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

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 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.

EXECUTIVE SUMMARY

The current drought in Somalia has resulted in a rapid deterioration of the humanitarian context in the country[1]. In addition, insecurity and the presence of 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 water, sanitation and hygiene (WASH), food security, health and nutrition needs of the population in Dhuusamareeb District. The assessment was carried out by REACH, with support from KAAH Relief and Development Organization (KAAH), and was based on a household-level survey of 637 households. Households were randomly sampled and the findings presented here are representative at the district level with a 95% confidence level and a 5% margin of error.

The findings from this assessment aim to inform future programming on WASH, food security, health and nutrition in Dhuusamareeb. Key sector findings were as follows:

Water, Hygiene and Sanitation

The vast majority of assessed households (70%) reported that they did not have access to enough water for domestic purposes. In addition, only 14% of households met the SPHERE standard of 15 litres of water per person per day. The most commonly reported reason for a lack of access to enough water related to water shortages at the source, reported by 84% of assessed households. This reflects the ongoing drought situation in Somalia. Concerns over water are not however limited to quantity; the quality of water is also of major concern, with 80% of assessed households reportedly relying on unprotected sources for both drinking, washing and/ or cooking water supply. This is especially problematic given that only 4% of assessed households reported treating their drinking water.

In terms of hygiene, only 8% of assessed households indicated access to soap. The key reported barrier to accessing soap was financial, that is, households were unable to afford it. Households demonstrated sporadic awareness of good hygiene practices. While 93% of assessed households reported washing their hands before eating, only 17% reported washing their hands after defecating. This may partially account for the prevalence of Acute Watery Diarrhoea (AWD) in the district. Seventy-nine percent (79%) of households indicated that at least one member had experienced AWD in the three months prior to the assessment.

Sixty-five percent (65%) of assessed households reported having no access to either private or communal latrines, a reflection of the limited coverage of latrines in the area. In addition, 97% of these households reported practicing open defecation, which is problematic considering the significant contribution of the practice to the spread of diseases.

Food Security and Livelihoods

Eighty percent (80%) of assessed households reported that they were unable to access enough food, indicating an acute food insecurity situation. This situation is further reflected in the reported low quantity and variety of foods consumed by households as demonstrated by their Food Consumption Score (FCS) and Diet Diversity Score (DDS); 85% and 78% of assessed households fell in the low DDS and poor FCS categories, respectively.

The most commonly reported reasons for a lack of access to enough food pointed to a protracted drought: death of livestock, crop failure, high food prices and lack of cultivation land. Households' primary food sources had reportedly reduced, an indication of diminishing access to food. For instance, whereas 41% of assessed households reported livestock production as their primary source of food in normal (pre-drought) times, only 23% reported relying on this source at the time of assessment. In addition, relatively more households indicated resorting to coping strategies to meet their food needs, such as relying on family and friends for food and foraging wild foods at the time of assessment compared to pre-drought times, again suggesting that the ability of households to meet their food needs has deteriorated. Despite an overall indication that household income sources had declined (52%

[1] FEWSNET & FSNAU, Somalia Food Security Outlook, 2017
www.fsnau.org/downloads/FSNAU-FEWSNET-SOMALIA-Food-Security-Outlook-October-2017.pdf

of assessed households reported that they had lost access to one or more of their livelihood sources over the year prior to the assessment), a high proportion (67%) of households reported an increase in food prices over the last month. This implies that households, especially those relying on only one source of income, are likely to be experiencing increased inability to afford food items.

Health

Ninety-seven percent of households reported having no access to a formal healthcare facility, indicating substantial gaps in healthcare service provision in the district. The key reported barriers to healthcare access were a lack of healthcare facilities, no longer functional healthcare facilities and a lack of staff and/ or medicine in existing healthcare facilities. In a further reflection of limited coverage of healthcare facilities in the district, 60% of assessed households indicated going to a pharmacy when sick rather than to a clinic or hospital and 56% of the 3% of households that reported having access to a formal healthcare facility stated that their nearest facility was approximately half a day's walk away.

In terms of health-related issues, malaria and AWD were the most common health problems reported by assessed households, suggesting that waterborne diseases are posing a significant threat outside traditional 'problem' areas, such as riverine livelihood zones. In what is likely linked to the ongoing drought in Somalia, half of the assessed households reported that at least one household member had experienced AWD two to five times in the three months prior to the assessment.

A low proportion (14%) of vaccine-aged children had reportedly received either measles, polio, diphtheria or Bacillus Calmette-Guerin (BCG) vaccines, suggesting low vaccination rates.

Nutrition services

A low proportion (18%) of assessed households reported access to nutrition services, which is likely linked to poor access to healthcare facilities, as seen in the above section. As with healthcare, this indicates that households require greater support to access nutrition services.

Despite the fact that malnutrition was reportedly the second most common health problem among children after malaria, only 26% of assessed households reported exclusive breastfeeding of children under six months. This could potentially be linked to a lack of knowledge on appropriate breastfeeding and weaning practices.

TABLE OF CONTENTS

List of Acronyms

AWD	Acute Watery Diarrhoea
AfDB	African Development Bank
BCG	Bacillus Calmette-Guerin
CLTS	Community-Led Total Sanitation
DDS	Diet Diversity score
FCS	Food Consumption Score
FEWSNET	Famine Early Warning Systems Network
FSNAU	Food Security and Nutritional Analysis Unit
IPC	Integrated Phase Classification
JMCNA	Joint Multi-Cluster Needs Assessment
KAAH	KAAH Development and Relief Organization
NDVI	Normalized Difference Vegetation Index
SWALIM	Somalia Water and Land Information Management
UNICEF	United Nations Children's Fund
WHO	World Health Organization

List of Figures

INTRODUCTION

The past four consecutive seasons of poor to below average rainfall in Somalia have resulted in a deterioration of the humanitarian context in the country[2]. In October, at the start of the Deyr[3] season, rainfall in the country was estimated to be 50% below normal[4].

These drought conditions have led to acute water shortages and as a result, created food, health and nutrition crises in most parts of Somalia[5]. Large-scale livestock losses have occurred due to limited regeneration of water and pasture. Coupled with below-average crop production, these livestock losses have significantly reduced households' access to income and food. The Famine Early Warning Systems Network (FEWSNET) and Food Security and Nutritional Analysis Unit (FSNAU) estimate that current food security needs in Somalia are nearly double the last five-years average with an estimated 2,444,000 people currently in crisis (Integrated Phase Classification (IPC) phase 3) and 866,000 in emergency (IPC phase 4)[6]. In addition, due to the ongoing drought conditions, 5.5 million people are reportedly in danger of contracting waterborne diseases, half being women and children under the age of five years[7].

Insecurity and the presence of active armed groups continue to limit humanitarian access, especially in South Central Somalia, further exacerbating households' vulnerabilities. While substantial humanitarian and development effort is being made to ameliorate the negative effects of drought, the lack of adequate and relevant information limits the design and monitoring of interventions. Against this backdrop, a rapid assessment was requested within the framework of the REACH/WASH Cluster partnership, to assess the water, sanitation and hygiene (WASH), food security, health and nutrition needs of the population in Dhuusamareeb District.

The assessment was coordinated by REACH with logistical and operational support from KAAH Relief and Development Organization (KAAH), and utilized a harmonized household survey tool, which was developed in partnership with the Food security, Health and WASH Clusters to improve the quality and comparability of localized assessments across Somalia.

This report presents assessment findings on households' needs and gaps in service provision in the following sectors:

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

[2] FEWSNET & FSNAU, Somalia Food Security Outlook, 2017.
[3] Deyr season is a rainy season in Somalia that generally starts in late September and ends in November.
[4] FSNAU, Monthly rainfall and Normalized Difference Vegetation Index , 2017.
[5] UNICEF, Drought Affects Water Quality in Somalia, 2017.
[6] FSNAU, Monthly rainfall and Normalized Difference Vegetation Index , 2017.
[7] UNICEF, Drought Affects Water Quality in Somalia, 2017.

METHODOLOGY

Within the framework of the REACH/WASH Cluster partnership, a rapid assessment was requested to assess water, sanitation and hygiene (WASH), food security, health and nutrition needs of the population in Dhuusamareeb District. REACH provided technical support on research design, tool development, data cleaning and analysis, and reporting. KAAH did the sampling for the assessment, 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 WASH, Food Security and Health Clusters, has developed a series of harmonized 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 Somalia humanitarian context.

The assessment entailed a multi-cluster needs assessment at the household level focusing on WASH needs, food security and access to livelihoods, health and nutrition needs. Data was collected using the Open Data Kit (ODK) data collection tool and KoBo.

Sampling methodology

This assessment targeted all households in Dhuusamareeb District. Settlements in the district were first stratified into two, Guri-Ceel and Dhuusamareeb and samples representative at the stratum level at a 95% level of confidence and a 5% margin of error calculated. The samples were derived from World pop population estimates from 2015, adjusted for the most recent population estimates by the United Nations (UN)[8]. In addition, sample size per settlement was proportional to the overall settlement population, so settlements with a higher overall population had a higher sample size. In order to select the households for the assessment, enumerators were assigned random GPS points as their starting point, from which they surveyed every three to five households, depending on area density. The overall sample consisted of 637 households. Data collection was carried out by a team of 14 enumerators from KAAH between 7 and 12 October.

