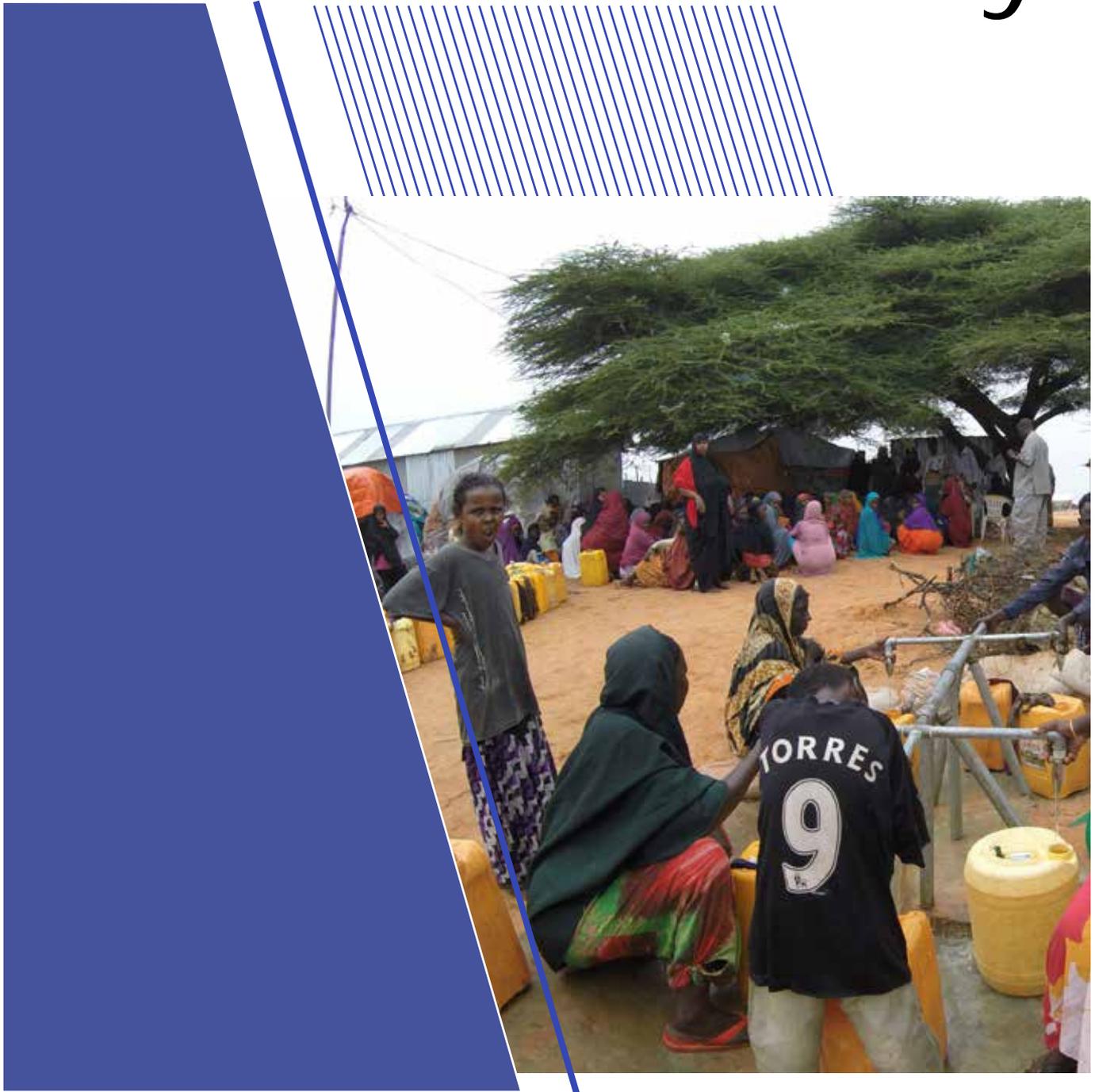


NUTRITION
CAUSAL
ANALYSIS
STUDY

South and Central Somalia

Executive Summary



A Study by the

SNS
CONSORTIUM



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Programme

NUTRITION
CAUSAL
ANALYSIS
STUDY

South and Central Somalia



Executive Summary

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The SNS Consortium with support from WFP, carried out a Nutrition Causal Analysis (NCA) study across six locations in South Central Zone (SCZ) Somalia, between March and November 2015. These included the following Livelihood Zones: Beletweyne riverine, Baidoa agro-pastoral and Dollow pastoral rural livelihood zones, as well as Mogadishu urban, plus Mogadishu and Dollow Internally Displaced Persons (IDP) settlements. This NCA Report includes a specific section on each of the six NCA studies undertaken. The aim of the study was to investigate key factors that contribute to acute malnutrition in particular contexts, and the relationship between these factors as experienced by the communities studied, to highlight recommendations for service providers in the interest of strengthening prevention and support initiatives. The Mogadishu urban community, which displays stronger nutritional status, was specifically included as a relatively positive case to highlight learning for key actors.

The study drew on the Link-NCA methodology developed by ACF, adapting and applying it in the six South Central Somalia study locations as feasible. It should be noted that the SNS Consortium was established to work in particularly vulnerable, prolonged malnutrition “hotspots” in South Central Somalia which means that the study was undertaken in extremely challenging circumstances. Each of the six location NCA Study findings are to a degree context specific and caution should be taken when extrapolating the findings of a particular NCA study more widely. At the same time, many key findings are common across the locations and livelihood groups studied. Therefore the research can be seen to have wide relevance across many Somali contexts. Significant, extreme challenges have been faced throughout the process for many reasons and inevitably, the main challenges impacting on the study itself are those which continue to affect all humanitarian efforts and actors in South Central Somalia. Related challenges faced and learning are highlighted in the report’s final section. The research explicitly sought to develop more nuanced recommendations to inform related programming by key SCZ actors, in particular locations. In-depth Focus Group Discussions and Key Informant Interviews were the main methods used to gather qualitative data on the underlying drivers of acute malnutrition in select locations.

While many NCA findings are widely relevant across Somalia and serve to confirm existing knowledge, as anticipated, others provide more nuanced, context-specific understandings of issues with particular local significance. In all NCA study locations the causes of acute malnutrition are multiple and complex. See the six Causal Pathways on pages 7 - 13 below which summarize the findings per NCA study. They include less known underlying drivers in need of urgent attention, as well as factors already typically addressed in nutrition-sensitive

programming in South Central Somalia.

