SOMALIA COUNTRY PROGRAMME EVALUATION

2018 - 2020

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Map of Somalia[1]

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[1] The boundaries and names shown and the designations used on the maps on this site do not imply official endorsement or acceptance by the United Nations Population Fund.

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The Evaluation Team hopes that the findings and recommendations presented in this report will positively contribute to building a sound foundation for the development of 4th UNFPA Somalia country programme, national development plans and the United Nations Sustainable Development Cooperation Framework (UNSDCF) in Somalia.

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ABBREVIATIONS AND ACRONYMS

AADPD	Addis Ababa Declaration on Population and Development
AIDS	Acquired ImmunoDeficiency Syndrome
ANPPCAN	African Network for the Prevention and Protection Against Child Abuse and Neglect
ART	Antiretroviral Therapy
AWP	Annual Work Plan
BEmONC	Basic Emergency obstetric and newborn care
CCCM	Camp Coordination and Camp management
CEDAW	Convention on the Elimination of Discrimination Against Women
CEmONC	Comprehensive Emergency Obstetric and New-born Care services
CERF	Central Emergency Fund
CMR	Clinical Management of Rape
CO	Country Office
CP	Country Programme
CPD	Country Programme Document
CPE	Country Programme Evaluation
CPR	Contraceptive Prevalence Rate
CSO	Central Statistics Office
DAC	Development Assistance Committee
DaO	Delivering as One
DFID	Department for International Development (UK)
EM	Evaluation Manager
EPHS	Essential Package of Health Services
ERG	Evaluation Reference Group
FAO	Food and Agriculture Organization
FGD	Focus Group Discussion
FGM	Female Genital Mutilation
FGM/C	Female Genital Mutilation/Circumcision
FGS	Federal Government of Somalia
GAM	Global Acute Malnutrition
GBV IMS	Gender-Based Violence Information Management Systems
GBV	Gender-based Violence
GDP	Gross Domestic Product
GEWE	Gender Equality and Women Empowerment
GPS	Global Positioning system
HACT	Harmonised Approach to Cash Transfers
HCT	Humanitarian Country Team
HIV	Human Immuno-Deficiency Virus
HR	Human Rights
HRP	Humanitarian Response Plan
HSSP	Health Sector Strategic Plan
ICPD	International Conference on Population and Development
IDMC	Internal Displacement Monitoring Centre
IDPs	Internally Displaced Persons
IEC	Information, Education and Communication
ILO	International Labour Organisation
IMF	International Monetary Fund
IPs	Implementing Partners

JUNTA	Joint United Nations Team on AIDS
KII	Key Informant Interview
LDC	Least Developed Country
LMIS	Logistics Management Information System
M&E	Monitoring and Evaluation
MMR	Maternal Mortality Ratio (Rate)
MNCH	Maternal New born and Child health
MoH	Ministry of Health
MoNP&ND	Ministry of National Planning and National Development
MoPIC	Ministry of Planning and International Cooperation - Puntland
MOPIED	Ministry of Planning, Investment and Economic Development
MPTF	Multi Partner Trust Fund
NBS	National Bureau of Statistics
NDP	National Development Plan
NGO	Non-Governmental Organization
NRC	Norwegian Refugee Council
ODA	Official Development Assistance
OECD	Organization for Economic Cooperation and Development
OECD/DAC	Development Assistance Committee of the Organisation for Economic Cooperation and Development
PBF	Peace Building Fund
PD	Population Dynamics
PMT	Programme Management Team
PMTCT	Prevention of Mother to child transmission
PoA	Plan of Action
PPE	Personal Protection Equipment
PwC	PriceWaterhouseCoopers
RBM	Results Based management
RHWG	Reproductive Health Working Group
RMNCH	Reproductive maternal newborn and child health
RRF	Results Resources Framework
SDGs	Sustainable development Goals
SHDS	Somalia Health and Demographic Survey
SHF	Somalia Humanitarian Fund
SMT	Security Management Team
SOLO	Somali Lifeline Organization
SOPs	Standard Operating Procedures
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
TFR	Total Fertility Rate
ToC	Theory of Change
ToR	Terms of Reference
TVET	Technical and Vocational Education and Training
UBRAF	Unified Budget Results and Accountability Fund
UN	United Nations
UN HABITAT	United Nations Human Settlements Programme
UN IGME	UN Inter-Agency Group for Child Mortality Estimation
UNCT	United Nations Country Team
UNDP	United Nations Development Programme

UNEG	United Nations Evaluation Group
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNSAS	United Nations Somalia assistance Strategy
UNSF	United Nations Strategic Framework
UNSF	United Nations Strategic Framework
USA	United States of America
VCAT	Values, clarification and attitudes transformation
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization
YAB	Youth Advisory Board
YES	Youth Employment Somalia

Somalia: Key Facts

Indicators	Facts (Data Value)	Source/ Year
Land		
Geographical location	Eastern Africa	
Surface area	637,657	UNFPA
People		
Population	15.3 Million (est.)	World Bank (2019)
Population aged below 15 years	54.8%	SHDS (2020)
Population aged 15 – 24 years	17.2%	SHDS (2020)
Population aged below 30 years	78%	SHDS (2020)
Population aged 65 years and above	3.3%	SHDS (2020)
Women of reproductive age (15 – 49)	38.2%	SHDS (2020)
Urban population	44.97[2]	Statista (2018)
Rural population	55.03	World Bank (2018)
IDPs	2.6 M	IDMC (2019)
Religion	Islam	Somalia Constitution (2012)
Population growth Rate	2.8	World Bank (2018)
Health		
Infant mortality rate (deaths per 1'000 live births)	76.6	World Bank (2018)
Child mortality rate age 1 to 4 (deaths per 1'000 live births)	48.7	UN INGME (2018)
Neonatal mortality rate (deaths per 1'000 live births)	37.5	UN INGME (2018)
Under-5 mortality (deaths by 1'000 live births)	121.6	UN INGME (2018)
Adolescent fertility rate (per 1'000 women)	140	SHDS (2020)
Contraceptive prevalence rate (% of women aged 15-49)	6.7%	SHDS (2020)
Unmet need for contraceptive use	37%	SHDS (2020)
Maternal Mortality ratio (per 100'000 live births)	692	SHDS (2020)
Life expectancy at birth	56.7 years	World Bank 2017
Total fertility rate (average number of children per woman)	6.17	World Bank 2017
Adults aged 15-49 HIV prevalence rate	0.58%	UNAIDS (2014)
Proportion of births attended by skilled health personnel	31.9	SHDS (2020)

[2] This covers the period between 2008 – 2018, accessed from www.statista.com on 10/06/2020.

Total of Health Expenditure (% of GDP)	35%	World Bank (2001)
Government		
Type of government	Federal Government	Somalia Constitution (2012)
Head of government	President	
Economy		
GDP	US$ 7.7 billion	World Bank (2019)
GDP annual growth rate	2.9	World Bank (2019)
Per capita income	US$ 187	World Bank (2010)
Unemployment rate	13.98% (est)	Statista[3] (2019)
Youth unemployment rate	24.9% (est)	ILO (2019)
Multidimensional Poverty Index	0.518	UNDP (2006)
Social and Development Indicators		
Human Development Index rank	165/170 (0.285)	UNDP (2012)
Literacy rate	40%	UNFPA (PESS, 2014)
Net enrolment in Primary school	18.5%	SHDS (2020)
Net enrolment in secondary school	9.2	SHDS (2020)
Gender Inequality Index	0.776	UNDP (2012)
Seats held by women in national parliament	24%	World Bank (2019)
Women experienced GBV (Percentage of ever-married women aged 15-49 who have ever experienced emotional, physical or sexual violence committed by their husband)	15.3%	SHDS (2020)
Prevalence of female genital mutilation (proportion of girls and women aged 15-49 years who have undergone female genital mutilation/cutting)	99.2%	SHDS (2020)
Prevalence of child marriage (proportion of women aged 20-24 years who were married or in a union before age 18)	45%	UNICEF (2006)

[3] https://www.statista.com/statistics/808953/unemployment-rate-in-somalia/

STRUCTURE OF THE COUNTRY PROGRAMME EVALUATION REPORT

This Country Programme Evaluation Report is structured according to the UNFPA Evaluation Handbook. Chapter One introduces the purpose and objectives of the Country Programme Evaluation, outlines its scope as well as the methodology and processes. Chapter Two, describes the programme implementation context, highlighting the development challenges, in addition to the national strategies, and the role of external assistance. Chapter Three describes the UN and UNFPA strategic response as well as the UNFPA response through the current 3rd CP and previous 2nd CP country programmes.

Chapter Four presents the findings of the CPE guided by the evaluation questions under each evaluation criteria of relevance, effectiveness, sustainability, efficiency, coordination, Coverage and Connectedness. Chapter Five covers the conclusions to the report presented at both strategic and programmatic levels; and the Lessons learnt. Chapter provides the CPE recommendations and are also presented at strategic and programmatic levels. Prior to the main chapters the report includes acknowledgements, acronyms and abbreviations, the list of tables and figures, a key facts table and an Executive Summary. Finally, the report provides the following annexes: Terms of reference, list of persons/ institutions visited and interviewed, documents reviewed, evaluation matrix, the CPE agenda and stakeholders map.

EXECUTIVE SUMMARY

Purpose, Scope and intended audience: This report presents the process, findings, conclusions and recommendations of the UNFPA 3rd programme cycle (2018 – 2020) Country Programme Evaluation (CPE). The purpose of the evaluation serves two primary purposes, namely; enhance accountability of the UNFPA CO towards its stakeholders, donors and partners by demonstrating its performance in terms of achieving expected results at the country level; and (ii) supporting evidence-based decision-making at country level by generating high quality information and data, which will serve as a basis for the planning, design and implementation of the next Country Programme. Further, it was to examine to what extent the UNFPA Somalia CO has contributed to the international response to the on-going humanitarian crises, as well as to assess its contribution to humanitarian preparedness, response and recovery. Specifically, the CPE aimed to provide an independent and objective assessment of the relevance, effectiveness, efficiency and sustainability of UNFPA support and progress towards the expected outputs and outcomes articulated in the results and resources framework of the Somalia Country Programme 2018-2020; examine the role played by the UNFPA Somalia CO in the coordination mechanisms of the United Nations Country Team (UNCT) with a view to enhancing the United Nations contribution to national development results; analyse the contribution of the Somalia Country Programme to the humanitarian-development-peace nexus, with a particular focus on the establishment of linkages between development and humanitarian interventions, resilience building and capacity development of national partners and stakeholders; and draw key lessons and good practices from past and ongoing interventions under the Somalia CP and provide a set of realistic and concrete recommendations to improve the design, implementation and monitoring and evaluation of the next CP cycle. The CPE covered the period from 2018 up to July 2020, including the CP four outcomes and all the provinces covered by the 3rd CP. The intended audience for the CPE report include; UNFPA Somalia CO; its implementing partners; UNCT and Humanitarian Country Team (HCT) in Somalia; donors of UNFPA-supported interventions; and UNFPA Arab States Regional Office.

The 3rd Country Programme: The 3rd Country Programme was designed in alignment with the National Development Plan, the 2030 Agenda for Sustainable Development (particularly Goals 3, 5, 10 and 17), and the United Nations Integrated Strategic Framework (UNSF) 2017-2020; focusing on four thematic outcome areas Sexual and Reproductive Health Rights (SRHR), Adolescent and Youth (A&Y), Gender Equality and Women's Empowerment (GEWE), and Population Dynamics (PD). The programme contributed to the reduction of maternal mortality in Somalia with women, youth, populations affected by humanitarian crisis, and key populations at risk of HIV, as the primary targets, integrating both development and humanitarian interventions, as well as gender mainstreaming and human rights approaches. The emphasis of the programme at output level is to strengthen the capacities of the national stakeholders to improve SRHR, A&Y, GEWE and PD indicators in the country, utilizing all the five modes of engagement: advocacy and policy dialogue; capacity development; knowledge management; partnership and coordination, and service delivery.

Methodology: The CPE had five phases. It started with a **preparation phase**, when the CO engaged an evaluation reference group (ERG), developed terms of reference and recruited the four consultants, two international and two national. Next, the consultants undertook evaluation **design phase** and produced the CPE design report; the **field phase** of data collection and analysis; and **reporting and validation** with the CO, ERG and other stakeholders; and the **facilitation of use and dissemination phase** in which the CO implements the full communication plan to share the report, and final evaluation quality

assessment prior to the publication of the report. The UNFPA Evaluation Handbook[4], guided the entire evaluation process, in addition to the formats of the design and evaluation reports. The CPE was a theory-based non-experimental design using a participatory approach, and guided by a set of 10 questions corresponding to the evaluation criteria mentioned earlier.

Using a purposive sampling method, UNFPA stakeholders were selected from all over the country, where the Country Programme was implemented. The stakeholder selection process was guided by stronger and weaker IPs, and financially large and small programmes and projects; partners from government and civil society organisations (CSOs), donors, strategic partners and, direct and indirect beneficiaries. The data collection methods for the evaluation included four main methods; namely i) Document review; ii) remote-based key informant interviews (KIIs) at group and individual levels with the selected stakeholders and CO staff conducting a total of 46 sessions; iii) Focus group discussions with stakeholders and beneficiaries conducting three sessions; and d) three selected site visits. Triangulating the sources and methods of data collection, evaluation used both qualitative and quantitative data in the analysis and generation of the evaluation report. All the data were collected virtually through Zoom and Google Meet platforms, except three FGD sessions that were conducted. Ethics and quality control requirements were adhered to by the consultants and assured by the Evaluation Manager There were no major challenges encountered during the field phase, and the purpose and objectives of the CPE were fully met with invaluable support from the CO team. The CPE report was validated by the CO and stakeholders in Somalia.

Main Findings and Conclusions: The 3rd Somalia Country Programme was **strategically aligned** with national and international development priorities, as expressed in the Somalia National Development Plan 2020 - 2024 (NDP-9) the UNSF 2017-2020, International Conference on Population and Development, and the UNFPA Strategic Plans (2018-2022) and contributing to the Sustainable Development Goals (SDGs). The programme was also **responsive** to humanitarian and emerging needs, occasioned by changes in the implementation context, especially occasioned by drought, floods and conflicts; as well as integrating a high level of consultative approaches during design and implementation with the government, advancing national ownership and capacity building. There were however inherent weaknesses in the design, especially on the definition of the result indicators. UNFPA Somalia exhibited strength in the areas of mandate in advancing access to SRHR by women, girls and youth; strengthening advocacy on policy and legislative framework towards GBV prevention and response, and abandonment and elimination of harmful practices; and in improving existing capacities for evidence-based planning and development in the country. In addition, the UNFPA's strength is well identified and recognized within the UNCT and contributes to its coordination mechanism within the country.

Towards **effectiveness,** the CP's implementation rate and achievement of output targets in the results framework was generally high, with the PD surpassing expectations in the level of achievement, save for the targets that were affected by inadequacy of funding. UNFPA made significant progress towards realization of results across all the four component result areas of the country programme. **Under SRHR**, UNFPA contributed to strengthening capacities of the health systems prioritizing access to sexual and reproductive health and rights information and improved service delivery. UNFPA strengthened the capacities of the national stakeholders in delivering quality integrated Reproductive Maternal Neonatal Child Adolescent Health (RMNCAH). The CO supported improvement of quality of birth attendance in the country through financing and strengthening Somalia midwifery capacity by training midwives through 14 midwifery schools, with 222 graduating, and a further admission of 514 to the schools; supporting review of the midwifery curriculum to the International Conference of Midwives/WHO standards, and

[4] Evaluation Handbook: How to Design and Conduct a Country Programme Evaluation at UNFPA, 2019

incorporating FP; and developing, in collaboration with the FGS ministry of health, the yet-to-be launched Midwifery Employment and Retention Strategy. UNFPA supported the ministries of health across the country through development of guidelines and standard operating procedures (SOPs) for service delivery, in addition to support supervision and mentorship of the health workers. Further, the CP contributed to strengthening service delivery and policy framework through facilitating and coordination development of RMNCH advocacy strategy and guidelines, Family Planning strategy in the Islamic context and training guidelines, Clinical Management of Rape (CRM), Logistic management information system (LMIS) Policy and related tools, initiation of anti-medicalization of female genital mutilation (FGM) policy and complication management, BEmONC and CEmONC guidelines, and contributing to the development of various strategic plans ensuring clarity in results. There were however gaps in the SOPs and guidelines implementation, due to inadequate capacity and commitment of the government authorities and among the healthcare workers.

The CP also supported setting up a functional electronic Logistics Management Information System and training the staff on it, facilitating reporting and evidence-based forecasting and monitoring of reproductive health commodities. On service delivery, UNFPA expanded quality preventive as well as life-saving services for the management of complications of pregnancy and childbirth across the country through strengthening the delivery of integrated BEmONC and CEmONC services, both stationery service points and complementary outreaches targeting the marginalized and hard-to-reach areas; in addition to skills development for health workers, health facility infrastructure management, supplies management. UNFPA supported provision of medical supplies, training and funds for fistula prevention, treatment and social reintegration programmes in Somalia, with a total of 425 cases repaired in 2018 and 2019. There is still a need for training of surgeons and expansion of the fistula treatment services, in addition to prevention and integration in the country. UNFPA strengthened capacities of healthcare workers to provide quality contraceptive counselling and administration of methods, including development of Islamic-sensitive Family Planning (FP) strategy and training curriculum incorporating human rights, and advocacy on the importance of birth spacing and increased demand for FP services. Male-engagement in FP service uptake is still low, FP commodity stock outs, long-held cultural beliefs and misconception and inadequate information on FP method preferences and inadequate funding hindered and still impede access and uptake of FP service. UNFPA enhanced coordination in delivery of SRHR services through co-chairing the Reproductive Health Working Group (RHWG), the Fistula Steering Committee; and the Clinical Management of Rape (CMR) taskforce, maternal death surveillance and response (MDSR) taskforce, enhancing service delivery and minimizing overlaps in SRHR response. UNFPA secured funding of 1 Million Canadian Dollars from GAC and 1 Million Euros from the Finnish Government to respond to the COVID-19 pandemic, supporting treatment, prevention and control within Somalia, in addition to supporting establishment of the national blood bank in Mogadishu.

In the **adolescents and youth** component, the 3rd CP financially and technically supported the development of National Youth Strategy and National Youth Policy, milestones in the country, providing a framework for a roadmap for meaningful youth engagement targeting youth on state building and empowerment. UNFPA enhanced access to youth and adolescence sexual and reproductive and rights (ASRHR) services in the country through training of healthcare workers on youth friendly services, enhancing awareness raising mechanisms and establishment of youth-friendly service, including counselling points in health facilities and youth centres. Through the CP, UNFPA supported youth and adolescent to receive information on ASRH, HIV&AIDS, and harmful traditional practices including FGM and early marriage, targeting behaviour change through use of engagement approaches such as theatre-based performance, school clubs, youth associations and peer to peer. The CP also contributed to elevating the role of youth in governance and peacebuilding through supporting establishment of structured youth participation forums, allowing them to dialogue and come up with solutions to their

issues in the country, with the efforts leading to elections of considerable percentage of youth into Parliament of the South-West and Jubaland States. In addition, UNFPA facilitated the establishment of the Youth Advisory Board to facilitate consolidation and coordination of youth activities at the UNCT level. UNFPA responded in addressing youth pressing needs through targeting the vulnerable and marginalized youth for skills development on various technical and vocational education training (TVET), literacy and numeracy training, and access to various information through the internet and library from the youth centres. There were however gaps in supporting start-up activities for the trained youth. It was also a great achievement of the Adolescent and Youth component of securing funding from European Union (EU) to support business start-ups by the youth. UNFPA also engaged Islamic religious authorities to address challenges to youth and adolescent sexual and reproductive health rights. More synergy among stakeholders should capitalize on the existing youth strategy and policy to strengthen empowerment of youth and adolescents in the country. UNFPA also supported vulnerable girls, particularly in the IDP settlements and hard-to-reach locations with menstrual hygiene supplies including reusable sanitary pads, protecting their dignity as well as promoting school attendance for young adolescent girls who are at school age.

UNFPA made considerable contributions towards **GEWE** through strengthening policy, legal, and accountability frameworks, transformation of attitudes, values, norms that perpetuate GBV, FGM, and, child marriage, and provision of services to GBV survivors promoting reproductive rights and women's empowerment. UNFPA, in the 3rd CP expanded access to integrated and multi-sectoral services including psychosocial support, legal aid, medical support, dignity kits support and referrals services through establishment and management of 35 one-stop centres across the country, in addition to supporting women and girls' safe spaces offering broad-based services including skills training, trauma healing, psychosocial support, literacy and numeracy support, and referrals, for women and girls facing stigma in their communities. UNFPA also enhanced synergies and leveraging of resources, partnerships for prevention and response to GBV in the country through technically and financially supporting GBV sub-cluster coordinating meetings. UNFPA is also an active and permanent member of the Gender Technical Working Group (GTG) enhancing gender mainstreaming across the UN agencies; in addition to supporting GBV Information Management System (GBV IMS) for evidence-based programming, streamlining response. There are however still challenges with GBV data generation in the country, with the existence of other IMS managed by other agencies, collecting different data. Through integration, SRHR addressed advocacy issues on the anti-medicalization of FGM, while the adolescent and youth component enhances sensitization among the harmful practices aimed at abandonment of the vice. 3rd CP supported advocacy mechanisms towards abandonment of FGM/C as well as strengthening legislations towards zero tolerance to FGM/C. However, FGM/C advocacy mechanisms in the country are affected by inaccuracy of information on the extent of FGM/C, inadequate funding, absence of legislation, poor monitoring of the FGM/C, and confusion on the mix of religion and cultural understanding of what FGM/C is. UNFPA supported drafting of the Sexual Offenses Bill (SOB), approved by the Federal cabinet in 2019, but pending Parliamentary endorsement; supported the drafting of the Zero tolerance FGM Bill 2019, which are still pending in both FGS and Puntland; drafting FGM anti-medicalization law; and FGS approved the Human Rights Commission into Law. UNFPA intensified successful advocacy at the community and levels through dialogues. Somalia ratified for the first time the CEDAW charter and UNFPA supported its reporting instruments, including that of the ICPD.

Under PD, UNFPA made significant contributions to strengthening evidence-based planning and development through successful financial and technical facilitation of the mobile technology–enabled Somali Health and Demographic Survey, in addition to strengthening capacities of national statistics units towards design and implementation of surveys, generation, analysis and dissemination of data on SRH, adolescents and youth, gender and population dynamics enabling mapping of inequalities and inform

interventions during humanitarian crisis. The SHDS report enabled, for the first time in Somalia, real-time planning, policy formulation and programmes as well as generation of key indicators for monitoring the localized Sustainable Development Goals (SDGs) through establishment of baselines, International Conference on Population and Development (ICPD) goals, National Development Plans (NDPs) and other strategic development frameworks for the Somali Authorities. Generation of thematic reports of the SHDS report increases focus on vulnerabilities, particularly the marginalized, with service delivery. UNFPA ensured a highly participatory approach to implementation of the SHDS, immensely contributing to strengthening the capacities of the statistical departments for FGS, Puntland and Somaliland governments in analysis and use of disaggregated data to inform plans, policies, and programmes, in addition to enabling development of sampling frame for the whole country. Statistics staff capacity improved on survey development, data analysis using various analysis systems, data disaggregation, socio economic characteristics analysis, data tabulation and tables generation from SHDS data sets, database structuring along with related measures and indicators development and estimations. The SHDS report also contributed to the development of the Addis Ababa Declaration on Population and Development (AADPD), for the first time, and ICPD@25 report. UNFPA supported the drafting of the bill for establishment of a National Bureau of Statistics. There is still a need for institutionalizing production of data and strengthening dissemination and use of data.

On **efficiency**, UNFPA efficiently utilized its human, financial, logistics and technical resources at the CO level to achieve the desired and intended results. The CO has skilled and technical staff in all the programme and operation areas, and in addition to clear and robust internal systems. There were however notable staff gaps in GEWE and M&E where there were inadequacies, leading to overstretching in the existing teams. UNFPA has a presence in Somalia, in addition to field offices able to support programme implementation processes and effectively support the IPs. The CO surpassed the indicative resources mobilized for the 3rd CP by over 64%, with good utilization rates. The UNFPA partnership and technical assistance approach enabled coverage for the areas of need and strengthened capacities of implementing partners, and government. Training and provision of guidelines and operating manuals enabled compliance and enhanced quality of achievements. The integration approach to implementation of the CP component themes enabled achievement of the planned results in the CP for implementation, despite funding gaps and inadequacy of staff. There were marked delays in the disbursements of funds to the CO which also affected implementation activities by the implementing partners. The CP had a robust monitoring and evaluation systems enhancing quality and compliance in the planning, implementation, monitoring and evaluation activities. limitations included; high turnover among partner staff, especially the government, inadequate capacity and commitment of the government in monitoring and weaknesses in design of the CP in results areas.

With respect to **Sustainability**, UNFPA strengthened national ownership through directly supporting government line ministries as both strategic and implementing partners, with high levels of consultations supporting delivery of the national priorities. UNFPA also contributed to strengthening the strategic, policy and legal framework through supporting policy development, enactment and implementation of laws and strategies in different CP components. The 3rd CP strengthened the capacities of the national stakeholders in various areas, strengthening skills which are bound to stay beyond the programme period. Ineffective implementation framework and weak monitoring processes, inadequate data, high staff turnover within the ministries, inadequate commitment of the government and inadequate funds inhibits sustainability.

Concerning **coordination**, UNFPA significantly contributed to the functioning of the UNCT coordinating mechanisms building on the triple mandate of coordination, accountability and capacity building, and it is contributing to the implementation of the United Nation Strategic Framework (UNSF). UNFPA is an active

participant and applied comparative advantage for the effective and efficient running of the UN coordination mechanisms. UNFPA contributed to strong linkages and synergies within the UNCT, enhancing the UN's Delivering as One mandate. There were however aspects of overlaps, especially among the UN health partners.

The UNFPA humanitarian programme contributed to addressing the needs of the vulnerable populations through capacity building, integration, standardization of response, coordination and leveraging resources, mapping, distribution of emergency kits and service delivery through outreaches. However, limited resource allocation limited coverage. The 3rd CP ensured connectedness through strengthening capacities of the actors, development of strategies, guidelines and policies to guide implementation, coordination and promoting integration of programmes and national ownership of interventions and results. The 3rd CP also contributed directly to the NDP-9 which was developed incorporating resilience as the framework of implementation.

Main Recommendations:

At the **Strategic level**: UNFPA should strengthen national and international partnerships in the development and humanitarian frameworks, and strengthen evidence-based programming capacities for effective response to national development and humanitarian priorities in Somalia. UNFPA should expand resource base to cover for arising deficits, particularly on Family planning, FGM, Adolescent and youth, and RH commodities; strengthen financial planning mechanisms to reduce delays in funds disbursement to IPs and enhance accountability mechanisms in the utilization of resources to facilitate delivery of results. UNFPA should enhance programme integration and capacity building through strong leadership in areas of mandate at national and regional levels; and enhance the level of policy dialogue, partnerships and coordination for improvement on the legislative and policy frameworks in the country. Due to the increasing shift in programming approach in Somalia context to bridge the humanitarian-development nexus, UNFPA needs to strengthen resilience programming by strengthening the capacities of local and national actors to identify and deal with associated risks, vulnerabilities and their underlying causes, in addition to establishing performance indicators for humanitarian programming.

