SOMALI CASH CONSORTIUM

MERAKI LABS

# Referral Mechanisms in Somalia

**Draft Report**

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Schweizerische Eidgenossenschaft
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# Executive Summary

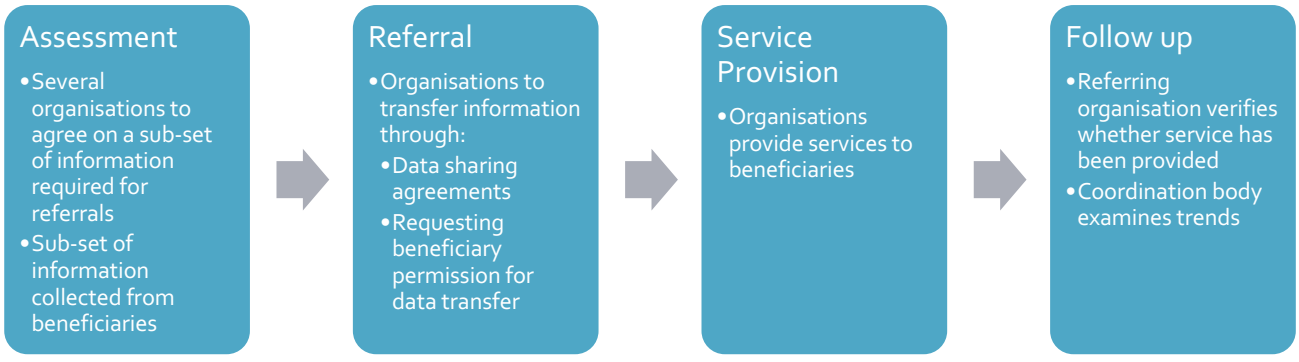
Over 6.9 million people face acute humanitarian need in Somalia, according to the 2024 Humanitarian Needs Overview. Need is driven by complex and long-term crisis, in which conflict has interacted with climate effects over the course of decades. For many individuals and households, need is multi-dimensional – for example, lack of water and sanitation can lead to health issues (e.g., acute watery diarrhoea) and associated nutrition issues. Need is compounded by displacement dynamics: 2.9 million people were newly displaced in2023, and for many, coping mechanisms were eroded through the displacement process.

In the complex context of humanitarian action in Somalia, referrals have not received significant focus. This is despite the fact that an efficient and effective referral system could help individuals and households address multi-dimensional need in a smooth and streamlined fashion – thus both reducing need and reducing cost for the humanitarian system.

The overall objective of this report is to **better understand the interconnections between cash and other sectors, to analyse the barriers to developing interconnections and to propose improved referral pathways**. It draws on an extensive desk review as well as 52 interviews with individuals and organisations at the coordination, management and field levels from consortia, clusters, UN agencies, INGOs, LNGOs, donors and independent actors.

## What are Referrals and What Is Needed for Referrals to Work?

The term **"referral"** has been defined by the Inter Agency Standing Committee (IASC) as "the process of directing a client to another service provider because s/he requires help that is beyond the expertise or scope of work of the current service provider. A referral can be made to a variety of services." Referrals play a critical role in humanitarian action, as they allow individuals and households to access many services from a different service providers, in contexts where single agencies cannot provide the range of services required to meet all needs.




- **"Individual"** referrals are those which address the specific needs of individuals or households, usually through a one-off service provision. They can take place between any sectors and are usually tailored to an individual's or household's specific needs.
- **"Scale"** referrals are those in which individuals or households are registered in large-scale programs for aid distribution, such as WFP's SCOPE or IOM's BRAVE. Scale programs provide uniform, basic services and support to populations in need – that is, they reach a large number of people often through regular and periodic distributions.

- **"Batch"** referrals are those in which groups of individuals or households, or whole communities, are referred between systems.

| Referral Type | Sectors | Databases | Examples |
|---|---|---|---|
| Individual | Protection<br>Health<br>Nutrition<br>Cash | GBVIMS<br>CPIMS<br>PRIMES<br>(proGres) | Referral of a GBV survivor from CMR services to justice to rehabilitation<br>Referral of a malnourished child and his/her household from OTP services to cash services |
| Scale | Food Security/ Distribution<br>Social Protection | SCOPE<br>BRaVE<br>USR | Inclusion of a household with a malnourished child into SCOPE to receive general food distribution support<br>Inclusion of a household with an elderly member into USR to get pension |
| Batch | Livelihoods<br>WASH | n/a | Identification of individuals appropriate to be registered in a vocational training course taking place twice per year. |

This study identified six prerequisites to effective referral systems based on the literature review and primary data collection. These are:

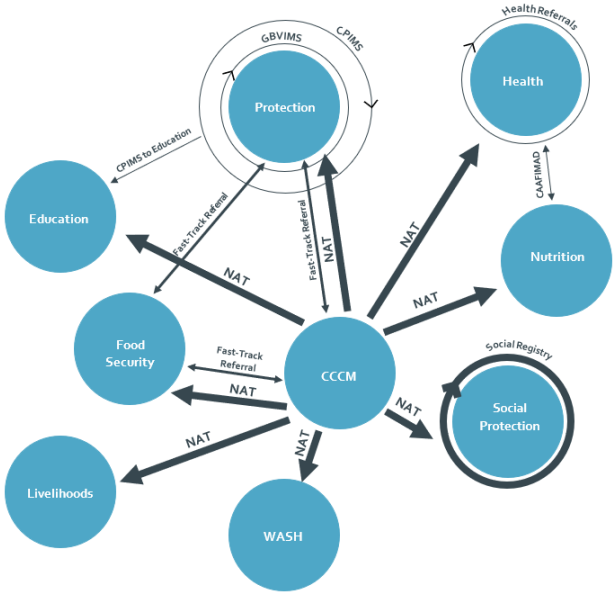
- **Adequate density of services**. Referral services are more likely to work, and to work effectively, in locations with density of services. Urban areas, for instance, are more likely to have a higher number of service providers in different sectors, therefore individuals and households are more likely to be able to access services in the referral system at minimal cost.
- **Adequate capacity of existing service providers**. The service providers that are present in a specific location need to have the capacity to accept new individuals in order for a referral system to maximise positive impact for populations in need.
- **Clear and accurate service mapping**. In order to refer individuals, service providers must have a clear understanding of what other services are available, where they are available, and what constraints exist to accessing services.
- **High and effective coordination, including clear consistent protocols**. In order for referrals to work, different agencies need to be able to clearly communicate about several things, including the needs of the beneficiary, the process for registering him or her in another service, the costs associated with any such service, etc. Coordination can take place on an ad hoc basis, or more systematically. Large scale referrals also need to integrate escalation protocols.
- **Relatively unified data collection and/or registration system**. Referral systems need to operate efficiently and parsimoniously in order for beneficiaries to want to access them – if they involve multiple time consuming assessments, beneficiaries are likely to drop out of the system. Effective referral systems that operate at scale are therefore likely to adopt a relatively unified data collection system which provides enough information to support transfer of individuals to relevant services, and which reduces the need for supplementary data collection.
- **Staff with adequate capacity and motivation to inform and follow up on referrals**. Referral systems are implemented by staff in various sectors. Staff need to be able to perform several tasks, including but not limited to identifying individuals in need of multiple services, registering individuals through the data collection/registration system, transferring information to another service provider, and following up to ensure that individuals receive services.

## The Referral System in Somalia

**The current referral system can be described as sectorally atomised and strongly concentrated in urban areas.** Ten different referral mechanisms were identified; some of these were led by clusters, others by

consortia, and others by individual agencies. The strongest referral mechanism, and the mechanism which had greatest buy-in across different sectors, was operated by the CCCM cluster and used the New Arrivals Tracking 2.0 or 2.5 form. Some specific sectoral mechanisms were also highly trusted, notably the referral system between a health and nutrition consortium (CAAFIMAD) and a cash consortium (SCC).

**Very few actors, at any level, have a clear picture of the referral landscape – indicating that referrals are unlikely to be broadly effective or impactful.** During primary data collection, interviewees were asked to list the referral systems they were aware of in Somalia. Of the 52 interviews conducted for this research, no two actors identified the same set of referral systems. The lack of cohesion with regard to referrals was associated with several different factors, notably the sectoral specificity of some mechanisms, the divide between humanitarian and development actors, and the use of informal mechanisms.




**There are geographic gaps: very few referral mechanisms cover hard to reach areas and rural areas, in large part due to lack of services in these areas and lack of adequate funding for services**. Across the interviews conducted, over 90% of interviewees indicated that it was challenging to set up referral mechanisms in hard to reach and rural areas. One of the primary reasons for lack of referrals in hard to reach areas was associated with lack of services in these areas, associated with lack of sufficient funding.

**Referral systems are siloed: even when they do exist, they are likely to focus on a small range of sectors**. Currently most operational referral mechanisms in Somalia focus on specific sectors, and staff who make the referrals do not know what to do when they identify a need in another sector. The health-nutrition-cash referral system is effective, but if staff identify a protection issue, they struggle with (a) lack of knowledge about protection referral systems (e.g., GBVIMS, CPIMS) and lack of engagement with protection specific actors.

**Some sectors have limited engagement with referrals, likely because they require 'batch' referrals**. Some sectors find it difficult to manage referrals because they engage in one-off or periodic service provision (e.g., start of a vocational training course). These challenges can be illustrated through an example – field staff in a non-WASH sector may observe a lack of water in a specific community, but their capacity to quantify the gap, or to raise the gap to higher level management of a different organisation who are responsible for selecting new sites for boreholes, is likely to be limited.

**Despite these challenges, the pre-requisites to achieve referrals are broadly in place**.

| Prerequisite | Status | Explanation |
|---|---|---|
| Density of services | | Services present in urban areas<br>Services not present in rural/Hard to Reach<br>Transport from rural to HTR has not been explored |
| Capacity of Service Providers | | Service providers in urban areas often have the capacity to provide services – for example Banadir hospital accepts referrals.<br>Major drawbacks identified through the interviews are (1) the funds to provide and/or expand services, (2) flexibility from donors to include referrals in their caseload, and (3) logistical and operational capacity. |
| Service mapping | | More than 75% of respondents said service mapping was not present or insufficient<br>No cluster TORs included accountability for service mapping<br>Service mapping needs to be localised to specific areas and regularly updated. |
| Coordination (incl protocols) | | With the exception of CCCM, no evidence that clusters felt accountable for referral coordination<br>Clear feedback on coordination from the IAHE<br>Coordination needs to take place at a sub-national level, through ABCs or OCs – the way forward for local coordination is currently unclear. |
| Unified data collection system | (conditional) | Development and rollout of the SRF represents progress and opportunity<br>Work needs to be done to identify "eligibility thresholds" that automatically flag candidates for referrals |
| Staff capacity to conduct referral | | Effective referrals between SCC and CAAFIMAAD demonstrate capacity<br>Discussions with field staff (15) through this research indicate capacity |

## Barriers to Effective Referral Mechanisms

The most significant barriers to effective referral mechanisms are as follows:

- **Lack of accountability for referral systems**: No organisation or structure is currently responsible for ensuring that referral mechanisms are effective in Somalia. OCHA is the natural organisation to assume accountability for referral mechanisms – but currently is not seen as a leader with regard to referrals. While donors push referrals on a regular basis, the lack of a 'lead' or an accountable organisation is perceived as a major gap in changing operational modalities.
- **Lack of organisational incentives to ensure that referral systems are effective**: Humanitarian organisation have a mandate to reduce need, and implied in this is an assumption that organisations should be people centred and accountable to effective populations. In practice, humanitarian organisations are accountable, less to people, and more to donors for meeting operational funding targets, and to the humanitarian system for a specific level of engagement in coordination forums, etc. Given this incentive structure, organisations obtain no specific benefit from investing in an effective referral system. Instead, they incur costs – notably staff time, budget associated with travel for beneficiaries, and management time.

- **Lack of a clear referral infrastructure (coordination, protocols and service mapping)**: A key barrier to implementation of referral mechanisms is the rapid shutdown and startup of services, combined with the absence of a referral infrastructure.
    - **Service Mapping.** Over 75% of interview respondents noted lack of service mapping as a major barrier for referrals; field staff who encountered specific beneficiary needs could not access service mapping, so instead relied on personal networks to refer. To support effective referrals, interviewees specified that service mapping needs to be (1) adequately localised (i.e., to refer to a specific district or neighbourhood), (2) adequately detailed with regard to both activities and acceptance criteria (i.e., specific activity level details should be provided, and any restrictions on beneficiary engagement or acceptance should be outlined, and (3) adequately updated (i.e., services that are no longer functional should be identified, as should services that no longer have the capacity to accept referrals).
    - **Coordination and protocols.** Several interviewees noted that formal protocols were not necessary for a referral mechanism to function effectively, with one interviewee pointing out that the development of protocols for one specific referral mechanism coincided with the collapse of that mechanism. Others noted that it was important for protocols to be adaptable to local and sectoral specificities – for example, it could be difficult to roll out a full referral protocol in a hospital context with a patient who wanted to leave.


