Targeting Evaluation of Somalia's Shock-Responsive Safety Net for Human Capital Project (SNHCP)

FINAL REPORT

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EXECUTIVE SUMMARY

Over 70% of Somalis live in poverty, and many more are vulnerable to recurring droughts and violent conflicts. In response to this, the Ministry of Labour and Social Affairs (MoLSA) rolled out of its first government-led social protection programme, the Shock-responsive Safety Net for Human Capital Project (SNHCP), nationally referred to as the Baxnaano programme, in 2019. One major component of the SNHCP is to provide nutrition-linked unconditional cash transfers to vulnerable households in all states in Somalia and Somaliland. The SNHCP cash transfers were targeted at poor households with at least a child aged under five. Districts and villages were first selected through geographical targeting; households were then selected based on a community-based targeting approach. Each selected household was given USD 20 per month.

This report aims to assess the programme's targeting accuracy, identify the sources of targeting errors, evaluate the extent of sharing at the community level, and develop recommendations for future programmes.

We do this by firstly conducting a representative survey of households, both beneficiaries and non-beneficiaries, and community leaders in the targeted communities. The final household dataset contains detailed expenditure, livelihoods, and transfer-related data on 3,171 households. In addition, we surveyed community leaders in 93 villages to gather information about the community-based targeting process and the composition of the committee which was set up to select households.

We find that among SNHCP beneficiaries, 62 % came from the poorest two quintiles of the population, while 37% belong to the top three quintiles (inclusion error). Due to the modest total coverage of the program and targeting errors, SNHCP extended benefits only to 24% of households in the poorest two quintiles and conversely excluded 76% of these households (exclusion error), demonstrating that insufficient coverage of the poor is a challenge. At the same time, SNHCP's coverage in the top three quintile was significantly lower at 12%. While this points to errors of inclusion, it also indicates that SNHCP coverage was broadly pro-poor despite targeting errors. Our regression analysis shows that households at the bottom of the welfare distribution (e.g. in the poorest decile) are significantly more likely to be enrolled in the programme than households higher up the distribution. Recipients have statistically significant lower levels of pre-transfer welfare than non-recipients (between 17 to 36% lower, on average, depending on the model specification).

Targeting errors occurred at both the geographical and household level. At the geographical level, the accuracy of geographical targeting and quota setting was hampered by the lack of up-to-date subnational data and reliance on distress ratings. There was also a feasibility-targeting trade-off where implementors in certain situations had to prioritise more accessible and secure villages despite these communities having high levels of poverty. We find that some states with higher proportion of the households in the bottom quintile of the welfare distribution had lower share of beneficiaries compared with some states with fewer households in the bottom quintile.

At the community level, we find that there is a high variation across villages in the level of preparedness of the selection process and the way in which the selection was eventually carried out. Villages vary in level of understanding of the programme among community leaders, effectiveness of communication channels, and inclusivity of the selection process across communities. We find some suggestive evidence that certain aspects of the processes, such as making special efforts to include persons with disability, are correlated with targeting performance. The clan compositions of targeted households were also different. In Hiirshabelle and Jubaland, there was a significantly higher proportion of households who were members of the majority clans in the recipient group compared to the non-recipient group. These differences in recipient and non-recipient profiles may reflect both the selection process, but also the profiles of households who fit the eligibility criteria.

Despite being implemented in an extremely challenging environment, the SNHCP cash transfer programme has successfully reached many vulnerable and poor households. Moving forward, by learning from the targeting errors identified, this programme provides important learning points for similar cash transfer programmes in the future.

LIST OF ACRONYMS

AWS	Amazon Web Services
CAPI	Computer-Assisted Personal Interview
CBT	Community-Based Targeting
COVID-19	Coronavirus
CSC	Community Selection Committee
FE	Fixed effects
IDA	International Development Association
IDP	Internally Displaced Person
MAM	Moderate Acute Malnutrition
MoLSA	Ministry of Labour and Social Affairs
NGOs	Non-Governmental Organisations
OLS	Ordinary Least Squares
PCA	Principal Component Analysis
PLWG	Pregnant and Lactating Women and Girls
PPS	Probability proportionate to size
PSU	Primary Sampling Unit
PWD	Person with disabilities
SAM	Severe Acute Malnutrition
SNHCP	Shock-Responsive Safety Net for Human Capital Project
SHFS	Somalia High Frequency Survey
SP	Social Protection
TE	Targeting Evaluation
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
WG-SS	Washington Group Short Set on Functioning
WFP	World Food Programme

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I. INTRODUCTION

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A. Background

Facing political, economic, climate, and social insecurities, 7 in 10 Somalis live in poverty, with a particularly heavy impact on rural communities, internally displaced people (IDPs), and children.[1] The exacerbated climate conditions, with a combination of slow and sudden-onset events, are worsening existing vulnerabilities. They have already led to increasing internal displacement, deteriorating food security, and a scarcity of resources in rural and urban areas.[2] Most of the approximate 15.42 million[3] population are living below the poverty line, and data over the past decades have provided sufficient evidence of the imminent need for social protection (SP) systems in order to support the poor and vulnerable, lessening the impact of natural and man-made shocks, and building long-term resilience.[4]

SP has numerous definitions, but always refers to the set of public policies and programmes that serve to address social and economic vulnerabilities. It encompasses a framework of measures to cushion the impact of household and community level shocks on income, standards of living, and general wellbeing.[5] By definition, SP is government-owned. It is enshrined as a human right in the Universal Declaration of Human Rights, the two Covenants on Economic, Social, and Cultural Rights, and Civil and Political Rights, and more recently in the UN 2030 Agenda.

In 2019, the Ministry of Labour and Social Affairs (MoLSA) of the Federal Government of Somalia developed Somalia's first Social Protection Policy in partnership with UNICEF and the World Food Programme (WFP).[6] This policy was a milestone for developing a nationally owned SP system. It defines social protection as "… *government-led policies and programmes which address predictable needs throughout the lifecycle in order to protect all groups, and particularly the poor and vulnerable, against shocks, help them to manage risks, and provide them with opportunities to overcome poverty, vulnerability, and exclusion.*"[7]

In 2019, MoLSA rolled out of its first government-led SP programme, the Shock-responsive Safety Net for Human Capital Project (SNHCP), nationally referred to as the Baxnaano programme. SNHCP addresses immediate needs faced by poor and vulnerable Somali households while supporting recipients in building resilience through a reliable safety net. The project design works across the humanitarian-development nexus to strengthen vulnerable groups' capacity to cope with shocks and address social exclusion in the long term. Furthermore, it aims to contribute to government capacity and citizens' confidence in national institutions.[8]

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[1] The World Bank, 'Somali Poverty and Vulnerability Assessment: Findings from the Wave 2 Somali High Frequency Survey' (Washington, D.C.: World Bank Group, April 2019).
[2] Samuel Hall, 'Identifying Climate Adaptive Solutions to Displacement in Somalia' (IOM and UNEP, 2021).
OCHA, '2021 Somalia Humanitarian Needs Overview', March 2021.
[3] The World Bank Data, 2019.
[4] Gabrielle Smith, 'Designing Social Protection Frameworks for Three Zones of Somalia', Final Report (UNICEF, December 2014).
[5] Rachel Sabates-Wheeler and Stephen Devereux, 'Transformative Social Protection: The Currency of Social Justice', in Social Protection for the Poor and Poorest: Concepts, Policies and Politics, ed. Armando Barrientos and David Hulme (London: Palgrave Macmillan UK, 2008), 64–84, https://doi.org/10.1057/978-0-230-58309-2_4.
[6] Samuel Hall was contracted by WFP to support the draft.
[7] ASiST, 'Somalia: In Pursuit of a Safety Net Programme in the Short Term Paving the Way to a Social Protection Approach in the Long Term: Issues and Options', Final Report, 23 November 2017.
[8] MoLSA, 'Somalia Shock Responsive Safety Net for Human Capital: Project Operations Manual', October 2019.

SNHCP is implemented by MoLSA with the support of WFP and UNICEF and funded by the International Development Association (IDA) of the World Bank Group. The programme includes three components: (1) Nutrition-linked Unconditional Cash Transfer (implemented in collaboration with WFP and UNICEF); (2) Delivery Systems and Institutional Capacity Building; and (3) Project Management, Monitoring and Evaluation, and Knowledge Management. These components are based on the premise of building government capacities to gradually hand over the project, including policy formulation and delivering of interventions, to the MoLSA.[9]

Component 1 provides nutrition-linked cash transfers to poor and vulnerable households in five Federal Member States (Jubaland, Puntland, South-West, Hiirshabelle, Galmudug) and Somaliland based on an initial geographic targeting and, subsequently, a community-based targeting (CBT) approach. The programme's operations manual introduced guidelines to ensure eligible households are reached. While in theory, the CBT approach positively contributes to targeting, implementation, monitoring and sustainability, it involves practical challenges as it might be less transparent due to its subjectivity.[10]

After one year of implementing component 1, the World Bank assigned Samuel Hall and Development Pathways to assess the targeting approach of the nutrition-linked cash transfers.

B. SNHCP Component 1: Targeting approach

Component 1 provides cash transfers to the chronically poor and those vulnerable to drought and malnutrition, and it connects households with nutritional support as needed.[11] Households in need of it are identified during the selection stage and subsequently linked to existing nutrition services, subject to their availability in the area. These nutrition services are provided by WFP as no direct nutrition intervention is implemented under SNHCP.

The programme aims to reach 200,000 beneficiary households[12] and approximately 1.2 million individuals with a monthly payment of 20 USD for a period of three years. The programme targets poor households with at least one child under the age of five. The project aims to improve their socioeconomic status and contribute to equity, poverty reduction, and gender empowerment by targeting women. As of June 2021, more than 795,282 individuals have benefitted from Baxnaano. The cash transfers cover five Federal Member States (Jubaland, Puntland, South-West, Hiirshabelle, Galmudug) and Somaliland, with 21 districts in total. Recipient selection is based on an initial geographic targeting and, subsequently, a community-based targeting (CBT) approach, which can be broken down into the following three main steps:

[9] MoLSA.
[10] Stephen Devereux et al., 'The Targeting Effectiveness of Social Transfers', Journal of Development Effectiveness 9, no. 2 (3 April 2017): 162–211, https://doi.org/10.1080/19439342.2017.1305981.
[11] MoLSA, 'Somalia Shock Responsive Safety Net for Human Capital: Project Operations Manual'.
[12] Based on the 2014 population data, the target districts will account for 18 percent of all children under five years, 24 percent of rural population, and 26 percent of all IDPs.

1. Selection of districts based on their distress ratings (a composite index comprising food insecurity, malnutrition, and concentration of rural population), security, accessibility, and political economy considerations.

2. Selection of communities in the targeted districts: Once three districts in each region or state are selected, two conditions guide community selection: (a) accessibility to UNICEF, and WFP and its cooperating partners; and (b) accessibility to payment service providers responsible for delivering cash to households.

3. Community-based participatory targeting (CBPT) of households: A community-based committee is appointed to support the identification of poor households with children under the age of five. Among the long list of eligible households, priority is given to those with malnourished children, pregnant and lactating women; high dependency ratio; child-headed households; sole breadwinner; persons with disability; and limited livelihood assets.

Firstly, three districts in each region were selected based on their high distress index ratings and vulnerability to malnutrition and the impact/risk of drought.[13] As a next step, SNHCP districts were adjusted based on security access and subsequently from a conflict-sensitivity perspective considering clan dynamics.[14] The SNHCP Project Operations Manual explains that due to limited funding, the 200,000 households targeted for SNHCP are distributed across the districts proportionately to the share of households with children under 5 years of age in the districts. This calculation was done with the latest available population data from 2014. Communities within the selected district were prioritized with input from district level authorities and the selection was based: (1) on available nutrition services; and (2) on the presence of cooperating partners (NGOs) to support implementation; (3) security access; and (4) lack of support from humanitarian programmes.

Finally, the beneficiary households within the districts were chosen by community groups[15] of community representatives, and local NGOs facilitated the CBT process to ensure inclusiveness of community-based selection. Households were eligible if they belonged to the poverty ranking of poor and very poor as defined by the community and had children under the age of 5 years. The community-based targeting processes can be broken down into the following key steps:

1. Cooperating partner consults with local authority and leaders
2. Initial community meeting
3. Establishment of Selection Committee
4. Development of list with nominated households
5. Validation of list
6. Enrolment into SNHCP

[13] According to the Project Manual, Poverty rates have not been considered in the distress rating given that the number of poor people per district seem to be heavily contested.
[14] MoLSA.
[15] The term 'community' varies considerably, and is generally referring to some kind of notionally representative sample of the community.