In the **SRHR,** UNFPA should continue to strengthen technical and financial support for integrated services in the areas of its mandate, in addition to strengthening capacity building, development of guidelines, supervision, mentorship, quality assurance, sensitisation, and coordination; advocate for increased investment on RMNCH; and strengthen scale up of family planning through partnership, capacity building, demand creation through evidence-based response, increased male involvement, enhancing FP commodity supplies, supervision and quality assurance and mentorship. In **Adolescent and Youth**, UNFPA should enhance consolidation and coordination of youth-targeted interventions while advocating for youth participation in the humanitarian and sustainable development; and strengthen partnerships and coordination to enhance capacities to increase integration of youth- and adolescent friendly SRH services and reproduction rights, and policy development.

Under **GEWE**, UNFPA should sustain and strengthen lead role of GBV sub cluster as well as capacity strengthening of key actors in GBV and FGM/C and child marriage; and scale up legislative and policy reforms to ensure accountability for human rights of marginalised groups, attaining gender equality and women empowerment. Under **PD**, UNFPA should broaden strategies for statistical systems capacity for evidence-based development planning and policy formulation, including hastening institutionalized approach to capacity building in addition to enhancing stakeholder engagement in thematic analysis of data and strengthen data quality; and engage in advocacy efforts to ensure that the needs of people with disabilities, marginalized and other vulnerable populations are deliberately targeted and are adequately addressed.

CHAPTER 1: INTRODUCTION

The United Nations Population Fund (UNFPA), Somalia country office is currently implementing the third UNFPA Country Programme of Cooperation, which started in 2018 and slated to end in 2020. The UNFPA Somalia Country Office commissioned the Country Programme Evaluation (CPE) in compliance with the 2019 UNFPA Evaluation Policy[5]. The policy, along with the 2019 version of the *Handbook on How to Design and Conduct Country Programme Evaluations at UNFPA* guided the design, management and governance of the CPE process.

1.1 Purpose and Objectives of the CPE

The purpose of the CPE was two-fold: (i) enhance accountability of the UNFPA CO towards its stakeholders, donors and partners by demonstrating its performance in terms of achieving expected results at the country level; and (ii) supporting evidence-based decision-making at country level by generating high quality information and data, which will serve as a basis for the planning, design and implementation of the next Country Programme[6].

In addition, the CPE seeks to examine to what extent the UNFPA Somalia CO has contributed to the international response to the on-going humanitarian crises, as well as to assess its contribution to humanitarian preparedness, response and recovery. Specifically, the objectives of this evaluation are:

1. To provide an independent and objective assessment of the relevance, effectiveness, efficiency and sustainability of UNFPA support and progress towards the expected outputs and outcomes articulated in the results and resources framework of the Somalia Country Programme 2018-2020.
2. To examine the role played by the UNFPA Somalia CO in the coordination mechanisms of the United Nations Country Team (UNCT) with a view to enhancing the United Nations contribution to national development results.
3. To analyse the contribution of the Somalia Country Programme to the humanitarian-development-peace nexus, with a particular focus on the establishment of linkages between development and humanitarian interventions, resilience building and capacity development of national partners and stakeholders.
4. To draw key lessons and good practices from past and ongoing interventions under the Somalia Country Programme and provide a set of realistic and concrete recommendations to improve the design, implementation and monitoring and evaluation of the next Country Programme cycle.

The main target audience and primary intended users of the evaluation are: (i) the UNFPA Somalia CO; (ii) its implementing partners; (iii) the UNCT and Humanitarian Country Team (HCT) in Somalia; (iv) donors of UNFPA-supported interventions; and (v) the UNFPA Arab States Regional Office.

1.2 Scope of the Evaluation

Time scope: The CPE covered the 3rd Country Programme interventions and activities implemented within the period from 1st January 2018 to June 2020.

[5] See The UNFPA Somalia 3rd Country Programme Evaluation Terms of Reference.

[6] Ibid.

Geographic scope: The CPE covered all the locations where the UNFPA Somalia CO and its implementing partners implemented projects and programmes within the current country programme cycle, including the Federal Members States. Majorly, the evaluation focused on the contributions of the CP across the three administrative areas of Puntland, Somaliland and the Federal Government of Somalia. The sampling included stakeholders from the areas covered by the CP during the period of implementation.

Thematic scope: The CPE assessed the four outcomes and the five associated outputs in all the Country Programme's thematic areas of SRHR, adolescents and youth, gender equality and women's empowerment, and population dynamics. The design of the evaluation responded to DAC-OECD evaluation criteria of Relevance, Effectiveness, Efficiency and Sustainability. In addition, it assessed UNFPA contribution within the UNCT coordination, and focused on the linkages between development, humanitarian action and peacebuilding, including resilience-building components of the Country Programme.

1.3 Methodology and Process

1.3.1 Methodology

1.3.1.1 Evaluation Criteria and Evaluation Questions

The design of the CPE was informed by the UNFPA Evaluation Handbook "*How to design and conduct a CPE at UNFPA*" and covered the following four criteria of the Development Assistance Committee of the Organization for Economic Cooperation and Development (OECD/DAC): Relevance, Effectiveness, Efficiency and Sustainability[7]. In addition, the CPE will also assess the strategic positioning of UNFPA within the UNCT and the role it has played in United Nations system-wide coordination mechanisms. Further, given the humanitarian crises in Somalia, the evaluation has examined to what extent UNFPA has been able to provide life-saving services to affected populations that are hard to reach and how well UNFPA support bridges the humanitarian-peace-development nexus and contributes to enhancing resilience by examining the criteria of connectedness[8]. The CPE design took into consideration two levels of analysis, i.e. programmatic and strategic levels, where the four OECD-DAC evaluation criteria entailed analysis of UNFPA programmatic areas; and analysis of UNFPA's strategic positioning in the UNCT and the country's implementation context (coverage and connectedness). Also included is addressing the cross-cutting issues of gender mainstreaming and a human rights approach integration into the programme.

[7] The OECD/DAC Criteria for International Development Evaluations https://www.oecd.org/dac/evaluation/49756382.pdf

[8] See The UNFPA Somalia 3rd Country Programme Evaluation Terms of Reference.

Table 1.1 List of Evaluation criteria and corresponding Evaluation Questions

Final Evaluation Questions for the CPE
Relevance
EQ1: To what extent has the Country Programme addressed national priorities and needs of the population, in particular vulnerable groups, vis-à-vis the UNFPA mandate? **EQ2:** To what extent has the UNFPA Country Office been able to respond to changes in priorities and needs of the population over time, including those of vulnerable groups, especially in response to shifts caused by new or evolving humanitarian crises? **EQ3:** To what extent have UNFPA-supported interventions been aligned to the UNFPA Strategic Plan 2018-2021 and international normative frameworks, policies and standards related to development and humanitarian action?
Effectiveness
EQ4: To what extent have the outputs of the Country Programme been achieved, and to what extent have these outputs contributed to the achievement of the expected outcomes? What were the constraining and facilitating factors and the influence of context on the achievement of results? (*Applies to all the four thematic areas*) **EQ5:** To what extent has the programme integrated cross-cutting issues of gender equality and human rights?
Efficiency
EQ6: To what extent has UNFPA used available financial and human resources, its technical expertise, as well as funding, operations and commodity supply systems, mechanisms and policies in an adequate manner to achieve the intended results of its Country Programme in the most efficient way?
Sustainability
EQ7: To what extent has UNFPA been able to support its partners and the beneficiaries (women, adolescents and youth) in developing capacities and establishing mechanisms to ensure ownership and the durability of effects as well as what kind of exit strategy UNFPA applied to ensure smooth transfer of its support to the national counterparts?
Coordination
EQ8: To what extent has the UNFPA country office contributed to the functioning and consolidation of existing United Nations system-wide coordination mechanisms for both development assistance and humanitarian action?
Coverage
EQ9: To what extent has the UNFPA humanitarian response reached those most in need and vulnerable in crisis situations both geographically and demographically?
Connectedness
EQ10: To what extent does UNFPA humanitarian action support and plan for longer-term development goals articulated in the results and resources framework of the 2018-2020 Country Programme and contributed to resilience building?

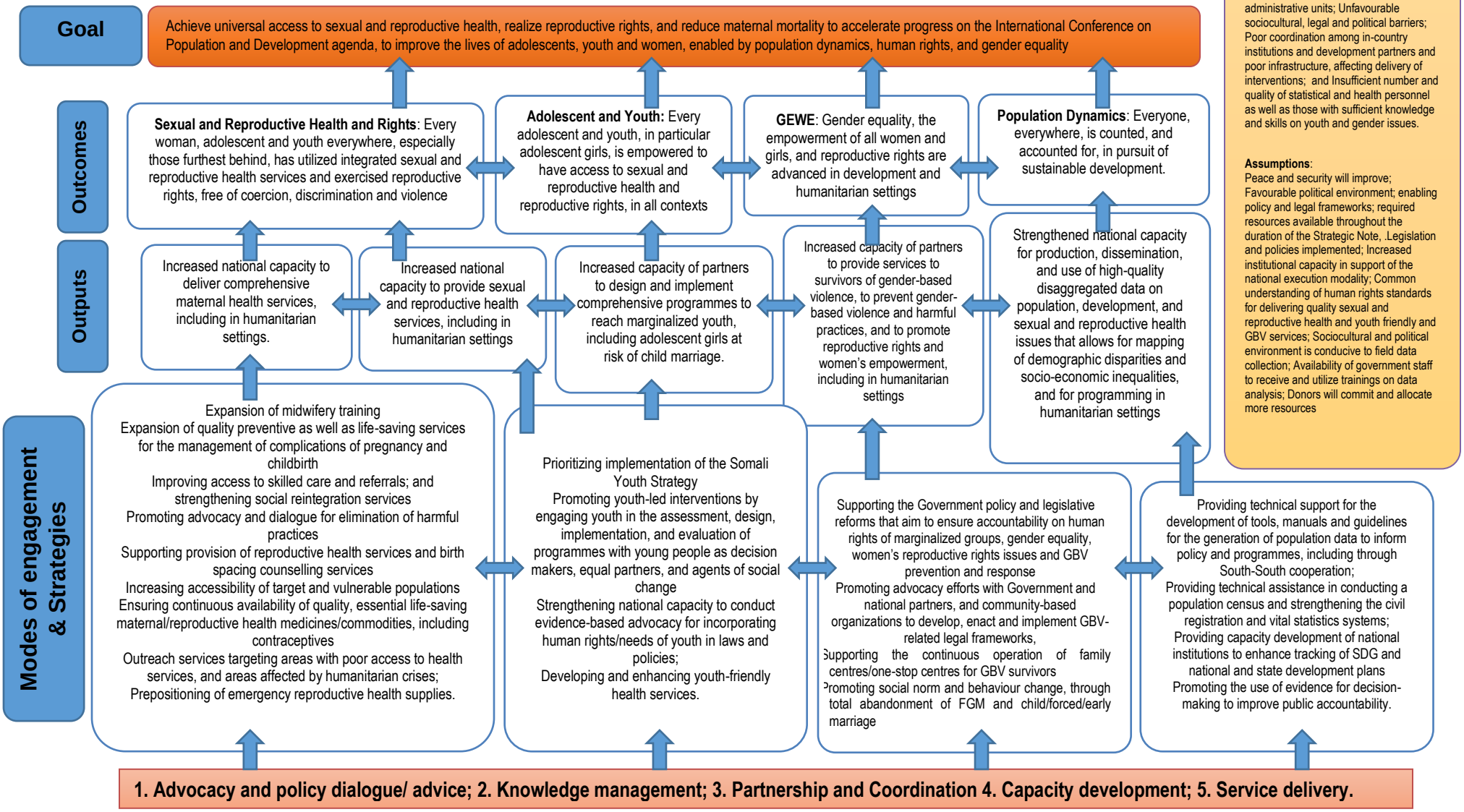
1.3.1.2 Evaluation Approach

Evaluation Design: The CPE was conducted in accordance with the "Norms and Standards for Evaluation", "Ethical Guidelines for Evaluation", the "Code of Conduct for Evaluation in the United Nations System" and the "Guidance on Integrating Human Rights and Gender Equality in Evaluations of the United Nations Evaluation Group" (UNEG), and designed and implemented in consistency with the UNFPA Evaluation Handbook "How to design and conduct a CPE at UNFPA" and adhered to the standards and principles of evaluation at UNFPA, particularly utility, credibility, independence, impartiality, ethics, transparency, and human rights and gender equality. This was a non-experimental design given the expected descriptive and non-normative nature of the objectives and the related evaluation questions. This design was also relevant due to the time and resource constraints and it also allowed the evaluators to analyse the contributory relationship between the programme interventions and their effects on the UNFPA programme's strategy in the Somalia context.

Theory-based approach: The CPE adopted a theory-based approach to assess the performance of the 3rd UNFPA Somalia Country Programme. This entailed **reconstructing the theory of change (ToC)** underlying the Country Programme (see Figure 1.1) and the analysis of the causal links of the country programme interventions and strategies across the results chain. In the analysis of the ToC, the process established the mechanisms of change, considering the risks, critical assumptions and the implementation context underlying the programme logic. The evaluation team reviewed and redefined the theory of change, depicting the sequence of expected changes across the intervention logic of the country programme. The theory of change further illustrates how the planned interventions under the CP are expected to contribute to a sequence of results (outputs and outcomes) that contribute to the strategic goal of UNFPA, as defined in the UNFPA Strategic Plan 2018 – 2021. The interpretation of the causation process guided the evaluators in understanding the programme's contribution to the observed results and in gathering evidence to validate the conclusions on the performance of the programme in the period of implementation. The ToC was tested during the data collection phase using the evaluation matrix and was reconstructed as stated in Figure 1.1. The outputs were adequate and were likely to contribute to the achievement of the results, though the timeframe was shorter for the achievement of the same, given the volatile and unstable context of implementation. Adjustments were made to refocus the causal links (arrows) across the results chain from the original ToC. This further entailed linking the result areas to reflect integration within the programme and the contribution that implementation of the interventions and achievement of the results at both output and outcome levels results into the strategic goal. In addition, the evaluators added the modes of engagement and strategies for each thematic area. The assumptions and risks in the ToC fit well with the assumptions in the evaluation matrix.

***Participatory approach*:** The CPE implementation was based on an inclusive, transparent and participatory approach, involving a broad range of partners and stakeholders at national and sub-national levels. These stakeholders provided insights and information, as well as referrals to data sources that the evaluation assessed the contribution of UNFPA and to answer the evaluation questions. Particular attention was paid to ensuring participation of women, adolescent girls and young people, especially those from vulnerable and marginalized communities. Further, the Evaluation Reference Group (ERG) established by the UNFPA Somalia CO for the CPE comprises key stakeholders of the Country Programme. The ERG served as a quality assurance mechanism from a technical perspective by providing inputs on evaluation deliverables at different stages of the evaluation process. In addition, the engagement of the ERG helped facilitate knowledge-sharing and ensure the use of the evaluation results.

Figure 1.1 Reconstructed Theory of Change (ToC)



1.3.1.3 Methods for Data Collection

The Evaluation Matrix (Annex 2) adapted to the country programme implementation context provided the framework of the evaluation and is key for the data collection and analysis. The Evaluation Matrix provided the foundation for drafting the findings for each evaluation question and for drawing conclusions and formulating recommendations that cut across different evaluation questions.

The evaluation methods used both quantitative and qualitative methods for data collection. The data collection methods were designed around the evaluation questions, related assumptions and indicators proposed in the Evaluation Matrix and taking into account the limitations that the COVID-19 and insecurity restrictions posed to on-site data collection. The evaluators collected data considering the gender lens, especially where there was need to look and the gender divide. The data collection techniques used during the evaluation were, Key Informant Interviews, Document Review, Focused Group Discussion and Group Interviews, as explained below:

i. **Document Review:** This entailed review of programme-related documents and analysis of their content to inform the CP design, implementation and management, and monitoring and evaluation. This was a continuous process during the evaluation, as it aimed at enriching the quality and content of the report. Over the course of the evaluation, the evaluation team identified and obtained other key documents with the support of the UNFPA Somalia CO, in addition to related documents by other stakeholders to inform the evaluation process. Documentary evidence was a major part of this evaluation given the constraints in accessing primary data. Further, the quantitative performance of the programme as defined by the CPD Results Framework have been informed by this technique from the various reports provided by the UNFPA Somalia CO. Some of the key documents that have been reviewed are CPD, Annual Work Plans (AWPs), Strategic Information Systems (SIS), UNFPA Global Strategies 2018 – 2021, evaluation reports, financial documents, programme reports, implementing partners' reports, government policy and strategy documents, monitoring and evaluation, and relevant secondary data, including webpages. These will be referenced as appropriate in the report, to provide evidence-based feedback on the programme performance.

ii. **Remote-Based Key Informant Interviews (KII):** This entailed conducting interviews with individuals or groups as key informants from a range of stakeholders identified and selected from the stakeholder map. The respondents included key implementing partners, donors and strategic partners[9]. Those interviewed include UNFPA Somalia CO staff, officials from the government line ministries, representatives of UN agencies, UNFPA donors, strategic partners, and national and international NGOs as implementing partners (refer to Annex 3 for complete list). Group interviews were conducted with key informants, mostly CO staff with key informants to collect key information on progress towards the intended outputs and outcomes of the Country Programme. The evaluation team prepared interview guides for KIIs with stakeholders (UNFPA staff, government counterparts, donors, other UN agencies, and national and international implementing partners) in the various thematic areas of programming. A total 42 key informant/ group interviews conducted for the period.

iii. **Focus group discussion (FGD) -** The FGDs guides were designed to gather information among primary programme beneficiaries, including those benefiting from UNFPA capacity building interventions. These are targeted to included government staff like the health workers, statistics and planning department, among other ministry staff who directly benefited from the UNFPA CP support, midwifery trainees, adolescent and youth, and community level beneficiaries like women and girls benefiting from the safe spaces supported by UNFPA CP. The discussion guides were designed

[9] The Strategic partners are those implementing similar programmes as UNFPA who were contacted for their relevance in the framework of implementation.

thematically to gather information regarding the extent to which the programme achieved its intended results, in addition to establishing some of the arising needs or unintended results. This technique was used based on its advantage of collecting data quickly and effectively from a large number of programme beneficiaries. It also has the ability to provide further insights into data obtained from other categories of respondents. Purposive sampling was used for selecting participants in the FGDs to ensure balanced representation of respondents from all the different socio-economic backgrounds. The FGDs were conducted within the constraints of COVID-19 control-restrictions on gathering and the remote nature of data collection, ensuring compliance. The national consultants conducted the FGDs face-to-face, for those in their locality, and the others in other locations because of the language barrier to the international consultants. The CPE team ensured gender disaggregated sessions with female and male beneficiaries being interviewed differently, and data collected being gender sensitive in each group. A total of six FGD sessions were conducted.

iv. **Site Visits and photography:** Based on the results of the document review and consultations with the UNFPA Somalia CO, and situation allowing, the national member of the evaluation team visited youth centres in the course of data collection to verify the facilities in the youth centres in Mogadishu and Garowe.

Field organization

Nearly all the field data were collected virtually using Zoom and Google Meet, except for the face-to-face FGDs conducted with youth beneficiaries in Mogadishu and Garowe. After identifying the respondents, UNFPA CO secured appointments with them, in addition to sharing the links for the online platforms used. The UNFPA Evaluation Manager and the Administration Assistant made all the preparations and the linkages. The field teams were instrumental in mobilizing the respondents. The IPs ensured that social distancing was observed during the period of FGDs, in addition to having face masks minimizing exposure to the risk of contracting COVID-19. Most of the sessions were attended to by all the team members, except the sessions with donors that the Team Leader conducted. There were also sessions where members were comfortable speaking in Somali, and the National evaluation team members handled the sessions.

The United Nations Evaluation Group (UNEG) Code of Conduct, Ethical Guidelines and Norms and Standards informed the whole evaluation process. Throughout, the evaluation team was objective and impartial, ensuring informant confidentiality.

1.3.1.4 Data Validation, Analysis and Report Writing

The evaluation team validated collected data on a routine basis through debriefing sessions, building themes along the CPE objectives. The data analysis methods employed depended on the type of data gathered to contribute to the findings of the report. The quantitative and qualitative data from primary and secondary sources were assessed and referenced, with findings and systematically triangulated to ensure that they were robust. The process involved contribution analysis, content analysis and trend analysis. Beneficiary focus group and key informant interviews were assessed through thematic content analysis, and data were quantified, where appropriate, from different primary sources. Contribution analysis identified how far documented inputs and activities were sufficient and relevant to the outputs and outcomes and likely to have contributed meaningfully to them. This involved exploring the theory of change in the results chain logic for each component area of the country programme. In addition, descriptive statistics have been used to describe or summarize key characteristics of quantitative data obtained from secondary sources, especially, the programme COAR and financial reports. The

descriptive statistics have been presented in the form of charts and graphs for financial reports. The evaluation matrix has informed the analysis and report writing.

1.3.2 Selection of the Sample of Stakeholders

Purposive sampling of stakeholders took into account the comprehensive UNFPA guidelines on stakeholder selection and sampling was agreed in discussion with the Evaluation Manager and CO staff. The guidelines used to select the respondents were: stronger and weaker IPs, and financially large and small programmes and projects; partners from government and civil society organisations (CSOs), donors and, direct and indirect beneficiaries. Included are UNFPA direct and strategic partners (stakeholders who do not work directly with UNFPA but play a key role in a relevant outcome or thematic area in the national context). In relation to coordination and strategic positioning, partners in the United Nations Country Team (UNCT) with whom UNFPA has mainly worked, the UN Delivering as One coordinator, and core donors were also selected for interview. The annexes provide further details, and on the selected stakeholders for CPE. The sample frame was from all the stakeholders in the country, in all the federal member states where UNFPA Somalia had programmes or interventions implemented.

Limitations and Risk

1. **Remote data collection mechanisms** due to the constraints emanating from the COVID-19 response and insecurity restrictions the consultants did not visit the field locations to meet the programme participants face-to-face, in addition to verifying some of the support provided by the CP. The evaluation team maximized liaison with the two national consultants on the ground to visit some of the CP locations and were able to share with the team what they verified, like the Youth centres and their functionality. The evaluation team utilized a lot of information from various reliable sources for triangulation of information shared by the respondents, and confident that the information shared in this report is reliable and can be verified.
2. Limited information and quality of relevant documents and reports given to the evaluation team. The evaluation team used cross validation from stakeholders, staff, secondary documents, in addition to using expert opinions for objective evidence, to mitigate the potential bias. On the other hand, none of the limitations was sufficient to invalidate the evaluation, and the team is confident that a wide, sufficiently representative range of stakeholders was reached at national and community levels.
3. Weak design in the M&E results framework posed inherent gaps in making conclusions on the performance of the CP in various result areas in the framework, especially on a number of achievements at the output levels. However, the evaluation team used triangulation, to qualitatively describe the extent of achievement through a number of data sources.
4. This CPE was based primarily on qualitative information collected from government counterparts and implementing partners (direct beneficiaries) rather than from programme indirect beneficiaries for evaluation of outcome level results, due to the nature of the design of the CP interventions, which were aimed at strengthening the capacity of the government and its stakeholders to deliver in key areas. The evaluation assessed achievement of the CP outputs and the likelihood of results on the outcome level. The scope of this exercise did not allow the team to collect quantitative data from the field, thus the analysis and conclusions are based on quantitative data collected from the Country Office through secondary sources. This is already a source of bias. However, the evaluation team triangulated the data sources to make conclusions on arising phenomenon, mitigating any bias that would have arisen based on data sources.

1.3.3 Evaluation Process

The overall evaluation process involved five phases: (i) preparation; (ii) design; (iii) field; (iv) analysis and reporting; and (v) facilitation of use and dissemination phase, as summarised in the table below.

Table 1.2 Evaluation process

Phase	Main Activity
Preparatory	Drafting and approval of the ToR
	Hiring of Consultants
	Assembly of Evaluation Reference Group (ERG)
	Compile Initial list of documentation\Stakeholder mapping and list of Atlas Projects.
Design	Document Review:
	- Stakeholder mapping - Analysis of the theory of change of the programme - Finalization of the list of evaluation questions; and preparation of evaluation matrix; - Development of a data collection and analysis strategy - Work plan for the field phase.
	Drafting of the Design Report
	Submission and discussion of Design Report
	Revision and Approval of the Design report
Field	Conduct Data collection
	Preliminary data analysis
	Presentation of preliminary findings, conclusions and recommendations to UNFPA CO and ERG
Reporting	Comprehensive data analysis, integrating comments provided during the debriefing with UNFPA CO and Regional Office
	Development of draft CPE Report
	Preparation of Second Draft CPE Report based on review comments of the UNFPA CO, Regional Office and ERG
	Submission of the Second Draft CPE Report for review
	Evaluation Quality Assurance by UNFPA HQ
	Production of Final CPE Report
Facilitation of Use and Dissemination	Development of an Evaluation Brief Dissemination of the CPE Findings

CHAPTER 2: COUNTRY CONTEXT

2.1 Development Challenges

Somalia is a country with an area around 637,657 square kilometres located in Africa, mainly in the Horn of Africa, on the eastern coast, which has the Gulf of Aden and the Indian Ocean on its northern and eastern shores, respectively. The country is a federal-based system called the Federal Republic of Somalia. Somalia faces one of the most complex and protracted humanitarian crises in the world. Climatic shocks, combined with other persistent drivers of vulnerability and food and nutrition insecurity, including armed conflict and protracted displacement, have left over 5 million people in need of humanitarian assistance.[10]

Several years of conflict and fragility have left Somalia's economy with a range of challenges, including population growth outstripping economic growth, acute poverty and vulnerability, recurrent external trade and climate shocks. Weak fiscal space and institutions, active insurgency and an incomplete political settlement have also affected the country's economic strength.[11] Since the disintegration of the central authority in 1991, warring local factions filled the remaining power vacuum. The country suffered from armed conflict and several humanitarian crises linked to the conflict, as well as to drought and deprivation.[12] The number of people displaced has increased significantly, there are now 2.6 million people across Somalia displaced from their home[13]. Analysis of the 2017-2018 SHFS revealed that 77 percent of Somalis currently live below the International poverty line of US$1.90 per capita, per day, which is the third highest in the region after South Sudan and Burundi.[14] Underlying high poverty rate are low levels of economic activity, reflected in a per capita gross domestic product (GDP) of $535.[15] Opportunities to ensure a development trajectory face many challenges since the country remains a fragile state subject to multiple shocks. The country remains extremely fragile due to conflict and these trends have had a disproportionate impact on women and girls.[16]
Widespread poverty and food insecurity is a recurring developmental issue**.** Most of the population remains poor and is vulnerable to a range of shocks, including repeated cycles of devastating droughts such as the one in 2017. In 2019, a delayed and erratic *Gu* rainy season resulted in the poorest harvest since the 2011 famine and flooding.[17] The spike in incidents of severe drought and flooding is a reminder that Somalia has become increasingly vulnerable to climate change.

