THE KENYA CASH CONSORTIUM RESPONSE TO THE UNREGISTERED REFUGEES IN DADAAB REFUGEE CAMPS - ENDLINE SURVEY, NOVEMBER 2022

BACKGROUND & OVERVIEW

The Dadaab refugee complex was first established in 1991, when refugees fleeing the civil war in Somalia started to cross the border into Kenya. A second large influx occurred in 2011.[1] The first two camps (Dagahaley and Ifo) are located in Lagdera (Dadaab) subcounty while the third camp, Hagadera, is located in the neighbouring Fafi subcounty. As of 31st of October 2022, the population hosted in the three Dadaab camps amounts to 233,726 refugees and asylum seekers.[2] According to the multi-sector needs assessment conducted by REACH in Kenya's Dadaab Camp in 2021,[3] these refugees and asylum seekers are reportedly in need of livelihood opportunities among other needs such as food, education, health and nutrition, WASH items, and protection services. Some do not have proper documentation while other households (HHs) reported perceiving that unregistered HH members experienced challenges such as arrests or reduced access to basic services. The drought situation prevailed[4] at the time of data collection, resulting in an influx of refugees and may have worsened the living conditions in the camps.

In order to support their needs, humanitarian agencies have increasingly adopted cash transfers as central elements of their social protection and poverty reduction strategies. A growing number of studies[5] provide rigorous evidence on the impact of cash transfers, and the role of specific cash transfer design and implementation features in shaping outcomes. The Kenya Cash Consortium (KCC) intervened to improve the livelihoods of the 'Unregistered Refugees'.[6] The intervention consists of six rounds of Multi-Purpose Cash Transfers (MPCTs) to 1,055 unregistered HHs in Dadaab refugee camps, planned between June and November 2022. This intervention is funded by the European Civil Protection and Humanitarian Aid Operations (ECHO). The cash transfers are led by the Relief, Reconstruction & Development Organisation (RRDO), the Arid, and Semi-Arid Lands Humanitarian Network (AHN) and ACTED.

To monitor the impact of the MPCTs provided by the KCC on the targeted HHs, IMPACT Initiatives provided impartial third-party monitoring and evaluation. IMPACT Initiatives conducted the endline assessment between 14th to 17th of November 2022, after the last cycle of cash transfer.

This factsheet presents the key findings from the endline, and a comparison of some indicators from the baseline and midline.

