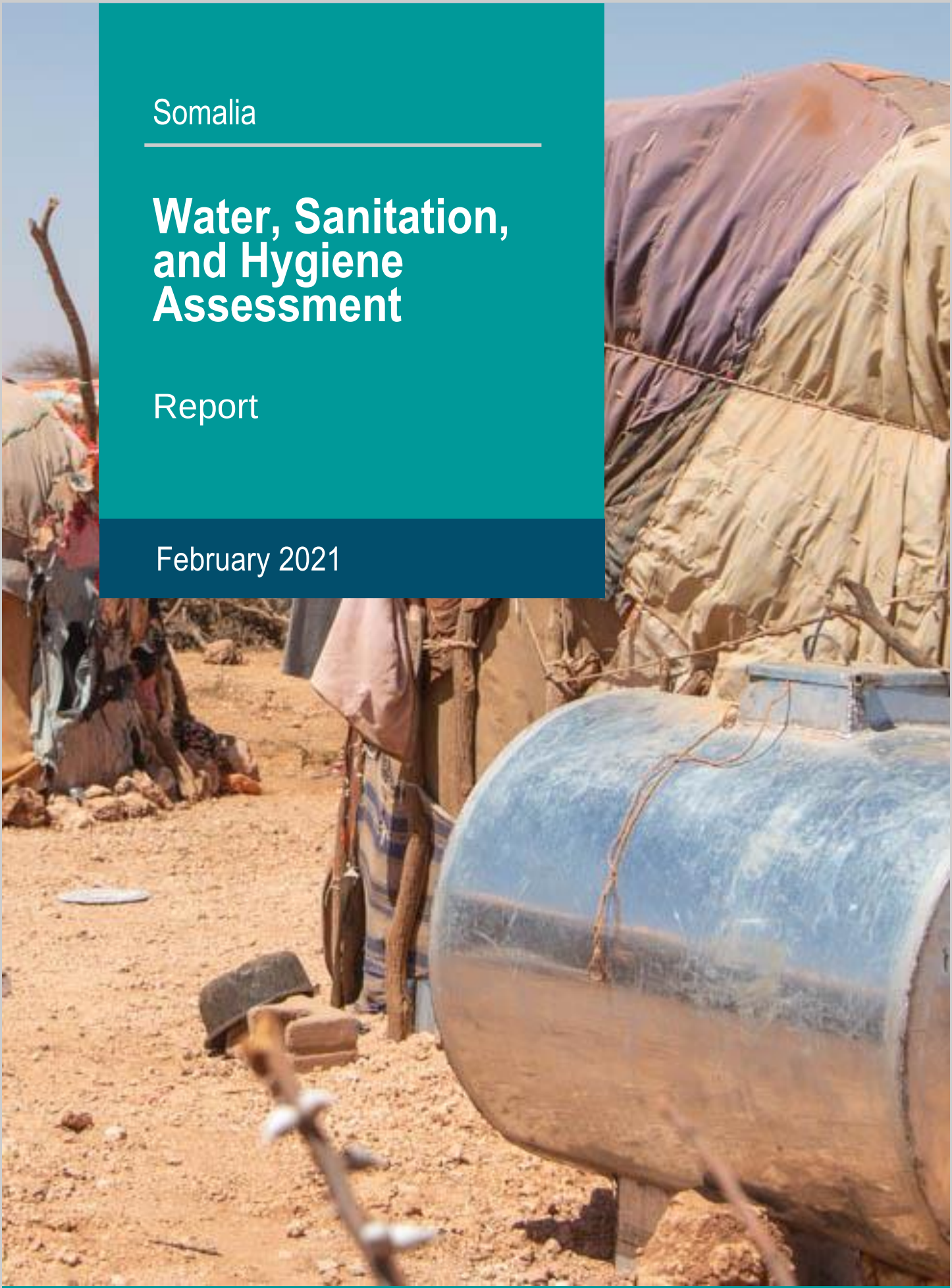
Somalia

Water, Sanitation, and Hygiene Assessment

Report

February 2021



WASH Cluster Somalia

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Funded by:

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Somalia

Cover image: Abdirahman Yusuf. Xaafuun, after cyclone Gati, November 2020. © IMPACT Initiatives, 2021

About REACH

REACH Initiative facilitates the development of information tools and products that enhance the capacity of aid actors to make evidence-based decisions in emergency, recovery and development contexts. The methodologies used by REACH include primary data collection and in-depth analysis, and all activities are conducted through inter-agency aid coordination mechanisms. REACH is a joint initiative of IMPACT Initiatives, ACTED and the United Nations Institute for Training and Research - Operational Satellite Applications Programme (UNITAR-UNOSAT). For more information, please visit our website: www.reach-initiative.org. You can contact us directly at: somalia@reach-initiative.org and follow us on Twitter @REACH_info.

SUMMARY

In Somalia, 4.5 million people are still in need of humanitarian Water, Sanitation and Hygiene (WASH) support[1] after decades of protracted crisis. United Nations agencies, non-governmental organizations, and organizations specialised in assessments collect large amounts of data, which is often challenging to analyse because of its overwhelming amount, uneven quality and incomplete coverage. This report is collating data and information in order to provide an overview of the state of the humanitarian situation in Somalia with regards to WASH needs.

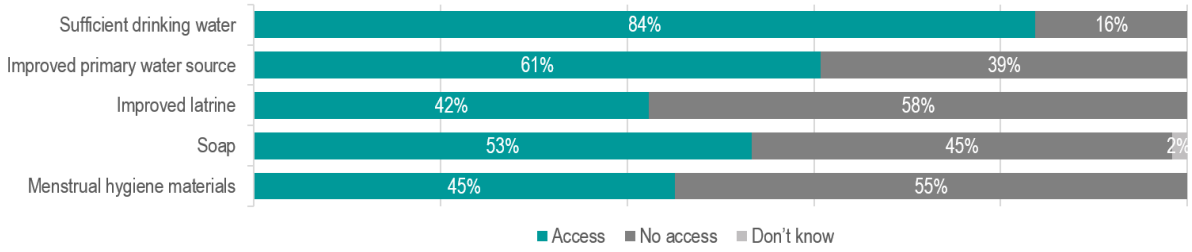
The general objective of this report is to better understand and analyse WASH-related needs across Somalia to support evidence-based planning and advocacy by the WASH cluster. To achieve this goal, it contains the following specific objectives:

1. To understand the current WASH-related needs in Somalia.
2. To identify key factors and underlying causes of these needs and vulnerabilities.
3. To lay the foundation for continued monitoring and analysis by the WASH cluster of WASH related needs across Somalia.
4. To provide a robust evidence base to assist WASH cluster planning in Somalia and improve the effectiveness and efficiency of programming.

The report uses three sources of data to inform its analysis[2]. First, a review of quantitative WASH data, which includes data used by the WASH cluster in support of the 2020 Humanitarian Needs Overview (HNO) and Humanitarian Response Plan (HRP). Second, REACH's fourth annual Joint Multi-Cluster Needs Assessment (JMCNA); a survey conducted in July 2020 with 10,222 households across 54 of the 74 districts in Somalia, results of which are available for households from both IDP and non-IDP settlements at the district-level. Finally, results of a WASH/COVID-19 focused knowledge, attitudes and practices (KAP) survey based on key informant (KI) interviews which have been conducted in September 2020 across seven locations Somalia, one in each state to ensure complete geographic coverage are used to understand WASH-related needs in the context of the pandemic.

The following key indicators used for the JMCNA show the pressing level of WASH needs in Somalia.[3] Sixteen percent (16%) of households reported not having access to enough drinking water, 39% reported having no access to an improved water source, 45% reported having no access to soap, while more than half of HHs reported lacking access to improved latrines and menstrual hygiene materials.

Figure 1: Proportions of households suveyed in the JMCNA with or without access to basic WASH services.



While 84% of all households reported having access to a sufficient quantity of drinking water, 39% of interviewed households reported not having access to an improved water source. There is also a significant difference between districts with Dhuusamarreeb, where 95% of all interviewed households reported having access to an improved primary water source,

[1] Somalia WASH Cluster. 2020. WASH Sectoral PIN. Humanitarian Needs Overview (HNO) 2021.

[2] Results for the JMCNA and KAP surveys are indicative.

[3] REACH. 2020. Joint Multi-Cluster Needs Assessment (JMCNA) data. http://bit.ly/37cOo62

being on one end and Kismayo, where only 24% of all interviewed households reported having access to an improved primary water source, being on the other end.

There is an inadequate quantity of improved latrines. The JMCNA additionally found that open defecation (11%) or defecation in open holes (20%) remains widespread.[4] Of those households that reported having access to a latrine (69%), the majority nationally (74%) reported having their own latrine, while the rest (26%) reportedly use shared facilities.[5] Non-displaced households (80%) were reportedly more likely to have private latrines compared to displaced households (53%).[6]

Of those households that reported having access to a latrine, the vast majority (95%) additionally reported that latrines were further than 50 metres away from their home and most latrines (99%) were reportedly not accessible for people with disabilities.[7] Most households with access to a latrine reported that there were missing features like lighting outside (91%), lighting inside (79%), or locks (43%). Only 4% of all households with access to a latrine reported separation by gender and marked as such.[8]

Reported hygiene practices remain insufficient, which could lead to a heightened risk of water-borne disease as well as the spread of COVID-19. Only 58% of all interviewed households reported washing their hands regularly after defecating or urinating.[9] JMCNA data showed that a quarter of the households (25%) reportedly have a handwashing facility with a tap.[10] However, only 3% of households reported a functional handwashing facility with soap at their latrine.[11] When soap was unavailable, 38% of interview households reported relying on soap substitutes such as sand or ash.[12]

The COVID-19 pandemic further increased the need for hygiene routines such as regular handwashing and social distancing. KAP survey data showed that 77% of all interviewed KIs reported that people have taken any action to prevent getting COVID-19[13]. However, 40% of KIs reported that all or many members in their communities attended any large gathering like public prayers, funerals or weddings in the week prior to data collection.[14] On the other hand, 40% of KIs reported that all or many members in their communities were washing their hands more often than before they heard about COVID-19 in the week prior to data collection.[15]

The key figures above indicate a high level of WASH needs in Somalia. Physical wellbeing and living standards conditions remain severely low, while there is limited availability and use of coping mechanisms. The results of this assessment are intended to assist policy makers in evidence-based decision making. While this report provides a general summary, the accompanying database and information products contain the complete range of WASH indicators aggregated by district and nationally and by displaced, non-displaced, and total populations.

