CADALE DISTRICT RAPID NEEDS ASSESSMENT: HEALTH, NUTRITION, WASH AND FOOD SECURITY

SOMALIA

REPORT

OCTOBER 2017

WASH Cluster
Water Sanitation Hygiene

OCHA

REACH Informing more effective humanitarian action

Cover photo: 2016 Somalia Initial Rapid Needs Assessment (SIRNA) Team

About REACH

REACH is a joint initiative of two international non-governmental organizations - ACTED and IMPACT Initiatives - and the UN Operational Satellite Applications Programme (UNOSAT). REACH's mission is to strengthen evidence-based decision making by aid actors through efficient data collection, management and analysis before, during and after an emergency. By doing so, REACH contributes to ensuring that communities affected by emergencies receive the support they need. All REACH activities are conducted in support to and within the framework of inter-agency aid coordination mechanisms. For more information please visit our website: www.reach-initiative.org.
You can contact us directly at: geneva@reach-initiative.org and follow us on Twitter @REACH_info.

MEDAIR
EMERGENCY RELIEF AND RECOVERY

EXECUTIVE SUMMARY

Ongoing drought conditions have contributed to a rapid deterioration of the humanitarian context in Somalia, with four successive seasons of below average rainfall in many parts of the country[1]. Additionally, insecurity and the presence of hostile armed groups continue to limit humanitarian access, most notably in the South Central region. Against this backdrop, a rapid assessment was requested within the framework of the REACH/WASH Cluster partnership, to assess the health, nutrition, water, hygiene and sanitation (WASH) and food security and livelihoods needs of the population in Cadale District. The assessment was carried out by REACH, with support from Medair and Shabelle Relief and Development Organisation (SHARDO), and was based on a household-level survey of 343 households, in addition to a mapping exercise of existing health facilities in the district. Households were randomly sampled at a confidence interval of 97/10 and the findings presented here are representative at the district level.

The findings from this assessment are envisaged to inform future programming on WASH, health, nutrition and food security in Cadale District.

Health

Access to healthcare was limited, with just over half (57%) of assessed households reporting having access to a healthcare facility. This was to a large extent linked to a lack of formal healthcare facilities, which either never existed or are no longer functional. The only two functional health facilities in the district are both located in Cadale Town. This suggests inequality of access between urban catchment areas, such as Cadale Town, and more rural areas, such as Adow-Ul. Relatedly, just under half (49%) of assessed households with vaccine-aged children (6 months to 15 years) reported that their children had not received any vaccination. Low vaccination rates are likely linked to the absence of healthcare facilities, with lower coverage in rural areas further from Cadale Town.

Malaria, gastrointestinal issues and acute watery diarrhoea (AWD) were the most commonly reported health problems for all age groups. Available healthcare services broadly reflect these health needs, with treatment for malaria and AWD being the most commonly reported types of services where healthcare facilities did exist.

Nutrition

Of the assessed healthcare facilities, only one - based in Cadale Town - offered nutrition services, suggesting a disparity in access between urban populations in and around town, and rural households located further away. Further, 65% of assessed households indicated no access to nutrition services over the past month, indicating that a substantial proportion of the district population is underserved, as with healthcare facilities.

In a reflection of deteriorating food security in Cadale District, one-quarter of under-five year olds that were included in the middle-upper arm circumference (MUAC) screening in Cadale were categorised as having moderate or severe malnutrition. Although only 3% of children under five in assessed households were reported to demonstrate bilateral pitting oedema, almost half were also reportedly at risk of malnutrition. Given the declining food security in the district, this group is vulnerable to becoming malnourished without adequate intervention. Additionally, despite the 25% of assessed under-fives being categorised as malnourished, less than one third of assessed households reported feeding children under 6 months old with breast milk only, indicating limited awareness of infant and young child feeding best practices

Water, Hygiene and Sanitation (WASH)

Findings indicate insufficient water access and rising water prices across the district, a trend which is extremely likely to deteriorate further given the below-average Dery rainfall in October 2017. One-quarter of assessed households reported not having adequate access to water for drinking, cooking and washing. The main reported reason for lack of water access related to shortages at water source, reflecting ongoing drought conditions in the district. Three-quarters of households which pay for water reported that water expenditure had increased over the past three months.

[1] FEWSNET & FSNAU. 2017. Somalia Food security outlook September 2017.

Households demonstrated sporadic awareness of good hygiene practices, with gaps in understanding and reported behaviour relating to the link between faecal-oral disease transmission routes, particularly the transmission of AWD. Poor hygiene behaviours may partially account for the prevalence of AWD in the district; with 42% of households indicating that at least one member had been affected by the issue in the past month. One third (33%) of assessed households reported having no latrine access, indicating high rates of open defecation and increased consequent health risks associated with this practice.

Food Security and Livelihoods

Assessed households indicated deteriorating food security, with almost half of all assessed households reporting that the amount of food from their primary food source had reduced over the past three months. Additionally, findings indicate a decline in crop yields and livestock herd depletion, further limiting household food security. Additionally, a high proportion of households stated an increase in household expenditure on food over the last month, despite an overall indication that household income sources are declining. This implies that households with lower financial security, for example those relying on only one source of income, are increasingly feeling the pressure of rising prices. Combined, these factors have resulted in a growing reliance on food donations, both from humanitarian actors and from within households' existing social networks

The impact of increased household food insecurity was reflected in findings on consumption; over one-third of assessed households scored as 'poor' in the Food Consumption Score (FCS), while use of consumption coping strategies was consistently more frequent than the national average[2].

[2] As measured against the findings from the Somalia Joint Multi-Cluster Needs Assessment 2017 (forthcoming).

CONTENTS

List of Acronyms

AWD	Acute watery diarrhoea
CHW	Community health workers
FEWSNET	Famine Early Warning Systems Network
FCS	Food Consumption Score
FGD	Focus Group Discussion
FSC	Food Security Cluster
FSNAU	Food Security and Nutritional Analysis Unit
GPS	Global Positioning System
IDP	Internally Displaced Persons
IPC	Integrated Phase Classification
JMCNA	Joint Multi-Cluster Needs Assessment
KII	Key Informant Interview
MUAC	Middle upper arm circumference
NGO	Non-governmental organisation
OCHA	Office for the Coordination of Humanitarian Affairs
ODK	Open Data Kit
OFDA	Office of US Foreign Disaster Assistance
SHARDO	Shabelle Relief and Development Agency

List of Figures and Tables

INTRODUCTION

Ongoing drought conditions have contributed to a rapid deterioration of the humanitarian context in Somalia, with four successive seasons of below average rainfall in many parts of the country[3]. At the time of this assessment, the Deyr rains (which fall between October and December annually) were approximately 50% below the long term average[4], and satellite imagery indicated extremely poor vegetation conditions across much of southern and central Somalia[5]. Drought has resulted in substantial livestock herd depletion and a reduction in cereal production, while cereal prices have risen to well above the average, resulting in reduced household access to food and income. Acute malnutrition is estimated to be affecting 388,000 people and the Integrated Phase Classification (IPC) has estimated that over 2.3 million people will be in food security stage Crisis (IPC phase 3) and a further 802,000 in Emergency (IPC phase 4) by December 2017.

Additionally, insecurity and the presence of active armed groups continue to limit humanitarian access, most notably in the South Central region of Somalia. Lack of availability of humanitarian services is further exacerbating household vulnerability, and has resulted in significant gaps in information. Against this backdrop, Medair, through the Somalia Health and WASH clusters, triggered a rapid household needs assessment in Cadale District, Middle Shabelle, to inform intervention on WASH, health, nutrition and food security.

This district-level assessment was co-ordinated by REACH with logistical and operational support from Medair and Shabelle Relief and Development Agency (SHARDO) and with funding provided by the Office of US Foreign Disaster Assistance (OFDA). The assessment used a harmonised household survey tool which was developed in partnership with the Food Security, Health and WASH clusters and designed to improve the quality and comparability of localised assessments across Somalia.

This report provides detailed findings on household needs and gaps in service provision, organised into the following sections:

1) Health
2) Nutrition
3) WASH
4) Food security and livelihoods.

[3] FSNAU. 2017. Climate update: September 2017 monthly rainfall and normalised difference vegetation index (NDVI).
[4] FEWSNET. 2017. Somalia seasonal monitor Nov 2.
[5] Ibid.

METHODOLOGY

Medair Somalia triggered this rapid assessment as part of its emergency response programming. REACH provided technical support on research design, tool development, sampling, data cleaning and analysis, and reporting. Additional support was provided by SHARDO, a partner organisation with a permanent presence in Cadale District, who trained enumerators for data collection and provided up-to-date contextual information on access and security.

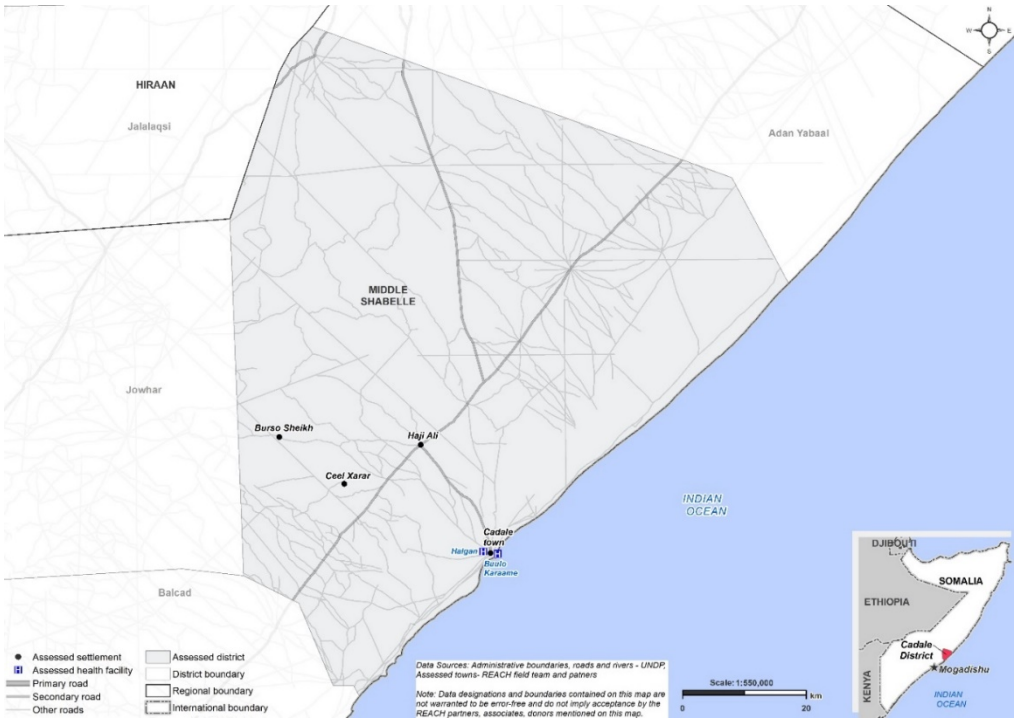
Data collection strategy

Data collection for this assessment used a harmonised multi-cluster needs assessment tool. REACH, in partnership with the Food Security, WASH and Health Clusters, has developed a series of harmonised data collection tools designed specifically for rapid needs assessments. These tools can be used by multiple partners conducting their own assessments to strengthen assessment capacity and produce data that is comparable over space and time within the Somali humanitarian context. All household-level data from this assessment is publically available to partners.

The assessment consisted of the following research elements:

- Harmonised multi-cluster household-level survey, focusing on health, nutrition, WASH, food security and livelihoods.
- Middle Upper Arm Circumference (MUAC) screening of children under five years old: All children aged 0-4 present in assessed households were screened.
- Health facilities mapping in Cadale District to assess the availability, accessibility, location and quality of services provided.
- Findings from the household survey were supplemented by Key Informant Interviews (KIIs) and Focus Group Discussions (FGDs) with community members. KIIs and FGDs were gender-segregated and focused on the availability of healthcare and key health concerns in the community.

Figure 1: Map of assessed districts



Sampling methodology

Clustered villages

Settlements in Cadale District were first clustered based upon health facility catchment areas. A proportional population sampling (PPS) model with a confidence interval of 97/10 was then used to randomly select settlements for the sample as well as the number of households to be interviewed in each of the selected settlements. In order to select the households for assessment, enumerators were assigned a random GPS point as their starting point, from which they surveyed every 3 to 5 households, depending on area density. A 10% buffer was added to each sample size to allow for the deletion of surveys during cleaning. The sample of households per settlement was proportional to the overall settlement population, so settlements with a higher overall population also had a higher number of households in the sample. This ensured that the sample would be representative of the overall district population of Cadale.

Data collection was carried out between 2 and 7 October 2017 by a team of enumerators from Medair and SHARDO.

