-economic factors, which are examined below.

Zero-dose prevalence varies notably across districts and population groups, reflecting differences in access to health facilities, outreach services, and mobility of the population. Examining these geographic differences helps identify areas and communities where immunization services are most needed.

According to Figure 3.4, zero-dose prevalence shows clear variation across districts and residences. Beletweyne reports the highest rates at 44 percent, followed by Baidoa 36 percent, while Kahda and Kismayo reported the least zero-dose children at 23 percent

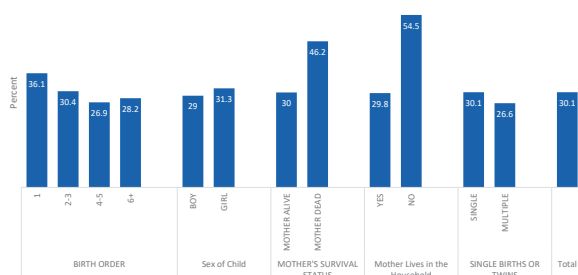
and 24 percent respectively. Nomadic populations experience the greatest coverage gaps at 58 percent slightly more than double the urban rate of 27 percent. The rural prevalence of zero-dose children is close to that of the nomadic at 50 percent. These patterns highlight the role of access, mobility, and local service delivery context in shaping vaccination coverage.

Figure 3.4 Geographic Distribution of zero-dose children



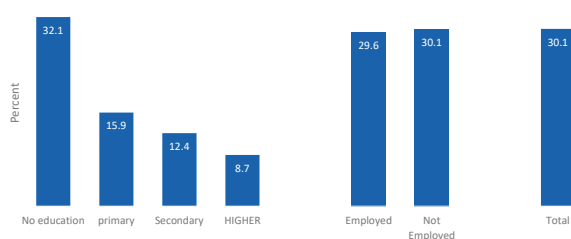
To better understand which children are most likely to miss immunization entirely, the survey examined key demographic characteristics, including birth order, maternal presence, and birth type, presented in Figure 3.5. Firstborn children have a higher zero-dose prevalence compared with later-born siblings 36 percent compared to 28 percent among 6th-borns and above. Children not living with their mothers are more frequently zero-dose than those residing with their mothers 53 percent compared to 30 percent. Children whose mothers are deceased show similarly elevated rates at 48 percent compared to 30 percent. Singletons are slightly more likely to be zero-dose than multiple births, 30 percent versus 27 percent, while girls are marginally more affected than boys, 31 percent versus 29 percent. These patterns suggest that zero-dose children are concentrated among firstborns, children not living with their mothers, and children whose mothers are deceased, which can guide targeted outreach strategies.

Figure 3.5 Demographic Factors Associated with Zero-dose



The survey also looked at the connection between zero-dose and maternal education as well as maternal employment status. The findings are presented in Figure 3.6. Zero-dose prevalence also varies by maternal education, showing a clear gradient. Children of mothers with no formal education are more likely to be zero-dose, 32 percent compared with those whose mothers completed primary at 16 percent, secondary with 12 percent, or higher education with 9 percent. No notable differences were observed by maternal employment status. These patterns indicate that maternal education is closely linked with immunization coverage, emphasizing the importance of tailored health communication and outreach for low-literacy populations.

Figure 3.6 Socio-Economic Drivers of Zero-Dose



3.4 Childhood Illnesses and Treatment

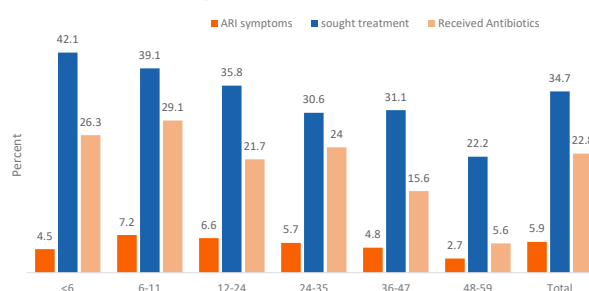
Understanding the most prevalent illnesses affecting children under five years and the accompanying health-seeking behavior is important for control of under-five morbidity and mortality. This section focuses on Acute Respiratory Infection (ARI), diarrhea, and fever, looking at their distribution across the districts and place of residence, as well as the health-seeking practices for these illnesses.

3.4.1 Acute Respiratory Infection (ARI)

Acute Respiratory Infection (ARI) is a serious condition that impairs normal breathing. It often begins as a viral infection affecting the nose, trachea, or lungs, and if left untreated, can spread across the entire respiratory tract. Prompt diagnosis and appropriate antibiotic therapy can greatly lower the death rate from ARI. The World Health Organization (WHO) lists ARI as a leading global cause of morbidity and mortality among children. In the SDS 2026 study, ARI prevalence was measured by asking mothers whether their children under the age of five had presented with any symptoms of ARI during the two weeks preceding the survey. ARI symptoms are a clinical proxy for pneumonia among children under five years. Pneumonia is among the leading causes of death among children under five mainly due to the rapid progression of its symptoms. Table 3.4 presented at the end of this chapter, shows that across the districts, 6 percent of children exhibited ARI symptoms in the two weeks preceding the survey. Among these symptomatic children, professional advice or treatment was sought for 35 percent, while only 23 percent received antibiotics.

Figure 3.7 reveals that ARI prevalence follows a distinct age-based curve, peaking at 7 percent among infants aged 6–11 months and declining to 3 percent by age 48–59 months. This peak in respiratory vulnerability coincides with the “weaning window”. Furthermore, the likelihood of seeking professional care also diminishes as the child ages, falling from 42 percent for infants under six months to 22 percent for children of 48–59 months.

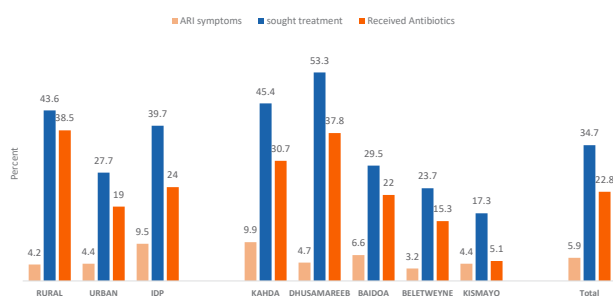
Figure 3.7: Children Presenting with ARI Symptoms and Treatment-Seeking Behaviour



As presented in Figure 3.8, district and residential disparities in the prevalence and management of ARI identify specific geographic “hotspots” where child survival is most at risk. Kahda district reported the highest proportion of children with ARI symptoms at 10 percent, with 45 percent of those cases seeking professional treatment and 31 percent provided with antibiotics. In contrast, Dhusamareeb recorded a moderate prevalence of 5 percent but exhibited the most robust health-seeking behavior in the surveyed districts, with 53 percent of caregivers seeking professional advice and 38 percent of symptomatic children receiving antibiotics. The data highlights a significant access-treatment gap in districts like Kismayo and Beletweyne, which reported the lowest treatment-seeking rates at 17 percent and 24 percent respectively. In Kismayo 17 percent sought treatment but only 5 percent received antibiotics.

Residential analysis confirms that IDP settlements face the most acute health crisis, with a 10 percent ARI prevalence rate—more than double the rate of urban and rural at 4 percent each. This high morbidity in displaced settings could be attributed to overcrowding. Interestingly, while rural children have a lower prevalence of symptoms, they have the highest rate of seeking professional medical advice at 44 percent, compared to 40 percent for those in IDP settlements and 28 percent in urban areas. They also have the highest rate of those who received antibiotics at 39 percent compared to 24 percent among the IDP children and 19 percent among those in the urban areas.

Figure 3.8 Children Presenting with ARI Symptoms and Treatment-Seeking Behavior



3.4.2 Diarrhea

Diarrhea is dangerous in children under-five because it can quickly lead to dehydration, malnutrition, and, if untreated, death. Repeated episodes can also contribute to stunting and impaired growth. Key risk factors include unsafe drinking water, poor sanitation, inadequate handwashing, lack of exclusive breastfeeding, and limited access to healthcare. Figure 3.9 shows the prevalence of children presenting with diarrhoea and the treatment sought for their condition. The prevalence of diarrhoea among children under five across the five districts stands at 11 percent, with 61 percent of symptomatic children receiving advice or treatment from a health facility or healthcare provider.

Analysis by age identifies a critical “vulnerability window” among infants aged 6–11 months, who experience the highest diarrhea prevalence rate at 16 percent. This peak coincides with the weaning period and the gradual waning of maternal antibodies, a stage during which completion of the Rotavirus and routine immunization schedule is particularly important. However, as highlighted in the immunization section, the health system currently experiences a 28 percent dropout rate between initial and final routine vaccine doses, leaving many children in this age group under-protected.

In addition, hygiene practices play a critical role in the prevention and control of diarrheal disease. With the introduction of complementary feeding during the weaning period, increased awareness and practice of proper hygiene are essential to reduce exposure to contamination and infection risks.

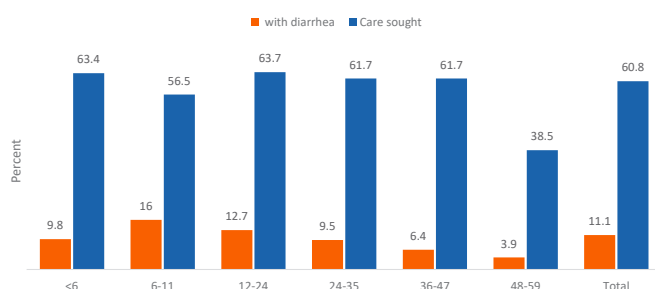
While treatment-seeking behaviour remains relatively consistent among younger children, it declines sharply to 39 percent among children aged 48–59 months, suggesting a reduced perception of the need for professional care as children grow older. Notably, the 6–11 month age cohort records the second-lowest proportion of children for whom treatment was sought, despite experiencing the highest prevalence of diarrhea.

A woman wearing a bright blue hijab and a patterned skirt is sitting on a white bench outdoors. She is holding a young child wrapped in a white and orange patterned blanket. The background shows a white wall and a yellow pillar. In the foreground, the legs and feet of another person wearing colorful sandals are visible.

Somalia's main vaccination challenge is a massive 50% to 65% dropout rate between the first and final doses. While over half of children start their vaccines (55% for Pentavalent and 61% for Polio), coverage drops sharply to just 28% and 24% by the third dose, leaving the majority of children unprotected because they fail to complete the series.



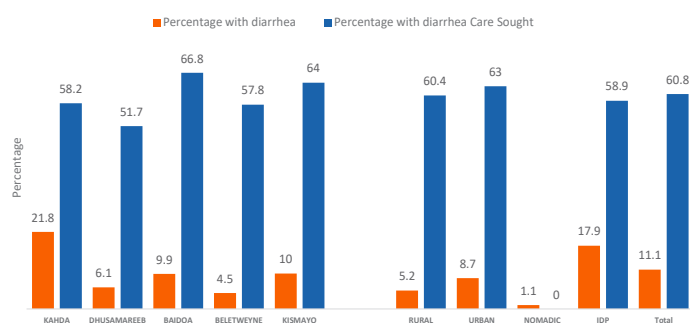
Figure 3.9: Children Presenting with Diarrhoea and Treatment-Seeking Behaviour



According to Figure 3.10 Kahda has the most severe morbidity hotspot, reporting a diarrhea prevalence of 22 percent-the highest. Kahda, Baidoa and Kismayo report prevalence rates almost half that of Kahda, 10 percent each. Notably, Baidoa demonstrates the highest resilience in response to illness, with 67 percent of symptomatic children seeking professional treatment, followed by Kismayo at 64 percent. In contrast, Beletweyne recorded the lowest prevalence at 5 percent and highest proportion of those that sought treatment, 58 percent. Dhusamareeb reported the least treatment-seeking rate of 52 percent, highlighting a significant missed opportunity to provide integrated care.

There are stark disparities in health outcomes based on place of residence, with children in IDP settlements bearing a disproportionately high burden. Diarrhea prevalence in these areas reaches 18 percent, more than double the rate found in urban settings 9 percent and triple the rate in rural areas 5 percent. Despite having the highest prevalence, IDP settlements exhibit a lower treatment-seeking rate 59 percent compared to urban areas 63 percent and rural 61 percent.

Figure 3.10: Children Presenting with Diarrhoea and Treatment-Seeking Behaviour by District



3.4.3 Fever

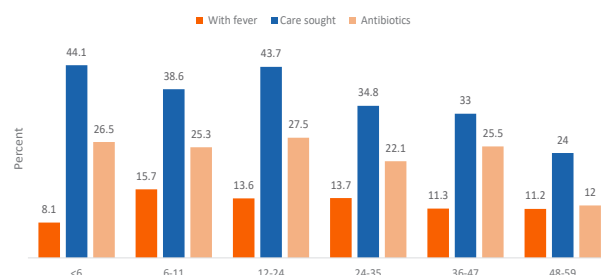
Fever is a key indicator of malaria, pneumonia, or other systemic infections among children under five. Figure 3.11 presents an analysis of the under-fives presenting with fever and the care sought. According to the survey, the prevalence of fever is 13 percent. Among symptomatic children, advice or treatment was sought from a health facility or provider for only 38 percent, and 25 percent received antibiotics.

Analysis by age, as presented in Figure 3.11, identifies infants aged 6–11 months as the most vulnerable group, with a fever prevalence of 16 percent. This peak coincides with the “weaning window,” a period during which children gradually lose maternal antibodies while also experiencing increased environmental exposure through complementary feeding and mobility.

Although infants under six months record the highest rate of medical care-seeking (44 percent), there is a notable decline in treatment-seeking behaviour as children grow older. Among children aged 48–59 months, care-seeking falls to 24 percent, while antibiotic use declines to 12 percent.

This pattern suggests a possible “perception gap,” whereby caregivers may consider older children to be more resilient, potentially leading to delayed or inadequate treatment for illnesses that may still require prompt medical attention.

Figure 3.11: Children with Fever and Treatment-Seeking Patterns by Age Group

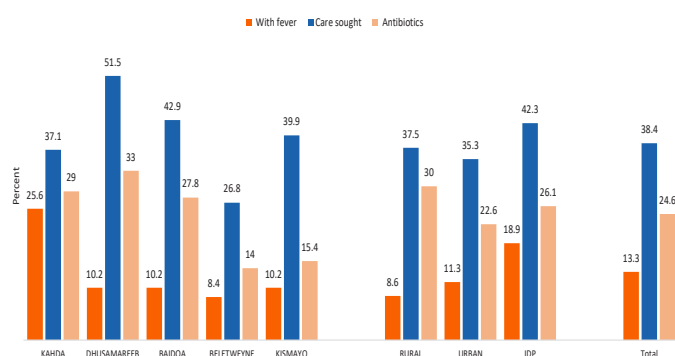


Place of residence significantly influences the fever burden. According to Figure 3.12, IDP settlements experience the highest prevalence at 19 percent. While IDP settlements report a higher treatment-seeking rate of 42 percent than urban areas at 35 percent, a substantial proportion—52 percent of symptomatic children—still do not receive formal care.

District-level analysis identifies Kahda as a major health hotspot, recording the highest fever prevalence at 26 percent. Despite this high burden, only 37 percent of symptomatic children in Kahda receive professional care. In contrast, Dhusamareeb demonstrates the most effective clinical response, with 52 percent of symptomatic children seeking care and 33 percent receiving antibiotics.

Beletweyne presents a concerning pattern, with the lowest fever prevalence of 8 percent and also the lowest treatment-seeking at 27 percent, suggesting barriers to healthcare utilization despite relatively lower disease burden. Similarly, Kismayo shows potential service delivery constraints, where 40 percent of caregivers seek care but only 15 percent report receiving antibiotics, indicating possible gaps in medicine availability or supply chain functionality even after reaching health facilities.

Figure 3.12: Children Presenting with Fever and Health-Seeking Behaviour by District and Residence



3.5 Availability and Access to Health Care

The analysis of Figure 3.13 and Table 3.7 provides a critical “missing link” in understanding why child health outcomes across the five districts remain poor despite the apparent availability of health facilities. The findings reveal a clear “proximity paradox,” where physical access to services does not necessarily translate into effective service utilization or improved health outcomes. Table 3.7 presents the distance to the nearest health facility, while Figure 3.14 shows whether households have a facility within their settlement and the type of access to public or private services.

As shown in Table 3.7 that is presented at the end of this chapter, although 89 percent of households live within 1 km of a health facility, utilization of essential services remains low, with only 16 percent achieving full vaccination coverage and just 35 percent of children with acute respiratory infection (ARI) symptoms seeking care. Similarly, while 85 percent of households report having a health facility within their settlement, the high “zero-dose” rate of 30 percent indicates that proximity alone is not sufficient to ensure service uptake. These findings suggest that many facilities may function as “service cold spots,” where infrastructure exists but essential inputs such as vaccines, medicines, staffing, or consistent service delivery are inadequate or unreliable.

Figure 3.13: Availability and Access to Health

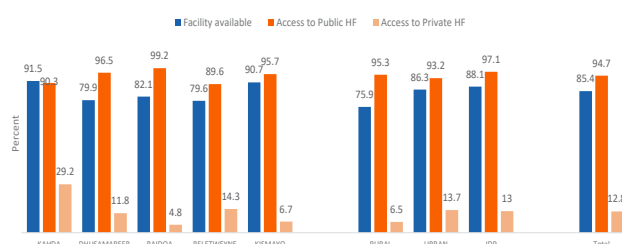


Table 3.7 presented at the end of this chapter, shows a detailed overview of health facility availability, distance to services, and type of facility accessed across the five districts. Overall, 85.4 percent of households report that a health facility is available within their settlement or IDP camp, indicating generally high spatial availability of services. This is particularly high in Kahda (91.5 percent) and Kismayo (90.7 percent), while lower levels are observed in Dhusamareeb (79.9 percent) and Beletweyne (79.6 percent).

Distance data further confirms strong physical proximity to services, with 88.7 percent of households located within 1 km of a health facility. This proximity is consistently high across districts, ranging from 81.6 percent in Beletweyne to 92.5 percent in Kahda. Only a very small proportion of households report living more than 5 km from a facility (1 percent overall), although Dhusamareeb records a relatively higher share at 6.9 percent. A small proportion of respondents (4.1 percent) reported not knowing the distance, with notably higher uncertainty in Beletweyne (12 percent).

In terms of service type, access to public health facilities is very high across all districts at 94.7 percent, peaking in Baidoa (99.2 percent). In contrast, access to private health facilities is much more limited, at 12.8 percent overall. Private sector access is highest in Kahda (29.2 percent) and lowest in Baidoa (4.8 percent), indicating strong reliance on public health provision across the surveyed areas.

Overall, the findings suggest that while geographic access to health facilities is relatively strong, disparities in facility functionality, service quality, and availability of private alternatives may continue to influence health outcomes across districts.

3.6 Conclusions and Recommendation

3.6.1 Conclusions

Geographic “Zero-Dose” Clusters : Somalia’s “Zero-Dose” children (the 30 percent who have never received a single vaccine) are not randomly distributed but are clustered in specific demographics. Nomadic populations, where 58 percent are completely unvaccinated, lack access to health facilities -38 percent are 5 km or more away from a health facility. Beletweyne district, which faces a catastrophic 44 percent zero-dose and IDP settlements where high morbidity (18 percent) meets 31 percent zero-dose rate and 25 percent low birth weight rate.

The Proximity Paradox: The data reveal a stark “Proximity Paradox”: 85 percent of households have a health facility available, and 89 percent live within 1km of one, yet treatment-seeking for life-threatening ARI is only 35 percent. This indicates that physical distance is no longer the primary barrier for the majority. Instead, functional access is restricted by financial constraints (62%) and gender-based autonomy gaps (34%), which prevent mothers from utilizing the clinics in their immediate vicinity.

3.6.2 Recommendations

1. Strengthen “Routine-Plus” Integrated Mobile Outreach: Given that 58 percent of nomadic children are zero-dose and mobile clinics currently make up only 2 percent of facilities, the health ministry should enhance mobile health outreaches that follow nomadic routes. These units need to be well-equipped to provide both the full routine vaccine schedule and treatment.

2. Address the financial barrier through health vouchers: Given that 62 percent of women cite cost as the primary barrier to accessing healthcare, physical proximity to health facilities is insufficient without corresponding economic access. In the context of Somalia’s weak health financing systems, high reliance on out-of-pocket payments, and limited insurance coverage, a National Maternal and Child Health Voucher Scheme would be more effective in the short to medium term, with a social health insurance model considered as a long-term objective.

The proposed voucher scheme should directly target IDPs and rural populations, who face the greatest financial and access constraints. It would cover consultation fees and essential medicines for maternal and child health services, including common childhood illnesses, thereby removing point-of-service payment barriers for vulnerable households.

Given that 62 percent of women cite cost as the primary barrier to accessing healthcare, physical proximity to health facilities is insufficient without corresponding economic access. In the context of Somalia's weak health financing systems, high reliance on out-of-pocket payments, and limited insurance coverage, a National Maternal and Child Health Voucher Scheme would be more effective in the short to medium term, with a social health insurance model considered as a long-term objective.

The proposed voucher scheme should directly target IDPs, nomads, and rural populations, who face the greatest financial and access constraints. It would cover consultation fees and essential medicines for maternal and child health services, including common childhood illnesses, thereby removing point-of-service payment barriers for vulnerable households.

3. The findings indicate that first-born children are disproportionately more likely to be unvaccinated or to experience delayed treatment. In addition, approximately 34 percent of women report experiencing permission-related barriers to accessing healthcare, highlighting the influence of household decision-making dynamics on child health outcomes.

We propose a First-Born Navigator Program that will

deploy Community Health Workers (CHWs) as dedicated “navigators” for first-time mothers. These CHWs will engage not only mothers but also household decision-makers, including fathers and elders, to improve awareness, trust, and timely healthcare-seeking behavior.

The program recognizes that physical proximity to health facilities (e.g., within 1 km) does not necessarily translate into access, as economic, cultural, and decision-making constraints often pose more significant barriers.