## The Way Forward for Referrals

**The humanitarian system faces a range of competing priorities in Somalia – and a recent evaluation has pointed out that accountability is poor**. There is a need for internal reform, which has been started but also requires strengthening. A recent IAHE evaluation found that coordination structures are very heavy that there have been critical gaps in recent response. An increased focus has been placed on aid diversion following the production of a post-distribution aid diversion (PDAD) report and the setup of a workstream to address underlying issues. **Given the scale of needs and the range of competing priorities, why should referrals be prioritised?**

| Reason for Prioritising | Target Audience | Associated Policy Initiatives |
|---|---|---|
| Delivering holistic services to those most in need | Community<br>Humanitarian System<br>Field Staff | People Centred Approach<br>Accountability to affected populations<br>Operationalisation of the 'nexus' |
| Litmus test for improvement of coordination systems | Coordination<br>Management and Leadership | Response to IAHE |
| Risk mitigation for de-duplication initiatives | Humanitarian System<br>Management and Leadership | Response to PDAD |
| Inclusion of sectors which are currently not fully reflected | Community<br>Humanitarian System<br>Field Staff<br>Coordination | People Centred Approach<br>Accountability to affected populations<br>Operationalisation of the 'nexus'<br>Response to IAHE |
| Reduced funding availability | Humanitarian system<br>Coordination<br>Management and Leadership | Response to global events and trends |

**What parameters are required for a referral system?**

| **Question** | **Answer** |
|---|---|
| Are biometrics a pre-requisite for starting to improve the referral system? | **NO** |

**Rationale**

Effective referral involves balancing two factors: (1) the need to ensure smooth data transfer between organisations, especially those of different size and capacity, and (2) the need to support beneficiary data protection and privacy. This research finds that currently, smooth data transfer does not take place, especially between, on the one hand, smaller INGOs and LNGOs, and on the other hand, large-scale systems (SCOPE, BRAVA). In order for a referral mechanism to function, a wide range of actors need to be able to access the system – both to refer beneficiaries into the system, and to accept referrals from other organisations. Many of these organisations, especially LNGOs and smaller INGOs, lack the budget to invest significantly in data and IM systems. If biometrics are established as a pre-requisite for a referral mechanism, then the majority of LNGOs and small INGOs will be excluded from the system.

| **Question** | **Answer** |
|---|---|
| Is it necessary to have interoperable IM systems to start building a referral system? | **NO** |

**Rationale**

An optimally efficient referral mechanism will involve automatic data transfer from the IM system of the referring agency to the IM system of the accepting agency. This can be facilitated through global/blanket data sharing agreements, such as the types which have already been negotiated between WFP, UNHCR, IOM and the Somali Cash Consortium. Existing efforts to support data sharing agreements should be

expanded. But IM systems are NOT a pre-requisite to effective referral mechanisms. There are instances of effective referral systems functioning using excel databases and ad hoc data transfer mechanisms.

| Question | Answer |
|---|---|
| Should a referral system be sequenced or holistic? | **SEQUENCED** |

**Rationale**

In Somalia the humanitarian, development and peacebuilding sectors operate in parallel, given the scale and scope of the crisis. In building a more effective referral mechanism, it is possible either to (1) focus on the humanitarian system alone, or (2) develop a system that actively addresses the needs of all systems at once.

| Question | Answer |
|---|---|
| To what degree does the Government of Somalia need to be involved in the referral system? | **LIMITED INVOLVEMENT IN THE INITIAL STAGES** |

**Rationale**

One of the most significant perceived obstacles to referral systems is data sharing between different organisations. Organisations have limited trust in each other's capacity to adhere to data protection regulations, and this is particularly difficult in a context where beneficiaries face significant physical risk. Although it may not be possible to share data with the Government of Somalia, there are other options for engagement. Some of these include (1) structuring referrals around neighbourhood and area structures that are also used by government actors (e.g., through DANWADAAG), (2) engaging systematically with the USR and UBR mechanisms, and (3) conducting regular update sessions that include government actors, in which data from the referral system is analysed.

| Question | Answer |
|---|---|
| Who should be accountable for the referral mechanism? | **OCHA (policy)**<br>**ICCG (national tracking)**<br>**ABC and OC (local tracking)** |

**Rationale**

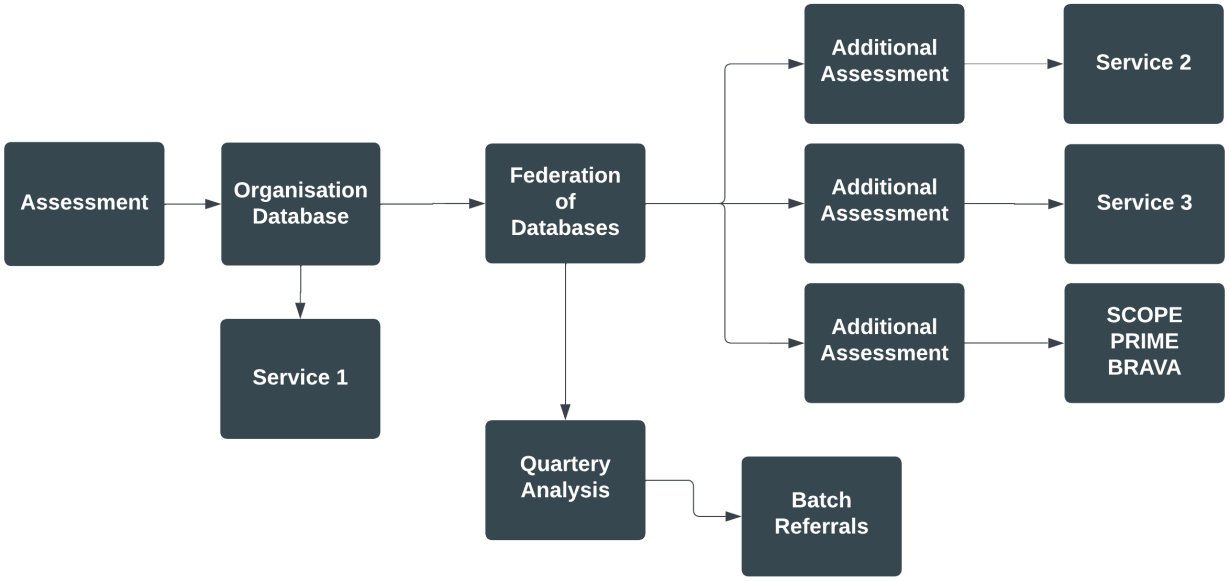
This report recommends that a clear split take place with regard to accountability for referral systems, as follows; it also recommends that clear and actionable targets be set for each agency/forum with regard to referrals

- OCHA is accountable for establishing policies and standards relevant to referrals
- The ICCG is accountable for tracking (1) the number of referrals that have taken place, and (2) the number of referrals that have received follow up services, at a national level
- The ABC/OC is accountable for: (1) service mapping, (2) tracking the number of referrals that take place, (3) tracking the number of referrals that have received follow up services, and (4) conducting quarterly analysis workshops to identify trends and feed into improved future programming, on a local level.

**What are we aiming for?**

- The referral process involves providing an individual, household or community with a comprehensive set of services – and the process can start with any agency including LNGOs.
- A sub-set of data is transferred from any agency – small, medium or large – to other agencies who could provide related services.
- After data transfer takes place, the accepting organisation reviews and accepts the beneficiary only if pre-existing criteria are met.
- ABCs/OCS provide the underpinning infrastructure – service mapping and tracking – and the ICCG monitors at the national level.
- ABCs/OCs conduct quarterly analysis and batch referrals to medium-term and community programs (e.g., livelihoods programs).

**Diagram 3 - Likely Case**




## Key Actions and Next Steps

Eight key actions need to be taken to improve referrals. These are:

1. **The humanitarian leadership should make a commitment to track progress of referrals – and use this to demonstrate response to IAHE recommendations**. There have been increasing calls for reform of the coordination system in Somalia, including in but not limited to the IAHE. Referrals require coordination – if referrals are taking place, then effective coordination between the agencies that refer and receive must, by default, be taking place. Measurement of referrals in Somalia thus provides a tangible and concrete way for humanitarian leadership to address questions about coordination
2. **Humanitarian leadership should assign accountability for national level tracking of referrals to the ICCG**. Referrals currently are not the responsibility of any single agency in the humanitarian system. Assignment of accountability will support progress , as one institution will be responsible for following up, and less will fall through the cracks. This report recommends that, at the national level, the ICCG tracks the number of referrals and their success rates per location; this is in line with the ICCG's responsibilities, as per their global level TORs. OCHA should be responsible for developing relevant standards and policies.

3. **Accountability for accurate local-level service mapping and local level tracking of referrals should be explicitly assigned to ABCs/OCs**. One of the most frequent issues that arose in data collection was lack of accurate service maps, and lack of updating. This should be clearly included in the TORs of ABCs or OCs. It should be conducted at a district level to enhance utility. Similarly, ABCs and OCs should be explicitly assigned responsibility for tracking the number of referrals that take place in their areas, as well as the outcome of these referrals. This responsibility should be included in their TORs.
4. **Donors should explicitly include achievement of successful referrals as a condition for provision of grants and top ups**. There should be, at least for the short term, the development of organisational incentives for implementing effective referral systems. This could include (1) ensuring that a specific proportion of beneficiaries are identified through referrals in new programming, (2) allocating top-ups on the basis of successful achievement of referrals, (3) allocating new funding in part based on engagement in the referral system, and (4) asking organisations to explain their performance on referrals in regular reporting.
5. **Donors should ensure that the majority of grants – and all grants in priority sectors – include targets for the proportion of beneficiaries to be identified through referral mechanisms**. Donors across the humanitarian and development communities should ensure that referrals and referral tracking are integrated into program design. This includes ensuring that all grants in priority sectors, and the majority of grants outside priority sectors include targets for the proportion of beneficiaries identified through referral mechanisms, and ensuring that implementing partners report on the number of beneficiaries identified through referral mechanisms over the grant period.
6. **Agencies responsible for major data systems – UNHCR, WFP and IOM – should jointly commit to ensuring that their systems can interact with referrals from small INGOs and LNGOs, and to building interoperability**. Currently individual agencies operate specific data collection and management systems; the purpose of these systems is primarily internal. In order for a referral system to work, an interface needs to be developed between these systems. The process of developing such an interface is technical, and work has already started through the Somali IO. This report recommends that agencies hosting major data systems (1) jointly commit to ensuring that small INGOs and LNGOs can access their systems, (2) agree on a sub-set of information which can constitute the basis for referrals, and (3) agree on the importance of prioritising referrals.
7. **The humanitarian community, led by the HC and donors, should develop a sustainability strategy focusing on a systemic approach to integrated programming and referrals, which should then be advocated for more widely**. Several of the issues associated with successful referrals are systemic (e.g., short term, funding dependent service providers). A sustainability strategy should be developed that focuses on developing practical solutions to these issues for both donors and implementing partners. This should include sequencing of referrals, a gradual and phased engagement between humanitarian and development actors, and sustained funding for referral infrastructure.
8. **Rollout of referral systems should be accompanied by extensive engagement measures for staff**. This should include staff capacity building, on the job implementation, and regular refreshers and trainings. It should be based on existing best practices, and should include TOTs.

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# Abbreviations and Acronyms

| | |
|---|---|
| AAH | Action Against Hunger |
| ABC | Area Based Coordination |
| BRaVE | IOM data management system |
| CAAFIMAD | Health and Nutrition Consortium |
| CCCM | Camp Coordination and Camp Management |
| CFM | Complaint and Feedback Mechanisms |
| CP IMS | Child Protection Information Management System |
| GBV IMS | Gender Based Violence Information Management System |
| GDPR | General Data Protection Regulation |
| HCT | Humanitarian Country Team |
| IAHE | Inter Agency Humanitarian Evaluation |
| IASC | Inter Agency Standing Committee |
| INGO | International Non Governmental Organisation |
| IPA | Individual Protection Assistance |
| LNGO | Local Non Governmental Organisation |
| NGO | Non Governmental Organisation |
| OC | Operational Cell |
| PDAD | Post Distribution Aid Diversion |
| PRIMES | UNHCR data management system |
| progress | UNHCR data management system |
| SCC | Somali Cash Consortium |
| SCOPE | WFP data management system |
| TOR | Terms of Reference |
| UBR | Universal Beneficiary Registry |
| UN | United Nations |
| UNICEF | United Nations Children's FUnd |
| USR | Universal Social Registry |
| WASH | Water, Sanitation and Hygiene |
| WFP | World Food Program |

# 1.0 Background

Over 6.9 million people face acute humanitarian need in Somalia, according to the 2024 Humanitarian Needs Overview. Need is driven by complex and long-term crisis, in which conflict has interacted with climate effects over the course of decades. For many individuals and households, need is multi-dimensional – for example, lack of water and sanitation can lead to health issues (e.g., acute watery diarrhoea) and associated nutrition issues. Need is compounded by displacement dynamics: 2.9 million people were newly displaced in2023, and for many, coping mechanisms were eroded through the displacement process.

The humanitarian system has maintained relatively stable priorities and objectives over the last five years – (1) reducing loss of life for the most vulnerable and in need with a focus on nutrition, health and mitigating the effects of conflict, (2) sustaining lives through supporting access to livelihoods and essential services, and (3) upholding the centrality of protection. These priorities are strongly interlinked. Funding for humanitarian aid has been high – in 2022 the country received 2.3 billion USD in reported funding, and in 2023 it received 2.3 billion USD. Despite the reasonably high levels of funding allocated to humanitarian aid in Somalia, operational agencies face severe challenges, including lack of access to rural locations as well as those held by Al Shabaab.

The long-term nature of humanitarian intervention has also created additional complexities for humanitarian actors in Somalia. Humanitarian action in Somalia started in 1991, associated with the outbreak of civil war. Over this time, several specific challenges have arisen associated with aid diversion. These include, but are not limited to, duplication of beneficiaries within large scale databases such as WFP's SCOPE, strengthening of community gatekeepers who restrict access to the most vulnerable, the presence of ghost beneficiaries and the exploitation of aid by power networks. In response to these issues, the humanitarian community conducted an Operational Peer Review and developed a report on post-distribution aid diversion (PDAD). The priorities set out in the PDAD report have influenced recent humanitarian action.

In the complex context of humanitarian action in Somalia, referrals have not received significant focus. This is despite the fact that an efficient and effective referral system could help individuals and households address multi-dimensional need in a smooth and streamlined fashion – thus both reducing need and reducing cost for the humanitarian system. There are clear indications that effective referrals can (1) support a more accountable and people-centred humanitarian response, (2) provide an objective measure of the effectiveness of coordination systems, and (3) mitigate some of the risks associated with deduplication and implementation of PDAD measures. This report aims to outline the relevant definitions and terms, to assess the current referral system and analyse barriers to effective referrals, and to outline a way forward to build effective referrals in Somalia.

# 2.0 Objective, Scope and Methodology

The overall objective of this report is to **better understand the interconnections between cash and other sectors, to analyse the barriers to developing interconnections and to propose improved referral pathways**. Specifically, the research will answer the following questions:

- **Why is it a priority to improve referral mechanisms in Somalia?** Humanitarian intervention in Somalia is complex, involving many competing priorities within the humanitarian sector as well as development and peacebuilding actors. The report will make the case for prioritisation of referrals.

- **What referral mechanisms currently exist, and what are the characteristics of the referral landscape?** The report will identify and analyse existing referral systems to better understand the effectiveness of the overall system for the most vulnerable populations in Somalia
- **What barriers exist to establishing an effective referral mechanism?** The report will investigate the factors that hinder the establishment of effective referral systems using a people-centred approach. It will consider barriers at the level of communities, staff, organisations, IT infrastructures, coordination structure, management and leadership, and the wider system.
- **What options exist for improving the referral mechanism in Somalia?** The report will outline three scenarios for referrals in Somalia, estimate the costs and benefits associated with each scenario, and identify the risks and opportunities associated with each scenario.

The **scope** of this project is significant given the scale of the humanitarian response in Somalia, but is characterised by some specific limitations and focuses.

- **External referrals**. Referrals can take place either between service providers (e.g., DRC to Banadir Hospital or AAH to WFP), or within service providers (e.g., from UNICEF nutrition to UNICEF education). This report focuses on referrals between different agencies – that is, a beneficiary receives a service from one NGO or UN agency, and is put directly in touch with another agency to receive a complementary services. External referrals were chosen as the topic of this study because (1) no agency can provide a full and comprehensive set of services, so external referrals will always be needed, (2) the development of the single registration form provides a unique opportunity to improve external referrals, and (3) improving external referrals can also help to address specific challenges outlined in the IAHE report as well as the PDAD workstreams.
- **Focus on the humanitarian system – but with a longer-term view**. The study considered referrals, not only between humanitarian actors, but also between humanitarian, development and government actors. The analysis provided in the report, however, focuses on the humanitarian system. The focus on the humanitarian system was selected because (1) there are significant challenges, barriers and constraints facing effective referrals in the humanitarian system, and (2) referrals to development and government actors are likely to be ineffective, and few systemic solutions are likely to be identified, if the humanitarian system itself is not coherent. While the study focuses on the humanitarian system, it also accounts for an expectation that the humanitarian system will need to build referrals to development and government actors in the (hopefully near) future.

