

MODIFICATION REQUEST 1 (MR1) ASSESSMENT FINDINGS FOR SOMALI CASH CONSORTIUM'S DIRECT NUTRITION REFERRAL APPROACH

JUNE 2025

BANADIR, SOMALIA

KEY MESSAGES

- **The cash assistance contributed to short-term improvements in food consumption, reduced reliance on negative coping strategies, and increased household (HH) resilience.** The food security status improved significantly at the time of endline. The proportion of households found to have an acceptable Food Consumption Score (FCS) improved significantly, **increasing from 2% at baseline to 73% at endline.** The Reduced Coping Strategy Index (rCSI) **reduced from 18.5 to 12.1**, indicating decreased food-related distress. Similarly, use of emergency coping mechanisms (e.g., selling assets) declined from **29% to 10%**, showing greater financial stability which can be attributed to the cash assistance.
- HH income and expenditures increased, **but most HHs still relied heavily on casual labor and humanitarian aid**, suggesting that MPCA alone is not sufficient for long-term livelihood recovery. Average monthly income rose from \$95.51 to \$247.08, and expenditures doubled. However, 54% of HHs still depended on casual labor and 39% on humanitarian assistance.
- **The integration of MPCA with nutrition, health, and WASH services improved outcomes.** Access to nutrition rose from 56% to 78%, health from 27% to 67%, and WASH from 1% to 12%, **highlighting the value of multi-sectoral support.**

CONTEXT & RATIONALE

The Somali Cash Consortium (SCC) activated a response in the Banadir region of Somalia in November 2024 to support HHs with children under 5 years affected by Severe Acute Malnutrition (SAM).¹ The activation was led by Concern Worldwide, an SCC member, and primarily focused on HHs with children receiving treatment for SAM with complications at stabilisation centers (SCs), following the Direct Nutrition Referral (DNR) "onrolling basis" modality.*

The designated SCs included Banadir Health Center, Deynile SC, Hodan SC, and SOS Mother & Child Hospital. Over a three-month period, the selected HHs received three rounds of Multi-Purpose Cash Assistance (MPCA), each round at \$100. The MPCA was aligned with the harmonised super-regional transfer values, based on the Minimum Expenditure Basket (MEB).² To help address the challenges faced by these HHs, SCC³, with funding from the European Union Civil Protection and Humanitarian Aid (ECHO), **delivered the MPCA between November 2024 and January 2025.**

At the time of activation, an estimated 1.6 million children aged 6 to 59 months were projected to experience acute malnutrition and urgently required treatment between August 2024 and July 2025 in the whole of Somalia.⁴ This included around 403,000 cases of SAM and 1.2 million cases of Moderate Acute Malnutrition (MAM). Significantly, 66% of the total burden was concentrated in southern Somalia. Banadir was among thirteen regions classified as Integrated Phase Classification (IPC) 4, indicating a critical level of acute malnutrition, with approximately 70,960 children identified as having SAM in the region.⁵ In Banadir, the burden of acute malnutrition among internally displaced persons (IDPs) was significant, contributing to 27% (approximately 446,950 individuals) of the national estimate.⁶

***The DNR approach links nutrition treatment with cash support by ensuring that HHs with children under five admitted for SAM with complications in SCs are immediately referred to SCC partners for MPCA. Implemented on a continuous "on-rolling basis," the modality enables families to meet essential needs such as food, rent, and transport while the child receives treatment, thereby reducing economic barriers to recovery, preventing harmful coping strategies, and strengthening both nutrition and household welfare outcomes.**



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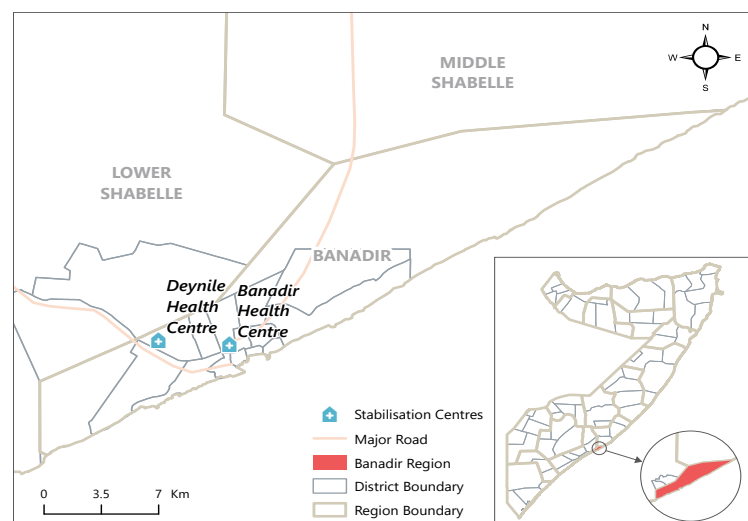
ASSESSMENT OVERVIEW

The DNR is an emerging strategy designed to improve treatment outcomes for children suffering from SAM with complications by linking MPCA directly to their admission and treatment in SCs. This approach aims to overcome the economic and logistical barriers that often prevent caregivers, typically mothers, from fully adhering to the facility-based care at the SCs.