Key components of the program should include:

- » Targeted counselling and follow-up for first-time mothers;
- » Household-level engagement to address permission and decision-making barriers;
- » Health education focusing on the critical 6–11 month period, when children are most vulnerable to illness and missed vaccinations;
- » Facilitation of rapid decision-making and referral pathways for prompt care-seeking.

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Table 3.1 Child's Weight and Size At Birth

Percentage of live births in the five years preceding the survey that have a reported birth weight; percent distribution by birth weight; and percent distribution of all live births in the five years preceding the survey by mother's estimate of baby's size at birth, according to background characteristics, SDS 2026

Background characteristic	Child born very large, large, average, small and very small				Total	Percentage of all births that have a reported birth weight	Number of births	Among births with a reported birth weight ¹		
	Large	Average	Very small	Don't know				Less than 2.5 kg	2.5 kg or more	Number of births
Mother's age at birth										
<20	3.2	85.4	9.7	1.6	100.0	100.0	371	23.5	76.5	371
20-34	3.9	84.8	11.0	0.3	100.0	99.8	2805	19.9	79.9	2799
35-49	2.7	88.0	8.2	1.1	100.0	99.7	1139	18.7	81.0	1136
Total	3.5	85.7	10.1	0.6	100.0	99.8	4315	19.9	79.9	4306
Districts										
Kahda	5.9	76.5	17.5	0.1	100.0	99.6	1056	14.7	84.9	1052
Dhusamareeb	6.8	85.4	7.0	0.7	100.0	99.8	541	12.0	87.8	540
Baidoa	0.4	90.0	7.5	2.0	100.0	99.7	689	60.2	39.5	687
Belet weyne	4.3	83.9	8.3	3.5	100.0	100.0	230	11.7	88.3	230
Kismayo	2.2	89.8	7.9		100.0	99.9	1799	11.0	88.9	1797
Total	3.5	85.7	10.1	0.6	100.0	99.8	4315	19.9	79.9	4306
Enumeration Area Type										
Rural	4.5	84.5	9.1	1.8	100.0	100.0	220	6.4	93.6	220
Urban	3.3	86.1	10.3	0.4	100.0	99.8	3104	19.2	80.6	3098
Nomadic	14.3	71.4	14.3		100.0	100.0	7		100.0	7
Idp	4.1	85.1	9.9	1.0	100.0	99.7	984	25.3	74.4	981
Total	3.5	85.7	10.1	0.6	100.0	99.8	4315	19.9	79.9	4306
1 Based on either a written record or the mother's recall										

¹ Based on either a written record or the mother's recall

Table 3.2 Immunization Coverage

Percentage of children age 12-23 months who received specific vaccines at any time before the survey (according to a vaccination card or the mother's report), and percentage with a vaccination card, by background characteristics, SDS 2026

Background characteristic	DPT/Pentavalent					Polio 1			Measles	All basic vaccinations	No vaccinations2	Percentage with a vaccination card	Number of children
	BCG	1	2	3	0	1	2	3					
Districts													
Kahda	74.4	66.0	54.8	40.3	70.4	70.4	54.5	31.4	57.2	20.8	22.5	56.0	2012
Dhusamareeb	71.3	64.4	51.0	34.1	67.1	67.1	50.8	24.4	59.9	19.4	26.2	59.0	913
Baidoa	61.5	46.3	34.7	18.5	53.0	53.0	36.2	19.1	46.5	11.3	36.3	43.9	2401
Beletweyne	53.0	36.1	27.9	18.3	42.1	42.2	31.8	13.7	38.4	6.9	43.8	43.5	1062
Kismayo	72.1	59.2	47.6	31.1	67.6	67.6	52.5	28.3	62.2	19.1	24.3	66.2	1831
Sex of Children													
Boy	68.0	55.9	44.7	29.6	61.9	61.9	46.4	24.5	53.9	15.9	29.0	54.2	4302
Girl	65.9	53.3	42.1	27.0	59.3	59.3	44.2	23.5	52.2	15.4	31.3	52.7	3916
Enumeration area type													
Rural	47.2	38.1	28.9	17.3	42.4	42.4	30.0	14.6	33.9	10.1	49.7	41.6	646
Urban	70.9	58.0	45.9	29.2	64.5	64.5	48.3	25.2	58.8	16.8	26.5	57.9	4568
Nomadic	35.2	33.0	20.5	11.4	33.0	33.0	22.7	9.1	29.5	8.0	58.0	26.1	88
IDP	66.3	53.8	43.4	29.9	59.6	59.6	44.8	24.9	49.0	15.5	30.5	50.0	2917
Total	67.0	54.7	43.4	28.3	60.7	60.7	45.4	24.0	53.1	15.7	30.1	53.5	8219

¹ Polio 0 is the polio vaccination given at birth

² BCG, measles, and three doses each of DPT and polio vaccine (excluding polio vaccine given at birth)

Table 3.3 Vaccinations by Background Characteristics

Percentage of children age 12-23 months who received specific vaccines at any time before the survey (according to a vaccination card or the mother's report), and percentage with a vaccination card, by background characteristics, SDS 2026													
Background characteristic	DPT				Polio 1				Measles	All basic vaccinations	No vaccinations ²	Percentage with a vaccination card	Number of children
	BCG	1	2	3	0	1	2	3					
Birth order													
1	61.1	50.8	40.8	26.1	56.0	56.1	41.1	22.3	47.9	13.8	36.1	50.8	1544
2-3	66.8	52.6	40.2	24.7	59.3	59.3	43.0	21.6	53.1	13.2	30.4	53.3	2652
4-5	69.8	57.1	46.2	30.5	63.7	63.7	48.0	25.2	56.1	17.0	26.9	54.5	2021
6+	69.1	57.9	47.1	32.7	63.0	63.0	49.2	27.4	54.0	19.2	28.2	54.7	2002
Mother's survival status													
Mother alive	67.1	54.7	43.5	28.4	60.7	60.7	45.4	24.0	53.1	15.7	30.0	53.5	8192
Mother dead	44.4	40.7	37.0	22.2	44.4	44.4	37.0	22.2	37.0	18.5	48.1	40.7	27
Mother live in this household													
Yes	67.3	54.9	43.7	28.5	60.9	61.0	45.6	24.2	53.3	15.7	29.8	53.8	8101
No	44.0	37.4	25.3	18.7	41.8	41.8	28.6	13.2	36.3	11.0	52.7	30.8	91
Single births or twins													
Single	66.9	54.5	43.3	28.3	60.5	60.6	45.2	23.9	52.9	15.6	30.1	53.4	8091
Multiple	71.9	64.8	52.3	33.6	68.8	68.8	54.7	30.5	62.5	22.7	26.6	60.9	128
Total	67.0	54.7	43.4	28.3	60.7	60.7	45.4	24.0	53.1	15.7	30.1	53.5	8219
1 Polio 0 is the polio vaccination given at birth													
2 BCG, measles, and three doses each of DPT and polio vaccine (excluding polio vaccine given at birth)													

Table 3.4 Prevalence and Treatment of Symptoms of ARI

Among children under age five, the percentage who had symptoms of acute respiratory infection (ARI) in the two weeks preceding the survey and among children with symptoms of ARI, the percentage for whom advice or treatment was sought from a health facility or provider and the percentage who received antibiotics as treatment, according to background characteristics, SDS 2026					
Background Characteristic	Among children under age five		Among children under age five with symptoms of ARI		Number of children
	Percentage with symptoms of ARI 1	Number of children	Percentage for whom advice or treatment was sought from a health facility or provider	Percentage who received antibiotics	
Age in Months					
<6	4.5	419	42.1	26.3	54
6-11	7.2	1538	39.1	29.1	317
12-23	6.6	3441	35.8	21.7	597
24-35	5.7	2112	30.6	24.0	287
36-47	4.8	934	31.1	15.6	94
48-59	2.7	669	22.2	5.6	41
Enumeration Area Type					
Rural	4.2	932	43.6	38.5	83
Urban	4.4	5274	27.7	19.0	637
Nomadic	2.1	95			3
IDP	9.5	2812	39.7	24.0	667
Districts					
Kahda	9.9	2064	45.4	30.7	568
Dhusamareeb	4.7	955	53.3	37.8	91
Baidoa	6.6	2003	29.5	22.0	303
Belet weyne	3.2	1861	23.7	15.3	129
Kismayo	4.4	2230	17.3	5.1	299
Total	5.9	9113	34.7	22.8	1390
1 Symptoms of ARI (cough accompanied by short, rapid breathing which was chest-related and/or by difficult breathing which was chest-related) is considered a proxy for pneumonia					

Table 3.5 Prevalence and Treatment of Diarrhea

Among children under age five who had diarrhea in the two weeks preceding the survey, the percentage for whom advice or treatment was sought from a health facility or provider, the percentage given oral rehydration therapy (ORT), the percentage given increased fluids, the percentage given ORT or increased fluids, and the percentage given other treatments, by background characteristics, SDS 2026

Background characteristic	Percentage with diarrhea	Number of children	Among children under age 5 with diarrhea:	
			Percentage of children with diarrhea for whom advice or treatment was sought from a health facility or provider	Number of children with Diarrhea
Age in Months				
<6	9.8	419	63.4	41
6-11	16.0	1538	56.5	246
12-23	12.7	3441	63.7	438
24-35	9.5	2112	61.7	201
36-47	6.4	934	61.7	60
48-59	3.9	669	38.5	26
Districts				
Kahda	21.8	2064	58.2	450
Dhusamareeb	6.1	955	51.7	58
Baidoa	9.9	2003	66.8	199
Belet weyne	4.5	1861	57.8	83
Kismayo	10.0	2230	64.0	222
Enumeration area type				
Rural	5.2	932	60.4	48
Urban	8.7	5274	63.0	459
Nomadic	1.1	95		1
IDP	17.9	2812	58.9	504
Total	11.1	9113	60.8	1012

Note: ORT includes fluid prepared from oral rehydration salt (ORS) packets, pre-packaged ORS fluid, and recommended home fluids (RHF).

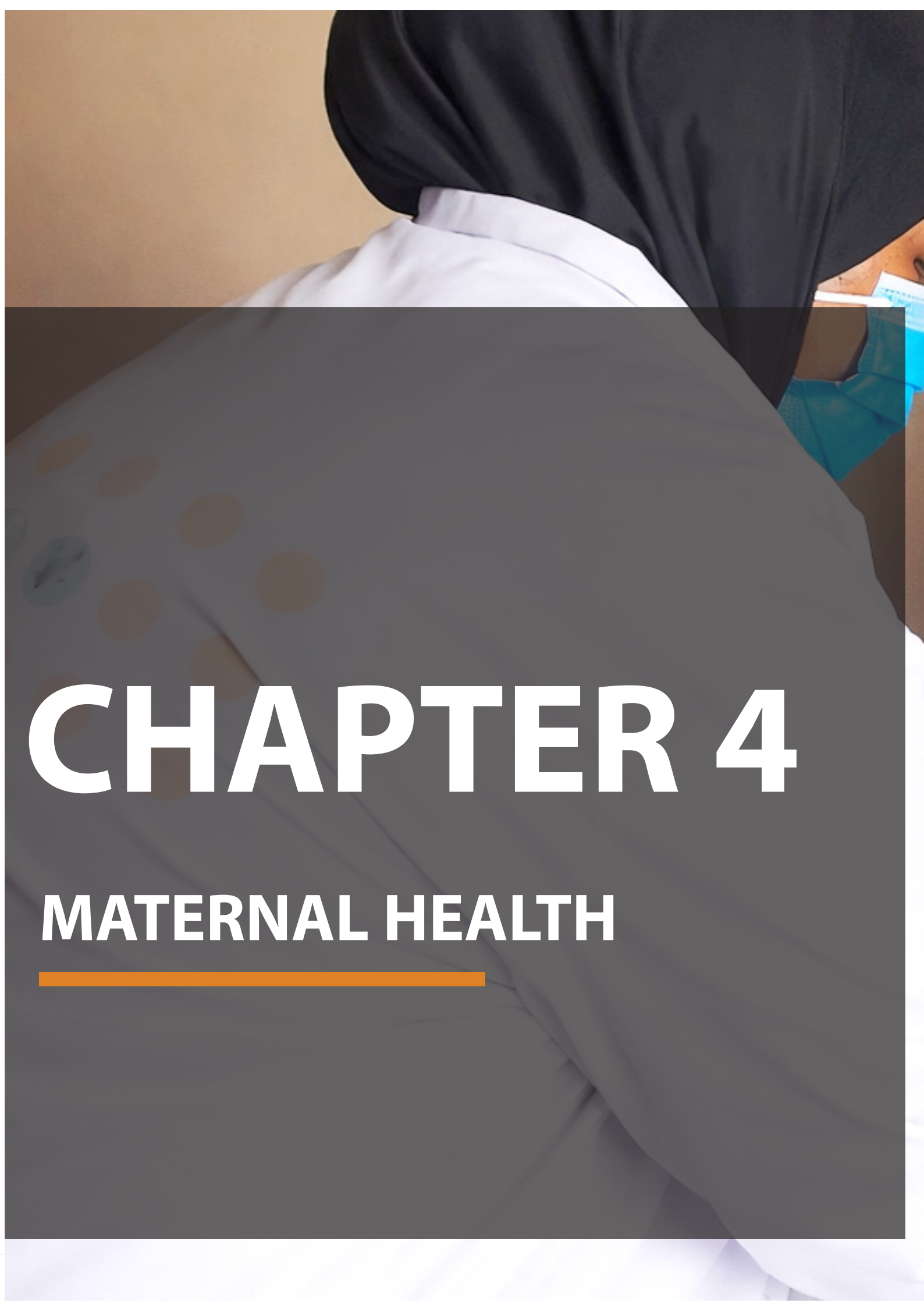
Table 3.6 Prevalence and Treatment of Fever

Among children under age five, the percentage who had a fever in the two weeks preceding the survey and children with fever, the percentage for whom advice or treatment was sought from a health facility or provider, percentage who took antimalarial drugs, and the percentage who received antibiotics as treatment, by background characteristics, SDS 2026

Background characteristic	Among children under age five:		Among children under age five with fever:		Number of children with fever
	Percentage with fever	Number of children	Percentage for whom advice or treatment was sought	Percentage who took antibiotic drugs	
Age in Months					
<6	8.1	419	44.1	26.5	34
6-11	15.7	1538	38.6	25.3	241
12-23	13.6	3441	43.7	27.5	469
24-35	13.7	2112	34.8	22.1	290
36-47	11.3	934	33.0	25.5	106
48-59	11.2	669	24.0	12.0	75
Districts					
Kahda	25.6	2064	37.1	29.0	528
Dhusamareeb	10.2	955	51.5	33.0	97
Baidoa	10.2	2003	42.9	27.8	205
Belet weyne	8.4	1861	26.8	14.0	157
Kismayo	10.2	2230	39.9	15.4	228
Enumeration Area Type					
Rural	8.6	932	37.5	30.0	80
Urban	11.3	5274	35.3	22.6	598
Nomadic	5.3	95	20.0	20.0	5
IDP	18.9	2812	42.3	26.1	532
Total	13.3	9113	38.4	24.6	1215

Table 3.7 Availability of Health Facility, Distance To Health Facility and Type of Health Facility

Availability & Access to HF	District					Total
	Kahda	Dhusamareeb	Baidoa	Belet weyne	Kismayo	
Health facility available in settlement/IDP camp	91.5	79.9	82.1	79.6	90.7	85.4
Distance to the health facility						
Less than 1 km	92.5	83.7	89.7	81.6	91.4	88.7
1 KM	1.1	1.3	3.1	1.4	3.0	2.2
2-3 KM	3.1	1.5	0.9	0.7	2.1	1.7
4-5 KM	2.1	0.7	0.1	0.2	0.4	0.6
More than 5 km	0.3	6.9	0.1	0.2	0.1	1.0
Don't know	0.4	4.1	5.0	12.0	0.8	4.1
Access to Public Health Facilities	90.3	96.5	99.2	89.6	95.7	94.7
Access to Private Health Facilities	29.2	11.8	4.8	14.3	6.7	12.8



CHAPTER 4

MATERNAL HEALTH



Chapter Four summarizes key findings on maternal healthcare across the five surveyed districts, covering antenatal care (ANC), delivery, and postnatal care (PNC). It highlights the use and quality of maternal health services and their importance for improving the health and survival of mothers and newborns.

KEY FINDINGS

ANTENATAL CARE COVERAGE

45%



of women received
skilled health professional
ANC during their last pregnancy

Baidoa:	30%
Beletweyne:	31%
Dhusamareeb:	55%
Kahda:	60%
Kismayo:	49%



40%

Had zero ANC visits



Baidoa:	40%
Beletweyne:	65%
Dhusamareeb:	40%
Kahda:	29%
Kismayo:	31%

38%

of the last births were protected against neonatal tetanus

Baidoa:	37%
Beletweyne:	33%
Dhusamareeb:	40%
Kahda:	38%
Kismayo:	41%

46%

of births delivered in a health facility



Baidoa:	38%
Beletweyne:	26%
Dhusamareeb:	65%
Kahda:	47%
Kismayo:	60%

82%

of mothers intend to circumcise their uncut daughter

Baidoa:	87%
Beletweyne:	77%
Dhusamareeb:	74%
Kahda:	86%
Kismayo:	82%



4.1 Introduction



This chapter outlines the key findings on maternal healthcare for the five surveyed districts, focusing on antenatal care (ANC), delivery, and postnatal care (PNC). These services are essential for meeting key health policy objectives across the five surveyed districts and Somalia more broadly. By understanding these findings, policymakers and health professionals can design better strategies to reduce maternal morbidity and mortality rates among mothers and newborns. The findings highlight the quality of ANC, including the number of check-ups and medical services received, as well as the safety of delivery where the birth took place, who assisted the birth, and the availability of postnatal care for both mothers and newborns. The ANC data pertains to the most recent birth to a woman in the last five years.

4.2 Antenatal care

Table 4.1 presented at the bottom of this chapter, illustrates the percentage distribution of women aged 15 to 49 who had a live birth in the five years preceding the survey by the type of ANC provider they consulted. This information is vital in understanding access to ANC during pregnancy, which directly affects the survival and health of both mothers and babies. Overall, only 45 percent of the women reported that they received antenatal care from a skilled health provider during their most recent pregnancy.

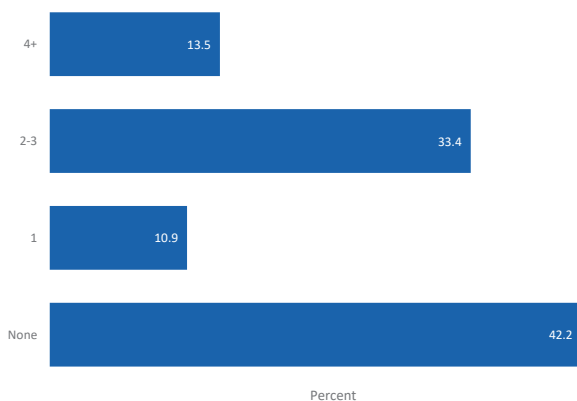
Among those who sought ANC, 40 percent received care from a nurse, midwife, or auxiliary midwife, while only 5 percent sought care from a doctor or clinical officer. Traditional birth attendants (TBA) or community health workers provided care to 16 percent of mothers interviewed and a staggering 40 percent of women received no antenatal care at all. Kahda reported the highest proportion of women that sought care from a skilled provider at 60 percent, followed by Dhusamareeb at 55 percent and Kismayo at 49 percent. In contrast, coverage is much lower in Beletweyne at 31 percent and Baidoa at 30 percent, where roughly seven out of ten women do not have access to skilled providers during pregnancy.

The urban advantage is evident in ANC attendance where twice as many -50 percent mothers sought skilled ANC care compared to the nomadic 24 percent and rural 29 percent. Internally Displaced Persons (IDPs) fall in the middle, with 39 percent accessing skilled care. These disparities further highlight that 76 percent of nomadic mostly located in the temporary nomadic settlements near the villages and 60 percent of rural women reported receiving no antenatal care whatsoever compared to 35 percent among the urban women and 41 percent among the IDPs, emphasizing an urgent need for better healthcare outreach in these underserved environments.

4.2.1 Number of antenatal care visits and timing of first visit

Figure 4.1 and 4.2 present a detailed overview of antenatal care (ANC) utilisation, focusing on both the number of visits and the timing of the first visit respectively, which are critical for ensuring a healthy pregnancy and safe delivery outcomes. Among women who sought ANC services, 11 percent attended only once, 33 percent reported between two and three visits, while only 14 percent achieved the recommended minimum of four or more visits (Figure 4.1).

Figure 4.1 Number of ANC Visits

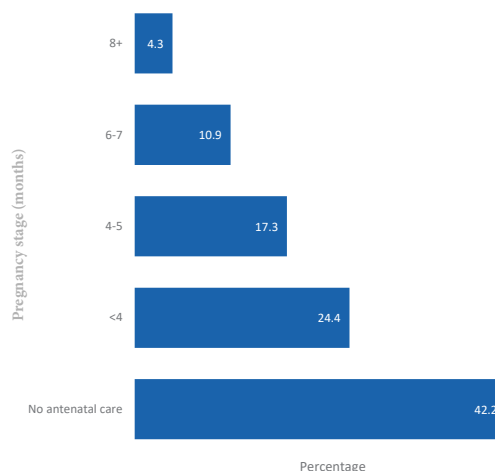


The median timing of the first ANC visit was at four months of pregnancy. However, only 24 percent of women initiated ANC early, before the fourth month (Figure 4.2). A further 17 percent began care during the fourth or fifth month, while approximately 15 percent delayed their first visit until six months of pregnancy or later. These patterns indicate generally late initiation of antenatal care services.



Median age at first ANC visit is 4 months. Urban mothers typically have their first visit at 4 months while rural, nomadic and IDP generally wait until their 5th month.

