Ministry of Health and Human Services
Federal Republic of Somalia

SOMALIA NUTRITION STRATEGY

2020 -2025

Somalia Nutrition Strategy

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List of Acronyms

BMI	Body Mass Index
BPHNS	Basic Package of Health and Nutrition Services
BSNP	Basic Nutrition Services Programme
C4D	Communications for Development
CHDS	Child Health development services
CHWs	Community Health Workers
CRF	Common Results Framework
DHIS	District Health Information System
ECCD	Early Childhood Care and Development
ECD	Early Childhood Development
EPHS	Essential Packages of Health Services
FAO	Food and Agriculture Organization
FGM	Female Genital Mutilation
FGS	Federal Government Somalia
FMoH	Federal Ministry of Health
FSNMS	Food Security and Nutrition Monitoring System
GAM	Global Acute Malnutrition
GDP	Gross Domestic product
HC	Health Centre
HMIS	Health Management Information System
HSSP	Health Sector Strategic Plan
ICCM	Integrated Community Case Management
IDP	Internally Displaced Persons
IMAM	Integrated Management of Acute Malnutrition
IYCF	Infant and Young Child Feeding
IYCN	Infant and Young Child Nutrition
M&E	Monitoring and Evaluation
MAM	Moderate Acute Malnutrition
MCH	Mother and Child Health
MIYCN	Maternal, Infant and Young Child Nutrition
MNCH	Maternal, Neonatal and Child Health
MoH	Ministry of Health
MUAC	Middle Upper Arm Circumference
NDP	National Development Plan
NIMS	Nutrition Information Management Systems
ORS	Oral Rehydration Salts
OTP	Outpatient Therapeutic Programme
PHCC	Primary Health Care Centres
PHCU	Primary Health Care Units
RMNCAH	Reproductive, Maternal, Neonatal, Child and Adolescent Health
SMAC	Social Mobilization, Advocacy and Communications Strategy
SNS	Somalia Nutrition Strategy
SUN	Scaling Up Nutrition Movement
WHO	World Health Organization

Introduction

Although there have been improvements in the nutrition status of women and children in Somalia in the last five years, children and women continue to suffer from multiple nutritional deprivations, constituting a violation of children's right to survival, development and to adequate health and nutrition. The greatest burden of all forms of malnutrition is shouldered by children, women of reproductive age and adolescents from the poorest and most marginalized communities, perpetuating poverty across generations. The high burden of hunger and malnutrition is largely a result of the poverty trap that exists in Somalia, with the country being among the least developed countries globally. It has a GDP of US$ 7.3 billion, GDP per capita of US$ 499, a poverty headcount rate of more than 51 percent. Over seventy percent of the population engages in agro-pastoralism, pastoralism, agriculture and charcoal production[1].

In Somalia, nutritional deficiencies stemming from inadequate maternal and child nutrition pose a serious problem that has devastating consequences for infants, young children, adolescent girls and women. Undernutrition in communities results in increased morbidity, mortality, cognitive delays and losses, long-term disability and poor health into adulthood impacting the next generation, which affects the overall social and economic development of the country. It is estimated that undernutrition causes 45 percent of all child deaths in settings like Somalia[2] – where the neonatal, infant and under-five mortality rates are among the highest globally.

Delivery of nutrition services remains a key challenge. The existing functional health facilities are inadequate and inequitably distributed across regions and districts, creating a need for the Federal and State Ministries of health to increase the number of facilities in order to bring them closer to vulnerable populations. Health facilities are also poorly equipped to provide quality nutrition services.

There is an increased understanding of the short- and long-term consequences of undernutrition especially during the first 1000 days in the life of a child (a critical period of vulnerability between conception and a child's second birthday when nutritional deficits are potentially irreversible for life). This Strategy is guided by an emergent body of evidence that supports the delivery of key interventions to address undernutrition and micronutrient deficiencies during the first 1000 days and best practices stemming from a global and local application of key interventions in similar settings.

After more than twenty years of violence and political instability, Somalia is on the way to recovery with the establishment of the Federal Government of Somalia. This second iteration of the Somalia Nutrition Strategy is ambitious in its scope and in the depth of the results it seeks to achieve and fully cognizant of the need to strengthen the institutional capacity of Federal and State ministries of health. It reflects Somalia's commitment to

[1] Somali Roadmap towards Universal Health Coverage (2019-23)

[2] Black et al. Maternal and child undernutrition and overweight in low-income and middle-income countries. Lancet. 2013. 2013 Aug 3; 382(9890):396.

address the unacceptably high levels of malnutrition and translates into a single comprehensive national health-sector plan aimed at improving maternal and child nutrition outcomes to safeguard the survival, health and development of Somali children. As a policy instrument, the Strategy will not be implemented in a siloed manner, but in concert with other policies and strategies, including the Somalia Multi-Sectoral Nutrition Strategy

Policy Context

The Somali government's commitment to improve nutrition through evidence-informed strategies commenced with the adoption of the first Nutrition Strategy (2011-2013). The government's current commitment is guided by key policy documents that include the National Development Plan (2020-2024)[3], the SUN Multi-sectoral Common Results Framework (CRF) and Strategy (2020-2024) in addition to health sector policy documents.

The National Development Plan outlines several proven and cost-effective nutrition-specific interventions integrated into the wider set of health interventions under the country's Essential Package of Health Services. It identifies priority interventions that include enhanced and expanded quality services for the management of acute malnutrition and the prevention/treatment of micronutrient deficiencies. It aspires to increase access to and utilisation of micronutrient supplements, fortified supplementary food among vulnerable groups and deworming interventions through health campaigns, health facilities, schools, outreach programmes, and other nutrition programmes. Food based interventions are identified as a priority that should scaled up to prevent undernutrition in high-risk populations.

The Somalia Nutrition Strategy (2020-2025) is in line with the NDP and other downstream policies and strategies and is strategically designed to address the triple burden of malnutrition (coexistence of overnutrition, undernutrition and micronutrient deficiencies). It is also designed to contribute to the achievement of the nutrition-related Sustainable Development Goals (SDGs), World Health Assembly resolutions and Global Nutrition Targets for 2025.

Core Principles

Strengthening Gender and Social Equity

Interventions and program objectives will focus on reaching the most disadvantaged and vulnerable social groups. Particular attention will be paid in this regard to women and girls' equity and empowerment and excluded groups, including people with disabilities. To this end, all program and project data shall be gender-disaggregated, and nutrition interventions will include a gender analysis, and targets and indicators that are appropriately gendered.

[3] The Ministry of Planning, Investment and Economic Planning, Federal Government of Somalia, Somalia National Development Plan 2020-2024, http://mop.gov.so/wp-content/uploads/2019/12/NDP-9-2020-2024.pdf Accessed 5 march 2020

Building the Resilience of Households, Communities and Government

Risk identification and management will form a core aspect of interventions. Nutrition interventions will be implemented with the view to increasing the resilience of communities and households. Improving nutrition outcomes and enhanced availability, access and affordability of nutritious diets is recognized as a dimension of poverty reduction, which when added to benefits of other monetary interventions, will increase resilience of households and communities and ensure that gains made can withstand internal and external shocks.

Strengthening the Interface between Humanitarian and Development Planning

Interventions in the nutrition strategy are almost entirely dependent on external donors and partners working in the humanitarian field. It is imperative for development partners to explore ways to strike balance between short-term life-saving humanitarian interventions with long-term efforts to reduce poverty, vulnerability and malnutrition. It is critical for humanitarian relief to continue to meet the immediate needs of crises effected populations, including by reducing acute (severe and moderate) malnutrition and mortality. However, it should be recognized that humanitarian relief needs to be formulated and delivered in ways that strengthen population resilience to future crises, FMoH and State MoH's capacity for emergency preparedness and response and to facilitate the longer-term transition from humanitarian to longer-term development assistance. Participatory planning should prioritize engaging local communities and getting their active participation and insights on how best to increase the resilience of their communities and the best use of resources.

Governance and Institutional Building

The Strategy's interventions include activities that strengthen the capacity of Federal and State Ministries of Health for effective governance of the health sector. It is widely acknowledged that strong institutions will assist Somalia to recover from many years of political instability and chronic health and nutrition crises which have contributed to the fragility of the State. Because of extended periods of conflict and instability, Somalia has become the quintessential fragile state. Strengthened Ministries at the Federal and State level will assist to reverse the destruction of the health infrastructure and lead to the provision of quality health and nutrition services.

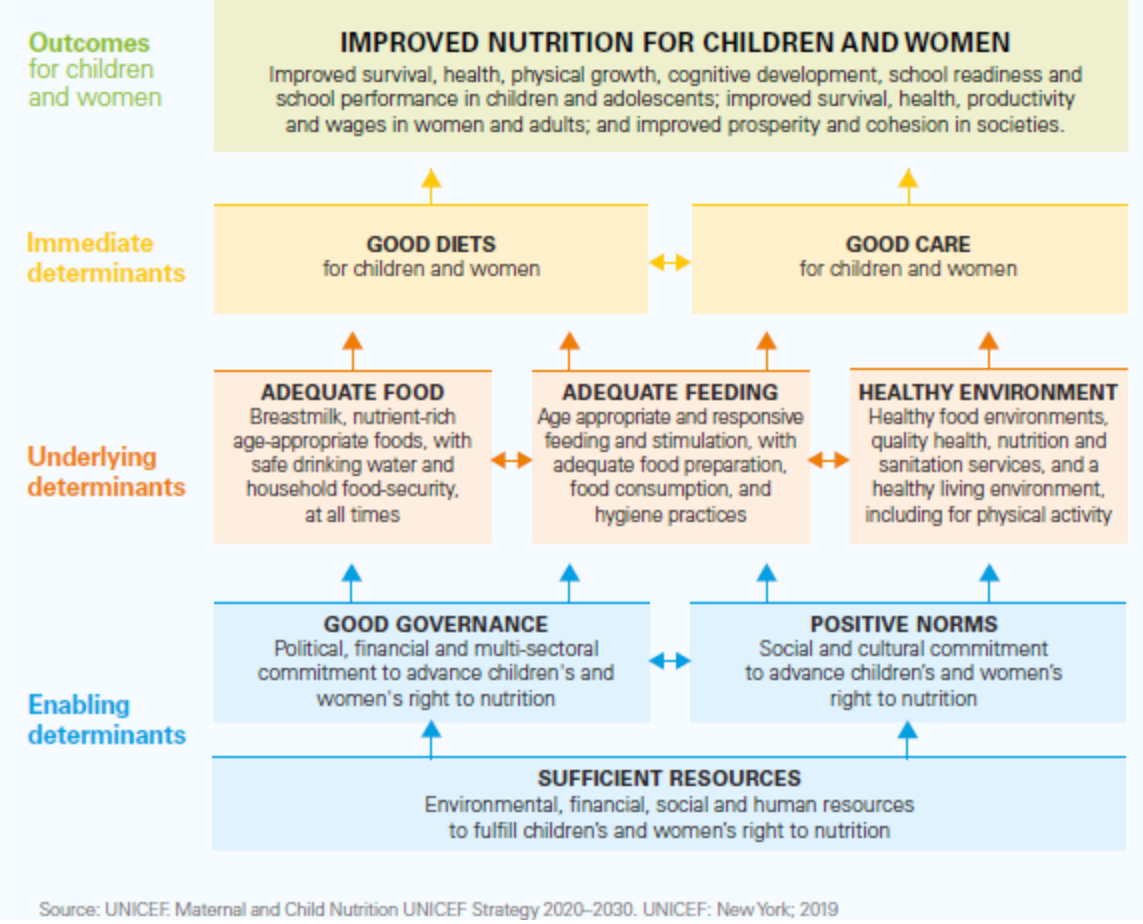
Private Sector Partnerships

The complexity of the causal factors of undernutrition will require local private sector partnerships to ensure sustainable solutions in the fight against all forms of malnutrition, including local production fortified and nutrient dense foods. The SNS 2020-2025 identifies and prioritizes evidence-informed approaches that will form the basis of public-private partnerships in the efforts to reduce malnutrition in Somalia. The SNS (2020-2025) recognizes that a key to its success is the creation of an environment where private actors and public

sector officials discuss the regulatory and competitiveness environment required to develop a structured framework that works for both.

