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# Bringing humanitarian and development frameworks, financing and programmes closer together

A case study of nutrition resilience  
building in Somalia



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Name	Acronym	Name	Acronym	Name	Acronym
Action Against Hunger	ACF	General food distributions	GFDs	New Ways of Working	NWW
African Development Bank	ADB	Health Monitoring Information System	HMIS	Norwegian Agency for Development Cooperation	Norad
African Development Bank Somali Infrastructure Fund	ADB SIF	Himilo Relief and Development Association	HIRDA	Nutrition Cluster Coordinator	NCC
Blanket supplementary feeding programmes	BSFPs	Humanitarian Africa Relief Development Organisation	HARD	Office of the Prime Minister	OPM
Breast-milk substitutes	BMS	Humanitarian and Development Nexus	HDN	Office of U.S. Foreign Disaster Assistance	OFDA
Building Resilient Communities in Somalia	BRCiS	Humanitarian Country Team	HCT	Official development assistance	ODA
Community Development Management Committee	CDMC	Humanitarian Response Plan	HRP	Outpatient treatment programmes	OTPs
Central Emergency Response Fund	CERF	Infant and young child feeding in emergencies	IYCF-E	Primary Health Care	PHC
Civil Society Alliance	CSA	Integrated emergency response teams	IERTs	Pillar working groups	PWGs
Civil Society Organisations	CSOs	Integrated Food Security Phase Classification	IPC	Qatar Red Crescent	QRC
Collective Outcome Document	COD	Integrated Management of Acute Malnutrition	iMAM	Ready-to-use supplementary food	RUSF
Common Results Framework	CRF	Inter-Agency Standing Committee	IASC	Ready-to-use therapeutic food	RUTF
Community Activity for Development Relief Organization	CAF DARO	Inter-cluster coordinating group	ICCG	Resident and Humanitarian Coordinator	RC/HC
Community Health Workers	CHWs	Internally displaced population	IDP	Resilience and Recovery Framework	RRF
Community organization for relief and development	CORD	International Committee of the Red Cross	ICRC	Save the Children UK	SC UK
Comprehensive Refugee Response Framework	CRRF	International development assistance	IDA	Scaling Up Nutrition	SUN
Country Programmable Aid	CPA	International non-governmental organisations	INGOs	Somalia Development and Reconstruction Facility	SDRF
Department for Foreign Affairs, Trade and Development	DFATD	Irish Aid	IA	Somalia Humanitarian Fund	SHF
Department for International Development	DFID	Maternal and child health	MCH	Somalia Resilience Program	SomRep
Deputy Special Representative of the Secretary General	DSRSG	Mid-upper arm circumference	MUAC	Stabilisation centres	SCs
Deutsche Gesellschaft für Internationale Zusammenarbeit	GIZ	Multi-donor Partner Trust Fund	MDPTF	Strengthening Nutrition Security	SNS
Direct budget support	DBS	Ministry of Health	MoH	Supplementary feeding programmes	SFPs
Drought Impact and Needs Assessment	DINA	Ministry of Humanitarian Affairs and Disaster Management	MoHADM	Sustainable Development Goals	SDGs
Durable Solutions Initiative	DSI	Ministry of Planning and International Cooperation	MoPIC	Swedish International Development Cooperation Agency	SiDA
European Civil Protection and Humanitarian Aid Operations	ECHO	Ministry of Planning, Investment and Economic Development	MoPIED	Targeted Supplementary Feeding Programme	TSFP
European Commission Humanitarian Aid- Resilience Building and Creation of Economic Opportunities in Ethiopia	ECHO RESET	Mogadishu International Airport	MIA	Terms of Reference	TOR
Federal Government of Somalia	FGS	Multi Donor Trust Fund	MDTF	United Nations Development Assistance Framework	UNDAF
Food and Agriculture Organisation	FAO	Multi Partner Fund	MPF	United Nations International Children's Emergency Fund	UNICEF
Food Security and Nutrition Assessment Unit	FSNAU	Multi-year funded	MYF	United Nations Jesuit Refugee Service	UN-JRS
General food distributions	GFDs	Mutual Accountability Framework	MAF	United Nations Office for the Coordination of Humanitarian Affairs	OCHA
		National Development Plan	NDP	United States Agency for International Development	USAID
		Negotiated indirect cost rate agreement	NICRA	Water sanitation and hygiene	WASH
		New Partnership for Somalia	NPS	World Bank	WB
				World Food Programme	WFP

# Executive Summary



**T**his case study on nutrition resilience and the humanitarian and development nexus (HDN) in Somalia draws on interviews, field observations and meetings with over 70 stakeholders based in Nairobi, Kenya; Mogadishu, the capital of Somalia; and Dollow district on the Ethiopia-Kenya border. It was carried out between April and September 2018. The overarching question for the study is: ‘What opportunities exist to increase nutrition resilience through strengthening the Humanitarian Development Nexus (HDN)’. Nutrition resilience is defined as the ability to maintain adequate nutrition status when faced with ‘shock’. The HDN and its potential to strengthen nutrition resilience is examined on three levels: policies; frameworks, institutional architecture and financing arrangements; and programme design and implementation. Furthermore, the focus has been to look at basic social services resilience through a lens of systems building and/or health systems strengthening.

Most stakeholders in Somalia recognise that, after 27 years of conflict and periodic drought and periodic famine, it is time to move away from annual cycles of humanitarian intervention and support the relatively new Somali government (established in 2012) to build resilience among its populations and services. However, there is a lack of leadership and clarity with regard to institutional mandates and the structural arrangements of key players for resilience-building (including nutrition resilience) in Somalia, and consequently poor delineation with respect to how resilience is embedded in multiple policies, plans and frameworks. This creates tensions and confusion between stakeholders supporting key plans and frameworks.

Financing arrangements for nutrition programming in Somalia have been largely geared towards life-saving humanitarian action, at a time when there is growing demand for longer-term resilience-building initiatives which may lessen the need for future humanitarian interventions. Recently there has been a shift in focus towards investing in resilience although there appears to be some flexibility in humanitarian funding, which though substantial, it is poorly suited to nutrition resilience-building programming: it is annual, inflexible and carries substantial transaction costs for local civil society

organisations (CSOs). Furthermore, this type of funding is, in large measure, allocated to development partners rather than government and therefore incurs enormous (but largely ‘invisible’) transaction costs. Recently engaged development donors such as the World Bank and the German government are rapidly testing the feasibility of direct budget support to government, with a view to scaling up this kind of financing as rapidly as possible. It is their hope that other donors, more risk-averse until now, will follow suit.

There are clear differences in programme focus and approach of agencies working on resilience-building and, apart from consortia-led programming, there is little in the way of harmonisation. Poorly defined programme objectives and definitions of resilience have made it difficult to evaluate the impact of resilience-building programmes. Evaluations have instead tended to focus on process but, where nutrition has been monitored, no impact has been found. There are rather stagnant high level of malnutrition over the years despite continued short-term investments as shown in Figure 1 below. There is a sense amongst many stakeholders that there is limited and/or poor levels of accountability for these programmes and that objectives need to be clearly defined in terms of resilience building and that these must be measured at baseline and throughout the life of a programme. Moreover, there is a critical need for objectively measuring the continuity and/or systems building/strengthening these projects leave behind beyond merely measuring beneficiaries reached – the “low hanging” fruit.

Despite all the constraints confronting Somalia, the expansion and rollout of these nutrition resilience-building efforts present an unprecedented opportunity for the nutrition sector to both clarify the nature of nutrition resilience-building and how to measure impact. This will, in turn, shine a light on the extent to which efforts to strengthen the HDN in Somalia are proving effective in mitigating the need for recurrent and long-term humanitarian programming though this will only be achieved if the opportunities are acknowledged and harnessed by all key stakeholders with a common vision towards resilience building.

# Introduction and concepts

This case study report examines the current state of the humanitarian and development nexus (HDN) in Somalia and considers the means by which it could be strengthened. The report is part of a multi-country study on HDN through a nutrition lens. It was conducted by ENN in collaboration with the Federal Government of Somalia, the Somalia Nutrition Cluster and its key stakeholders and it is the second HDN study, following work already undertaken in Kenya ([www.enonline.net/hdnkenya](http://www.enonline.net/hdnkenya)). Further case studies are planned for 2019 after which a synthesis of key findings and recommendations will be developed.

The rationale and framework for a series of case studies on HDN is that an increasing number of countries are experiencing protracted crises (for example, Somalia has experienced crisis since 1991) and that repeated cycles of humanitarian programming have become the entrenched norm in these countries, with little prospect of transition and development. The 2018 Global Nutrition Report states that “an estimated 86% of international humanitarian assistance goes to long- and medium-term crisis affected countries”.<sup>1</sup> This assistance is mostly in the form of short-term annual programming, which is unable to deliver the resilience-building required for crisis-affected populations to avoid deterioration in nutritional status. The purpose of strengthening the HDN is therefore to increase a population’s ability to withstand shocks, which should lead to a concomitant reduction in the need for repeated humanitarian support.

ENN has taken a simple conceptual approach to the case study work. The goal of strengthening the HDN is viewed as increased nutrition resilience to all types of shock (climate, conflict, political, etc.). Three enabling factors, each of which forms the basis of the main chapters in this report, are necessary to achieve this goal:

1. Policies, frameworks and institutional architecture at the interface of humanitarian and development activities;
2. Availability of ‘resilience-building’ financing; and
3. Sustainable nutrition-specific and nutrition-sensitive programming.

There are academic definitions of resilience which include a combination of ‘adaptation, adoption and transformation’. There are also agency-specific definitions and programme-specific definitions. In this report we apply a more operational set of descriptors and terms to describe and define resilience. These descriptors include prevention, early warning, surge capacity and integrated programming. Resilience is a multi-sector term; i.e. it can be understood in terms of individual sector-specific operational needs and challenges, as well as in terms of multi-sector convergent actions and outcomes. The term

‘nutrition resilience’ is a sub-set of resilience and is used by many, but it is even less clearly defined and articulated than ‘generic resilience’.

Keeping ‘shock’ and the ability to withstand shock at the centre of our focus, consideration of different nutrition-resilience levels is given as follows:

1. **Individual nutrition resilience** – the ability of an individual to maintain nutrition status in the face of shock. This is influenced by the nutrition status baseline of the individual as well as having access to resources that, in an emergency, protect nutrition. Operationally, this might translate into linking programmes such as immunisation or cash transfer to treatment programmes for wasting. It might also encompass enhanced knowledge of mothers around infant feeding and hygiene practices.
2. **Household nutrition resilience** – the ability of all members of a household to maintain nutrition status in the face of shock. Operationally, this might be enabled through providing general food distributions (GFDs), livelihood support, blanket supplementary feeding programmes (BSFPs), or carer rations as part of wasting treatment programmes.
3. **Community nutrition resilience** – the ability of all members of a community to maintain nutrition status in the face of shock. Enabling approaches may include multi-sector nutrition programme convergence, sentinel site surveillance and related surge capacity.
4. **Nutrition system resilience** – the ability of a system to maintain and scale up nutrition support in the face of a shock. The operational underpinning of this type of resilience is health-systems strengthening, including early warning and surge or scale-up in capacity of nutrition prevention and treatment programmes, strong commodity pipeline management, and resourcing, etc.
5. **Resilient nutrition governance systems** – the ability of government to plan, fund and implement nutrition programmes in the face of shock. This requires government plans (disaster preparedness) and policies (e.g. breast-milk substitute (BMS) donations), strong government systems (e.g. health systems and social protection systems) and resources to allocate through these systems (e.g. government budget lines, direct budget support (DBS) from development partners and pooled funding from development partners).

Operational actions which support these different levels of nutrition resilience-building may well work at a number of levels simultaneously. For example, providing cash

<sup>1</sup> *Global Nutrition Report: Shining a light to spur action on nutrition, 2018.* Development Initiatives, Bristol, UK.

transfers to families with children in treatment programmes for wasting will protect the nutrition resilience of the individual malnourished child as well as the whole household. Strengthening health systems will build nutrition resilience of households and communities, etc. Consideration should also be given to nutrition resilience-building in terms of transience or duration. For example,

cash transfers that only provide for a minimum expenditure food basket will not build lasting resilience, but may well protect against shock ‘in the here and now’. Larger cash transfers may allow families and communities to build up productive assets or strengthen livelihoods which engender future nutrition resilience beyond the life of the resource transfer.

## Background to Somalia

Since the fall of President Siad Barre in 1991 Somalia has been engulfed by civil conflict with periodic but recurrent drought, flooding and pest attacks. It has an increasing internally displaced population (IDP) (estimated at 2.6 million people in December 2018), due in large measure to armed conflict and insecurity, drought and other shocks and resulting in loss of livelihoods and homes with 80 per cent of IDPs living in urban areas. The most recent drought, which threatened widespread famine, extended over two years (2016-2017) and four agricultural seasons. After decades of conflict and instability, a Federal Government of Somalia (FGS) was established in 2012, built through national dialogue and consensus.

It is widely acknowledged that IDPs are the most nutritionally vulnerable population in Somalia; of the 2.6 million IDPs, over one million left their homes in 2017 alone, as a result of drought, conflict or continued lack of access to humanitarian assistance in their areas of origin. Of those displaced, 40% are estimated to be in need of humanitarian assistance. Urban areas experienced a

surge in IDPs arriving from rural areas throughout 2017, particularly from hard-to-reach areas in southern and central Somalia that are controlled by the Al-Qaeda-linked Al-Shabaab group. SMART surveys conducted in June 2017 indicate critical levels of wasting in nine out of twelve IDP settlements.

