

Somali Cash Consortium – Baseline and Endline Findings MPCA Outcomes from the Direct Nutrition Referral Approach

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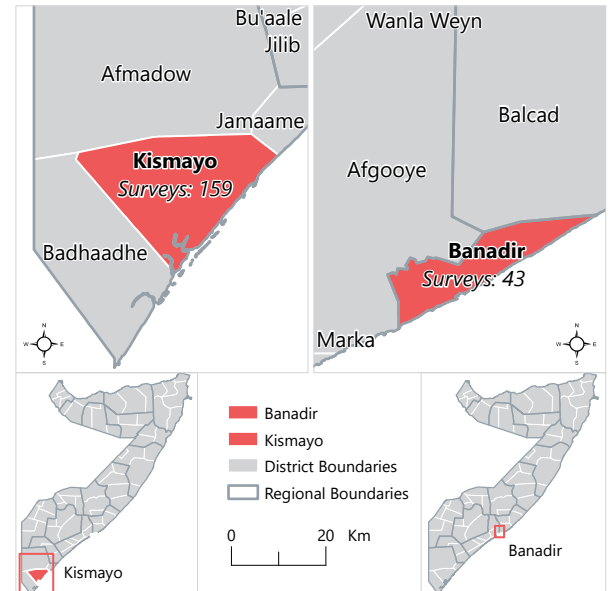


SOMALI CASH
CONSORTIUM

KEY MESSAGES

- **The use of consumption-based coping strategies declined.** The proportion of households with high reduced Coping Strategy Index (rCSI) decreased sharply, from 47% to 2%, while low or medium rCSI increased to 87%. **While the proportion of HHs relying on emergency, crisis or stress livelihood coping strategies (LCS) declined,** a substantial share continued to rely on these strategies at endline, including 42% using emergency LCS, highlighting continued pressure on livelihoods despite improvements in food consumption.
- HH income and expenditures increased, with the largest share spent on food and medical expenses. **However, most HHs still relied mainly on casual labour and humanitarian assistance as their primary source of income.** Despite this improvement, HHs with debt remained widespread. More than three-quarters of assessed HHs (83%) reported having debt at endline, although the average debt burden declined from USD 84.51 at baseline to USD 70.42 at endline.
- **Findings indicate that HHs remained highly financially vulnerable, with limited ability to build savings,** despite improvements in income and a modest reduction in debt levels. The proportion of HHs with any savings fell sharply from 13% at baseline to just 3% at endline, while average savings declined from USD 3.32 to USD 1.89.

COVERAGE MAP 2026



CONTEXT & RATIONALE

Between January and June 2026, an estimated 1.84 million Somali children aged 6–59 months are expected to suffer from acute malnutrition, including approximately 483,000 cases of Severe Acute Malnutrition (SAM) requiring lifesaving treatment. Acute malnutrition remains a major public health concern across Somalia, driven by worsening food insecurity, recurrent drought, displacement, disease outbreaks, poor dietary intake, and declining humanitarian assistance. The Integrated Food Security Phase Classification (IPC) projected that 38 of 48 analysed areas would be classified in IPC Acute Malnutrition (AMN) Phase 3 or above during February–March 2026, increasing to 45 of 48 analysed areas during April–June 2026, reflecting seasonal peaks in malnutrition and disease burden as well as reduced access to healthcare and nutrition services.¹

Kismayo continues to experience significant nutrition challenges associated with recurrent displacement, climate-related livelihood shocks, food insecurity, inadequate dietary diversity, poor water, sanitation and hygiene (WASH) conditions, and periodic disease outbreaks. Humanitarian agencies report persistent vulnerability among internally displaced populations residing in and around Kismayo, while funding constraints have reduced access to essential nutrition and health services.² In Banadir region, particularly Deynile and Kahda districts, high concentrations of internally displaced persons, poverty, overcrowding, inadequate sanitation, recurrent diarrhoeal disease outbreaks, and reliance on humanitarian assistance continue to contribute to elevated risks of acute malnutrition. Ongoing displacement, reduced humanitarian funding, rising food insecurity, and constrained access to nutrition treatment and health services further increase vulnerability among children under five years of age, pregnant women, and breastfeeding mothers.¹

In response to these challenges, the Somali Cash Consortium (SCC)³, with funding from European Union Civil Protection and Humanitarian Aid (ECHO), implemented multipurpose cash assistance (MPCA) using the Direct Nutrition Referral (DNR) approach that linked nutrition services with MPCA for households with acutely malnourished children. Between February and May 2026, SCC delivered three rounds of MPCA aligned with the Minimum Expenditure Basket (MEB)⁴ to help address economic barriers to food security and access to nutrition services. While findings indicate improvements in household food security and economic wellbeing, the assessment did not measure child nutrition recovery, treatment completion, relapse, or other nutrition outcomes directly. Therefore, results should be interpreted as household-level outcomes rather than evidence of improved child nutrition status.