Conceptual Framework

The Somalia Nutrition Strategy (2020-2025) aligns with the UNICEF (2020-2030) Conceptual Framework of the Determinants of Maternal and Child Nutrition which builds on UNICEF's 1990 framework on the causes of child undernutrition and acknowledges the evolving and multiple nature of maternal and child malnutrition. The Conceptual Framework uses a positive narrative about what contributes to improving maternal and child nutrition and preventing malnutrition in all its forms in children, adolescents and women. It provides conceptual clarity about the enabling, underlying and immediate determinants of ma-



Source: UNICEF. Maternal and Child Nutrition UNICEF Strategy 2020–2030. UNICEF: New York; 2019

ternal and child nutrition, and about the outcomes resulting from improved nutrition in children, adolescents and women (see below).

UNICEF 2020 Conceptual Framework of the Determinants of Maternal and Child Nutrition

The Somalia Nutrition Strategy (2020-2025) lays emphasis on promoting an improved access and availability of adequate maternal nutrition before and during pregnancy and lactation and nutritious, diverse and safe foods in early childhood. It recognizes that the

children who are not growing well are the victims of malnutrition and seeks to intervene on the enabling, immediate and underlying determinants of maternal and child nutrition.

As per the UNICEF 2020-2030 framework, the government of Somalia and nutrition stakeholders recognize that for children to eat well at each stage of growth, not only must food be of good quality and consistently available, accessible and affordable, but several other factors must be in place. Their families need resources. These include physical availability of food and money, but also knowledge of how to access and provide a healthy diet. They need support in the face of limited availability of fortified and nutrient dense foods, financial stress and time pressure. They need access to quality health services and a healthy environment, free of disease and unsanitary conditions. Children's diets are also determined by broader forces at play, such as political commitment, economic priorities and social norms (UNICEF 2020)[4]

Gender Dimensions of Nutrition

There are many socio-cultural issues that affect maternal, infant and young child nutrition and restrictive gender roles in society is a key element of these. The links between mothers' education, the mothers age at first pregnancy and nutrition status of their children are well-established, highlighting that education of girls through secondary level and beyond is a critical intervention for reducing early pregnancies and establishing well-nourished children, households and communities. In addition, delaying first pregnancy beyond the adolescent years is a vital measure for the health and nutrition of girls and young women, as well as their children (Somali Multi-Sectoral Nutrition Strategy, 2019). Gender inequalities are both a cause and an effect of hunger and malnutrition, with higher levels of gender inequality being associated with higher levels of undernutrition,

In the Somalia context, efforts to mainstream gender in the nutrition strategy and successes of improving the nutritional status of women and girls will contribute to reducing gender inequality and at the same time breaking the cycle of intergenerational malnutrition. It is known that improving women's decision-making power relative to that of men is associated with improved maternal and child nutrition status. This contrasts poorly with the current situation in Somalia where women; face widespread and severe social and economic discrimination; experience high rates of violence; undergo Female Genital Mutilation (FGM); frequently undergo marriage while still in childhood; lack of birth spacing and have high maternal mortality. In many areas of Somalia customary law (Xeer) and religious law (Sharia) operate in place of or alongside the secular state legal system and women have historically suffered severe discrimination within this customary and legal processes.

[4] UNICEF (2019).The State of the World's Children 2019.Children, Food and Nutrition: Growing well in a changing world. UNICEF, New York.

Objectives, Expected Results, Initiatives and Interventions

This document articulates the Somalia National Nutrition Strategy for the period 2020-2025 which coincides with the second Five-Year National Development Plan (NDP 9, 2020-2024)[5] and provides an evidence-informed update to the first National Nutrition Strategy (2011-2013). It has been developed to align to existing policy initiatives of the Somali government and translates into concrete strategic actions that can address the unacceptably high levels of malnutrition in Somalia. This Strategy is prescriptive in the sense of providing the overarching strategic results required to arrest and reverse the high levels of malnutrition in Somalia. It dovetails and complements the strategic activities of the Somalia Multi-sectoral Nutrition Strategy (2019-2024). Greater detail and nuance of the implementation of this strategy should be included in a plan of action and accompanying monitoring plan.

The expected results for the Somalia Nutrition Strategy (2020-2025) are designed to address all forms of malnutrition (undernutrition, micronutrient deficiencies and overweight) that threatens the survival, growth and development of children and vulnerable groups. To achieve this goal, the Strategy seeks to focus on activities aimed at reducing all forms of malnutrition including stunting, wasting, micronutrient deficiencies, overweight and obesity.

VISION[6]

The vision of the Somalia Nutrition Strategy (2020-2025) is that the Somali people enjoy the highest attainable standard of health and quality of life, including increased availability, access and affordability of nutritious diets and universal, equitable access to essential quality health services with a priority focus on maternal, neonatal and child health and nutrition, and on the prevention and control of high burden diseases and related risk factors.

MISSION[7]

To ensure the provision of quality essential nutrition specific and sensitive services for all people in Somalia, with a focus on women, children, and other vulnerable groups and to strengthen the national and local capacity to deliver evidence-based and cost-effective services based on the Essential Package of Health Services (EPHS) and Primary Health Care approach.

GOAL

The goal of the strategy is to end hunger and achieve food security and improved nutrition.

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[5] The Ministry of Planning, Investment and Economic Planning, Federal Government of Somalia, Somalia National Development Plan 2020-2024, http://mop.gov.so/wp-content/uploads/2019/12/NDP-9-2020-2024.pdf Accessed 5 march 2020

[6] Adapted from the Somali Health Policy – The Way Forward, 2014

[7] Adapted from the Second Phase Health Sector Strategic Plan (2017 – 2021). Federal Ministry of Health and Human Services

TARGETS

The targeted results of the Nutrition Strategy are that;

- By 2025, the proportion of children who are stunted and aged under five years will decrease by 6 percentage[8] points using the 2019 baseline estimates (derived from the Somalia micronutrient survey, 2019)
- By 2025, more than half of the children aged under two years will be consuming the minimum acceptable diet.
- By 2025 the proportion of children aged 5 years and below who are wasted will reduce from 13.1[9] percent to less than 10%

OBJECTIVES

The Somalia Nutrition Strategy (2020-2025) envisions the following nine objectives;

Objective #1:

To prevent malnutrition in the first five years of life, with particular emphasis on the first 1000 days of life from conception to 2 years of age

Objective #2:

To prevent over- and undernutrition in school-age children and adolescent boys and girls

Objective #3:

To prevent over and undernutrition in women of child-bearing age, with particular focus on pregnant and lactating women

Objective #4:

To provide care and treatment for acute malnutrition in development and humanitarian contexts

Objective #5:

To increase awareness and demand of optimal IYCF practices and provide caregivers with knowledge, skills and support healthy IYCF practices

Objective #6:

To strengthen capacities at all levels, including at community level, to assess the nutrition situation and to design, implement and monitor nutrition interventions

Objective #7:

To create and sustain an enabling policy environment for preventing maternal and child malnutrition in Somalia

[8] Target based on the Ministry of Health and Human Services Federal Republic of Somalia, Localization of Health Related, Sustainable Development Goals 2030 for Somalia

[9] FAO FSNAU, Somalia 2019 Post Deyr Seasonal Assessment Key Nutrition Results Summary. 3 February 2020 https://www.fsnau.org/downloads/2019-Post-Deyr-Assessment-Key-Nutrition-Results-February-2020.pdf

Objective #8:

To mainstream nutrition as a key component of nutrition-sensitive sectors, including the private sector, agricultural sector and social protection sector.

Objective #9:

To integrate nutrition into the health system strengthening

Objective #1: Prevention of malnutrition in the first five years of life with an emphasis on the first 1000 days

Targets by 2025

1. The proportion of children aged 0-6 months who are exclusively breast-fed increases to 53+% from 33% by 2025
2. The proportion of children who are fed the minimum acceptable diet increases from 9% to 30% by 2025
3. Proportion of vulnerable children accessing specialized nutritious foods are >70 per cent in the targeted areas annually by 2025
4. The proportion of women aged 15-49 years who consume an adequately diverse diet with at least 5 out of 10 defined food groups[10] increases by 50 percent from the 2019 baseline
5. Prevalence of anemia among children aged 6-59 months of age (hemoglobin concentration <11 g/dl) decreases to <30% from 59%
6. Deworming coverage reaches 80% of children under five years old
7. Proportion of targeted children getting biannual vitamin A supplementation is at least 80%
8. 85% of health workers are trained and sensitized on micronutrients deficiency control and management by 2025

It is estimated that undernutrition causes 45 percent of all deaths in children under 5 years in settings similar to Somalia (Black et al, 2013)[11] – which elevates the priority of preventive measures outlined in this objective. Nutrition continues to be a major problem in Somalia, as evidenced by the prevalence of acute malnutrition that consistently exceeds the World Health Organization (WHO) emergency thresholds, high levels of micronutrient deficiencies and extremely poor infant and young child feeding practices.

[10] Fiat Panis, II F, European Union, USAID, FHI360. Introducing the Minimum Dietary Diversity – Women (MDD-W) Global Dietary Diversity Indicator for Women; 2014 15-16 July; Washington DC. http://www.fao.org/fileadmin/templates/nutrition_assessment/Dietary_Diversity/Minimum_dietary_diversity_-_women__MDD-W__Sept_2014.pdf.

