Evaluation of BRCiS' 2022 IRF Phase II Emergency Response: Final Report

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Executive summary

Context. The UK Government established the Building Resilience for Communities in Somalia (BRCiS) Consortium after Somalia's 2011 drought in a spirit of "never again," with the knowledge and experience that early action both prevents famine and saves lives. While the last 8 years have shown that the BRCiS approach works to mitigate the effects of moderate shocks and build resilience, BRCiS has never been up against a drought like the one Somalia is facing now, with the prospect of a fifth failed rainy season on the horizon, over a million people displaced, and an increasing number of drought-related deaths.

Project. When the main BRCiS II project ended in March 2022, the UK Government's Internal Response Fund (IRF) and Qatar Fund for Development (QFFD) stepped in, providing GBP 5 million and USD 1.5 million, respectively, to meet emergency needs. This was later supplemented with a GBP 2 million IRF top-up, which included a pilot in hard-to-reach (H2R) areas. The IRF project was divided into two phases, the second of which targeted 27,000 families with MPCA, 84,000 families with water interventions, and 50,000 people with health and nutrition support through fixed and mobile clinics, awareness, and surveillance over the April to August period.

This report asks: In a drought that is bringing back images of the 1980s famine, is the IRF enabling BRCiS to live up to its original mandate? The results from three surveys with 4,001 of the initial Phase II households and two surveys with 1,897 top-up households confirm that while the drought has greatly affected IRF families, the interventions immediately and significantly improved the food security and water access of many of the most vulnerable households.

IRF recipients. Over two-thirds of the IRF households were pastoral or agro-pastoral, and the rest were a mix of rural and urban IDPs, urban households, and farmers. While 11% of initial and 30% of top-up households reported being displaced, triangulation suggests that this is likely underestimated and that the project's coverage of displaced populations may have been greater. Over half of IRF households were female-headed, and 7% of initial households and 13% of top-up households had a member with a disability. Overall, 16% of initial households participated in BRCiS II. Only 5% of surveyed households in hard-to-reach areas had received any other humanitarian support in the last 12 months.

Extent of the drought. Three-quarters of initial and top-up households said the drought was worse than that in 2017. Its effects were compounded by rising food prices and clan conflict in key areas. The evaluation of the initial response estimated that around 25 people in the 124 surveyed communities died between November 2021 and May 2022 as a result of the drought, though confidence intervals are wide. Reported deaths within project households themselves were as high as 19% among those identifying as urban IDPs. Over the same period, an estimated 500 households were displaced from—and around 1,000 new arrivals were being hosted by—the surveyed villages. Livestock deaths were reported in all communities, with a large portion reporting to have lost half of their herds or more.

Immediate impacts. The front-loaded one-time transfer of three months' worth of cash was a significant influx, which households used to buy food, water, and pay back debts. Collectively, the IRF interventions resulted in rapid and impressive short-term impacts and helped recipients get back on their feet. On both survey panels, perceptions of food security and well-being more than doubled. While fewer than 40% of households always, mostly, or often had enough to eat at baseline, this rose to around 80% at

post-distribution monitoring (PDM), and the percentage of households that were "doing well" rose from around 15 to 47%. Overall, domestic dry season water access remained low and stable at around one-third, but it increased by as many as 30-60 percentage points in districts where the water interventions were primarily targeted, such as Adado, Berdale, Bardere, and Afgoye. Households' social capital, measured by their confidence that their support networks would help them recover during a crisis, roughly doubled from one- to two-thirds. On the PDM survey, around three-quarters reported that they had recovered to some extent.

Medium-term impacts. Triangulation across indicators suggests that the MPCA did not last the intended three months, likely due to price increases and inflation, use of the transfer to repay accumulated debt, and possible spillover. In the last half of the initial project's three-month intended impact window, its effects were already fading. At endline, only 55% regularly had enough to eat. Reliance on coping strategies was high, with a Reduced Coping Strategies Index of 15, and 28% had a poor Food Consumption Score (FCS), which the Integrated Food Security Phase Classification would categorise as emergency level or worse. Only 28% of households had access to water, and 32% had access to healthcare. With the conclusion of the project, optimism for the future was dwindling. Thirty percent did not anticipate recovering to their initial level of well-being, another 17% did not expect to recover at all, and 8% did not know what to expect. Estimates of social capital declined to 49% as households' ability to help one another diminished.

These project-level figures would be even worse—likely nearer to baseline levels—had households in some districts not received additional humanitarian support from another project. Indeed, in many districts, endline needs had already skyrocketed to baseline levels or above. For instance, as many as 100% of households in Diinsoor and 79% in Berdale had a poor FCS, and water and healthcare were largely unavailable in many places.

Additional needs. This evaluation offers a glimpse into the experience of IRF households—those determined to be the most vulnerable families in the most vulnerable, but still accessible, communities. Unfortunately, even with the top-up, the IRF project was too small to match the massive scale of need in the country, or even in the targeted communities. At baseline, many deserving, vulnerable families seeking support had to be turned away. Their story—of displacement, of having no water to drink and no food to feed their children, of resorting to the most extreme coping strategies—is not reflected in this report. for many, is expected to be much worse.

Recommendations. The initial evaluation demonstrated how short-term injections of funds can lead to peaks and valleys in the experiences of people who are already facing extreme need and great uncertainty. To truly support households during long-run emergencies, interventions should cover at least 6 months and include climate resilience and drought recovery plans in the emergency response to kick-start the recovery process. Continued support is greatly needed for communities in hard-to reach areas, which are even more vulnerable than others; for urban IDPs, who appear to face disproportional mortality rates; and origin sites to help discourage further displacement.

Future outlook. With upcoming rains projected to fail for the fifth—and now sixth—season in a row and drought monitoring bodies continuing to weigh whether to finally officially declare this a famine, additional funding is urgently needed to prevent further deterioration of IRF families' health, nutrition, and food and water security and to support more drought-affected vulnerable families.

Introduction

Context

The people of Somalia are inherently resilient, having survived and thrived for centuries in the harsh environment that characterises the region. However, the growing frequency of climate shocks, fragile political and security contexts, and other crises have led to a longstanding, complex, and dynamic humanitarian situation.

In 2011-12, the country was struck by severe food insecurity and famine, which affected over half of the country's population and killed an estimated 258,000 people.[1] Along with other factors, a delayed and inadequate humanitarian response compounded the famine's impacts, which earlier and more sufficient action could have avoided.[2]

It was largely in response to this failure, in a spirit of "never again," that in 2013 the UK Government established Building Resilient Communities in Somalia (BRCiS, see Annex 1 for list of acronyms), a consortium of 9 local and international non-governmental organisations.[3] Since that time, BRCiS has significantly helped to curb the effects of droughts and other shocks and successfully worked alongside Somali communities on longer-term objectives, demonstrating that the BRCiS model of resilience building works.

However, the Consortium has never been up against a drought as large as the one engulfing the Horn of Africa since 2021. On November 23, 2021, after three failed rainy seasons, the Federal Government of Somalia declared a state of emergency and appealed for humanitarian assistance.[4] By mid-December, already 3.2 million people were affected, including 169,000 people displaced.[5]

With BRCiS II slated to close out in March 2022 and no long-term funding on the horizon,[6] in January, the Consortium used the last of its GBP 1.7 million in savings to initiate a response. This was rapidly supplemented with GBP 5 million from the UK Government's Internal Risk Facility (IRF), GBP 1.4 million from the United States Agency for International Development (USAID), and USD 1.5 million from the Qatar Fund For Development (QFFD). A further GBP 2 million top-up was later added by the IRF. This report focuses on reviewing the IRF and QFFD-funded activities, referred to as the "IRF project."

Drought conditions have continued to worsen and compound since the beginning of the BRCiS IRF response. The April to June 2022 gu rains not only failed, but they were also one of the driest on record, making this an exceptional four-season drought. While famine has not yet been officially declared,

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[1] Francesco Checchi and Courtland Robinson, "Mortality among populations of southern and central Somalia affected by severe food insecurity and famine during 2010–2012" FAO/ FEWS NET, Rome/Washington DC, 2013

[2] "Somalia famine killed nearly 260,000 people, half of them children – reports UN" UN News, 2 May 2013

[3] BRCiS is headed by the Norwegian Refugee Council (NRC) and includes Action Against Hunger, Concern Worldwide, Save the Children, International Rescue Committee, CESVI, KAALO, Gredo, and Candlelight.

[4] Save the Children, "Drought threatens millions in Somalia as government declares state of emergency" Mogadishu, ReliefWeb, 24 November 2021.

[5] UN OCHA. "Somalia: 2022 Drought Response Plan" 17 December 2021.

[6] The BRCiS Consortium is primarily funded by four-year UK Government contracts, which allow it to implement rapid humanitarian responses while simultaneously working with Somali communities to build their longer-term resilience. In times of crisis, BRCiS' core funding is not always enough, and the Consortium seeks additional support through traditional humanitarian funding mechanisms, such as the UK Government's Internal Risk Facility (IRF).

drought monitoring bodies have been warning of the risk of famine since the beginning of the year, and they are forecasting a strong likelihood of a fifth—and now sixth— failed rainy season.[7] Beyond climatic factors, food insecurity has been driven higher by local conflict and the Russia-Ukraine war, which has increased prices for imported food, fuel, and fertilizer.

These factors have created a growing crisis for the Somali people. Over 1 million people were displaced in the first half of the year.[8] While there have been confirmed UN reports that over 700 children have already died, drought-induced mortality in Somalia is not adequately measured, leaving many casualties – mostly children – unaccounted for.[9]

Project

The aim of the IRF project was to deliver a lifesaving intervention by addressing the most urgent and severe humanitarian needs and reducing the risk of mortality and morbidity of the most vulnerable, drought-affected people. Given BRCiS' resilience-building experience in the region, wherever possible, programming was implemented with an eye to enabling longer-run benefits.

Box 1. IRF Phase II components

The initial part of the Phase II response consisted of:

- a single three-month lumpsum multi-purpose cash assistance (MPCA) transfer of USD 180-270[10] targeting 10,100 of the most vulnerable households in the most vulnerable communities in 17 districts in south and south-central Somalia (Figure 1);
- community-level emergency water vouchers targeting 36,600 households and rehabilitation and construction of water points targeting 46,800 households;
- and basic health and nutrition services through fixed and mobile clinics, awareness, and surveillance targeting 49,750 households in Baidoa, Wanlaweyn, and Afgoye.

After the initial response was underway, another part of the initial IRF funding was mobilised through the Crisis Modifier. This enabled a scale-up targeting an additional 5,870 households in 11 districts[11] with MPCA.

The IRF top-up allowed the project to target another 11,100 households in 12 districts,[12] including 1,380 located in hard-to-reach areas, with MPCA and another 715 households in Afgoye and Belet-Hawa with community water vouchers. It was implemented roughly three months after the initial response.

[7] Famine Early Warning Systems Network (FEWS NET), "Food Security Outlook February to September 2022: Historic multi-season drought leads to Emergency (IPC Phase 4), with risk of further deterioration" February 2022; FEWS NET and FSNAU, "Somalia Food Security Alert: Without urgent assistance, Somalia is projected to face its second famine in just over a decade" 5 September 2022

[8] United Nations High Commissioner for Refugees (UNHCR) and NRC, "One million people displaced by drought in Somalia" 11 August 2022

[9] Emma Farge and Abdi Sheikh, "More than 700 children have died in Somalia nutrition Centres, UN says" Reuters Geneva/Mogadishu, 6 September 2022

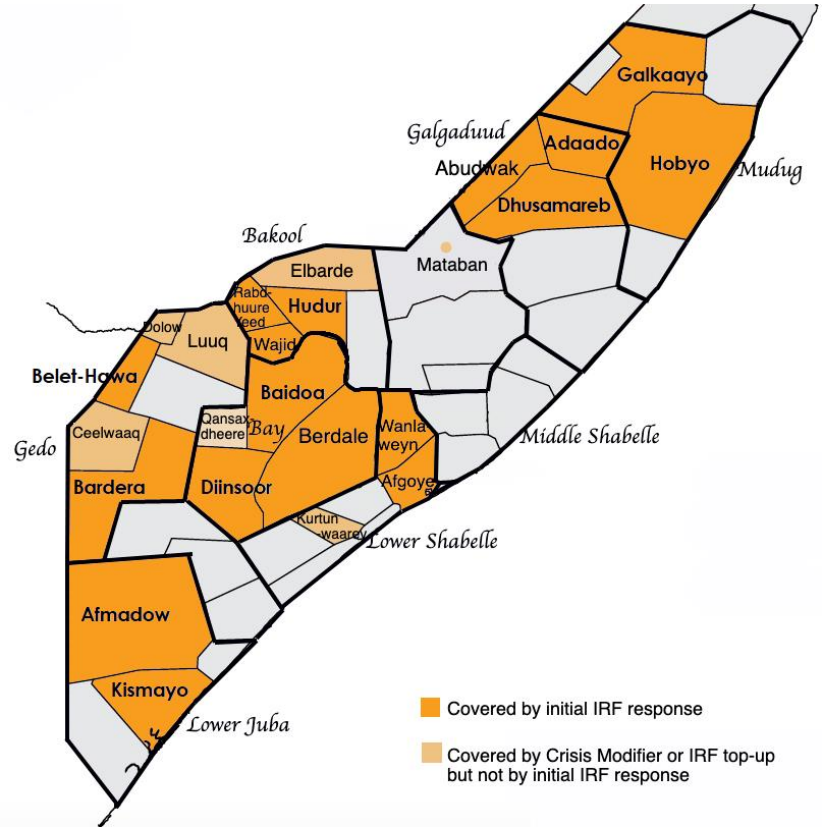
[10] The Somalia Cash Working Group (CWG) recommends MPCA transfer values based on the minimum expenditure basket. The April 2022 recommended values were 90 in Gedo and Lower Juba; 70 in Hiraan; and 60 in other project districts.