The SCC in partnership with the Caafimaad+ Consortium⁶, has operationalized this model since 2022 across multiple districts, including Banadir and Gedo. Under this approach, MPCA is provided on a rolling basis to HHs whose children are admitted to SCs. This cash is not meant to directly treat SAM, but to indirectly support clinical recovery by easing caregiver constraints such as loss of income, transport and meal costs, out-of-pocket medical expenses, and food insecurity post-discharge, all of which are key reasons for high default and relapse rates in SAM treatment programs.

This factsheet presents the key findings from the endline assessment, as well as indicative comparisons of key indicators from the baseline assessment for the assessed beneficiary HH in Banadir region.

COVERAGE MAP 2025



1. SAM results from insufficient energy (kilocalories), fat, protein and/or other nutrients (vitamins and minerals, etc.) to cover individual needs. It is a condition where a person doesn't have enough nutrients to meet their needs and can lead to serious health problems, including metabolic issues and weakened immunity.

2. [Identifying Gaps in Households Economic Capacity to Meet Essential Needs \(food and non-food\) and the New Cash and Voucher Assistance \(CVA\) Transfer Value Recommendations](#)

3. SCC is led by Concern Worldwide and further consists of ACTED, Cooperazione Internazionale (COOPI), Danish Refugee Council (DRC), Norwegian Refugee Council (NRC), and Save the Children (SCI).

4. [Integrated Acute Food Insecurity Malnutrition \(July-December, 2024\) Somalia](#).

5. Ibid

6. Ibid

7. A consortium of eight (3 national and 5 international) humanitarian organisations dedicated to providing emergency life-saving intervention to populations in the Hard-to-Reach areas of Somalia.

FOOD SECURITY AND LIVELIHOODS (FSL)

FOOD CONSUMPTION SCORE (FCS)⁹

% of HHs by Food Consumptions Score category:

	Baseline:	Endline:
Acceptable (>42)	2%	73%
Borderline (28-42)	31%	27%
Poor (<28)	67%	0%
	Baseline:	Endline:
Average FCS per HH	25.7	46.9

With health and nutrition components integrated into the MPCA (on page 4), there was a notable increase in the proportion of HHs with acceptable and borderline FCS, contributing to an overall rise in the average FCS to levels indicative of acceptable food consumption. This shift reflects improved dietary diversity and frequency, suggesting that HHs had access to more food and dietary diversity. The positive change highlights the short-term effectiveness of the MPCA in enhancing food security outcomes.

More than half of the Hhs (57%) were found to rely on market purchases as their primary food source. This underscores the role of cash assistance in improving economic access to food.

HOUSEHOLD HUNGER SCALE (HHS)¹⁰

% of HHs by levels of hunger in the HH:

	Baseline:	Endline:
No or little hunger	17%	90%
Moderate hunger	75%	9%
Severe hunger	8%	1%

The reduction in food consumption gaps suggests that cash assistance significantly enhanced the HHs' access to food, allowing them to meet their basic nutritional needs without resorting to engage in negative coping strategies. Moreover, this improvement points to a strengthened HH capacity to manage food related shocks during the intervention period. However, sustaining these gains may depend on longer-term support or integration with livelihood and resilience-building.

USE OF COPING MECHANISMS

% of HHs by average reduced Coping Strategy Index (rCSI) category:¹¹

	Baseline:	Endline:
Low	2%	6%
Medium	55%	84%
High	43%	10%
	Baseline:	Endline:
Average rCSI per HH	18.5	12.1

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

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

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

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

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

Most commonly adopted coping strategies:^{*}

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

	Baseline	Endline
Relied on less preferred, less expensive food	3.0	1.7
Reduced the number of meals eaten per day	2.5	1.5
Reduced portion size of meals	2.6	1.6
Borrowed food or relied on help from friends or relatives	2.5	1.8
Restricted adults consumption so children can eat	1.8	1.1

LIVELIHOOD-BASED COPING STRATEGIES (LCS)¹²

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

	Baseline:	Endline:
None	24%	40%
Stress	31%	40%
Crisis	16%	10%
Emergency	29%	10%
	Baseline:	Endline:
Average LCSI per HH	4.6	2.0

The rCSI score declined significantly from 18.5 at baseline to 12.1 during the endline, indicating a marked reduction in the frequency and severity of negative consumption-related coping mechanisms. HHs were less likely to skip meals, reduce portion sizes, or prioritize food for certain members, suggesting improved food access and consumption stability.

