GLOBAL NUTRITION CLUSTER
Technical Alliance

The Multi-sectoral Minimum Response Package in Somalia

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About this Brief

The Global Nutrition Cluster (GNC) Technical Alliance (known as the Alliance) is an initiative for the mutual benefit of the nutrition community, and affected populations, to improve the quality of nutrition in emergency preparedness, response and recovery, by enabling and providing coordinated, accessible and timely technical support through multiple channels. To help fulfil this mandate the Alliance holds monthly learning meetings, were members identify potential learning gaps in nutrition in emergency preparedness, response and recovery by reflecting on questions coming to the Alliance and discuss optimal ways of filling such gaps. In 2022, participants in the learning review meeting identified the need for greater documentation and examples of Inter-Cluster/Sector Collaboration (ICSC) in practice. The Minimum Response Package (MRP) in Somalia was suggested as a valuable story to highlight.

Background

At the start of 2022, Somalia experienced a considerable influx of people into cities and informal settlements from neighboring rural areas. This was the result of a prolonged drought that spanned multiple seasons, beginning in 2020, as well as sharp increases in food prices. As a result, families lost their crops, cattle, and livelihoods, and were unable to pay for basic food items. Consequently, many started moving to cities seeking humanitarian assistance and other means of subsistence, with mass migration ensuing.

Somalia's Food Security Integrated Phase Classification and Famine Risk Analysis, published in April 2022, projected that six million people were likely to experience a crisis situation that year and recommended scaling up interventions such as food and water distribution to avert the risk of famine. In Somalia, the displaced population is dispersed and/or constantly moving over large distances, with formal and informal camps being formed. This makes identifying and targeting those needing support challenging. At the end of April 2022, the Somalia Nutrition Cluster published an urgent call for the scale-up of coordinated multi-sectoral actions.

In response to the worsening situation in Somalia and the challenges in targeting displaced populations, the International Organization for Migration (IOM), the United National Children's Fund (UNICEF), and the World Food Programme (WFP) came together to jointly target their services to displaced populations in Baidoa, Benadir, and Beledweyne. IOM, UNICEF and WFP's implementing partners, Camp Coordination and Camp Management (CCCM), Health, Nutrition, Food Security, Water Sanitation and Hygiene (WASH) and Shelter clusters were also quickly engaged in this collaboration. Jointly, they developed the MRP, which conducts nutrition screening and targets displaced populations with a range of lifesaving multi-sectoral interventions at the point of registration. The UK Foreign, Commonwealth and Development Office (FCDO) stepped up to contribute to funding this initiative at an early stage.

> *"We approached it as three agencies; without having a leader, we formed an equal partnership."*
> Quote from a key informant speaking about the initial partnership among the three UN agencies

This brief learning piece aims to document the process of developing, implementing, and monitoring the MRP in Somalia to capture learnings on how ICSC can happen in practice. While the need for ICSC is well recognized, it is under-resourced and challenging to implement and there are few documented learnings on how it can work in practice. By capturing learnings from the MRP in Somalia we aim to help other contexts looking to understand how best to implement a multi-sectoral package of interventions.

What resources and support are available at the global level for country-led multi-cluster/multi-sector initiatives?

- As part of the GNC Coordination Team, the GNC ICSC Help Desk is available to support countries designing and implementing multi-cluster/sector initiatives. The GNC ICSC Help Desk can be reached by requesting support via the GNC Technical Alliance website.
- The ICSC Working Group meets monthly at the global level. It is chaired by the GNC ICSC Help Desk and its members are composed of GNC partners.
- At the global level, an ICSC platform with technical focal points from the Food Security, Health, WASH, and Nutrition clusters meets weekly.

What is ICSC?

- "ICSC refers to the joint actions carried out by relevant clusters/sectors to coordinate joint responses with their partners towards a common objective. Joint responses are delivered at the same time, in the same place, for the same people based on prioritization of needs to achieve a jointly agreed outcome." Quote from What is "Inter-Cluster / Sector Collaboration (ICSC)"? . A short video clarifies the relationship between the Inter-Cluster Coordination Group (ICCG) and ICSC.

What documents and resources are available for ICSC?

