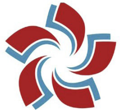
FACTSHEET

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

Funded by European Union Humanitarian Aid



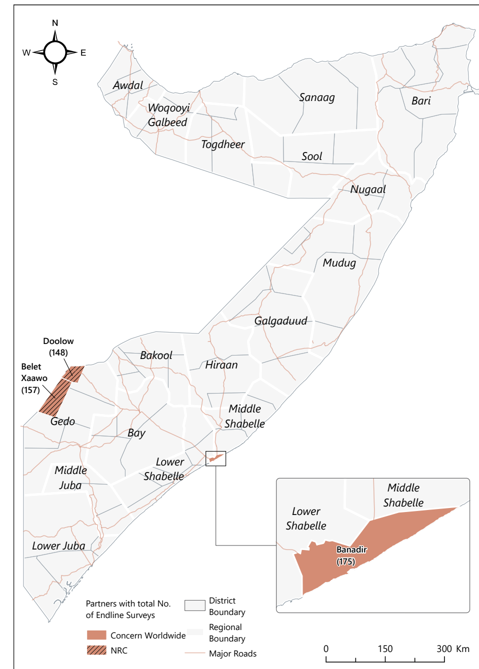
SOMALI CASH CONSORTIUM

NOVEMBER 2025
GEDO & BANADIR REGIONS, SOMALIA

KEY MESSAGES

- The endline results demonstrate **improvements in household (HH) food security status.** Food consumption score (FCS) improved, with HHs reporting acceptable FCS increasing from 5% at baseline to 41% at endline, while poor FCS decreased from 60% to 12%. **Hunger levels also shifted significantly:** HHs with no or little hunger increased from 19% to 63%, and severe hunger nearly disappeared, decreasing from 14% to just 1%.
- **Multi-purpose cash assistance (MPCA) strengthened HH economic capacity.** Average monthly income increased by 72% (USD 79 to USD 136), while expenditure increased by 80% (USD 74 to USD 133), **with food absorbing more than half of total spending.** Debt prevalence fell from 90% to 70%, and average debt declined by 41% (USD 104 to USD 61). Savings, though modest, roughly tripled from 5% to 17%, showing progress in financial stability.
- **The use of consumption-based coping strategies by households declined.** High reliance on reduced Coping Strategy Index (rCSI) decreased, with the proportion of HHs in the high rCSI category dropping from 62% to 12%, while the proportion of HHs reporting low or medium rCSI increased to 88%. **However, livelihood-based coping showed a mixed trend;** stress and crisis strategies declined, though emergency coping increased slightly, reflecting persistent fragility.

COVERAGE MAP 2025



CONTEXT & RATIONALE

By mid-2025, Somalia was facing one of its most complex humanitarian crises in recent years. An estimated 4.6 million people were experiencing acute food insecurity (IPC Phase 3 or above), with 1.8 million children acutely malnourished.[1] The Gu season (April–June) brought mixed outcomes: while parts of the country saw improved pasture and water availability, localized flooding in southern regions destroyed crops and displaced households, while northern areas remained dry, exacerbating drought conditions. Cholera and measles outbreaks were reported in multiple districts, further straining already fragile health systems. Funding gaps persisted across humanitarian clusters, with less than half of required resources mobilized, limiting coverage and leaving many households without assistance.[2]

In Dollow and Belet Xawo (Gedo region), renewed clashes between Federal Government forces and Jubaland State security forces triggered significant population displacement.[3] Displaced households faced restricted movement, insecurity, and limited access to humanitarian assistance due to ongoing tensions and logistical constraints in the area.[4]

In Banadir, high levels of urban displacement continued to drive humanitarian vulnerability, as large numbers of displaced households reside in informal settlements characterized by overcrowding, poor sanitation, and limited access to essential services.[5] These conditions have contributed to recurring disease outbreaks, including cholera and measles, which disproportionately affect children and exacerbate nutrition vulnerabilities among already food-insecure households.[6]