The **methodology** for the research included primary and secondary research and builds on parallel research and assignments being conducted for the HCT and the PDAD task force. 55 key informant interviews were conducted with members of management and field staff of INGOs and UN agencies, as well as cluster coordinators, donors and subject or area experts. 52 internal documents provided by interviewees, SCC members and the SCC Secretariat were reviewed, and a literature review was conducted drawing on academic and grey literature from Somalia and other humanitarian contexts.

| Organisation Type | # KIIs Conducted |
|---|---|
| Cluster Representative | 5 |
| Consortium Representative | 5 |
| Donor | 4 |
| INGO | 12 |
| LNGO | 12 |
| UN Agency | 12 |
| Other | 2 |
| **TOTAL** | **52** |

# 3.0 What Are Referrals and What is Needed for a Functional Referral System?

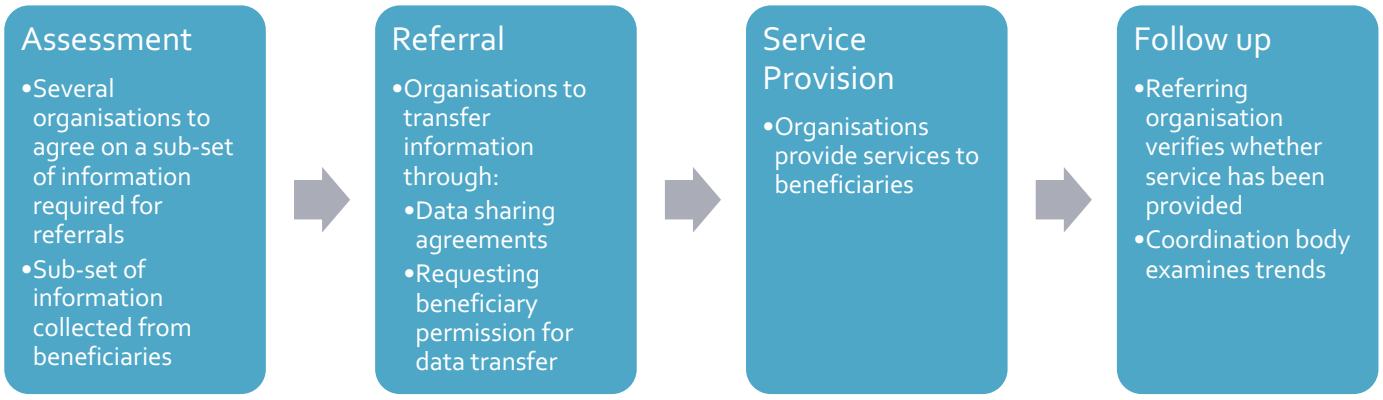
This section aims to provide a conceptual framework for referrals. It outlines a definition for referrals and a typology of the different types of referrals that currently exist in the humanitarian system. It also outlines generic prerequisites for referrals that are applicable to any humanitarian context.

## 3.1 Definition and Typology

The term **"referral"** has been defined by the Inter Agency Standing Committee (IASC) as "the process of directing a client to another service provider because s/he requires help that is beyond the expertise or scope of work of the current service provider. A referral can be made to a variety of services." Referrals play a critical role in humanitarian action, as they allow individuals and households to access many services from a different service providers, in contexts where single agencies cannot provide the range of services required to meet all needs. Referrals acknowledge that no agency can work alone, and provide templates and systems for agencies to work together as effectively as possible to meet critical needs.

Referrals can take place internally – that is, if a service provider directs a client to another department of the same organisation – or externally – that is, if a service provider directs a client to another organisation to receive additional services. The scope of this study is limited to external referral mechanisms; examination of internal referral mechanisms requires significantly more resources than were available, as mechanisms differ strongly between different agencies.

It should be noted that external referrals, by definition, take place between different types of systems. Some organisations – particularly larger ones – adopt highly quantitative approaches to beneficiary selection; others adopt more community-based approaches. Other organisations are in the process of transferring between community based and quantitative approaches. Referral mechanisms exist to ensure smooth transfer of individuals, households and communities between these different systems. As such, they rely on organisations (1) identifying a minimum set of information that should be transferred between each other to ensure that individuals/households/communities get holistic services, (2) regularly transferring this information, and (3) regularly following up and delivering services to individuals/households/communities whose information has been transferred.



Referrals can be divided into three types, some of which can be correlated with higher prevalence in specific sectors:

- **"Individual"** referrals are those which address the specific needs of individuals or households, usually through a one-off service provision. They can take place within an organisation or between organisations and/or consortia. They can take place between any sectors and are usually tailored to an individual's or household's specific needs. Individual referrals can take place in two ways. First, referrals can take place concurrently with long-term programming – for instance, a person receiving multi-month cash = can be referred to a hospital for health services in Month 1. Second, they can take place sequentially – for example, at the conclusion of a short term cash program a survivor of gender-based violence (GBV) can be referred to appropriate specific services. Referrals should be thought of as a non-linear process that support individuals in meeting priority needs.
- **"Scale"** referrals are those in which individuals or households are registered in large-scale programs for aid distribution, such as WFP's SCOPE or IOM's BRAVE. Scale programs provide uniform, basic services and support to populations in need – that is, they reach a large number of people often through regular and periodic distributions. Scale programs are likely to be implemented by large UN agencies or consortia and provision of aid through scale systems can support cost efficiencies.
- **"Batch"** referrals are those in which groups of individuals or households, or whole communities, are referred between systems. Sectorally, batch referrals generally take place into sectors which provide standardised, not tailored, support. For instance, batch referrals can take place for a full community requiring water trucking services, or a set of households all requiring a specific vocational training or income generation activity. Batch referrals often take place sequentially, either because a program is at the end of its mandate (e.g. a first-line response is structurally designed to provide very short term assistance, even if a community requires medium term support), or because the intake process for a specific activity requires collecting individuals (e.g., a vocational training course should start at the same time for all members of an intake).

| Referral Type | Sectors | Databases | Examples |
|---|---|---|---|
| Individual | Protection<br>Health<br>Nutrition<br>Cash | GBVIMS<br>CPIMS<br>PRIMES<br>(proGres) | Referral of a GBV survivor from CMR services to justice to rehabilitation<br>Referral of a malnourished child and his/her household from OTP services to cash services |
| Scale | Food Security/ Distribution<br>Social Protection | SCOPE<br>BRaVE<br>USR | Inclusion of a household with a malnourished child into SCOPE to receive general food distribution support<br>Inclusion of a household with an elderly member into USR to get pension |
| Batch | Livelihoods<br>WASH | n/a | Identification of a community without access to water, and construction of a well or provision of trucking services<br>Identification of individuals appropriate to be registered in a vocational training course taking place twice per year. |

Referrals should be seen in the context of two other related concepts, notably case management and integrated programming; in order to conduct either case management or integrated programming with impact, effective referral systems are needed. As such, referral is a prerequisite for both case management and integrated programming.

- **Case Management** was defined by the Global Protection Cluster as "a way of organising and carrying out work to address an individual['s] …needs in an appropriate, systematic, and timely manner, through

direct support and/or referrals, and in accordance with a project or programme's objectives." Case management is a wider concept than referrals, encompassing provision of direct support as well as specific methods of engaging and following up with vulnerable individuals. The focus with case management is to secure the optimal set of services for an individual and to follow an individual until he or she reaches a specific and agreed outcome; in contrast the focus with referrals is to ensure that individuals have access to additional services.

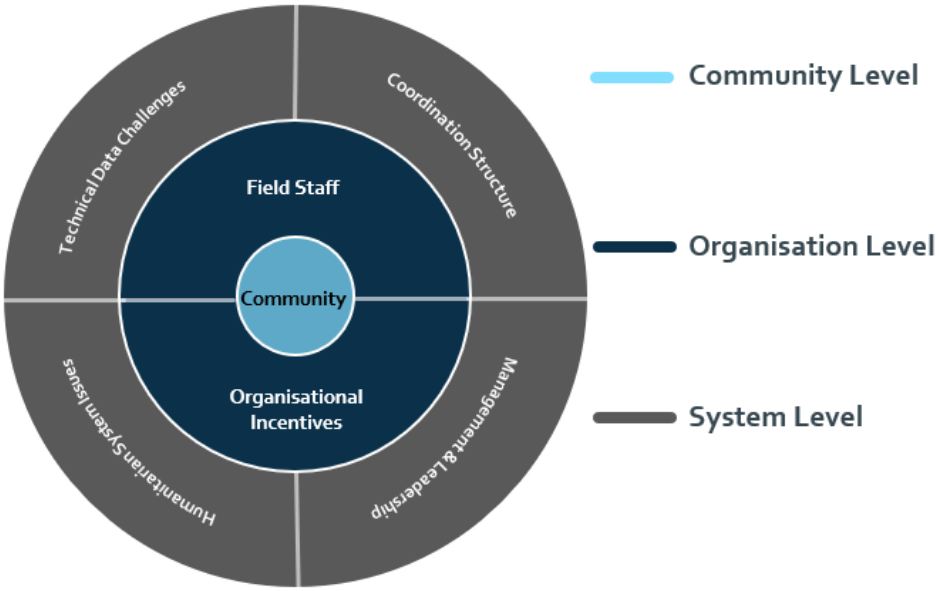
- **Integrated Programming** is the intentional combining of one or more sectoral interventions to improve humanitarian outcomes. Integrated programming and is generally pre-designed - that is, several different sectors are included within a single program intervention, and links between the sectors are planned from inception phase. It can take place within one agency (with an intervention consisting of several sectoral components) or between agencies with different mandates and sectoral expertise. In Somalia, during the most recent drought, clusters and the HCT developed guidance for a integrated first-line response in October 2022. This response included food/cash, nutrition, health and shelter/NFI components to be distributed within one week to newly displaced and critically underserved people in newly accessible, hard-to-reach and extreme constraint areas.
- **(Needs) Assessments** take place when humanitarian organisations, either together or jointly, analyse the specific needs of communities. In some cases, needs assessments can focus on a particular sector or set of sectors, and in other cases, a more holistic approach is adopted. Needs assessments generally take place periodically (i.e., once per year, once per project cycle) and not on an ongoing basis. The decision on when to undertake a needs assessment is often driven by a range of different data sources; it is possible for referrals to trigger a needs assessment (e.g., a high number of serious referrals may provoke a comprehensive multi-sectoral needs assessment, or a single-sector needs assessment).
- **Beneficiary selection** takes place when humanitarian organisations choose individuals, households or communities to receive services; this involves re-assessing needs, and verifying alignment with donor criteria. In some circumstances and for some programs, the process of beneficiary selection may be long and/or independent of other activities (e.g., selecting individuals for a vocational training program incurs a separate set of costs, whereas individuals self-select for health programs, and little cost beyond sensitisation is incurred). Referrals aim to identify individuals, households or communities who **might be appropriate** for beneficiary selection processes; they do not replace the process. The organisation providing services is responsible for analysing the information received from the referring organisation and confirming (if necessary through an additional assessment, including agency-specific biometrics), eligibility for a specific program and/or service.

## 3.2 Referrals and the Humanitarian System

Referrals bring together every aspect of the humanitarian system, from individuals and households which receive services to international actors which create the systems and structures through which household data is exchanged. In order for the effectiveness of a referral system to be maximised, seven different levels need to be considered. Not every level needs to be fully engaged for a referral system to be effective, but the interactions between the levels can influence the effectiveness of the system.

- '**Community**' refers to the individuals or households which receive services and are referred to additional services. Referral systems should target communities, households and individuals that are in the greatest need or are the most vulnerable. This group needs to have adequate levels of trust in the humanitarian system to choose to access the system.
- '**Field Staff'** refers to staff members from operational partners (LNGOs, INGOs and UN agencies) who deliver services. These staff members need to have adequate literacy, numeracy, digital numeracy and technical capacity to identify individuals, households and communities in need of additional assistance.

- '**Organisational Incentives**' refers to LNGOs, INGOs and UN agencies. These organisations generally have a mandate to meet humanitarian need, but they may perceive financial, operational or reputational risks to engagement. They are more likely to engage if they perceive an organisational benefit as well as an opportunity to fulfil their mandate.
- '**Technical Data Systems**' refers to the IT and IM systems used to manage referrals. Some agencies have large agency-specific systems (e.g., WFP's SCOPE), and in order to effectively make referrals, they need develop interfaces with other data systems. In addition, an optimally-performing referral system will include data collection and analysis on the number of referrals made, the number of referrals carried out, and the reasons why referrals failed.
- '**Coordination Structures**' refers to mechanisms used to coordinate different actors in the humanitarian system. This includes both national level cluster systems and any relevant sub-national systems. It is assumed that coordination structures are responsible for developing and rolling out protocols for conducting referrals, as well as bringing together referral actors.
- '**Management and Leadership**' refers to those in senior level positions in international agencies, UN agencies and donors. These individuals are responsible for setting organisational priorities, and as such play a key role in ensuring that referral mechanisms are both developed and operationalised.
- The '**Humanitarian System**' refers to structural aspects of humanitarian work, including the short-term nature of funding, lack of data in complex contexts and challenges associated with development of infrastructure in short-term funding contexts. The major parameters of the humanitarian system are likely to be governed, not by actors in the country or the region, but rather by historical structures.




## 3.3 Prerequisite for Effective Referrals

This study identified six prerequisites to effective referral systems based on the literature review and primary data collection. These are:

**Adequate density of services**. Referral services are more likely to work, and to work effectively, in locations with density of services. Urban areas, for instance, are more likely to have a higher number of service providers in different sectors, therefore individuals and households are more likely to be able to

access services in the referral system at minimal cost. In areas with only one or two service providers, it is unlikely that the services needed by some individuals will be available. It is possible to mitigate against lack of density by providing beneficiaries with transport to urban centres.

**Adequate capacity of existing service providers**. The service providers that are present in a specific location need to have the capacity to accept new individuals in order for a referral system to have impact. This implies that they require (1) the funds to provide and/or expand services, (2) flexibility from their donor to include referrals in their beneficiary caseload, and (3) the logistical and operational capacity to assess referred individuals. If service providers cannot accept new referrals for any of these three reasons, then referral systems will not be effective and will not support improved outcomes for individuals and/or households in need.