- Yemen Integrated Famine Risk Reduction Case Study
- A Case Study on the Inter-cluster Famine Response Strategy in South Sudan
- Synthesis: Multi-sector programs at sub-national levels: Insights from Ethiopia, Niger and Bangladesh

Description of the MRP

Overview

The objective of the MRP was to deliver timely lifesaving multi-sectoral interventions to newly displaced households located in priority districts through a coordinated area-based approach. The MRP was designed to reach newly displaced households with multi-sectoral assistance and ensure the most vulnerable households have access to food and lifesaving services.

The entry point for the MRP was the registration of displaced families by the CCCM teams. The CCCM teams completed the registration lists, which were then used by IOM, UNICEF, WFP, and their implementing partners to target the services included in the MRP. The services included cash assistance to cover a minimum expenditure basket or Multi-Purpose Cash Assistance (MPCA), distribution of a hygiene kit, a standard plastic sheet or tarpaulin, access to water via water trucking services, latrine installation, and access to the nearest nutrition and health services (see Figure 1).

Figure 1: The multi-sector services included in the MRP

With guidance from the Nutrition Cluster, nutrition partners conducted a series of training sessions with CCCM teams to enable them to screen children under five years of age and pregnant and lactating women (PLW) using Mid-Upper-Arm Circumference (MUAC). Screenings were conducted by CCCM teams during the registration of displaced families. Children under five years of age identified as severely wasted (MUAC <11.5 cm) were referred to the nearest outpatient therapeutic feeding center (TFC), while children identified as moderately wasted (MUAC between 11.5 cm and 12.5 cm) were referred to supplementary feeding centers (SFCs). PLW with a MUAC below 12.5 cm were also referred to an SFC. A second screening happened at the TFCs and SFCs – using weight-for-height, MUAC, and bilateral pitting edema – and PLW and children were subsequently enrolled into services.

Separate from the MRP, families were linked to additional available services as needed. For example, mothers of children under five enrolled in TFC or SFC and PLW enrolled in SFC were referred by nutrition partners to the WFP Relief Programme, which provided cash payments to these vulnerable groups. This cash support aimed to complement the MPCA in the MRP rather than duplicate it. WFP also enacted a digitalized registration system through SCOPE[1] that was critical in ensuring there was deduplication with other ongoing programs.

The MRP was implemented in phases, each lasting 30 days, within which registration and access to services needed to be completed.

[1] SCOPE is WFP's beneficiary information and transfer management platform. It is a flexible cloud-based digital platform that helps WFP better understand the people it serves to be able to provide them more personalised and helpful assistance.

"So everybody, all the different sectors, are waiting for the registered households. Then we get a list of registered houses and it's basically 'On your marks!' Can we have the services within 30 days?"
Quote from a key informant speaking about the 30-day phases

The first phase was implemented in May 2022 in Baidoa and Benadir Regional Administration and was immediately followed by phase two (see Table 1). As can be seen from Table 1, some phases lasted longer than 30 days.

Table 1: Dates, areas covered, and number of households reached during the four phases of the MRP

Round no.	Dates	Areas covered	No. of households reached
1	March–August 2022	Baidoa and Benadir Regional Administration	15,000
2	September 2022	Baidoa and Benadir Regional Administration	5,000
3	October 2022–March 2023	Beledweyne	9,200
4	March 2023	Baidoa and Benadir	24,000

Coordination

At the national level, weekly interagency meetings were held among the actors involved in the MRP. Weekly coordination meetings were also held in each zone between CCCM teams and implementing partners. During the weekly coordination meetings, partners jointly updated the 'who's doing what and where' maps, reviewed the week's achievements, and addressed challenges and issues. Although convened by IOM/the CCCM Cluster, no single agency led these meetings; they were held in equal partnership, with each agency responsible for their specific technical area.

Although the MRP was originated by UNICEF, IOM, and WFP, the Food Security, Nutrition, Health, WASH, CCCM, and Shelter clusters were involved and updated regularly on the implementation. The Nutrition Cluster coordinated monthly with the CCCM Cluster, conducted frequent trainings for MUAC screening, provided MUAC tapes, and checked the quality of the CCCM teams' MUAC screening data. The Food Security Cluster provided a platform for information exchange and sharing of the lessons learned on the MRP through the national- and sub-national-level cluster monthly meetings. These meetings also allowed progress against the MRP to be reviewed, especially the sequencing of the rapid response and referral to services and routine activities. The ICSC Working Group – an information sharing and coordination group – was also aware of the initiative and regularly kept updated on the progress.

