Multisectoral Needs Assessment Report
Southwest State, Somalia
Drought Crisis

July 22, 2022

Sector(s): Health (PHC & RH), Nutrition, Environmental Health, ERD and Protection (WPE)

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INTRODUCTION AND JUSTIFICATION

Over 80% of Somalia faces severe or extreme drought, leading to food insecurity and malnutrition across many parts of the country, with no significant rains expected until October. More than 7 million people are affected, up from 6.1 million in May, with over 918,000 displaced due to shortages of food, water, and viable pastures.[1] Women and children constitute 82% of those displaced since October 2021. There are now 17 areas facing a heightened risk of localized famine if crop and livestock production continue to fail, prices of commodities continue to rise, and humanitarian assistance fails to reach the most vulnerable people.[2] For the first time since 2017, pockets of "catastrophic" food insecurity have been confirmed, affecting more than 213,000 people.[3] According to the latest International Organization for Migration (IOM) Displacement Tracking Matrix (DTM) analysis, drought conditions could imminently displace over 1 million people in Somalia, on top of the 2.9 million already displaced prior to the current drought crisis. Alarming projections suggest that up to 1.4 million people could be displaced within the next 6 months.[4]

Southwest State (SWS) is among the places hardest hit by the drought, with projections that conditions will continue to deteriorate further and faster over the next 2-3 months. The Protection Cluster estimates that since January, over 250,000 people have been displaced from their rural villages to Baidoa due to a combination of drought and insecurity; 80% of those displaced during this period live in makeshift shelters and are living in conditions that are highly conducive to safety issues, as well as the spread of communicable disease. In Baidoa, health and nutrition partners are already reporting a surge in disease outbreaks, notably acute watery diarrhea(AWD)/cholera and measles, among both IDP and host populations.

[1] Somalia: The Cost of Inaction, July 2022
[2] Somalia: The Cost of Inaction, July 2022
[3] SOMALIA : IPC Risk of Famine Snapshot I May - September 2022
[4] IOM Displacement Tracking (DTM), Somalia Drought Analysis, January 2022

With drought conditions severely limiting availability and access to food throughout SWS, rates of malnutrition have increased significantly. One international partner, in collaboration with state health teams, screened 10,829 children during the month of May and found that 1,226 had SAM, a staggering 11.3%. 365 were admitted for inpatient care, a marked increase from the 193 cases just the month before, in April 2022. However, even in the face of such massive need, the same partner recently had to close two blanket supplementary feeding sites and two maternal and child health sites due to funding shortfalls[5]. Partners and state government have been reporting a similar lack of basic services across all sectors, including health, water, sanitation and hygiene, protection, and education, in large and rapidly growing IDP sites across SWS. On June 20, Southwest State authorities appealed for a scale-up of emergency assistance to new IDPs, especially in Baidoa town, noting that over 500 IDPs arrive in the town weekly to join crowded sites where basic services and infrastructure are overwhelmed, and in some cases nonexistent. Baidoa town already hosts the vast majority of IDPs in the Bay region (94-97%), which is suggests that IDPs in this and neighboring regions will likely continue to move to this central urban location.[6]

In light of the above, IRC and GREDO, IRC's partner in Baidoa, have carried out a rapid multisectoral emergency needs assessment in two hard-hit districts in Southwest State in order to better understand the needs of the affected populations and the current gaps in health/nutrition and GBV service provision, food security, and water and sanitation.

Assessment Objective(s)

1. Determine which needs the affected population prioritizes in terms of both severity and urgency.
2. Identify current gaps in delivery of lifesaving services to the drought-affected population.
3. Inform the development of a Response Strategy that addresses the most urgent humanitarian needs/gaps in South West State, Somalia.

Core Assessment Questions

- What are the needs of the affected population?
- What are the main barriers to accessing humanitarian services?
- What state are the markets in currently, and can existing markets be leveraged to provide the required goods/services?
- What are the main health concerns within the assessed communities?
- What are the most appropriate modalities to deliver the required humanitarian services?
- What is the best way to continue to engage and communicate with the affected population?

[5] **SOMALIA**: Drought response and famine prevention: Situation Report No. 8

[6] DTM Baseline, 2020 & CCCM Cluster/REACH Initiative, Detailed Site Assessment, 2021

METHODOLOGY

Tools and Sampling

This rapid multisectoral emergency needs assessment was conducted in the Baidoa and Hudur districts of Southwest State, where drought-affected communities are living in IDP camps and host communities. (See Annex, 2a.) The assessment employed mixed methods of quantitative and qualitative data collection (see Figure 1), over the course of a five-day period from July 5-10, 2022.

Quantitative data was collected via a household (HH) questionnaire. Using the IRC's emergency needs assessment cluster sampling guidance, 210 households (32% IDP, 68% host community) across the two districts were selected, and an adult representative from each household was interviewed (59% female, 41% male). In addition, Key Informant Interviews (KIIs) were administered with a range of healthcare workers (5), community/camp leaders (11), and market traders (8 wholesalers and retailers) to better understand the needs and priorities within their communities and assess gaps in service provision.

IRC/GREDO team in new IDP camps in Baidoa, July 2022

In complement, qualitative data was collected through 16 focus group discussions (FGDs) conducted with gender-segregated groups (8 with men and 8 with women), comprised of 8-12 community members from the selected locations. Focus Group Discussions included diverse community stakeholders, including at-risk, elderly, and minority groups, as well as participants residing in different areas of the camps. A Health Facility Mapping tool was also used to assess the current state of (5) health facilities serving these communities.

GREDO identified and trained 17 enumerators on assessment tools and methodology, including 5 female enumerators to facilitate FGD and KIIs with women, thus gaining more accurate and nuanced understanding of the female experience in this context. Data was encoded using a combination of Kobo Collect and Excel. GREDO was responsible for data collection and support to field teams, while IRC oversaw data quality assurance, data analysis, and reporting.

The tables below outline the assessment tools used, the locations assessed, and the breakdown of the methods used in each sector and location.

FIGURE 1. Assessment tools (included in the Annex section):

Type of data collection	Tool	Audience
Key Informant Interviews	Key Informant Interview Guide (qualitative/quantitative)	Healthcare workers
	Key Informant Interview Guide (quantitative)	Market vendors/traders
	Key Informant Interview Guide (quantitative)	IDP camp and host community leaders
Focus Group Discussions	Focus Group Discussion Guide (qualitative)	Female community members (IDP & host community)
	Focus Group Discussion Guide (qualitative)	Male community members (IDP & host community)
Observation	Health Facility Mapping Form (quantitative)	Health facilities
Household/Individual Survey	Questionnaire (quantitative)	Community households (IDP & host community)

FIGURE 2. Assessment methodologies and sample sizes, by sector:

Sector	Methodologies & sample sizes			
	HH	KII	FGDs	Observation
Health (PHC and RH)	210	5	16	5
Nutrition				
WPE		11		
ERD		8		

FIGURE 3. Assessment activities, by assessment location:

Location details				FGDS		KIIS				Observation
Region	District	Locations	Type	ERD, Nutrition, Health & WPE (Men)	ERD, Nutrition, Health & WPE (Women)	Community/ Camp Leader	Wholesale Traders	Retail Traders	Healthcare Workers	Health Facility Mapping
Bakol	Hudur	Bulow	Urban	1	1	1			1	1
Bakol	Hudur	Moragabey	Urban	1	1	1			1	1
Bakol	Hudur	Abal IDP	IDP Camp	1	1	1				

Bakol	Hudur	Howlcade IDP	IDP Camp	1	1	1				
Bay	Baidoa	Juwaare IDP	IDP Camp			1				
Bay	Baidoa	Allaweyn IPD	IDP Camp	1	1	1			1	1
Bay	Baidoa	Waraajin IDP	IDP Camp	1	1	1				
Bay	Baidoa	El-Cadow	Rural	1	1	1			1	1
Bay	Baidoa	Awdiinle	Rural	1	1	2			1	1
Bay	Baidoa	Geldheere	Rural			1				
Bay	Baidoa	Baidoa Market	Market				2	2		
Bakol	Hudur	Hudur Market	Market				2	2		
Total				**8**	**8**	**11**	**4**	**4**	**5**	**5**

Limitations

- **Child protection and education**: While the assessment was multisectoral, logistical constraints, notably time and budget, limited the number of sectors that could be covered in depth. Sector prioritization was based on a combination of secondary data, partner recommendations, and IRC strategic priorities, and informed by the Somalia Country Programs technical expertise, existing program sectors, and Strategic Action Plan (SAP). Significant needs and service gaps emerged during data analysis related to child protection and education in particular, further reinforced by anecdotal reports and shifts in context. However, limitations in data collection did not allow for detailed assessment in these areas. Additional primary data and partner mapping would be required to inform intervention in either sector.
- **Adolescent girls**: Girls between the ages of 10 and 19 years have unique needs, notably in the areas of reproductive health and protection. Though assessment tools were designed to draw out information specific to this important subgroup, these nuances were lost during data collection: for example, if numerators skipped over/sped through the questions pertaining to adolescent girls, if they asked the questions but respondents failed to provide an appropriate answer, or if this perspective was lost during incomplete data entry. As a result, data analysis does not accurately capture the perspectives or experiences of adolescent girls.
- **Restricted access:** due to insecurity in and around the assessed areas, IRC/GREDO enumerator teams were not able to conduct surveys/interviews in all relevant communities / IDP sites. The findings in this report therefore do not reflect the needs/experiences of these populations, which likely differ substantially from less access-restricted households.
- **Comparison across groups**: Two major groups participated in this assessment, drought-affected IDPs and drought-affected host communities. Being able to compare these groups and analyze the disparities between the displaced and host population's living conditions, health status, service access, etc., would

be extremely useful to be able to improve targeting, tailor advocacy efforts, and better understand any strain on the social systems and dynamics that may have been created by the sudden influx of people. However, this would have required broader coverage (i.e. larger sample sizes) in order to be properly powered to be able to compare the two groups in a valid way. This was beyond the scope of this assessment, in terms of both time and budget. Data was collected from both groups, but it is important to remember that, at the analysis phase, no valid comparison across the two groups is possible.