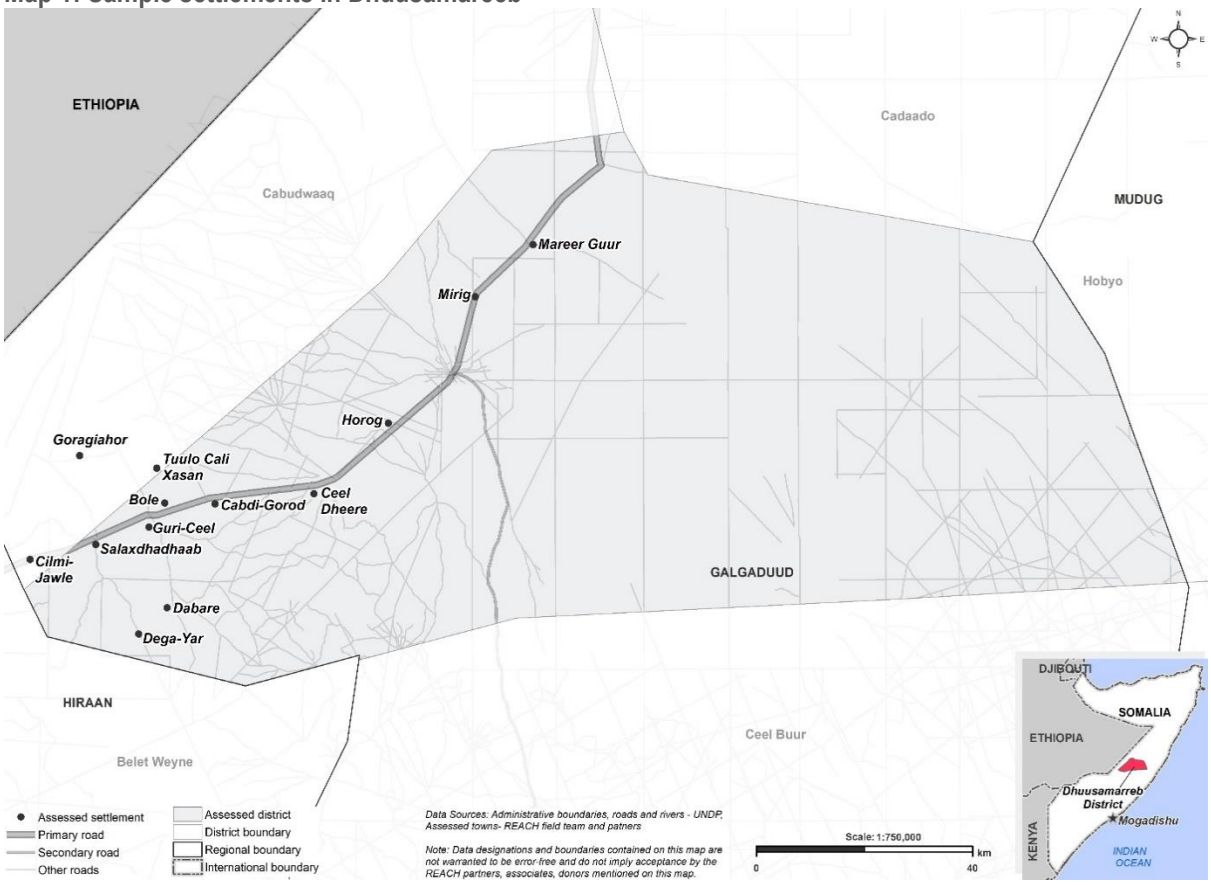
Table 1: Assessed settlements and sample frame

Dhuusamareeb	
Settlement	**Sample size**
Ceel Dheere	41
Horog	176
Mareer Guur	38
Mirig	35
Total	**290**
Guri- Ceel	
Settlement	**Sample size**
Bole	50
Cabdi-Gorod	37
Cilmi-jawle	27
Dabare	50
Dega-Yar	47
Goragiahor	30
Guri-Ceel	1
Salaxdhadhaab	85

[8] Worldpop, Somalia Population Metadata, 2015
http://www.worldpop.org.uk/data/summary/?contselect=Africa&countselect=Somalia&typeselect=Population

Tuulo Cali Xasan	20
Total	**347**

Map 1: Sample settlements in Dhuusamareeb



Secondary data

Findings have been triangulated with secondary data. This includes previous assessments conducted by REACH, such as the 2017 Joint Multi-Cluster Needs Assessment (JMCNA), and external data sources including seasonal analysis from FSNAU and FEWSNET and situation analyses by the United Nations Children's Fund (UNICEF) and the World Health Organization (WHO).

Analysis

Where relevant, findings have been disaggregated by the respective strata.

Limitations

- Due to a lack of sufficient data, findings have not been disaggregated by displacement status nor rural-urban settlements.
- Findings are based on self-reported answers and can be biased.
- Findings are representative at the district level only and cannot be generalised further.

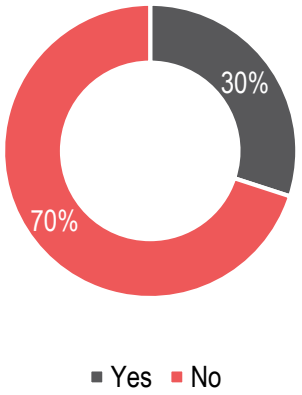
FINDINGS

This section of the report presents the main results from the rapid assessment and is comprised of a series of sector and location specific findings relating to availability of water, access to sanitation and hygiene facilities, household food security, access to livelihoods and income-generating activities, healthcare and nutrition services availability and access.

WASH

Water access and availability

Figure 1: Proportion of households indicating access to enough water for drinking, washing and cooking

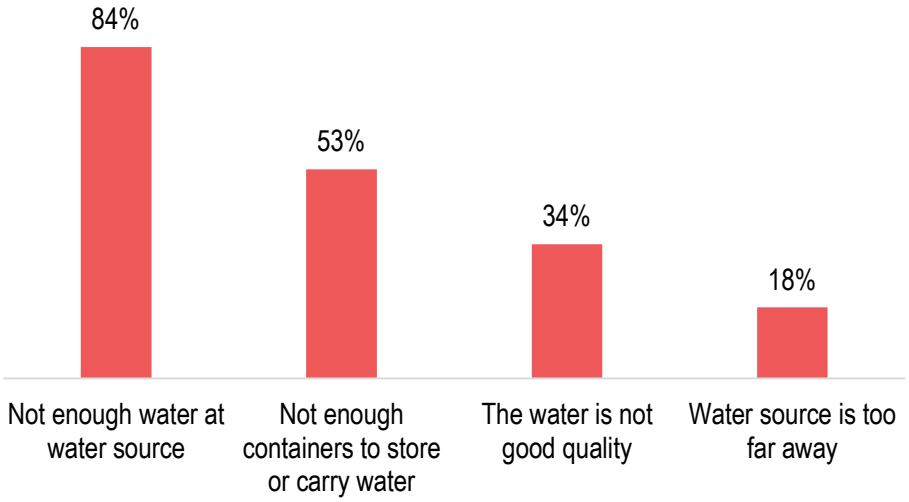


The majority (70%) of assessed households reported not having access to enough water for domestic purposes. Further, only 24% of assessed households met the SPHERE standard of 15 litres of water per person per day.

Given that households in the assessed area are largely pastoralists (see food security and livelihoods section below), hence are reliant on water for livestock, it is likely that these households are experiencing further acute water shortages.

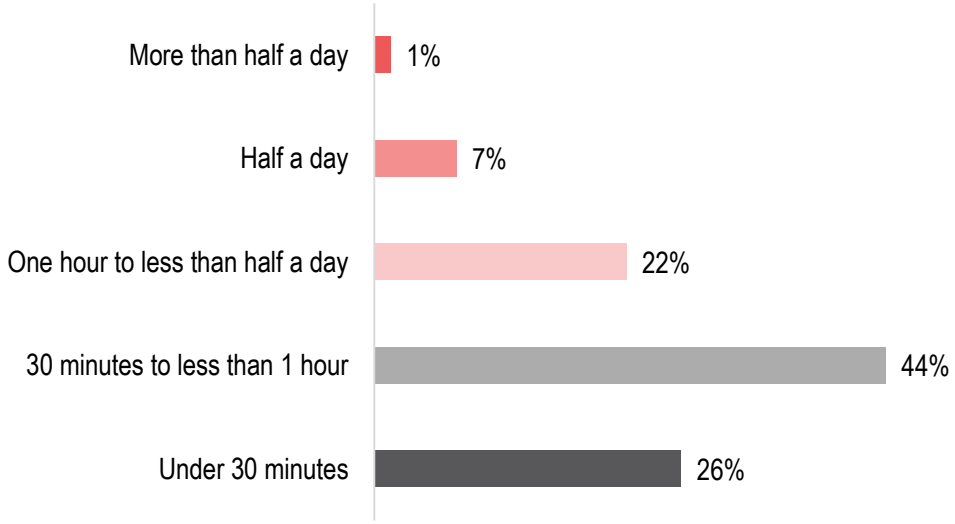
The most commonly reported reason for a lack of access to enough water related to shortages at the source, reported by 84% of households. Given that Somalia is currently witnessing a fourth consecutive season of poor to below average rains, it is likely that most water sources have not replenished hence negatively impacting households' access to water. This was followed by a lack of enough containers to store or carry water, reported by 53% of assessed households. In addition, 34% of assessed households reported a problem with the quality of water.

Figure 2: Four most commonly reported reasons for a lack of access to enough water (households could select multiple responses)



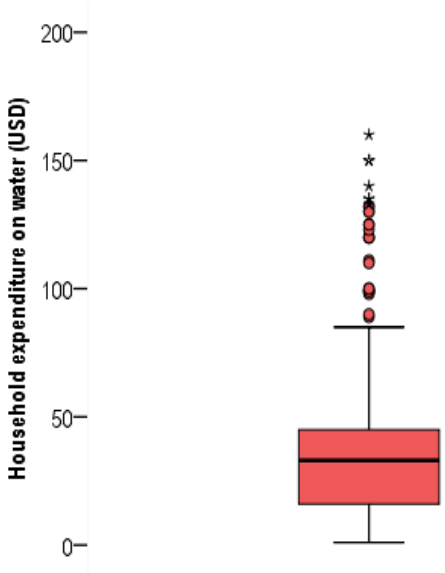
Only 18% of households reported a problem with the distance to the water source. However, when asked to report the amount of time a household takes to access the nearest water source, 70% of assessed households indicated more than 30 minutes. Judging against the SPHERE standard of a maximum distance of 500 metres (estimated to take 6 minutes based on the average human walking speed[9]) from any household to the nearest water source, households are covering long distances to access water sources.