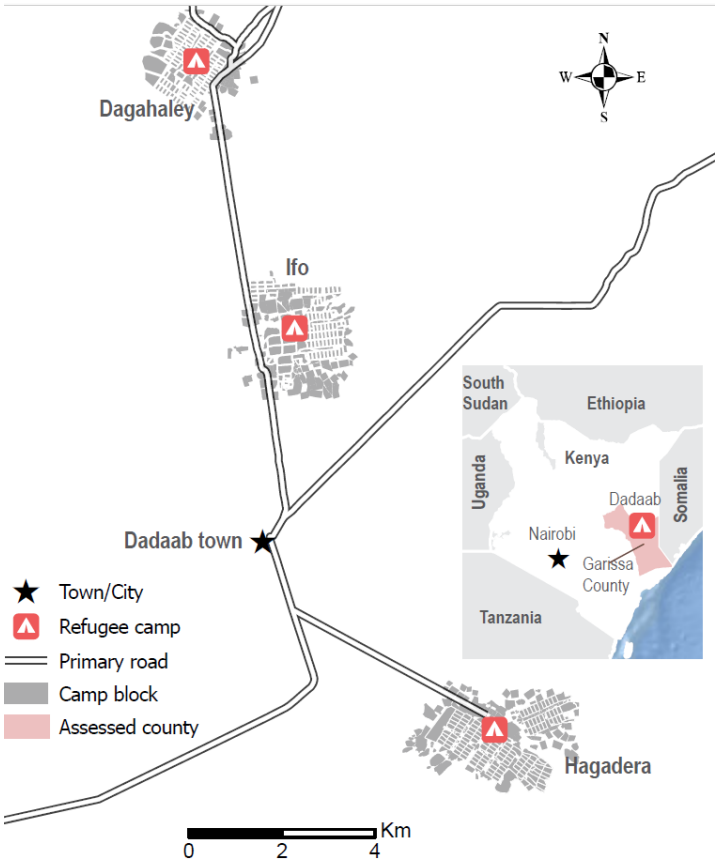
METHODOLOGY

The endline tool was designed by IMPACT Initiatives in partnership with KCC members. The tool covers income and expenditure patterns, food consumption, dietary diversity, and coping strategies.

A simple random sampling approach was used to ensure data was representative of the beneficiary HHs enrolled for the MPCTs by the KCC, at the HH level. Out of the 1,055 beneficiary HHs, a sample of 313 HHs were interviewed (Ifo 109, Dagahaley 106, and Hagadera 98). The data was representative of the target unregistered HHs, with a 95% confidence level and a 5% margin of error.

The interviews were conducted remotely through mobile phone calls and beneficiary responses entered in open data kit (ODK). Data cleaning, integrity checks, quality assurance and analysis were conducted using the R statistical software.

LOCATIONS COVERED



DEMOGRAPHICS

From the demographic findings, there was a higher proportion of female respondents as compared to the male, (55% female, 45% male). The proportion of HHs that were reportedly headed by men were 55% while those headed by women were 45%.

Average age of the head of HH:	45 years
Average HH size:	10

CHALLENGES & LIMITATIONS:

- Data on HH expenditure was based on a 30-day recall period; a considerable period of time which makes it difficult for HHs to remember their expenditures accurately. This might have negatively impacted the accuracy of reporting on the expenditure 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 with a known confidence level and margin of error and should be considered indicative only.
- As no statistical significance check was conducted, comparisons between baseline and endline findings should be considered indicative only.

The Project is funded by the European Union.

INCOME & EXPENDITURE

AVERAGE MONTHLY INCOME & SOURCE

All assessed HHs reportedly had some income and expenditure in the 30 days prior to data collection.

Average reported amount of income earned in the 30 days prior to data collection:[7]

Baseline KES 4,996
Midline KES 13, 772
Endline KES 11,651

Most commonly reported primary sources of HH income in the 30 days prior to data collection:[8,14]

1. **98%** Humanitarian assistance
2. 59% Sale of humanitarian assistance
3. 34% Remittances
4. 32% Formal employment
5. 27% Casual labour wage (portage, construction etc.)

The most frequently reported source of HH income is the humanitarian assistance (98%). The prevailing drought at the time of data collection may have led to dwindled incomes. According to the respondents, the situation is likely to worsen with the MPCTs coming to an end.

EXPENDITURE SHARE

Average reported amount of expenditure for HHs that had spent any money in the 30 days prior to data collection (100%):

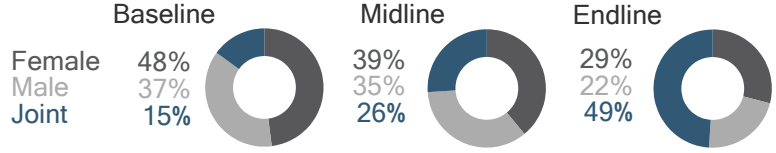
Baseline KES 4,933
Midline KES 10,933
Endline KES 9,123

Share of average expenses made in the 30 days prior to data collection per expenditure category:

Expenses (KES)	Baseline	Midline	Endline
Food	2,011	5,449	5,092 (56%)
Medicine	526	1,229	1,882 (11%)
Repayment of debt taken for food items	409	2,033	1,311 (9%)
Education	485	976	832 (9%)
WASH items	448	871	538 (6%)
Other expenses	258	385	1,029 (6%)