Ethical Considerations

- Prior to each interview, the emergency assessment team member conducted a thorough informed consent process. S/he explained to the participant who IRC and GREDO are, why they were conducting interviews, the uncertainty of IRC and GREDO's ability to intervene, the confidentiality of the interview, and that the assessment did not represent a commitment by either IRC or GREDO to intervene or provide assistance. The interviewee was then always provided with the option to decline the interview, with assurances that it would in no way negatively affect his/her likelihood of receiving assistance from the organizations in the future.
- Given the safety and ethical considerations of discussing protection concerns, the team adjusted the way these questions were framed according to the audience, or developed more acceptable proxy questions to learn more about protection concerns without creating stress, impacting dignity, or creating unsafe situations for participants.
- As the IDP population had potentially experienced displacement-related distress in the very recent past, the assessment team carefully considered the best ways to learn more about protection issues without inadvertently causing further stress to the affected population. This was especially critical knowing that psychosocial support services are not widely available in the assessment locations.
- To this point, assistance has been scarce and sporadic or poorly coordinated, at best. The assessment team took into careful consideration the implications of their presence and the expectations that may create for immediate help. The informed consent that proceeded all data collection therefore clearly stated that no assistance would be given at that time, or on the basis of participation in the assessment.
- All results of the assessment, including the report and the data will be considered a common good of the humanitarian community and will be shared with all humanitarian actors.

KEY FINDINGS

To properly frame the findings, it is important to have an accurate picture of who provided the responses that have been analyzed below. For the breakdown of FGD and KII locations and participants, see FIGURE 3 in the Tools and Sampling section, above.

FIGURE 4: Basic demographic breakdown of households surveyed

Basic demographic breakdown of households surveyed					
Location (district)	**Cluster type**	**IDP HHs vs. host community HHs**	**Gender of respondents**	**Age range of respondents**	**Average HH size**
Hudur district: 161 / 210 (77%) ***Baidoa district***: 49 / 210 (23%)	***Urban: 18*** ***Rural: 4*** ***Camp: 8***	***IDP***: 68 / 210 (32%) ***Host community:*** 142 / 210 (68%)	***Female:*** 125 / 210 (59%) ***Male:*** 85 / 210 (40%)	***18-49 years***: 74% ***50+ years***: 26%	7.73 persons

Food Security

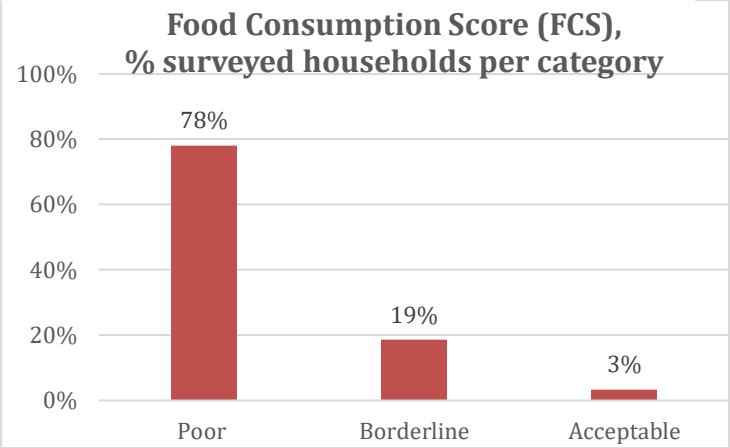
With below average precipitation and an early end to this most recent Gu[7] 2022 season, this June marks the fourth consecutive failed rainy season in Somalia. This prolonged and recurring drought is the major driver of acute food insecurity in the country, compounded by other major drivers such as desert locust infestation, disease outbreaks, the impacts of the COVID-19 pandemic, and more recently, the fuel crisis linked to the conflict in Ukraine. The situation, which has already reached historic levels, is expected to further deteriorate in the coming months if the Gu season crops and livestock production fails.[8] (see map, Annex 2b.)

The food security situation in Bay region, where the IRC/GREDO conducted its rapid multisectoral emergency needs assessment, is particularly concerning. The threshold for Famine (IPC Phase 5) is comprised of three criteria, two of which must be met for Famine to be declared. Currently, one of the three has already been breached: the rate of acute malnutrition in Baidoa district has surpassed the threshold for Famine (IPC Phase 5). The crude death rate has reached the Emergency threshold (IPC Phase 4) in Bay Agropastoral of Burhakaba and Baidoa districts, and death rates among children have reached the Emergency threshold (IPC Phase 4) in Bay Agropastoral of Baidoa district. This increase in acute malnutrition levels and mortality may not yet technically rise to the level of Famine, but it is a clear indication that loss of life and livelihoods is already a reality.[9]

[7] ***Jilaal***: *a warm, sunny and dry season from December to mid-March.*
Haggai: *a cool, dry and rather cloudy season starting in July and lasting until mid-September*
Gu: *main rainy season starting in mid-March and running to June.*
Deyr: *the secondary rain season, from October to December.*
[8] **SOMALIA :** IPC Risk of Famine Snapshot I May - September 2022
[9] **SOMALIA :** IPC Risk of Famine Snapshot I May - September 2022

The data from the IRC/GREDO assessment demonstrates in stark and distressing detail the severity of the food security crisis and the urgency of the humanitarian needs in the assessed locations. For example, nearly 80% of all surveyed households indicated that they do not have access to sufficient food, as measured by the Food Consumption Score (FCS). The Food Consumption Score is a "composite indicator that measures dietary diversity, food frequency, and the relative nutritional importance of food groups based on a seven-day recall of food consumed at household level".[10]

FIGURE 5: Food Consumption Score (FCS), % surveyed households per category



The average FCS among surveyed households was 18.72 **(**0-28: Poor; 28.5 – 42: Borderline; >42: Acceptable).[11] Only 3% of surveyed households had an "Acceptable" FCS, while the other 97% fell into either the "Borderline" FCS category (19%) or "Poor" FCS category (78%). Households in the "Poor" and "Borderline" categories are considered food insecure and are at significant risk of caloric and nutrient deficiencies and the myriad health risks associated.

Some 63% of households surveyed said that their family does not have any food stocks at all. Of those with some food stocks, 90% said that their stock of cereals would be depleted in less than two weeks. When asked about the top reasons they are unable to access sufficient food, the number one reason respondents cited was prohibitively high food prices (42%), and number two being the death of livestock (23%), which equals both loss of sustenance and income. Beyond these top-cited reasons, there is a long and varied list of additional reasons given by respondents, demonstrating the devastating confluence of drought-related factors currently impacting the population's food security.

FIGURE 6: Top reason(s) for insufficient food access

Top reason(s) for insufficient food access			
Reason #1		**Reason #2**	
Prices too high	41.72%	Livestock have died	23.31%
Not enough land	15.34%	No relief aid distribution	17.79%
Unsafe to access land	12.88%	Prices too high	15.34%
Crops destroyed	9.82%	Not enough land	12.27%
Livestock have died	6.75%	Growing season too short	11.04%
No relief aid distribution	4.91%	Unsafe to access land	8.59%
No functioning market	4.29%	Crops destroyed	6.75%
Growing season too short	3.07%	No functioning market	3.68%
Crops stolen	0.61%	Crops stolen	0.61%
Crops destroyed by conflict	0.61%	Crops destroyed by conflict	0.61%

83% of households surveyed noted changes in their primary food source in the past 6 months, with the

[10] Food Security Cluster Indicator Handbook, Food Consumption Score (FCS) Section

[11] NOTE: standard FCS thresholds are 0-21: Poor; 21.5-35: Borderline; >35: Acceptable. Based on guidance from the IRC's Economic Recovery and Development team, the thresholds used in the analysis of the SWS needs assessment data have been adjusted to account for high consumption of sugar and oils, which leads to overestimation of household food security.

most frequently mentioned changes being a reduction in the amount of food available, as well as marked reductions in the quality and variety. By far the most commonly cited cause of this change was the drought (147 HHs), followed by price increases (88 HHs), and conflict (62 HHs), though many respondents referred to a combination of factors that have led to these changes.

Households are using a variety of coping strategies to deal with the deteriorating food insecurity situation. The Reduced Coping Strategies Index (rCSI) is used to measure these coping mechanisms and can serve as a proxy indicator of household food insecurity. It looks at both the frequency and severity of five pre-selected coping strategies that the household used in the seven days prior to the survey.[12]

The coping strategies included in rCSI are:

- ***Buying less expensive food***: used by surveyed households an average of 3 days in the past week
- ***Reducing the number of meals per day***: used by surveyed households an average of 2.5 days in the past week
- *Reducing the size of meals*: used by surveyed households an average of 2 days in the past week
- ***Borrowing food from friends/family***: used by surveyed households on average of 2 days in the past week (considered more severe, weighted accordingly in rCSI calculation)
- ***Having only children eat if not enough for all members of the household***: used an average of 1.5 days in the past week (considered more severe, weighted accordingly in rCSI calculation)

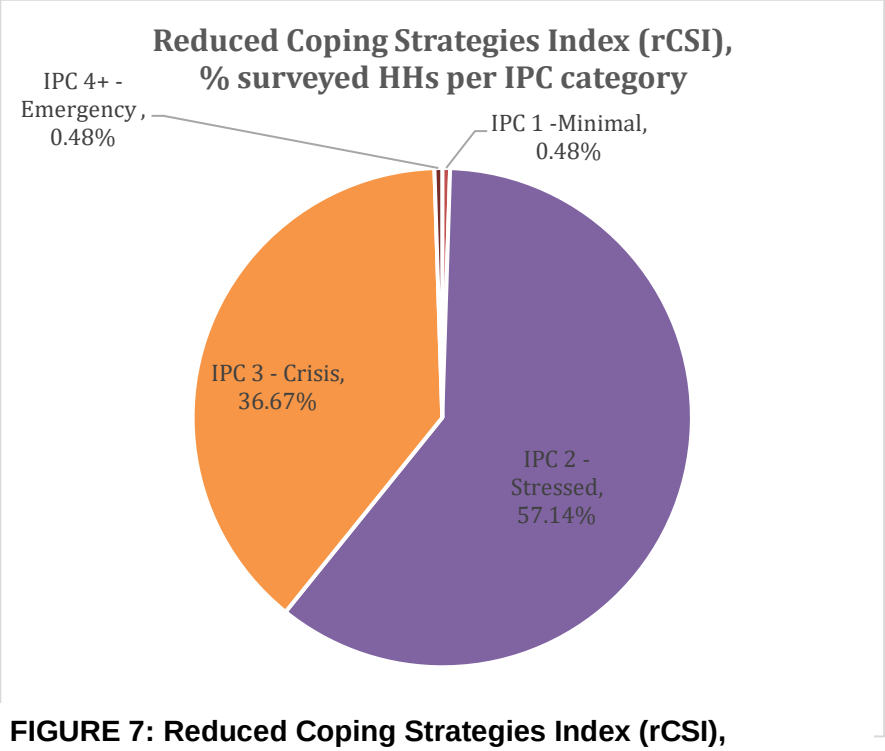


FIGURE 7: Reduced Coping Strategies Index (rCSI), % surveyed HHs per IPC category

The average rCSI score among of surveyed households was 16.75, which corresponds to the “Stressed” (IPC 2) food security category. Based on their household scores, 57% of households fell into this “Stressed” (IPC 2) food security category, and 37% of households in the “Crisis” (IPC 3) food security category. Several households (<1%) fell into the “Emergency” (IPC 4) food security category.