Figure 3: Reported amount of time taken by households to access the nearest water source



In a further indication of reduced water supply, 84% of assessed households reported that they paid for water. The average reported household expenditure on water in the month prior to the assessment was 36 United States Dollars (USD). Of the households paying for water, 74% indicated that the amount they spend on water had increased in the three months prior to the assessment, again, a reflection of the impact of the ongoing drought, which has reduced water supply, pushing prices up.

Figure 4: Household spending on water in the month prior to the assessment (in USD)



[9] The average human walking speed is about 5 kilometres per hour

Cooking and washing water sources differed little from drinking water sources, suggesting reliance on a single source for different household water needs.

The majority (80%) of households are largely dependent on unprotected sources for domestic water supply. Berkads followed by unprotected water wells were reportedly the most common water sources in Dhuusamareeb. This is consistent with REACH findings that most of Somalia population depends on unprotected water sources for domestic supply[10]. This is problematic given the knock-on effect of low-quality drinking water on health and nutrition.

Figure 5: Five most commonly reported sources of water for drinking, and washing and/ or cooking (households could select multiple responses)

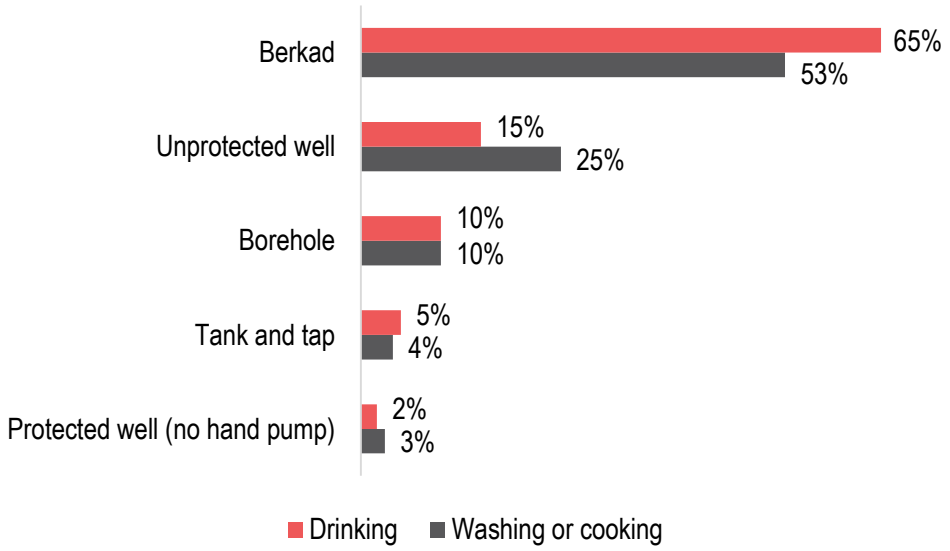
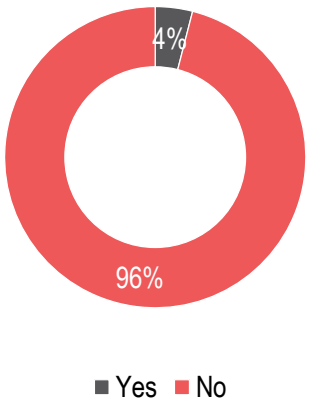


Figure 6: Proportion of households indicating treating drinking water



Despite households' dependence on unprotected water sources, only 4% reported household-level treatment of drinking water, a proportion that is notably lower than the national average of 13%[11]. This further increases the risk of households drinking contaminated water.

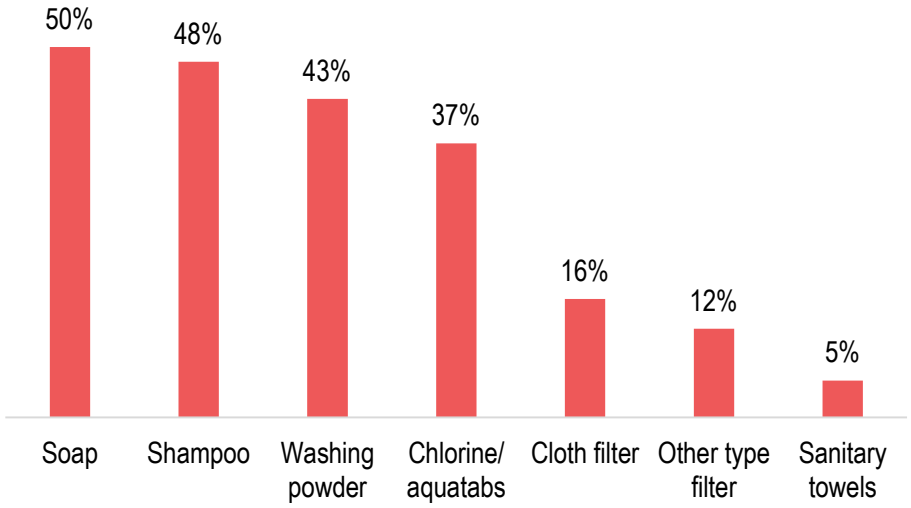
Relatedly, chorine/ aquatabs was the fourth most needed household hygiene item, reported by 37% of assessed households (see figure 7).

[10] REACH, Somalia Initial Rapid Needs Assessment (SIRNA), 2016
[11] REACH, Somalia Joint Multi-Cluster Needs Assessment, 2017

Hygiene

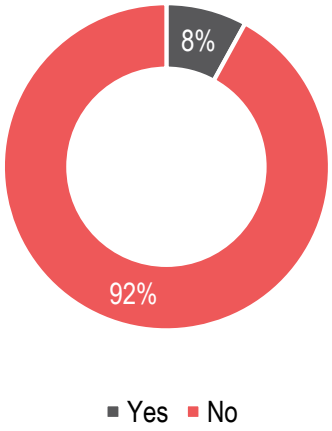
Half of the assessed households reported that they had not received assistance of any hygiene items in the three months prior to the assessment. Soap, reportedly, was the most needed hygiene item, indicated by 50% of assessed households. The low proportion of households indicating access to soap (see figure 8) corroborates this finding.

Figure 7: Most needed hygiene item reported by households (households could select multiple responses)



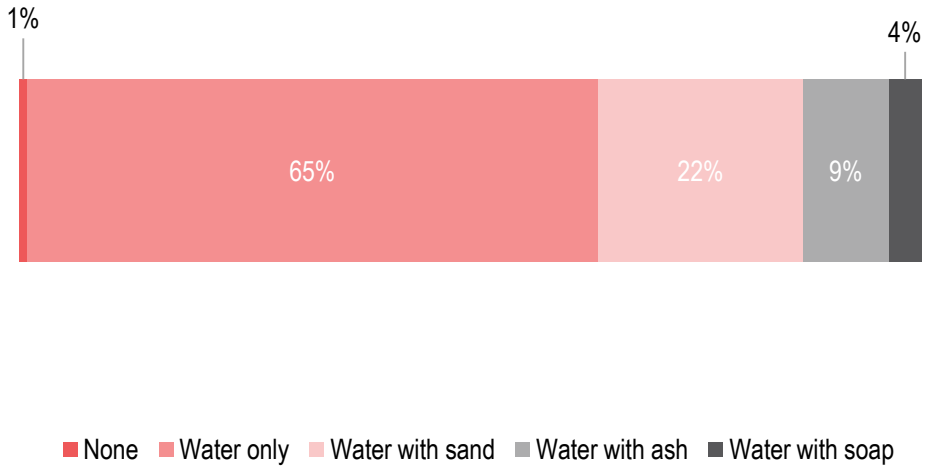
Only 8% of assessed households indicated access to soap. The low access to soap could potentially be linked to the socio-economic status of households. Of the households indicating no access to soap, the majority (55%) reported being unable to afford it, as the reason for a lack of access. Only 10% of these households reported that they thought soap was not necessary. This suggests that the key barrier to the use of soap is financial rather than as a result of cultural practices.

Figure 8: Proportion of households reporting access to soap



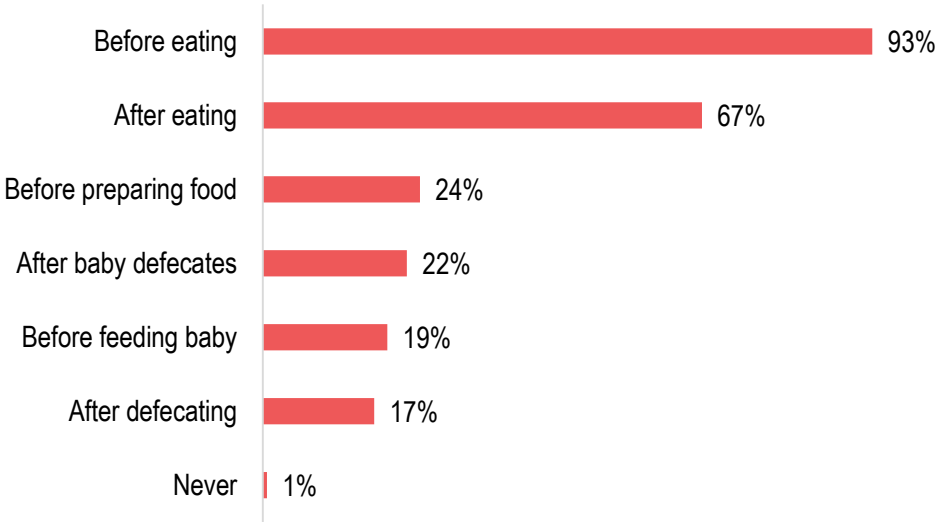
In a further reflection of the lack of soap, the majority (65%) of assessed households indicated using water only to wash their hands. In addition, 22% and 9% reported using water and sand, and water and ash, respectively, to wash their hands. This further reinforces the earlier observation that households do not use soap because they are unable to access it, rather than because they do not want or do not know how to use it.

Figure 9: Reported household handwashing practices



Households demonstrated sporadic awareness of good hygiene practices. Awareness of when to wash hands was highest in relation to eating, with the majority (93%) of respondents indicating that one should wash hands before eating. However, there appeared to be much lower awareness around handwashing in relation to defecation, with only 22% of households stating that you should wash your hands after cleaning up infants when they defecate and 17% stating that you should wash your hands after defecating. This suggests limited understanding of faecal-oral transmission routes, which is particularly problematic given the current outbreak of cholera in Somalia[12].