Therefore, this factsheet presents the key findings from the modification request 3 (MR3) endline assessment, as well as indicative comparisons of key indicators from the baseline assessment for the assessed beneficiary HH in Kismayo and Banadir.

1. IPC, [Acute Food Insecurity And Acute Malnutrition Analysis](#) (January - June, 2026)

2. FSNAU, [Updated Acute Malnutrition Burden by District](#) (January–December 2026)

3. SCC is led by Concern Worldwide and further consists of Acted, Action Against Hunger (ACF), COOPI (Cooperazione Internazionale), Danish Refugee Council (DRC), Norwegian Refugee Council (NRC), Save the Children (SCI), Save Somali Women and Children (SSWC), Lifeline Gedo (LLG), GREDO, and IMPACT Initiatives.

4. MEB Review and Gap Analysis Task Force (SNBS, CWG, FSC, FSNAU, REACH, FAO, WFP). [Identifying Gaps in Households Economic Capacity to Meet Essential Needs \(food and non-food\) and the New Cash and Voucher Assistance \(CVA\) Transfer Value Recommendations](#) (September 2024).

FOOD SECURITY AND LIVELIHOODS (FSL)

FOOD CONSUMPTION SCORE (FCS)⁵

% of HHs by Food Consumption Score category:

	Baseline	Endline
Acceptable (>42)	7%	31%
Borderline (28-42)	10%	58%
Poor (<28)	83%	11%
	Baseline	Endline
Average FCS per HH	21.8	38.0

Endline findings show a notable improvement in HH food consumption. The average FCS increased from 21.8 to 38.0, crossing from the "poor" into the "borderline" threshold, while the proportion of HHs with poor FCS dropped sharply from 83% to 11%. These improvements may reflect the contribution of MPCA in enabling HHs to diversify their diets and access more food groups.

HOUSEHOLD HUNGER SCALE (HHS)⁶

% of HHs by levels of hunger in the HH:

	Baseline	Endline
No or little hunger	16%	67%
Moderate hunger	72%	33%
Severe hunger	12%	0%

Positive improvements were seen in the proportion of HHs with no or little hunger. The proportion of HHs reporting no or little hunger considerably increased from 16% at the baseline to 67% at the endline, indicating a reduced frequency and severity of hunger experienced by households. The cash distributions likely played a role in the lower levels of hunger experienced by these HHs during the programming period.

USE OF COPING MECHANISMS

% of HHs by average reduced Coping Strategy Index (rCSI) category:⁷

	Baseline	Endline
Low	0%	11%
Medium	53%	87%
High	47%	2%
	Baseline	Endline
Average rCSI per HH	21.6	10.8

Most commonly adopted coping strategies:^{*}

Average number of days HHs reported using each coping strategy in the 7 days prior to data collection:

	Baseline	Endline
Relied on less preferred, less expensive food	3.5	2.1
Reduced the number of meals eaten per day	2.7	1.3
Reduced portion size of meals	2.7	1.3
Borrowed food or relied on help from friends or relatives	6.4	3.2
Restricted adults consumption so children can eat	6.4	2.9

LIVELIHOOD-BASED COPING INDEX (LCSI)⁸

% of HHs by LCS category in the 30 days prior to data collection:

	Baseline:	Endline:
None	7%	17%
Stress	1%	0%
Crisis	46%	41%
Emergency	46%	42%

The rCSI indicator showed improved results from the baseline to the endline, with the average rCSI decreasing from 21.6 at the baseline to 10.8 during the endline. The proportions of HHs with a high rCSI also decreased within this period, from 47% to 2%. **HHs reported relying less frequently on negative food consumption strategies** such as skipping meals, reducing meal sizes, consuming less preferred foods, borrowing food, or restricting adult consumption to prioritise children during the endline.

At the same time, the LCS results highlight continued pressure on HHs' livelihoods despite improvements in food consumption outcomes. The proportion of HHs resorting to emergency, crisis, or stress level coping strategies decreased from 93% during the baseline to 83% at the endline. Despite improvements in food consumption and short-term coping, the continued reliance on emergency livelihood strategies among 42% of households suggests persistent vulnerability and limited resilience to future shocks.