Further, LCSI reflected improvements in HH resilience. The use of 'emergency' coping strategies, such as selling productive assets, decreased from 29% to 10%, while reliance on 'crisis' strategies fell from 16% to 10%. Although 'stress' coping slightly increased from 31% to 40%, the overall decline in high-risk behaviors contributed to a drop in the average LCSI score from 4.6 to 2.0.

These findings suggest that HHs were better able to meet their basic needs without depleting critical assets or engaging in negative survival mechanisms. The MPCA likely played a central role in strengthening HHs' capacity to cope with shocks and maintain more sustainable, dignified livelihoods in the short term.

LIVELIHOODS

HHS' INCOME SOURCES

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

	Baseline	Endline
Casual labour (wage labour)	57%	54%
Humanitarian assistance	13%	39%
Livestock Sales & production	2%	33%
Business	18%	39%
Average reported monthly amount of income for HHs that received any income in the 30 days prior to data collection (100%):¹³	95.51 USD	247.08 USD

Despite access to MPCA, **casual labour remained the primary source of income for 54% of HHs, followed by humanitarian assistance at 39%**. This reliance on casual labour suggests that while MPCA provided critical short-term financial relief, it was not sufficient to fully offset the need for daily income-generating activities, especially in the context of ongoing livelihood disruptions.

These findings align with insights from a recently concluded nutrition study¹⁴, **where the majority of key informants and beneficiary HHs recommended extending the duration of MPCA support from three to five cycles**. Many advocated for making cash transfers more continuous to ensure sustained financial stability. **This highlights that while MPCA has been essential in bridging immediate gaps, its current duration may be too short to achieve long-term resilience and recovery for vulnerable families.**

	Baseline	Endline
Average reported monthly expenditure for HHs that had spent any money in the 30 days prior to data collection (100%):	87.36 USD	203.73 USD

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

	Average amount spent in the 30 days prior to data collection by HHs reporting spending >0 USD in this category		Proportion of total spending across all HHs including HHs who spent 0 USD ¹⁵ at the endline
	Baseline	Endline	
Food	50.49 USD	93.52 USD	46%
Debt repayment for food	4.56 USD	18.24 USD	9%
Rent	2.14 USD	15.67 USD	8%
Medical expenses	8.35 USD	17.26 USD	8%
Clothing	5.28 USD	13.28 USD	6%
Debt repayment for non-food items	1.30 USD	11.40USD	6%

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

13. At the endline, it was observed that all (100%) had incomes exceeding 130 USD. CMU categorizes HHs with incomes above 130 USD as high-income HHs.

14. [IMPACT-SOM-Deynile-Nutrition-Study-March-2025](#).

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

** [Joint-FEWS-NET-FSNAU-Somalia-food-security-outlook-report](#)

*** [Country Cooperation Strategy for WHO and Somalia 2021-2025](#)

**** [wfp-somalia-country-brief-may-2025](#)

SPENDING DECISIONS

Proportion of HHs by the primary decision maker on how to spend:

	Baseline	Endline
Joint decision-making	61%	71%
Female members of the HH	36%	28%
Male members of the HH	3%	1%

HHS' SAVINGS & DEBT

Most HHs (85% , n=134) were found to have debts. The average HH debt was found to be \$73.10 at the endline. This was a decrease from the baseline, where 67% reportedly had debts averaging to \$51.50.

Only 15% (n=24) of the HHs reportedly had savings averaging to \$4.37 USD during the endline. During the baseline assessment, the proportion of HHs found to have savings was 10% averaging to \$5.10.

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

	Baseline	Endline
Market purchase with cash	36%	57%
Market purchase on credit	6%	14%
Loan	5%	11%

Findings indicate that food expenses represented 46% of total HH expenditure, with an additional 9% allocated to repaying food-related debts, highlighting the role of food in meeting basic needs. This aligns with the 2025 FEWS NET/FSNAU outlook, which confirms that Somali households, particularly those in flood-affected, agropastoral, and IDP areas, remain heavily reliant on markets for food, often resorting to debt repayment to secure essential supplies.