[11] Afgoye, Baidoa, Bardere, Galkayo, Hobyo, Hudur, Kismayo, Luuq, Mataban, Rabdhuure-Yeed, and Wanlaweyn.

[12] Afgoye, Afmadow, Baidoa, Dollow, Elbarde, Ceelwaaq, Hudur, Kismayo, Kurtunwaarey, Qansaxdheere, Wajid, and Wanlaweyn.

The project was implemented in two phases: Phase I from January to March, funded by the UK Government, and Phase II from April to August, co-funded by the UK Government and the Qatar Fund For Development (QFFD). Phase II was comprised of three components: an initial response, which this report primarily focuses on; an IRF top-up response, which this report also addresses; and a Crisis Modifier response, which is not covered here.

Figure 1. IRF Phase II districts



Evaluation

Surveys. This evaluation involved two survey panels, the first covering the initial response and the second covering the top-up. The bulk of the report focuses on the initial response, using a three-survey panel conducted with 4,001 recipients of the initial MPCA in all 17 of the targeted districts.[13] These three surveys included:

- a baseline carried out from April 28-June 30,
- a post-distribution monitoring (PDM) survey conducted from June 14-July 19 generally between a few days and 2.6 months after the distribution (see Figure 7 below), and
- an endline implemented from July 26-August 22, between 15 days and 3.5 months of the distribution.

[13] Some of the results draw on an analysis of the full baseline sample of 6,287 respondents. The water and health interventions are geographically localized and implemented at a community level. While many of the surveyed households were within the catchment areas for these activities, not all MPCA or surveyed households necessarily benefitted from them. Results on water and health, presented below, are contextualized to the extent possible.

The report also includes some high-level findings on the top-up response, evaluated using a two-survey panel with recipients of the top-up-funded MPCA in the 12 districts where it was implemented. These surveys included a baseline enumerated from July 25-August 28 and a PDM carried out from August 30-September 18. Given the differences in distribution and survey timing and analytical approaches, the results for the two studies are presented separately.

Research questions. This report explores how key variables related to the drought, incomes, food security and coping strategies, water and health access, well-being, and social capital changed over the intervention period. It addresses the following research questions.

Box 2. Research questions

RQ1: Intervention. Who were the IRF recipients? Did the MPCA reach vulnerable households?

RQ2: Drought impact. What are the most urgent and severe humanitarian needs? How severe was the drought's impact on IRF participants and their communities? How were its effects compounded by other shocks? How did it affect human mortality and illness, population displacement, and livestock death?

RQ3: Outputs and outcomes. To what extent have the most urgent and severe humanitarian needs been alleviated? How rapidly did these effects occur after the intervention, and how long might they be expected to last (both in response to the intervention and other relevant factors)?

- How did recipients' incomes change? How did they spend the assistance they received?
- Using food security and coping strategies as a guide, to what extent can we infer that the risk of mortality and morbidity was reduced among the most vulnerable, drought-affected people?
- How did recipients' water and healthcare access change? Were there differences between districts/communities that received water and health interventions and those that did not?
- To what extent did households' perceptions about their well-being and ability to recover change?

RQ4: Additional consequences. Did social capital and community cohesion change over the project life?

RQ5: Disaggregation. How did the results for the above questions vary across livelihood zones, residency (displacement), gender, and disability?

Interpreting the results: Important notes on methods

Annex 2 provides a detailed look at the evaluation's methodology. The following notes are useful in understanding and interpreting the findings.

Project population: Whose story do the results tell?

The results in this report reflect the situations faced by IRF Phase II MPCA recipients – *the most vulnerable families in the most vulnerable of the accessible communities* – not the situation faced by *all or most households* in the districts.

That said, conditions are so dire that most of the population is extremely vulnerable. Even at baseline, most households met the same targeting criteria, the teams struggled to distinguish between households, and ultimately, many suffering households had to be turned away. Since that time, the situation has continued to deteriorate, and the number of vulnerable families seeking support from the

programme has continually increased. As a result, many families who did not receive assistance are likely now worse off than the results presented here suggest.

While some MPCA recipients benefitted from the water and health interventions, the report does not necessarily reflect the circumstances of water and health recipients.

Representativeness: How confident are we in the results?

The evaluation was designed to be representative of the targeted IRF MPCA recipients at the district level, at a 90% confidence level. In other words, the statistics from the study were intended to accurately reflect the situation in each district. This required a large sample size, and as many as 62% of the initial project's participants were surveyed at baseline.

While the initial survey panel experienced 36% dropout, with only 4,001 of the 6,287[14] households surveyed at baseline responding to all three surveys, the final sample still covered 40% of the project participants. The high rates of attrition were due to a combination of factors, including low answer rates on the telephone-based PDM surveys and mobility and displacement of respondents between rounds.

Because dropout varied significantly across districts, confidence in the final district-level estimates varies. For instance, in Wajid and Diinsoor, which experienced less than 10% dropout in the initial panel, there is still a high degree of confidence that the results accurately reflect the experience of IRF project participants. There is less confidence in estimates for districts like Afgoye and Baidoa, where dropout was between 60-75%.

Final sample sizes ranged from a low of 80 in Afmadow and 88 in Afgoye to over 300 in several Galmudug districts and Wajid. See Table A1 for further details on sample sizes and dropout rates for the initial panel and Table A2 for details for the top-up panel.

Weighting: Interpreting grand totals

To correct for the uneven dropout and account for slight district-level variation in project targets, overall and subgroup totals for the initial study were population-weighted at the district level. This means that they reflect, to the extent possible, the conditions faced by the 10,100 initially-targeted MPCA recipients. Because data on the number of recipients *reached* was not yet available at the time of the analysis, the weights were based on MPCA *targets*. Details on the initial project's targets and resulting weights are available in Table A3, and those for the top-up panel are provided in Table A4.

Sources of bias: How accurate are the findings?

While the aim in any study is to minimise bias and error, these can never be fully eliminated. Understanding potential issues underlying the data helps to interpret the findings, and cross-checking findings with trusted sources on the ground can help to validate any unusual or suspect results. Some of the main sources of bias in this survey, most of which are common in development and humanitarian surveys, are highlighted in Box 3.

[14] 6,589 households were surveyed at baseline but 302 of these were in districts that were not ultimately included in the initial response and are therefore excluded from this measure.

Box 3. Sources of bias and error

Data collection and the nature of humanitarian evaluations. Baseline data collection was conducted at registration. Households knew that the surveys were linked with the project and may have therefore felt compelled to paint their situation in a more positive or negative light.

Reliance on perceptions. Linked to the above point, many of the survey questions relied on households' perceptions rather than on objective measures. For instance, households self-identified the head of their household, livelihood zone, and displacement status. Several outcome indicators were based on respondents' judgements. More objective measures like the food consumption score and reduced coping strategies index were used to validate the food security perceptions measures at PDM and endline.

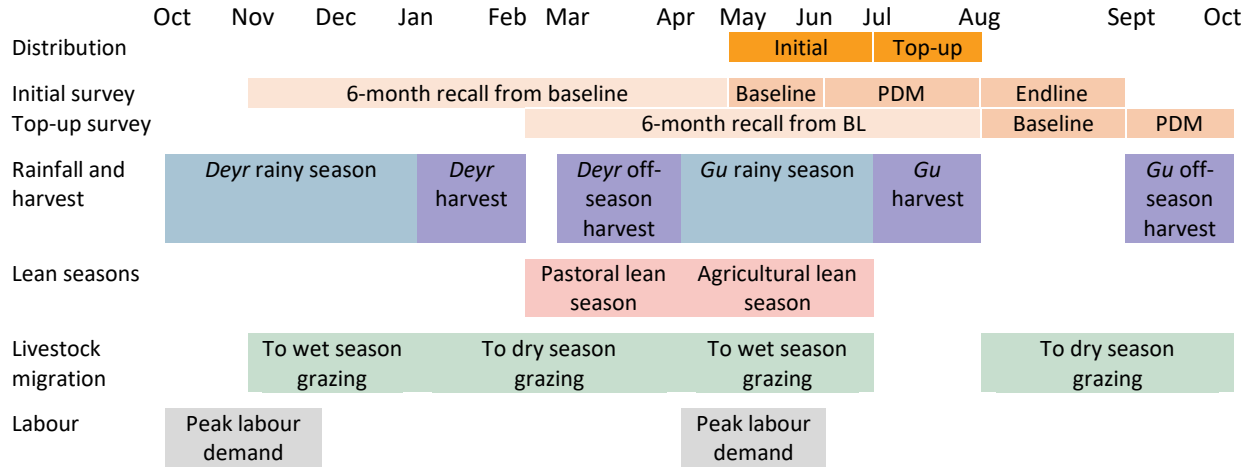
Disproportional response rates. As further discussed in Annex 2, despite strong efforts and policies to reduce attrition, there was a 34% dropout rate on the telephone-enumerated PDM. Phone-based surveys are well-known for disproportionately excluding vulnerable groups who may not own, be able to charge, or have other access to a cell phone, leading to bias in the panel. Even though the endline was enumerated in person, dropout was still 22% relative to the baseline. Consortium Members attributed this to movement, displacement, and unavailability as the households struggled to meet their daily needs, suggesting that attrition disproportionately affected the most vulnerable. Indeed, 47% of rural internally displaced persons (IDPs) dropped out at some point in the study compared to 31-38% for the other livelihood groups, and 56% of displaced households dropped out versus 33% of residents. Because these groups were small (see Table A5-A8), the dropout should not significantly bias the results. Still, the results do not *fully* reflect the situations of these vulnerable groups.

Causality: Why did these changes happen?

In line with the Do No Harm principle of humanitarian action, it was not possible for this study to include a control group, which enables an evaluation to confidently attribute changes to an intervention. Still, triangulation of the results with programme information on the interventions and correlations across indicators clearly shows that the project made a significant difference in the lives of project participants.

Because households were simultaneously impacted by several competing factors, the extent of the project's impact is not known. For example, even in the drought context, it is likely that normal seasonal patterns, depicted in Figure 2, positively affected IRF households to some extent over the project period.

Figure 2. Seasonal calendar[15]



[15] Adapted from FEWS NET's Somalia Seasonal Calendar.

Any potential overlap with other humanitarian interventions, for instance in urban areas where the Somali Cash Consortium coordinated activities, would also have had a positive impact, although not necessarily along the same impact timeline. Conversely, while the worsening drought is the predominant shock detrimentally affecting Somali households, local clan conflict and insecurity, macroeconomic variables such as the war in Ukraine, and population displacement exacerbated negative outcomes and add complexity to interpreting some of the study's results.

Results from the initial evaluation

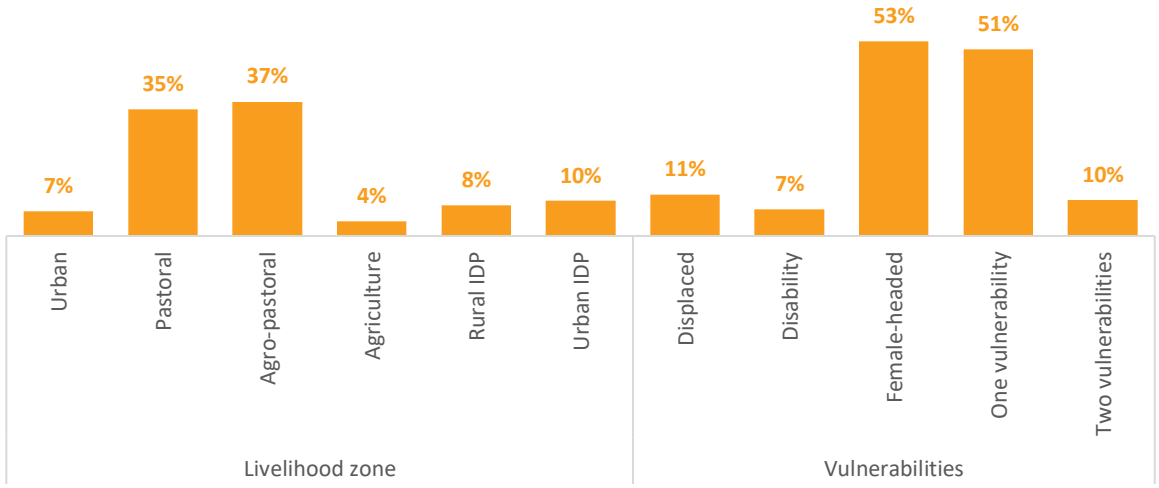
This section addresses each research question in turn, except for RQ5 on subgroups, which is integrated alongside the others. While the focus of the main report is on sharing overall trends across the project, Annex 3 provides a full breakdown of all indicators, including disaggregation by donor.

RQ1: Intervention. Who were the IRF recipients? Did the MPCA reach vulnerable households?

Given the disproportional dropout across the panel, to best address the research question, this section presents the demographics of all 6,287 households surveyed at baseline.[16]

The IRF households targeted to receive the initial MPCA response were fairly evenly distributed across the 17 districts, as demonstrated by the population weights presented in Table A3. As shown in Figure 3, of the surveyed participants, nearly three-quarters identified as pastoral or agro-pastoral, and 61% had at least one of the measured vulnerabilities.

Figure 3. Demographics of IRF households



Livelihood zones. Figure 3 shows that over 70% of IRF project participants identified as pastoral or agropastoral, and the rest identified as rural or urban IDPs, urban, or farmers.[17]

[16] While using the baseline data for this question is more precise, for the most part, the totals calculated using the panel dataset were not so different (for reference, compare against Tables A6 and A8).

[17] Only five households identified as "fishery," so this group is excluded from the subgroup analysis.

As shown in Table 1 (and Table A5), livelihood zones varied significantly by district. Importantly, the fact that some livelihood groups were concentrated in certain districts can lead to what is known as spurious relationships in the results. This means that **in some cases, livelihood zone results are actually driven by district-level factors and vice versa**. For instance, findings about urban households may truly be the result of urban dynamics or they could reflect local contextual issues in Abudwak, where 76% of urban households in the study lived.