The Community Selection Committee were given instruction that the eligible households are poor households with at least one child under five years of age. Among the long list of eligible households, priority was given to households with the following characteristics, which are further discussed in the next sections:

- Malnourished children
- Malnourished pregnant and/or lactating women and girls
- High dependency ratio to sole breadwinner
- Child-headed household
- Households with a member with a disability
- Lack of limited livelihood assets
- *"Other vulnerability indicators communities may regard as relevant to their specific area, this will be subject to WFP verification and approval and documentation."* [16]

Regarding the prioritisation process, the SNHCP Project Operations Manual gives the following instructions:

> *"In each community, the community group will be asked to list households in need of assistance and group them in 4 categories: first (most needy), second, third, and fourth priority for inclusion into the programme according to their level of vulnerability. This will allow for a clear and transparent decision making for HHs prioritization when not all identified HHs can be enrolled due to the district threshold."* [17]

It also provides definitions for the following four prioritisation criteria:

Malnourished children: Under the targeting exercise, community groups prioritised eligible households which had children that appeared malnourished. The SNHCP Project Operations Manual defines those as *"SAM and MAM currently enrolled in the programme with WFP/ UNICEF; relapse cases during the last 6 months"*. [18]

High dependency ratio on sole breadwinner: For the purpose of the SNHCP, a High Dependency Ratio is defined as "[*M]ore than 6 family members who are dependent on a sole bread winner. Must belong to the poverty ranking of Poor and Very Poor as defined by the community. High dependency ratio of children/ elderly to sole bread winner is an age-population ratio of dependent part ages 0 to 14 not in the labour force and those typically in the labour force (the productive part ages 15 to 64). It is used to measure the pressure on the productive population."* [19]

Child-headed household: SNHCP defines child-headed households as *"A child below the age of 14 years who is the sole breadwinner for her/his household. Must belong to the poverty ranking of Poor and Very Poor as defined by the community."* [20]

Disabled dependant: As defined by SNHCP: a household that has a dependent with a disability.[21]

[16] MoLSA, 'Somalia Shock Responsive Safety Net for Human Capital: Project Operations Manual'.
[17] MoLSA, 'Somalia Shock Responsive Safety Net for Human Capital: Project Operations Manual'.
[18] MoLSA, 'Somalia Shock Responsive Safety Net for Human Capital: Project Operations Manual'.
[19] MoLSA, 'Somalia Shock Responsive Safety Net for Human Capital: Project Operations Manual'.
[20] MoLSA, 'Somalia Shock Responsive Safety Net for Human Capital: Project Operations Manual'.
[21] MoLSA, 'Somalia Shock Responsive Safety Net for Human Capital: Project Operations Manual'.

C. Objectives and main evaluation questions

The targeting evaluation aims to assess the accuracy of the targeting approach under Component 1 in an objective manner within the first year of its implementation, to ultimately adjust and improve the targeting approach. It does so by better understanding the errors of inclusion and exclusion, and the sharing behaviour of beneficiary households. Household selection decision under SNHCP is delegated to communities through CBT — this entails a strong subjective component, which can be influenced by various factors, including prejudice against marginalised groups, favouritism, elite capture, and intra-community sharing arrangements.

Against this backdrop, the research pursued the following key objectives:

Objective 1	Objective 2	Objective 3
Assess the accuracy in terms of errors of inclusion and exclusion. Measure the accuracy of the SNHCP targeting approach in reaching the poorest households by estimating a more objective measure of household welfare, and comparing the community-based selection decisions to the objective level of household welfare.	*Identify sources of exclusion and inclusion error and develop recommendations for improved targeting.* This will include examining those SNHCP business processes that affect targeting performance, most important communications and outreach, household selection, registration and enrolment, and grievance redress.	*Evaluate the extent of sharing at the community level and its implications for the targeting approach.*

This report presents the current targeting approach of SNHCP and the methodology used for the targeting evaluation. Subsequently, the data collection findings in five Federal Member States (Jubaland, Puntland, South-West, Hiirshabelle, Galmudug) and Somaliland are discussed, and recommendations are provided.

II. DATA COLLECTION & METHODOLOGY

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This chapter describes the quantitative methodology that was adopted for the targeting evaluation of the SNHCP, including the sample design, questionnaires, fieldwork, and the development of sampling weights and welfare metrics. The survey was designed to provide representative estimates of welfare indicators and perceptions of targeting processes among households and communities in programme areas where the SNHCP is active. A multi-stage, stratified cluster sampling approach was used to select 11 recipient and 11 non-recipient households in 150 clusters (i.e., villages or segments of large communities) , with a total target sample of 3,300 households. Survey implementation resulted in 3,171 valid household interviews (1,407 recipient and 1,764 non-recipient households) and 92 community-level interviews.

A. Sample Design

The sampling frame was constructed from anonymised data that was extracted from the SCOPE database by WFP Somalia and shared with the evaluation team through a secure file transfer protocol in May 2021. The SCOPE data consisted of a list with 108,569 entries – one for each household enrolled in the SNHCP programme – with seven variables: a unique household identifier; geographical variables with the names of each household's location (village/community), administrative area, district, region, and state; and a binary dummy indicating whether the household had given consent to be contacted for third-party monitoring and research. Households that had not given such consent (4,095 or 3.8 per cent of all households) were dropped from the list. This is unlikely to have introduced any systematic bias as non-consenting households were spread evenly across all locations.

To create the frame for area-based sampling, the data were first aggregated to obtain the total number of recipient households by location. The SCOPE database included 600 unique locations with a median size of 64 households and an average size of 174 households. Next, locations with less than 11 households – i.e., less than the cluster take – were dropped, which reduced the total number of recipient households in the list by 569, to 103,905. Locations with large numbers of recipient households were segmented into smaller clusters with approximately 250 households. This procedure led to an area-based sampling frame consisting of 867 clusters, with clusters referring to either communities/villages or segments of large communities.

Security assessments conducted in the run-up to the fieldwork revealed that a significant number of programme areas in Galmudug, Hirshabelle, and South-West states were not accessible due to the presence of Al-Shabab or clan fighting. These insecure locations had to be dropped from the sampling frame. As a result, the final sampling frame consisted of 547 clusters covering 359 communities across 26 districts in six states, with 75,870 recipient households in total.

Implementation of the sampling followed a two-stage design that was intended to allow estimates of key welfare indicators for SNHCP programme areas as a whole and for the six federal member states. The first stage consisted of area-based sampling of 150 clusters. The sampling frame was stratified by state and the number of clusters allocated to each state was determined using the square-root-allocation formula (27 clusters in Galmudug; 31 in Hirshabelle; 27 in Jubaland; 15 in Puntland; 24 in Somaliland; and 26 in South-West). Selection of clusters was done independently within each stratum, by sorting the lists according to region, district, administrative area, and location (to achieve implicit stratification) and applying probability proportional to size (PPS) sampling, with the number of recipient households in each cluster as the measure of size.

In the second stage of sampling, 11 recipient households were randomly drawn from within each of the sampled clusters. The evaluation team then provided a list with the unique identifier codes for the

1,650 sampled beneficiaries to WFP who, in turn, extracted their phone numbers from the SCOPE database to help the field teams in locating the sampled households. Within each cluster, field workers also randomly selected 11 non-recipient households, using systematic sampling by selecting every fourth household and screening it to verify beneficiary status.

Overall, therefore, the survey is representative of targeting outcomes in communities with (recipient) households that meet the following criteria: (a) they were enrolled in the programme before May 2021 (when the evaluation team received the extract from the SCOPE database); (b) they provided consent for third-party research and monitoring; (c) they were living in sample clusters with at least 11 recipients (the minimum cluster take); and (d) they were located in areas that were accessible to the field teams at the time of the survey (i.e., where access was not restricted due to clan fighting or the presence of Al-Shabab). Table II-1 provides a comparison of the total number of recipient households that were recorded in WFP's SCOPE database and the number of households that had to be excluded from the sampling frame. The overall extent of under-coverage is 30 per cent, largely driven by the inaccessibility of programme areas in Galmudug, Hirshabelle, and South-West states. The coverage error may lead to biased survey estimates especially when disaggregated by state, as the omitted households and their communities may have relevant characteristics that differ from those of the included households. However, weighting was used to help address the impact of under-coverage of the sampling frame (see section E).

Table II-1: Number of recipient households excluded from the sampling frame according to reason

State	Total in SCOPE database	No consent for research	Living in cluster with size <= 11	Living in insecure area	Final sampling frame	Percentage excluded
Galmudug	19,463	439	46	10,693	8,285	57
Hirshabelle	29,058	2,709	89	10,853	15,407	47
Jubaland	19,733	77	34	0	19,622	1
Puntland	6,374	13	119	0	6,242	2
Somaliland	15,212	176	222	0	14,814	3
South-West	18,729	681	59	6,489	11,500	39
Total	**108,569**	**4,095**	**569**	**28,035**	**75,870**	**30**

B. Questionnaires

Two questionnaires were used for the survey: the Household Questionnaire and the Community Questionnaire. During the development of the questionnaires, comments were solicited from various stakeholders including MOLSA, World Bank, and WFP. After the questionnaires were finalised in English, they were translated into Somali and scripted with the software Survey Solutions to facilitate computer-assisted personal interviewing (CAPI) for data collection with mobile phones.

The Household Questionnaire collected basic socio-demographic information on all members, including age, sex, ethnicity, marital status, education, employment, and relationship to the head of the household. For children under age 18, survival status of parents was determined. The Washington Group Short Set on Functioning (WG-SS) was used to determine disability status. Modules on food and non-food consumption were designed with the rapid consumption survey methodology (Pape and Mistiaen, 2018), starting from the questionnaire used in the second wave of the Somalia High

Frequency Survey (SHFS). In particular, the 240 items in the SHFS questionnaire were reduced to 73 items that captured over 85 per cent of total consumption in the SHFS. The questionnaire also included modules that collected information related to livestock and agricultural land, assets, housing conditions, displacement and migration, awareness of the SNHCP, perceptions of community-based targeting, sharing and decision-making on the use of transfers, and other sources of household income.

The Community Questionnaire was administered to small groups of local leaders and representatives who were involved in overseeing the community-targeting of the SNHCP in each of the sampled villages. It collected detailed information on community characteristics, including its population size and composition, the main economic activities and income sources, access to basic services, and infrastructure. Other modules collected data on well-being and shocks, conflict, and accountability of local leadership. The module on the SNHCP covered questions related to levels of understanding of the programme and implementation of the community-based targeting processes. Interviewers facilitated a short discussion on each question until consensus was reached on the answer.

C. Training of field staff

A total of 115 field workers were recruited and trained to serve as supervisors (9) and interviewers (106) for the main fieldwork. Selection criteria for recruitment included experience with quantitative data collection, management of teams (for supervisors), command of local languages and English, and performance on a short test and during training.

Field supervisors participated in a three-day training of trainers workshop in June 2021. This covered the purpose and objectives of the survey, trainers' roles and responsibilities, procedures for completing the questionnaires, use of CAPI and mobile phones, fieldwork procedures and logistics, quality control, and health and safety measures. This was followed by a two-day pilot to test the decentralised training approach and data collection instruments in Galmudug at the end of June 2021. Upon completion of the pilot, supervisors delivered a three-day training for the interviewers in the states and districts assigned to them, which covered instructions on interviewing techniques and procedures, a detailed review of the questionnaires, setup of mobile phones for CAPI, and mock and practice interviews with a small number of households. Supervisors and interviewers received thorough briefings on the risk of COVID-19 prior to fieldwork and on protocols to minimise risk to themselves and the communities they worked in.

D. Fieldwork operations and challenges

Data collection took place over a seven-week period, from the 7th of July to the 21st of August 2021. Team leaders were responsible for fieldwork planning, management of data collection, logistical coordination, support to security assessments, and quality control, while interviewers administered the households and community surveys. Each field team was composed of one supervisor and between 4 to 11 interviewers, depending on the workload in the location that they were assigned to.

COVID-19 safety measures were adhered to throughout the fieldwork. All field staff were provided with sanitisers, wore masks both indoors and outdoors, and abided by social distancing guidelines, always remaining six feet (or 2 metres) apart from one another and participants. Interviews took place in appropriate outdoor shaded areas; where this was not possible, field teams identified an open room where ample distance could be enforced between participants.

Interviews were conducted with the Survey Solutions Interview App installed on mobile phones and uploaded to a Survey Solutions Server that was installed on the cloud platform Amazon Web Services (AWS). Completed interviews were first submitted to the field supervisors for review and quality

control, and then synchronised to the central server on a daily basis, or as soon as internet connectivity was available. Supervisors organised daily morning briefings with their teams and sent nightly update briefings to the evaluation team on their progress. The evaluation team also conducted regular quality control checks on the data submitted to the sever.

While in the field, our teams realised that some beneficiaries could not be located in the areas recorded in WFP's data. Some beneficiaries were no longer living in the villages they had been registered at. For example, all the villages the team targeted in Xudur, South-West, were empty because people had been displaced. Whole villages resettled at the outskirts of Xudur town to seek safety and are now living in IDP camps. To mitigate that challenge, the field team called the beneficiaries to inquire about their location and travelled to the IDP camps to interview them there.

During the data collection, the field teams encountered two challenges with the random sampling approach of non-recipient households. First, in villages with a limited number of households and a relatively high proportion of SNHCP recipients, the field team was not able to follow the instructions of targeting every fourth household. To mitigate this challenge, the field teams consulted the respective community leaders to support the identification of non-recipient households. Second, in one village in Taleex, Somaliland, all households were recipients of SNHCP and, therefore, no non-recipient households could be interviewed as a comparison group. These two challenges also indicate a relatively homogeneous socioeconomic status of households in those locations.

E. Sampling weights

Three types of sampling weights were developed, and numbers presented throughout this report are based on analysis of weighted data. The first set of sampling weights was derived to produce estimates as representative as possible for households living in communities where the SNHCP is active. The design weight of a household was computed as the inverse of the overall probability with which the household was selected in the sample. By design, SNHCP recipient households had an equal probability of selection in each stratum because of the combination of probability proportionate to size (PPS) sampling of clusters and the use of a fixed cluster take (11).

Non-recipient households had unequal probabilities of selection which were computed after the fieldwork was completed using data on the total number of households in each location as reported in the Community Questionnaire. The design weights were then adjusted for non-response using strata as the response groups and normalised so that the sum of the weighted and unweighted number of households is similar.