Somalia's vulnerable population has high exposure to risk and lacks access to public and private sector safety nets and insurance systems. Somalia's authorities have inadequate capacity to mitigate risks and to protect households against shocks, due to a lack of institutional setup required to administer such programmes.[18] Humanitarian organizations are filling the void. Drought, conflict, forced evictions and flooding have fuelled an enormous displacement crisis in Somalia, which continues to worsen, leaving little chance for those affected to achieve self-reliance. Recurrent shocks mean that the displaced are in a constant state of flux, moving from one crowded settlement to another, with limited livelihood opportunities and insufficient access to sustainable shelter, tenure security and basic services. At the same time, displacement continues to accelerate rapid urbanization in the country, making it increasingly

[10] "Somalia," United Nations Office for the Coordination of Humanitarian Affairs (OCHA).
[11] Somalia Humanitarian Bulletin March 2020.
[12] Wave 2 High frequency survey, Word bank (2018).
[13] The total Somali population in displacement as of 31st December 2019 is 1,648,000. Accessed from https://www.internal-displacement.org/countries/somalia on 10/06/20.
[14] Wave 2 High frequency survey, Word bank (2018)
[15] Somalia Economic Update, World Bank (2018).
[16] Fund for peace, "fragile state index (2018).
[17] Somalia Humanitarian Response Plan, 2020.
[18] World Bank 2017.

necessary to address displacement-related challenges through long-term and urban development approaches. [19] Approximately 2.6 million Somalis currently are displaced within their own country.[20] The largest concentration, around half a million, are in the Somali capital, Mogadishu. Some were displaced nearly 30 years ago, whereas others continue to arrive in the city on a daily basis due to conflict and climate factors.[21] The majority of those displaced are women and children[22]. They are now living in formal and informal settlements for internally displaced persons (IDPs that are largely managed by private landowners who often take advantage of their vulnerable status by charging exorbitant prices for necessities and providing little in terms of personal protection. GBV data indicates that 74% of survivors who accessed services in 2016 were IDPs; 99% of whom were females.[23]

IDPs are poorer and have worse living conditions than the average Somali resident has**.** Although almost **s**even in 10 Somali residents are poor, over three in four IDPs live on less than $1.90 per day and more than one in two IDP households go hungry.[24] Large numbers of IDPs must share essential amenities such as toilets, crowding out the improved WASH facilities in settlements. Compared to host communities, IDPs in settlements are also further away from essential facilities such as primary schools, health centres, and markets. Global Acute Malnutrition (GAM) rate among displaced people in Mogadishu is at 16 percent above the emergency threshold.[25] Although a lack of food is one contributing cause, this consistently high rate is also partially the result of extremely poor and congested living conditions, as well as poor hygiene and sanitation.[26] These factors promote disease and illness that can contribute to malnutrition. In addition, many people are malnourished even before they arrive in urban areas. Furthermore, the rising trend of forced evictions influenced by the increasing urban population density, rising property prices and a lack of tenure security and regulatory frameworks also constitutes a significant and prevalent protection threat to IDPs and poor urban families. Between January and December 2018, nearly 312,000 IDPs were evicted across Somalia, representing a 50 per cent increase compared to the same period in 2017.[27]

Unemployment in Somalia is widespread and generally impedes economic development and political stability, since, for example, around 67% of the young population is unemployed and generally underemployed.[28] The lack of decent work opportunities is often cited as one of the main drivers of people to support violence in Somalia. [29] There is no formal and government led social protection programme in Somalia. Around 96 per cent of the employed indicated that they are not covered by any employment insurance scheme.[30] Lack of employment opportunities and decent work deficits, especially in the absence of social protection measures, are a significant source of frustration for the youth. Associated consequences include being forced to emigrate or particularly for men, joining militias of various forms. Cultural pressures regarding social status from a salary, having a spouse (a recurrent recruitment promise of al-Shabaab) and others influence these decisions. [31]2017 unemployment statistics

[19] UN Somalia country result report 2018.
[20] Somalia: Estimated IDP Population in Informal Sites and Camp-Like Settings," UNHCR 2018.
[21] Ibid.
[22] Humanitarian Needs Overview 2018.
[23] Somalia GBV Sub cluster Annual Report 2016.
[24] Wave 2 Somalia High frequency survey, World Bank 2018.
[25] Somalia 2019 Post Gu FSNAU Nutrition Survey Summary Results," Food Security and Nutrition Analysis Unit.
[26] Ibid.
[27] Norwegian Refugee Council, IDPs displacement 2018.
[28] IMF (2017) Article IV Consultation and First Review Under the Staff-Monitored Program-Press Release.
[29] Youth employment and migration 2016.
[30] ILO; 2014.
[31] Youth employment and migration, IOM 2016.

indicate that fewer than 20% of women and around 33% of men are employed.[32] Income inequality and disparities are very pronounced, with poverty being much more pronounced in rural than in urban areas.[33]

While public investment in agriculture can generate growth and reduce poverty. The agro-pastoral economy has experienced vulnerability to climate related events and to environmental degradation resulting from instability, conflict and stagnation of the sector that in turn has contributed to poverty.[34]

The country currently faces a significant threat from a recent locust invasion and COVID-19. The Ministry of Agriculture declared a national emergency on 2 February 2020 following a locust invasion, which threatens food security. The Food and Agriculture Organization of the United Nations (FAO) projects that the number of locusts could grow 400 times by June if not treated. FAO put out a $76 million appeal to fund the spraying of the affected areas with bio pesticides. Spraying commenced in February, but might be disrupted due to COVID-19 related restrictions. The exponential rise in the number of confirmed COVID-19 cases in Somalia continues standing at 2416 as of 9th June 2020, with 85 deaths and 489 recoveries.[35]. Somalia's capacities to prevent, detect and respond to any global health security threat scored 6 out of 100[36] The number of health workers in different parts of the country is 2 per 100,000 people compared to the global standard of 25 per 100,000 people.[37] Less than 20 percent of health facilities have the required equipment and supplies to manage epidemics.[38]

2.1.1 Sexual and reproductive health

Somalia also has some of the worst health indicators in the world, with women and children most affected. Despite a reduction over the past five years, the maternal mortality rate in Somalia is 692 deaths per 100,000 live births, among the highest rates in the world[39]. Geography, social hierarchy, livelihood vulnerability, internal displacement, and exposure to shocks and conflict-related stresses have resulted in communities having different levels of access to affordable services. Furthermore, the reproductive health needs of adolescents and youth have been largely ignored, and access to relevant information remains inadequate. [40]

Less than one-third, at 32 percent, of births are delivered with the assistance of a skilled health professional, which includes a doctor/clinical officer or nurse/midwife/auxiliary midwife.[41] Without any current holistic financial support, around half of Somali households (48 percent) are paying for their health expenses from their income.[42] Among women of the ages of reproductive health, the death rate is highest among women aged 30-34, at 10.9 deaths per 1,000 population.[43] This is also the age group where childbearing is at its peak in Somalia. The main causes of maternal mortality are postpartum haemorrhage, preeclampsia/eclampsia, obstructed labour and sepsis[44].

[32] Somalia national development plan-8 2017-2019.
[33] Labour force survey, ILO 2014.
[34] World Bank and FAO (2018). Rebuilding Resilient and Sustainable Agriculture in Somalia.
[35] https://www.worldometers.info/coronavirus/country/somalia/
[36] Health Emergency Preparedness Index 2016.
[37] Ibid.
[38] Ibid.
[39] Directorate of National Statistics, Federal Government of Somalia. *The Somali Health and Demographic Survey 2020.*
[40] UN Somalia country result report 2018.
[41] Directorate of National Statistics, Federal Government of Somalia. *The Somali Health and Demographic Survey 2020.*
[42] Ibid.
[43] Ibid.
[44] Ibid.

The proportion of teenagers who have begun childbearing rises rapidly with age.[45] Two percent of women aged 15 have started childbearing, but by the age of 19, 39 percent of women have had a baby, or are pregnant with their first child.[46] Prevalent use of contraceptives in Somalia is all time low majorly due to cultural and religious orientation. Only 7 percent of the currently married women are using any contraceptive method and 1 percent are using modern methods. [47]

Prevalence of self-reported cases of sexually transmitted infections is very low in Somalia. Only 8 percent of ever-married women reported that they had an STI in the 12 months preceding the survey. [48]Many people in Somalia believe that HIV&AIDS is a disease for people who have committed bad deeds. Extensive stigma and discrimination against people living with HIV&AIDS adversely affects both people's willingness to be tested and their adherence to ART. For instance, people may hesitate to take an HIV test because they are afraid of how other people will react if they find out the test result is positive.[49]
Female circumcision, also known as Female Genital Mutilation/Cutting (FGM/C), has been practised in Somalia for several decades. The SHDS shows that circumcision in women aged 15–49 is high, at 99 percent. Additionally, 72 percent of women believe that FGM/C is a religious requirement.[50]

2.1.2 Adolescents and Youth

According to the World Bank estimates, Somalia's population was 15.3 million. Like many countries in sub-Saharan Africa, that population is predominantly young with 75 percent of it estimated to be under the age of 30, and almost 50 percent under the age of 15.[51] Despite forming the majority of the society, Somalia's young people have been inhibited from reaching their potential as catalysts for long-term stability and development in their country due to the continuing conflict and socioeconomic and political exclusion.[52]

More than half of the youth are illiterate, two out of three have no formal education, and literacy declines with age where the .[53] Young women are more likely to be married than the male youth**.** On average, youth marry in their 20s, men slightly later than women, with women at 20 years while men at 23 years old.[54] Nearly all women (97%) are married by the age of 35 years. More women are married between the ages of 15-35 (55 percent) than men (40 percent).[55] More rural youth are married (60 percent) than urban youth (40 percent). [56]Youth-headed households are most likely to be led by men (80 percent). [57] Most youth live in poverty and with high food insecurity. Two out of three youth ages 15-24 live in poverty.[58] Larger households are more likely to be in poverty (7.23 members compared to non-poverty households

[45] Ibid.
[46] Directorate of National Statistics, Federal Government of Somalia. *The Somali Health and Demographic Survey 2020.*
[47] Ibid.
[48] Ibid.
[49] Ibid.
[50] Ibid.
[51] Somalia National Development Plan-9 2020-2024.
[52] UN Somalia country result report 2018.
[53] Directorate of National Statistics, Federal Government of Somalia. *The Somali Health and Demographic Survey 2020.*
[54] Ibid.
[55] Ibid.
[56] Ibid.
[57] Ibid.
[58] UN, Somalia Youth Engagement & Empowerment (May 2019).

with 5.57 members). [59] This is driven partially by food insecurity as over half of Somalis are acutely food insecure.[60]

Access to and quality of education are a work in progress**.** Youth ages 18-24 and 25-34 are less likely to be in school (36.6 and 16.8 percent, respectively.[61] While urban enrolment rates show greater education access, the urban poor are among those most affected by inequities. Other affected groups include those living in rural areas, especially pastoralists, IDPs, and girls. Gender inequities remain high, although less so for those in IDP camps due to interventions. [62] Existing educational institutions and curricula fail to meet the needs of youth with skills needed in the job market and for livelihood opportunities. This issue includes TVET curriculum, which, if an approved curriculum is established, would mean graduates would have greater competency and productivity.[63]

Youth unemployment and lack of economic opportunities is a push factor toward unrest and violence**.** Evaluation of the Joint Programme on Youth Employment Somalia (YES) includes the following as push factors toward violence: "insufficient, unequal, and inappropriate education and skills combined with poor governance and weak political participation from the legacy of past conflicts." High inflation is a constraint for youth employment[64]. Other enabling environment factors affecting youth employment include low levels of investment, a lack of financial services and infrastructure, and low labour productivity[65]. In addition to inadequate health care, adolescent marriages contribute to one of 18 women in Somalia dying, due to complications during pregnancy or childbirth.[66] Teenage pregnancy is acknowledged as a concern for vulnerable groups.[67] Adverse effects of pregnancy and childbirth and limited access to contraception and health care can affect married adolescent girls. [68]

2.1.3 Gender Equality and women's empowerment

Somalia is a patriarchal society with firmly entrenched gender roles that often subjugate women and girls. Notably, the constitution of Somalia has a number of positive implications for the status of women, particularly on the involvement of women in leadership and decision-making. However, most Somali women are still either excluded from decision-making and asset ownership, or operate through a patriarchal filter in these areas mainly due to cultural restrictions on their movement and asset ownership[69]. Despite a strong history of activism centred on increasing women's political rights, and valued roles in clan activities and local peacebuilding processes, Somali women have not experienced notable increases in their formal political power or status. Parliamentary elections were held in Somalia in October and November 2016, resulting in 66 women being elected to the House of the People out of 275 and 13 women being elected out of 54 seats in the Upper House, Both Houses fall short of the designed 30% quota.[70]

Generally, employment is assumed to go hand in hand with payment for work. However, not all Somali women receive earnings for the work they do, and among those who do receive earnings, not all receive

[59] Somalia Social Protection Policy (March 2019).
[60] Food and Agricultural Organization of the United Nations, Somalia Situation Report (October 2019).
[61] UNFPA, Looking Towards a Brighter Tomorrow: Educational Characteristics of the Somali People, Volume 3 (2016).
[62] UNICEF, Somalia Education Strategy Note 2018–2020.
[63] Ibid.
[64] The National Youth Policy of the Federal Government of Somalia.
[65] Chiwara, et al. Youth Employment Somalia Mid-term Evaluation Report. (2018).
[66] Population Services International, Increasing Access to Quality Maternal and Child Health Services, Support for International Family Planning and Health Organizations 2.
[67] Smith, D., and Designing Social Protection Frameworks for Three Zones of Somalia. Final Report to UNICEF (2014).
[68] UNFPA, strengthened efforts to serve the Somali girl child (report) (June 7, 2017).
[69] Somalia national development plan-9 2020-2024.
[70] Somali women's political participation and leadership-evidence and opportunities, East Africa research fund 2017.

cash. 66 % of currently married women who reported being employed receive earnings in cash, 12 % are paid in cash and in kind, 6 % receive their earnings in kind only and the remaining 17 % were not paid at all.[71] On control over their earnings among women who receive cash payment is also limited with one in every two currently married women reporting they decide on their own how their earnings will be used, while 41 % decide jointly with their husbands. Ten percent of women reporting their husband is the main decision maker and controls their cash earnings.[72]

Asset ownership are greatly gendered, with less than 15% of women owning land or house alone and 35% jointly with their husbands[73]. Only 4% of women have a bank account that they use, however three quarters of women own a mobile phone, and among those with a mobile phone, 64 % use their phones for financial transactions.[74] This could be attributed to the devaluation of the Somali shilling and lack of small denomination, as well as convenience, which makes mobile money the preferred mode of payment for women throughout the country.

Gender-Based Violence (GBV) is one of the most prevalent human rights violations faced by people, particularly women, all around the globe. In Somalia, over 60 % of women considered physical abuse, denial of education, forced marriage, rape and sexual harassment forms of domestic violence. [75] There are no laws prohibiting domestic violence, spousal rape or sexual harassment except Puntland state of Somalia who passed sexual offences law criminating rape, and other forms of sexual harassment. Most incidents of violence against women go unreported; there is a culture of impunity surrounding sexual and domestic violence. [76] GBV is known to be under-reported in Somalia due to stigma and fear of retaliation from a survivor's own family members and/or perpetrators. Communities often shun sexual assault survivors in particular under the misguided belief that they are tainted and unmarriageable. Most GBV cases in rural areas are heard before the customary courts (*Xeer*) which rarely act in the best interest of women and girls.[77]

2.1.4 Population dynamics

Somalia is classified among the least developed countries by the United Nations with the majority of its population being dependent on agriculture and livestock for their livelihood[78]. According to the World Bank estimation, the population of Somalia is reached 15.3 million by 2019 with a growth rate of 2.8%. The life expectancy at birth is 57 years (2018)[79]. According to the SHDS, 55 % of Somalia's population is under 15 years of age, with 62% being 17 years and below, and the elderly (65 years and above) being 3% of the population. On the other hand, the UNFPA's 2014 Population Estimation Survey of Somalia indicated that 81.5% of the population is under the age of 35. Somalia's population is characterised by three distinct type of residence, namely rural, urban and nomadic and this also defines the wellbeing of the population in terms of access to services, with those in the urban dwellings likely to receive better services followed by those in the rural set-ups and lastly the nomadic populations.

After years of conflict and fragility, Somalia's economic outlook appears on the upward trend. According to the World Bank, the country's economic growth is forecasted to grow to 3.2% in 2020 from 2.9% in

[71] Somalia health and demographic survey, UNFPA 2020.
[72] Ibid
[73] Ibid
[74] Ibid
[75] Ibid.
[76] Rutgers, fact sheet; sexual reproductive health in Somalia 2017.
[77] Somalia National GBV Strategy 2018 - 2020.
[78] Central Bank of Somalia, 2012.
[79] https://data.worldbank.org/indicator/SP.DYN.LE00.IN?locations=SO&view=chart , accessed on 14/06/2020.

2019[80]. While the country recovers from the devastating instability, the country still grapples with the effects caused by the prolonged period of political instability and natural disasters such as drought and floods leading to acute poverty and vulnerability. As at 2019, Norwegian Refugee Council's (NRC) Internal Displacement Monitoring Centre (IDMC) reported that about 2.6 million Somalis are in protracted displacement in the country, while UNHCR reported about 870,000 being registered as refugees and asylum seekers in the Horn of Africa and Yemen[81]. World Bank estimates 51.6% of the Somali population is living below the poverty line, with poverty more pronounced in the IDP camps and the rural areas[82]. International Labour Organization (ILO) estimates the youth unemployment at 25%[83]. Somalia is further characterised by some of the lowest development indicators, including being among the countries with inequalities. The SHDS (2020) found out that the median age at first marriage is 20 for women and 23 for men with 14 % of women aged between 15 and 19 years having either given birth or with their first child. The total fertility rate for Somali women is 6.9, with only seven percent using any contraceptive method, while only one percent uses modern methods.

Somalia has several opportunities, as the economy is transitioning from traditional, rural pastoralism to urban, trade and services. The Federal Government of Somalia is currently implementing its ninth National Development Plan (NDP – 9). The NDP-9 is premised on taking the country on the path to a just, stable and prosperous Somalia and it focuses on how to achieve higher economic growth, create jobs, and absorb the Somali refugees returning from Kenya; remittances flows; and prioritizing social safety nets and pressing humanitarian conditions to address socio-economic challenges. Somalia, through UNFPA has made great strides in strengthening the national statistics system capacity but still faces challenges of to collect, compile, and report accurate and credible national social, economic and environmental data and information, as most of the information available are derived from estimates by the IMF, World Bank and other organisations[84]. There is therefore a need for increased access to data and information to inform planning, decision-making and monitoring of the plan's milestones.

2.2 The Role of External Assistance

Overseas Development Assistance (ODA) and remittances continue to play a significant role in the Somali socio-economic context. Both sources are fuelling Somalia's consumption-driven growth. According to an aid flow report prepared by the Ministry of Planning, Investment and Economic Development, Somalia received US$ 2 billion each in official ODA 2017 and 2018[85] and US$ 1.9 billion in 2019[86]. In the period 2015 to 2019, the remittances were estimated by World Bank at US$ 1,332; US$ 1,364; US$ 1,420; US$ 1,478; and US$ 1,532; with the amounts being on the upward trend on a yearly basis[87]. Table 2.1 below presents the total ODA for the period covering the CPD.

[80] World Bank estimates that Somalia's economic growth is likely to increase from 2.9% in 2019 to 3.2% if the reforms are implemented, and the country's stability continues. Accessed from https://www.worldbank.org/en/country/somalia/overview on 14/06/2020.
[81] UNHCR data estimates the number of Somali refugees registered as 870,000, as per 2018 data, accessed from https://www.unhcr.org/somalia.html on 14/06/2020.
[82] World Bank: Somali Poverty Profile – Wave 1 of the Somali High Frequency Survey, 2017.
[83] A labour force survey conducted by ILO in selected districts in South Central districts of Somalia in 2017 estimated the unemployment rate, taking into consideration of the young people who are available and willing to work but have given up searching for jobs.
[84] Africa Development Bank Group: Somalia Brief 2017 - 2020.
[85] Somalia Ministry of Planning, Investment and Economic Development (May 2019): Aid Flows in Somalia.
[86] Somalia Ministry of Planning, Investment and Economic Development (April 2020): Aid Flows in Somalia.
[87] These are estimates by the IMF in the Country Report (2019).

Table 2.1 ODA for Somalia in the CPD Period (2018 -2020)

Donor Envelope	Year (Amounts in US$ m)		
	2018	2019	2020[88]
Humanitarian	1,196.0	934.3	93.1
Development	975.3	924.1	864.7
Total ODA	2,171.3	1,858.4	957.8

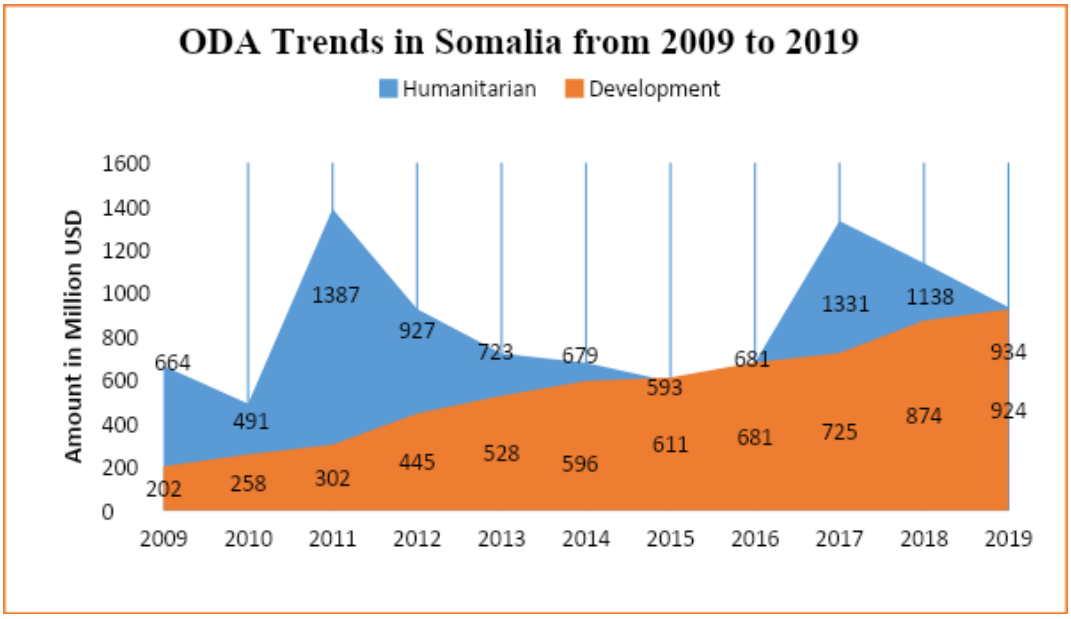
Source: Somalia Ministry of Planning, Investment and Economic Development

The ODA to gross domestic product (GDP) ratio in 2018 was 45.9%. The European Union, the United Kingdom, Germany, the World Bank, the United States of America (USA), Norway, Italy, the Netherlands and Turkey were the top ten largest providers of development aid in 2018, providing 90% (US$ 785 million) of development aid in 2018.[89] The European Union, United Kingdom and Germany combined provided more than half of development aid in 2018 (US$ 454 million).

The United States, the United Kingdom, the European Union and Germany were the largest providers of humanitarian assistance, together accounting for 78% (US$ 883 million) of total humanitarian aid in 2018[90]. On the other hand, in 2019, The World Bank, United Kingdom, European Union and Germany were the largest providers of development aid in 2019, together providing more than 50% of total development aid (approx. US$ 500 million), while the United States provided nearly half of all humanitarian aid in 2019 (US$ 455 million).[91]The trends in both humanitarian and development assistance between 2009 and 2019 are as presented in Figure 2.1 below.

[88] The 2020 figures capture projections and do not reflect the totals for the year.
[89] Somalia Ministry of Planning, Investment and Economic Development (May 2019): Aid Flows in Somalia.
[90] Ibid.
[91] Somalia Ministry of Planning, Investment and Economic Development (April 2020): Aid Flows in Somalia.

Figure 2.1 ODA Trends in Somalia from 2009 to 2019



Source: Somalia Ministry of Planning, Investment and Economic Development.

CHAPTER 3: UNITED NATIONS / UNFPA RESPONSE AND PROGRAMME STRATEGIES

3.1 United Nations/ UNFPA Strategic Response

UNFPA is the United Nations' agency that is responsible for the sexual and reproductive health (SRH), aiming to ensure that every pregnancy is wanted, every birth is safe and every young person's potential is fulfilled. The current UNFPA Strategic Plan 2018-2021 is premised on transformative results aimed at ending unmet need for family planning, ending preventable maternal death, and ending gender-based violence and harmful practices (including child and forced marriage) by 2030[92]. The Strategic Plan is aligned with the 2030 Agenda for Sustainable Development, with goals of achieving universal access to sexual and reproductive health, realizing reproductive health rights, reducing maternal mortality and improving the lives of women, adolescents and youth, enabled by population dynamics, human rights and gender equality. UNFPA also aims to accelerate progress on the International Conference on Population and Development (ICPD) Plan of Action.

UNFPA work takes a human rights-based approach, and focuses on four thematic result areas namely; sexual and reproductive health, adolescents and youth, gender equality and women's empowerment, and population dynamics. The outcome areas ensure that every woman, adolescent and youth has access to quality and integrated SRHR services and exercise reproductive rights, adolescents and youth, especially girls, are empowered to access SRHR in all contexts, gender equality and empowerment of all women and girls is achieved in development and humanitarian settings, and that all are counted and accounted for with regards sustainable development[93]. UNFPA Somalia adapted these outcome areas in the development of its Country Programme Document (CPD) and the alignment is discussed later in the CPE findings.

Towards adopting the 'Delivering as One' approach among partners and stakeholders in Somalia, the United Nations implements activities through the United Nations Strategic Framework 2017 – 2020 (UNSF). The UNSF is focused on supporting Somalia's peace- and state-building with five interlinked and mutually reinforcing strategic priority areas, with the implementation hinged on the central principle of 'leaving no one behind' by endeavouring to reach the most vulnerable populations and empower them as active agents of their own development[94].

3.2 UNFPA Response through the Country Programme

3.2.1 Brief Description of UNFPA Previous Cycle Strategy, Goals and Achievements

The second UNFPA Country programme, implemented from 2011 to 2015, with an extension to 2017 sought to improve the overall quality of life of the Somali people through focusing on three main priorities namely; a) decreasing maternal mortality; b) managing population growth and the 'youth bulge'; and c) improving humanitarian preparedness and response. These priorities were addressed under three programme components; a) sexual and reproductive health; b) population and development; and c) gender equality; while mainstreaming the needs of the adolescents and youth. The was developed in alignment with UNFPA Strategic Plans 2012 -2013; and 2014 – 2017. The programme also contributed to the three outcomes of the United Nations Somalia Assistance Strategy 2011 – 2015 (UNSAS), extended

[92] UNFPA strategic plan, 2018-2021.