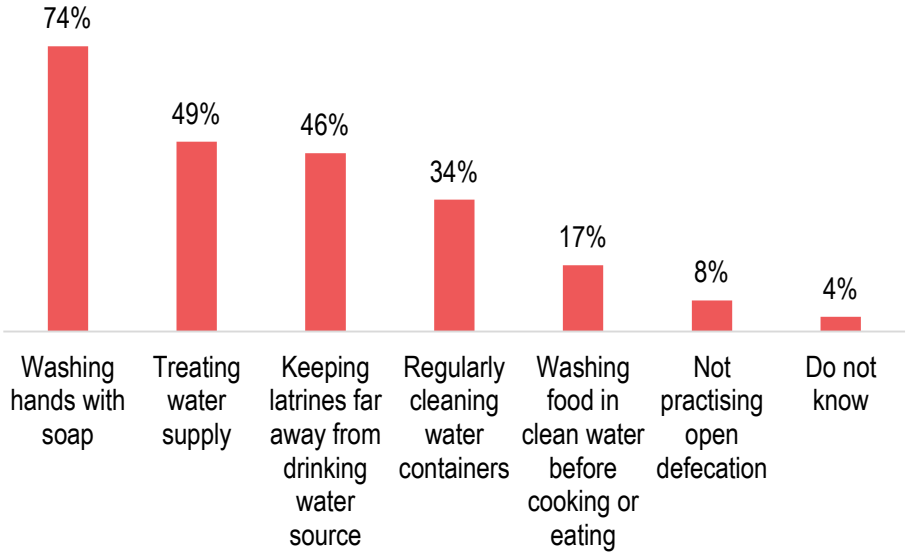
Figure 10: Proportion of households indicating awareness of when to wash hands (households could select multiple responses)



[12] https://blogs.unicef.org/blog/fighting-cholera-cases-somalia/

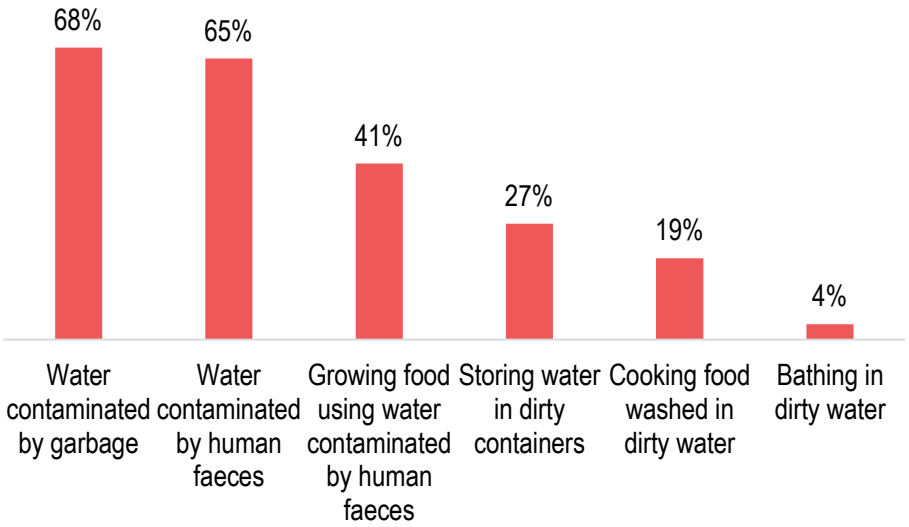
Relatedly, there appears to be a lack of understanding of the relation between open defecation and water contamination. Only 8% of assessed households indicated not practicing open defecation as a preventative measure against AWD.

Figure 11: Proportion of households reporting awareness of AWD preventative measures (households could select multiple responses)



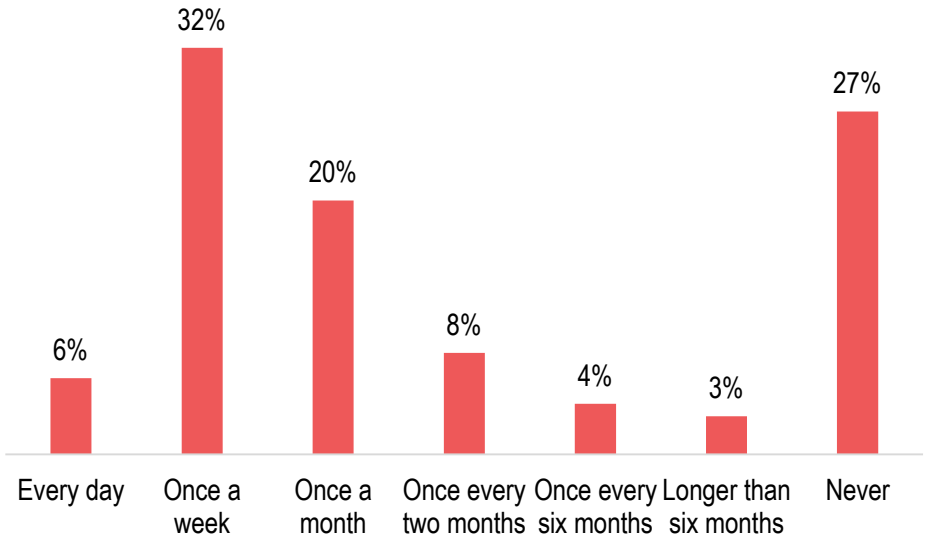
Washing hands with soap was the AWD preventative measure that households were most aware of, indicated by 74% of assessed households. However, as seen earlier, most households did not use soap to wash their hands. When asked about the causes of AWD, only 27% of assessed households reported that they were aware that storing water in dirty containers could cause AWD.

Figure 12: Proportion of households reporting awareness of causes of AWD (households could select multiple responses)



Relatedly, only 6% of assessed households reported that they cleaned their drinking water storage containers daily. This potentially hints at a link between a lack of awareness that storing water in dirty containers can cause AWD and the practice of regularly cleaning containers, indicating greater need for hygiene sensitization programmes.

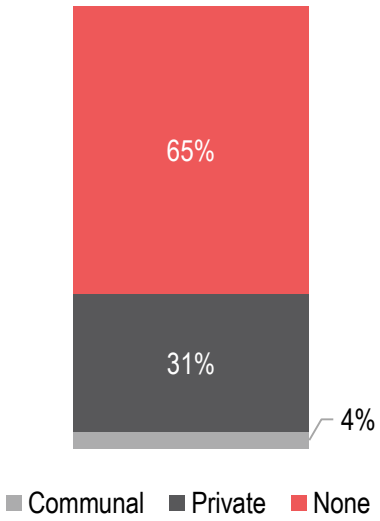
Figure 13: Frequency that assessed households reportedly clean their drinking water containers



Sanitation

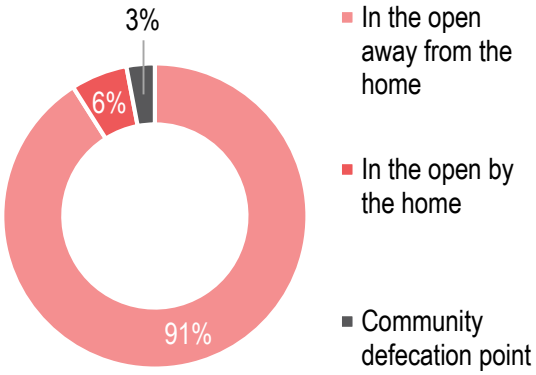
The majority (65%) of assessed households reported having no access to latrines, a figure that is substantially higher than the national average of 22%[13]. Only 4% of assessed households reported access to communal latrines. Of these households, 27% reported that communal latrines were suitable for the disabled, 5% reported that they were gender segregated, another 5% reported they had handwashing facilities and 4% reported they were hygienic. This reinforces findings by REACH[14] that communal latrines in most parts of Somalia fail to meet minimum standards, particularly in terms of protection provisions and hygiene.

Figure 14: Proportion of assessed households reporting having access to each type of latrine



[13] REACH, Somalia Joint Multi-Cluster Needs Assessment, 2017
[14] REACH, Somalia Rapid Needs Assessment, 2016

Figure 15: Reported defecation practices for households without access to a latrine

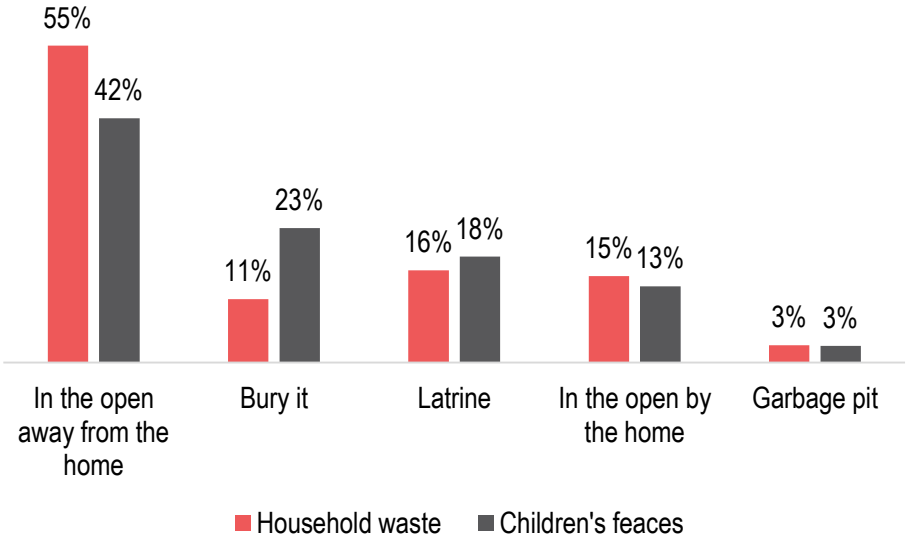


Harmful sanitation practices were persistent in Dhuusamareeb. Of the 65% of households without access to latrines, 91% indicated that they practiced defecation in the open away from home and 6% in the open by home. Open defecation remains a concern in Somalia considering its significant contribution to the spread of diseases, especially faecal-transmitted diseases such as cholera.