Table 1. Correlation between district and livelihoods zones and displacement

Region	District	Urban	Pastoral	Agro-pastoral	Farming	Rural IDP	Urban IDP	Displaced
Lower Juba	Kismayo	1%	6%	17%	1%	74%	2%	25%
	Afmadow	0%	48%	23%	3%	22%	3%	22%
Gedo	Bardere	0%	4%	40%	54%	0%	1%	11%
	Belet-Hawa	0%	41%	54%	0%	3%	2%	18%
Bakool	Rabdhuure	0%	85%	0%	0%	13%	2%	33%
	Hudur	7%	5%	82%	3%	0%	2%	0%
	Wajid	16%	0%	57%	13%	0%	13%	0%
Bay	Baidoa	0%	1%	21%	10%	11%	56%	56%
	Berdale	1%	10%	8%	1%	44%	36%	60%
	Diinsoor	0%	12%	73%	6%	9%	0%	2%
Lower Shabelle	Wanlaweyn	0%	0%	99%	0%	0%	1%	0%
	Afgoye	0%	0%	99%	0%	0%	0%	0%
Galgadud	Abudwak	97%	0%	0%	0%	0%	2%	1%
	Dhusamareb	0%	75%	0%	0%	0%	24%	0%
	Adado	0%	100%	0%	0%	0%	0%	0%
Mudug	Galkayo	6%	85%	0%	0%	4%	5%	2%
	Hobyo	0%	50%	50%	0%	0%	0%	0%

Displacement. Table 1 also shows that like IDP livelihoods, displacement was notable in Berdale, Baidoa, Kismayo, and Afmadow and was also reported in Rabdhuure-Yeed, Belet-Hawa, and Bardere. However, overall, while 18% of households reported being in an IDP-related livelihood zone, only 11% described themselves as being displaced in some way, either as an IDP, a refugee, or a returnee (Figure 3). Interestingly, these were largely *different* households—only 60% of rural IDPs and 22% of urban IDPs considered themselves to be displaced (Table A7), and conversely, only 64% of those that were displaced considered themselves to be in an urban or rural IDP livelihood zone (and Table A5).

Box 4. Contextualising identities in Somalia

This type of discrepancy is common in Somalia, where respondents' views of their identities are highly contextualised. For instance, a household may consider themselves to be urban IDPs because they moved to a city for humanitarian assistance but may not consider themselves to be displaced because they do not plan to return to their place of origin. Similarly, a household may consider themselves to be rural IDPs because they left their homes due to prolonged drought, but may not consider themselves to be displaced because they are part of the prominent clan in their new home. As such, in reading this report, **livelihood and displacement groupings should be viewed as representing households' identities rather than as objective classifications.**

Gender and age. Overall, 53% of IRF households were female-headed (Figure 3, Table A7). This is significantly higher than the 32% reported in the 2020 Somalia Demographic and Health Survey (DHS).[18] Only 14 of the 6,287 households surveyed at baseline were child-headed.

Disability. Seven percent of all households had a family member with a disability (Figure 3, Table A7), slightly more than the 4.7% reported in the Somalia DHS. The main disabilities reported were physical (4%), hearing impairments (2%), visual impairments (2%), and mental illness (1%, Table A9).

BRCiS II and new households. Overall, 16% of the respondents were BRCiS II households (Table A7). Most of these were in Wajid, where 79% had participated in BRCiS II, as well as in Adado, Galkayo, Belet-Hawa, and Kismayo (20-45%). In the remaining districts, the vast majority of IRF households were new. BRCiS II households were slightly more likely to have a disabled member than new households (13% compared to 6%), whereas new households were more likely to be female-headed (55% versus 46%). Although the prevalence of IDP livelihoods were similar, more new households reported being displaced (13% compared to 5%) and dropped out over the course of the panel (39% versus 22%), possibly due to onward migration.

RQ2: Drought impact. What are the most urgent and severe humanitarian needs?

In the 6 months leading up to IRF Phase II, households were greatly affected by the drought and related shocks, and issues such as rising food prices and clan conflict compounded its effects. Livestock death was extensive, with a large portion of communities having lost over half of their herds. Population displacement and illness were widespread and significant, with perhaps around 500 households displaced from and 1,000 displaced to the 124 surveyed villages. An estimated 25 people had died.

How severe was the impact of the drought on IRF participants and how were the drought's effects compounded by other shocks?

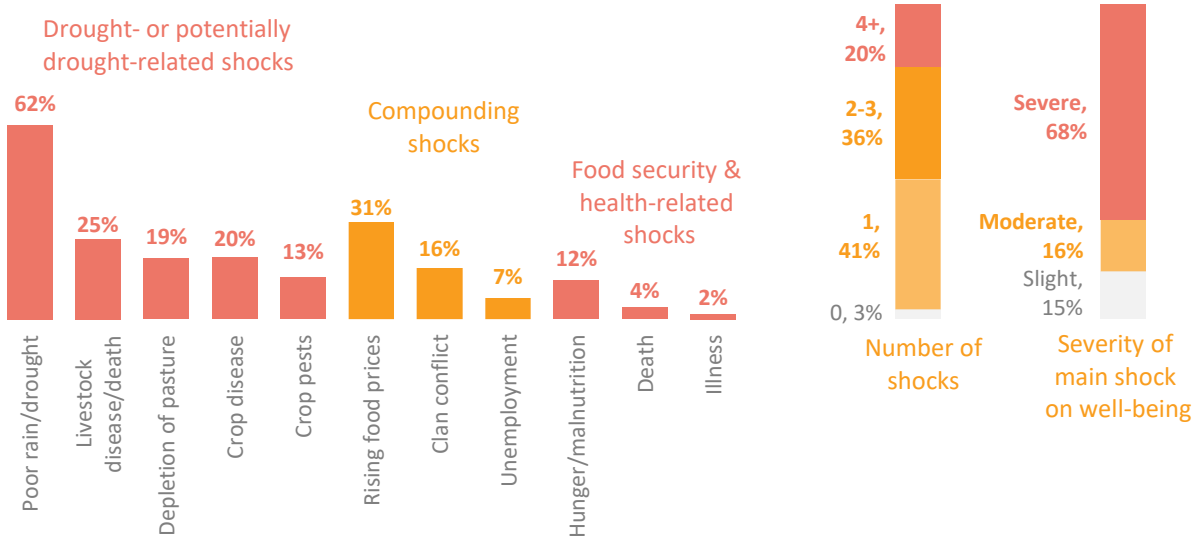
Drought-related shocks. Going into the IRF project, households were asked which shocks they experienced in the last six months, which covered November 2021 to May 2022 and included the 2021 deyr and start of the 2022 gu rainy/growing seasons, the typical pastoral lean season, and the start of the agricultural lean season (see Figure 2).

As expected, failed or below-average rain or drought was the most pervasive, though it reportedly affected only 62% of households (Figure 4, Table A10). It appears that this is much lower than expected because of households' interpretation of the survey question. A closer look at the district-level data shows that where drought reports were low, accounts of drought-caused or -correlated shocks such as depletion of pasture, livestock disease and death, and crop pests and disease were higher, indicating that—while not explicitly cited—the drought actually was the major shock for most households. For example, in Rabdhuure-Yeed, while 1% of households reported drought, 70% reported experiencing depleted pasture and 52% reported livestock disease and death.

Overall, 25% of IRF households experienced livestock disease and death, 19% depleted pasture, 20% crop disease, and 13% crop pests. Only 3% reported not experiencing any shock.

[18] Somalia National Bureau of Statistics, Federal Government of Somalia, "The Somalia Health and Demographic Survey 2020"

Figure 4. Shocks experienced in the 6 months before baseline

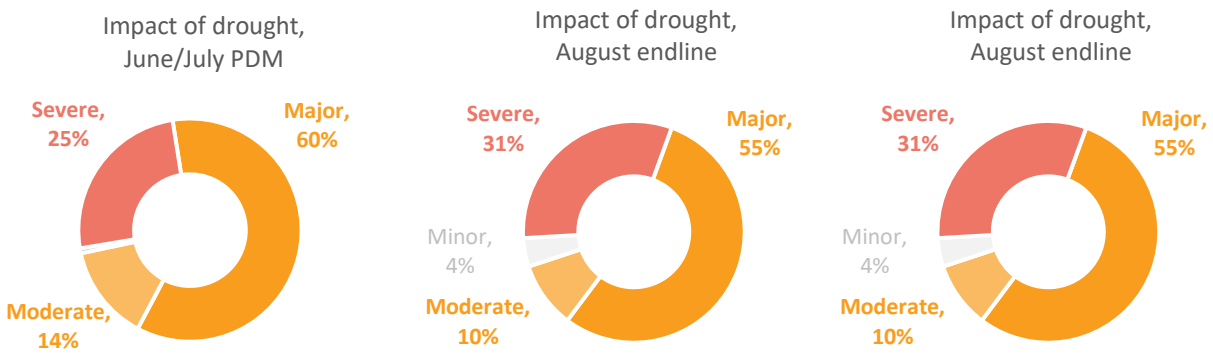


As is to be expected, the effects of the drought were experienced differently in each of the livelihood zones. Drought-related shocks affected urban and urban IDP households the least. For instance, only one-quarter of urban and urban IDP households cited drought specifically compared to around three-quarters of others. Similarly, while 47% of pastoralists lost livestock to disease and death, greatly impacting their lives and incomes, this was not an issue for urban and urban IDP households.

Drought severity. While the baseline did not ask directly about the severity of the drought, it did ask households to report the extent to which their well-being was affected by the main shock they experienced (which were mostly drought-related). As shown in Figure 4 (and Table A11), 68% of households were severely and 16% moderately impacted at baseline. This worsened progressively throughout the study, with 81% severely and 11% moderately affected at endline.

Direct questions about the drought were added to the PDM and endline surveys. As Figure 5 (and Table A12) shows, on both rounds, the vast majority of households (85%) were severely or majorly affected, and about 75% agreed that the current drought was worse than the one in 2017, the last time that Somalia was on the brink of famine.

Figure 5. Drought severity



Compounding shocks. As indicated by field reports, other commonly experienced shocks that interacted with and compounded the drought's effects on households' lived experiences at baseline included rising food prices, clan conflict, and unemployment (Figure 4).

These were predominantly experienced in key hot spots and among certain subgroups (Table A10). For instance, rising food prices were commonly reported in Hudur, Hobyo, and Galkayo (~75%) and greatly affected pastoralists (46%) while having limited impacts on urban IDPs, farmers, and displaced households (<12%). Comparatively, clan conflict was a major concern in Hobyo, Abudwak, Berdale, and Afmadow (31-66%) and among urban and urban IDP households (26%, 36%). It did not notably affect rural IDP, farming, or displaced households (<5%). Unemployment largely affected respondents in Afmadow (39%) as well as some in Baidoa, Hudur, and Belet-Hawa (14-20%).

Taken together, 36% of households reported experiencing two or three shocks in the six months before baseline. Another 20% reported experiencing four or more. The collective burden of facing several threats at once speaks to the load that the IRF households have been bearing.

What have been the effects of the drought in terms of human mortality and illness, population displacement, and livestock death?

The evaluation findings support reports from other organisations of widespread population displacement, human illness, and livestock mortality as well as some degree of human death in the six months prior to and during the survey periods.[19]

Box 5. Understanding the community-level results

As mentioned in the introduction, reporting of drought-induced mortality and morbidity is a major gap in Somalia, and many casualties, especially in rural areas and of vulnerable groups including children, go unaccounted for. This evaluation attempts to provide some insight into these issues.

That said, estimating mortality, population displacement, and illness, particularly in an emergency context, is a complex, sensitive, and weighty task, and doing so using survey data is not ideal. To best make use of the available data, estimates of these issues are presented using confidence thresholds. If the issue was reported by more than 66% of households in a given community, we are highly confident that the issue occurred there. If it was reported by 33-66%, we can have a moderate level of confidence, and if it was reported by less than 33%, confidence is low. This method was developed based on the assumption that these issues are of major concern within a community and their occurrence should generally be well known.

Furthermore, while aggregated median estimates of prevalence across communities are provided, confidence in the precision of these numbers is relatively limited considering the wide variability in household-level reports, as evidenced by the ranges presented in Figure 6. **While these numbers are useful in giving a sense of the presence and scale of these critical issues, they are indicative only and should be followed up and validated with community leaders and/or local health clinics who often keep records of such incidents.**

Finally, the community-level estimate covers the 124 surveyed villages, not all communities that received IRF support. Given the localised nature of these issues, the results are not generalisable beyond the surveyed areas.