[93] Ibid.

[94] Somalia United Nations Strategic Framework 2017 - 2020.

to 2016, in alignment with the New Deal/ Somali Compact. The indicative assistance for the 2nd CP was US$ 27.2 million (US$ 12.7 million from regular sources and US$ 14.5 million from other sources for five-year period 2011 – 2015[95].

The 2nd CP had several achievements whereupon Somalia realized improved access to reproductive health services through enhanced reproductive health care service delivery processes, increased family planning service uptake and increased reproductive health commodity security, obstetric fistula prevention and management as well as strengthened capacities of national and local authorities. More specifically the number of midwives trained according to international standards rose from about 250 in 2011 to about 1000 in 2017. The number of obstetric fistula successfully repaired increased from a few estimated cases in 2011 to almost 800 in 2017. The number of regions and communities declaring the abandonment of female genital mutilation went from zero in 2011 to 240 in 2017. It is also during this period that UNFPA contributed significantly to availability of population-based data to guide policy formulation and planning through Population Estimation Survey of Somalia (PESS) and strengthening the statistical capacity in the country. The lessons learnt during the programme were that partnerships between UNFPA, Government and NGOs proved to be instrumental, particularly for gender-based violence response across the country, in addition to coordination and capacity strengthening of local level structures including religious leadership, community based organization, traditional and community leaders were a critical in the success of the programme.

Table 3.1 2nd Country Programme Areas, Outcome and Outputs

Outcome 1 (Sexual and Reproductive Health): Increased availability and use of integrated sexual and reproductive health services (including family planning, maternal health and HIV) that meet human rights standards for quality of care and equity in access **Output 1:** Improved healthcare delivery to reduce maternal and neonatal mortality and related morbidity; **Output 2:** Increased capacity of government, community-based and non-governmental organisations to offer high-quality, comprehensive sexual and reproductive health services, education and information for young people, with a focus on those who are most at risk
Outcome 2 (Population and Development): Availability of reliable demographic and related data is ensured, along with institutional capacity and systems for planning, delivering and monitoring humanitarian, recovery and development policies and programmes, especially at zonal and sub-zonal levels. **Output 1:** Improved systems for generating, analysing and disseminating disaggregated population and related data, with a focus on improving the monitoring of maternal health at zonal and sub-zonal levels in order to inform interventions in this area. **Output 2:** Strengthened capacity of selected sectoral ministries and partner organisations to collect, analyse, disseminate and utilise disaggregated population data for planning and delivering humanitarian, recovery and development assistance.
Outcome 3 (Gender): Gender improved socio cultural environment to advance gender equality, reproductive health and women's and girls' empowerment, including for the most vulnerable and marginalized women, adolescents and youth **Output 1:** Increased capacity for advocacy and community engagement in the reproductive health and right of women and adolescent girls and the elimination of harmful practices affecting maternal health; **Output 2:** Creation of enhanced systems and mechanisms for prevention and of protection from all forms of gender-based violence, using human rights perspective, including emergency and post-conflict situations.

[95] This amount is for indicative assistance at the time of the CPD development. In 2015, the CP resources totaled US$ 74,871,837.38, with an expenditure of US$ 65,860,659.82 (Source: 2nd UNFPA Somalia CPE).

The third Country programme 2018-2020 was developed and implemented building on the achievements and experiences of the 2nd CP. The programme implementation has been in collaboration with other United Nations organizations within the framework of 'delivering as one', as well as civil society, bilateral and multilateral development partners, and is aligned to the UNFPA's Strategic Plan 2018-2021, the National Development plan (NDP) of Somalia, Health Policy for Somali People and the Somali Health Sector Strategic Plans, the Sustainable Development Goals (SDGs), the United Nations Secretary General's Global Strategy guiding the interventions for the Women's, Children's and Adolescents Health (2016-2030) and the H6 partnership.

3.2.2 Current UNFPA Country Programme

The 3rd Country Programme was designed in alignment with the National Development Plan, the 2030 Agenda for Sustainable Development (particularly Goals 3, 5, 10 and 17), and the United Nations Integrated Strategic Framework (UNSF) 2017-2020. The programme seeks to contribute to the reduction of maternal mortality in Somalia with women, youth, populations affected by humanitarian crisis, and key populations at risk of HIV, as the primary targets. The programme integrates both development and humanitarian interventions, and builds individual, community, institutional, and system resilience, maintaining at the same time a contingency fund and sufficient emergency response capacities to respond to humanitarian emergencies. The programme is implemented through implementing partners including government, non-governmental and faith-based organizations covering the whole country[96]. The UNFPA Strategic Plan 2014-17 guided the development of the country programme, however this was aligned with the UNFPA Strategic Plan 2018-2021 through reporting and implementation[97], as later explained under the CPE findings under the criteria of relevance.

The 3rd Country Programme contributes to four out of the five priority areas of the UNSF through its four results areas. These include; SRH and GEWE components contribute to increasing the delivery of equitable, affordable, and sustainable services that promote national peace and reconciliation among Somalia's regions and citizens and enhance transparent and accountable revenue generation and equitable distribution and sharing of public resources; Adolescent and Youth component contributes to expanding opportunities for youth employment through job creation and skills development; and the Population dynamics component contributes to strengthen basic sectoral and core government functions in support of the establishment of a responsive, inclusive and accountable public sector. On the other hand, it contributes to the national development priorities, aiming towards improving the wellbeing of Somali people, particularly women, girls and young people. The design and implementation of the interventions take into account the lessons learned during the UNFPA's work in Somalia and its comparative advantages as a development agency with strong involvement in humanitarian contexts which consistently applies a rights based approach in its work.

The CP results and resources framework, in Table 3.2 below shows the four outcomes of the programme. It has a total of five outputs, with the SRH component has two, while GEWE, adolescents and youth, and Population dynamics components have one each. The programme is implemented using different strategies in the country aimed at increasing access and availability to SRH services, GBV response and availability of data for evidence-based decisions. These are explicitly shown in the framework below.

[96] Country programme document for Somalia DP/FPA/CPD/SOM/8.

[97] Document review and interviews.

Table 3.2 3rd Country Programme Outcome, Output and Interventions

<table>
<tr><td colspan="2">National priority: Reduce maternal and child mortalities and improve quality of life through improved access to essential health services of acceptable quality and through prevention and control of communicable and non-communicable diseases ISF outcome: Increase the delivery of equitable, affordable, and sustainable services that promote national peace and reconciliation among Somalia's regions and citizens and enhance transparent and accountable revenue generation and equitable distribution and sharing of public resources</td></tr>
<tr><td>Strategic Plan Outcome</td><td>CP Output</td></tr>
<tr><td rowspan="2">Outcome 1 (Sexual and Reproductive Health): Increased availability and use of integrated sexual and reproductive health services, including family planning, maternal health and HIV, that are gender-responsive and meet human rights standards for quality of care and equity in access</td><td>Output 1: Increased national capacity to deliver comprehensive maternal health services including in humanitarian settings</td></tr>
<tr><td>Output 2: Increased national capacity to provide sexual and reproductive health services, including in humanitarian settings</td></tr>
<tr><td colspan="2">National priority: Enhance the participation of the youth in the development of the nation through effective mobilization, empowerment, training and sports to foster national cohesion, enhance peace and improve quality of life
ISF outcome: Expand opportunities for youth employment through job creation and skills development</td></tr>
<tr><td>Outcome 2 (Adolescents and youth): Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education and SRH services</td><td>Output 1: Increased capacity of partners to design and implement comprehensive programmes to reach marginalized youth, especially adolescent girls, including those at risk of child marriage</td></tr>
<tr><td colspan="2">National priority: Ensure a society that upholds gender equality, dignity, respect and fairness for all women and men
ISF outcome: Increase the delivery of equitable, affordable, and sustainable services that promote national peace and reconciliation amongst Somalia's regions and citizens and enhance transparent and accountable revenue generation and equitable distribution and sharing of public resources.</td></tr>
<tr><td>Outcome 3 (Gender equality and women's empowerment): Advanced gender equality, women's and girls' empowerment, and reproductive rights, including for the most vulnerable and marginalized
women, adolescents and youth</td><td>Output 1: Increased capacity of partners to provide services to survivors of gender-based violence, to prevent gender based violence, harmful practices, and to promote reproductive rights and women's empowerment, including in humanitarian settings</td></tr>
<tr><td colspan="2">National priority: N/A
ISF outcome: Strengthen basic sectoral and core government functions in support of the establishment of a responsive, inclusive and accountable public sector</td></tr>
<tr><td>Outcome 4 (Population dynamics):
Strengthened national policies and international development agenda through integration of evidence-based analysis on population dynamics and their links to sustainable development, SRH and reproductive rights, HIV and gender equality</td><td>Output 1: Strengthened national capacity for production and dissemination of high-quality disaggregated data on population, development and sexual and reproductive health issues that allow for mapping of demographic disparities and socio-economic and health inequalities, and for programme in humanitarian settings</td></tr>
</table>

Somalia remains one of the largest and most complex emergencies in the world[98]. In line with the UNFPA Strategic Plan 2018-2021 Business Model, it is classified in the red quadrant with the focus on an enabling environment and on institutional and individual levels due to the extent of need, government inability to finance and the existence of humanitarian crises. In this regard, all five modes of engagement, i.e. advocacy and policy dialogue, capacity development, partnerships and coordination, knowledge management and service delivery, are the main implementation strategies across the CP outcome areas[99]. Further, towards compliance with the "Grand Bargain" concluded at the World Humanitarian Summit, UNFPA emphasises integration of development interventions and building individual, community and institutional resilience, whilst maintaining a contingency fund and sufficient emergency response capacities to respond to humanitarian emergencies[100].

3.2.3 The Country Programme Financial Structure of the Programme

At the time of programme design, UNFPA proposed $44.7. million for the execution of the Country Programme over the three-year period from 2018 to 2020. However, during the period covered by the CPE, the country programme had been able to mobilize US$ 73,392,674, 64.2% more than the indicated programme amount. Table 3.1. below provides a breakdown of the budget of the Country Programme by thematic areas of programme and source of funding (core and non-core sources). The table also shows that the SRHR component received more resource allocation followed by the PD component, with GEWE, and Adolescent and Youth respectively followed.

Table 3.3 Proposed Amount allocated for the Somalia CP

Programme Thematic Area	Amount in US$			% allocation by Source		
	Core Resources	Other Resources	Total Resource	Core Resources	Other Resources	Total Allocation as % of Budget
Outcome 1: SRHR	28,270	23,521,810	23,550,080	0.1	99.9	32.1
Outcome 2: A&Y	2,593	4,996,441	4,999,034	0.1	99.9	6.8
Outcome 3: GEWE	131,653	8,108,927	8,240,580	1.6	98.4	11.2
Outcome 4: PD	55,331	10,819,812	10,875,143	0.5	99.5	14.8
Programme Coordination and Assistance[101]	6,527,071	19,200,767	25,727,838	25.4	74.6	35.1
Total	**6,744,918**	**66,647,757**	**73,392,675**			**100**

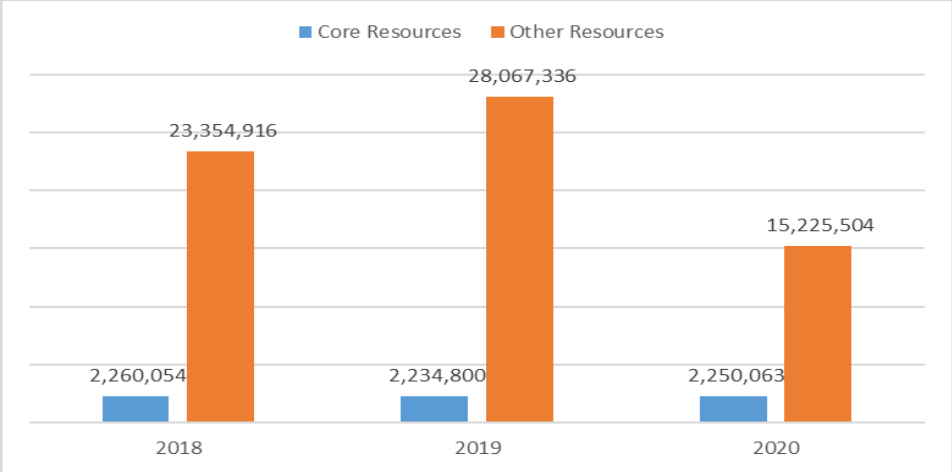
Source: UNFPA Somalia

Programmatically, SRHR component accounted for the highest (32.1%) funding allocation, which majorly were from the other sources, followed by PD (14.8%), GEWE (11.2%), and lastly Adolescent and Youth at 6.8%. During the period of coverage, the Core resources appeared constant across the three years,

[98] Country programme document for Somalia DP/FPA/CPD/SOM/8.
[99] UNFPA Strategic Plan 2018 – 2021.
[100] Country programme document for Somalia DP/FPA/CPD/SOM/8.
[101] PCA includes Operations support, Programme Support, and HR support costs. **Operations support** includes funds allocated on UNFPA DEX Projects for Support of Operations; **Programme support** includes the funds allocated on UNFPA DEX projects for the direct support of programmatic interventions and coordination; and **HR Support** includes the funds allocated on UNFPA DEX projects for the direct support of salaries of staff and consultants hired by UNFPA.

accounting for 9.2% of the total CP budget. On the other hand, the other resources for the CP accounted for 90.8% of the total CP budget, with the highest resources being mobilized in 2019. Figure 3.1 below shows the distribution of resources by source and year of implementation. While Programme Coordination and Assistance thematic area appears to have taken the highest share of the programme budget, it is a composite of operations support, programme support and HR support, most of which went into direct implementation of the CP interventions

Figure 3. 1 Country Programme Resource Distribution by Year of Implementation[102]



Source: UNFPA Somalia.

CP Budget Utilization rate

Overall, the CP's performance in resource management is nearly 80%, with the highest utilization being witnessed in 2019 at 85.3%. Since the CPE covered the period up to 30 June 2020, the utilization rate may rise to above 80%, though the achievement's budget utilization rate is lower. The CO may need to reassess the resources available to commit in areas of gaps before the end of the CP period for effectiveness. However, interviews with CO staff indicated that the low rate of funds utilization was majorly attributed to delays in disbursement of funds from donors, which usually come in large amounts in the last quarter of the calendar year with considerable difficulty in attaining full utilization. Most of the times the balances are rolled over to the next programme year.

Table 3.4 CP Budget Utilization rate[103]

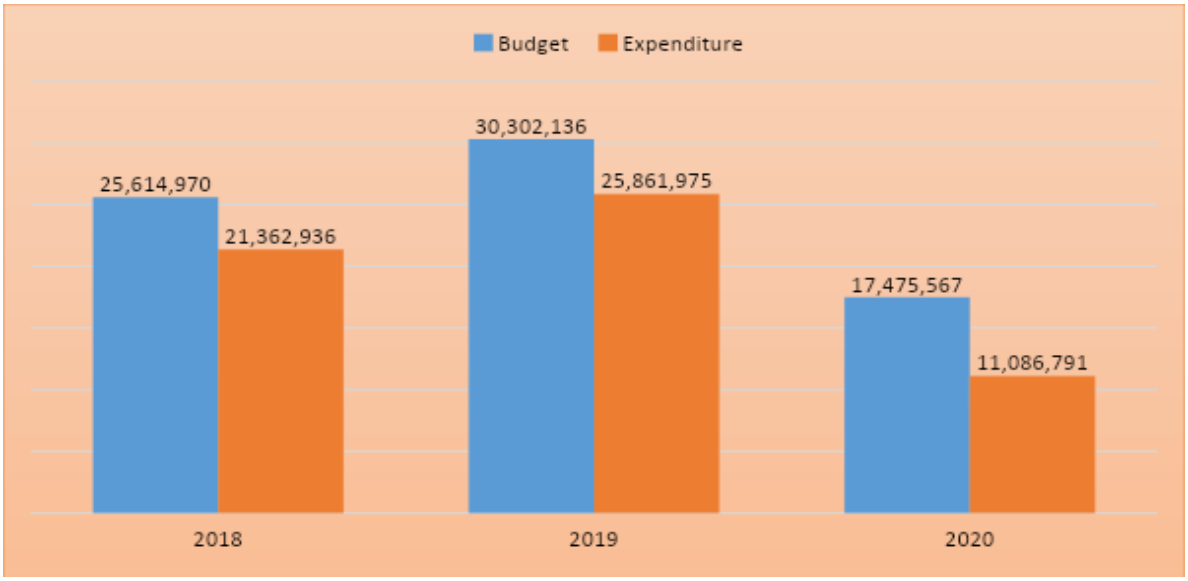
Year	Budget (US$)	Expenditure (US$)	% utilization
2018	25,614,970	21,362,936	83.4
2019	30,302,136	25,861,975	85.3
2020[104]	17,475,567	11,086,791	63.4
Total	**73,392,674**	**58,311,702**	**79.5**

Source: UNFPA Somalia

[102] The Financial data in 2020 is up to the month of June.
[103] The Financial data in 2020 is up to the month of June
[104] Ibid

The evolution of the Country programme budget and the expenditures from 2018 to mid-2020 is represented in Figure 3.2 below. The expenditure and budget levels were highest in 2019, followed by 2018, with a registered reduction in 2020, where the expenditure is likely to change.

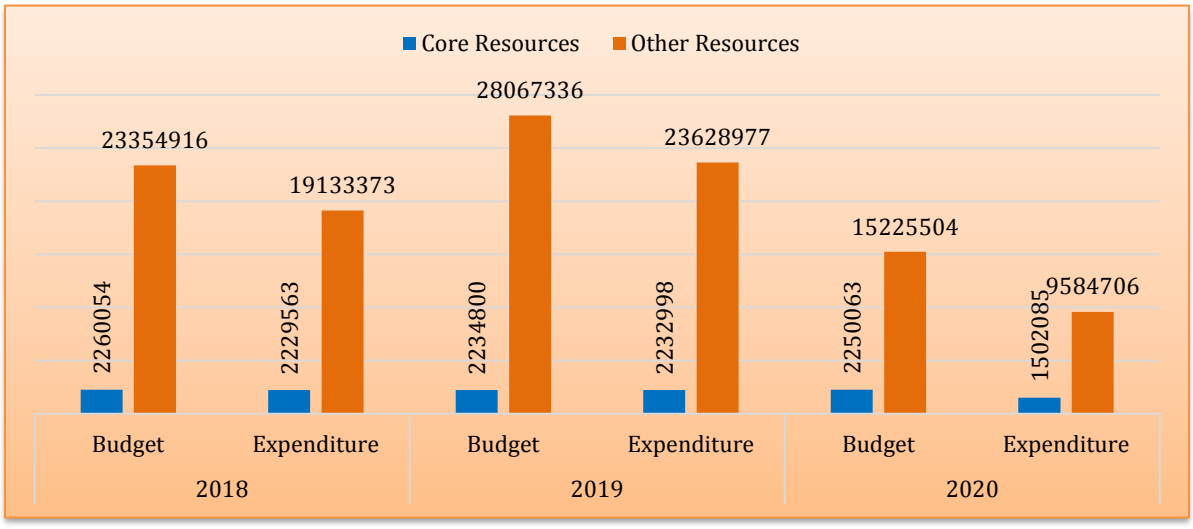
Figure 3.2 Evolution of the CP Budget and Expenditure 2018 to June 2020 (US$)



Source: UNFPA Somalia

The budget and expenditure of the CP by source of funds is represented in Figure 3.3 below. It shows that nearly all the core funds were used in the years, including 2020 where it is also likely to be utilized by the end of the year.

Figure 3.3 Somalia 3rd CP Yearly Budget and Expenditure by Source of fund105

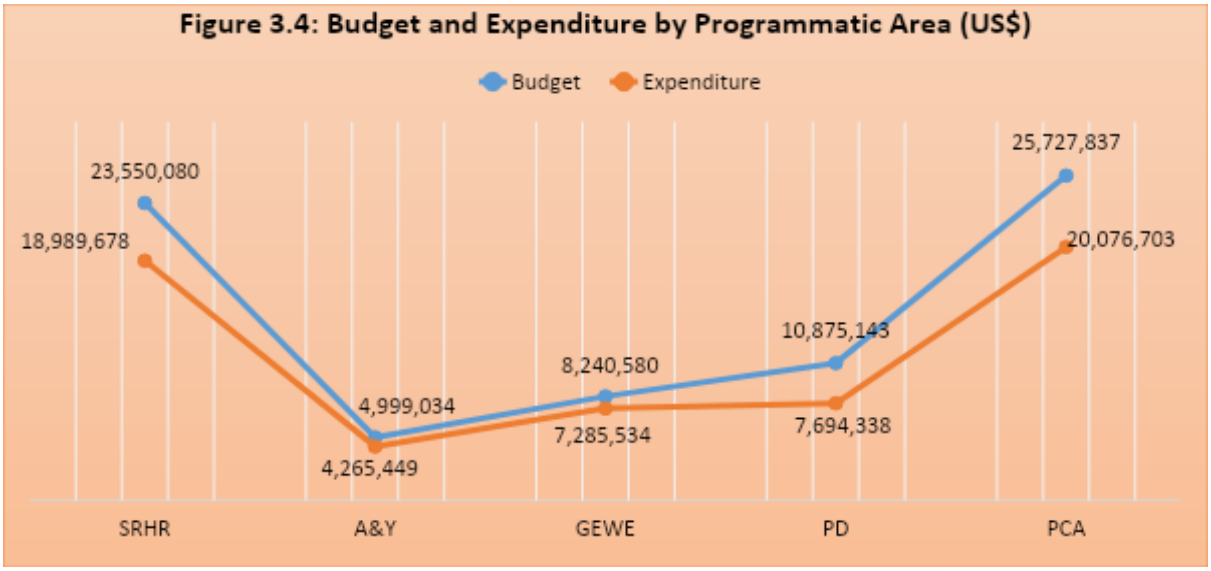


Source: UNFPA Somalia

[105] The 2020 data is up to June

The budget and expenditure across the programme thematic areas are represented in Figure 3.4 below. It shows that the Adolescent and Youth, and GEWE components had higher budget utilization rates than SRHR, PD and PCA.

Figure 3.4 Budget and expenditure by Programmatic area[106].



Source: UNFPA Somalia

[106] The 2020 data is up to June

CHAPTER 4: FINDINGS: ANSWERS TO THE EVALUATION QUESTIONS

4.1 Introduction

This chapter presents the findings of the 3rd Country Programme Evaluation, in compliance with the UNFPA Evaluation Handbook on how to conduct Evaluation. It involves addressing the evaluation questions in relation to the evaluation criteria. The findings have been guided by the evaluation matrix, triangulating multiple data sources as elaborated in the methodology design. The extent to which the results have been realised is described in the text, with some generalized for the interventions of the 3rd CP as the feedback is based on opinions expressed on the performance of the programme, especially on the result areas.

4.2 Relevance

EQ1: To what extent has the Country Programme addressed national priorities and needs of the population, in particular vulnerable groups, vis-à-vis the UNFPA mandate?

EQ2: To what extent has the UNFPA Country Office been able to respond to changes in priorities and needs of the population over time, including those of vulnerable groups, especially in response to shifts caused by new or evolving humanitarian crises?

EQ3: To what extent have UNFPA-supported interventions been aligned to the UNFPA Strategic Plan 2018-2021 and international normative frameworks, policies and standards related to development and humanitarian action?

Summary of Findings

The Somalia 3rd Country Programme is well aligned with the UNFPA Global Strategy. In addition, it is also aligned to the 2030 Agenda for Sustainable Development to contribute to the achievement of the Sustainable Development Goals (SDGs). Further, the CP directly responds to the national priorities (Documentary Reviews and Interviews). It is also with this background that the CPE concludes that the CP is fully aligned to the International Conference on Population and Development ICPD Plan of Action, SDG, UNFPA global strategy and the national development plans.

UNFPA was fully responsive to merging needs and changes in the implementation context. UNFPA responded to the emergency SRH and GBV needs of those affected by Cyclone Sagar along the shores of the Red Sea in Bari and Lughaya regions in Puntland and Somaliland states, respectively. UNFPA also responded effectively to the emergency needs of those affected by floods in Beledweyne town in 2018 and 2019. Similar response and contribution were made during IDPs influx in Baidoa in 2018. Interviews with CO staff and IPs also indicated UNFPA provided emergency support to IDPs in major cities of Mogadishu, Baidoa, Kismayu, Garowe and Hargeisa who faced frequent evictions. UNFPA also support the line ministries of planning, health and humanitarian affairs in production of maps and indicators for COVID-19, in addition to coordinating meetings for surveillance and response of COVID-19.

4.2.1 Strategic Relevance

From documentary review and interviews with the various respondents, it is evident that the CP was implemented to directly achieve the ICPD Plan of Action. The CP particularly focused on increasing access to sexual and reproductive health and rights (SRHR) services, including family planning, aimed at reducing maternal, child and infant mortality in the country; promoting gender equality and women and girls' empowerment; and availability of population data for measuring progress on development. From the CPE feedback in interviews and documentary reviews, great strides were made during the CP to drive this agenda and covered all the three ICPD goals. It is also in the period that Somalia was able to report on 36 indicators on the ICPD agenda, that had been reported on before, in addition to the government signing the plan of action (ICPD-PoA) and committing to the treaty on Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW).

The country programme is aligned and contributed to the achievement of SDGs in Somalia. The CP contributed immensely to SDG 3 (Good health and wellbeing); SDG 5 (Gender equality); SDG 10 (Reduced inequalities); and SDG 17 (Partnership building); and to some extent SDG 1 (Eradicating Poverty), SDG 16 (Peace, Justice and Strong institutions), and SDG 4 (Quality Education). The CP contributed to achievement of SDG 3 by increasing access to quality SRH services through supporting technical and financial assistance on SRH, training of midwives for skilled birth attendance, strengthening access to family planning services through demand creation, and availing data through surveillance. Towards SDG 5, the CP addressed GBV response and prevention, elimination of harmful practices like child marriage and FGM, strengthening legal and policy framework on gender issues in the country, increasing women's right in making decision of their SRH choices, including family planning. On SDG 10, the CP addressed issues of inequalities, by increasing focus on the marginalized populations in the hard-to-reach areas and increasing their access to SRH services, supporting laws and legislations that promote equality and eliminates discrimination, especially for women and girls and people with disabilities and provision of data on access to services by the nomadic segment of the society. In SDG 17, the programme implementation approach embraced multi-stakeholder engagement through partnership and supporting coordination mechanisms in the delivery of the thematic services or functions, in addition to provision of information through the Somali Health and Demographic Survey (SHDS) for further development endeavours in the country. Further, the programme contributed to eradication of poverty (SDG1) through strengthening access to technical and vocational education skills by the youth, especially women, girls and people with disabilities at the youth centres. The CP contributed to SDG 4 through enhancing access to numeracy and literacy skills for the youth, especially women and girls, in addition to availing data related to measurement of the education indicators in the country. Lastly, the programme also contributed to SDG 16 through strengthening resilience mechanisms in the country, increasing participation of the youth in peace and justice processes in the country, and supporting development of laws and legislations that strengthen the justice system for the violated.

