Detailed Site Assessment (DSA)

March 2021

Borama district

CONTEXT

The protracted humanitarian crisis is multi-layered and complex. Limited development coupled with recurring climatic shocks, such as drought and riverine-/flash-flooding give rise to high levels of need among affected populations, while insecurity and conflict severely hinder access to humanitarian actors. The majority of internally displaced persons (IDPs) reside in overcrowded shelters in densely populated urban areas, further increasing their exposure to the risks and impact of COVID-19.

The Detailed Site Assessment (DSA) was initiated in coordination with the Camp Coordination and Camp Management (CCCM) Cluster in order to provide the humanitarian community with up-to-date information on the location of IDP sites, the conditions and capacity of the sites, and an estimate of the severity of humanitarian needs of residents. Data collection for the current round of the DSA took place from December 2020 to March 2021.

METHODOLOGY

Findings are based on key informant (KI) interviews with purposefully sampled KIs who reported on the settlement level. Interviews were conducted by REACH in accessible locations. Targeted areas within districts were determined based on a secondary data review, which drew on previous assessments conducted on IDP populations. After identifying target areas, REACH located IDP settlements by contacting the lowest level of governance[1].

The methodology for the fourth round of the DSA was developed in close consultation with clusters and partner organisations and updated to improve the quality and reliability of data collected regarding IDP settlement locations, estimated size of resident populations, and the severity of humanitarin needs. The severity scale goes from 1 to 4+ and the severity phases are none/minimal, stress, severe, extreme and extreme+. For the list of indicators and the severity score calculations, see page 4 of this factsheet. All findings presented on this factsheet relate to the % of sites with a given response, and should be considered indicative, rather than representative, of the humanitarian situation in assessed sites.

To provide a local, context-specific overview and allow more targeted responses, this factsheet presents a summary of findings of assessed settlements in Borama district only.