SPENDING DECISIONS

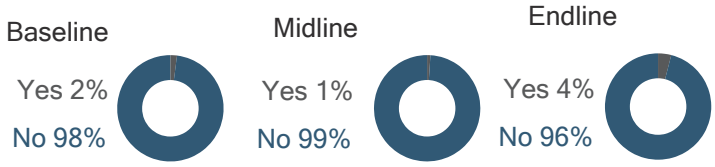
% of HHs by reported primary spending decision-maker:



The spending decisions were more jointly reached at the end of the endline (49%) compared to the baseline assessment (15%).

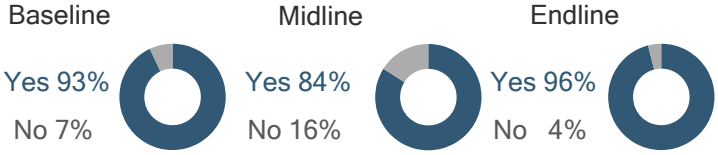
SAVINGS & DEBT

% of HHs reporting having any amount of savings at the time of data collection:



The percent of respondents reporting having any amount of savings at the time of data collection slightly increased at endline compared to the baseline assessment.

% of HHs reporting being in debt at the time of data collection:



Average reported amount of debt for HHs with at least some debt at the time of data collection:

Baseline KES 26,874
Midline KES 26,073
Endline KES 23,702

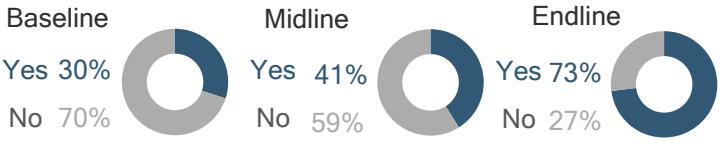
A slightly higher proportion of HHs reported being in debt at the time of the endline data collection (96% up from 93% during the baseline). The overall average debt amount among those who reported debt was however lower by 3,172 KES.

Among the HHs who reported being in debt at the time of endline data collection (n=299), % of households by most frequently reported reasons for taking debt:[8,14]

1. 92% Accessing food
2. 68% Paying for healthcare
3. 60% Paying for education
4. 36% Paying for other basic needs
5. 21% Paying for shelter maintenance

BARRIERS IN ACCESSING SERVICES

% of HHs reporting that their HH members faced barriers in accessing services in Dadaab due to the lack of registration in the 12 months prior to data collection:



A much a higher proportion of HHs reported facing barriers in accessing services due to the lack of registration at the time of endline data collection (73%) compared to baseline (30%).

Among those HHs reporting facing barriers in accessing services (n=227), services that they faced barriers when accessing were: healthcare (82%), food assistance (68%), education (55%) and WASH items (17%).

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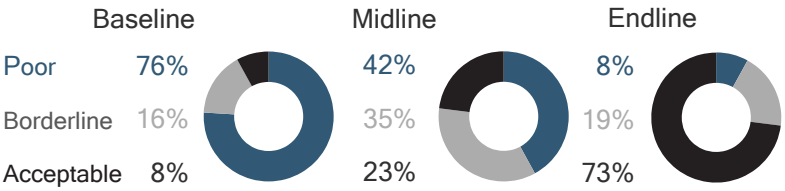
Key Indicators on Food Security and Livelihood

The key indicators include: Food Consumption Score (FCS), Household Dietary Diversity Score (HDDS), reduced Coping Strategies Index (rCSI), and Livelihood Coping Strategies Index (LCSI).