On the ground realities in many complex and highly insecure SNS SCZ locations where the NCA took place, combined with weak qualitative research capacity amongst local research teams able to access the NCA study locations, largely explain significant limitations in the NCA process and findings. Overall, NCA Advisory Group members remain disappointed with the limited depth apparent in much NCA data, which has inevitably impacted on the comprehensiveness of the findings which are not as nuanced as expected¹. Notwithstanding these weaknesses, at the same time the findings do serve to highlight some critical underlying drivers of acute malnutrition in specific SCZ contexts and more generally, to raise important questions about appropriate nutrition sensitive programming and the limitations of dominant responses.

Unsurprisingly, the NCA research has confirmed that as well as insecurity, climatic and seasonal factors and notable poverty amongst some communities, dominant child care practices and select socio-cultural beliefs remain core drivers of malnutrition in SC Somalia, due to their negative impact on the lives, livelihoods and nutrition status of the communities studied. In all communities studied, weak infant and child feeding and care practices, combined with poor hygiene, the lack of basic health and WASH facilities and women’s excessive workloads, which commonly take mothers away from their very young children, are seen to have a major impact.

Dominant socio-cultural beliefs and related social norms including dietary taboos and, in some communities, extremely young marriage (from 13 years old) and child-bearing ages for girls, Female Genital Mutilation and the growing phenomenon of female-headed households in many areas, widely impact adversely on the health, well-being and nutritional status of communities studied. Dominant beliefs about the “inadequacy” of a mother’s breast milk to satisfy the needs of her new-born, continue to fuel diarrhoea and heightened vulnerability among infants. The lack of adequate basic health, nutrition, education, WASH and other services continues to negatively impact on nutrition status. So too do limited or non-existent income generation opportunities for more vulnerable community members. In farming and pastoral areas, many respondents noted with concern the lack of support to strengthen community skills (agricultural and livestock related) and their lack of access to resources like livestock specialists, basic farm equipment and quality seeds, which they perceive could help to increase local production, strengthen livelihoods and nutritional status.

Social support networks, clan and other, are also of significance in relation to helping families and wider communities more effectively negotiate periods of extreme shock, stress and vulnerability. The NCA has taken place in the late aftermath of the 2011 drought

¹ This has proved the case despite the extensive technical, logistical and other support the lead researchers and research teams received throughout the process.

and famine, at a time of reducing humanitarian actors and services in South Central Somalia, which is heightening the vulnerability of some communities who had come to depend on such support to feed and raise their families. South central Somalia is also the region where families, particularly vulnerable ones, have least access to diaspora family members and remittances. Notwithstanding the above factors, in all livelihoods studied the relatively better off are seen to have stronger nutritional status, albeit to varying degrees. The most vulnerable community members are further hit by the lack of income generation opportunities, on top of all the above. Limited access to income across the assessed communities impacts significantly on their ability to meet their basic needs, including for health care and education, most of which services remain private. Asset-poor communities also display a limited social support system, which heightens their vulnerability to poor health and malnutrition.

As well as the many widely relevant findings, the six NCA Study reports included here document a range of community and location-specific factors that impact on malnutrition in particular contexts. In contrast lessons can be learned from the Mogadishu urban communities studied, which illustrate the significance of strong social networks and support, access to formal education, higher marriage and child-bearing ages for girls.

Analysis of the NCA data has highlighted the following key recommendations per study area.

NCA 1 - Mogadishu IDP Communities Key Recommendations

1. Increase household access to basic health, nutrition, WASH and education services, especially amongst minority communities.
2. Support income generation activities and opportunities for minority families in particular.
3. Explore ways to increase cash flow into Mogadishu IDP settlements in a sustainable manner. For example:
 - Explore options to open up markets in the settlements where IDPs trade among themselves
 - Improve IDP business and vocational skills
 - Help ensure that vulnerable community members have access to formal education, especially women and children.
 - Consider establishing Cash Transfer Programmes that specifically target Mogadishu IDPs, including issuance of revolving funds or loans to support new businesses.
4. Reduce the high incidence of childhood disease:
 - Ensure local accessibility to immunization services and MCHs, to better control communicable disease.
 - Ensure adequate WASH facilities and actively promote improved hygiene by raising awareness on the importance of personal and environmental hygiene.
5. Improve the public health environment:
 - Ensure appropriate health and nutrition education and promotion.
 - Strengthen the quality of health services, e.g. train health personnel to diagnose and treat simple ailments, train staff on ethical service delivery including not discriminating against patients from particular backgrounds or locations and ensure the availability of essential drugs.
5. Improve the public health environment:
 - Sanitation: Support community members to keep their environment clean, e.g. to bury children's stool and empty full latrines using exhausters, on a regular basis. Provide the necessary equipment.
 - Water: Support the provision of adequate WASH facilities, e.g. by providing basic instruments to dig (for urban settlements where shallow wells are available), as well as helping IDPs access water tanks, jerry cans (for water storage), taps, pipes and aqua-tabs.
 - Hygiene: Run Nutrition, Hygiene and Health Promotion (HNNP) programmes to raise awareness and foster improved hygiene in IDP communities.
 - Health care: Provide MCH programmes in IDP settlements, specifically for IDPs, include family planning services, EPI, assisted deliveries, pre-natal and ante-natal services. Ensure IDP access to outpatient services and hospitals with qualified personnel, drugs, and EPI supplies. Consider providing EPI services through the Madrasas where children congregate for lessons.
6. Improve the socio-care environment for women and children. Specific areas of focus to include:
 - Programmes to help reduce women's heavy workload so they are better able to care for children and themselves, e.g. through supporting Madrasas to offer day care for children left unattended while their mothers are working. Involve IDPs in managing and staffing such facilities.
 - Set up long term social and behavioural change initiatives to tackle questionable socio-cultural beliefs and practices that impact negatively on health and nutrition. For example, FGM, beatings and rape against women and girls.
 - Raise awareness on the importance of child spacing and its significance to the health of women, infants and children.
 - Consider ways to effectively address the phenomenon of rising divorce rates and irresponsible husbands who often fail to support their families following divorce. The NCA study showed this to be critical to nutritional status as it happens more often when girls are forced to marry at a young age and bear children when they are neither physically, emotionally, nor socially mature enough. Divorced young mothers (often 15 or 16 years old) are ill placed

to meet the needs of their young children.

- Explore potential support mechanisms to strengthen the wellbeing of vulnerable women, e.g. self-help groups and mobile counselling services. Consider a legal framework where complaints can be channelled and addressed.
- Explore opportunities to strengthen the protection of vulnerable women and children in particular, e.g. enhancing security in settlements and making referrals to local Social Protection actors.

Health and nutrition related challenges associated with premature girls' marriage, underage pregnancies and poor child spacing are already known by the IDP communities. This provides a good starting point for related social and behavioural change initiatives.

