ILED TIPF Social Protection

Somalia Social Transfer to enhance human capital through the first 1000 days

First lessons learnt from SAGAL project implementation

Brief 1

Programmatic Approach and Partnerships

This paper has been prepared by the ILED TIPF Social Protection Team with the support from the SAGAL partners and the outcomes of their MEAL activities. The Real-Time Learning Agenda of SAGAL aims to contribute to adjusting the programme and strengthening the National Social Safety Net system by building evidence around best practices, and documenting and disseminating it. The Learning agenda is mobilising a wide range of tools and stakeholders across the country, including the Government of Somalia, the Donor Working Group, and other Agencies.

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ACRONYMS

CHW	Community Health Worker
HQ	Headquarters
IPs	Implementing Partners
M&E	Monitoring and Evaluation
MCH	Mother and Child Health
MESAF	Ministry of Employment, Social Affairs and Family (Somaliland)
MMO	Mobile Money Operators
MoH	Ministry of Health
MoLSA	Ministry of Labour and Social Affairs
NGO	Non-Governmental Organisation
PDM	Post Distribution Monitoring
PLW	Pregnant and Lactating Women
VRCs	Village Community
UNICEF	United Nations International Children's Emergency Fund

1. INTRODUCTION

SAGAL and its social transfer scheme targeting mothers and young children is an ambitious project aiming at contributing to enhancing Somalia's human capital and informing and supporting the development of the national social protection system. To date over 21,000 mother and child couples have been benefitting from the project in the 4 ILED corridors.

While investing in human capital through the first 1,000 days window is acknowledged as a very crucial approach, evidence and experience are still scarce globally and in Somalia. Learning from the SAGAL programmatic approach is contributing to the future efficient scaling up of the approach towards a universal scheme.

2. THE SAGAL ST1 PROGRAMMATIC APPROACH

The objective of the social transfer scheme is to improve access to health and nutrition services for pregnant and lactating women (PLW) and children under two years. In the pilot phase, the number of beneficiaries is limited to 21,000 mother-child couples across 18 districts over 24 months. While the targeting is categorical, based on observable criteria, the pilot scheme is not yet universal and does not cover fully the 1,000 days windows. Localities have been selected based on the accessibility and functionality of Mother and Child Health (MCH) centres and local administrations, within the most vulnerable districts in ILED corridors.

The project is providing a coordinated package of assistance including monthly social transfers of 20 USD as an incentive to access health services, and Behaviour Change Communication, to complement the routine services provided by the MCH centres at the core of the scheme implementation.

3. WHO IS INVOLVED?

What	Who	How
Defining the strategy and approach	MoLSA/MESAF with SAGAL CMU	Based on Save the Children expertise and technical lead, in consultation with UNICEF Regional Office and Concern HQ to reflect on other models' experience
Districts and localities selection	MoLSA/MESAF, MoH, IPs and municipalities	MCH mapping based on specific guidelines and direct consultations
Programme implementation supervision	State and district Health focal points, IPs	Regular scheduled and spot check monitoring visits
Community mobilisation and outreach	Village committees (VRC), CHWs, IPs	Using standard and programme-specific guidelines
Registration	MCH staff, NGO staff, clinic staff, VRCs/CHWs	MCH propose a list of eligible mothers
Verification	MCH staff, IP staff, VRC, CHW	The observable criteria are verified by the MCH staff and the list is verified by IPs through house visits
Cash transfers	MMO staff	Lists of recipients are provided to MMO by IPs. Scheduled mobile money transfers
SBCC	MCH staff	Using standard and programme-specific guidelines and materials

M&E	IPs, Min of Planning, MOLSA/MESAF	Regular scheduled and spot check monitoring visits

4. WHAT HAVE WE LEARNT SO FAR?

The MCH centres and staff are playing a central role in the implementation of the scheme. They are demonstrating a strong commitment and capacity to cope with the increased workload but require specific support.