[4] REACH. 2020. Joint Multi-Cluster Needs Assessment (JMCNA) data.
[5] Ibid.
[6] Ibid.
[7] Ibid.
[8] Ibid.
[9] Ibid.
[10] Ibid.
[11] Ibid.
[12] Ibid.
[13] REACH. 2020. COVID-19 KAP Survey.
[14] Ibid.
[15] Ibid.

CONTENT

List of tables and figures

List of acronyms

AWD	Acute watery diarrhoea
FAO	Food and Agricultural Organization
HNO	Humanitarian Needs Overview
HRP	Humanitarian Response Plan
IDP	Internally Displaced Person
JMCNA	Joint Multi-Cluster Needs Assessment
KAP	Knowledge, Attitudes and Practices
KI	Key informant
NFI	Non-food item
NGO	Non-governmental organization
PiN	People in need
WASH	Water, Sanitation & Hygiene
WFP	World Food Programme

INTRODUCTION

According to the Humanitarian Needs Overview (HNO) 2021, about 4.6 million people are in need of humanitarian WASH support in Somalia[16], a country that has been in a state of protracted emergency for decades. The Gu rains[17] caused floods in many parts of the country, displacing more than 400,000 and affecting a total of more than 900,000 people.[18] More floods and subsequent displacement was caused by cyclone Gati, which made landfall in Bari region on 22 November 2020 and affected an estimated 180,000 people in northern Puntland and parts of Somaliland.[19] Additionally, people's livelihoods and resilience was affected by multiple waves of desert locusts.[20] In 2020, the situation was further compounded by the effects of COVID-19. First cases in Somalia were recorded in March 2020, and while case numbers remained relatively low as compared to other countries, numbers rose throughout the year.[21] Unreliable access to water often from unimproved sources is still an important feature of the WASH humanitarian landscape in Somalia. Nationwide, access to an improved water source remains low, with large variations from one region to another.[22] In drought affected regions, water scarcity is a leading cause of displacements and conflicts.[23] Protection risks are high in all parts of Somalia, resulting in all categories of users being at high risk of violence when using facilities.[24] Given the severe needs described, a strong understanding of the humanitarian conditions of the affected population is essential for the WASH cluster to better perform its 6+1 core functions[25] in Somalia. To this end, a detailed analysis of WASH data is important to providing the evidence-base necessary to support the more effective implementation of these key functions.

The general objective of this report is to inform on WASH-related needs across Somalia to support evidence based planning and advocacy by the WASH cluster. To achieve this goal, it contains the following specific objectives:

1. To understand the current WASH-related needs in Somalia.
2. To identify key factors and underlying causes of these needs and vulnerabilities.
3. To lay the foundation for continued monitoring and analysis by the WASH cluster.
4. To provide a robust evidence base to assist WASH cluster planning in Somalia and improve the effectiveness and efficiency of programming.

In Somalia, United Nations agencies, non-governmental organizations, and organizations specialized in assessments collect large amounts of data, which is often challenging to analyse because of its overwhelming amount, uneven quality and incomplete coverage. For the purposes of this assessment, secondary data was mostly limited to the 2020 Joint Multi-Cluster Needs Assessment (JMCNA), supplemented by a knowledge, attitudes and practices (KAP) survey with a focus on WASH and COVID-19 in Somalia, and data provided for the HNO process.

The aim of the analysis is to further investigate specific issues and themes pre-identified by the WASH Cluster, based on the 2019 WASH report. The analysis is based on an analysis framework set on the key information needs identified by the WASH Cluster to deliver on its core functions. As part of this framework, a list of key indicators and a methodology was developed to track WASH People in Need (PIN) and severity levels over the coming years.

[16] OCHA Somalia, Humanitarian Needs Overview 2020, https://hum-insight.info/plan/1011
[17] Gu rains describe the rainfall period from July until September in Somalia
[18] WASH Cluster Somalia. 2020. 2020 Gu Floods Update. https://reliefweb.int/map/somalia/wash-cluster-somalia-2020-gu-floods-update-21-may-2020
[19] OCHA Somalia. Tropical Cyclone Gati Update #5.
[20] FAO. 2020. Desert locust bulletins No. 495 – No. 506.
[21] Johns Hopkins University. Coronavirus resource centre. https://coronavirus.jhu.edu/map.html
[22] REACH. 2020. Joint Multi-Cluster Needs Assessment (JMCNA) data.
[23] Somalia WASH Cluster. 2020. WASH Sectoral PIN. Humanitarian Needs Overview (HNO) 2021.
[24] OCHA. 2018. Humanitarian Needs Overview 2019.
[25] Supporting service delivery, strategic decision-making, developing/implementing strategies and plans, contingency planning, monitoring, advocacy, and accountability to the affected population.

RESEARCH METHODS

Information and data presented in this report is primarily based on two assessments conducted by REACH in 2020. To better understand caveats of these assessments this section aims to provide a summary over the respective methodological approaches for data collection. For more information and the final products, as well as the dataset for the JMCNA, please visit https://www.reachresourcecentre.info/country/somalia/.

The 2020 JMCNA entailed surveys of 10,222 households collected in July 2020 in 54 of the 74 districts in Somalia. Due to the situation created by COVID-19, data collection for the JMCNA was done remotely through phone interviews. The contact lists of respondents were obtained mainly from previous assessments conducted by REACH. Additional contacts were obtained through referrals during the data collection period. Therefore, results should only be seen as indicative. Results were aggregated to district level. During the aggregation process a weighting was applied to respective results for households from IDP settlements and for households from non-IDP settlements respectively. District-level results were aggregated to the national level by weighting district averages by the percent of the national population in the district. Population figures are based on those officially endorsed by OCHA for the Humanitarian Needs Overview 2021.

Furthermore, a COVID-19 KAP survey was done by REACH in cooperation and coordination with the Somalia WASH cluster. Data collection for this KAP survey took place in September 2020 via phone interviews. A total of 1,052 key informants were interviewed in a total of seven locations. The choice of locations was mainly driven by a goal to achieve an even geographical coverage, and some pre-identified criteria by the WASH cluster such as existence of IDP camps at the location, proximity to borders or ports of entry, and cholera / acute watery diarrhoea (AWD) hotspots.[26] For each of the seven locations at least 100 KIs, with an even distribution of 50 displaced and 50 non-displaced, were targeted. Furthermore, especially knowledgeable KIs were preferred. For this assessment, community leaders, religious leaders, members of various resident committees, health workers and vendors were assumed to be especially knowledgeable of the situation. For each location a target of 10% especially knowledgeable KIs was set. Out of the 1,052 KIs, 1,001 KIs had heard about COVID-19. Only those who had heard about COVID-19 were considered for the full interview. Data was aggregated to the national level.

Additional information is derived from a desk review of WASH related resources. Most of the resources can be found on the web presence of the WASH Cluster Somalia on https://www.humanitarianresponse.info/en/operations/somalia/water-sanitation-hygiene .

[26] WASH Cluster Somalia. 2020. Confirmed AWD / Cholera cases.

FINDINGS

Water

Access to water

A significant share of the population of Somalia reportedly does not have reliable access to safe drinking water. Nationally, the JMCNA found that 14% of non-IDP households and 21% of IDP households reported not having enough water for drinking.[27] Furthermore, 32% of non-IDP households and 46% of IDP households reported not having enough water for personal hygiene.[28] For both access to water for drinking and personal hygiene, regional differences can also be observed as shown in figure 2 and figure 3. More than half of households (68%) reportedly have a water source within 15 minutes of their home,[29] while 84% within 30 minutes.[30]

While above numbers suggest a significant improvement of the WASH situation as compared to JMCNA results for 2019, it is important to note that due to the change in methodology caused by COVID-19, a comparison of results should only be seen as indicative.

Figure 2: % of interviewed households reporting having access to a sufficient amount of drinking water[31]

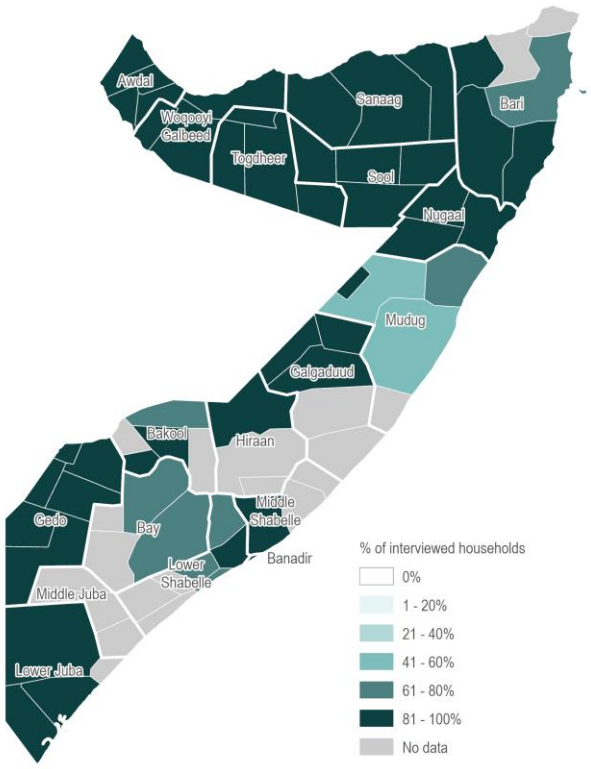
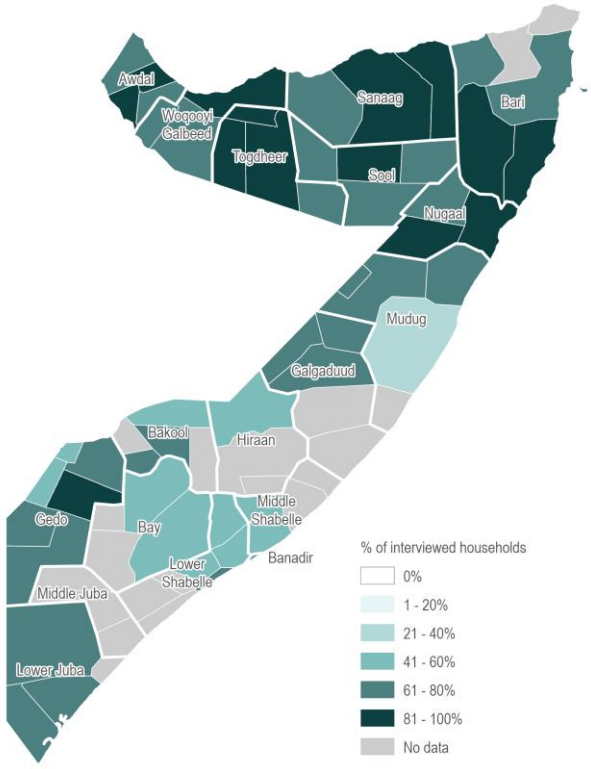