7. Improve Infant and Young Child Feeding (IYCF) practices.
 - Implement related social and behavioural change programmes to strengthen awareness, tackle deeply rooted, negative beliefs and practices, and foster environments conducive to optimal IYCF.
 - Consider opportunities to establish local mentoring programmes which bring together positive deviants and young mothers or soon-to-be mothers, to enhance IYCF support and practice.
 - Explore ways of effectively engaging community and religious leaders (including grandmothers and other opinion leaders) in related promotion efforts.
8. Strengthen household food security, e.g. by enhancing the access of vulnerable community members, including minorities, to income generation and Cash Transfer Programmes. Specifically target IDPs and women-headed households to enable them to access resources to improve their livelihoods.
9. Improve household diets. Raise awareness on what constitutes an appropriate diet for the household, in particular for children under five years old, based on locally available resources.
10. Increase IDP access to existing humanitarian services and resilience programmes. Address related issues of distance/ transport costs, discrimination in service delivery, lack of awareness and service quality.
11. Adopt and advocate for more integrated service provision. Current stand-alone projects in IDP settlements are unlikely to have a significant impact due to the common lack of synergy with complementary programmes in other sectors. Nutrition, health, WASH and livelihood services should be integrated, to ensure a more holistic basic service package for vulnerable community members.

12. Governance: Consider ways to effectively address the barriers that contribute to the further marginalization of Somali minorities, which hinder their access to opportunities to improve their own lives.

NCA 2 - Mogadishu Urban Communities Key Recommendations

1. Strengthen programmes that increase income generation opportunities among the vulnerable urban poor. These might include (i) Cash Transfer programmes which could be undertaken between July and September during sea port closure as a result of monsoon winds, which decreases casual job opportunities; (ii) Provide business skills training; (iii) Explore ways to address social or discriminatory barriers that limit the poor from participating in retail and trade activity.
2. As 90-100% of Mogadishu resident household food is purchased, income generation opportunities should enhance household access to food. Related programmes need to target women in particular.
3. Support the formation of social support groups where members can exchange information and address common concerns. Provide skills training where feasible.
4. Consider policy decisions (at employer, donor and government levels) to actively foster the employment of members of the urban poor, in particular of minority clan members, who voiced significant concerns about widespread discrimination and lack of access to services. For example, while women from some communities jump the queue at health facilities and spend a relatively long time with health staff, those interviewed shared experiences of having to spend far longer in health facility queues and being granted very little time with health personnel.
5. Strengthen and expand livelihood and resilience programmes to address long term poverty.
6. Sharia compliant credit facilities or grants, where the urban poor can access soft grants, could be considered for self-help groups
7. Address weak IYCF practices that hinder nutrition:
 - Develop long term social and behavioural change programmes to raise awareness and promote optimal IYCF. For example, to discourage giving new-born babies sugary water soon after birth.
 - Foster enabling environments to facilitate appropriate IYCF at community level. For example, day care centres for infants and young children while their mothers are working.
 - Establish mentorship programmes to enable young mothers and soon-to-be mothers to learn from positive role models within the community.

8. Address negative socio-cultural beliefs and practices which affect infant and child health and nutrition, through long term social and behavioural change programmes. For example, the belief that children should not be immunized within forty days of birth and the use of burning and cuts to accelerate healing in children.
9. Improve the socio-care environment for vulnerable urban women and children.
 - Strengthen awareness about the dangers of FGM:
 - NCA findings show that men and women, older women and community leaders all consider FGM to endanger girls and believe that it impacts on health and nutritional well-being. This provides important openings, for example, to work with relevant actors to support social change efforts towards more positive rites of passage.
 - Tackle early age marriage for girls, premature childbearing and traumatic deliveries:
 - Develop and enforce laws against early marriage for girls.
 - As about 80% of mothers deliver with the assistance of Traditional Birth Attendants (TBAs), barriers that hinder women from using official health services need to be explored. For example, MOH supported midwives need a stronger presence among Mogadishu urban poor communities to ensure appropriate antenatal care and safe childbirth.
 - The MOH could be supported to provide ambulances with skilled health personnel, to service affected communities and take those in need to hospital.
 - Raise awareness on the benefits of child spacing to family health. Promote culturally acceptable options.
 - Enhance the security and protection of girls and women. For example, liaising with key protection actors and involving local leaders in efforts to tackle factors that contribute to violence and rape.
10. Ensure access to Maternal and Child Health programmes where antenatal care, postnatal care and immunization services can be accessed and common diseases treated, e.g. through non-discriminatory mobile clinics.
11. Ensure adequate WASH facilities and Nutrition, Hygiene and Health Promotion (NHHP) initiatives². As well as fostering hygiene, increased household access to wells and taps would reduce the time women spend fetching water and liberate time for child care (although this is not to be assumed).
12. Explore options to strengthen poor family access to health services, especially for childbirth. For example, negotiate public-private partnerships with

2 The UNICEF developed NHHP Manual and resources are widely available and already translated into Somali

3 Conservation Agriculture (CA) is an approach to managing agro-ecosystems for improved and sustained productivity, increased profits and food security while preserving and enhancing the resource base and the environment. It is characterized by three linked principles: Continuous minimum mechanical soil disturbance; Permanent organic soil cover and the diversification of crop species grown in sequences and/or associations (<http://www.fao.org/ag/ca/1a.html>).

hospitals to provide subsidized services to the poor.

13. Improve the targeting of beneficiaries in lifesaving programmes, and non-discriminatory practice, to ensure that the basic needs of the most vulnerable, including the urban poor, are addressed.
14. Research the impact of men's khat chewing on family nutritional status and child care.

NCA 3 - Beletwayne Riverine Communities Key Recommendations

1. As crop production constitutes the main livelihood in Beletwayne Riverine communities, contributing to over 50% of food and income despite high insecurity, this livelihood needs securing for sustainable optimal nutrition. The study recommends the provision of small-scale agricultural farming support for approaches which make the most efficient use of available water, to increase field cultivation and harvests for households with access to land. This includes supporting access to appropriate farming techniques (i.e. Conservation Agriculture³), seeds and basic tools, as well as to technical crop management support (how to cultivate, plant, manage, harvest and store crops appropriately in local conditions). Advice on growing nutritional food is also recommended.
2. Increase access to public health services and to health promotion:
 - Provide accessible health services in Beletwayne rural areas. Consider mobile services, or subsidies to private health care, to enable the poor to access necessary services.
 - Provide MCH services where ante- and post-natal care can be accessed locally. To include immunization services, health education and advice on child spacing.
 - Raise awareness about health and nutrition within these communities to strengthen health seeking behaviour. Involve TBAs, older women (mothers-in-law) and men as potential change agents, given their influence on decisions about the types of food pregnant women and children eat.
 - Focus explicitly on personal and environmental hygiene, as well as appropriate household diets.
 - Address personal and environmental hygiene and WASH issues including dominant practices of open defecation and inadequate hand-washing. Link with related initiatives like local Community Led Total Sanitation (CLTS) programmes.
3. Provide OTP services in riverine areas close to areas of need and ensure Stabilization Centre access for severely malnourished children.