**Clear and accurate service mapping**. In order to refer individuals, service providers must have a clear understanding of what other services are available, where they are available, and what constraints exist to accessing services. Service mapping should be updated in case of the shutdown of a provider (because, for example, funding has run out), and should reflect programmatic specificities where possible (e.g., if a program only accepts women, this should be clear so that men are not referred to the program). Service mapping should also be adequately specific, and should provide information about specific activities. For example, it is possible for service mapping to be conducted by sector, and for organisations to identify the number of WASH beneficiaries they anticipate reaching – but this target needs to be broken down by sanitation services, hygiene services and water services, and by specific towns and villages in order to support effective referrals.

**High and effective coordination, including clear consistent protocols**. In order for referrals to work, different agencies need to be able to clearly communicate about several things, including the needs of the beneficiary, the process for registering him or her in another service, the costs associated with any such service, etc. Coordination can take place on an ad hoc basis, with staff from different agencies communicating informally or through the phone, and this can be effective at a small scale. In order to be effective at a large scale, however, some systematisation is needed, both around coordination (e.g., regular meetings between agencies who refer frequently, around guaranteeing accurate service mapping) and around protocols (e.g., making sure that sending and receiving organisations understand what process to follow, within how many hours or days to expect responses, etc). Large scale referrals also need to integrate escalation protocols, including (1) processes to follow in case agencies are non-responsive, (2) process to follow in case of unexpected blockages, and (3) methods of conducting higher-level analysis of barriers on a semi-systematic basis.

**Relatively unified data collection and/or registration system**. Referral systems need to operate efficiently and parsimoniously in order for beneficiaries to want to access them – if they involve multiple time consuming assessments, beneficiaries are likely to drop out of the system. Effective referral systems that operate at scale are therefore likely to adopt a relatively unified data collection system which provides enough information to support transfer of individuals to relevant services, and which reduces the need for supplementary data collection. In the medium to long term, data collection systems need to be harmonised between humanitarian, development, peacebuilding and governance actors in order to ensure that individuals and households are referred appropriately, not only during periods of extreme need, but also through a system that is transitioning toward development. Some factors which could support this kind of transition are: adopting standardised definitions of neighbourhoods and/or areas and strengthening area-led approaches.

**Staff with adequate capacity and motivation to inform and follow up on referrals**. Referral systems are implemented by staff in various sectors. Staff need to be able to perform several tasks, including but not limited to identifying individuals in need of multiple services, registering individuals through the data

collection/registration system, transferring information to another service provider, and following up to ensure that individuals receive services. As such, they need capacity (technical skills, IT skills, literacy, numeracy) as well as motivation (staff need to have interest in supporting the most vulnerable, and they need to believe that the system will provide tangible benefits).

Factors that would support effective referrals but are not necessary are

- **Community trust in the system**. Community trust in the system supports start-up of referral mechanisms. In the absence of trust, communities may fail to access the system, or put in place barriers to access for vulnerable individuals. Where trust is developed, it is also self-reinforcing, as individuals will spread information about referral mechanisms through word of mouth, and will self-refer.
- **Reasonable quality of data.** Higher data quality will support more impactful and cost-efficient referrals. Where data is of reasonable to high quality, fewer re-assessments and re-verifications will be required, reducing staff time and operational costs. Reasonable quality data can also help to support improved analysis, which in turn can help organisations to build infrastructure in locations with the greatest need and/or vulnerability. It should be noted that data quality is not a prerequisite; referrals can operate with limited data quality if organisations conduct verifications and re-assessments.
- **Interoperable databases**. If data collection and registration systems can transfer data between themselves, then it becomes possible to implement referral systems that draw on data from other databases, and to find those in greatest need as well as those who are most vulnerable from the entire set of data. Batch referrals and scale referrals also become easier and more likely. It should be noted that interoperable databases are not a prerequisite for referral systems, as low-tech solutions such as excel spreadsheets and meetings to exchange information on case files can be used.
- **Clear understanding of barriers to accessing referrals, and phased and realistic strategies for addressing these barriers.** Individuals may not be able to access services, even following the referral process, if they have inadequate access to service providers (i.e., if they live in hard to reach or distant areas). Other issues, including but not limited to social stigma, marginalisation including due to minority clan status, and preference for traditional coping strategies (traditional healers, moneylenders, etc) may also deter some individuals or households from participating in referrals.
- **Linkage to CFM mechanism**. Referral mechanisms may face issues, including but not limited to delays in receiving a secondary service, lack of receipt of a secondary service, lack of responsiveness of a service provider, and poor quality services. Linking a referral system to a CFM mechanism can help to guarantee quality and usability, as complaints and feedback about the referral process could be logged and analysed. In addition, it could be possible for CFM mechanisms to be an input to referral mechanisms: existing data from the CFM mechanisms in Somalia shows that one of the primary reasons for accessing hotlines is to request services or to ask about details. It should be noted that linkages to CFM mechanisms rely on the assumption that CFM mechanisms are coherent – whereas currently there are more than 70 hotlines in Somalia with limited interactions between them. Data collected from CFM mechanisms should also clearly differentiate between complaints, request s for services, and other inputs/feedbacks.
- **Accountability for the system**. Referrals, by their very nature, involve interaction between different sectors. In general, accountability within a sector is the responsibility of cluster coordinator(s), and of the lead agencies for the cluster. Responsibility for referrals, in contrast, does not sit with a particular agency or position. Assuring such accountability supports improved information flow and results. It should be noted that accountability is not a prerequisite for referrals to function – currently in both Somalia and elsewhere there are small-scale referral systems that operate on an ad hoc basis due to good relationships between different service providers. Accountability is, however, required for referral mechanisms to reach scale and to provide consistent service quality.

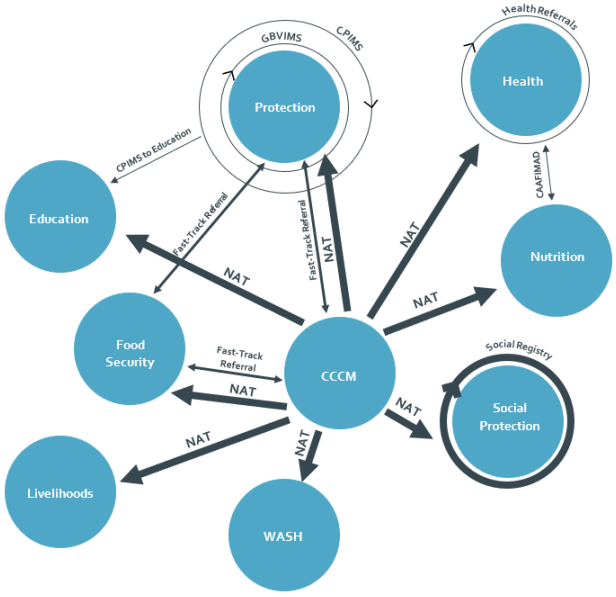
# 4.0 The Referral System in Somalia

This section draws on 52 interviews with humanitarian actors in Somalia, and aims to describe the referral landscape. A mapping of referral mechanisms is included as Annex A, and the major characteristics of the landscape are outlined. The degree to which the context in Somalia provides the prerequisites for referrals, as outlined in Section 3.2, is also assessed.

## 4.1 What are the Characteristics of the Referral Landscape?

**The current referral system can be described as sectorally atomised and strongly concentrated in urban areas.** This research included a mapping of referral mechanisms that are currently operational in Somalia. Ten different mechanisms were identified; some of these were led by clusters, others by consortia, and others by individual agencies. The strongest referral mechanism, and the mechanism which had greatest buy-in across different sectors, was operated by the CCCM cluster and used the New Arrivals Tracking 2.0 or 2.5 form. Some specific sectoral mechanisms were also highly trusted, notably the referral system between a health and nutrition consortium (CAAFIMAD) and a cash consortium (SCC). Interestingly, some longer-term referral mechanisms that are a structural part of the humanitarian system (GBVIMS and CPIMS) were not generally known, and were not perceived as being effective. Part of the success of referrals in CCCM was perceived to be density of services – CCCM conducted referrals in urban areas with high service density. Part of the success of the SCC-CAAFIMAD referral system was perceived to be the strength of relationships between consortium actors, and the high levels of coordination.

**Very few actors, at any level, have a clear picture of the referral landscape – indicating that referrals are unlikely to be broadly effective or impactful.** During primary data collection, interviewees were asked to list the referral systems they were aware of in Somalia. Of the 52 interviews conducted for this research, no two actors identified the same set of referral systems. The lack of cohesion with regard to referrals was associated with several different factors. First, individuals with specific sectoral specialisms (e.g., health experts or GBV experts) were often aware only of the referral mechanism associated with their sector, and had limited time and resources to consider how this mechanism related to other sectors or systems. Second, individuals operating in first-phase humanitarian response – and specifically in operations – were less likely to be aware of longer-term referral mechanisms and registries (e.g., the Government of Somalia's Universal Social Registry) compared to those in management and higher level positions. Third, several field level colleagues relied, not on a formal understanding of referral mechanisms – or on formal mechanisms – but instead on personal contacts with individuals in other agencies that were disconnected from formal referral systems. In addition, some interviewees did not identify any referral system, but instead spoke about the data systems they were engaged in as if they were interchangeable with referral systems.




**There are geographic gaps: very few referral mechanisms cover hard to reach areas and rural areas, in large part due to lack of services in these areas and lack of adequate funding for services**. Across the interviews conducted, over 90% of interviewees indicated that it was challenging to set up referral mechanisms in hard to reach and rural areas. One of the primary reasons for lack of referrals in hard to reach areas was associated with lack of services in these areas, associated with lack of sufficient funding. In several hard to reach and rural areas, services are both geographically dispersed (so that a small number of service providers can reach the widest catchment area possible) and unavailable (due to operational constraints). Referrals become challenging (1) because the required services are not available within a relatively close geographic area, and (2) because the required services are not available at all. A second challenge associated with referrals in hard to reach areas was lack of consistency – where services were set up, they were dependent on funding and thus would often shut down after six months of operation. As such it was difficult for operational field staff to maintain updated service mapping and to regularly develop new relationships with different service providers. A third challenge was associated with developing strong and cooperative relationships in hard to access areas. Entry into al-Shabaab controlled areas often takes place through complex negotiations. For operational actors, the dominant relationship to maintain is the relationship with local authorities; relationship development and coordination with other operational actors is considered less of a priority.

**There is little effort to support short-term access to services for rural populations – leading to a situation where households displace to access aid**. Actors interviewed for this research indicated that providing services in hard to reach areas is often difficult in part due to organisational and security restrictions. These security restrictions limited the specific locations in which services could be provided and the ways in which services could be provided. Some agencies experimented with methods of supporting vulnerable individuals to access services – for example, gathering beneficiaries in al-Shabaab held areas at a nearby point, providing transport to an urban area and access to necessary services, and providing transport back to the gathering point. Such pilots were only mentioned, however, by two interviewees. Several other actors pointed to the fact that many individuals and households displaced to urban areas in part because they could not access services in rural or hard to reach areas.

**Referral systems are siloed: even when they do exist, they are likely to focus on a small range of sectors**. Currently most operational referral mechanisms in Somalia focus on specific sectors, and staff who make the referrals do not know what to do when they identify a need in another sector. The health-nutrition-cash referral system is effective, but if staff identify a protection issue, they struggle with (a) lack of knowledge about protection referral systems (e.g., GBVIMS, CPIMS) and lack of engagement with protection specific actors. This issue is compounded by operational constraints including low technical or IT capacity (e.g., limited ability to utilise GBVIMS for non-specialist actors), and lack of time on the part of staff. Where referrals are made, there can be challenges associated with beneficiary trust in the system – individuals may choose not to follow up on the referral because they have limited trust that they will receive support.

**Some sectors have limited engagement with referrals, likely because they require 'batch' referrals**. While referrals have been effectively operationalised in some sectors – notably health, nutrition, cash, and CCCM – other sectors – notably WASH and livelihoods – have faced challenges. In part, this is due to the 'batch' nature of referrals into these sectors. These challenges can be illustrated through an example – field staff in a non-WASH sector may observe a lack of water in a specific community, but their capacity to quantify the gap, or to raise the gap to higher level management of a different organisation who are responsible for selecting new sites for boreholes, is likely to be limited. Similarly, field staff may refer individuals to education or vocational training courses, but without a system to manage referrals of individuals into 'batch' programs, it is highly possible that referrals slip through the cracks. This research did not identify examples of (a) organisations referring to field staff from different organisations before making decisions about infrastructure investments, or (b) organisations developing a mechanism to accept referrals from other organisations for 'batch' programs.

**Referral mechanisms currently are not designed to ensure that they meet the needs of target individuals and households**. Households often need support in accessing referrals after the transfer of data occurs. This includes meeting transport costs, supporting households who have limited experience with participation in referral systems, and navigating through community barriers including the presence of gatekeepers, particularly for marginalised groups and minority clans. To overcome these barriers, humanitarian actors require (1) mechanisms to provide those in need with individual protection assistance and mechanisms of meeting transport costs, (2) adequate staff capacity and assignment of responsibility for follow up with very vulnerable cases, and (3) regular outreach to those who restrict access, notably gatekeepers and clan elders. In this research, some reference was made to IPA by management staff, but field staff often did not know how to support beneficiaries who had limited access to transport. None of the field staff interviewed stated that follow up with beneficiaries was one of their core responsibilities – instead, this was considered as beneficial but not essential duty. Finally, while significant outreach did take place to gatekeepers and clan leaders, particularly among those with a presence in hard to reach areas, the outreach focused on organisational priorities rather than support for the humanitarian system and referrals.

## 4.2 Are the Prerequisites in Place for Referrals?

**In Somalia, significant effort has been put in place to establish prerequisites for referrals, specifically regarding a unified data collection system and staff capacity**. Through one of the PDAD workstreams led by ECHO, a specific effort is currently underway to develop a Single Registration Form (SDF). The form has been developed and high level agreement has been achieved with regard to content and usage. The rollout of the SRF represents a significant opportunity to develop the referral mechanism in Somalia. Similarly, effort has been made to support staff capacity with regard to referrals both in sector-specific mechanisms (SCC-CAAFIMAD) and cluster-specific mechanisms (CCCM). These efforts have demonstrated that staff do have the capacity to effectively engage in referrals and to expand the current system.

**Service provision in Somalia could support improved referrals – and improved integration of referrals into program design presents an opportunity**. A significant amount of funding – over 2 billion USD in 2022 – is devoted to aid in Somalia. Between 2017 and 2024, an average of 1.7 billion USD per year has been invested in Somalia. Adequate service density to support referral mechanisms has been achieved in urban areas. Similarly, some key service providers (e.g., Banadir hospital) have clearly demonstrated the capacity to accept referrals. There are however drawbacks, including lack of adequate service density in rural areas, limited service provider capacity in rural areas, and issues associated with beneficiary selection and registration through referrals in a variety of sectors. Some of these issues could be addressed through improved program design on the part of organisations, and clear alignment of donors around referrals (notably through requirements to accept a minimum proportion of beneficiaries through referrals).