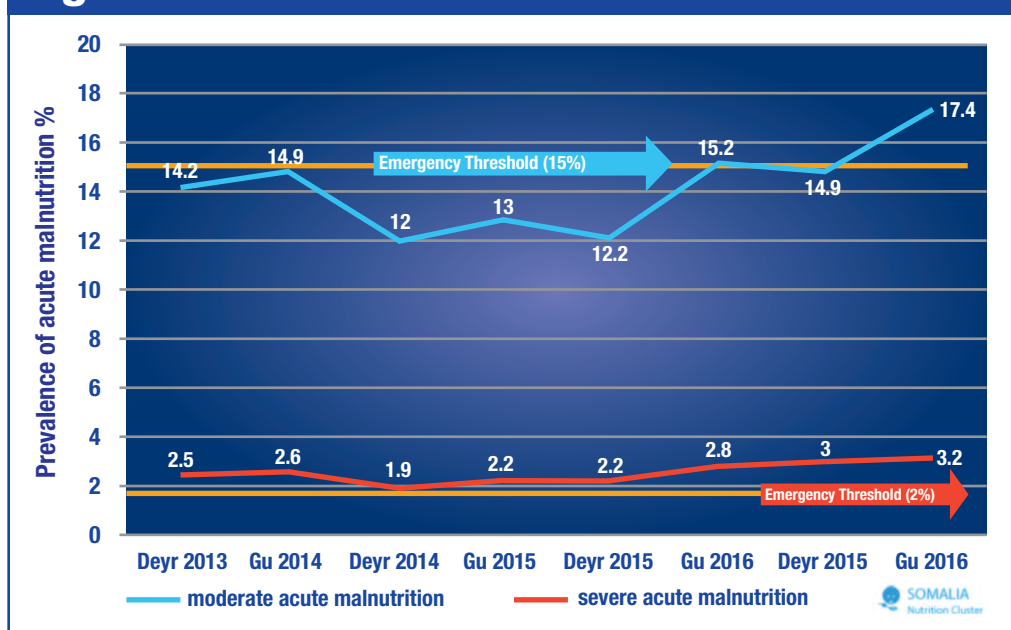
Somalia has a high prevalence of malnutrition. A meta-analysis of nutrition survey data between 2001-2011 found a median rate of 16% wasting (and bilateral oedema) and a median stunting rate of greater than 20%.<sup>2</sup> The nutrition situation has been worse in south and central Somalia, where conflict is greater than in either Puntland or Somaliland, which are both autonomous and relatively secure states. For example, the equivalent data for Somaliland showed a median of 13% wasting<sup>3</sup> and 18% stunting for the same period.

<sup>2</sup> Somalia Drought Impact and Needs Assessment Volume 1. Synthesis Report 2017.

<sup>3</sup> We mainly use the term ‘wasting’ in this report rather than acute malnutrition as bipedal oedema, indicative of kwashiorkor, is rare in Somalia.

<sup>4</sup> The Gu season (long rains) lasts from April to June. The Deyr season of short rains is from October to December.

**Figure 1** Prevalence of Acute Malnutrition 2013-2017



More recent nutrition data for 2011 and 2017 found that, during the *Gu* season of 2011 (a year of famine), wasting rates were 17.8% nationally, declining in the *Dery*<sup>4</sup> season of 2014 to 12% following a succession of good crop years, increasing again to 17.4% in the drought period of 2017. Data for the period 2013-2017 is shown in Figure 1 below.

Data on other forms of malnutrition are out of date for Somalia, although the targets for a set of indicators in the 2017-2019 National Development Plan (NDP) indicate that the most recent data shows 33% of women exclusively breast feed; vitamin A deficiency in children aged between 6-59 months is 31%; and anaemia in pregnant and lactating women and children aged between 6-59 months is 49% and 59% respectively.

In the first formal nationwide analysis of the predictors of malnutrition in Somalia,<sup>5</sup> the proximal determinants among the child-level variables most significantly associated with wasting, stunting and low mid-upper arm circumference (MUAC) were fever and diarrhoea in the

two weeks before the survey. In relation to distal determinants, the strongest association observed between all three indicators of child malnutrition was the enhanced vegetation index, which is a proxy for vegetation cover and is a product of a combination of several variables, including rainfall and other water sources for agriculture and livestock. The authors conclude that infection and climatic variations are likely to be key drivers of malnutrition in Somalia. A subsequent analysis concluded that the determinants of wasting and stunting are largely common in Somalia, but that hotspots of different forms of malnutrition occurred in the south-central regions of the country.<sup>6</sup>

With an official development assistance (ODA) to GDP ratio of 21%, Somalia is highly aid-dependent. Remittances are estimated at US\$1.4 billion in 2016. At US\$113 million, domestic revenue represented just 2% of GDP in the same year.<sup>7</sup> The 2018 Humanitarian Response Plan (HRP) requested US\$1.5 billion to deliver assistance to 5.4 million people. ODA for Somalia amounted to US\$1.3 billion in 2016 alone.

## Case study methodology

ENN undertook the case study in Somalia by working closely with the Nutrition Cluster Coordinator (NCC) for Somalia, the SUN Focal Point and other FGS staff. Interviews with key Somalia stakeholders based in Nairobi were first held with donors, UN agencies, international non-governmental organisations (INGOs) and resilience-building consortia. This was followed by a series of meetings with FGS representatives, the United Nations Office for the Coordination of Humanitarian Affairs (OCHA), and sector cluster coordinators in Mogadishu, along with other UN and INGO representatives. Field-based work was also undertaken in Dollow district on the Ethiopia-Kenya border, which is currently home to thousands of IDPs. Representatives from the FGS and INGOs and NGOs implementing nutrition programmes were met, in addition to observing a number of integrated nutrition programmes. Numerous reports, policies and frameworks were made available to ENN before, during and after the country visit. In total, more than 70 people were met and contributed to the understanding of HDN in Somalia.

Following the country visit, calls were held with the SUN Focal Point and the representative of the Office of the Prime Minister (OPM) to explore in much more detail some of the questions relating to the coherence of policies, financing and programming and to better understand the FGS perspective.

The report is organised into three main chapters. Chapter 1 looks at enabling policies and frameworks. Chapter 2 examines the financing landscape. Chapter 3 looks at resilience programmes.

<sup>5</sup> Kinyoki DK, Berkley JA, Moloney GM et al. *Predictors of the risk of malnutrition among children under the age of 5 years in Somalia*. Public Health Nutrition, May 2015.

<sup>6</sup> Kinyoki DK, Kandala N-B, Manda SO, et al. *Assessing comorbidity and correlates of wasting and stunting among children in Somalia using cross-sectional household surveys: 2007 to 2010*. BMJ Open 2016;6:e009854. doi:10.1136/

<sup>7</sup> Aid flows in Somalia, Aid Coordination Unit, OPM, April 2017.

# Chapter 1: Policies and frameworks

In recent years, many policies, frameworks and supporting institutional architecture have emerged in Somalia which, at least theoretically, provide the basis for strengthening HDN. Seven of these, which are seen as key, are briefly described below, followed by a summary of stakeholder perspectives on their coherence, complementarity and ultimate utility with respect to HDN.

## 1.1 National Development Plan (NDP)

The NDP, led by the Ministry of Planning and International Cooperation (MoPIC), covers the fiscal period 2017 to 2019. It is Somalia's first NDP since 1986 and builds on the foundations laid by the New Deal Compact for Somalia, which articulated national priorities during the period 2014-2016. The NDP aims to accelerate socio-economic transformation in order to achieve the stated objectives of poverty alleviation, economic revival and societal transformation in a socially just and gender-equitable manner.

Specifically, the NDP aims to:

1. Build more resilient communities that can withstand internal and external shocks, including cyclical droughts and other natural disasters;
2. Increase the availability and accessibility of quality education, health, water and sanitation services; and
3. Improve health outcomes and lead to reduced maternal and child mortality, a reduction in malnutrition rates, and the prevention and control of communicable and non-communicable diseases.

The implementation bodies responsible for the NDP are nine pillar working groups (PWGs). Nutrition falls under the Social and Human Capital PWG. There is also a 'Resilience' PWG. The PWGs each have related action plans. Line ministries chair with key donors and UN as co-chairs.

The NDP (2017-2019) has a clearly articulated vision for transition from humanitarian to development-funding support with implementing partner programmes closely aligned with, and informed by, the NDP.

## 1.2 Somalia Drought Impact and Needs Assessment (DINA)

Following four consecutive inadequate rainy seasons in 2016 and 2017, the FGS initiated a rigorous exercise to

identify the root causes of drought and develop a strategy for immediate recovery and longer-term resilience-building. This resulted in the Drought Impact Needs Assessment for Somalia<sup>8</sup> a comprehensive effort that mobilised over 180 national and international experts to assess and quantify drought recovery and resilience-building needs across 18 sectors.

Completed in January 2018, the DINA estimates the cost of damages or losses due to drought at more than US\$3 billion, equivalent to 50% of annual GDP. Multi-sector recovery and resilience-building needs were estimated at around US\$2 billion. In comparison, since the 2011 famine, some US\$5.4 billion has been spent on humanitarian responses to save lives. Thus, according to a recent USAID study,<sup>9</sup> resilience-building in Somalia would save an average of US\$53 million per year in humanitarian response, and investing in early response and resilience measures would yield average benefits of US\$2.8 for every US\$1 invested.

## 1.3 Resilience and Recovery Framework (RRF)

Translating the DINA findings into action, the MoPIED (Ministry of Planning, Investment and Economic Development) led the development of the RRF to establish a collective vision and strategy for recovery and resilience-building priorities. The RRF proposes a financing approach and institutional arrangements for the FGS and its international partners to act upon. The RRF is not a funding appeal.

It prioritises 653 interventions identified in the DINA according to three levels: high, medium and low, based on the assessed contribution of each intervention. The financing framework calls for high-priority projects and programmes to be subject to a government-led funding and investment planning and management process. Partners are meant to target their own investments in Somalia in support of the priorities set out in the framework.

The intention is that the RRF will be pursued alongside and build on the HRP in order to support recovery and development interventions in a crisis setting. In an effort

<sup>8</sup> DINA (2017): Somalia drought impact and needs assessment volume 1 synthesis report.

<sup>9</sup> MAF (2018): New Partnerships for Somalia. Mutual Accountability Framework. 13th July 2018.

to ensure that the activities led under the RRF and HRP are coherent, complementary and in line with the OCHA New Ways of Working (NWW), 'collective outcomes' have been defined by humanitarian and development partners, along with a broad plan to ensure that activities will be appropriately layered and sequenced.

The intention is that the RRF will be supported through the Somalia Development and Reconstruction Facility (SDRF), which is both a coordination framework and a financing architecture for implementing the NDP. Additionally, the PWGs are to be used for reviewing, prioritising and validating sector needs within the RRF. Wasting is used as an intermediate outcome indicator

## 1.4 The SUN Movement

Somalia joined the SUN Movement in May 2014. A Common Results Framework (CRF) has now been developed (November 2018) as an overarching strategic document to improve the nutritional status of the population through strengthening/building of integrated systems (workforce, supplies, finance and governance) and by bringing multi-disciplinary ideas into actionable programmes. The CRF structure was developed using a results-based approach whereby intermediate results (presenting activity-level outputs) feed into strategic results. The overall aim of the CRF is to reduce the prevalence of malnutrition in Somalia and control the fluctuating rates of wasting, establishing a more predictable and stable pattern of nutritional status. The CRF has seven strategic objectives: enabling environment, multi-sector coordination, development of human resource, comprehensive package of nutrition interventions, optimal use of nutrition-sensitive programmes (agriculture, water sanitation and hygiene (WASH), health, social protection, education and environment), and addressing gender and social cultural issues.

## 1.5 Somalia's Mutual Accountability Framework (MAF)

A New Partnership for Somalia (NPS), developed in July 2018, sets out how Somalia and the international community will work together to meet the most pressing political, security and economic needs and aspirations, as set out in the NDP. Built around the key organising principle of mutual accountability, the MAF was developed in the form of a scorecard providing light-touch, biannual updates of progress against the mutual undertakings that drive the agreement. The SDRF Steering Committee leads the management of this score-taking, supported by the monitoring and evaluation functions of government. The milestones included in the MAF are derived from the PWGs, lead ministries and ongoing commitments. This will complement the more detailed and comprehensive results/monitoring and evaluation framework that has

been developed for the NDP. The MAF is revised on a rolling, annual and iterative basis.

## 1.6 Humanitarian Response Plans (HRPs)

Annual HRP budget requests have been creeping up gradually with the 2018 plan, developed by the Somalia Humanitarian Country Team (HCT) in close consultation with federal and state authorities, amounting to approximately US\$1.5 billion. Based on assessed needs and projection for the coming year, the HRP is focused on four key strategic objectives: (1) Providing lifesaving assistance; (2) reducing acute malnutrition (mainly wasting); (3) reinforcing provision of protection services to affected communities; and (4) strengthening resilience. The response strategy has an emphasis on integrated, multi-sector service provision. Cash programming, which proved crucial in the famine prevention effort in 2017, again features prominently.

The HRP states that "the extent of growing and increasingly severe humanitarian needs underline the urgent requirement for investment in longer-term efforts to build Somalia's structural resilience to climatic and humanitarian shocks."

The HRP estimates that 6.2 million people (half the population) will continue to need humanitarian assistance and protection. Of these, 3.3 million will require urgent life-saving assistance. More than one third of those in need are IDPs.