[12] Food Security Cluster Indicator Handbook, Reduced Coping Strategies Index (rCSI) Section

Tthe Household Hunger Scale (HHS) was also deployed as part of the household survey.[13] Notably, a large majority (83%) of households indicated that at some point in the past 30 days, there was no food of any kind to eat in their home due to lack of resources. An even higher proportion of households (85%) indicated that in the past 30 days a family member(s) had gone to bed hungry. Slightly less than half of households (45%) reported having a family member who had gone an entire day with no food at all at some point in the past 30 days.

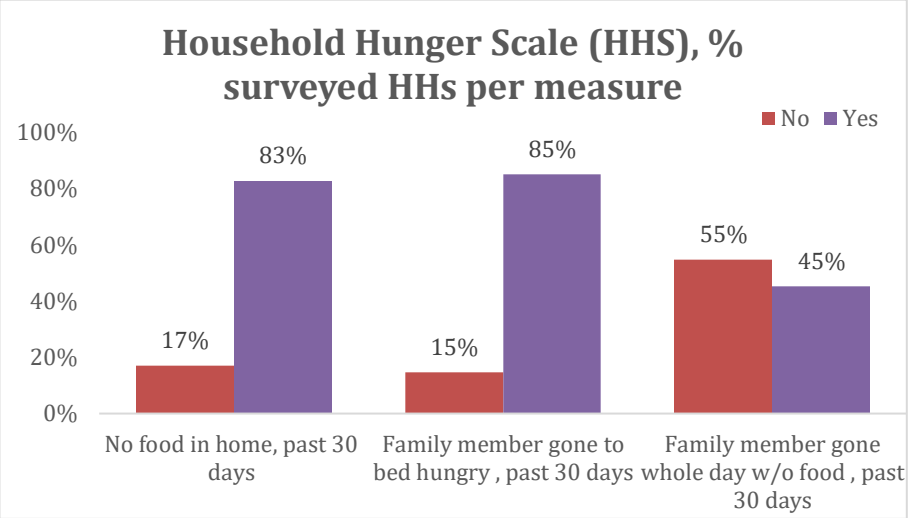


FIGURE 7: Household Hunger Scale (HHS), % surveyed HHs per measure

Each of these food security indicators/proxy indicators has its strengths and drawbacks. For example, rCSI is strongest for monitoring purposes, particularly in early stages of a crisis. The indicator becomes less accurate for severe and long-term emergencies where households have already run out of many food coping options. In these situations, which includes the current situation in SWS, rCSI can yield results that overestimates the number of households categorized as food secure.[14] The IRC/GREDO assessment therefore deployed multiple measures in the household survey in order to be able to triangulate findings and compile the most accurate picture possible of food security in the surveyed areas. In this case, all indicators point to an extremely dire situation that requires immediate humanitarian action to avoid excess morbidity and mortality (see Recommendations section).

Livelihoods

With agriculture as the most common source of income among surveyed households (125 HHs), the direct and devastating effect that the drought has had on respondents' livelihoods is immediately apparent in their survey responses. Other frequently mentioned sources of income for this population include casual labor (106 HHs), small business/trading (98 HHs), pastoralism (97 HHs), and agro-pastoralism (86 HHs), often in combination (i.e. multiple sources per household) to cover basic needs. Overall, 59% of respondents have lost income in the past 6 months–1 year, whether it was their farm, herd of livestock, small business, or casual labor job.

Households are taking measures to cope with lost income, including selling livestock, household items, and reducing expenditures – the top 3 most frequently mentioned strategies. Some families have also sent family members to live elsewhere until such a time that they were better able to provide for their basic needs. Others indicated that they are engaged in risky activities to try to make ends meet. Further inquiry is needed to better understand the specific types of risks these respondents are referring to. Some 40% of

[13] Food Security Cluster Indicator Handbook, Household Hunger Scale (HHS) Section

[14] Food Security Cluster Indicator Handbook, Reduced Coping Strategies Index (rCSI) Section

households have accessed credit as another way to cover basic needs, most commonly food, rent (land), healthcare costs, and school-related expenses.

For farmers, access to land and agricultural assets is highly constrained, with 71% of households surveyed indicating that they do not have access to land for cultivation and 80% unable to access agricultural assets. While it's likely that access to land has been negatively impacted by the drought as more and more land becomes inarable and access to agricultural assets negatively impacted by the reduction in household income for reinvestment, the survey did not explicitly inquire about the underlying causes of the reduced access. Only 49 out of the 210 households surveyed (23%) still maintain any livestock, and of those who do, 80% reported that their animals are either "thin" or "very thin" and produce an average total daily milk yield of only 1.35 liters. Virtually no one (5.7%) in either district is expecting their Gu harvest to yield any crops this year. This kind of shortfall in food production, particularly in a region that is historically the breadbasket of Somalia, would require an increase in imports to fill the gaps, which would in turn drive prices even higher than current levels and intensify pressure on household food access.

With regard to markets, the majority of households surveyed reported having a functional market within 1 hour or less. The availability of food in these markets appears to be highly variable, with cereals, sugar, and oil/fats mentioned as available most frequently, while produce was on the other end of the spectrum, mentioned far less often (fruit only 11 mentions). According to market trader KIs, staples like maize, sorghum, and beans/pulses have not been available at all in certain markets, nearly all of which are located in Hudur district. These KIs also testified that, where these staples are available, prices are generally rising sharply. Some market traders who have had to start sourcing imported goods due to local and national shortages have seen prices jump dramatically, as much as 200% for vegetable oil in the past 3 months in one Baidoa district location.

FIGURE 8: Recent price changes in top food staples

Top 5 staples	Average price change – past 3 months	Average price change – past 1 year
Rice	+ 27.83%	+ 3.34%
Wheat flour	+ 5.40%	+ 18.39%
Pasta	+ 28.15%	+ 12.24%
Sugar	+ 19.63%	+ 10.34%
Vegetable Oil	+ 45.34%	+ 56.10%

The trend in household food expenditure is mixed, with 38% of respondents saying their weekly food expenditure has decreased, while 46% cite an increase. It's unclear from the data collected whether this is due to changes in prices, changes in available household income, changes in other household expenses, contracting debt, or some combination thereof.

To date, livelihoods assistance in both Baidoa and Hudur has been extremely limited; only 27 households (out of 210) had received any form of livelihoods support in the past 3 months, the most common type of support being unconditional cash transfers from NGOs/UN. When asked about the 3 top types of support that their households need to improve their household's food security, vouchers were the most frequent response modality, followed by technical assistance and market linkages.

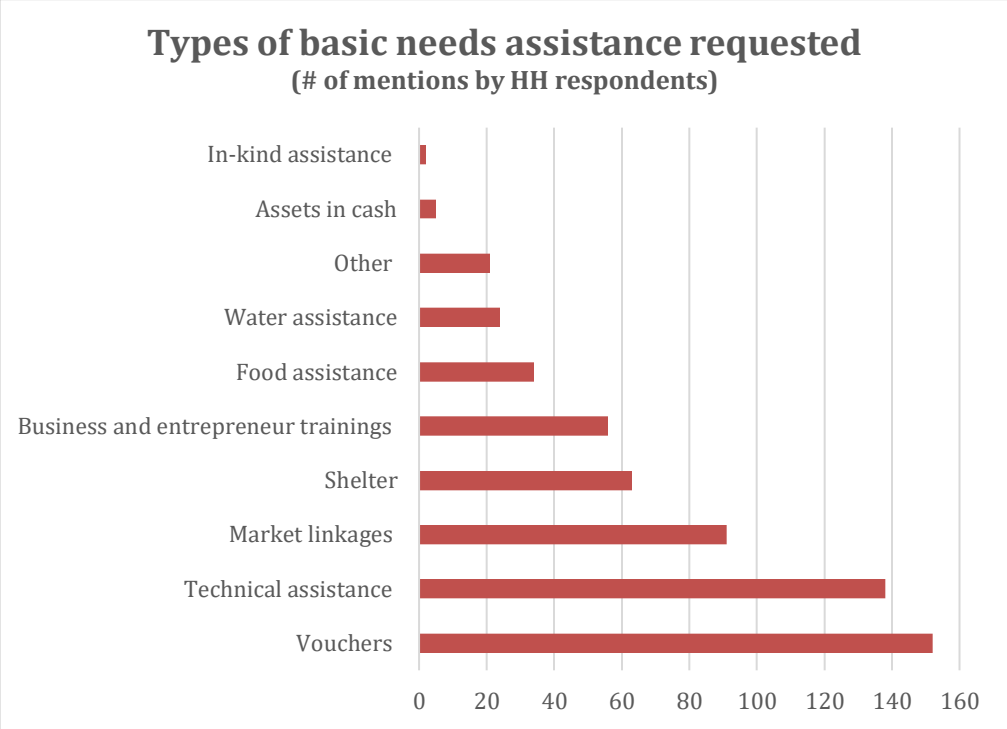


FIGURE 9: Types of basic needs assistance requested by HH respondents

Nutrition

Of the 210 households surveyed, 169 (80%) include members under the age of 5; 89 (42%) include members under 6 months old who are breastfeeding. Children under 5 and pregnant and lactating women (and by extension their breastfeeding infants) are the groups most vulnerable to malnutrition, which in Baidoa and neighboring districts has reached "Phase 4 – Critical" levels.[15] (See map, Annex 2c.)