In light of the recent outbreak of cholera in the country, UNICEF highlighted that open defecation has made the spread of cholera a growing threat particularly for children who are more susceptible to infection[15]. This is linked to the high probability of open defecation contaminating ground water sources, which are the most common sources for domestic and livestock water in Somalia, including in Dhuusamareeb where berkads and unprotected water wells are the most common sources of water (see figure 5).

In addition, 55% and 42% of assessed households reported disposing household waste and children's feaces, respectively, in the open away from home, which again risks polluting water sources as wastes seep their contents into groundwater.

Figure 16: Proportion of assessed households reporting each method of disposal of children's faeces and household waste (note: grey bars indicate proportion of households with children disposing of children's faeces)



Despite the poor hygiene and sanitation practices reported by households, only 3% of assessed households indicated the presence of a WASH committee in their settlement, suggesting that limited hygiene and sanitation sensitization and community awareness is taking place.

[15] https://blogs.unicef.org/blog/fighting-cholera-cases-somalia/

Food security and livelihoods

Food security

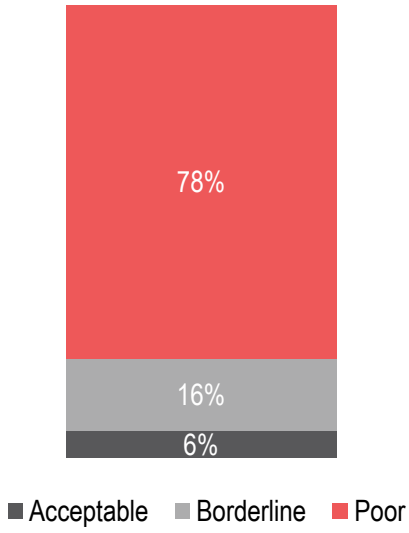
Post-Gu[16] analysis by FEWSNET and FSNAU estimated that 3.1 million people, that is 25% of the total population in Somalia, are likely to be in crisis (IPC phase 3) or emergency (IPC phase 4) through December 2017[17]. In this analysis, Guri-Ceel, which is a Hawd pastoral livelihood zone, is forecasted to be in crisis whilst Dhuusamareeb which is an Addun pastoral livelihood zone, is forecasted to be in emergency. For that reason, Dhuusamareeb and Guri-Ceel are considered as priorities for interventions aimed at reducing food consumption gaps.

The state of acute food insecurity in Dhuusamareeb and Guri-Ceel is further broadly reflected in the data presented here which indicates decline in the quantity and variety of food consumed, diminished food access among assessed households, reliance on a range of coping strategies, and a simultaneous increase in monthly spending on food by households.

The current acute food insecurity in Dhuusamareeb and Guri-Ceel is reflected in the reduction in the quantity and variety of foods consumed by households as demonstrated by households' Food Consumption Score (FCS) and Diet Diversity Score (DDS).

The FCS enumerates the relative nutritional importance of various food groups consumed by a household, and is used to categorize households into three groups: poor, borderline or acceptable food consumption depending on their dietary patterns and access to food. More than three-quarters (78%) of all assessed households are considered to be in the poor FCS category, with little variation across households in Dhuusamareeb (83%) and households in Guri-Ceel (75%). Further, another 16% are considered to be in the borderline FCS, still with little variation across households in Dhuusamareeb (11%) and households in Guri-Ceel (19%). Considering the current drought situation, it is extremely likely that households in the borderline FCS category will move into the poor FCS category in the coming weeks or months.

Figure 17: Proportion of assessed households categorised as having poor, borderline and acceptable FCS[18]

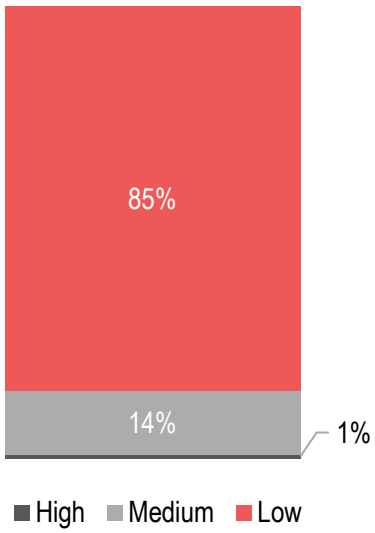


The DDS on the other hand enumerates the number of different food groups consumed by a household to give an estimation of its dietary diversity. Household DDS is categorized into three categories: high, medium and low. In a reflection of the ongoing drought in Somalia, the majority (85%) of assessed households had a low DDS. Within

[16] The Gu season is the main cropping season in Somalia as it is more dominant in terms of quantity of rain and generally starts in March and ends in June.
[17] FEWSNET and FSNAU, FEWNET – FSNAU 2017 Post Gu Technical Release Final, 2017
[18] Poor < 28; Borderline ≥ 28 < 42; Acceptable ≥ 42

this, households in Dhuusamareeb appeared to be slightly more vulnerable with 88% reporting low DDS, compared to 84% in Guri-Ceel.

Figure 18: Proportion of assessed households categorised as having a high, medium or low Diet Diversity Score (DDS)[19]



In addition, 80% of all assessed households reported that they were unable to access enough food, indicating an acute food security situation. Households in Dhuusamareeb compared to households in Guri-Ceel appeared to be more vulnerable - 11% of households in Dhuusamareeb compared to 26% of households in Guri-Ceel reported access to enough food. This is consistent with analysis by FEWSNET and FSNAU which forecast Dhuusamareeb to be in emergency and Guri-Ceel to be in crisis.

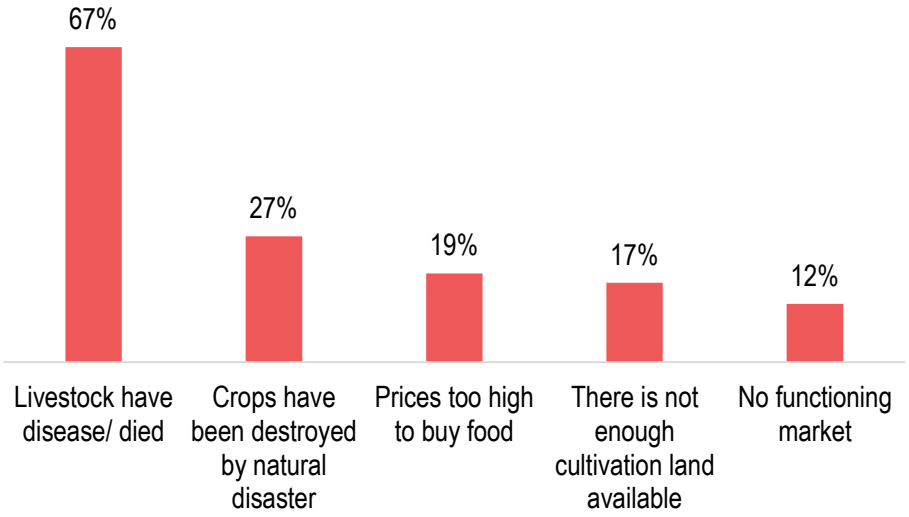
Figure 19: Proportion of households reporting that they are able to access enough food, at the time of assessment

The majority (67%) of assessed households attributed their lack of access to enough food, to death or diseases of livestock. This is consistent with the assessed population being mainly pastoral. In line with this, FSNAU and FEWSNET, in a September Post Gu Special Brief, highlighted that substantial livestock losses had lowered livestock births and milk production, and consequently lowered households' access to food and income in most pastoral zones, a situation expected to persist through the end of the year[20]. A further 27% attributed their lack of

[19] Low ≤ 4; Medium ≥ 5 ≤ 6; High > 6
[20] FEWSNET and FSNAU, Special Brief – Focus on Post Gu 2017 Assessment Results, 2017

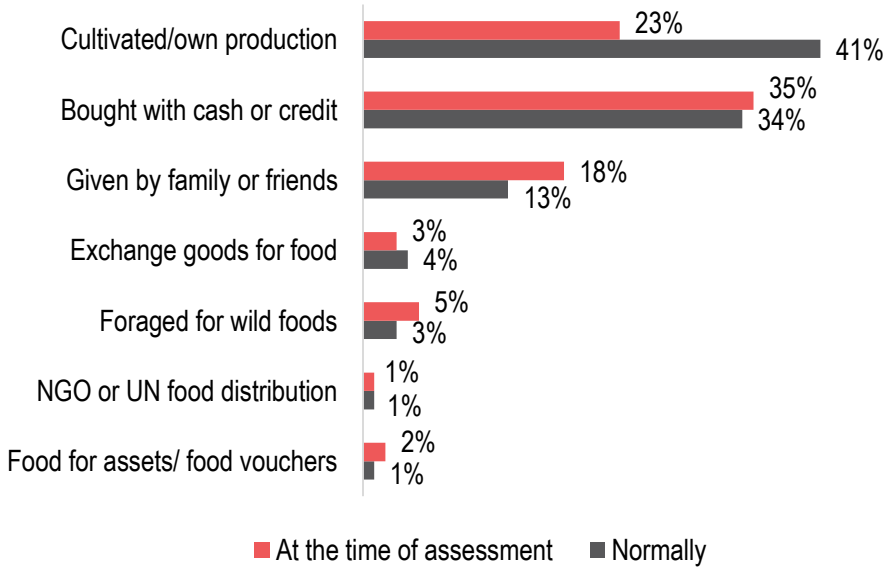
access to enough food to crop failure due to natural disaster, 19% to food items being too expensive, 17% to lack of enough cultivation land and 12% to non-functional markets. These reasons point to a protracted drought situation.

Figure 20: Five most commonly reported reasons for a lack of access to food (households could select multiple responses)



The impact of the acute food insecurity in Dhuusamareeb and Guri-Ceel is also reflected in the difference in primary food sources during pre-drought period and at the time of assessment, and in the utilization of coping strategies to meet food needs. Whereas 41% of assessed households reported livestock production as their primary source of food in normal (pre-drought) times, only 23% reported relying on this source at the time of assessment. This is likely due to significant livestock losses and consequently reduction in livestock produce.