Table 2: Number of assessed households per settlement

Settlement	Parent Cluster	Sample
Bulo-Karamao	Cadale Town	35
Burso-Sheikh	Adow-Ul	21
Cadale	Cadale Town	68
Ceel Xarar	Burdhere	38
Danwadag	Cadale Town	54
El-Harar	El-Harar	2
Haji-Ali	Haji Ali	20
Halgan	Cadale Town	61
Hawl-Don	Cadale Town	44
Total		343

Analysis

Where relevant, findings have been disaggregated by rural and urban areas. These are linked to health centre catchment areas; with Cadale Town and Haji Ali being considered urban, and Burdhere and Adow-Ul considered rural. Findings have also been triangulated with secondary data. This includes previous REACH assessments, such as the 2017 Joint Multi-Cluster Needs Assessment (JMCNA), and external data sources including seasonal analysis from the Food Security and Nutritional Analysis Unity (FSNAU) and the Famine Early Warning Systems Network (FEWSNET).

FINDINGS

This section of the report presents the main results from the rapid assessment and comprises a series of sector and location-specific findings relating to healthcare, nutrition, WASH, food security and livelihoods. Where relevant, findings are disaggregated between rural and urban households.

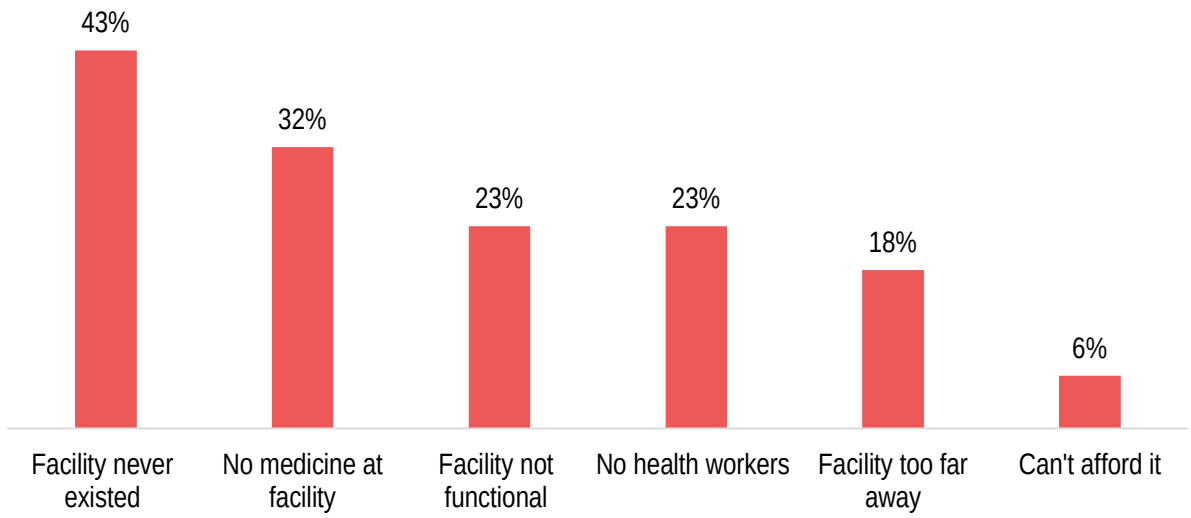
Health

Access and availability

A total of 43% of assessed households indicated being unable to access a formal healthcare facility. For these households, the most commonly reported barrier was that no facilities existed in the area, reported by 43% of households with no access. In addition, 23% of households with no access to a formal health facility reported that their facility was no longer functional and 18% that the facility was too far away. Lack of medicine and a shortage of health workers were also reported as barriers to healthcare access, reported by 32% and 23% of households without access respectively. This suggests that where facilities do exist they are under-equipped and under-staffed.

The vast majority (94%) of households reporting access to a healthcare facility were located in Cadale Town, which was the only catchment area with functional facilities – two functional facilities were identified in the health facility mapping for this assessment. This suggests that a relatively high proportion of the assessed population in Cadale District are not currently served by a formal healthcare facility. This points to the likelihood of a disparity in healthcare access between households located in and around Cadale Town, and households located in more rural areas further away from the town.

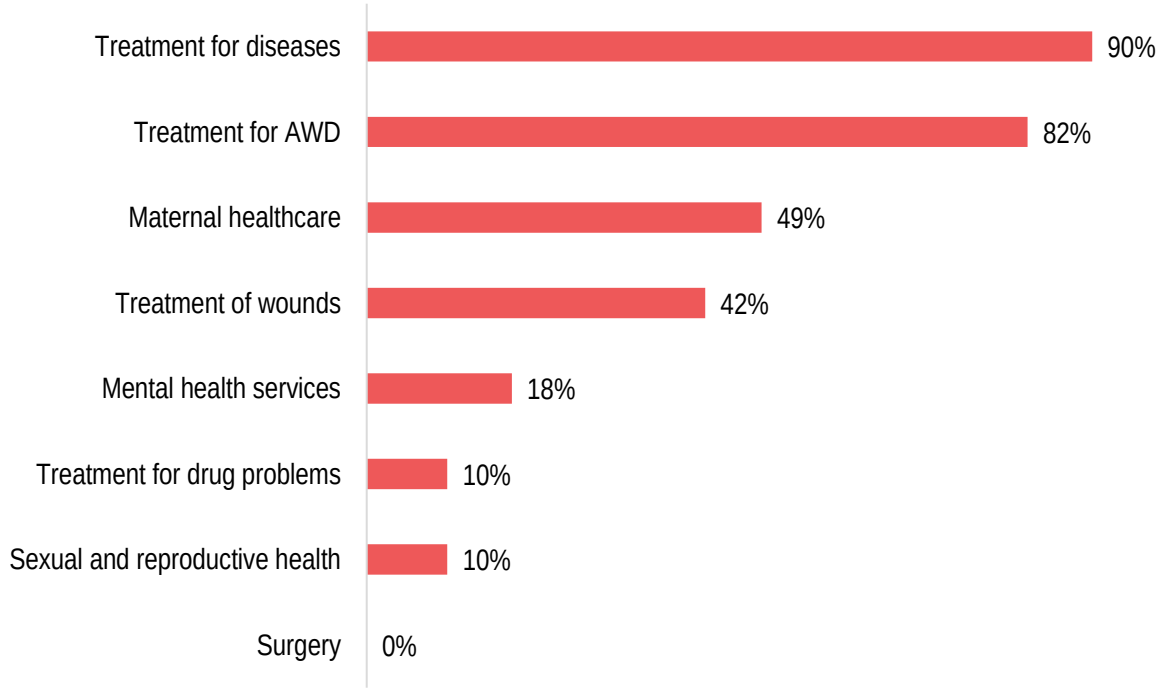
Figure 2: Proportion of households without access to a formal healthcare facility reporting each barrier to access (households could select multiple answers)



Treatment for malaria and acute watery diarrhoea (AWD) were the most commonly reported services available identified by 90% and 82% of households with healthcare access, respectively (Figure 3). More complex or culturally sensitive services, such as treatment for drug problems (for example miraa[6] addiction) and sexual and reproductive health, were reportedly much less commonly available, reported by 10% of households with access to a health facility. It is likely that they are underreported due to stigma, and/or a lack of awareness of service availability.

[6] Miraa, or khat, is an amphetamine-like stimulant extremely common in Somalia.

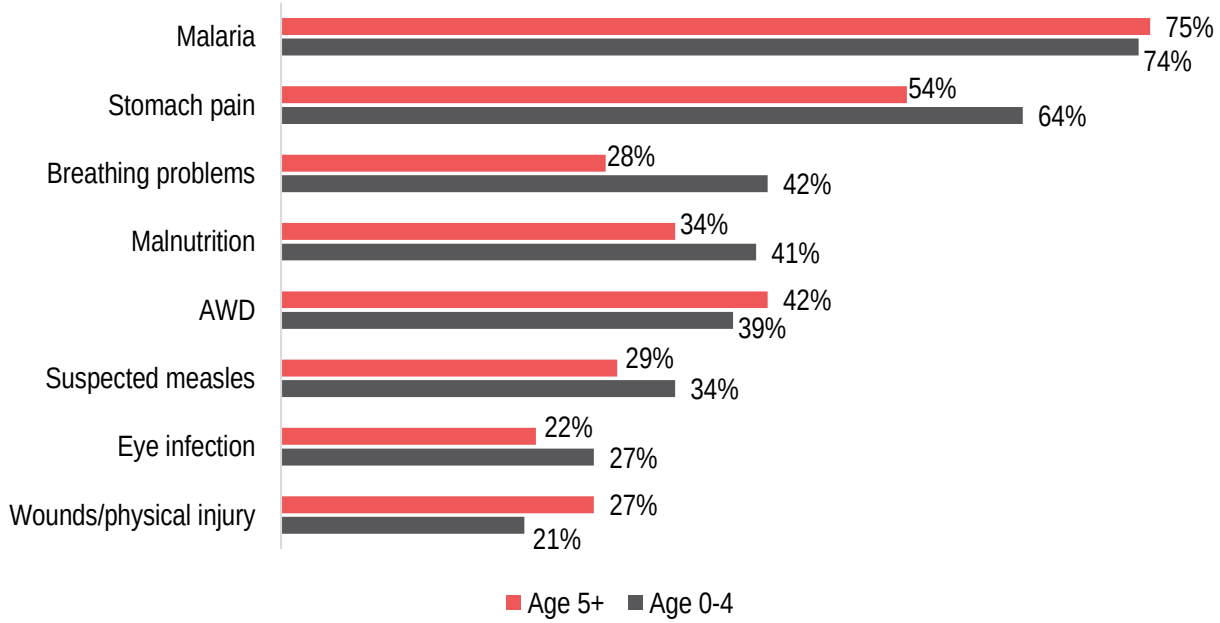
Figure 3: Proportion of households with access to a health facility reporting awareness of available services



No households indicated that surgery was available at their healthcare facility and a small number of FGD respondents indicated travelling to Mogadishu to receive surgery.

Malaria and gastrointestinal issues were the most commonly reported health problems for all age groups mirroring the most commonly reported available health services (Figure 4). Approximately three-quarters of all assessed households indicated that a household member (both adults and children under the age of five) had experienced malaria in the past month. The second most commonly reported health issue was stomach pain, with a slightly higher proportion of under-fives than aged five and above reportedly experiencing problems in the past month. In a reflection of increasing food insecurity, malnutrition was also a commonly reported issue, particularly for under-fives; reported by 41% of assessed households.

Figure 4: Proportion of assessed households reporting that a member had experienced a health issue in the past month, disaggregated by age



Seventy-nine percent of households with access to a formal healthcare facility reported having to walk less than 30 minutes to reach it, and 18% indicated having to walk for 30 minutes to one hour (Figure 5). However, a small proportion indicated having to walk for 1 hour to half a day or over half a day. As mentioned above, distance to healthcare facility was a common reason for lack of access, reported by 18% of households which had indicated not being able to access a formal facility. This suggests that few households travel long distances to access healthcare. Distance is therefore evidently a barrier to access.

Figure 5: Average distance to nearest formal healthcare facility

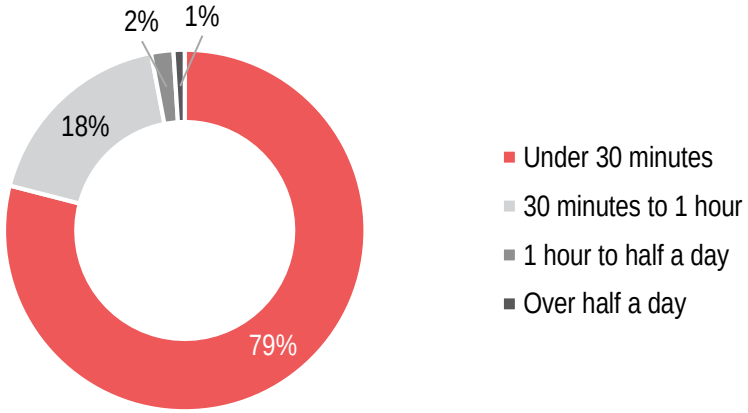
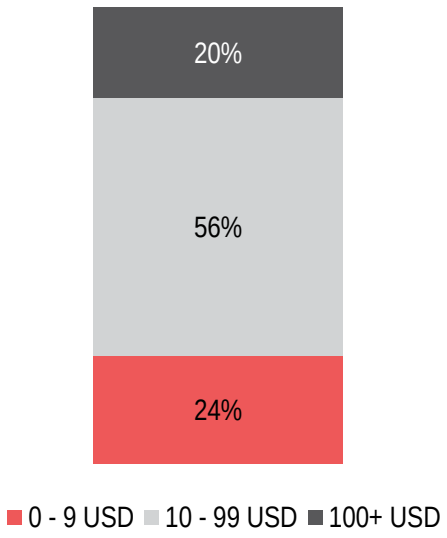