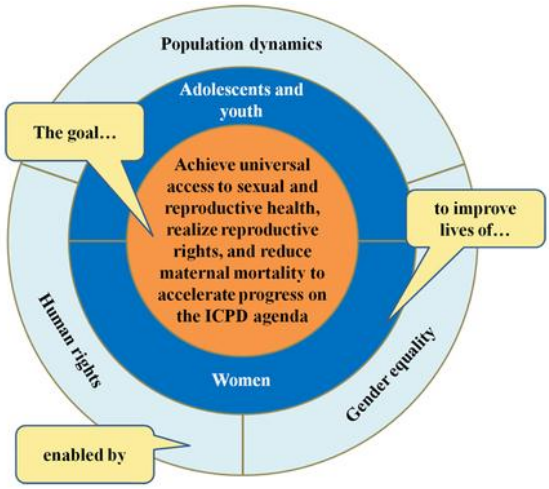


Figure 4. 2 Strategic direction of UNFPA

The Somalia 3rd Country Programme 2018-2020 was designed and implemented in alignment with the UNFPA Strategic Plan 2018 – 2021. The CP covered all the four strategic outcome components of SRH, adolescent and youth, gender equality and women's empowerment, and population dynamics and effectively contributed to the overall goal aimed at achieving universal access to sexual and reproductive health, realize reproductive rights, and reduce maternal mortality to accelerate progress on the (ICPD) agenda, to

improve the lives of adolescents, youth and women, enabled by population dynamics, human rights, and gender equality, which is the Bull's eye as represented in Figure 4.1. The CP in essence emphasizes gender responsive SRH services, including access to SRH by the adolescents and youth, gender equality and empowerment of women and girls, including the most vulnerable, and further strengthening national legislation, policies, coordination and integration of population dynamics for sustainable development. While the definition of the results in the CPD still reflected those of the Strategic Plan 2014 – 2017 including the IP AWPs, document reviews and interviews revealed that the implementation-framework, including reporting (SIS and GPS) reflected the new SP outputs. There was also no evidence of deliberate realignment of the CP to the Strategic Plan 2018 – 2021 (SP). Towards alignment with the SP, UNFPA Somalia applies all the five modes of engagement (partnership and coordination, knowledge management, advocacy and policy dialogue, capacity development and service delivery) in the implementation of its interventions, which are relevant for the context as Somalia is classified as a least developed country (LDC)[107]. There is a high level of scarcity of services, especially in the marginalized populations like the nomadic and rural communities, further exhibiting the relevance of the modes used by UNFPA.

The design of the programme took into consideration the priorities of the National Development Plan 2017-2019 (NDP-8)[108] and is still aligned to the NDP-9. The design of the CP was aligned with the three priorities in the NDP 8, Spanning areas of SRH, enhancing adolescents and youth participation in the development of the nation, contributing to ensuring a society that upholds gender equality, dignity, respect and fairness for all women and men, and through strengthening accountability in the public sector by availing data for decision-making**.** The NDP-9 focuses on four key pillars[109] on inclusive politics (Pillar 1), strengthening security and the rule of law (Pillar 2), economic development (Pillar 3), and social development (Pillar 4). The CP contributed directly to Pillar 2 through focusing on strengthening policies and promoting human rights and access to justice for the vulnerable; Pillar 3 through provision of data for measuring development and supporting adolescent and youth, particularly vulnerable women, girls, those living with disabilities and the marginalized to enhance their technical and vocational, literacy and numeracy skills and building of resilience capacities; and Pillar 4 through strengthening increase of access to quality SRH services in the country. To a little extent, the CP is also aligned to Pillar one through promotion of peace processes within the country through supporting youth participation in peace and reconciliation, and governance processes.

The 3rd UNFPA Somalia Country Programme is fully aligned to the United Nations Strategic Framework Somalia 2017 – 2020 (UNSF) which provides the overall UN support to the Federal Government of Somalia (FGS). Documents reviews and interviews revealed that UNFPA mandate in Somalia is guided by these results in the framework, with collective contribution to the achievement of the UN priorities in Somalia. As described in Chapter 3, UNFPA programme contributed to three UNSF priority areas through all the four thematic components. There was also evidence through interviews of joint programmes between UNFPA and UNHABITAT on youth political empowerment and peacebuilding; and UNICEF on female genital mutilation/ circumcision (FGM/C). UNFPA also received funding from various UN mechanisms to support the Country Programme. These included, UN Central Emergency Fund (CERF), UNAIDS Unified Budget, Results and Accountability Framework (UBRAF), and UN Peace-Building Fund (PBF), in addition to UN's Multi-Partner Trust Fund (MPTF). In addition to that, UNFPA was a member of and actively participated in a number of coordination mechanisms within the UNCT, in addition to leading some of them. During the period of evaluation, interviews indicated that a common communication

[107] Somalia is classified as a least developed country by the UN due to her low development indicators, in addition to unavailability of clear information on development in the economy. Accessed from: https://unctad.org/en/pages/aldc/UN-list-of-Least-Developed-Countries.aspx

[108] National Development Plan 2017 - 2019.

[109] Somalia National Development Plan 2020 – 2024.

strategy endorsed by the UN Country Team (UNCT), to improve inter-agency cooperation, ensure consistent, and cohesive messaging, and to enhance the image of the UN and its activities at the national and regional levels.[110] These manifested the concept of Delivering as One (DaO).

UNFPA also contributed directly to Somalia's strategies of the various donor-countries that funded the Country Programme being evaluated. For example, the Strategy for Sweden's development cooperation for Somalia 2018 – 2022 aims to contribute to sustainable peace, strengthened resilience to crises and disasters, greater respect for human rights, gender equality, and environmentally and climate-resilient sustainable development, areas which were mostly covered in by the UNFPA result areas. Other donor-countries included Italy, Finland, Switzerland and the United Kingdom.

UNFPA's Strategic Positioning Note makes a strategic decision on a collaborative and partnership building approach – hence it is working with other UN agencies, the Government, NGOs, private sector, Faith Based Organizations, religious leaders, men and women, boys and girls at the community level with all actors and partners engaged in reducing risks of vulnerability of women and girls to inequality, discrimination and practices of GBV. Overall, UNFPA through the prioritized interventions targeted promoting human rights, gender equality and strengthening of Gender-Based Violence (GBV) prevention, mitigation and response.

4.2.2 Relevance to National Priorities

4.2.2.1 Sexual and Reproductive Health

The SRH component of the UNFPA country programme is fully aligned to Somalia development needs and priorities, and greatly contributed to addressing them through development of strategies, guidelines and policy, capacity strengthening and development, commodity supply, support to service delivery, advocacy and community awareness raising on services.

The 3rd CP is implemented directly through various line Ministries and NGOs across the federal states and the FGS Ministry of Health and Human Services is the lead strategic partner for UNFPA in Somalia. UNFPA contributed financially and technically to the development of the Somalia and Somaliland National Development Plans (NDP), especially in the areas of SRH and Adolescent and youth, aimed at increasing access to the related services by the target groups. The UNFPA 3rd CP is also aligned to the UN strategic Framework which contributed directly to the NDP. UNFPA contributed to the development of Somalia health sector strategic plan (HSSP), BEmONC training guidelines, RMNCH Strategy jointly done with WHO, Family Planning guidelines, midwifery curriculum review and Midwifery Employment and Retention Strategy, Clinical Management of Rape (CMR), among others (Document review and Interviews with IPs and CO staff). UNFPA ensured an integrated approach in the implementation of the component to ensure SRH issues also addresses the other CP components, particularly adolescents and youth, and GEWE. UNFPA also addressed the priorities in the Humanitarian Response Plans (HRP) for 2018, 2018 and 2020 ((Document review and Interviews with IPs and CO staff).

The SRH component of the 3rd CP has consistently taken into consideration and addresses the needs of women, adolescents, youth, people at the risk of HIV infection, disabled, older persons, IDPs and marginalized (Document review and Interviews with IPs and CO staff). There is evidence of community consultation through needs assessments by both the IPs, UNFPA and other government partners to inform programme of the UNFPA SRH programme ((Document review and Interviews with IPs and CO staff). UNFPA conducted annual planning with the national stakeholders to prioritize areas of need in the

[110] UN Country Results 2019.

area of SRH and this informed the interventions of the component (Document review and Interviews with IPs and CO staff).

The Somalia Reproductive, maternal, neonatal, child and adolescent health (RMNCAH) strategic plan recommends and promotes universal health coverage to ensure equitable health service delivery in Somalia. UNFPA supported the Ministries of Health to implement lifesaving health services through supporting BEmONC, CEmONC facilities and conducting outreaches in marginalized locations in filling the existing gaps. UNFPA, in partnership with various organizations and the government authorities selected hard-to-reach populations with services ensuring access to quality SRH services by the marginalized and vulnerable people. UNFPA supported the operations of the RH working group, in addition to supporting taskforces on Clinical Management of Rape, Fistula, Maternal death surveillance and response (MDSR) and FGM anti- medicalization.

Somalia has one of the highest maternal mortality rates in the world. The 3rd CP directly contributed to addressing this through supporting midwifery schools to increase access to skilled birth attendance in the country. UNFPA also led the review of the Midwifery training curriculum, in addition to financing the development of Midwifery Employment and Retention Strategy which, if implemented, will address the issues of midwives' deployment and availability of skilled birth attendance in the health facilities, particularly in the marginalized and hard-to-reach locations in the country (Document reviews and interviews).

The Somali National Youth Policy identifies health and quality lifestyle for the youth as a priority. The SRH component of the 3rd CP is addressing this through supporting access to SRH services by training and supporting organizations and institutions to deliver youth friendly services in the country (Document review and interviews with CO staff).

With over two decades of conflict causing immense damage to the country's infrastructure, this has led to chronic human resource shortages, poor infrastructure, and inadequate health commodity supplies. UNFPA contributed to health systems strengthening and increasing access to health services in the area of SRH through building the capacities of healthcare workers including nurses, midwives, doctors and community health workers, enhancing quality of service delivery (Interviews and document reviews) and eliminating suffering among the affected populations. In addition, UNFPA established guidelines to guide quality and standardized delivery (Interviews and document review). UNFPA also supported development of the RH commodity supplies logistics management information system (LMIS) with evidence of MoH contribution (Interviews and Document review).

Somali women are exposed to potential risk factors for an obstetric fistula with limited ability to prevent and seek treatment for a fistula due to inadequate facilities, human resources and information. In addition, Obstetric fistula often leads to depression and social isolation, UNFPA through the 3rd CP contributed addressing obstetric fistula through provision of medical supplies, training and funds for fistula prevention, treatment and social reintegration programmes in Somalia (Interviews and Document review).

Somalia has one of the most complex and protracted humanitarian crises in the world. UNFPA contributes to the humanitarian response in Somalia through implementation of the Minimum Initial Service Package (MISP) for SRH services, which guides the humanitarian actors on the minimum actions to be taken in response to populations' SRH needs during emergencies, in addition to coordinating the GBV sub-cluster and the RH Working Group to ensure access to services by the affected population (Interviews and Document review). During these periods, UNFPA procured and distributed Emergency Reproductive Health Kits, Dignity Kits and reproductive health supplies (Document review and Interviews with IPs and CO staff).

4.2.2.2 Adolescent and Youth

It was evident that the UNFPA 2018-2020 country programme was introduced through consultation with the relevant stakeholders in the country including at all levels of government structures. The country programme unitarily sought to support line ministries and national agencies to adequately deliver on their mandate through financial and technical support. Discussion with ministry staff established that the country programme covered majorly respective ministries national strategic priorities, for example under the Ministries of Youth in Puntland and Somaliland, the priority areas of expanding skills availability in the informal sector and engaging the youth on their rights including sexual and reproductive rights have been extensively undertaken. Such support also contributed to achievement of the ministries priority goals that they are not directly supported by UNFPA such as employment creation and strengthening of youth group structures in various parts of the country.

The country programme 2018-2020 is well aligned to strategic priorities of the country as stipulated in the national development plan (2017-2019) and 2030 agenda for sustainable development particularly goals (3, 5, 10 and 17). Through the implementation of NDP, the government envisioned to increase employment opportunities and decent work particularly for youth and targeted to create 500,000 stable jobs. UNFPA vehemently contributed to this priority through adequately training targeted youth on various skills and effectively positioning them for employability through equipping them assessment backed employable skills that improved their access to employment opportunities. The FGDs sessions with programme participants found that the majority of them were self-employed after under-going life skills trainings. Through equipping the youth with skills UNFPA contributed to increasing their chances to obtain employment opportunities. FGDs Participants echoed that most of them were able to raise little to start business enterprises, sometimes partnering among themselves and seeking the mentorship support of their teachers at youth friendly spaces.

NDP strategic priority of meaningful youth engagement in peace building and state formation were also achieved as they youth get empowered and assume various leadership and transformational roles to participate in making decisions that affect their lives. The PBF peace building project implemented with UNFPA worked on a long standing need of youth social inclusion and peace building. According to national youth policy, involvement of youth in governance structures was a priority of the current government. The strategy was envisaged to adequately address pertinent needs of the youth especially in regional member states and provide references for designing and implementation of youth support programmes. The 3rd CP complemented the wider youth economic development effort by providing a platform for youth political dialogue, discussion of community issues and discourse and knowledge sharing.

The 3rd CP also contributed to progress in advocating for and responding to youth sexual and reproductive rights. Youth were particularly sensitized about the sexual and reproductive rights including the rights to conclusively decide on their marriage, sexuality and reproduction. The youth were also increasingly supported to access sexual and reproductive health services including family planning and HIV testing that are otherwise impossible to obtain due to the cultural orientation that surrounds the sexual and reproductive issues among the Somalis. As established during the KIIs, vulnerable and marginalized girls had improved access to reusable sanitary pads, menstrual education as well as access to family planning services including the contraceptives. The vigorous awareness creation sessions improved young women's effort to openly discuss otherwise valid issues such as family planning and access products such as condoms provided at the UNFPA supported facilities. Discussions with young women beneficiaries' identified significant empowerment in SRH decision making in contrast to usual embracing of parent/guardian decisions without forging discussions.

The youth centre has created a platform where adolescence girls from different parts of the target location can meet and openly discuss their sexual and reproductive rights issues and support one another in adequately accessing the required services through continued widespread information sharing.

The national youth policy has provided central reference for youth programme design and planning. The strategy has laid a good foundation for collaboration between the government line ministries and the UN agencies and also strengthening discussion on joint programmes among the UN agencies to address challenges faced by the youth in the country.

4.2.2.3 Gender Equality and Women Empowerment

UNFPA Somalia's gender equality and women's empowerment (GEWE) component of the Somalia 3rd CP was confirmed to be highly relevant to the national priorities of the country (document review and interviews with IP and CO staff). The focus of the component output of aiming to increase capacity of partners to provide services to survivors of gender-based violence, to prevent gender-based violence and harmful practices, and to promote reproductive rights and women's empowerment, including in humanitarian settings, is consistent with the needs of the country, particularly those of the most vulnerable and relevant to the context (Interviews and document review).

The 3rd CP GEWE component activities were implemented based on priorities identified at the annual review and planning meetings with participation of the national stakeholder, including the Ministries of Justice and Women affairs (Interviews with IP and CO staff). There was also evidence of consultations identifying gaps through community level engagements, government requests, gender-based violence (GBV) working groups meetings, assessments within the affected communities, GBV information management systems (GBV IMS) data which also informed decisions based on the cases reported (Interviews with IP and CO staff).

Somalia's Constitutional framework provides for equality and non- discrimination, hence the interventions of UNFPA's 3CP in supporting awareness and support towards domesticating normative gender frameworks is aligned. The relevant treaties aimed at ensuring member States domesticate equality and non -discrimination of women in all spheres include the Convention on Elimination of All Forms of Discrimination Against Women (CEDAW) and the Protocol to the African Charter on the Rights of Women in Africa (Maputo Protocol) (Interviews with IP and CO staff).

Somalia is resource-constrained, therefore the contribution of UNFPA to coordinate resources through the GBV sub-cluster, mobilizing resources and coordination service delivery among many stakeholders ensuring that priority gaps are filled, in addition to minimizing overlaps is relevant. Through the GBV sub-cluster, advocacy mechanisms are enhanced to ensure implementation of various legislative and policy frameworks which are of key interest to the country (Interviews with IP and CO staff, and document review). UNFPA also finances the management of GBV data through the GBV IMS which informs decisions, including policy reforms and is able to estimate the level of performance trends since there are inadequate mechanisms for monitoring and data collection (Interviews with IP and CO staff).

After more than two decades of conflict and disasters, in addition to strong cultural and religious beliefs, there is deeply rooted gender inequality with high levels women discrimination formal decision making and asset ownership; high cases of rape, high level of female genital mutilation, violence against women and child marriage. UNFPA seeks to address all these through promoting social norm and behaviour change, particularly focusing on total abandonment of female genital mutilation and child/forced/early marriage using various mechanisms, including supporting legislative frameworks to

ensure a conducive environment for all, particularly the vulnerable women, girls and marginalized populations (document review and Interviews with IP and CO staff).

The Somalia National GBV Strategy (2018-2020) highlights GBV as a major concern in Somalia, particularly FGM, early marriage and psychological abuse. Physical violence perpetrated by intimate partner is rampant across the three regions of Somalia (document review). GBV is underreported due to stigma, fear of retaliation from a survivor's family members and/or perpetrators. Communities shun sexual assault survivors under the misguided belief that they are tainted and unmarriageable. The judicial systems of justice are reported to be particularly weak and in most cases, cases of GBV are heard before the customary courts (Xeer), where the survivors never get fair hearing (document review and Interviews). The GEWE components are relevant to advocate, address and strengthen the systems for policy and legislative reforms that aim to ensure accountability on human rights of marginalized groups, gender equality, women's reproductive rights issues and gender-based violence prevention and response; promotes advocacy efforts to develop, enact and implement gender-based violence-related legal frameworks. Implementation of the frameworks and commitments from the various Somali authorities is however inadequate.

4.2.2.4 Population Dynamics

UNFPA Somalia's population dynamics (PD) is consistent with the national priorities, designed and implemented to the development needs of the country. The component focused on strengthening the national capacity on production and dissemination of disaggregated data on population, development and sexual and reproductive health issues that informed decision-making on the related sectors of the country's development. As explained in the strategic section above, UNFPA enhanced evidence-based accountability in the public sector through availing data used to measure key development indicators, in addition to strengthening the statistics capacity in the country. Notable during the CP implementation period was the production of the Somali Health and Demographic Survey (SHDS) report which helped the government in setting baseline data and targets for monitoring progress of the newly developed NDP-9 in addition to assess the performance of the previous NDP-8. The SHDS also provided data for monitoring the performance of the Somalia/ Somaliland Health Sector Strategic Plan (HSSP) and Somalia Health Policy; brought out clear understanding of the extent of various needs within the targeted sectors in the survey thereby enhancing evidence-based planning and targeting; and increased targeting of the nomadic and rural populations with services, reducing inequalities and marginalization.

The strengthening of the statistics capacities in the country, including those in the federal member states, was a relevant contribution to the country's statistics system which have been eroded for years due to conflicts and weak capacities to produce data to formulate policies, inform evidence-based decision and improve delivery of public service to the populations (Interviews and documentary reviews). In addition, Somalia has significant deprivation in data coverage, quality, and accessibility to inform policy. UNFPA's capacity building approach used was highly relevant and enabled the national and federal member state planning ministry staff to take charge of the processes right from design, implementation, data analysis and report writing, an experience that was lauded by the beneficiaries (Interviews with IPs and CO staff). For the first time Somalia has a digitized sampling frame which they is currently being used for other surveys in the country, which was never possible before (Interviews with IPs and CO staff)[111].

Interviews with PD IPs consistently indicated how the UNFPA's financial and technical support was an important contribution to the country's statistical systems as they did not have the capacity to undertake or finance their data needs. During the 3rd CP, Somalia for the first time reported on the SDGs in the

[111] Labour Force Survey supported and conducted by ILO using the digital sampling frame built by UNFPA.

related indicators (youth, education, health, gender and other social sectors) for the country, in addition to setting baselines for the same; and got comprehensive data on health for women and children, which interviews with IPs indicated had never happened since independence. The Government of Somalia committed to the ICPD Plan of Action (PoA) for the first time in 2019 since its inception in 1994, and this was because they have data, particularly on the 36 indicators of the PoA (Document review and Interviews with IPs and CO Staff).

The IP respondents confirmed being consulted on their existing population dynamics needs to be addressed, to ensure the CP deliverables and support were consistent to and took into account the needs in the country, in addition to capturing the needs of the marginalized and vulnerable populations during implementation of the programme. Planning processes during the design and implementation of the programme also indicate decisions targeting areas of gaps and selection of target beneficiaries of the 3rd CP interventions (Interviews with IPs and CO Staff). At the same time, the government respondents confirmed making requests to the UN development partners on the need to fill the gaps in data production and strengthen their statistics capacity, and based on their identified needs. Important to note is that implementation of the PD of the 3rd CP was contextualized and utilized local resources and knowledge in all the deliverables, for example most of the enumerators were women, taking into contextual sensitivities of the data to be collected, and the data tools translated into the local language. While UNFPA strengthened the capacities of the various teams to produce data for the government, there was little evidence of dissemination and wider utilization of the data generated by the various ministries, and this aspect may need strengthening.

4.2.3 Country Programme Responsiveness to Emerging Needs

Interviews with IPs, CO staff and other stakeholders revealed that UNFPA was fully responsive to emerging needs and changes in the implementation context. UNFPA responded to the emergency SRH and GBV needs of those affected by Cyclone Sagar along the shores of the Red Sea in Bari and Lughaya regions in Puntland and Somaliland states, respectively. UNFPA also responded effectively to the emergency needs of those affected by floods in Beledweyne town in 2018 and 2019. Similar response and contribution was made during IDPs influx in Baidoa in 2018. Interviews with CO staff and IPs also indicated UNFPA provided emergency support to IDPs in major cities of Mogadishu, Baidoa, Kismayo, Garowe and Hargeisa who faced frequent evictions.

In the period of coverage, UNFPA responded to emergency needs of those affected by drought, floods and conflicts in Somalia through integrated SRHR and GBV outreach services and static facilities. Routine outreaches were also conducted based on request from the various ministries of health across Somalia. The outreaches targeted highly populated areas with little access to healthcare services and provided by paediatrician, obstetric gynaecologist, general practitioners, lab technicians, midwives and senior people from the MoH for integrated SRHR and GBV services including BEmONC. In addition, UNFPA ensured targeted the vulnerable populations with emergency kits, including distribution of dignity kits to vulnerable women and girls in the IDP settlement and in the hard-to-reach areas in Somalia. While the outreach service provided emergency level services, they also made referrals to facilities with CEmONC services in the localities, with UNFPA facilitating transportation costs. Interviews with CO staff indicated that UNFPA allocated resources for emerging needs in the country. For example, based on the CO mission to the Kismayu regional referral hospital and established that the facility lacked basic CEmONC services, decided to partner with Save the Children to strengthen the services and trained the staff, including deployment of surgeons to provide quality services.

UNFPA, at the request of the FGS Ministry of Health is supporting an initiative to establish a National Blood Bank within the Banadir Hospital complex in Mogadishu, and will contribute to providing much

needed blood supplies to respond to the needs for saving maternal lives as well as trauma victims. (Interviews and document review).

UNFPA secured EUR 1 million funding from Finland and 1 million Canadian Dollars in 2020 to support national COVID-19 testing, isolation and treatment centres, contributing to access to services by those infected until the end of 2020. This support brought relief to the already constrained resources and facilities in the country. The funding was used to procure the protective equipment, supplies and provision of preventive information to the general public through radio sessions. In addition, UNFPA mobilized USD 2 Million towards financing the COVID-19 Preparedness and Response Plan (Interviews with MoH and CO staff).

Interviews with IPs indicated that UNFPA was responsive to PD emerging needs and issues across the country. In Somaliland for example, UNFPA supported in development of the NDP, especially in defining the baselines, structuring the chapters in addition to writing the health, gender and youth sections of the plan ensuring that they were results-based, and paid for the cost of consultant who was involved in its development (Interviews with IP and CO staff). During the implementation of the SHDS, UNFPA exhibited flexibility in addressing emerging issues due to the context. For example, when there were changes in the targeted enumeration areas, may be due to floods or security issues, the team was readily there to support on identification of other areas within a short notice, using technology. UNFPA was also responsive to the changes at the policy level, where there were frequent changes of policy staff in the ministries of planning and health, and would come with different needs, which UNFPA managed to address through consistent dialogue using local resources (Interviews with IP and CO staff).

The initial design document of the SHDS was to use the 18 pre-war regions, which was never in conformity with the Somaliland-defined regions. UNFPA had to introduce more samples to include the regions in Somaliland. The database also had to be expanded to ensure that the respective districts in the regions were covered (interviews with CO staff). The 3rd CP also contributed immensely to the establishment of the Somalia National Bureau of Statistics by an act of Parliament through facilitating a familiarization tour for the Parliamentary committee on planning to Rwanda. The visit enabled the committee to understand the importance of establishing the bureau, and this culminated in the bill being passed by the Parliament, Council of Ministers and signed into law by the President.

The 3rd CP also effectively responded to data needs for emerging issues across the country during the 3rd CP implementation period. UNFPA takes great leadership in the development of the Somalia Humanitarian Needs Overview (HNO) in addition to being a key contributor in the Inter-agency and inter-cluster assessments and data. On request, UNFPA provided data on those affected by floods in Beletweyn and conflict in Tuqarak, and the IDP influx situation in Baidoa which enabled planning for response in the humanitarian settings. UNFPA also responded to the Prime Minister's request for data for production of 21 NDP-9 indicators, and had to produce proxy indicators to fill the data gaps in the plan, since they had only completed rural and urban surveys. UNFPA also supported the line ministries of planning, health and humanitarian affairs in production of maps and indicators for COVID-19, in addition to coordinating meetings for surveillance and response. Other responses were on provision of requests on Essential Package of Health Services (EPHS) data, revision, endorsement and approval of the National Statistics Act for Somaliland addressing data policy and confidentiality, passing of the addendum to the National Statistics Act in Puntland.

4.3 Effectiveness

EQ 4: To what extent have the 3rd CP outputs been achieved, and to what extent have these outputs contributed to the achievement of the expected outcomes?

EQ 5: To what extent has the programme integrated the cross-cutting issues of gender and human rights based approaches?

4.3.1 Sexual and Reproductive Health and Rights

Summary of Findings

Considerable progress was achieved regarding integration of the country programme components within the SRHR component, improving the delivery of services at regional and health facility level as confirmed by the stakeholders interviewed. UNFPA strengthened the capacities of the national stakeholders in delivering quality integrated Reproductive Maternal Neonatal Child Adolescent Health (RMNCAH) through supporting midwifery training, development of guidelines and standard operating procedures (SOPs) for service delivery, in addition to support supervision and mentorship of the health workers. Further, the CP contributed to strengthening service delivery and policy framework. UNFPA expanded quality preventive as well as life-saving services for the management of complications of pregnancy and childbirth across the country through strengthening the delivery of integrated and services and treatment, prevention and reintegration of those affected by fistula; in addition to skills development for health workers, health facility infrastructure management, supplies management. Gaps in the SOPs and guidelines implementation, inadequate capacity and commitment of the government authorities and among the healthcare workers. UNFPA enhanced coordination in delivery of SRHR services.