**The most significant drawback to referral in Somalia are associated with coordination; efforts are currently underway to improve coordination and this presents opportunities**. Challenges associated with coordination are prevalent in Somalia and have been identified in several forums, notably the Operational Peer Review, the PDAD and the recent IAHE evaluation. For this research, lack of service mapping and lack of adequate coordination mechanisms were identified by over 75% of the interviewees as key barriers to implementation of an effective referral mechanism. Coordination mechanisms are currently the most significant gap with regard to referral mechanisms – but efforts to improve coordination also open possibilities to improve referrals going forward.

| Prerequisite | Status | Explanation |
|---|---|---|
| Density of services | | Services present in urban areas<br>Services not present in rural/Hard to Reach<br>Transport from rural to HTR has not been explored |
| Capacity of Service Providers | | Service providers in urban areas often have the capacity to provide services – for example Banadir hospital accepts referrals.<br>Major drawbacks identified through the interviews are (1) the funds to provide and/or expand services, (2) flexibility from donors to include referrals in their caseload, and (3) logistical and operational capacity. |
| Service mapping | | More than 75% of respondents said service mapping was not present or insufficient<br>No cluster TORs included accountability for service mapping<br>Service mapping needs to be localised to specific areas and regularly updated. |
| Coordination (incl protocols) | | With the exception of CCCM, no evidence that clusters felt accountable for referral coordination<br>Clear feedback on coordination from the IAHE<br>Coordination needs to take place at a sub-national level, through ABCs or OCs – the way forward for local coordination is currently unclear. |
| Unified data collection system | (conditional) | Development and rollout of the SRF represents progress and opportunity<br>Work needs to be done to identify "eligibility thresholds" that automatically flag candidates for referrals |
| Staff capacity to conduct referral | | Effective referrals between SCC and CAAFIMAAD demonstrate capacity<br>Discussions with field staff (15) through this research indicate capacity |

# 5.0 Barriers to Effective Referrals and Potential Mitigation Measures

This section outlines the most urgent barriers to implementation of effective referral systems in Somalia. It then describes the types of barriers to effective referrals that are present across different aspects of the humanitarian system in Somalia. The section is based on information from primary data collection. A list of all barriers, divided by different levels, and accompanied by potential mitigation mechanisms, is included as Annex B.

## 5.1 The Most Urgent Barriers to Effective Referrals

Based on the interviews conducted, the research team identified three urgent barriers to establishing effective referral systems. These barriers were identified by both management and field level staff; they also correspond to key challenges in the humanitarian system, as identified by the research team.

It should be noted that some barriers were discussed extensively by management level staff but have not been included in the most urgent list. Notably, lack of interoperable data systems was discussed frequently by management level staff, but not by field level staff. Field staff noted that referral mechanisms could work in the absence of data systems, if accountability, incentives and infrastructure was in place. Similarly, lack of capacity was noted as a barrier by field level actors- but management level actors pointed out that it would be possible to assure capacity through engagement with donors and/or target setting for minimum beneficiaries to be identified through referral mechanisms.

**Lack of accountability for referral systems**: No organisation or structure is currently responsible for ensuring that referral mechanisms are effective in Somalia. This lack of accountability arises to a degree from interpretation of mandates – organisations interpret their mandates as service delivery, rather than as contribution to more holistic service provision. The responsibilities of clusters are often considered to be advocacy and engagement (according both to cluster TORs and interviews with cluster coordinators). Referral systems and service mapping are considered to be secondary responsibilities. There is no staff position, organisation or forum that takes responsibility for referral systems. OCHA is the natural organisation to assume accountability for referral mechanisms – but currently is not seen as a leader with regard to referrals. Very few interviewees referred to OCHA's role in assuring accountability for referral systems and no documentation could be found in which OCHA assumed responsibility for referrals in Somalia. While donors push referrals on a regular basis, the lack of a 'lead' or an accountable organisation is perceived as a major gap in changing operational modalities.

**Lack of organisational incentives to ensure that referral systems are effective**: Humanitarian organisation have a mandate to reduce need, and implied in this is an assumption that organisations should be people centred and accountable to effective populations. This assumption is strong, however, that few efforts are made to incentivise humanitarian organisations to be accountable and people-centred. In practice, humanitarian organisations are accountable, less to people, and more to donors for meeting operational funding targets, and to the humanitarian system for a specific level of engagement in coordination forums, etc. Given this incentive structure, organisations obtain no specific benefit from investing in an effective referral system. Instead, they incur costs – notably staff time, budget associated with travel for beneficiaries, and management time. Potential benefits could be offered for organisations with effective engagement in referral systems, including but not limited to additional funding for referral-heavy programs or top ups for projects that have successfully implemented referrals, advocacy benefits within the humanitarian system, or reputational benefits. Currently, however, such benefits do not seem to

be either available or realised. It would also be possible apply a 'stick' approach in which organisations who do not perform according to specific referral targets (e.g., accepting a specific proportion of their beneficiaries through referral systems) experience funding cuts in subsequent years.

**Lack of a clear referral infrastructure (coordination, protocols and service mapping)**: A key barrier to implementation of referral mechanisms is the rapid shutdown and startup of services, combined with the absence of a referral infrastructure. Humanitarian action is predicated on short term funding cycles, and a result some/many service providers establish activities that are not sustainable, but are instead designed to meet a specific and time-bound need. In a context with a range of short-term service providers, referrals will only be effective if there is a clear and commonly understood infrastructure. Two key elements of this infrastructure are coordination mechanisms (including protocols and regular forums for engaging with other actors), and service mapping. Neither are currently present in Somalia.

- **Service Mapping.** Over 75% of interview respondents noted lack of service mapping as a major barrier for referrals; field staff who encountered specific beneficiary needs could not access service mapping, so instead relied on personal networks to refer. In several cases, staff had limited personal networks in different sectors, and thus could not single-handedly provide referral services. In order to support effective referrals, interviewees specified that service mapping needs to be (1) adequately localised (i.e., to refer to a specific district or neighbourhood), (2) adequately detailed with regard to both activities and acceptance criteria (i.e., specific activity level details should be provided, and any restrictions on beneficiary engagement or acceptance should be outlined, and (3) adequately updated (i.e., services that are no longer functional should be identified, as should services that no longer have the capacity to accept referrals).
- **Coordination and protocols.** In this research, several different issues were identified with regard to coordination and protocols for referral mechanisms. In contrast to service mapping – for which the majority of interviewees agreed that detailed service mapping was needed – the perceived requirements for coordination and protocols ranged. Several interviewees noted that formal protocols were not necessary for a referral mechanism to function effectively, with one interviewee pointing out that the development of protocols for one specific referral mechanism coincided with the collapse of that mechanism. Others noted that it was important for protocols to be adaptable to local and sectoral specificities – for example, it could be difficult to roll out a full referral protocol in a hospital context with a patient who wanted to leave.

## 5.2 Barriers to Effective Referrals Analysed by Systemic Level

**Barriers to effective referrals exist at several different levels**. In this research, a range of different barriers was identified through engagement with different humanitarian and development actors. These barriers can be categorised into seven different levels, notably (1) community members, (2) field staff, (3) organisations (INGO and UN agencies), (4) coordination systems, (5) technical systems, (6) management and leadership (of organisations and the humanitarian system) and (7) the wider system. These seven levels, described in Section 3.2, provide a framework through which barriers to effective referrals can be better understood. A comprehensive list of barriers identified through interviews can be found in Annex 2.


**Community level barriers to referrals are associated primarily with lack of trust in the humanitarian system and associated tendencies to misrepresent information and/or enrol multiple times**. At the community level, individuals, households and key actors (clan elders, gatekeepers) may not support referrals due to limited trust in the humanitarian system. While this research did not conduct direct primary data collection with community members, field level staff did discuss issues associated with accessing referral mechanisms. Community members have relatively low trust in the humanitarian community and in referral systems, in part due to the perceived temporary nature of many humanitarian services. An interesting discrepancy should also be noted about data collected from different levels of the humanitarian system: field staff discussed community lack of trust within the humanitarian system, whereas management level staff, particularly in larger agencies, referred primarily to communities misrepresenting information and enrolling in multiple programs. It is highly likely that the two factors intersect: community actors do not trust humanitarian systems, and this lack of trust reinforces behaviours such as multiple enrolment and misrepresentation of information. The move to vulnerability based targeting may further erode trust particularly among clan elders; while many NGOs have made this move successfully, the UN has not yet done so, and several UN agencies provide resources at a scale that can have significant implications for community trust. Marginalised groups – in particular minority groups – have also experienced a range of barriers in engaging with humanitarian actors. These barriers have resulted in relatively low trust levels in the humanitarian system.

**Field level staff face operational challenges such as lack of time and lack of training**. At a practical level, referral systems will only work if field staff identify individuals and households in need of additional support, and make use of the referral system to ensure that a variety of services are provided. In order to carry out these tasks, field staff need (1) to be aware of referral systems, (2) to have adequate literacy and technical capacity to engage actively with referral systems, (3) to have adequate operational capacity to conduct referrals and (4) to have regular refresher trainings about referrals. It is possible for field staff to undertake these tasks, as demonstrated by the success of the CCCM and SCC-CAAFIMAD referrals. However, wider rollout of referral systems requires additional investment. This is particularly with regard to the operational feasibility of referrals. Interviews with field staff indicated that they struggled with the length of referral forms, lack of beneficiary interest in answering questions and lack of support in case they encountered operational issues.

**Organisations need to incur costs to implement referrals, and they do not see specific and associated benefits**. Organisations perceive costs associated with implementing referrals. Specifically, these include operational level costs – field staff time and resources, transport costs for beneficiaries – as well as management level costs – engagement in coordination systems, effort required to conduct and contribute to service mapping, etc. They also perceive risks associated with referrals, notably the risks associated with raising beneficiary expectations of receiving services, and risks associated with opening up their databases which are highly likely to include duplication and inclusion errors. Security risks were also listed as a risk – especially by large organisations which provide 'blanket' services. High levels of cost and risk were perceived to be associated with referrals – but little, if any, organisational benefit was perceived to be associated with improved referrals.

**The dominant technical infrastructure systems are not equipped either to engage with each other, or to support referrals**. A significant amount of attention was devoted to the technical infrastructure required for referrals at a management level – but it was notable that at the field level, staff did not consider that technical systems were a pre-requisite for referrals. As such, operationalisation of referral mechanisms should take place in parallel with changes to technical infrastructure. In this context, some of the major challenges associated with developing interoperable frameworks include lack of data sharing agreements between different actors, lack of consensus around approaches to biometrics, and the breadth of services to be covered. Many of these issues are being considered in the context of development of a single registration form; the technical discussions and analyses that have taken place for the SRF should be applied to referral systems. A technical system should also be built to cover the full referral cycle – that is, not just transfer of data from one organisation to another, but also receipt of service (and, if no service was received, why it was not received). **The coordination system is critically weak in Somalia – and improvement is a priority**. Humanitarian coordination in Somalia has been acknowledged as a critical problem, with the IAHE report stating that coordination structures are duplicative and parallel. This same report suggests severely reducing (or halving) the number of people employed in coordination and the resources devoted to coordination mechanisms. At the same time, it is becoming steadily more essential to ensure that

**Lack of trust between organisations that hinders development of referral infrastructure**. The level of trust between different humanitarian organisations is at critically low levels. The secondary literature review indicated that lack of trust can be rooted in lack of transparency – decisions not to share specific reports or the details of specific incidents, for instance, reduced trust between agencies. Interviews conducted for this research indicated that the initial phases of cooperation between organisations could erode rather than build trust – for example, sharing data systems could highlight issues of beneficiary duplication and diversion. Interviews also suggested specific challenges with regard to trust between large and small organisations. The major flashpoint for lack of trust concerned data sharing protocols and interoperable data systems – but the lack of trust went beyond this to include operational issues. These trust issues impede development of referral infrastructure – field staff were clear that referral mechanisms rely, less on IT systems, and more on prioritisation of referrals by organisation management and development of trust between organisations.

**The humanitarian system is dominated by short-term perspectives – and this has influenced investment in referral systems**. Although the humanitarian system has been present in Somalia for over thirty years, funding is generally short term, and relatively little investment is devoted to infrastructure (IM systems, protocol development, etc). Many services are structured to be available only for limited periods. The increasing focus on the humanitarian development nexus has sparked some engagement between the two types of actors – but there are still stark differences between investments by the World Bank in the Universal Social Registry and investments in the humanitarian system in ad-hoc systems to respond to the

drought. These issues are exacerbated by lack of coherent data that encompasses the needs of both humanitarian and development actors.

**The issue of data sharing demonstrates how organisational and technical barriers, together with lack of trust, are compounded – and the potential negative effects to beneficiaries of failing to develop solutions**. The processes and mechanisms for data sharing agreements demonstrate some of the barriers facing development of referral mechanisms, and the ways in which technical and organisational barriers intersect. Lack of processes for data sharing were highlighted by several interview respondents, primarily at management (rather than field staff) level. Two specific challenges were discussed: (1) each organisation needs to comply with GDPR rules and regulation, and must therefore conduct its own due diligence with regard to data sharing. (2) In the context of Somalia, with high levels of duplication and inclusion errors, several organisations (particularly large ones) are concerned about whether data sharing exacerbates these errors. The consequences of this management focus on organisational GDPR compliance and technical capacity (or lack thereof) to manage duplication has had an unexpected effect: it has actually significantly worsened practical beneficiary data protection. Field staff who want to make referrals currently use, not formal organisational mechanisms, but instead messenger services, email and telephone – thus achieving referrals and avoiding data regulations.

# 6.0 The Way Forward for Referrals

This section proposes a way to build referral systems in Somalia. It starts by developing an argument to convince key stakeholders to invest in referral systems. It then outlines key trade-offs associated with developing referrals systems, and proposes approaches to address these. Next, it outlines specific approaches to some of the most contentious issues associated with referrals, including rationales for why these approaches are proposed. After this, it sets a target for the referral mechanism in Somalia that is (based on interviews and desk review) both realistic and impactful. Finally it outlines costs, benefits and risks. The way forward has been developed by the research team on the basis of primary and secondary data, but has also been discussed and validated with key actors including the project steering committee.

## 6.1 Why Prioritise Referrals in Somalia?

**The Somali context is characterised by complexity**. Over the past 25 years, Somalia has experienced several extended droughts as well as two declared famines. These climate crises have taken place in an environment characterised by severe and persistent insecurity and fragility, which generate high levels of internal and international displacement. In 2024, the Humanitarian Needs and Response Plan identified 6.9 million people as requiring humanitarian support, with most acute needs in WASH, health and nutrition. Needs have been increasing in a context characterised by reduced availability of funding and steadily more complex access issues. In addition, humanitarian actors are themselves fragmented and often engage in predatory competition. This context has given rise to the need for more efficient humanitarian action that is better connected to development, resilience, and peacebuilding.