Figure 4.2 Timing of First Visit



Place of residence also influenced the timing of ANC initiation. Urban mothers typically commenced ANC around the fourth month of pregnancy, whereas rural, nomadic, and internally displaced persons (IDP) mothers generally initiated care later, around the fifth month. Overall, these findings highlight significant disparities in access to and utilisation of antenatal care services, underscoring the need for strengthened outreach, improved health education, and targeted interventions for vulnerable populations.

4.2.2 Components of Antenatal Care

The content of ANC is a vital element in the quality of maternal health services provided during pregnancy. Beyond basic care, every pregnant woman should be monitored for potential complications. It is important that all ANC visits routinely include educating pregnant women and screening them for any complications.

Table 4.3 presented at the end of this chapter, provides a comprehensive overview of the components of ANC received by women in the surveyed districts during their pregnancy check-ups highlighting significant variation across districts and the received essential medical care, such as taking iron supplements to prevent anemia, and undergoing vital screenings like blood pressure checks and blood or urine testing during pregnancy. The components provided include the provision

of iron tablets or syrup, administration of intestinal parasite drugs, and various health assessments such as blood pressure, urine, and blood sampling. By examining these components, the survey results reveal the quality of care provided and identify which districts are successfully delivering these life-saving health assessments. Healthcare services during pregnancy vary significantly depending on where a woman lives.

Blood pressure checks are the most common service provided, while iron supplementation remains consistently low. Overall 93 percent of women reported they had their blood pressure checked, fewer received blood and urine tests (87 percent and 85 percent, respectively), and 85 percent providing urine samples to screen for underlying health issues. These high figures suggest that when women do reach a clinic, healthcare providers are consistently performing these essential physical assessments.

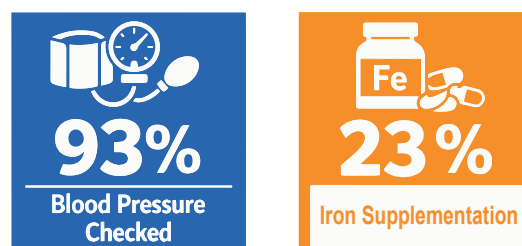
Dhuusamareeb and Kismayo lead in medical screening both reaching a near-perfect 98 percent for blood pressure checks and over 90 percent for urine tests. Baidoa recorded the least proportion in routine monitoring with 85 percent of women having had their blood pressure checked and 74 percent having their urine tested.

From a geographic perspective, urban women generally receive more comprehensive care than those in rural or IDP residence who are less likely to have their blood pressure or urine monitored compared to their urban counterparts, highlighting a need for better resource allocation in these underserved environments.

Despite the success in screening, there is a gap in preventative treatment. Iron supplementation, which is vital for preventing anemia and maternal exhaustion, remains strikingly low at 23 percent. Disparities across districts are apparent, Kahda, shows a strong focus on monitoring, with an impressive 96 percent of women getting their blood pressure checked, 88 percent undergoing blood and 91 percent urine tests respectively. However, only 30 percent of women reported taking iron supplements.

In Dhusamareeb the survey results reveal that use of iron supplements is lower with only 22 percent of women reporting they took iron supplements, while in Baidoa, the uptake of iron supplements was lowest at 17 percent. However, the district reported that 34 percent of women received intestinal parasite drugs, which can play a crucial role in maternal health, particularly in regions where such infections are prevalent. Kismayo stands out with a high 58 percent uptake of intestinal parasite medications, the highest among all the surveyed districts, suggesting a targeted initiative in this area, while only 26 percent of women took iron supplements.

The influence of experience and place of residence plays a critical role significantly impacting the care a woman receives. Interestingly, experienced mothers (those with six or more children) are the most likely to take iron supplements at 33 percent compared to first-time mothers recording 10 percent.



4.2.3 Tetanus Toxoid Vaccination Trend

Tetanus toxoid injections are a vital part of a healthy pregnancy, administered during pregnancy to prevent neonatal tetanus, a major cause of early infant mortality in many developing nations, commonly linked to inadequate hygiene during childbirth.

Table 4.4 presented at the end of this chapter, provides important insights into maternal health by illustrating the percentage of women aged 15-49 who experienced a live birth in the five years preceding the survey who received tetanus toxoid injection. Specifically, it highlights those who received two or more tetanus toxoid injections during their most recent pregnancy, categorized by birth order, residence, and district.

The survey shows a clear link between a mother's birth order and tetanus protection: first time mothers are more likely to receive two or more tetanus injections during pregnancy at 29 percent compared to mothers pregnant with their sixth or more child at 21 percent. The percentage declines with subsequent births: 26 percent for women having a second or third child, 23 percent for those having their fourth or fifth child. Interestingly, the percentage of last live births protected against neonatal tetanus appears to be better for mothers with more than one child. The findings show that 33 percent of first-time mothers indicated their children were protected against neonatal tetanus compared to 40 percent of children of birth order six and above. This disparity may indicate that mothers with more experience might be more aware of the importance of receiving vaccinations during pregnancy and ensure they get at least one dose of tetanus vaccine. This raises the need for awareness among all mothers on the importance of getting at least two doses of tetanus during pregnancy.

The survey findings also reveal that healthcare access for tetanus protection varies depending on the place of residence. In rural areas, only 17 percent of women received the recommended two or more tetanus injections, and just 24 percent of their last live birth was protected from neonatal tetanus. In contrast, urban women showed slightly higher rates, with 27 percent receiving the minimum two doses and 41 percent having protected births. Internally displaced persons fell somewhere in between, with 22 percent receiving the minimum two injections and 36 percent having protected births. These variations highlight the impact of access to healthcare resources across the different types of residents which remain a major barrier to receiving life-saving vaccinations, highlighting the urgent need for better healthcare resources in these underserved areas.

Analysis of tetanus protection by district reveals that while vaccination rates during pregnancy are similar across most districts,

the actual protection for newborns varies. Kismayo leads with 41 percent of last live births being protected against neonatal tetanus, followed closely by Dhusamareeb and Kahda at approximately 40 percent and 38 percent, respectively. In contrast, Beletweyne shows the lowest safety levels, with only 33 percent of last live births protected. These differences highlight how local variations in healthcare access and vaccination history directly affect the health and safety of both mothers and their infants across the country.

4.3 Delivery care and skilled attendance

To decrease maternal and neonatal morbidity and mortality, every child needs to be born with the support of trained skilled birth attendants. The choice of where to give birth is one of the most important decisions for a mother's and baby's health.

4.3.1 Place of delivery

Table 4.5 presented at the end of this chapter, illustrates the distribution of live births over the five years preceding the survey, categorized by place of delivery. The data reveals that 47 percent of births in the five years preceding the survey were delivered in a health facility, while more than half occurred at home—accounting for 53 percent of the total births. This preference for home deliveries may reflect cultural practices, or the lack of access to healthcare facilities, economic hardships, or personal choices regarding childbirth. Hospital deliveries present a window of opportunity for children to receive polio 0 which is given within the first 48 hours of life and other vaccines given at birth.

Deliveries in the public sector comprise 40 percent, indicating a significant reliance on public healthcare services for childbirth. On the other hand, 6 percent of births took place in a private facility.

Dhusamareeb and Kismayo lead in health facility deliveries with 65 percent and 60 percent respectively, reporting they delivered their last child in a health facility. Beletweyne and Baidoa lead in home deliveries at 74

percent and 62 percent, respectively. Kahda district reported 52 percent home births, while 47 percent were in a health facility.

Analysis by residence type reveals that the urban advantage is strong, with 55 percent of births delivered in health facilities, followed by IDPs at 37 percent, while the lowest is in rural and nomadic areas at 27 percent and 25 percent respectively. Worth noting, the nomadic households, mainly the women interviewed, were residing in settlements near urban centers due to the peak of the dry season; this proximity could influence the proportion of facility-based births.

The survey highlighted a powerful link between ANC attendance and place of delivery. The number of ANC visits increases the chances of a health facility delivery. Those reporting more than one visit are much more likely to deliver in a health facility. Among those who attended only one ANC visit, 56 percent delivered in a health facility compared to 71 percent among those who attended at least 4 ANC visits, and 21 percent among those with zero ANC attendance. Surprisingly, home deliveries exceed non-ANC attendance, contrary to expectation. While 40 percent did not attend ANC, 53 percent delivered at home. This means 14 percent of those who attended ANC did not deliver in a health facility. This calls for further investigations into why women opt to deliver at home even after attending ANC and more education to pregnant mothers on the importance of health facility delivery.



Home deliveries exceeded non-attendance at ANC 53% of births occurred at home, while 40% of women did not attend antenatal care (ANC)

4.3.2 Maternal Healthcare: Assistance During Delivery

Safe childbirth is a top priority for health policy, as having a trained professional present during delivery significantly reduces risks for both the mother and the newborn. This section examines who assisted women during childbirth in the five surveyed districts, highlighting the balance between modern medical care and traditional practices

Table 4.6 presented at the end of this chapter, illustrates the percent distribution of live births that occurred in the five years preceding the survey, categorized by person assisting in delivery. Overall, 63 percent of births in the surveyed districts were delivered with the assistance of a skilled health professional, which includes a doctor/clinical officer or a nurse/midwife/auxiliary midwife. The survey reveals that nearly half of the deliveries at 49 percent, were assisted by nurses, midwives, or auxiliary personnel, indicating a reliance on skilled healthcare workers during childbirth. The attendance by doctors, mostly gynecologists, is relatively low at 14 percent. TBAs played a significant role as well, assisting in approximately 34 percent of cases. In contrast, a small proportion of births were delivered by friends and relatives at 3 percent, highlighting the predominance of informal and formal healthcare providers in the childbirth process.

The survey results show that among women who attended four or more ANC clinics, the rate of professional assistance is at 80 percent, compared to women who did not receive any antenatal care; only 43 percent of those who did not seek professional ANC were assisted by a skilled health worker during delivery. Essentially, these pregnancy check-ups serve as a vital gateway, encouraging mothers to choose a health facility or hospital for delivery where they can get the life-saving support they need.

Among the surveyed districts, Dhusamareeb leads with the highest rate of professional assistance at 71 percent, followed by Kahda and Kismayo, both at approximately 67 percent. Baidoa has the lowest rate of professional support at 53 percent, whereas a higher number of mothers still rely on traditional attendants.

There is a sharp divide in the type of residence; 70 percent of urban women give birth with a skilled birth attendant, while only 47 percent of the rural mothers have access to the same level of skilled care. This highlights a significant need for better healthcare outreach to these underserved communities.

4.3.3 Caesarean Section

A Caesarean section or a C-section, is a life-saving surgery used when natural childbirth poses a risk to the mother or the baby. This section provides a comprehensive analysis of the percentage of live births delivered through C-section in the five years preceding the survey, specifically focusing on cases in which the decision for the surgical procedure was made after the onset of labor pains. The data is categorized according to various background characteristics, such as maternal age, birth order, districts and type of residence.

Table 4.7 presented at the end of this chapter, illustrates the percentage distribution of live births delivered by C-section in the five years preceding the survey, highlighting births that were determined to be C-sections post-onset of labor pains. This analysis is segmented by maternal age and birth order, revealing no significant variations in C-section delivery rates. Findings show a 6 percent c-section delivery rate in the past five years. Analysis by birth order reveals that first-time mothers have a slightly higher rate of C-section at 9 percent, contrasting with a slight decrease to 7 percent for second and third births, and 4 percent for subsequent births (6+). This data underscores there is no apparent relationship between maternal age and C-section delivery;

all age groups had a 6 percent rate of C-section deliveries.

The survey results show that ANC visits are not related to C-Section delivery; those with 2-3 visits recorded the least proportion of C-sections at 8 percent compared to those with one or 4 plus visits at 10 percent.

In specific districts, such as Kahda, only 6 percent of births had C-section delivery, while Dhusamareeb and Baidoa reported almost the same rates at 6 percent and 5 percent respectively. Notably, Beletweyne exhibited the lowest incidence of C-sections at just 3 percent, whereas Kismayo had a considerably higher rate of 9 percent. It is worth noting that only 27 percent of births in Beletweyne happened at a health facility compared to 60 percent of deliveries in Kismayo. This underscores the potential consequences of delivery-related complications for home deliveries.

For place of residence, urban areas lead in surgical deliveries, with 8 percent of births occurring through C-section. In contrast, rural and nomadic residents both report a significantly lower rate of 3 percent. Internally displaced persons sit slightly higher than those groups, with C-sections accounting for 4 percent of births.

4.4 Postnatal care

Many maternal and neonatal deaths happen within the first 48 hours of delivery. After delivery, mothers are at risk of serious conditions like postpartum hemorrhage, infections, and high blood pressure. Safe motherhood programs have placed greater emphasis on postnatal care, advocating for all women to have a health check-up within two days of giving birth. To evaluate the coverage of postnatal care (PNC) in the surveyed districts, the respondents who had given birth in the five years before the survey were asked if they received a health check after their most recent delivery. Figure 4.3 shows analysis of the timing of the first PNC check up for mothers.

Figure 4.3 reveals a concerning gap in maternal healthcare, as a staggering 88 percent of mothers did not receive any post-natal check-up; 90 percent among those who delivered through the normal childbirth process, and 46 percent among those who delivered through C-section. Only 9 percent of mothers received PNC within the first 6 hours of birth, 35 percent of those who delivered through C-section, and 7 percent of those who had normal deliveries. The probability of PNC reduces as the period after delivery increases.

These figures suggest that the vast majority of new mothers are navigating the critical recovery period without any professional health assessment, essential for their recovery and well-being during the crucial postpartum period. It also highlights a gap in maternal health service delivery, where 46 percent of births happened in a health facility but only 12 percent were reviewed after delivery, with only 9 percent getting a check-up within the first 6 hours, 2 percent within 1-2 days and 2 percent on the third day and above. While all mothers need postnatal care, C-section mothers need closer and more careful follow-up because of the added risks from surgery, but less than 50 percent received PNC.

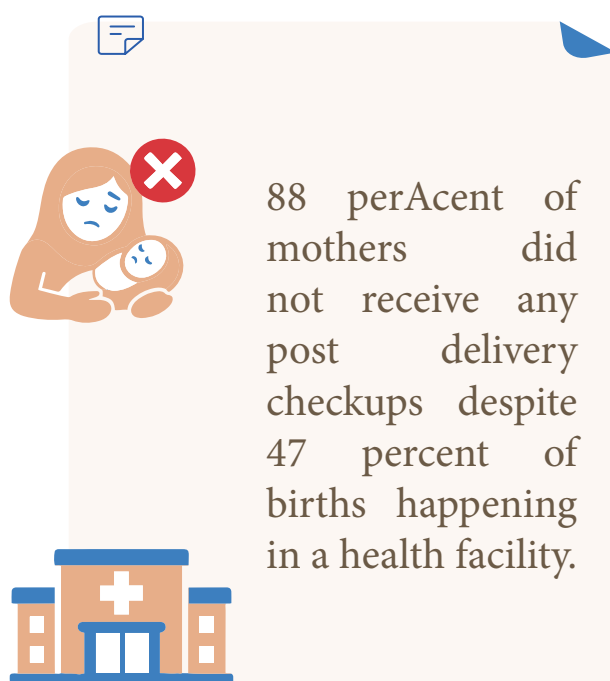
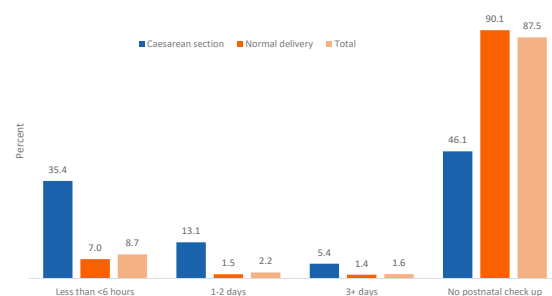


Figure 4.3 Timing of First Post-Natal Check-up for the Mothers by Type of Delivery



4.5 Maternal health complications.

Pregnancy and childbirth are transformative experiences, but they also come with specific health risks that require careful monitoring. Table 4.8 presented at the end of this chapter, shows data on pregnancy complications experienced by women aged 15-49, categorized by specific complications. Pregnancy/antepartum complications were reported by 16 percent of women interviewed. Notably, women in IDP residences faced the highest percentage of antepartum complications at 21 percent, indicating significantly greater risks compared to other groups. Urban women exhibited a 16 percent rate for delivery complications, while rural women reported 10 percent. The data also reveals that nomadic women experienced some of the lowest rates at 9 percent. It is worth noting that urban mothers had better access to professional health care, hence more likely to get detected.

During pregnancy, severe vomiting is noted as the most common issue, affecting 9 percent of women. Following closely behind, anemia emerges as a prevalent concern, impacting 8 percent of expectant mothers, which can lead to fatigue and increased risks during pregnancy if not addressed effectively. Malaria is also a notable complication, reported by 4 percent of women, underscoring the importance of preventive measures in areas where this disease is endemic. Meanwhile, bleeding during pregnancy is documented

at 4 percent, which can pose significant risks to both maternal and fetal health. Additional complications include swelling of limbs at 3 percent and urinary tract infections (UTIs) at 2 percent. Prolonged labour, another serious issue, also affects 2 percent of women, emphasizing the need for efficient healthcare interventions during childbirth. Overall, these statistics shed light on the various health risks associated with pregnancy, underscoring the necessity for comprehensive healthcare and support systems to improve outcomes for women during this vulnerable stage.

Where a woman lives significantly impacts the likelihood of facing these health challenges; the IDP residence faced the highest rate of pregnancy-related complications at 21 percent. Kahda and Baidoa districts reported the highest rates of pregnancy complications at 23 percent and 21 percent followed closely by Kismayo at 17 percent. In contrast, Beletweyne reported the lowest rate at approximately 7 percent.

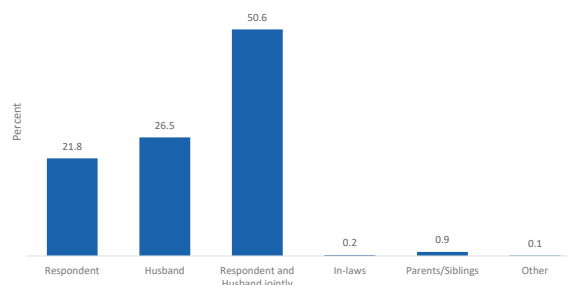
4.6 Gender Roles and Health Care Decision-Making

Health care decision-making is strongly influenced by gender roles, which shape who has authority, autonomy, and responsibility in seeking and utilising health services within households. Understanding these dynamics is essential for explaining patterns of delayed care, differential access to services, and variations in maternal and child health outcomes across different population groups. Figure 4.2 shows an analysis of the responsibility for health care decision-making in the household.

Figure 4.4 shows that household decision-making on health is largely shared between spouses, with 51 percent of decisions made jointly by the respondent and her husband. However, a notable proportion of decisions are still made independently by husbands at 27 percent compared to the women themselves at 22 percent, indicating that women's autonomy in health-related

decisions remains somewhat limited. The role of extended family members, such as in-laws (less than one percent) and parents/siblings (one percent) is minimal, suggesting that decision-making is primarily concentrated within the nuclear household. These findings emphasize the role of male involvement and women's empowerment in maternal health care.

Figure 4.4 Household Decision Making on Health Care



4.7 Female Genital Mutilation/Circumcision

Female genital mutilation (FGM), often called female circumcision, is deeply rooted in Somali culture, making the country one of the highest prevalence rates globally. As presented in Table 4.9 (at the end of this chapter), overall, 92 percent of Somali women have undergone female circumcision, with the Pharaonic type being the most prevalent, affecting 53 percent of them. Additionally, the findings indicate that 19 percent of women have undergone the Intermediate type, while 27 percent have had the Sunni type.

Figure 4.5 illustrates the distribution of women of 15 to 49 years who have undergone FGM/C, segmented by age group. In the youngest cohort, aged 15-19, 90 percent reported having experienced FGM/C, with 33 percent identifying as Sunni, 24 percent as Intermediate, and 42 percent as Pharaonic (Table 4.9).

For the 20-24 age group, with 91 percent having undergone FGM/C (Figure 4.5), where 31 percent are Sunni, 24 percent are Intermediate, and 43 percent are

Pharaonic, while in the 25-29 age group 92 percent reported FGM/C, 31 percent Sunni, 21 percent Intermediate, and 47 percent Pharaonic (Table 4.9).

Among women from the 30-34, the prevalence rises to 94 percent (Figure 4.5), 22 percent identify as Sunni, 17 percent as Intermediate, and 61 percent as Pharaonic. The percentages for the 35-39 age group are similarly high at 94 percent, where 22 percent are Sunni and 62 percent Pharaonic (Table 4.9). Among the 40-44 age cohort, 94 percent reported having undergone FGM/C, with 17 percent reporting Sunni and 14 percent intermediate, while those identifying as Pharaonic increased to 68 percent (Table 4.9).

The data suggest that the overall prevalence of FGM/C has remained consistently high across generations, with only a very slight decline among younger women. However, the distribution of FGM/C types shows an important generational shift. Younger cohorts reported lower proportions of the more severe Pharaonic form and relatively higher proportions of Sunni and Intermediate forms compared to older women.

Figure 4.5: Distribution of Circumcised Women Aged 15–49 Years, by Age Group

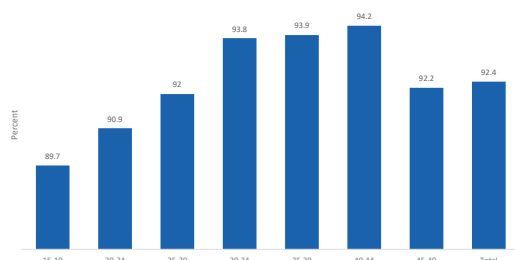


Figure 4.6 illustrates the percentages of women aged 15 to 49 who have undergone female circumcision across different districts. In Kahda, 93 percent of women reported having gone through FGM/C, with the breakdown showing that 19 percent underwent the Sunni type, 19 percent the Intermediate type, and the majority, at 69 percent, underwent the Pharaonic type. In Dhusamareeb, the prevalence is slightly lower at 90 percent, with 17 percent identifying their cut as Sunni, 17 percent as Intermediate, and 65 percent as

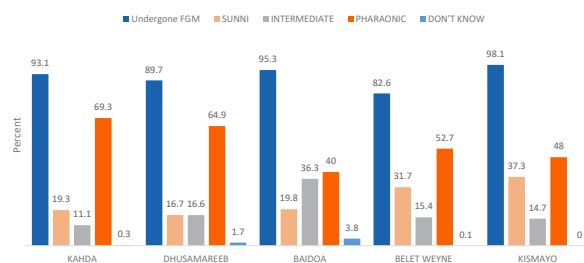
Pharaonic.