One of the HRP 2018 strategic objectives is to build on nutrition approaches from 2017 to attain more sustainable reductions of emergency levels of wasting through prevention. This requires integration of nutrition, health, food security and WASH services, and focusing on both nutrition-specific and nutrition-sensitive actions in an integrated manner. The activities will focus on treatment and community resilience-building activities in prioritised geographical areas, including all locations with a high prevalence of wasting, such as IDP settlements and host communities, as well as preventive nutrition programmes across the country. Improving the livelihoods of the most vulnerable, addressing underlying protection risks and delivering social protection programmes with a focus on children under five years old and pregnant women are key objectives. Another strategic objective is to build resilience to current and future shocks by promoting livelihoods diversification and protecting and conserving natural resources that provide livelihoods for millions of Somalis. For individuals and households at risk, the provision of targeted safety nets will help mitigate the effects of seasonal risks and contribute to food security.

One concrete achievement in support of the global localisation agenda in 2017 was the prioritisation of local partners, where and when possible, by the Somalia



Humanitarian Fund (SHF). The Fund, which remains the single largest source of funding for national and local partners, had allocated 37% of its funds to local and national NGOs by November 2017 and the SHF Advisory Board has recommended that this approach continues. The pool of SHF partners has expanded to more than 100, of whom more than two thirds are national or local partners. Overall, some 231 humanitarian partners are providing assistance across the country, of whom 159 are national NGOs.

In line with the NWW, humanitarian and development partners have begun a process of identifying collective outcomes to be achieved by 2022 to reduce needs, risks and vulnerabilities and increase resilience. Collective outcomes<sup>10</sup> are measurable results focused on the reduction of people's needs, risks and vulnerabilities and an increase in resilience, to be achieved over a period of three to five years. The outcomes are designed to strengthen coherence and complementarity between humanitarian and development efforts, and ultimately aim to reduce needs and vulnerabilities to the point where humanitarian action is no longer required.

The humanitarian and development community in Somalia is proposing four collective outcomes as a way to ensure alignment and complementarity between the RRF and HRP. The outcomes identified were based on a needs overview and DINA at the end of 2017, and are aligned with the results framework of NDP and the Sustainable Development Goals (SDGs). They represent the key goals that require combined humanitarian and development action, with the activities required to meet them to be defined in relevant planning frameworks, including the HRP and RRF. The operationalisation of the collective outcomes will seek to ensure that the activities led under the RRF and HRP are complementary and effectively layered and sequenced in a way that reduces needs, risks and vulnerabilities. The intention is to review

progress towards the collective outcomes yearly on the basis of indicators that are either part of existing or planned results frameworks (NDP, RRF, HRP). The proposed collective outcomes are presently undergoing a process of validation with the government, humanitarian and development partners, and key donors.

## 1.7 Durable Solutions Initiative (DSI)

In December 2015, in a concerted effort to address issues around displacement and voluntary refugee returnees, the FGS and the Deputy Special Representative of the Secretary General, Resident and Humanitarian Coordinator (DSRSG/RC/HC) launched a collective initiative with the World Bank (WB), NGOs and the donor community to find durable solutions to displacement in a more effective, coherent and coordinated way. This government-led and community-focused DSI, developed in line with the NDP, provides another framework for harmonising programming.

It is hoped that the programmes, frameworks and coordination mechanisms established under the DSI will play a key role in supporting the overarching objectives of the RRF with respect to finding long-term solutions to Somalia's IDPs. The DSI serves as a national implementation framework of relevant regional and global commitments, such as the Nairobi Declaration on Durable Solutions for Somali Refugees and Reintegration of Returnees in Somalia, the New York Declaration for Refugees and Migrants, and the application of the Comprehensive Refugee Response Framework (CRRF).<sup>11</sup> CRRF and accompanying government-led National Action Plans will be implemented in close coordination with the DSI, particularly given the intersection between and challenges faced by refugee returnees, IDPs and the host communities.

## Stakeholder views

The array of policies and frameworks in Somalia is testament to the effort being made to meet humanitarian needs while also moving towards a longer-term resilience way of thinking. As part of the work in Somalia, time was spent in a series of one-day meetings to understand the connectivity between these initiatives. These views are summarised below.

### The DINA and the RRF

The DINA started as a post-disaster needs assessment in 2017. Discussions moved on very quickly to whether the DINA could inform a list of actions for an RRF. The MoPIED, who coordinated DINA, received considerable technical support from international experts and the

needs assessment was very fast paced. The analytical framework for the assessment focused on how to link humanitarian response with early recovery and medium-term needs. It was an opportunity to show that Somalia was coming out of conflict and humanitarian dependence and that FGS institutions were strong enough to take control. The RRF, launched in early 2018, resulted in the identification of US\$1.7 billion of

<sup>10</sup> Collective outcomes are not expected to cover all action in a country. Thus, not all activities will necessarily contribute to the collective outcomes (some may remain under the sole remit of development or humanitarian responses and not address a collective outcome).

<sup>11</sup> The CRRF is a set of commitments made by all 193 UN Member States on the New York Declaration promulgated at the UN General Assembly in September 2016.

interventions; by the last quarter of 2018 FGS was trying to prioritise for phase one of the recovery and resilience-building process with the hope that funds could be raised at local and national level. Key priorities identified were (and remain) water management, institutional strengthening for disaster management and response, and building the asset base for people’s livelihoods.

While this was fast moving, some development partners felt that the process was not sufficiently transparent. Many stakeholders articulated their concern that the HRP and RRF could become competitors and separate donor financing windows are needed for both. There has also been concern that the RRF is too aspirational and dependent on untried, new ways of financing. Some, including the European Civil Protection and Humanitarian Aid Operations (ECHO), have described it as “wishful thinking”, with little prospect of funding, arguing instead that it should simplify and focus on two or three sets of activities, such as safety nets and livestock. At the same time, donors have been pushing to operationalise the RRF but, due to the difficulties of financing government directly, this will inevitably be a challenge in the short term.

In recognition that there is overlap between the RRF and the HRP, there is an ongoing FGS process to limit duplication. The hope is that this will culminate in clear delineation. It is apparent that part of the reason this duplication has emerged is that, in the absence of development funding, the HRP has been under pressure for many years to include recovery and resilience-building activities – a form of ‘development creep’.

The Inter-Agency Standing Committee (IASC) clusters have been involved in developing collective outcomes for HRP and RRF, but there is still uncertainty about which activities fit where. Humanitarian actors are still uncertain how the HRP relates to the RRF and whether the latter is a framework or a plan. OCHA’s senior management is trying to get clarity on this question and to explore whether the HRP 2019 appeal can include elements for RRF funding.

There is a problem in Somalia regarding what donors are prepared to fund and where development ends and humanitarian activities begin. For example, under the HRP, it is possible to fund the rehabilitation of infrastructure following a flood, but not the strengthening of flood barriers to reduce future risk. While the agenda behind the RRF is to move away from humanitarian response to development, the continuing challenge is that many actors want certain activities that should probably be in the RRF to be in the HRP, as they are confident that this will continue to be funded.

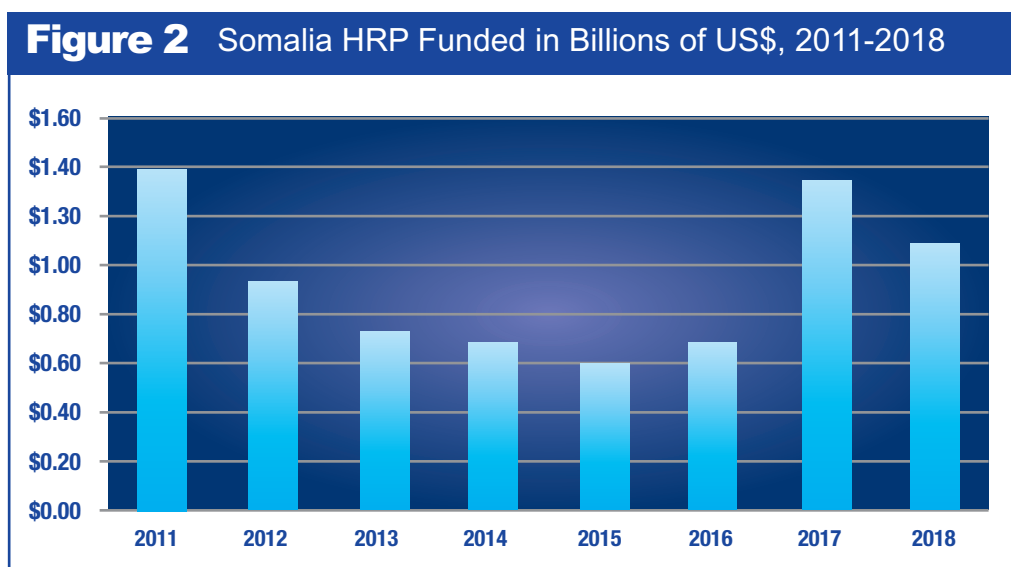
Finally, it is of note that stunting is not an outcome of the RRF as it is not seen as a priority in Somalia due to its relatively low prevalence. The two-season assessment reports by the FAO-led Food Security and Nutrition Assessment Unit (FSNAU) (see ‘Information and surveys’ below) show a stunting rate of 12-18% nationally, apart from three districts, where it is reported to be above 30%. Given the growing understanding that the risk factors for wasting and stunting in Somalia are common and a better understanding of the physiological links between wasting and stunting, there may be a missed opportunity to track both anthropometric indicators.

## The HRP

The current Somalia HRP budget request is in the region of US\$1.5 billion, to be spent over a six-to-nine-month period. Figure Two shows the HRP budgets over an eight year period between 2011 to 2018 .

The HRP mechanism and process involves each cluster steering group reviewing project sheets uploaded by member agencies. The sum total of accepted project sheets is the total HRP request. All HRP funding goes

<sup>12</sup> The data is extracted from <https://fts.unocha.org> on 14 Dec 2018 and often the amount per year might change based on daily reports received and processed in the system while the system usually depends on voluntarily reporting/disclosure by fund recipients. Note also that this figure does not show the amounts requested under the HRP.



towards projects on the sheet, but clusters won't necessarily know what each agency receives, because agencies may receive bilateral funding aligned to but outside of the HRP. The Nutrition Cluster strategic advisory group that oversees project selection comprises representatives from FGS (MoH), UN agencies (WFP, UNICEF), INGOs (ACF, SC UK, Concern), national NGOs (Somali Aid, Aid Vision) and representatives from each state government. Scoring criteria for submitted projects include gender mainstreaming, alignment of objectives, and integration and coordination with projects implemented by other agencies.

While the FGS signs off on the HRP, it has not had a significant role in its formulation. Furthermore, the HRP and the PWGs are not aligned and there has been a strong indication from FGS for several years that it wants to work more closely with, and be part of, the HRP process.

At the time of writing this report, it was clearly stated by staff in the Office of the Prime Minister that the PM expects his government to bring all external implementing partners closer to the line ministries, with a view to building their capacity to integrate programmes into government systems. In future, the expectation is that the FGS and OCHA will develop the HRP together, with FGS leading, and that, in order to effect this transition, the FGS must take control of and own all humanitarian programming-related data. The FGS recognises that it still requires technical capacity support from partners but is clear in its expectation that it will assume much more of a leadership role over sectors and clusters. The FGS wants donors to trust the systems of government more and to demonstrate this by making pooled funds available for government sectoral programmes.

## NDP-PWGs

The FGS vision is to bring development partner resilience-building programmes under government control. The NDP has a chapter on nutrition advocating for a multi-sector approach. Nutrition-specific activities fall under the health chapter of the NDP, with both nutrition-sensitive and nutrition-specific interventions aimed at the reduction of stunting and wasting.

While humanitarian actors are involved in PWGs, there is limited engagement of civil society actors, although discussions with the Somalia NGO Network are ongoing to get greater CSO involvement. The PWGs can and do try to extend mandate and process boundaries; for example, making the case for multi-year funding as well as influence over the HRP. However, some development partners believe that the PWGs needs to be more realistic about what they can actually achieve; i.e. the FGS will not be able to pay for its own health system in the short-term, so the MoH should instead focus on protocol development and harmonisation of approaches.

## SUN and CRF

There have been several changes of government since Somalia joined the SUN Movement, each newly committing to SUN and re-endorsing the NDP. The SUN Focal Point and Secretariat are based in the OPM. A CRF has been developed, aligned with the NDP, with the help of external technical assistance from MQSUN+. The Nutrition Cluster has also had some involvement in the development of this framework. It is hoped that the CRF will be finalised and fully costed by the end of 2018. There is a SUN Civil Society Alliance (CSA), led by Save the Children. Most of the partners are members of the nutrition cluster, although some are new, such as Building Resilient Communities in Somalia (BRCiS) and FAO. However, there is not a SUN donor or UN SUN Network.

The CRF has approximately 20 activities, of which six or seven are to be funded by UNICEF/WFP. UNICEF is committed to ensure progress of SUN ideas and networks in Somalia. It wants to enable an SBN and SUN academic network and support a vibrant CSA. SUN actors and the Nutrition Cluster meet quarterly, with many seeing this as a quarterly CSA meeting.

CSA partners are prioritising engagement with parliamentarians and greater advocacy around nutrition, leading eventually to a dedicated nutrition budget line in the next iteration of the NDP. UNICEF also wants to see development of a community nutrition strategy, as well as nutrition-sensitive activities in a number of line ministries. UNICEF currently supports the annual SUN self-assessment and is planning to allocate up to US\$370,000 to support SUN-related activities. While some nutrition stakeholders are impatient with the slow progress of the SUN Movement in Somalia, there is a sense that the SUN multi-sector approach probably has more traction there than in other countries, where there may be greater government bureaucracy and ministerial resistance.

## Nutrition Cluster

The Nutrition Cluster has been prominent in south and central Somalia for the last 12 years since it was activated. This contrasts with Somaliland, where the state government has resisted efforts to establish a cluster system and insisted on a sector approach.