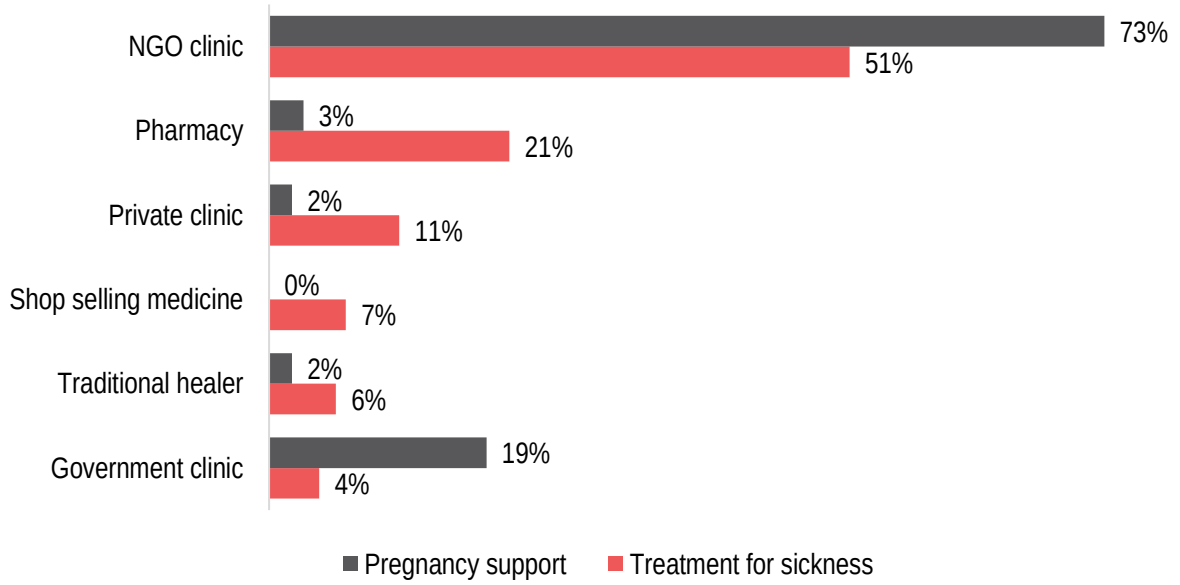
Figure 6: Average spending on healthcare in the past month, as reported by households with access to a healthcare facility



Just over half (56%) of households with access to a facility reported paying between 10 USD and 99 USD on healthcare in the past month. Calculated healthcare costs also included transport to and from a health facility. Given that the only identified available facilities were located in Cadale Town, it is probable that transport costs increase for households the further away they are located from town; the cost of travel is likely a key barrier to healthcare access for these households. Findings from FGDs indicated that, if they are able to afford it, households will travel on donkey cart or use wheelbarrows to transport the sick. However, if they are unable to afford the transport costs they are forced to stay at home; "*we pray and stay home*" (FGD participant, Haji-Ali).

Twenty percent of all assessed households indicated that they spent 100 USD or more on healthcare in the past month. The higher costs reflect the expenditure on travel and generally relate to households which had travelled from Cadale to Mogadishu or Jowhar to access healthcare. This is corroborated by findings from FGDs, in which several participants indicated travelling to larger towns when there were complications with child birth, or "*when my child is very sick*" (FGD participant, Cadale Town).

Figure 7: Reported healthcare service provider that households access when a member is sick, compared with preferred healthcare provider for pregnancy support

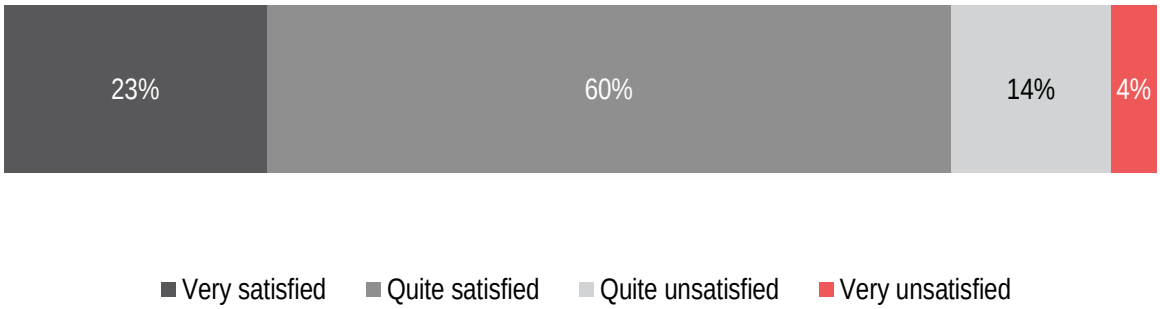


As Figures 7 indicates, **there is a difference in the type of health facility households prefer to access depending on whether they are seeking treatment for sickness or pregnancy support**. NGO clinics were the most popular for both issues; 73% of assessed households indicated a preference for an NGO clinic for pregnancy care, and 51% indicated preference for an NGO clinic when they are sick. A much smaller proportion of all households (4%) indicated choosing a government clinic when seeking treatment for sickness than for pregnancy support (19%). The difference in preference is most likely linked to the capacity and services offered by each facility. For example, 21% of all assessed households indicated that they would access a pharmacy to treat sickness, where they would most likely be able to purchase medicines, while only 3% of households indicated the same for pregnancy support, as pharmacies generally do not offer specific pre and post-natal services.

Very few households indicated that they would chose a traditional healer for either sickness (6%) or pregnancy (2%), suggesting that, where they are available, people generally prefer accessing healthcare from formal facilities.

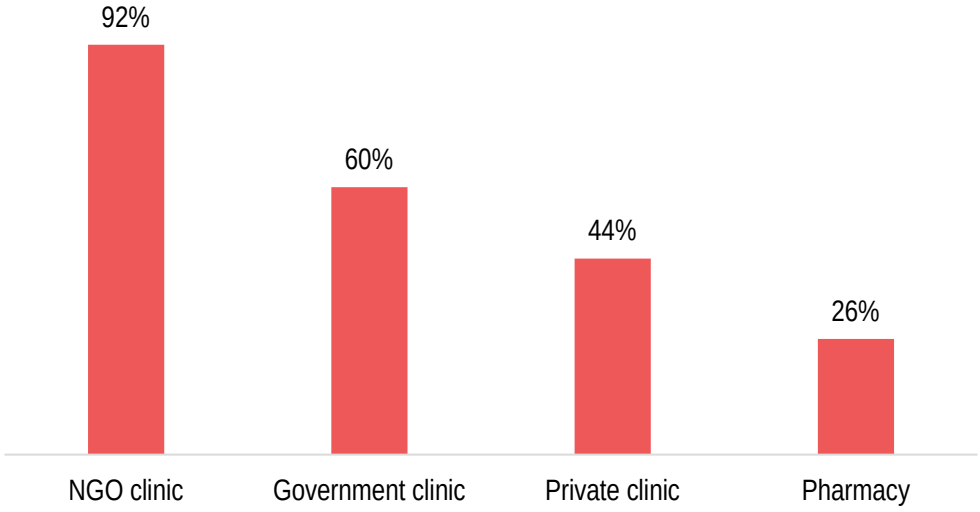
As indicated in Figure 8, the broad majority of households with access to healthcare services were satisfied with the service provided; 23% reported being very satisfied and 60% being 'quite satisfied'.

Figure 8: Reported household satisfaction with healthcare services accessed in the past month



This is potentially linked to the reliance on NGO clinics as the healthcare provider – reported by 51% of households (Figure 7) - as the quality of services available tends to be higher in NGO-run facilities than in government or private clinics or hospitals. As Figure 8 demonstrates, 92% of households accessing NGO clinics indicated that they were satisfied with the facility, as opposed to 44% of households accessing private clinics, and just 26% of households receiving healthcare from pharmacies.

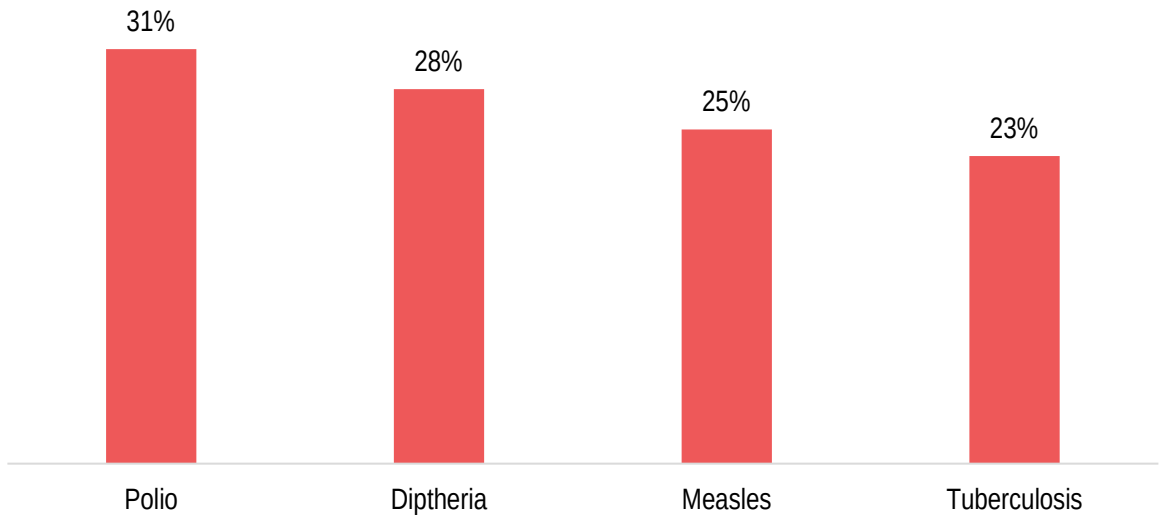
Figure 9: Proportion of households with healthcare access reporting that they were 'quite' or 'very' satisfied with each healthcare provider (households were only able to select one answer)



Just under half (49%) of assessed households with vaccine-aged[7] children (81% of all assessed households) reported that children had received no vaccinations. Overall, polio vaccine was the most commonly received vaccine, with 31% of vaccine-aged children in assessed households in the district reportedly having received it (Figure 10). Further probing revealed that there had recently been a polio vaccination drive, which likely accounts for this higher proportion. In addition, 28% of vaccine-aged children in assessed households reportedly received the diphtheria vaccination, 25% received measles vaccine and 23% their Tuberculosis vaccination.

[7] Vaccine aged children refers to children between the ages of 6 months and 15 years.

Figure 10: Proportion of vaccine-aged children (6 months to 15 years) in assessed households who have received vaccinations



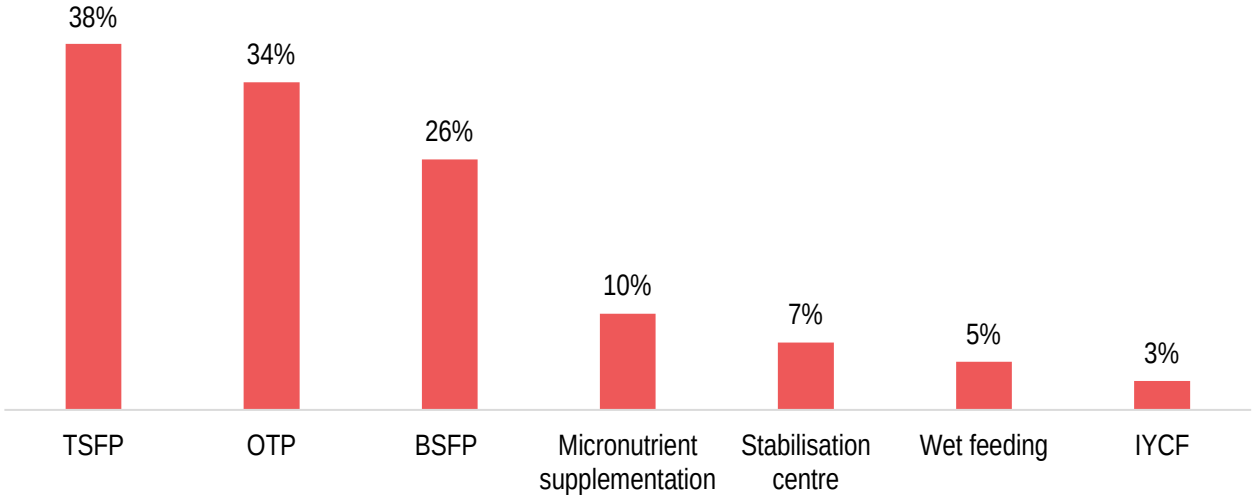
Additionally, there is a probable link between the presence of community health workers (CHWs) and household awareness of vaccinations. Data from the health facility mapping indicated that one facility in Cadale Town (run by local NGO SHARDO) had a high number of CHWs (16 male and 21 female). As CHWs are frequently involved in awareness campaigns in the community, their presence in Cadale Town has likely resulted in greater community awareness of the availability of vaccinations.

Only 37% of households with vaccine-aged children that indicated that their children had received vaccinations were able to produce physical evidence of vaccine cards. The lack of evidence of received vaccinations suggests that households may have over reported the number of children who had received vaccinations in this assessment. Lack of available health facility was the most commonly reported reason for children not receiving vaccinations, indicated by 40% of all households with vaccine-aged children. Additionally, 12% reported that vaccinations were not available in their health facility and a further 10% indicated not being aware that they should vaccinate their children.