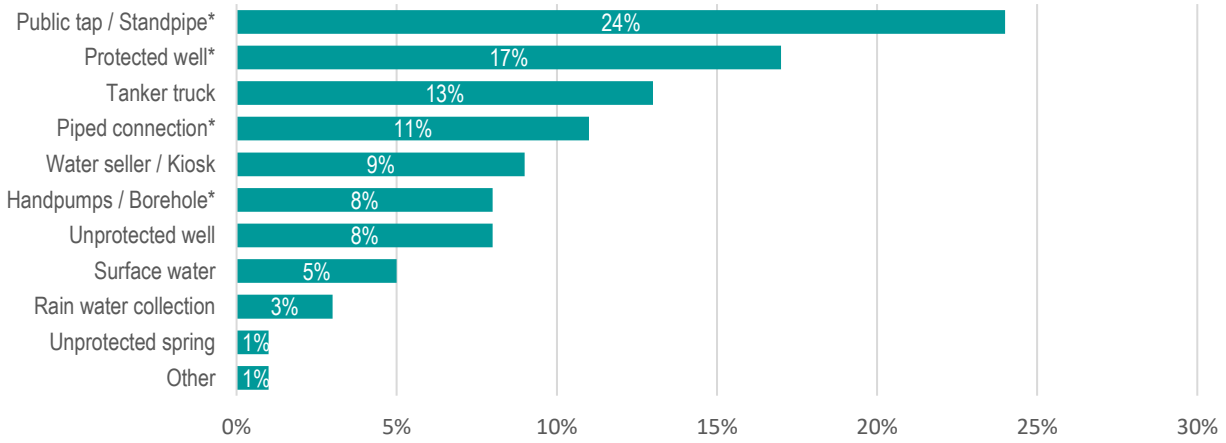
Figure 3: % of interviewed households reporting having access to a sufficient amount of water for personal hygiene[32]



[27] REACH. 2020. Joint Multi-Cluster Needs Assessment (JMCNA) data.
[28] Ibid.
[29] By foot, fetch water and return.
[30] REACH. 2020. Joint Multi-Cluster Needs Assessment (JMCNA) data.
[31] Ibid.
[32] Ibid.

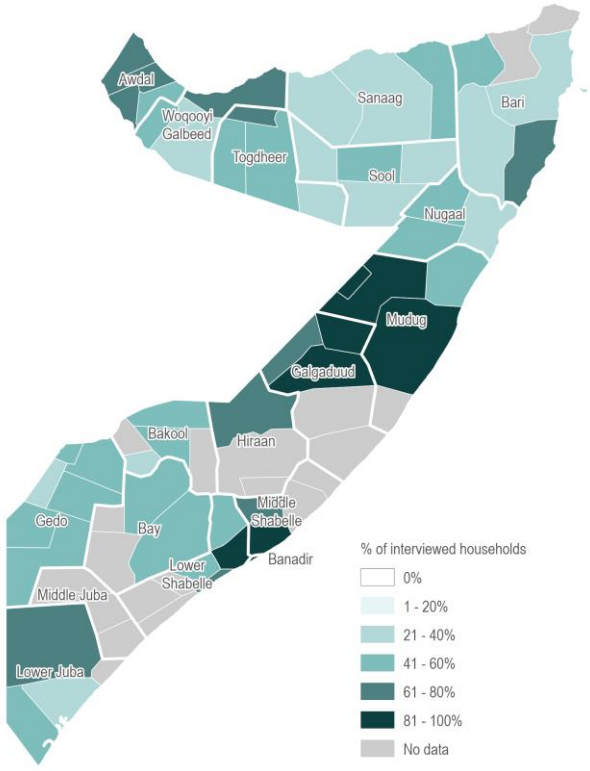
According to the JMCNA data, less than two thirds of households (61%) reported accessing an improved primary water source, while 31% reported using an unimproved source and 7% rely on surface water or rain water. [33]

Figure 4: Primary source of drinking water as reported in the JMCNA 2020, as a percentage of the national population. Improved water sources are marked by an asterisk (*)[34]



The JMCNA data furthermore reveals regional differences with regards to access to an improved water source as shown in figure 5.

Figure 5: % of interviewed households reporting having access to an improved water source[35]



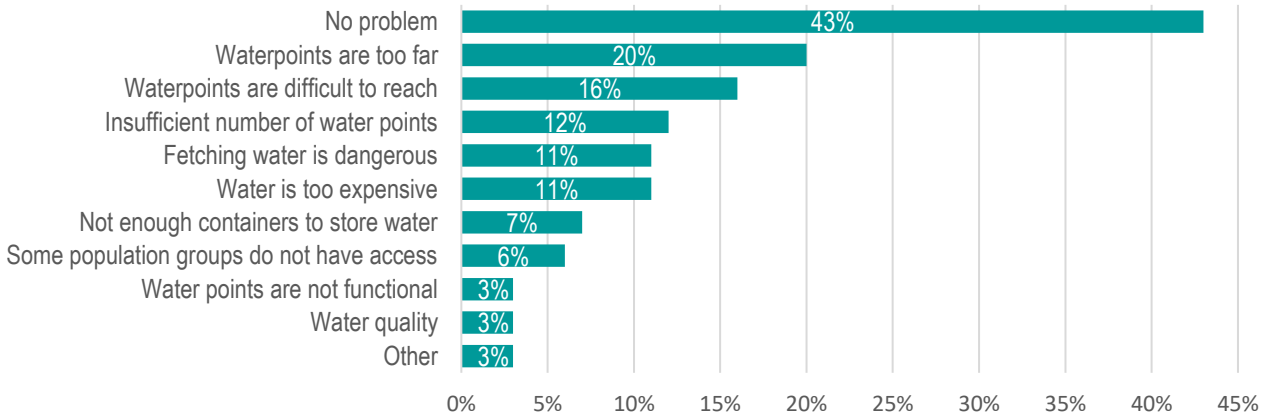
While there was a general slight decrease in water prices across large parts of Somalia, water prices have increased locally in the Districts of Laasqoray, Rab Dhuure, Badhaadhe, Kismaayo, and in Gedo Region.[36]

[33] REACH. 2020. Joint Multi-Cluster Needs Assessment (JMCNA) data.
[34] Ibid.
[35] Ibid.
[36] WASH Cluster Somalia. 2020. Water price monitoring (March 2020 and January 2021).

Barriers to accessing water

Forty-three percent (43%) of interviewed households reported no barriers to accessing water.[37] The two most reported barriers were linked to the physical accessibility of water points. While 20% reported that water points are far away, 16% reported that water points are difficult to reach. [38] Beyond the physical access barriers, the fact that 11% of interviewed households reported that "fetching water is a dangerous activity" and 6% reported that some population groups (age, gender, ethnic groups, etc.) do not have access to the water points raises protection concerns. Respondents were able to select multiple types of barriers, but not in combination with the option "No problem".

Figure 6: Barriers to accessing water as reported in the JMCNA 2020 as a percentage of the national population.[39]



Coping strategies to accessing water

Only 29% of all interviewed households reported accessing water is not an issue that would require any coping strategies.[40] While there is only a small difference for respondents from IDP settlements (24%) and respondents from non-IDP settlements (30%), there are considerable geographic differences between districts (see figure 7), ranging from 6% to 71%, with households in Berbera, Sheikh and Dhuusamarreeb reporting the least use of coping strategies and districts Jubaland and South West State reporting the most issues in accessing water, and the need to engage in coping strategies.[41] The most commonly reported coping strategy for insufficient access to water was relying on less preferred water sources (29%), followed closely by relying on surface water as source of drinking water (22%).[42] Surprisingly, the coping strategy of resorting to surface water as source of drinking water was named more frequently than resorting to surface water for cooking (9%).[43] One explanation might be that respondents who already use surface water for cooking might fully switch to surface water as primary source of water for all uses. Very few households reported using severe coping strategies that affect the household's future productivity and are dramatic or difficult to reverse.[44] For example, using money that was meant for other purposes, resorting to water sources that might be dangerous to access, or the reduction of drinking water altogether were all reported by less than 10% of the interviewed households.[45] Reducing drinking and domestic water use constitutes a potential physical/psychological risk, depending on the amount reduced, and relying on seasonal water sources likely increases the risk of water contamination as well as travel time highlighting subsequent protection-related concerns, as with sending children to fetch water.

[37] REACH. 2020. Joint Multi-Cluster Needs Assessment (JMCNA) data.
[38] Ibid.
[39] Ibid.
[40] Ibid.
[41] Ibid.
[42] Ibid.
[43] Ibid.
[44] Based on the livelihood coping strategies guidance in: WFP. 2015. *Consolidated Approach to Reporting Indicators of Food Security (CARI)*.
[45] REACH. 2020. Joint Multi-Cluster Needs Assessment (JMCNA) data.