Medical spending nearly doubled from USD 8.35 to USD 17.26, serving as a proxy for improved access to health services and reflecting the intended outcomes of the DNR pathway, whereby MPCA supports households post-discharge for children treated for SAM. This is consistent with the World Health Organisation (WHO) Somalia strategy, which highlights that nearly half of HHs finance healthcare directly from their own income.***

Geographically, the assessment revealed that almost all households (98%) were from urban livelihood zones, with the majority concentrated in the Banadir region.

This urban concentration significantly shaped household expenditure patterns, particularly in relation to housing. Average monthly rent increased sharply from USD 2.14 at baseline to USD 15.67 at endline, reflecting both the enhanced purchasing power provided by cash assistance and the inherently higher cost of living in urban areas. These findings align with broader evidence highlighting the compounded strain of urban displacement and elevated cost burdens in Banadir and other major city centers.****

ACCOUNTABILITY TO AFFECTED POPULATION

Proportion of beneficiary HHs reporting on key performance indicators (KPI):¹⁶

Indicator	Baseline	Endline
Programming was safe	98%	100%
Programming was respectful	98%	100%
Community was consulted	30%	8%
The assistance was appropriate	78%	63%
No unfair selection	100%	100%
Raised concerns using complaint response mechanism (CRM)	5%	1%
Satisfied with the response (n=9 & n=1 respectively)	100%	100%
Overall KPI score	75%	79%

Only 1 out of the 158 assessed HHs during the endline reported being aware of at least one option to contact the NGO (Concern Worldwide).

Of HHs reporting being aware of any option to contact Concern Worldwide (n=1), the most frequently known ways to report complaints and problems in receiving the assistance during the endline were:^{**}

	Baseline	Endline
Use the dedicated NGO hotline	n=7	n=1
Talk directly to NGO staff	n=1	n=0
Use the dedicated NGO desk	n=1	n=0

The most frequently reported complementary service received alongside cash assistance in the past three months:^{**}

	Baseline	Endline
None	16%	4%
Health	27%	67%
Nutrition	56%	78%
WASH	1%	12%
Protection services	1%	4%

Organisations that provided the services alongside the cash assistance.^{**}

	Baseline	Endline
ACF	9%	17%
Concern World Wide	40%	83%
International Medical Corps	10%	12%
SOS	23%	17%
Trocaire	18%	0%

The top mentioned requests by the assessed HHs who provided comments and feedback (26%):^{**}

	Baseline	Endline
Food assistance	87%	64%
Livelihood support	33%	64%
Shelter support	48%	52%
Educational support	51%	45%
Increase field visits by NGO (Concern) staff	16%	41%
Need of non food items	9%	34%

CONCLUSION

The findings from the Direct Nutrition Referral (DNR) baseline and endline assessment in Banadir highlights the effectiveness of linking MPCA with nutrition treatment services for HHs affected by SAM. **Improvements in food security indicators, HH income and expenditure, and access to health and nutrition services demonstrate the value of an integrated approach in fragile urban settings.** However, persistent gaps in economic self-sufficiency and limited awareness of feedback mechanisms suggest the need for more sustained and accountable programming. **As Somalia continues to face compounding crises, scaling such nutrition-sensitive cash interventions,** particularly through key SCs, offers a viable pathway to strengthening resilience and ensuring no child is left behind in recovery.

The overall KPI score saw a slight decline from 79% to 75%, largely driven by a drop in community consultation and low CRM utilisations. This is likely so since this implementation modality relies on referrals from the health and nutrition partners without directly involving the beneficiaries in the targeting process. Despite high satisfaction levels, awareness and use of complaint and feedback mechanisms remained very low. **Only 38% of HHs were aware of any option to contact Concern during the endline, and just one respondent knew how to reach out.** Use of dedicated hotlines or NGO staff for complaints was negligible. The decline in expressed concerns via CRM (from 5% to 1%) and minimal engagement with reporting tools indicate a critical gap in accountability structures. This limits the ability of the program to respond to evolving beneficiary needs in real time.