**The humanitarian system faces a range of competing priorities in Somalia – and a recent evaluation has pointed out that accountability is poor**. There is a need for internal reform, which has been started but also requires strengthening. A recent IAHE evaluation found that coordination structures are very heavy that there have been critical gaps in recent response. An increased focus has been placed on aid diversion following the production of a post-distribution aid diversion (PDAD) report and the setup of a workstream to address underlying issues. Simultaneously, humanitarian actors are increasingly called upon to coordinate with development and peacebuilding actors, and to actively participate in durable solutions initiatives. Somalia also hosts a range of humanitarian innovation programs. Despite the heavy focus on

coordination, both within the humanitarian system and with development and peacebuilding actors, accountability to affected populations remains low. Not only is trust in the humanitarian system limited, but recent reforms risk continuing to de-prioritise accountability.

**Given the scale of needs and the range of competing priorities, why should referrals be prioritised?**

- **Referrals are essential to ensuring that the response is people centred and accountable**. Humanitarian need is severe in Somalia, and among those who are in need, many experience multi-faceted and intersecting issues. For example, lack of WASH facilities can give rise to increased incidence of water-borne diseases, requiring health services, as well as increased incidence of malnutrition, requiring nutrition services. Long-term recovery may require both cash and food security interventions. In a humanitarian system with a strong referral mechanism, a single individual can move relatively seamlessly through the international system and receive a range of services. In contrast, in a weak referral system, he or she may not receive all services, and the cost associated with accessing services (transport costs, time spent in assessments, etc) will be higher because it is duplicated for each service requested and/or received. In addition, he or she will need to "shop" for services by himself, meaning that he incurs higher costs and experiences reduced trust in the system.
- **Referrals act as a benchmark for the functionality and effectiveness of the coordination system**. Recent assessments suggest that the coordination system in Somalia is heavy and duplicative, and its overall effectiveness has been questioned. There have also been suggestions that recent reforms have been process oriented rather than people or results oriented. A referral system can only generate results if key building blocks – notably effective coordination and efficient data transfer mechanisms – are in place. Referrals also clearly generate people-oriented results. Referrals therefore act as a proxy for the effectiveness of coordination mechanisms as a whole. It is possible to monitor the number of referrals taking place and use this as evidence for changes in the effectiveness of coordination mechanisms.
- **An effective referral system can mitigate the risk associated with implementation of other targeting and de-duplication initiatives**. A range of initiatives are currently being rolled out, specifically associated with response to the PDAD report. Some of these initiatives – specifically the transfer from community-based targeting to vulnerability-based targeting – are seen as posing risks to the humanitarian response. There are fears that clan elders will not only push back against the changes, but also spread mistrust of the changes within their communities. The existence of a functional referral mechanism will help to mitigate against this risk. If community members start receiving a suite of services through referral processes, with less time and money invested in multiple assessments and transport to different service providers, they will associate the changes with positive results.
- **An effective and holistic referral system can support inclusion of sectors which currently are not fully performing.** Some sectors have been identified as performing less well in the most recent drought – notably the WASH sector was evaluated as being less involved and effective. This is in part due to the community nature of WASH. Interventions are better conducted for neighbourhoods and communities rather than households, and as such it can be difficult for these sectors to engage with data and referral systems that focus on individual needs. An effective data management and referral system can allow for periodic data analysis to identify communities which can be batch referred to WASH or livelihoods programs, thus improving the overall effectiveness of the response. Similarly, the education sector is somewhat distanced from 'first line' humanitarian response, but effective referral systems can allow for inclusion of vulnerable children, especially through nutrition programming.
- **Impactful programming in a challenging funding environment.** Currently, the scale of humanitarian funding to Somalia is significant, and has averaged approximately 1.3 billion USD per year since 2017. A range of international factors are likely to put pressure on funding in the upcoming period. These factors include, but are not limited to, the exacerbation of a range of conflicts including Ukraine and

Gaza, and changes in donor governments and associated likely changes in funding conditions (notably the US). In this context, it is likely that the humanitarian response in Somalia will continue to need to meet needs, but with constant or decreased funding. In this situation, referrals can help to (1) identify those most in need with lower investment, (2) analyse the nature of needs, and (3) provide a more holistic, effective and cost-effective response.

| Reason for Prioritising | Target Audience | Associated Policy Initiatives |
|---|---|---|
| Delivering holistic services to those most in need | Community<br>Humanitarian System<br>Field Staff | People Centred Approach<br>Accountability to affected populations<br>Operationalisation of the 'nexus' |
| Litmus test for improvement of coordination systems | Coordination<br>Management and Leadership | Response to IAHE |
| Risk mitigation for de-duplication initiatives | Humanitarian System<br>Management and Leadership | Response to PDAD |
| Inclusion of sectors which are currently not fully reflected | Community<br>Humanitarian System<br>Field Staff<br>Coordination | People Centred Approach<br>Accountability to affected populations<br>Operationalisation of the 'nexus'<br>Response to IAHE |
| Reduced funding availability | Humanitarian system<br>Coordination<br>Management and Leadership | Response to global events and trends |

## 6.2 What are Realistic Parameters for Referrals?

As a part of this research, actors from different parts of the humanitarian system outlined several key questions associated with development of referral systems. This research states the major questions and proposes responses. The responses are proposed on the basis of (a) an analysis of the available primary and secondary data, and (b) a discussion with key humanitarian actors who formed a part of the steering committee for this research.

| **Question** | **Answer** |
|---|---|
| Are biometrics a pre-requisite for starting to improve the referral system? | **NO** |

**Rationale**

Effective referral involves balancing two factors: (1) the need to ensure smooth data transfer between organisations, especially those of different size and capacity, and (2) the need to support beneficiary data protection and privacy. This research finds that currently, smooth data transfer does not take place, especially between, on the one hand, smaller INGOs and LNGOs, and on the other hand, large-scale systems (SCOPE, BRAVA). Explicit references were made from smaller INGO and LNGO management, as well as field staff from agencies of all sizes, about the challenges associated with data transfer processes.

The data collected for this research thus indicates that, at an organisational level, privacy is being prioritised over meeting beneficiary needs. This is in large part due to organisational need to meet GDPR regulations and other similar requirements. Field staff openly discussed choosing to use informal data

transfer mechanisms (messenger services, phone calls) because pre-existing data transfer systems are too complicated.

In order for a referral mechanism to function, a wide range of actors need to be able to access the system – both to refer beneficiaries into the system, and to accept referrals from other organisations. Many of these organisations, especially LNGOs and smaller INGOs, lack the budget to invest significantly in data and IM systems. If biometrics are established as a pre-requisite for a referral mechanism, then the majority of LNGOs and small INGOs will be excluded from the system.

Please also note that it is possible for a large organisation to accept data from a small organisation, conduct a supplementary assessment, and in the process of this assessment to collect biometric data.

Biometrics should therefore NOT be a prerequisite for referral systems – though the system should be structured to engage, in the future, with the national ID system and the USR.

| **Question** | **Answer** |
|---|---|
| Is it necessary to have interoperable IM systems to start building a referral system? | **NO** |

**Rationale**

An optimally efficient referral mechanism will involve automatic data transfer from the IM system of the referring agency to the IM system of the accepting agency. This can be facilitated through global/blanket data sharing agreements, such as the types which have already been negotiated between WFP, UNHCR, IOM and the Somali Cash Consortium. Existing efforts to support data sharing agreements should be expanded.

But IM systems are NOT a pre-requisite to effective referral mechanisms. There are instances of effective referral systems functioning using excel databases and ad hoc data transfer mechanisms.

It is critical for large organisations holding major databases (SCOPE, BRAVE) to undertake exercises to ensure that their systems are open to small INGOs and LNGOs. This should include taking on feedback from existing technical efforts (e.g., the Somalia IO project), committing to starting up and furthering these projects, and consulting with smaller INGOs and LNGOs to better understand how to build a system that is effective and phases in biometrics. Please note that interoperability – in the form of automatic transfer of a sub-set of data between agencies – can take place alongside supplementary assessments, including biometric registration, if needed by the referring or accepting agency.

As these systems are being developed, however, it should be recognised that effective referral mechanisms are built on the key pre-requisites identified in section 3.3. It is possible to build a referral system that is effective using a single tracking system, and to build interoperability over time.

| **Question** | **Answer** |
|---|---|
| Should a referral system be sequenced or holistic? | **SEQUENCED** |

**Rationale**

In Somalia the humanitarian, development and peacebuilding sectors operate in parallel, given the scale and scope of the crisis. In building a more effective referral mechanism, it is possible either to (1) focus on the humanitarian system alone, or (2) develop a system that actively addresses the needs of all systems at once.

This research proposes that it will be more effective to develop a referral mechanism that targets humanitarian actors. Currently referrals within the humanitarian system are fragmented and ineffective; there are significant efficiency and impact gains to be made by simply focusing on the humanitarian system. In addition, focusing on the humanitarian system provides a scope that is realistic – it helps to develop a set of 'champions' for referral mechanisms and reduces the risk of a large-scope program that may fail given the number of actors involved.

It is possible to develop a referral system that is designed for the humanitarian system – but is also structured to interact with other actors over time. This involves first engaging with sectors conducting individual referrals, then batch referrals, and gradually expanding from urban to rural and hard to reach areas. It also involves developing data collection mechanisms that (a) link to ongoing development work (e.g., the USR and the UBR) and (b) include all the data required to engage with social protection systems in the future.

| **Question** | **Answer** |
|---|---|
| To what degree does the Government of Somalia need to be involved in the referral system? | **LIMITED INVOLVEMENT IN THE INITIAL STAGES** |

**Rationale**

One of the most significant perceived obstacles to referral systems is data sharing between different organisations. Organisations have limited trust in each other's capacity to adhere to data protection regulations, and this is particularly difficult in a context where beneficiaries face significant physical risk. At a broad level, there is evidence that communities trust humanitarian organisations more than they trust government actors, and there are concerns about the objectiveness of government actors. Data sharing with the Government of Somalia may thus prove difficult.

Although it may not be possible to share data with the Government of Somalia, there are other options for engagement. Some of these include (1) structuring referrals around neighbourhood and area structures that are also used by government actors (e.g., through DANWADAAG), (2) engaging systematically with the USR and UBR mechanisms, and (3) conducting regular update sessions that include government actors, in which data from the referral system is analysed.

| **Question** | **Answer** |
|---|---|
| Who should be accountable for the referral mechanism? | **OCHA (policy)**<br>**ICCG (national tracking)**<br>**ABC and OC (local tracking)** |

**Rationale**

Currently no organisation has accountability for referral systems. It is also challenging to take responsibility for referrals in Somalia, given (1) the complexity associated with assuring information flows between sectors, (2) the difficulty associated with supporting service provision both in areas with high service density and capacity (urban areas) and low service density and capacity (hard to reach and rural areas), and (3) the presence of different types of actors – notably humanitarian, development and peacebuilding.

Coordination is currently weak in Somalia, as recognised by both the PDAD and the IAHE evaluation. Policy level initiatives, including PDAD and the IAHE evaluation, have indicated that improved

coordination is an imperative for Somalia. However, these initiatives have not provided benchmarks for measurement of improvement of coordination mechanisms. This report recommends that clear targets be set for referrals: these can be used as benchmarks for coordination.

Accountability for referral systems can be seen to rest with several actors. Many interviewees for this research saw that the natural accountability-holder for referrals was OCHA; however OCHA currently lacks capacity for inter-agency coordination, and sees its mandate as limited to inter-cluster coordination, specifically around policies and standards. The ICCG is also a key coordination player, and can support action within individual clusters. The global standard TOR for the ICCG specifies that the forum has a mandate to: "Maximise resources, minimise duplication and enhance complementarities between clusters", as well as to "Identify and facilitate the coordination of multi-sectoral or joint programming".

This report recommends that a clear split take place with regard to accountability for referral systems, as follows; it also recommends that clear and actionable targets be set for each agency/forum with regard to referrals

- OCHA is accountable for establishing policies and standards relevant to referrals
- The ICCG is accountable for tracking (1) the number of referrals that have taken place, and (2) the number of referrals that have received follow up services, at a national level
- The ABC/OC is accountable for: (1) service mapping, (2) tracking the number of referrals that take place, (3) tracking the number of referrals that have received follow up services, and (4) conducting quarterly analysis workshops to identify trends and feed into improved future programming, on a local level.

## 6.3 What are the Costs, Benefits and Risks?

**On average, the net effect of investing in referral mechanisms is positive, if the parameters outlined in 6.2 are adhered to**. This research aimed to identify both the fungible and the intangible benefits and costs associated with referral systems. The major fungible benefits of investing in referral mechanisms are as follows: (1) reduction of the cost associated with identification and assessment of beneficiaries, (2) reduction in the cost associated with beneficiaries who 'backslide' because they have not received holistic services, and (3) lower cost associated with coordination, due to the presence of accurate updated service mapping and relevant forums. The costs of investing in referral mechanisms – if estimated using the parameters outlined in 6.2 – are reasonably marginal, and include (1) establishment and maintenance of a data collection and analysis system, (2) the cost associated with providing initial and refresher training to staff and (3) the cost associated with community engagement and assuring buy-in. The intangible benefits associated with improved referral systems are also significant, and include increased community trust and greater capacity to reach out to hard to reach and rural areas. A full list of costs and benefits is included in Annex 3.

**Quantification of the costs and benefits of referral mechanisms is challenging, due to the wide range of estimates that exist.** This research aimed to provide a quantification of the costs and benefits associated with referral systems. It was not possible to quantify the analysis for several reasons, First, there is very poor data on population and needs in Somalia, and this poor data leads to significant challenges in estimating rates of relapse for beneficiaries and costs associated with assessing full communities. Second, organisations are reluctant to provide data about their budgets, and particularly about operational overheads and expenditure. Lack of budget data leads to challenges in estimating the costs associated with building data collection and analysis systems, and conducting community engagement. Third,

organisations do not disaggregate costs to account for referrals – for example, staff time is not disaggregated to calculate the amount of time spent on referrals, and estimates of the time spent vary dramatically not only across agencies, but also within agencies at different levels.

**Key cost and benefit 'buckets' are relatively clear and can be tracked over time**. This research has aimed (1) to identify all buckets of fungible benefits associated with referral systems, (2) to identify all buckets of fungible costs associated with referral systems, and (3) to identify non-tangible benefits and risks associated with referral systems. Interviewees at field, management and coordination level were asked about costs and benefits, and while the specifics of their answers differed widely, many people identified the same or similar cost buckets. Few interviewees were able to identify fungible benefits associated with referral systems – but this is largely due to the fact that these benefits are associated with reduced duplication and parallel processes within the system. Those who were able to identify benefits provided answers that were relatively coherent between each other.

| Costs | Benefits |
|---|---|
| • Data collection and analysis system<br>• Staff time<br>• Community engagement | • Savings on beneficiary identification and assessment<br>• Reduced morbidity and mortality, especially associated with 'backsliding'<br>• More effective and measurable coordination |

## 6.3.1 Costs

**There is no consensus about the costs of implementing improved referral systems**. Each of the 52 actors interviewed for this research was asked about the cost of implementing improved referral systems. Answers ranged between agencies and respondent types, with some interviewees stating that no additional funding was required and others indicating that it would cost up to 4 million USD to develop a referral system, and an additional 1 million USD per year to operate the system. Similarly, when interviewees were asked about the amount of time spent by staff on referrals, answers ranged from no time at all, to 40% of time. The breadth and diversity of answers – especially between actors within the same organisation – suggests that organisations have devoted little time and effort to scoping referral systems.