Food Consumption Score (FCS)[9]

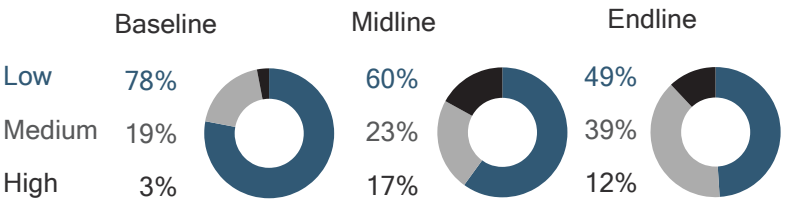
% of HHs by FCS category



A positive shift in the FCS appears to have been registered among HHs at the endline, for HHs that had an acceptable FCS (8% at the time of baseline data collection which increased to 73% at the time of the endline).

Household Dietary Diversity Score (HDDS)[10]

% of HHs by HDDS category



Reduced Coping Strategies Index (rCSI)[11]

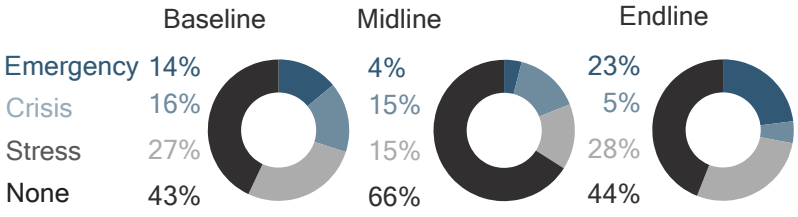
The average rCSI for HHs at the time of endline data collection was found to be 21.88, as compared to 14.69 at the time of baseline data collection.

% of HHs by types of negative consumption-based coping strategies reportedly employed in the week prior to data collection:[14]

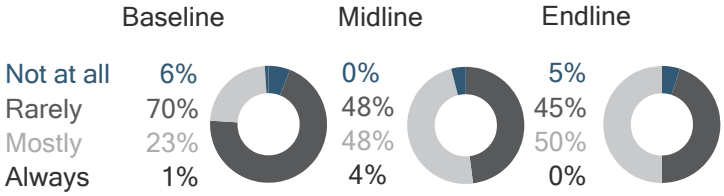
Strategy adopted	Average number of days per week per strategy	
	Baseline	Endline
Reduced portion size of meals	2.1	4.1
Reduced the number of meals eaten per day	2.2	3.7
Restricted adults' consumption so children can eat	1.7	1.9
Relied on less preferred, less expensive food	1.9	4.2
Borrow food, or rely on help from friends or relatives	1.7	1.9

Livelihood-based coping strategies (LCS)[12]

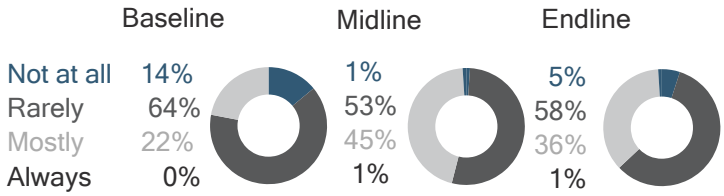
% of HHs by LCS category



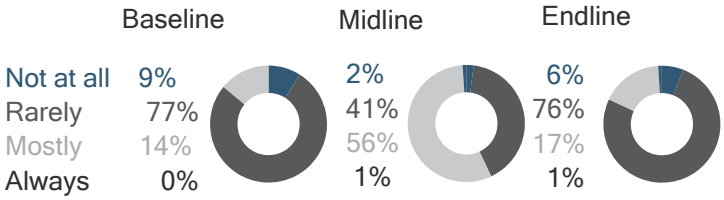
% of HHs reporting having had sufficient quantity of food to eat in the 30 days prior to data collection:



% of HHs reporting having had sufficient variety of food to eat in the 30 days prior to data collection:

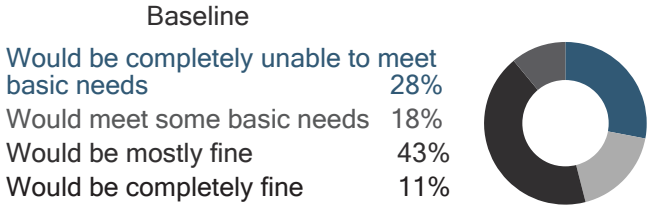


% of HHs reporting having had enough money to cover basic needs in the month prior to data collection:

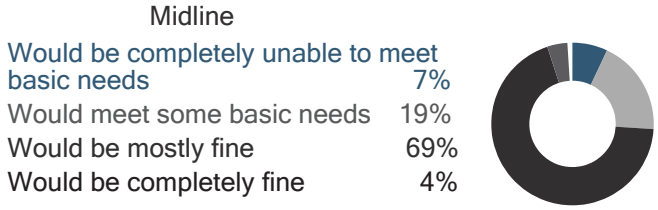


% of HHs reporting the expected effect that a crisis or shock would have on their wellbeing at the time of data collection:

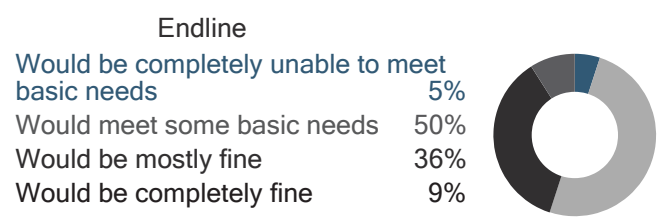
Baseline



Midline



Endline



The positive food security outcomes may have been a result of heavy reliance on negative coping strategies among the HHs. This is also evident from the LCS. The highest share of expenses among HHs was accessing food (56%) which may imply that in the long run, when the coping mechanisms are depleted, HHs will remain food insecure.

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Accountability to Affected Populations

The accountability to affected populations is measured through the use of Key Performance Indicators (KPIs) which have been put in place by the ECHO to ensure that humanitarian actors consider the safety, dignity and rights of individuals, groups and affected populations when carrying out humanitarian responses.

The % of beneficiary HHs reporting on key indicators on accountability to affected populations.

	Baseline	Midline	Endline
Programming was safe	100%	100%	100%
Programming was respectful	99.7%	100%	100%
Community was consulted	15.1%	15.6%	21.4%
No payments to register	99.4%	100%	100%
No coercion during registration	99.4%	99.7%	100%
No unfair selection	99.7%	100%	100%
Average KPI Score	86%	86%	92%

% of HHs that reported their awareness on how to contact the agency in case of questions or problems with assistance:

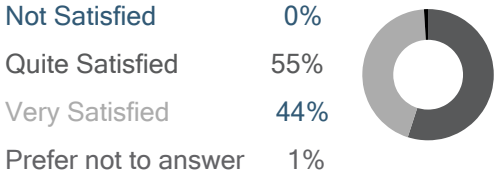
Awareness of options	Baseline	Midline	Endline
Use the dedicated NGO hotline	37%	1%	51%
Talk directly to NGO staff	46%	56%	49%
Use the dedicated NGO desk	8%	24%	15%

The use of the dedicated NGO hotline had the highest awareness at the time of the endline data collection (51%) compared to the time of the midline data collection (1%) or at the time of the baseline data collection (37%).

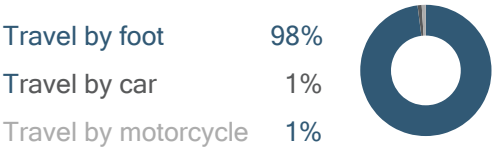
This may be attributed to the sensitization activities conducted. At the time of the baseline data collection, beneficiaries were sent SMS (short message service) with the hotline number. The main message was on how to use the hotline number. Subsequently, focus group discussions and the Complaints, Response, and Feedback Mechanism (CRFM)[13] awareness activities were conducted to sensitise the community on the hotline options.

Payment Process

% of HHs reporting their overall level of satisfaction with the payment process:



% of HHs reporting their mode of travel to receive their cash:



Preferred method of assistance

All HHs' (100%) preferred mobile money.