Nutrition

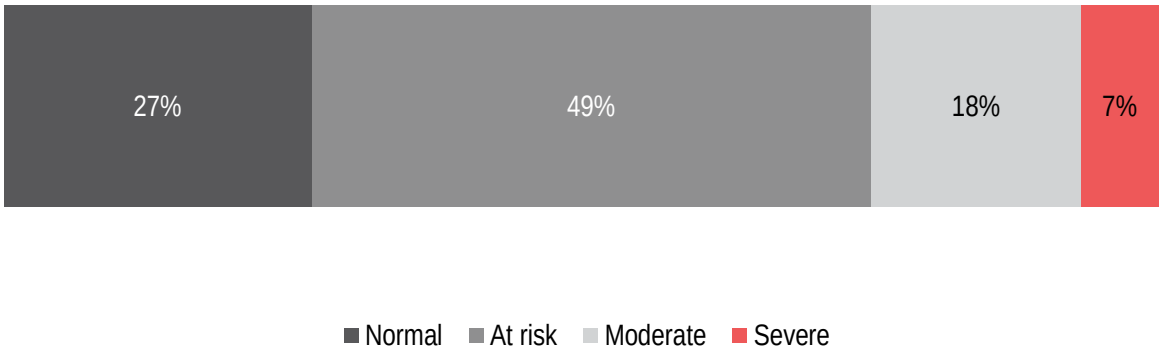
Just under half of assessed households (45%) reported having accessed nutrition services in the past month. Of the facilities mapped during this assessment (see Annex, only one offered nutrition services; this facility was located in Halgan, Cadale Town. The lack of available nutrition services in other parts of the district points to a clear need for targeted intervention in these areas.

Figure 11: Proportion of all assessed households reporting availability of different nutrition services (respondents could select multiple answers)



The most common form of nutrition assistance was targeted supplementary feeding programmes (TSFP), outpatient therapeutic programmes (OTP) and blanket supplementary feeding programmes (BSFP), reported by 38%, 34% and 26% of all households, respectively. This reflects the findings from the healthcare mapping, which showed that the health facility in Halgan provided BSFP, TSFP, OTP and micronutrient supplementation.

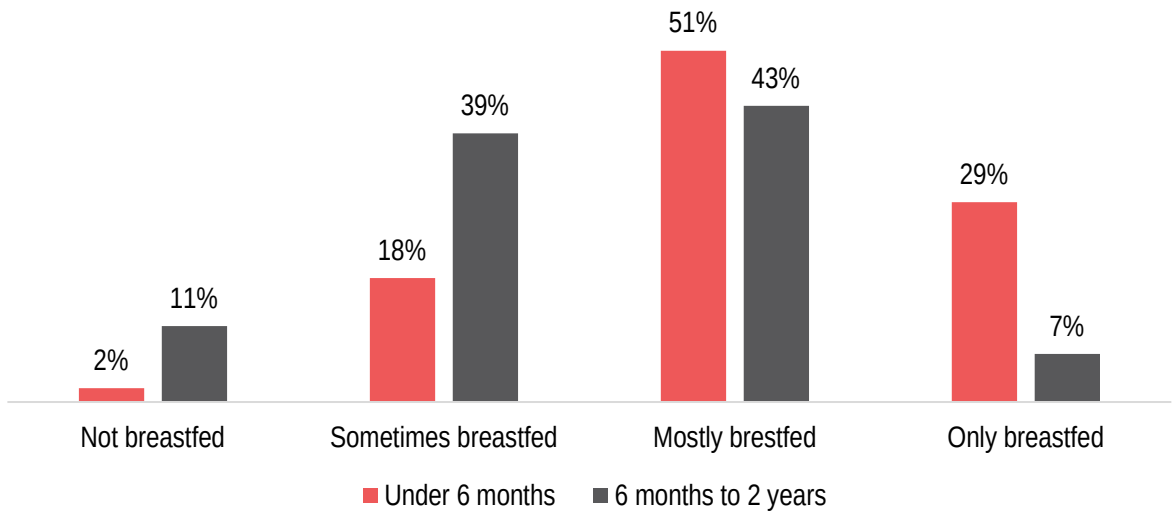
Figure 12: Proportion of under 5 years old children in each MUAC category



Eighteen percent of children under five years old in assessed households were categorised as having moderate malnutrition, with an arm circumference of 115-124mm, while 7% were categorised as severely malnourished (115mm and below). However, only a very small proportion (3%) were reported to demonstrate pitting oedema, suggesting that the prevalence of Kwashiorkor[8] is low. Just under half of under five years old children in assessed households were found to be at risk of malnutrition. Given the deteriorating food security situation in most of the district (see Food Security and Livelihoods section further in this report), it is highly likely that the rates of malnutrition will continue to rise without adequate intervention, resulting in a higher proportion of at-risk children experiencing moderate and severe malnutrition.

[8] Kwashiorkor is a life-threatening form of malnutrition caused by a lack of protein in the diet.

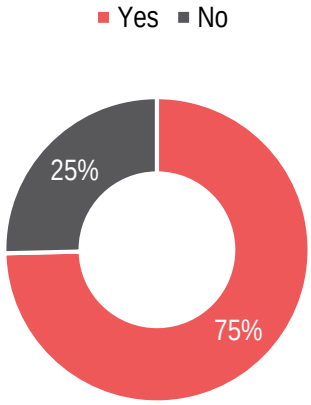
Figure 13: Proportion of assessed households reporting each breastfeeding behaviour for children under six months, and aged six months to two years old



While 29% of households with children under 6 months old indicated that they only fed their child with breast milk (and not powdered milk or any other food), a higher proportion indicated breastfeeding most (51%) or some (18%) of the time, suggesting that infant breastfeeding practices are not as widespread as they could be. Similarly, less than half (43%) of households reported breastfeeding children aged between six months and two years most of the time, and 11% indicated never breastfeeding children of this age.

WASH

Figure 14: Proportion of households indicating being able to access enough water for drinking, washing and cooking



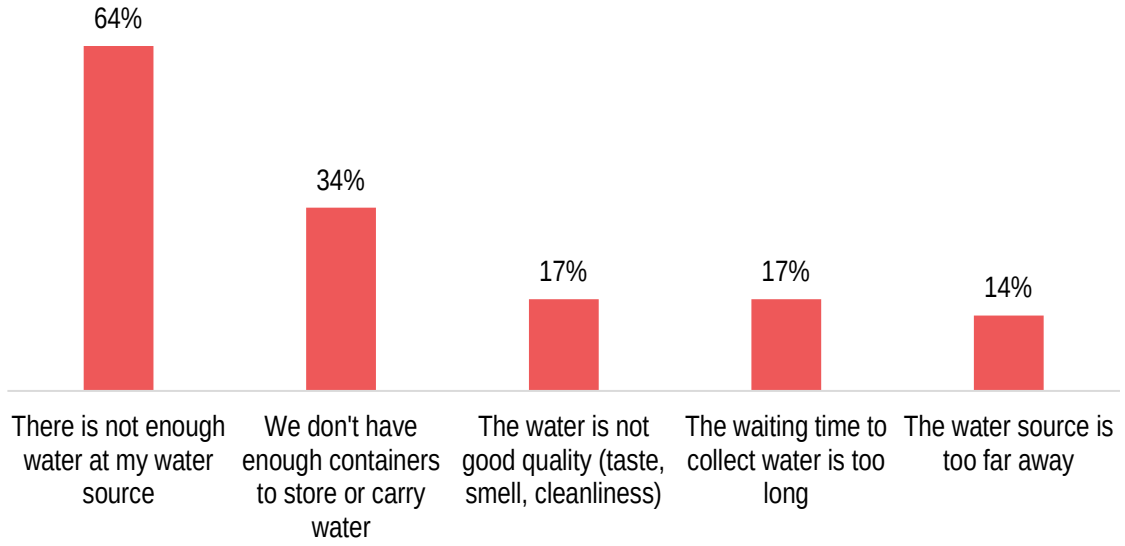
Water

Three-quarters of assessed households indicated being able to access enough water to meet their needs for drinking, washing and cooking. However, households reported accessing an average of 78 litres of water per day. If we assume that the average household size in Somalia is 6 persons[9], then the average number of litres of water per person per day is 13, which is slightly lower than the SPHERE minimum standard of 15.

A small proportion of households (4%) indicated accessing well above the average amount of water per day; at between 200 and 400 litres. This was reportedly because these households had access to larger storage containers, such as tanks, which can hold 200+ litres of water at once.

[9] As identified by the World Health Organisation (WHO). 2014. Somalia Humanitarian and Development Statistics.

Figure 15: Five most commonly reported reasons for lack of access to enough water for drinking, washing and cooking (households could select multiple answers)



The most commonly reported reason for lack of access to enough water for drinking, washing and cooking related to water shortages at the water source, as cited by 64% of households without access to enough water. This reflects the ongoing drought situation in Somalia, which has affected water table levels. Thirty-four percent of assessed households without adequate water access reported not having enough containers to store water. Intervention to provide jerry cans or other water storage containers would therefore likely have an immediate impact on the water storage capacity of these households.

There was little variation in the most commonly reported sources of drinking water and water used for cooking or washing, suggesting that households generally use the same water source for both. As Figure 17 indicates, piped water was the most common source of water, with 23% of households reporting using this for washing or cooking and 22% reporting it as their source of drinking water. The second most common water source, for both drinking and washing or cooking, was an unprotected well, reported by 20% of households. Given the open nature of unprotected wells and the subsequent exposure to sources of contamination, the water quality tends to be lower, potentially increasing the risk of water-borne diseases. This is particularly problematic given that across the district, only 15% of households indicated treating their drinking water.

Figure 16: Five most commonly reported sources of water for drinking and washing or cooking

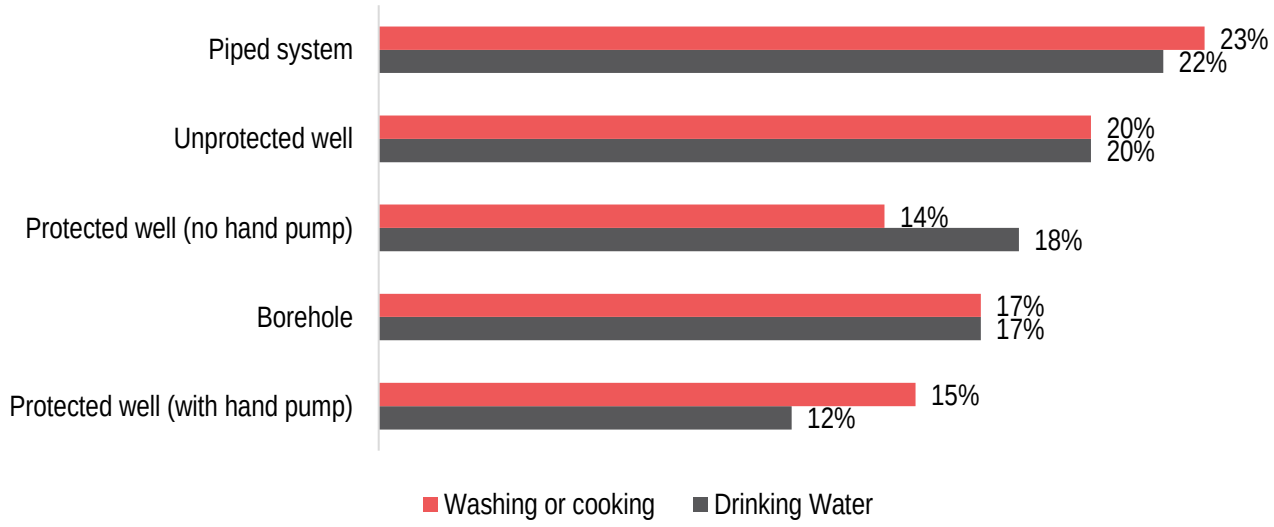
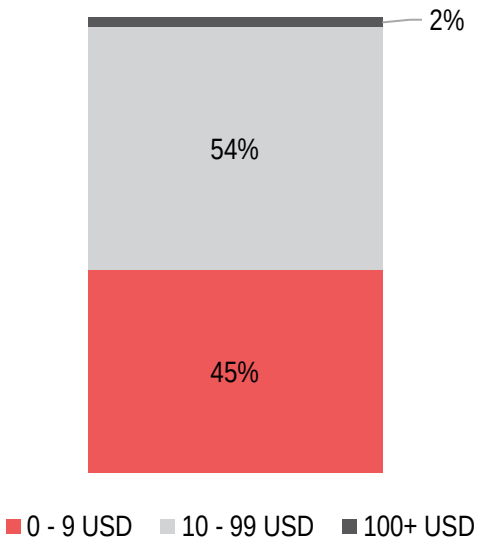


Figure 17: Household spending on water in the past month



The majority of assessed households indicated the close proximity of a water point; 75% stated that the nearest source was less than half an hour's walk away, and a further 20% reported it to be between 30 minutes and an hour away. Only 5% of households indicated that their nearest water source was over one hour's walk away.