[11] Black et al, Maternal and child undernutrition and overweight in low-income and middle-income countries. Maternal and Child Nutrition Study Group. Lancet. 2013 Aug 3; 382(9890):427-451. doi: 10.1016/S0140-6736(13)60937-X. Epub 2013 Jun 6.

By focusing on preventive nutrition actions, the Strategy aims to keep children well-nourished during the first 1,000 days of life to avoid irreversible damage that can impact their health and productivity for a lifetime. Infant and Young Child Nutrition (IYCN) related preventive interventions include behavioral interventions (breastfeeding, optimal complementary feeding etc.), micronutrient supplementation, regulatory actions etc. The Strategy is consistent with Somalia IYCF program strategies that supports households and communities to adopt optimal nutrition practices through implementing small changes in feeding behaviors as the most effective and cost-efficient way to address malnutrition. Prevention of malnutrition not only protects children from lifelong effects, but it costs far less than treatment, which can be a burden for households, communities, and on the Somalia health system.

Because the impact of undernutrition already starts at conception, ensuring that pregnant and lactating women are adequately nourished requires intervening before pregnancy, i.e., during adolescence and before a next pregnancy. Therefore, interventions focusing on prevention of malnutrition, such as ensuring that pregnant and lactating mothers are adequately nourished and consuming an adequately diverse diet will ensure that children receive the appropriate feeding to decrease the prevalence of malnutrition.

The Somalia Nutrition Strategy (2020-2025) also supports preventive and curative interventions outlined in the Somalia Micronutrient Control Strategy[12] for the control and management micronutrient deficiencies. These include: i) breastfeeding ii) supplementation for prevention and treatment iii) home-based food fortification iv) diet diversification v) commercial food fortification and vi) promotion of public health measures and social behavior change communication. The main micronutrients of public health concern in Somalia include iodine, iron, and vitamin A. In Somalia 59% of children aged under-five and 50% of women suffer from anemia (HSSP 2017-2021)[13]. Though deficiencies in these micronutrients affect all population groups, the worst affected are children under 2 years and pregnant and lactating women. Micronutrient deficiencies' most serious and lasting damage occurs during pregnancy and the first two years of life. Health consequences suffered during this period are irreversible at a population level even if good nutrition is provided later in life, which creates a vicious cycle of under-development, especially to the already underprivileged groups.

The SNS (2020-2025) recognizes the importance of *preventing* malnutrition in areas of chronic food insecurity using specialized nutritious foods that target vulnerable population groups to improve nutrition during the first 1000 days of life. Approaches that supplement the diets of vulnerable and food insecure households include school feeding, food for work programs and provision of specialized nutritious foods through supplementary feeding (targeted and blanket programs). Specialized nutritious foods can increase nutrient intake for children aged 6-23 months to complement breast milk. The 2009 nutrient gap study in Somalia found that provision of Super Cereal Plus, a micronutrient powder

[12] Somalia national micronutrient deficiency control strategy (2014 – 2016)

[13] Replace with data from Micronutrient survey of 2019

or a Lipid-based Nutrient Supplement could reduce the daily cost of providing a nutritious diet to a child aged 12-23 months by 14, 22 and 49 percent respectively.

Interventions and Initiatives

Result 1.1: Improved nutritional status of children aged 0–24 months

1. Promotion, support and protection of optimal breastfeeding practices for infants aged 0–6 months at community and facility levels through promoting early initiation of breastfeeding within one hour of birth, exclusive breastfeeding in the first 6 months of life and continued breastfeeding up to 2+ years.
2. Establishment of a phased scaling-up of baby friendly health facilities to ensure that the health care system protects, promotes and supports optimal breastfeeding practices while providing women with the support they require
3. Promotion of adequate and age-appropriate complementary feeding; introduction of solid, semi-solid or soft foods from the age of 6 months, ensure minimum dietary diversity through consumption of at least four out of the seven food groups[14] and consumption of a minimum meal frequency
4. Prevention and control of micronutrient deficiencies through promotion of optimal diets, supplementation, fortification and age-appropriate public health measures e.g. malaria control etc.
5. Early detection and management of acute malnutrition and common childhood infections consistently with national IMAM guidelines
6. Supplemental feeding of children and pregnant women in chronically food insecure areas to prevent malnutrition in the 1000 days window
7. Enforcing the Code of Marketing of Breast Milk Substitutes in hospitals, NGO and private facilities

Result 1.2: Improved nutritional status of children 24–59 months

1. Promotion of appropriate dietary practices including utilization of diversified foods and continued feeding during illness/recovery.
2. Prevention and control of micronutrient deficiencies through promotion of optimal diets, supplementation, fortification and public health measures (e.g. deworming, malaria control, ORS with zinc to treat diarrhea etc.)
3. Early detection and management of acute malnutrition and common childhood infections
4. Weighing and measuring of infants and children presenting to primary healthcare facilities to determine obesity status. Obese children should be assessed to

[14] UNICEF, WHO Indicators for assessing infant and young child feeding practices; Part 1. Definitions, 2008

develop a management plan by qualified health workers (as per the WHO guidelines of integrated childhood illness, 2017)[15]

5. Integrating Early Childhood Care and Development (ECCD) stimulation with existing community and facility-based child nutrition activities.

Objective #2: To prevent over- and undernutrition in school-age children and adolescent boys and girls

Targets by 2025

1. Sugar consumption in Somali school-age children and teenagers decreases from 19 percent[16] to less than 10% percent of total energy intake
2. Prevalence of anaemia among school-age children and adolescent girls is reduced by 50% by 2025
3. The proportion of adolescent girls aged 15–19 with a BMI <18.5 reduced by five percent
4. At least 80% of formal institutions, including schools, in Somalia promote hygiene and good nutrition

The SNS (2020-2025) is consistent with the Somalia RMNCAH Strategy (2019-2023) that identifies adolescent health as a priority strategic areas and outlines addressing undernutrition, particularly micronutrient deficiencies as a key intervention targeting adolescents. Investing in adolescent health brings triple dividends: better health for adolescents now, improved well-being and productivity in their future adult life and reduced health risks for their children (WHO, 2018)[17].

The Somali Nutrition Strategy supports evidence-informed interventions that include actions to promote healthy diets; provision of additional micronutrients through supplementation; managing acute malnutrition; promoting good preconception and antenatal nutrition, reducing the consumption of sugar in diets and promoting hygiene and disease prevention. Sugars contribute to the overall energy density of diets and higher intakes threaten the nutrient quality of the diet by providing significant energy without specific nutrients, leading to unhealthy weight gain and increased risk of obesity and various NCDs. WHO recommends a reduced intake of sugar throughout the life course. In both

[15] Guideline: assessing and managing children at primary health-care facilities to prevent overweight and obesity in the context of the double burden of malnutrition. Updates for the Integrated Management of Childhood Illness (IMCI). Geneva: World Health Organization; 2017. Licence: CC BY-NC-SA 3.0 IGO.

[16] WFP, Fill the Nutrient Gap Summary Report, October, 2019

17 Guideline: implementing effective actions for improving adolescent nutrition. Geneva: World Health organization; 2018. Licence: CC BY-NC-SA 3.0 IGO.

adults and children, WHO recommends reducing the intake of sugars to less than 10% of total energy intake[18].

Assuring optimal nutrition among adolescents requires coordinated actions across multiple sectors. As adolescents undergo a period of rapid growth and development, adequate nutrient intake (of both macro and micronutrients) is critical. Many of the risk factors that impact maternal and newborn health exist right from adolescence, including nutritional deficiencies. Pre-pregnancy wasting in adolescents (usually reflected as low body mass index—BMI < 18.5) increases perinatal risks including stillbirths, preterm births, small for gestational age, low birth weight (LBW) babies and increased risk of maternal morbidity and mortality, osteoporosis, night blindness, increased risk of infection, lethargy and weakness, pre-eclampsia and interrupted linear growth.

School feeding is an important aspect of achieving multiple goals among school-age children in food insecure areas. It can be used to reduce malnutrition and educate children about nutrition specific and nutrition-sensitive topics. "For children who show up to school on an empty stomach, it can be difficult to focus on lessons. In other instances, for economic reasons, children simply do not go to school because they are required to help their families in the fields or around the house. A daily school meal can mean better nutrition and health for children and it can also act as a strong incentive for parents to regularly send their children to school. The WFP's School Feeding in Somalia provides a vital safety net for vulnerable households, particularly during lean seasons and times of crisis when children are likely to be pulled out of school" (WFP, 2019)[19]. School meals including Super Cereal, cereal, a micronutrient powder or fortified maize meal have been shown to reduce the cost of a nutritious diet by 30, 26 and 23 percent, respectively[20].

The SNS (2020-2025) reinforces the significance of investing in the prevention of anemia for non-pregnant women of reproductive age, including adolescent girls aged 15–19 years (in addition to adult women aged 20–49 years) using WHO-approved approaches like the weekly iron and folic acid supplementation. Iron deficiency anemia is among the top 10 causes of disability-adjusted life years lost among adolescents. Although other sectors play important roles in reducing anemia, the health sector plays a critical role in the generation of evidence and implementation of supplementation programs through primary health care facilities.

The main challenges of improving nutrition outcomes for adolescents in Somalia include difficulties related to accessing essential health services, accessing a nutritious diet and accessing nutrition education, which impacts current and future nutrition outcomes. The Somalia Nutrition Strategy relies on other broader nutrition-sensitive strategies to mitigate these challenges and mainly focuses on improving adolescent nutrition through promoting positive nutrition behaviors in adolescents.

[18] Diet, nutrition and the prevention of chronic diseases: report of a Joint WHO/FAO Expert Consultation. WHO Technical Report Series, No. 916. Geneva: World Health Organization; 2003 (http://www.who.int/dietphysicalactivity/publications/trs916/en/).

19 WFP Somalia, 2019, School Feeding Programme Using Scope Saving Lives Changing Lives

20 This paragraph consists of feedback and insights from WFP, changes suggested by UNICEF need to be discussed between the two UN agencies.

Interventions and Initiatives

Result 2: The nutritional status of school-age children and adolescents (10–19 years), including out-of-school, children is improved

1. Provision of comprehensive and routine nutritional assessment and counseling services for adolescents at community, school and health facilities aimed at reducing free sugars intake in children and adult meals and reducing consumption of sugar-sweetened beverages to reduce the risk of childhood overweight and obesity
2. Conduct Behavioral Change Communication to prevent harmful traditional practices that cause under and over-nutrition in school-age children and adolescent girls
3. Streamline nutrition education into the education curriculum aiming to delay early marriage till age 18 and shift social norms on food taboos that hinder adequate nutrition for adolescent girls.
4. Conduct regular monitoring of the nutritional status of school-age children/students together with biannual de-worming.
5. Promote the reduction of Sugar intake among adolescents to less than 5% of total energy intake—which is less than the recommended 10% of total energy intake—a further reduction suggested by WHO[21]
6. Provision of micronutrient and protein-energy supplements or fortification programs in targeted areas.
7. Management of moderate and severe malnutrition among school-age children and adolescents using WHO recommendations for management of severe acute malnutrition.