In south and central Somalia the NCC has worked closely with government and a number of ministries, allowing multi-sector engagement. As an invitee to a number of nutrition-sensitive ministry meetings, the NCC has also been very engaged in the nutrition and resilience PWG of the NDP. Indeed, until now, many see the Nutrition Cluster as more influential than the PWGs because the Cluster has over 100 members and high levels of funding.

Over several years, the NCC has worked to move beyond annual cycles of wasting treatment and infant and young child feeding practices in emergencies (IYCF-E) programming and tried to expand the scope of the nutrition component of the HRP. This is in order to build more nutritionally resilient communities, in spite of the fact that, as a rule, agencies only get six to nine months to spend under the HRP once contracts have been awarded. These efforts have included the gradual rollout of inter-cluster programming as a minimum package of nutrition-sensitive interventions with collective nutrition objectives. This initiative is helped significantly by the fact that all cluster leads are based in one office in Mogadishu. The Nutrition Cluster also promotes programmes for adolescents and school-age children. Other initiatives and activities include rationalisation ‘plan three’, whereby most nutrition programmes are moved into health centres, moving away from standalone nutrition projects. The NCC has also developed a document on ‘nutrition referrals’, linking livelihood

programmes to families with children who have been in treatment programmes. The NC vision is to roll out more community-based nutrition programmes, including growth monitoring supported by the HRP.

The Nutrition Cluster recognises that donors spend a great deal of their resources on UN-implemented programmes and that this undermines resource flows to hard-to-access populations through local NGOs that do have access. (The Central Emergency Response Fund (CERF) captures roughly double the resources of the SHF).

In spite of (and perhaps partly as a result of) the vibrancy of the Nutrition Cluster in Somalia, there are those in government who believe the cluster relationship with donors is damaging and perpetuates a lack of trust in government, arguing that FGS is too weak to “entrust with programming and coordination”. Some FGS members have indicated that the cluster system may soon be overtaken by events in Somalia, with transition to an FGS-led sector approach by June 2019.

## Key findings

A number of critically important plans and frameworks with associated implementing bodies have recently been written that present an opportunity to strengthen the HDN (and therefore resilience-building) in Somalia. However, lack of clarity in delineation of activities, authority and accountability have resulted in tensions between these various initiatives.

The RRF has been criticised for being in competition with the HRP, being too aspirational, lacking activity prioritisation, and omitting stunting reduction as an objective alongside prevention of wasting. The HRP and the process of its formulation have been criticised for lack of government involvement and not being sufficiently aligned with the NDP.

The HRP has increasingly included resilience-type activities, contributing to lack of clarity around what should go where. Furthermore, the HRP always receives funding, so resilience actors try to embed activities into HRP, and the FGS sees the HRP (and the Nutrition Cluster) as a threat to longer-term funding and the process of transitioning responsibility and leadership to FGS.

The most recent NDP is an overarching framework for Somalia and clearly articulates a vision for transition from humanitarian programming. However, there has been limited INGO/NGO involvement in PWGs, which have in turn been criticised for not being realistic about what they can achieve; some stakeholders argue that they should focus more on protocols and harmonisation of approaches, such as resilience-building, rather than implementation.

The Nutrition Cluster has been and remains very active and influential in Somalia, with over 100 implementing partners. It has been increasingly involved in elements of resilience-building, such as health systems strengthening, multi-sector programming and activities aimed at preventing undernutrition. However, its level of influence has also been seen as a threat to certain government initiatives.

Progress towards SUN Movement aims has been observed recently with a national CRF finally endorsed in 2018. There is, however, no SDN or SBN, and the Nutrition Cluster partners and SUN CSA membership are largely the same agencies. However, there appears now to be an unprecedented opportunity for the Nutrition Cluster and SUN actors to collaborate, especially around health systems strengthening and multi-sector nutrition programming.

There has been considerable discussion about the extent to which the FGS is committed to the NWW, which many view as driven by humanitarians with OCHA as their representative. It is clear that, if OCHA is to make significant progress on HDN in Somalia, it needs to involve large development actors, such as the Africa Development Bank, World Bank, and the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ). Currently, the development budget is less than 10% of UN spend in Somalia. However, it is argued that there is no clear guidance about the NWW from the global level and that, without an OCHA Somalia vision, HDN is no more than a sentiment that the ‘old way’ of working’ cannot continue.

The development of the collective outcome document (COD) is a step towards a strengthened HDN for Somalia. However, it needs to be more 'granular' and less generic. For example, if the aim is to reduce prevalence of wasting by 5%, the document needs to develop a problem tree with a timed sequence of activities across the HRP and RRF and the SUN-CRF, which in turn needs to be budgeted and programmed. There are also a number of challenges and opportunities around the COD, which in large measure relate to the Somalia and global institutional architecture. These include the following;

1. The COD and supporting process is supposed to be mediated via the PWGs in collaboration with clusters. Although the PWGs have existed for about 18 months, their terms of reference (ToRs) are still not finalised. There are also concerns about their leadership and the fact that a number of Nairobi-based stakeholders who are part of the PWG are too far removed from discussions.
2. The PWGs are not strongly connected to the inter-cluster coordinating group (ICCG). The Cluster-PWG relationship needs to be strengthened, with closer alignment of vision and process in order to operationalise the COD.
3. While OCHA wants to get more involved in the United Nations Development Assistance Framework (UNDAF), the challenge is that the OCHA mandate

does not allow for meaningful resilience-building work. The key question is whether, in a country like Somalia, where there is high fragility and protracted crisis, the HRP should allow for longer-term and more resilient-focussed activities and, in so doing, explicitly reference 'resilience', so that it becomes the Humanitarian Response and Resilience Plan. However, the resilience activities would need to be clearly delineated from those allowable under the RRF. At the same time, the PWGs and RRF discussions on the need for multi-year resilience funding is where donors are increasingly being sensitised to the need for change and may encourage greater flexibility around what HRP budgets can support.

4. Currently, OCHA Somalia lacks capacity to conceptualise and plan for more development or resilience-building activities. It needs a form of capacity development itself.
5. The centre of gravity of humanitarian coordination for Somalia remains in Nairobi, although coordination meetings in Mogadishu still take place. Furthermore, although regional governments are regularly invited to Mogadishu for meetings, some are reluctant to travel due to the high levels of insecurity. This continues to undermine opportunities to strengthen humanitarian and development linkages.

# Chapter 2: Financing for strengthening the HDN



WFP/WILL Baxter, Somalia

ODA for Somalia totalled US\$ 1.3 billion in 2016. With an ODA to GDP ratio of 21%, Somalia is highly aid-dependent. Remittances are another key flow, estimated at US\$1.4 billion in 2016. Humanitarian aid experienced a spike in 2017 akin to the response to the 2011 famine, during which humanitarian aid surged to nearly US\$800 million. Between 2007 and 2017 annual humanitarian aid increased from US\$247 million to US\$614 million. The 2018 HRP budget is close to US\$1.5 billion, which has been almost fully funded with US\$1.1 billion dollars secured as of December 2018. Development aid to Somalia continues to be stable. Donors reported US\$613 million in aid for development in 2017, an 11% decrease from the previous year's spending.

Only 8% of development aid was channelled 'on treasury' in 2016. On-treasury aid is disbursed into the government's main revenue funds and managed through government systems. Most on-treasury grants (92%; US\$ 50.4 million) were delivered through three channels: projects financed through the WB Multi Partner Fund (MPF), general budget support provided by Saudi Arabia, and sector budget support provided by Turkey. The use of pooled funding instruments in Somalia is declining, based on reporting by donors. Whereas 30% of development aid was channelled through pooled funds in 2015, the share for 2017 is estimated at only 21%. The share has also declined for funds established under the Somalia SDRF, from 23% in 2015 to an expected 16% in 2017. Significant progress has been made in improving aid transparency, which has served to inform better coordination. A total of 45 (82%) of development partners reported their aid flows to the Aid Coordination Unit of the Office of the President in 2016.

At US\$ 113 million, domestic revenue represented just 2% of GDP in the same year. The slight decline in development aid seen in 2017 may be attributed to the falling value of several donor currencies relative to the US dollar, as well as the diversion of funds to humanitarian activities in response to the drought. With multi-year funding cycles, development envelopes are more predictable and therefore less likely to increase significantly from the currently reported levels. On a per capita basis, Somalia received flows of aid similar to

Afghanistan; US\$130 and US\$141 per capita respectively in 2015. However, the composition and potential for long-term impact of this aid differs significantly. Whereas 76% of ODA to Afghanistan consisted of country programmable aid (CPA), only 42% of Somalia's aid was categorised as such. CPA provides a "closer proxy of aid that goes to partner countries than the concept of ODA." It excludes humanitarian aid and debt relief, which are inherently unpredictable. It also attempts to exclude aid that does not involve flows to the recipient country, such as administrative costs, research and advocacy, and refugee spending in donor countries. CPA is therefore a better measure of aid spent in country for longer-term development goals<sup>13</sup>. Total CPA to Somalia is limited by the fact that the country is currently not eligible for concessional financing, which can dramatically alter the aid profile of the recipient country.

The predictability of general and budget support improved significantly in 2016; 88% of committed funding for budget support was delivered by Saudi Arabia and Turkey. In 2015, only 4% of committed budget support by the United Arab Emirates, Turkey and the Arab League materialised. Approximately one third of budgeted financing for on-treasury projects was disbursed in 2016. Government and development partners share the responsibility for delays in implementation as the specific causes varied from project to project.

The use of pooled funding instruments in Somalia is declining, based on reporting by donors. Whereas 30% of development aid was channelled through pooled funds in 2015, the share for 2017 is estimated at only 21%. The share has also declined for funds established under the SDRF, from 23% in 2015 to an expected 16% in 2017. The SDRF brings together several MPFs under common governance arrangements to promote: (a) coordination across activities and instruments, (b) alignment with national priorities, and (c) reduced transaction costs for government. Administered by three technical agencies, the SDRF funds include the African Development Bank (ADB) Somali Infrastructure Fund (ADB SIF), the UN MPTF, and the WB MPF. The apparent

<sup>13</sup> OPM (2017). Aid Flows in Somalia. Aid Coordination Unit, Office of Prime Minister, Federal Republic of Somalia

decline is attributed to several factors: decreased value of several donor currencies relative to the US dollar, a lack of forward projections of new commitments still in discussion, and shifting preferences away from pooled funding mechanisms.

## Government funding challenges and main nutrition donor policies and approaches

According to the Transparency International Corruption Perception Index<sup>14</sup>, Somalia is reported to be one of the least transparent countries in the world with regard to tracking income and expenditure. This has undoubtedly had a marked impact on the way ODA is configured. With a domestic budget of around US\$270 million in 2017 and US\$90 million going to basic services like water and health, there is little to spend on anything else.

The US government has for many years supported programming through USAID's Office of U.S. Foreign Disaster Assistance (OFDA) and other departments, with the majority spent on food and cash. OFDA has been supporting treatment of wasting and acknowledges a failure to support multi-year funding, although this is now being considered as a way forward. A significant constraint for OFDA has been the limited spend on health by FGS. USAID currently has a US\$1.5 million health development programme in country and Somalia is one of the few countries where US development funding is actually increasing.

The majority of Irish Aid's (IA) portfolio in Somalia is humanitarian aid via the civil society unit, which gives grants to NGOs. The support has been approximately €6 million per year, predominantly via the SHF. IA is developing a new strategy for Somalia which includes strengthening the HDN. Major fraud having taken place in Somalia (as well as in Uganda) has created for IA some institutional resistance to DBS. Nonetheless, IA envisages increasing support to Somalia over the next few years, with a particular focus on cash programming in the form of social safety nets, using mobile phone technology. This is where IA sees a real opportunity for strengthening HDN.

The World Bank (WB) has only been investing directly in Somalia for approximately one year. It has not deemed FGS to be eligible for concessional loans (international development assistance) in terms of governance and repayment of loans. The WB has therefore been supporting development indirectly through MDFs; for example, to help pay civil servant salaries in the health and education sectors.

The WB has recently established an emergency fund for Somalia, which is a grant to mitigate effects of drought. This fund is used mainly for wasting treatment, water conservation and resilience-building; the FGS does not

need to pay this back. The World Food Programme (WFP) is the main recipient of this funding.

The WB is now also implementing a small project on recovery and financing reform. It administers this grant as an MDF and receives funding from other donors. It is worth about US\$130 million and is being used to rebuild civil servant payrolls at federal and state level.

ECHO only funds annual humanitarian initiatives, while the UK Department for International Development (DFID) and the Foreign Affairs, Trade and Development Canada (DFATD) fund development as well as humanitarian programming.

DFID has been one of the more 'innovative' donors to Somalia and has invested significant funding in BRCiS, with a £64 million multi-year initiative. This programme, which is implemented by a consortium of partners (see Chapter 3), has funding from other donors as well. It is a multi-sector approach aimed at addressing the root causes of malnutrition and mortality. DFID is unable to provide DBS in Somalia. The SDRF, which is a donor pooled funding mechanism (see above), is chaired by the deputy PM; DFID is a key donor. SDRF commits some funds to PWGs.

The Swedish International Development Cooperation Agency (Sida) and the Norwegian Agency for Development Cooperation (Norad) give unearmarked funding for economic reconstruction and resilience-building.

So called 'traditional donors' (EU/DFID/IA/OFDA/USAID, etc) are said to be well aligned on humanitarian matters. In addition, there are interactions between humanitarian and development donors, but stakeholders acknowledge that this could be significantly strengthened. There is currently no donor SUN network. With implementation of the Durable Solutions Initiative starting now, DFID and other donors are attempting to convene authorities, development colleagues and donors around it.