A second set of sampling weights was developed for analysis of households within each community (e.g., for assessing targeting outcomes within each of the sampled communities separately). These post-stratified weights for within-community analysis make adjustments that factor in the unequal sampling rates of recipient and non-recipient households as well as non-response at household level in the sampled communities.

A third set of weights was developed for the analysis of community level indicators (i.e. data collected with the Community Questionnaire). The design weight of a community was computed as the inverse of the probability with which the community was selected in the sample. The design weights were then post-stratified to ensure that the weighted distribution of communities by state matched the distribution of communities in the sampling frame and normalised so that the sum of the weighted and unweighted number of communities is similar.

F. Consumption aggregate and other welfare measures

The main welfare measure used in the targeting evaluation is pre-transfer household consumption per capita. Deaton and Zaidi's (2002) three-step procedure was used for constructing the consumption-based measure of welfare. First, the different components of household consumption were aggregated to construct a nominal consumption aggregate. In the second step, spatial price deflators were developed to adjust for differences in the cost of living in different parts of the country. Finally, the real consumption aggregate was adjusted for differences in household composition. The methodology is broadly consistent with the approach followed by the World Bank in the Somalia High Frequency Survey (SHFS).

Before deriving the consumption aggregate, three components of consumption – data on food consumption, non-food consumption, and durable assets – were cleaned to correct missing values and outliers. For food consumption data, consumption and purchase quantities with missing values for items reported as consumed were replaced with median consumption/purchase quantities by item and village.

Furthermore, food quantities were capped at 20kg and per unit prices were capped at US$15. The non-food data only reported prices for non-food items, which were reported as consumed without quantities and units. Outlier prices of non-food item prices were replaced with the 95th percentile value. Missing values for non-food items were replaced with item-specific medians. All medians were estimated at the village level. While cleaning the food and non-food consumption data, all prices were converted to a single currency (USD).

Durable goods last for many years and therefore when calculating total expenditure, it is the use of a durable good that contributes to welfare. The use of the durable good is rarely observed directly; it is typically assumed to be proportional to the stock of the good held by the household (Deaton and Zaidi, 2002).

Hence, we estimated the consumption flow of the assets using the user-cost approach and included it in the consumption measure. The user-cost approach defines the consumption flow as a difference of selling the asset price at the beginning and end of the year. This is the opportunity cost of keeping the asset. If the durable item is sold at the beginning of the year, the household would receive the market price p_t and the interest (i_t) on the revenue for one year. The value of the item will thus be $p_t(1 + i_t)$ and if the household sells the asset at the end of the year, it will receive the depreciated value of the item while considering inflation π_t and depreciation rate d that is assumed constant over time. The household will obtain $p_t(1 + \pi_t)(1 - \delta)$ and hence the consumption flow y_d is as follows:

$$y_d = p_t\,(1 + i_t) - p_t\,(1 + \pi_t)(1 - \delta)$$

$$y_d = p_t(r_t + \delta)$$

where r_t is the real market interest rate in period t. Assuming an average annual inflation rate π_t, the depreciation rate can be estimated utilizing its relationship to the market price:

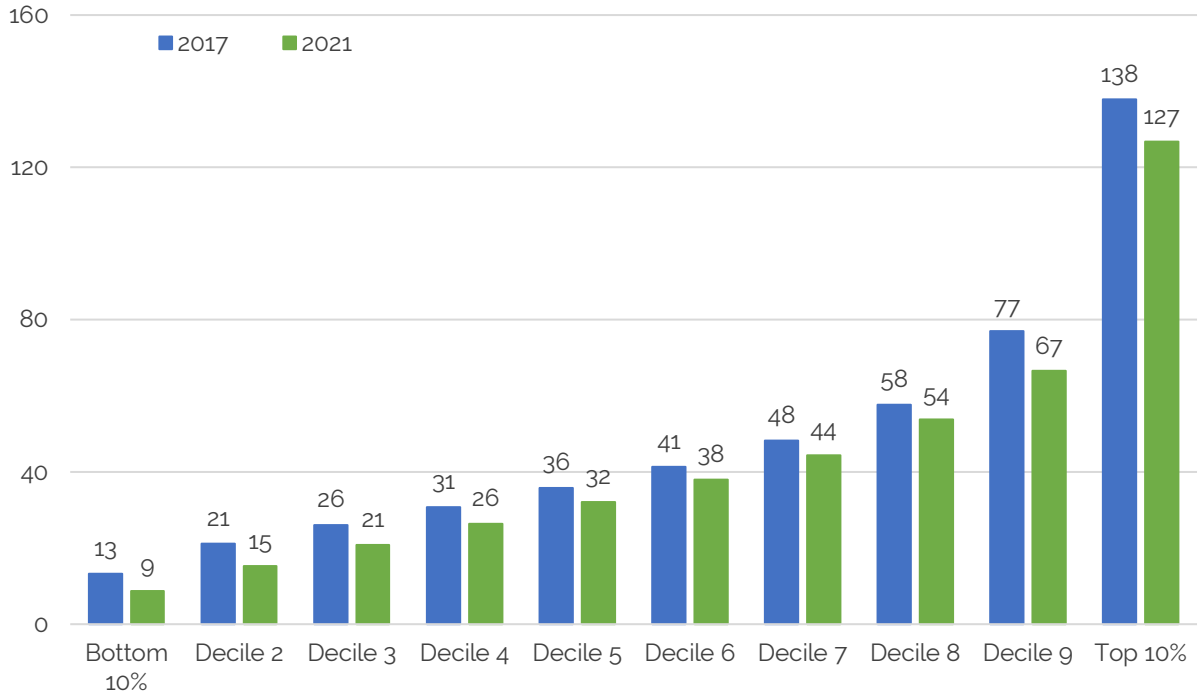
$$\delta = 1 - \left(\frac{p_t}{p_{\{t-k\}}}\right)^{\frac{1}{k}} \times \frac{1}{1 + \pi}$$

For all households who owned a durable good but did not report its current value, the item-specific median consumption flow was used. For households that own more than one of the durable good, the consumption flow of the newest item was added to the item-specific median of the consumption flow times the number of those items without counting the newest item.

Spatial price indices were calculated using a common food basket and spatial prices to make consumption comparable across five states of Somalia and Somaliland. For our analysis, we used Laspeyres index which is calculated by state based on the price data collected in the survey. The index reflects the item-weighted relative price differences across products. Item weights are estimated as household-weighted average consumption share across all households before imputation. Then the consumption shares are calculated at the household level. The items use total household food and non-food consumption as a reference. The shares are aggregated at the national level (using household weights) and then calibrated by average consumption per state. The item-weights are applied to the relative differences of median item prices for each state. Missing prices are replaced by the item-specific median over all households. All prices were converted to a single currency (USD) using market exchange rates. We deducted the monthly USD 20 from the monthly household expenditure for SNHCP recipient households. The pre-transfer monthly household expenditure was divided by household size to obtain the per-capita pre-transfer welfare.

Figure II-1 compares the 2021 average monthly household consumption expenditure per capita with the average per capita consumption from the 2017 Somalia High Frequency Survey (SHFS). The average monthly per capita household consumption was US$49 in 2017 SHFS and US$43 in our 2021 survey. In the bottom decile, the average monthly per capita household consumption was US$13 in 2017 compared with US$9 in 2021. However, it is important to note that the per capita consumption expenditure from 2021 is not directly comparable with the consumption from 2017 SHFS because of differences in the areas covered by the survey, the sampling design, and the items included in the questionnaire.

Figure II-1: Comparison of average monthly household consumption expenditure per capita with 2017 SHFS, by decile (expressed in 2021 US$)



We also used the alternative welfare measures as robustness checks. An asset index and a wealth index were constructed using principal component analysis (PCA), following the standard approach commonly used in Demographic and Health Surveys (DHS). An asset index employs household assets such as durable and semi-durable goods to describe household welfare. We used 25 items (durable goods used in the house, e.g., beds and computers, transportation such as tractors and cars, and seven types of livestock) from the household survey to create an index. Each household asset for which information is collected is assigned a weight or factor score generated through principal components analysis. The resulting asset scores are standardized in relation to a standard normal distribution with a mean of zero and a standard deviation of one. The wealth index is a composite measure of a household's cumulative living standard and is calculated using data on a household's ownership of selected assets, such as televisions and bicycles; materials used for housing construction; and types of water access and sanitation facilities. Using PCA, the wealth index places individual households on a continuous scale of relative wealth. The main limitation of these two alternative welfare measures is that households may have used transfers to purchase assets or improve their dwelling. Hence, it is difficult to assess the pre-transfer asset base or wealth index.

III. EVALUATION FINDINGS

III. EVALUATION FINDINGS

This chapter discusses the main evaluation findings. It starts by estimating levels of programme coverage and examines targeting efficiency, both in terms of reaching consumption-poor households and adherence to the programme selection parameters. We also examine whether certain types of villages tend to perform better in targeting than others. Next, we discuss the main drivers behind the targeting performance of the programme at the geographical and household level. This includes a detailed review of the quality of the implementation of community-based targeting processes. Finally, we examine to what extent SNHCP transfers are shared with other non-enrolled households.

PROGRAMME COVERAGE & TARGETING EFFICIENCY

A. Programme coverage and targeting efficiency

Estimating programme coverage is complicated by the lack of population and household data at subnational levels. The number of households enrolled in the SNHCP are recorded in WFP's SCOPE database, but data on the total numbers of households living in programme areas generally do not exist or are outdated. The latest census in Somalia was conducted in 1986 (but not published) while UNFPA conducted a Population Estimation Survey in 2013. Subnational population projections remain highly uncertain because of high levels of fertility, mortality, and migration in the country. To circumvent this challenge, we asked respondents to the Community Questionnaire to estimate the number of people and households living in their community as best as possible. By combining data from SCOPE and the Community Questionnaire, we were able to derive estimates of the coverage of the SNHCP in the programme areas sampled for the survey.

Who is covered by the SNHCP?

Overall, across the entire sample, some 17 per cent of (weighted) households are enrolled in the SNHCP programme. At the level of the federal member states, the estimated coverage in programme areas ranges from around 11 per cent of households in Jubaland to 24 per cent in Somaliland (see Figure III-1).

Figure III-1: Percentage of households living in programme areas receiving SNHCP transfers, by state

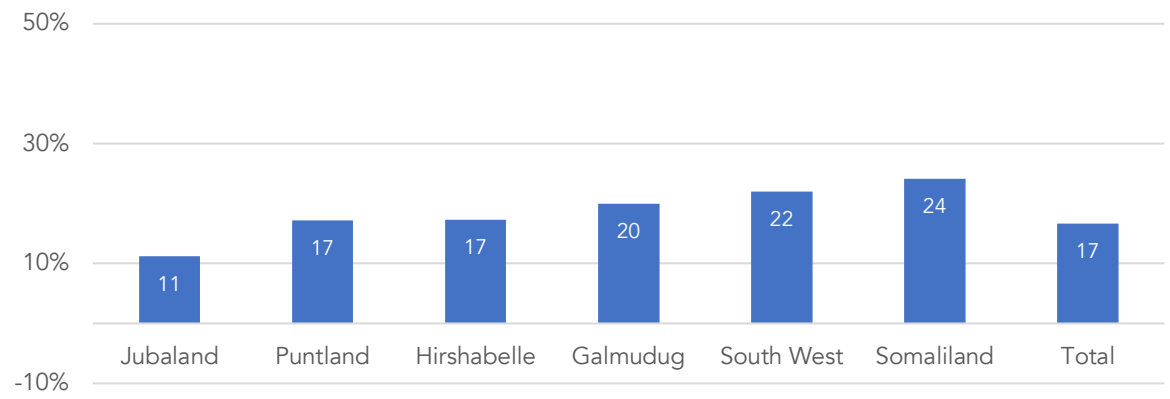
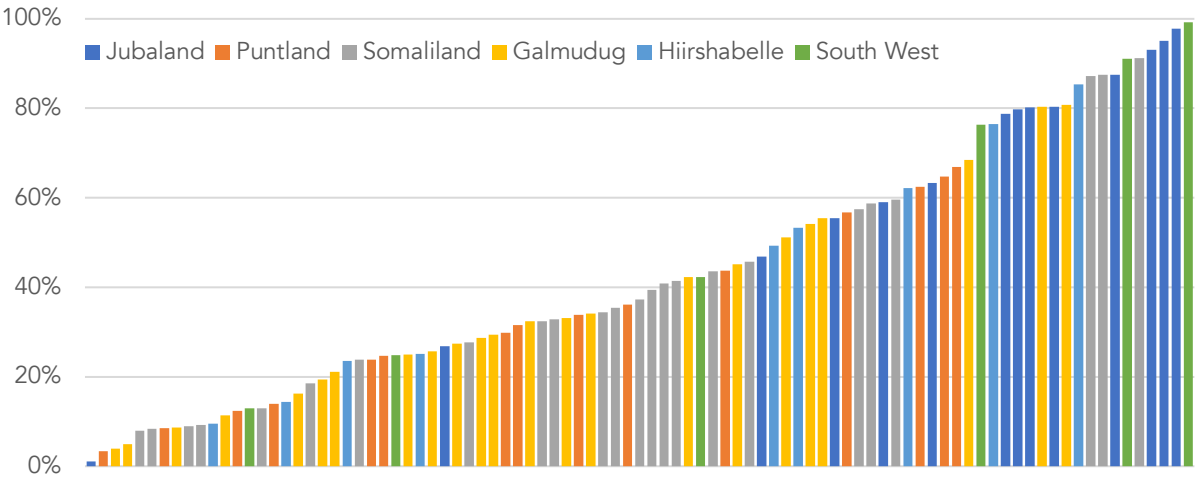


Figure III-2: Percentage of households enrolled in the SNHCP in the villages sampled for the survey



We examine the extent to which the SNHCP recipient and non-recipient households have different demographic profiles in Table III-1. The columns report the normalised difference in means of each characteristic between recipient and non-recipient households by state. We interpret these differences as ones associated with the selection process, rather than a reflection of the impact of the transfer, with the assumption that these differences existed prior to the SNHCP cash transfer distribution. In other words, these indicators are unlikely to change because of the SNHCP in the very short term. For example, we would expect a household to remain being headed by a female member even after receiving the cash transfer.