Objective #3: To prevent over- and undernutrition in women of child-bearing age with particular focus on pregnant and lactating women

Targets by 2025

1. Anemia (hemoglobin concentration <11 g/dl) in women of reproductive age decreased from 49% to under 20%
2. Proportion of vulnerable pregnant and lactating women and girls (PLWGs) accessing specialized nutritious food are >70 percent in the targeted areas annually and by 2025.
3. 80% of all pregnant women access iron and folic acid supplements

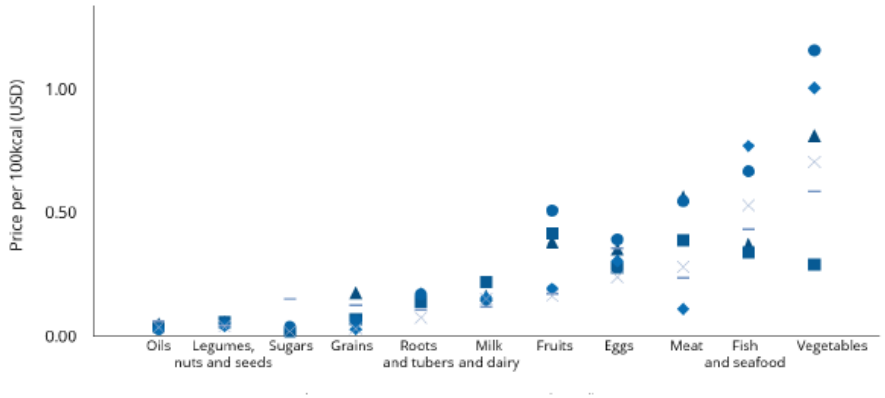
[21] Guideline: implementing effective actions for improving adolescent nutrition. Geneva: World Health Organization; 2018

4. Proportion of non-pregnant women of reproductive age with a BMI between 18.5 and 24.9 increases from x to y

This objective aligns with other strategy documents of the Somali government, particularly the Somalia Health Policy (MoH, 2014) and the RMNCAH (2019-2023) strategy that seek to improve the nutrition status of women of child-bearing age, pregnant women and lactating mothers.

The 2019 "fill the nutrient gap report" included a cost of diet analysis (WFP, 2019)[22] that found that energy-dense foods such as grains, oil and sugar are cheaper per calorie than nutrient-dense foods in Somalia. The study also found that the availability of nutritious foods in local markets is limited. This creates a situation where the poorest and most vulnerable continually utilize non-nutritious foods that increases the risk of various forms of malnutrition.

Food prices per 100Kcal (US$) per the "fill the Nutrient Gap" Analysis 2019



The study found that Somalis derive their dietary energy mainly from staples (46 percent), oil (14 percent) and sugar (19 percent); nutritious foods provide 20 percent of dietary energy, mainly from meat (5 percent), milk (4 percent), fruit (4 percent) and pulses (3 percent). This consumption pattern did not vary substantially across livelihood systems. The cost of diet study found that vegetables, fruits and animal-source foods were most expensive per calorie (see figure below) and their prices varied widely across the country. On average, energy-dense foods such as grains, oil and sugar cost $0.04 (oil, sugar) and $0.08 (grains) per 100 calories; nutrient-dense foods cost $0.32 (eggs) and $0.52 (vegetables) per 100 calories. Meeting energy needs is cheapest with commodities low in other essential nutrients, including protein, vitamins and minerals.

Interventions and Initiatives

Result 3: The nutritional status of women of child-bearing age (15–49 years) is improved consistently with the RMCAH Strategy (2019-2023)

[22] WFP, Fill the Nutrient Gap Summary Report, October, 2019,

1. Provision of comprehensive and routine nutritional assessment, counselling and support services at health facilities including, screening for anaemia at antenatal and postpartum visits, promoting optimal maternal nutrition including adequate intake of diversified foods and daytime rest during antenatal and postnatal periods etc.
2. Provision of counseling for increased physical activity (protective from overweight) and for reduction of sedentary lifestyles (causative for overweight)
3. Provision of specialized nutritious foods to malnourished pregnant and lactating women.
4. Ensure that pregnant and lactating women have access to micronutrient services including; daily iron and folic acid supplementation in pregnant women with the WHO- recommended daily intake of 30-60 mg of elemental iron and 400 µg (0.4mg) of folic acid, deworming during the 2nd and 3rd trimester of pregnancy.
5. Distribution and utilization by pregnant and lactating women of insecticide-treated nets in all malaria-endemic zones.
6. Promote access and affordability of time and labour-saving technologies to minimize the workload of women in reproductive age.
7. Ensure that lactating mothers, adolescent girls and women have access to appropriate reproductive health services.
8. Promote shifts of social norms on food taboos preventing adequate nutrition for pregnant and lactating women.
9. Promote access and utilization of reproductive health services (birth spacing).

Objective #4: To provide care and treatment for acute malnutrition in development and humanitarian contexts

Targets by 2025

1. Reduce the prevalence of wasting in children aged 0-59 months (weight-for-height z-score <-2 SD) from 13.1[23] percent to less than 10% at all times.
2. Reduce the prevalence of wasting in pregnant and lactating women (MUAC>21 cm) by 10 percentage points by 2025
3. Reporting rate for facilities implementing the IMAM program is consistently above 80% in ONA/DHIS2

[23] FAO FSNAU, Somalia 2019 Post Deyr Seasonal Assessment Key Nutrition Results Summary. 3 February 2020 https://www.fsnau.org/downloads/2019-Post-Deyr-Assessment-Key-Nutrition-Results-February-2020.pdf

4. Coverage for cases of severe and moderate acute malnutrition among children under five years of age with access to treatment remains >50 per cent in rural areas, >70 per cent in urban areas and 90 per cent in camp settings
5. The minimum proportion of children discharged from therapeutic care who have died, recovered or defaulted to be died: <10 per cent, recovered: >75 per cent and default rates <15 per cent
6. In camp settings the minimum coverage of children with access to treatment for moderate acute malnutrition in areas of chronic food insecurity and/or emergencies to be >50 per cent in rural areas, >70 per cent in urban areas and >90 per cent at all times
7. The proportion of discharges (children & PLW) from targeted supplementary feeding programs to be died: <3 per cent, recovered: >75 per cent, defaulted: <15 per cent at all times
8. The minimum coverage of malnourished adults (PLW and people living with HIV or TB) with access to treatment for moderate acute malnutrition in areas of chronic food insecurity and/or emergencies to be >50 per cent in rural areas, >70 per cent in urban areas and >90 per cent in camp settings at all times

This strategy prioritizes curative nutrition actions to rehabilitate severely acutely malnourished children at stabilization centers (SC), outpatient therapeutic programs (OTP) and targeted supplementary feeding programs (TSFP) as life-saving interventions consistent with the Somalia guidelines for the Integrated Management Acute Malnutrition (IMAM).

The Strategy also recognizes the importance of preventing cases of moderate acute malnutrition from worsening to severe acute malnutrition (with an increase in the relative risk of death, see below). In emergencies or areas of chronic food insecurity, the primary strategy for treating and managing moderate acute malnutrition through supplementation of local diets using specialized nutritious foods provided either through prevention or treatment programs.

Acute malnutrition, or wasting, in children is the result of the weight of a child falling significantly below the weight expected of a child of the same length or height and indicates current or acute malnutrition resulting from failure to gain weight or actual weight loss. Determinants of wasting include inadequate food intake, incorrect feeding practices, disease, and infection. In the Somalia context, the frequent causes of wasting in children is a combination of these determinants of undernutrition. Both moderate and severe acute malnutrition have serious consequences, contributing to increased morbidity and mortality, impaired intellectual development, suboptimal adult work capacity and increased risk of disease in adulthood[24].

[24] Black et al, Maternal and child undernutrition and overweight in low-income and middle income countries. Paper 1 Lancet Maternal and Child Nutrition Series 2013

The annual estimated caseload of acutely malnourished children in Somalia is unacceptably high. Children classified as moderately malnourished are at an increased risk of worsening to Severe Acute Malnutrition (SAM) and have roughly three times higher risk of mortality from common communicable diseases than if they were well-nourished (Black et al, 2008). Children with moderate acute malnutrition are four times as likely to die while severe acute malnutrition are nine times as likely to die compared to those who are not undernourished (UNICEF/WHO, 2009, Black et al, 2008)[24,25].

Interventions and Initiatives

Result 4: high quality care and treatment for acute malnutrition is provided in development and humanitarian contexts

1. Scale-up of the Integrated Management of Acute Malnutrition Programme, including both treatment and prevention, nationally focusing on high burden regions
2. Scale up of community screening and referral for cases of acute malnutrition through mass screening campaigns, family led MUAC screening and community-based screening
3. Communities are educated on identification of acute malnutrition, short- and long term consequences of malnutrition and the importance of seeking early treatment
4. Ensure an effective and secure supply chain of therapeutic foods, specialized nutritious foods, routine medicines and anthropometric equipment for the management of acute malnutrition
5. Capacity building of facility based health workers and community health workers on Basic Nutrition Service Package (BNSP) and Integrated Management of Acute Malnutrition (IMAM) activities
6. Establish nutrition stabilization centres in all regional hospitals and main district level referral health centres with the required equipment, staff and supplies
7. Ensure community sensitization and awareness of the available nutrition services to improve uptake of both health and nutrition services and work with communities to address barriers to service uptake

[25] WHO child growth standards and the identification of severe acute malnutrition in infants and children. A Joint Statement by the World Health Organization and the United Nations Children's Fund. 2009

Objective #5: To increase awareness and demand of optimal IYCF practices and provide caregivers with knowledge, skills and support healthy IYCF practices

Targets by 2025

1. Increase by 30 percent the number of breastfeeding mothers who can list three benefits of exclusive breastfeeding for all infants 0 to 6 months old, including knowledge of the importance of feeding colostrum[26]
2. Increase the percentage from baseline by 30 per cent of breastfeeding mothers who can list three benefits of complementary feeding of children over 6 months and practice it[27]
3. Increase the proportion of breastfeeding mothers who can identify and use age-appropriate nutritious complementary foods and supplements from 33% to 66%
4. Increase the proportion of mothers who breastfeed exclusively in the first 6 months of life from 33% to 53%
5. Over 10,000 community and facility health workers are trained in communication and community mobilization to promote optimal nutrition practices in the first 1000 days of life.
6. Influencers, champions and celebrities are identified and empowered to promote good nutrition and are engaged in 50% of nutrition campaigns and events in Somalia
7. At least 4 legislative bills aimed at protecting, promoting and supporting optimal maternal and nutrition are passed in parliament as a result of engagements with parliamentary committee on nutrition and food security
8. More than 5000 community leaders and religious leaders are trained in communication and community mobilization to promote optimal practices in the first 1000 days of life

The Somalia Nutrition Strategy (2020-2025) seeks to increase awareness of optimal nutrition practices and provide caregivers with knowledge, skills and support required to adopt healthy nutrition practices through comprehensive and sustained campaigns of behavioral change communication. The Strategy recognizes the need for a structured and coordinated approach to improve nutrition that involves a combination of approaches that include advocacy, social mobilization, dialogues and a mix of interventions focused at the community and household levels and policy makers - all aimed at behavior and social changes that are consistent with optimal nutrition practices.