Baidoa shows a higher rate at 95 percent, where 20 percent had the Sunni cut, 36 percent Intermediate, and 40 percent Pharaonic. Baidoa has the highest prevalence of those who underwent the Intermediate type of cut.

Beletweyne reports 83 percent of women having undergone FGM/C, with the breakdown showing 32 percent are Sunni, 15 percent Intermediate, and 53 percent Pharaonic.

Lastly, Kismayo stands out with an even higher rate at 98 percent, where 37 percent of women fall into the Sunni category, 15 percent in the Intermediate category, and 48 percent the Pharaonic category, with no women in this district reporting uncertainty about the type. These statistics highlight significant district variations in the practice of female circumcision among Somali women.

Figure 4.6: Prevalence of Female Genital Mutilation/Cutting (FGM/C) Among Women Aged 15–49 Years, by District



4.7.1 Intention to Perform FGM

Mothers' intention not to subject their daughters to FGM/C is a critical factor in ending the practice, as intention strongly influences future behavior, particularly in family-based decision-making. It serves as an important indicator of progress toward the abandonment of FGM/C. Beyond protecting individual girls, mothers' intentions contribute to broader and long-term social change aimed at eliminating the practice.

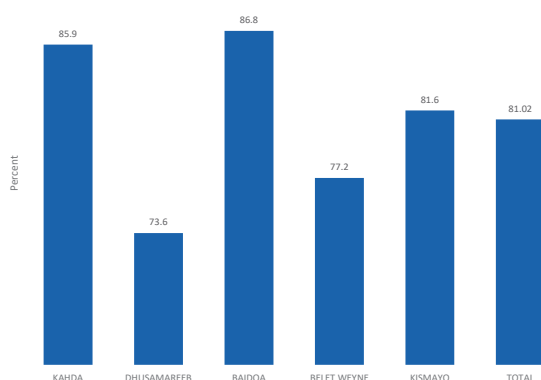
Figure 4.7 presents the proportion of women who intend to subject their uncircumcised daughters to FGM/C across the five districts. The findings reveal substantial variation

between districts, although the overall prevalence of intention remains high. On average, 82 percent of women across the five districts reported that they intend to subject their daughters to the practice.

Baidoa recorded the highest proportion, with 87 percent of women expressing the intention to perform FGM/C on their daughters, indicating a particularly strong persistence of the practice in the district. Kahda followed closely at 86 percent, while Kismayo, at 82 percent, reflected the overall average across the study areas. Lower proportions were observed in Beletweyne with 77 percent and 74 percent in Dhusamareeb, suggesting comparatively greater progress toward reducing support for the continuation of FGM/C in these districts.

These percentages collectively underscore the persistent cultural attitudes towards FGM/C, suggesting that despite ongoing efforts for awareness and education regarding the harmful effects of such practices, there remains a strong inclination among a significant portion of women to continue the tradition of FGM on their daughters. This raises critical questions about the effectiveness of interventions and the necessity for more comprehensive strategies to change such deeply entrenched beliefs and practices within these communities.

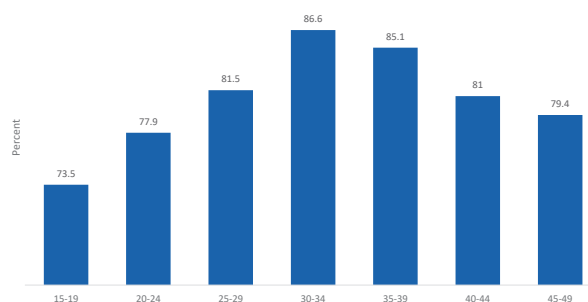
Figure 4.7: Percentage of Mothers Intending to Subject Their Daughters to FGM/C, by District



Mothers' age is an important factor in understanding attitudes toward FGM/C, as generational differences may influence the intention to continue or discontinue the practice. Examining intentions to circumcise daughters across age groups provides insight into the persistence of social norms and the extent of changing perceptions toward FGM/C over time. Figure 4.6 presents mothers age and their intention to circumcise their daughters.

Figure 4.8 reveals the intention to circumcise daughters increases with age, peaking among mothers aged 30–34 at 87 percent, and remains consistently high across older groups. Even among younger mothers (15–19), a substantial majority of 74 percent intend to continue the practice. These findings indicate that FGM/C remains deeply rooted across generations, with only limited signs of decline among younger women. Overall, the persistence of high intention suggests slow progress in shifting social norms.

Figure 4.8 - Mothers intention to perform FGM on Daughters by Mother's Age-Group



Somalia: 92% of women have already undergone FGM, most through the highly dangerous Pharaonic type. Yet 82% of mothers still intend to circumcise their daughters showing that the practice remains deeply rooted and that urgent awareness is needed.





4.8 Conclusions and Recommendations

4.8.1 Conclusions

Gateway Effect of ANC: Antenatal care is not only vital for monitoring complications but serves as a primary driver for facility-based delivery. The data proves that increasing ANC visits directly increases the likelihood of a safe, facility-based birth.

Link between ANC attendance and health facility delivery: The survey reveals a strong positive association between the number of ANC visits and facility-based deliveries. However, a concerning gap persists, 14 percent of women who attended ANC still opted for home delivery.

Vulnerability of First-Time and Young Mothers: Awareness of the significance of maternal health services is lowest among young mothers and those with first-order children, who are more likely to miss essential care.

The data highlights a significant gap in postnatal care (PNC) utilization, with the overwhelming majority of mothers—particularly those who delivered normally—failing to receive any professional follow-up during the critical postpartum period. Even among mothers who delivered in health facilities, PNC coverage remains alarmingly low, indicating missed opportunities within the healthcare system. Although mothers who underwent C-sections had relatively higher PNC access, coverage is still insufficient given their elevated risk of complications such as surgical site infection and postpartum hemorrhage. Overall, the findings point to systemic weaknesses in continuity of maternal care after delivery.

4.8.2 Recommendations

Integrated ANC-PNC Outreach: Given the 62 percent ANC gap and 88 percent PNC gap, the Ministry of Health should prioritize community-based outreach that links ANC registration with a “PNC Commitment” plan.

Strengthen the link between ANC attendance and health facility delivery through targeted follow-up and behavior change interventions.

- » Conduct qualitative studies to understand the social-cultural and economic barriers and reasons why women who attend ANC still choose home delivery
- » Intensify community awareness and counseling during ANC visits on the importance of delivering in a health facility, with emphasis on birth preparedness and complication readiness.
- » Implement targeted follow-up mechanisms (e.g., SMS reminders, community health worker visits, or transport support) for women attending ANC to ensure they deliver at a facility.
- » Train ANC providers to actively discuss and address myths or concerns about facility delivery and promote the benefits of skilled birth attendance.

Prioritize High-Risk Districts: Tailored interventions and resource allocation for instance, special focus on Beletweyne to address its 74 percent home delivery rate and 33 percent neonatal tetanus protection rate (the lowest among surveyed districts).

Normalize Postnatal Checks for Natural Births: Facilities must implement a mandatory 24-hour observation period and a 48-hour follow-up protocol for all deliveries, specifically targeting the 90 percent of ‘normal delivery mothers who currently receive no follow-up. No mother should receive a discharge before any post natal checks.

Improve health system accountability: Establish protocols and monitoring systems to ensure healthcare providers consistently deliver PNC services.

Targeted Education for Young Mothers: Launch a “First-Born Safety” campaign to increase neonatal, infant, and maternal health literacy among first-time and young mothers, who are statistically more likely to miss out on ANC screenings and supplements and deliver aided by a TBA.

Strengthen Component Uptake: Address the “supply-side” gap where iron supplement uptake is as low as 26 percent, despite high blood pressure monitoring rates (98 percent).

Leverage Public-Private Reliance: Since 40 percent of deliveries already occur in the public sector, the government should focus on improving the quality of these services to encourage the 53 percent of “home delivery” mothers to transition to facility care.

To reduce maternal mortality, the 88 percent gap in postnatal care must be closed by utilizing ANC as a strategic tool to bring the 53 percent home births into a clinical environment.

Enhance women’s autonomy: Implement empowerment initiatives that improve women’s confidence, knowledge, and ability to make independent health decisions.

Engage men in maternal health: Target husbands through awareness campaigns so they actively support timely healthcare-seeking, including postnatal care.

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Table 4.1 Antenatal Care: Distribution of Women Who Had Live Births by Type of Antenatal Care Provider, SDS 2026

Background Characteristics	ANC Provider (Highest Qualification)				Unskilled /None	Skilled provider	Total (N)
	Doctor/Clinical Officer	Nurse/ Midwife/ Aux Midwife	TBA/CHW/Other	No ANC			
District							
Kahda	5.2	54.8	11.3	28.7	40.0	60.0	2,672
Dhusamareeb	5.3	49.6	4.7	40.1	44.8	54.9	1,308
Baidoa	5.0	24.7	30.2	40.1	70.2	29.7	2,689
Belet weyne	1.1	29.6	4.4	64.8	69.2	30.7	2,209
Kismayo	6.1	43.3	19.3	30.8	50.1	49.4	3,029
Residence							
Rural	3.9	25.0	11.4	59.5	71.0	28.9	1,223
Urban	4.5	45.4	14.7	35.1	49.8	49.9	7,326
Nomadic	5.3	18.3	0.8	75.6	76.3	23.7	131
IDP	5.2	33.6	19.9	41.3	61.2	38.8	3,227
Total	4.7	39.8	15.6	39.8	55.3	44.5	11,907
Note: If more than one ANC provider was mentioned, only the provider with the highest qualification is used. Skilled providers includes doctor/clinical officer and nurse/midwife/aux midwife.							

Table 4.2 Number of Antenatal Care Visits Distribution of Births By Number and Timing of Antenatal Care Visits, SDS 2026

		Residence				
		Rural	Urban	Nomadic	IDP	Total (N)
Number and timing of ANC visits						
Number of ANC visits						
None		62.2	38.0	77.9	42.7	42.2
1		9.6	10.1	3.1	13.4	10.9
2-3		21.3	35.7	15.3	33.5	33.4
4+		6.9	16.2	3.8	10.4	13.5
Total		100.0	100.0	100.0	100.0	100.0
Number of months pregnant at time of first ANC visit						
No antenatal care		62.2	38.0	77.9	42.7	42.2
<4		14.1	28.4	4.6	20.1	24.4
4-5		10.5	18.1	10.7	18.2	17.3
6-7		8.6	10.6	3.1	12.6	10.9
8+		3.8	3.9	2.3	5.6	4.3
Don't know/missing		0.7	1.1	1.5	0.7	0.9
Total		100.0	100.0	100.0	100.0	100.0
Number of women		1,223	7,326	131	3,227	11,907
Median months pregnant at first visit (for those with ANC)		5	4	5	5	4
Number of women with ANC		494	4,733	32	1,892	7,151

Table 4.3 Components of Antenatal Care Distribution of Births by Components of Antenatal Care Received, Sds 2026

Background Characteristics	Percentage who during pregnancy:			Among women who received ANC for their most recent birth			Number of women with ANC
	Took iron tablets or syrup	Took intestinal parasite drugs	Number of women	Services			
				Blood pressure measured	Urine sample taken	Blood sample taken	
Age at birth							
<20	15.8	29.2	867	84.6	81.4	80.6	527
20-34	23.0	31.8	8711	94.1	85.2	87.6	5,343
35-49	27.2	32.2	2329	94.1	86.8	87.4	1,281
Birth order							
1	9.5	35.3	2425	92.4	85.0	88.8	1,417
2-3	21.0	31.6	3726	93.0	84.7	86.6	2,221
4-5	27.9	31.7	2804	93.2	84.3	84.8	1,699
6+	33.1	29.0	2952	94.8	86.9	88.1	1,814
District							
Kahda	30.4	22.3	2672	95.7	88.1	91.3	1,905
Dhusamareeb	22.0	13.8	1308	97.6	94.2	93.6	779
Baidoa	17.1	34.3	2689	84.7	73.5	78.4	1,610
Beletweyne	20.0	14.4	2209	89.3	76.4	81.7	776
Kismayo	25.5	58.1	3029	97.9	91.5	89.3	2,081
Residence							
Rural	16.0	23.2	1223	92.3	86.4	84.6	494
Urban	24.4	33.5	7326	94.8	87.4	89.1	4,733
Nomadic	10.7	6.1	131	*	*	*	32
IDP	23.9	31.9	3227	90.0	79.2	82.3	1,892
Total	23.3	31.7	11907	93.4	85.2	87.0	7,151
Note: An asterisk indicates that a figure is based on fewer than 50 cases and has been suppressed							

Note: An asterisk indicates that a figure is based on fewer than 50 cases and has been suppressed.

Table 4.4 Tetanus Toxoid

Tetanus toxoid injections by background characteristics Distribution of birth order by tetanus toxoid vaccination status and newborn protection, SDS 2026			
Background Characteristics	Percentage receiving two or more injections during last pregnancy	Percentage whose last live birth was protected against neonatal tetanus	Number of women
Birth order			
1	28.6	33.2	2,425
2-3	25.8	38.1	3,726
4-5	23.0	38.8	2,804
6+	20.8	40.1	2,952
Residence			
Rural	16.6	24.0	1,201
Urban	27.2	41.3	6,925
Nomadic	13.3	17.7	113
IDP	22.3	36.3	3,668
District			
Kahda	21.0	37.6	2,672
Dhusamareeb	27.1	39.8	1,308
Baidoa	26.9	36.8	2,689
Beletweyne	23.4	33.3	2,209
Kismayo	25.1	41.2	3,029
Total	24.5	37.8	11,907

Table 4.5 Place of Delivery

Percent distribution of live births in the five years preceding the survey by place of delivery and percentage delivered in a health facility, according to background characteristics, SDS2026

Background characteristic	Health facility - sector		Non-facility delivery			Percentage delivered in a health facility 1	Number of births
	Public sector	Private sector	Home	Other	Total	Yes	
Antenatal care visits							
None / Don't know	19.1	1.5	78.7	0.2	100.0	20.7	4,987
1	48.3	8.0	43.6	0.2	100.0	56.3	1,278
2-3	57.6	7.8	34.2	0.3	100.0	65.4	3,936
4+	55.1	15.5	29.1	0.3	100.0	70.6	1,602
District							
Kahda	31.3	16.0	51.9	0.8	100.0	47.3	2,619
Dhusamareeb	52.8	12.5	34.4	0.0	100.0	65.3	1,302
Baidoa	37.2	0.6	62.0	0.2	100.0	37.8	2,678
Beletweyne	22.1	3.5	74.3	0.0	100.0	25.6	2,201
Kismayo	57.7	2.0	39.7	0.0	100.0	59.8	3,003
Residence							
Rural	24.2	2.3	73.4	0.0	100.0	26.5	1,196
Urban	46.5	8.5	44.6	0.1	100.0	55.0	6,847
Nomadic	20.7	4.5	74.8	0.0	100.0	25.2	111
IDP	33.6	3.3	62.5	0.6	100.0	36.9	3,649
Total	40.0	6.2	53.3	0.2	100.0	46.2	11,803

1 Includes only the most recent birth in the five years preceding the survey.

Table 4.6 Assistance During Delivery

Percent distribution of live births in the five years preceding the survey by person assisting in delivery and percentage of births assisted by a skilled provider, SDS 2026

Background characteristic	Doctor/Clinical Officer	Nurse/Midwife/Auxiliary	Traditional Birth Attendant	Relative/Friend/Other	No one	Missing/Other	Total	Percentage delivered by skilled provider ¹	Number of births
Number of ANC visits 2									
None	6.5	36.7	51.6	4.4	0.4	0.4	100.0	43.2	4,987
1	16.8	58.4	21.8	2.8	0.2	0.0	100.0	75.2	1,278
2-3	16.8	60.0	20.8	2.3	0.0	0.0	100.0	76.8	3,936
4+	24.2	55.4	18.5	1.7	0.1	0.0	100.0	79.6	1,602
Place of delivery									
Health facility	26.3	72.9	0.8	0.0	0.0	0.0	100.0	99.2	5,458
Elsewhere	2.4	29.2	62.1	5.9	0.4	0.0	100.0	31.6	6,323
Missing	*	*	*	*	*	*	*	*	22
District									
Kahda	12.1	54.9	27.9	5.1	0.0		100.0	67.0	2,619
Dhusamareeb	18.9	51.8	26.1	2.5	0.3	0.3	100.0	70.7	1,302
Baidoa	3.1	49.4	41.9	5.3	0.3	0.1	100.0	52.5	2,678
Belet weyne	10.0	50.3	38.4	0.8	0.4	0.1	100.0	60.3	2,201
Kismayo	24.1	42.7	31.0	1.7	0.1	0.5	100.0	66.8	3,003
Residence									
Rural	9.4	37.6	49.3	3.3	0.2	0.1	100.0	47.1	1,196
Urban	17.5	52.8	27.6	1.5	0.2	0.3	100.0	70.3	6,847
Nomadic	5.4	29.7	57.7	5.4	1.8	0.0	100.0	35.1	111
IDP	7.4	47.3	39.0	6.1	0.1	0.1	100.0	54.7	3,649
Total	13.5	49.4	33.6	3.2	0.2	0.2	100.0	62.8	11,803

Note: If the respondent mentioned more than one person attending during delivery, only the most qualified person is considered in this tabulation. 1 Skilled provider includes doctor, nurse, midwife, and auxiliary nurse/midwife 2 Includes only the most recent birth in the five years preceding the survey

Table 4.7 Caesarean Section Deliveries

Percentage of live births in the 5 years preceding the survey delivered by Caesarean section (C-section), which was decided after the onset of labor pains, according to background characteristics, SDS 2025

According to background characteristics, DHS 2019			
Background characteristic	Have Caesarean section		Number of births
	No	Yes	
Age at birth			
<20	94.5	5.5	780
20-34	93.7	6.3	8,711
35-49	95.1	4.9	2,312
Birth order			
1	91.5	8.5	2,402
2-3	93.5	6.5	3,698
4-5	95.4	4.6	2,772
6+	95.6	4.4	2,931
Number of ANC visits			
None	97.9	2.1	4,987
1	89.9	10.1	1278
2-3	92.2	7.8	3936
4+	89.8	10.2	1602
District			
Kahda	94.0	6.0	2,619
Dhusamareeb	94.2	5.8	1,302
Baidoa	94.7	5.3	2,678
Beletweyne	97.0	3.0	2,201
Kismayo	91.3	8.7	3,003
Enumeration Area Type			
Rural	96.7	3.3	1,196
Urban	92.5	7.5	6,847
Nomadic	97.3	2.7	111
IDP	96.0	4.0	3,649
Total	94.1	5.9	11,803

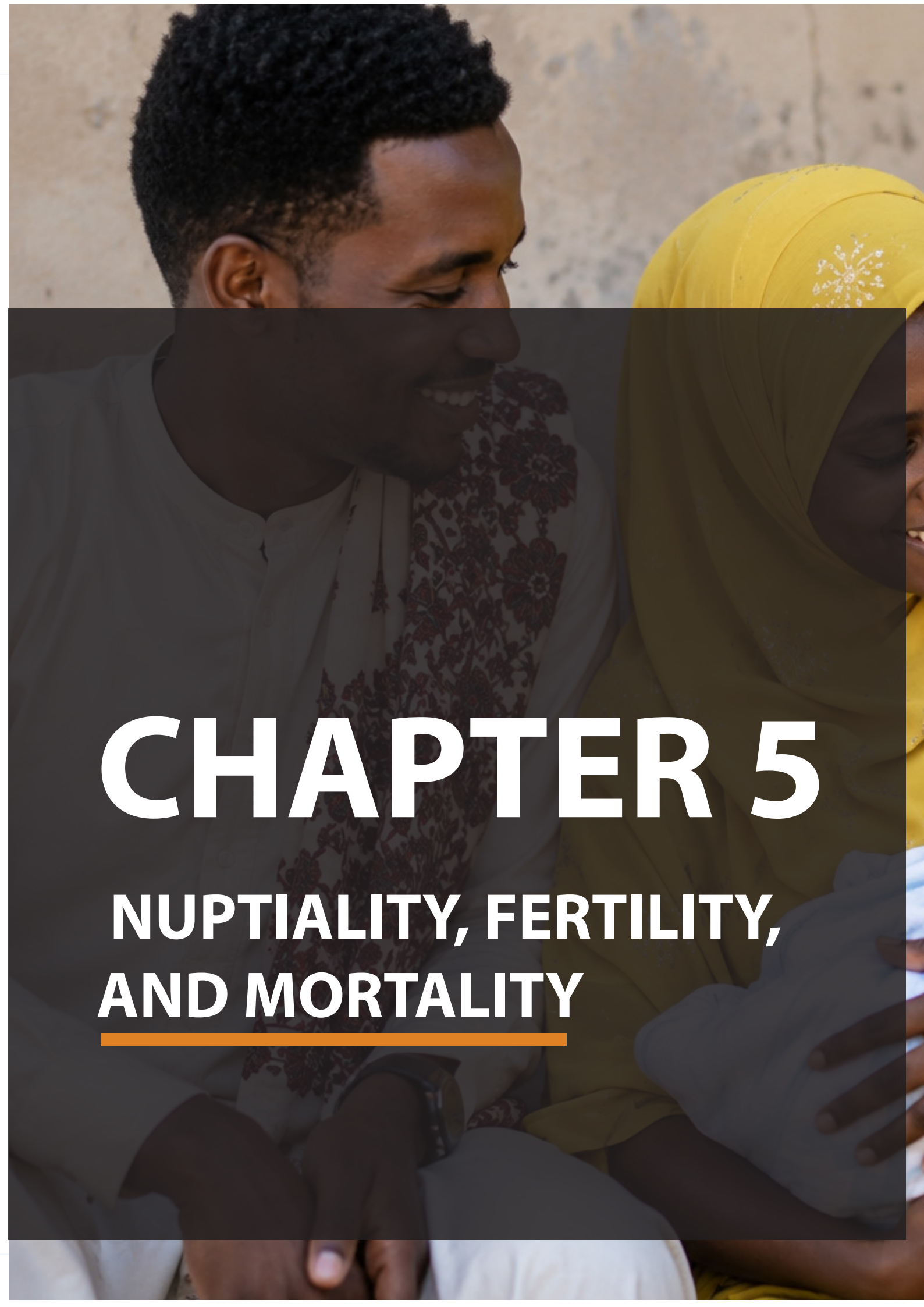
Note: The question on c-section is asked only of women who delivered in a health facility. In this table, it is assumed that women who did not give birth in a health facility did not receive a c-section. 1 Includes only the most recent birth in the 5 years preceding the survey