First, we examine the characteristic which is linked with one of the eligibility criteria – households with at least one child aged less than five. We do not find significant differences between the recipient and non-recipient groups in the proportion of households who had at least one child aged less than five prior to the transfer.22 In fact, at the time of the survey, 30% of the recipient households did not have a child that would have been under age 5 when enrolled. This result is however not surprising due to a number of reasons beyond non-compliance to the eligibility criterion. First, child mortality rates are high23 (one in eight new-borns is estimated to die before their fifth birthday). Second, age is difficult to measure, especially in a setting where not many individuals have birth certificates. Third, this criterion was combined with a poverty criterion – it is possible that many households who had children under the age of five were not defined as poor. We will analyse the average differences in pre-transfer welfare between recipient and non-recipient households in next section.

We also find that the characteristics related to the prioritisation criteria were not significantly different between recipient and non-recipient groups. One exception is the presence of a household member with disability. In Jubaland and Galmudug, the proportion of households with a member with disability was higher in the recipient group compared to the non-recipient group. Other prioritisation characteristics – high dependency ratio and child-headed household – were generally not significantly different between recipient and non-recipient groups. These results are not surprising or reflective of poor selection, as these prioritisation criteria were only to be followed after the eligibility criteria were met. For example, it is possible that many families with high dependency ratio were not defined as poor.

We do observe differences between recipient and non-recipient groups in other demographic characteristics, and these differences also varied across states. In Jubaland state only, we observe that there was a significantly higher proportion of households headed by a married member among the recipient group compared to the non-recipient group. In Hirshabelle state, less households were headed by a member with a legal ID among the recipient group compared to the non-recipient group. In the same state, the average head of household was more educated and less likely to be a forced migrant in the recipient group compared to the non-recipient group.

The clan compositions were also different. In Hiirshabelle and Jubaland, there was a significantly higher proportion of households who were members of the majority clans in the recipient group compared to the non-recipient group. These differences in recipient and non-recipient profiles may reflect both the selection process, but also the profiles of households who fit the eligibility criteria.

[22] Since the survey was conducted a bit more than a year after the first transfer distribution, we included households with at least one child who was under seven years old.
[23] We estimate that one in eight newborns die before their fifth birthday.

Table III-1: Comparison of characteristics of recipient and non-recipient households

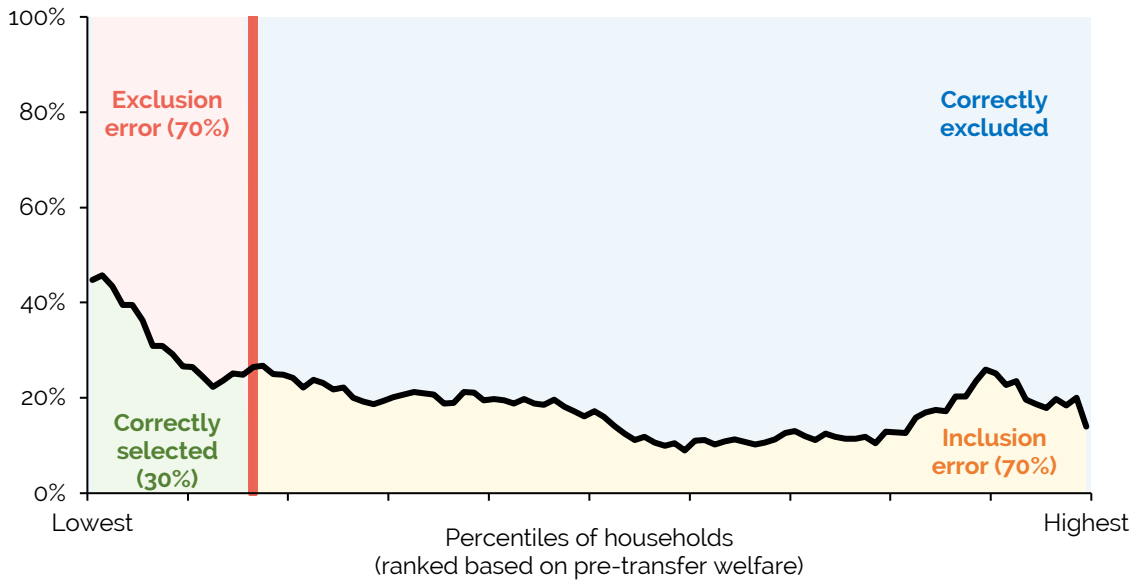
Indicators	Normalised difference (mean of indicators for non-recipient households minus those of recipient households)							
	All	Somalia	Somali-land	Galmu-dug	Hiirsha-belle	South West State	Jubaland	Punt-land
HH w/ child <5 in 2019	-0.148	-0.232	0.168	0.145*	-0.314	0.347	-0.187	0.116
High dependency ratio	0.014	0.029	-0.046	-0.143*	-0.019	0.027	0.002	0.111
HH w/ member with disability	-0.159***	-0.194***	0.043	-0.211**	-0.147	-0.106	-0.241***	-0.252
Child-headed HH	-0.041	-0.065	0.102	-0.014	-0.048	-0.121	-0.084	N/A
Head of HH is a female	-0.003	-0.093	0.233*	-0.196	0.082	0.295	-0.185	-0.078
Head of HH is married	-0.092	-0.089	-0.073	0.013	0.126	0.248	-0.318**	0.033
Head of HH is widowed	0.036	0.038	0.076	-0.102	-0.058	-0.118	0.184	-0.003
Head of HH: has a legal id	-0.068	0.163	-0.140	-0.059	0.383***	N/A	-0.050	0.077
Head of HH: highest level of education received	0.141	0.136	-0.042	0.021	-0.151*	0.066	0.219	-0.349
Forced migrant	0.162	0.167	N/A	N/A	0.322*	N/A	N/A	N/A
Head of HH: Darod	-0.229**	-0.317***	0.257*	0.687	0.060	-0.085	-1.237***	0.145
Head of HH: Digil	-0.255***	0.007***	-0.446	N/A	N/A	-0.039	0.023	N/A
Head of HH: Dir	-0.167	-0.209	0.179	-0.104	0.004	-0.661	-0.053	0.044
Head of HH: Hawiya	0.391**	0.360**	N/A	-0.366	-0.531***	-0.121	1.821***	-0.208
Head of HH: Ishaak	-0.025	-0.030	N/A	N/A	0.020	N/A	-0.032	-0.137
Head of HH: Rahanwein	0.064	0.053	0.197	N/A	0.518**	0.690	-0.012	N/A
Head of HH: Other	0.076	0.065	0.059	N/A	0.263*	-0.085	-0.137	0.037

Notes: T-tests are conducted for each indicator to test the null hypothesis that the difference in means between recipient and non-recipient groups is zero. Indicators are listed on the left. * p<0.10 ** p<0.05 *** p<0.01. Column (1) reports the normalised difference in means for the full sample. Second column reports the normalised difference in means for households in Somalia, excluding Somaliland. Column (2) reports the normalised difference in means for households in Somaliland. Columns (4)-(8) report difference in means for households in Galmudug, Hiirshabelle, South West State, Jubaland, and Puntland. *Dependency ratio relates the number of children (0-14. years old) and older persons (65 years or over) to the working-age population (15-64 years old).*

Does the SNHCP reach the very poorest households?

The SNHCP reached 17 out of every 100 households. We define exclusion error as the proportion of the poorest 17% of households who were not enrolled in the programme, and inclusion errors as the proportion of recipient households who did not belong to the bottom 17%. With these definitions, the two equate to 70% (Figure III-3). This means 70% of the very poorest households were not reached, and 70% of recipients were not among the very poorest households.

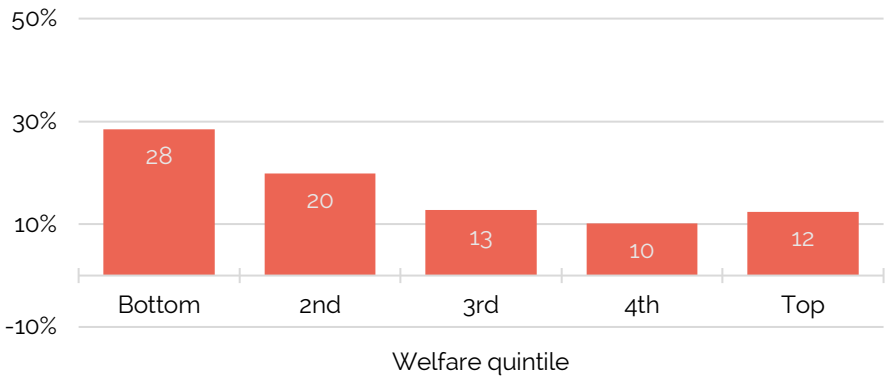
Figure III-3 Percentage of households covered, by pre-transfer welfare percentile



Notes: Households weights applied. Pre-transfer welfare is measured by real pre-transfer household expenditure per capita. Real expenditures take into account of the regional differences in living costs.

Recognising that Somalia has a high headcount poverty rate and that these targeted villages were selected due to their low levels of living standard, it is possible that those who were not the poorest 17% were also living in poverty. With that in mind, we also examine the coverage by quintiles. 28% of households in the bottom quintile were covered, but also 12% of households in the top quintile (Figure III-4). If the target was to be widened to the bottom two quintiles (bottom 40%), 76% of households in the bottom two quintiles were not covered, and 12% of the households in the other quintiles were covered.

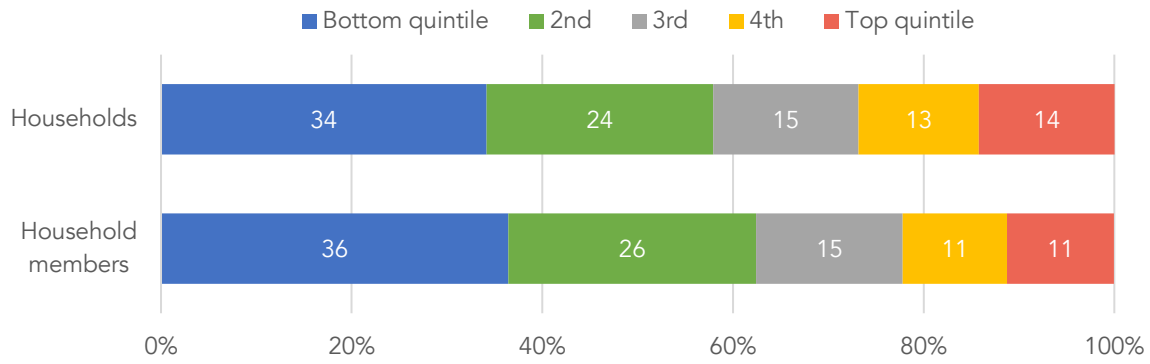
Figure III-4 Program coverage of each pre-transfer consumption quintile



Another way of assessing poverty targeting performance is to examine beneficiary incidence across the welfare distribution: that is, the percentage of SNHCP households or their members in a quintile relative to the total number of programme recipients. A programme is considered pro-poor if more than 20 per cent of its total beneficiaries belong to the bottom 20 per cent of the distribution, or if more than 40 percent of its total beneficiaries belong to the bottom 40 percent of the distribution (World Bank, 2018).

Figure III-5 shows the percentage distribution of SNHCP recipient households. In the pre-transfer welfare distribution, 34 per cent of SNHCP households belong to the bottom quintile, while 58 per cent belong to the bottom 40 per cent. The beneficiary incidence of individual recipients is even more pro-poor, as households at the bottom of the distribution tend to have more family members than households at the top, with 62 per cent of people in SNHCP households belonging to the bottom 40 per cent of welfare distribution. The SNHCP programme primarily targets the population in the bottom 40 per cent of the welfare distribution, however about 42 per cent of the SNHCP recipient households belong to the top 60 per cent of the pre-transfer welfare distribution.

Figure III-5: Percentage distribution of SNHCP recipients by quintile of pre-transfer welfare



We also used ordinary least squares (OLS) regressions to further explore the relationship between households' pre-transfer level of consumption and programme participation. Specifically, we estimate the following equation:

$$y_i = \alpha + \beta \cdot SNHCP_i + \epsilon_i, \quad (1)$$

where y_i is pre-transfer welfare of household i, $SNHCP$ is a dummy variable taking the value of one if household i received SNHCP transfers, and zero otherwise. β is the coefficient of interest, which captures the extent to which pre-transfer welfare is correlated with selection into the programme. If β is negative, programme recipients are, on average, less well-off compared to non-recipients. Other model specifications included community fixed effects (see Table III-2). Results from the regression analyses confirm that recipients have statistically significant lower levels of pre-transfer welfare than non-recipients. In absolute terms, the pre-transfer monthly household consumption per capita among recipients of the SNHCP is estimated to be between USD5 and USD11 lower than that of non-recipient households, depending on the model specification (Columns 1 and 2). In relative terms, recipient households' pre-transfer welfare is between 17 and 36 per cent lower (columns 3-4). SNHCP households are also 8 to 14 percentage points more likely to be living in the bottom welfare decile before the start of the programme than non-recipient households.