The social transfer scheme is fully integrated into the MCH services. Both MCH and Ministry of Health (MoH) staff are playing a key role in the different steps of the project cycle. The scheme also had an impact on the number of people visiting the MCH generating additional workload and pressure on the supplies and equipment. While generally, the MCH have the technical capacities and resources to cope with this increased demand, the implementation has been more efficient and timely when procedures are kept simple, notably for the targeting, registration and verification, and where partnerships with the implementing partners were already established.

The project is not providing direct financial support to the MCH and local health authorities, however material and financial support is required to cope with the increased demand for the health and nutrition supplies, to implement the specific tasks required by the project in the medium-term and to support the system capacity strengthening and develop an appropriate health information system to ensure M&E and accountability. In the short term, additional support to the MCH is required to improve the case management, referrals, information management and M&E.

The level of engagement from key stakeholders varies greatly across localities, partners and activities.

The understanding of social protection and its role in human capital development as well as the development of the national social protection systems are gradually evolving as the scheme is being implemented. While the project would have benefitted from stronger engagement and coordination of the main stakeholders, notably MOLSA/MESAF and the MoH, for the design, implementation and monitoring of the project, it is progressing along with the project being implemented. These resulted in a lack of visibility of the government and the scheme being part of the implementation of the national social protection policy.

The engagement of local implementing stakeholders has been stronger, however, the institutional setup varies greatly across states and districts and roles. Roles and responsibilities are also not very well delineated in the absence of a systematic stakeholder mapping and engagement processes, including for coordination and capacity building planning.

The programme has benefitted from strong community mobilisation, but the engagement of the health care workers and MCH staff has been uneven, despite the level of skills required to ensure quality mobilisation on improved health and nutrition practices. On the other hand, the long-lasting experience with MMO, and some district health authorities and MCHs, has allowed for smooth and timely delivery.

The objectives of the scheme are not widely understood by stakeholders, generating challenging expectations and complexity.

At this early stage in the implementation of the project, the first outcome observed is the increased use of MCH services by beneficiaries and non-beneficiaries. Antenatal and postnatal consultations and screening of children under 5 has increased steadily from Q2 2021 to Q3 2021 (mobilization months) and even more in Q4 2021 (registration months). This could lead to durable outcomes if the quality of the services is maintained and appreciated.

The PDMs are showing a slight increase in the beneficiaries' food security. However, there is a lot of confusion surrounding the objectives of the social transfer scheme, still consider a cash transfer scheme, with a lower transfer value, by most, while it has been designed as a comprehensive care package including a monetary incentive. There is also confusion surrounding the target groups, as financial and technical constraints prevent universal coverage of the whole 1,000 days window. The scheme has been designed to cover all individuals within the 1,000 days window, i.e. to use a categorical targeting and a universal scheme, to ensure durable impact on Somalia's human capital and development.

5. NEXT STEPS AND HOW TO SCALE UP THE SOCIAL TRANSFER SCHEME

While the risk of overload of the health services from implementing this programme did not materialise, **the pilot scheme's coverage is quite low**. It is not universal yet and does not encompass the overall 1,000 days windows due to limited financial resources.

When scaling up, the sheme will have to **continue to be fully integrated into the MCH routine**. Its institutionalisation requires an improved collaboration from and between the MOH and MOLSA and the development of a systematic stakeholder engagement and capacity development plan.

Moving towards a universal scheme will be progressive, considering the fiscal space constraints. Enrolment will become continuous and the programmatic approach should be kept as simple as possible to remain commensurate with the implementing actors' capacities and find the appropriate trade-off between accountability, efficiency and coverage. **It will also require clarifying** the main objective of the scheme, how it translates into its monetary and non-monetary components, how it fits within the overall social protection system and communicating on these adequately.

It is equally important for **IPs and stakeholders to invest more time and financial resources in community mobilization** to create awareness on the scheme buy-in especially by the marginalized communities.