BASELINE FOR THE KENYA CASH CONSORTIUM RESPONSE TO THE UNREGISTERED REFUGEES IN DADAAB REFUGEE CAMPS

June 2022

Overview

A total of 234,034[1] refugees and asylum seekers, mostly of Somali origin resided in Dadaab refugee camps (Dagahaley, Hagadera and Ifo) as of the 30th of April 2022. Evidences gathered through the multi sectoral needs assessment (MSNA)[2] conducted in Dadaab in November 2021 show the presence of unregistered refugees in all the three camps. A considerable proportion (30%) of households (HHs) in Dagahaley, 5% in Ifo and 2% in Hagadera reported that none of their HH members were registered as refugees or asylum seekers at the time of 2021 MSNA[2] data collection. The two main reported reasons for HHs not being registered were unavailability of registration documents as refugees in the camps (33%) and some HHs had just arrived from other countries (7%). The MSNA 2021[2] findings suggested that unregistered HHs experience challenges unique to their status, including increased risk of arrest by security personnel, reduced access to services by humanitarian actors, lack of shelter and lack of access to food.

Therefore, in an urgent response to the deteriorating food security situation and with the aim of addressing rising livelihoods needs of the unregistered refugees, the Kenya Cash Consortium (KCC), led by ACTED, and the Arid and Semi-arid lands (ASAL) Humanitarian Network (AHN) and implemented by the AHN member the Relief, Reconstruction and Development Organization (RRDO) intervened. The intervention consists of six rounds of multi-purpose cash assistance (MPCA) to 1,055 unregistered HHs in Dadaab refugee camps, planned between June and September 2022.This action is funded by the European Civil Protection and Humanitarian Aid Operations (ECHO).

To monitor the impact of multipurpose cash assistance (MPCA) provided by the KCC to the targeted HHs, IMPACT Initiatives will provide impartial third-party monitoring and evaluation. IMPACT Initiatives conducted a baseline assessment from 1 to 4 June 2022, prior to the first round of cash transfers. A midline assessment will be conducted two weeks after the second cash transfer, and an endline assessment after the last round of transfers. **This factsheet presents the key findings from the baseline assessment among target beneficiaries.**

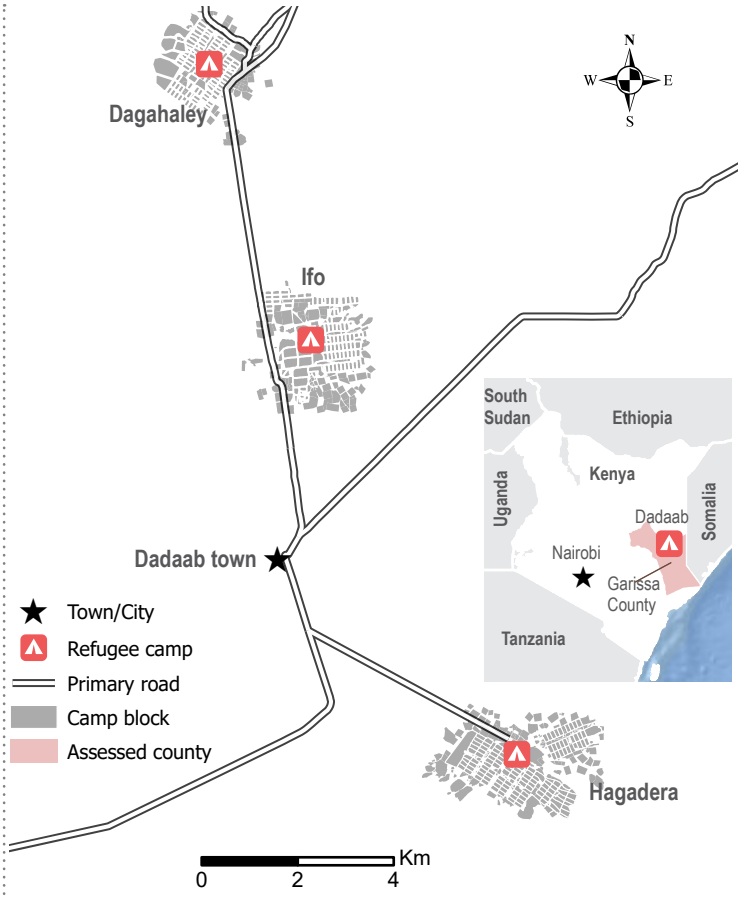
Methodology

The baseline tool was designed by IMPACT Initiatives in partnership with the 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 population HHs that are enrolled for the MPCAs by the KCC with a 95% confidence level and a 5% margin of error at Dadaab level. Out of the 1,055 beneficiary HHs, a sample of 318 HHs were interviewed. The surveys were conducted remotely through mobile phone calls and beneficiary responses entered in open data kit (ODK). More information on the methodology can be found here.

Challenges & Limitations:

- Data on HH expenditure was based on a 30-day recall period; a considerably long period of time over which to expect HHs to remember 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, may not be generalizable with a known confidence level and margin of error and should be considered indicative only.
- Some indicators may have been under- or over- reported due to the subjectivity and perception of the respondents. Some of the respondents may have responded according to what they think is the 'right answer' to certain questions.