Table III-2: Relationship between pre-transfer welfare and receiving SNHCP transfer

	(1)	(2)	(3)	(4)	(5)	(6)
	Pre-transfer exp (USD)	Pre-transfer exp (USD)	Pre-transfer exp (log)	Pre-transfer exp (log)	HH in lowest decile	HH in lowest decile
Received SNHCP transfer	-11.45**	-5.173**	-0.363***	-0.174***	0.143***	0.0816***
	(4.628)	(2.162)	(0.102)	(0.0303)	(0.0288)	(0.0158)
N	3137	3137	3096	3096	3137	3137
R-squared	0.0135	0.148	0.0320	0.258	0.0313	0.215
With village FE?	No	Yes	No	Yes	No	Yes

Notes: Clustered standard errors by village in parentheses. * p<0.10 ** p<0.05 *** p<0.01. Outcome variable is pre-transfer expenditure in USD for columns 1-2, pre-transfer expenditure in logs for columns 3-4, and a dummy variable taking value of 1 if household was in lowest decile, and zero otherwise, for columns 5-6. Columns 2, 4, 6 include village fixed effects. Sampling weights applied.

B. Drivers of targeting performance

The second objective of the evaluation is to assess the drivers of targeting performance. In this context, it is worth restating that the evaluation assessed targeting performance of the programme against welfare rankings based on household consumption per capita. In practice, it is not feasible to perfectly identify the poorest households based on this welfare measurement. As with other social protection programmes, implementors of SNHCP had to rely on targeting methods which made use of proxies for which data was easier to obtain. In this section, we review the targeting methods used to identify SNHCP beneficiaries: geographical targeting and community-based targeting.

Does the geographical targeting mechanism prioritise the poorest locations?

The geographical selection of programme districts was performed based on population estimates. The subsequent selection of villages was based on distress ratings, as well as accessibility, conflict sensitivity, clan dynamics, and implementing capacity of local partners. In each district, a quota was placed on the maximum number of recipients in proportion to their share of the total number of households with children under five in all selected districts. With the lack of up-to-date district-level data, these population estimates were extrapolated from the 2014 UNFPA census. Within districts, villages were selected based on their proximity to nutrition and health centres and the presence of WFP implementing partners.

As a result of the geographical targeting, therefore, locations with the largest numbers of consumption-poor households were not automatically selected or did not necessarily receive the highest quotas. For example, Figure III-6 compares the average pre-transfer consumption expenditure per capita of households living in a village with a health facility – i.e., those that were more likely to have been selected in the geographical targeting process – with that of households in villages with no health facility. On average, households living in the vicinity of a health facility have levels of consumption that are 47 per cent higher. Figure III-7 compares the distribution of SNHCP households across states with the distribution of households in the bottom quintile of the overall welfare distribution. It suggests that some states have a 'disproportionately' large or small share of recipients in relation to their share of the overall number of households in the poorest quintile.

Figure III-6 Mean household pre-transfer welfare (US$) according to presence of a health facility in the village, by state

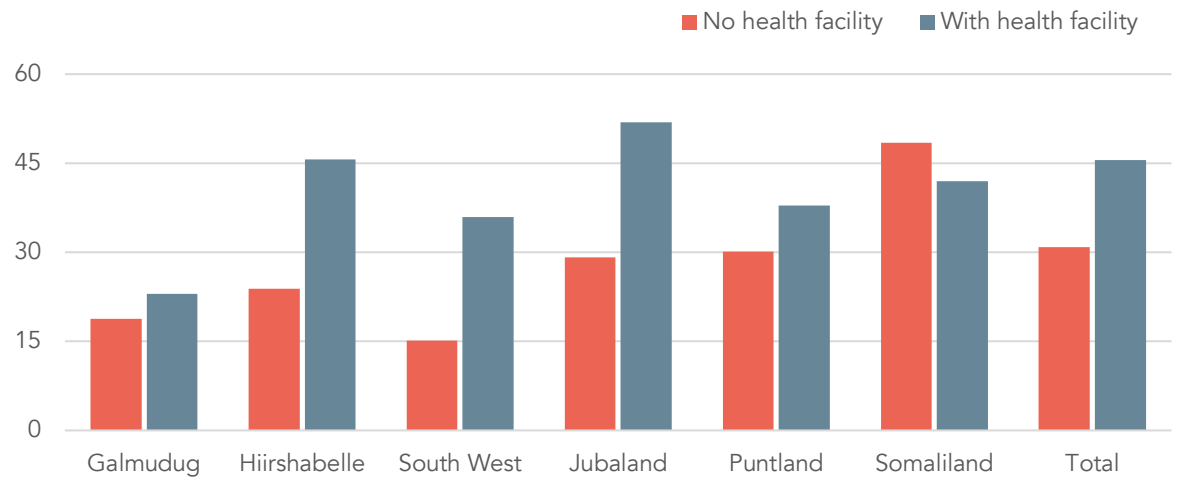
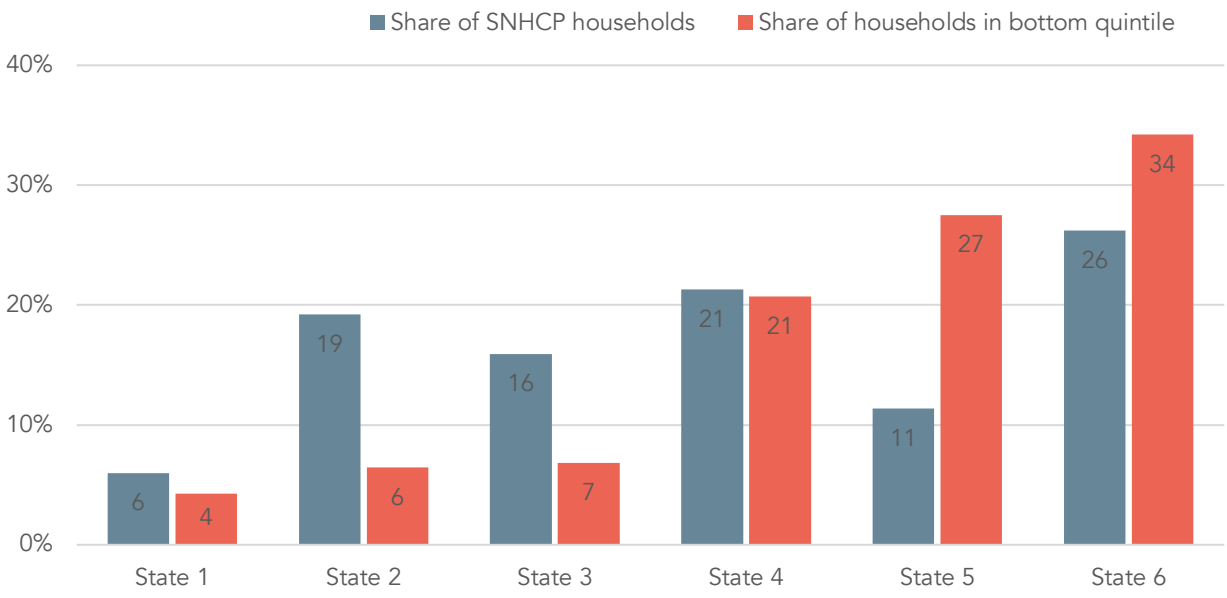


Figure III-7: Percentage distribution of (weighted) number of households in bottom quintile of the pre-transfer welfare distribution and households covered by SNHCP, by state



How was community-based targeting implemented?

Community-based targeting implies, by definition, that decision-making is delegated to the local level. Local selection criteria are thus not defined in terms of household consumption expenditure (nor would this be measurable easily or accurately in a way that is consistent with the welfare metric used in the targeting evaluation). The behaviours and decisions of community leaders and selection committees are shaped by a range of local political economy factors and social dynamics. However, the general literature on community-based targeting indicates that the quality of the facilitation and process is an important factor in targeting performance. This section therefore reviews how community-based targeting was implemented and to what extent it adhered to the processes described in the Project Operations Manual.

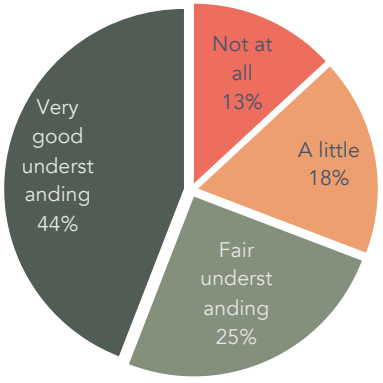
Understanding and awareness

From a programmatic and practical standpoint, the first step of the process after the community was selected was for the cooperating partner to inform community leaders about the SNHCP. Key information about the programme is shared with community leaders; misinformation at this point could lead to a snowball of inaccurate targeting further down the process.

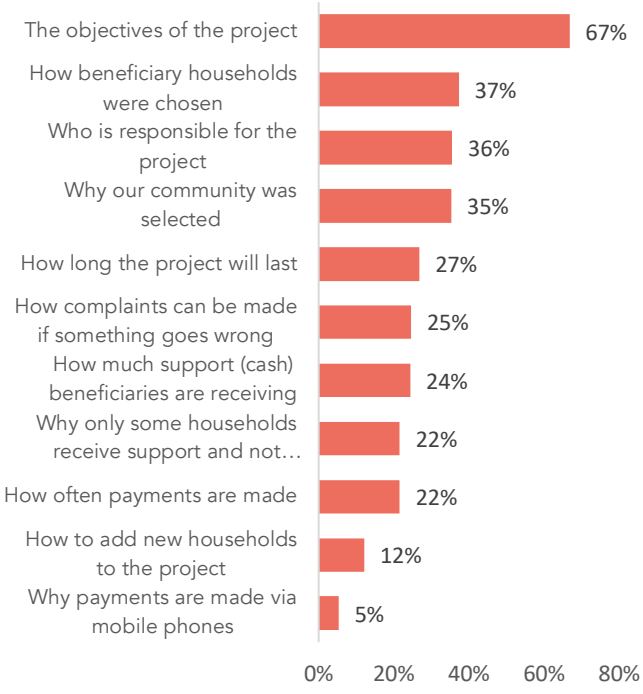
How effective was this communication? Just under half of the community leaders self-reported themselves to have a 'very good understanding' of the SNHCP, and a quarter of them thought that they had a 'fair understanding' of the SNHCP (see Figure III-8). However, while respondents generally understood the end goal, they seemed to struggle with the specific objectives of the intervention: two-thirds of community leaders admitted that they did not understand the objectives of the SNHCP well. Other aspects which were not well understood by a substantial proportion of community leaders were "Who was responsible for the project" (36%), "Why our community was chosen" (3%), and "How beneficiary households were chosen" (37%) – with the latter two being directly related to targeting. Finally, technical aspects were also mentioned by over a quarter of respondents (frequency of payments, duration of the project, cash amounts).

Figure III-8: Community leaders' understanding of SNHCP

How well do community leaders understand the programme?



Which aspects are not well understood?



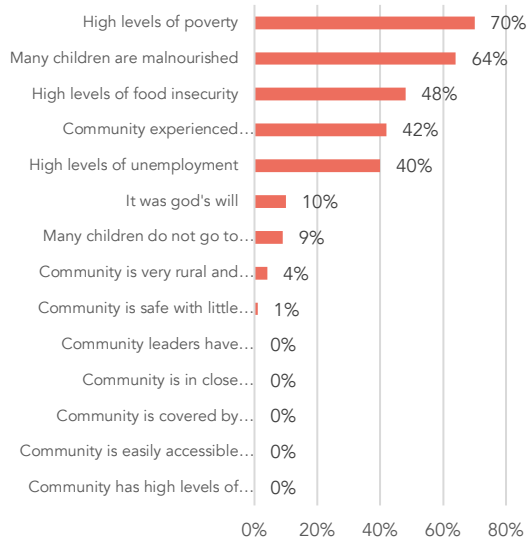
Limited clarity about the community and household selection criteria for some community leaders was also reflected in their responses to questions about the type of communities and households which should be chosen to receive the transfers (see Figure III-9). While there was an explicit decision to not use poverty rates to select communities, 70% of the community leaders thought that their communities were chosen due to "high levels of poverty". This notion ('poverty') remains difficult to assess in the Somali context and even more so among the communities and households interviewed, as it often refers to a subjective assessment and comparison with other communities, as opposed to a

standard or normative approach. Other reasons chosen by community leaders were closely linked to IPC rating; over half of the community leaders chose "high levels of food insecurity". It appears that there was an understanding that communities were chosen for their low level of living standards, but the exact measurements of living standards were not always understood.