A number of donors are also working to establish a critical mass and momentum around supporting a safety net cash programme that builds on the back of the large cash transfer programme being implemented as part of humanitarian responses and architecture. This will need to include development actors. Ideas in the mix currently include a public works approach, with perhaps one million people on multi-year funding. The estimated cost for 200,000 households (five persons per household) is about US\$80 million.

## Challenges

Many development partners cited the same five challenges in relation to donor funding approaches:

1. It has been difficult to get funding for non-treatment activities, such as IYCF, micronutrient programming and preventive programming, into humanitarian proposals.

<sup>14</sup> Transparent Perceptions Index Table, 2017. [www.transparency.org/news/feature](http://www.transparency.org/news/feature)

2. Humanitarian funding needs to be spent by the end of the short budget period; usually six to nine months once the grant has been agreed. This becomes administratively cumbersome and makes it very hard to implement longer-term programmes. It also means programmes start, close and start again, and that there are frequent gaps.
3. Working within or with the health system is made very difficult because the majority of government health system staff have never been paid or received a regular salary.
4. Donors need to support the commodity pipeline for drugs and foods. This necessitates a nationally owned commodity security programme with a five-year strategy focusing on forecasts, warehousing and support.
5. Donors rarely support programming in Al Shabaab-controlled areas.

As a consequence of the above, development partners have in the past endeavoured to ‘hide’ what are sometimes viewed as development-type nutrition activities in humanitarian proposals and ‘see what they can get away with’. They would like to see less risk-averse behaviour from donors which supports government to establish systems like commodity pipelines.

## Inter-cluster mechanisms

The two main forms of coordinated humanitarian funding in Somalia are the Somalia Humanitarian Fund (SHF) and the Central Emergency Response Fund (CERF). The amounts allocated are through the SHA shown in Tables 1 and Two below for the 2017 and 2018 period.

Most of the SHF goes to supporting food security through NGOs implementing cash transfers. The 2017 and 2018 HRP in Somalia have seen a significant shift towards multi-sector programming; i.e. an inter-cluster approach. The new approach means there is less competition for SHF and adoption of joint outcomes among clusters. In the early days clusters used to fight over resources, but the integrated project approach reduces this tension. The clusters now implement a minimum package of food security, nutrition, health and WASH, and it is hoped that shelter, protection and education can be added to the package depending on available resources and need. The SHF is now also responding to the NWW by promoting more localisation. Fifty per cent of 2018 SHF went to local NGOs, an increase from 40% in 2017. However, local partners tend to specialise in a narrow range of programming, which limits opportunities for integrated programmes. SHF resources are also limited, so this limits the scale-up of an integrated package.

The view of cluster leads is that, although the HRP process is functioning well, there is a risk of trying to do too much in the development arena and that there is a need to set firmer boundaries in order not to compromise

the primary life-saving aim of the HRP. However, this is difficult to manage when agencies come with large humanitarian programme requests that include an element of resilience-building and development, and because the HRP in Somalia is rarely fully funded. This kind of ‘development creep’ is even more concerning.

Some cluster stakeholders believe there is a ‘bigger conversation’ to be had about the SHF being more

**Table 1:** SHF allocations by sector-approved and received amounts in \$USD 2018

Number of projects funded by sector	Approved budget - \$USD	Net Funded Amount \$USD
Multi-Cluster Projects (59)	23,318,708	23,318,708
Food Assistance (18)	5,274,325	5,009,533
Water and Sanitation (15)	3,272,561	2,816,285
Shelter – NFIs (9)	2,806,283	2,705,598
Nutrition (14)	2,314,264	1,505,353
Protection (16)	2,287,916	2,107,386
Education (6)	2,035,930	2,035,930
Direct Cost Budget (2)	1,999,696	1,709,984
Health (11)	1,482,921	895,126
Logistics (2)	1,100,000	1,100,000
Enabling Programming (9)	905,343	835,733
Camp Coordination & Management (3)	514,359	514,359
Livelihoods (3)	0	-251,771

**Table 2:** SHF allocations by sector-approved and received amounts in \$USD 2017

Number of projects funded by sector	Approved budget \$USD	Net Funded Amount \$USD
Multi-Cluster Projects (28)	15,375,096	15,375,096
Direct Cost Budget (5)	8,592,307	6,844,037
Food Assistance (29)	8,164,502	7,953,892
Water and Sanitation (28)	6,489,001	6,477,465
Health (26)	5,897,490	5,874,107
Protection (23)	5,396,062	5,394,250
Nutrition (25)	3,859,445	3,854,202
Education (13)	3,220,820	3,220,820
Shelter – NFIs (10)	2,184,731	2,184,731
Enabling Programming (14)	1,728,825	1,724,279
Camp Coordination & Management (1)	303,402	303,402
Logistics (1)	250	250
Livelihoods (2)	0	-1,094
Totals	61,461,683	59,455,187



flexible and allowing resilience-building activities. These actors supported the request for a multi-year funded (MYF) SHF in 2015 and many would support an integrated humanitarian and development fund in Somalia. These stakeholders assert the need for MYF and activity-based costing rather than project-based costing. This is mainly due to the fact that activity based costing reduces the transaction costs related to project planning and vetting. In addition, the budgeting of the HRP is less influenced by an organisation's concerns about funding requirements and sectors are under less time pressure. However, this has not been implemented and the 2019 HRP is designed around project based costing.

Currently, the SHF can support capacity development but not construction of buildings of small centres, while CERF (UN fund) cannot fund infrastructure, training or capacity development but only life-saving medicine and supplies. The CERF is generally a significantly larger fund than the SHF.

The FGS have concerns over the increasing number of local NGO recipients of humanitarian funding and their accountability. There is a view that their accounting is limited to reporting on inputs and outputs, rather than impact. This creates a sense of frustration in the FGS that donors are prepared to fund unaccountable local NGOs, but not provide DBS for FGS. There is also a sense of frustration among government over the large amounts of money channelled to and through the UN, especially given its comparatively high overhead costs (20%) and additional need for costly security arrangements. One member of the FGS wryly observed that “the amount the UN receives in Somalia could have financed the construction of Dubai.”

## Recent and promising developments

A number of promising financing developments are in process.

The WB has allocated approximately US\$80 million to the Ministry of Finance to build capacity for the health system, including training for 400 staff to work in what will be government-managed health facilities. Funding is also being made available for community health worker salaries. Small amounts of WB funding have also been allocated for the RRF via the Ministry of Energy and Water. The EU is also planning to allocate approximately €100 million via treasury, although this money may be contingent on how debt relief discussions progress in the short term.

Trials are ongoing for ‘on-treasury funding’ and the FGS anticipates substantial developments in 2019 as it works directly with donors. It is trying to put the right ‘public finance management systems’ in place rapidly to

demonstrate it can manage large grants. Not all donors are convinced that the systems will be in place and are therefore keenly observing how DBS works out. (For example, although DFID is putting health at the centre of its engagement in Somalia, this funding is still allocated through trust fund mechanisms.)

The WB anticipates that the first three years of its re-engagement in Somalia will be preparatory, with key debt discussions, and hopes to have international development assistance (IDA) in place in five to six years' time. It is also examining where it can get most impact from its resources. For example, according to DINA, losses in the health sector only account for a few hundred million dollars, whereas livestock losses are over two billion dollars. The WB believe there is a need to focus on multi-sector interventions and resilience-building. Resumption of IDA funding is key to the RRF as there is very little that can be done with a Multi Donor Trust Fund (MDTF) as this doesn't go through FGS. The WB is required to build capacity of the FGS and some in the bank believe other donors could do more to support FGS via DBS. In the meantime, the WB recognises that it needs to show that DBS can work so that others follow suit.

Other donors are asking WB to support and prioritise the FGS health system specifically. FGS has the capacity to develop an essential package of health and nutrition services, including treatment and prevention of malnutrition, and the WB has helped fund a comprehensive health package in the north. Currently, Turkish and Arab donors do fund via the FGS and this is where the vast majority of their DBS originates.

One other donor currently paving the way for longer-term nutrition funding is the German government, who is in discussions over funding for the Somalia Resilience Program (SomReP) and BRCiS 2, as well as the CRF.

## FGS vision

The FGS vision is to increase the legitimacy and appetite for this type of DBS gradually. At the same time, the FGS is increasingly impatient with a humanitarian-driven system that effectively competes with the RRF and potential funding of the new CRF. The PM aims to forge greater alignment with the RRF and put the line ministries in the driving seat. The Office of the Prime Minister OPM has already held meetings on how to conflate RRF and HRP, including how donors can put more resilience-building into HRP. In effect, it wants the HRP to become a subset of the NDP. The problem is that a more resilience-focused HRP conflicts with OCHA's mandate. The FGS view, however, is that Somalia is unique in terms of the duration of crisis, the huge cost of HRPs, and increasing caseload of IDPs and other vulnerable groups. It believes value for money is a big question which needs to be addressed, arguing that HRPs have to focus on community resilience-building and that the HRP could be used to generate funding for the RRF.

The FGS has had internal discussions about integrated humanitarian and development financing. It argues that it was able to take a leadership role in 2017, thereby helping to avert famine, but that levels of wasting are

already back on the rise as a result of longer-term vulnerability and lack of services. At the same time, while the FGS is building its leadership capacity and profile (among donors), regions are claiming semi-autonomy, thereby further complicating lines of authority and governance.

## Key findings

Aid dependence is inherently problematic for a country like Somalia due to its lack of tax revenue and control over expenditure. However, when that aid is predominantly in the form of humanitarian funding, additional challenges arise. Two principle challenges in Somalia are that HRP-related funding does not adequately support resilience-building, and that most ODA is not channelled through government (i.e. The FGS). For nutrition, this means that most resources are devoted to treatment programmes rather than preventive resilience-building initiatives; thus there is very little prospect of integrating nutrition programmes into government health systems (most staff are unpaid or paid irregularly), or of scaling up multi-sector nutrition programmes and integrating these into government-led, nutrition-sensitive sector initiatives. It is clear that OCHA and other UN agencies, as well as the INGO sector, must increasingly engage with longer-term development donors if resilience-building is to take place in Somalia. Multi-year financing for the HRP should also be implemented to effect meaningful resilience-building. This was requested by certain clusters in 2015 but, for reasons that are unclear, not sanctioned. The HRP also needs to become more flexible with regard to resilience-building activities like health systems strengthening and multi-sector nutrition programming if it is to move beyond treatment of wasting. In addition, the HRP must be enabled to have activity-based costing rather than project-based costing.

To date the lack of DBS for government has been challenging on a number of levels. It has meant government has not had opportunity to establish and test robust and accountable financial systems or establish and refine budget lines for key areas of expenditure. Apart from the Turkish government and

Arab donors, who have provided DBS for a number of years, the WB and EU are now piloting different forms of DBS and support to government financial management systems. The FGS has found it difficult to understand why many traditional donors have been able to fund NGOs through the SHF and other means, many of whom have poor accounting systems and minimal accountability for programming, yet have not been able to provide DBS to government, citing lack of transparency of FGS systems. There is also frustration that relatively new donors like the WB are forcing through a DBS agenda through rapid piloting, yet other donors have remained 'risk averse' in their funding through UN and INGOs, in spite of the enormous (but undocumented) transaction costs of this way of working. There are questions around how development actors such as the WB manage to move to DBS so quickly and what other donors can learn from this approach.

At the same time, shifting to longer-term development donor funding may lead to different challenges. Actors such as the WB and Africa Development Bank arguably operate through a more economy-centric model than donors who traditionally work in humanitarian crisis contexts. Cost effectiveness and cost-efficiency criteria may therefore be more evident in decision-making. Whether this translates into prioritising economic investment (such as livelihoods programming) over more social investment (such as health systems strengthening) is unclear.

Finally, it is worth noting that, although the localisation agenda is progressing well in Somalia, current financing mechanisms available are not ideally suited to the finance and management capacity of many local actors, who may require a different form of 'donor support' to ensure robust handling and accounting of finances.

# Chapter 3: Resilience programme approaches in Somalia

**R**esilience-building (including nutrition resilience-building) is a commonly cited objective of most programmes in Somalia. After 27 years of conflict and periodic droughts, development partners and government are only too aware of the need to help populations become more resilient. However, just as definitions and understanding of resilience-building vary between actors and agencies, programmes designed to build resilience also vary in design, scale and approach. The main nutrition resilience-building programming types and approaches currently taking place in Somalia are described below. This includes the main consortia-led resilience-building initiatives and programmes which attempt to integrate nutrition into health systems (system resilience) and programmes with a preventive objective (individual and household resilience-building). Evidence for the impact of programmes on nutrition resilience or resilience more generally is explored, as is the localisation agenda as an important approach for building resilient systems and governance across sectors.

## Development partner definitions and programme approaches

Some agencies have resilience strategies, while others have more of an ‘understanding’ at country level rather than clear strategies. Resilience-building consortia may also have their own approach and definition of what resilience is and how it should be built.

In 2012, FAO, WFP and UNICEF adopted a joint strategy on community resilience for Somalia (UN-JRS). This drew on household risk management, sustainable livelihoods and disaster risk reduction models. It targeted the community and household levels through three complementary activities: strengthening the productive sectors; improving basic services; and establishing predictable safety nets. An analysis during the pilot phase identified the following key resilience-related messages:

- The status of nutrition and food security are good indicators of overall resilience in Somalia.
- Improving nutrition-sensitive agricultural production and natural resource management are key to resilience-building.