To address the impact of some of these challenges, the Somali Cash Consortium (SCC),[5] with funding from European Union Civil Protection and Humanitarian Aid (ECHO), delivered three rounds of MPCA to vulnerable households **between June 2025 and September 2025.** The MPCA was aligned with the harmonised regional transfer values, based on the Minimum Expenditure Basket (MEB).[6] This intervention targeted vulnerable households in Afgoye and Banadir, with IMPACT assessing pre- and post-assistance outcomes through a baseline and endline methodology covering food security, coping strategies, income, expenditure, and accountability. **While the findings provide evidence of improvements in household food security and economic stabilization among nutritionally vulnerable households, the assessment did not measure child nutrition recovery, treatment completion, relapse, or post-treatment nutrition outcomes directly.**

This factsheet presents the key findings from the modification request 2 (MR2) endline assessment, as well as indicative comparisons of key indicators from the baseline assessment for the assessed beneficiary HH in Banadir and Gedo regions.

1. UNICEF, Humanitarian Situation Report No. 06 (Jan–June 2025).
2. OCHA, Humanitarian Situation Update, June 2025.
3. NAPAD, Humanitarian Situation Report: Conflict-Induced Displacement in Belet-Hawa and Dolow, Somalia.
4. ibid.
5. OCHA, Humanitarian Needs and Response Plan, Somalia 2025.
6. ibid.
5. SCC is led by Concern Worldwide and further consists of Acted, Cooperazione Internazionale (COOPI), Danish Refugee Council (DRC), Norwegian Refugee Council (NRC), and Save the Children (SCI).
6. 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).

IMPACT Shaping practices Influencing policies Impacting lives

FOOD SECURITY AND LIVELIHOODS (FSL)

FOOD CONSUMPTION SCORE (FCS)[8]

% of HHs by Food Consumption Score category:

	Baseline	Endline
Acceptable (>42)	5%	41%
Borderline (28-42)	35%	47%
Poor (<28)	60%	12%
	Baseline	**Endline**
Average FCS score per HH	26.3	43.1

Endline findings show a remarkable improvement in HH food consumption compared to the baseline. The average FCS rose from 26.3 to 43.1, crossing into the "acceptable" threshold. These improvements highlight the role of MPCA in enabling HHs to diversify their diets and purchase more diverse food, even in the face of inflationary prices and disrupted markets.

Against this backdrop, cash assistance is likely to have provided a critical buffer, allowing HHs to access food despite widespread shortages.

HOUSEHOLD HUNGER SCALE (HHS)[9]

% of HHs by levels of hunger in the HH:

	Baseline	Endline
No or little hunger	19%	63%
Moderate hunger	67%	36%
Severe hunger	14%	1%

The Household Hunger Scale results reinforce the positive impact of MPCA on food security. At baseline, only 19% of HHs reported no or little hunger, while 14% experienced severe hunger. By the endline, HHs with no or little hunger had increased to 63%.

These findings suggest that cash assistance likely reduced acute food deprivation and allowed families to meet their immediate consumption needs. However, moderate hunger persists, reflecting ongoing structural constraints.

USE OF COPING MECHANISMS

% of HHs by average reduced Coping Strategy Index (rCSI) category:[10]

	Baseline	Endline
Low	3%	20%
Medium	35%	68%
High	62%	12%
	Baseline	**Endline**
Average rCSI per HH	23.1	9.6

Most commonly adopted coping strategies:**

The average days utilizing the coping strategy reported in the 7 days prior to data collection:

	Baseline	Endline
Relied on less preferred, less expensive food	3.9	1.7
Reduced the number of meals eaten per day	3.2	1.3
Reduced portion size of meals	3.1	1.2
Borrowed food or relied on help from friends or relatives	3.2	1.3
Restricted adults consumption so children can eat	2.2	0.9

LIVELIHOOD-BASED COPING INDEX (LCSI)[11]

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

	Baseline:	Endline:
None	17%	24%
Stress	34%	24%
Crisis	20%	16%
Emergency	30%	36%

The proportion of households with low rCSI increased markedly from baseline to endline, rising from 3% to 20%. As shown in Annex 1, among the assessed HHs, HHs in Dollow recorded the most significant improvement, with high rCSI dropping from 70% to just 1%. Assessed HHs in Belet Xaawo also showed substantial progress, declining from 68% to 4%, although most remained in the medium coping category.