Assessment information

11 assessed sites hosting

2,658 households*

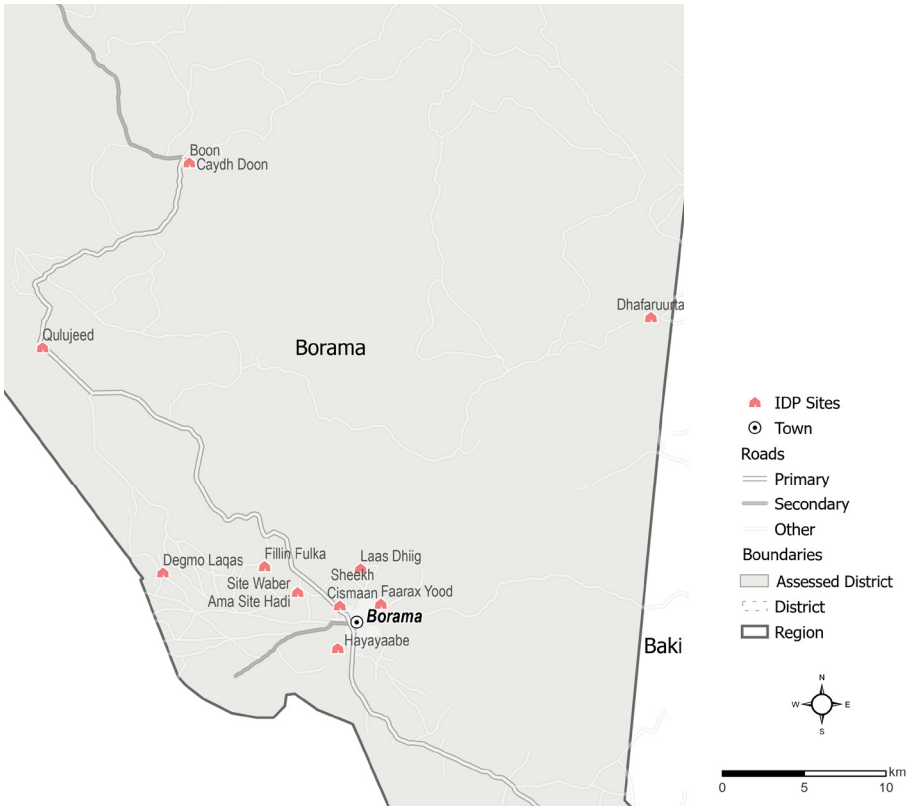
17,154 individuals*

Displacement

Total number of IDP individuals* arriving into a new settlement in the past 3 months	**263**
Total number of IDP individuals* departing from an old settlement in the past 3 months	**22**

*This is an estimated number

ASSESSMENT COVERAGE MAP



[1]District Office, Mayor's Office, etc.

Summary of severity score*

Clusters	Severity Score	Severity phase
Food Security & Livelihoods	4	Extreme
Nutrition	3	Severe
Health	4	Extreme
Protection	3	Severe
Shelter & Non-Food Items	2	Stress
Education	3	Severe
Water, Sanitation & Hygiene	3	Severe

For the list of indicators and the severity score calculations, see page 4 on this factsheet.

*The analysis methodology was adjusted between 2020 and 2021 in order to align with other multi-sectoral assessments carried out by REACH and other partners. This included adapting the ranking system. Therefore, the results for 2021 cannot be compared directly with the previous years, but can be useful to show the differences between the sectors and districts.

Borama district

FOOD SECURITY & LIVELIHOODS (FSL)

% of sites per FSL severity score:

No or minimal	Stress	Severe	Extreme	Extreme+
0%	9%	9%	82%	0%

Proportion of sites with no access to food markets: 90%

Proportion of sites where the nearest market is more than 60 minutes away on foot: 0%

Three most commonly reported primary sources of food[2]:

Market purchases	44%
Household production	22%
Trade for labour	22%

Most commonly reported strategies used by people in the settlement to cope with a lack of food[2,4]:

Borrowing food	100%
Asking non-relatives for food	73%
Purchase food with borrowed money	73%

Proportion of sites where the population was reportedly not able to access enough food in the month prior to data collection: 0%

NUTRITION

% of sites per nutrition severity score:

No or minimal	Stress	Severe	Extreme	Extreme+
18%	9%	73%	0%	0%

Proportion of sites with no access to nutrition services: 29%

Proportion of sites where the nearest nutrition facility is more than 60 minutes away on foot: 29%

Proportion of sites where the following nutrition items had been received in the 3 months prior to data collection[2,3]:

Therapeutic & Supplementary Food	73%
Super Cereal Plus	64%
Therapeutic milk products	36%

Proportion of sites by most common barriers to accessing nutrition services[2,3]:

Facility not open	54%
Treatment center is too far	46%
No materials available	27%

HEALTH

% of sites per health severity score:

No or minimal	Stress	Severe	Extreme	Extreme+
9%	9%	36%	46%	0%

Proportion of sites with no access to healthcare facilities: 27%

Proportion of sites where KIs reported no women are able to access skilled personnel while giving birth: 71%

Proportion of sites by type of health services reportedly available in the site[2,3]:

Basic primary healthcare	54%
Vaccinations	54%
Child healthcare	54%

Proportion of sites by type of health facilities available in the site[2,3]:

Government run clinic	46%
First aid post	27%
No access to any health facility	27%

EDUCATION

% of sites per education severity score:

No or minimal	Stress	Severe	Extreme	Extreme+
0%	73%	27%	0%	0%

Proportion of sites reportedly having no access to learning facilities: 27%

Proportion of sites where the nearest education facility is more than 60 minutes away on foot: 50%

Reported type of learning facilities available at sites[2,3]:

Quoranic	73%
Primary	64%
Secondary	36%

Most commonly reported barriers accessing education for girls[2]:

School fees	82%
Distance to school	64%
Child helping at home / farm	54%

Most commonly reported barriers accessing education for boys[2]:

School fees	73%
Distance to school	54%
No barriers	46%

[2]Respondents could select multiple options. *Applies to all questions with reference '2'.*
[3]This relates to most common responses. *Applies to all questions with reference'3'.*
[4]The findings related a subset of 10 sites where KIs reported not having access to enough food.