The Sexual and Reproductive Health and Rights (SRHR) component of the 3rd Country Programme was designed and implemented to ensure increased availability and use of integrated sexual and reproductive health services (including family planning, maternal health and HIV) that are gender-responsive and meet human rights standards for quality of care and equity in access. The component has two expected output results namely increased national capacity to deliver comprehensive maternal health services including in humanitarian settings; and increased national capacity to provide sexual and reproductive health services, including in humanitarian settings. The main government partners in the component's implementation included; Federal Ministry of Health and Human Service; Puntland Ministry of Health; Somaliland Ministry of Health Development. The component had two outcome indicators and seven output indicators as indicated in Table 4.1. In addition, the first output had four areas of intervention, while the second had five.

Achievements of Planned Component Results

From the results framework table below, the 3rd CP had mixed results on the performance, measured by the indicators in the SRHR. From analysis of UNFPA-funded Somali Health and Demographic Survey (SHDS) National report, the Total Contraceptive prevalence rate in the country was 6.9% (against a baseline of 6%), while the Percentage of live births attended by skilled health personnel was 31% (against a baseline of 33%). Among the output indicators, nearly all the targets were or will be achieved by the trends in the 2018 and 2019 annual, and the 2020 quarterly reports. While the performances in the outcome indicators appear lower than expected, through the 3rd CP, UNFPA made tremendous achievement towards improving SRHR service delivery in the country. In the period, UNFPA increased the number of midwives graduating from the midwifery schools; developed SRHR policies, guidelines and protocols, enhancing quality of service delivery and adhering to international guidelines; enhanced

capacity building to both the government and healthcare workers in all the aspects of SRHR, including operational support, equipment and training; contributed to expansion of the number of health facilities providing BEmONC and CEmONC services; and improved access to services by the hard-to-reach areas and humanitarian settings through outreaches and partnerships. Further, UNFPA enhanced coordination and advocacy through SRHR Working Group, CMR taskforce, Fistula steering committee, and initiation of FGM anti-medicalization taskforce, among other actions aimed at increasing access to SRHR services in the country. On the other hand, various components, especially Family planning and fistula service delivery had inadequate funding and therefore services could not be delivered as planned. In addition, commitment and capacities of the government to implement and enforce some of the developed guidelines and policies is a gap, in addition to long-held cultural beliefs and misconception on some of the services, like family planning is still high.

Table 4.1 M&E Framework for the Sexual and Reproductive Health component of the 3rd CP

UNFPA strategic plan outcome: Every woman, adolescent and youth everywhere, especially those furthest behind, has utilized integrated sexual and reproductive health services and exercised reproductive rights, free of coercion, discrimination and violence						
Indicators	**Baseline**	**Targets**	**Progress**			**Comments**[112]
			2018	**2019**	**2020 Q2**	
Contraceptive prevalence rate (total)	6%	15%	N/A	N/A	6.9%	Data from SHDS shows a slight improvement from baseline, but the target is not achieved
Percentage of live births attended by skilled health personnel	33%	60%	N/A	N/A	31%	Data from SHDS shows a decrease in the skilled birth attendance from baseline, and the target is not achieved.
Output 1: Increased national capacity to deliver comprehensive maternal health services including in humanitarian settings						
Number of midwives graduating from training that is in accordance to ICM-WHO standards	*979 (2011-2017)*	*1,479 (2011-2020)*	1201	N/A	N/A	Since the 2018 graduation of 222 midwives, there has been no other graduation among the UNFPA-supported student. In 2019, a total of 514 midwives were enrolled across the 15 midwifery schools with UNFPA support. The target will therefore be surpassed if all of them graduate.
Number of facilities with all the signal functions to provide skilled delivery	69	89	53	71	71	The reduction in the number of facilities in 2018 was occasioned by reduced funding of the Somalia Health sector as the Joint Health and Nutrition Programme (JHNP), which supported most of the Somalia health facilities in Somalia, implemented from 2012 - 2016 came to an end.
Number of fistula repair surgeries	*779 (2016)*	*1,429*	1010	1204	Not reported	225 repairs are planned for in the last quarter of the year. If that is achieved, then the target will be achieved. Not done in the first three of 2020
Output 2: Increased national capacity to provide sexual and reproductive health services, including in humanitarian settings						
The country has humanitarian contingency plans that include elements for addressing sexual	No	Yes	Yes	Yes	Yes	National humanitarian plan incorporates SRH needs of women, adolescents and youth, including services for survivors of

[112] Green implies that the target has been achieved; Yellow means the achievement in significant; Red means far from being achieved

and reproductive health needs of women, adolescents and youth, including services for survivors of sexual violence in crises						SGBV in drought-stricken areas in place, with the participation of UNFPA humanitarian team.
Number of national counterparts with the capacity to implement MISP at the onset of crisis	120	200	155	183	Not in 2020	A total of 63 regional medical officers and other programme managers from the Ministry of Health and Development and SRH partners.
Percentage of health facilities with personnel with the capacity to implement the new family planning human rights protocol	<60%	85%	N/A	68% (est.)	N/A	During 2019, 166 health care providers and practitioners were trained on FP issues and services provision to the target groups.
The country is using a functional electronic logistics management information systems for forecasting and monitoring reproductive health commodities	No	Yes	Yes	Yes	Yes	A functional Logistics Management Information System (LMIS) is in place with the right tools and the human resources. Utilization of the tools is still low and needs strengthening.

Midwifery Capacity Development

UNFPA in the 3rd CP, supported and contributed immensely to quality birth attendance in the country through financing and strengthening Somalia midwifery capacity in various ways. These included review and development of National Midwifery Curriculum meeting International Conference of Midwives/WHO standards, and incorporating FP; developed, in collaboration with the FGS ministry of health, Midwifery Employment and Retention Strategy; and supported a total of 15 midwifery schools for production of qualified midwives across the country. The support included learning materials, salaries of the tutors, stipend to the trainees, equipment and rent for the buildings. The deployment of newly graduated midwives to the public sector greatly enhanced the provision of quality health care services in the areas of assignment, particularly in the remote parts of the country. UNFPA ensured that the graduates were equipped with kits to conduct their midwifery activities. UNFPA supported a total of 14 midwifery schools distributed equitably across the country. During the period, a total of 222 midwives graduated through UNFPA support, contributing to provision of skilled birth attendance. In addition, 514 were admitted into the 14 midwifery schools with the support of UNFPA (Document reviews and Interviews with IP and CO staff).

> Without skilled health workers and professionals, we cannot decrease the MMR in Somalia. We used to have women from the rural areas bleeding to death while giving birth because we did not have skilled health workers in the locations. Due to UNFPA support to midwifery training in the country, the graduates go back to the villages to work and the rural women are able to access skilled maternal service in the remote areas of Somalia, and have contributed a lot to bringing down the maternal mortality rates. – **Key Informant in Galkayo**

While the criteria for selection and admission into the midwifery schools require that they would go back to work in their villages of origin, deployment and retention is a challenge. Some graduates end up being employed by private clinics in the cities (Interviews). However, through advocacy in the RH working group, co-chaired by UNFPA, these have been employed by MoH, UN agencies and NGOs to ensure continuous provision of quality SRH services in the remote localities (CO and IP interview). UNFPA also introduced a performance-based incentive project for midwives to reward exemplary service delivery and this motivated them to go beyond the normal efforts to provide the services (Interviews with CO and IP staff). During the period, UNFPA advocated for more support from donors and secured funding from

Global Affairs Canada to increase 500 more midwifery students enrolled in the country (Interview with CO staff).

In terms of quality assurance and standardization of midwifery and nursing services, the 3rd CP supported the operations Midwifery and Nursing Associations both technically and financially. The associations were supported to conduct quarterly visits to the midwifery schools, administer midwifery examination, advocacy on service delivery and deployment for the midwives, in addition to ensuring that services are delivered in the health facilities according to standards (Interviews with IPs).

SRH Policy Development and Dialogue for Quality service delivery

The 3rd CP also provided technical and financial support for the development and revision of various SRHR policies and strategies, implementation frameworks and guidelines. These include development of RMNCH advocacy strategy and guidelines in collaboration with UNICEF and WHO, Family Planning strategy in the Islamic context and training guidelines, Midwifery deployment and retention strategy[113], Clinical Management of Rape (CRM), Logistic management information system (LMIS) Policy and related tools, initiation of anti-medicalization of FGM policy and complication management, BEmONC and CEmONC guidelines (Interviews and document reviews). During the same period, UNFPA, together with other health stakeholders reviewed the health sector strategic plan (HSSP). These have improved the SRHR policy environment and streamlined implementation across the country, to a larger extent (interviews with IP and CO staff and document review). To further enhance policy implementation on SRH, UNFPA Somalia organized a technical event regarding the Women in Global Health (WGH) – Somalia Chapter, held in Garowe, bringing together key stakeholders including the President of Puntland State of Somalia, government officials, donors, health experts, mental health professionals, members of the media, academia, civil society and the public (Document reviews). UNFPA also supported a 5-day Medical Fair and Conference in Somaliland, bringing together decision makers, professionals, healthcare providers and users (Document review). While these policies and guidelines are in place, with review of some ongoing, there were gaps cited in their implementation, due to inadequate capacity and commitment of the government authorities and among the healthcare workers.

Sexual and Reproductive Health Commodity Security

UNFPA strengthened the Supply Chain System through supporting and setting up a functional electronic Logistics Management Information System (LMIS) which is in place with the right tools and the human resources. The system facilitated reporting on logistics data, informing consumption, evidence-based forecasting and monitoring of reproductive health commodities (document review and CO interviews). UNFPA also supported integration of a costed Supply Chain Master Plan into the Commodity Security Strategic Plan, and 270 supply chain staff on the LMIS to improve their performance (Document review). The Master Plan incorporates rights-based contraceptive delivery as recommended by UNFPA/WHO implementation guide (Document review). The implementation of the Commodity Security Programme experienced insufficient level of funding and the resulting below-optimal level of commodity procurement, with stock-outs of RH commodities, including contraceptives reported in several locations during the period. UNFPA however provided some of the needed commodity security items and kits to the people in need, in particular vulnerable women and girls.

Interviews with Federal MoH indicated that UNFPA strengthened the ministry's capacity in distribution, management and warehousing and establishment of Supply chain management unit. Gaps were however cited in the infrastructure support for the supply chain where the system was based on the push method

[113] The Midwifery Deployment and Retention strategy has not yet been finalized, but at an advanced stage of approval at the time of the CPE.

instead of demand-based pull. Interviews with CO and IPs staff revealed that the LMIS tools were not fully utilized by the government and this aspect requires further advocacy and capacity enhancement for them to be utilized (Document reviews and Interviews with IP and CO staff). UNFPA also supported the institutionalization of Commodity Security at the University of Hargeisa, School of Midwifery and Nursing with a Logistics Management curriculum developed under the guidance and technical assistance of UNFPA (Document reviews and Interviews with CO staff).

Emergency obstetric care and service delivery

The 3rd CP expanded quality preventive as well as life-saving services for the management of complications of pregnancy and childbirth across the country during the period covered. These included strengthening the RMNCH (BEmONC and CEmONC) service delivery through supporting a total of 15 CEmONC service delivery sites for maternity care in the country, supporting full packages including commodities, equipment, fully functioning theatre and staff incentives, and functional throughout the year. The CEmONC centres were strategically positioned providing Midwifery Schools so that the trainees got clinical exposure, under the supervision of the experts (Interviews with CO staff). UNFPA also ensured compliance with the WHO recommendation of ensuring four BEmONC centres were referring cases to one CEmONC facility. This improved access to RMNCH service delivery by making the CEmONC facilities more available for referral mechanisms, able to provide required signal function at the BEmONC, ease of training and enhancing infection and prevention and control in the country (Document reviews and Interviews with IP and CO staff). With the presence of trained midwives qualified to deliver mothers safely mothers, there was evidence of an increased number of people visiting health facilities for skilled deliveries.

To strengthen referrals for emergency response for MNCH services, UNFPA supported procurement and distribution of lifesaving equipment in various health facilities, supported operation costs for ambulances, development of health infrastructure, and establishment of BEmONC centres, mostly near IDP settlements and rural areas. UNFPA also ensured that communities were sensitized on the available MNCH services in their communities to create demand and access to skilled health service delivery to the marginalized communities.

UNFPA 3rd CP engaged in extensive capacity development interventions to expand access to improved quality of RMNCH care and services across the country. These interventions targeted skills development for health workers, health facility infrastructure management, supplies management. The skills development interventions included Birth Spacing/Family Planning, Fistula Identification and Social Reintegration, Youth-friendly health services, Gender-Based Violence mainstreaming for health professionals, Training on PMTCT, values clarification and attitudes transformation training (VCAT) and training of trainers on FP.

UNFPA targeted areas with poor access to health services, and areas affected by humanitarian crises with routine integrated supplementary outreach interventions with all the RMNCH services. The services included BEmONC, incorporating EPHS, family planning and community sensitization using rights-based approaches. The outreaches targeted highly populated areas with little access to healthcare services and provided by paediatricians, obstetric gynaecologists, lab technicians, midwives and senior people from the MoH. Interviews and document reviews indicated that the outreaches made a lot of difference in the locations targeted as they also made referrals to facilities with CEmONC services in the localities, with UNFPA facilitating transportation costs. UNFPA also responded to the emergency needs of those affected by drought in Somalia through integrated SRH and GBV outreach services. UNFPA also conducted outreaches in the IDP settlements with no access to health services. In addition to the health services, UNFPA ensured targeted the vulnerable populations with emergency kits, including distribution of dignity kits to vulnerable women and girls in the IDP settlement and in the hard-to-reach areas in

Somalia. UNFPA also strengthened different partners and healthcare workers on emergency response through training on minimum initial service package (MISP) in the humanitarian setting, incorporating family planning (Interviews with partners) to respond during crisis. In order to increase evidence-based response, UNFPA conducted maternal death surveillance and response (MDSR). This was however reported to be limited in coverage, and needed to be cascaded to the district and community levels, as the health management information system is not working well (interviews with IP). Even though the efforts put in place are yielding results, commodity shortages, inadequate capacity in facilities and government systems, and poor infrastructure with limited access to highly vulnerable populations still prevail amid humanitarian crisis and a high burden of communicable and non-communicable disease (interviews with IPs and CO staff and document review).

UNFPA also supported health facility operations and ensured uninterrupted service delivery in a total of 48 facilities through payment of salaries for staff and running costs including supplies, equipment, generators for power, water and other utility services. During the period, UNFPA supported renovation and equipment of health facilities in Banadir, Bardere, Belethawe, and Kismayu referral hospitals to increase their capacities to deliver CeMONC services (Interviews with MoH and CO staff).

With the outbreak of the COVID-19 pandemic, UNFPA was strategically positioned and supported various activities related to treatment, prevention and control within Somalia. UNFPA secured funding EUR 1 Million and CAD 1 Million from Finnish Government and GAC respectively to respond to the COVID-19 related interventions. At the time of the CPE, UNFPA supported the national COVID-19 isolation and treatment centre in Mogadishu ensuring access to services by those infected until the end of 2020. UNFPA supported Puntland to set up a laboratory for testing through training of the laboratory technologists and providing necessary equipment for service delivery and research, in addition to paying for the running costs and staff in the laboratory. UNFPA also supported procurement and distribution of PPEs for nurses and Midwives to ensure uninterrupted service delivery due to COVID-19 risks, in addition to enhancing information access through production and distribution of information, education and communication materials, in addition to mainstreaming COVID-19 messaging into SRHR and FGM sensitization messages.

In order to contribute to the reduction of the maternal mortality rates in Somalia, UNFPA, in collaboration with UNOPS and WHO is supporting the Federal government in establishing a blood bank (interviews and document reviews). It is aimed that this will immensely address the excessive bleeding of mothers during deliveries, in addition to contributing to saving lives in emergencies response during the frequent bomb blasts in the region. Towards ensuring this, there is a need for a proper system in place with proper equipment and mechanisms for refill and supply established.

Obstetric fistula prevention, care, treatment and strengthening social reintegration services

UNFPA continued to address obstetric fistula through provision of medical supplies, training and funds for fistula prevention, treatment and social reintegration programmes in Somalia. (Interviews and Document review). The target for the repair surgeries in both 2018 and 2019 were not achieved due to inadequacy of funds and surgeons, with a total of 425 repair cases against the targeted 530, handled in the period. The CP also continued to intensify training and campaigns on fistula prevention, identification, referrals and social reintegration. Preventing and treating obstetric fistula remains essential in Somalia and requires more efforts including integration of fistula treatment in the CEmONC service package, building the capacity of health care workers, in addition to improving multi-sectoral coordination, and enhancing community mobilization. In addition, there is still a shortage of skilled fistula repair surgeons hence the need for more strategic partnerships to accelerate training to better face the growing demand of fistula (document review and interviews).

To enhance treatment and handling of fistula in the country, UNFPA financially and technically supported the integration of fistula in the reviewed Midwifery curriculum by adding a module. In addition, UNFPA trained the directors of the midwifery schools on the curriculum and how to integrate the fistula module including how to prevent fistula among women and girls (Interviews and document review). Additionally, UNFPA supported the national fistula task force meetings attended by doctors, midwives' association, regional health officers, partners, midwifery schools and community groups, as part of fistula combating and preventing process in Somalia (document review).

Family Planning

UNFPA supported provision of family planning (birth spacing) service throughout the country. This was accomplished through technical and financial assistance in development of Family Planning (FP) training curriculum for Somalia, training of healthcare workers on FP and conducting training on VCAT, and advocacy on the importance of birth spacing to strengthen the quality of care and increase demand for FP services (document review and interviews).

The 3rd CP strengthened capacities of healthcare workers to provide quality contraceptive counselling and administration of methods. UNFPA supported revision of the Family Planning Guidelines including a section on ensuring human rights in the provision of FP counselling and services. The healthcare workers including midwives, nurses and doctors were equipped with skills to deliver. Master training of trainers was conducted to cascade training and mentorship the healthcare workers from national to the regional levels to strengthen skills. Further, the revised national family planning guidelines was disseminated among stakeholders to ensure compliance during delivery of the services. Midwifery schools were also targeted through revision of the curriculum to include FP modules (document review and interviews). Interviews with MoH staff indicated that equipment to administer some of the FP methods like intrauterine device (IUD) were lacking in some of the facilities whose staff were trained.

With funding from DfID, UNFPA, and UNICEF, Population Service International (PSI) implemented a joint programme, Somali Health and Nutrition (SHINE) 2016 – 2021, with the aim of reducing mother and child deaths in Somalia by improving the supply and demand for improved health and nutrition services. In this arrangement, UNFPA is responsible for distribution of FP supplies and capacity building, PSI responsible for demand creation in target location, while UNICEF is the fund manager, while at the same time handling the EPHS delivery and district system strengthening. Interviews with partners indicated that UNFPA contributed immensely in making FP commodities available and building the capacity of the service providers in remote locations of Awdal, Banadir, Togdheer and Sanaag regions. FP funding for UNFPA programme is limited and hindered cascading of training to other areas in Somalia. Interviews with partners also indicated that there was inadequacy of coordination in training, where UNICEF conducted similar training where UNFPA had conducted the same (interviews and document review).

On FP evidence-based demand creation, UNFPA enhanced implementation of culturally-sensitive SRH outreach interventions at the community level, integrating Behaviour Change Communication (BCC). UNFPA enhanced advocacy on uptake of family planning through high level engagement of government policy makers, religious and community leaders and other influential community members, in addition to holding discussions with men, women and youth. These sessions were facilitated by health workers, addressing misconceptions and tailor information to meet the specific needs of different groups like pregnant women, girls and youth (interviews and document review). Interviews confirmed that the level of awareness raised in the country using key messages, with UNFPA technical support has increased at the community level. To enhance evidence-based demand for family planning services, UNFPA is collaborating with PSI in Somaliland to support the *hoyo ko hoyo* (mother-to-mother) and male champions

approaches to enhance male involvement in FP service delivery. Male involvement in the advocacy for family planning uptake in the country was however cited to be low, and more advocacy and deliberate efforts to be put in order to target them.

While progress has been made in increasing demand for FP services, including acceptance and utilization, Interviews with the health care workers, IP and CO staff revealed that FP awareness raising is still a hard-sell in the Somalia context. Limited supplies and services in some locations was cited to contribute to low uptake of FP services. Similarly, FP method preference vis-a-vis the available methods was also cited as affecting uptake (interviews and document review).[114]. Interviews with partners in Somaliland indicated that the demand for FP services is on the upward trend, however the capacity of facilities to serve the needs is limited and this aspect needs more efforts to support.

Multi-sectoral coordination mechanisms on SRHR

Interviews with UN agencies, IPs and CO staff and documentary reviews revealed that UNFPA was effective in SRH coordination mechanisms and contributed stronger synergies and efficiencies in delivery of services and advocacy in the country. UNFPA continued to co-chair with the Federal Ministry of Health, namely, the Reproductive Health Working Group (RHWG) at national and sub-naitonal levels meeting on a monthly basis; the Fistula Steering Committee, which meets quarterly; and the Clinical Management of Rape (CMR) taskforce, maternal death surveillance and response (MDSR) taskforce (Document review and Interviews with IPs and CO staff). These coordination mechanisms were reported to have enhanced service delivery in addition to minimizing overlaps in response.

At the UN level, UNFPA is an active member of the United Nations Country Team (UNCT), Security Management Team (SMT), Humanitarian Country Team (HCT) and Programme Management Team (PMT), ensuring advocacy for delivery (Document review and interviews). Advocacy for SRHR service delivery by the RHWG saw the revision of the Somalia Humanitarian Response Plan (HRP) in 2018, incorporated other components of sexual and reproductive health and rights (SRHR) such as family planning, sexually transmitted infections (STIs) and HIV prevention, basic and comprehensive EmONC services and clinical management of rape to develop the capacity of partners to respond to new challenges in the Somalia humanitarian context (Interviews and Document review). Interviews with some partners revealed that there was however inadequate coordination among UN agencies in health, with some roles not clearly defined, leading to overlaps. An example in the UNFPA-UNICEF arrangement in commodity supplies, where UNICEF is responsible for procurement of commodities and kits while UNFPA is responsible for distribution and at the same time procuring FP commodities and drugs (Document review and Interviews with IPs and CO staff). Interviews from some stakeholders suggested the need for UNFPA to improve on participation in health coordination at the country level, as are mostly conspicuous in gender coordination. Further, in Jubbaland, UNFPA and Save the Children International are encouraged to strengthen supervision and coordination to ensure uninterrupted delivery of services at the referral hospital in Kismayu.

[114] UNFPA and PSI collaborated and planned together on how to increase demand creation, but is yet to be implemented due to inadequate funding for FP.

4.3.2 Adolescent and Youth

UNFPA financially and technically supported the development of National Youth Strategy and National Youth Policy; enhanced access to youth and adolescence sexual and reproductive and rights (ASRHR) services in the country through training of healthcare workers on youth friendly services, enhancing awareness raising mechanisms and establishment of youth-friendly service, including counselling points in health facilities and youth centres; and supported youth and adolescent to receive information on ASRH, HIV&AIDS, and culturally endorsed harmful practices including FGM and early marriage, targeting behaviour change. The CP also contributed to elevating the role of youth in governance and peacebuilding through supporting establishment of structured youth participation forums. UNFPA also targeted the vulnerable and marginalized youth for skills development on various technical and vocational education training (TVET), literacy and numeracy training, and access to various information through internet and library from the youth centres. There were however gaps in supporting start-up activities for the trained youth. UNFPA also supported vulnerable girls, particularly in the IDP settlements and hard-to-reach locations with menstrual hygiene supplies including reusable sanitary pads, protecting their dignity.

The adolescence and youth component was introduced into the 3rd CP after critical analysis need to holistically address the challenges facing young people in the country. With such a high number of youth in the country, the youth will require special attention that critically focuses on enhancing their capacity to lead a promising life and take the yardstick for fostering development changes in the country. Adolescence and youth activities were also centrally embedded in other programmes such SRH and GEWE and harmoniously implemented with support of expertise from either side.

The 3rd country programme critically addressed the needs of the youth from multi-faceted approaches. Including building their knowledge gap in sexual reproductive rights, responding to their medical needs and safety through the one stop centres and enhancing their skills through vocational training to acquire employment and improve their socio-economic wellbeing. On the other hand, midwifery schools were utilized to prepare young nurses and midwives for employment in the formal sectors.

Crucially, UNFPA enormously increased knowledge building through publishing youth focused strategies and guidelines with the support of the respective line ministries. These strategies that included national youth strategy, curricula and road map on youth engagements are instrumental in guiding the designing and implementing of youth programmes in future.

Table 4.2 M&E Framework for the Adolescent and Youth component of the 3rd CP

UNFPA strategic plan outcome: Every adolescent and youth, in particular adolescent girls, is empowered to have access to sexual and reproductive health and reproductive rights, in all contexts.						
Indicators	**Baseline**	**Targets**	**Progress**			**Comments**[115]
			2018	**2019**	**2020 Q2**	
Percentage of young women and men aged 15-24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission (female/male)	41%	60%	N/A	62%	N/A	Data according to HIV Youth behavioural survey we did in 2019. Target surpassed as at June 2020. None was done in 2020.

[115] Green implies that the target has been achieved; Yellow means the achievement in significant; Red means far from being achieved

Output 1: Increased capacity of partners to design and implement comprehensive programmes to reach marginalized youth, including adolescent girls at risk of child marriage						
Number of girl centres established to provide adolescents with reproductive health services	0	3	3	6	6	Target surpassed as at June 2020
Number of health care providers with the capacity to provide youth friendly services	0	120	120	28	.14	Target surpassed as at June 2020
Number of health, social and economic asset building programmes that reach out to adolescent girls at risk of child marriage	1	3			3	Target reached as at June 2020

The achievements of the planned results.

The adolescents and youth component was developed on the premise that with an increased capacity of partners to design and implement comprehensive programmes to reach marginalized youth, including adolescent girls at risk of child marriage, will contribute to increased priority on adolescents in development policies and programmes. The component successfully achieved the planned deliverables for the country programme, an over achievement was realized under the peace building programme which mainly focused on youth engagement for peace and leadership representation in the government structures. The programme utilized structured synergy with other UNFPA programmes to develop holistic approaches to providing comprehensive support to the targeted youth (document review and interviews).

During the 3rd Country programme, the adolescents and youth programme undertook massive awareness raising on youth and adolescence sexual and reproductive and rights (ASRHR) through employing varied communication approaches including radio, messaging, youth centres, mobile caravans, community forums, with evidence of increased knowledge and change in behaviours and perceptions on access to ASRH services by the adolescents and the youth. The adolescence and youth mainly received information on prevention of harmful traditional practices including FGM and early marriage (interviews) targeting social behaviour change among the youth and adolescents. Innovative youth engagement approaches such as theatre based plays, school clubs, youth associations and peer to peer to peer were synthesized to clearly pass the message on pertinent issues that are not openly discussed including HIV and FGM. Additionally, UNFPA, with the support of Ministry of Religion and Endowment engaged religious clerics to give Friday sermons on the sexual and reproductive rights challenges of the youth by intertwining it with the religious teachings obscure rigid cultural believes that have no roots in Islam (interviews and document review).