[26] Indicator derived from the Somalia C4D Strategy for Maternal Neonatal Child Health, 2015-2020
[27] *Ibid*

The case for the need to increase awareness of optimal nutrition practices and provide caregivers with knowledge for good nutrition practices is clear; In Somalia, cultivated crops are mainly cereals – sorghum and maize- with very little legumes, pulses, fruits and vegetables. The main diet of the majority in the population comprise of rice or pasta accompanied with tea. This diet has no variety and is clearly lacking in micronutrient rich foods such as milk, eggs, meat, legumes, fruits and vegetables. The unavailability and affordability pushes these foods further from the reach of majority of the population. This has consequently led to a poor micronutrient status and especially in young children of under 5 years and women of reproductive age (Somalia MoH, 2014)[28]. According to the 2019 cost of diet analysis (WFP, 2019)[29], diets in Somalia are based on staple foods (maize, sorghum, rice, wheat and pasta), oil and sugar, with limited consumption of nutritious foods. The study found that the availability of nutritious foods in local markets is limited, especially in markets accessed by only one livelihood system.

The Nutrition Strategy aligns with the objectives of two important behavior change and social mobilization documents: the Somalia Communications for Development (C4D) Strategy for Maternal Neonatal Child Health (2015-2020)[30] and the Somalia Nutrition Social Mobilization, Advocacy and Communications Strategy (SMAC; 2019-2021)[31]

According to the C4D strategy, Somalia has experienced an exponential growth in the number of domestic mass media outlets including FM radio that air locally produced content and both urban and rural populations depend on radio as the main source of news[32]. The Somalia Communications for Development Strategy approach is ideal to promote optimal nutrition practices since it addresses key behaviors along with intervening factors that facilitate enabling environments for behavior and social change. The approach uses a combination of strategies including advocacy, social mobilization, dialogues and a mix of interventions focused at the community and household levels and policy makers.

The Infant and Young Child Nutrition (IYCN) interventions supported by the SNS 2020-2025 include: initiating breastfeeding within one hour of birth; exclusive breastfeeding for the first six months of life and continued breastfeeding up to the age of 2 and beyond, together with safe, age-appropriate feeding of solid, semi-solid and soft food starting at 6 months of age and growth monitoring.

To achieve success in the adoption of these behaviors, the Strategy prescribes Behavior Change Communication (BCC) approaches to improve caregiver practices that specifically also target increasing the nutrition density of complementary foods; providing complementary foods, with or without added micronutrients; and fortifying foods through home fortification including use of multiple micronutrient powder (MNP), and prevention

[28] Somalia national micronutrient deficiency control strategy (2014 – 2016)
[29] WFP, Fill the Nutrient Gap Summary Report, October, 2019
[30] The Somali C4D Strategy for Maternal Neonatal Child Health, 2015-2020
[31] Somalia Nutrition Social Mobilisation, Advocacy and Communications Strategy (SMAC), 2019-2021
[32] The Somali C4D Strategy for Maternal Neonatal Child Health, 2015-2020

and control of diet related non-communicable diseases, in each case paying greater attention to most vulnerable and socially marginalized groups.

Interventions and Initiatives

1. Behaviour change communication targeting mothers, grandmothers and male family members etc. to promote optimal breastfeeding and complementary feeding, delaying early marriage till age 18, preventing traditional practices that adversely affect optimal nutrition (e.g. taboos that inhibit adequate nutrition) etc.
2. Local and national leaders and in particular the parliamentary committee on nutrition and food security are mobilized and sensitized on nutrition issues. At least 50% of politicians and elected leaders from local to national level are sensitized on nutrition situation and importance of the first 1000 days of life.
3. Community outreach using a branded communication multimedia campaign involving; radio- call in programs, talk shows, radio debates; TV- talk shows, documentaries, public service announcements, drama; folk media-community performances of song, dance, poetry and drama, promotional items etc.
4. Community outreach using social and religious networks involving; community dialogues; use of multiple and sustained individual and community engagement points (mosques, schools, health facilities tea shops, women's prayer sessions, community groups); etc.
5. Develop a comprehensive integrated Nutrition social behavior change communication (SBCC) strategy covering different topics
6. Establish mother-to-mother support groups (MTMSG) in community and Mother Baby Areas in IDP settings for awareness on Infant and young child nutrition
7. Capacity building of facility-based health workers and community health workers on appropriate maternal and child nutrition (Maternal Infant and Young Children Nutrition and Interpersonal Skills)
8. Support advocacy and social mobilization at different levels of key decision makers on nutrition related issues

Objective #6: To strengthen capacities at all levels, including at community level, to assess the nutrition situation and to design, implement and monitor nutrition interventions

Targets by 2025

1. The MoH develops a human resource development strategy for nutrition with a clear and practical action plan by 2021
2. Federal and State Ministries of Health form functional coordination mechanisms and convene quarterly coordination meetings
3. Development of a workforce that addresses the priority nutrition needs of Somali population, which is adequate in number, well trained, remunerated and motivated to provide essential nutrition services
4. Establishment of a government-led nutrition information system that provides routine data aggregated at the gobol and degmo levels by 2025
5. Capacity of Federal, State and local governments to provide basic nutrition services is enhanced in an inclusive and equitable manner
6. Increased availability of skilled health staff and community health workers delivering basic nutrition services at facility and/or community level
7. A training package on nutrition, tailored for different cadres and levels of staff in the nutrition-specific and -sensitive sectors is developed or identified

The formulation of the Somalia Human Resources for Health (HRH, 2016-2021) policy is a major milestone that provides MoH an opportunity to develop the human resource capacity for health and nutrition. Achieving this objective requires a strong commitment from Federal and State Ministries of Health and the strategic collaboration of development partners in order to accelerate progress towards achieving the objectives set forth in the Somalia Nutrition Strategy (2020-2025) and beyond. Increasing the capacity of the human resources for health and nutrition (through increasing the workforce, improving the balance of skills and strengthening capacities) is one of the building blocks of a well-functioning health system highlighted in the Somalia Health Sector Strategic Plan for 2017-20121(and adopted from WHO building blocks of a functional health sector).

The Somalia Nutrition Strategy (2020-2025) emphasizes the production and supply of nutrition workers that are aligned with the HRH goals of the health system, the delivery of Essential Package of Health Services (EPHS) and who will form the basis to deliver the required promotive, preventive and curative nutrition services. One of the Human Resources for Health Policy[33] objectives is to ensure the availability of the appropriate number of workers with the correct knowledge, skills, attitudes and training that are equitably deployed, fairly remunerated and well managed, supervised and monitored to perform and comply with the tasks assigned to achieve the health outputs and outcomes targeted by the health system. Similarly, objective #6 of the SNS (2020-2025) supports the policy priority of the Somalia Health Policy (MoH, 2014) that aspires to "develop a health

[33] The Somali Human Resources For Health Development Policy, 2016-2021. Ministry of Health, Federal Government of Somalia, Ministry of Health, Puntland; and Ministry of Health, Somaliland

workforce that addresses the priority health needs of Somali population, which is adequate in number, well trained, equitably distributed and motivated to provide essential health services"

The capacity of the Ministry of Health to assess the nutrition situation and to design, implement and monitor nutrition interventions will be strengthened through building the institutional capacity to monitor health and nutritional status of the population, supply reliable and sustainable data on the nutritional status of vulnerable people, show trends and enable comparisons across time, raise awareness about nutritional problems and provide guidance to health and nutrition programs locally and nationally.

The Somalia Nutrition Strategy (2020-2025) requires community involvement in a multisectoral approach as a cornerstone of successful implementation of nutrition programs in both emergency and development contexts. It attempts to place affected populations at the center of decision-making about how assistance will be provided when setting up programs and projects. In the Somalia context, community mobilization is of primary importance to ensure maximum program coverage and to have a good rapport with clan elders and key decision-makers to ensure the project are well understood and accepted by tribal leaders to avoid costly misunderstandings.

Interventions and Initiatives

Result 6.1: Capacity of FMoH and FMS to assess the nutrition situation is enhanced

a) A MoH-led nutrition information system that measures changes in the nutrition status of the most vulnerable population groups and communities is established to enable tracking of SNS (2020-2025) results.

b) A training package to increase MoH's capacity to appraise the nutrition situation at community, State and/or National level is developed or identified and tailored for different cadres.

c) Regular joint planning and review meetings between Federal and State MoH to align annual nutrition planning processes to the Somalia Nutrition Strategy (2020-2025) based on vulnerability data and information

d) Federal and State Ministries of Health develop detailed plans with a detailed implementation and M&E plans to track progress of results towards improving maternal and child nutrition

Result 6.2: Technical and managerial capacity to provide basic nutrition services is enhanced

1. A MoH capacity development strategy is developed and implemented
2. Federal and State MoH produce technical guidelines for both nutrition-sensitive and -specific sectors which are disseminated to targeted users for implementation

3. Building and strengthening the institutional capacity of Federal and State Ministries of Health to provide strong leadership, effective governance and coordination to enable stakeholders to provide core nutrition functions that bear results.
4. Federal and State Ministries of Health form functional coordination mechanisms to coordinate nutrition activities in their jurisdictions. Conveners are identified and provided clear mandates.
5. Training packages on nutrition, tailored for different cadres and levels of staff in nutrition-specific (both pre-service and in-service) and for nutrition-sensitive sectors are developed and rolled out
6. Nutrition-sensitive educational/ training materials developed and disseminated for nutrition sensitive sectors at all levels (national, state, district, facility)
7. Ensure training of new cadres of nutrition workers including periodic refresher trainings for existing staff in both nutrition-specific and -sensitive sectors

Result 6.3: Human resource capacity to provide quality nutrition services is enhanced

1. Comprehensive assessment of current size, capacity and training needs in the nutrition workforce including identification of human resource needs and gaps. The assessment will provide a reference point of competencies needed to implement nutrition policies and strategies
2. Competencies and training needs for the provision of appropriate technical and managerial support at the National and Sub-national levels identified
3. Conducting assessment to determine current providers of nutrition services, and the types of services they provide, estimates of workforce numbers, competencies and capacity gaps.
4. Conduct assessments to determine the number and calibre, level of additional nutrition staff required to implement National and sub-national Nutrition Plan, develop scopes of work for each and develop a staffing action plan consistent with the capacity development strategy.
5. Competencies and training needs for coordination mechanisms (technical, management, leadership, coordination, implementation etc.) are identified for the provision of appropriate support at National and Sub-national level

Result 6.4: Capacity to assess the nutrition situation and to design, implement and monitor nutrition interventions increased at the community level

1. Increase the capacity of State Ministries of Health to carry out participatory planning of nutrition programs at the community level as a means of appraising the situation, sensitive community leaders and increase the effectiveness of the program.