Of the households paying for water, 69% reported that the amount they spent had increased over the last three months. Again, this is reflective of the impact of the ongoing drought, which has reduced water supply, driving up prices.

Nearly three-quarters (71%) of assessed households reported paying for their water. More than half of them (54%) indicated paying between 10 USD and 99 USD and 45% below 10 USD. While the figures are too low to be statistically significant, data at the catchment level indicates a disparity between urban areas (Cadale Town and Haji Ali) and rural areas (Burdhere and Adow-Ul), with a higher proportion of urban households stating that they do not pay for water. This is perhaps indicative of the greater provision of water by NGOs in urban areas.

Jerry cans were the most common method of storing drinking water, reported by 79% of assessed households. Households owned an average of four 20-litre-sized jerry cans. The second most common water storage facility was a water tank, reported by 18% of households.

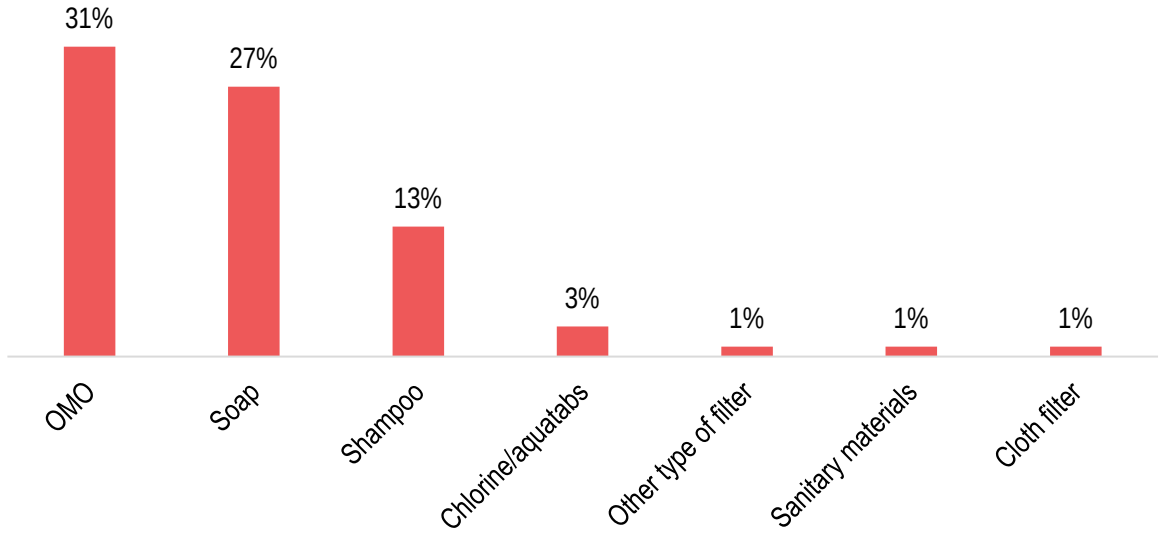
Only 17% of assessed households indicated the presence of a WASH committee in their settlement.

Hygiene

Over half (61%) of households reported having no access to soap. Cost was the most commonly reported barrier, reported by 94% of households with no soap access. Only 3% reported considering soap as a non-necessary hygiene item and 2% indicated preferring using an alternative to soap (such as ash or sand). When disaggregated at the catchment level, the data suggests that households in Cadale Town and Haji-Ali have greater access to soap than the two rural catchment areas of Burdhere and Adow-Ul, which may be indicative of more humanitarian intervention in urban areas[10].

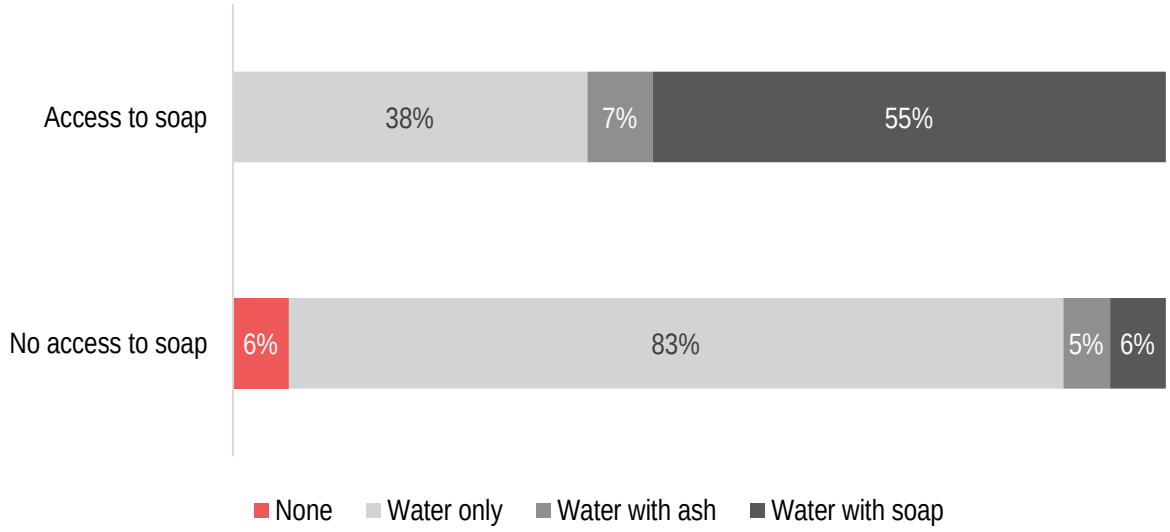
[10] Note: the sample size was not large enough for findings disaggregated to the catchment level to be statistically significant. However, they are likely indicative of broad trends.

Figure 18: Proportion of households indicating having received WASH items from humanitarian organisations or government in the past three months (households could select multiple responses)



Sixty-two percent of assessed households indicated that they had not received any WASH items from NGOs or government agencies in the past three months. Among the 38% of households stating that they had received WASH items, OMO[11] and soap were the most common, reported by 31% and 27% respectively.

Figure 19: Reported household handwashing practices, as a proportion of households having access to soap (39% of all assessed households) and not having access to soap (61% of all assessed households) respectively

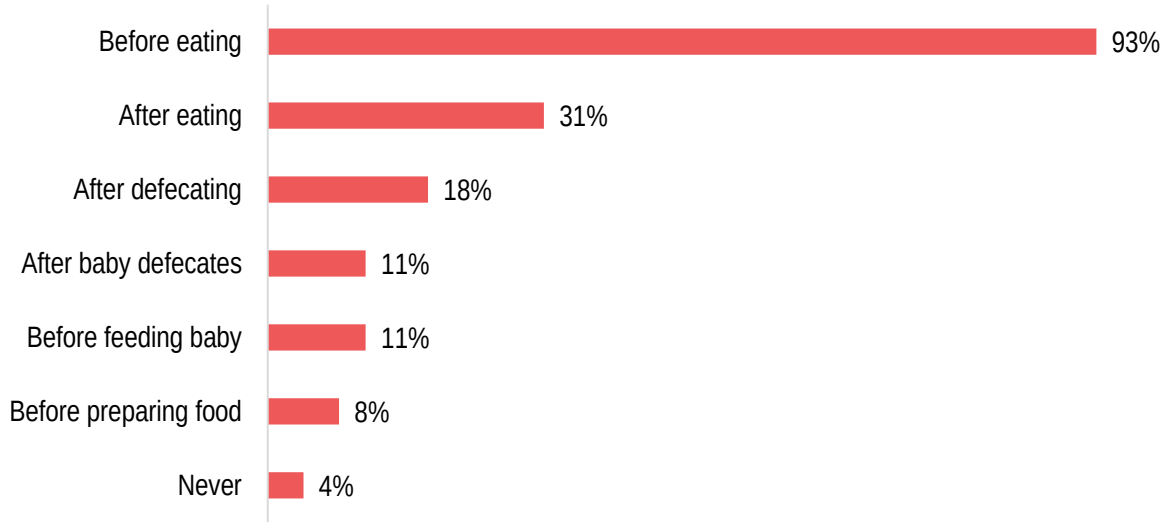


Eighty-three percent of assessed households without access to soap indicated that they only used water to wash their hands, while 5% indicated using water and ash. A small proportion (6%) of households without access to soap indicated that they did not wash their hands at all[12]. On the other hand, a much higher proportion (55%) of households with soap access reported using soap to wash their hands. However, a considerable 38% of assessed households with access to soap reported that they only used water to wash their hands, which suggests there is still a limited understanding of good hygiene practice in some areas.

[11] OMO is a clothes washing powder which is commonly used as body and hand soap.
[12] Please note that the 6% of households reporting using soap to wash their hands, despite previously indicating no soap access is likely related to an enumerator error.

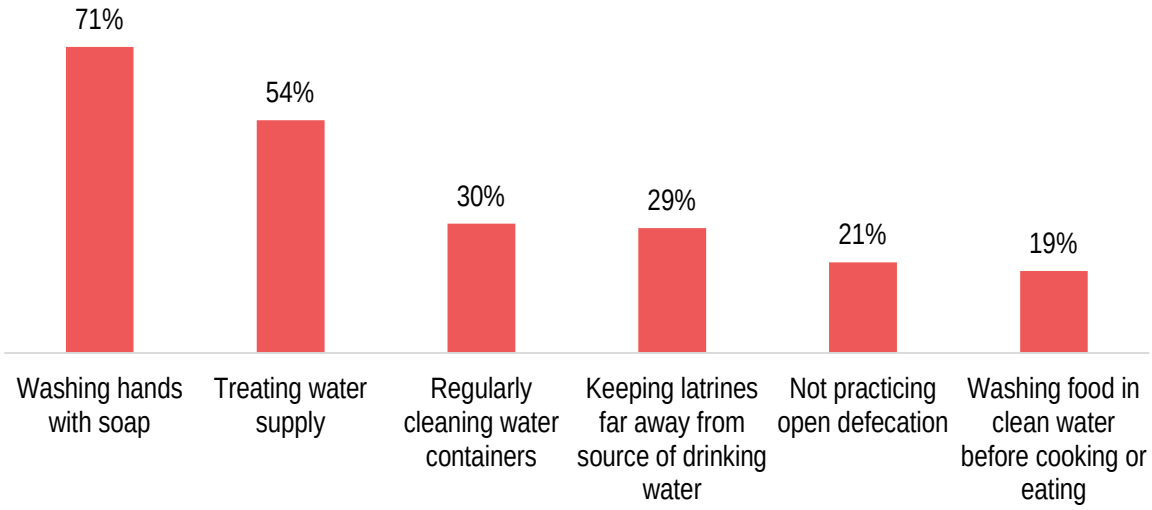
There was sporadic household awareness of good hygiene practice, with gaps in both awareness and reported behaviour relating to the link between defecation and water contamination, particularly in the context of contraction of AWD. Awareness of when to wash hands was the highest in relation to eating, with almost all assessed households (93%) indicating that you should wash your hands before eating. However, there appeared to be much lower awareness around handwashing in relation to defecation, with only 18% of households indicating that you should wash your hands after defecating and 11% after cleaning up when an infant defecates, which suggests limited understanding of faecal-oral transmission routes. Given the ongoing presence of AWD in many parts of Somalia[13], this lack of awareness is particularly problematic.

Figure 20: Proportion of assessed households reporting awareness of good handwashing practices (households could select multiple responses)



When asked specifically about the causes and prevention of AWD, households demonstrated similar gaps in understanding. Whilst 61% of assessed households indicated awareness that water contaminated by faeces and by garbage could cause AWD, less than one-third (29%) were reportedly aware of the need to ensure a minimum distance between drinking water sources and latrines, and only 21% indicated being aware that not practicing open defecation was a preventative measure for AWD (Figure 21).