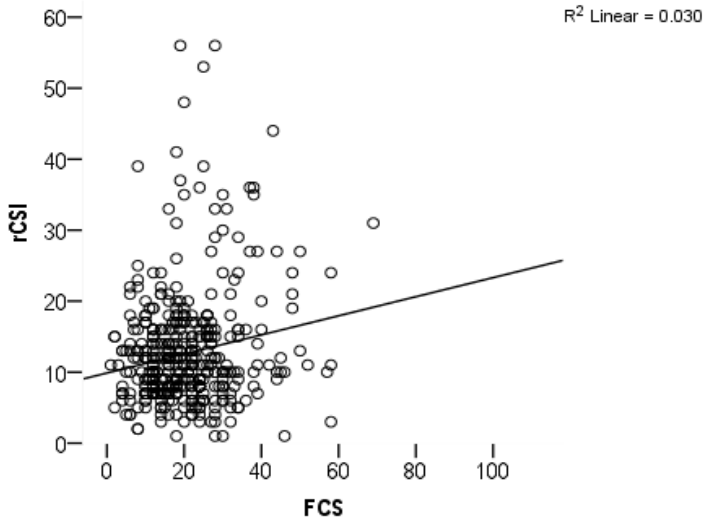
Figure 21: Comparison of households' primary food sources in normal (pre-drought) times to at the time of assessment



In addition, the proportion of households reporting resorting to coping strategies to meet their food needs appears to have marginally increased from normal (pre-drought) times. Thirty-five percent (35%), 18% and 5% of assessed households indicated food bought with cash or credit, donations from friends/ family and wild foods respectively as their primary sources of food at the time of assessment, compared to 34%, 13% and 3% respectively in normal times. This again suggests that the majority of households are facing acute food shortages.

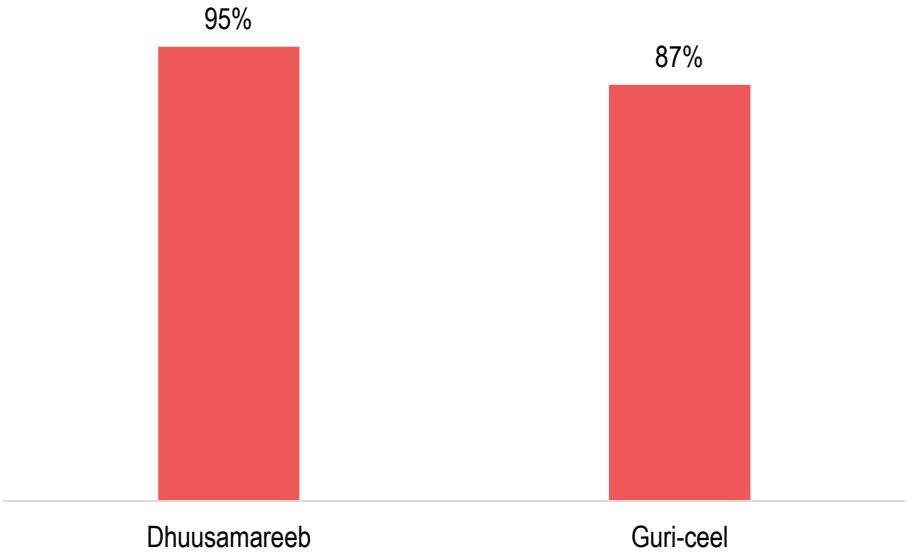
Correlation between households' FCS and reduced coping strategy index (rCSI)[21] showed that the majority of the households had a low FCS and a correspondingly low rCSI. It is therefore likely that these households have already exhausted their coping mechanisms and as such, are extremely food insecure.

Figure 22: Correlation between FCS and rCSI



Thirty-two percent (32%) of assessed households indicated that their primary food source had changed. In a further indication of declining levels of households' food security, of these households, 88% indicated that the amount of food they were able to access had reduced, an additional 27% reported that the quality had reduced and another 20% reported reduction in food variety. Data from this assessment further supports the findings from Post-Gu classifications by FEWSNET and FNSAU, indicating households in Dhuusamareeb are likely to be more food insecure than households in Guri-Ceel. Ninety-five percent (95%) of households in Dhuusamareeb compared to 87% of households in Guri-Ceel, that had indicated a change in food source, reported that the amount they could access had reduced in the three months prior to the assessment.

Figure 23: Proportion of households reporting a decrease in their primary food source in the three months prior to the assessment



The average number of days that households' cereal stock at the time of the assessment would last was reportedly 4 days, further indicating low food stocks. This could potentially be linked to an earlier than normal run out of cereal

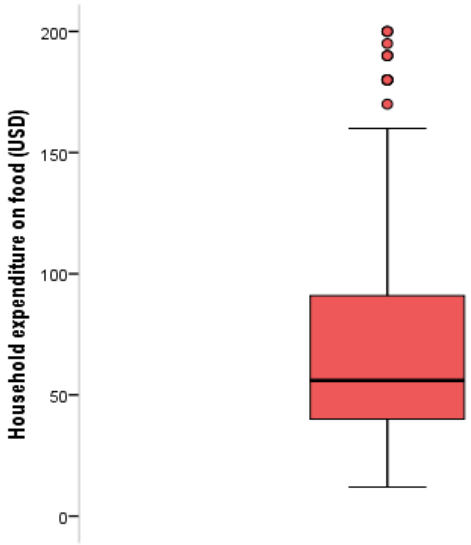
[21] The reduced coping strategy index (rCSI) measures behaviours adopted by households when they have difficulties in covering their food needs

stock due to below normal harvests. There appears to be little variation across households in Dhuusamareeb (4 days) and households in Guri-Ceel (4.5 days).

Although the above indicators point to acute food insecurity, only 11% of assessed households reported that they had received food assistance in the three months prior to the assessment, with little variation across households in Dhuusamareeb (7%) and in Guri-Ceel (14%). This potentially indicates limited humanitarian interventions in the area in the recent months.

Food prices have reportedly increased, as indicated by 68% of households. This likely reflects tightening supplies of food commodities due to the ongoing drought. As a result, households' food expenditure reportedly increased pointing to a potential deterioration in food access, especially among vulnerable households. Around two-thirds (67%) of assessed households reported that the amount they spend on food per week had increased over the month prior to the assessment. This is notably higher than the national average of 43%[22]. The average reported household expenditure on food in the month prior to the assessment was reportedly 74 USD.

Figure 24: Reported household spending on food in the month prior to the assessment



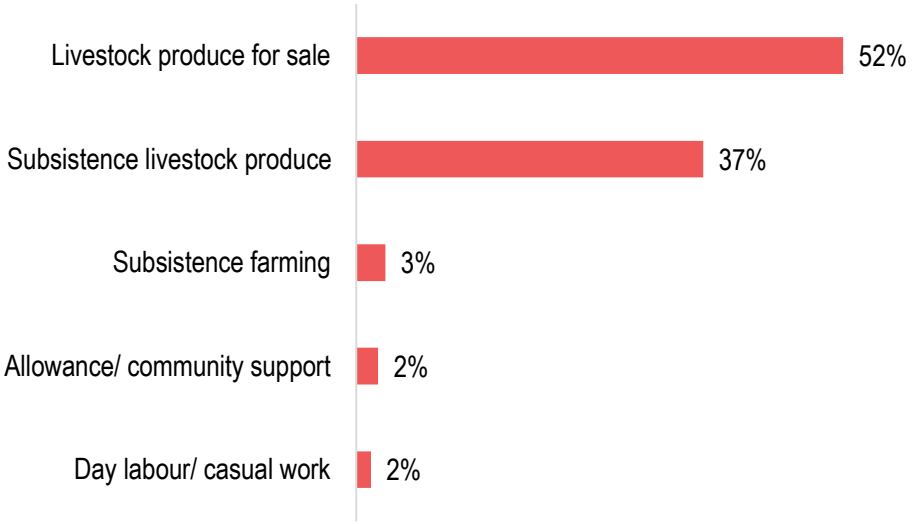
Livelihoods

The ongoing drought has caused significant disruptions to households' livelihoods. Over the year prior to the assessment, 52% of assessed households reported losing access to one or more income sources. In addition, 35% reported relying on only two sources of household support, suggesting limited economic resilience of the households as limited diversity of livelihood sources restricts the ability of households to respond to economic shocks.

In a reflection of the primarily pastoral nature of the assessed population group, the most commonly reported primary source of household support was commercial livestock production (52%) followed by subsistence livestock production (37%). Considering the indicators discussed in the previous sections and the broadly observed substantial livestock losses in Somalia, especially in pastoral livelihood zones[23], it is likely that these support sources are not sufficiently meeting household needs. In a similar indication, FEWSNET and FSNAU, in an assessment conducted in October, observed that pastoral households have limited access to animal produce and livestock sales to fund household purchases, especially cereal purchases[24]. This is likely the reason for the low average food stocks (4 days) reported by households, as indicated in the previous section.