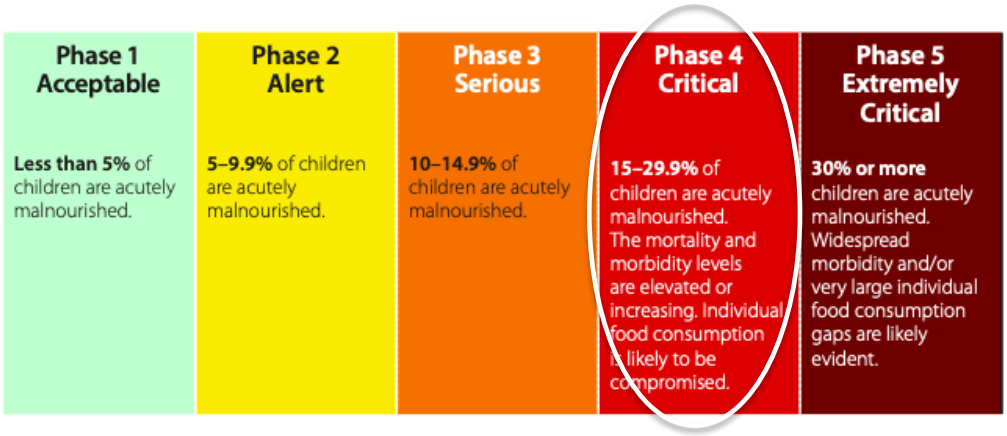


FIGURE 10: Acute malnutrition phases and descriptions
Source: SOMALIA : IPC Risk of Famine Snapshot I May - September 2022

According to an assessment following the 2022 Jilal season (May 2022), the Global Acute Malnutrition (GAM) among children (aged 6-59 months) in Bay Agro-Pastoral and Baidoa IDPs was 26.9% and 20.7%,

[15] FSNAU, Somalia 2022 Jilal food security & nutrition preliminary findings.

respectively, based on the SQUEAC coverage survey methodology. The Severe Acute Malnutrition (SAM) prevalence in Bay Agro-Pastoral and Baidoa IDPs was 8.7% and 4.8%, respectively. This represents an alarming increase from the GAM and SAM rates measured back during the post-Deyr period of 2021.[16]

FIGURE 11: GAM & SAM prevalence, children 6-59 months, Baidoa IDPs and Bay Agro-Pastoral

Season	Post-Deyr 2021		Post-Jilal, May 2022	
	GAM %	SAM %	GAM %	SAM %
Baidoa IDPs	12.3	1.0	20.7	4.8
Bay Agro-pastoral	17.3	2.4	26.9	8.7

These dire rates of malnutrition were reflected in the KIIs with healthcare workers, who routinely cited malnutrition as the most frequent condition presenting at their respective facilities. Although collection/analysis of health facility admission data was not collected during the IRC/GREDO assessment, a peer organization implementing nutrition programming in Baidoa recently shared data that provides anecdotal insight into admissions trends for SAM in the district and much of the region. Between January to June 2022, a Baidoa stabilization center run by Save the Children saw 1435 admissions into the clinic, which represents a twofold increase over admissions during the same period in 2021. June's admissions for SAM with medical complications were four times higher than even just 5 months prior, in January 2022.[17]

FIGURE 12: 2021/2022 year-over-year admissions and death, Baidoa stabilization center (partner)

2022	January	Feb	March	April	May	June
New admissions	118	139	190	193	324	471
Death	1	1	2	4	8	18
2021						
New admissions	97	87	105	77	119	138
Death	2	2	2	2	5	5

SOURCE: SOMALIA: Rise in Severe Malnutrition Cases Sees 300% Surge in Children, July 7, 2022

Key informant healthcare workers also confirmed that health facilities are seeing high rates of diarrheal disease, including AWD and suspected cholera, as a result of intensifying drought conditions that have severely limited access to safe water and sanitation in the area. The combination of AWD/cholera and

[16] Semi-Quantitative Evaluation of Access and Coverage (SQUEAC) Survey Report Conducted in Baidoa District, Bay Region, Southwest State, Somalia, 11th May-14th June 2022
[17] SOMALIA: Rise in Severe Malnutrition Cases Sees 300% Surge in Children, July 7, 2022

malnutrition results in high rates of infection and often fatal outcomes for children under 5. The cyclical and deadly relationship between AWD/cholera and malnutrition can rapidly escalate and requires swift humanitarian intervention to prevent large-scale excess morbidity and mortality (see Recommendations section).

Health

The protracted drought in the Bay and Bakool regions has had profound impacts on the health of the affected populations. This includes both direct physical consequences of not having sufficient food and water (e.g. malnutrition, infectious disease outbreaks), as well as indirect consequences, such as displacement, interruption of basic services, etc., which have associated health effects of their own.

The most frequent conditions currently presenting at health facilities in the area are, according to healthcare worker KIIs, malnutrition, diarrheal diseases, and malaria. The household survey portrayed a very similar burden of disease among the households interviewed:

FIGURE 13: Households with members suffering from disease in past 2 weeks

Illness	Households with member(s) with disease in past 2 weeks
Diarrheal disease	123 / 210 households (59%)
Malaria	117 / 210 households (56%)
Acute respiratory infection (ARI)	96 / 210 households (46%)
Cholera	57 / 210 households (27%)
Measles	49 / 210 households (23%)

In the past month, 46 of the 210 households surveyed (22%) reported deaths in the household, 41 of which were children, with stated causes of death that including cholera, diarrheal disease, measles, malnutrition, and respiratory illness.

In terms of health services, the household survey demonstrated that a large majority of respondents (80%) know where to access healthcare when a family member is sick, and most (87%) live within 1 hour or less of some kind of health facility. A significant proportion of respondents (69%) felt that healthcare was generally accessible, however follow-up questions revealed a number of important barriers. The cost of transportation was cited as the number one barrier to seeking healthcare; while in many cases, the

distance may not be objectively far, it is impracticable, or at least a major financial burden, for the many families struggling with household income due to the drought. For the most part, healthcare is available without charge, though 17% of households reported paying for services (unclear whether official consultation fees, cost of supplies/equipment, or prescription costs). Poor quality of health services was also flagged during the household survey as a significant barrier to accessing medical care. While the household survey did not prompt respondents to specify further, key informant interviews with healthcare workers identified lack of medical/nutrition supplies and a shortage of staff as among the top 3 healthcare gaps, both of which directly impact the quality of services provided.

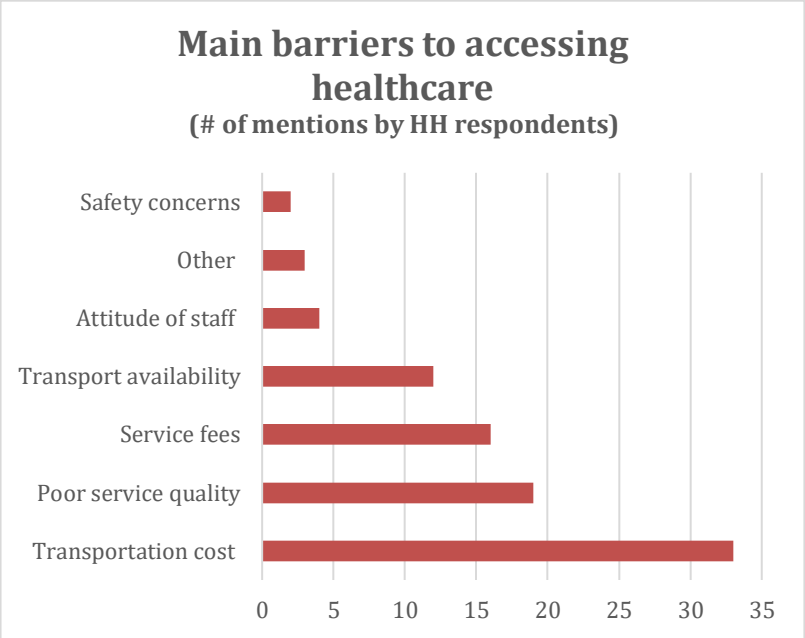


FIGURE 14: Main barriers to accessing healthcare, according to HH survey respondents

During KIIs with healthcare workers, maternity services surfaced as another major gap in healthcare service provision. A number of healthcare workers flagged the gap explicitly, ranking it among their top 3 healthcare issues of greatest concern. With others, this gap became apparent when they were unable to provide data on maternal deaths because no delivery or postpartum services were offered at the facility. The Health Facility Mapping exercise confirmed that only 1 of the 5 facilities assessed is equipped for deliveries. Given the food insecurity context and the fact that maternal malnutrition decreases immunity in pregnant women, increases susceptibility to infectious diseases, and thus increases risk of complications such as congenital malformations, stillbirth, or miscarriage, this gap in maternal care is particularly critical. Moreover, the Health Facility Mapping exercise revealed that the gap extended to reproductive health services more broadly, with only 1 out of 5 assessed

IRC/GREDO team in new IDP camps in Baidoa, July 2022

facilities providing family planning, and 2 out of 5 facilities providing clinical management of rape (CMR) services, treatment of STIs, and safe abortion care.

While all health facilities mapped during the assessment offer routine immunizations (EPI), the household survey had 17% of households reporting not having access to vaccination services. Many vaccine-preventable diseases require high vaccination coverage in order to maintain herd immunity and prevent outbreaks, so with nearly a fifth of respondents reporting that they are not able to keep up with their children's vaccination schedule, there is heightened risk of outbreaks of vaccine-preventable diseases such as measles and diphtheria. This risk is further compounded by COVID-19-related disruptions to vaccination activities throughout the pandemic.