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PROTECTION

% of sites per protection severity score:

No or minimal	Stress	Severe	Extreme	Extreme+
27%	18%	46%	9%	0%

Proportion of sites reportedly having no child friendly spaces: 54%

Proportion of sites reportedly having no designated spaces where women and girls can gather: 91%

Proportion of sites where restrictions on movement during the day were reported: 0%

Proportion of sites by types of safety and security incidents that reportedly happened in the site in the 3 months prior to data collection[2,3,5]:

No incidents occurred	73%
Gender based violence	18%
Taxation by non-government actors	9%

Proportion of sites by reported locations where safety and security incidents typically occur[2,3,6]:

When leaving IDP site	67%
On the way or at the NFI markets	67%
In shelters	33%

SHELTER & NON-FOOD ITEMS

% of sites per nutrition severity score:

No or minimal	Stress	Severe	Extreme	Extreme+
36%	64%	0%	0%	0%

Proportion of sites reportedly having no access to markets selling NFIs: 54%

Three most commonly reported types of NFIs available at markets[2,7]:

Medicines	100%
Hygienic menstruation materials	100%
Local construction materials	100%

Proportion of sites where KIs reported fires occurred in the sites in the 3 months prior to data collection: 18%

Proportion of sites where KIs reported floods occurred in the sites in the 12 months prior to data collection: 9%

Most commonly reported types of shelters at sites[2,8]:

Buul	91%
CGI sheet wall and roof	27%
Stone/brick wall with CGI roof: Type 1	27%

WATER, SANITATION & HYGIENE (WASH)

% of sites per WASH severity score:

No or minimal	Stress	Severe	Extreme	Extreme+
9%	36%	54%	0%	0%

Water

Proportion of sites where the nearest functioning water source is more than 60 minutes away on foot: 22%

Three most commonly reported primary sources of water[2,4,9]:

Vendors or shop	27%
Piped system	27%
Protected well without hand pump	27%

Proportion of sites by reported methods used to treat water[2,3]:

Chlorine tablets/aquatabs	73%
Boiling	27%
Do not treat water	27%

Sanitation:

Proportion of sites where the nearest functional latrine is more than 60 minutes away on foot: 0%

Proportion of sites by reported strategies for disposing of solid waste[2,3]:

Burial if in designated areas far from houses	67%
In open	33%
NA	

Hygiene:

Top three groups reportedly facing impediments in accessing latrines[2,10]:

Elders (Persons aged 60 and more)	86%
Persons with disabilities	86%
Children	57%

Proportion of sites where the population reportedly received hygiene support in the 3 months prior to data collection: 64%

[5] Incidents due to UXO ("Unexploded ordnance (UXO) is any sort of military ammunition or explosive ordnance which has failed to function as intended")
[6] The findings related a subset of 3 sites where KIs reported incidents occurred in the sites in past 3 months prior to the data collection
[7] The findings related a subset of 5 sites where KIs reported having access to NFI markets.
[8] Corrugated Iron Sheets.
[9] The findings related a subset of 4 sites where KIs reported presence of water sources at the sites.
[10] The findings related a subset of 7 sites where KIs reported having access to functioning latrines or bathing facilities.