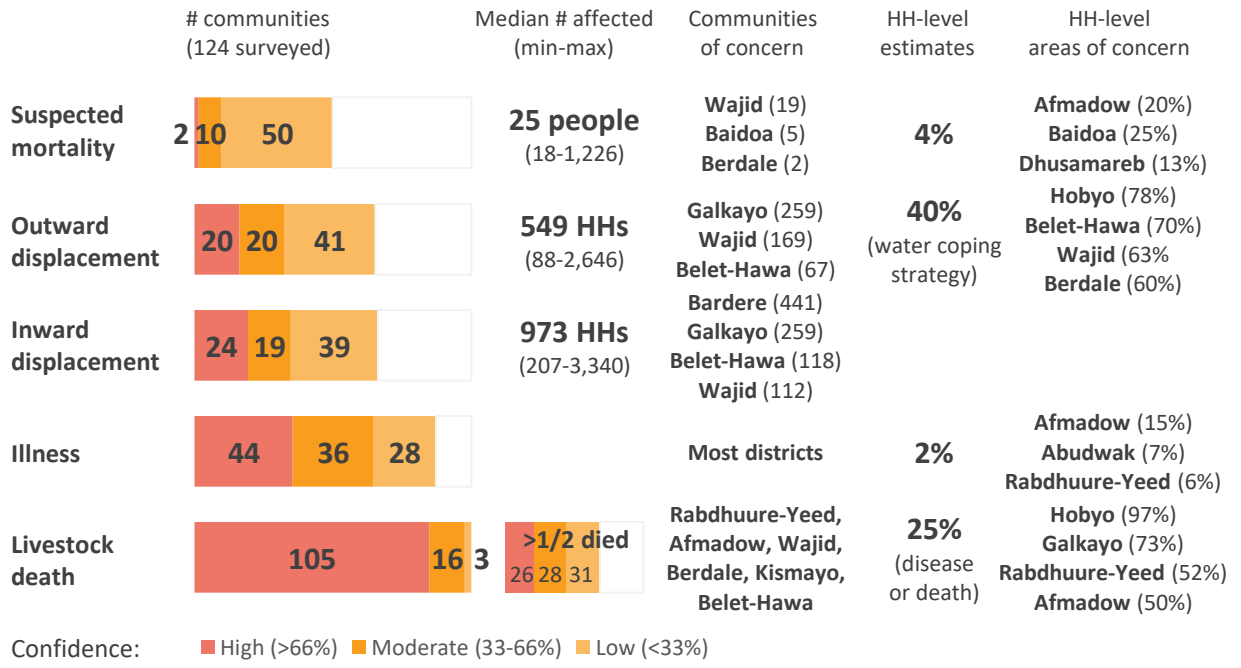
[19] Community-level displacement and household-level shock information were asked on all surveys. Community-level indicators for human disease and death and livestock mortality were not added until PDM. Because of the six-month recall period of these indicators was quite long relative to the one-to-two-month interval between surveys, the data determined to be most reliable was that from the first survey on which the question was asked.

Suspected human mortality. UNICEF's September report that at least 700 Somali children have died as a result of the drought is deeply concerning, especially as both the UN and other actors acknowledge that these deaths are likely significantly undercounted.[20] Indeed, recent results from BRCiS' sentinel Nutrition and Mortality Monitoring Surveys in three selected IDP camps in Banadir, Baidoa, and Diinsoor estimated that out of every 10,000 people, 0.6-0.9 died each day over the late June-early September period. This rate was higher for children, between 2.2-3.0, indicating an emergency-level situation.

This evaluation verified that drought-related deaths occurred in IRF communities during roughly the first half of 2022. We estimated that around 25 people in the 124 surveyed districts died, using the median number of reported deaths in each village (Figure 6, Figure A1). Looking at the lowest and highest reports in each village suggests that the actual number may have been as few as 18 people and, though unlikely, as high as 1,226. Confidence in these reports was high in two communities, moderate in 10, and low in 50. The area of greatest concern was in Wajid, followed by Baidoa and Berdale.

Indeed, while only 4% of IRF households had experienced a death in the six months before the baseline survey, this was as high as 25% in Baidoa (Figure 6, Table A10). It was also very high in Afmadow (20%) and Dhusamareb (13%), all of which included a notable proportion of IDPs. **The prevalence of household-level deaths was as high as 19% among urban IDPs, suggesting that household members may have died on their way to or after arrival in the camps.**

Figure 6. High-level effects of the drought on surveyed IRF communities and households (HH)



*Community-level displacement data and all household-level estimates are for the 6 months prior to the baseline survey. Community-level data for human mortality, illness, and livestock deaths was collected at PDM.
*Median and range are calculated by summing across the median, low, and high reports from households in each community.

[20] Emma Farge and Abdi Sheikh, "More than 700 children have died in Somalia nutrition centres, UN says" Reuters Geneva/Mogadishu, 6 September 2022

Population displacement. According to country-wide estimates reported by UNHCR and NRC in August, the drought displaced over 1 million people between January and July 2021.[21]

Community-level information from this evaluation confirms that there are thousands of people on the move in IRF communities. In the six months before the baseline survey, an estimated 550 households were displaced from as many as two-thirds of the 124 surveyed communities (Figure 6, Figure A2). Areas of greatest concern included Galkayo, Wajid, Belet-Hawa, Hobyo, and Kismayo. Many people reportedly went to IDP camps in urban centres such as Mogadishu and were not expected to return. Others stayed closer to home, in some cases temporarily moving to nearby villages or forested areas.

While the survey could not directly capture outward displacement at the household level, there are a few other indicators that, when triangulated with this community-level information, confirm widespread displacement. For example, at baseline, migration was reported as the primary water coping strategy by 40% of all households but was as high as 63-78% in Hobyo, Belet-Hawa, and Wajid—all areas of concern—and 53% among urban IDPs (Table A14). In addition, attrition was particularly high for displaced people (56%) and rural IDPs (47% compared to 36% overall) who may have been in transit at the time of the first survey or decided to move on since (Table A1).

Estimates of outward displacement rose markedly at PDM, to a median of nearly 2,500 households.[22] At least half of these were coming from Berdale and many from Baidoa, Diinsoor, Wanlaweyn, Adado, and Galkayo. This is in line with UN reports of increased drought displacement in June, July, and August.[23]

Population inflows. As shown in Figure 6 and Figure A3, **an estimated 1,000 displaced households arrived in up to two-thirds of the 124 surveyed villages in the six months before baseline.** Communities in Bardere seemed to be hosting the most new arrivals, followed by Galkayo, Belet-Hawa, and Wajid. Interestingly, the survey itself covered very few displaced and rural and urban IDPs from these districts, despite the BRCiS team reality-checking these trends, at least in Bardere and Belet-Hawa. **This suggests that the IRF project may not be covering the latest new arrivals or that these groups do not perceive themselves as displaced** and may be worth following up with Consortium Members and community leaders.

Reports of new arrivals to the 124 surveyed villages rose substantially over the survey period, reaching a median of 3,000 households at PDM and nearly 8,650 at endline. At PDM, challenges with IDPs were reported in roughly 60% of communities with new arrivals, especially those in Wajid, Rabdhuure-Yeed, Diinsoor, and Dhusamareb (Figure A4).

[21] United Nations High Commissioner for Refugees (UNHCR) and NRC, "One million people displaced by drought in Somalia" 11 August 2022

[22] Community-level data from the PDM and endline is less reliable than that for the baseline due to overlap and apparent inconsistency in response compliance with the six-month recall periods.

[23] International Organisation for Migration (IOM), UNHCR, United Nations Office for the Coordination of Humanitarian Affairs (OCHA), "Drought Displacement Monitoring Dashboard (August 2022)" ReliefWeb, 20 September 2022; UNHCR Refugees Operational Data Portal, "Somalia: Internal Displacement" 8 September 2017.

Illness. **Drought-related illnesses had reportedly occurred in 108 (87%) of the 124 surveyed communities in the six months before the PDM survey** (Figure 6, Figure A5). However, of the IRF households themselves, only 2% reported experiencing any illness in the six months before the baseline (Figure 4).

Of the community-level accounts, diarrhoea was most common, reported in 100 communities and, of these, at a high degree of confidence in 30 (Table A13). Measles was reported in 95 and at a high degree of confidence in 11 including several in Wajid. Cholera was reported in 43 communities and at moderate confidence in Wanlaweyn and Adado.

Reports of, and confidence in, drought-related illnesses increased at endline. While the potential cholera outbreaks in Wanlaweyn and Adado seemed to have resolved, new outbreaks were reported elsewhere. New and worsening outbreaks of measles were also apparent.

Livestock disease and mortality. According to drought monitoring agencies, over 3 million herd animals died between mid-2021 and April 2022.[24] The IRF PDM survey confirmed that livestock deaths were pervasive. **Livestock losses were reported in all of the surveyed communities and with high confidence in most, and in many villages, over half of the herds had died** (Figure 6, Figure A6). **As noted above, as many as 25% of IRF households themselves were affected by livestock disease and death** (Figure 4, Table A10).

Both the community and household indicators suggest that the impacts were especially severe in Rabdhuure-Yeed and Afmadow, where most households are pastoral. About half personally experienced livestock disease or death (Table A10), and nearly all of the surveyed communities lost more than half of their herds (Figure A6). Other livestock-dependent districts were also of great concern.

What were the most urgent and severe humanitarian needs going into IRF Phase II?

Heading into IRF Phase II, erosion of livelihoods, food insecurity, and lack of access to water were all serious concerns, and the survival of IRF families and their communities was at stake.

- **Erosion of livelihoods.** At baseline, 53% of households had already changed their primary source of income because of the drought and 59% were relying on casual labour.
- **Food insecurity.** In the month before the baseline survey, 23% of households never had enough food to eat, 41% rarely did, and only 5% always did. Household reports of 12% facing hunger and malnutrition were likely underestimated (Figure 4).
- **Lack of access to water.** Only 32% of households had access to water for domestic use. It took a median of 40 minutes for them to collect water but as long as 6 hours for some. To deal with water shortages, families were relying on extreme coping strategies: 40% were migrating, 17% – mostly those along riverine and coastal areas – were using unsafe sources, and 35% were buying water at increased prices.
- **Survival.** At baseline, 18% of IRF households could not meet their basic survival needs and another 65% did not expect to or were worried about meeting their needs in the future. Only 17% reported being able to meet most or all of their needs.

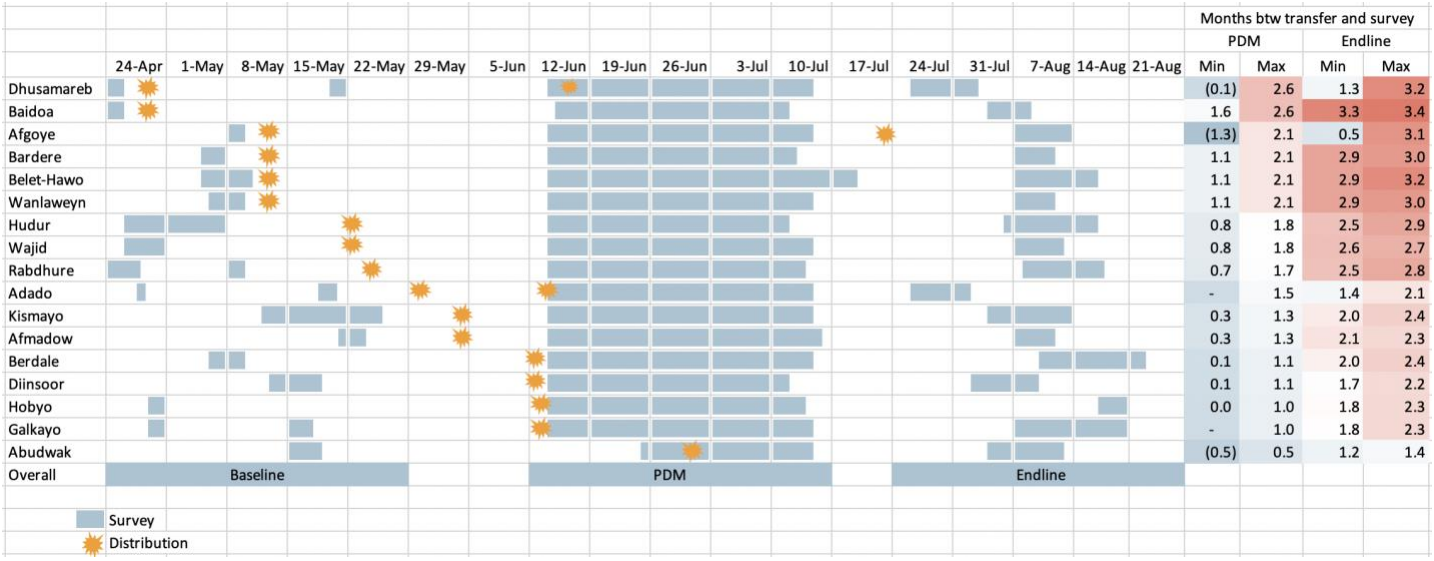
[24] FEWS NET, "Somalia Food Security Outlook June 2022 to January 2023: Famine (IPC Phase 5) would likely occur if food assistance plans do not materialize" June 2022.

RQ3: Outputs and outcomes. To what extent have the most urgent and severe humanitarian needs been alleviated?

The project successfully temporarily supported households' incomes, enabling them to meet their immediate needs, allowing them to catch up on accrued debts, and offering a temporary reprieve and moderate recovery from the onslaught of the drought's effects. This dramatically improved perceived and objective measures of food security and, together with water activities, boosted water access, overall perceptions of well-being, and households' willingness or ability to support one another. However, these positive impacts evaporated quickly. Even though many households were still well within the anticipated impact window, at endline, overall indicators had already declined substantially. With the conclusion of the project, households' optimism for the future dwindled.

The findings in this section are based on an analysis of the 4,001 panel households. Importantly, as shown in Figure 7, the timing of the surveys relative to the distribution varied across districts. Having a sense of this timeline is useful when interpreting the below results.