4. Develop long-term social and behavioural change initiatives to raise awareness about and strengthen IYCF practice. To include the promotion of exclusive breastfeeding, persistent breastfeeding and appropriate complementary feeding. Actively discourage bottle-feeding, except in extreme cases.
5. Strengthen the social welfare of women and children affected by acute malnutrition by supporting local social/ support groups, offering counselling services at health facilities and developing mentorship programmes where positive deviants can support families with malnourished children.
6. Explore opportunities to support income generation and to secure adequate access to food. Business skills and social welfare programmes should target training vulnerable groups in particular, including minorities.
7. Consider efforts to strengthen access to livestock (mainly chicken, goats and cattle), to ensure adequate household access to eggs, milk and meat and to strengthen access to income through related sales. Explore opportunities to provide the necessary veterinary support services.
8. Food security strategies need to take into account the impact of seasonality, increased reliance on irrigation rather than rainfall and the particular burdens faced by women and girls.
9. Enhance security and ensure the protection of women and children, in particular from armed militia.
10. Proactively address barriers that serve to marginalize Somali minorities and which prevent them from accessing basic services and land.

NCA 4 - Dollow IDP Communities Key Recommendations

1. Address environmental health issues, e.g. ensuring access to clean toilets and safe drinking water for all IDPs.
2. Explore opportunities to introduce day care centres for children, for the benefit of families when mothers have to leave their children to seek casual labour e.g. expand existing madrasa facilities (which most children attend) to include day care for infants and younger children.
3. Ensure the integration of basic health (including Mother and Child Health) and nutrition services among the IDPs. Integrate nutrition services with protection rations and ensure equity in distribution, to avoid the inappropriate sharing of RUTF within and between families.
4. Engage religious and community leaders, teachers, community health workers and other influential community members in nutrition promotion efforts,

IYCF in particular.

5. Explore opportunities to stimulate IGAs, especially amongst the most vulnerable community members.
6. Monitor rigorously and ensure that the most vulnerable IDP families have access to the necessary humanitarian assistance.
7. Implement short and long term behavioural and social change programmes to tackle the multiple factors that mitigate against optimal IYCF.

NCA 5 - Dollow Pastoral Communities Key Recommendations

1. Strengthen awareness and empower caregivers and other community members with health, nutrition and other necessary knowledge, including on:
 - Use of livestock products to improve their nutritional status.
 - Optimal breastfeeding
 - Complementary feeding
 - The importance of appropriate health seeking behaviour
 - The importance of proper sanitation and hygiene practices
 - Knowledge about balanced diets.
2. Develop and support long term social and behavioural change communication programmes linked to all the above.
3. Improve nutrition, WASH and related knowledge and awareness amongst pastoralist leaders, Community Health Workers (CHWs), Traditional Birth Attendants (TBAs) and others as feasible. Strengthen referral services to accessible health and nutrition services (where they exist).
4. Improve the capacity of Community Animal Health Workers (CAHWS) on livestock management. Ensure their accessibility, in particular to vulnerable community members.
5. Make a concerted effort to both provide urgently needed basic health and nutrition service, and to encourage their use, by ensuring they are accessible to vulnerable community members and of quality.
6. Opportunities to educate boys and girls on nutrition through schools (including Quranic schools) and School Health Clubs should be further explored.
7. Improve the health and security of pastoralist community livestock.
8. Provide mobile health, nutrition and livestock programmes to circulate amongst these settled pastoralist communities:
 - Introduce mobile services along migratory

- routes, or construct Health Posts along long term migratory routes.
 - Develop and support teams of mobile health and nutrition workers to service these communities.
9. Establish mobile schools and educational programmes, accessible to the communities studied.
 10. Strengthen community resilience to drought by supporting collective action to reduce and mitigate the effects of drought, and establish appropriate drought recovery mechanisms.

NCA 6 – Baidoa Agro-Pastoral Study Key Recommendations

1. Improve caregivers' basic knowledge about nutrition through IYCF promotion, one to one counselling of mothers and other promotion efforts.
2. Establish appropriate long-term behavioural and social change communication programmes.
3. Work closely with CHWs, TBAs and others regularly consulted by local communities when official health services remain largely inaccessible. Upgrade their knowledge, skills and referral mechanisms (to official services) as feasible.
4. Explore opportunities to support local communities with farming resources such as quality seeds, basic farm tools and training on appropriate, low-input, sustainable agricultural practices.
5. Improve availability of and access to veterinary services and appropriate livestock drugs.
6. Explore opportunities to strengthen fathers' engagement in IYCF and other programmes linked to the health of their families.
7. To support the above, explore opportunities to effectively engage community and religious leaders in IYCF promotion efforts.
8. Explore local opportunities to strengthen women's support networks and establish effective mentorship schemes.
9. Further research is needed into the impact of fathers chewing khat regularly, on family nutritional status.

NCA Recommendations valid across all communities studied

1. Strengthen links with Resilience and Income Generation programmes in particular, to foster access to income and strengthened community resilience amongst vulnerable groups. Ensure that the poorest and most vulnerable are prioritized.

2. Increase access to basic health, nutrition and WASH services, particularly for women, infants and children.
3. Strengthen integration between basic health and nutrition and WASH programmes and services.
4. Urgently address gaps in access to safe water, hygiene and sanitation. Address related poor behaviour and questionable community norms, through long-term social and behavioural change initiatives.
5. Use all opportunities to strengthen awareness and knowledge on basic health, nutrition and hygiene. This could include engaging community and religious leaders, TBAs and others in a variety of complementary promotion efforts.
6. Support the formation of social support groups, especially for mothers. Explore opportunities to offer vocational skills training to these groups.
7. Actively engage fathers, community leaders and other influential community members in nutrition and IYCF promotion efforts.
8. Monitor humanitarian initiatives rigorously to ensure that support provided is reaching those intended, including the most vulnerable in particular settings.
9. Raise awareness at all levels about the impact of different forms of violence against girls (i.e. under 18 years old) and women on nutritional and health status. This includes the impact of early marriage and related pre-mature child bearing and of FGM and its consequences. Advocate for urgent action in this area.
10. Actively seek to build on local strengths and assets, human resources in particular, in all related programming. Somali communities are known internationally for their exceptional energy, entrepreneurial skills and strong social support networks, which should be drawn on in efforts to promote the above changes.
11. Advocate for more intergrated nutrition-sensitive programmes across sectors.