Measles is endemic in Somalia, with hundreds of cases still reported every year, in large part due to persistently low vaccination coverage, estimated at 46% (MCV1) nationally.[18] At least 9,800 suspected measles cases have been reported thus far in 2022 (as of mid-July), which is more than four times the number reported at the same time last year.[19] These cases have been concentrated in drought-affected areas, including Bay region, where Baidoa is located, which reported 1194 suspected cases during the first two months of 2022 alone (January-March).[20] Baidoa hosts the second largest (and rapidly growing) IDP population in Somalia[21], and the conditions in many of the IDP camps/settlements – arid, overcrowded, and poorly ventilated shelters – are highly conducive to the spread of measles and other respiratory diseases. KIIs with healthcare workers indicated that the health facilities in the area continue to see measles cases, with several ranking it as among the top causes of death among U5s in their catchment zone.

Healthcare workers from facilities in both Baidoa and Hudur districts also cited recent cholera outbreaks locally within the past 6 months. Over 6,861 suspected cases of acute watery diarrhea/cholera have been reported nationally in 2022 (as of July 14), which represents a 130% increase as compared to the same time last year. 19 deaths have been confirmed.[22] 2,700 of those suspected cholera cases have come from the South West State health ministry, including 11 deaths in Afgoye, Baidoa and Marka districts (see map, Annex 2d.) While cases remain well below the level of previous major outbreaks in the country (e.g. 2017, 13,000+ cases/per month at peak), the current drought conditions - including food shortages, large scale displacements, and widespread lack of clean water and sanitation – create high risk of rapid spread of waterborne infectious disease. As Ghulam Popal, MD, the WHO's former representative in Somalia, said back in 2017, *"Normally, these diseases are easy to treat and prevent, but they can turn deadly when people are living in overcrowded spaces and are too weak to fight off infection."*[23]

Drought has left several of the assessed health facilities without a reliable water source; others have

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[18] Somalia: WHO and UNICEF estimates of immunization coverage: 2021 revision
NOTE : MCV2 partially introduced in 2021, not included in coverage data as of July 2022. At least 95% vaccination coverage is required to achieve herd immunity against measles.

[19] WASH Cluster Somalia: Drought Update, July 14 2022

[20] https://www.who.int/emergencies/disease-outbreak-news/item/2022-DON371

[21] Semi-Quantitative Evaluation of Access and Coverage (SQUEAC) Survey Report Conducted in Baidoa District, Bay Region, Southwest State, Somalia, 11th May-14th June 2022

[22] WASH Cluster Somalia: Drought Update, July 14 2022

[23] https://www.cidrap.umn.edu/news-perspective/2017/08/continued-measles-spread-somalia-crisis-prompts-who-call-donor-support

insufficient storage capacity to meet UNHCR emergency standards per patient and staff. The Health Facility Mapping exercise demonstrated inconsistent presence of other essential IPC supplies and equipment, as well, including appropriate waste collection bins (3/5), acceptable ash pit (3/5) or functional incinerator (1/5), and autoclave (0/5); only 1 of the 5 facilities visited had documented IPC procedures available. Not a single one of the assessed facilities had isolation capacity for infectious disease cases. With ongoing measles and AWD/cholera outbreaks and conditions prime for numerous other disease outbreaks, the inability to maintain rigorous infection prevention and control practices poses an extreme risk of nosocomial disease transmission, which can rapidly become a driver of community-level spread, particularly in an under-vaccinated, undernourished population.

Environmental Health

Water, or lack thereof, is at the core of the drought crisis. Insufficient quality and quantity of water creates a host of risks, some distal (upstream) and some more direct, but all quite dire in terms of the potentially catastrophic impact on the economic well-being, health, and safety of the affected population.

IRC/GREDO team in new IDP camps in Baidoa, July 2022

In the districts assessed, wells – most frequently unprotected - were the most common water source mentioned by household survey respondents, followed by rainwater. Both source types are extremely vulnerable to drought conditions. At the time of assessment, a mere 25% of respondents surveyed said that they always had sufficient water in their households.

On average, surveyed households collected approximately 64 liters of water the day before, which, given the average household size of 7.73 persons among surveyed households, means that each person, on average, has access to 8.3 liters of water per day. This is barely half of the Sphere minimum emergency standard of 15 liters of water per person per day.[24] Only 44 out of 210 households treat their drinking water before use, and 107 out of 210 store their water in covered containers.

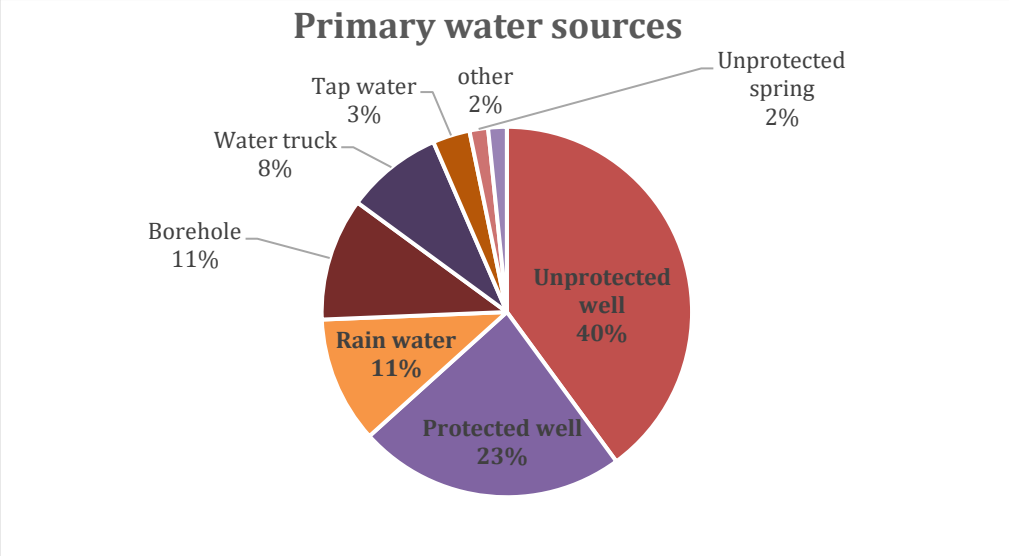


FIGURE 15: Primary water sources accessed by HH respondents

The 75% of households that reported not consistently being able to meet their families' daily water needs cited increasingly long distances to get to functional protected sources, increasingly long wait times as more people have to rely on fewer functional wells, and insufficient funds to purchase water as an alternative. Collecting water requires significant time every day – more than a third of households surveyed said they require 1-2 hours for each round trip to a water source; 18% said it takes them more than 2 hours, the opportunity cost of which is tremendous. Those charged with collecting water – most often women and girls – forfeit hours of their days that could otherwise be spent on incoming-generating activities, schoolwork, etc. Female focus group participants also flagged that any daily activity - collecting

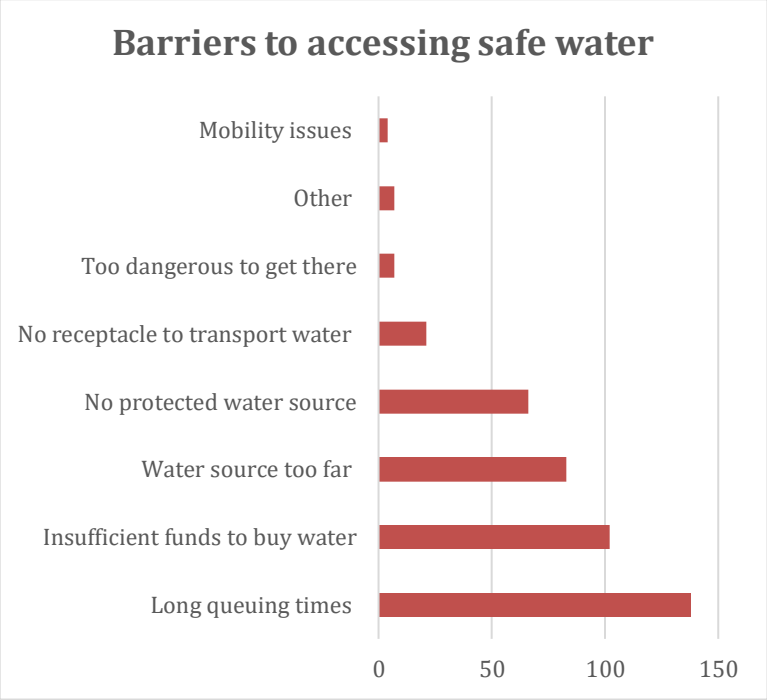


FIGURE 16: Barriers to accessing safe water according to HH survey respondents

[24] SPHERE Handbook, Humanitarian Charter and Minimum Standards in Humanitarian Response, Water Supply, Sanitation, and Hygiene Promotion Chapter

water, gathering firewood, etc. – that requires regularly traveling extended distances in remote/isolated areas puts them at risk of sexual violence.

With regard to latrines, 192 out of 210 of households surveyed (83%) reported having access to a latrine. Approximately half of the households with latrine access have private latrines (93 / 175), while the other half use public latrines (99 / 175). In surveyed IDP camp settings, 64 / 68 households reported having access to latrines, 50 / 64 of which were public. Overall, 18 households (out of 210) reported no latrine access, citing either open defection (15 /18) or unspecified other (3 / 18) as an alternative. The main concern expressed by household survey respondents regarding latrines was the lack of water to clean both the latrines and themselves after use. 170 / 210 respondents also reported no access to soap, largely due to the prohibitive cost. These conditions are favorable for the spread of diarrheal diseases and outbreaks of other excreta-related waterborne diseases, hence the multiple outbreaks of AWD/cholera in the last 6 months alone. Healthcare worker KIs cited diarrheal diseases as one of the top health issues that they see presenting at their facilities, and it constitutes one of the main causes of under 5 mortality in area facilities.

Solid waste management at community level was not flagged by either focus group discussion participants or healthcare worker KIs as a major sanitation concern.