The integration of MPCA with complementary services improved significantly, reinforcing the value of a multi-sectoral approach. Nutrition service access rose from 56% to 78%, health from 27% to 67%, and WASH from 1% to 12%. Only 4% of households reported receiving no additional services, down from 16%. Concern Worldwide played a key role, expanding its reach from 40% to 83% of HHs. ACF and IMC also contributed, though service delivery from partners like Trocaire and SOS declined or ended. **These trends reflect growing coordination but highlight the need for consistency across implementing agencies.**

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

* Nutrition-based approach relies on enrollment via referrals, which limits opportunities for early consultation.

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

METHODOLOGY

The methodology was quantitative, with both baseline and endline surveys survey conducted through mobile data collection (MDC). The sample was drawn from the MPCA beneficiaries using the DNR. The baseline and endline assessments conducted collected data on the HHs' demographics, their overall food security situation, income, expenditure, overall well-being, as well as their perceptions of whether the humanitarian assistance offered was delivered in a safe, accessible, accountable, and participatory manner. The baseline assessment was conducted between **30th October and 7th of November 2024**, while the endline assessment followed **after the third and last round of cash transfer, from 19th to 22nd of February 2025**.

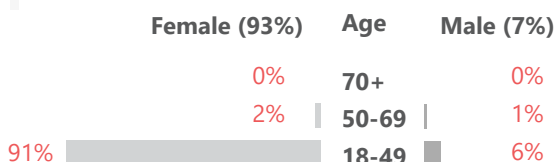
A probability simple random sampling approach was employed at the cohort level (**referrals of HHs with children under the age of five suffering from SAM**), with a 95% confidence level and a 7% margin of error. IMPACT received beneficiary list weekly on rolling basis as part of the DNR approach. Therefore the baseline data collection was conducted on rolling basis **until the overall desired sample size was achieved and that the data is representative at cohort 5 of the entire beneficiaries targeted in Banadir under Concern Worldwide activation**. Of the 1,350 beneficiary HHs, **a total of 345^{*} HHs were interviewed remotely via telephone during the baseline and endline assessment**. A 15% buffer was applied to account for potential non-responses and surveys that may need to be excluded during the data cleaning process.

LIMITATIONS

- Findings referring to a subset of the total population may have a wider margin of error and a lower level of precision. **Therefore, they may not be generalizable and should be considered indicative only.**
- Certain indicators may be under-reported or over-reported due to subjectivity and perceptions of respondents (in particular "social desirability bias" - the tendency of people to provide what they perceive to be the "right" answers to certain questions). HHs may sometimes try to give answers they feel will increase their chances of getting more assistance. This risk is mitigated by training enumerators on neutral probing and daily data-checks and data audits are carried out daily during the data collection period to help reduce this bias.
- Data on HH expenditure was based on a 30-day recall period; a considerably long duration over which to expect HHs to remember expenditures accurately and to such a degree of detail, which hence might have negatively impacted the accuracy of reporting.
- Due to slight differences between the baseline and endline demographics, only endline demographics are reported.

ENDLINE DEMOGRAPHICS**

% of HHs by head of the HH demographic characteristics:**



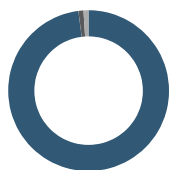
Average age of the head of HH **29**

Average HH size: **7**

53% Of the endline interviews were conducted with members who identified as the IDPs

52% Of surveyed HHs at the endline included six or more HH members, thus classified as big HHs.

Livelihood Zone breakdown:



Of the Somali Cash Consortium (SCC) beneficiary HHs surveyed, **98% were categorized as urban HHs, 1% as pastoral and 1% as agro-pastoral.**

* A total of 187 beneficiaries were surveyed at baseline, while only 158 were interviewed at endline. The endline aimed to follow up with the same HHs, but some were unreachable due to switched-off phones. Additionally, surveys under 15 minutes were excluded during data quality checks.

**Endline and baseline demographics are not 100% similar. In all surveys, the age and gender of the reported head of HH were collected for disaggregation, regardless of whether the respondent identified as the head of household.

** Due to rounding up, findings may not add up to 100%.

ABOUT IMPACT

IMPACT Initiatives is a Geneva based think-and-do-tank, created in 2010. IMPACT is a member of the ACTED Group. IMPACT's teams implement assessment, monitoring & evaluation and organisational capacity-building programmes in direct partnership with aid actors or through its inter-agency initiatives, REACH and Agora. Headquartered in Geneva, IMPACT has an established field presence in over 30 countries. IMPACT's team is composed of over 300 staff, including 60 full-time international experts, as well as a roster of consultants, who are currently implementing over 50 programmes across Africa, Middle East and North Africa, Central and South-East Asia, and Eastern Europe.