Improvements and changes made during implementation

In August 2022, after phase two of the MRP, a lessons learned workshop was organized that focused on improving the targeting, training, and delivery of services in the MRP. Some of the lessons discussed during the workshop and subsequent adaptations are unpacked below.

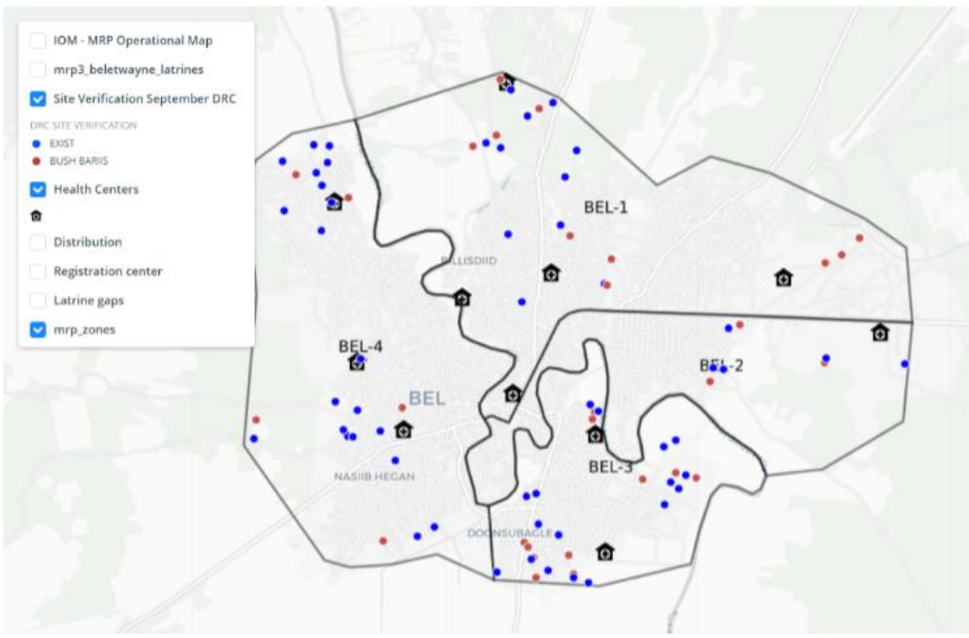
A) Criteria for enrollment in the MRP

Being a new arrival was used as a criterion for vulnerability and subsequent enrollment in the MRP. During the workshop, partners identified the need to review this criterion, as there were concerns that being a new arrival was not necessarily equivalent to being vulnerable and in need of additional support. It was suggested that families with one or more members diagnosed with a disability, a chronic illness, PLW, a severely wasted or a moderately wasted child, families headed by a child, and/or belonging to a minority ethnic group should be given a score. Families with a score above an agreed-upon threshold would then be targeted with the MRP. However, due to the rapid nature of the intervention mechanism and the high needs of newly arrived households, the vulnerability matrix was never used for targeting the MRP. Instead, this vulnerability matrix served more as a tool to better understand and learn about the characteristics of newly arrived households who were supported through the MRP.

B) Accessing services

During the second phase of the MRP, those implementing the MRP started to question whether the children and PLW identified as malnourished were accessing the nutrition, health, WASH, and food security services. Therefore, all services a part of the MRP (nutrition and non-nutrition services) were mapped by zone to better understand their distances to families needing support (see Figure 2). If services were far from the registered families, then the partners implementing that service were consulted and asked to move closer to the population in need or a mobile unit was set up to provide the service.

Figure 2: Example of mapping done by zone



In addition, the Nutrition Cluster implemented the use of yellow and red referral slips for children moderately and severely wasted, respectively. This would allow centers to count the number of slips received and the partners to compare them to the number of slips given by the CCCM teams to determine the number of children accessing nutrition services. The slips had the additional benefit of giving the mothers confidence to access the nutrition services. The count showed that most children referred by CCCM teams were attending the nutrition services and helped identify underperforming zones. In these zones, partners were consulted to try to improve access to services.

C) Additional changes

The table below highlights additional changes that were agreed upon following the lessons learned workshop, including the scale-up of assistance in rural areas to reduce migration into cities and the use of an interoperable system for

registering displaced families between IOM and WFP. This was intended to reduce the time required for the lengthy process of deduplicating entries after each registration.