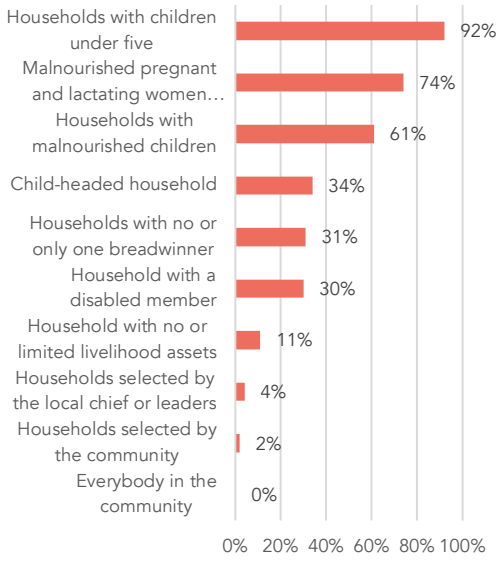
More importantly, especially from the point of view of social cohesion at the intra-community level, 92% of village leaders chose 'households with children under five' as the main criterion for selecting households. This clearly suggests that community leaders are aware of the rationale for the programme and can explain to their community members why the programme benefits some households and not others. Given the prevalence of this criterion (+15 percentage points) compared to the others, it may also explain why some better-off households (9th or 10th deciles) were selected at the expense of poorer households, when strictly speaking they were not as poor or vulnerable. This hypothesis would require further analysis - and in particular in-depth interviews with community leaders and better-off households. Other criteria appeared to be less effectively communicated. Only 30% of the village leaders knew that households with a member with a disability were a priority group, and only a third knew about the priority for child headed households.

Figure III-9: Community leaders' perspective on why the communities and households were selected, % of community leaders

Panel A: Community selection criteria



Panel B: Household selection criteria



Public meeting and information sessions

The next step of the process was for the community leaders to hold an initial community meeting 'la kulanka bulshada' to inform all members of the community about the SNHCP. One in ten sampled communities (11%) did not organise a public meeting to inform people about the project, with the most common reason being the presence of conflict and lack of resources or time.

Given the context of increasing insecurity in many of the targeted locations, this is a relatively good performance and it suggests – based on evaluations of cash-based interventions in the Somali contexts – that community leaders felt comfortable with the why, what, and how of the programme:

"For us, it is always difficult to tell our people that a new project will start if we don't understand or agree with the reasons why that programme starts. It may play against us and create tensions in the community".24

There are some reporting discrepancies between community leaders and households (see Table III-4). 25 Out of the villages with leaders who reported having held an initial public meeting, only 86% of these villages had more than half of the responding households reporting that there were initial public meetings. Such figures do not necessarily indicate an error or inaccuracy in the reporting by community leaders. Rather, if we relate this figure to the percentage of households that say they have attended public meetings, we see that a communication problem (medium rather than message) is possibly at the source of such discrepancies.

37% of the households in villages where initial meetings took place participated at the initial community meeting. The main reasons given by households for not participating are listed in the table below: lack of information (46%) and childcare responsibilities (22%) as shown in Table III-3.

Table III-3: Reasons given for not attending the public community meeting, % of households

Reasons for not attending public community meeting	
Not informed about the meeting	46
Caring responsibilities (for children or others)	22
Represented by community leaders	11
Work responsibilities (could not take time off)	10
Do not have a good relationship with rest of community	4
Local community leader(s) did not allow	2
Live too far away to walk	2
Too sick to attend	1
No money for transport	1
Well-off, do not need support	0
Total	100

Improving this situation would require particular attention to the content, location, and timing of information sessions. While there is no doubt that "la kulanka bulshada" is a contextually sound approach, the great disparities in the organisation of the sessions are questionable: between 5 and 1500 participants, with varying durations and very unequal interactions. An effort must be made to optimise the programme's outcomes in terms of ownership, awareness, and delivery.

24 FGD with community leaders in Beletweyne (Hirshabelle), May 2018.

25 *Table* III-4 provide a comparative analysis between community leaders and households as well as a rapid situational analysis of these sessions and the obstacles faced in terms of attendance and organisation.

Table III-4: Participation of the initial public meeting, reported by community leaders and by households

Comparative analysis: questions	Reported by community leaders	Reported by households	Plausible explanations or comments (based on similar interventions in Somalia – 2015 to 2020)
Was there an initial public meeting?	95% of villages	83% of villages have more than half of the household respondents saying that there was an initial public meeting.	The comparison is difficult to make but suggest that many households were not aware of these public meetings. Particular attention is needed to optimise the societal acceptability and socioeconomic dividends of the programme.
What are the three most common reasons for not attending the public community meeting?	Had to take care of children or other family members (33%) Live too far away to walk (20%) Not informed about the meeting (12%)	Not informed about the meeting (46%) Had to take care of children or other family members (22%) Had to work and could not take time off (10%)	Despite the 34-percentage point discrepancy on the issue of information ("not informed about the meeting"), it is probably the main reason. It is also one that can be addressed easily, through better planning and improved understanding of information networks (e.g. word of mouth and mosques).
Were households adequately informed?	17% of communities made no special efforts to inform people who had not attended the initial meeting.	23% of households were not aware of the SNHCP	For some IPs, the main goal of public meetings among community leaders is to promote: 1) acceptability; 2) social cohesion; 3) awareness. Implementing partners should implement corrective measures to harmonise approaches
What is the proportion of households participating in the initial public meeting?	51% of the villages reported that more than half of the households in the village were represented	84% of the households reported participating in the initial meeting in a village.	Out of the villages where the leader reported having more than 90% of the households represented, only 73% of the households reported participating in the initial meeting. Improvements should be considered.
Organisational modalities	Reported by community leaders		Comments
Attendance	227 participants on average (min 5, max 1,500).		More attention should be paid to 1) critical size (maximum 50); 2) templates and messages; 3) interactive communication.
Communication channels to invite people	Word-of-mouth (80%); announcements during other community meetings (34%), posters and flyers (5.0%) or in religious gatherings (3.4%)		Given the literacy level and sociocultural norms, word-of-mouth is unsurprisingly the most efficient channel.

Support provided by Baxnaano administrators	Drafting of agenda (38% of communities); leaflets and flyers (16%); speeches (14%); financial resources for food or drinks (5%); provision of megaphone (7%).	The organisation and modus operandi of public meetings need to be streamlined, as many Baxnaano saw it as a box to check, regardless of the specific context of the community.
Day of the week chosen for the meeting	Meetings tend to take place on weekdays – Monday (14%); Tuesday (28%); Wednesday (18%); Thursday (16%); Friday (7%); Saturday (14%); Sunday (3%)	The lack of a clear trend calls for more discussion among Baxnaano administrators to identify the most relevant day and inform households in time.
Inclusion of vulnerable groups	Most communities (93%) said they made special efforts to involve women or people with disabilities.	These findings are generally coherent with a good understanding of the rationale of the intervention (and its target audiences) among community leaders.

Perception of the selection process and targeting criteria

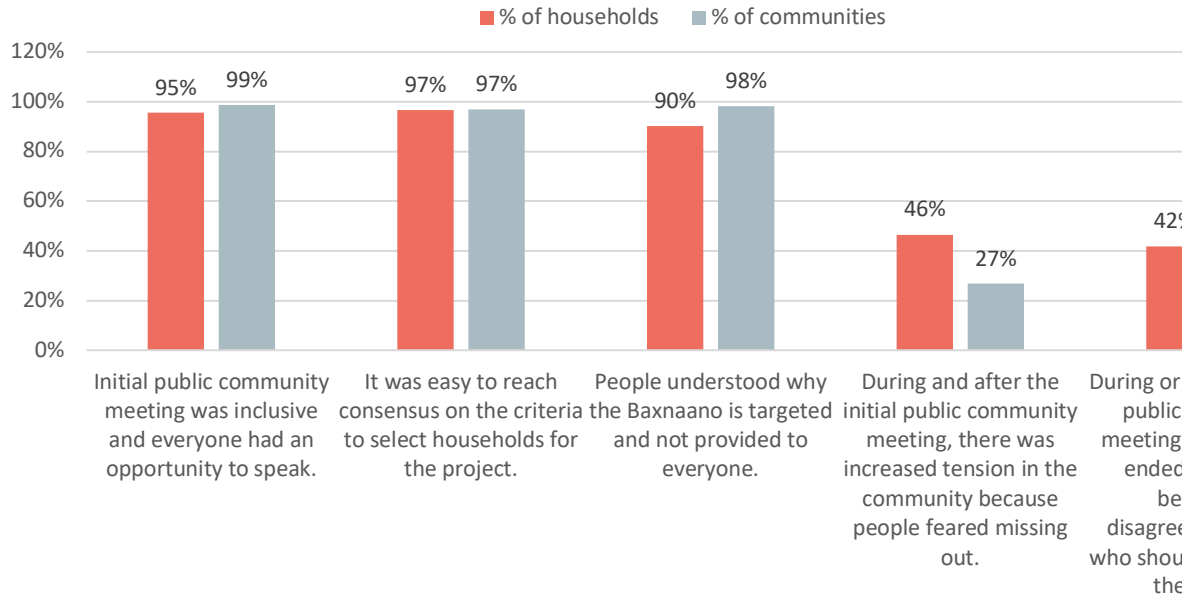
Another two questions where discrepancies between households and community leaders are not only remarkable but also useful in terms of future programming opportunities are: 1) physical fights, as 42% of households but only 6% of community leaders reported some fights about the selection process; 2) increased social tension, 46% versus 27% respectively (see Figure III-10). While the differences (+36 and +19 percentage points) are significant, it is worth considering the nuances, as there are many potential biases here: community leaders under-reporting incidents or, by contrast, frustrated non-beneficiary households over-reporting tensions and violence.

More importantly, given the relative socioeconomic homogeneity among the first 8 deciles (from US$ 9 to US$ 54, with a linear progression), it is naturally essential to bear in mind that even limited cash assistance can make a significant difference in terms of wellbeing. This difference might be objective (as evidenced in the present research) or purely subjective.

However, it can lead to tensions, especially at a time of crisis (conflict, drought), as households from the 5th decile may not understand while households from the 9th or 2nd deciles receive some assistance while they do not: 'targeting is extremely complex in such deprived communities, because you favour a few households who are supposed to be "extra-poor" versus others who are "very poor" or "simply poor". But the truth is that they all suffer from the same shocks and are equally vulnerable and poorly resilient to the next crisis. And they know it'26 This situation and the recurrency of drought, floods, conflicts, and other natural or human-made disasters might explain the paradoxical unanimity when both community leaders and households are asked to comment on the selection of beneficiaries (in principle), the criteria used, and the overall quality of the meetings: almost all respondents agree that the formal SNHCP targeting process procedure and prioritisation were optimal. However, this consensus does not always pass the test of reality – when 'people see their neighbours receiving cash or non-food items, while their family is also suffering from the same drought'27

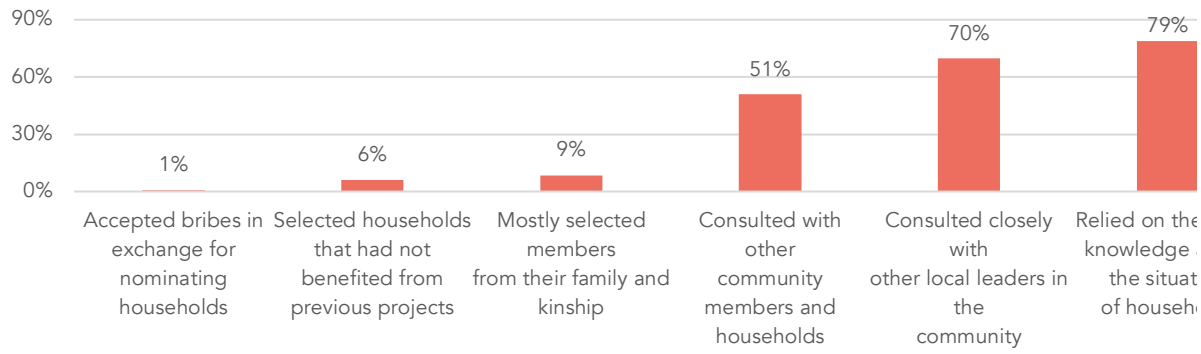
26 KII with WFP Somalia, August 2020.
27 KII with FAO-Somalia, August 2019.

Figure III-10: How well the initial community meeting went, perspectives from village leaders and households



Notes: Percentage of village leaders/households who have answered "strongly agree" or "agree" to these statements. Survey weights applied.

Figure III-11: Methods of household selection, percentage of villages

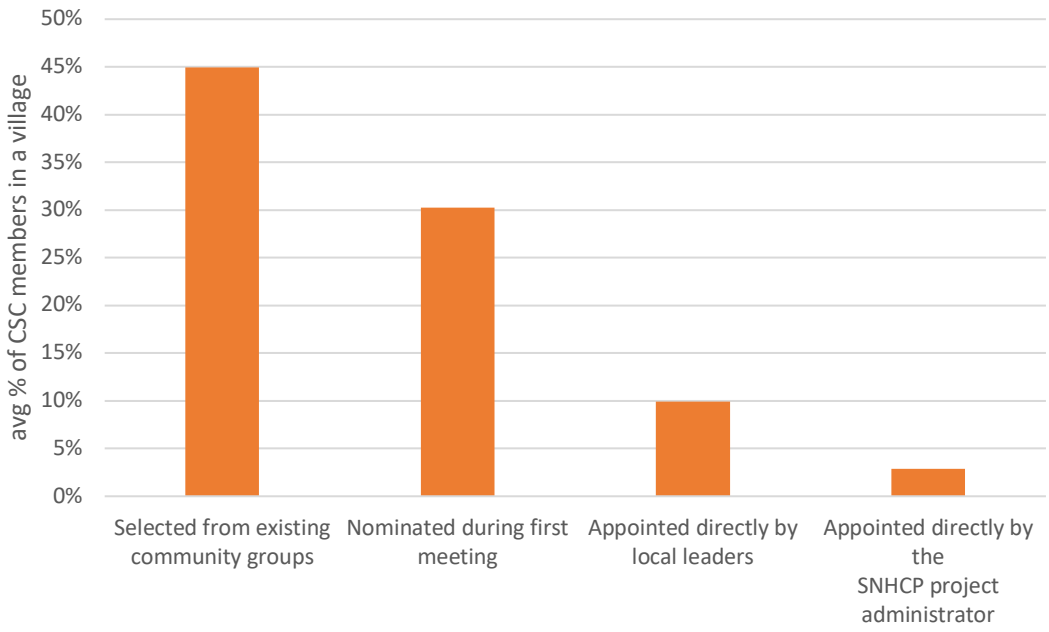


Notes: Responses to the question "How did the community selection committee decide on the initial list of beneficiaries for SNHCP". The option "Accepted bribes in exchange for nominating households" was translated as "Waxay aqbalen musuq ayago Kuwodelanaya in lo soo magacaba qosaska". Survey weights applied.