Figure 7. Timeline of initial MPCA distribution and survey pane



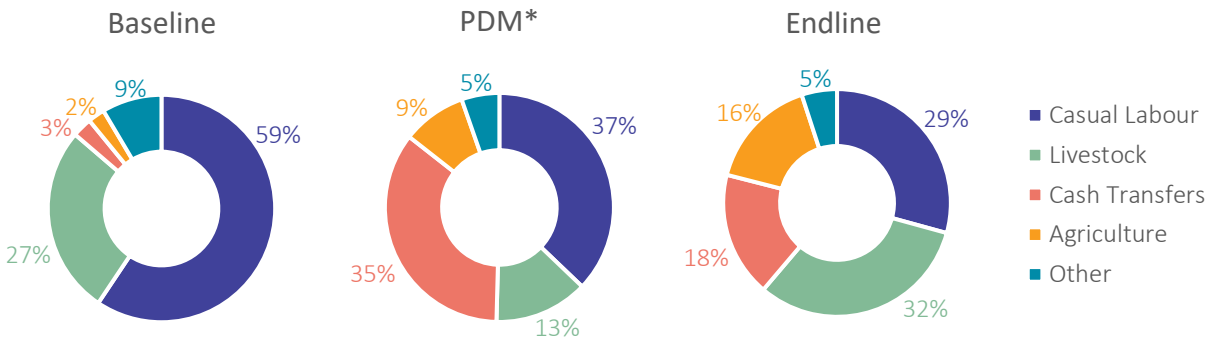
	Months btw transfer and survey			
	PDM		Endline	
	Min	Max	Min	Max
Dhusamareb	(0.1)	2.6	1.3	3.2
Baidoa	1.6	2.6	3.3	3.4
Afgoye	(1.3)	2.1	0.5	3.1
Bardere	1.1	2.1	2.9	3.0
Belet-Hawo	1.1	2.1	2.9	3.2
Wanlaweyn	1.1	2.1	2.9	3.0
Hudur	0.8	1.8	2.5	2.9
Wajid	0.8	1.8	2.6	2.7
Rabdhure	0.7	1.7	2.5	2.8
Adado	-	1.5	1.4	2.1
Kismayo	0.3	1.3	2.0	2.4
Afmadow	0.3	1.3	2.1	2.3
Berdale	0.1	1.1	2.0	2.4
Diinsoor	0.1	1.1	1.7	2.2
Hobyo	0.0	1.0	1.8	2.3
Galkayo	-	1.0	1.8	2.3
Abudwak	(0.5)	0.5	1.2	1.4

How did recipients' incomes change? How did they spend the assistance received?

Baseline. **At baseline, over half of the households reported that they had already changed their primary income source in response to the drought** (Table A15). This was as high as 75% among farmers and 63% among households with a disabled member.

As shown in Figure 8, a total of 59% of households were primarily earning from casual labour followed by 27% from livestock (Table A16).

Figure 8. Main income source



*cash transfers would likely have been higher if the PDM had been conducted within the one month recall period in all districts

PDM. The MPCA distributions of 270 USD in Belet-Hawa, Bardere, Afmadow, and Kismayo and 180 USD elsewhere created a substantial shift, as households received a massive inflow of three months' worth of MPCA at once.

Box 6. An in-depth look at the PDM income results

Interpretation of the PDM income results (Figure 8, Table A16) requires a more nuanced look at the timing of the survey relative to the distribution (see Figure 7) in each district.

- In five districts,[25] the PDM was carried out more than one month after all households had received their distribution, meaning the MPCA transfer was outside the recall period. Indeed, in these districts, reports of cash transfers as the primary source of income were low, and households were instead mainly earning from farming and casual labour.
- In another five districts,[26] the PDM was timed such that the transfer was outside the recall period for some households but within it for others. This seems to be reflected in the data, as roughly a third of households—likely those whose recall period overlapped with the distribution—reported cash transfers as their primary income source.
- In most of the other districts,[27] the PDM was carried out almost immediately after the distribution, so the recall period overlapped almost perfectly with the survey. Here, cash transfers were the main income source for nearly half of households.
- In Abudwak, the transfer was made after the PDM started, so a share of households had not received it when they were surveyed. Still, 58% reported cash transfers as their main source of income.

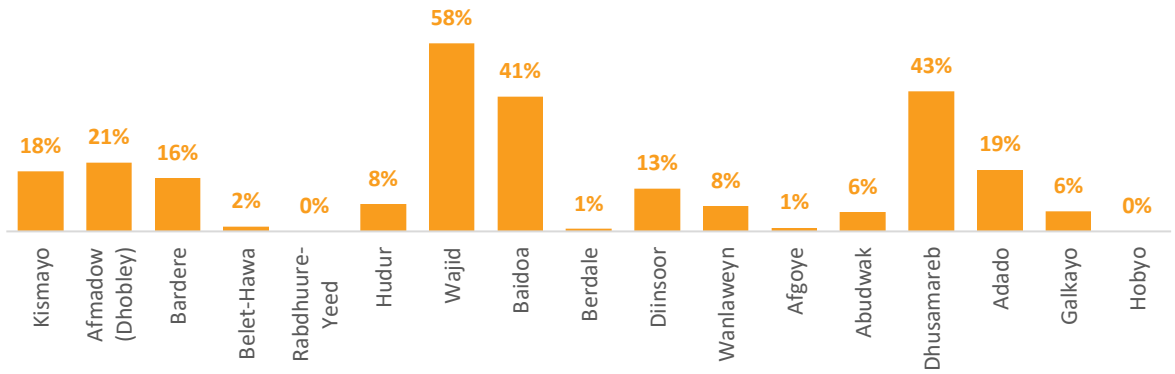
Endline. At endline, while the limited rainfall and marginal July gu harvest (Figure 2) allowed some households to return to earning income from livestock (32%) and farming (16%), 29% remained dependent on casual labour (Figure 8, Table A16).

However, 18% of households still viewed cash transfers as their main income source. While this could be the result of an underlying issue with data quality, quite common in income data, triangulation with district-level food security and well-being indicators suggests that **some households in certain districts**

[25] Baidoa, Afgoye, Bardere, Belet-Hawa, and Wanlaweyn
[26] Dhusamareb, Hudur, Wajid, Rabdhuure-Yeed, and Adado
[27] Kismayo, Afmadow, Berdale, Diinsoor, Hobyo, and Galkayo

may have benefitted from a second, slightly later, cash transfer from another project (Figure 9). It may be worth exploring this possibility with BRCiS Members on the ground.

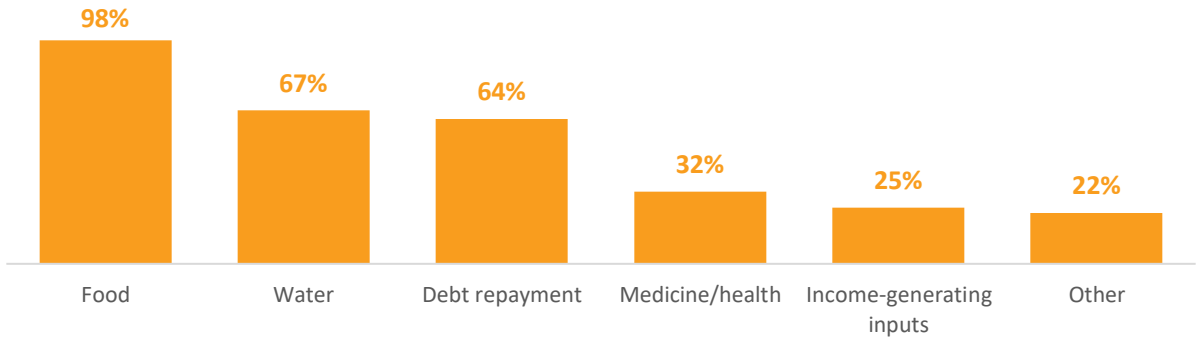
Figure 9. Proportion of households whose main source of income was cash transfers in the month before endline



Use of MPCA. On the PDM survey, households were asked to list the top three items they purchased with the MPCA. Nearly all used it to purchase food and two-thirds used it to buy water (Figure 10, Table A17). While the size of the MPCA was directed by the Somalia CWG's April 2022 recommendations, **recent large price increases and inflation, especially in certain areas** (see Table A10), **may have reduced the purchasing power of these funds**.

Perhaps because the transfer represented a substantial cash inflow of three months' worth of MPCA at once during a prolonged drought, almost two-thirds of households used it to pay back debts they owed. While households may have accumulated this debt for a variety of reasons, it is likely that for many of them, it was a coping strategy used to meet basic needs in the initial drought period. **While the large cash infusion enabled them to relieve themselves of this debt burden, which adds undue financial stress in an already extraordinarily trying time, the use of the cash for this purpose likely meant that it did not last most households the full three months for which it was intended.**

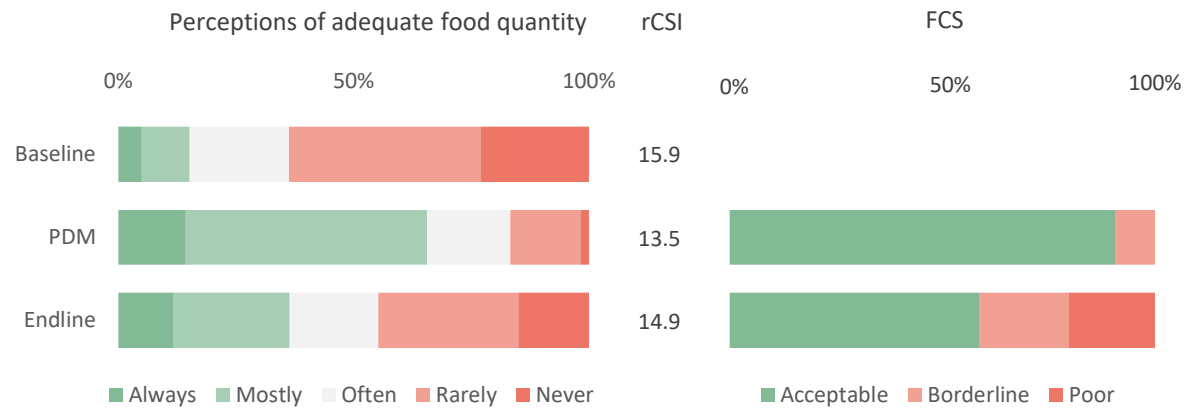
Figure 10. Use of MPCA



Using food security and coping strategies as a guide, to what extent can we infer that the risk of mortality and morbidity was reduced?

Baseline. Baseline levels of food security were low. A quarter of the 10,100 households targeted to receive MPCA never and 41% rarely had enough food to eat in the month leading up to the survey (Figure 11, Figure A7).

Figure 11. Food security and coping strategies



Changes at PDM. Household perceptions of adequate food quantity[28] skyrocketed after the distribution, from 36% at baseline to 83% at PDM. The PDM levels were verified with the Food Consumption Score (FCS), which confirmed that 82% of households had acceptable food security (Table A18). The trends were also triangulated with the Reduced Coping Strategies Index (rCSI), a measure of the coping strategies undertaken in response to limited food availability, which declined from 15.9 at baseline to 13.5 at PDM, indicating an improvement in food security (Table A18). Dietary diversity, measured using both household perceptions and the Household Dietary Diversity Score, followed similar trends (Figure A7 and Table A18). These remarkable, positive shifts were observed in nearly every district (Figure 12).[29]

While part of the improvement may attributable to normal seasonal trends (Figure 2), the gu season harvest across southern Somalia was abysmal, at 50% below the long-term average.[30] It follows that the sizeable increase in food security was largely due to the large IRF cash transfers.

Endline. Adjusting for both the timing of the survey and the recall period,[31] it appears that during the second half of the three-month impact period, overall levels of adequate food security had already declined to 55%. As many as 30% of households rarely and 15% never had enough to eat. Reliance on coping strategies increased, reflected by an rCSI of 14.9, and the prevalence of acceptable FCS declined to 54%. **Before households reached the end of the impact window, as many as 28% had a poor FCS, which the Integrated Food Security Phase Classification (IPC) classifies as emergency level or worse.**[32]

Subgroup analysis. All of the subgroups followed the same food security trend (Figure A7-Table A18). While pastoralists and farmers seemed to be worse off at baseline, at endline, rural IDPs and displaced households were struggling the most, and 50% of both groups had a poor FCS. Comparatively, urban,

[28] Measured as households always, mostly, or often having enough food to eat in the last month.
[29] Only in Afgoye, where some households did not receive their transfer until after the PDM survey (Figure 7), did baseline to PDM food security decline, and even here only slightly.
[30] FEWS NET, "Somalia Food Security Outlook Update: Food assistance needs remain high in Somalia, with Famine (IPC Phase 5) projected in parts of Bay Region" August 2022.
[31] One month for adequate food security and 7 days for FCS and rCSI.
[32] IPC Global Partners, "Integrated Food Security Phase Classification Technical Manual Version 3.1: Evidence and Standards for Better Food Security and Nutrition Decisions" Rome, 2021

urban IDP, farming households, and displaced families were relying on the most coping strategies (17+) at endline.

District-level analysis. The overall endline results hide some notable variation at the district level, as demonstrated using food adequacy and FCS in Figure 12 (details available in Figure A7 and Table A18).[33]

In six districts—Wajid, Baidoa, Adado, Afmadow, Kismayo, and Dhusamareb—there were sustained improvements in adequate food quantity from baseline to endline. Several of these districts also had the lowest endline FCS scores. This trend was unexpected, and it was particularly surprising that it occurred in Baidoa, where FEWS NET is forecasting famine[34] and where the IRF MPCA was distributed more than three months before the endline survey (see Figure 7). While these curious results may be driven by any number of factors, the income data shows that **in all of these districts, between 18-58% of the population reported receiving cash transfers—presumably from another project—at endline.**

In almost all of the remaining districts, food security plummeted after the PDM. **In eight districts, endline food adequacy declined to or dropped below baseline levels.** In Bardere and Belet-Hawa, the endline levels reflect the last weeks of the impact window, when a shift back toward baseline might be expected. However, **in districts like Abudwak, Berdale, and Diinsoor, the endline results reflect the midpoint of the impact window, when households should have still been greatly benefiting from the transfer**.

Overall, endline FCS exceeded the IPC emergency threshold in eight districts and was dangerously close in others—even though households in many districts were still well within the impact window.

All in all, it seems that if the endline results had not been bolstered by another intervention, they would reflect a much poorer food security situation, potentially similar to that observed at baseline. Furthermore, there is consistent evidence to suggest that the MPCA did not last households the intended three months and that by the time of publication, rates of food insecurity will have further skyrocketed.[35]

[33] While the trends are slightly different for coping strategies (also available in Table A18), the general takeaway, that the overall picture hides important localized variability, is consistent.

[34] FEWS NET, "Somalia Food Security Outlook Update: Food assistance needs remain high in Somalia, with Famine (IPC Phase 5) projected in parts of Bay Region" August 2022.