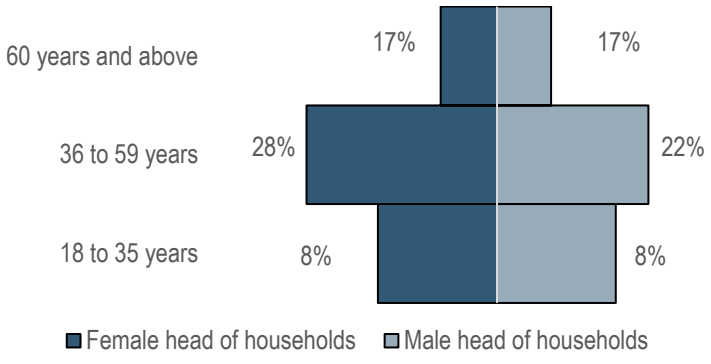
Locations Covered



Demographics

Majority of the interviews (56%) were conducted with female respondents. A higher proportion of HHs (53%) were reportedly headed by women while 47% of HHs were reportedly headed by men. A considerable proportion of HHs (34%) were headed by persons aged 60 years and above.

% of HHs by age and gender of the head of household:



Average age of the head of HH: 44 years

Average HH size: 9.11

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Barriers in accessing services for unregistered refugees

% 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:

Yes	30%
No	70%

The top reported reasons for the unregistered refugees lacking access to services in the 12 months prior to data collection were lack of money to pay for services (95%), lack of documentation (65%), as well as lack of money to cover for transport to facilities where the services were offered (61%).

Top reported services that HH members faced barriers in accessing due to lack of registration documents in the 12 months prior to data collection:[4]

Food assistance	98%
Health services	85%
Education services	76%
Water, sanitation and hygiene services	51%

Income & Expenditure

Income Source

Most commonly reported primary sources of HH income in the 30 days prior to data collection:[4]

Humanitarian assistance	89%
Sale of livestock and/or livestock products	45%
Casual labour wage (farm labour)	26%
Casual labour wage (construction labour)	25%
Remittances	23%

Average reported amount of income for HHs that received any income in the 30 days prior to data collection: 4,996 KES[3]

Expenditure Share*

The average reported amount of expenditure for HHs that had spent any money in the 30 days prior to data collection: 4,933 KES[3]

Most commonly reported expenditure categories and average amount spent (in KES[3]) per category per HH in the month prior to data collection:[4]

Food (2,011 KES[3])	45%
Medical expenses (526 KES[3])	12%
Education (485 KES[3])	11%
WASH items (448 KES[3])	11%
Debt repayment for food items (409 KES[3])	7%

*The expenditure share relates to 93.4% of the total HHs who reportedly spent money as per the listed categories, at the time of data collection.

Spending Decisions

% of HHs by reported primary spending decisions maker:

Female	48%
Male	37%
Joint decision-making	15%

Four percent of HHs (4%) reported experiencing problems or conflict over how to spend their income in the 30 days prior to data collection. The most common issues experienced by HHs were verbal violence (53.9%), physical violence (23.1%), and HH members being denied access to basic needs by others (15.4%).

Savings & Debt

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

Yes	2%
No	98%

Average reported amount of savings for HHs with any savings at the time of data collection: 3,901 KES[3]

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

Yes	93%
No	7%

The average reported amount of debt for HHs with any debt at the time of data collection: 26,874 KES[3]

HHs top reported reasons for taking debts at the time of data collection:[4]

To access food	98%
To access health care services	66%
To access education services	55%
To pay for rent or shelter maintenance	27%

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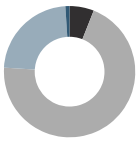
Subjective Well-being

% of HHs by most commonly reported primary sources of food in the 7 days prior to data collection:[4]

1	Food assistance	58%
2	Own production	15%
3	Market purchase with cash	9%

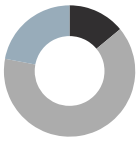
% of HHs reporting having had sufficient quantity of food to eat in the 30 days prior to data collection:

Not at all	6%
Rarely	70%
Mostly	23%
Always	1%



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

Not at all	14%
Rarely	64%
Mostly	22%
Always	0%



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

Not at all	9%
Rarely	77%
Mostly	14%
Always	0%

% of HHs reporting being able to meet their basic needs at the time of data collection:

Not at all	15%
Rarely	37%
Mostly	29%
Always	18%

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

Would be mostly fine	43%
Would be completely unable to meet basic needs	28%
Would meet some basic needs	18%
Would be completely fine	11%

Food security

Food consumption score (FCS)[5]

The FCS measures how well a HH is eating by evaluating the frequency at which differently weighted food groups are consumed by a HH in the seven days prior to data collection. Only foods consumed inside the HH living place are counted in this indicator. The FCS is used to classify HHs into three groups; those with a poor FCS, those with a borderline FCS, and those HHs with an acceptable FCS. Only HHs with an acceptable FCS are considered food secure, while those with borderline and poor FCS are considered moderately or severely food insecure respectively.