Figure 7: % of interviewed households reporting that access to water is not an issue that would require them to employ coping strategies.[46]

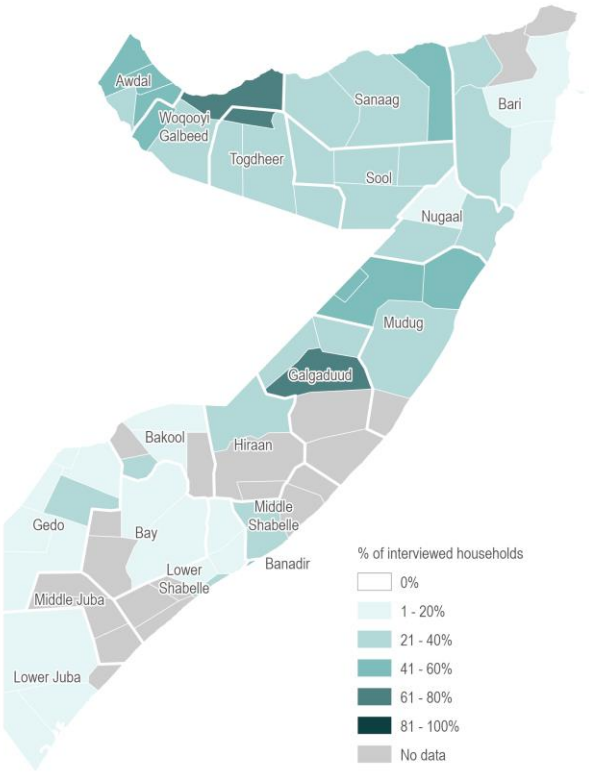
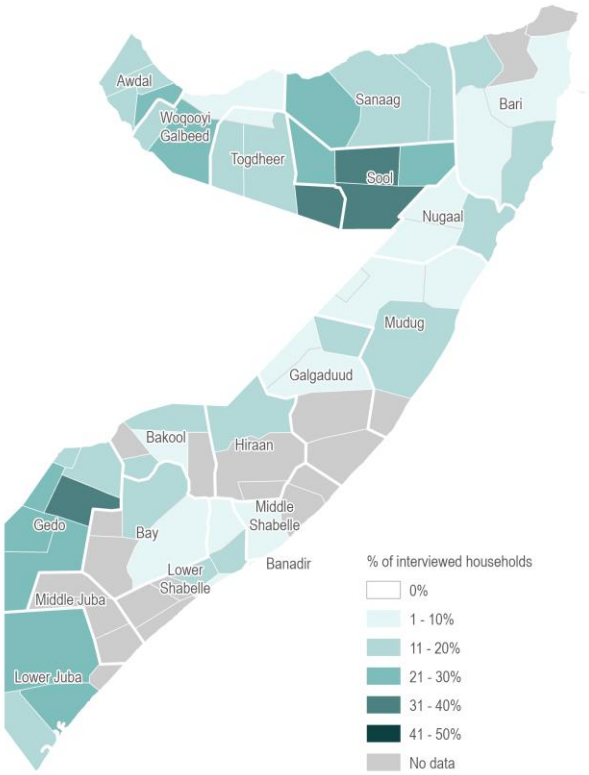


Figure 8: % of interviewed households reporting access to drinking water as one of their top three needs[47]



Despite these considerable issues with access to safe water, only 2% of all respondents listed access to drinking water as their number one needs priority.[48] Overall, 12% of all interviewed households listed access to drinking water as one of their top three priority needs.[49] There are no significant differences between IDP and non-IDP settlements. However, significant regional differences can be observed as shown in figure 8.

Sanitation

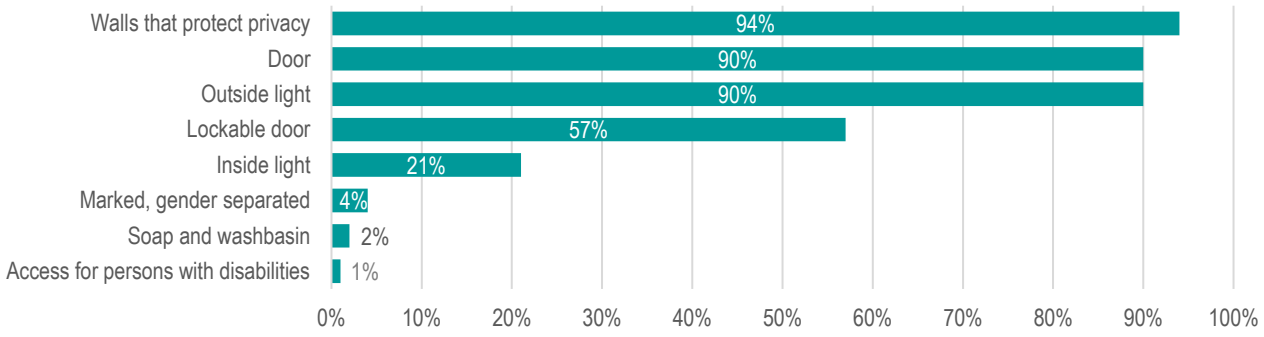
Access to sanitation facilities

Access to basic sanitation remains a major issue for the country. According to JMCNA data, less than half of the households (42%) nationally reported having access to an improved latrine, while a quarter (25%) reported using an unimproved latrine, and the remainder (31%) had no access[50,51]. For those with access to a latrine, only 5% reported it to be close to their shelter (50m or less)[52]. Data from the 2019 JMCNA showed that latrines are reportedly located within 15 minutes of their homes by foot for a large majority (84%).[53] Additionally, for those with access to a latrine, just under three quarters of

[46] REACH. 2020. Joint Multi-Cluster Needs Assessment (JMCNA) data.
[47] Ibid.
[48] Ibid.
[49] Ibid.
[50] The missing 2% result from 1% of answers that could not be classified clearly, and 1% difference due to rounding.
[51] REACH. 2020. Joint Multi-Cluster Needs Assessment (JMCNA) data.
[52] REACH. 2020. Joint Multi-Cluster Needs Assessment (JMCNA) data.
[53] REACH. 2019. Joint Multi-Cluster Needs Assessment (JMCNA) data.

households (73%) reported having their own, while 26% used shared facilities[54,55]. Households from IDP settlements (46%) were more likely to have to share latrines compared to households from non-IDP settlements (19%).[56]

Figure 9: % of households with access to latrines that reported latrines having the following features.[57]



As shown in figure 9, only 4% report marked, gender separated latrines.[58] Another general concern is the access for persons with disabilities to the latrines which is only reported by 1% of interviewed households.[59] From a hygiene perspective, and aggravated by the ongoing COVID-19 pandemic, the very low availability of soap and washbasins at latrines (2%) needs to be highlighted.[60]

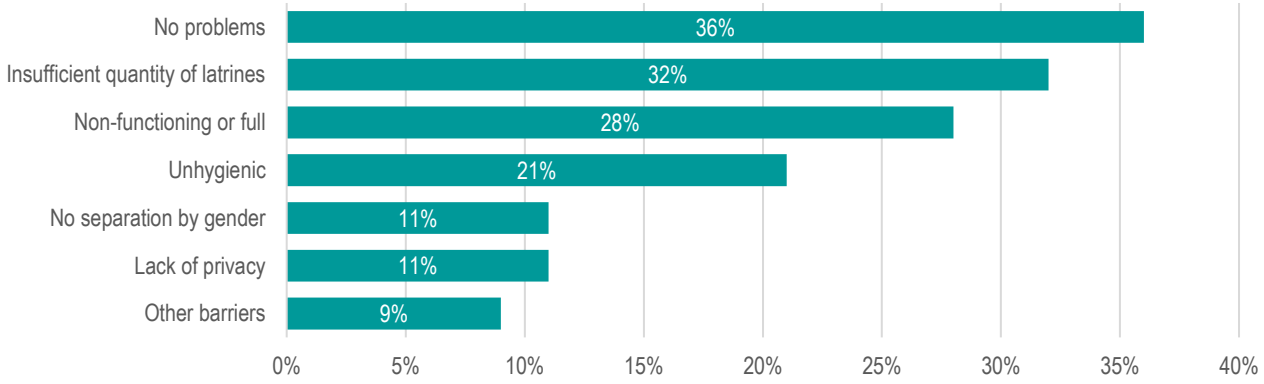
According to JMCNA data, strategies to dispose of solid household waste and faeces like burning (36%), burial in designated areas (24%), or in covered pits (13%) are widely employed.[61] However, 26% of all interviewed households reported to dispose of solid household waste and faeces in the open.[62] Faecal matter is of particular concern from a public health standpoint in particular when considering the prevalence of open defecation (11%) and improper disposal of faeces, as reported in other sections of the JMCNA.[63]

Barriers to accessing sanitation facilities

During the JMCNA assessment, just under two thirds (64%) of interviewed households reported barriers to accessing sanitation facilities. The most commonly reported issues were a lack a sufficient quantity of latrines (32%), non-functional or full latrines (28%) and unhygienic conditions at the latrines (21%).[64] It is also for these three issues that a difference between the reported situation for households in IDP and non-IDP settlements can be observed. The issue of lack of a sufficient quantity of latrines was reported by 45% of households in IDP settlements (27% of non-IDP settlements).[65] Problems with non-functional or full latrines in IDP settlements (34%) and unhygienic conditions at latrines in IDP settlements (27%) were reported more often than in non-IDP settlements (25% and 18% respectively).[66] Overall, 40% of households in non-IDP settlements reported no problems, whereas only 24% of households in IDP settlements reported no problems with regards to sanitation.[67]

[54] The missing 1% could not be clearly classified.
[55] REACH. 2020. Joint Multi-Cluster Needs Assessment (JMCNA) data.
[56] Ibid.
[57] Ibid. Respondents could give multiple answers.
[58] Ibid.
[59] Ibid.
[60] Ibid.
[61] Ibid.
[62] Ibid.
[63] Ibid.
[64] Ibid.
[65] Ibid.
[66] REACH. 2020. Joint Multi-Cluster Needs Assessment (JMCNA) data.
[67] REACH. 2020. Joint Multi-Cluster Needs Assessment (JMCNA) data.