Table 2: Changes implemented following the lessons learned workshop

Lessons learned	Changes implemented	Way forward
Coordination between CCCM teams (responsible for registration) and technical teams (responsible for delivering services) required improvement in order to streamline assistance	More structured and regular site-level coordination meetings were held	More supervision and coordination from UN agencies and their local partners are needed, with post-implementation checks Given the travel restrictions and hardship due to ongoing conflict, localized coordination and leadership is needed closer to families requiring support
Registration processes needed to be shortened and streamlined to ensure vulnerable households received the services they needed in a timely manner	CCCM was able to improve the registration process by reducing the deduplication time to increase the response speed	WFP tracks those accessing their services through SCOPE, a beneficiary information and transfer management platform that uses biometrics. However, as CCCM teams were not collecting biometrics at registration, newly arrived households had to travel to the SCOPE registration sites for the biometric registration required to access WFP services As a solution to this issue, a decision was made during the workshop to collect biometrics and roll out IOM's BRaVe system, a biometric beneficiary data management system that is interoperable with WFP's SCOPE
The need to reduce migration into urban centers through a scale-up of assistance in rural and hard-to-reach areas	MRP continued to focus on urban areas, while supporting rural-focused assistance mechanisms	Ensure funding and assistance in Beledweyne Continue informing rural-focused programming through the analysis of internally displaced population trends
The need for joint monitoring and evaluation planning was identified	All agencies jointly developed a monitoring and evaluation plan to monitor progress	Continue joint monitoring and evaluation planning

Monitoring and evaluation

Monitoring the MRP evolved throughout the different phases of the response.

For phases one and two, a third-party monitor was engaged by IOM at the end of the response to conduct post-distribution monitoring (PDM) surveys both in person and remotely. Additionally, the IOM Remote Monitoring Team (RMT) was engaged in ad hoc follow-up for verification and monitoring purposes throughout the response.

For phase three, a third-party monitor was engaged at the end of the response to conduct both PDM and referral monitoring surveys to understand the level of service intake followed by the referrals for health, nutrition, and protection components.

Additionally, the IOM RMT was engaged in the rollout of a remote survey to:

- Unpack elements of the protection risks that beneficiaries might have faced before, during, and after the implementation of the project;
- Unpack the types of loss faced by beneficiaries (including rent, taxes, and other fees, pay-to-play schemes, transport, etc.);
- Assess overall satisfaction and perceived impact of the MRP; and
- Determine areas of improvement to increase safety, protection, and accountability to affected populations.

For phase four, additional monitoring activities were included to strengthen the monitoring system throughout the response:

- A post-registration rapid survey to ensure households were successfully registered and could be contacted;
- Protection monitoring teams deployed to conduct onsite observations during in-kind joint distribution of hygiene kits and plastic sheets to assess the protection risks faced by different vulnerable groups;
- A rapid 'no-show survey' to understand the main obstacles in reaching distribution points; and
- A service rating and risk rapid survey to collect beneficiaries' perceptions on services provided.

Successes, challenges, and lessons learned

Successes

- Despite the complex environment, IOM, UNICEF, WFP, and the CCCM, Food Security, Health, Nutrition, Shelter, and WASH clusters successfully delivered a multi-sectoral package of interventions that involved jointly targeting the same populations.
- By leveraging the presence of CCCM teams in formal and informal camps, the MRP was able to successfully identify vulnerable families and children under five years of age and PLW in need of nutritional support. The utilization of the registration process as the entry point for the MRP allowed for the comprehensive screening (shelter by shelter) of the population to identify those in need of support. This was an innovation within the Somali context, as the typical practice has been to rely solely on local governance and/or landlords to identify families in need.
- The good relationship and close collaboration between the Nutrition Cluster and the CCCM Cluster was essential to the successful identification of children under five years of age and PLW in need of nutritional support. In addition, as part of the MRP, the Health and WASH clusters worked on a joint acute watery diarrhea/cholera outbreak control and ensured common standards and guidelines were followed.
- The MRP considerably improved the timely distribution and targeting of services.
- The MRP facilitated increased accountability between implementing partners, as where services were available and who received services was closely monitored, helping ensure no vulnerable families fell through the cracks.
- Having frequent coordination meetings allowed implementing partners to adapt and quickly respond to any challenges. Having specifically the ICCG coordination meet at state level augmented collective as well as MRP-driven response in areas of increased displacement due to the ongoing conflict.