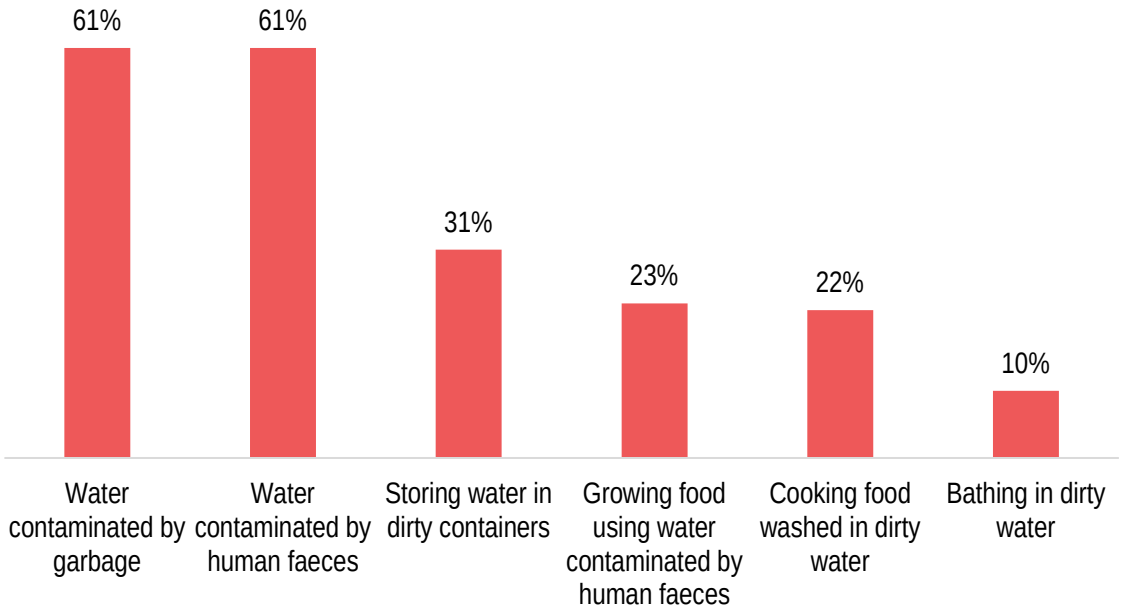
Figure 21: Proportion of households reporting awareness of AWD preventative measures (households could select multiple responses)



[13] Middle Shabelle region was reported to have 2,491 cumulative cases of AWD/cholera as of week 39 (25/09/17 – 01/10/17) of the outbreak. Reported by the Somalia Ministry of Health.

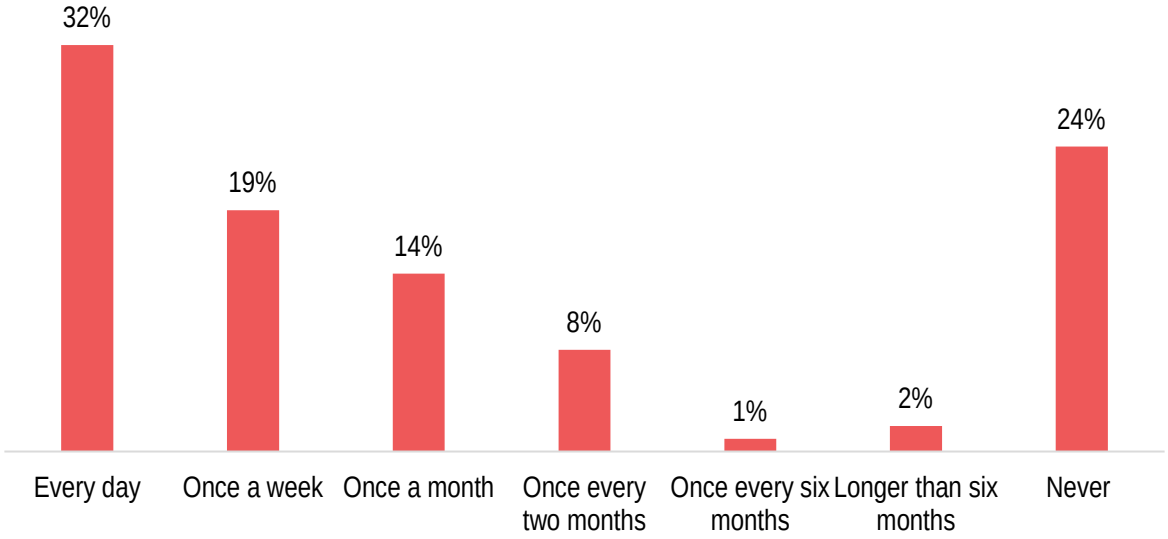
Washing hands with soap and treating the drinking water supply were the preventative AWD measures that households were most aware of, indicated by 71% and 54% of assessed households, respectively. However, as illustrated earlier, households did not necessarily use soap to wash their hands even when it was available to them, suggesting a potential disconnect between reported awareness levels and behaviour in practice.

Figure 22: Proportion of households reporting awareness of causes of AWD (households could select multiple responses)



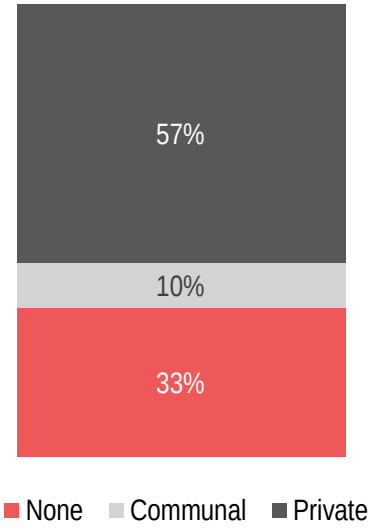
As illustrated in Figure 22, just under one third (31%) of assessed households reported that storing water in dirty containers was a cause of AWD. Relatedly, almost one-quarter of assessed households indicated that they never cleaned their drinking water containers, again indicating a lack of awareness of the causes of AWD (Figure 23).

Figure 23: Frequency that assessed households reportedly clean their drinking water containers



Sanitation

Figure 24: Proportion of assessed households reporting having access to each type of latrine

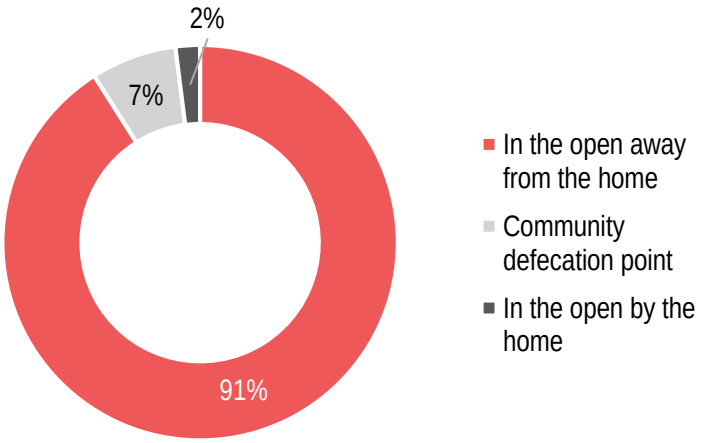


One-third (33%) of assessed households indicated having no latrine access, suggesting open defecation is relatively widespread. Fifty-seven percent of households reported having access to a private latrine.

Communal latrines were the least common type of latrine, reportedly accessed by just 10% of all assessed households. Of these 10%, 94% of households reported that the latrines they used were lockable from the inside, 65% reported they were gender segregated, and just 9% reported handwashing facilities. No households using communal latrines indicated that they had disabled access.

Ninety-one percent of households with no latrine access reported defecating in the open away from the home, rather than at a defecation point designated by the community. While it presents fewer health risks than defecating close to the home, defecation in the open away from the home can still result in contamination of water sources and is less contained than defecating at a designated community defecation point. Intervention targeting increased latrine access is thus likely to have a considerable impact on reducing open defecation practices.

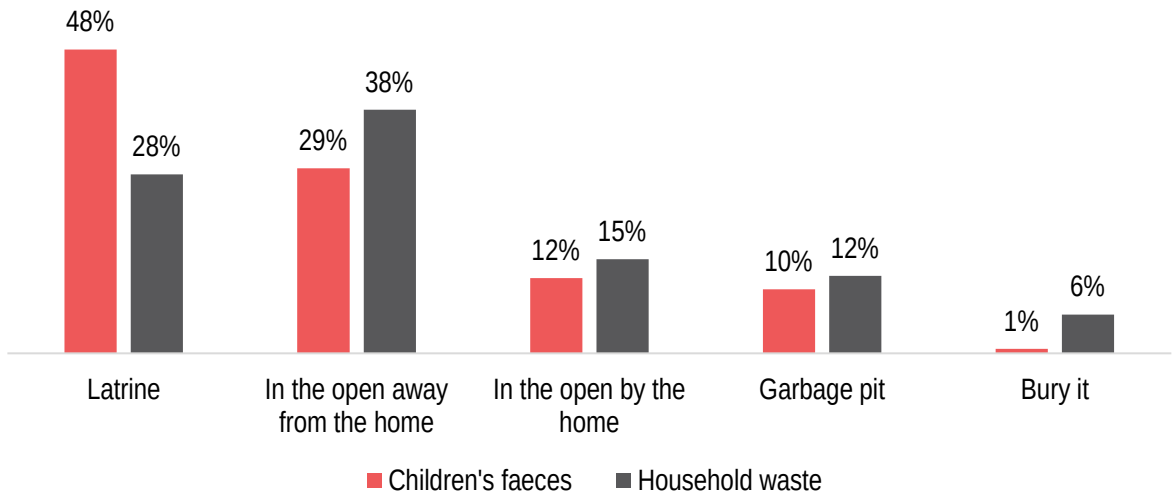
Figure 25: Reported defecation practices for the 33% of assessed households without access to latrine



.

Similarly, 29% of assessed households with children (81% of the total assessed households) reported disposing of children's faeces in the open away from the home, and a further 12% indicated leaving them in the open by the home.

Figure 26: Proportion of assessed households reporting each method of disposal of children's faeces and household waste (note: red bars indicate proportion of households with children disposing of children's faeces)



Food security and livelihoods

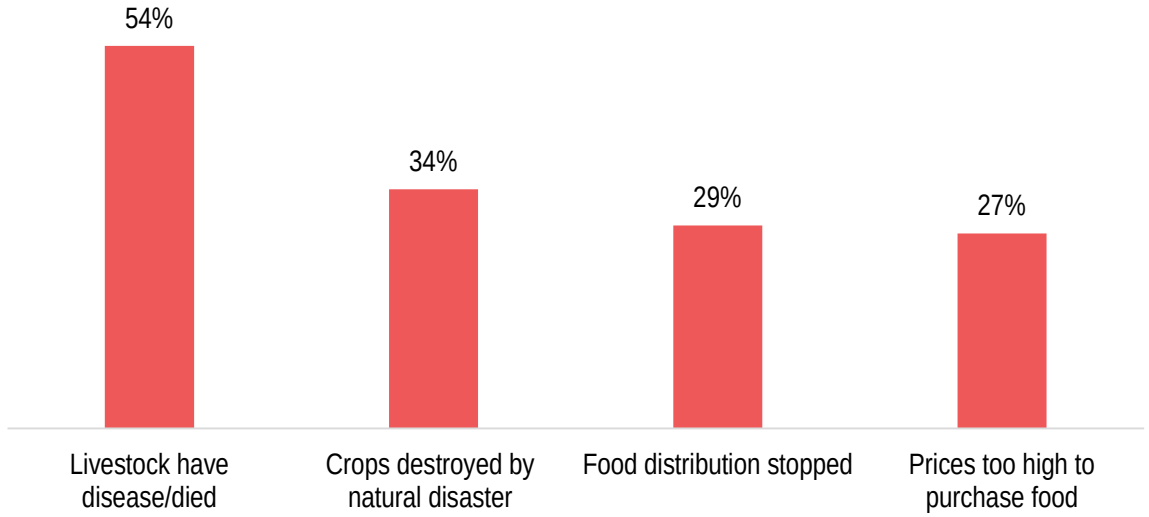
Food security

Post-Gu analysis by FEWSNET and FSNAU indicated that an estimated 3.1 million (25% of the total population of Somalia) is predicted to be in Crisis (IPC Phase 3[14]) or Emergency (IPC Phase 4) between August and December 2017. Within this, Cadale District is forecasted to be in Emergency[15]. This is broadly reflected in the assessment findings presented here, which indicate increasing levels of food insecurity and decreasing household economic resilience.

Sixty-one percent of assessed households reported that they did not have adequate access to food. Reflecting the ongoing drought conditions in Somalia, the two most commonly reported reasons for lack of access to food were the death or disease of livestock[16] and crop failure due to natural disaster, reported by 54% and 34% of households without adequate access to food, respectively.

[14] The IPC is a set of standardised tools used to classify the severity of food insecurity
[15] FEWSNET. 2017. Somalia Food Security outlook October 2017 – May 2018.
[16] High rates of livestock death are linked to lack of water and fodder, caused by drought conditions. For more information, see Office for the Coordination of Humanitarian Affairs (OCHA). 2017. Somalia: Operational Plan for Famine Prevention.