[35] Assuming no other outside assistance has been provided in the interim

Figure 12a. Adequate food quantity, by district (higher levels reflect better food security)

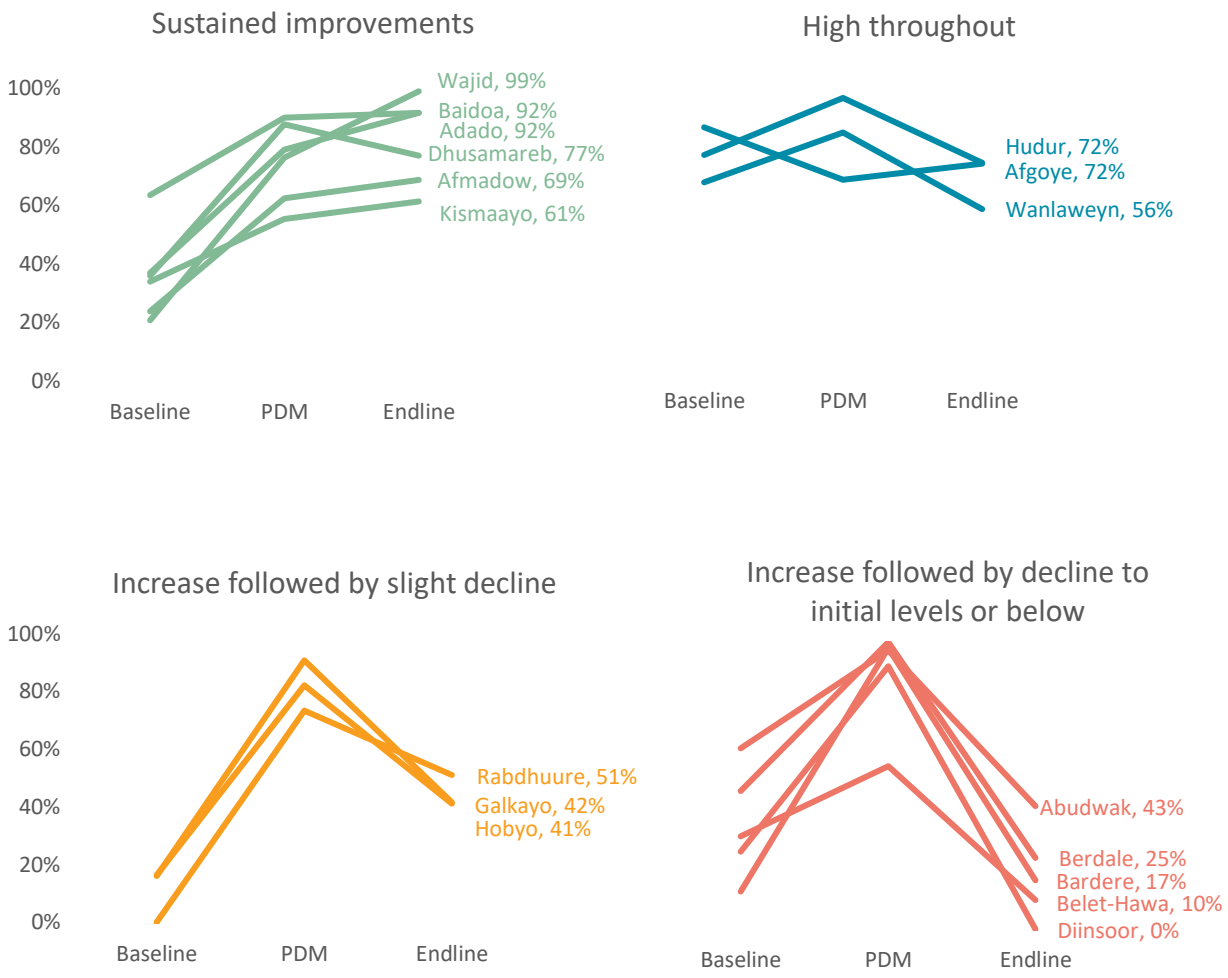
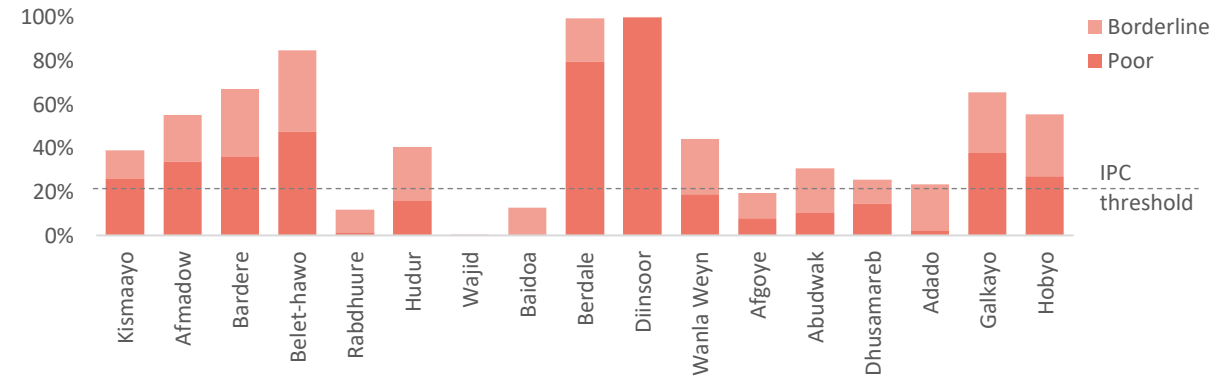


Figure 11b. Endline Food Consumption Scores (higher levels reflect worse food security)



Water: How did recipients' water security change? Were there differences between districts that received water interventions and those that did not?

Box 7. Interventions and special notes for this analysis

IRF Phase II included both MPCA, which households could use to purchase water, as well as direct water interventions. The project targeted 36,650 households with community water vouchers for 60-90 days and 46,800 households with rehabilitated and new water infrastructure.

Although water activities were carried out in all districts, implementation was highly localised and the distribution of targets varied significantly across districts (see Table A3). As such, while there was often overlap between the MPCA and water intervention catchment areas, not all MPCA households, on whom this evaluation focuses, necessarily benefitted from the water activities.

The findings presented here give the best available picture of how water access changed for MPCA recipients, but the extent to which these results are generalisable from the sample to the population may be limited.

Overall trend. Overall, domestic dry season water access remained relatively stable across the project period, declining slightly from 32% at both baseline and PDM to 28% at endline (Table A19). The median water collection time increased from 40 minutes at baseline to 70 at PDM but returned to 44 at endline. Comparatively, productive dry season water access declined from 21% to 8% before returning to 17%. The rest of this analysis focuses on domestic dry season access as the main indicator of concern.

Interestingly, baseline water access was significantly higher among households that reported having participated in BRCiS II than for new households (45% versus 29% for domestic and 33% versus 18% for productive). However, this trend reversed at PDM, with new households having better water access, possibly due to the geographical locations and intensity of IRF water interventions. By endline, water access was similar for the two groups.

District-level trends.[36] As shown in Figure 13 (and Table A19), **the overall picture of domestic dry season water access hides remarkable variability.**

Dramatic rapid but temporary improvements were evidenced in several districts where water activities were slated to reach a large number of households (Figure 14, Table A3). These included Adado, Berdale, Bardere, and Afgoye, which together constituted 27% of community water voucher, 55% of water infrastructure, and 43% of overall water targets. Unfortunately, given the emergency nature of the project, many of the benefits evaporated as quickly as they came. By the August endline, water access in these districts had dropped back to baseline levels – as low as 5% and 10% in Bardere and Berdale (Figure 13, Table A19).

Interestingly, the exact opposite trend occurred in Baidoa, also the location of a high proportion of water targets. This may suggest that water interventions began later in this district. More information is

[36] Apparent trends in the livelihood zone data are likely due to underlying localized patterns driven by spatial variables like rainfall and intervention locations. For instance, the apparent distinctive trends in urban and farming livelihoods simply reflect the trends in Abudwak, where nearly all urban households dwell, and Bardere, where most farming households are located. Comparatively, the trends in other livelihood zones are neutral because they average out marked district-level variability. Similarly, while water access changed from 17% to 43% to 31% among displaced households, this is likely driven by the trends in Berdale where 60% of households were displaced.

needed to know for sure. Comparatively, stable or declining trends were observed in Dhusamareb, Belet-Hawa, and Galkayo, although these districts were also slated to be major recipients of water activities. These unexpected trends could be related to the location of the water interventions relative to the surveyed MPCA recipients in these districts. For instance, if some surveyed communities were within the water activities' catchment areas and others were not, the overall effects would average out, as in the overall totals presented above. Further analysis could offer more insight if warranted.

Figure 13. Water access

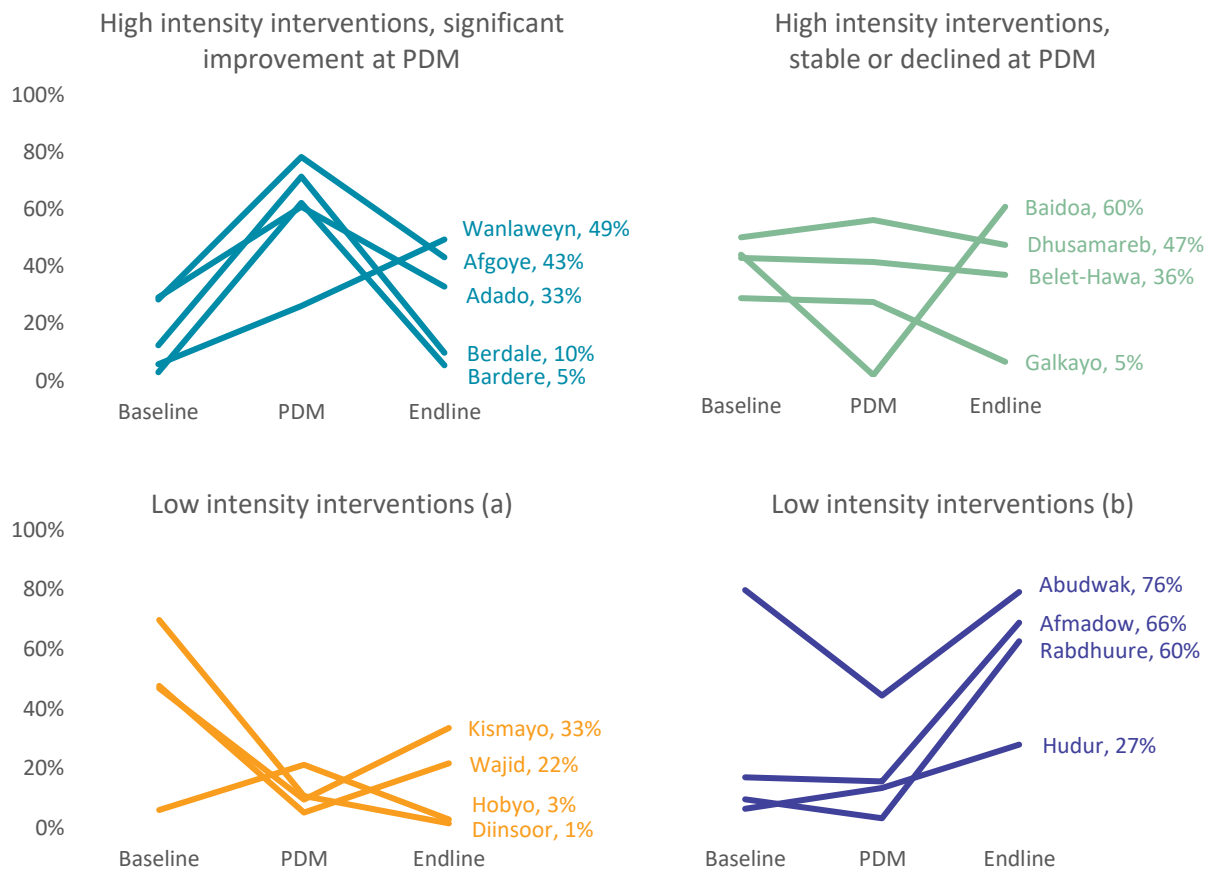
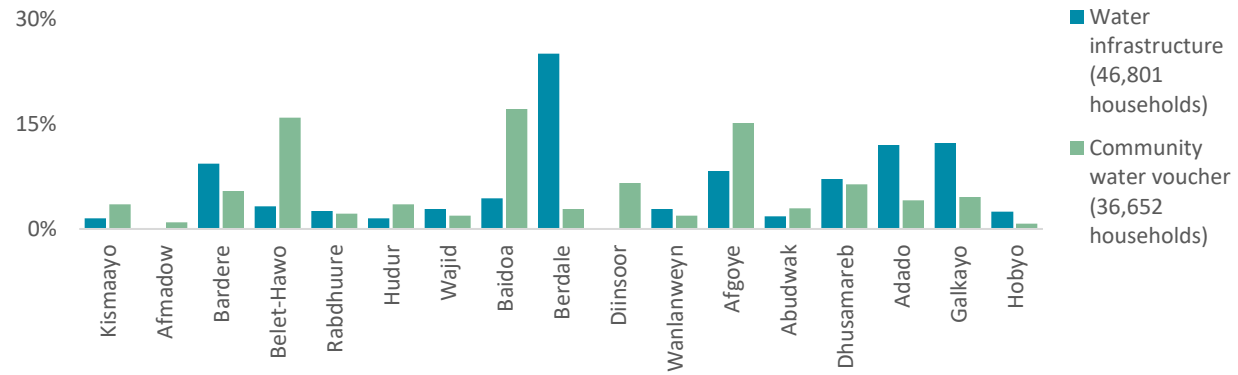


Figure 14. Proportion of water intervention targets in each district



The only districts where water access improved from baseline through endline were Hudur and Rabdhuure-Yeed—where light rainfall sufficiently refilled primary water sources and led the BRCiS team to reprogram the water interventions to MPCA—and in Wanlaweyn and Afmadow. This is an important reminder that despite all humanitarian efforts, natural rainfall is the most effective solution to drought.