Protection (WPE)

The drought has placed tremendous pressure on a shrinking pool of resources – water, food, access to income – which has forced affected populations to make major changes to their lives in order to survive. For some, this has meant displacement from their homes; for many, finding new ways to earn a basic income, and for others, new approaches to sourcing basic goods and services. These social disruptions place vulnerable groups (e.g. women and girls, children, elderly, the disabled, the chronically ill, among others) at heightened risk of harm because their usual services, support systems, safety nets, and coping strategies are no longer intact.

A number of vulnerable groups were present in the households surveyed as part of the IRC/GREDO assessment (see FIGURE 17, below), underscoring the importance of targeted health and protection interventions that take into consideration the unique vulnerabilities, needs, and access barriers facing these and other minority groups.

FIGURE 17: Number of individuals belonging to vulnerable groups present in surveyed HHs

Vulnerable groups present in surveyed HHs	Number of individuals
Pregnant and/or lactating women	176
Elderly	113
Sick children under 5	110

Unaccompanied or separated children	94
Female heads of household (widowed or divorced)	71
Persons with chronic illnesses	53
Persons with disabilities	42
Persons suffering from psychological distress	19

The IRC/GREDO assessment focused primarily on gaining a better understanding of the protection risks facing women and girls living in Baidoa and Hudur districts. IRC/GREDO plans to conduct additional assessments to understand the needs of other groups, notably children, as soon as is feasible and in the meantime will consult secondary data to ensure proper consideration in integrated response planning.

IRC/GREDO team in new IDP camps in Baidoa, July 2022

An overwhelming majority (94%) of household survey respondents, 60% of whom were female, said that they felt safe in their community. The GREDO assessment team did note, however, that in a number of assessment locations, it was not feasible to maintain privacy during household interviews. In IDP camps, shelters were extremely close together and poorly insulated for sound. In some cases, small crowds gathered around respondents as neighbors assumed that enumerators were conducting some kind of registration. In the urban and rural settings, interviews were conducted in more private household settings, though in some cases enumerators reported back that a number of family members were present while the household representative provided his/her responses. Though impossible to quantify retrospectively, it's important to consider that this may have impacted the positivity of respondents' answers. That being said, a number of female focus group participants, who were in a closed, gender segregated setting, also mentioned that while rape and sexual assault are always a worry, they are actually quite rare occurrences in their communities. As compared to before the emergency, however, several KIs noted that security concerns had increased somewhat. Collecting firewood, water, and other activities on the remote "outskirts" of the towns/camps were the most

frequently mentioned settings for the violence. Women and girls described protective measures that they regularly employ to lower their risk of sexual violence, including traveling in groups and avoiding nighttime movements whenever possible.

The household survey suggested that other forms of GBV are more prevalent within the assessed communities. When asked if they had experienced any form of GBV in their current location, the most frequently mentioned was forced marriage and early marriage (in many instances forced early marriage), followed by intimate partner violence (IPV) and sexual exploitation/abuse by a humanitarian actor or other person in authority. Focus group discussions reinforced the quantitative data, with many women and girls describing incidents where the offenders were known parties, in many cases, members of their own family (e.g. forced marriage, female genital mutilation (FGM), IPV). National GBV data from UNFPA, which shows a rise in GBV overall in 2022, points to higher rates of IPV this year, as compared to last, in particular among food insecure households where tensions are high due to stress about meeting basic needs and having to share resources sharing amongst wider family groups.[25]

With the drought heavily affecting household incomes, many household survey respondents indicated that many women and girls – around 70% - are currently going outside their communities to earn income to meet basic needs. Although respondents were not asked to specify the ages of women/girls working outside the home, if any are indeed children or adolescents, this is generally a red flag of increased risk of more severe forms of child labor and exploitation. Households also reported that intentionally separating families is sometimes used as a coping strategy, with certain family members sent away from the home until they were better able to meet basic needs. Domestic work and collecting firewood/straw were the most frequently mentioned types of work, both of which were also flagged by KIs and FGD participants as areas of potentially heightened risk of sexual violence, abuse, and exploitation.

When asked about services that are available to women and girls in their camp/community, household survey respondents referenced latrines, shelter, and education most frequently. WPE KIIs and some participants in the female FGDs underscored that although latrines are generally available, accessing them is an area of increased risk of sexual violence for women and girls, particularly at night and in camp settings. Household survey respondents noted barriers to accessing other services, notably healthcare. Both household survey respondents and KIIs raised the issue that men are often given priority, resulting in women and girls not receiving the care they need when staff, supplies, etc. are limited.

The availability of GBV services in the assessed locations varied, with 45% of household survey respondents indicating that GBV health services are available in their communities. The psychosocial support (PSS) component of GBV response seems, however, to be largely absent from survivor care; only 12% of household respondents said that PSS services were available where they live. Focus group discussions with women also revealed that stigma remains a significant deterrent for women in seeking

[25] Overview of Gender-Based Violence Situation in Somalia, Advocacy Brief, 2022

GBV support services; women in multiple groups expressed reluctance to either report an incident of GBV or seek care for their injuries and/or trauma due to “shame”/”embarrassment”, as well as concerns about being identified as a survivor.

Additional Sectors: Education & Child Protection

IRC/GREDO team in new IDP camps in Baidoa, July 2022

While neither education or child protection was a stated sector in the assessment plan, some information about children’s schooling and protection came to be known via other assessment activities. For example, the household survey demographic breakdown showed that there were a number of separated and unaccompanied children (94) living in the surveyed households. While there is no additional data to explain how they came to be separated/ unaccompanied, the fact of their presence is an important consideration to note and can be followed up on in future assessments. In a subsequent question on the household survey, sending family members to live elsewhere was listed as a coping strategy to deal with household food shortages, which, if any of these are children or adolescents, raises critical questions about the risks they may face in households that are not their own. Again, this is something that future assessments would assess more deliberately in order to design an appropriate intervention to address the identified concerns.

Malnutrition was the main context in which children, specifically the under-5 age group, were discussed in this current assessment. With Critical levels of GAM and a SAM prevalence of more than 8% in some of the assessed locations, many children are in a heightened state of vulnerability, in terms of not only physical health and development but psychosocial well-being, as well. Child protection must be integrated into the humanitarian response to the malnutrition crisis in order to 1) ensure that the broader, underlying context of children and their families is fully understood and accounted for in nutrition programming 2) reduce harm to children in nutrition programming 3) address protection risks that exacerbate the consequences of malnutrition and food insecurity existing protection risks, and 4) support the adaptation of nutrition programming to avoid barriers to care. Additional data will be required to inform this integration.

The men’s focus group discussions also offered a glimpse into the impact of the drought on education and special needs support services. Though the IRC/GREDO assessment did not collect quantitative data to triangulate the qualitative findings of the focus group discussions, a number of themes emerged very clearly. Firstly, it seems that in both IDP and host communities alike, there are no services, or even

referrals to services elsewhere, for children with special needs - e.g. cognitive disabilities, mobility concerns or other types of physical disability, etc. “They just stay home without any support,” as one participant phrased it. Given the developmental delays and childhood disabilities linked to acute and chronic malnutrition, it can be expected that the demand for these kinds of services will only increase going forward, as the drought crisis deepens and drags on as it is predicted to do.

Secondly, children, in particular those who have been displaced due to the drought, appear to have very limited access to education. It was noted by all of the IDP men’s focus groups (where questions pertaining to education were asked) that there are no schools in the camps and that the town schools are too far for most IDP children to attend. In the host community men’s focus groups, educational opportunities were reported to be somewhat more available, though a number of locations had only religious options (madrasas or duksi) and/or a primary school. When asked about attendance during the emergency, most groups said that attendance rates had dropped because of the economic hardship caused by the drought. In many cases families can no longer afford school supplies and/or fees. Others noted that some students have to work to support their families and/or stay home with younger siblings to allow parents to look for work, which highlights the critical link between education, protection, and basic needs. The drought’s impact on livelihoods not only compromises children’s educational attainment, but can also lead to major child protection concerns around child labor, hazardous working conditions, and sexual exploitation and abuse.

Finally, perhaps the most common, and concerning, explanation for reduced attendance rates was that education is simply no longer being prioritized when families are struggling to meet basic survival needs. Various versions of “a hungry child can’t concentrate and learn” were heard repeatedly in nearly every focus group, accompanied by frustration that very few schools offered feeding programs to combat this issue and support not only students’ continued education and protection, but also, fundamentally, their survival.

RECOMMENDATIONS

Food Security and Basic Needs

- Provide unconditional basic needs cash assistance (Multipurpose Cash) to vulnerable households in IPC 3 and above (using a more updated transfer value recommendation, as the MEB has increased in all regions except Middle Juba, Banadir, Bakool and Lower Juba) in order to support them to meet their food, WASH, health and other basic needs by accessing goods and services available on the local market.
- Provide conditional cash transfer through cash for work initiatives that support households rehabilitate critical community infrastructure and increase their income.
- Provide cash and agricultural inputs to small-holder farmers whose harvests were impacted in order to meet their food needs and have access to the necessary agricultural inputs ahead of planting season.

- Support poor pastoral households with access to emergency livestock feed and, where water is available, support quick fodder production schemes and redistribute to poor pastoral households.