Figure 10: Barriers to accessing sanitation facilities as reported in the JMCNA 2020, as percentages of households interviewed.[68,69]

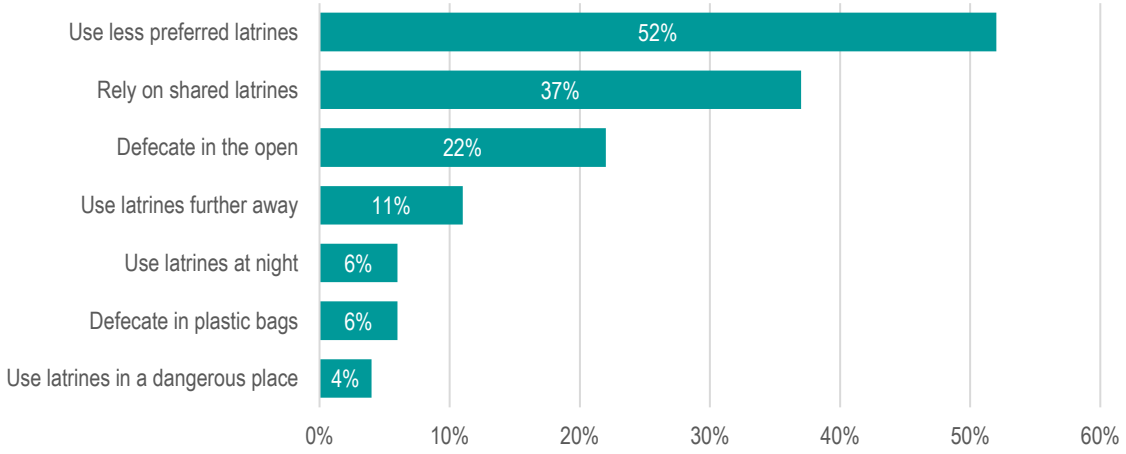


Coping strategies to access sanitation facilities

JMCNA data shows that around a third of the households (36%) reported having sufficient access to sanitation facilities so that they do not need to employ any coping strategy. Subsequently, figures regarding coping strategies are only based on the subset of respondents that reported facing any barriers to accessing sanitation facilities.[70]

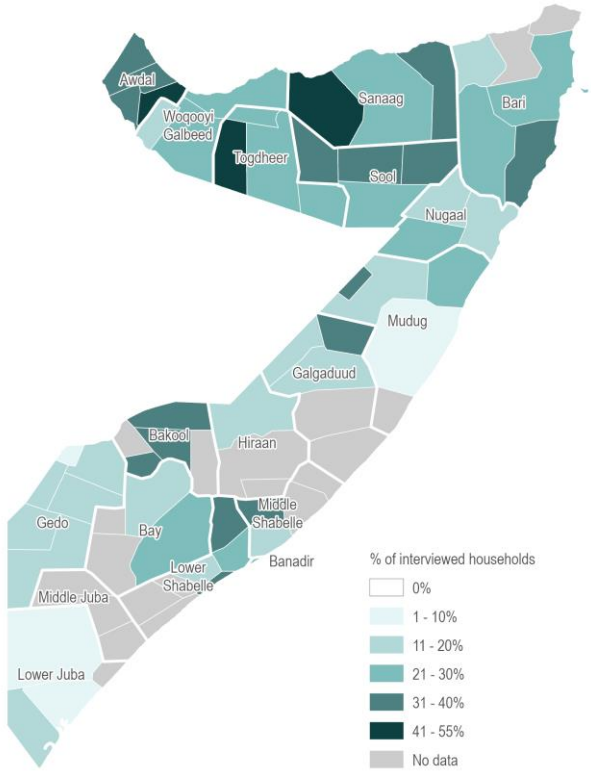
The most prevalent coping strategy for the lack of access to sanitation facilities reported is the use of less preferred or unhygienic latrines (52%), followed by resorting to shared latrines (37%). Resorting to open defecation as a coping strategy (22%) raises concerns regarding public health. Significant regional differences could also be observed (figure 12).[71]

Figure 11: Coping strategies employed by those facing barriers to accessing sanitation facilities.[72]



[68] Other includes: Facilities are too far away (2.1%); Facilities are difficult to access (especially for persons with disabilities) (2.6%); Going to facilities is dangerous (1.2%); Some population groups (age, gender, minority groups) do not have access to facilities (1.5%).
[69] REACH. 2020. Joint Multi-Cluster Needs Assessment (JMCNA) data. Respondents could give multiple answers.
[70] Ibid.
[71] Ibid.
[72] Ibid. Respondents could give multiple answers.

Figure 12: % of interviewed households reported to employ open defecation as a coping mechanism among those which reported facing barriers to accessing sanitation facilities.[73]



Hygiene

Access to handwashing and menstrual hygiene materials

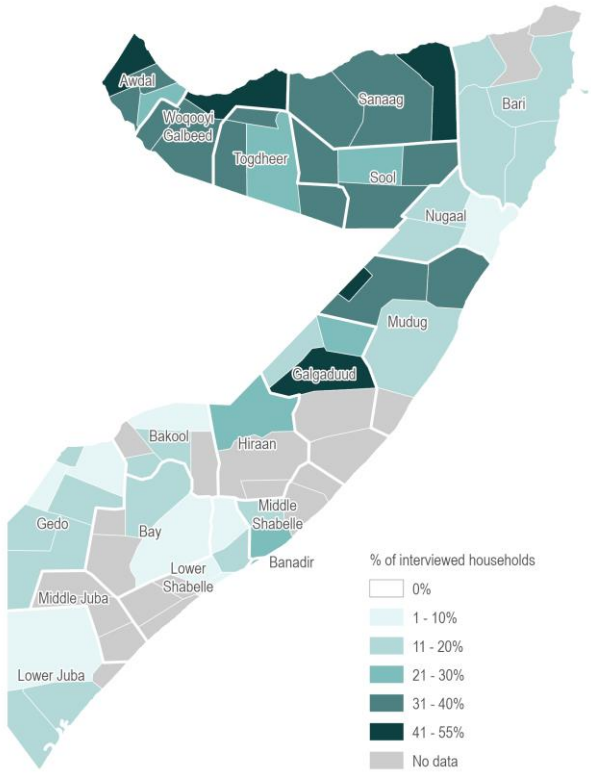
While 2% of the households self-report that they never wash their hands, handwashing appears not to be a common practice at all key moments.[74] For instance, 85% of households reportedly wash their hands before eating, but only 58% of the households reported doing so after defecation.[75] During the COVID-19 KAP Survey, 30% of interviewed KIs reported that all or many members of their communities wash their hands more frequently since hearing about COVID-19. Another 49% reported that some members of their communities wash their hands more frequently since hearing about COVID-19.[76] Access is likely the driving factor explaining these differences in handwashing practices as a majority of households (72%) report not having a specific handwashing device (no tap of any kind).[77] As already mentioned in the above section, only 2% of all households reported having a handwashing basin and soap at the latrines. According to the COVID-19 KAP survey, only 42% of all KIs reported having access to handwashing facilities and soap.[78] Access to soap was another pressing issue highlighted by the JMCNA since only about half of the households nationally (53%) reported having regular access to soap.[79] Furthermore, less than half of all interviewed households (45%) reported having no problems accessing menstrual hygiene products. Of those reporting problems, 42% indicated not having enough money to buy menstrual hygiene products whereas 20% reported that menstrual hygiene products are not available to purchase.[80]

[73] REACH. 2020. Joint Multi-Cluster Needs Assessment (JMCNA) data.
[74] REACH. 2020. Joint Multi-Cluster Needs Assessment (JMCNA) data.
[75] Ibid.
[76] REACH. 2020. COVID-19 KAP Survey.
[77] REACH. 2020. Joint Multi-Cluster Needs Assessment (JMCNA) data.
[78] REACH. 2020. COVID-19 KAP Survey.
[79] REACH. 2020. Joint Multi-Cluster Needs Assessment (JMCNA) data.
[80] Ibid. Some respondents stated that supplies were not available, but they would also not have the money to pay for it if they were.

Coping strategies to handwashing and obtaining menstrual hygiene materials

According to the 2019 JMCNA, around a fifth of the households (22%) reported having access to soap or menstrual hygiene materials so that they did not need to employ any coping strategy. There were considerable geographic differences between districts, ranging from 5% to 53%, with households in Somaliland reportedly having greater access to soap and menstrual hygiene materials than households in the south and central regions (see figure 13).[81]

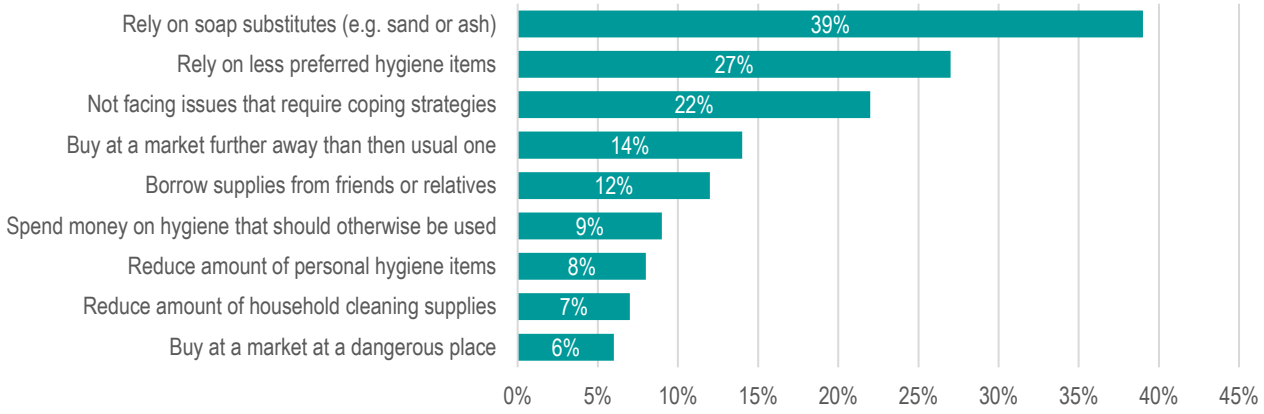
Figure 13: % of households per district reported not having any issues accessing hygiene materials that would require coping strategies.



The three most commonly reported coping strategies involved using soap substitutes for handwashing or cleaning of clothes or menstrual products (39%), relying on less preferred hygiene items (27%) and buying hygiene items and cleaning supplies from a market which is further away than the usual one (14%). Especially during the ongoing pandemic, relying on soap substitutes for handwashing, as well as the reduced use of personal hygiene items (8%) can constitute serious issues.[82]

[81] REACH. 2019. Joint Multi-Cluster Needs Assessment (JMCNA) data.
[82] Ibid

Figure 14: Coping strategies employed to access hygienic materials as reported in the JMCNA 2020, as a percentage of the national population (households)[83]



COVID-19

The year 2020 was marked by the effects of the COVID-19 pandemic. By the end of the year, Somalia saw some 4,714 confirmed cases.[84] Since the spread of the virus can largely be reduced through measures of social distancing and hygiene procedures, the access to adequate WASH facilities plays an important part in the control of the disease. In addition to information obtained through the JMCNA 2020, a KAP survey provided some information useful to the Somalia WASH Cluster and its partners.