The most serious decline over the project period was in Diinsoor, where water access dropped from 70%, one of the highest levels observed at baseline, to 11% at PDM and 1% at endline and where the median water collection time shot up from an initial 30 minutes to an endline value of nearly 2.5 hours. Initial investigation into these unexpected findings did not yield insight.[37]

Although we may expect to see different trends for districts that primarily received water infrastructure versus community water vouchers, this is not readily apparent in the data and would require additional information for a more nuanced analysis.

Endline levels. **Despite these varying trends, at endline, only 28% of MPCA households had access to water for domestic use, which took a median of 44 minutes to fetch**. Endline access was 10% or lower in five districts (Figure 13). The median collection time reached as high as 3.5 hours in Berdale, but fetching water took some households as long as 6 hours. Even in districts with better endline water access, reports of illness and disease outbreaks linked with poor quality water, such as cholera and diarrhoea, were prevalent.

Box 8. Inferring impact on non-MPCA water recipients

The above analysis provides a picture of how water access may have changed for the 10,100 MPCA households, some of whom received water interventions and some of whom did not. However, the water interventions were slated to reach a vastly greater number of households – 83,500 – most of whom did not receive MPCA. What happened to these families over the project life?

While we cannot know for sure, **we can infer from the district-level trends and water intervention targets that water access for non-MPCA water recipients improved significantly, at least in the short run**. Furthermore, if we mimic what the overall trends might look like for the 83,500 water recipients by weighting the results by district-level water targets (for indicative purposes only), water access increases remarkably, from 28% at baseline to 44% at PDM, before dropping back down to 31% at endline.

Of course, the true extent of these effects depends on underlying unknowns, such as how many of the surveyed households were reached by the water interventions and the relative effects of the MPCA and water activities on surveyed households' water access. Still, this provides some insight in the absence of data on the water interventions specifically.

With global and regional monitoring systems projecting deyr rainfall from October and January to fail for a fifth—and now sixth—season in a row,[38] continued emergency water relief and interventions promoting sustainable water systems are greatly needed.

[37] The trends in productive dry season water access were similar to those for domestic dry season access. Follow-up with the programme team revealed that the project ultimately reached 690 households with community water vouchers and nearly 10,500 with rehabilitated water infrastructure.

[38] FEWS NET and FSNAU, "Somalia Food Security Alert: Without urgent assistance, Somalia is projected to face its second famine in just over a decade" 5 September 2022

Health: How did access to health change? Were there differences between communities that received health interventions and those that did not?

Box 9. Intervention and notes for interpreting results

IRF Phase II implemented health and nutrition activities specifically targeting women and children, who tend to bear the brunt of the drought's impacts. The interventions included fixed and mobile clinics, awareness, and surveillance targeting 6,700 households in Afgoye, 3,600 households in Wanlaweyn, and 40,000 households in Baidoa.

Data on healthcare access was only collected at PDM and endline, limiting the ability to draw insightful conclusions as to the project's impact. The statistics presented here are for MPCA recipient households in the three targeted districts, who may or may not have been in the catchment areas of the IRF health and nutrition interventions and who may or may not have benefitted from similar activities implemented by other organisations. For those interested in the larger picture of healthcare access and gaps across the full panel, the full set of results is available in Table A20.

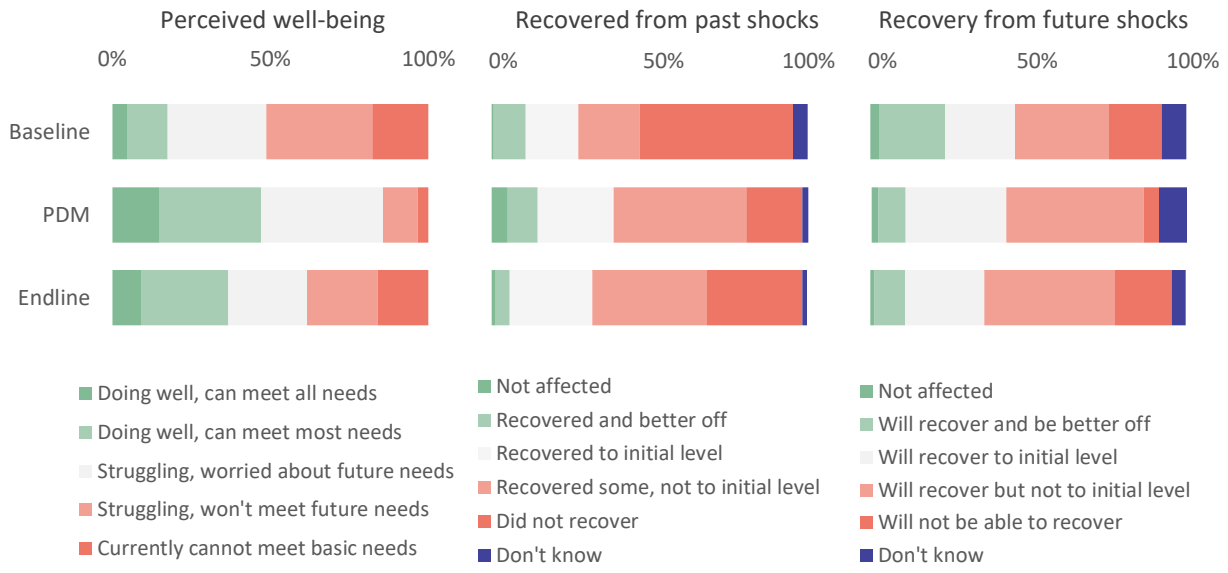
Healthcare access in project districts. In Baidoa, the location of 79% of the IRF project's health and nutrition targets, healthcare access increased from 45% at PDM to 60% at endline. Many households that gained access did so at the cost of long distances. At endline, half had to travel around 3km and some had to go as far as 30km to reach the nearest facility. The situation in Wanlaweyn was similar at PDM, with 53% of households having access but at the cost of long distances. Half had to travel 25km for services. However, access plummeted to 14% at endline. In Afgoye, only 24% of households had access at PDM, and this declined to 3% at endline.

To what extent did households' perceptions about their well-being and ability to recover change?

Well-being. Households' perceptions of their well-being reflected the improvements in food security and water access, improving markedly at PDM and declining at endline (Figure 15). Overall, well-being was very low at baseline, when only 18% felt they were "doing well," 65% were struggling, and 18% could not meet their immediate needs. Comparatively, by PDM, 47% were doing well, 50% were struggling, and only 3% could not meet their immediate needs. By endline, which represented the second half of the impact window for most households, 37% were doing well but 47% were struggling and 16% could not meet their immediate needs.

As for water access, the subgroup results for well-being appear to hide underlying spatial variation, best understood by looking at the district-level data (available in Figure A9). As observed in the district-level results on food security perceptions (shown in Figure 12), there were significant sustained improvements in well-being in Baidoa, Wajid, Afmadow, Kismayo, Adado, and Dhusamareb, many of the districts where cash transfers were reported at endline (Figure 9). **Again, this suggests that the endline results may be bolstered by interventions from other actors and that the MPCA did not last the full three months.**

Figure 15. Perceived well-being and past and future recovery



As for food security, endline well-being was poorest in districts such as Diinsoor, where as many as 95% of households could not meet their current needs even at the midpoint of the impact window, and in Berdale, Belet-Hawa, Bardere, Hobyo, and Galkayo, where 90% or more were struggling or could not meet their current needs.

Recovery. **The intervention initially enabled project participants to start getting back on their feet.** By PDM, 81% of households had recovered to some extent from the shocks they had experienced over the prior six months (Figure 15, Figure A10).[39] The frequent use of the MPCA for debt repayment—in addition to meeting current food, water, and other needs (see Figure 10)—likely contributed to this sentiment. However, the continuation of the drought through a fifth failed rainy season meant that by endline, 30% of households were still experiencing the worst of its impacts and felt they had not recovered at all.[40] Furthermore, **with the conclusion of the project, households' optimism for their future was dwindling**. Only 36% thought that they would recover to their initial level or better, while 41% did not expect to return to their initial well-being, and 18% did not expect to recover at all (Figure 15, Figure A11).

RQ4: Additional consequences: Did community cohesion and social capital change over the course of the project?

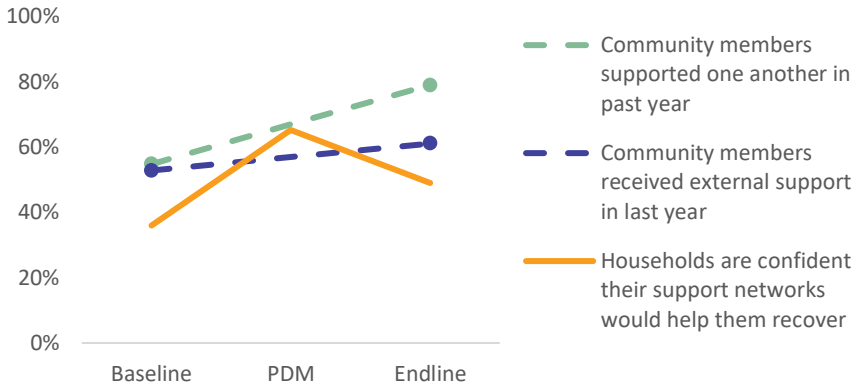
Community cohesion within IRF communities. Before the IRF projects, many communities were working together to help one another cope with the impacts of the shocks they had experienced. At baseline, 55% of IRF recipients reported that members of their communities had supported one another during the previous year (Figure 16, Table A21), primarily by sharing food (46%) but also by sharing money and water (~20%, Table A22).

[39] This was notably higher for urban (98%) and female-headed (85%) households and those without a disabled member (83%). There were quite significant differences between residents (84%) and displaced households (58%).
[40] This was highest for displaced households (37%), those with a disability (35%), and rural IDPs and agro-pastoralists (28%).

Baseline level community cohesion was higher among urban households, rural IDPs, and farmers (63%-86%), as well as among vulnerable groups like households with a disability (72%) and those who were displaced (61%). It also varied significantly by district, from around 80% or more in Southwest State, Wajid, Hudur, and Hobyo; to around 30-50%, in Baidoa, Berdale, and most districts in Galmudug; and to around 10%, in Rabdhuure-Yeed, Diinsoor, Afgoye, and Wanlaweyn.

By endline, community cohesion increased in most districts and subgroups, reaching 79% overall. However, a notable decrease to 53% occurred among rural IDPs.

Figure 16. Community cohesion and social capital



External support. The prevalence of external support was similar, starting at 53%, with comparable subgroup trends and marked district-level variation. Overall, it improved to 61% at endline (Figure 16, Table A21). This increase may have been larger if not for significant declines among rural IDPs, farmers, and households with disabilities, as well as in Kismayo, Wajid, and Rabdhuure-Yeed. Again, the support received was mainly in the form of food, money, and water (Table A22).

Social capital. The above indicators reflect IRF households' retrospective views of support within and to their communities broadly. Comparatively, when asked about the current social capital of their family, specifically, only 36% of households were quite or very confident that their support networks would (and, presumably, could) help them recover in a crisis (Figure 16, Table A21).

Interestingly, the subgroup trends were almost exactly the opposite of those observed in the broader community cohesion measures. While more vulnerable groups may indeed have lower social capital than their peers, their vulnerabilities may lead them to perceive their own situation as worse and others' situations as better off than they are in reality.

Overall, social capital increased to 65% at PDM, with marked improvement among displaced households, but declined to 49% at endline.

Influencing factors. The community cohesion and social capital findings may truly indicate improvements in social cohesion, or *willingness* to help one another, potentially driven by the project's community-led implementation approach, which, like all BRCiS projects, involved close coordination with Community Resilience Committees (CRCs), community stakeholder meetings, community-based targeting, and community-developed water interventions. Since district-level trends in social capital indicators were very similar to those of other perception-based indicators, such as food security and

well-being, these improvements may alternatively, or also, reflect households' increased agency, or *ability* to help one another, which had dwindled due to the drought but improved as a result of the sudden, large one-time cash inflow. Alternatively, they could simply reflect households' *general outlook and optimism* in response to the IRF project activities.

Sources of support. Out of all households, over 20% had no one within their community, and around 30% had no one outside their community, who would help them in the event of a crisis (Table A23). While around two-thirds could turn to relatives, their ability or willingness to do so declined from baseline to endline. Comparatively, households became increasingly able to rely on their neighbours and clan group over the course of the project period. These shifts could reflect the growing community-wide impact of the drought, which may have eroded relatives' ability to support one another and led households to cast their net for support more widely.

Findings from the GBP 2 million IRF top-up study

As mentioned above, a second survey panel was carried out to assess changes among the 11,100 additional households—including 1,379 located in hard-to-reach (H2R) areas—targeted to receive MPCA through the IRF top-up. Unlike in the initial project, the top-up targets were unevenly distributed across districts, with fewer targets in the hard-to-reach areas to minimise risks associated with the pilot and a greater share in more accessible communities (see Table A4).

Like the initial study above, the top-up study found that the MPCA led to direct, significant, and positive impacts for recipient households. It also found that H2R households were even more vulnerable than the other IRF participants.

Because the top-up distribution and surveys were carried out against a different seasonal backdrop (see Figure 2) and later in the drought than the initial project and survey panel, and because some of the analytical methods differed between studies (see Box 10), findings from the top-up study are not directly comparable to those from the initial study and are presented here separately. The detailed results tables for the top-up study are available on request from BRCiS.

Box 10. Interpreting the results from the IRF top-up analysis

Data cleaning and analysis were carried out by a team of external consultants for the initial study but by the BRCiS team for the top-up study.