- Changing behaviour is critical for improved consumption at the household and individual level and for improving health-seeking and wellbeing practices;
- Increasing income, reducing women’s work burden and improving knowledge will increase demand and utilisation of essential services.

The UN-JRS is scaling up for 2018-2022 to support more than 250,000 households through three outcome areas of focus:

1. Improved consumption of adequate nutritious food through increased and diversified agricultural production and income sources;
2. Increased proportion of households involved in and using quality essential services and adopting essential family practices to improve family health and wellbeing;
3. Strengthened capacities of communities and institutions for effective resilience-based planning, policy development and learning.

While this UN view of resilience-building in Somalia overlaps and mirrors the understanding of many other agencies, there are significant differences in focus, priorities and perspectives among other agencies, as outlined below.

ECHO describes four pillars for resilience in Somalia: safety nets, shock response systems, basic access to services, and livelihoods. This model has also been applied in Ethiopia (EU/ECHO RESET project).

For OFDA, resilience-building in Somalia has been promoted through cash for assets and cash for work, as well as livelihood support programmes. None of these programmes have a nutrition focus.

USAID asserts that strong governance and systems are a prerequisite for resilience-building.

INGOS like Save the Children (SCI) (who are part of the BRCiS consortium) have been critical of resilience programmes focused on food security rather than nutritionally vulnerable populations. They are also critical of cash transfers that target poor households rather than families with malnourished children. Critical to the BRCiS consortium approach is the fact that it is a community-focused project, with activities identified and driven by communities and their contexts.

UNICEF's nutrition resilience-building approach is based on an integrated programme approach; i.e. WASH/education/health and nutrition activities targeted to the same population.

DFID has been supporting a number of resilience-building programmes in Somalia with significant nutrition elements that have provided both preventive and curative functions. These programmes have incorporated early and rapid response to shocks and have worked with the community model for integrating treatment of wasting with WASH and IYCF. DFID has also encouraged curative work to be implemented via health centres; key learning has been around the need to consolidate services and rationalise them so that they are 'leaner and meaner'. An enormous challenge expressed by DFID staff is how to blend in (integrate) preventive work in the absence of FGS health systems. Like others, DFID is critical of resilience approaches that have not evolved such as the use of cash for work or assets.

SomReP is based on the 'absorptive, adaptive and transformative' resilience model and defines resilience 'as the ability of communities and households to manage change by maintaining or transforming living standards in the face of shocks or stresses – particularly drought, without compromising long-term prospects'. Resilience means households should not become malnourished. The resilience focus of Action Against Hunger (ACF) is strongly on health systems strengthening, with the aim of getting the FGS to gradually take over major hospitals and then smaller health units as its capacity increases.

The NCC believes that protection mainstreaming in all clusters is important for resilience-building; i.e. trying to build resilience in communities via targeting and community accountability.

The FGS understanding of and approach to resilience-building is described in detail in chapter one of this report and articulated clearly in the RRF.

## Consortia-led resilience-building programmes in Somalia

There have been at least four major resilience-building consortia-led programmes in Somalia (BRCiS, SNS, SomRep, UN-JRS). These have all been funded by a small number of donors and involve either INGOs or UN agencies. The existence of consortia reflect a convergence of approach and understanding around resilience and how to enable it among consortium partners. SNS and BRCiS are two of the best known. Both have been funded by DFID, although other funders have also supported BRCiS.

Strengthening Nutrition Security in South Central Somalia (SNS) was a consortium approach funded by DFID between 2013-17. The SNS had four pillars: treatment of

severe wasting, IYCF, surveillance and strengthening structures. However, the system-strengthening component was challenging and ultimately led to SNS being absorbed into phase two of BRCiS (see section on impact of resilience programming). Under SNS, treatment of SAM took place through 35 outpatient treatment programmes (OTPs) and three stabilisation centres. Prevention of acute malnutrition was mainly built around IYCF initiatives to promote behavioural and social change. Surveillance and early warning were enabled through data collected and submitted by community health workers, the researchers and programme staff through mobile phones. Capacity-building was realised through cascaded training, extensive on-the-job training, technical and survey skills development of national staff, and the establishment of community support structures.

BRCiS phase one comprised a consortium of five INGOs and was implemented between 2013-17. Its main aim was to help communities better cope with shock. It has had a number of evaluations over the four years. Originally funded just by DFID, the BRCiS and SNS 'operating mode' was not well established and in the next BRCiS phase, health and nutrition will be more central, with SNS being absorbed into BRCiS. There are five different objectives for BRCiS 2, with a myriad of context-specific and livelihood-specific activities. DFID wants this new phase of BRCiS to be more multi-sector, integrated and targeted to the poorest. The SNS prevention and social change elements will also fall under BRCiS 2.

BRCiS had approximately double the budget of SNS and up to 150 community activities including cash transfers. Phase one cost is about £170 million over three and a half years, with a significant component comprising emergency response through health centres. BRCiS worked closely with FGS (particularly MoPIED and the Ministry of Humanitarian Affairs) and has endeavoured to get all partners to work under the resilience PWG of the NDP. The consortium worked to strengthen state-level coordination and one of the consortium partners focused on interfacing with state ministries, with MoPIED as the entry point.

DFID has been highly flexible on BRCiS spend, with 10-15% of budget being for developing new partnerships, including strengthening FGS. However, BRCiS has to date only managed limited capacity-building of FGS. BRCiS is now funded by DFID, EU and WB and operates in all states of Somalia.

The next phase of BRCiS, running from 2018-22, will try and embed learning from the first phase. It will involve more community consultation to identify what programme types are needed. One overarching challenge for BRCiS (as was the case with SNS) is that it has been difficult to move beyond humanitarian programming. This will not be helped by the recent

decision of the Nutrition Cluster to leave emergency programming to BRCiS's partners when they are working in an emergency affected area.

SomRep is a consortium of seven INGOs with the express aim of building household and community resilience to drought and related risks in Somalia. It is targeted to 70,000 pastoralists, agro-pastoralists and peri-urban households. It is a five-year programme costing around US\$80 million.

The type of activities included in SomRep are: building livelihoods; supporting livelihood innovation; improving preparedness and contingency resources; improving natural resource bases; and supporting communities and government social response capability, such as animal health and husbandry strengthening, natural resource management, marketing and value addition, early warning, contingency planning and creating dry season water points.

## Agency resilience-building programmes

### Health systems strengthening

Somalis have faced multiple climatic shocks in the form of drought and, as in previous years, the main nutrition response to the ensuing crises was treatment and attention to IYCF; in 2017, for example, approximately 1,800 OTPs, targeted supplementary feeding programmes (SFPs) and stabilisation centres (SCs) were established in south and central Somalia.<sup>15</sup>

Considerable efforts were made to link and integrate these programmes to health systems but, for various reasons, (including funding mechanisms and lack of health infrastructure) this proved extremely difficult.

There are many hospitals and health centres in south and central Somalia, but many of these are funded by NGOs and the diaspora rather than government. Without the same level of humanitarian funding the number of OTPs and TSFPs, as in previous post-emergency years, will inevitably decline post HRP-2018. The overriding challenge for humanitarian and development partners is how to integrate the humanitarian-funded programmes into such a weak and disparate government health system, where services are not run or funded by government. There is no mapping of the percentage of nutrition programmes integrated within health systems, although it is thought that 60-70% of the population has access to some form of treatment services. The Health Cluster does not map overlay of health, nutrition and WASH, but these are mapped separately. DFID and USAID have both heavily promoted nutrition integration into health services and WASH facilities.

The Nutrition Cluster has been pushing for nutrition services to be implemented only in health facilities (fixed and mobile). Its most recent rationalising plan has redefined health centres to include “pretty much all

structures”, so that nutrition can be integrated into all existing systems and infrastructures. A critical challenge is the lack of health workers at community level on which to build on integration from this level.

The SNS consortium devoted considerable resources to building government capacity and structures. However, IYCF and social behaviour change was particularly difficult as staff were very medicalised and treatment was always the ‘low hanging fruit’ and a priority in times of emergency. The consortium trained Community Health Workers (CHWs) in all locations, and INGOs and NGOs have also been training CHWs in nutrition, as well as MoH staff where feasible. For example, ACF is currently supporting over 200 CHWs through training, while local NGOs have been paying a small number of MoH salaries or mentoring MoH staff who are invited to learn by doing.

Puntland is held up as an excellent model of how nutrition can be integrated into health systems in Somalia. When local NGOs get donor funding for treatment, they then disburse money through the MoH to employ staff on their projects. If NGOs refuse to work in this way, they do not get permission to work in an area. Some view this as an excellent way to ‘force’ the strengthening of government systems.

### Information and surveys

The main source of nutrition and nutrition-related data for Somalia has been the FSNAU, which has been in existence for over 20 years. FSNAU reports are based on surveys that are amalgamated each year. FSNAU produces biannual food security and nutrition trend and map data for 18 livelihood zones. Data are collected by a group of Somali food and nutrition security monitors. Areas where surveys use the SMART methodology are distinguished from more rapid, MUAC-type assessments. Nutrition and other data are combined to produce integrated scores. Market, rainfall, livestock and health data are also used. However, there are data gaps due to insecurity and the findings are often challenged methodologically.

The vision for FSNAU is to move the system over to FGS in three to four years' time. To this end, it has been training MoH staff in the approach. The transition can only occur, however, with continued funding and FSNAU is facing funding constraints. High FGS staff turnover and staff retention is another challenge. FSNAU is also working more with local NGOs to build field capacity, especially in highly-insecure areas, and is hoping that, by the end of the next FSNAU phase, it will have built sufficient government capacity to transition responsibility. The Nutrition Cluster has led an online reporting system for CMAM/IMAM<sup>16</sup> and it is hoped that this, too, will be

<sup>15</sup> WHO is supporting SCs by assessing capacity, doing quality assurance, two rounds of training for all staff, monitoring supervision of centres and implementing master training of trainers and key partners.

<sup>16</sup> CMAM is the Community Management of Acute Malnutrition. IMAM is the Integrated Management of Acute Malnutrition. The terms are sometimes used interchangeably.

owned by the MoH in due course. This is a cloud-based information system which allows capture of service site delivery data. All CMAM sites use the FGS Health Monitoring Information System (HMIS) forms.

## Commodity pipeline

As of March 2018 there were 1,925 functional emergency nutrition service delivery centres (62 stabilisation centres; 1,270 OTP centres; and 583 targeted supplementary feeding centres). The Nutrition Cluster received a total of US\$145 million (52.7 % of its funding requirement), which enabled 955,976 (the highest ever) acutely malnourished children under five years of age and 227,000 pregnant and lactating acutely malnourished women to receive therapeutic services, with a performance well above SPHERE standards.

The extension of services, while impressive, posed challenges around managing the annual supply of 400,570 cartons of ready-to-use therapeutic food (RUTF); 3,431 cartons of F75; 2,308 cartons of F100 and 28,379 metric tons of ready-to-use supplementary food (RUSF) (including vegetable oil and super cereal/CSB+), and several other essential nutrition supplies, such as ReSoMal,<sup>17</sup> drugs and stationery. Furthermore, these supplies were often spotted for sale in the urban Mogadishu and Hargeisa markets.

In 2018, as preparation for a plan to strengthen the supply chain and ultimately transit and integrate the supply chain into the national health system, the Nutrition Cluster proposed that UNICEF, WFP and BRiCS comprise a core team to draft a strategy with key recommendations that would ultimately be part of the ongoing revision of national iMAM guidelines.

## Continuity of care

Continuity of care for treatment of wasting has also been challenging.<sup>18</sup> There are virtually no data on the extent to which treatment programmes also provide other forms of nutrition-specific interventions, although there are a number of organisations, who provide a comprehensive package of nutrition-specific services, including IMAM, micronutrients, IYCF, maternal nutrition and care, surveillance, IMCI, immunisations, food fortification and deworming.

The data on the extent to which moderate and severe wasting treatment are aligned to provide continuity for treatment of acute malnutrition are of particular concern. There are numerous reasons for this:

1. The WFP and UNICEF have different security protocols and needs assessment approaches and therefore often do not operate in the same geographic areas. Food commodity pipeline interruptions have also affected one agency or the other. As a result, UNICEF has frequently had to provide MAM treatment where WFP has not been present. It is also apparent that, during implementation of SNS, MAM was not included, largely as a result of the cost.

2. WFP has worked hard with UNICEF on better integration of MAM/SAM. In Somaliland and Puntland this has now almost reached 100% integration. In south and central it is happening more slowly. WFP now has a strategy whereby it only establishes TSFP where UNICEF has an OTP and SC.

3. Part of the difficulty of ensuring continuity of care has been the large number of implementing partners, as well as the short-term nature of funding. For example, HARD (a local NGO) run OTPs and SCs, with funding ending in December 2018. However, it does not have resources to implement an SFP; this leads to reported high levels of relapse. HIRDA (another Somali NGO) ran OTPs in 2015 but ended in July 2018 due to lack of funding. It now only implements TSFPs through WFP. CEDA has managed to provide continuity of care by partnering with UNICEF to run Primary Health Care, OTPs and SFPs. It has managed to integrate its programmes so each programme is within walking distance. Its challenge is that funding is too short-term, with the need to submit proposals every year and inevitable gaps in programming (sometimes up to five months). CEDA tends to run out of food if World Vision is late in establishing its annual programme; reportedly this is a fairly regular occurrence.

## Prevention of malnutrition

By definition, preventing malnutrition is synonymous with resilience-building in that people can only be described as resilient if, when faced with shock, they are able to withstand the shock through their own innate physiological health/nutritional status, through the actions in their household, community, local services or government. While the empirical evidence for what types or combinations of programmes prevent wasting and stunting is weak, there is a broad consensus that nutrition-sensitive programmes are key. Such programmes can either link households that have malnourished children to the activities being supported (resilience-building at the level of the individual) or by co-locating nutrition-sensitive interventions in areas/population groups that are vulnerable to malnutrition, especially when faced with repeated shocks.