Table 4.8 Maternal Health Complications

Percentage of women 15-49 who reported specific complications, by background characteristics, SDS 2026										
Background characteristic	Enumeration Area Type				District					Total
	Rural	Urban	Nomadic	IDP	Kahda	Dhusamareeb	Baidoa	Beletweyne	Kismayo	
Had Complication										
Pregnancy (Antepartum) complications	9.8	15.8	9.2	20.6	23.3	12.8	20.6	6.9	17.0	16.4
Delivery (Childbirth) complications	1.3	2.2	2.9	2.9	4.1	4.1	0.5	0.5	3.0	2.3
Post delivery (Postpartum) complications	0.6	0.9	0.6	1.4	1.4	1.1	0.9	0.1	1.5	1.0
Type of complication										
Severe vomiting	6.0	9.7	4.6	10.1	12.8	8.6	10.5	5.1	9.7	9.4
Anaemia	5.4	6.8	5.7	10.3	8.6	7.3	14.4	0.8	6.8	7.6
Malaria	2	3.8	1.1	5.4	3.8	2.7	7.6	0.3	4.8	4.0
Bleeding in pregnancy	2.3	3.4	2.9	4.9	3.9	1.6	4.8	2.3	4.4	3.7
Swelling of limbs	0.9	2.8	1.7	2.8	4	2.7	2.5	1.3	2.6	2.6
Uti (urinary tract infections)	0.7	1.3	1.1	3.4	3.4	0.8	3	0.4	1.3	1.8
Prolonged labour	1.3	1.5	2.9	2.4	3.6	3.4	0.4	0.5	1.8	1.8
Pre-eclampsia	0.4	0.8	0	1.4	1.4	0.1	1.7	0.3	0.8	0.9
Post-partum hemorrhage	0.6	0.4	0.6	0.7	0.3	0.9	0.4	0	0.8	0.5
Miscarriage	0.4	0.4	0	0.6	0.7	0.2	0.4	0.1	0.6	0.4
Sepsis	0	0.3	0	0.7	1.1	0.1	0.2	0	0.4	0.4
Eclampsia	0.1	0.3	0	0.3	0.3	0.2	0.1	0.1	0.5	0.3
Gestational diabetes	0.2	0.4	0	0.2	0.2	0.2	0.3	0	0.6	0.3
Presentation	0.2	0.2	1.1	0.3	0.3	0.5	0	0	0.5	0.2
Uterine rupture	0	0.3	0	0.1	0.1	0.2	0.1	0	0.5	0.2
Excessive bleeding	0	0.2	0.6	0.2	0.1	0.4	0	0	0.5	0.2
Cord prolapse	0	0.1	0	0.2	0.1	0.1	0	0	0.1	0.1
Premature birth	0	0.1	0	0.1	0	0.2	0	0	0.3	0.1
Retained placenta	0	0.1	0	0.1	0	0	0.2	0	0.1	0.1
Mental health issues	0	0.1	0	0	0	0.1	0	0	0.2	0.1
Other	0	0.1	0	0	0.2	0.2	0	0	0	0.1
Fistula	0.1	0	0	0	0	0.2	0	0	0	0
Leakage of feces/urine	0	0	0	0	0	0.1	0	0.1	0	0
Total	1,709	9,632	174	4,250	2,970	1,847	3,327	3,234	4,387	15,765

Table 4.9 Female Circumcision

Distribution of women by status and type of circumcision, circumcision status of daughters and intention to circumcise uncircumcised daughters by district and type of residence								
Background characteristic	Undergone FGM	Type of FGM undergone				Has biological daughters who have undergone FGM	Has biological daughters who have not undergone FGM	Has plans to perform FGM on biological daughters who have not
		Sunni	Intermediate	Pharaonic	Don't know			
District								
Kahda	93.1	19.3	11.1	69.3	0.3	48.0	75.6	85.9
Dhusamareeb	89.7	16.7	16.6	64.9	1.7	48.9	68.9	73.6
Baidoa	95.3	19.8	36.3	40.0	3.8	39.8	66.3	86.8
Beletweyne	82.6	31.7	15.4	52.7	0.1	49.7	60.2	77.2
Kismayo	98.1	37.3	14.7	48.0	0.0	51.7	59.6	81.6
Residence								
Rural	89.2	22.0	16.1	61.2	0.7	47.0	65.0	79.0
Urban	91.9	31.9	19.9	47.2	1.0	49.3	63.5	80.6
Nomadic	86.8	7.3	11.3	78.1	3.3	51.1	67.6	77.9
Idp	95.2	18.0	18.7	61.9	1.4	44.4	69.1	85.3
Age group								
15-19	89.7	33.0	23.5	42.4	1.1	16.6	46.6	73.5
20-24	90.9	31.1	24.1	43.3	1.5	19.4	59.6	77.9
25-29	92.0	31.4	21.0	46.8	0.8	39.3	65.9	81.5
30-34	93.8	22.1	16.5	60.6	0.9	60.2	74.2	86.6
35-39	93.9	22.3	14.2	62.4	1.1	75.1	70.7	85.1
40-44	94.2	16.9	13.5	68.3	1.4	83.3	64.5	81.0
45-49	92.2	17.8	13.9	66.7	1.7	80.3	57.1	79.4
Total (%)	92.4	26.7	19.1	53.1	1.1	47.8	65.2	81.6
Total (n)	15,770	3,895	2,778	7,738	161	15,770	15,719	15,737

A photograph of a man and a woman. The man, on the left, has dark skin and short, curly black hair. He is wearing a grey thobe with a dark floral patterned vest over it. He is smiling and looking down towards the woman. The woman, on the right, is wearing a bright yellow headscarf with a small white floral pattern. She is also smiling and looking down. The background is a light-colored, textured wall. A semi-transparent dark grey rectangle is overlaid on the image, containing the chapter title.

CHAPTER 5

NUPTIALITY, FERTILITY, AND MORTALITY

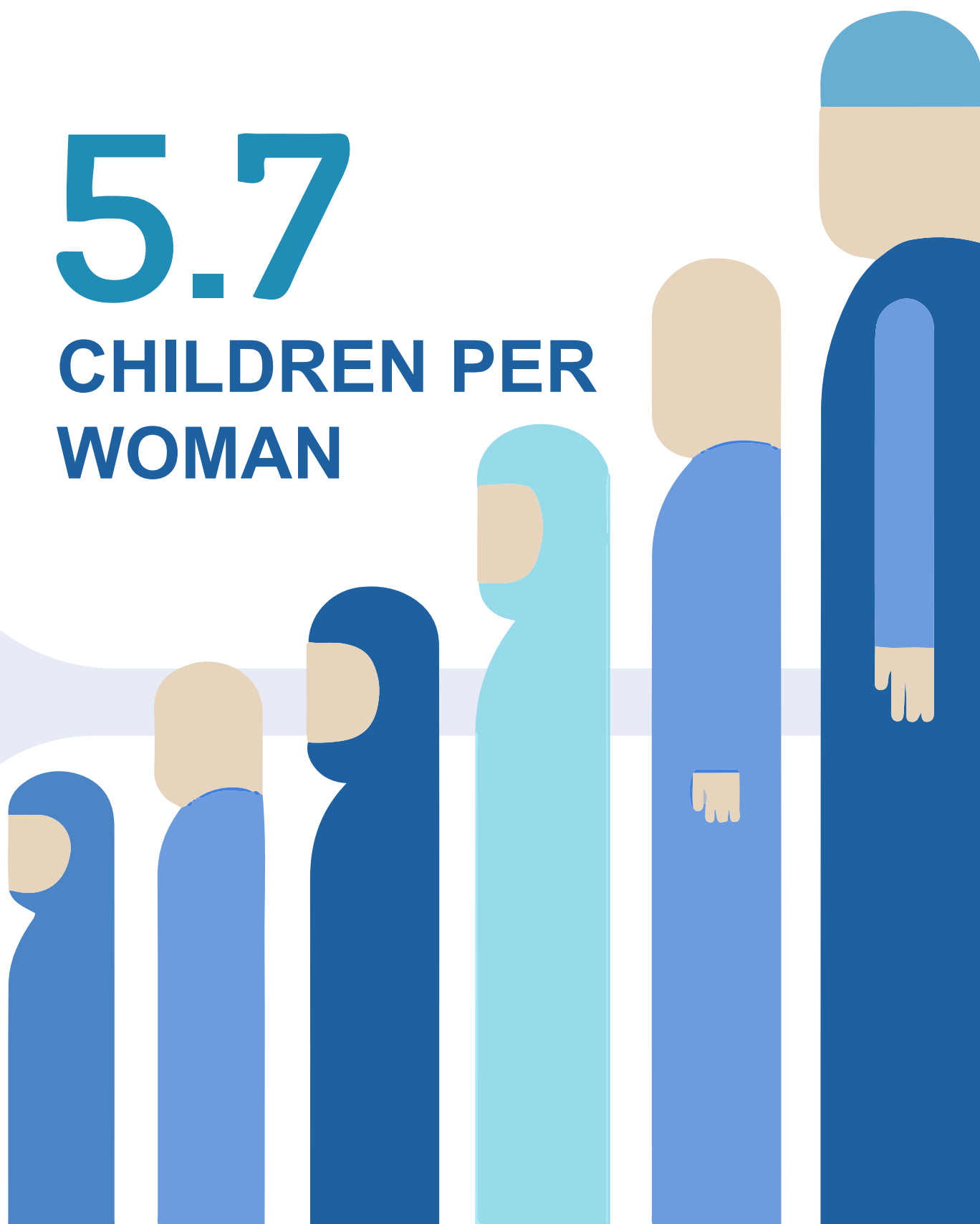


Chapter Five summarizes key demographic indicators from the SDS 2026, covering nuptiality, fertility, and mortality across the five surveyed districts. It presents patterns of marriage, fertility, and mortality by district and place of residence to provide insights into population dynamics.

KEY FINDINGS

5.7

CHILDREN PER WOMAN



Baidoa
6.9

Beletweyne
4.5

Dhusamareeb
5.3

Kahda
5.9

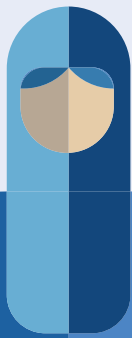
Kismayo
5.6



6.8

DEATHS PER 1000 POPULATION

Baidoa	Beletweyne	Dhusamareeb	Kahda	Kismayo
9.7	3.1	3.4	5.0	10.4



18
Years



23
Years

AGE AT FIRST MARRIAGE

The overall mean age at first marriage is 20 years, with females marrying at 18 years compared to 23 years for males.

5.1 Introduction



This chapter presents key demographic indicators from the SDS 2026, focusing on nuptiality, fertility, and mortality patterns across the five surveyed districts. It examines the mean age at first marriage, as well as current fertility measures—including the Total Fertility Rate (TFR), Crude Birth Rate (CBR), General Fertility Rate (GFR), and Age-Specific Fertility Rates (ASFR)—disaggregated by district and type of residence (urban, rural, nomadic, and IDP settlements). The chapter also analyses mortality through the Crude Death Rate (CDR) and Age-Specific Death Rates (ASDR).

By highlighting geographic and residential disparities in these fundamental demographic processes, the analysis provides essential insights into the population dynamics shaping health needs, service planning, and social development in the surveyed areas. Understanding these patterns is critical for designing targeted interventions to improve reproductive health, child survival, and overall population well-being.

5.2 Nuptiality

5.2.1 Mean Age at First Marriage

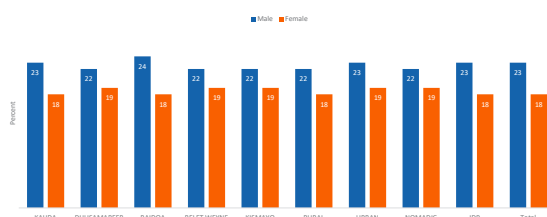
The mean age at first marriage holds central importance in demographic analysis as it directly influences the timing and level of fertility, determining when women begin their reproductive careers within marriage, and it shapes the length of exposure to childbearing risks. Figure 5.1 presents the mean age at first marriage by sex, type of residence (urban, rural, nomadic, and IDP), and district. Overall, the mean age at first marriage is 20 years. A clear gender difference exists, with females marrying at a mean age of 18 years compared to 23 years for males. This gender gap in age at first marriage is consistent with prevailing social and cultural norms in the surveyed communities, where females tend to marry earlier than males. Early marriage among females can influence subsequent life opportunities, including educational attainment and entry into the labour force.

At the district level, the mean age at first marriage for females shows very minimal variations, ranging from a low of 18 years in Kahda and Baidoa to 19 years across the other districts. For males, the mean age ranges from 22 years in Dhusamareb, Beletweyne and Kismayo to 24 years in Baidoa.

By type of residence, the mean age at first marriage is largely similar. Females in urban areas marry at 19 years on average, compared to 18 years in rural areas and among the IDPs. Among the males, the mean age is 23 among the urban and IDP males compared to 22 among the rural males. These patterns indicate that the place of residence has limited influence on the timing of first marriage in the surveyed population.

These nuptiality patterns provide essential context for the fertility analysis that follows, as the age at which women enter marital unions directly shapes their exposure to the risk of pregnancy and childbearing.

Figure 5.1: Mean Age at First Marriage



5.3 Fertility

Current Fertility Measures

Table 5.2 presents key current fertility indicators for the five surveyed districts, disaggregated by district and type of residence. These include the ASFR, TFR, CBR, and GFR.

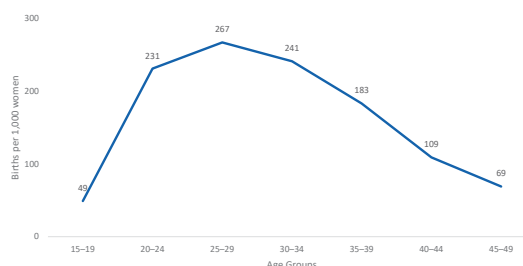
5.3.1 Age-specific fertility rate (ASFR)

ASFR quantifies the annual live births per 1,000 women within a specific age group, typically segmented in five-year intervals from ages 15 to 49. This rate is calculated by dividing the number of births to women in that age category by the total number of women in the same group. The ASFR offers a more detailed understanding of fertility patterns across various age groups compared to the TFR. Figure 5.2 provides the ASFR for the five districts.

The chart reveals distinct patterns in fertility rates across various age groups, highlighting significant variations. The age group of 25 to 29 demonstrates the highest fertility rate at 267 live births per 1,000 women, indicating a peak period for childbearing. This is closely followed by the 30 to 34 age group, which has a fertility rate of 241 live births per 1,000 women. In contrast, the younger group (15 to 19 years) shows a much lower rate of 49 live births, suggesting that in the surveyed districts, early teenage years are less associated with childbearing in the surveyed areas. Between these extremes, the 20 to 24 age group shows a fertility rate of 231, while

the 35 to 39 and 40 to 44 age groups exhibit declining rates of 183 and 109, respectively. Finally, women aged 45 to 49 experience a further decrease, with a fertility rate of 69. This data reflects the changing dynamic of childbearing as women age and underscores that the critical reproductive years are typically found in the late twenties to early thirties.

Figure 5.2 Age-Specific Fertility Rate (ASFR)

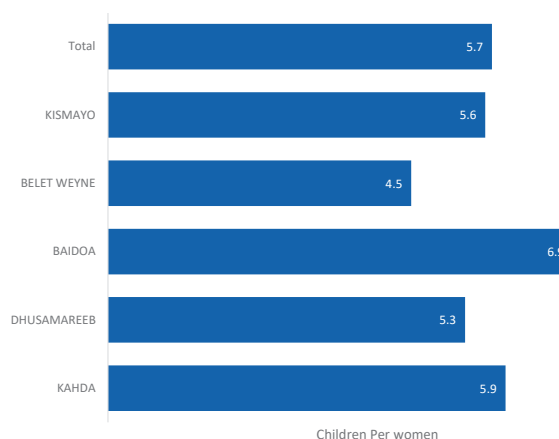


5.3.2 Total Fertility Rate

The TFR represents the average number of children a woman would give birth to by the end of her reproductive years (15–49) if she experienced the current age-specific fertility rates throughout her lifetime. Figure 5.3 presents the TFR for each of the five districts and the average for the five districts.

According to Figure 5.3, the overall TFR across the five districts is 5.7 children per woman. Baidoa recorded the highest TFR at 6.9 followed by Kahda at 5.9, while Beletweyne had the lowest at 4.5, which is less than the average across the five districts. Dhusamaareeb also recorded a TFR less than the average at 5.3 while Kismayo was slightly below the average at 5.6 children per woman.

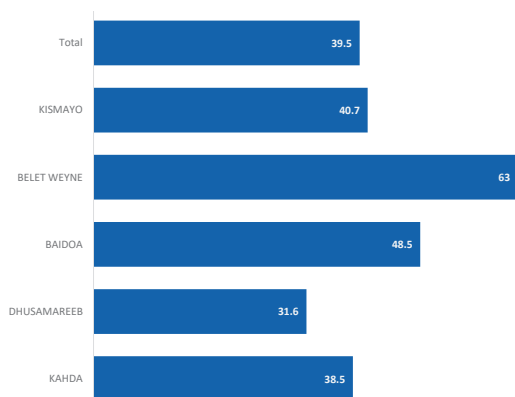
Figure 5.3 Total Fertility Rate (TFR)



5.3.4 Crude Birth Rate

The CBR is defined as the number of live births in a given year per 1,000 mid-year total population. The analysis of the CBR across the five districts is presented in Figure 5.4. Across the surveyed areas, the CBR stands at 39.5 per 1,000 population. Dhusamareeb recorded the lowest CBR of 31.6 compared to 63 in Beletweyne, which recorded the highest TFR followed by Baidoa at 48.5. These variations signal uneven population growth pressures and differing demands for maternal and child health services.

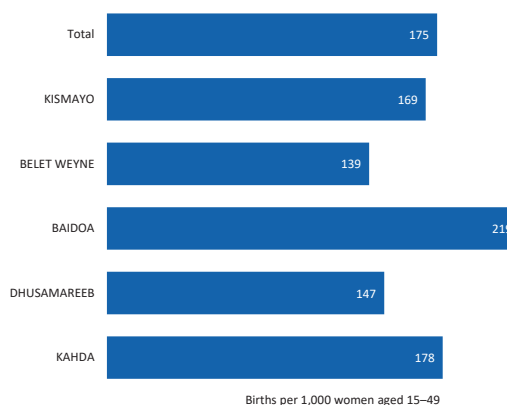
Figure 5.4 Crude Birth Rate (CBR)



5.3.5 General Fertility Rate (GFR)

The General Fertility Rate (GFR) measures the number of live births per 1,000 women of reproductive age (15–49 years) in a given year. Unlike the CBR, it focuses exclusively on the population at risk of childbearing, providing a more refined measure of fertility intensity. Figure 5.5 presents the GFR across the five districts. The overall GFR across the five districts is 175 births per 1,000 women aged 15–49. The pattern mirrors the TFR trends, with Beletweyne recording the lowest rate at 139 births, while Baidoa has the highest GFR at 219 live births per 1,000 women.

Figure 5.5 General Fertility Rate (GFR)



The high and relatively early-peaking fertility observed in this survey is consistent with the young mean age at first marriage for females (18 years) as reported in Section 5.1. Together, these patterns indicate sustained population growth and underscores the importance of strengthening birth spacing services, particularly in high-fertility districts such as Baidoa and Kahda.

5.4 Mortality

Mortality patterns provide critical insights into the health status and living conditions of the population in the surveyed districts. While fertility levels remain high across most areas, as shown in Section 5.2, the mortality experience — particularly child and adult deaths — directly influences net population growth, family structures, and the demand for health services. Understanding both age-specific and crude mortality rates is essential for identifying vulnerable groups and designing targeted interventions to improve child survival, maternal health, and overall population well-being, especially in a context marked by displacement and uneven access to care.

5.4.1 Age-Specific Death Rate (ASDR)

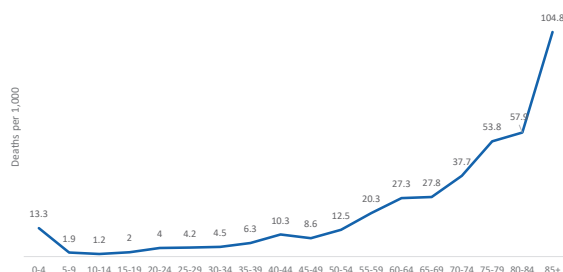
The Age-Specific Death Rate (ASDR) measures the number of deaths within a specific age group divided by the total population in that same age group, expressed per 1,000 people. It offers a detailed view of how mortality risk varies across the life course. Figure 5.6 presents

the age-specific death rates from the SDS 2026.