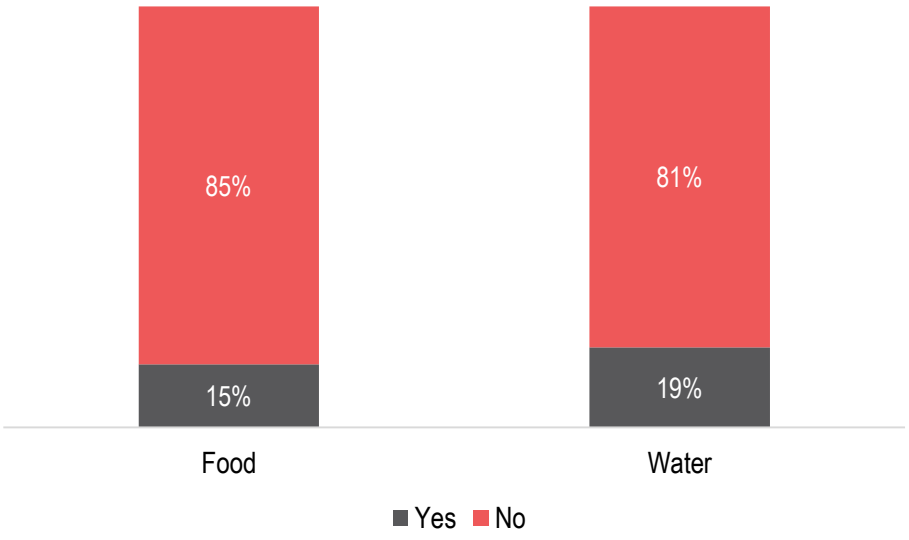
[22] REACH, Somalia Joint Multi-Cluster Needs Assessment, 2017
[23] FSNAU, Somalia Food Security Alert, 2017
[24] FSNAU, Somalia Food Security Alert, 2017

Figure 25: Five most commonly reported primary sources of household income or support (households could select multiple responses)



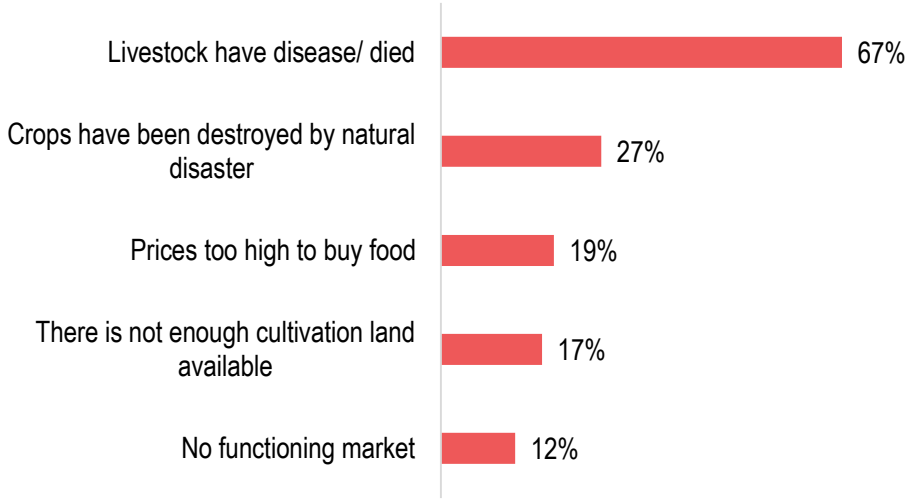
Below average to poor pasture and water availability appear to be fueling livestock losses in most pastoral livelihood zones. The vast majority (85% and 81%) of assessed households reported a lack of enough food and water for their livestock, respectively, in the three months prior to the assessment. Some variation can be observed across Dhuusamareeb and Guri-Ceel, with 96% and 95% of households in Dhuusamareeb reporting that they could not access enough food and water, respectively, for their livestock in the three months prior to the assessment, compared to 79% and 73% in Guri-Ceel, respectively. This is consistent with earlier findings by FEWSNET and FSNAU that pasture and browse conditions are average in Hawd pastoral livelihood zones, but below average in Addun pastoral livelihood zones.

Figure 26: Proportion of households reporting being able to access adequate food and water for their livestock



There is likely a correlation between the ongoing drought conditions and the use of livelihood coping strategies as seen in the data presented below. The sale of productive assets such as livestock indicates a reduction in households' resilience, as their means of support diminish. Increasing food insecurity is likely forcing households to resort to more unusual/ extreme behaviours in order to survive.

Figure 27: Proportion of households reporting employing livelihood coping strategies in the month prior to the assessment (households could select multiple responses)

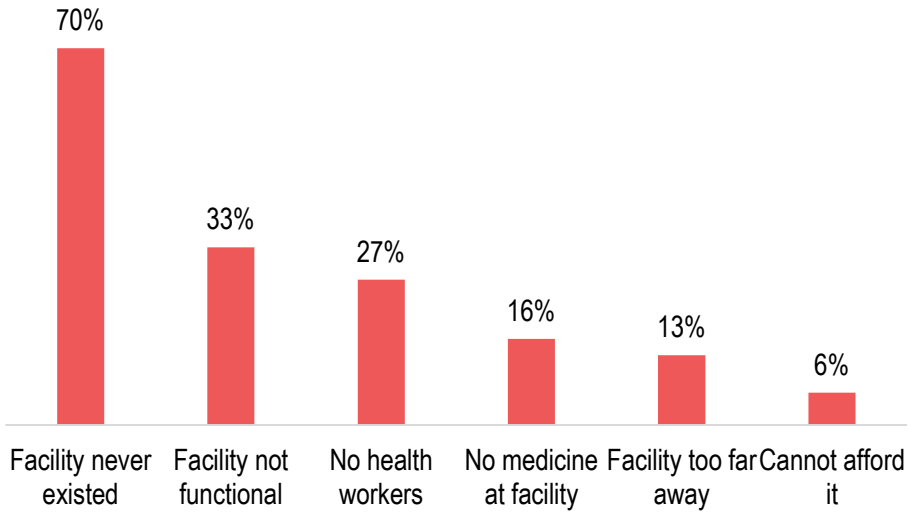


Health

Access and availability

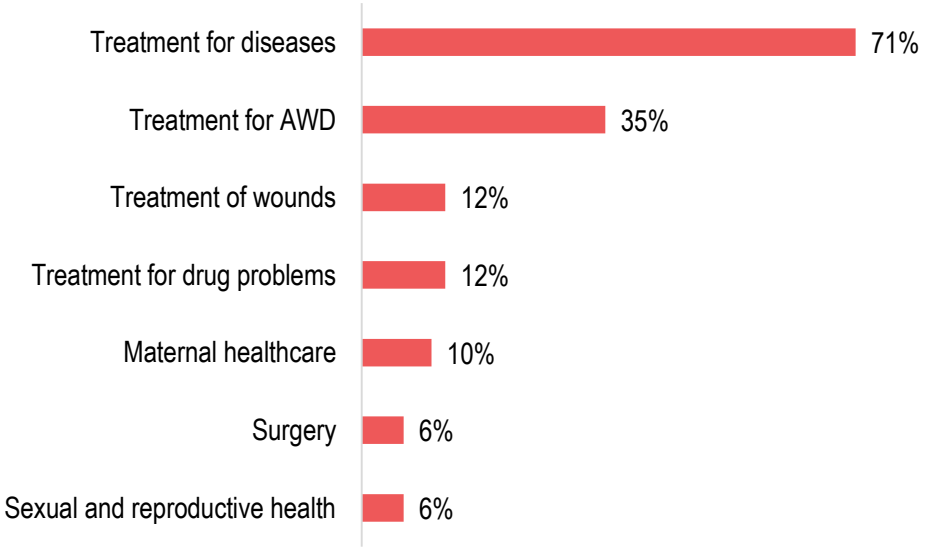
The overwhelming majority (97%) reported having no access to a formal healthcare facility, indicating substantial gaps in the provision of healthcare services in the area. This figure is substantially higher than the national average of 30%[25]. Of these households, 70% reported that the most common barrier to health access was the lack of facility in the area. In addition, 33% reported that though facilities existed, they were non-functional.

Figure 28: Reported barriers to accessing formal healthcare facilities



Where healthcare facilities existed, the most common services largely mirrored the common health issues in the area. Treatment for diseases such as malaria was reportedly the most common service in health facilities, reported by 71% of households, followed by treatment for AWD, reported by 35%. Culturally sensitive services such as sexual and reproductive health services were reportedly less commonly available, indicated by just 6%, though it is likely that such issues are under-reported due to stigma and/ or lack of awareness of service availability. Complex services such as surgery were also reportedly less commonly available, indicated by 6% of households.

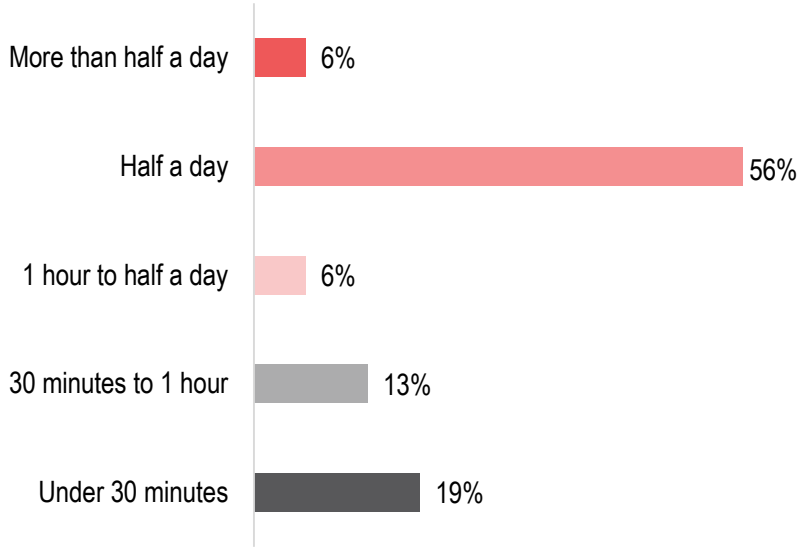
Figure 29: Proportion of households with access to a health facility reporting awareness of available services



[25] WHO, Somalia Health Update, 2014

Over half (56%) of those households that reported accessing healthcare facilities indicated that the nearest healthcare facility was approximately half a day's walk away, again indicating a lack of healthcare facilities and barriers to access. The average reported households' expenditure on healthcare in the month prior to the assessment was 31 USD. It is likely that healthcare cost also included transport cost to and from healthcare facility, given the lack of healthcare facilities in the area.