As anticipated, most NCA Study findings are not new and serve to confirm what key actors in Somalia already know about the factors that combine to heighten vulnerability to and incidences of malnutrition. Unfortunately for many reasons (in particular due to insecurity which did not allow lead researcher access to the field, or rigorous quality assurance in notably insecure NCA locations, combined with limited capacity), the extent of probing evident from the field research transcriptions remains limited. As well, the process of developing NCA study hypotheses was done

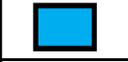
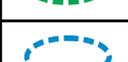
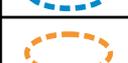
too quickly, without engaging enough diverse stakeholders and therefore remained limited.⁴ Consequently, the study has elicited less “new”, in-depth knowledge relevant to the underlying drivers of acute malnutrition than anticipated. These issues are discussed in the final section under learning and recommendations.

At the same time, however, the research has highlighted a range of findings and recommendations relating to core drivers which influence the nutritional and health status of many South Central Somali communities, which should be used to strengthen and advocate for nutrition-sensitive programming. It is worth noting here that the SNS Consortium was established to work in particularly vulnerable, prolonged malnutrition “hotspots” in South Central Somalia, that NCA Study findings are to a degree context specific and that caution should be taken when extrapolating the findings of a particular NCA study more widely.

The NCA has highlighted the negative impact that prolonged conflict, insecurity and vulnerability, as well as select beliefs, child care practices, socio-environmental factors and socio-cultural norms can have on malnutrition. The wider community cannot afford to turn a blind eye to these findings.⁵

Although significant challenges have been faced at every stage in the NCA Research process, with major implications for the time, budget and capacity required, the report includes much of value. The process has been rich in learning for all involved, at every level, as shared in the report. We hope the NCA findings will stimulate interest in better understanding the underlying drivers of Acute Malnutrition in SCZ locations and the complex factors that continue to fuel these drivers. The study is intended to catalyze deeper thought, more informed discussion and positive change in key actor efforts to strengthen nutrition and related programming and impact in South Central Somalia contexts.

NCA Causal Pathway per Study - Key

	Outcome
	Most influential immediate cause
	Most influential underlying cause
	2nd most important underlying factor
	Important factor
	Major pathway
	Important (less major) pathway
	Minor pathway
	Core driver
	Important driver
	Most influential basic factor
	2 nd most influential basic factor
	3 rd most influential basic factor
	Basic factor of minor influence

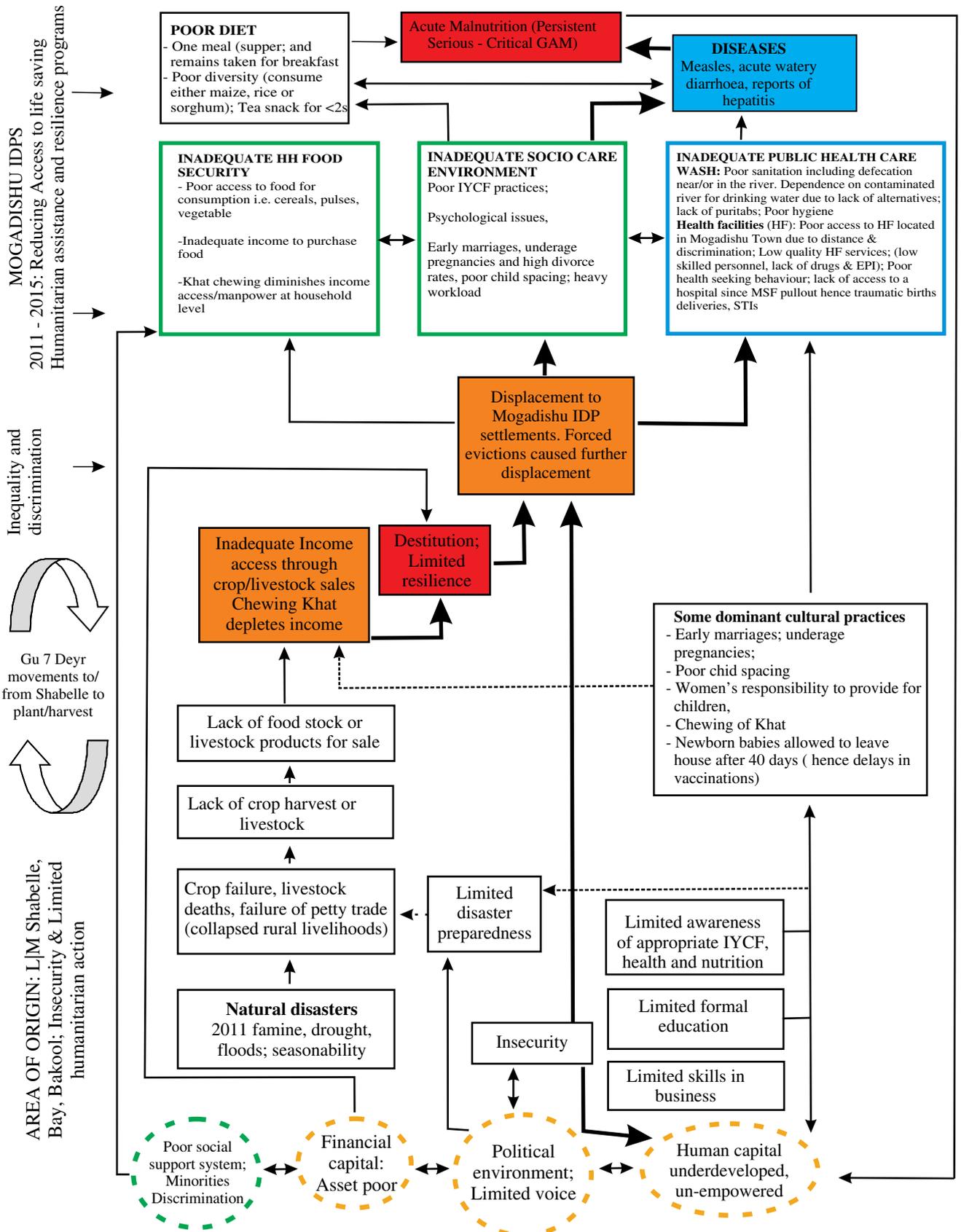
4 In retrospect, to help ensure a more open, wider perspective befitting qualitative inquiry and the NCA Study aims, more than the “usual nutrition suspects” should have been involved in a rigorous process to interrogate secondary literature and inform the initial NCA study hypotheses. Given the ambitious NCA timeframe and challenges faced throughout, however, by the time this was realized by the core team it was too late to re-do. The ACF team leading Link NCA studies globally notes that this remains a common weakness of Link NCA Studies and calls for further attention.