While 98% of all interviewed KIs had heard about COVID-19 and are generally well informed about how the virus spreads, which population groups are most likely to get seriously ill from COVID-19 and which measures can help to prevent getting the virus, one area where general knowledge can be improved is around symptoms of COVID-19. Only 38% of all KIs listed loss of taste or smell as a possible symptom of COVID-19. Additionally, 83% of all KIs were not aware that infected persons can be asymptomatic.[85]

More than two thirds of all KIs reported that members of their communities are somewhat worried (37%) or very worried (34%) about COVID-19. Eighty-four percent (84%) of KIs also reported a perceived discrimination against certain groups because of COVID-19. The most reported groups that are discriminated against are infected persons (whether confirmed cases or not) (52%), their families (51%), suspected infected persons (51%) and health workers (40%).[86] Subsequently, 77% of all KIs reported that members of their communities have taken any measures to prevent getting COVID-19. However, despite the good level of information and awareness, 50% of all KIs believe that the general attitude of community members is that people should still shake hands or kiss hands to greet each other. A similar attitude exists towards the believe that people should still participate in social gatherings (39%).[87]

WASH safety

WASH Safety Index

The cluster developed in 2019 a WASH Safety Index[88] based on the conditions and usage of WASH facilities in the area where the households live. This index was adjusted to account for the data available in 2020. The index was based on the

[83] REACH. 2020. Joint Multi-Cluster Needs Assessment (JMCNA) data. Respondents could give multiple answers.
[84] Johns Hopkins University. Coronavirus resource centre. https://coronavirus.jhu.edu/map.html
[85] REACH. 2020. COVID-19 KAP Survey.
[86] Ibid.
[87] Ibid.
[88] Somalia WASH Cluster. 2019. WASH Sectoral PIN. Humanitarian Needs Overview (HNO) 2020.

indicators in the table 1 below along with their weights. The analysis found 6% of the population of the country was classified as in phases 3 to 5 which qualify them as "in need" (down from 37% in 2019)[89]. The indicators that were most frequently reported by households, leading to a worse score, were the inaccessibility of latrines by persons with disabilities (99%) absence of gender-separated latrines (96%), as well as the distance to latrines (94%).[90] The most commonly stated safety concern reported was women and girls not feeling safe at water points (2%).[91]

Table 1: WASH Safety Index indicators and weights.

WASH safety indicator	Weight
% Households reporting use of latrines with walls and locks on inside of door	2
% Households reporting use of latrines with internal source of light	1
% Households reporting use of gender-segregated latrines	1
% Households reporting presence of latrines reachable within 50m or less of the dwelling	2
% Households reporting latrine accessibility for persons with disabilities	1
% Households reporting presence of improved water source reachable in less than 30 minutes of travel total (by walking or available means of transport)	1
% Households reporting females feeling not safe at water points	2
% Households reporting females feeling not safe at latrines	2
% Households reporting females feeling not safe at bathing areas	2
% Households reporting males feeling not safe at water points	2
% Households reporting males feeling not safe at latrines	2
% Households reporting males feeling not safe at bathing areas	2

A household safety index score of under 5 attributed that household a severity score of 1. Safety index scores from 6 – 10, 11 – 15 and 16 – 20 resulted in severity scores of 2, 3 and 4 respectively.

[89] REACH. 2020. WASH report 2019.
[90] REACH. 2020. Joint Multi-Cluster Needs Assessment (JMCNA) data.
[91] Ibid.

WASH severity and PIN

The WASH sector PIN for 2020 found a total of 4.5 million people in need (PIN), representing 3.3 million non-displaced and 1.2 million displaced. A total of 10.6 million were found to be affected and at risk of need if conditions deteriorate. The table below shows the estimated number of people (in million) and share of the population for each severity phase and aggregate groupings such as affected, in need, and in urgent need.

Table 2: WASH severity and PIN estimates (in millions of people).

	1	2	3	4	5
Phase	**Minimal**	**Stress**	**Severe**	**Extreme**	**Catastrophic**
Profile	**12.3**	**Total population**			
		10.6	**Affected**		
			4.5	**PiN**	
				2.3	**Urgent PiN**
PiN	**1.7**	**6.1**	**2.2**	**1.1**	**1.2**
% PiN	**14%**	**49%**	**18%**	**9%**	**10%**

The WASH severity and PIN calculations are based on the following method:[92]

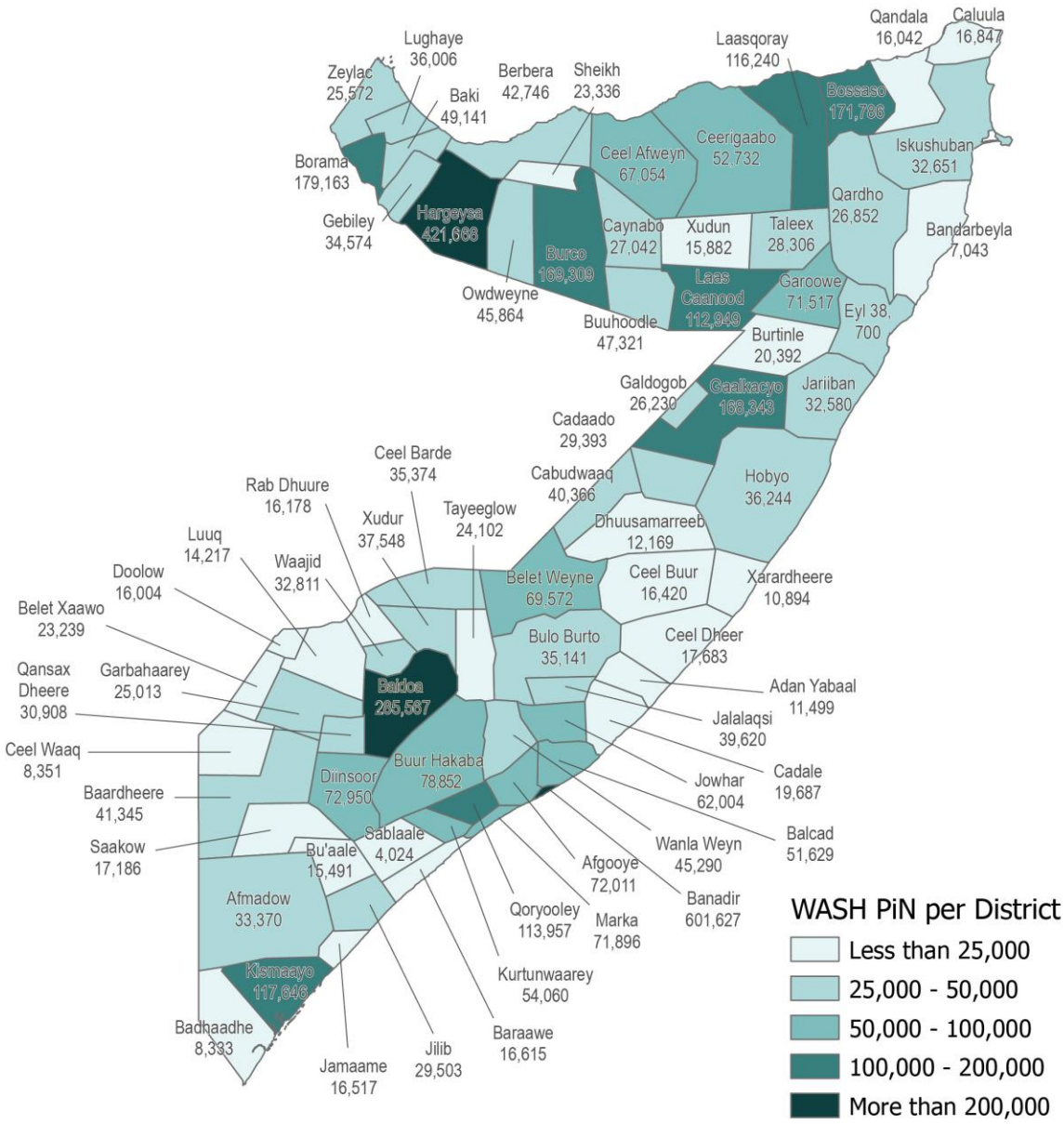
1. For each household, indicator values are classified along a five-point scale to determine sub-pillars severity
2. Sub-pillar severities are aggregated by the mean of the 4 highest sub-pillar scores to determine the pillar severities.
3. The Cluster can determine critical indicators. If any critical indicator is higher than the mean, the household will be assigned the critical indicator score instead of the mean.
4. WASH Humanitarian Condition scores are classified using the "Rule of 20%" to determine the WASH Severity Phase for each geographical area (district, nation) and affected group (host communities, IDPs, combined).
5. WASH Humanitarian Condition scores of 3-5 are proportioned using survey weights to determine the number of People in Need (PIN) for each geographical area (district, nation) and affected group (host communities, IDPs, combined).
6. For districts where data is scarce or unavailable projections are made based on a values from adjacent districts and adjusted by expert opinion.

The indicators used and how they are combined into pillars and sub-pillars are outlined in the Annex 1.[93] The indicators used are also those described in the beginning of the report and are available in the accompanying dataset and maps aggregated to the district and national level. The WASH severity and PIN analysis method was developed by the Global WASH Cluster in line the with Joint Inter-Sectoral Analysis Framework (JIAF) pillars. It is based on a holistic assessment of WASH conditions, rather than a relying on a single or limited number of proxy indicators. For this year's calculation, four sub-pillars within the living standards pillar were considered. They included "access to an improved water source", "access to a sufficient quantity of water", "access to adequate, appropriate and functional sanitation facilities", and "access to functional handwashing facilities and soap". The sub-pillar "access to a sufficient quantity of water" was categorized as critical by the Somalia WASH Cluster.

There are considerable regional differences in WASH need. The overall WASH PiNs per district are shown in figure 15. Maps of selective PIN sub-scores are included in Annexes 2-7.

[92] Somalia WASH Cluster. 2020. WASH Sectoral PIN. Humanitarian Needs Overview (HNO) 2021.
[93] The complete analytical method is available by contacting the cluster team.