Selection Committees

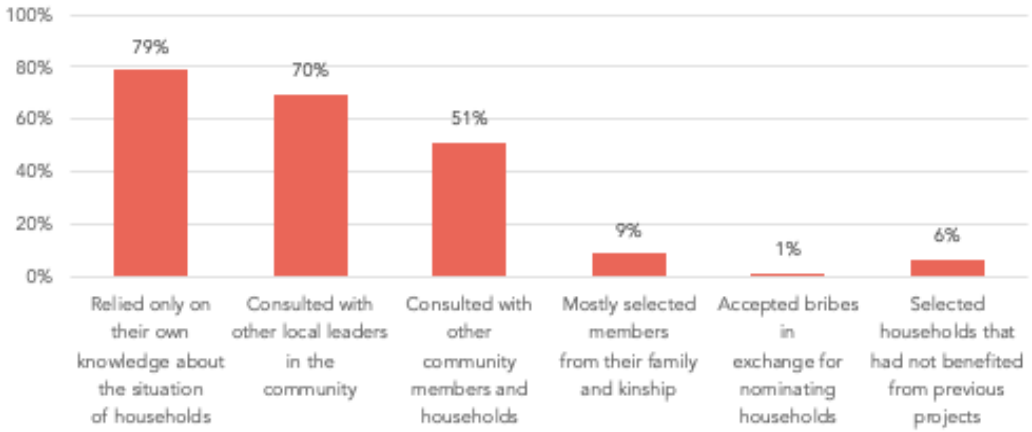
Looking at the composition of the CSCs (Figure III-12) which is a critical guarantee of transparency in the selection and targeting process, there is a prevalence of participatory methods (30% nominated during the first meeting) or approaches that recognise experience (45% selected from existing community groups). These data are consistent with other interventions that rely on community-based selection processes (in particular BRCIS, SomRep or STREAM in Somalia).

Figure III-12: Methods of CSC members selection, average percentage of members in a village



When members of CSCs (surveyed community leaders) were asked how their decisions were made (see Figure III-13), there was a willingness to be inclusive (51% consulted with other community members, 70% with other non-CSC local leaders) even though personal expertise was still favoured by 79% of the community leaders surveyed ('own knowledge').The fairly high percentage (9%) who say they selected members of their family or kinship may have two opposite reasons: either because the issue was put into context in communities where almost all members are of the same lineage or kinship; or because favouritism or nepotism was indeed put in place. The latter point deserves further qualitative analysis by the programme.

Figure III-13: Methods of household selection, percentage of villages



Comparative analysis: questions	Reported by community leaders	Comments (based on field observations and KIIs 2017-2020)[28]
Number of villages that established a CSC	93% of villages	The figure is consistent with field observations (discussions), even if there is a possible risk (over-reporting) as it is a key aspect of community leaders' responsibility.
Composition of CSCs	The mean number of members of the CSC is 9.	No comment – it all depends on the context.
Training conducted for CSCs	29% of the villages with a CSC received training.	This is too low and may contribute to misunderstanding and miscommunication – hence possible negative societal externalities. This figure needs to be discussed (and possibly further analysed) with implementing partners.
Inclusion of vulnerable groups	Only 19% of the CSC members in a village were female. 39% of the villages had a CSC member who had a disability.	Regarding the limited involvement of women, this is a missed opportunity given their pivotal role not only at the household level (traditional domestic role + financial management and resource allocation) but also at the community level (social intermediaries, income generation). Finally, many women are either left behind or are de facto heads of households when men have left to seek work in urban centres (construction). For people with disabilities, a case-by-case analysis would be more relevant to understand the nature of the disability, possible stigmatisation, as well as the modalities of subsequent inclusion.

Transparency, accountability, and complaint mechanisms

The last stage of the CBT process, in practice, concerns all the validation procedures and modalities by which a household is formally included in the group of SNHCP beneficiaries: how are households informed of the decision?

On the first point, it is positive to note that, according to community leaders, 97% of surveyed communities held public meetings to discuss and finalise the list of beneficiaries. In contrast, only 38% of households who were aware of SNHCP reported that the list of beneficiaries was displayed publicly. This figure covers two distinct realities: in some communities, the lists were not made publicly available; in other communities, it was the households (beneficiaries or non-beneficiaries) that were unaware of the publication.

However, some community leaders may have chosen not to voluntarily make the list public, as one NGO member of the BRCiS consortium pointed out in 2018: 'For the communities, it is complicated. Often, they have to make the lists accessible to everyone, but this is risky, and some are reluctant. This is not because of a lack of transparency or to avoid stigmatizing the most vulnerable, which can happen in other contexts; rather, it is to avoid creating tensions within the community between those

[28] Given the lack of additional qualitative data, apart from workshops and interviews with the World Bank, MoLSA, WFP, other UN agencies and implementing partners, this column and more generally this section has used quotes from KIIs conducted for other research projects in Somalia, either on social protection or cash distribution since 2017. Relevant KIIs were identified from counterparts at the World Bank, MoLSA, WFP, NRC, IOM, DRC, ILO, FAO, UNDP, Care, Save the Children, BRCIS, SomRep and ReDSS. None of the relevant quotes contradicted the data in the study, although some useful nuances were made here and there. Only a few of these have been included and their authors anonymised, in order to give more perspective to the information collected and the analyses conducted by the research team.

who receive aid and those who do not. This is especially true for cash.'[29] The final list of beneficiaries was displayed for an average of 39 days.

On the second point, the results are more mixed. Only 1/3 of households thought they could contest the choice of the beneficiaries, which does not so much indicate distrust of the programme as a kind of resignation to the decisions of the community (socio-cultural determinant). This total even falls to 18% for households with disability. Looking at appeals and complaints, only 31% of beneficiary households knew how to complain about the choice of the beneficiaries. This is a particularly sensitive point, which is confirmed by the large gap between the community leader survey and the beneficiary household survey: 50% of villages had the complaints helpline publicly announced, but only 28% of the recipient households stated that they knew the helpline to call to file complaints about SNHCP.

On the most serious complaints, such as corruption, it should finally be noted that the figures were higher than the norm for other cash-based interventions:[30] 12% of the recipient households admitted that someone offered them money in exchange for becoming a beneficiary.[31] Out of these households, 91% accepted these offers. Such offers were most commonly made by community leaders and are a clear violation of the project procedures

The data on potential bribery remains difficult to analyse without additional qualitative information, but it calls for several comments: 1) even if comparisons are always superficial, given the differences in context, other evaluations or studies conducted by the same research teams place the norm at around 5-6%.; 2) the consequences of the pandemic, recurrent conflicts, but also the recurrence of exceptional natural disasters (drought, locusts) may have contributed to increasing the trend; 3) households have little to gain from revealing these types of practices and may even have an interest in concealing them - in order not to lead to retaliatory measures - which suggests an underestimation of the scale of the phenomenon. If the SNHCP is to be extended, it will therefore be necessary to better identify the determinants of these direct cash requests, using qualitative data at the EU level but also more specific sociological analyses. While, from the point of view of the program, enrolling someone for a price is obviously a violation of procedures, it is Are these customs or practices generally accepted and considered as informal redistribution (or even redistribution) by community members? Are they, on the contrary, proven cases or attempts at corruption? In both cases, additional measures must be taken to avoid negative externalities and ethical abuses.

[29] Samuel Hall (2019) *Developing a Social Protection Policy for Somalia*, Scoping study and workshops for MoLSA, WFP, and UNICEF.
[30] While the methodologies and contexts differ (Afghanistan, Ethiopia, Somalia, Kenya, and Nigeria), a rapid review of 20 databases of 2015-2020 Samuel Hall reports – with almost similar questions for cash-based interventions – shows that on average responses hover around 4-7% - with only two outliers at 12% and 16%, the latter in a region notorious for rampant corruption in southern Afghanistan.
[31] The exact question was "Did anyone offer to help you with becoming a Baxnaano (SNHCP) beneficiary in exchange for money?" The Somali translation was "Ma jiraa qof kaa caawiyay inaad ka- faa'iideysto Baxnaano (SNHCP) iyadoo aad ku kala badalateen lacag?"

C. CBT process and targeting effectiveness

Do CBT processes matter to targeting effectiveness? We answer this question by using community-level regression analysis. Specifically, we estimate the following equation using OLS:

$$T_c = \alpha + \beta x_c + \gamma' Z_c + \epsilon_c \quad (2)$$

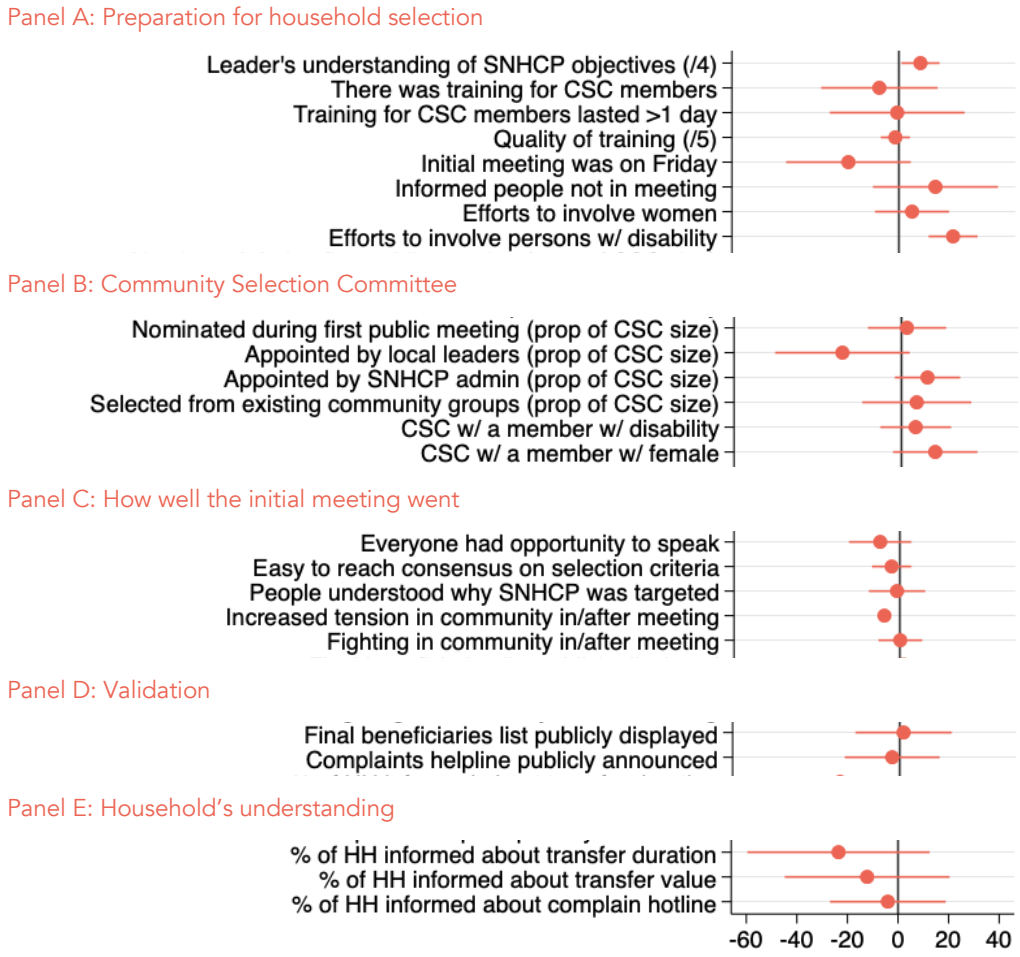
where T_c is a measure of targeting effectiveness in community c, x_c is a variable describing an aspect of the CBT process, and β is the coefficient of interest which informs us of the extent to which an aspect of the CBT process is associated with targeting effectiveness. Z_c is a vector of control variables, capturing the state in which community c is located, community size, and the mean pre-transfer welfare in that community.

To measure community-level targeting performance, we use the coverage rate of households in the bottom quartile of the village welfare distribution. Note that with the data at hand, these estimates are only correlational, and should not be interpreted as causal. In addition, acknowledging that we are analysing with a relatively small sample size, many estimates are imprecise with large standard errors; not being able to reject the null hypothesis does not mean that these processes do not matter to targeting effectiveness, but should rather be interpreted as inconclusive evidence. We report the corresponding estimates in Figure III-14.

We find that the processes to prepare for household selection in the community are important for improving coverage. An improvement of one point (out of four) in leaders' understanding of the programme's objectives increases coverage rate by 8.5 percentage points, significant at 10% level. Efforts from the leaders to involve persons with disability also improves coverage – coverage rate is 21 percentage points higher if a village puts special effort in involving persons with disability compared to if a village does not, significant at 5% level.