**Much of the disagreement associated with the costs of implementing referral systems is associated with the parameters associated with implementation**. Interviewees were asked to review the expected costs associated with implementing a referral system. It was notable that most interviewees developed their cost estimates based on differing assumptions about referral parameters. Some assumed that biometrics were a necessary prerequisite for conducting referrals, whereas others assumed that referrals would be run informally, through excel spreadsheets. Some included the cost of extensive government engagement, whereas others assumed that on a small number of international agencies would be involved. The breadth of cost estimates indicates that it is essential to agree on realistic parameters for referral before costing takes place.

**The costs associated with implementing a referral system are marginal if the parameters outlined in Section 6.2 are adopted**. In Section 6.2, this research outlines the parameters for developing a feasible and impactful referral system in Somalia. These parameters have been selected both because they enhance inclusion (they leave space for engagement with small NGOs, LNGOs and non-traditional actors) and because they reduce the investment cost associated with referrals.

## 6.3.2 Benefits

**The major quantitative benefit associated with improved referral systems is reduced spending on beneficiary identification and assessment.** A major cost associated with humanitarian operations in Somalia is community assessment and beneficiary identification.

- **Community assessment** can be costly for several reasons including the costs of obtaining community buy-in, collecting data and analysis. These assessments can also be characterised by bias and inaccurate information. Data collected through the SRF and referrals could provide a strong base for community assessment – it would be possible to see major needs within the community (through analysing the major sectors in which requests for referrals are generated), the dynamics of people in need (through analysing demographic data of those who are referred) and levels of service provision and gaps (through referrals that are not met). This information could be generated without additional cost, simply through analysis of existing data.
- **Beneficiary identification** can be costly as organisations need to engage in a process of engaging with community leaders, assessing individual or household vulnerability, and taking specific measures to reduce duplication. A referral system can help to reduce many of these challenges. Identification takes place through delivery of programming in another sector. While the beneficiary needs to be re-assessed, less information needs to be collected and the process is less costly. The process of re-assessment also reduces risks of duplication.

**Improved referral systems provide immediate benefits to beneficiary individuals and households**. There is a common underlying understanding that people in Somalia who have experienced humanitarian need are very likely to relapse. When individuals recover from a situation of extreme need, they are often extremely vulnerable, and there is significant research on the ways in which recurrent crises and repeated displacements cause relapse. In addition to contextual factors, however, relapse is also caused by lack of holistic programming and service availability. For example, nutrition programming supports those who are malnourished, particularly young children and PLW, to achieve acceptable nutrition outcomes. In the absence of WASH programming, however, it is highly likely that these individuals will contract water-borne diseases, and thus fall back into malnourishment.

**There are systemic benefits associated with improved referral systems that also support programmatic savings and structurally lower costs**. Currently, lack of referral infrastructure has implications both for referrals and for the broader humanitarian system. Interviews conducted for this research indicate that field level staff spend a significant amount of time trying to understand what other actors offer services in their areas, and how to engage with these actors. These challenges are likely to be experienced, not only by field staff, but also beneficiaries seeking to receive appropriate services. At a structural level, there is a body of evidence indicating that coordination structures in Somalia are not fully effective. Focusing on building accurate and up to date service mapping as well as appropriate protocols, can both help to reduce the time organisations invest in coordination mechanisms and ensure that this time is more directly related to improved outcomes for individuals, households and communities.

## 6.4 What are We Aiming For?

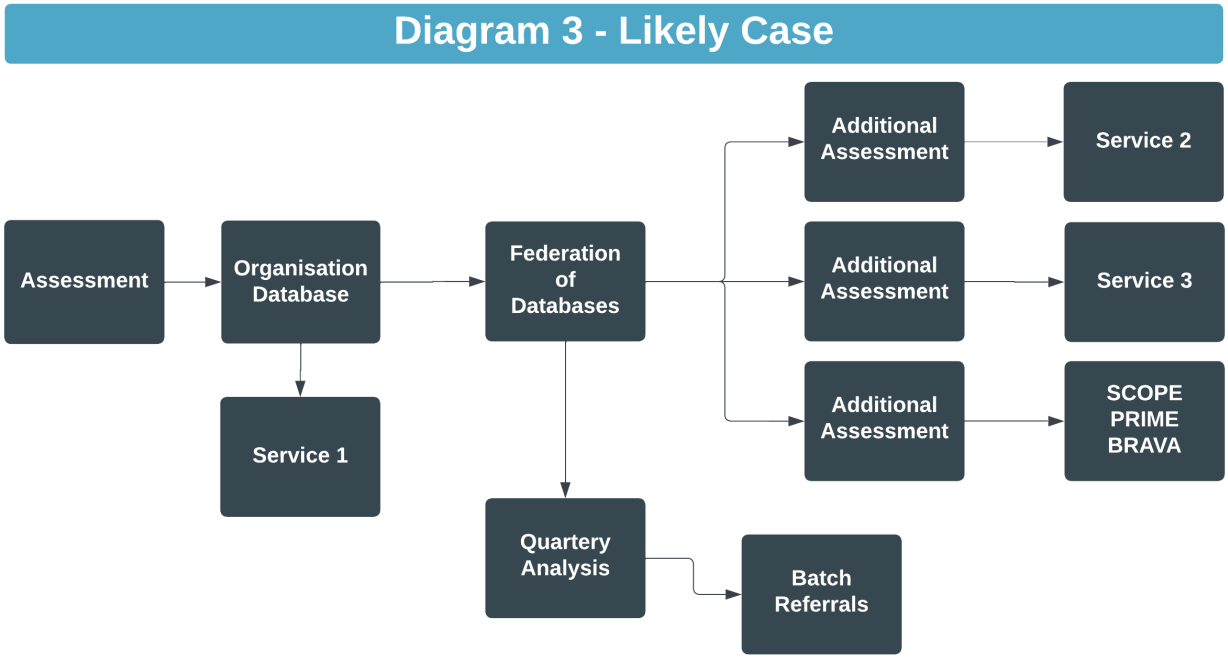
**The referral process involves providing an individual, household or community with a comprehensive set of services – and the process can start with any agency including LNGOs.** An individual or household enters into the referral mechanism when he or she is first assessed by any agency. A single agency engages with an individual or household with the intent of providing the services in which it specialises – but also of supporting the individual/household to access an array of relevant services from other service providers. At the point of data collection, beneficiary individuals or households are requested for permission, not only to collect data, but also to share data with other agencies providing potentially relevant services.

**A sub-set of data is transferred from any agency – small, medium or large – to other agencies who could provide related services**. Agencies have agreed on a sub-set of information which is required in order to accept a referral. This sub-set of data can be collected by any agency – LNGO, INGO or UN Agency – and can be transferred to any other agency, either automatically through linked databases, or through a pre-agreed data transfer process. Large scale databases (SCOPE, BRAVE, PRIMES) have a specific interface to receive the pre-agreed subset of information.

**After data transfer takes place, the accepting organisation reviews and accepts the beneficiary only if pre-existing criteria are met**. The agency accepting data on beneficiaries is responsible for reviewing the data; they can refuse referrals for which the referring agency: (1) has provided insufficient data, or (2) has provided data clearly indicating that a referral is out of scope. If the review indicates that a referral is possible, the accepting agency is then responsible for verifying the referral. This process depends on procedures within the accepting agency, and may include: (1) conducting a re-assessment, (2) conducting a biometric registration, or (3) verifying beneficiary criteria against donor or program criteria. This review process ensures that continued progress is made on de-duplication

**ABCs/OCS provide the underpinning infrastructure – service mapping and tracking – and the ICCG monitors at the national level**. ABCs and OCs regularly update service mapping so that agencies transfer to other organisations who: (1) definitely have a presence in the area, and (2) are highly likely to have capacity. This mapping should be updated on a frequent (monthly) basis. ABCs and OCS collect data from both referring agencies and accepting agencies in their local areas, and triangulate to identify discrepancies. This data collection process should take place on a frequent (monthly) basis. Responsibility for both service mapping and tracking should be included in the TORs for the ABCs/OCs. ABCs/OCs communicate this information on a regular (quarterly) basis to the ICCG, which then tracks the progress of referrals at a national level against specific benchmarks.

**ABCs/OCs conduct quarterly analysis and batch referrals to medium-term and community programs (e.g., livelihoods programs)**. ABCs and OCs receive information on the number of referrals out (as identified by the referring agency), the number of referrals in (as identified by the accepting agency), as well the number of referrals completed (as identified by both the accepting and the referring agencies). They also regularly triangulate this information. On a quarterly basis, they produce an analysis of: (1) what types of referrals are most requested, (2) what types of referrals are most frequently not completed, as well as why, and (3) potential referrals into specific 'batch' programs – notably livelihoods projects (vocational training, small business grants etc) and community WASH projects. A quarterly analysis debrief takes place, with relevant major agencies as well as government actors (ideally members of NIRA).




## 6.5 How Do We Get There?

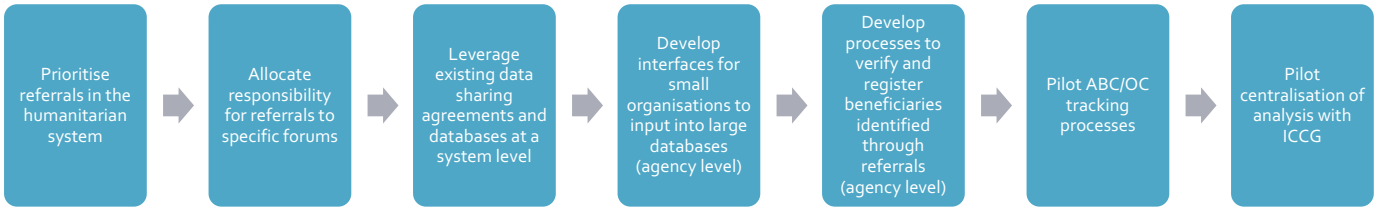
**A more effective referral system builds on pre-existing assessment and data systems including the SRF**. This research suggests that referral systems should build on ongoing efforts to improve the humanitarian system. A significant amount of effort has been devoted to developing the SRF, and the data management systems required for the SRF to function. An improved referral mechanism should leverage the SRF by (1) using SRF data as the common unified data collection system, (2) taking lessons learned from efforts to improve data sharing and adapting them to referrals, and (3) working with sectors and agencies who are already involved in the process of rolling out the SRF, and thus have demonstrated commitment to improved coordination and accountability.

**Large agencies and clusters will agree on a sub-set of information required for referrals.** Specifically, in a more effective system, a sub-set of data will be identified from the SRF; this sub-set will consist of the data that agencies agree constitutes the minimum requirement to make a referral. Organisations hosting major databases (SCOPE, BRAVE, PRIMES), will (1) explicitly agree to use this subset of data to both refer out to other agencies and to accept referrals from other agencies; (2) if necessary, develop an interface so that their databases can accept referrals from small INGOs and LNGOs, and (3) develop rollout plans (which may be phased, so that inward referrals and outward referrals are implemented sequentially). This can then be followed by an analysis process.

**A more effective referral system adopts a 'federation' system built around a core of information**. Data collection, management and analysis is a severe challenge in Somalia. This is in part due to the seriousness of risks associated with poor data management (notably transfer of data to parties which can misuse data or pose risks to beneficiaries). However, data sharing agreements have been signed, in the course of SRF development, between key actors (notably WFP, IOM, SCC). Referral mechanisms can build from these pre-existing data sharing agreements, as per the process outlined above. Following the implementation of this process: (1) an analysis process can be integrated so that on a quarterly basis all data from all organisational

systems is shared, and the products can benefit the wider humanitarian community, and (2) implementation of successful referrals can encourage other agencies to share data.

**Supplementary assessments can be used to (a) assure de-duplication and (b) assure alignment with project and donor criteria**. Data sharing through the 'federation' system represents a step toward smoother beneficiary identification and management – but it does not eliminate the need for re-assessment. It is anticipated that the referral process involves transfer of basic beneficiary data (e.g., demographic information) as well as information about need. It is **not** anticipated that the SRF will collect all information required to complete the intake of a beneficiary into a new program. This is both because different programs have specific and varying requirements, and because the SRF needs to be logistically implementable for field staff with limited time and resources.




# 7.0 Key Actions and Next Steps

Eight key actions need to be taken to improve referrals. These are:

9. **The humanitarian leadership should make a commitment to track progress of referrals – and use this to demonstrate response to IAHE recommendations**. There have been increasing calls for reform of the coordination system in Somalia, including in but not limited to the IAHE. Progress in coordination can be difficult to measure, particularly because coordination is an internal dynamic (i.e., not beneficiary-facing). Referrals however require coordination – if referrals are taking place, then effective coordination between the agencies that refer and receive must, by default, be taking place. Measurement of referrals in Somalia thus provides a tangible and concrete way for humanitarian leadership to address questions about coordination and outcomes for affected populations. j
10. **Humanitarian leadership should assign accountability for national level tracking of referrals to the ICCG**. Referrals currently are not the responsibility of any single agency in the humanitarian system. Some clusters (CCCM and Protection) are more visibly linked with referrals, but they do not have accountability. Assignment of accountability will support progress , as one institution will be

responsible for following up, and less will fall through the cracks. Assignment of accountability is also the first step in addressing other issues related to resourcing, capacity building and IM; after accountability is assigned, then the organisation accountable for referrals will advocate for, and develop strategies for, operational necessities. However it is challenging to assign accountability for referrals, given their cross-sectoral nature, and the relative lack of resources in Somalia. This report recommends that, at the national level, the ICCG tracks the number of referrals and their success rates per location; this is in line with the ICCG's responsibilities, as per their global level TORs. OCHA should be responsible for developing relevant and related standards and policies.