School clubs and Sports engagement ensured robust and extensive information sharing among the adolescent girls in the primary and secondary school. Increased awareness on harmful cultural practices such as FGM, early marriages and GBV were realized through debated among adolescence girls. According to the programme staff youth increased their self-awareness on impending retrogressive cultural issues such as forced marriages and rape in the society that downplays their efforts to pursue the careers and aspirations. Awareness messages on HIV&AIDs were continuously provided to the youth in schools and universities through class facilitations, HIV&AIDs clubs and during weekly gatherings. Theatre performances were effective in disseminating information on the significance of family planning

among the youth, including in school. Such performance also targeted elimination of child marriages and promoting girl child education by advocating against the practices, with changes reported during community sessions.

Through the support of respective ministries of youth and sports, 48 football clubs were continuously supported with sport materials such as new jerseys, shoes and balls. The club members were targeted with awareness raising on HIV&AIDS and behavioural change messages that included safe sex and proper social interactions that changed the perception of the youth on their sexual and reproductive health. The training was useful in enhancing knowledge against deep rooted cultural drawbacks of sexual and reproductive health taboos (interviews).

Advocacy and Youth participation in Peacebuilding and Governance

Structured engagement of youth enhances their engagement in peacebuilding and political participation. A joint programme implemented between UNFPA and UN Habitat was instrumental in ensuring increasing representation of youth in the governance structures. Targeted youth in Jubbaland and South West States undertook parliamentary roles improving the representations of youth on the decision making table. As a result, 17% and 45% of youth were respectively elected to the regional parliamentary sitting in Jubbaland and south west state (interviews and document review). The peacebuilding programme remarkably utilized innovative approaches including arts-for-social change and positive living initiatives that were systematically created platforms for dialogue among youth to share their view and systemize engagement process, identifying their challenges and discussing their possible solutions. These processes contributed to reaffirming the UN Security Council's Resolution 2250 (2015)[116] by enabling the youth to have a greater voice in the society and identify their potentials in state building, peacebuilding and leadership, where they felt empowered to participate in state building through active involvement in political decision making processes (interviews).

UNFPA supported establishment and strengthening of Youth District Councils in 4 locations: Baidoa, Kismayo, Dollow and Afmadhow, as part of the Joint Programme, through capacity building in Jubbaland and South-West States. Interviews with the CO programme team and the youth group members revealed that youth groups provide effective mechanisms for collective dialogue on youth issues in the country.

While co-chairing the UN Somalia Inter-Agency Youth coordination mechanisms played a crucial role in the establishment of the UN Youth Advisory Board (YAB) that brings together youth from different youth associations in Somalia. The Board provides a supervisory role within the UN programme implementation and provides informed advice on improving the implementation of youth programmes in the country. In 2019, UNFPA capacity built the youth advisory board on key aspects of leadership and governance, including UN operations in Somalia. It is however a concern that there are other platforms existing in the country and therefore needs coordination. UNFPA supported equal age and sex representation of the adolescents and youth to participate in the formulation and development of national policies (Interviews and document review).

Youth-Friendly Services and Youth Centres

UNFPA, during the 3rd CP established six youth-friendly centres located in Garowe, Gabiley, Mogadishu, Bosaso, Buhodle and Hargeisa. The established centres provide comprehensive youth-related services, including adolescent sexual and reproductive health (ASRH) services provided by skilled health staff

[116] The UN Security Council's Resolution 2250 (2015) identifies five fundamental pillars for action: (1) participation; (2) protection, (3) prevention; (4) partnerships; and (5) disengagement and reintegration, advocating for youth to be given a greater voice in decision-making at the local, national, regional and international levels, and to consider setting up mechanisms that would enable young people to participate meaningfully in peace processes.

trained by UNFPA, technical and vocational education skills training (TVET), numeracy and literacy training, and spaces for dialogue and interactions. Additionally, provide internet services, psychological support, career consultations and meeting venues for youth groups (Interviews with the IPs and CO). While the youth centres provided in-reach programmes, there were also outreach activities conducted to target the youth and adolescents, where UNFPA used innovative art for social change to bring out the change on various issues targeting the youth and adolescents. The evaluation team, however established challenges among some of the youth beneficiaries' who were unable to work with the attained skills due to lack of capital to buy the required equipment to start their own businesses. It was also a great achievement of the Adolescent and Youth component for securing funding from European Union (EU) to support business start-ups by the youth. UNFPA also invested in strengthen SRH Youth Champions to facilitate in the awareness creations on FGM, FP and other advocacy services in the centre. Youth participant's engaged during the FGDs session stated that the services at the centres were instrumental in targeting marginalized and vulnerable youth IDPs without access to formal education due to displacement. The facility created avenues for social interactions, information sharing and political dialogue. At the time of CPE, a total of 1400 youth benefitted from various life skills training that included Tailoring, Beautification/Salon, Computer science, traditional artefacts and catering. The training initiatives were provided for a period between three to six months and the graduated students were issued certificates of competence, presided over by the Ministry of Sports and Youth. Discussions with previous youth graduates reported that they had received mentorship through the UNFPA support, which enabled them to strengthen their life skills in going about their daily life confidently and some were able to start their own business, while others sought employment in the informal sectors. In addition to the life skills training, the participants were also sensitized on gender-sensitive messages. Young women were particularly targeted with awareness messages on harmful cultural practices such as early marriages, FGM and GBV. Young women specific life skills training such as Beatification, cooking and traditional artefacts design. UNFPA also supported vulnerable girls, particularly in the IDP settlements and hard-to-reach locations with menstrual hygiene supplies including reusable sanitary pads, protecting their dignity. It is worth noting that UNFPA piloted menstrual hygiene programming targeting girls from the marginalized populations and IDPs. This enhanced and uplifted the dignity of the girls, in addition to protecting them from infections during their menstruation period.

Youth Strategy and Policy Development

In the period of coverage, UNFPA financially and technically supported the development of the UN Somalia Youth Strategy and National Youth Policy, in close collaboration with the youth line ministries and were enacted as guiding documents in the country on youth activities. The development of the National Youth policy is a milestone in the country providing a framework for a roadmap for meaningful targeting of youth on state building and empowerment. The policy was widely disseminated for use and laying the foundation for youth targeting, especially on issues particularly addressing youth issues, and adapted for use during the youth programme design and planning. Further, UNFPA supported integration of ASRH in the National Youth Strategy as well as in the humanitarian strategy. The strategy provides a basis for resource mobilization by the Ministry of Youth and Sports to exhaustively address the needs of the youth in the country. A Roadmap to Youth Engagement was also published in coordination with the UN Habitat and Ministry of Youth and Sports to highlight evidence-based peacebuilding needs of the youth, particularly in the urban settings. The document provides a detailed analysis on youth priority areas, involvement in political inclusions and leadership development.

Through the 3rd CP, UNFPA contributed to the development of the current Somaliland NDP through support on writing up the youth component of the plan. Expertise service was engaged to help the Ministry of National Planning and Development, in documenting the needs of the youth as well as

formulating possible measures of intervention to address the challenges they face. This is in addition to capacitating youth peer networks members on youth education curriculums that specifies minimum standard requirements for youth engagements.

There were reported aspects of coordination gaps, which required redress among implementing partners. In one of the sessions in Somaliland, a key informant from one of the youth IPs, as at times they would have clashing schedules in some of the geographical locations, targeting similar beneficiaries with the same activities of awareness raising on FGM and HIV&AIDS among young adults in schools and universities. The local organizations who are implementing HIV&AIDS related activities were also established to have limited coordination link with National AIDS commission which is the coordinating agency in the country to provide guidance and support in implementing of HIV&AIDS related programme.

4.3.3 Gender Equality and Women Empowerment

Summary of Findings

UNFPA contributed to strengthening policy, legal, and accountability frameworks, transformation of attitudes, values, norms that perpetuate GBV, FGM, and, child marriage, and provision of services to GBV survivors promoting reproductive rights and women's empowerment. UNFPA also enhanced synergies and leveraging of resources, partnerships for prevention and response to GBV in the country through technically and financially supporting GBV sub-cluster coordinating meetings. UNFPA also led Gender Technical Working Group (GTG) enhancing gender mainstreaming across the UN agencies; in addition to supporting GBV Information Management System (GBV IMS) for evidence-based programme, streamlining response. Inaccuracy of information on harmful practices, inadequate funding, absence of legislation, poor monitoring, and confusion on the mix of religion and cultural understanding inhibit GEWE.

The Gender equality and women empowerment (GEWE) component of the 3rd country programme was designed and implemented to strengthen the capacity of partners to provide services to survivors of gender-based violence, to prevent gender-based violence and harmful practices, and to promote reproductive rights and women's empowerment, including in humanitarian settings. The main government partners were: Ministry of Women and Human Rights Development FGS; Ministry of Employment, Social and Family Welfare, Somaliland; Ministry of Women's Development and Family Affairs Puntland and the Ministry of Justice, Religious Affairs and Rehabilitation.

The component had one outcome indicator and four indicators at the output level as illustrated in Table 4.3. UNFPA supported this component's implementation through technical capacity and systems strengthening of GBV prevention and response as well as its strategic and productive role as the national chair of the GBV sub-cluster. The strategies utilized to achieve the results are fourfold, namely: supporting the government policy and legislative reforms that aim to ensure accountability on human rights of marginalized group, gender equality, women's reproductive issues and gender based violence prevention and response; promoting advocacy efforts with government and national partners and community based organizations to develop enact and implement gender based violence related legal frameworks; supporting the continuous operations of family centres/one-stop centres which provide medical psychosocial, legal support and temporary shelters/safe homes to gender based violence survivors and promoting social norm and behaviour.

Achievements of Component Planned Results

The GEWE component was designed and implemented on the premise that when partners' capacity increases to provide services to survivors of gender-based violence, to prevent gender-based violence

and harmful practices, and to promote reproductive rights and women's empowerment, including in humanitarian settings; there will be advanced gender equality, women's and girls' empowerment.

From the Results framework table, the 3rd Country programme surpassed most of its targets. As the national chair of the GBV cluster UNFPA has contributed towards strengthened coordination and integration of GBV and FGM components across sectors and ministries. The coordination of actors has facilitated broad based consistent messaging around the protection of women's rights particularly GBV resulting in draft Sexual Offences and strengthened implementation capacities across the justice sector in Puntland, where the SOB was enacted in 2016. The leadership and coordination has also enabled different actors at different levels gain an appreciation and understanding that FGM/C is not based on religious beliefs and potential for abandonment emerging as seen in draft FGM laws and in an FGM Policy in Puntland. Through its systems strengthening of GBV prevention and response, UNFPA has stimulated healthy conversations around social norms and practices that hinder women's and girls' enjoyment of rights as well as set up mechanisms for GBV response. This is evidenced by a series of outputs during the CP which include: establishment of One Stop GBV Centres and Safe spaces; engagement with the religious leaders to champion the abandonment of FGM/C; engagement with Council of Ministers to review provisions of the draft Sexual Offences bill; convening of the first Somali Women Conference and launching the Women's Charter; development and implementation of GBV/IMS system; strengthening the referral pathway for GBV survivors through capacities for survivor centred approaches and regularly updated GBV Referral Directory. The component however had inadequate funding challenges, with some activities not being able to be accomplished. For example, UNFPA Somalia did not receive any funding from the joint global programme on FGM in 2018.

Table 4.3 M&E Framework for the Gender Equality and Women's Empowerment component of the 3rd CP

UNFPA strategic plan outcome: Gender equality, the empowerment of all women and girls, and reproductive rights are advanced in development and humanitarian settings				
Indicators	**Baseline**	**Targets**	**Progress**	**Comments**[117]
			2020 Q2	
Percentage of women aged 15–49 who think that a husband/partner is justified in hitting or beating his wife/partner under certain circumstances	*44%*	*20%*	36.3%	The recent SDHS 2020 results indicate that 36% of women believe that a husband is justified to beating his wife for at least one of the justified reasons (neglect of household duties, argues with husband, goes out without telling husband, wastes resources, neglects children and refuses to have sex with him). Further finding indicates that formal education contributes to lowering the percentage of women with attitudes that wife beating is justified.
Output 1: Increased capacity of partners to provide services to survivors of gender-based violence, to prevent gender-based violence and harmful practices, and to promote reproductive rights and women's empowerment, including in humanitarian settings.				
Number of communities supported by UNFPA that declare the abandonment of female genital mutilation	180	400	286	Data based on 2019 SIS. Abandonment of FGM/C in Somalia is still a challenge given the various socio-cultural factors, including perceived religious perspectives to the practice.

[117] Green implies that the target has been achieved; Yellow means the achievement in significant; Red means far from being achieved

Number of policies that aim to ensure accountability on human rights of marginalized groups, gender equality, women's reproductive rights issues and gender-based violence prevention and response	3	6	4	UNFPA engaged more on programme towards the roadmap and supported partners towards the development of policies and laws.
Number of religious leaders trained to advocate against gender-based violence and FGM/C	50	200	469	The set target was surpassed and was implemented in 2018 and 2019 as programmed.
Number of gender-based violence one stop centres with the capacity to provide medical and psychosocial support to survivors of gender-based violence	12	20	47	The programme registered great success- more than double their target for 2018 and 2019.

Supporting One-Stop Centres and Women and Girls Friendly Spaces

UNFPA in the 3rd CP, strengthened access to justice and services for GBV survivors, women and girls through establishment and equipment of one-stop centres and women and girls' friendly spaces respectively (Interviews and document review). The establishment and expansion of the One-Stop centres enabled GBV survivors to access multi-sectoral services including psychosocial support, legal aid, medical support, dignity kits support and referrals for services not available in the centres. in the period of reporting, UNFPA supported a total of 31 one-stop centres across Somalia (interviews with CO and IP staff and document reviews). UNFPA, with partners, endeavoured to strategically positioned the centres within health facilities to enable ease of access to related services. The introduction of the one-stop centres has made it easier for the most vulnerable including IDPs and marginalized GBV survivors to access integrated services including ensuring close follow-up until closure of cases. The centres work closely with the legal service providers, including the police, lawyers, medical practitioners and counsellors.

Interviews with partners indicated that before the one-stop centres, the survivors would give up along the way, therefore cases would not be concluded. In the period, UNFPA supported development of guidelines on the operation of the one-stop centres which ensured delivery of comprehensive services. UNICEF, in collaboration with UNFPA conducted a safety audit for the one-stop centres. In addition, UNICEF planned to develop a standard checklist for quality service delivery in the centres, in addition to conduct joint monitoring missions, but this got slowed down by COVID-19. Referrals were also made through the cluster level engagement for the survivors to access economic support from other agencies. Coordination within the cluster was reported by partners to have improved a lot ensuring that the survivors were able to get services effectively. UNFPA's support towards the development of GBV service directory is intended to strengthen and assure effective referrals. The directory is updated annually and distributed to members of the GBV working group as a mechanism for a sound comprehensive referral pathway for survivors of GBV (interviews and document review).

The women and girls' spaces' establishment and support enhanced safe integration and social support to women and girls facing stigma in their communities. The facilities offered broad-based services including skills training, trauma healing, psychosocial support, literacy and numeracy support, and referrals for

those requiring help on other services, where UNFPA also facilitates referral costs (Interviews with IPs). The skills training, particularly the tailoring services were given to GBV survivors and those at risk of GBV. While the safe spaces are meant for women and girls facing particular discrimination challenges, they are open to all women and girls in the localities, as they act as connection points for women and girls and they are able to discuss their issues openly and find support from one another. In addition, UNFPA supported the centres with trained people to provide psychosocial support (Interviews with CO and IPs staff). UNFPA also supported awareness creation among the community leaders and women focal points in the localities to facilitate reintegration of the GBV survivors, addressing issues of stigma in their localities. (Interviews with IPs).

Co-leadership and chairing of GBV cluster and coordination in Somalia

Interviews and document reviews indicated that the GBV sub-cluster under the Somalia Protection cluster, coordinating meetings, with technical and financial support by UNFPA were regularly held with key issues discussed, informing programme in the various areas of responsibility. The meetings enabled partners to discuss progress achieved in GBV in the country, with challenges and action points documented for follow ups made in the subsequent meetings. The coordination mechanisms also enable leveraging resources and partnerships to ensure that areas of gaps were prioritized for response by the partners. Resource allocation was also ensured, maximizing achievement with the available resources and eliminating duplication of effort among the actors addressing GBV (interviews with IPs and CO staff and document review). Interviews with partners and CO staff further confirmed that the GBV sub-cluster was found to be a useful synergetic platform for coordination of activities, learning from members' experiences, replicating approaches, and collaborating among partners, which is a potential for enhancing the humanitarian-development nexus. It also provided a platform for advocacy on key issues of priority, in addition to enhancing awareness of GBV as a human rights violation. The accompanying harmonized messages developed have empowered working group members to confidently cascade consistent and informed messages at different fora particularly amongst community members, traditional justice actors and the government (interviews with IPs and CO staff and document review). The sub-cluster coordination also formed a platform for capacity building on various aspects on GBV response and prevention, including reporting. UNFPA coordination role and oversight also made remarkable and visible the importance of integrating GBV response in humanitarian settings through provision of dignity kits at IDP settlement as well as GBV services (interviews). As part of the overall humanitarian cluster systems, the GBV sub-cluster operates at both national and sub-national level.

At the UN level, the role of UNFPA in leading the Gender Technical Working Group (GTG) was identified by UN agencies engaged during the CPE interviews. Through the joint efforts of GTG members, gender mainstreaming is strengthened across the UN agencies. During the same period, Somalia Gender Strategy was developed for the UNCT, with Annual Work plan for the GTG developed and implemented (Interviews).

GBV IMS: During the period, the country GBV stakeholders also depended on the UNFPA-managed GBV Information Management System (GBV IMS) for evidence-based programmes. The system provides a platform for updating members on the developments with regards to GBV response in the country, in addition, this role gives UNFPA an added value within its mandate and areas of concern, especially the violence and harmful practices, mainly FGM and child marriage (document review). Through the GBV sub-cluster platform, the members ensured that the cases were appropriately handled, including referrals for support services (Document review and interviews with IPs and CO staff). UNFPA has two full-time specialised staff charged with maintaining the GBVIMS, generating information on case management data, as well as the survivors' harmful practices and fistula issues. UNFPA also facilitated development of guidelines on information sharing with clear protocols, enhancing confidentiality mechanisms in the data

shared, including survivor data protection. This has also led to harmonization of GBV data in the country, where all partners contribute to reporting cases. This has also streamlined response, with no duplication of support (Interviews). While GBV IMS has contributed immensely to the GBV data in the country, it cannot be taken as a perfect representation of the national data. There are however still challenges with GBV data generation in the country, with the existence of other IMS managed by other agencies, collecting different data. Agencies are also limited to data on the areas they are covering. Currently, on 49 organizations are reporting to the IMS against those reporting to the 5W Matrix report (Interviews with CO).

Female Genital Mutilation / Circumcision and Other harmful practices

UNFPA ensured an integrated approach to addressing the 3rd CP's contributions to FGM/C interventions. The intervention themes were cross-cutting in the SRHR and Adolescent and Youth component, where SRHR addressed advocacy issues on the anti-medicalization of FGM, while the adolescent and youth component enhances sensitization among the harmful practices aimed at abandonment of the vice. In addition, the interventions were also supported through the UNFPA-UNICEF Joint Programme (Document review and interviews).

The 3rd CP continued to support advocacy campaigns aimed at supporting mechanisms towards abandonment of FGM/C as well as strengthening legislations towards zero tolerance to FGM/C (document review and interviews with IPs and staff). The main challenges identified as the main drivers to the FGM/C practice in the country include absence of accurate information on the extent of FGM, poor monitoring of the FGM/C, confusion on the understanding of what FGM/C is in Somalia, as there are some beliefs that it is 'Pharaonic' type (infibulation), while 'Sunna' is believed to be sanctioned by Islam (Document reviews and Interviews with IPs and CO staff). While the Constitution protects human dignity and equality, in addition to expressly prohibiting circumcision of girls describing it as cruel and degrading practice, confusion still reigns on the meaning, especially along tradition and religious beliefs. UNFPA, together with partners and UNICEF continued to tackle the vice through strengthening legislation on FGM, enhancing engagement of the custodians of religious and cultural beliefs, community level engagement, including the traditional circumcisers and the policy level engagement. The UNFPA-UNICEF joint programme continued to work together in engaging various rights holders and duty bearers while engaging communities, developed communications strategies, provided protection and support services for women and girls affected by FGM and other harmful practices and trained and engaged religious leaders' in the country.

The GEWE component, learning from different experiences on the progress made in the country and SHDS data, focused on engaging the religious leaders, engaged champions at the community level and involving the adolescent and youth, efforts aimed at increasing public declarations on the abandonment of FGM/C practice in the country (Interviews and document review). UNFPA engaged the religious and community leaders with indigenous platforms as champions of abandonment of FGM/C through training and enhanced community dialogue sessions, while sensitizing the masses. In the period of coverage, a total of 286 communities, with support from UNFPA and partners made public declarations on the abandonment of female genital mutilation / circumcision (document review). By the time of the CPE, the targets had not been achieved, though the data available was up to 2019 Annual report. Further, UNFPA supported implementation of strategies promoting inclusion and participation of vulnerable girls in dialogues and education sessions on changing discriminatory gender norms, especially in relation to abandonment of FGM/C and participation in discourses on implementing their reproductive rights (Interviews and document review). The SHDS indicated that the prevalence of FGM/C among the Somali

community is 99.8%, though varied in different parts of the country. This implies that FGM/C is deeply-rooted in the culture, with a religious having a lot of influence on the practice, in addition to identified increase in medicalization of FGM/C. Multi-stakeholder approach needs to be put in place, with more emphasis placed on religious leaders as partners and champions for the abandonment of FGM/C, gender equality and elimination of child marriage.

Strengthening legal and policy Framework

Progress was made during the period on legislation and policy framework development with a number of bills initiated and task forces established for enhanced advocacy under the leadership of UNFPA. UNFPA, with technical and financial support contributed drafting of the Sexual Offenses Bill (SOB) which was approved by the Federal cabinet in 2019, but pending Parliamentary debate as there are perceived controversies on it surrounding the marriageable age and it is perceived to be in conflict with the culture and traditions. The FGS approved the Human Rights Commission into Law and is expected to promote and support implementation of human rights of persons, including FGM/C and harmful practices like child marriage. In the same period, UNFPA supported the drafting of the Zero tolerance FGM Bill 2019, which are still pending in both FGS and Puntland. If enacted, they would prohibit FGM/C in the two locations. UNFPA also facilitated the development of the draft FGM anti-medicalization law, while at the same time established a taskforce to spearhead its implementation UNFPA and partners also engaged healthcare workers on sensitising them on compete abandonment of the practice (interviews and document review).

While progress has been made, especially by Puntland, towards ending FGM/C, a mixture of civil law, Islamic law (fatwa) and customary law (Xeer) hampers implementation, in addition to unavailability of implementation plan, and pending parliamentary legislation in Somalia that expressly criminalises and punishes the practice of FGM[118]. Through the joint UNICEF/UNFPA interventions with religious leaders support to end FGM/C there is emerging optimism that both policies, laws and the practice of FGM/C will be in place (Interviews with IPs and CO). UNFPA was however successful in bringing on board more women organization to advance the advocacy and have managed to get support of various religious leaders towards ensuring Zero tolerance to FGM/C. In Somaliland, for example, UNFPA successfully engaged the religious leaders to defeat the perceived Islamic 'fatwa' on FGM. The skills building of cohort of women leaders as champions to enable them influence shifting in beliefs at community levels and act as change agents has enabled momentum in having declarations on the abandonment of FGM/C. At community level, investments in community dialogues continues to shape and influence positive changes around women's autonomy and importance of respect for their human rights. With the difference in development levels of the FMS, it will still be a challenge implementing the policies of laws after enactment. Further, there is need for harmonization of key government institutions, especially on coordination among the policy drivers in the country at inter-ministry and government levels for enhanced coordination as it has been achieved by the population dynamics.

Towards advocacy to develop the legislative framework in the country, UNFPA through the GBV Sub-cluster leadership, was actively in drafting the Sexual Offences Bill and the eventual approval by the council of the Federal cabinet. A staff commission was created through the GBV sub cluster to enhance engagement of the government and other CSOs in enacting the bill. When the content of the bill was changed, in addition to changing its title, UNFPA together with like-minded stakeholders, continued with the advocacy to engage on the strategies to influence this decision. A meeting bringing together UNDP, UNFPA, UNICEF, US Embassyand UN Women ensured a common view on the Bill after analysing it, culminated into a high level statement from the Special Representative of UN Secretary-General (SRSG)

[118] https://www.28toomany.org/static/media/uploads/Law%20Reports/somalia_law_report_(july_2018).pdf

to add voice to the advocacy mechanisms to have the Parliament engage on the Bill. The efforts have gained momentum and has attracted various stakeholders and has become critical, with more voices being raised for the need to discuss the Bill (Interviews with IPs and other stakeholders).

Advocacy and Community awareness raising campaigns

UNFPA continued strengthening its mission's global commitment to realize zero violence and intensified advocacy and awareness raising campaigns among the Somali communities and other stakeholders on GBV issues, including the harmful practices, with noticeable awareness levels existing in the communities (Interviews and document review). UNFPA utilized various mechanisms to advance the campaigns based on evidence. To strengthen focus on community level engagement to address the consistently rigid cultural and religious norms that continue to hinder improvement in the social status of women and girls to facilitate participation and access to services. This was done through engagement of community and faith based leaders as well as the religious leaders and Imams in Somalia.

UNFPA, in collaboration with other gender stakeholders, collaborated to produce knowledge products to ensure common advocacy messages on FGM, Gender, GBV and other harmful practices. UNFPA, together with UN Women, contributed immensely to the development of the Somalia National Development Plan, ensuring that gender was mainstreamed across the thematic areas in the NDP. UNFPA was also successful in incorporating important themes into the National Humanitarian and Gender strategies, including the rights of women and adolescent girls, particularly reproductive rights (Interviews with IPs, CO and other stakeholders). In addition, UNFPA through on going seminars and workshops played a major coordinating role between the GBV sub-cluster and the related religious, women and justice ministries in the country to advocate against all the issues affecting women and girls, and vulnerable populations.

Somalia ratified for the first time the CEDAW charter and UNFPA supported its reporting instruments, including that of the ICPD (Interviews and document review). With the ratification of the CEDAW, it is hoped that the women and girls' social issues, including discrimination will be improved. While UNFPA supported strengthening of the integration of GBV survivors into health facility services, there is still a lot to be done to improve their access to justice and the system is still not strong. UNFPA also supported the elaboration of the gender aspects in reports through promoting sex disaggregation of interventions data and analysis (Interviews and document review). During the period, Somaliland Nursing and Midwifery Association (SLNMA), with support for UNFPA conducted sessions (2-day session) with the health professional associations – medical association, pharma, laboratory association and media on how to educate the society how to harmonize messages to ensure that there is consistency in messaging to accelerate the abandonment of FGM/C.