Reasons for preferring mobile money by % of HHs:

1. 97% Mobile money is easily accessible
2. 27% Gives more flexibility during purchase
3. 2% Personal preference

Endnotes

[1] https://www.unhcr.org/ke/dadaab-refugee-complex

[2] https://www.unhcr.org/ke/wp-content/uploads/sites/2/2022/11/Kenya-Refugee-Population-Statistics-Package-31-October-2022.pdf

[3] REACH Kenya MSNA (2021), "Multi-Sector Needs Assessment, Dadaab refugee complex, Garissa County, Kenya" available at: https://www.impact-repository.org/document/repository/fcb82a24/REACH_KEN_MSNA_SO_Dadaab_December-2021-.pdf

[4] https://reliefweb.int/report/kenya/drought-somalia-triggers-new-influx-refugees-dadaab

[5] Bastagli F., Hagen-Zanker J., Harman L., Barca V., Sturge G., & Schmidt L., "Cash transfers: what does the evidence say?, A rigorous review of programme impact and of the role of design and implementation features", ODI.

[6] Unregistered refugees and asylum seekers are people who have left their country because of a threat to their life but are not granted the refugee status in the hosting country. Kenya stopped processing refugee registration in 2016.

[7] The midline and endline income are inclusive of MPCTs. Without the MPCTs, HHs would be more susceptible to food insecurity and engage in negative coping strategies.

[8] Respondents could select multiple options. Findings may therefore exceed 100%.

[9] The FCS measures how well a HH is eating by evaluating the frequency at which differently weighted food groups are consumed. The FCS is used to classify HHs into three groups; "poor", "borderline", and "acceptable" FCS. Only HHs with an acceptable FCS are considered food secure, while those with borderline or poor FCS are considered moderately or severely food insecure respectively.

[10] The HDDS for HHs can be further classified as food insecure if their diet is generally considered non-diversified, unbalanced and unhealthy. The HDDS is used to classify HHs into three groups: high, moderate or low dietary diversity. HHs with a high HDDS are considered food secure, while those with moderate or low HDDS are considered moderately or severely food insecure.

[11] The rCSI is an indicator used to understand the frequency and severity of changes in food consumption behaviors. The higher the rCSI value, the higher the degree of food insecurity. The minimum possible rCSI value is 0, while the maximum is 56.

[12] The LCS is a measure used to better understand longer-term HH coping capacities. HHs are classified into four groups: "emergency", "crisis", "stress", or "neutral" coping strategies. The first three LCS reduces the HHs' resilience and assets, in turn, increasing their likelihood of being food insecure.

[13] The Complaints, Response, and Feedback Mechanism (CRFM) provides an array of channels which are context specific to enable beneficiaries provide feedback and raise complaints. The other channels of communication are direct phone lines, SMS, banners and posters.

[14] Most frequently reported choices

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Breakdown of Key Indicators

Key Indicators		Baseline	Midline	Endline
Food Consumption Score (FCS)	Poor (0-21)	76%	42%	8%
	Borderline (21.5 - 35)	16%	35%	19%
	Acceptable (> 35)	8%	23%	73%
Livelihood Coping Strategy Index (LCSI)	Emergency	14%	4%	23%
	Crisis	16%	15%	5%
	Stress	27%	15%	28%
	Neutral	43%	66%	44%
Household Dietary Diversity Score (HDDS)	Low	78%	60%	49%
	Medium	19%	23%	39%
	High	3%	17%	12%
Average Reduced Coping Strategy Index (rCSI)		14.69	8.81	21.88
Average household income in the month prior to data collection		KES 4,996	KES 13,772	KES 11,651
Average household total expenditure in the month prior to data collection		KES 4,933	KES 10,933	KES 9,123
Average proportion of total expenditure spent on food in the month prior to data collection		45%	50%	56%