Compared to the assessed districts in Gedo, **Banadir HHs demonstrated more limited improvements across several food security and coping indicators**. This may reflect the constraints associated with urban displacement contexts, including higher living costs, rental obligations, stronger dependence on market purchases, and reduced access to own-production or livestock-based coping options.

These patterns suggest that while reliance on negative consumption-based coping strategies declined across all assessed districts, households in Banadir continued to face greater constraints, likely linked to urban vulnerability and displacement. Whereas most HHs were concentrated in the high rCSI category at baseline, by endline the majority had shifted into medium and low categories. Therefore, these changes point to reduced dependence on harmful coping mechanisms and improved food security, though broader contextual factors may also have influenced outcomes.

The analysis of LCS presents a mixed trend. Stress and crisis coping mechanisms declined from 34% to 24% and 20% to 16% respectively, indicating reduced reliance on short-term negative strategies. **However, the continued use of severe coping remains notable:** reducing essential health expenditures (30%) and entire household migration to urban areas (29%) were most commonly reported, followed by withdrawing children from school (14%), selling last female productive animals (11%), and begging (2%).

8. 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.
9. The Household Hunger Scale (HHS) is an indicator to measure household hunger in food insecure areas. Read more here.
10. 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.
11. 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.
* Modification Request 2
** 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)	**79%**	**62%**
Humanitarian assistance	**15%**	**36%**
Livestock sales & production	**10%**	**29%**
Casual labour (farm labour)	**24%**	**12%**

	Baseline	Endline
Average reported monthly amount of income for HHs that received any income in the 30 days prior to data collection (100%):	**79.28 USD**	**136.08 USD**

EXPENDITURE

	Baseline	Endline
Average reported monthly expenditure for HHs that had spent any money in the 30 days prior to data collection (100%):	**73.83 USD**	**133.07 USD**

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

	Average amount spent in the 30 days prior to data collection by HHs reporting spending >0 USD in this category		Proportion of total spending across all HHs, including HHs who spent 0 USD[12] at the endline
	Baseline	Endline	
Food	40.55 USD	69.47 USD	**54%**
Medical expenses	5.81 USD	12.74 USD	**10%**
Clothing	4.14 USD	11.27 USD	**9%**
Debt repayment for food	5.58 USD	10.56 USD	**7%**
Debt repayment for non-food items	2.67 USD	6.96 USD	**5%**
Water	4.08 USD	5.87 USD	**5%**

SAVINGS & DEBT

More than two-thirds assessed households (70%) were found to have debt. The average household debt was found to be **USD 61.47** at the endline. This was a decrease from the baseline, where **90% reportedly had debt averaging USD 103.78.**

Only 17% (n=80) of the households reportedly had marginal savings, averaging USD 10.6 at the endline. During the baseline assessment, the proportion of households found to have savings was 5% averaging to USD 1.24.

ECONOMIC CAPACITY TO MEET ESSENTIAL NEEDS[13]

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

	Baseline	Endline
Yes	17%	26%
No	83%	74%

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

	Baseline	Endline
Market purchase with cash	**41%**	**52%**
Loan	**11%**	**11%**
Market purchase on credit	**15%**	**6%**

At endline, casual wage labour (62% of households) and farm labour (12%) remained key income sources, alongside increased diversification. Reliance on humanitarian assistance rose from 15% to 36%, and livestock sales from 10% to 29%. However, these shifts should be interpreted in light of seasonal dynamics. Baseline data collection (June–August) coincided with the post-Gu period, when labour opportunities are relatively higher, while endline data (September–October) aligned with the onset of the lean season, when households typically experience reduced income and may resort to livestock sales or increased reliance on assistance. **As such, the observed increase in livestock sales likely reflects seasonal and potentially distress-driven coping rather than sustained livelihood improvement.**

Average monthly income increased from USD 79.28 to USD 136.08, alongside a rise in expenditure from USD 73.83 to USD 133.07, reflecting both improved purchasing capacity and seasonal cost pressures. **Food remained the largest expenditure category,** representing 54% of total spending, while medical expenses accounted for 10% and clothing 9%. Debt repayment also featured prominently, with 7% of spending on food-related debts and 5% on non-food debts, underscoring the burden of credit reliance. Debt prevalence fell from 90% to 70%, and average debt declined from USD 103.78 to USD 61.47, while savings increased from 5% to 17%, averaging USD 10.6.