Like the initial study, the top-up study began with a panel approach, following up with the same households in both rounds. However, unlike the initial study, which only analysed the panel households (those that were surveyed all three rounds), the top-up study analysed all viable records from each survey. After dropout and sample loss during data cleaning, the top-up analysis was run on 2,621 baseline and 1,897 PDM households,[41] some of which were the same (i.e. panel households) and some of which differed between rounds.[42] As such, the two surveys represent somewhat different populations (see Table A2) and may not be comparable.

[41] Including 321 H2R households at baseline and 270—mostly in Qansaxdheere and Kurtunwaarey—at PDM.
[42] For instance, the baseline included 113 households in Bardere, which did not ultimately receive the intervention and were not followed up at PDM. In Baidoa, baseline sample loss was high and only 78 records were analysed. However, data quality was better at PDM and 209 records were analysed.

Like in the initial study, because dropout in the top-up study differed across districts confidence in the final district-level estimates varies. Despite the variability in the distribution of targets, dropout, and final sample sizes across districts, unlike for the main study presented above, the totals presented for the top-up are *not weighted*, meaning that they reflect the situations and experiences of the sampled households and are *not necessarily generalisable* to the whole population of top-up recipients. Still, they do seem to give a good overall picture of the experiences of targeted households.

Finally, some of the measures and calculations used for each study differ. Despite all of these differences, it is notable that **many of the overall messages and takeaways are similar for both studies**.

Who were the surveyed top-up households? Were they vulnerable? Just over half of the top-up households surveyed at baseline were female-headed.

A similar portion was agro-pastoral, 21% were urban, 18% were pastoral, and 9% were farmers. Unlike the initial study, the top-up questionnaire did not include an option to select urban or rural IDP as a livelihood. **As many as 30% of top-up households reported being displaced,** indicating a high level of vulnerability overall—especially in H2R areas—and suggesting that a significant portion would have self-selected into an IDP livelihood zone if given the option. However, displacement varied significantly by district, from essentially none in Ceelwaaq, Wanlaweyn, Afgoye, and Kurtunwaarey to nearly all in Baidoa. This likely reflects top-up project and survey sample targeting at a community level. Given the notable dropout and sample loss on the two surveys, these statistics may be different for the PDM sample. While not asked at baseline, 13% of the households surveyed at PDM reported having a disabled member. This varied from none in Kurtunwaarey to 25% in Ceelwaaq.

Drought impact. On the PDM survey, 75% of top-up households reported that the current drought was worse than that in 2017. Its impact was severe for 25% of households and major for 61%. Its effects were slightly worse for H2R households (34% severe, 54% major). However, when asked about the shocks they had experienced in the past six months, a surprisingly low proportion of households reported experiencing drought (23%, 32% for H2R). As on the main survey, increasing food prices was a critical issue (18%, 16% for H2R), and malnutrition and hunger were notable (13%, 17% for H2R). Shocks had a strong impact on both the income and well-being of households at baseline (~63%) and PDM (~80%). At baseline, 18% of all and 32% of H2R households had no way of coping. While this dropped to 18% at PDM for H2R households—signalling an improvement, it increased to 25% across the whole sample—possibly suggesting an overall decline.

Incomes. According to the PDM, the drought led 80% of surveyed top-up households to change their primary source of income. While 50% previously earned from farming and 38% from livestock, at PDM, cash transfers were the primary income source for 44% of households and casual labour for 42%. Trends were similar for H2R areas. Of the 552 IDPs surveyed at PDM, 30% reported sending money home to their areas of origin. This varied significantly across districts, possibly reflecting different characteristics of the IDP populations in each area. Notably, **only 5% of H2R households reported having received any support aside from the BRCiS IRF MPCA in the 12 months before the PDM survey,[43] verifying that these areas are largely excluded from humanitarian and development support.**

[43] 7% in Qansaxdheere and 3% in Kurtunwaarey, where sample sizes were sufficient. 0% in the remaining districts where sample sizes were very low.

Use of MPCA. Like recipients of the initial MPCA activity, top-up households primarily used their cash transfers for food, debt repayment, and water.

Food security, coping, and well-being. Again, although the initial and top-up distributions and surveys were carried out at different times of the year, **similar outcome-level trends were observed in both studies. This supports the assertion that at least some of the positive changes are attributable to the MPCA.** For instance, adequate food quantity increased from 39% before the top-up to 80% after, and the percentage of households that were "doing well" increased from 16% to 47%. H2R households experienced even larger gains in perceived well-being, from 4% to 58% at PDM.[44]

Despite these major improvements, food security remained precarious, and even poor, in some areas and among certain populations at PDM. For instance, while 9% of all households had a poor FCS, this exceeded the 20% IPC threshold in Baidoa (28%) and Kurtunwaarey (39%) and was dangerously close in the H2R areas (18%).

Water and health facility access. The top-up water interventions were minimal, limited to 590 households targeted with community water vouchers in Belet-Hawa and 124 in Afgoye. Still, some of the surveyed top-up households may have been within the catchment areas of the initial water interventions and therefore benefitted from these activities. This could potentially explain the trends in domestic dry season water access observed in a few districts, namely Baidoa, where it declined from 87% at baseline to 32% at endline. However, in eight of the 12 districts, water access improved at least slightly. The change was greatest, growing from 1% to 62%, in Ceelwaaq. A more nuanced understanding of the factors driving these shifts would require additional information. Overall, domestic dry season water access was below 20% in eight districts at baseline and below one-third in eight districts at PDM.

Between 40-70% of households reported drought-related illnesses in their communities in the six months before the PDM, including cholera and measles outbreaks. Access to health facilities varied significantly, from 19% in Wanlaweyn to 76% in the H2R community in Qansaxdheere.

Social capital. In general, trends in social capital among the surveyed top-up households were similar to those for initial project participants, again validating the impact of the IRF project. The proportion of top-up households who were quite or very confident that their support networks would help them recover in a crisis increased from 29% at baseline to 68% at PDM. This improvement was even greater for H2R households (17% to 71%). Like the main findings, top-up households said they were less likely to turn to relatives and more likely to turn to friends and neighbours for support within their community. The percentage of households who had someone outside their community to turn to in case of urgent needs increased from 58% to 81%.

[44] These overall trends may hide significant district-level variations. The rCSI, for instance, improved dramatically, from 37 to 9, in Qansaxdheere but worsened markedly, from 9 to 17 in Ceelwaaq.

Discussion: Addressing the OECD-DAC criteria

Effectiveness: Did the intervention achieve its objectives? The primary objective of this evaluation was to address the OECD-DAC criteria of effectiveness.[45] As demonstrated throughout the results sections above, **it is quite clear that the IRF project—both through the main component and the top-up—was very effective in meeting its aim of being a lifesaving intervention, addressing the most urgent and severe humanitarian needs and reducing the risk of mortality and morbidity of the most vulnerable drought-affected people**.

While many factors were at play, including light rainfall in some districts, triangulation across indicators suggests that the IRF project significantly contributed to staving off the immediate worst-case scenarios for participant households. According to PDM data, acceptable levels of food security increased dropped to 82% among the initial households, 75% among top-up households, and 67% among the even more vulnerable H2R top-up households. Although overall water access remained stable, significant improvements were observed in the districts receiving the most intense interventions.

Connectedness, sustainability, and impact:[46] Were the short-term emergency activities carried out in a context that takes longer-term and interconnected problems into account? While this evaluation was not designed to look at these questions specifically, the BRCiS Consortium's resilience-building mandate is built around linking short-term emergency relief with sustained, long-term solutions. This is implemented through its community-led approach including the rehabilitation of water points and the establishment of water management committees to climate-proof water systems for the future.

Furthermore, it is well-known that the enduring consequences of even short-term food and water insecurity and malnutrition, especially for children, can be devastating and life-long. While the evaluation cannot extrapolate the extent to which these impacts were avoided, it is clear that the IRF project briefly staved off this possibility during a critical period for a subset of households.

As noted above, evidence from the evaluation shows that in practice, the lump-sum transfer did not last households the intended three months. Endline results from the initial study showed that needs skyrocketed in the second half of the impact period, and if it weren't for additional cash programming in some districts, the situation would likely have been as bad as—or potentially worse than—observed at baseline. Factors leading to this unexpected rate of consumption and reduced impact window likely included inflationary pressures and price increases that reduced household purchasing power, common use of the transfers to pay off accumulated debt, and potential spillover as project participants helped others in desperate need. The latter two uses are not necessarily negative outcomes and may reflect households' priorities, financial decision-making, social context, and other factors. For instance, in this context, where funding constraints meant that many equally deserving households had to be excluded from receiving MPCA, spillover may be a positive result. A qualitative investigation of households' use of MPCA would yield greater insight into their values and the constraints they face.

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[45] In line with guidance from the Organisation for Economic Cooperation and Development (OECD) Development Assistance Committee (DAC), the OECD-DAC criteria are meant to be applied thoughtfully and contextualized. The use of each, or all, of the criteria depends on the purpose of the evaluation and the needs of the relevant stakeholders. See "Better Criteria for Better Evaluation" 10 December 2019.

[46] ALNAP's 2006 "Evaluating Humanitarian Action Using the OECD-DAC Criteria" written by Tony Beck, recommends replacing the criteria of sustainability with connectedness and considering the concept of appropriateness (see below) when assessing relevance in humanitarian contexts.

Relevance and appropriateness: Was the project in line with and tailored to local needs and priorities? While this evaluation was not designed to assess relevance and appropriateness per se, it is worth noting that all of BRCiS' interventions are designed and implemented in close coordination with communities via the CRCs and that as a result of its eight years of experience working with vulnerable communities in Somalia, BRCiS has a good understanding of their needs. Both relevance and appropriateness—for instance whether the interventions were culturally appropriate, met the needs of different groups, etc.—were considered carefully in the project's design and contributed to the selection of the specific activities undertaken.

As noted above, it may be worth reviewing whether the three-month lumpsum modality at the set MPCA values is the best approach to meeting the project's goals. A qualitative review of households' use of the MPCA funds would help to guide the selection of future transfer amounts and modalities, ensuring that they align with the project's values.

Coverage: Who was supported and why? The project clearly moderated the impact of the drought on the roughly 27,000 MPCA and 84,000 water recipient households, identified using community-based targeting as the most vulnerable households in the most vulnerable yet accessible communities.

The surveys confirmed that the project successfully reached vulnerable groups, including female-headed households, displaced populations and families with disabled members. In total, 61% of the initial IRF MPCA recipients identified with at least one of the measured vulnerabilities. In both studies, baseline-level needs for food security and water access to ensure survival and limit displacement were high. Triangulation and inference suggest that as many as around two-thirds of households may have had poor or borderline food security at baseline and the data shows that only 32% of the initial households had access to any water for domestic use. **The top-up intervention explicitly included hard-to-reach areas, which the analysis shows were even more vulnerable than the regular project participants.**

However, while not explicitly measured by this evaluation, we can infer that even with the top-up, the project was not large enough to provide adequate coverage. While it did help mitigate the worst of the drought for participants themselves, community-level indicators signalled that livestock death, human death and illness, and population displacement continued to affect others in their communities. Given that baseline level needs were so great that project staff had to turn many deserving people away, the current condition of many families in the IRF communities is likely significantly worse than the endline levels here suggest.

Programme-level recommendations

This evaluation identified the following recommendations for future programming and research.

Box 11. Recommendations

While short-term injection of funds temporarily alleviates the worst symptoms of drought, it ultimately creates further instability for households already facing acute needs and extreme uncertainty. This evaluation shows the rollercoaster many aid recipients experience: unable to eat for months, support suddenly fully meets their needs for a month or two, after which they end up back in their original situation, again unable to feed their children. To truly support people during long-term crises, **humanitarian interventions should cover at least six months and include climate resilience and drought recovery plans to help kick-start the recovery process.**

To the extent possible, **continue supporting communities in hard-to-reach areas**, which are notably more vulnerable. **Continue supporting vulnerable groups**, but carry out studies on the links between contextualised vulnerability identities and more standardised definitions used by programme managers, policy-makers, and donors to ensure accurate views of field-level situations and enable effective decision-making.

After validating findings with ground-level sources and honing in on the exact hotspots, **continue supporting urban IDPs, who appear to have faced disproportional mortality rates**, likely due to difficulties experienced on their journeys as well as challenges in urban IDP settlements. At the same time, **it is critical to continue to intervene in origin sites to discourage further displacement**, which can lead to worse consequences for those who choose to move and place further pressure on urban centres.

Continue incorporating water interventions, which are more effective at increasing water access than MPCA. Adjust existing evaluation methods and tools and/or implement additional studies to better understand the impact of water and health access and interventions and the multiple links between water and displacement.

Review the three-month lump-sum payment modality and (potentially) transfer amounts, considering whether they are the best approaches to meet the intended objectives and align with the project's values.

Consider implementing **alternative approaches to estimate displacement and mortality**, and continue to advocate for improved methods of measuring these indicators, particularly mortality, and particularly among vulnerable groups to ensure that their lives and deaths are recognised and counted.

Conclusions and big-picture recommendations

This evaluation adds to the large existing body of evidence that timely relief is effective in meeting short-term needs in an emergency as well as to the growing set of evidence that water and other resilience-building interventions reduce even the more extreme impacts of drought-induced migration. **The data clearly shows that the IRF project effectively addressed the most urgent and severe needs of the targeted 27,000 MPCA families, and allows us to infer the same for the 84,000 water participants, reducing their risk of mortality and morbidity over the last few months.**

However, given the extent of the drought, the scale and duration of the intervention was simply not enough. The needs are now worse, the risk of mortality and morbidity is now greater, and the number of vulnerable people is now much larger than at the outset of the project.

As the global humanitarian community, we know what works to mitigate the impacts of the drought—saving lives in the short run and limiting the long-run repercussions. Proven programs and systems like BRCiS are already in place to meet the most urgent needs in a sustainable way. **What is truly needed now is for donors to step up and commit sufficient funds for these programs to reach the large and growing numbers of people in extreme need—both in Somalia and the rest of the Horn.**