As expected, mortality rates generally increase with age, reflecting the growing vulnerability of older populations. However, the death rate for children aged 0–4 years stands at a relatively high 13.3 deaths per 1,000 before dropping sharply to 1.9 among the 5–9 year olds. This highlights persistent challenges in child survival. Mortality remains moderate through childhood and young adulthood before rising more noticeably in middle age. For the 45–49 age group, the rate is 8.6 per 1,000. It then escalates sharply in older ages, reaching 58 per 1,000 in the 80–84 group and peaking at 104.8 per 1,000 among those aged 85 and above.

This trend underscores age as a critical determinant of mortality risk. The elevated under-five mortality, in particular, points to ongoing vulnerabilities related to infectious diseases, nutrition, and access to basic healthcare.

Figure 5.6 Age-specific Death Rate (ASDR)



5.4.2 Crude Death Rate (CDR)

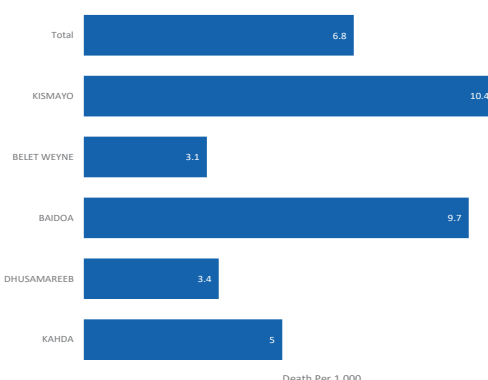
The Crude Death Rate (CDR) is a key demographic indicator that quantifies the total number of deaths in a population over the past 12 months per 1,000 individuals. It reflects broader health conditions, living standards, and access to healthcare services.

Figure 5.7 presents the CDR across the five districts. The five districts have a CDR of 6.8 per 1,000 population. Kismayo recorded the highest CDR at 10.4 deaths per 1,000 population, followed by Baidoa at 9.7 deaths per 1,000 population. In contrast, lower mortality rates were observed in Kahda 5.0 per

1,000 population, Dhusamareeb 3.4 per 1,000 population, and Beletweyne 3.1 per 1,000 population.

The comparatively lower CDRs in Kahda, Dhusamareeb and Beletweyne may suggest relatively better health outcomes and more stable living conditions, potentially reflecting stronger community health interventions, improved access to healthcare services, or lower exposure to factors associated with increased mortality.

Figure 5.7 Crude Death Rate (CDR)



5.5 Conclusions and Recommendations

5.5.1 Conclusions

The SDS 2026 highlights persistent early marriage among females (mean age of 18 years) and high fertility across the surveyed districts, with an overall TFR of 5.7. Fertility peaks in the 25–29 age group (ASFR of 267 per 1,000 women) and is markedly higher among women in Baidoa and Kahda. The age specific death rate increases with age, except for the age 0–4 years which remains elevated (13.3 deaths per 1,000 population) compared to 1.9 among the 5–9 age cohort after which it increases. Kismayo and Baidoa recorded the highest CDR of 10.4 and 9.7 deaths per 1,000 population.

These patterns indicate rapid population growth driven by early marriage and high fertility, compounded by uneven mortality and persistent gaps between ANC attendance and facility-based deliveries observed in earlier chapters.

5.2.2 Recommendation

1. **Delay Age at First Marriage and Expand Girls' Education:** Implement community-based programmes to raise awareness of the benefits of later marriage, combined with targeted interventions to keep girls in school beyond primary level. Delaying marriage by even two to three years can significantly reduce lifetime fertility and improve maternal health outcomes.
2. **Targeted Child Survival and Mortality Reduction Interventions:** Prioritise integrated child health packages (immunization, nutrition, and management of common childhood illnesses) to reduce under-5 mortality, particularly in high burden districts
3. **Invest in Data and Monitoring:** Institutionalize regular collection and analysis of age-specific indicators (ASFR and ASDR) at the district level to track progress and enable timely programme adjustments.

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Table 5.1: Mean Age at First Marriage by Sex, District and Residence

Background characteristic	Age at First Marriage		
	Male	Female	Total
Population (District)			
Kahda	23	18	20
Dhusamareeb	22	19	20
Baidoa	24	18	20
Belet weyne	22	19	20
Kismayo	22	19	20
Total	23	18	20
Population (Type of residence)			
Rural	22	18	20
Urban	23	19	20
Nomadic	22	19	20
IDP	23	18	20
Total	23	18	20

Table 5.2: Fertility Distribution: Age specific fertility Rates (ASFRs), Total Fertility Rates (TFRs), Crude Birth Rates (CBRs) and General Fertility Rates (GFRs) by District and Residence (SDS 2026)

	District					Place Residence				
	Kahda	Dhusamareeb	Baidoa	Belet weyne	Kismayo	Rural	Urban	Nomadic	IDP	Total
Age Group										
15–19	47	29	80	43	39	55	38	52	77	49
20–24	242	159	304	204	192	208	196	236	317	231
25–29	305	217	312	210	258	212	249	207	328	267
30–34	251	216	273	194	243	215	231	186	271	241
35–39	177	179	202	144	199	180	174	154	200	183
40–44	98	126	131	70	114	97	106	105	118	109
45–49	51	129	73	31	81	88	67	83	65	69
Total	1170	1054	1375	896	1126	1056	1061	1023	1377	1149
TFR	5.9	5.3	6.9	4.5	5.6	5.3	5.3	5.1	6.9	5.7
CBR	38.5	31.6	48.5	63	40.7	34.9	36.8	29.5	46.7	39.5
GFR	178	147	219	139	169	160	157	152	221	175

Table 5.3: Crude Death Rates by Selected Background Characteristics, SDS

Background characteristic	population	Deaths in last 24 months	Deaths in last 12 months	CDR
District				
Kahda	53822	540	270	5.0
Dhusamareeb	30431	205	103	3.4
Baidoa	54238	1048	524	9.7
Belet weyne	35161	216	108	3.1
Kismayo	47478	990	495	10.4
Total	221130	2999	1499	6.8
Residence				
Rural	20231	165	83	4.1
Urban	131494	1585	792	6.0
Nomadic	3035	18	9	3.0
IDP	66370	1231	616	9.3
Total	221130	2999	1499	6.8
age				
0-4	42996	1145	573	13.3
5-9	43349	167	84	1.9
10-14	29599	72	36	1.2
15-19	22017	86	43	2.0
20-24	15409	124	62	4.0
25-29	16714	141	71	4.2
30-34	12652	113	57	4.5
35-39	10845	137	69	6.3
40-44	8755	181	91	10.3
45-49	4953	85	43	8.6
50-54	4765	119	60	12.5
55-59	1966	80	40	20.3
60-64	2915	159	80	27.3
65-69	1115	62	31	27.8
70-74	1551	117	59	37.7
75-79	437	47	24	53.8
80-84	656	76	38	57.9
85+	420	88	44	104.8
Total	221114	2999	1499	6.8



CHAPTER 6

EDUCATION



Chapter Six summarizes key findings on literacy and educational attainment across the five surveyed districts. It highlights literacy levels and educational attainment by age, sex, and place of residence, providing insights into disparities in access to and achievement in education.

KEY FINDINGS

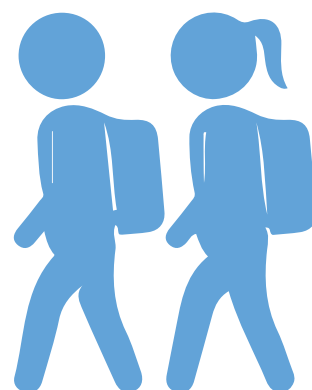
50%

of the population
aged 15 years
and above
are literate

Baidoa:	40%
Beletweyne:	57%
Dhusamareeb:	54%
Kahda:	59%
Kismayo:	53%



Baidoa:	Male	7%	Female	3%
Beletweyne:	Male	8%	Female	4%
Dhusamareeb:	Male	10%	Female	5%
Kahda:	Male	9%	Female	6%
Kismayo:	Male	7%	Female	2%



8%

Males

4%

Female

have attained post-secondary
education levels

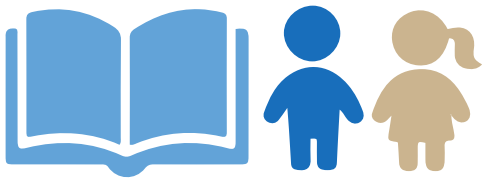
PRIMARY SCHOOL GAR



27%

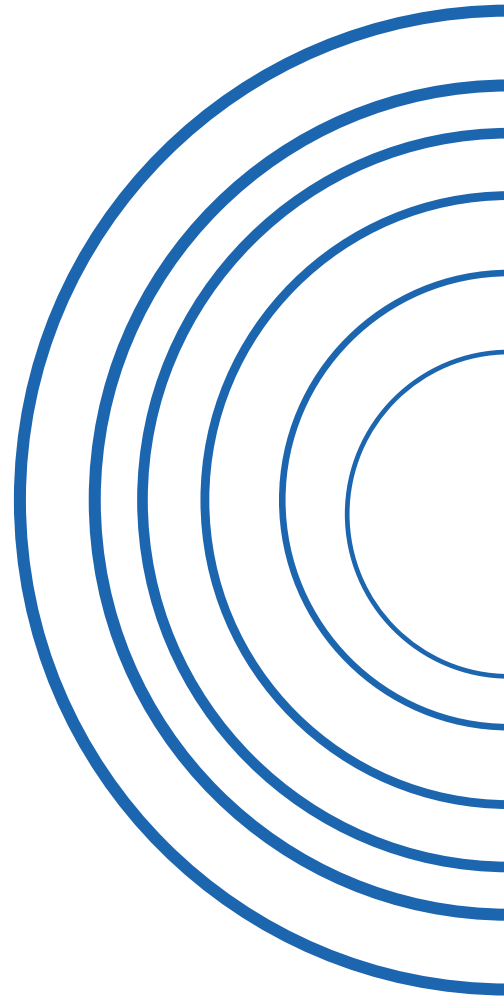
GPI: 0.936

PRIMARY SCHOOL NAR



15%

GPI: 0.929



6.1 Introduction



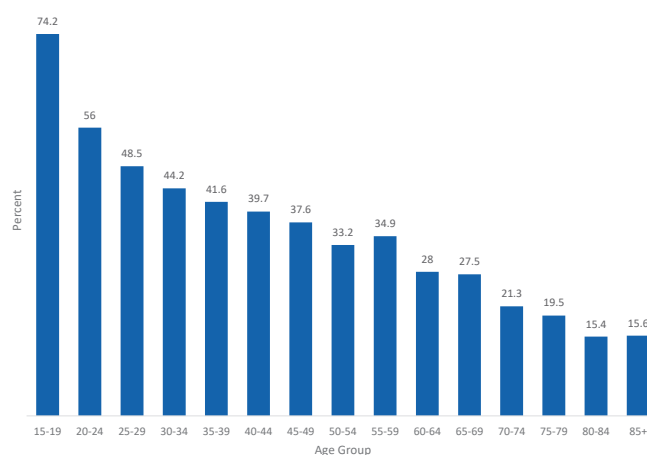
This chapter provides a comprehensive analysis of literacy rates and educational attainment among the population within the five districts covered in the survey, highlighting the disparities observed across different demographic groups. It examines the percentage of individuals who are literate by various socio-demographic factors such as age, sex, and place of residence, as well as the levels of educational attainment, from primary education to higher degrees. The chapter aims to identify key challenges and opportunities for improving educational access and quality in these districts.

6.2 Literacy

Adult literacy is defined as the proportion of the population aged 15 years and older who can, with understanding, both read and write a short, simple statement about their everyday life. (UNESCO Institute for Statistics, 2013). Figure 6.2 presents the adult literacy rates across districts and residences. Overall, 52 percent of the population in the five districts are literate. Males have a higher proportion of those who are literate at 59 percent compared to 45 percent among females.

Analysis of the literacy rate across the different age groups is presented in Figure 6.1. Literacy rates decline with increasing age, illustrating a historical transformation in the accessibility of education. Literacy rates are highest among the youngest cohort, with 74 percent of those aged 15–19 demonstrating the ability to read and write. This figure declines steadily across older populations, eventually reaching a low of just 16 percent for individuals in the 80-year-old bracket. This profound gap between the youth and the elderly serves as a clear testament to the cumulative gains made in the education sector over the past several decades. It suggests that while the system still faces hurdles in equity and reach, the foundational reach of literacy has expanded significantly for the most recent generations.

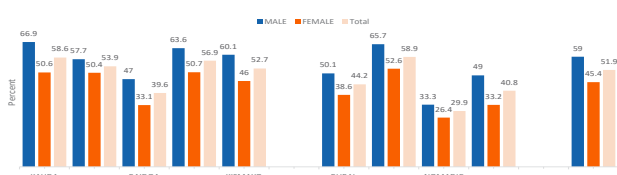
Figure 6.1 Literacy rate by age



Literacy rates (typically among adults aged 15+) reveal significant disparities across the five districts and residence types, highlighting uneven access to education influenced by location, stability, and infrastructure. Kahda recorded the highest literacy rate at 59 percent, followed closely by Beletweyne at 57 percent, Dhusamareeb 54 percent, and Kismayo at 53 percent. Baidoa stands out with a substantially lower rate of 40 percent, indicating greater barriers to education in this area.

Figure 6.1 further shows marked differences by place of residence. Urban populations exhibited the highest literacy rate at 59 percent, demonstrating the relative educational advantage associated with urban settings. Literacy levels were lower among rural residents at 44 percent and IDPs at 41 percent, while nomadic populations recorded the lowest literacy rate at 30 percent. These findings highlight persistent inequalities in access to education, particularly among mobile and displaced populations, and underscore the need for targeted interventions to improve educational outcomes among underserved communities.

Figure 6.2 Adult Literacy Rates by District and residence



6.3 Educational attainment

This section examines the distribution of the household population aged 6 and above by the highest level of education they have attended or completed. Figure 6.3 shows gender differentiated analysis of education attainment. According to Figure 6.3, while access to education remains a broad challenge, a consistent advantage for males exists across all metrics. On an aggregate level, approximately 53 percent of males have no formal education, compared to

56 percent of females. This gap becomes increasingly pronounced at higher academic tiers: secondary education is attained by 15 percent of males versus 12 percent of females, while post-secondary achievement for males (8 percent) is double that of their female counterparts (4 percent).

Figure 6.3 – Educational Attainment by Sex

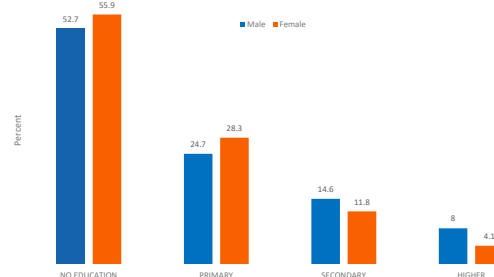


Figure 6.4A and Figure 6.4B present education attainment for males and females. According to Figure 6.4A, there exist significant variations in male education attainment across regions, with Dhusamareeb consistently emerging as the leader in educational outcomes. Dhusamareeb records the lowest proportion lacking formal education at 43 percent, contrasting sharply with Baidoa, Kismayo, and Kahda, where roughly 55 percent of the male population has no formal education. Dhusamareeb also leads in secondary attainment at 17 percent and higher education at 9.9 percent, while Baidoa and Kismayo record the lowest post-secondary attainment for males at approximately 7 percent each.

Figure 6.4A Education Attainment for Males Per District

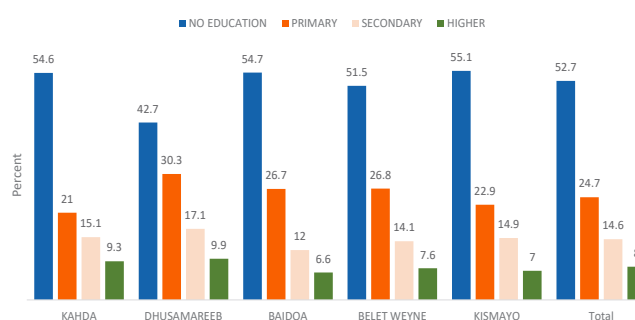
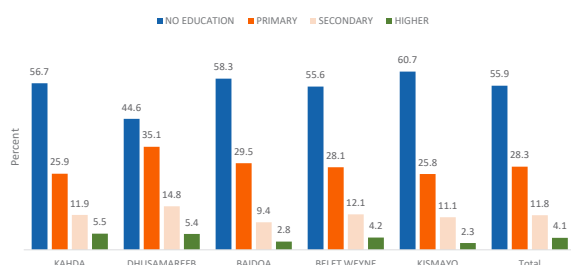


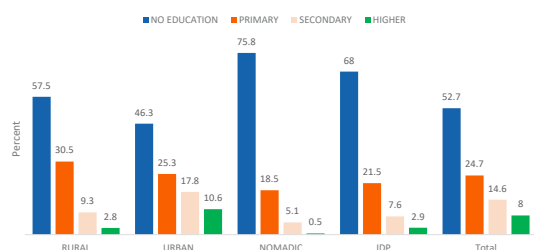
Figure 6.4B shows that barriers to education for females are more acute in specific regions. Kismayo faces the most significant challenge, with 61 percent of females lacking formal education, followed closely by Baidoa at 58 percent. Once again, Dhusamareeb presents the most favorable environment, maintaining the lowest “no-education” rate for females at 45 percent. In terms of advanced schooling, Kahda, Beletweyne and Dhusamareeb show the strongest post secondary outcomes for women at 6 percent, 5 percent and 4 percent respectively, while Kismayo lags severely, with only 2 percent of females attaining higher education.

Figure 6.4B Education Attainment for Females Per District



The two Figures (6.5A and 6.5B) reveal a stark “urban advantage,” where residents of urban areas consistently achieve superior outcomes compared to their rural, nomadic, or displaced counterparts. In urban areas, the proportion of the population with no formal education is at its lowest, recorded at 46 percent for males (Figure 6.5A and 51 percent (Figure 6.5B) for females.

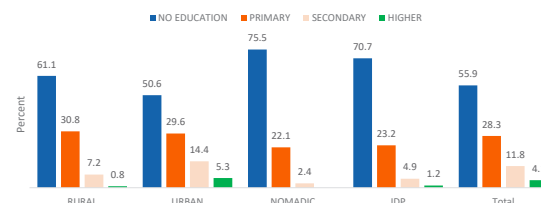
Figure 6.5A Education Attainment for Male Per residence



Urban centers also serve as the primary hubs for advanced learning, with 18 percent of males and 14 percent of females attaining secondary-level education. At the higher education tier, the gap between males and

females widens, with 11 percent of males and 5 percent of females attaining post-secondary education.

Figure 6.5B Education Attainment for Female Per residence



In contrast, rural populations occupy a middle ground; while they fare better than nomadic or displaced groups, they still face significant hurdles, with “no-education” rates climbing to 58 percent for males and 61 percent for females. However, the most severe barriers to entry are found among nomadic communities. In these groups, the lack of formal education reaches approximately 76 percent for both genders. The transition to higher learning is nearly non-existent for nomadic populations, with secondary attainment at just 5 percent for males and roughly 2 percent for females, while higher education remains negligible at less than one percent for both.

Internally Displaced Persons (IDPs) similarly face high levels of educational deprivation. Approximately 68 percent of males and 71 percent of females in IDP settings have no formal education, with very limited progression beyond the primary level with 8 percent having attained secondary education among males and 5 percent for females. Less than 3 percent for both have post-secondary education.

The data underscores a systemic gender inequality that intensifies at the secondary and post-secondary levels, highlighting a critical need for localized policy interventions that prioritize both equity and access. The “urban-rural-nomadic” divide highlights that proximity to established schools and economic stability are essential for educational retention. Consequently, while urban areas require support to maintain their higher education momentum, nomadic and IDP communities require specialized, mobile, or flexible educational interventions to bridge these profound gaps in basic literacy and schooling.

6.4 School Attendance

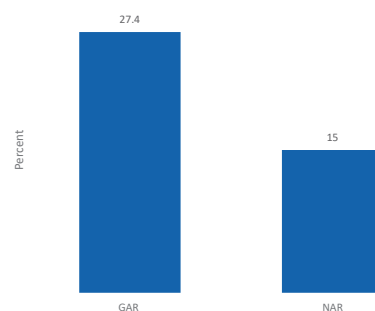
This Section provides data on gross attendance ratios (GARs) and net attendance ratios (NARs) by school level, gender, and location. The NAR for primary education is defined as the percentage of children aged 6-13 enrolled in primary school and the GAR for primary schooling is measured as the total number of primary school students relative to the official primary-school-age population. The gender parity index (GPI) is a measure that indicates the relative access to education for girls compared to boys, with a value of 1 implying parity, values below 1 indicating a disadvantage for females, and values above 1 indicating an advantage.

Figure 6.6 shows that for primary education, the GAR is considerably higher at 27 percent than the NAR of 15 percent, this disparity exists because the GAR also counts those who are outside the official age range for that level. A net attendance ratio of 100 would mean that all children within the appropriate age range are attending school, whereas the GAR may exceed 100 if there are significant numbers of out-of-age students. Currently, only 15 percent of children in primary school are of the correct age for that level. While the GAR may appear somewhat higher (27 percent), it masks a deeper problem—very low participation of children in the correct age group. This could imply:

- » **Late school entry is common:** Many children start school later than expected, which leads to over-age enrollment reflected in the higher GAR.
- » **Access and retention issues:** A large proportion of children are missing out on primary education altogether.
- » **Inefficiency in the education system:** When children are not in the correct grade for their age, it can affect learning outcomes, progression, and completion rates.

This highlights the need to focus not just on enrollment in general, but on timely school entry, retention, and ensuring children progress through school at the appropriate age.

Figure 6.6 Gross Attendance Ratio and Net Attendance Ratios (NAR)



6.4.1 Gross Attendance Ratio (GAR) and Gender Parity Index (GPI)

Table 6.3 presented at the end of this chapter, provides insightful data on GAR and the corresponding GPI for primary school education across various districts and types of residence. This data is crucial as it provides insights into the efficiency of the education systems.