2. Increase the capacity of State Ministries of Health to carry our community sensitization of programs by working with communities in formulating outreach messages
3. Increase the capacity of State Ministries of Health to carry out Nutrition Information and Education (NIE) at the community level to engage the target communities in behavior change approaches

Objective #7: An Enabling Environment for Preventing Maternal and Child Malnutrition in Somalia is Created and Sustained

Targets by 2025

1. Federal MoH coordinates and provides technical support and oversight in the development of the Somalia Food Security and Nutrition Policy and related action plans by 2023
2. Federal MoH engages the FGS Parliamentary Committee on Food Security and Nutrition to pass at least 5 legislations aimed to promote optimal nutrition in Somalia
3. State Ministries of Health are supported to develop detailed nutrition plans with sub-national implementation plans and monitoring and evaluation frameworks by the end of 2021
4. Gender is mainstreamed in Federal and State MoH planning, implementation and reporting of nutrition activities using gender-disaggregated data
5. Develop the capacity of the Ministry of Health to establish and maintain a functioning country nutrition coordination mechanism led by Federal and/or State MoH and include participation of governmental institutions, UN agencies, NGOs, SUN group and civil society organizations

Recent evidence has placed emphasis on the importance of an "enabling environment" to improve nutrition outcomes, which refers to "the sociocultural, economic, political, institutional, and policy contexts that govern the design and implementation of nutrition-relevant actions"[34].

This Strategy includes practical ways for Federal and State Ministries of Health to ensure that functional and effective coordination mechanisms enable an improved and coordinated service delivery. Coordination of the implementation must be a priority of the Federal MoH which should have a clear vision of the 'big picture' and a good understanding of its role in ensuring that coordination activities are strategic and effective.

Interventions and Initiatives

[34]Van den Bold, M., Kohli, N., Gillespie, S., Zuberi, S., Rajeesh, S., & Chakraborty, B. (2015). Is There an Enabling Environment for Nutrition-Sensitive Agriculture in South Asia? Stakeholder Perspectives from India, Bangladesh, and Pakistan. Food and Nutrition Bulletin, 36(2), 231–247. https://doi.org/10.1177/0379572115587494

Result 7.1: The Federal Ministry of Health coordinates and/or is technically engaged in the development of food and nutrition related policies, strategies and plans of actions

1. The Federal Ministry of Health coordinates the development of nutrition policies, strategies and plans of action.
2. The Federal Ministry of Health provides technical support in the development of policies, strategies and plans of action related to Food Security and is linked in with agricultural policies and import/trade policies that can impact nutrition.

Result 7.2: Effective nutrition coordination mechanisms are created at national and State levels

1. The Federal MoH and Federal Member States (FMS), being the authorities of Nutrition at the national and subnational levels, to set up and lead nutrition coordination mechanisms and coordinate activities
2. Federal MoH and FMS convene quarterly coordination meetings with stakeholders working on nutrition (governmental institutions, UN agencies, NGOs etc.) within their respective mandates and create a forum for sharing and disseminating relevant nutrition information, documents: standards, guidelines, tools etc.
3. The Federal MoH and FMS are able to identify nutrition priorities and to better coordinate nutrition actions and interventions to improve their timeliness and effectiveness

Result 7.3: Gender and socio-cultural issues that affect maternal, infant, and young child nutrition are addressed

1. Promotion of awareness of gender equality and its impact on maternal and child nutrition in capacity building activities and nutrition-related campaigns and building the capacity of the nutrition workforce on gender-sensitive programing
2. Strengthening the capacity of State and Federal Ministries of Health to undertake operational research on the impacts of gender on nutrition outcomes, including on gender mainstreaming and specific gender related research.
3. Harmful traditional practices such as food taboos for women and girls (especially pregnant and lactating women), early marriage, Female Genital Mutilation (FGM) and violence against women have contributed to the poor nutritional status are addressed by MoH as part of Somalia Social Mobilization, Advocacy and Communications Strategy for nutrition
4. Incorporate a gender analysis as part of the regular nutrition situation analysis, analysing the needs, priorities and roles of men and women.
5. Promote meaningful male involvement in nutrition interventions to help address their needs and sensitize them on gender aspects of improving nutrition outcomes.
6. Gender actions to improve nutrition are incorporated in National and sub-national level plans and planning processes

Objective #8: Mainstreaming nutrition as a key component of nutrition-sensitive sectors

Targets by 2025

1. Ministry of Agriculture policies, strategies revised after 2020 are nutrition-sensitive and aligned with the Somalia Nutrition Strategy (2020-2025)
2. WASH, Health, Education, Social Protection policies, strategies and activities are nutrition-sensitive
3. At least 30% of WASH and Agriculture extension workers are trained to deliver key nutrition messages as part of the overall SBCC services

The SNS 2020-2025 aligns with the multi-sectoral nutrition strategy developed by the SUN network in Somalia. The Strategy focuses on actions that Federal and State Ministries of Health can initiate or undertake to make activities of other sectors nutrition sensitive.

The 2013 Lancet Series on maternal and child undernutrition reviewed evidence of nutritional effects of programs in four sectors: agriculture, social safety nets, early child development and schooling. Some key points on nutrition-sensitive interventions from the series include the following: Nutrition-sensitive interventions and programs in agriculture, social safety nets, early child development, and education have enormous potential to enhance the scale and effectiveness of nutrition-specific interventions; improving nutrition can also help nutrition-sensitive programs achieve their own goals.

The nutrition-sensitivity of programs can be enhanced by improving targeting; using conditions; integrating strong nutrition goals and actions; and focusing on improving women's physical and mental health, nutrition, time allocation, and empowerment.

Interventions and Initiatives

1. Support the development/revision of the policies, strategies and implementation of key line ministries documents to ensure they are nutrition-sensitive
2. Facilitate the capacity building of the line ministries extension workers on nutrition sensitive programming
3. Integrate nutrition-sensitive WASH by promoting access to and utilisation of appropriate WASH practices targeting caregivers and children aged below 5 years
4. Ensure the families of vulnerable children, when needed, have access to nutrition-sensitive social protection
5. Integration of Early Childhood Development (ECD) activities with existing community- and facility-based nutrition programmes to ensure development and use of locally relevant ECD materials and adoption of appropriate psycho-social care practices.
6. Increasing the nutrition-sensitivity of agriculture and food security policies, strategies, action plans and practices.

Objective #9: A full package of nutrition-specific interventions is consistently integrated into basic health services at national and sub-national levels

Targets by 2025

1. The revised Essential Package of Health Services to include all the Basic Nutrition Service Package (BNSP)
2. An integrated human resource team for delivery of health and nutrition services included in the EPHS staffing framework
3. Nutrition Information management is included in the DHIS2 by 2022/link ONA to DHIS2 Platform
4. 80% of health facilities and outreach teams offer integrated nutrition and health services

The concept of nutrition-specific and nutrition-sensitive interventions is now a fundamental element in the discourse of the global nutrition community, helping to distinguish between two types of interventions, each of them essential in the battle to eliminate malnutrition. The nutrition strategy lays emphasis on activities to integrate nutrition within the health sector based on the critical role the primary health care plays in the prevention and management of many leading causes of morbidity and mortality.

The Nutrition Strategy advocates for stronger national capacities and systems for scaling up nutrition actions within the primary health care system, effective campaigning and advocacy for the nutrition scale-up within the health care system, social mobilization to sensitize vulnerable population groups on integrated health and nutrition activities, etc.

Interventions and Initiatives

1. Finalize the Essential Package of Health Services to include all the Basic Nutrition Service Package (BNSP) and HR structure for Nutrition and Health
2. Support the migration and linkage of ONA and DHIS2 for Nutrition Information (key Nutrition indicators are capture in DHIS2)
3. Support the roll out of integrated health and nutrition services in primary health centers and primary health units.
6. Early detection and management of acute malnutrition and common childhood infections provided at health facilities
7. Develop and introduce service standards, technical tools, guidelines and protocols in all health facilities in line with the EPHS.

Challenges

Limited access and availability of health and nutrition services: Only 50% of the Somali population have access to EPHS services (HSSP 2017-2021). Primary Health Units are supposed to provide services at the community level, but many do not operate properly due to lack of qualified health workforce and poor infrastructure and supplies. Health centers (also referred to as maternal and child health centers) are supposed to provide preventive and curative services, focused on women and children, together with basic health services for the general population particularly in rural settings. Hospitals do not provide the full range of secondary or higher-level care services identified in EPHS, and most of the regional hospitals are functional for limited services only (ibid).

Health Authorities, Donors and Civil Society Organizations face multiple challenges due to insecurity. Both manmade and natural disasters pose a challenge to providing routine health and nutrition services to the population and internally displaced people. Furthermore, these insecurities compound challenges in other nutrition-sensitive including education, social protection and agriculture, therefore impacting the quality of and access to these services and safety nets.

New and emerging threats — for example, the COVID-19 pandemic that disrupted activities globally — puts an extra layer of challenges on Somalia's weak health system, realigning the priorities of the entire health system and affecting both the demand and supply of health services. The effects of the COVID-19 pandemic go beyond the health system and have had ramifications in terms of income and employment opportunities, food prices resulting in the reduced affordability of nutritious foods and the closure of schools increasing the risk of early marriage and gender-based violence.

The achievement of the SNS 2020-2025 is based on key assumptions and risks. It is assumed that communities are open to receiving information, behavior change messages and efforts to change sociocultural beliefs (and that they can be reached using appropriate means of communication). While initiatives aimed at sharing knowledge and promoting behavior change have generally been embraced by communities and families in Somalia, there is always a risk that other issues (e.g., religious and household power dynamics particularly the role of women in decision making) are a barrier to effective behavioral change. The risk mitigation measures include continued advocacy efforts by engaging with political, religious and community leaders to highlight the key role of women in achieving optimal infant and child nutrition and by publicizing information in forms that reach the general public to trigger change (UNICEF, 2018). Poor economic access to nutrition is also a serious barrier to optimal nutrition which is best mitigated by nutrition-sensitive and multi-sectoral approaches that seek to reduce extreme poverty, improve agricultural value chains, strengthen livelihoods and income generating activities etc.

It is assumed that capacity development efforts will not be rendered useless through brain drain and high attrition rates of health and nutrition workers. The major risk to this is in the emergence of humanitarian situations which pull human resources from the government through recruitment by non-governmental actors.