Health (PHC & RH) and Nutrition

Additional assessment

- Map out coverage gaps for health and nutrition services – consider mobile health teams for hard-to-reach villages
- Identify vulnerable demographics such as pregnant/lactating women, children under 5 years, people with disabilities, and geriatric patients and tailoring services to meet the needs of those most vulnerable to the effects of malnutrition, including illness and arrested growth development in children

Programming

- Provide medical supplies and consumables to supported facilities, including nutrition supplies such as RUTF and RUSF
- Train healthcare workers, staff and volunteers on MUAC assessments for rapid screening for malnutrition
- Support Infant Feeding in Emergencies (IFE) through the provision of training, tools and other IFE materials
- Coordinate mass malnutrition screening campaigns monthly to ensure any new arrivals are screened as early as possible
- Strengthen universal IPC measures in all supported facilities, including staff training and supervision, as well as provision of necessary supplies, equipment, and infrastructure, as needed.
- Train healthcare workers on outbreak toolkits and other IRC resources, specifically with regard to cholera and measles
- Support supplementary interventions - including vaccination campaigns, treatment centers, transmission-based/disease-specific IPC, etc. - during outbreaks, as indicated
- Support RH services, particularly EmONC and safe deliveries, as well as postnatal care, with a focus on nutrition and breastfeeding for the infant

Links to other sectors

- Ensure strong referral pathways from primary healthcare facilities to Protection, Nutrition, and Early Childhood Development programming
- Establish linkages (from PHC and/or nutrition services) for severely malnourished children from very food insecure homes to access cash and other basic needs assistance
- Develop multi-level Health and Hygiene promotion messaging to reduce transmission of water-borne and respiratory illnesses, in collaboration with EH teams

Environmental Health

- Increase water coverage to at least 15litres/person/day as recommended by the SPHERE standards through water trucking initially and transition to rehabilitation/construction of water sources
- Distribute household water treatment chemical such as aqua tabs, PUR etc. to households, train them and monitor use by conducting regular water quality testing
- Construct/rehabilitate water storage tanks at IDP sites and create more water collection points (250 persons/tap) to reduce queuing time during water collection
- Distribute water collection and storage containers to maintain water safety during collection, transportation, and storage
- Construct additional safe communal latrines in IDP camps (with lockable doors and well lit) and support households to construct family latrines to minimize open defecation. Where possible consider desludging existing latrines that are full
- Work with IDP camp leadership to also establish a system for cleaning the communal latrines.
- Conduct hygiene awareness and regular Knowledge, Attitudes and Practices (KAP) surveys to prioritize messages.

Links to other sectors

- In collaboration with women's protection team, distribute hygiene kits and dignity kits for women and girls of reproductive age (further FGDs with women and girls to be conducted to agree on kit contents)

Protection

Additional assessment

- Conduct comprehensive child protection and early childhood development assessment to better understand the needs, risks, and barriers to accessing services faced by children (including 0-5 years) and adolescents in particular, and inform response design
- Carry out community mappings and safety audits to understand specific risks and threats facing women and girls, children, and at-risk community members, and development of action plans to address these risks and improve safety in communities

Programming

- Establish safe spaces for women and girls to ensure safe entry points to protection and psychosocial support services for women and girls at risk or survivors of gender-based violence, including IPV, early and forced marriage, and exploitation
- Implement community engagement and outreach to prevent GBV, exploitation, family separation, and malnutrition, and to promote access to protection and nutrition services

Links to other sectors

- Work with EH and/or ERD teams to distribute dignity kits, or cash/vouchers for dignity items (based on clients' modality preferences and logistical feasibility)
- Collaborate with shelter/site planning and other service delivery sectors to ensure risk mitigation around camp infrastructure
- Train IRC staff (all response sectors) and humanitarian actors on protection mainstreaming, recognizing and referring GBV and other protection concerns, PSEA and safeguarding
- Facilitate access to basic needs (ex. referrals to MPCA, cash for protection) and safe, age-appropriate livelihoods and income generation opportunities by at-risk women and girls, to prevent and mitigate risk of exploitation or engaging in risky coping strategies
- Integrate child protection and early childhood development interventions into nutrition programming, such as:
  - Integration of CP and ECD messages into infant and young child feeding (IYCF) curricula, and of IYCF messages into CP and ECD responsive parenting interventions
  - Screening and referrals between nutrition, child protection, and early childhood development

Safeguarding

- Conduct community engagement and outreach to prevent sexual exploitation and abuse (SEA) and other safeguarding risks
- Establish of community feedback, complaints, and reporting mechanisms for safe entry points to disclose SEA
- Establish referrals and linkages to services for survivors of SEA and safeguarding violations
- Train IRC staff (all response sectors) and humanitarian actors on IRC Way, safeguarding, PSEA, and reporting and response mechanisms

ANNEXES

1. Assessment Tools

Assessment tools can be found embedded below, or on Box, here.

Health facility maping - BASIC | Needs assessment questionnaire-IRC | Multisector Needs assessment | Market (Traders) KII-ERD.docx | IRC multisectoral needs assessment | Individual-Interview-Tool-

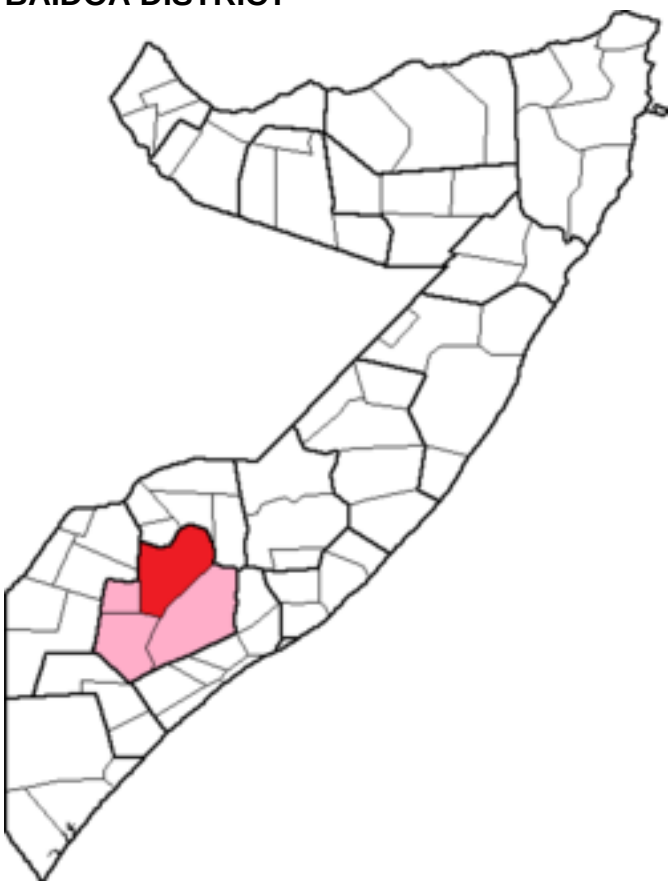
2. Maps

a. Districts covered by the IRC/GREDO rapid multisectoral emergency needs assessment
b. IPC Acute Food Insecurity, May 2022
c. IPC Acute Malnutrition Phase Classification, May 2022
d. Confirmed AWD/Cholera Cases Map in Somalia, July 2022

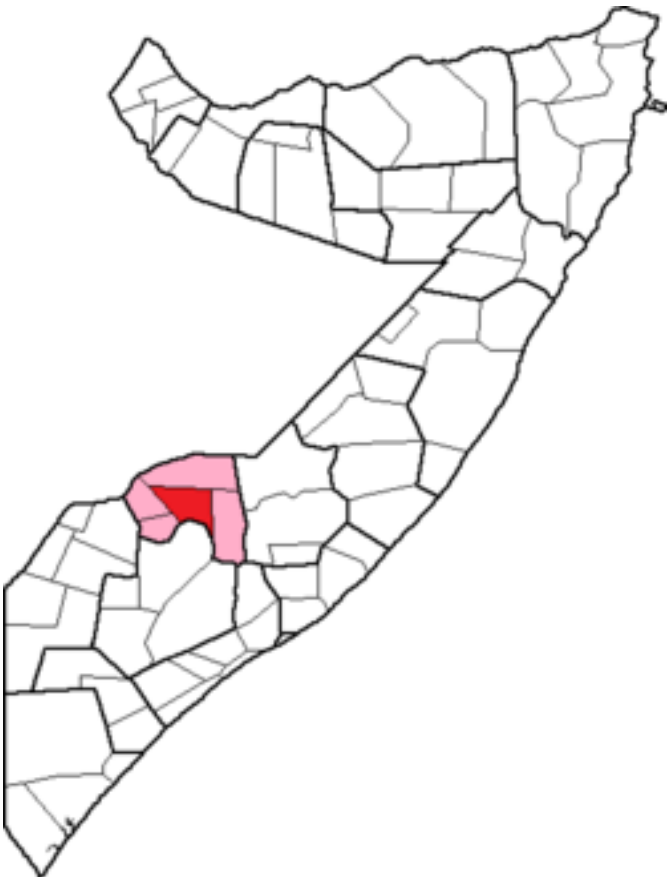
Annex 2a.

Districts covered by the IRC/GREDO rapid multisectoral emergency needs assessment