5. Find more information on the food consumption score [here](#). The cutoff criteria utilized for Somalia were as follows: Households with a score between 0 and 28 were categorized as "poor," those with a score above 28 but less than 42 were considered "borderline," and households with a score exceeding 42 were classified as "acceptable." These categorizations were determined based on the high consumption of sugar and oil among the beneficiary households. High average FCS values are preferred since low average values indicate a worse food situation.

6. The Household Hunger Scale (HHS) is an indicator to measure household hunger in food insecure areas. Read more [here](#).

7. The reduced Coping Strategies Index (rCSI) is an indicator used to compare the hardship faced by households due to a shortage of food. The index measures the frequency and severity of the food consumption behaviours the households had to engage in due to food shortage in the 7 days prior to the survey. The rCSI was calculated to better understand the frequency and severity of changes in food consumption behaviours in the household when faced with a shortage of food. The rCSI scale was adjusted for Somalia, with a low index attributed to rCSI <=3, medium between 4 and 18, and high if higher than 18. Read more [here](#). The three rCSI cut offs indicate different phases of food security situations, and in this context, lower average values of rCSI are preferred.

8. The Livelihood Coping Strategies Index (LCSI) is an indicator used to understand the medium and longer-term coping capacity of HHs in response to a lack of food or lack of money to buy food and their ability to overcome challenges in the future. The indicator is derived from a series of questions regarding the households' experiences with livelihood stress and asset depletion to cope with food shortages. Read more [here](#).

* Respondents could select multiple options. Findings may therefore exceed 100%.

HOUSEHOLD ECONOMIC OUTCOMES

INCOME SOURCES

Top reported primary sources of HH income in the 30 days prior to data collection:*

	Baseline	Endline
Casual labour (wage labour)	58%	79%
Humanitarian assistance	10%	61%
Casual labour (farm labour)	19%	22%
Livestock sales & production	7%	14%

Average reported monthly amount of income for HHs that received any income in the 30 days prior to data collection:

Baseline	Endline
63.89 USD	143.54 USD

EXPENDITURE

Average reported monthly expenditure for HHs that spent any money in the 30 days prior to data collection:

Baseline	Endline
62.71 USD	133.75 USD

Reported average HH expenditure, by top most reported expenditure type in the 30 days prior to data collection:

Expenditure category	Average amount spent in the 30 days prior to data collection by HHs reporting spending >0 USD in this category		Proportion of each expenditure in the total spending across all HHs ⁹	
	Baseline	Endline	Baseline	Endline
Food	28.82 USD	75.24 USD	48%	58%
Medical expenses	5.50 USD	11.97 USD	9%	8%
Debt repayment for food	5.51 USD	10.40 USD	7%	8%
Clothing	6.80 USD	9.63 USD	12%	7%
Debt repayment for non-food items	3.78 USD	6.19 USD	5%	4%
Education	1.7 USD	6.17 USD	3%	4%

SAVINGS & DEBT

More than three-quarters of assessed households (83%) reported having debt at endline, with an average household debt of USD 70.42. Although debt remained widespread, the average debt burden declined from USD 84.51 at baseline, suggesting a modest improvement in HHs' financial situation.

The proportion of HHs with savings decreased from 13% at baseline to just 3% (n=6) at endline, while average savings declined from USD 3.32 to USD 1.89. These findings indicate that despite improvements in HH income and a reduction in average debt levels, most households remained financially vulnerable and were largely unable to accumulate savings.

ECONOMIC CAPACITY TO MEET ESSENTIAL NEEDS¹⁰

% of HHs who reportedly spent above the minimum expenditure basket (MEB):

	Baseline	Endline
Yes	7%	67%
No	93%	33%

% of HHs by most commonly reported primary sources of food in the 7 days prior to data collection:

	Baseline	Endline
Market purchase with cash	29%	34%
Own production	22%	20%
Loan	21%	17%

HH income and expenditure increased considerably between baseline and endline, the period during which households received MPCA. Average HH income increased substantially, enabling HHs to spend more on essential needs. Food and medical expenses constituted the primary expense for assessed HHs. Although household income increased, most additional resources appear to have been directed towards immediate consumption needs, healthcare expenditures, debt repayment, and other essential expenditures. This may explain why savings remained uncommon despite improved economic indicators.