Monitoring, Evaluation and Learning

This Strategy calls for ambitious efforts to establish MoH-led routine data reporting for nutrition at the gobol (administrative region) and degmo (district) level in health facilities. Although in the past there has been no emphasis on government-led systematic reporting mechanisms, it is recognized that the routine collection of nutrition data and information will assist to monitor the implementation of this National Strategy and will start to transfer the responsibility from the emergency nutrition cluster to the Ministry of Health, both at the Federal and State levels.

The Somalia Health Policy (MoH, 2014) recognizes that a Health Information Systems (HIS) is one of the key components of the health system and plays a major role in evidence based decision making, on all aspects related to the other five building blocks of the health system, and particularly, for health policy priority setting. The policy recognizes that some HMIS data are generated through the analysis of the routinely collected information from the outpatient departments of public health facilities, including hospitals and complemented by the information generated by vertical programs and through the disease surveillance system and nutrition surveys. However, no data are routinely generated from the in-patient facilities or from the many components of the health system, due to inadequate capacity for the timely collection of data, reporting, analysis and dissemination.

Establishing and strengthening the routine collection and reporting of nutrition data and information is a necessity of building the capacity of the Federal and State Ministries of Health to achieve objective #6 of the Nutrition Strategy (to strengthen national capacity, including community level, to assess nutrition situation and design, implement and monitor nutrition interventions).

The SNS (2020-2025) requires the Federal and State Ministries of Health to plan and support health facility staff in the selection and promotion of nutrition indicators collected through health facility-based reporting and proposes the 'minimum' nutrition indicators to be collected. The targeted minimum indicators and proposed reporting frequencies are listed in the table below.

Nutrition Indicators targeted in routine collection at health facilities

Indicator	Numerator	Denominator	Frequency
General			
Percent of children 0-59 months weight for age below -2 Z –scores	No. of children 0-59 months attending health facilities for any reason with WAZ below -2 Z –scores (using WHO standards)	Total number of children 0-59 months in all catchment areas / in district	Quarterly
IYCF			
Proportion of infants initiated on breast milk within 1 hour after delivery in facility	No. of infants breastfed within the first hour after birth	Number of live births delivered in all catchment areas / in district	Monthly
Proportion of mothers of children 0-5 months who have received counselling, support or messages on optimal breastfeeding from a HW during the past x months	No. of mothers of children 0-5 months who have received counselling, support or messages on optimal breastfeeding from a HW during the past x months	Number of mothers of children 0-5 months in all catchment areas / in district	Monthly
Proportion of mothers of children 6-23 months who have received counselling, support or messages on optimal complementary feeding during the past [xx] months	no. of mothers of children 6-23 months who have received counselling, support or messages on optimal complementary feeding AND/OR supplements from a Health Worker during the past [xx] months	Number of mothers of children 6-23m months in all catchment areas / in district	Monthly
Micronutrients			
Proportion of children 6-59 months receiving at least one dose of Vitamin A supplementation during the previous six months	Number of children 6–59 months who received vitamin A supplements at the facility or through campaigns during the previous six month period	Total number of children 6-59 months in all catchment areas / in district	Bi-annually
Proportion of children 12-59 months receiving at least one dose of de-worming medication during the previous six months	children 12-59 months receiving at least one dose of de-worming medication during the previous six months	Total number of children 12-59 months in all catchment areas / in district	Bi-annually
Percent of pregnant women receiving iron supplements for at least 90 days during pregnancy	Number of pregnant women who received iron supplements	Total number of pregnant women in all catchment areas / in district	Quarterly
% of beneficiaries reached with MNPs (by age-group) 6-11 months; 6-17 months; 6-23 months; 6-59 months; 12-23 months; School children; etc.;	No. of beneficiaries reached with MNPs within target category	Total no. of within target category in all catchment areas / in district	Monthly
SAM			
Proportion of children 6-59 months screened by a HW with MUAC or W/H for acute malnutrition identified as SAM/MAM	Total number of children 6-59 months who have been screened by a CW for acute malnutrition that have SAM/MAM	Total number of children 6-59 months who have been screened by a CW for acute malnutrition	Monthly
Proportion of children 6-59 months with severe acute malnutrition receiving treatment	No. of **new** SAM cases who received treatment (outpatient or in-patient care) in the month preceding	No. of SAM cases* in all catchment areas / in district	Monthly
Proportion of children 6-59 months with severe acute malnutrition discharged as a) cured, b) died and d) defaulted	Number of children 6-59 months with severe acute malnutrition discharged a) cured, b) died and c) defaulted	Number of children 6-59 months with severe acute malnutrition discharged (exc. Transfers)	Monthly
% of HFs with a stock out in the last month	Number of HFs with a stock out in the last [x] weeks	Total number of HFs in catchment areas / district	Monthly

Adapted from "Guidance: Minimum nutrition-related indicators reported at health facility level"

ANNEXES

Annex 1: Results Framework for the Somalia Nutrition Strategy (2020-2025)

Result	Indicator	Baseline	Target	MOV
Objective #1: Prevention of undernutrition in the first five years of live with an emphasis on the first 1000 days of life				
Result 1.1: Improved nutritional status of children aged 0–24 months	Proportion of children breastfed within the first hour of birth*	80%	90%	Surveys
	The proportion of children aged 0-6 months who are exclusively breastfed	33%	53+%	Survey
	Maternal health facilities that are certified as baby friendly			Survey
	Proportion of infants 6–8 months of age who receive solid, semi-solid or soft foods*	81	90	Survey
	Proportion of children 6–23 months of age who receive foods from 4 or more food groups.	15	30	Survey
	Proportion of children 6–23 months of age who receive a minimum acceptable diet (apart from breast milk)*	9	30	SDHS
Result 1.2: Improved nutritional status of children 24–59 months	The proportion of women aged 15-49 years who consume an adequately diverse diet with at least 5 out of 10 defined food groups	MS 2019	50% increase from2019 baseline	SDHS, surveys
	Prevalence of anemia in children aged 24-59 months (hemoglobin concentration <11 g/dl)	59%	<30%	SDHS, surveys
	Children u5 receiving two doses of deworming medicine annually	MS 2019	80+%	Program data
	Proportion of children getting biannual vitamin A supplementation	MS 2019	80+%	SDHS
	proportion of health workers trained and sensitized on micronutrient deficiency control and management	MS 2019	70%	FMOS/FMS data
	Proportion of vulnerable children accessing food supplements	MS 2019	>50% (rural) >70% (urban) >90% (camps)	program data
	Proportion of children less than 5 years of age with weight for length or height > +2 z-scores of the median WHO child growth standards.	13.1	<10	Survey
Objective #2: To prevent over- and under-nutrition in primary school-age children and adolescent boys and girls				
Result 2.1 Improve the nutritional status of school-age children and adolescents (10–19 years) including out of school children	Sugar consumption in Somali school-age children and teenagers	19	< 10% percent of total energy intake	Surveys, studies
	Prevalence of anaemia among school-age children and adolescent girls	2019 Micronutrient survey	Reduced by 50% by 2025	Survey
	Proportion of adolescent girls aged 15–19 with a BMI <18.5	MS 2019		Survey
	Proportion of formal institutions, including schools, which promote hygiene and good nutrition.		At least 80% of formal institutions	Reports
Objective #3: To prevent over- and under- nutrition in women of child bearing age with a particular focus on pregnant and lactating women				

Result 3: the nutritional status of women of child-bearing age (15–49 years) is improved consistently with the RMCAH Strategy (2019-2023)	Anemia (hemoglobin concentration <11 g/dl) in women of reproductive age	49%	<20%	
	Proportion of pregnant women accessing iron and folic acid supplements*	58%	80%	Survey
	Proportion of vulnerable pregnant and lactating women and girls (PLWGs) accessing nutritious food supplements (in the targeted areas)			
	Proportion of non-pregnant and non-lactating women with adequate intake of diversified foods.	MS 2019		Survey
	Proportion of non-pregnant and non-lactating women with access to nutrition-sensitive reproductive health services (e.g. birth spacing)		>50%	Survey
Objective #4: To provide care and treatment for acute malnutrition in development and humanitarian contexts				
Result 4L: High quality care and treatment for acute malnutrition is provided in development and humanitarian contexts	Prevalence of wasting in children aged 0-59 months (weight-for-height z-score <-2 SD)	13.1	<10%	Surveys
	Facilities implementing the IMAM provide timely and accurate program data consistently		100%	Reports
	Coverage for cases severe acute malnutrition (SAM)		>50% rural >70% urban >90% camps	Reports
	Minimum proportion of children discharged from therapeutic care who have died, recovered or defaulted		died: <10% recovered: >75% defaulted <15%	Reports
	The minimum coverage of children with access to treatment for moderate acute malnutrition in areas of chronic food insecurity and/or emergencies		>50 % in rural areas, >70 % in urban areas and >90 % in camp settings at all times	Reports
	The proportion of discharges from targeted supplementary feeding programs who have died, recovered or defaulted		Died: <3 %, Recovered: >75 %, Defaulted: <15 %	Reports
Objective #5: To increase awareness and demand of good nutrition practices and provide caregivers with knowledge, skills and support required to adopt healthy nutrition practices.				
Awareness and demand of good nutrition practices is increased and caregivers provided with knowledge, skills and support required to adopt healthy nutrition practices.	Proportion of breastfeeding mothers who can list 3 benefits of exclusive breastfeeding for infants 0 to 6 months old, including knowledge of the importance of feeding colostrum.		Increase by 30 per cent	C4D M&E reports, other reports
	proportion of breastfeeding mothers who can list 3 benefits of complementary feeding of children over 6 months and practice it		Increase by 30 per cent	C4D M&E reports, other reports
	proportion of breastfeeding mothers who can identify and use age-appropriate nutritious complementary foods and supplements	33%	66%	C4D M&E reports, other reports

