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SOMALI CASH CONSORTIUM

Briefing Paper # 5 – Ensuring Inclusivity.

Lessons learned from SAGAL Programme Implementation.

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This paper was prepared by the ILED TIPF Social Protection Team, with support from the SAGAL partners and information from the SAGAL MEAL, the TIPF learning activities and independent TPM. The TIPF learning agenda aims to adjust the program, inform future programming, and strengthen the National Social Safety Net system by building evidence around best practices and documenting and disseminating this knowledge. The learning agenda mobilizes a wide range of tools and stakeholders across the country, including the Government of Somalia, the Social Protection Donor Working Group, and other agencies.

Introduction

The SAGAL programme was designed to support the development of inclusive social protection for all Somalis and pilot a range of social transfer schemes specifically addressing the needs of the population across the lifecycle, prioritizing the most vulnerable.

Targeting is a critical design element of social transfers; however, to ensure inclusion, the SAGAL program also emphasizes other essential aspects such as defining and applying effective eligibility criteria, community mobilization and outreach, communication, and accountability. This approach has generated valuable lessons for expanding social protection systems in Somalia.

The SAGAL Programme Approach to Inclusion

The Somali Cash Consortium (SCC) leveraged the experience of its members, gained from implementing humanitarian and multi-year projects, to design approaches tailored to the Somali social context. The eligibility criteria and selection processes for the various SAGAL social transfer schemes aimed to fulfil their different objectives and reach their specific target groups.

The program prioritized selecting households typically excluded from social networks, such as female headed households, People Living with Disability (PLWD), elders, and minority groups. The program employed simple, cost-effective, transparent, and acceptable methods, favoring a universal approach inclusive of all individuals within a targeted category. Geographical targeting adapted the targets to the program scale and financial allocation.

To ensure the inclusion of these groups, the program emphasized community mobilization, outreach, communication, and involved local stakeholders such as governments, municipalities, civil society organizations, and community representatives. Specific conditions were implemented to ensure equitable representation of women and minority groups among the beneficiaries.

This approach utilized geographical, categorial, and vulnerability-based criteria, along with referral, application, and community-based methods. Sample verification was systematically conducted by SCC partners with their government counterparts, and Complaints and Feedback Mechanisms (CFM) were made available to beneficiaries and non-beneficiaries.

What Have We Learnt So Far?

Eligibility Criteria and Selection Process

Monitoring of all social transfer (ST) models included questions about process fairness, and various MEL activities allowed for a comparative analysis of the different approaches used.

Targeted communities provided positive feedback on the program and the assistance offered. Overall, they felt the program reached deserving individuals and households. The targeted communities particularly appreciated the categorical targeting approach, especially the ST1 scheme, which used observable criteria and referrals from skilled professionals. This approach was perceived as more equitable, transparent, and reduced inclusion errors. Eligibility criteria were easily understood and applied by the health staff. However, insufficient coverage led to the exclusion of many pregnant women. Consequently, MCH centres developed prioritization criteria, such as physical appearance or regular attendance to ANC, to address this issue. This approach facilitated the increased inclusion of marginalized groups who generally attended MCH centres rather than private facilities.

The feedback on other social transfers selection processes was mixed. While the categorical approach was appreciated, applying the eligibility criteria, and ensuring community committees' accountability was often challenging.

The ST2 scheme aimed to provide training opportunities to the poorest youth. It succeeded in ensuring gender equity by offering training corresponding to traditional gender roles and imposing quotas for women's recruitment. The scheme also enrolled a diverse group of youth from different backgrounds, such as IDPs as well as youth from mostly urban areas. However, the application process and the training entry requirements inadvertently excluded the poorest and most vulnerable youth who lacked secondary education. Enrolment in the training program was contingent on passing literacy and numeracy tests, as well as interviews. Most of the selected beneficiaries had completed secondary education. Additionally, the provision of start-up grants was contingent on the development of a business plan and final test scores, which effectively left out 50% of ST2 beneficiaries.

The ST3 and ST4 schemes integrated categorical and community-based targeting strategies to accommodate the budget constraints. Implementation of both schemes was relatively challenging, and the implementing agencies had to adapt the selection criteria and communication efforts around the selection process in some locations to improve the process outcomes and clarity.

The age-based targeting approach used in ST3 posed challenges in communities where birth registration is still not systematic and was not available for the oldest generations targeted by the scheme. Identification of eligible individuals relied on community structures, which could lead to inclusion and exclusion errors as detailed below. Overall, the socio-economic profile of the final ST3 beneficiaries corresponded to very vulnerable individuals: a majority of women-headed households, with a monthly household income below average, mostly spent in food and engaging in negative coping mechanisms.

Regarding the ST4 scheme targeting PLWD, stakeholders highlighted that the eligibility criteria were not clear as they focused on individuals aged range 6-65 years and suffering of a physical disability. Implementing agencies made the best use of the few existing CSOs and associations of PLWD but their coverage and their database were often limited to guide the beneficiary selection process. The lack of specific skills working with PLWD was also highlighted and its consequences on outreach, community mobilisation and the overall selection process, even if some implementing agencies has more experience than others.