5 Includes humanitarian and development actors and the government

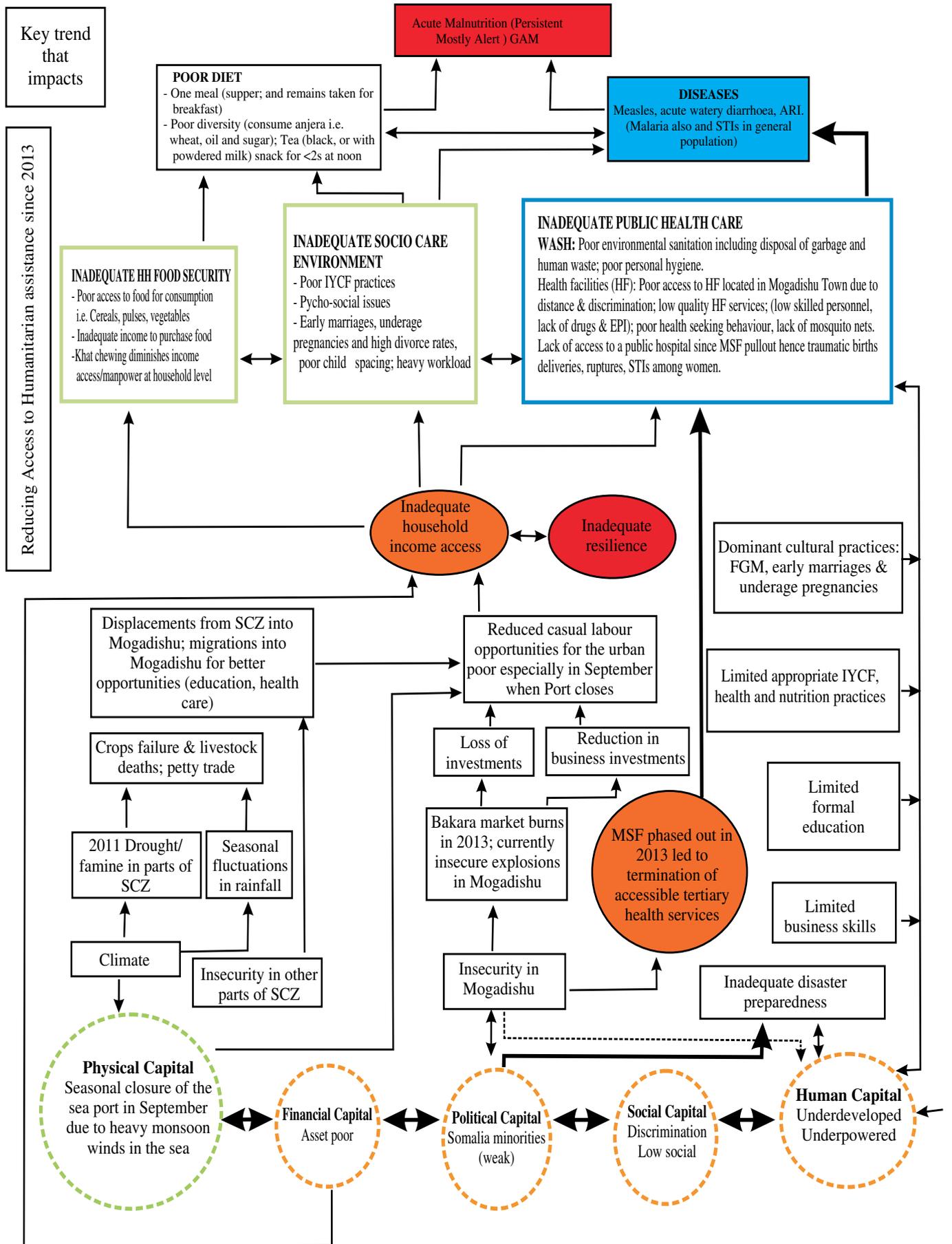
Causal Pathway NCA 1 - Mogadishu IDPs

The link between the situation in areas of IDP origin prior to displacement (basic factors) and in Mogadishu IDP settlements is depicted in the diagram.