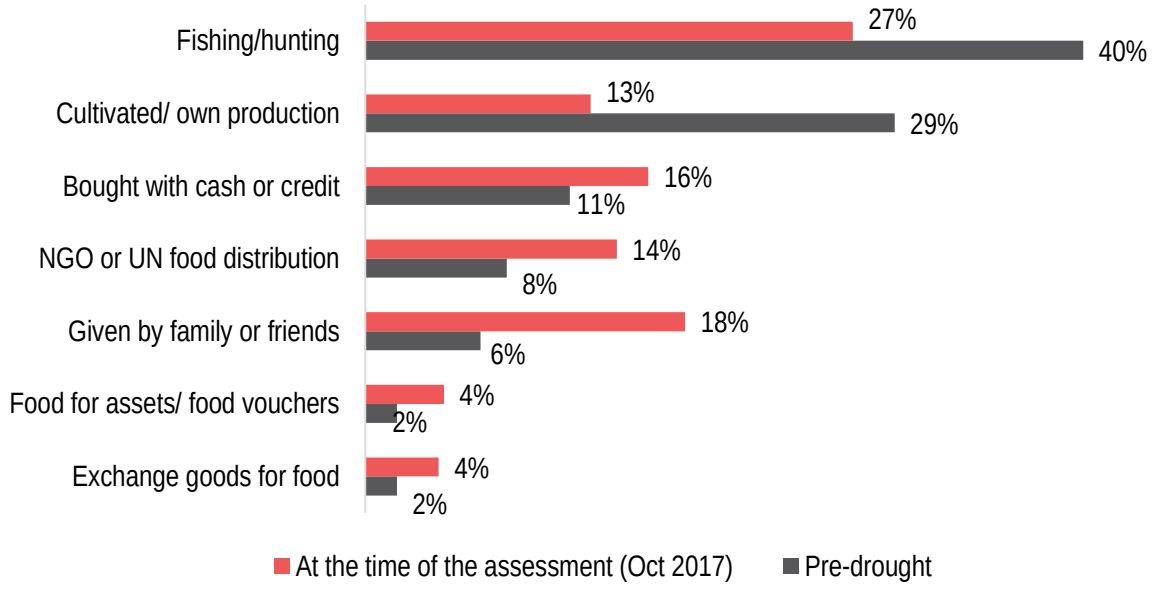
Figure 27: Four most commonly reported reasons for lack of access to food, reported by households without adequate access to food (households could select multiple answers)



Findings suggest a growing reliance on food donations (both from humanitarian actors and from within households' existing social networks) as the effects of drought reduce livestock and crop yields. The proportion of assessed households reporting reliance on cultivation as their primary food source has reduced by over half, from 29% pre-drought (the current drought began in approximately early 2015) to 13% at the time of the assessment. On the other hand, the proportion of households indicating a reliance on external support, either from humanitarian actors or from social networks, has increased. For example, 18% of assessed households indicated that their current primary food source was friends or family, as opposed to just 6% in pre-drought times. Similarly, 14% of assessed households reported relying on NGO or UN food distributions currently, compared with 8% in pre-drought times.

Just over half (54%) of assessed households reported that they had received food assistance in the past three months. Of these 73% were located in Cadale Town. As with health, nutrition and WASH services, this again suggests that much of the humanitarian intervention in the district has been focused in and around Cadale Town rather than in the more rural areas.

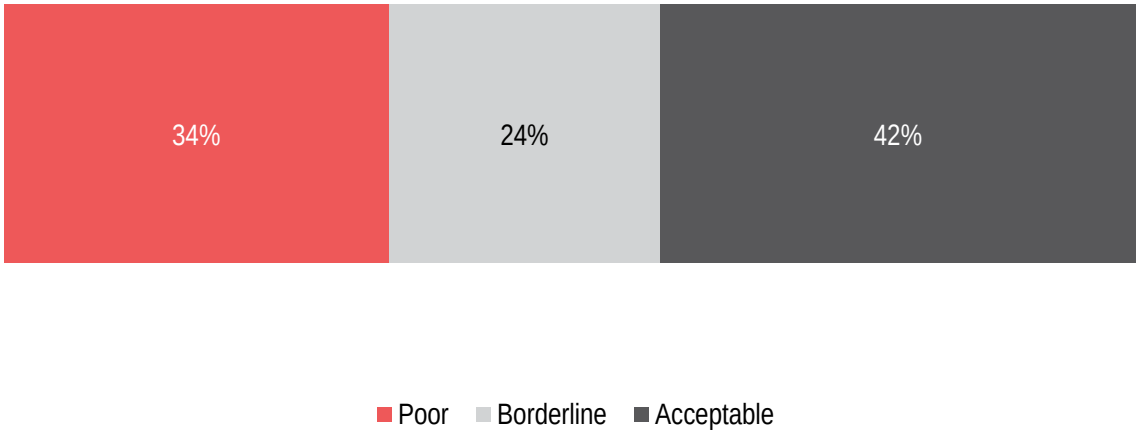
Figure 28: Households' primary food source pre-drought and at the time of the assessment



Just over half of assessed households (52%) indicated that there had been a change to their access to food in the last three months. Of these, 91% indicated that the amount of food they were able to access had reduced. In addition, 24% of households indicating a change to their food source reported that the variety of food they could access had reduced and 20% reported reduction in food quality.

Just over one-third of assessed households had a poor Food Consumption Score (FCS[17]) and a further 24% were scored as borderline; given the ongoing drought conditions and the declining household resilience it is extremely likely that households on the borderline will move into the 'poor' category in the coming weeks and months.

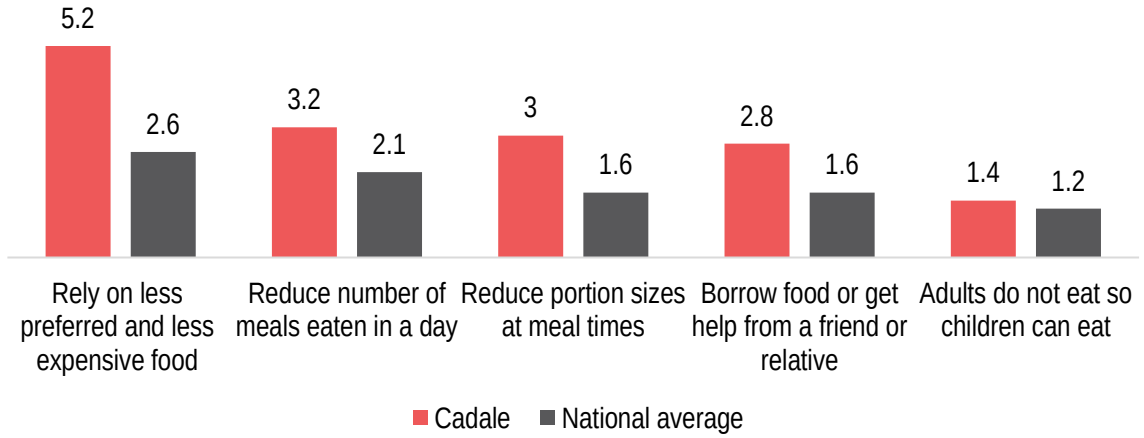
Figure 29: Proportion of assessed households categorised as having poor, borderline and acceptable Food Consumption Scores (FCS)



Households indicating lack of adequate access to food reported using reduced coping strategies more regularly in the past week than the national average[18]. Those households reported having relied on cheaper, lower quality food for an average of 5.2 days out of the past 7, as opposed to the national average of 2.6. Cutting household consumption by reducing the number of meals per day and reducing portion sizes were also commonly reported coping strategies, used an average of 3.2 and 3 days out of the past 7, respectively, compared to the national average of 2.1 and 1.6 days. The regular use of coping strategies indicates the extent to which households are being forced to alter their consumption to respond to the declining access to food.

[17] The FCS is a composite score based on dietary diversity, food frequency, and relative nutritional importance. It is calculated at the household level.
[18] According to 2017 JMCNA findings.

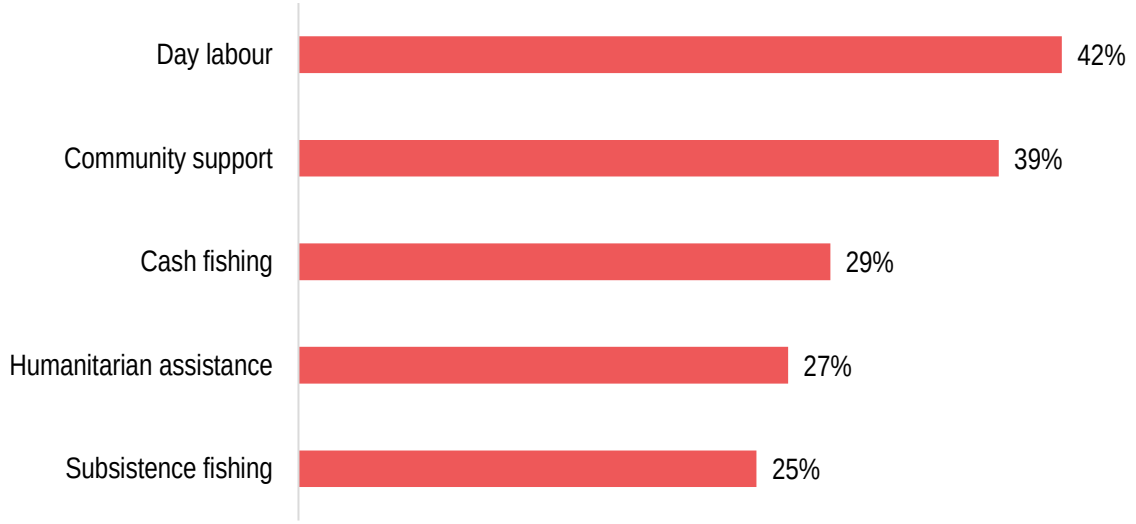
Figure 30: Average number of days assessed households reported using reduced coping strategies in the past 7 days



Livelihoods

Sixty-nine percent of assessed households reported losing access to livelihoods in the past year, indicating reduction in household resiliance as drought continues.

Figure 31: Five most commonly reported sources of household income or support (households could select multiple answers)



Day labour was the most common source of household income, reported by 43% of assessed households. Fishing, both commercial and subsistence, was also common, indicated by 29% and 25% of households respectively.

The majority of assessed households (59%) reported having only two sources of income, suggesting limited economic resilience. The limited diversity of income sources restricts the ability of households to respond to economic shocks, particularly if the household is relying on day labour, which is sporadic and often short-term.

Additionally, 69% of assessed households indicated that they had lost access to one or more income sources over the past year. This may be linked to the findings presented in Figure 33, which indicates that just over half of assessed households reported selling livestock over the last month in order to buy food. The sale of productive assets indicates a reduction in the means of households to support themselves. Relatedly, a high proportion of assessed households reported relying on external support, either from the community or through humanitarian assistance, reported by 39% and 27%, respectively.

Figure 32: Proportion of households reporting employing livelihood coping strategies over the past month

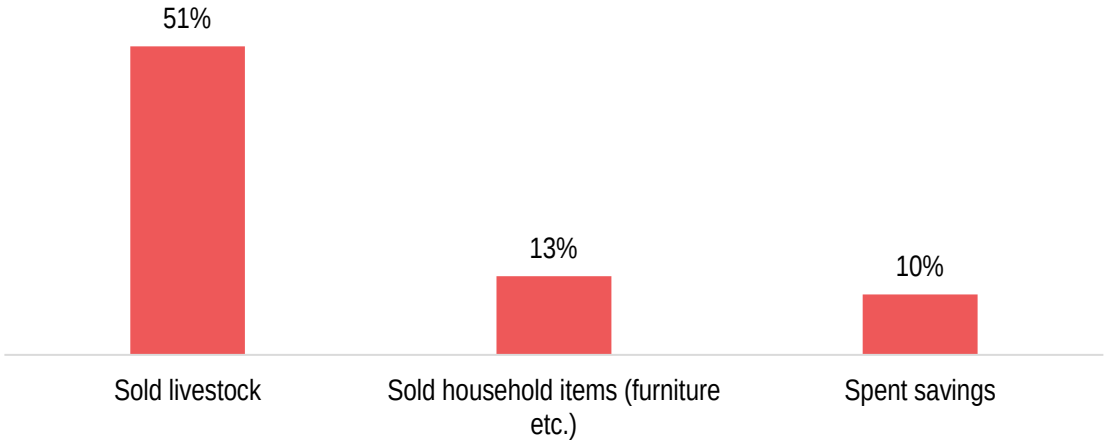
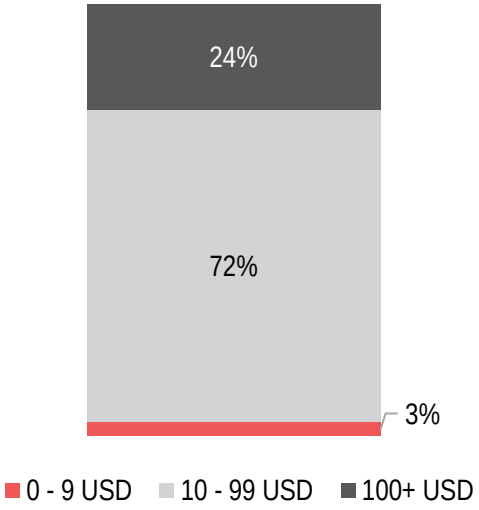


Figure 33: Reported household spending on food in the past month



The vast majority of assessed households (72%) indicated spending between 10 USD and 99 USD per month on food. Furthermore, 74% of assessed households reported that the amount they spent on food per week had increased over the last month, despite the overall indication that household income sources are declining. This proportion is notably higher than the national average of 43%[19]. This suggests that households with lower financial security, such as those relying on only one source of income are increasingly feeling the pressure of rising prices.

[19] Somalia Joint Multi-Cluster Needs Assessment 2017 (forthcoming).