Both resilience-building consortia and the Nutrition Cluster have been employing co-location of multi-sector, nutrition-sensitive programming as a means of preventing malnutrition and building resilience. A key priority in the 2017 humanitarian response was more multi-sector integration. For example, the Health, Nutrition and WASH Clusters established integrated emergency response teams (IERTs) to contain an outbreak of acute watery

<sup>17</sup> RUTFs: F75: Formula 75 (therapeutic milk for the treatment of SAM in Phase 1); F100: Formula 100 (therapeutic milk for the treatment of SAM in transition phase and Phase 2); ReSoMal: rehydration solution for severely malnourished.

<sup>18</sup> We use the term 'continuity of care' here to mean that services for the treatment of moderately and severely wasted children are both accessible to any given population, so that when a child has recovered from severe wasting they can graduate to a treatment programme for moderate wasting.

diarrhoea spreading across Somalia. The IERTs consisted of health professionals, including doctors, nurses, midwives and community health workers who were trained and equipped with health materials, to be deployed to rural and hard-to-reach areas. A total of 57 teams were deployed to nine regions. The objective was to ensure access to integrated, life-saving health, nutrition and WASH services to affected communities, and availability of health resources, including essential medicines and supplies. Building on lessons learnt and gains made in 2017, a joined-up, multi-sector approach continued to be an integral part of the humanitarian response and famine prevention efforts in 2018. The multi-sector, integrated approach requires coordination and integration with Health, WASH and Food Security Clusters, as well as agriculture and social protection partners. This was helped enormously by the fact that all cluster leads were based in the same office in Mogadishu International Airport (MIA).

The Nutrition Cluster has also developed a referral pathway model based on the premise that all treatment programmes should be linked in some way to cash and/or livelihood support programmes to support households with malnourished children and prevent relapses. A number of partners are now implementing integrated/converged multi-sector nutrition programmes and/or programmes directly linked to treatment programmes. For example, FAO livelihood programming including cash and nutrition-sensitive messaging will be linked to future IMAM programmes. This is a multi-year funded project.

Agencies such as ACF have adopted a community-based approach combining treatment, livelihoods, WASH and food security. Programmes are targeted to households with malnourished children and include caretakers. Some NGOs, such as CORD, link TSFPs with a blanket supplementary feeding programme (BSFP) for under-two-year-olds and a livelihoods programme, such as cash. A malnourished child's family gets assessed for food security to see if eligible for cash. A number of humanitarian donors are now linking treatment and IYCF with partners doing health interventions, as well as encouraging partners to co-locate programmes with other actors implementing nutrition-sensitive activities or to be more multi-sector themselves.

Intersos, who has been working in Somalia for 25 years, is implementing integrated health/nutrition/WASH programmes. The Qatar Red Cross, who are working in mobile clinics, is implementing integrated health, nutrition, WASH and livelihood programming with funding from the SHF.

WFP now has a country strategy (2019-2021) with seasonal BSFP, MAM/Supercereal (previously known as corn-soya blend plus or CSB+) via maternal and child health (MCH) services and prevention of malnutrition programmes for under two-year-olds with plumpydoz in

MCH, as well as cash and food rations in hospitals for mothers who come for pre- and post-natal care. WFP heads of nutrition and livelihoods sit together to co-target programmes, which helps enormously. There is also a Joint WFP/FAO WASH, health and nutrition project funded by the German government.

BRCiS phase one has had small-scale integrated programming, with 30,000 households receiving multi-sector support, such as health, WASH, nutrition, food security and livelihoods. This is quite close to the cluster integrated emergency programme model.

While there are many other examples of this type of integrated and linked activities, there are also many examples of challenges faced by agencies who want to adopt this approach. These are summarised below.

CEDA partnered with UNICEF/WVI and others to bring OTP/TSFP/Health and WASH under one roof, but a major issue for them has been to hold this integration together with short-term funding. HARD runs treatment programmes in Dollow and applied for a cash programme but did not get funding.

Trocaire has not managed to link stabilisation centres to livelihood programmes, although it is now trying to pilot links to livelihoods with IA funding, such as small grants to start a business. It is trying to find more partners/donors to do this with. Relapses are (verbally) estimated to be running at 30% without this kind of linkage/integration.

Some humanitarian donors in Somalia are reported to be non-receptive to an integrated programming approach, while others are critical of partners that fail to adopt more preventive programming for nutrition. DFID, for example, was critical of a missed opportunity in the SNS programme, which it believes should have worked in a more multi-sectoral way. DFID gave SNS multi-year funding for precisely this purpose, but it seemed that partners defaulted to treatment. Partly as a result of this experience, DFID and other donors have now collapsed SNS into BRCiS in an effort to get more joined-up programming to prevent malnutrition and strengthen health systems.

Most NGOs are not implementing livelihood programming; a very critical perspective voiced by some is that treatment programmes have become like a business, i.e. 'easy money', and that many NGOs run these programmes annually and nothing significantly changes or evolves.

NGOs like the Community Activity for Development Relief Organization (CAFDARO) have been implementing a food-for-assets programme for several years; for example building canals and roads in exchange for food-in-kind. These have been very short-term programmes. CAFDARO has also been implementing cash transfers, but recognises that small amounts of cash are mainly

spent on food and cannot be deemed resilience-building. One aspect of prevention of malnutrition that needs to be understood is that programmes can prevent malnutrition in the short-term, such as via general food distribution or minimum expenditure basket cash transfers, while others can have a longer-term preventive impact, such as cash amounts which restore or build livelihoods. Temporality of programmes might also impact in different ways; for example, a one-off transfer versus seasonal programmes (hunger-season safety nets). Work is ongoing around cash transfer modalities and nutrition impact globally and in Somalia, but knowledge-building on this is likely to take years. The Nutrition Sector needs to build an evidence base which can inform programme design and which speaks directly to resilience-building.

## Impact of programmes

Without clear and accepted definitions for resilience, and nutrition resilience specifically, it is not possible to determine the impact of resilience-building programmes.

Many stakeholders in Somalia believe that resilience-building programmes have failed due in large measure to the fact that there has been little, if any, change in the prevalence of malnutrition (NCC personal communication). DFID, however, has argued that in 2017 there was a much better response to the drought than in 2011. The dashboard showed that the emergency was coming way in advance. DFID was programming in 2015-2016 on the basis of IPC classification 3 and 4, with danger of slipping into phase 5. This helped DFID mobilise internal resources (£110 million between Jan-April 2017). Furthermore, the BRCiS and SNS infrastructure helped launch a speedy response. This also allowed for rapid scale-up of multi-purpose cash programming based on a minimum expenditure food basket. However, these are subjective experiences and not based on rigorous monitoring and evaluation or research methods.

The SNS has perhaps been one of the most rigorously evaluated resilience-building programmes in Somalia. Here, SAM treatment programmes have demonstrated results far in excess of SPHERE targets, but the programme as a whole appears to have had very little impact on preventing wasting and has consistently failed to meet targets. It has been argued that the droughts in 2016 and 2017 completely deflected SNS efforts to implement the 'soft/preventive' activities. A formal evaluation of SNS in 2017 pulled out some important lessons relating to its multi-year funding:

1. It meant there were no core funding resource gaps, hence fast action and wide access; there was flexibility in carrying over funds from one year to another, and reasonable projections, plans and less reactive implementation was possible.
2. Longer-term relationships with communities ensured progress towards meaningful change and there was relatively stable staffing.
3. The disadvantages included the fact that the fixed remuneration for the project duration was seen as a

demotivating factor for specialised staff; there was pressure for results right from the first year of implementation; and the relative financial security created no urgency to raise additional funding.

Among the recommendations from this evaluation were:

1. The critical need to think of new approaches to preventing malnutrition, bearing in mind the poor humanitarian situation in Somalia and the need to transition progressively from externally driven and managed interventions to Somalia-based ones. Central to this is the development of a strategy to hand responsibility over to the FGS systematically.
2. The need to promote integrated and multi-sector programming that includes WASH, education, basic health services and food security/livelihoods. This should include promotion of linkages with other resilience consortia.
3. Multi-year funding to enable meaningful change to be realised (such funding should come with strong systems for measuring impact).

The evaluation of the BRCiS phase one was also critical, especially regarding how impact was measured; i.e. through multiple indicators like FGS, hunger diversity, CSI, etc. BRCiS phase two is now looking at a shock monitoring model in which indicators are collected continuously or just before and just after a shock.

Key findings from the evaluation of BRCiS phase one include inappropriate targeting for resilience-building, lack of harmonised programme approach among partners and the need to form and guide both inclusive and representative community committees (CDMCs) to select and guide programme activities to ensure bottom-up programming.

A general criticism of resilience-building programmes like SomRep is that implementing partners have failed to follow up after the programme has ended to determine whether the communities supported have remained resilient.

There is also a widespread sense that resilience-building projects are not sufficiently community-owned and that, after a period of time, the expectation should be for the community to take over; for example by setting up health community committees. Health and nutrition projects implemented through the cluster mechanisms have been criticised for lack of community ownership.

The FGS has argued that resilience programmes implemented by development partners are not localised or locally owned, and that the only way to strengthen resilience is to support local systems. Furthermore, local NGOs often bypass local government structures such as clans and chiefs, who reflect the mandate of the people and therefore need to be supported, especially as clans give authority to local NGOs to work in an area.

Another concern is that resilience programmes have to take place over a number of years to achieve impact and



cannot be attempted through short-term humanitarian funding. If the aim of short-term humanitarian projects is to build resilience, each project needs to build on the work of previous projects, such as hand washing messaging following latrine building.

Some agencies (including Trocaire) assert that it is difficult to define exactly what resilience-building is or when it has occurred. They tend to think of projects in two ways – low-cost, high-impact, or high-cost, high-impact – and focus on the former. Examples provided by Trocaire of low-cost, high impact include: behaviour change; mother/MUAC screening leading to early identification; community engagement; and building partnerships with community (for example, IDPs and local community share a garden, with local community providing land and shelter while IDPs provide cash).

Many observers feel that resilience-building programmes have not been held accountable for delivering impact in Somalia and that this has been allowed as monitoring and evaluation has been too ‘output-focused’. There is a sense that programmes have not been delivered in an optimal way and that there is a need to pull learning together from the many experiences. Also, the types of programme must be based on partner comparative advantage and, at the same time, require greater FGS involvement, even if this slows down implementation. Furthermore, impact measurements are lacking and consortia like BRCiS need to do robust studies, which may mean research in secure areas through international partners to ensure valid and robust findings.

## Cash programmes

Multi-purpose cash programming is seen by many as both an important ‘tool’ for building resilience across multiple sectors but also as an approach which can help bridge the divide between humanitarian and development activities. The essence of this approach would be to establish cash safety nets for vulnerable populations which could be expanded or surge in the event of crisis. Cash programming has been used extensively in Somalia in recent years, especially during emergencies, with logistics increasingly relying on mobile technology.

There are three main routes for cash programmes in Somalia: via NGO consortiums; via WFP, who implement voucher and food-related programmes; and via the International Committee of the Red Cross (ICRC), who implement temporary emergency cash programmes.

There was a significant increase in cash programme funding in 2017. Most of it was unconditional and multipurpose, with the aim of saving lives. Prior to the 2017 emergency programme, up to 500,000 people were receiving cash through a variety of programmes. In 2017 ECHO alone increased cash recipients from half a million to three million, largely using the same partners. ECHO-resourced cash programming in 2018 dropped to two million, but in 2019 this is expected to be one million in

the form of humanitarian aid and a further one million from EU and others as part of a multi-year, vulnerability-focused conditional safety net.

In 2017 WFP reached about one million people with vouchers and cash. WFP focused on highly vulnerable areas and areas where there were ample retailers. Some donors prefer vouchers; others prefer unconditional cash.

The FGS, donors and implementing partners are all of the view that it is important to build on this emergency-related cash programming infrastructure so that it can transition into a form of social safety net, which in turn has a shock response capacity like the approaches in Kenya and Ethiopia. Having streamlined the cash system during the emergency response, donors like EU/ECHO are concerned not to lose all the capacity and coordination that has been established. Cash is seen as the ideal resilience-building modality for Somalia, which already has a US\$1.5 billion remittance economy, which means people ‘know how to move money around’.

WFP is particularly keen to progress the social safety net agenda in Somalia and is involved in several different activities to this end:

1. Development of a social protection framework with funding from Multi Donor Partner Trust Fund and under the umbrella of the PWG resilience group. NGO resilience consortia, MoPIED, the Ministry of Humanitarian Affairs and Disaster Management (MoHADMD) and the Ministry of Social Affairs are also involved in this work.
2. Under the inter-agency cash working group, WFP and partners are focusing on coordinating the drought response so that data collection systems will support future social protection programming. WFP has a small, ongoing study on information management systems and mapping what data are currently being collected.
3. Integrating current programmes into longer-term safety nets. For example, WFP has been providing cooked meals for IDPs close to Mogadishu and wants to transition to safety nets.

Nutrition considerations of cash programming do not appear to be prioritised as yet in Somalia. Recipients are either chronically food insecure and/or households have a child with acute malnutrition. The Nutrition Cluster attends the cash working group through its representation in Nairobi and cash transfer programmes use a food-basket approach, although varied amounts are given. The cash working group is co-chaired by WFP and an NGO. This is not a cluster. ECHO has also created a cash ‘alliance’ (a cash consortium involving six INGOs) which is chaired by Concern Worldwide. There is some overlap here with BRCiS, which is a resilience-building programme that has a large set of cash activities (led by NRC). ECHO sees the cash consortium as a long-term initiative.