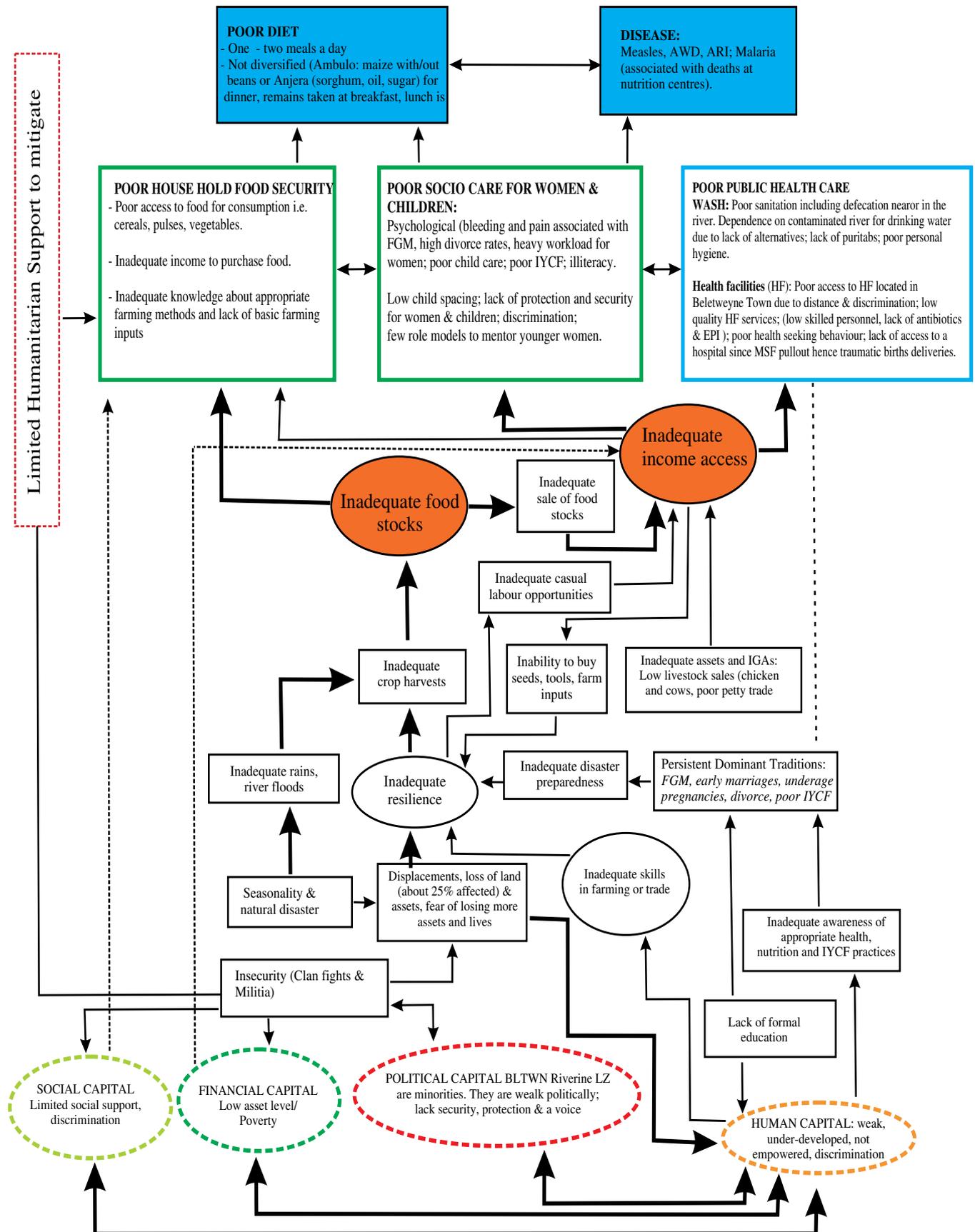
KEY Factors that impact



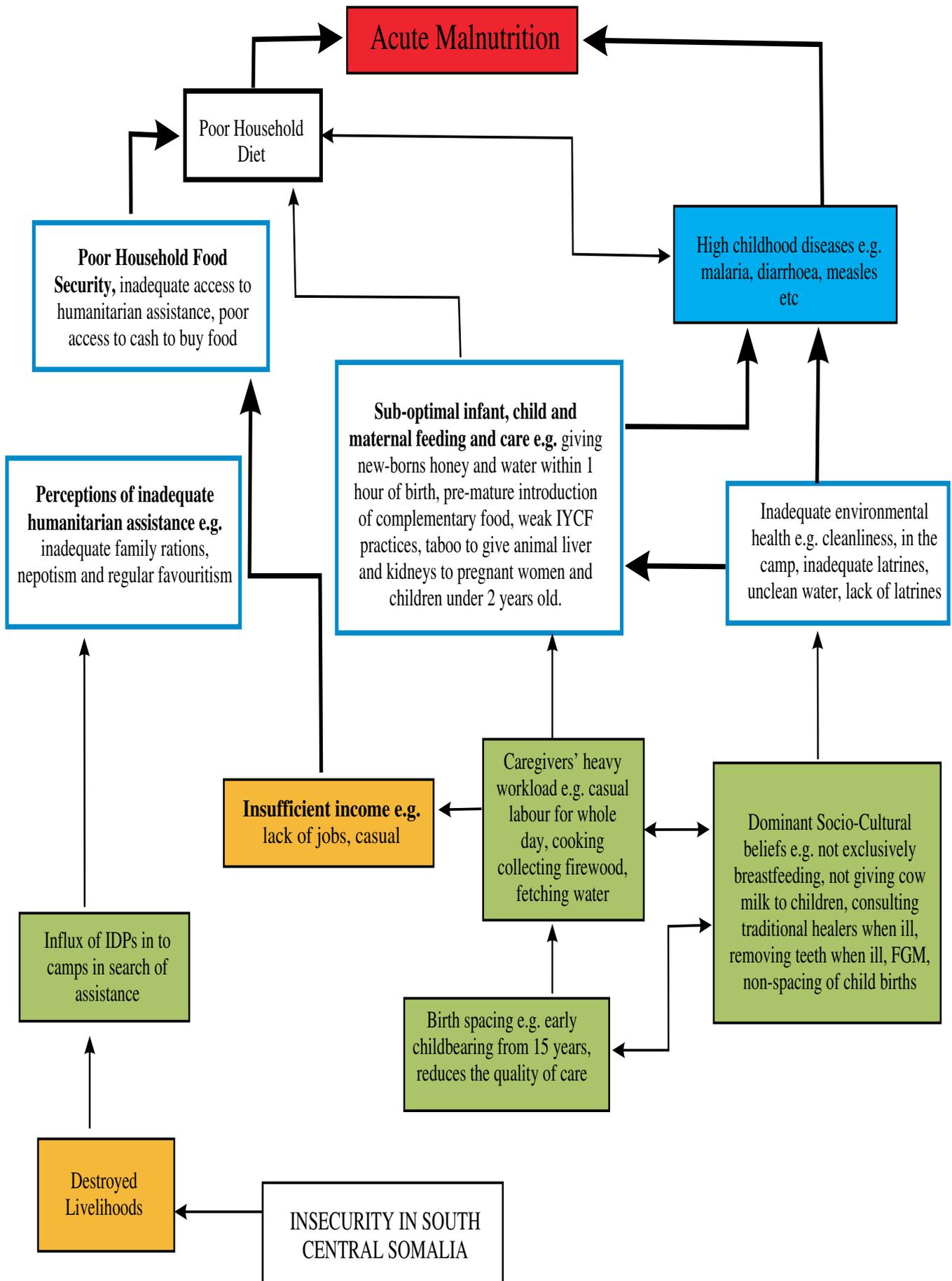
Causal Pathway NCA 2 - Mogadishu Urban (poor wealth group) Communities