We also find that tensions during or after initial community meetings are negatively associated with the coverage rate. One additional score (out of five) in the response for the statement "During and after the La kulanka bulshada (initial public community meet), there was increased tension in the community because people feared missing out. Do you agree with this statement?" decreases coverage rate by 6.1 percentage points, significant at 1% level.

Figure III-14: Associations between CBT processes and coverage rate of those in the bottom quartile



Notes: Each point represents a coefficient estimated from regressions of coverage rate on a village characteristic variable. These village characteristic variable are listed on the left side. The 90% confidence intervals are illustrated in the line across each point. Survey weights applied.

How much of the targeting errors are attributed to within-community targeting?

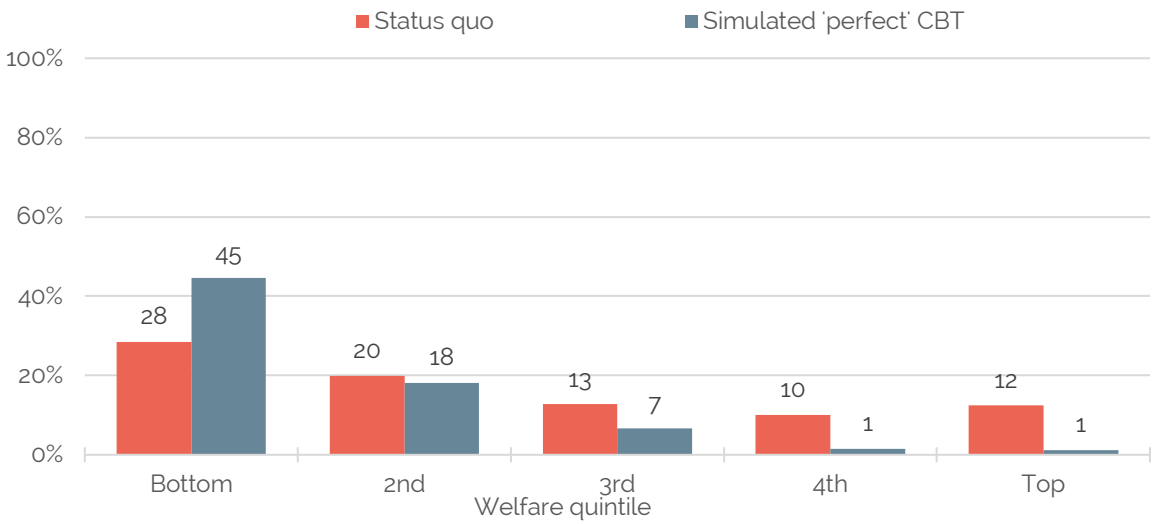
With SNHCP's multi-stage targeting processes, an important question is how many of the targeting errors we quantified in Section A were attributable to each stage of the targeting exercise. We provide a rough estimation of how many of the errors occurred during the geographical targeting and how many occurred at the community level.

We do this by simulating a hypothetical scenario with a fully accurate within-community consumption targeting in each village, but keeping the coverage rates the same. For example, if a village had a coverage rate of 10%, we hypothetically assign the households in the bottom 10% of the village-level welfare distribution as recipients. With this new assignment, we recalculate the overall inclusion and exclusion error.

With this scenario of 'perfect' local poverty targeting, we find that there would be an increase of the overall coverage among the bottom quintile from 28% to 45% (Figure III-15). The overall targeting error would drop by nearly one-third – from 70% to 48%. In other words, nearly half of the households in the bottom 17% would be reached (exclusion error), and nearly half of the recipients would not be in the bottom 17% (inclusion error).

Overall, we estimate that about a third of the poverty targeting error could be attributed to within-community and two-thirds to geographical targeting and quotas.

Figure III-15: Percentage of households covered, by pre-transfer welfare quintile



SHARING BEHAVIOURS

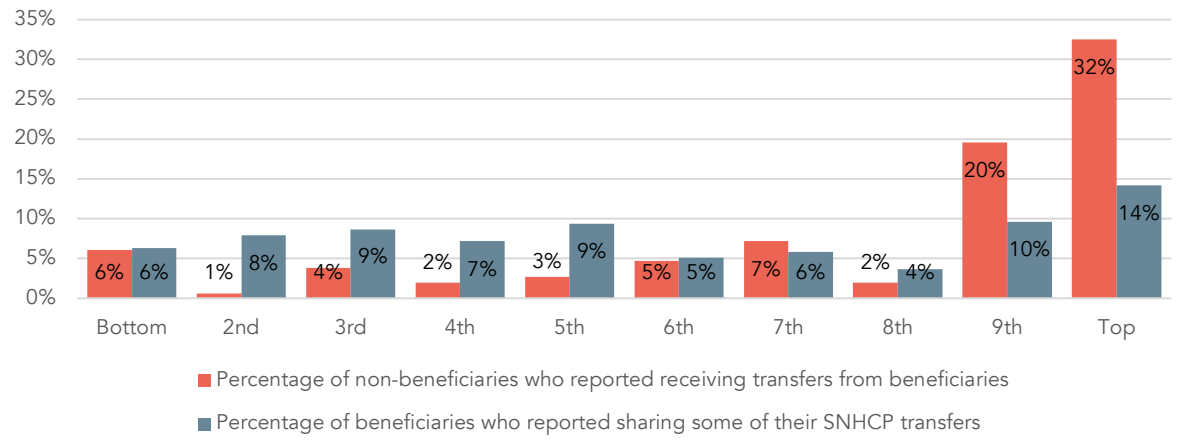
D. Sharing behaviours

The benefits of targeted transfers may be reduced if sharing is prevalent amongst communities. We find that only 8% of the recipient households reported having shared their transfers, and 8% of the non-recipient households reported receiving money from recipient households. Amongst the small percentage who reported sharing their transfers, the majority (88%) said that the sharing was voluntary, and the main recipients were beneficiaries' relatives (86%). The report amount shared is on average low – USD 0.85 per person after the most recent SNHCP transfer. This is equivalent to 7 percent of the quarterly value of SNHCP for a member of a 5-person household.[32]

While there is a strong sharing culture in Somalia and Somaliland (Herring et al., 2020), cash transfers – especially those which are delivered digitally – are easier to hide, and we do not find evidence that having the final list of beneficiaries listed publicly is correlated with the likelihood that a recipient household is asked to share their transfers. Households may also be sharing resources which are not directly from the transfers. Some 12% of the recipient households have given cash to other households in the past 12 months, and 22% of the recipient households gave in-kind transfers to other households in the past quarter. Indeed, we find that the likelihood of giving out both cash and in-kind transfers is significantly higher for recipient households compared with non-recipient households – by 12 percentage points and 13 percentage points respectively. Out of the recipient households who reported having given out cash or in-kind transfers to other households, 19% said that they had given out more than normal since the start of the SNHCP, with more responding that they had been giving out less (36%), or about the same amount (44%).

Sharing of resources between recipient and non-recipient households may not necessarily be 'negative' in the perspective of targeting effectiveness if there is a distributive system in the community. We find mixed evidence of this. While sharing of the transfers was most prevalent amongst recipient households who were in the highest pre-transfer welfare decile, receiving transfers from beneficiaries is also most prevalent amongst non-recipient households in the top decile (see Figure III-16.

Figure III-16: Percentage of recipient households who reported sharing transfers and percentage of non-recipient households who reported receiving transfers from recipient households, by decile

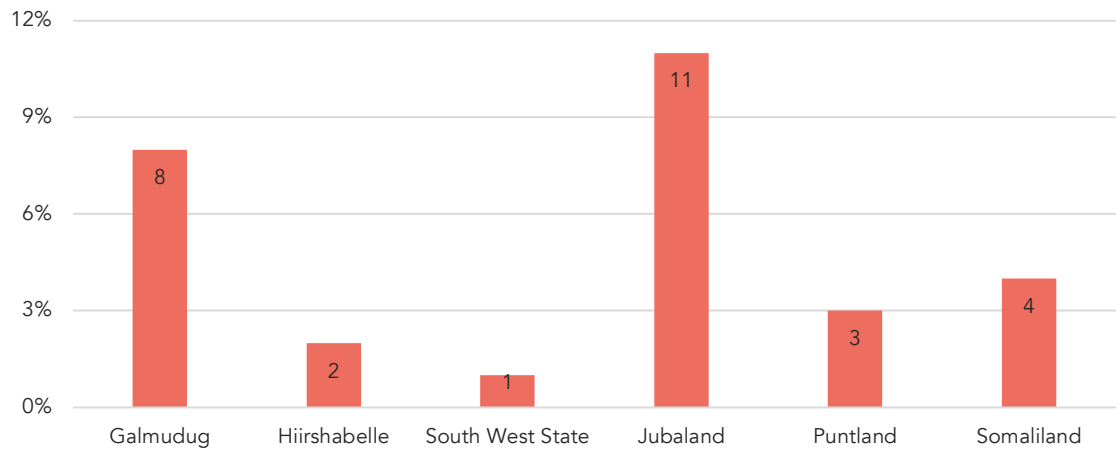


[32] Average household size is 5.3. SNHCP transfers are given quarterly.

Another possible concern is whether the SNHCP transfers crowd out other types of transfers which recipient households would have been receiving in the absence of the SNHCP transfer. We find that recipient households have a significantly lower likelihood of receiving domestic and international remittances, as well as social and insurance income, compared to non-recipients,[33] but we do not find any significant differences in the likelihood of receiving pension and income from charity/gift. These differences are difficult to interpret with the post-transfer data that we have, as it may be that households who are selected have lower remittances in the first place.

We also assess the decision-making patterns in the recipient households and whether the receipt of the SNHCP transfers lead to any intra-household conflicts. Figure III-17 shows the percentage of recipient households who reported a conflict arising due to transfers across five states of Somalia and Somaliland. Overall, only 5 percent of the SNHCP recipient households reported conflict arising from receipt of the transfer. However, at the state level, 11 percent of the recipient households in Jubaland reported intra-household conflicts arising due to transfers, while in South-West only 1 percent of households reported having conflicts about the programme transfers.

Figure III-17: Percentage of recipient households with conflict arising due to transfers



Further analysis of the intra-household decision-making pattern shows that about 88 percent of the recipient households have a female beneficiary of the programme, and among those 88 percent of the households, 74 percent report that female recipients decide how the SNHCP transfer is spent. In 21 percent of the households, the decision about how to spend the transfer amount is taken by their male spouse, and in 5 percent of households, elders and/or other persons in the household have the decision-making authority about the transfer amount.

[33] The reverse could also be true: SNHCP tends to help households who have limited access to remittances.

IV. CONCLUSION

IV. CONCLUSION

The first objective of the evaluation was to assess the targeting accuracy of the SNHCP, measured against welfare rankings based on pre-transfer household consumption per capita.

- Across the entire sample, 17 per cent of (weighted) households were enrolled in the SNHCP programme. Among SNHCP individual beneficiaries, only 62% came from the poorest two quintiles of pre-transfer consumption distribution, while the rest, 37%, came from the three better-off quintiles. Given the relatively low total coverage of the program and targeting errors, under-coverage is a problem since 76% of the poorest two quintiles were not reached by the program (exclusion error at 40th percentile).
- Notwithstanding inclusion and exclusion errors, targeting errors, SNHCP's coverage is broadly pro-poor. Our regression analysis shows that households at the bottom of the welfare distribution are significantly more likely to be enrolled in the programme than households higher up the distribution. Recipients have statistically significant lower levels of pre-transfer welfare than non-recipients (between 17 to 36 per cent lower, on average, depending on the model specification).
- While the evaluation assessed targeting performance of the programme against welfare rankings based on household consumption per capita, in practice, it is not feasible to perfectly identify the poorest households based on this welfare measurement.

The second objective of the evaluation was to assess the sources of targeting errors.

- The first stage of the targeting exercise -- geographical targeting of districts and villages – was challenging due to the lack of up-to-date population estimates and relied on imperfect distress ratings. Implementors also had to take into account the accessibility and security of the villages.
- Due to these challenges, the geographical targeting was conducted in such a way that resulted in imperfect targeting. Locations with the largest numbers of consumption-poor households were not automatically selected or did not necessarily receive the highest quotas.
- The effectiveness of the second stage of the targeting exercise – selection of households at the community level – depended on the adequacy of facilitation and adherence to the recommended process. For example, clan compositions of beneficiary households were different across the locations. In Hiirshabelle and Jubaland, there was a significantly higher proportion of households who were members of the majority clans in the recipient group compared to the non-recipient group. These differences in recipient and non-recipient profiles may reflect both the selection process, but also the profiles of households who fit the eligibility criteria.
- Overall, we found that there is a high variation across villages in the level of preparedness of the selection process and the way in which the selection was eventually carried out. Villages vary in the level of understanding of the programme among community leaders, effectiveness of communication channels, and inclusivity of the selection process across communities. We find some suggestive evidence that certain aspects of the processes, such as making special effort to include persons with disability, are correlated with targeting performance.

The third objective was to examine to what extent transfers are shared with households.

- Our analysis indicates that only 8 per cent of recipient households shared their transfers with others, and 8% of the non-recipient households reported receiving money from recipient households. Among those who reported sharing their transfers, the majority (88 per cent)) said that sharing was done voluntarily, and the main recipients were beneficiaries' relatives (86%). The amount shared is relatively low: USD 0.85 per person or around 7 percent of the quarterly value of SNHCP for a reference household of five persons. While other studies have found there to be a strong sharing culture in Somalia and Somaliland, our findings could indicate that cash transfers delivered digitally to mobile phones may be easier to 'hide' and therefore less commonly shared.

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