The findings also indicate an improvement in HHs' ability to meet essential needs. By the endline, most HHs were spending above the MEB and were most commonly accessing food through market purchases using cash. This suggests increased purchasing power and greater capacity to secure food and other essentials despite the difficult operating environment. However, debt was still widespread, while only a small proportion of HHs reported having any savings, and these savings were generally limited. This suggests that although HHs were better able to meet their immediate needs, many remained dependent on external assistance and lacked the financial buffers necessary to withstand future shocks.

* Respondents could select up to three options. Findings may therefore exceed 100%.

9. For each category, the proportion was calculated based on all HHs including those HHs that had not made any spending on each expenditure category. All HHs had made some spending 30 days prior to data collection.

10. ECMEN measures the ability of households to meet essential non-food needs after covering food requirements. In most humanitarian contexts, particularly those characterised by displacement, inflation, and fragile livelihoods, food expenditures absorb a disproportionate share of household income and cash assistance, leaving limited residual capacity to address non-food essentials. In addition, ECMEN is directly derived from the Minimum Expenditure Basket (MEB), and its performance is therefore highly sensitive to how MEB costs are defined.

ACCOUNTABILITY TO AFFECTED POPULATIONS

Protection mainstreaming key outcome indicators* (KOI):¹¹

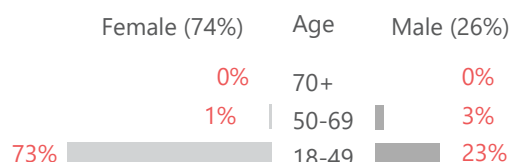
Indicator	Baseline	Endline
Programming was safe	99%	99%
Programming was respectful	100%	99%
Community was consulted	24%	25%
The assistance was appropriate	89%	80%
No unfair selection	99%	100%
Raised concerns using complaint response mechanism (CRM)	19%	21%
Satisfied with the response	100%	98%
Overall KPI score	82%	86%

Of households reporting being aware of any option to contact the NGO (24%, n=48) during the endline, the most frequently known ways to report complaints and problems in receiving the assistance:**

	Baseline	Endline
Use the dedicated NGO hotline	67%	81%
Talk directly to NGO staff	29%	20%
Use the dedicated NGO desk	32%	4%

ENDLINE DEMOGRAPHICS

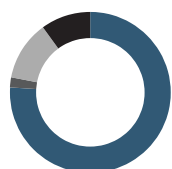
% of HHs by head of the HH demographic characteristics:



Average age of the head of HH: **32**

Average HH size: **6**

Endline Livelihood Zone breakdown:



Of the SCC beneficiary HHs surveyed, 76% were categorized as urban HHs, 2% as pastoral, 10% as riverine and 12% as agro-pastoral.

CONCLUSION

Findings suggest that the DNR implementation contributed to improvements in household food security and coping strategies across Kismayo and Banadir. Endline findings show that HHs were able to diversify diets, reduce hunger, and lower reliance on harmful coping mechanisms, with poor FCS dropping sharply and moderate hunger easing amongst the assessed HHs.

Findings suggest improved ability among assessed households to meet essential needs during the implementation period, and reduced dependence on credit purchases, choices that translated into more diverse diets and improved caloric intake. However, households remained financially vulnerable, with savings capacity declining despite improvements in income and reduced debt, indicating that most households were still unable to build financial reserves.

Accountability and protection indicators also point to encouraging progress. Beneficiaries consistently reported that programming was safe, respectful, and fair, while satisfaction with complaint response mechanisms increased. Although community consultation remained limited, awareness of feedback channels increased, helping to build trust between households and implementing partners. Community consultation remained low, increasing only marginally from 24% at baseline to 25% at endline. This is likely linked to the referral-driven design of the intervention, where the nutrition-based approach relied primarily on enrolment through referrals, inherently constraining early-stage community consultation.

The relatively low levels of community consultation and perceived appropriateness highlights a potential operational trade-off within referral-driven modalities. While the DNR approach may improve targeting efficiency for nutritionally vulnerable households, reliance on referral-based enrolment can reduce opportunities for broader community engagement and participatory design processes.

These findings must be read within the context of one of Somalia's most severe humanitarian emergencies in early 2026. Baseline data collection took place between January and February 2026 during Somalia's *Jilaal* dry season, while endline data collection in May 2026^{***}, coincided with a significant deterioration of the humanitarian situation — the drought crisis intensifying, water prices rising sharply, displacement continuing to rise, and more than six million people facing acute food insecurity, compounded by a substantial decline in humanitarian assistance.