Picture shared by the Nutrition Cluster of a displaced family in Somalia (2021)

Challenges

- While the MRP originated as a side project, it quickly became agencies' dominant project and dedicated staff solely focused on the delivery of the MRP were quickly required. Recruitment for a UN agency meant either short-term deployment or longer-term deployment. Short-term deployment enabled staff to be available quickly but also resulted in a loss of knowledge when deployment came to an end. On the other hand, longer-term deployment resulted in recruitment taking a few months but enabled the knowledge and capacity to be available for a longer period of time. There was no hybrid model for recruitment in the UN agencies.

"It was a side project initially; the colleagues were doing it in their spare time while running their usual programs. It quickly became dominant and the time it needed was massive."

Quote from a key informant on the MRP project

- High staff turnover was a challenge, with the training and retraining, briefing and debriefing of staff adding to the time needed for this project to adequately function.
- There was a lack of staff at sub-national levels to coordinate sub-clusters, leading to duplication of services in some zones and others facing service gaps.

- FCDO early funding allowed for the development and quick rollout of the MRP. However, more funding was required to implement the full MRP package, as a multitude of UN agencies and implementing partners needed to be funded for this multi-sector response.
- The transfer value between MRP beneficiaries and regular relief beneficiaries was different, especially during phase one in Baidoa. This created confusion, given that each was facing the same situation and also residing in the same settlements.
- Another challenge was the lack of interoperability to process biometric data. This meant that after beneficiaries were identified as new arrivals and registered by CCCM teams (non-biometric registration), they had to travel to the WFP SCOPE registration sites for the biometric registration, which was required to access WFP services.
- The balance between wanting to make the registration comprehensive and keeping it to a reasonable length that does not impact on the speed of delivering services was difficult to attain.
- WFP implementing partners were providing the SFC services once a month and using a digital data collection system, meaning data was immediately available. However, nutrition partners implementing TFC were providing services weekly and using a manual data collection system, meaning there was often a delay in when data was available. This was due to the lack of a system in place to collect the data. For instance, there was no agreement on who should collect the data from the treatment centers and when.
- Despite requests from donors, additional data on the number of severely wasted children referred and treated became difficult to collect. This process raised several questions for those interviewed, including: 'Should the management of severe wasting become digitalized? Should monitoring systems be clearly delineated and strengthened? Should less data be requested?' Possible solutions are still under discussion.

Lessons learned

- The MRP in Somalia showed that an effective entry point for providing a multi-sector intervention is registration via the CCCM teams. Once the registration was complete and the needs were identified, then the different partners were able to target those in need with adequate services. For example, the Nutrition Cluster successfully collaborated with the CCCM Cluster to enable MUAC screening and referral during the CCCM registration of newly displaced households. This collaboration was key to expanding the nutrition service coverage, as the CCCM teams were more numerous and were already registering families.
- Another important lesson learned was to ensure that sufficient data collection systems are in place and that systems and mechanisms used by different implementing partners and agencies are interoperable with each other.
- Key to the MRP success was starting the implementation in phases and improving based on the lessons learned from every phase. Conducting a lessons learned workshop is good practice, as it allows implementers to further unpack what needs to be improved.
- Implementing a multi-sector intervention such as the one delivered in Somalia has proven to be time-consuming and it would be recommended to plan for recruiting additional staff at the start of the project.
- The successful collaboration among the MRP implementing partners in Somalia can be replicated in other contexts and among different actors. The clusters and the ICSC Working Group would need to remind and encourage partners to replicate a similar multi-sectoral package of interventions.

Conclusion

The MRP is a good example of partners in emergencies coming together, joining forces, and creating a multi-sector intervention to respond to the needs of those most touched by the successive droughts.

As the program evolves, more questions come to mind for the future of this excellent initiative: How can one further take it to scale? Can the response be faster? What governance should the MRP interventions have? Should partners wait for a coordination group to lead such an initiative? How can the provision of services be improved? Could a mobile team

accompany the registration team to deliver on-the-spot support? For the time being, these questions remain. However, it is clear that the colleagues in Somalia will no doubt respond to them, given their dedication and unwavering commitment to the population in need.

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