The community-based selection process in the programme design included conditions and activities to ensure the inclusion of groups generally at risk of exclusion, including women and minority clans. All population, age, and gender groups were supposed to be represented in the community committees specifically constituted for the program beneficiary selection process. For the community targeting for ST3, the shock-responsive component, and ST4, VRCs were advised by program partners to ensure that all eligible members of clans or sub-clans living in the area were represented, however, this process was not verified by using a formula or quota system. The selection process required the mobilization of significant resources to ensure inclusivity through community mobilization, consultation, information meetings, and training of the community committees.

Despite the efforts deployed, both the representativity of the different groups and the transparency of the process were not guaranteed. The community committees tended to be the same as those for other programs, and it has been challenging to ensure a sufficient representation especially of women, PLWD, youth, and elders. Local governments did not often understand the program conditions and did not support them. Some inclusion errors were identified as part of the ST3 scheme monitoring. This included influence exerted on community committees to register households that did not meet the criteria.

The multi-layered approach used to select the final beneficiaries, including geographical, categorical, and vulnerability-based targeting was necessary to cope with resource limitations but generated extra costs and burden. It is, therefore, difficult to fully comprehend the cost-effectiveness of the different approaches.

Community Mobilisation, Outreach, and Communication

The programme deployed a large range of instruments and channels to mobilise the communities and the local government agencies to ensure the inclusion of the most vulnerable individuals. This included an extensive sensitization campaign conducted around the launch of the ST1 schemes, targeting communities and the MCH centres to ensure large participation from all groups, prior to referral and

registration. However, some stakeholders felt that health care workers should have been more involved at the community mobilization stage.

Communication and mobilization for all social transfers schemes involved the implementing agencies, including state and local governments, as well as traditional media (TV and radio) and an Interactive Voice Response (IVR) system. However, implementing agencies faced challenges in getting providers in place for the IVR messages, and messages started late. Nevertheless, the efforts made to improve the IVR system throughout the program implementation paid off as the most recent evaluation found that most beneficiaries could remember all the IVR messages shared for the ST schemes 1 and 3.

As a result, the mobilization around ST1 was highly successful, with most of the ST scheme beneficiaries reporting awareness of their cash entitlement and the duration of the transfers. While the objectives of the different social transfers schemes were widely understood, such as the nutrition and health/human capital objective of the ST1 scheme and the social protection nature of the different schemes, confusion between humanitarian assistance and social transfers persisted throughout the program implementation. Finally, while awareness of the CFM improved throughout the program implementation, it remained insufficient, reaching only 61% at the end of 2022.

Accountability

Accountability was a key aspect of the program, and efforts were made to sensitize beneficiaries on the importance of providing feedback and complaints through the CFM. Various methods, including posters, flyers, IVR, in-person engagement between staff and beneficiaries, and through the community committees, were employed to ensure information reached the wider community and encouraged all groups to submit feedbacks and complaints.

Beneficiaries preferred the hotline over other channels for CFM, followed by visiting the implementing agencies. SAGAL implementing partners (IPs) staff used their own existing CFM for the program and received training on CFM. However, they did not all have dedicated staff for accountability and sufficient resources, which was identified as a key gap. Despite this gap, feedback was provided systematically to the complaints sent to partners, on average within three days.

Although the Ministry of Labor and Social Affairs (MoLSA) has a CFM system at federal level with two dedicated staff and a free hotline, there were no linkages between what MoLSA was doing in terms of CFM with the SAGAL project, and there was limited sensitization at the field on this issue.

Next steps: How to Scale Up Social Assistance in the Context of Somalia

Based on the program's experience, there are several steps that can be taken to scale up social assistance in the context of Somalia:

1. Explore the potential for categorical targeting based on observable criteria and referral systems from specialized and skilled professionals and organizations. This approach could potentially be more cost-effective, allowing for increased coverage and moving towards more universal approaches to reduce exclusion.
2. Strengthen the role of social services, civil societies, and representative organizations in ensuring that the most vulnerable groups and individuals are heard, identified, and included. Traditional and face-to-face outreach and communication should be privileged, and the most vulnerable individuals may require extra support to meet social assistance requirements and conditions.

3. Enhance communication efforts to ensure that beneficiaries fully understand the objectives of social assistance schemes, target groups, and entitlements. This may require different communication approaches to address deeply ingrained misconceptions.
4. Find complementarities across services and move towards more integration to bring additional financial and inclusion gains and increase coverage. Case management, referrals, and social services could be more integrated to provide beneficiaries with an adequate package of benefits and services, allowing for cross-referrals.
5. Strengthen the social registry by building on referral systems and service integration and develop case management and social civil services to ensure that it includes people in need of assistance facing diverse risks and vulnerabilities, including disability, age, maternal and child health and nutrition, shocks, etc.

By implementing these steps, social assistance programs in Somalia can be scaled up to reach more vulnerable individuals while reducing exclusion and increasing cost-effectiveness.