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Accountability to Affected Populations (AAP)

Proportion of sites by sources of information reportedly used to receive information about humanitarian services[2,3]:

Radio	91%
Community leaders	91%
Television	27%

Three most common sources of information for persons with disabilities[2]:

Radio	91%
Community leaders	91%
Television	27%

Proportion of sites by problems reportedly experienced during the delivery of humanitarian assistance[2,3]:

Not enough for all entitled	56%
Assistance did not respond to the actual	44%
Fighting between recipients	22%

Proportion of sites where KIs reported people have access to a feedback mechanism: 9%

COVID-19 Knowledge, Attitude, and Practices (KAP)

Proportion of sites where most people reportedly think of COVID-19 as an important issue:

Yes	91%
No	9%
Do not know	0%

Proportion of sites by reported actions taken by most people to prevent the spread of COVID-19[2,3]:

Stopping physical contact	91%
Regular handwashing	82%
Keeping distance from people	73%

Average of reported estimate proportions of households per site with access to functioning hand-washing facilities with water and soap:

0 - 25%	26 - 50%	51 - 75%	76 - 100%
100%	0%	0%	0%

Camp Coordination and Camp Management

Proportion of sites by reported type of site management[2,3]:

Community leader	91%
UN agency	9%
Local NGO	9%

Proportion of sites by committees reportedly available in the site: settlements[2,3]:

Camp management committee	100%
Women committee	82%
Residents committee	73%

Proportion of sites where KIs reported that women are present in committees: 100%

SEVERITY SCORE CALCULATION

The severity scores for a given sector is produced by aggregating unmet needs indicators per sector. For this round of the DSA, a simple aggregation methodology has been identified, building on the Multidimensional Poverty Index (MPI) aggregation approach. Using this method, each site is assigned a deprivation score according to its deprivations in the component indicators. The deprivation score of each site is obtained by calculating the percentage of the deprivations experienced, so that the deprivation score for each site lies between 0 and 100. The method relies on the categorization of each indicator on a binary scale: does ("1") / does not ("0") have a gap. The threshold for how a site is considered to have a particular gap or not is determined in advance for each indicator. The DSA IV aggregation methodology outlined below can be described as "MPI-like", using the steps of the MPI approach to determine an aggregated needs severity score, with the addition of "critical indicators" that determine the higher severity scores. The section below outlines guidance on how to produce the aggregation using KI data.

1) Identified indicators that measure needs ('gaps') for each sector, capturing the following key dimensions: accessibility, availability, quality, use, and awareness. Set binary thresholds: does ("1") / does not ("0") have a gap;
2) Identified critical indicators that, on their own, indicate a gap in the sector overall;
3) Identified individual indicator scores (0 or 1) for each site, once data had been collected;
4) Calculated the severity score for each site, based on the following decision tree (tailored to each sector);

a. **"Super" critical indicator(s)**: could lead to a 4+ if an extreme situation is found for the site;
b. **Critical indicators**: using a decision tree approach, a severity class is identified based on a discontinued scale of 1 to 4 (1, 3, 4) depending on the scores of each of the critical indicators;
c. **Non-critical indicators**: the scores of all non-critical indicators are summed up and converted into a percentage of possible total (e.g. 3 out of 4 = 75%) to identify a severity sector;
d. The final score/severity class is obtained by retaining the highest score generated by either the super critical, critical or non-critical indicators.

The indicators for each cluster were selected in coordination with all the clusters. In total 53 indicators were selected to assess the severity of needs across 7 clusters.

Note: The indicators for CCCM and Accountability to Affected Population (AAP) are not part of the severity calculations across the sectors. Hence, the CCCM and AAP sections in this factsheet do not present the severity scores.

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HEALTH CLUSTER

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Data Collection partners

1. Islamic Relief
2. WISE
3. ACTED
4. Kaalo
5. IOM
6. SHACDO
7. IOM-CCM
8. ASAL

For a more detailed overview of the methodology and a comprehensive list of all the composite indicators that were used, you can access the terms of reference (ToR) here. The indicators and their respective thresholds are included in the annex section of the ToR, page 56-78.

About REACH:

REACH 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: geneva@reach-initiative.org and follow us on Twitter @REACH_info.

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