BAIDOA DISTRICT

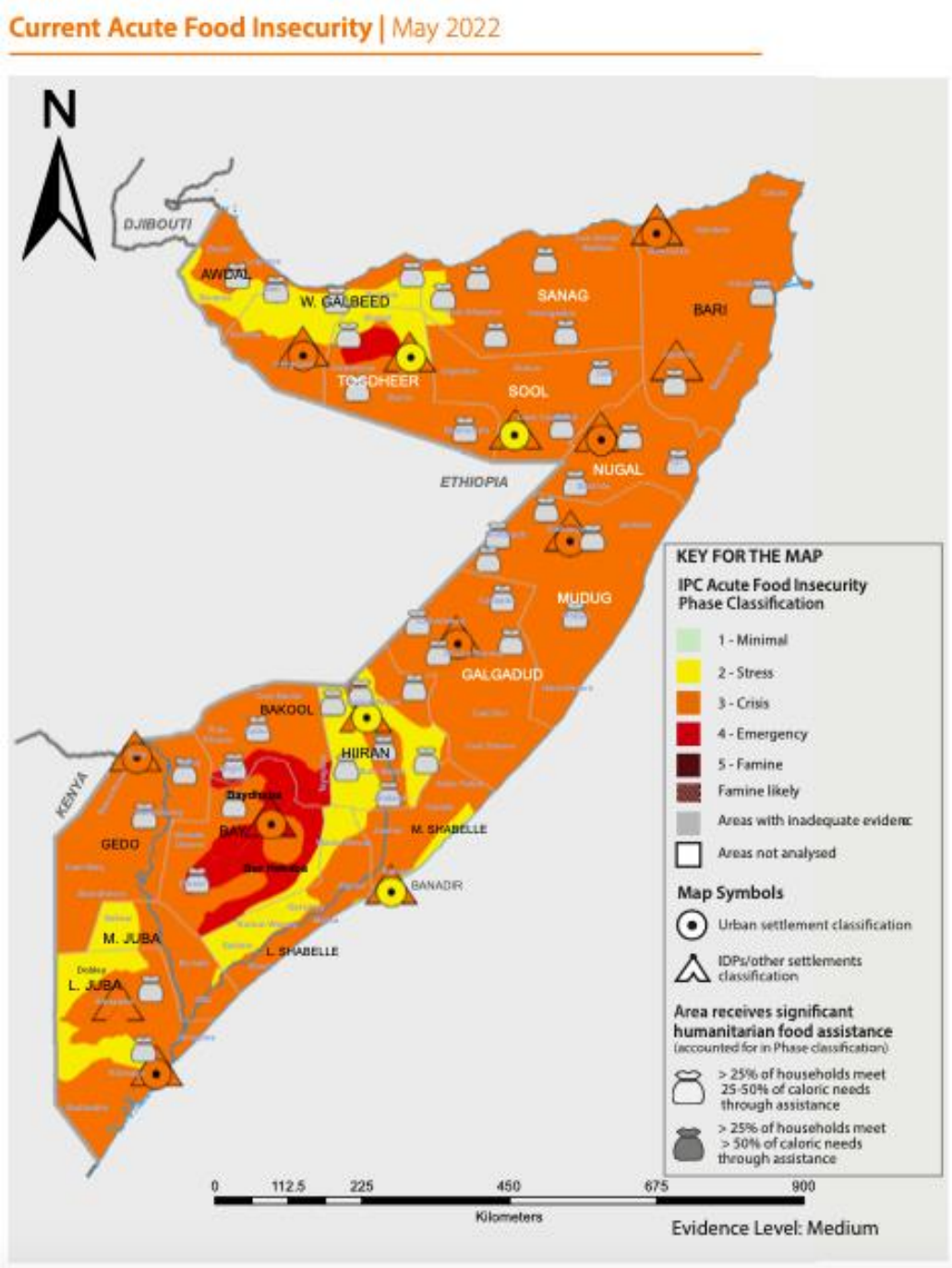


HUDUR DISTRICT



Annex 2b.

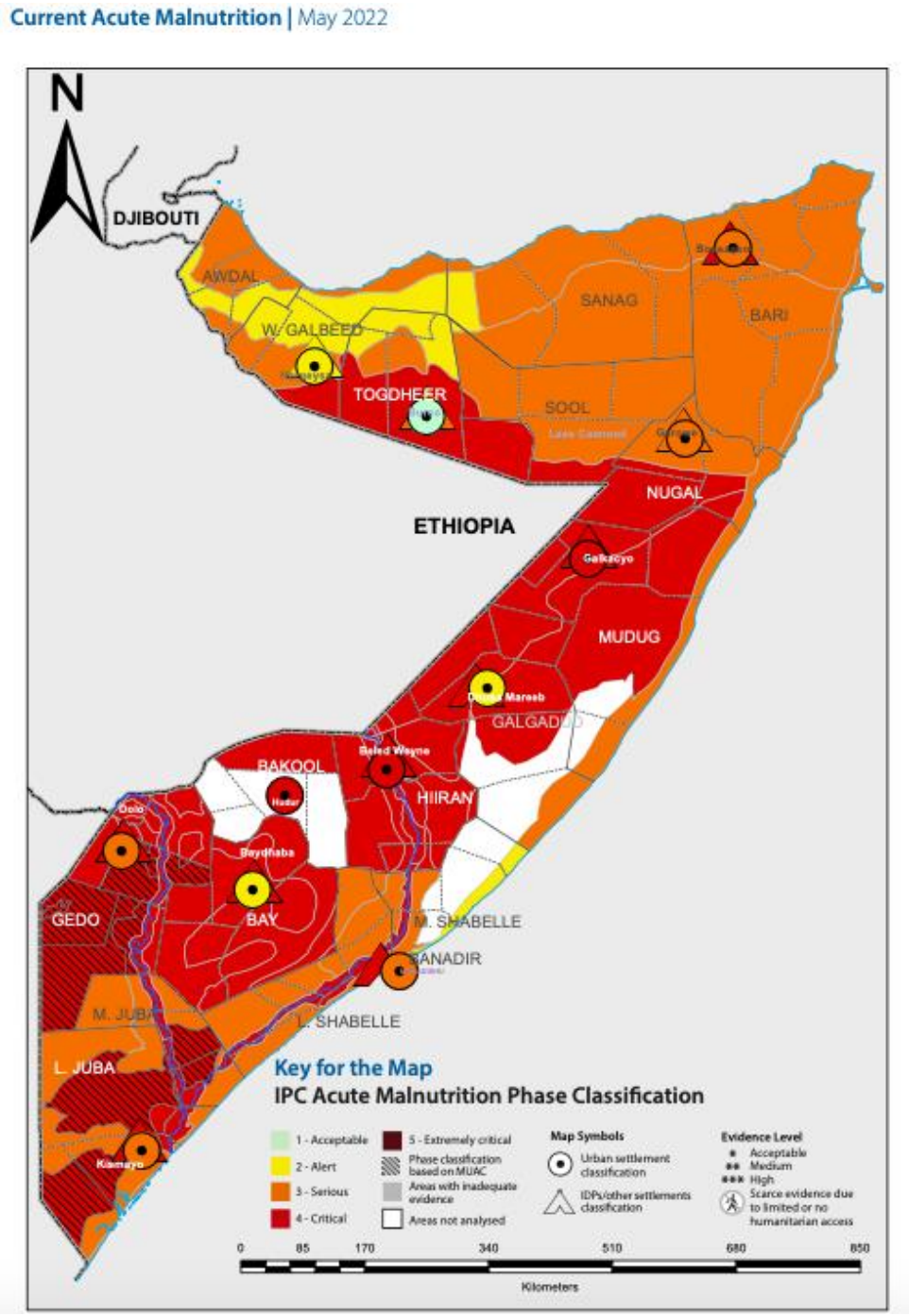
IPC Acute Food Insecurity, May 2022



Source: **SOMALIA :** IPC Risk of Famine Snapshot l May - September 2022

Annex 2c.

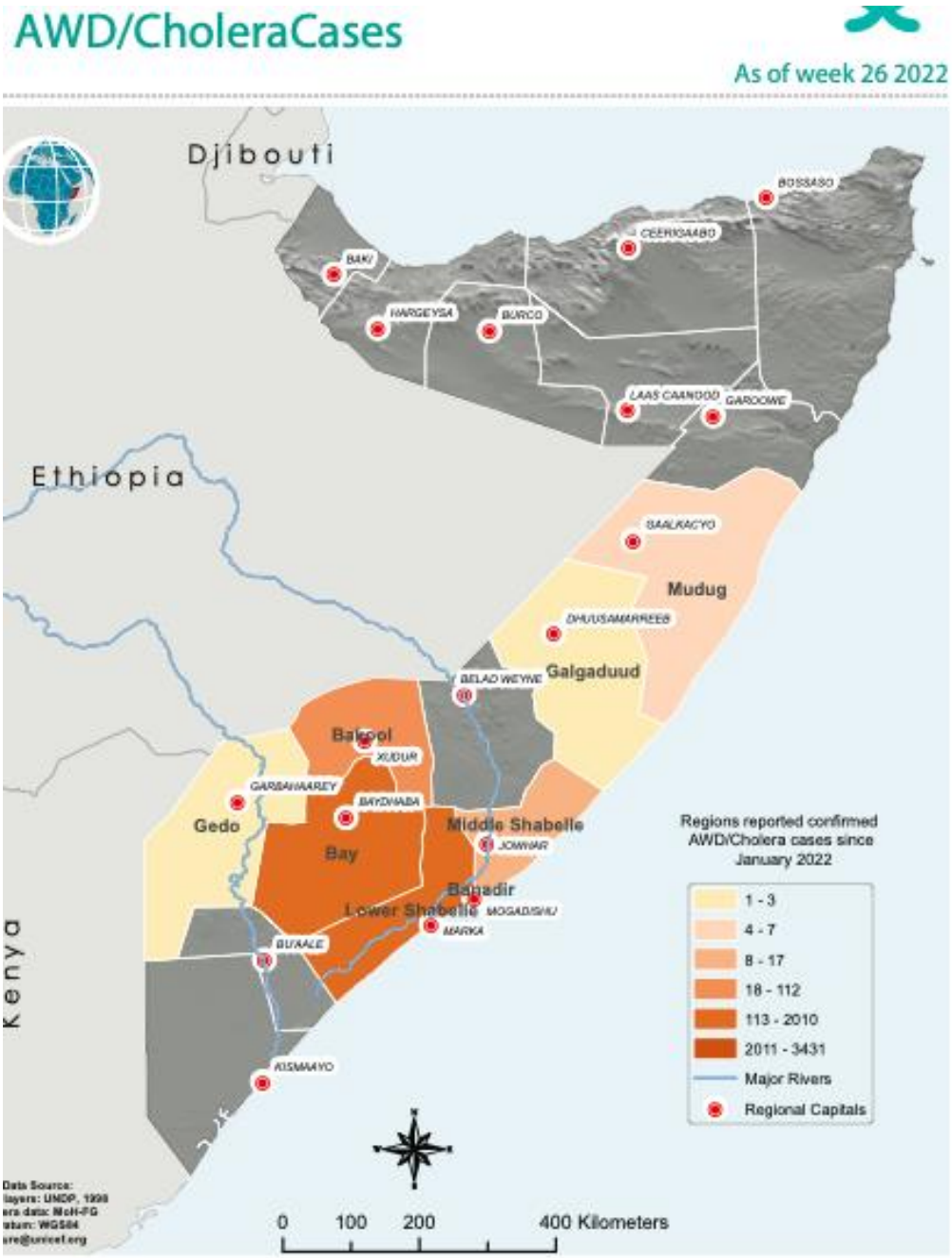
IPC Acute Malnutrition Phase Classification, May 2022



Source: **SOMALIA :** IPC Risk of Famine Snapshot I May - September 2022

Annex 2d.

Confirmed AWD/Cholera Cases Map in Somalia (As of week #26, July 12, 2022)



Source: Somalia WASH Cluster: 2022 Confirmed AWD/Cholera Cases Map in Somalia (As of week #26, July 12, 2022)