Figure 6.7 illustrates critical insights into the Gross Attendance Ratios (GAR) and Gender Parity Index (GPI) for primary education across different districts. This data reflects both male and female attendance rates while indicating how equitable access to education is between genders. Such statistics are essential for understanding educational gaps and disparities that can inform policy and resource allocation. The GAR at the primary education level is 27 percent, indicating low participation. Furthermore, the Gender Parity Index (GPI) of 0.936 suggests a modest gender disparity in attendance favoring boys, with girls' attendance being approximately 6.4 percent lower than that of boys.

Figure 6.7 shows variations in GAR and GPI across districts. In Dhusamareeb, the GAR is 37 percent, and near gender parity has been achieved, with a GPI of 1.008 indicating a slight advantage for girls of about 0.8 percent over boys. On the other hand, Kismayo exhibits a concerning situation, with a GAR of 27 percent and a GPI of 0.847, indicating both low overall participation in education and a marked gender disparity in which girls are significantly disadvantaged relative to boys.





Across the five surveyed districts, 50% of the population is literate, with males (60%) outperforming females (41%). Educational access is severely limited for nomadic and displaced populations, while Dhusamareeb leads in regional performance. Although youth aged 15-19 show promising literacy rates of 74%, the overall net school attendance ratio remains critically low at 15%, highlighting an urgent need for systemic improvement.

Figure 6.7 Gross Attendance Ratio and Gender Parity Index (GPI) by Districts

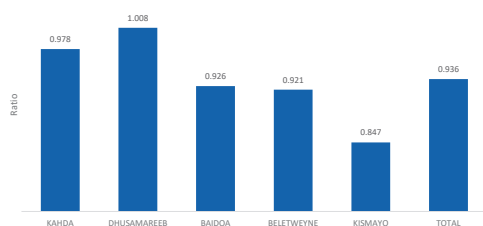
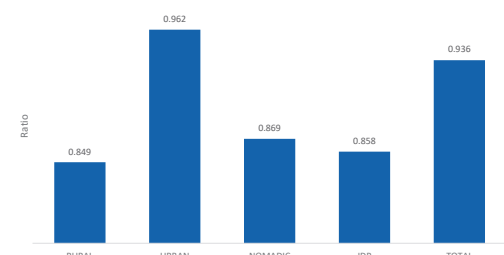


Figure 6.8 indicates that urban areas have higher GAR than rural and IDP populations. Urban areas record a GAR of 34 percent and a GPI of 0.962, reflecting a slight male advantage. Rural areas show a lower GAR of 29 percent and a more pronounced gender disparity (GPI = 0.849) favoring boys. Nomadic and IDP populations exhibit the lowest attendance levels, with GARs of 13 percent and 16 percent, respectively, highlighting significant barriers to educational access.

Figure 6.8 Gross Attendance Ratio and Gender Parity Index (GPI) by Type of Residence



6.4.2 Net Attendance Ratios (NAR with GPI)

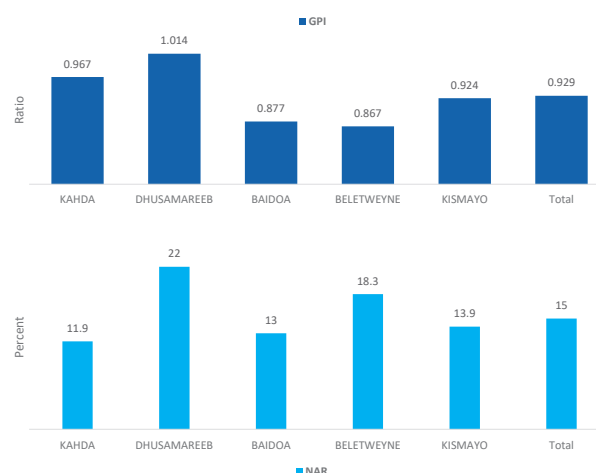
Table 6.4 presented at the end of this chapter, provides insightful data on the Net Attendance Ratios (NAR) and the corresponding GPI for primary school education across various districts and types of residence. This data is crucial for understanding educational access, timeliness and gender equity in schooling.

As presented in Figure 6.9, the overall NAR is 15 percent, with a corresponding GPI of 0.929. This suggests that only a small proportion of children are attending school at the official age, accompanied by

a moderate gender gap that favors boys.

Dhusamareeb recorded the highest NAR at 22, with near parity (GPI = 1.014), indicating a slight advantage for girls. This was followed by Beletweyne with a NAR of 18 percent and a notable gender disparity (GPI = 0.867) favoring boys. The highest gender disparity was observed in Baidoa (GPI = 0.877), although its NAR of 13 percent was higher than Kahda, which recorded the lowest NAR at 12 percent and near gender parity (GPI = 0.967), indicating that boys and girls are almost equally not attending school at the appropriate age. Kismayo reported a NAR of 14 percent and a slight gender disparity (GPI = 0.924) favoring boys.

Figure 6.9 Net Attendance Ratio (NAR) and Gender Parity Index (GPI) by District

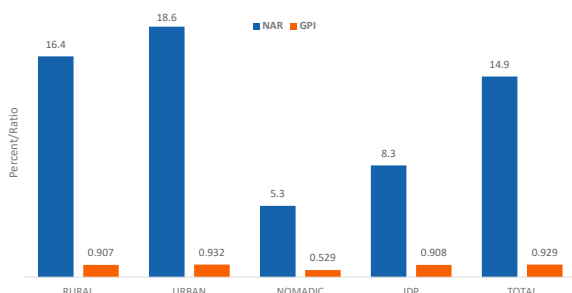


Urban areas recorded a higher NAR of 19 percent, with a GPI of 0.932, indicating a relatively more favorable environment for school attendance for both sexes, though still slightly favoring boys. Rural areas have an overall NAR of 16 percent, and a GPI of 0.907. This reflects a modest gender gap favoring boys. IDP and Nomadic settings exhibited the lowest NAR at 8 percent and 5 percent, with a GPI of 0.908 among the IDPs, highlighting severe constraints in access to age-appropriate education. Among nomadic populations, the GPI of 0.529 indicates a substantial gender gap in favour of boys, with girls' participation in age-appropriate schooling being considerably lower.

Overall, while some districts exhibit favorable conditions for female students, the data collectively indicates that significant gender

disparities persist, particularly in IDP and rural settings. Policymakers and educational authorities must focus on addressing these inequities to enhance access to education for all children, particularly in areas where attendance numbers are alarmingly low, and gender disparities are pronounced.

Figure 6.10 Net Attendance Ratio (NAR) and Gender Parity Index (GPI) by Type of Residence

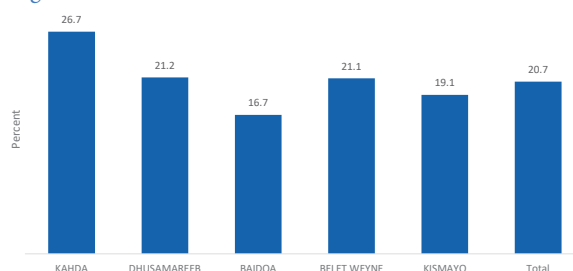


6.5 Access to Education Facilities

Data on the distribution of education facilities is important because it shows who has access to schools and who is left behind. It helps address inequality, low access, and poor educational outcomes, and supports the development of a more inclusive, efficient, and equitable education system.

Figure 6.10 shows the distribution of education facilities (schools, training centers) across the five districts. This is an indication of access to learning institutions. Generally, 21 percent of the non-residential structures in the surveyed districts are educational establishments. Kahda at 27 percent represents the district with the highest proportions of learning establishments, followed by Beletweyne and Dhusamareeb at 21 percent for both. Baidoa has the least at 17 percent followed by Kismayo at 19 percent. These variations highlight that districts with greater density of educational facilities tend to achieve better educational indicators, while lower-density areas face compounded barriers to access and retention. However, infrastructure presence is necessary but insufficient—quality, affordability, safety, and cultural factors remain critical determinants of actual enrollment and completion.

Figure 6.11 Distribution of Educational Establishments



6.6 Conclusions and Recommendations

6.6.1 Conclusions

Education remains profoundly unequal and exclusionary, entrenching intergenerational poverty and gender inequity. With adult literacy at only 50 percent—60 percent for men compared to 41 percent for women—and more than half of the population lacking any formal education, the system fails to provide basic skills to large segments of society. The burden falls disproportionately on women, older adults, nomadic communities, and internally displaced persons. This exclusion directly undermines economic participation, health decision-making, and resilience in a fragile context, where low education correlates with informal/low-skill employment and barriers to services.

Geographic and residence-based divides create parallel education realities, with urban areas as outliers in an otherwise deprived landscape. Urban literacy (59 percent) and attainment far outpace rural (44 percent), IDP (41 percent), and nomadic extremes, where higher education is virtually absent (<2 percent). District leaders like Dhusamareeb contrast sharply with laggards like Baidoa (40 percent literacy) and Kismayo (severe female exclusion). These gaps reflect unequal infrastructure, security, and resource distribution, reinforcing urban-rural/nomadic divides and limiting national cohesion and development.

Gender disparities are systemic and worsening at higher levels, signaling

entrenched cultural and structural barriers that disadvantage girls and women. Despite slight progress in younger cohorts, males dominate secondary (15 percent vs. 12 percent) and post-secondary (8 percent vs. 4 percent) attainment, with primary school attendance GPI below parity (primary GAR 0.936, NAR 0.929). Gaps widen from age 20, driven by norms (early marriage, domestic burdens), safety concerns, and limited female role models/teachers. This perpetuates cycles of low female empowerment, health outcomes, and economic contribution.

Primary education access is critically low and inefficient, with attendance ratios indicating massive exclusion and quality deficits. Primary GAR (27 percent) and NAR (15 percent)—reveal that most school-age children are out of school or over-age, due to delayed entry, dropout, costs, insecurity, and opportunity costs (e.g., herding/labor). Nomadic and IDP suffer most, signaling a broken pathway to foundational learning and future opportunities.

Recent generational gains in youth literacy are fragile and insufficient without accelerated, targeted action. Improvements in 15–24 age groups show post-conflict expansion potential, but stagnation or reversal risks loom if barriers persist. Without addressing root causes, these gains will not translate into broad societal transformation.

1. **Prioritize Equity-Focused District-Level Policies:** Develop targeted strategies to close residence and district gaps. Allocate resources disproportionately to Baidoa, nomadic, rural, and IDP areas via mobile schools, community-based learning, and incentives for teachers in underserved districts like Kismayo and Baidoa.
2. **Strengthen Gender-Responsive Policies:** Enact and enforce policies promoting girls' retention (e.g., scholarships, safe transport, menstrual hygiene facilities, community sensitization against early marriage). Aim for GPI ≥ 0.95 in attendance and reduce gender gaps in secondary/higher attainment through affirmative measures.
3. **Invest in Infrastructure and Access Expansion:** Scale up school construction/restoration in rural/IDP/nomadic zones, including flexible/mobile units for pastoralists. Integrate WASH, disability-inclusive designs, and solar-powered facilities to boost attendance.
4. **Targeted Interventions for Marginalized Groups:** Implement mobile/alternative education programs (e.g., radio/TV/community learning) for nomadic/IDP children, with accelerated learning for over-age entrants. Partner with NGOs for cash transfers/fee waivers to reduce financial barriers.

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Table 6.1 Literacy Rates

Literacy rate among adults (15+) by sex, age group, and place of residence SDS 2026						
Background characteristic	Sex					
	Male		Female		Total	
	%	Count	%	Count	%	Count
District						
Kahda	66.9	26605	50.6	27216	58.6	53821
Dhusamareeb	57.7	14963	50.4	15470	53.9	30433
Baidoa	47.0	25778	33.1	28462	39.6	54240
Beletweyne	63.6	17069	50.7	18088	56.9	35157
Kismayo	60.1	22789	46.0	24684	52.7	47473
Total	59.0	107204	45.4	113920	51.9	221124
Enumeration Area Type						
Rural	50.1	9898	38.6	10332	44.2	20230
Urban	65.7	63609	52.6	67882	58.9	131491
Nomadic	33.3	1550	26.4	1486	29.9	3036
IDP	49.0	32147	33.2	34220	40.8	66367
Total	59.0	107204	45.4	113920	51.9	221124
Age Group						
15-19	79.7	10459	69.2	11558	74.2	22017
20-24	70.5	5739	47.5	9670	56.0	15409
25-29	62.1	6389	40.2	10325	48.5	16714
30-34	56.0	6183	32.8	6469	44.2	12652
35-39	54.9	5144	29.6	5701	41.6	10845
40-44	50.5	5022	25.3	3733	39.7	8755
45-49	49.9	2626	23.8	2327	37.6	4953
50-54	43.7	2717	19.3	2048	33.2	4765
55-59	49.2	1034	19.0	932	34.9	1966
60-64	39.9	1604	13.6	1311	28.0	2915
65-69	43.1	538	13.0	577	27.5	1115
70-74	34.6	777	7.9	774	21.3	1551
75-79	33.3	204	7.3	233	19.5	437
80-84	25.5	330	5.2	326	15.4	656
85+	26.3	187	6.9	233	15.6	420
Total	60.3	48953	40.9	56217	49.9	105170

Table 6.2a Educational Attainment of Male Population

Percent distribution of the household populations age six and over by highest level of schooling attended or completed and median years completed, according to background characteristics, SDS 2026

Background Characteristic	Educational attainment of the household members					Total	Number of Persons
	No education	Primary	Secondary	Higher			
Population (District)							
Kahda	54.6	21.0	15.1	9.3	100.0		13484.0
Dhusamareeb	42.7	30.3	17.1	9.9	100.0		6,068
Baidoa	54.7	26.7	12.0	6.6	100.0		8,702
Belet weyne	51.5	26.8	14.1	7.6	100.0		8,370
Kismayo	55.1	22.9	14.9	7.0	100.0		10,507
Total	52.7	24.7	14.6	8.0	100.0		47,131
Enumeration Area Type							
Rural	57.5	30.5	9.3	2.8	100.0		3,628
Urban	46.3	25.3	17.8	10.6	100.0		31,776
Nomadic	75.8	18.5	5.1	0.5	100.0		372
IDP	68.0	21.5	7.6	2.9	100.0		11,355
Total	52.7	24.7	14.6	8.0	100.0		47,131
Age Group							
6-9	87.8	12.1	0.1	0.0	100.0		7,130
10-14	51.0	46.8	2.2	0.0	100.0		10,864
15-19	25.0	40.5	31.7	2.8	100.0		8,303
20-24	30.6	14.2	35.5	19.8	100.0		4,026
25-29	44.2	11.2	20.1	24.5	100.0		3,896
30-34	53.4	11.3	15.8	19.6	100.0		3,394
35-39	56.8	10.6	15.1	17.5	100.0		2,775
40-44	64.9	10.2	13.3	11.7	100.0		2,479
45-49	69.7	10.0	10.2	10.1	100.0		1,282
50-54	68.6	9.4	13.4	8.6	100.0		1,159
55-59	66.3	10.0	13.2	10.6	100.0		501
60-64	71.8	9.9	11.9	6.4	100.0		628
65-69	65.9	13.5	10.5	10.0	100.0		229
70-74	78.4	9.1	6.1	6.4	100.0		264
75-79	76.5	7.4	11.8	4.4	100.0		68
80-84	82.9	8.5	6.1	2.4	100.0		82
85+	87.8	2.0	8.2	2.0	100.0		49
Total	52.6	24.7	14.6	8.0	100.0		47,129

1 Completed 8th grade at the primary level

2 Completed 12th grade at the secondary level

Table 6.2b Educational Attainment of the Female Population

Percent distribution of the female household populations age six and over by highest level of schooling attended or completed and median years completed, according to background characteristics, SDS 2026

Background Characteristic	Educational attainment of the household members				Total	Number of females
	No education	Primary	Secondary	Higher		
Population (District)						
Kahda	56.7	25.9	11.9	5.5	100.0	10657
Dhusamareeb	44.6	35.1	14.8	5.4	100.0	5751
Baidoa	58.3	29.5	9.4	2.8	100.0	6922
Belet weyne	55.6	28.1	12.1	4.2	100.0	7244
Kismayo	60.7	25.8	11.1	2.3	100.0	8838
Total	55.9	28.3	11.8	4.1	100.0	39412
Enumeration Area Type						
Rural	61.1	30.8	7.2	0.8	100.0	3000
Urban	50.6	29.6	14.4	5.3	100.0	27690
Nomadic	75.5	22.1	2.4		100.0	290
IDP	70.7	23.2	4.9	1.2	100.0	8432
Total	55.9	28.3	11.8	4.1	100.0	39412
Age Group						
6-9	87.9	11.9	0.1	0.0	100.0	6445
10-14	50.5	47.2	2.3	0.0	100.0	10136
15-19	28.6	39.2	28.5	3.7	100.0	7963
20-24	42.3	19.7	24.1	13.9	100.0	4567
25-29	56.8	18.2	14.4	10.6	100.0	4107
30-34	68.5	15.7	10.0	5.8	100.0	2097
35-39	76.4	13.8	6.0	3.8	100.0	1674
40-44	80.0	11.7	6.2	2.1	100.0	938
45-49	84.7	9.0	2.9	3.4	100.0	554
50-54	81.6	9.9	7.4	1.0	100.0	392
55-59	77.3	15.9	5.1	1.7	100.0	176
60-64	84.2	10.7	3.4	1.7	100.0	177
65-69	82.4	12.2	4.1	1.4	100.0	74
70-74	93.3	5.0	1.7	0.0	100.0	60
75-79	100.0	0.0	0.0	0.0	100.0	17
80-84	94.1	5.9	0.0	0.0	100.0	17
85+	87.5	12.5	0.0	0.0	100.0	16
Total	55.9	28.3	11.8	4.1	100.0	39410

1 Completed 8th grade at the primary level

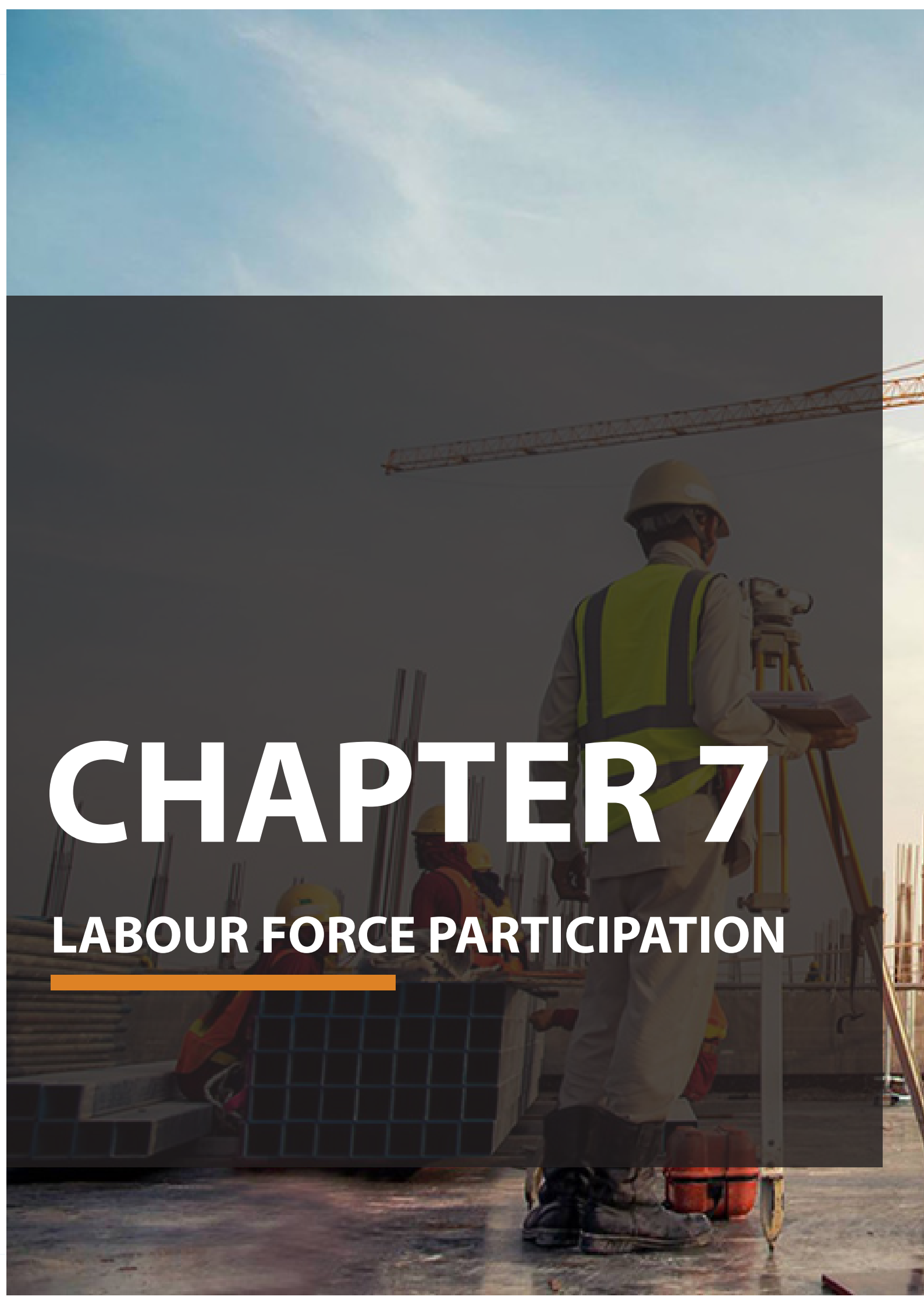
2 Completed 12th grade at the secondary level

Table 6.3 Gross School Attendance Ratio- Primary Gross Attendance Ratios (GAR) and Gender Parity Index (GPI) by sex, District and Type of Residence

Background	Male	Female	Total	GPI
District				
Kahda	22.5	22.0	22.3	0.978
Dhusamareeb	37.2	37.5	37.3	1.008
Baidoa	27.2	25.2	26.2	0.926
Beletweyne	31.5	29.0	30.2	0.921
Kismayo	28.8	24.4	26.6	0.847
Total	28.3	26.5	27.4	0.936
Residence				
Rural	31.1	26.4	28.8	0.849
Urban	34.6	33.3	33.9	0.962
Nomadic	13.7	11.9	12.8	0.869
IDP	16.9	14.5	15.7	0.858
Total	28.3	26.5	27.4	0.936

Table 6.4: Net School attendance ratio- Primary Net Attendance Ratios (NAR) and Gender Parity Index (GPI) by sex, District and Type of Residence

Background	Male	Female	Total	GPI
District				
Kahda	12.1	11.7	11.9	0.967
Dhusamareeb	21.9	22.2	22.0	1.014
Baidoa	13.8	12.1	13.0	0.877
Beletweyne	19.6	17.0	18.3	0.867
Kismayo	14.4	13.3	13.9	0.924
Total	15.5	14.4	14.95	0.929
Residence				
Rural	17.2	15.6	16.4	0.907
Urban	19.2	17.9	18.6	0.932
Nomadic	6.8	3.6	5.3	0.529
IDP	8.7	7.9	8.3	0.908
Total	15.5	14.4	14.9	0.929

A construction worker in a white uniform, yellow safety vest, and white hard hat stands on a construction site, looking at a clipboard. In the background, a large yellow crane is visible against a blue sky with light clouds. Other workers in safety gear are partially visible in the mid-ground.