	Proportion of mothers who breastfeed exclusively in the first 6 months of life		Increase by 20 percent	C4D M&E reports, other reports
	Frontline workers are trained in communication and community mobilization to promote optimal nutrition practices in the first 1000 days of life.		10,000+	C4D M&E reports, other reports
	Proportion of nutrition campaigns and events in Somalia where influencers, champions and celebrities promote good nutrition		50%	C4D M&E reports, other reports
	Community leaders and religious leaders trained in communication and community mobilization to promote optimal practices in the first 1000 days of life.		10000+	C4D M&E reports, other reports
	The number of legislative bills passed in parliament as a result of engagements with parliamentary committee on nutrition and food security	0	5	C4D M&E reports, other reports
Objective #6: To strengthen capacities at all levels, including at community level, to assess the nutrition situation and to design, implement and monitor nutrition interventions				
Result 6.1: Capacity of FMoH to assess the nutrition situation is enhanced	Establishment of a government-led nutrition information system that provides routine data aggregated at the gobol and degmo levels by 2025			Reports
	A MoH-led routine data reporting for nutrition at the gobol (administrative region) and degmo (district) level in health facilities is established			Reports
Result 6.2: Technical and managerial capacity to provide basic nutrition services is enhanced	Federal and State Ministries of Health form functional coordination mechanisms and convene quarterly coordination meetings	0 Coord. Meetings per year	4	Reports
	A training package on nutrition, tailored for different cadres and levels of staff in the nutrition-specific and -sensitive sectors is developed or identified.	0	1	Administrative reports
	Capacity building of Federal, State and local governments to provide basic nutrition services is enhanced in an inclusive and equitable manner			Administrative reports
Result 6.3: Human resource capacity to provide quality nutrition services is enhanced	Development of a workforce that addresses the priority nutrition needs of Somali population, which is adequate in number, well trained and motivated to provide essential nutrition services			Administrative reports
	MoH develops a human resource development strategy for nutrition with a clear and practical action plan by 2021			Administrative reports
Result 6.4: Capacity to assess the nutrition situation and to design, implement and monitor nutrition interventions increased at the community level	Increased availability of skilled health staff and community-based workers delivering basic nutrition services at facility and/or community level.			
	A training package on nutrition, tailored for community health and nutrition workers is developed or identified.			Administrative reports
Objective #7: An enabling policy environment for preventing maternal and child malnutrition in Somali is created and sustained				

Result 7.1: The Federal Ministry of Health coordinates and/or is technically engaged in the development of food and nutrition related policies, strategies and plans of actions	Federal MoH coordinates and provides technical oversight and leadership in the development of Somalia Nutrition Policy			Administrative reports
	Federal MoH provides technical support in the development of the Somalia Food Security and Nutrition Policy, Strategy and related action plans			Administrative reports
	Federal MoH engages the FGS Parliamentary Committee on Food Security and Nutrition to pass at least 5 legislations to improve nutrition in Somalia			Administrative reports
Result 7.2: Effective nutrition coordination mechanisms are created at national and State levels	The capacity of the Ministry of Health to establish and maintain a functioning country nutrition coordination mechanism led by Federal and/or State MoH and include participation of governmental institutions, UN agencies, NGOs, and any other stakeholder working on nutrition is established			Administrative reports
	State Ministries of Health are supported to develop detailed nutrition plans with sub-national implementation coordination and M&E plans by the end of 2021			Administrative reports
	Proportion of nutrition campaigns that target men in addition to women in supporting optimal nutrition		100%	Administrative reports
Result 7.3: Gender and socio-cultural issues that affect maternal, infant, and young child nutrition are addressed	Proportion of nutrition analyses that are disaggregated data and information by gender		100%	Surveys, Administrative reports
	Gender is mainstreamed in Federal and State MoH planning and implementation processes to improve nutrition		100%	Administrative reports
Objective #8: Mainstreaming nutrition as a key component of nutrition-sensitive sectors				
Nutrition is mainstreamed as a key component of nutrition-sensitive sectors	Ministry of Agriculture policies, strategies revised after 2020 are nutrition-sensitive and aligned with the Somalia Nutrition Strategy (2020-2025)			Administrative reports
	WASH policies and activities are nutrition-sensitive			Administrative reports
	All WASH related extension workers trained to deliver nutrition messaging as part of BCC services.			Administrative reports
	All agriculture extension workers are trained to deliver nutrition messaging as part of BCC services			Administrative reports
	Nutrition-sensitive components are included in social protection policies, strategies, plans and programs			Administrative reports
Objective #9: A full package of nutrition-specific interventions is consistently integrated into basic health services at national and sub-national levels				
Nutrition activities are integrated the health strengthening system strategies and activities	Proportion of women of reproductive age utilizing quality integrated nutrition and primary health-care services.		80%	Surveys
	Proportion of women of reproductive age utilizing family planning services with integrated nutrition counselling/services.		50%	Survey

	Proportion of women receiving minimum acceptable integrated nutrition and ANC & PNC services.		80%	Survey
	Health facilities and outreach teams offering integrated nutrition and health services.		80%	Reports
	Campaigns are conducted to promote ante- and postnatal care services.		300	MOH Reports
	Proportion of expectant mothers receiving health education from conception to delivery.		80%	Survey

* FSNAU, 2016 Somali infant and young child nutrition assessment; Infant and young child nutrition practices, barriers and facilitators Special study report no. VII 71, April 13, 2017

Annex 2: Somalia Nutrition Strategy Task Force

JAMHUURIYADDA FEDERALKA SOOMAALIYA

Wasaaradda Caafimaadka & Daryeelka Bulshada

جمهورية الصومال الفيدرالية

وزارة الصحة ورعاية المجتمع

Somali Federal Republic
Ministry of Health & Human Services
Director General Office

Ref: MOH&HS/DGO/1489/OCT/2019 29/OCT /2019/ Mogadishu

To: To Whom It May Concern

Subject: Nomination Somalia Nutrition Strategy Task force.

The Ministry of Health & Human Service of Federal Government of Somalia extends to its gratitude to your offices for your continues support and collaboration.

The Ministry of Health & Human Service officially nominated the Somalia Nutrition Strategy Task force, The Task Force is responsible to oversee the developmental Nutrition Strategy. that will outline strategic, approaches and activities Aimed at reduction of all forms of Malnutrition in Somalia.

1. Dr. Ahmed Adam Mohamed	Director Of public health, MOH
2. Nur Ali Mohamud	Director Of Policy and Planning, MOH
3. Ibrahim Mohamed Nur	Director of Human resource For health
4. Dr. Abdikadir Wehlie Afrah	Director of Medical Service
5. Dr. Mohamed Abdi Farah	Social Sector Advisor/SUN Focal Point, PMO
6. Khayriya Mohamed Ali	Head, Nutrition section, MOH
7. Dr. Abdirasak Yusuf Ahmed	Team lead HSS, MOH
8. Dr. Mohamed Abdelrahman Amin	Somali National University
9. Abdirahman Mohamed Shekh Abdi	Ministry Of Planning
10. Mohamed Tahlil Ahmed	Ministry of Finance
11. Mohamed Isse Farah	Ministry of Agriculture
12. Representative From UNICEF	UNICEF
13. Representative from FOA	FOA
14. Representative From WHO	WHO
15. Representative From WFP	WFP

The Ministry of Health and Human Services avails itself of this opportunity to present to your office its gratitude and highest consideration.

Your collaboration is highly appreciated

Wasaaradda Caafimaadka & Daryeelka Bulshada — Ministry of Health & Human Services — Somali Federal Republic

Mr. Mohamoud Bulle Mohamed

Acting General Director, and Director of finance Ministry of Health & Human Service

Annex 3: List of Nutrition Indicators Agreed by FMoH

ADMISSION And TREATMENT STATUS
SC
Total number of beneficiaries in SC at the beginning of the month
Number of children under five years in SC at beginning of the month
Total number of admissions to SC
Number of male children under five years admitted in SC
Number of female children under five years admitted in SC
Total number of beneficiaries admitted in SC with oedema
Total number of beneficiaries cured in SC
Number of male children under 5 cured in SC
Number of female children under 5 cured in SC
Total number of beneficiaries non cured in SC
Total number of beneficiaries died in in SC
Total number of beneficiaries defaulted in in SC
Number of male children under 5 defaulted in SC
Number of female children under 5 defaulted in SC
Total number of beneficiaries transferred from SC
Total number of beneficiaries discharged from SC
Total number of beneficiaries in SC at end of the month
OTP
Total number of beneficiaries in OTP at the beginning of the month
Number of children under five years in OTP at beginning of the month
Total number of admissions to OTP
Number of male children under five years admitted in OTP
Number of female children under five years admitted in OTP
Total number of beneficiaries admitted in OTP with oedema
Total number of beneficiaries cured in OTP
Number of male children under 5 cured in OTP
Number of female children under 5 cured in OTP
Total number of beneficiaries non cured in OTP
Total number of beneficiaries died in in OTP
Total number of beneficiaries defaulted in in OTP

Number of male children under 5 defaulted in OTP
Number of female children under 5 defaulted in OTP
Total number of beneficiaries transferred from OTP
Total number of beneficiaries discharged from OTP
Total number of beneficiaries in OTP at end of the month
TSFP
Total number of beneficiaries in TSFP at the beginning of the month
Number of children 6 to 59 months in TSFP at beginning of the month
Number of Pregnant and Lactating women in TSFP at beginning of the month
Total number of admissions to TSFP
Number of male children 6 to 59 months admitted in TSFP
Number of female children 6 to 59 months admitted in TSFP
Number of PLW children 6 to 59 months admitted in TSFP
Total number of beneficiaries cured in TSFP
Number of male children 6 to 59 months cured in TSFP
Number of female children 6 to 59 months cured in TSFP
Number of PLWs cured in TSFP
Total number of beneficiaries non-cured in TSFP
Number of children 6 to 59 months non-recovered in TSFP
Number of PLWs non-cured in TSFP
Total number of beneficiaries died in in TSFP
Number of children 6 to 59 months died in TSFP
Number of PLWs died in TSFP
Total number of beneficiaries defaulted in in TSFP
Number of male children 6 to 59 months defaulted in TSFP
Number of female children 6 to 59 months defaulted in TSFP
Number of PLWs defaulted TSFP
Total number of beneficiaries transferred from TSFP
Number of children 6 to 59 months transferred from TSFP
Number of PLWs transferred from TSFP
Total number of beneficiaries discharged from TSFP
Total number of beneficiaries in TSFP at end of the month
SCREENING
Total number of beneficiaries screened for acute malnutrition during the reporting period

Number of children 6 to 59 months screened with MUAC in RED (<115mm)
Number of children 6 to 59 months screened with MUAC in YELLOW (115-125mm)
Number of children 6 to 59 months screened with MUAC in GREEN (>125mm)
Number of pregnant and lactating women screened for acute malnutrition during the reporting period
COUNSELLING & TRAINING
Total number of PLWs receiving individual counselling on appropriate IYCF-E/IYCF
OTHER SERVICES
Total number of beneficiaries reached through BSFP
Number of male children under 2 reached through BSFP
number of female children under 2 reached through BSFP
Number of pregnant and lactating women reached through BSFP
Total number of children receiving micronutrient powders
Number of children 6-23 months receiving micronutrient powders
Total number of children receiving Vitamin A
Number of children under 5 receiving Vitamin A
Total number of PLWs given iron/ferrous
Total number of beneficiaries admitted in MCHN
Number of male children under 2 admitted in MCHN
Number of female children under 2 admitted in MCHN
Number of pregnant and lactating women admitted in MCHN
STOCK & SUPPLIES
Number of centers/sites that experience RUTF stock out this month?
Number of centers/sites that experience RUSF stock out this month?
Number of centers/sites that experience MCHN supplies' stock out this month?
Number of centers/sites that experience BSFP supplies' stock out this month?
Number of centers/sites that experience Iron Folate stock out this month?