Figure 15: WASH PiN 2020 per district

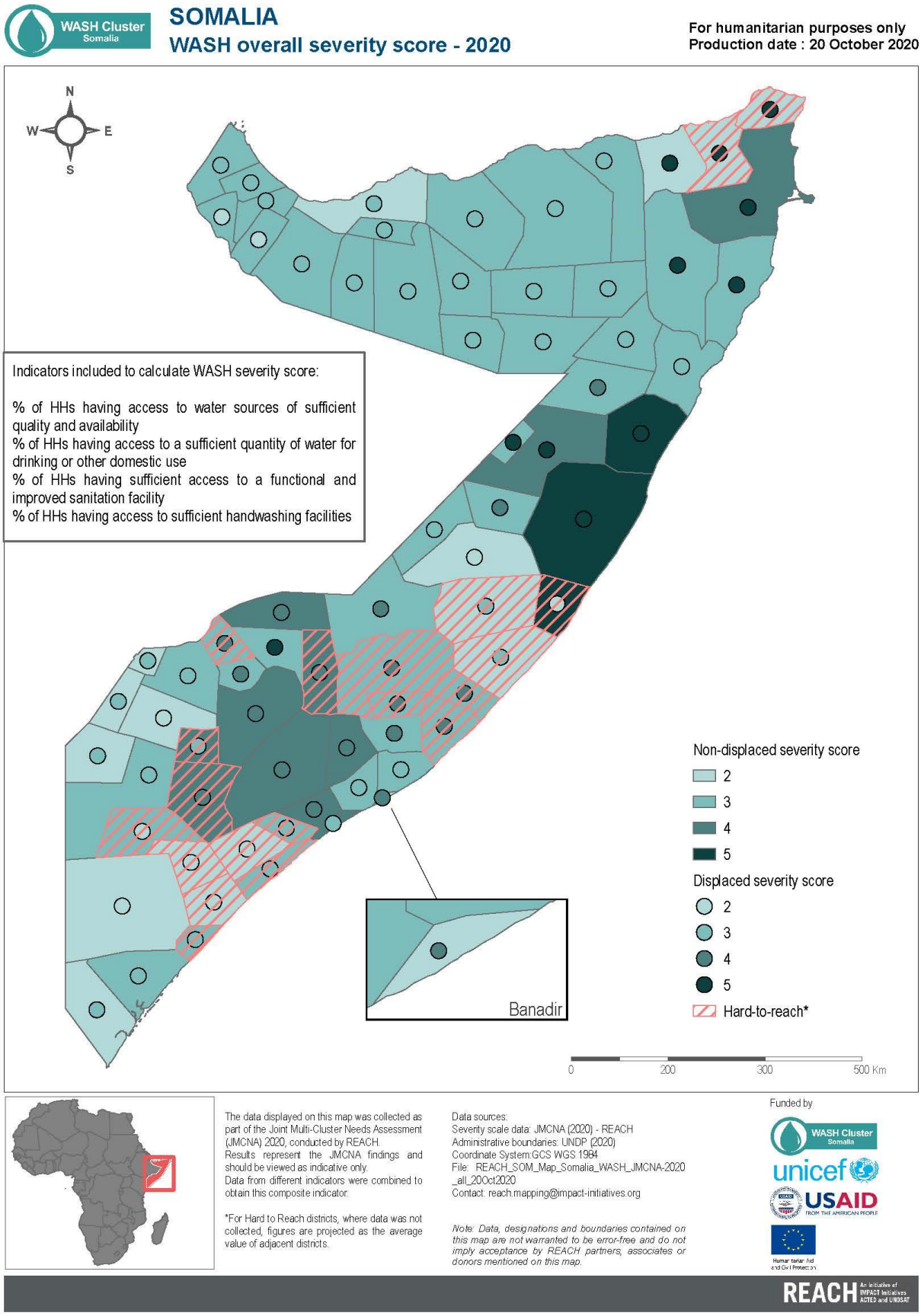


The PiN figures saw a significant increase compared to last year. The overall PiN increased from 2.7 to 4.5 million (urgent PiN increased from 0.2 to 2.3 million) while humanitarian conditions generally did not change as drastically. The main reason for this change in numbers is a slight change to the methodology. The calculation of the household-level severity score shifted from the median of all sub-pillar severities to the mean of the 4 highest sub-pillar scores. As a result, only one sub-pillar with a high severity score will influence the overall household severity score much more with the new methodology. Because the mean only uses the 4 highest sub-pillar scores, the WASH Cluster opted to keep only the most important indicators.

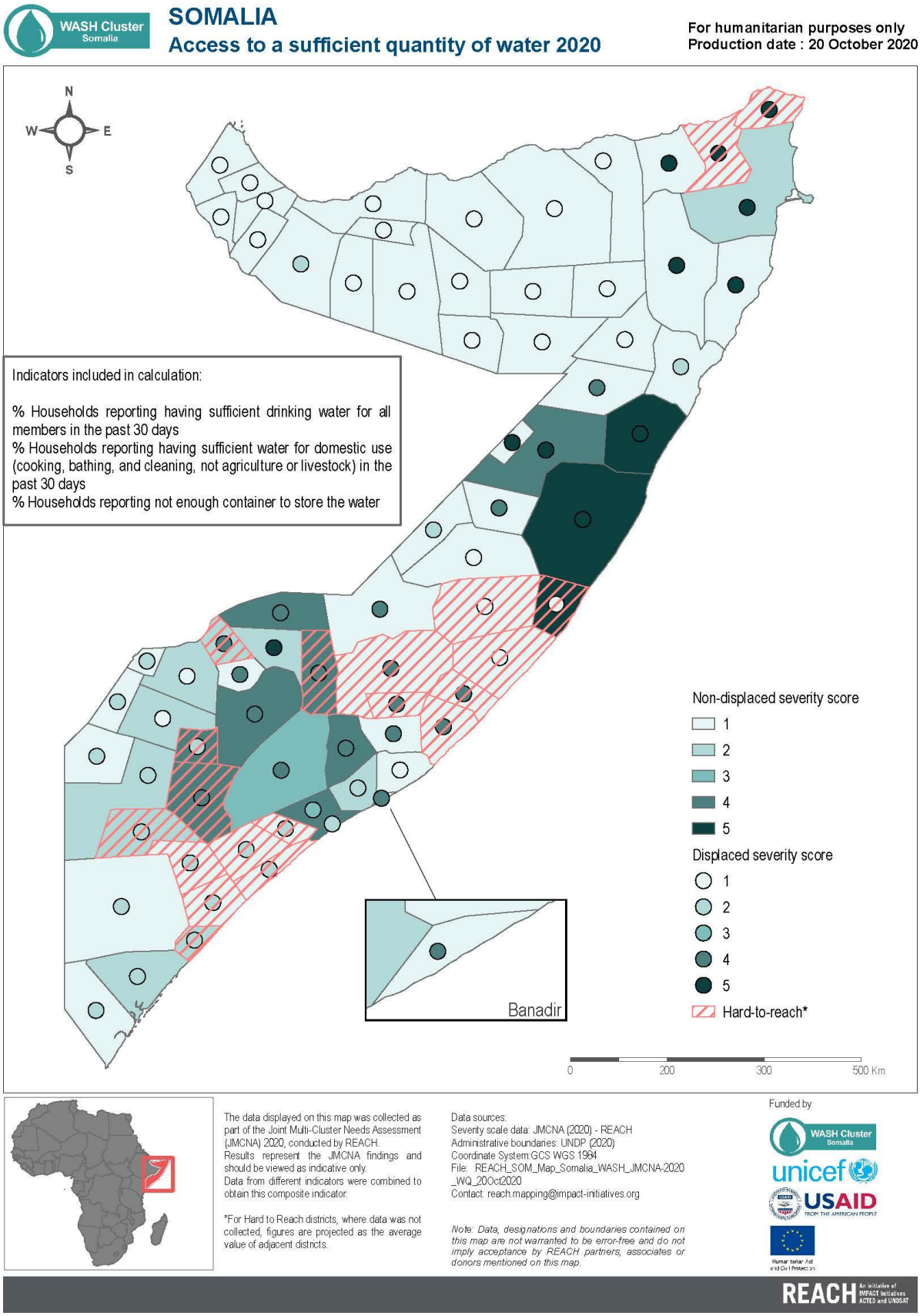
Annex 1. Indicators, sub-pillars, and pillars used in the WASH sectoral PIN.

Pillar	Sub-Pillar	Indicator	Source
Living Standards	Access to an improved water source	% Households reporting accessing an improved primary water source for drinking water in the past 30 days	JMCNA
		% Households reporting presence of improved water source reachable in less than 30 minutes of travel total (by walking)	JMCNA
	Access to a sufficient quantity of water	% Households reporting having sufficient drinking water for all members in the past 30 days	JMCNA
		% Households reporting having sufficient water for domestic use (cooking, bathing, and cleaning, not agriculture or livestock) in the past 30 days	JMCNA
		% Households reporting not enough container to store the water	JMCNA
	Access to adequate, appropriate and functional sanitation facilities	% Households reporting use of sanitation facilities, by type of facility	JMCNA
		% Households reporting using personal latrines	JMCNA
		% Households reporting sharing latrines with more than 3 households	JMCNA
	Access to functional handwashing facilities and soap	% Households reporting having soap at home or having daily access to soap	JMCNA
		% Households reporting availability of water and soap at latrines	JMCNA