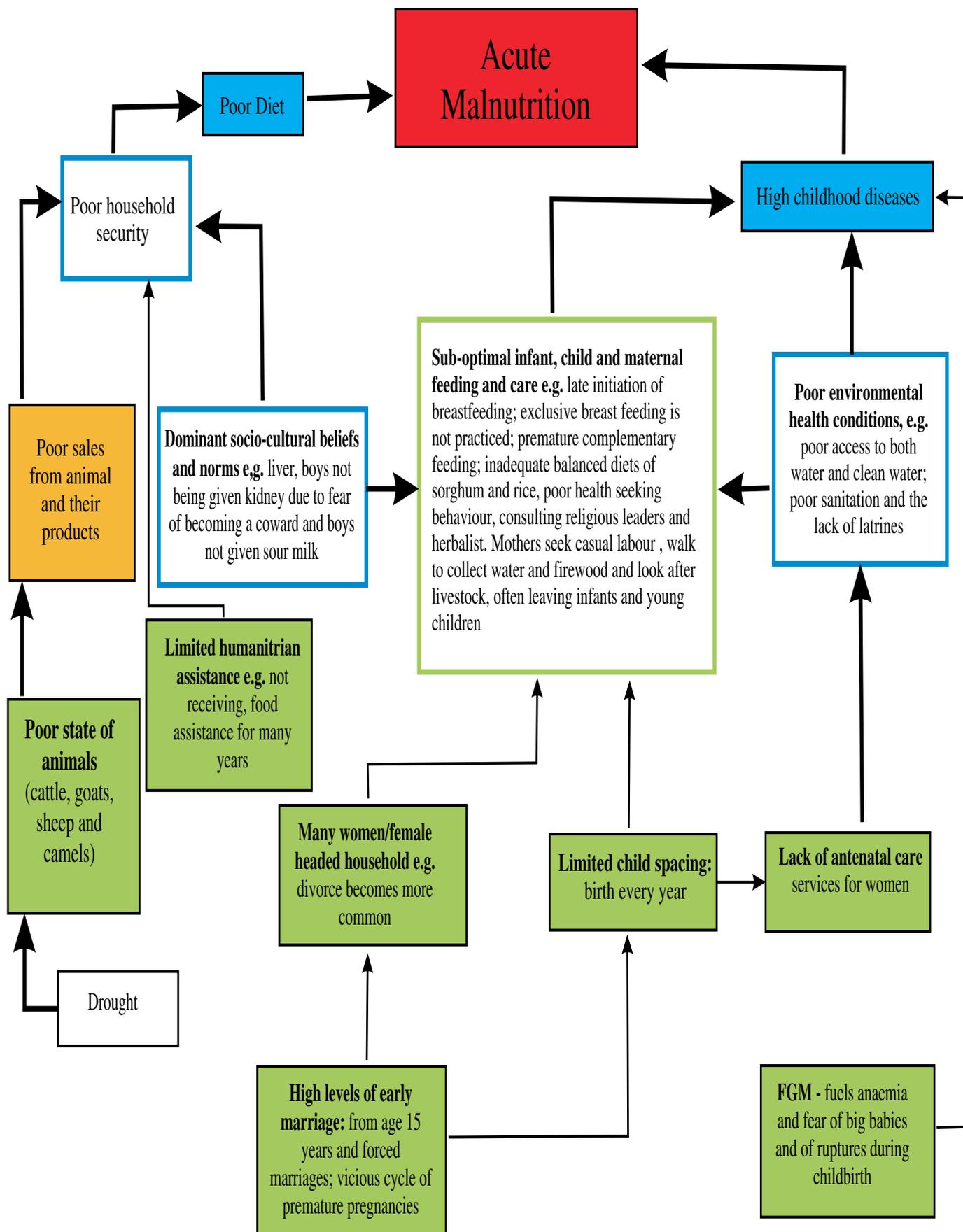
Causal Pathway NCA 3 - Beletweyne Riverine Communities



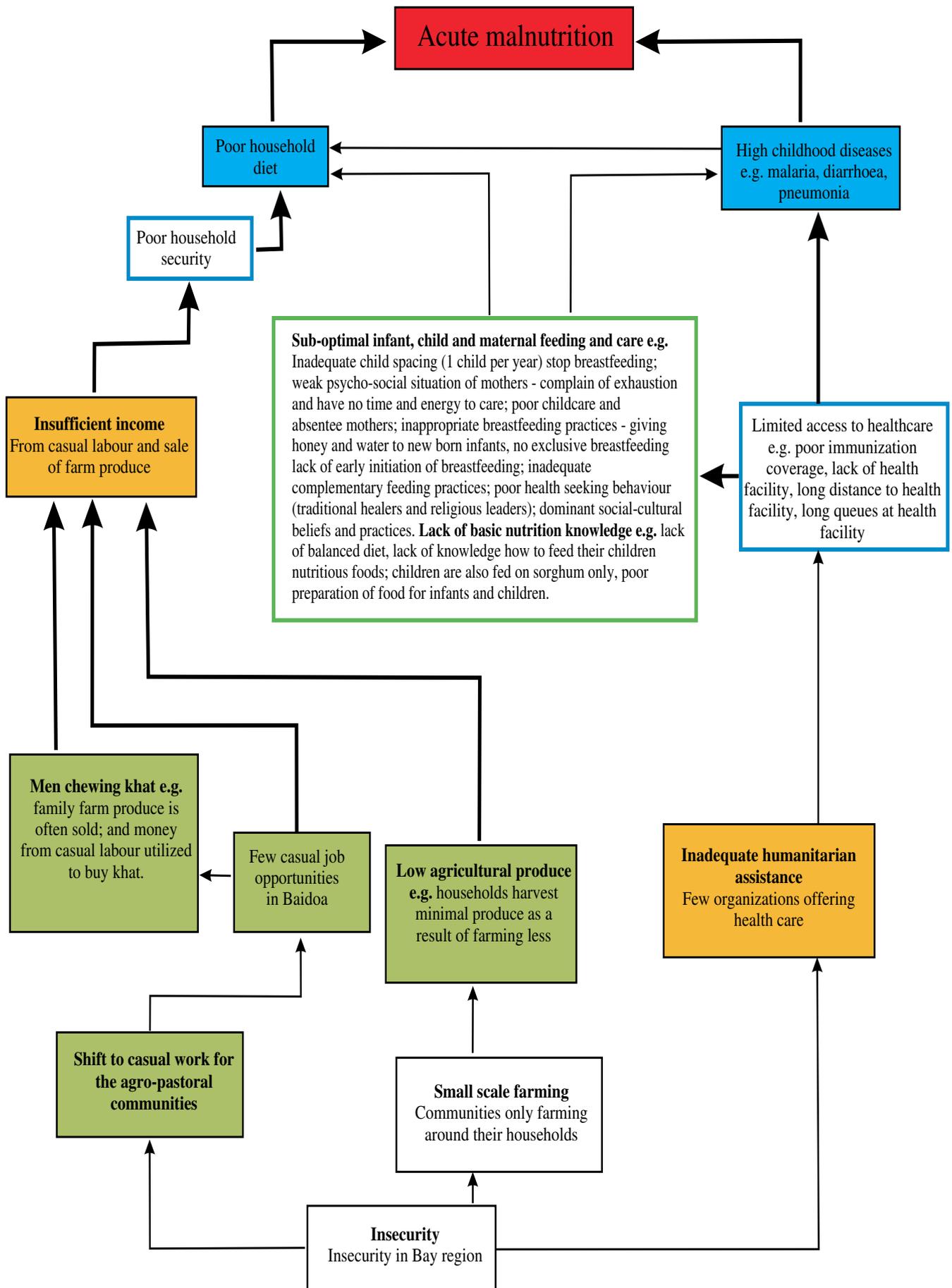
Causal Pathway NCA 4 - Dollow IDP Communities



Causal Pathway NCA 5 – Dollow Pastoral Communities



Causal Pathway NCA 6 – Baidoa Agro-Pastoral Communities





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