The Nutrition Cluster is currently planning a cost-of-diet survey and believes that donors supporting cash programming lack clarity and harmonisation of approach. A donor group for Somalia has been convened to look at this harmonisation. However, this will need to involve multiple ministries, with consideration given to programmes targeting the lean season, graduation and livelihood attainment. There are tensions around cash programming design, with some donors wanting to reduce dependency of IDPs with cash being used to build assets and create livelihoods. However, while cash amounts are pegged at the minimum food basket, there appears to be little prospect of building resilience.

To date, the FGS has had minimal involvement with emergency cash programming, but it is clearly understood that it will need to be central to all discussions and planning regarding longer-term, safety-net programming – especially the PWG on resilience-building. Implementing partners foresee a situation where FGS can work on policy and the monitoring and evaluation side but not implementation. WFP is encouraging the FGS to come up with a social protection strategy, building on cash transfers with other partners. This would be a kind of cash-for-asset programming based on community identification of need and planning.

MoHADM has a cash team, but the cash working group, which was set up in 2017 by OCHA and includes FGS, has its high-level meeting in Nairobi, so MoHADM cannot easily attend.

In October 2018 a high-level meeting in government with the Ministry of Labour, MoHADM, MoPIED and donors was held to discuss how cash programmes ongoing since 1991 can shift to social protection/social safety nets and whether the shift should or can be rapid or gradual. The discussion covered the fact that there has been little evidence of cash programming impact in Somalia, in spite of many years of cash programming. There are even less data on whether these programmes have built resilience. This raised the question why there has only been a small number of studies on cash programming impact.

## Localisation

Localisation (implementing programmes through local civil society organisations) has a long history in Somalia. The idea behind localisation (as expressed in the Grand Bargain) is that it builds up local capacity and therefore sustainability of programmes and, ultimately, resilience. It is a form of systems strengthening.

The Nutrition Cluster has been instrumental in driving the localisation agenda in Somalia. Forty per cent of SHF went to local NGOs in 2017 and 50% in 2018 by August 2018. However, as the cluster system is promoting an integrated multi-sector response, there is a challenge as local partners tend to be specialised, which limits

opportunities for integrated programmes. It is also worth noting that the Nutrition Cluster has needed to enforce plan III which is an equity focused scale up of iMAM which will be implemented by the end of March 2019. This has been necessary as the accounting by many local NGOs has jeopardised auditability of accounting.

Donors, UN agencies and INGOs have also been supporting the localisation agenda in Somalia, especially as local NGOs hold the key to accessing insecure and Al Shabaab-controlled areas where international staff are unable to work.

UNICEF has 60 active contracts with NGOs of varying sizes. There are 800 plus OTPs (360 fixed and the rest mobile), implemented by local NGOs. It has 40 contracts with local NGOs and 20 with INGOs, but the ratio of resources provided is more like 50/50 as INGOs have larger programmes. INGOs also sub-contract to local NGOs, which means large transaction costs. As a result, UNICEF is moving towards more direct contracting.

BRCiS has been keen to support localisation. The INGO partners differ, however, with some only working via local NGOs, others implementing directly and others doing both. Rationales vary but security and standard of programming are often cited as reasons for choosing one approach over another.

The UN and most INGOs work via local partners in unsafe areas. The challenge for local partners is that they get very little funding for overheads, so cannot maintain staff. The short-term nature of contracts is also a problem for staff retention. UNICEF can negotiate a negotiated indirect cost rate agreement (NICRA), but local NGOs cannot. Donors need to take a close look at budgets for sub-partners and encourage partnerships rather than sub-contract in order to build local NGO capacity (especially financial and management capacity). The localisation agenda is therefore compromised by sub-contracting by UN and INGOs, high transaction costs and lack of overheads for local partners, as well as the stop-start nature of humanitarian programming.

From an international development partners' perspective, accountability and 'auditability' are key issues. This challenge is often exacerbated by clan dynamics, which may necessitate multiple NGOs working in one area and resulting issues of coordination. Donors are increasingly getting behind the localisation agenda in Somalia, however, with OFDA and the German government making recent declarations of support for more localisation and examining multi-year funding to support the process.

Some donors still prefer consortia funding as this lessens the management burden, although consortia may generate other kinds of challenge.

The SomReP NGO consortium has been a coordination body for international and local NGOs since 1991. It

works across north as well as south and central Somalia and has offices in parts of Somalia and Nairobi. The consortium works by creating an enabling environment for resilience-building and drives outcomes and advocacy with donors and government. SomRep sits on the SHF advisory board, coordinates members and provides updates. It tries to improve FGS understanding of mandates and roles, funding and access for local NGOs. It has no relationship with the NCC and has a multi-sector purview.

The SomRep perspective is that FGS is at an early stage of development and the current context is one dominated by humanitarian players, with the FGS not in control of large parts of the country. Consequently, it is important to empower authorities to take more leadership. Resilience-building initiatives are also dominated by international actors, but if these fail to become localised then programmes are not sustainable. All expertise remains

with international partners. SomRep consortia are made up of one third local NGOs and this proportion is growing. Local NGOs need longer-term (not short-term) funding and SHF is too limiting/limited in that regard.

In SomRep's view, donors and UN agencies need to work in new ways. In Somaliland, for example, WFP and UNICEF now provide an amount of DBS to government; SomRep therefore questions why this cannot happen in south and central Somalia.

SomRep believes that, to enable a stronger HDN, the following are needed; i) a coordination mechanism where humanitarian, development and government actors meet on a regular basis (government and the clusters are currently too separate; ii) mechanisms for multi-year funding for NGOs and no funding for projects that do not clearly empower local actors; and iii) documentation of learning from localisation.

## Key findings

Resilience and nutrition resilience is defined in different ways by different stakeholders. Chapter three has examined programme approaches in order to shine a light on implicit and explicit understanding of resilience-building among development actors in Somalia. There are clear differences in programme focus and approach of agencies working on resilience-building and, apart from consortia-led programming, there is no harmonisation.

Poorly defined programme objectives and definitions of resilience have made it difficult to evaluate impact of resilience-building programmes. Evaluations have tended to focus on process, but where nutrition has been monitored no impact has been found. There is a sense among many stakeholders that there is a lack of accountability for these programmes and that objectives need to be clearly defined in terms of resilience-building and that these must be measured at baseline and throughout the life of the programme. Nutritionists must turn their attention to defining what nutrition resilience is and how this can be measured and assessed.

There have been four major, consortia-led, resilience-building initiatives in Somalia. They have all been multi-year funded and reflect a buy-in by partners to the approach. However, there has been no coordination between the four initiatives. All are moving into a new phase, with learning from the first phase incorporated into the design of phase two. Two – SNS and BRCiS – are being merged.

Implementing partners recognise that integration and health systems strengthening are imperative, but have little leeway to support health systems strengthening. Large agencies like UNICEF pay MoH staff to run IMAM and the SHF is able to support salary provision, although this is not the case for CERF. Local NGOs may pay salaries of a small number of MoH staff to monitor and learn about programming (capacity building).<sup>15</sup> Feeding centres (OTP/TSFP/SC) all use MoH immunisation and Health Management Information System (HMIS) books to record patient data. However, these initiatives are small scale and of limited impact. The fact remains that MoH is extremely weak in areas like Dollow (a large IDP location), so that when UNICEF requested local government to take over a number of centres, they said local government actors lacked capacity – even though UNICEF was prepared to pay MoH staff salaries.

The overall result is a highly complex system of treatment for wasting, administered via UN agencies, INGOs, NGOs and private-sector facilities, with varying levels of MoH involvement, support and leadership. Some donors are now prioritising integration of programming into health infrastructure, such as the German Development Fund, with its focus on

<sup>15</sup> WHO is supporting SCs by assessing capacity, doing quality assurance, two rounds of training for all staff, monitoring supervision of centres and implementing master training of trainers and key partners.

<sup>16</sup> CMAM is the Community Management of Acute Malnutrition. IMAM is the Integrated Management of Acute Malnutrition. The terms are sometimes used interchangeably.

widespread training of MoH staff. There is recognition of the need for a sustainable model of wasting treatment using simplified protocols. This is going to require a government-led and controlled system of commodity procurement for RUTF and essential medicines.

The extent to which comprehensive nutrition services are provided is not adequately mapped in Somalia. However, there is mapping of iMAM services as shown in Figure 3 below. These data show a serious disconnect in the services offered for the treatment of wasting (acute malnutrition), which is not helped by the short-term nature of humanitarian funding and the multiple partners involved in iMAM service provision.

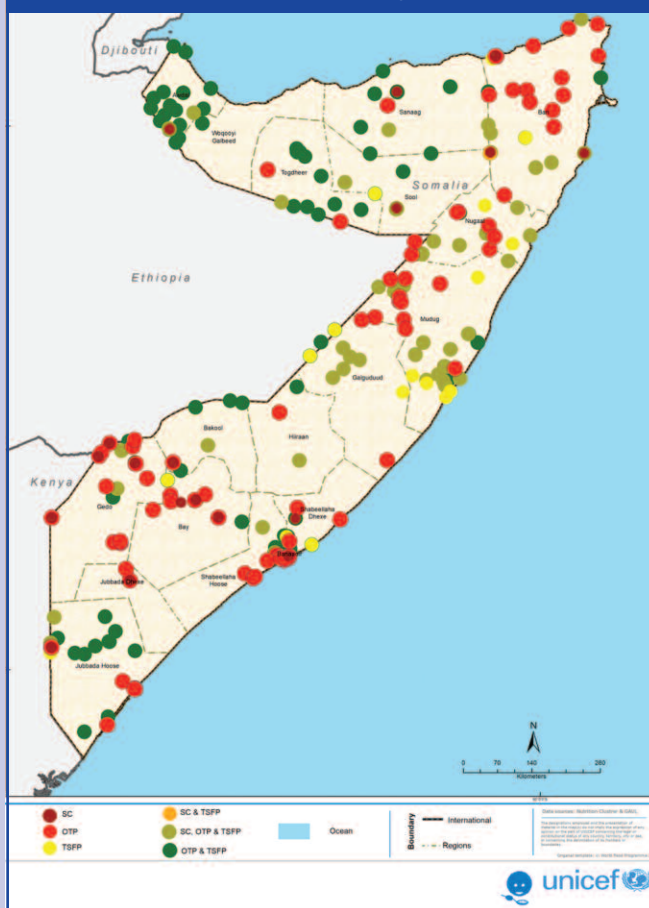
The nutrition sector has little input into the design of cash programming or the measurement of its impact. This may partly reflect the fact that there is no cash cluster. Although acknowledged to be a potentially important modality for resilience-building, cash programming is not evaluated in terms of resilience-building. It is understood that the amount of cash is an important determinant of resilience-building but, while it is pegged at a minimum expenditure basket, there is little potential for this. A key question for the nutrition sector is: How can nutrition insert itself more effectively into

the rapidly emerging and evolving cash programming architecture in Somalia and at global level?

Localisation is fairly advanced in Somalia. However, there are challenges with regard to how this impacts multi-sector programming. Certain financing arrangements of humanitarian and development partners are also not conducive to localisation.

There is no mapping of the degree to which wasting treatment programmes are integrated with, or linked, to nutrition-sensitive programming. There is also no mapping of co-located programming; i.e. multi-sector nutrition programming. There is also an assumption that these types of programme will help prevent undernutrition, yet there is little global evidence for this, although there is increasing interest in wasting prevention. We can also see that there are financing and capacity constraints in Somalia to implementing and rolling out programming for the prevention of undernutrition. The Somalia context does, however, provide an opportunity to test and evaluate these programmes and add to the global knowledge base on how to prevent wasting and stunting effectively through linked or co-located nutrition-sensitive and nutrition-specific programming.

**Figure 3** Somalia: SC, OTP & TSFP Sites in Somalia as of Sept.2018



# Annex 1: Interviewees

Name	Organisation
Abdul Qadir	UNDP
Abdurahman Sharif	Somalia NGO Consortium
Abraham Mulugeta	World Health Organisation
Abukar Yusuf	Food and Agriculture Organisation
Abukat Hussein	Mustaqbal University
Aden Mohamed	Concern Worldwide
Ali Haji	WFP
Ayan Harare	Ministry of Humanitarian Affairs and Disaster Management
Bashir Said	Protection Cluster Somalia
Bernard Mreuru	WFP
Bernard Olayo	World Bank
Binyam Gebru	Save the Children
Cassy Cox	Concern Worldwide
Christophe Beau	UNHCR
Craig Hampton	WHO
Dajib Ahmend	Save the Children
Dr. Farah	Ministry of Health
Emily Gish	USAID
F Patiguy	UNICEF
Hajir Maalim	Action Against Hunger
Hassan Abdullahi	Mustaqbal University
Johan Heffinck	ECHO
Liljana Jovceva	WFP
Lisa Doherty	Irish Embassy
Lokuju	UN
Majeed Ezatullah	UNICEF
Mark Agoya Senior	DFID
Martijn Goddeeris	NRC Somalia
Matija Kovac	UN
Max Schott	UNOCHA
Merey Riungu	Intersos
Mohamed Sheikh Abdiaziz	Qatar Red Crescent
Mohamud Mohamed Hassan	Save the Children
Muhammad Ilyas	UNHCR
Nurta Mohammed	UNHCR
Pauk White	UNHCR
Ridulan Abdi	UNFPA
Samson Desie	UNICEF
Seb Fouquet	DFID
Zakaria Ibrahim	UNICEF

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