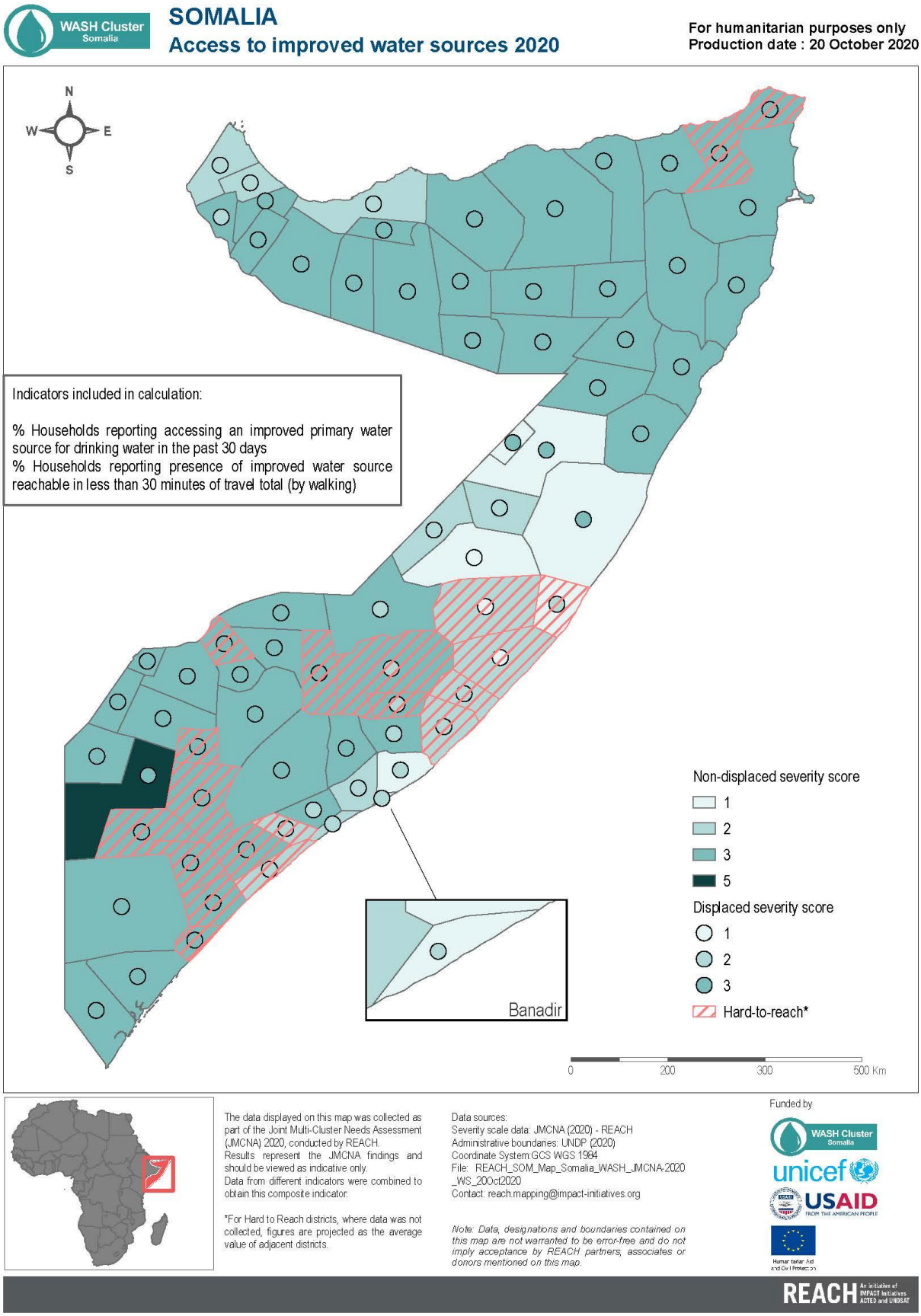
Annex 2. WASH sectoral severity score by district and displaced and non-displaced population.



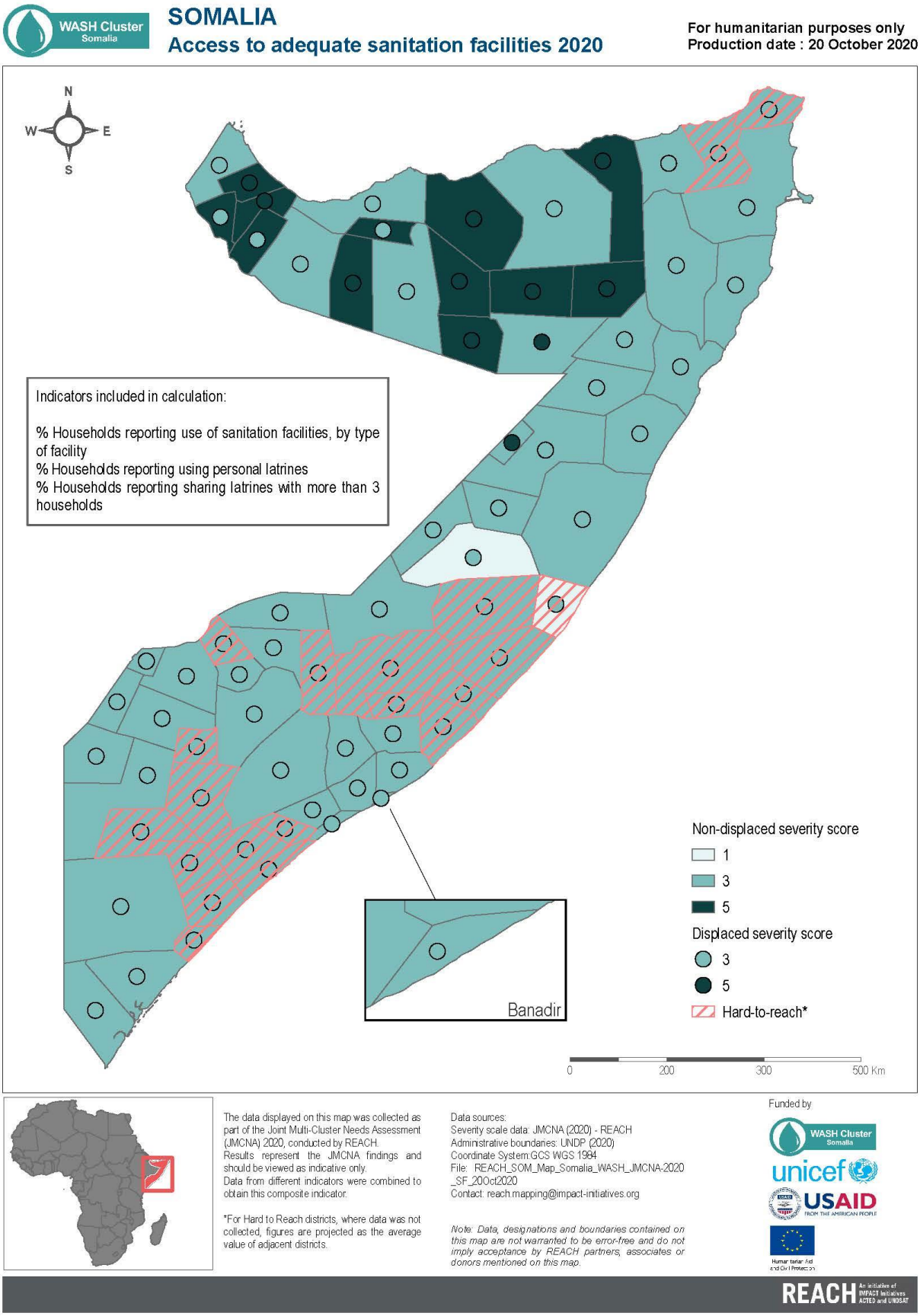
Annex 3. Access to a sufficient quantity of water severity score by district and displaced and non-displaced population.



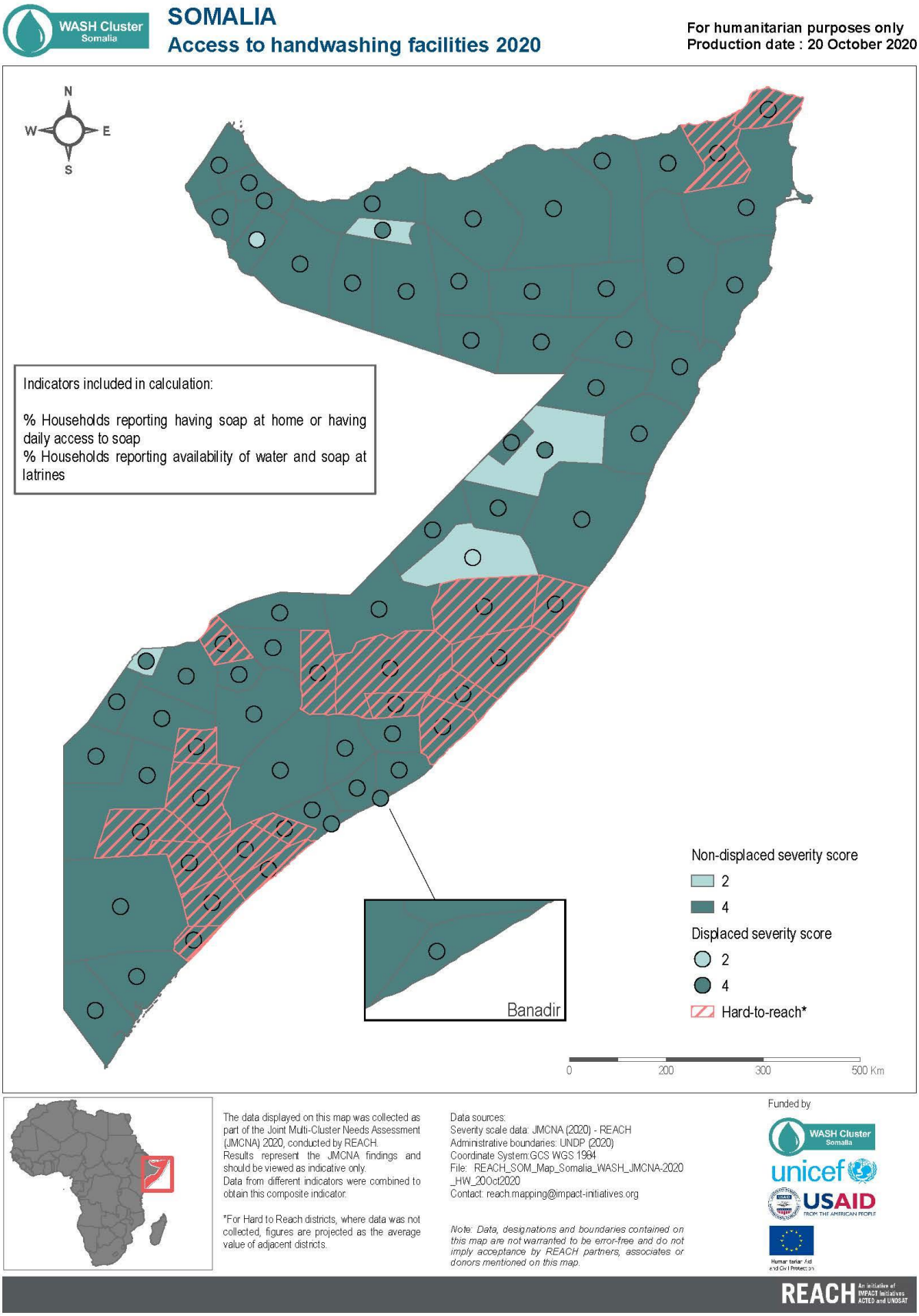
Annex 4. Access to improved water sources severity score by district and displaced and non-displaced population.



Annex 5. Access to adequate sanitation facilities severity score by district and displaced and non-displaced population.



Annex 6. Access to handwashing facilities score by district and displaced and non-displaced population.



Annex 7. WASH Safety Score PIN by district and displaced and non-displaced population.