Figure 30: Average reported distance to the nearest healthcare facility

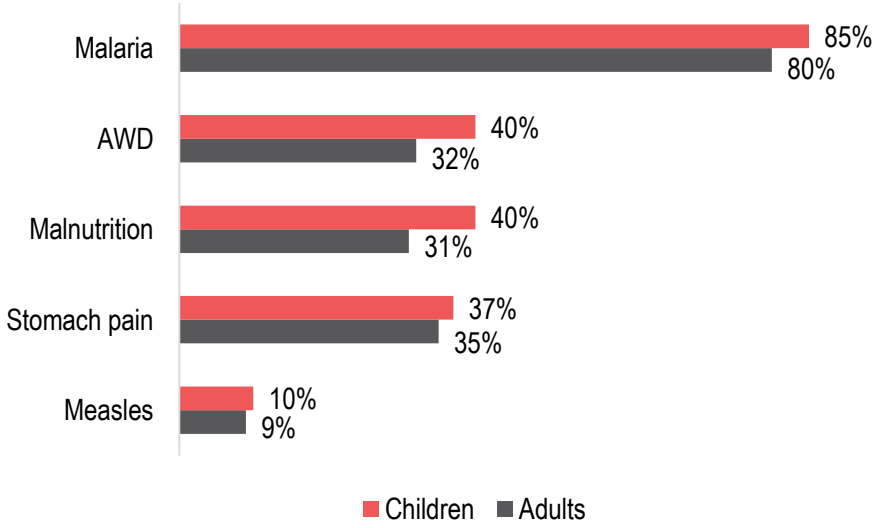


In addition, just over half (60%) of the assessed households indicated that they normally go to the pharmacy when sick rather than to a clinic or hospital, 20% reported going to a traditional healer and 8% to a shop selling drugs. Only 7%, 3% and 2% reported going to a private clinic, a NGO clinic or a government clinic, respectively. These indicators point to a substantial lack of formal healthcare facilities in the area.

Health issues in the household

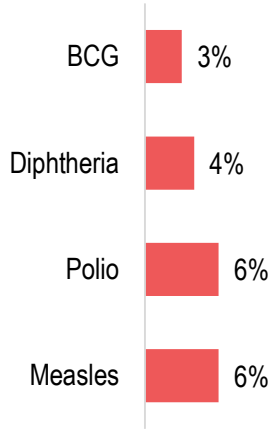
Malaria followed by AWD, malnutrition and stomach pain were reportedly the most common health problems for households. This suggests that water-borne diseases continue to pose a significant threat outside traditional 'problem' areas, such as riverine livelihood zones.

Figure 31: Proportion of assessed households reporting that a member had experienced a health issue in the month prior to the assessment, disaggregated by age



Likely linked to the current drought condition in Somalia and consequently the outbreak of AWD, half of assessed households reported that at least one household member had experienced AWD 2-5 times in the 3 months prior to the assessment. According to World Health Organization (WHO), limited access to health facilities, use of unsafe water, harmful hygiene practices and underlying malnutrition - all of which are challenges significantly reported by assessed households - are likely to exacerbate the spread of AWD[26].

Figure 32: Proportion of households with vaccine-aged children (6 months to 15 years) indicating that children had received vaccinations

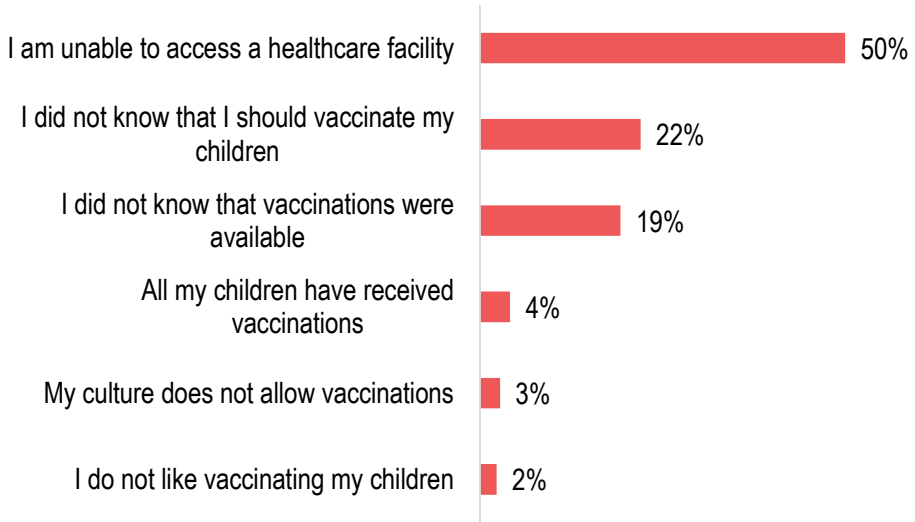


Households reported a low proportion of vaccine-aged children having received vaccination, mirroring considerably low immunization coverage in Dhuusamareeb.

Measles and polio were the most commonly received vaccines, with 6% of vaccine-aged children having reportedly received these vaccinations.

The most commonly reported reason for not receiving vaccinations was the households' inability to access a healthcare facility, reported by 50% of households, followed by households not knowing that they should vaccinate children, reported by 22%, and households not knowing that vaccinations were available, reported by 19%. Due mainly to the current drought situation coupled with low vaccination rates, Somalia was experiencing, at the time of assessment, its worst outbreak of measles in four years. Almost 19,000 suspected cases were reported this year, compared to between 5,000 to 10,000 total cases per year since 2014, with 80% of all those affected being children below the age of 10 years[27].

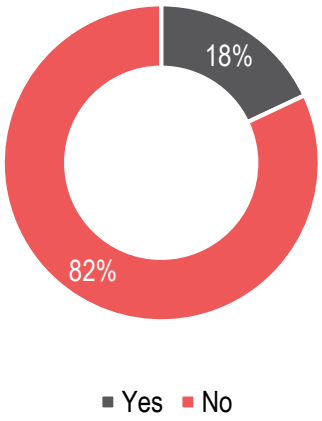
Figure 33: Reported reasons for not vaccinating children



[26] WHO, Somalia Humanitarian Response Plan 2017, 2017
[27] WHO, Somalia Emergency Response Bulletin, 2017

Nutrition services

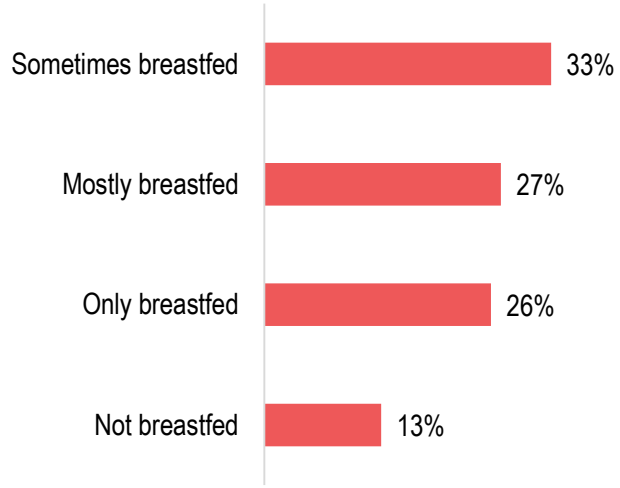
Figure 34: Proportion of households reporting access to nutrition services



Only 18% of assessed households reported access to nutrition services in the month prior to the assessment. This finding is consistent with UNICEF's, which reported that most Somali households do not effectively access appropriate nutritional services[28] and is highly likely to be related to the poor access to healthcare facilities.

The most available nutrition service was outpatient therapeutic programme (OTP), reported by 6% of assessed households. The availability of other forms of nutritional services, particularly wet feeding (WF), infant and young child feeding programmes (IYCF) and micronutrient supplementation (MS) was reportedly extremely limited.

Figure 35: Reported breastfeeding behaviour of children under 6 months



Only 26% of assessed households with children under 6 months in Dhuusamareeb reported exclusively breastfeeding them. Relatedly, UNICEF estimates that only 1 in 10 infants in Somalia is exclusively breastfed up to the age of 6 months[29].

This is problematic given the potential impact of breastfeeding on child survival. For instance, compared to non-breastfed children, breastfed children are 14 times less likely to succumb to diseases and infections during their first six months.

[28] UNICEF, Situation Analysis of Children in Somalia 2016, 2016
[29] UNICEF, Somalia Nutrition Report, 2016

Conclusion

Against the backdrop of the current acute food insecurity situation in Dhuusamareeb and Guri-Ceel, this assessment has analysed the current availability of, and access to, food, WASH, health and nutrition services.

The vast majority of assessed households reported not being able to access enough water for domestic purposes. Further, only 24% indicated meeting the SPHERE standard of 15 litres of water per person per day. This points to an acute level of water need considering amounts reported did not include water for livestock. The most commonly reported reason for a lack of access to enough water related to water shortages at source, reflecting the ongoing drought situation in Somalia.

The proportions of households reporting that they do not treat drinking water, have no access to soap and no access to latrines were considerably high. This is problematic given the substantial health risks posed by harmful hygiene practices and the current outbreak of AWD in Somalia.

Overall the data from Dhuusamareeb and Guri-Ceel indicates declining food security amongst the majority of assessed households, in a reflection of deepening drought conditions across the country. A high proportion of households scored poorly on the key food security indicators of FCS and DDS - 78% and 85% of assessed households fell in the poor FCS and the low DDS categories respectively. Additionally, the ability of households to provide food for themselves also appears to be declining as households reported an increasing reliance on food donations from friends and family as well as wild foods. Further, households' primary sources of food has reportedly reduced, further indicating decline in households' food access. Considering the reported increase in households' food expenditure, it is likely that food prices have gone up, suggesting that households relying on a single source of income are likely to be experiencing increased inability to afford food items.

Furthermore, 97% of assessed households reported no access to formal healthcare services. The most commonly reported reason for this was a lack of healthcare facilities in the area. In addition, more than half (56%) of assessed households that reported accessing healthcare facilities indicated that their nearest healthcare facility was approximately half a day's walk away, again pointing to very limited healthcare facilities in the area.

Malaria followed by AWD were the most common health problems reported by households suggesting that water-borne diseases are posing a significant threat outside traditional 'problem' areas, such as riverine livelihood zones. In a reflection of the current outbreak of AWD in Somalia, half of the respondents reported that at least a household member had experienced AWD 2-5 times in the three months prior to the assessment. Finally, low rates of vaccination, access to nutrition services and exclusive breastfeeding of children under 6 months were also reported.