Despite these improvements, high debt levels, continued reliance on emergency livelihood coping strategies, limited savings, and low levels of community consultation suggest that participating households remain highly vulnerable to future shocks and may require continued support.

11. The Protection Index score is a composite indicator developed by the Directorate-General for European Civil Protection and Humanitarian Aid Operations that calculates a score of the sampled beneficiaries who report that humanitarian assistance is delivered in a safe, accessible, accountable and participatory manner. **The calculations take into account a.) whether the beneficiary or anyone in their community was consulted by the NGO on their needs and how the NGO can best help, b.) whether the assistance was appropriate to the beneficiary's needs, c.) whether the beneficiary felt safe while receiving the assistance, c.) whether the beneficiary felt they were treated with respect by the NGO during the intervention, d.) whether the beneficiary felt some households were unfairly selected over others who were in dire need of the cash transfer, e.) whether the beneficiary had raised concerns about the assistance they had received using any of the complaint response mechanisms, and f.) if any complaints were raised, whether the beneficiary was satisfied with the response given or not.**

*These KOIs capture beneficiary perceptions but are classified and interpreted as process indicators, assessing implementation quality rather than programme outcomes.

**Respondents could select multiple options. Findings may therefore exceed 100%.

*** IPC, [Acute Food Insecurity And Acute Malnutrition Analysis](#) (April - June, 2026)

METHODOLOGY

The study employed a quantitative methodology, with baseline and endline surveys conducted through a **hybrid mobile data collection approach combining both in-person and remote interviews**. Baseline interviews were conducted in person at the Stabilisation Centers (SCs), while endline interviews were conducted remotely via telephone and the data was entered in Kobo Collect. **Under the Direct Nutrition Referral (DNR) approach, HHs were identified based on the nutritional status of children under five, particularly those diagnosed with severe acute malnutrition (SAM) and referred through SCs. As such, the assessed population represents a nutritionally vulnerable subgroup rather than the general population.** Following collection, the data was cleaned and analyzed using R software. The data was weighted to ensure representativeness of the target population, providing a statistically robust basis for comparing baseline and endline results. The study collected data on household demographics, overall food security, income, expenditure, overall well-being, as well as perceptions of whether the humanitarian assistance offered was delivered in a safe, accessible, accountable, and participatory manner.

Out of the 634 HHs targeted by the intervention, a total of 199 HHs were assessed physically during the baseline, conducted between 13th January and 18th February 2026 on-rolling basis. At the endline 202 HHs were surveyed after the third and last round of cash transfer, between 6th and 7th of May 2026. The targeted households were randomly selected from the list of registered beneficiaries. For sampling, a simple random sampling approach was used to have a representative sample of the beneficiary households, with a 95% confidence level and a 7% margin of error. As part of the DNR approach, IMPACT received beneficiary lists on a rolling weekly basis. Consequently, baseline data collection was conducted on a rolling basis until the required sample size was reached, ensuring that the sample remained representative of the cohorts assessed. **A 15% buffer was applied to account for potential non-responses and surveys that may need to be excluded during the data cleaning process.**

LIMITATIONS

- A broader issue relates to the alignment between the MPCA modality, particularly under the DNR approach, and the indicators currently being used. Some indicators may not fully capture the programme objectives or reflect the specific targeting criteria of this cohort, as households were selected based on the nutritional vulnerability of children within the household rather than broader economic vulnerability indicators.
- While the referral-based approach appears to have enabled targeted support to households with acutely malnourished children, the assessment did not examine referral completion rates, delays between referral and cash receipt, continuity of nutrition treatment, or continued access to stabilization and outpatient nutrition services. These remain important areas for future learning and operational monitoring economic vulnerability indicators.
- Findings referring to a subset of the total population may have a wider margin of error and a lower level of precision. Therefore, they may not be generalizable and should be considered indicative only.
- Due to slight differences between the baseline and endline demographics, only endline demographics are reported.
- As the two assessments took place during different seasonal periods, with the endline coinciding with the onset of the lean season, seasonal effects should be considered when interpreting changes in outcomes between baseline and endline.

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ABOUT IMPACT

Founded in 2010 and headquartered in Geneva, IMPACT Initiatives is a leading applied research organization and the largest independent provider of data in crisis-affected contexts. Through our initiatives—REACH, AGORA, and PANDA—we enable humanitarian and other aid actors to make better, evidence-based decisions by delivering timely, relevant, and methodologically rigorous data and analysis. Our extensive presence across crisis-contexts allows us to collect data directly from crisis-affected population, including among the most vulnerable and hard-to-reach.