HHs' ability to meet essential needs improved slightly, with those surpassing the MEB increasing from 17% to 26%. Most HHs remained below the MEB threshold at endline, suggesting that MPCA supported short-term consumption stabilisation but was insufficient on its own to fully close essential needs gaps in a context characterized by high vulnerability and rising living costs.

Market purchases with cash became the dominant food source, increasing from 41% to 52%, while reliance on credit purchases dropped from 15% to 6%. **Therefore, MPCA likely strengthened HH income, reduced debt, and enabled modest savings, though food costs continued to dominate spending and exposure to shocks remained high.**

* Respondents could select up to three options. Findings may therefore exceed 100%.
12. 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.
13. 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):[14]

Indicator	Baseline	Endline
Programming was safe	100%	100%
Programming was respectful	100%	100%
Community was consulted	32%	23%
The assistance was appropriate	86%	74%
No unfair selection	100%	100%
Raised concerns using complaint response mechanism (CRM)	12% (n=1)	20% (n=95)
Satisfied with the response	83% (n=83)	95% (n=95)
Overall KPI score	**82%**	**82%**

Of households reporting being aware of any option to contact the NGO (21%, n=101) during the endline, the most frequently known ways to report complaints and problems in receiving the assistance:**

	Baseline	Endline
Use the dedicated NGO hotline	88%	68%
Talk directly to NGO staff	22%	32%
Use the dedicated NGO desk	16%	14%

CONCLUSION

Findings suggest that the DNR implementation contributed to improvements in household food security and coping strategies across Banadir and Gedo regions. Endline findings show that households 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 households. Income and expenditure levels increased, debt burdens declined, and modest savings began to emerge, signalling progress toward greater financial stability. **It is important to note that the endline was conducted during the lean season, when households generally face reduced food access and increased reliance on coping strategies. Therefore, the observed improvements likely reflect programme contribution even within a seasonally adverse period.**

The programme seems to have strengthened HH' ability to meet essential needs, and reduced dependence on credit purchases, choices that translated into more diverse diets and improved caloric intake. **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 decreased from 32% at baseline to 23% at endline, indicating limited opportunities for meaningful engagement. **This reduction is likely linked to the referral-driven design of the intervention, where the nutrition-based approach relied primarily on enrollment through referrals, inherently constraining early-stage community consultation.**

At the same time, the decline in 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.**

Similarly, perceptions of assistance appropriateness decreased from 86% to 74% during the same time. Livelihood coping patterns at endline show a mixed picture. While reliance on less severe strategies declined, the continued use of emergency coping indicates that households remain vulnerable and still resort to asset-depleting measures when faced with shocks.

14. 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%.

METHODOLOGY

The study employed a quantitative methodology, with baseline and endline surveys conducted through **a hybrid mobile data collection approach combining in-person and remote interviews.** Baseline interviews were conducted in person at Stabilisation Centers (SCs), while endline interviews were conducted remotely via telephone. The sample was drawn from households receiving MPCA under the Direct Nutrition Referral (DNR) approach in Banadir and Gedo regions. **Under the 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**.

The baseline and endline assessments conducted collected data on the households' demographics, their overall food security situation, income, expenditure, overall well-being, as well as their perceptions of whether the humanitarian assistance offered was delivered in a safe, accessible, accountable, and participatory manner. The assessment focused on household-level outcomes and did not track individual child nutrition outcomes; therefore, it does not capture post-treatment nutritional status, relapse rates, or continued access to nutrition or health services.

The baseline assessment was conducted between 4th June 2025 and 18th of August 2025, while the endline assessment followed after the third and last round of cash transfer per activation, from 29th September 2025 to 26th of October 2025. A probability-based simple random sampling approach was employed at the cohort level **(referrals of households with children under five suffering from SAM**. The sample size was calculated using a 95% confidence level and a 7% margin of error.