Conclusion

Against the backdrop of ongoing drought and insecurity in Cadale, this assessment analyses the current availability of, and access to, health, WASH, nutrition and food security services in four catchment areas in the district.

Just over half of assessed households (57%) reported being able to access formal healthcare services. This is consistent with the health facilities mapping carried out during this assessment, which found that the only two functional facilities were located in Cadale Town. This indicates that a high proportion of the Cadale population is not served by a formal healthcare facility. Forty-nine percent of assessed households with vaccine-aged children reported that they had not received vaccinations.

Similarly, around half of assessed households (45%) reported having access to nutrition services. As with healthcare access, there is a link between reported nutrition access and the availability of services. Only one health facility in the district offered nutrition services. The lack of available nutrition services in other parts of the district points to a clear need for targeted intervention in these areas. Severe and moderate malnutrition was reportedly affecting one-quarter of children under five years old in assessed households, and the presence of kwashiorkor was low. However, almost half of under five years old children in assessed households were categorised as being at risk of malnutrition. Given the ongoing drought and declining food security indicators, it is extremely likely that the rates of malnutrition will rise without adequate intervention.

Three-quarters of assessed households indicated being able to access enough water for domestic purposes. Lack of water at the source was the most commonly reported reason for lack of access, reflecting the impact of drought on water point functionality. Relatedly, 69% of assessed households that were paying for water indicated that the amount they were paying had increased over the past three months.

The proportion of households reporting having access to soap and latrines was also notably higher in Cadale Town and Haji-Ali, again indicating greater humanitarian intervention in urban areas. However, cost was the most commonly reported barrier to accessing soap rather than a lack of awareness of good hygiene practices. Awareness of the need for handwashing was the highest around eating, as 93% and 31% of assessed households were aware of the need to wash hands before and after eating respectively. However, awareness of handwashing related to defecation practices and the link between defecation and the spread of AWD was less common. This suggests the need for greater hygiene awareness campaigning in the district, particularly in light of the ongoing presence of AWD cases.

Finally, the ability of households to provide food for themselves appears to be declining as the drought continues. Households reported a growing reliance on food donations (from both humanitarian organisations, and friends and family) as livestock herd sizes and crop yields decline. Additionally, over half (51%) of households indicated that there had been a change to their primary food source in the past three months, with 91% of these reporting that the amount of food they could access had declined., while 74% of assessed households indicated that household spending on food had increased over the last month. The erosion of household resilience is likely to continue, particularly given the below-average Deyr rainfall and the increased likelihood of a La Nina weather pattern taking place.

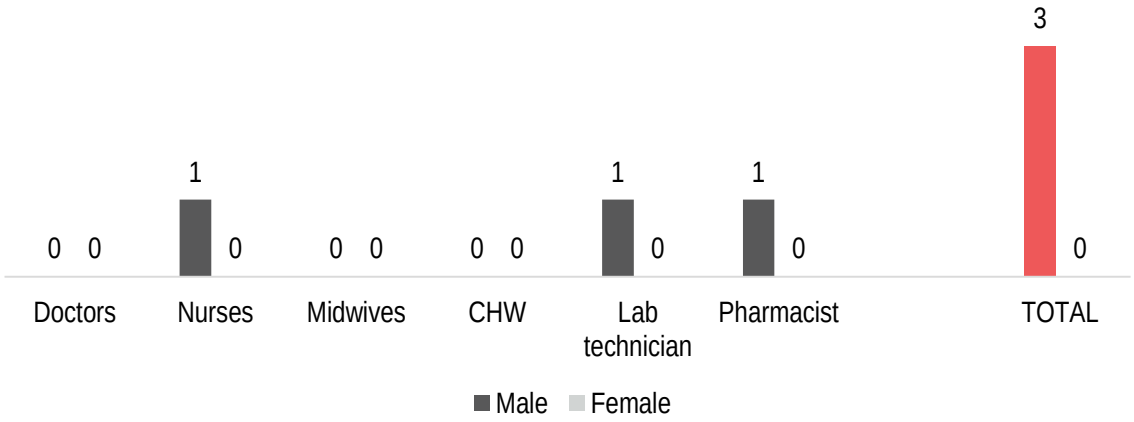
Annex 1: Health Facility Mapping

HEALTH CENTRE BULO KARAME

Region: *Middle Shabelle*
District: *Cadale*
Settlement: *Bulo Karame (Cadale Town)*
Managed by: *SAACID (Local NGO)*

Type of facility	Permanent
Number of rooms	6
Number of beds	0
Electricity supply	No
Water supply	Yes
Lockable storage	Yes
Type of waste disposal	Waste pit

Staff members at facility



Available services

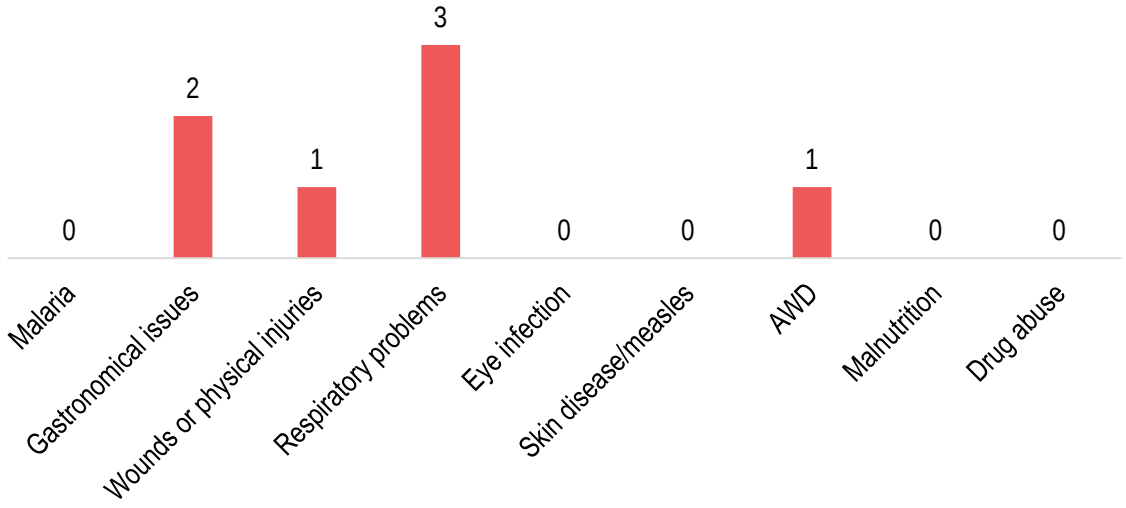
General consultations for adults	
General consultations for children	
Vaccinations	
Nutrition services	
Antenatal care	
Postnatal care	
Skilled birth deliveries	
Treatment for sexually transmitted infections	
Family planning	
Case management for SGBV	
Mental health support	
Treatment for diabetes	
First aid/treatment for wounds	
Ambulance services	
Treatment for drug and alcohol abuse	

Vaccinations available	
Measles	
Polio	
DTP	
BCG	

Supplies and equipment

Medicine and basic equipment	Available	Most needed
Oral Rehydration Salts (ORS)		
Antipyretics (for fevers)		
Anti-malarial drugs		
Contraception, including condoms		
Antibiotics (for infections)		
Dressing materials/bandages		
Drugs for sexually transmitted diseases		
Antiseptic creams		
Basic pain relief (paracetamol/ibuprofen)		
Post-exposure prophylaxis (PEP) kits for rape		
Sterile syringes		
Surgical gloves		
Soap		

Number of cases in the last 7 days

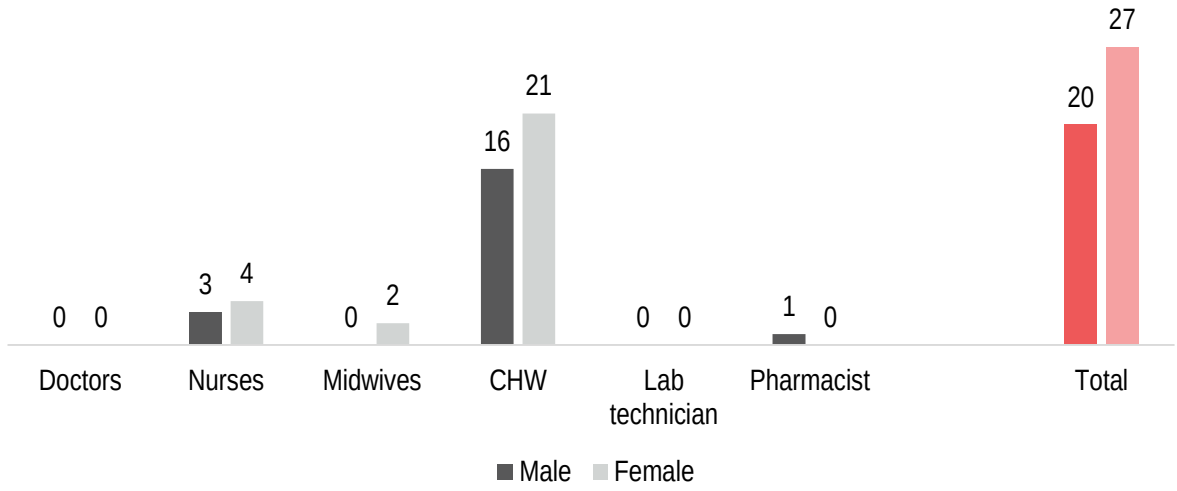


HEALTH CENTRE HALGAN

Region: *Middle Shabelle*
District: *Cadale*
Settlement: *Halgan (Cadale Town)*
Managed by: *SHARDO (Local NGO)*

Type of facility	Permanent
Number of rooms	6
Number of beds	3
Electricity supply	Yes
Water supply	Yes
Lockable storage	Yes
Type of waste disposal	Waste pit

Staff members at facility



Available services

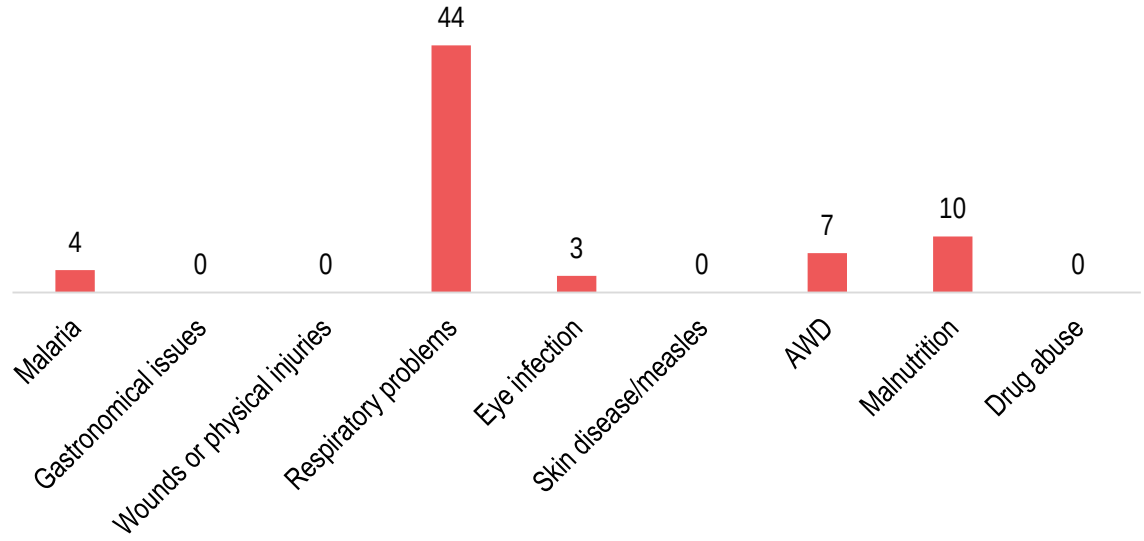
General consultations for adults	
General consultations for children	
Vaccinations	
Nutrition services	
Antenatal care	
Postnatal care	
Skilled birth deliveries	
Treatment for sexually transmitted infections	
Family planning	
Case management for SGBV	
Mental health support	
Treatment for diabetes	
First aid/treatment for wounds	
Ambulance services	
Treatment for drug and alcohol abuse	

Vaccinations available	
Measles	
Polio	
DTP	
BCG	

Supplies and equipment

Medicine and basic equipment	Available	Most needed
Oral Rehydration Salts (ORS)		
Antipyretics (for fevers)		
Anti-malarial drugs		
Contraception, including condoms		
Antibiotics (for infections)		
Dressing materials/bandages		
Drugs for sexually transmitted diseases		
Antiseptic creams		
Basic pain relief (paracetamol/ibuprofen)		
Post-exposure prophylaxis (PEP) kits for rape		
Sterile syringes		
Surgical gloves		
Soap		

Number of cases in the last 7 days



Nutrition services available

Outpatient Therapeutic Care Programme	
Targeted Supplementary Feeding Programme	
Blanket Supplementary Feeding Programme	
Infant and Young Child Feeding	
Micronutrient Supplementation	
Wet Feeding	
Stabilisation Centre	