From the baseline survey, a high proportion of HHs (92%) were found to be either moderately or severely food insecure. FCS would likely be worse if HHs were not engaging in negative coping strategies.

Food security

% of HHs by FCS category:

Poor	Borderline	Acceptable
76%	16%	8%

Household dietary diversity (HDDS)[5]

HHs can be further classified as food insecure if their diet is non-diversified, unbalanced and unhealthy. The previous 24-hours' food intake of any member of the HH was used as a proxy to assess the dietary diversity of HHs. 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 respectively.

From the baseline survey, a high proportion of HHs (97%) were found to be either moderately or severely food insecure.

% of HHs by HDDS category:

Low	Medium	High
78%	19%	3%

Consumption-based coping strategies

The reduced Coping Strategy Index (rCSI[5]) is an indicator used to understand the frequency and severity of changes in food consumption behaviors in the seven days prior to data collection when HHs are faced with a shortage of food. The higher the rCSI value, the higher the degree of food insecurity. The minimum possible rCSI value is 0, while the maximum is 56.

The average rCSI for HHs was found to be 14.7, which indicates that HHs are likely to resort to severe measures to cope with the shortage of food. The three most commonly adopted coping strategies were found to be: Reducing the number of meals eaten per day, limiting portion sizes and relying on less preferred and less expensive food, **(to which HHs reportedly resort 2 days per week on average)**.

Livelihood-based coping strategies(LCS)[5]

The LCS[5] is measured to better understand longer-term HH coping capacities. HHs' livelihood and economic security is determined by income, expenditures and assets. The LCS is used to classify HHs into four groups: HHs using emergency, crisis, stress or neutral coping strategies. The use of emergency, crisis, or stress-level livelihoods-based coping strategies typically reduces HHs' overall resilience and assets, in turn increasing the likelihood of food insecurity.

Over half of the HHs (57%) were found to engage in emergency, crisis or stress level coping strategies[6] which indicate that these HHs are engaging in unsustainable strategies to cope and are likely to see a deterioration in food consumption in the near future.

The most commonly reported reasons for HHs adopting LCS in the 30 days prior to data collection were; To access food (100%), health care (59), education (56%), shelter (45%) and WASH items (35%).

% of HHs by LCSI category:

Emergency	14%
Crisis	16%
Stress	27%
Neutral	43%

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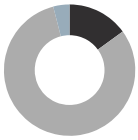
Accountability to beneficiaries

Proportion of beneficiary HHs reporting on key performance indicators (KPI):

	Baseline
Programming was safe	**100%**
Programming was respectful	**99.69%**
Community was consulted	**15.09%**
No payments to register	**99.37%**
No coercion during registration	**99.37%**
No unfair selection	**99.69%**
KPI Score	**88%**

% of HHs (n=251) reporting being aware of community members who had been consulted by the Non-Governmental Organisation (NGO) about their needs:

Yes	**15%**
No	81%
Prefer not to answer	4%



% of HHs reporting not being aware of options available to contact agencies: **21%**

% of HHs reporting being aware of the following options to contact the agency if they had any questions, complaints, or problems receiving the assistance:[4]

Talk directly to NGO staff	46%
Use the dedicated NGO hotline	37%
Use the dedicated NGO desk	8%

% of HHs reporting having ever raised concerns on the assistance they were receiving to the NGO :

Yes	**11%**
No	89%

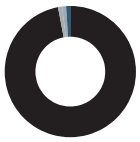
Of the 89% HHs that reported not having raised concerns on the assistance they were receiving, 35% did not know where to raise the concerns and 15% feared the repercussions of raising the concerns.

Of the % of HHs (n=36) that reported having raised concerns, % reporting being satisfied with the response:

Yes, satisfied	**53%**
No, not satisfied	19%
Partially satisfied	14%
Response was not received	**11%**
Prefer not to answer	**3%**

Most preferred method of receiving assistance by % of HHs:

Mobile money	**97%**
In-kind good assistance	1%
Cash voucher	1%
Food voucher	**1%**



Of the 10 HHs (3.1% of the total HHs surveyed) that reported not preferring to receive assistance through mobile money, top reported reasons for not preferring mobile money:[4]

6 HHs reported that they don't own any mobile phone while **5 HHs reported lack of knowledge to using mobile money.**

Endnotes

1. UNHCR statistical package, 30 April, 2022
2. MSNA 2021, conducted by REACH Initiative
3. 1 USD= 115.07748 KES on 23 June 2022.
4. Respondents could select multiple options. Findings may therefore exceed 100%
5. Find more information on food security indicators (FCS, LCSI, rCSI, HDDS) here.
6. The LCSI Stress category includes; selling HH assets/goods, purchasing food on credit or borrowing food, spending savings and selling more animals while emergency category comprise of selling house or land, begging, selling last female animal and livelihood activities terminated (entire HH has migrated in the last 6 months or plan to migrate to the new area within the next 6 months.

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