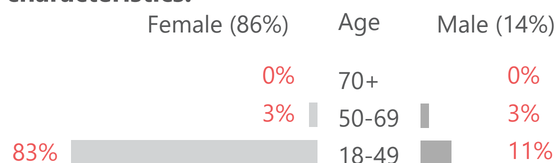
As part of the DNR approach, **IMPACT received beneficiary lists on a rolling weekly basis.** Consequently, baseline data collection was **conducted on a rolling basis until the required sample size was reached,** ensuring that the sample remained representative of the cohorts assessed. Out of a total of 1,600 beneficiary households, 1,160 households were successfully interviewed **using a hybrid data collection approach.** To account for potential non-response and the removal of incomplete or invalid surveys during the data cleaning process, **a 15% buffer was incorporated into the sample size calculation.**

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 child nutrition vulnerability 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.
- Baseline and endline data were collected during different periods (June–August and September–October 2025), which correspond to distinct seasonal phases. The endline period aligns with the onset of the lean season in many areas, when food access typically deteriorates. As a result, direct comparisons between baseline and endline findings should be interpreted with caution, as observed changes may partly reflect seasonal effects rather than programme impact alone.
- Due to slight differences between the baseline and endline demographics, only endline demographics are reported.

ENDLINE DEMOGRAPHICS

% of HHs by head of the HH demographic characteristics:



Average age of the head of HH: **33**

Average HH size: **7**

SAMPLE BREAKDOWN

Districts	Agency	Caseload	Baseline Surveys	Endline Surveys
Belet Xaawo	NRC	500	205	157
Dollow	NRC	400	178	148
Banadir	Concern Worldwide	700	297	175
Total		1600	680	480

Annex 1 - Key Indicators Summary Per Assessed District

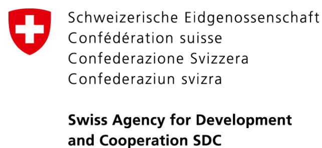
Districts	Food Security Indicators																	
	Food Consumption Score (FCS)						Households Hunger Scale (HHS)						Reduced Coping Strategy Index (rCSI)					
	Acceptable		Borderline		Poor		No/little hunger		Moderate hunger		Severe hunger		Low		Medium		High	
	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline
Belet Xaawo	0%	25%	5%	68%	95%	7%	1%	56%	65%	42%	34%	2%	0%	27%	25%	68%	75%	4%
Banadir	11%	39%	71%	43%	18%	18%	33%	54%	65%	45%	2%	1%	7%	8%	54%	66%	39%	26%
Dollow	0%	59%	8%	30%	92%	11%	15%	81%	74%	19%	12%	0%	1%	29%	15%	70%	84%	1%
Overall	**5%**	**41%**	**35%**	**47%**	**60%**	**12%**	**19%**	**63%**	**67%**	**36%**	**14%**	**1%**	**3%**	**20%**	**35%**	**68%**	**62%**	**12%**

BELET XAAWO
Food security outcomes improved but remain fragile. Acceptable FCS increased from 0% to 25%, showing households were able to diversify diets. Hunger also eased, with households reporting no or little hunger increasing from 1% to 56%, though moderate hunger remained high at 65%. Coping strategies shifted slightly, with households in the high rCSI category reducing from 75% down to 4%, and more households moving into medium coping.

BANADIR
Hunger levels improved, as households with no or little hunger increased from 33% to 54%, while severe hunger nearly disappeared, falling from 2% to 1%. Coping strategies also shifted positively: high rCSI households declined from 39% to 26%, while medium coping rose to 66%. **These results suggest that cash assistance helped urban households stabilize food access, though borderline consumption remains high, reflecting the pressures of displacement and urban poverty.**

DOLLOW
Dollow showed the most improvements across indicators. Acceptable FCS increased from 0% to 59%. Hunger levels shifted significantly, with households reporting no or little hunger increasing from 15% to 81%, and severe hunger falling from 19% to 12%. Coping strategies improved sharply: high rCSI households dropped from 70% to just 1%, while medium coping rose to 84%, indicating reduced reliance on harmful food-related practices. **Dollow's results demonstrate the strongest impact of MPCA, showing households were able to meet food needs more sustainably and reduce negative coping, though moderate hunger persists for a minority.**

FUNDED BY:



SCC IMPLEMENTING PARTNERS

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.

IMPACT Shaping practices Influencing policies Impacting lives