CHAPTER 7

LABOUR FORCE PARTICIPATION



Chapter Seven summarizes key findings on labour force participation across the five surveyed districts. It examines employment, unemployment, and labour market participation, providing insights into economic engagement and the factors influencing household livelihoods and wellbeing.

KEY FINDINGS

35%

LABOUR FORCE PARTICIPATION RATE

Baidoa	Beletweyne	Dhusamareeb	Kahda	Kismayo
34%	42%	34%	34%	33%



21%

EMPLOYMENT RATE

Baidoa:	24%
Beletweyne:	15%
Dhusamareeb:	13%
Kahda:	25%
Kismayo:	21%



41%

UNEMPLOYMENT RATE

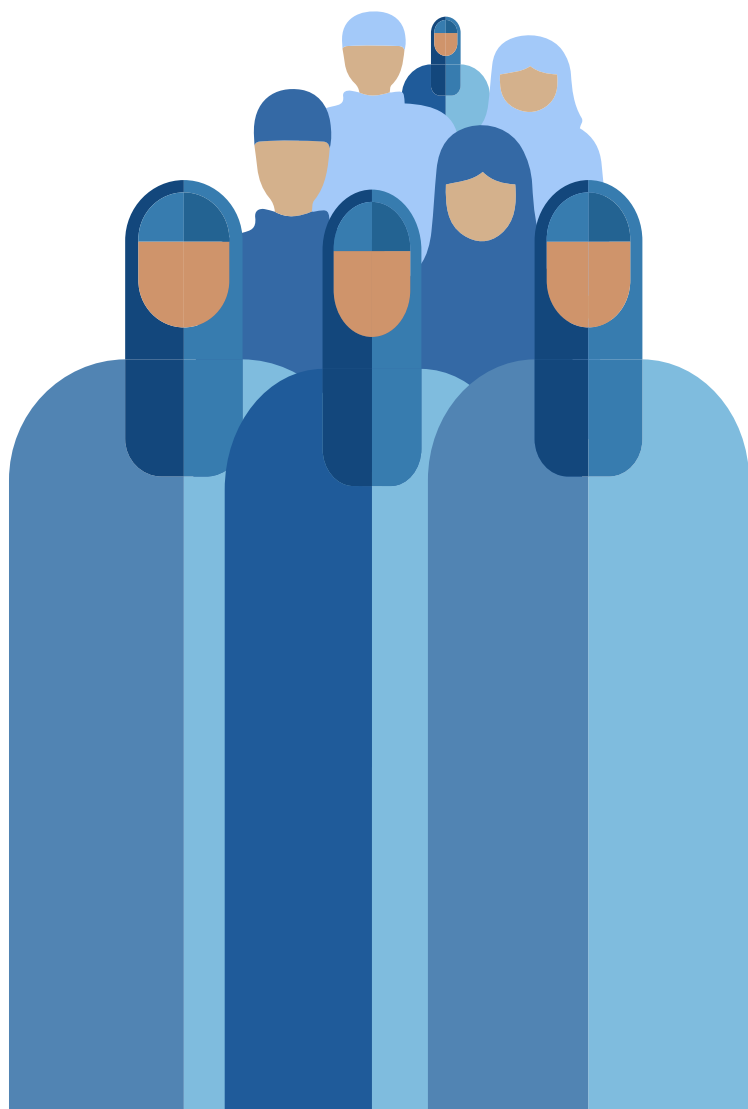
Baidoa:	29%
Beletweyne:	64%
Dhusamareeb:	62%
Kahda:	26%
Kismayo:	35%



61%

YOUTH UNEMPLOYMENT

Baidoa:	48%
Beletweyne:	83%
Dhusamareeb:	79%
Kahda:	44%
Kismayo:	59%



1%

OF CHILDREN WERE ENGAGED IN EMPLOYMENT

7.1 Introduction



Labour force participation remains one of the most direct mechanisms through which households secure stable income, build resilience against climate-related, economic, or personal shocks (such as job loss or health crises), and plan for the future by enabling savings, investments in education, and asset accumulation. Understanding who is employed, who is seeking work, and who remains outside the labour market is essential for designing policies that promote job creation, strengthen skills development, and protect vulnerable populations. This chapter examines labour force participation as a core measure of economic engagement and household wellbeing across the surveyed districts.

7.2 Employment Status

Employment status was measured by asking respondents aged 10 years and above about their main activity during the 12 months preceding the survey. While the International Labour Organization (ILO) generally sets the lower age limit for the working-age population at 15 years, the survey included questions on the economic activities of children below 15 to enable more accurate estimates of child labour.

7.2.1 Labour Force Participation Rate (LFPR)

The labour force participation rate (LFPR) is the share (or proportion) of the working-age population that is economically active (i.e., in the labour force). It measures the extent to which the country's working-age population engages actively in the labour market, either by working or actively seeking work.

According to Table 7.1 presented at the end of this chapter, 35 percent of the population across the five districts is economically active. The LFPR is relatively similar across the surveyed districts, Kismayo 33 percent, Kaxda, Baidoa and Dhusamareeb at 34 percent while Beletweyne shows a wider gap with a LFPR of 42 percent.

Marginal differences appear by type of residence. Those in IDP and rural settings record slightly higher rates at 37 percent and 35 percent respectively, while urban and nomadic residents each have an LFPR of 34 percent.

The gender gap remains substantial, with men showing a clear advantage in labour force participation: their LFPR stands at 52 percent compared to just 19 percent among women. This indicates that men are nearly three times more likely than women to be either employed or actively seeking work. These patterns point to persistent gendered barriers to labour market participation, likely shaped by care responsibilities, social norms, mobility constraints, access to education and skills, and limited employment opportunities for women.

7.2.2 Employment Rate

The employment rate, also known as the employment-to-population ratio, is the proportion of the working-age population that is employed. It indicates the percentage of the population of working age that is actually in employment—defined as being engaged in any activity to produce goods or services for pay or profit during the reference period (12 months for this survey; note that the ILO standard reference period is typically a short one, such as one week).

According to Table 7.1, the employment rate across the five surveyed districts stands at 21 percent. Kahda district reports the highest rate at 25 percent, while Dhusamareeb has the lowest at 13 percent. By type of residence, internally displaced persons (IDPs) have the highest employment rate at 26 percent. This is often because displacement leads to loss of assets and livelihoods, forcing households, particularly women and youth to take any available casual work to survive. The urban and peri-urban informal economies provide more casual labour opportunities (e.g., construction, vending, or domestic work) compared to the rural or nomadic residences. Despite the precarious nature of such jobs, they may represent one of the few available income sources for displaced households.

The urban residents recorded the second highest employment rate at 19 percent, while nomads recorded the lowest at 8 percent likely because their traditional way of life (herding livestock) is often disrupted by climate shocks. The gender gap mirrors that observed in labour force participation and remains wide: men have an employment rate of 34 percent compared to 8 percent among women.



Wide gender gap : 52% of men are employed compared to 19% of women.

7.2.3 Unemployment

The unemployment rate is the share of the labour force that is unemployed. Unemployed persons are those of working age who, during the reference period: (1) were without work (i.e., not in employment), (2) were currently available for work (for paid employment or self-employment), and (3) had taken specific steps to seek employment during a recent specified period (note: the ILO standard uses a short reference period for the “without work” and availability criteria, and a recent period—often 4 weeks—for active job search; this survey uses a 12-month reference period).

As presented in Table 7.1, the unemployment rate across the five districts stands at 41 percent, with marked variation across districts. Kahda records the lowest unemployment rate at 26 percent, while Beletweyne and Dhusamareeb have the highest at 64 percent and 62 percent, respectively.

The gender disparity is pronounced, female unemployment stands at 56 percent, compared to 35 percent among males. This wide gap reflects broader patterns in Somalia’s labour market, where women face greater barriers to employment due to factors such as limited access to opportunities, cultural norms, childcare responsibilities, and displacement-related vulnerabilities—contributing to higher discouragement or underutilization among women.



Wide variations in unemployment across districts- Kahda 26%, Dhusamareeb 62% and Beletweyne 64%

7.2.4 Youth Unemployment

Youth unemployment refers to the share of the youth labour force aged 15–24 years that is unemployed. Youth unemployment as presented in Table 7.1 shows that, across the five districts is substantially higher than the overall unemployment rate, standing at 61 percent compared to the aggregate unemployment rate of 41 percent. This elevated rate underscores the acute vulnerability of young people in the labour market, where limited job opportunities, skills mismatches, and structural barriers (such as conflict, displacement, and economic instability) disproportionately affect this group.

The situation is most severe in Beletweyne, where youth unemployment reaches 83 percent, and among nomadic populations, where it stands at 82 percent. These figures highlight the compounded challenges in conflict-affected or remote pastoral areas, where traditional livelihoods have been disrupted and alternative employment remains scarce.

The gender disparity among youth is even more pronounced than in the general population: male youth unemployment is 53 percent, while female youth unemployment is 74 percent. This stark gap reflects broader gender inequalities in the surveyed districts and Somalia in general, including restricted access to education, training, and job opportunities for young women, as well as cultural and household responsibilities that limit their labour market participation.

7.2.5 Children in Employment

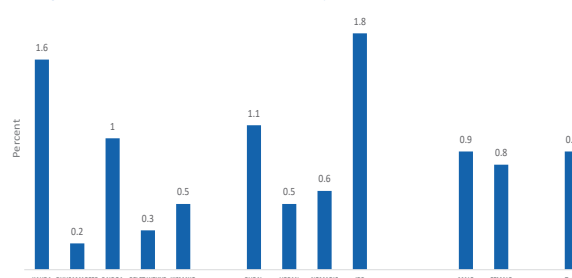
Child labour in Somalia is governed primarily by the Labour Code of 1972 (Law No. 65 of 18 October 1972), which remains the operative national labour legislation. According to the Code (Article 93), it is “unlawful to employ children under the age of 15 years”. Exceptions are permitted in the following limited cases:

- » Pupils attending public or state-supervised trade schools or non-profit-making training workshops; or
- » Members of the employer’s family or relatives who live with the employer, are supported by the employer, and are employed in family undertakings in which no other persons are employed.

Figure 7.1 shows the prevalence of children in employment (aged 10–14 years) which is particularly important given that Somalia law generally prohibits the employment of underage (below 15 years) children. The prevalence remains relatively low across the five districts at one percent. Kahda records the highest proportion of children in employment at 2 percent, followed by Baidoa at one percent, while Dhusamareeb and Beletweyne have the lowest engagement at less than one percent.

The survey shows that children living in the IDP camps exhibit the highest rate at 2 percent, nearly double the rate found in rural areas at one percent and significantly higher than rates in urban and nomadic residence, at 0.5 percent and 0.6 percent respectively. This suggests that the loss of traditional assets often forces displaced households to engage younger members in the informal labour market to secure basic needs. Furthermore, the gender gap in child employment is narrow, with 0.9 percent of males and 0.8 percent of females engaged in work, indicating that these economic pressures affect young boys and girls almost equally.

Figure 7.1 : Children in Employment



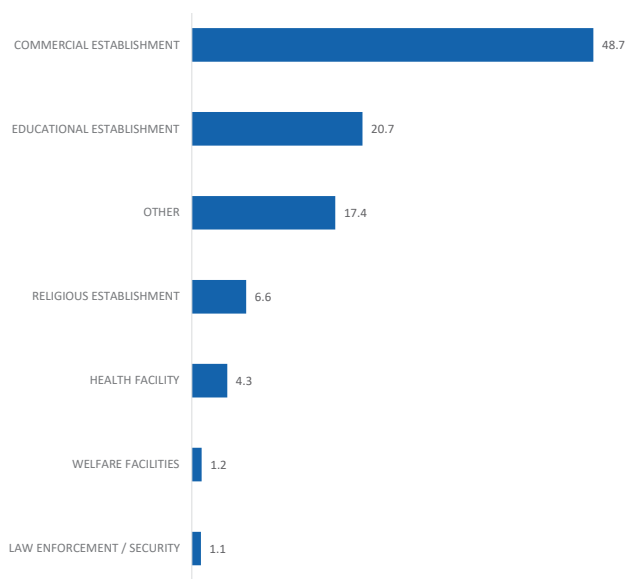
7.3 Interpreting the Economic Landscape

Figure 7.2 presents the distribution of economic and social infrastructure across the five districts. Non-residential structures are a proxy of availability of formal employment. Commercial establishments are the most dominant feature, accounting for nearly half (49 percent) of all non-residential structures.

Table 7.2 presented at the end of this chapter, shows that Beletweyne and Baidoa at 58 percent and 53 percent respectively, have higher concentrations of commercial structures suggesting these districts serve as primary hubs for trade and market activity.

Educational establishments are the second most non-residential structures at 21 percent, while health (4 percent), religious (7 percent), and law enforcement (one percent) facilities make up smaller portions of the landscape (Figure 7.2).

Figure 7.2: Distribution Non- Residential structure



Interestingly, Table 7.2 shows that rural areas show the highest proportion of commercial structures (57 percent) compared to 49 percent in the urban and 40 percent in the IDP settings. This likely reflects the concentration of shops and trade points in specific village centers rather than a broad industrial base that would exist in the urban areas.

7.3.1 Link Between Infrastructure and Employment (Table 7.3 and 7.1)

There is a clear relationship between the physical availability of commercial structures and the activity of the local workforce. For instance, Beletweyne, which has the highest percentage of commercial structures at 58 percent, also reports the highest LFPR at 42 percent. This suggests that where there is a visible marketplace, more people are encouraged to enter the labor force to seek opportunities. However, a high number of non-residential structures does not always guarantee stable jobs; despite Beletweyne's commercial density, it suffers from a 64 percent unemployment rate, indicating that the existing businesses may be too small or informal to absorb the large number of job seekers. Conversely, IDP residents show a lower share of commercial structures at 40 percent, but a higher actual employment rate of 26 percent, likely because displaced persons find themselves engaged in the urban/peri-urban informal economies.

7.3.2 Infrastructure Gaps and Employment

The survey also highlights how gaps in economic and social infrastructure may contribute to labour market vulnerability, including child employment among vulnerable households. In IDP camps, while commercial structures are fewer, there is a higher presence of educational (23 percent) and religious (6 percent) structures (Table 7.2), often supported by NGOs and local communities. Despite the presence of educational structures, children in IDP camps record the highest rate of employment at 1.8 percent (Table 7.1). This highlights a critical disconnect between the presence of educational infrastructure and children's ability to remain outside employment.

The extreme poverty and loss of traditional assets force families to prioritize immediate income over schooling, leading to the higher child labor rates observed among IDP households. Meanwhile, among nomadic populations, youth unemployment was at 82 percent, indicating that limited infrastructure, disrupted pastoral livelihoods, and weak access to diversified employment opportunities can deepen exclusion from the labour market.

7.4 Conclusions and Recommendations

7.4.1 Conclusions

The findings highlight profound structural weaknesses: overall labour force participation stands at just 35 percent while employment stands at 21 percent, leaving the vast majority of the working-age population inactive or excluded from productive work and heightening household dependence on limited or precarious sources of income. Unemployment is alarmingly high at 41 percent overall, surging to 61 percent among youth—with peaks of 83 percent in Beletweyne and 80 percent among nomads—indicating severe exclusion of young people and pastoral communities amid conflict, climate shocks, and livelihood disruptions. Furthermore, the survey identifies a critical vulnerability among the youngest cohorts, with children in employment (aged 10–14 years) reaching 2 percent in Kahda and 2 percent among IDP populations. This engagement, while relatively low overall, underscores how the loss of traditional assets and extreme household poverty can force younger members into the informal labour market despite national legal protections.

Gender disparities are stark and consistent: women record only 19 percent LFPR and employment rates versus 52 percent for men, with female unemployment at 56 percent overall and approaching 75 percent among young females, while occupational

data shows men dominating formal, technical, managerial, and higher-skilled roles across sectors, relegating women to informal petty trading, cleaning, midwifery, certain agricultural tasks, and caregiving positions—patterns rooted in limited access to education/training, cultural norms, mobility constraints, and childcare burdens that perpetuate inequality and constrain economic potential.

7.4.2 Recommendations

Based on the findings on labour force participation, employment, unemployment, youth unemployment, child employment, and gender disparities, the following recommendations are proposed:

- » To directly tackle the low participation and employment rates, implement targeted, large-scale job creation and skills development initiatives—including vocational training (TVET), apprenticeships, and youth entrepreneurship programs—with mandatory quotas and outreach for women, youth, nomadic groups, and IDPs to boost overall LFPR and employment while specifically reducing the 61 percent youth unemployment crisis through demand-aligned skills in agriculture revival, green jobs, digital tools, and light manufacturing.
- » To combat the engagement of children in employment, particularly in displacement settings, strengthen the enforcement of the Labour Code of 1972 while simultaneously expanding of social protection systems and improved access to education to mitigate the underlying economic hardships that drive families to rely on child labour.
- » To address the extreme gender gaps in the labour market, introduce affirmative and supportive measures such as quotas for women in formal sectors (health, education, business administration), mentorship schemes, safe workplace policies

(childcare facilities, flexible hours, secure transport), and targeted campaigns to challenge norms—enabling greater female entry into higher-value occupations and improving household resilience.

- » To mitigate geographic and displacement-driven exclusion—evident in high youth unemployment among nomadic populations and in Beletweyne and Dhusamareeb, as well as relatively higher but precarious employment among IDPs, location-specific interventions are required. These should include climate-resilient livelihood diversification and mobile skills training for nomadic groups (e.g., drought-resistant agriculture and solar-powered systems), urban informal-sector protections, job-matching services, and anti-exploitation measures for IDPs, as well as targeted infrastructure development, improved security, and private-sector partnerships in high-unemployment districts to promote inclusive recovery and reduce localized labour market inefficiencies.
- » To enhance routine sex-disaggregated monitoring of labour and occupational data to inform evidence-based policy responses, monitor progress in reducing disparities, and advance equitable labour force participation for sustainable and inclusive growth in Somalia.

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Table 7.1 Employment Status of Working Age Population

ID Background Characteristics	Labor force participation rate (%)	Employment rate (%)	Unemployment rate (%)	Youth unemployment rate (%)	Total
District					
Kahda	33.8	25.0	26.0	44.2	57355
Dhusamareeb	34.0	12.8	62.3	79.0	33740
Baidoa	33.7	23.9	29.1	48.1	60201
Belet weyne	41.7	14.9	64.1	82.5	39336
Kismayo	32.5	21.1	35.3	59.2	50564
Total	34.8	20.5	41.0	61.1	241196
Place Residence					
Rural	35.4	17.5	50.4	64.7	22666
Urban	33.9	18.8	44.5	68.9	142313
Nomadic	33.7	7.5	77.8	82.0	3151
IDP	36.7	25.9	29.5	42.9	73066
Total	34.8	20.5	41.0	61.1	241196
Sex					
Male	52.4	34.1	34.9	52.6	107204
Female	19.0	8.3	56.4	74.1	113920
Total	34.8	20.5	41.0	61.1	221124
Note: all numbers are for population aged 10 and older, youth unemployment based on 15-24 years old.					

Table 7.2 Distribution of Non- Residential structures

Type of non-residential structure	District						Residence				
	Kahda	Dhusamareeb	Baidoa	Beletweyne	Kismayo	Total %	Rural	Urban	Idp	Total (%)	Total (N)
Commercial establishment	35.6	41.7	53.2	57.9	51.1	48.7	57.3	49	39.9	48.7	3,526
Educational establishment	26.7	21.2	16.7	21.1	19.1	20.7	18.1	20.6	23.3	20.7	1,499
Health facility	3.3	4.9	3.3	5.4	4.4	4.3	3.9	4.5	3.7	4.3	311
Law enforcement / security	0.8	3.4	0.4	0.5	0.8	1.1	1	1.2	0.8	1.1	83
Religious establishment	5	9.8	4.2	6.3	7.8	6.6	6.7	6.7	5.8	6.6	477
Welfare facilities	0.5	1.6	1.1	1.6	1.2	1.2	0.3	1.4	1.1	1.2	87
Other	28.1	17.4	21.2	7.3	15.6	17.4	12.7	16.5	25.4	17.4	1,259
Total	1,221	1,415	1,608	1,666	1,332	7,242	1,048	4,956	1,176	7,242	7,242
Note Nomadic is not included in this analysis because they only had 62 non-residential structures.											

THE SOCIO- DEMOGRAPHIC SURVEY 2026



The Federal Republic of Somalia
Somalia National Bureau of Statistics (SNBS)
Socio-Demographic Survey (SDS)
2026