11. **Accountability for accurate local-level service mapping and local level tracking of referrals should be explicitly assigned to ABCs/OCs**. One of the most frequent issues that arose in data collection was lack of accurate service maps, and lack of updating. This should be clearly included in the TORs of ABCs or OCs. It should be conducted at a district level to enhance utility. Area and neighbourhood mapping should be aligned with the systems used by government actors; it is possible to use DANWADAAG systems to do this. Accountability for accurate service mapping should also be clearly linked to accountability for referrals as a whole – the organisation which is accountable for referrals should identify and advocate for local level service mapping mechanisms. Where possible, best practices from the CCCM cluster should be adopted. Similarly, ABCs and OCs should be explicitly assigned responsibility for tracking the number of referrals that take place in their areas, as well as the outcome of these referrals. This responsibility should be included in their TORs.
12. **Donors should explicitly include achievement of successful referrals as a condition for provision of grants and top ups**. There should be, at least for the short term, the development of organisational incentives for implementing effective referral systems. This could include (1) ensuring that a specific proportion of beneficiaries are identified through referrals in new programming, (2) allocating top-ups on the basis of successful achievement of referrals, (3) allocating new funding in part based on engagement in the referral system, and (4) asking organisations to explain their performance on referrals in regular reporting.
13. **Donors should ensure that the majority of grants – and all grants in priority sectors – include targets for the proportion of beneficiaries to be identified through referral mechanisms**. Donors across the humanitarian and development communities should ensure that referrals and referral tracking are integrated into program design. This includes ensuring that all grants in priority sectors, and the majority of grants outside priority sectors include targets for the proportion of beneficiaries identified through referral mechanisms, and ensuring that implementing partners report on the number of beneficiaries identified through referral mechanisms over the grant period.
14. **Agencies responsible for major data systems – UNHCR, WFP and IOM – should jointly commit to ensuring that their systems can interact with referrals from small INGOs and LNGOs, and to building interoperability**. Currently individual agencies operate specific data collection and management systems; the purpose of these systems is primarily internal. In order for a referral system to work, an interface needs to be developed between these systems. The process of developing such an interface is technical, and work has already started through the Somali IO project – but in the project inception report, specific issues were identified with regard to a common vision on why data systems should be interoperable and on program (rather than organisational) vision. This report recommends that agencies hosting major data systems (1) jointly commit to ensuring that small INGOs and LNGOs can access their systems, (2) agree on a sub-set of information which can constitute the basis for referrals, and (3) agree on the importance of prioritising referrals, as a part of a people-centred approach.
15. **The humanitarian community, led by the HC and donors, should develop a sustainability strategy focusing on a systemic approach to integrated programming and referrals, which should then be advocated for more widely**. Several of the issues associated with successful referrals are systemic

(e.g., short term, funding dependent service providers). A sustainability strategy should be developed that focuses on developing practical solutions to these issues for both donors and implementing partners. This should include sequencing of referrals, a gradual and phased engagement between humanitarian and development actors, and sustained funding for referral and basic service infrastructure. Advocacy for this should take place to states funding the response, and the strategy should be framed in the context of the humanitarian-development nexus. This strategy should also include a clear and coherent plan for linking referrals to CFM mechanisms, and to rationalising CFM mechanisms in Somalia.

16. **Rollout of referral systems should be accompanied by extensive engagement measures for staff**. This should include staff capacity building, on the job implementation, and regular refreshers and trainings. It should be based on existing best practices, and should include TOTs. Best practices should be identified through functional referral mechanisms, notably the CCCM mechanism and the SCC-CAAFIMAD mechanism.

# Annex 1: Mapping of Referral Mechanisms

| Referral Mechanism | Lead Agencies | Sectoral Scope | Geographic Focus | Referral Type | Comment |
|---|---|---|---|---|---|
| NAT 2.0<br>NAT 2.5<br>ZiteManager | CCCM cluster, IOM, DRC. | Wide | Urban Areas | Individual<br>Batch<br>Scale | Note that NAT is a registration form, ZiteManager is an Accountability Platform |
| SCC/CAAFIMAD+ | SCC/CAAFIMAD+ | Health<br>Nutrition | Overlap between the two consortia | Individual | Positive feedback from implementing staff |
| Fast-Track Referral | Protection, CCCM and FSL clusters | Protection<br>CCCM<br>FSL | Hard to Reach areas<br>Marginalised Clans | Batch | |
| GBVIMS<br>CPIMS | Protection Cluster | Protection | Wide | Individual | Small scale, uncertain capacity and follow up |
| Health Referrals | Health Cluster | Health | Wide (but focus on urban areas) | Individual | Challenging to implement the later stages (e.g., rehab) |
| Universal Social Registry/Universal Beneficiary Registry | MoLSA, World Bank, WFP | Social Protection | Wide (aiming to cover all individuals in Somalia | Individual<br>Scale | Not yet functional as a system, can't yet accept referrals |
| Child Protection to Education | CPIMS<br>UNICEF | Protection<br>Education | Unclear | Individuals | Limited information |
| Informal agency to agency referrals | Various | Various | Highly geographically dependent | Individual<br>Scale | |
| Project specific referral mechanisms | Various | Various | Various | Various | Sometimes a requirement of donors |
| Nutrition food security - DEFUNCT | | | | | |

# Annex 2: Barriers and Mitigation Measures

| Level | Barrier / Risk | Mitigation Measure |
|---|---|---|
| Community | Low community trust in referrals and preference for traditional medicine/support *PD – Field staff interviews* | Referral mechanisms are in and of themselves a mitigation measure – provision of a complete set of services, at lower effort, can rebuild community trust |
| | The move away from community-based targeting to vulnerability based targeting is likely to erode the trust of some elders and community members *PD – Interviews with UN actors and Others* | Referral mechanisms are in and of themselves a mitigation measure – provision of a complete set of services, at lower effort, can rebuild community trust |
| | Services are often not available in rural and HTR areas, and where they are available, they may stop after a few months due to funding changes *PD, SD(I)* | Advocacy from donors for a mid to long-term sustainability strategy for services in Somalia Increased government responsibility for service provision |
| | Access to services may be restricted by community/IDP gatekeepers *PD, SD(E)* | Common approaches to gatekeepers, red lines, etc could be |
| | Issues associated with minority clans and marginalised groups accessing the system *(PD, SDE, SDI)* | Reinforce existing efforts for inclusion |
| | Individuals and households often lack transport to access services that are far away from their locations *PD (field staff), SD* | Budgeting for transport and supplementary costs of beneficiaries accessing referrals |
| Field Staff | Field staff are often unaware of referral mechanisms *(PDs, field staff)* | Strengthening of coordination mechanism and service mapping |
| | Staff have low levels of literacy and technical capacity *(PDs, field staff)* | Training of staff |
| | Staff have challenges in administering long forms to individuals with short attention spans. *(PDs, field staff)* | Rollout at service delivery points, with specialised support to accompany staff as they start the SRF |
| | Where staff do have capacity, specialised training and regular refreshers will be needed. *(PDs, field staff)* | Updated training |
| Organisational Barriers | Donor driven targeting criteria can hinder alignment across sectors (e.g., if donors ask for a particular beneficiary group to be targeted in a specific project, it may render the data in the referral system less significant) *(PD, field and management staff, INGOs and UN agencies)* | Develop a system that is flexible enough to account for supplementary assessments |
| | Costs associated with referrals – notably staff time and transport or incentives for beneficiaries – are not budgeted into projects. (*PD, all)* | Organisations need to start budgeting staff time and transport/incentives (rough guide from the wide range in the interviews – 15 USD per beneficiary for transport, and 1 or 2 days per month for staff time) |
| | Referrals can fail due to the activity or lack thereof of other organisations – meaning that that organisations lose control over the outcome. (*PD, management, also SD I evaluations*) | Humanitarian leadership needs to set referrals as a priority (see 5.1) |
| | Organisations do not have explicit incentives to ensure that referrals work; the incentives that do exist support transfer of information, not assurance of service provision. (*PD, management, also SD I evaluations*) | Humanitarian leadership needs to set referrals as a priority (see 5.1) |

| | | |
|---|---|---|
| | Referrals rely on sharing information; in the current context and with the efforts around de-duplication, some large organisations perceive both reputational and security risks. (*PD – please note that this was super clear from interviews with small and large agencies*) | Small organisations – sign more information sharing agreements and operationalise these (e.g., SCC-BRCiS has an agreement that is not used for referrals, though it could be)<br>Large organisations – off the record trust building exercises |
| | Due to funding cycles, most organisations have a short-term approach to investment in the system. (*PD, SDI, SDE*) | Advocacy from donors for a mid to long-term sustainability strategy for services in Somalia |
| **Technical and Data Barriers** | Lack of data sharing agreements between different actors hinders the setup of an effective referral mechanism, as in the absence of data sharing agreements staff need to conduct multiple assessments (*PD, SDI – Inception and evaluation*) | Push for data sharing agreements when not in a crisis. Please note that several interviews pointed to the reactive nature of system building, with one interviewee saying that during periods of calm nothing was done, and in emergencies "we run around like chickens with our heads cut off" |
| | The role of biometrics in data collection, and in referral systems, is unclear. If it is necessary to be registered using biometrics, then capacity of smaller organisations, particularly LNGOs, to access referrals will be lower (*PD, SDI*) | Steering Committee point |
| | The complexity of the current array of referral systems is challenging operationally, and in terms of development of an effective system (large scale efforts to support interoperability are required) (*PD, SDI – inception*) | Interoperability work already underway – but stalled because of some associated issues. |
| | Technical systems need to account, not just for transfer of information, but also for provision of service (e.g., ZiteManager records a case as closed if a sector has responded – even if the response is 'we cannot provide services') (*PD, SDI, Team analysis*) | Design of the system to track referrals needs to include (1) regular analysis of data, and (2) specific methods of recording where cases are closed because services are not available. |
| | Current coordination structure is heavy with duplicative and parallel structures (*PD, SDI – evaluation*) | Significant ongoing work is in place to reform the coordination structures. This work should include ABCs/OCs having explicit responsibility for service mapping. |
| | Emphasis is currently placed on moving information through coordination mechanisms, rather than on moving information to follow-up service providers. (*PD – process mapping of how data moves through a system, particularly in fast-track referrals*) | Work on the coordination structure should help to resolve this issue |
| **Management & Leadership** | There is a lack of trust between organisations (*PD – management and field, SD I notably evaluation*) | This will require a larger focus, and belongs to the humanitarian system coordination (i.e., HCT) |
| | Referrals are not currently prioritised at the level of humanitarian leadership or organisational leadership. (*PD – management and field, SD I evaluation*) | Please see Section 5.1 |
| | Accountability for referral systems has not been allocated to an institution or forum (e.g., to WFP, to UNHCR, to the ICCG, etc) (*PD*) | This will require a larger focus, and belongs to the humanitarian system coordination (i.e., HCT) |
| | Rapid turnover in management and leadership leads to concerns about the sustainability of a referral mechanism. (*PD – field staff, management staff, cluster staff*) | Advocacy from donors for a mid to long-term sustainability strategy for services in Somalia |

| | | |
|---|---|---|
| **System** | Ensuring consistent availability of services is challenging due to funding cycles and constraints. | Advocacy from donors for a mid to long-term sustainability strategy for services in Somalia |
| | The humanitarian system is structured for short term engagement, but effective referrals require a medium-term investment | Advocacy from donors for a mid to long-term sustainability strategy for services in Somalia |
| | Data and assessments are currently inconsistent and insufficient, leading to challenges in assuring follow-up (e.g., no population data, inconsistent assessments at different geographic levels, etc). *SD I - Evaluation* | This will require a larger focus, and belongs to the humanitarian system coordination (i.e., HCT) |

# Annex 3: Costs, Benefits and Risks

| | Scenario 1 | Scenario 2 | Scenario 3 |
|---|---|---|---|
| **COSTS** | | | |
| Single registration form (development) | Medium | Medium | Medium |
| Single registration form (rollout) | Medium | Medium | Medium |
| Adjusting databases to automatically transfer data | None | High | Medium |
| Regular analysis of data to identify community trends | None | Medium | Medium |
| Beneficiary Assessment(s) - Initial | High | Low | Medium |
| Beneficiary Assessment(s) - Supplementary | None | Medium | Medium |
| Coordination | High | High | High |
| Transport for beneficiaries | Medium | Medium | Medium |
| Community Engagement | Low | Low | Low |
| Staff Time (ongoing) | Medium | Medium | Medium |
| Staff Capacity Building (initial + refreshers) | Low | Low | Low |
| **Overall Cost** | **Low setup costs, high operational costs** | **High setup costs, low operational costs** | **Medium setup costs, medium operational costs** |
| **BENEFITS** | | | |
| Community trust in the system | Low | High | Medium |
| Access to communities and areas | Low | Medium | Medium |
| Reduced mortality and morbidity | Low | Medium | Medium |
| More effective and measurable coordination | Low | High | Medium |
| Reduced duplication | Low | High | Medium |
| Provision of essential batch services | Low | High | High |
| More efficient identification of the most vulnerable | Low | Medium | Low |
| More timely service provision | Low | High | Medium |
| Improved collaboration between humanitarian actors | Low | Medium | Medium |
| **Overall Benefit** | Low benefits to the community, low change to trust in the system | High benefits to the community, medium changes to trust in the system | Medium benefits to the community, medium changes to trust in the system |
| **RISKS** | | | |
| Assessment fatigue | High | Low | Medium |
| Delays in assistance to beneficiaries | High | Low | Medium |
| Over-reliance on a small number of organisations | Low | Medium | Medium |
| Lack of interoperability with other systems (e.g., Baxnaano) | High | Medium | Medium |
| Inequitable distribution of services | Medium | Medium/low | Medium |
| Data security and privacy | Low | Medium | Medium |
| Overload of existing facilities | Low | Medium | Medium |
| **Overall Risks** | Duplication, fatigue, lack of trust | Centralisation, lack of openness to small organisations | Lack of substantial improvement |

**Meraki Labs** is a women-owned business focusing on humanitarian, migration and displacement Meraki Labs develops teams of consultants from the Global South and with displacement and conflict backgrounds to deliver research, assessment and evaluation projects to stakeholders. As an organisation, Meraki Labs aims to empower impacted communities to voice their own opinions on programs and policies, and to build their capacity to independently comment on programs and policies in a way that is credible in the international policymaking arena. Meraki Labs has successfully delivered projects to a range of stakeholders, including UN agencies (e.g. UNHCR, IOM, UNICEF, UNODC), INGOs (e.g. NRC, DRC, DCA, Plan) and civil society organisations (e.g. DEMAC, PCHR).

**The Somali Cash Consortium (SCC)** is comprised by humanitarian agencies (ACTED, COOPI, DRC, NRC, SCI, IMPACT Initiatives), led by Concern Worldwide (Concern). It aims to provide cash transfers to vulnerable households affected by conflict, displacement, and natural disasters in Somalia and implements both short-term humanitarian assistance (MPCA) and long-term social transfers programmes. The SCC works closely with local partners and community-based organizations.

**The European Commission's Civil Protection and Humanitarian Aid Operations department (DG ECHO)** was created in 1992 as an expression of the European solidarity with the people in need across the world. We have been providing humanitarian assistance for over 30 years, with the help of our field network and humanitarian partners. The EU's humanitarian work is guided by the humanitarian principles grounded in international humanitarian law (humanity, neutrality, impartiality, and independence).

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**Swiss Agency for Development and Cooperation SDC**

**The Swiss Agency for Development and Cooperation (SDC)** is Switzerland's international cooperation agency within the Federal Department of Foreign Affairs (FDFA). In operating with other federal offices concerned, SDC is responsible for the overall coordination of development activities and cooperation with Eastern Europe, as well as for the humanitarian aid delivered by the Swiss Confederation.