The 3rd UNFPA CP was successful in providing a comprehensive package on GBV that helped support the efforts of the implementing partners and the government. UNFPA supported advocacy efforts for GBV response and media campaigns; development of GBV resource and training materials, surveys, tools and guidelines; and capacity development of stakeholders; and healthcare workers. Further, UNFPA supported the IPs and NGOs to enhance sensitization on GBV service for IDPs and other vulnerable populations to prevent and manage GBV cases and referral mechanisms within the community (interviews).

UNFPA managed and supported at the national level the 16 days of activism on GBV, in addition to supporting commemoration of International Women's day, where a common statement was made among

the UN agencies via different communication platforms, enhancing consolidation of advocacy mechanisms in the country. Through the engagement of the media in GBV prevention, UNFPA succeeded in raising the visibility of the issue of GBV as a human rights violation in the country (Interviews and document review)

Capacity Strengthening and Technical assistance

UNFPA strengthened the capacities of various stakeholders in the area of GBV prevention and response, enhancing their abilities to effectively respond. The 3rd CP GEWE component supported training to the 16 GBV sub-cluster hubs operating in Somalia. This has contributed to enhanced skills on case management ensuring adoption of a survivor-centred approach and improvement in community perceptions around rights violations including GBV and FGM particularly in IDP camps. The skills building around GBVIMS was found to be extremely useful as it ensures that data on GBV is collected and used to quantify the extent of the issue, thus amplifying it and informing interventions. UNFPA supported psychosocial support to the GBV response so as to train on management of survivors as well as development of a manual to guide these services. The training curriculum was harmonised during the period ensuring uniform information and skills provision in the country. The national ministries were supported and mentored to conduct training activities for community members, and monitoring implementation, especially in underserved remote areas. In addition, healthcare workers and humanitarian workers were also trained on GBV assistance and were involved in awareness campaigns (Interviews with IPs and Document review).

The training of traditional elders has enabled them to become aware of the criminal nature of sexual offences and imminent psychological harm. In this way the programme interventions are tackling the traditional justice systems (that is often skewed against survivors) and demonstrating the lack of jurisdiction of customary courts with respect to these offences. This has facilitated increased reporting of rape, as well as criminal conviction of perpetrators (Interviews and document review).

UNFPA continued to support the forensic laboratory bureau in Garowe, through contributing to its running, in addition to other state and donor funds. The bureau has enhanced evidence-based GBV response, especially in enhancing providing forensic evidence for prosecution of rape perpetrators through provision of data. The forensic laboratory bureau is managed by the MoH, department of community health services. UNFPA also contributed to training of the staff in the bureau (interviews with CO and IP staff). UNFPA and UN Women are in discussion to roll out the same in South-West State. This investment is critical in closing the loop of communication that often arises between law enforcement and justice systems, forensic analysts and medical personnel thereby laying the ground for effective forensic processes. UNFPA also succeeded in enhancing coordination between the police and other law enforcers (including prosecutors) in Puntland through training on forensic investigations - what has to be done at the scene of the crime and the ensuing forensic science work in the follow-up, data management, including protecting the consent of the survivors and processing of cases to address the initial. This was done with a view to strengthen the implementation of the Sexual Offences Act 2016. Development of a training curriculum for gender-responsive investigative skills was also accomplished by UNFPA.

4.3.4 Population Dynamics

Summary of Findings

UNFPA contributed to strengthening evidence-based planning and development through successful financial and technical facilitation of the mobile technology–enabled Somali Health and Demographic Survey, in addition to strengthening capacities of national statistics units towards design and implementation of surveys, generation, analysis and dissemination of data on SRH, adolescents and youth, gender and population dynamics enabling mapping of inequalities and inform development and humanitarian crisis related interventions. The SHDS report enabled, for the first time in Somalia, real-time planning, policy formulation and programmes as well as generation of key indicators for monitoring the localized Sustainable Development Goals (SDGs), International Conference on Population and Development (ICPD) goals, National Development Plans (NDPs) and other strategic development frameworks for the Somali Authorities. There is still need for institutionalizing production of data and strengthening dissemination and use of data.

The Population dynamics component of the 3rd Country Programme was designed and implemented to strengthen the capacity of the Somali statistical system at the Federal and State levels to generate, disseminate, and analyse quality statistical information. The main government partners in the component's implantation included; Federal Ministry of Planning, Investment and Economic Development (MoPIED); Puntland Ministry of Planning and International Cooperation (MoPIC); Somaliland Ministry of National Planning and Development. The component only had one outcome indicator and two indicators at output level as indicated in Figure 4.4. UNFPA facilitated implementation of this component through technical and financial support. The strategies mainly used towards achieving the results of the component included a) providing technical support for the development of tools, manuals and guidelines for the generation of population data to inform policy and programmes, including through South-South cooperation; b) providing capacity development of national institutions to enhance tracking of the Sustainable Development Goals and national and state development plans; and c) promoting the use of evidence for decision-making to improve public accountability.

Achievements of Planned Component Results

From the results framework table below, the 3rd CP exceeded the achievement of the targets. Through the technical support of UNFPA, the Country produced the Somali Health and Demographic Survey (SHDS) National report, published and launched in April 2020. The report provides real-time data for planning, policy formulation and programmes as well as generation of in-depth analysis reports with disaggregated data on SRH, adolescents and youth, gender and population dynamics. In addition, the report generates key indicators for monitoring the localized Sustainable Development Goals (SDGs) through establishment of baselines, International Conference on Population and Development (ICPD) goals, National Development Plans (NDPs) and Health Sector Strategic Plans (HSSPs) for the Somali Authorities[119]. The fertility and mortality data was utilised by the Independent Panel of Experts (IPE) to adjust and project the population estimates for Somalia to be used for planning and humanitarian interventions. The Somalia government statistical departments (FGS, Puntland and Somaliland) had their capacities strengthened through the UNFPA technical and financial support, to analyse and use disaggregated data to inform plans, policies, and programmes in their respective areas of geographical coverage. In addition, the reports produced for the FGS and Somaliland used to report the development of the Addis Ababa Declaration on Population and Development (AADPD), identifying gaps and challenges and possible advocacy and policy changes required in order to achieve national development

[119] Documentary reviews and interviews with IPs and CO staff.

objectives and priorities, as outlined in the national development plans. All the set output targets have fully been achieved at the time of the CPE, with some additional important achievements in collection of nomadic data which is not usually included in the surveys, and coming up with maternal mortality survey data, which was not stated in the CPD.

Table 4.4 Results Framework for the Population Dynamics component of the 3rd CP

UNFPA strategic plan outcome: Everyone, everywhere, is counted, and accounted for, in the pursuit of sustainable development				
Indicators	**Baseline**	**Target**	**Achievement Q2 2020**	**Progress against targets**
Existence of collected, analysed and disseminated a national household survey that allows for the estimation of key population and reproductive health indicators (in the last 5 years)	0	1	1	The SHDS National report has been published and launched jointly by the Ministries of Planning and Health FGS and UNFPA.
Output 1: Strengthened national capacity for production, dissemination, and use of high-quality disaggregated data on population, development, and sexual and reproductive health issues that allows for mapping of demographic disparities and socio-economic inequalities, and for programmes in humanitarian settings.				
Number of government statistical departments that have the capacity to analyse and use disaggregated data for mapping of demographic disparities and socioeconomic inequalities	0	3	3	Target achieved by June 2020
Number of population situation analysis reports undertaken by national government to identify priorities and formulate policies and programmes	0	3	2	Target not achieved as at June 2020

Strengthened Capacity for Production and Dissemination of Data in Somalia

There is evidence from documentary reviews and interviews with IPs and CO Staff that the population dynamics component of the 3rd CP supported national efforts in collecting, analysing and disseminating population data in both development and humanitarian contexts. UNFPA worked closely with the Ministries of Planning and Health, in coordination with other stakeholders to address data needs. Successful facilitation and implementation of the national-led Somali Health and Demographic Survey was the major milestone in this component during the programme period of focus. At the beginning of the CP and at the request of the Somali authorities, the intention was to conduct a population-based census and household survey. To do this, the country team, led by UNFPA developed concept notes to assess the possibilities for conducting census as well as a national wide Demographic and Health Survey (DHS). This elicited the reality on the ground given the contextual challenges, in addition to unavailable statistical institutions and structures that could conduct facilitate implementation of a census. The conception of the DHS idea became an immediate feasible option for availing data in Somalia. As opposed to multiple indicator cluster survey (MICS) which had been implemented in the past in Somalia, DHS would yield more indicators for measuring the SDGs (interviews with CO staff), among other indicators to inform development and humanitarian response in the country.

The conception of the population dynamics component was guided by the need to strengthen the national capacities in the production of high quality data for use in decision-making[120]. The 3rd CP programme dynamics component built on the modes of engagement of partnership, coordination and advocacy to strengthen the statistics capacities within the country. In order to do this, UNFPA devised a mechanism through the SHDS, for the various Ministries of Planning and Health across the country for the first time, by providing them the opportunity to learn from the experiences of Demographic Health Survey (DHS) and build their capacities through the design and implementation processes. While DHS Programme facilitates collection and dissemination of accurate, nationally representative data on health and population in developing countries, interviews indicated that the context in Somalia was too fragmented to apply the methodology effectively[121]. UNFPA through the regional office, with the experience in Yemen and Syria which have similar contexts as Somalia, decided in consultation with the Somali governments and other stakeholders to conduct the SHDS, using a similar methodology as DHS. SHDS implementation also provided a roadmap for establishing, strengthening and putting structures in place for implementation of the population and housing census.

In order to bridge the existing statistical capacity gap in the country, UNFPA provided both external and internal technical expertise, and resources for capacity strengthening of the team to undertake all the processes involved in the survey, and generate reports for use in informing decisions in the country. Particularly, UNFPA led the coordination of the process through establishment of the Steering Committee (composed of the ministers and the Director Generals-DGs), Task Force (composed of the DGs, technical teams from the ministries and UNFPA), and Statistical Working Group (composed of the technical people from the government) for the SHDS. These ensured that there were consultations and coordination in the delivery of the activity.

To initiate the process, a project document was developed, with two sampling designs developed, one for a large scale Maternal Mortality survey (MMR) designed to be conducted alongside listing to help estimate Maternal Mortality Ratio (MMR); and a smaller sample for the Somali Health and Demographic Survey (SHDS). Due to the uniqueness of SHDS to the Somalia context, UNFPA ensured that the process was all-inclusive through the formation of a project committee which brought on board all the key stakeholders. In order to ensure understanding of the methodology and implementation process, UNFPA facilitated a visit to Kigali, Rwanda by the project committee, through the South-South Cooperation, so that they could learn from the Rwanda Statistics Institute which had just conducted a DHS. Based on the knowledge gained, the team was able to develop realistic timelines for the survey (Interviews with IPs and CO staff).

UNFPA ensured that the knowledge transfer on the survey methodology cascaded from the top to the lower level through training master trainers who trained trainers of trainees (ToTs), who then trained the respective enumerators and supervisors. The training process enabled testing of the data tools and translation of the tools into Somali language for clarity of purpose (Interviews with IPs and CO staff). At the lower level, the capacity of 299 female participants and 48 males, mostly nurses, midwives and doctors, was increased and strengthened in data collection and verification computer-assisted personal interviewing (CAPI)[122]. UNFPA provided technical and financial support, while at the same time ensuring that the tools required, guiding manuals, and questionnaires were in place, with systems well developed by the national statistics teams in readiness for SHDS implementation (Interviews with IPs and CO staff).

[120] Interviews indicated that the country did not have data to prioritize planning, the donors could not know the extent of accountability in the use of the resources granted in the country because there was no evidence to show it, and the various ministries could not tell their performance from their strategic implementation

[121] UNFPA reported approaching DHS Programme to implement the process in Somalia, but there were reported limitations in the context.

[122] Document review

To prepare the Somalia team for the digitization of the locations targeted in the sampling frame, UNFPA financed the training of selected technical team of four to be trained on geographical information system (GIS) and mapping at the Regional Centre for Mapping of Resources for Development (RCMRD), Nairobi. Kenya. This training enabled the ministry of planning staff to digitize locations, create boundaries for the districts[123], and subdividing enumeration areas for the SHDS in all the regions. Further, through the gained skills, geospatial techniques were applied in the estimation of the population of internally displaced persons, during the Baidoa IDP influx, floods in Beletweyne and cyclones in Sool and Sanaag.

To ensure standardization and quality assurance during implementation of the SHDS, UNFPA supported establishment of the three servers, each based in Garowe, Nairobi and the other in cloud for back-up and for monitoring field progress and making corrective measures. The United Kingdom's Department for International Development (DfID) conducted quality assurance through sampling of activities and enumerators on a quarterly or semi-annual basis through the Learning and Monitoring Programme - Somalia (LAMPS) to verify and validate the programme delivery of the activity for effectiveness. To further ensure that the methodology and report was meeting international quality standards, the report underwent validation and peer-reviews by UKONS, Statistics Sweden, Statistics Norway and Sampling experts, facilitated by the UNFPA. These processes ensured that the content of the report, including the methodology were valid and consistent with various international standards (Interviews with IP and CO staff and document review).

During the 3rd CP, UNFPA played a key role in developing the capacities of the national statistics team on data production, in-depth analysis and reporting. UNFPA supported the team to develop a sample frame, defining the units for the survey. Further, the teams gained knowledge on the use of high resolution satellite images to define the sample frame for all the 18 pre-war regions covering urban and rural strata of Somalia and these were also used by the national statistics teams to collect data from the locations (interviews with (IPs and CO Staff and documentary reviews). The same framework is the only one existing for use in the country by the donor community, international organizations and the Somali government. Interviews with the IPs confirmed that they gained the skills and were able to use the technology on their own. The national statistics teams also confirmed during interviews that their capacities were strengthened on configuration of the computer-assisted personal interview (CAPI) system, taking into consideration the data needs from the SHDS; and on programme skills on Android tablets using Census and Survey Processing System (CSPro).

On data analysis and production of reports, UNFPA facilitated training of 15 national statisticians and demographers on data analysis, data disaggregation, socio economic characteristics analysis, data tabulation and tables generation from SHDS data sets, database structuring along with related measures and indicators development and estimations. development of analysis plan, data cleaning, coding and manipulation, and report writing. The technical analysis skills gained and used were on Statistical Package for the Social Sciences (SPSS), Open Data Kit (ODK), Statistical Analysis System (SAS). UNFPA also facilitated development of federal state level reports. As per the 2020 second quarterly report, the analysis of data and report writing of the State Level reports for Puntland and Banadir was ongoing and at advanced stage, being written by the national statistics team with technical support from UNFPA.

[123] Since 1990, Somalia had witnessed creation of new districts, but there were no maps of them or demarcations, and in most times regions, also based on pre-war landmarks. In addition, there were no disaggregated data of the populations and GPS coordinates.

> "Unlike previous surveys that have been conducted in the country where services used to be outsourced using consultants, SHDS gave us the opportunity to lead, manipulate the data to get different parameters of interest to us and write the report. This has been a great breakthrough in the statistical system strengthening in the country" ~ **IP Key Informant.**

Evidence from interviews indicated that the various capacity building mechanisms for the Somalia statistics units have yielded different results across the country. In Somaliland, the statistics team have been able to conduct a perceptions survey as a result of training activities funded by the government. In Puntland, the team has conducted COVID-19 mapping survey and rapid assessments of flash floods to help humanitarian partners, where they designed CAPI, ODK, submitted, analysed and produced reports. The MoPIED staff also partnered, in the period of review, with the Ministry of Labour and Social Affairs (MoLSA) to conduct a Labour Force Survey, where they reviewed the methodology, including contextualizing the protocol to Somalia, training enumerators and supervisors on the tools, including ensuring quality assurance during the field work and reviewing the data analysis process. At the time of the CPE, the team was planning to conduct a Household Budget Survey in partnership with the World Bank and Swedish Government, where the Statistics Directorate was to directly implement it using the skills gained during the SHDS activity (Interviews with the IPs). Further, the teams were analysing and producing the state level SHDS reports, with UNFPA providing technical reviews (Interviews with IP and CO staff). This manifests the great capacity gained because of the UNFPA support during the 3rd CP. While UNFPA, through the 3rd CP, strengthened the capacities of the national statistics staff, there is high levels of turnover among the staff, who after gaining skills and expertise on data management, leave government positions to join the private sector or international NGOs. This threatens sustainability and strengthening of statistical systems.

Towards facilitating availability of data for monitoring and evaluation (M&E), planning and development formulation, the SHDS results, through UNFPA support has informed a lot of decisions in the country. Notable were the availability of data for planning, monitoring and reporting on SDG and ICPD PoA indicators. For the first time, Somalia prepared a report on the Addis Ababa Declaration on Population and Development (AADP)[124] with gaps, challenges and practical advocacy changes required in order to achieve the national development objective and priorities, incorporating human rights. The adjustment and projection of the population estimates for Somalia used for planning and humanitarian interventions done by an Independent Panel of Experts (IPE) chaired by the UNFPA Representative using the Fertility and Mortality data from the SHDS (Interviews with IP and CO staff, and documentary review). Other uses have been the change MMR from what had previously been estimated and remained unchanged over time at 732/100,000 live births, and is currently at 690/10,000 showing progress; Somalia got international recognition where they were invited, participate and presented papers in African Population Conferences in Uganda and South Africa on population monitoring using high resolution imagery, and this happened because they had data and understood the process (Interviews with IP and CO staff, and documentary review).

> "The production of SHDS has filled so many essential data gaps, in addition to providing latest information in the social sector. We can now determine where we are on development. It exceeded our expectations as everybody got something to use" – **Interview with IP in Somaliland.**

[124] The AADP was adopted by the African Union's (AU) Executive Council in 2014 to provide African-specific guidance on implementation and periodic review of the International Conference on Population and Development (ICPD) Programme of Action, harnessing a demographic dividend, advance human rights and meet sustainable development goals.

Towards strengthening institutions, UNFPA hired a short-term consultant to draft the Bill on establishment of a National Bureau of Statistics. To enhance advocacy and learning to influence decisions on the Bill. UNFPA and the FGS co-sponsored a familiarization tour for Parliamentary Committee on Planning to Rwanda, to learn from their experience on transition from a fragile context to establishment of law governing statistics (Interviews with IP and CO staff)[125]. This trip enabled the visiting team to refine the bill, and present it to the Parliament and Council of Ministers where it was passed and signed into law. Once established, the National Bureau of Statistics will enhance statistical systems, including production, dissemination, storage and use of data to inform development policies and planning in the country.

UNFPA enhanced technical assistance through payment of incentives for national consultants in the statistics offices across the country to provide technical support to the teams. These also contributed to capacity building and service delivery in the areas of deployment (Interviews with IP and CO staff).

To enhance evidence-based programme and incorporation of population dynamics into national development plans, UNFPA provided financial and technical support to the Somalia and Somaliland government to develop and structure the NDPs (interviews with CO and IP Staff). In Somaliland, for example, UNFPA supported in defining the baselines and targets based on the findings of the SHDS, paid for the consultant involved in the development, in addition to writing the health, gender and youth sections of the plan ensuring that they were results-based and incorporated the population dynamics in the country. On the other hand, both the plans ensured realistic targeting of the population segments, disaggregating indicators in the M&E framework by urban, rural and nomad, with different levels of planning targets for the various services, building on the gaps established in the SHDS (Interviews with IP and CO Staff and Document reviews). It is anticipated that the nomadic frame will enable the MoH to target children under 5, and women aged 15-49 in hard-to-reach areas (Document review). While there were a lot of gains made through production of the SHDS, there is need, however, for a consistent, clear tracking system on utilisation of the acquired knowledge and skills, and use of the data by planners at national and federal member states' levels.

The 3rd CP supported the Somali Authorities in commemoration of and participation in international and regional events including annual African Statistics Day, participation in the ICPD@25 conference held in Nairobi in 2019, and development of ICPD@25 and the Addis Ababa Declaration on Population and Development (AADPD reports for Somalia (Interviews with IP and CO Staff). Participation in the African Statistics days amplified the importance of statistics in policy formulation and development accountability, particularly to marginalized and vulnerable populations including girls and young people. The participation in the ICPD events raised the profile of Somalia in advocacy and integration of population dynamics in planning, incorporating gender and human rights in service delivery. In country, the ICPD events in Mogadishu and Garowe were used to advocate for empowerment of girls and young people in decision-making, including sharing key messages on how young people address their sexual rights, gender and elimination of harmful practices. The events also culminated into a high level of commitment by the Somali Federal Government President, who signed ICPD@25 commitments to reduce the overall maternal mortality rate across the country by 25% and achieve the 3 zero goals by 2030 (interviews with IP and CO staff and document reviews).

Towards progress on ICPD PoA, UNFPA facilitated and supported on development of the Youth Strategy incorporating the adolescents and youth access to quality SRH rights and participating in GBV prevention and response, and elimination of harmful practices like FGM and child marriages (Interviews with IP and

[125] The government sponsored the trip by the Parliamentarians through funding their trip costs for 10 days while UNFPA funded a further 5 days.

Co Staff). UNFPA, during the 3rd CP technically and financially supported the Statistics Working group to conduct their meetings on a quarterly basis, enhancing their engagement on strengthening evidence-based planning and policy development framework (Interviews with IP and Co Staff). The profile of the country on data production also improved through acceptance for presentation of two research papers on the SHDS sampling frame were accepted for presentation in the 8th African Population Conference on the use of geospatial techniques in predicting and monitoring population movement in Mogadishu, Somalia; and use of Geographic Information Systems (GIS) and remote sensing to build a sampling for household surveys in Somalia.

5.3.5 UNFPA's Contribution to the Somalia Humanitarian Response

UNFPA is recognized as a key partner for reproductive health in emergencies and assumed a coordination role during the period of coverage**.** The 3rd UNFPA Somalia Country Programme made considerable achievements in the humanitarian setting in the country using human rights-based approaches to enhance response. The contribution to humanitarian assistance was cited as a great contribution by the stakeholders interviewed during the CPE. By having an International Resilience Specialist along with a senior technical National Humanitarian Specialist, the UNFPA humanitarian programme is integrated into the each of the 3rd CP components of SRHR, Adolescent and Youth, GEWE and Population Dynamics, with contribution and targeting depending on the service. The Humanitarian Specialist coordinates the activities with the component leads to ensure that the response is effective. UNFPA actively enhanced coordination of the SRH and GBV interagency working groups, strengthened capacities of the national stakeholders and the UN agencies on humanitarian response, conducted outreaches and distributed supplies in the IDP settlements, emergency situation and hard-to-reach areas in the country (Document Review and Interviews with IPs and CO Staff).

UNFPA continued to support the BEmONC centres (previously the Maternity Waiting Homes) providing integrated SRH and GBV services in the IDP settlements to enhance access to comprehensive quality SRH and GBV prevention and response services by the IDPs, particularly women and girls, and with confidentiality. Further, UNFPA supported the FGS to establish an interagency SRH Coordinating body that meets on a regular basis to discuss SRH issues and service delivery on the humanitarian settings, in addition to reducing duplication, and enhancing coverage. In the period, UNFPA gave prominence for integrated SRH and GBV in emergencies through revision of the Minimum Initial Service Package (MISP) curriculum and trained of health service providers and manager on the same, in addition to supporting to the MISP focal points at national and sub-national levels ensuring quality assurance. In 2018, through UNFPA's advocacy efforts, the Somalia Humanitarian Response Plan (HRP) was revised to develop the capacity of partners to respond to new challenges, incorporating components of sexual and reproductive health and rights such as family planning, sexually transmitted infections (STIs) and HIV prevention, basic and comprehensive EmONC services and clinical management of rape (Document review and interviews with IPs and CO staff).

UNFPA contributed instrumentally during the emergency situations in Somalia through provision of service, data for response and provision of emergency services. In 2018 during the IDPs' Influx in Baidoa, flooding in Beletweyn, UNFPA used GIS technology combined with available population data and mapped and estimated those affected to support planning for response. During the current COVID-19 pandemic, UNFPA provides data updates to the humanitarian community including HCT to map out affected areas and indicators for monitoring and response, in addition to supporting the distribution of PPE and other protective measures to reduce the risk of spread of the vice to the vulnerable populations. On service delivery, UNFPA continues to support through emergency reproductive health kits, post-rape treatment kits, dignity kits and reproductive health supplies to the affected girls and women in IDP

settlements and marginalized locations (Document review and Interviews with IPs and CO staff). UNFPA, in collaboration with other UN agencies and the Ministry of Women Development and Family Affairs developed key messages on FGM and GBV linked with COVID-19 for broadcast using local radio stations to sensitize the locals on the pandemic, targeting women and girls with the schools closed and prone to many associated risks (Interviews with IPs, UN agencies and CO staff).

Through financing outreach activities, and in partnership with various IPs, UNFPA enhanced access to integrated SRH and GBV services by the IDPs, most affected during disasters or conflicts, those in hard-to reach areas and the nomadic populations. Due to the fluidity in service delivery, UNFPA ensures that the outreach services included ANC, Post-natal care and GBV cases were managed within the IDPs, with referrals done for the IDPs with complicated cases or needed further services. These were implemented based on the service mapping by stakeholders and response planning made for implementation (document reviews and interviews with IPs and CO staff). During the outreach activities, affected population were also sensitized on their rights to access SRH services and messages on FGM and GBV shared, increasing knowledge of vulnerable populations and enhancing their utilization of existing integrated service delivery points like BEmONC and one-stop centres. For example, a case in Afmadow where a woman died of labour complications and the citizens went to the media to demand for improved service delivery. During the period of evaluation, UNFPA strengthened the capacities of the government counterparts and CSOs in GBV area of responsibility and SRH in the humanitarian setting through training, GBV service quality assurance at the one-stop centres[126], advocacy on GBV, enhancing GBV IMS for assistance to survivors, and making available technical support in rapid needs assessment across the country (document review and Interviews with IPs, UN agencies and CO staff).

Towards strengthening humanitarian response in Somalia, UNFPA built capacities of the government agencies and the national counterparts on humanitarian preparedness and resilience building on a pilot basis to strengthen the humanitarian-development nexus in Somalia. In 2018, UNFPA hired a consultant who supported the FGS through the Ministry of Humanitarian Affairs and Disaster management to develop a National Humanitarian Strategy guiding humanitarian response in the country, in addition to enhancing preparedness and early warning mechanisms to the IDPs and vulnerable populations and respond to shocks. There is confirmed evidence of UNFPA Somalia hiring a Resilience Specialist who engaged stakeholders in training to strengthen resilience capacities of the humanitarian actors in the country (Document review and Interviews with IPs and CO staff). This is though yet to realize results as implementation, especially at the community levels, has been hampered by COVID-19. Interviews with IPs also indicated that UNFPA highly contributed to addressing coordination needs through the financial and technical support to the Country Humanitarian Forum (CHF) which meets on a quarterly basis brings all the UN agencies, national and International NGOs and other stakeholders, but currently curtailed by COVID-19. This has enabled effectiveness in planning for and consolidation of resources, response and mapping of service delivery to the marginalized and vulnerable populations including child and female-headed households, elderly, IDPs and those with disability. (Document review and IP and CO staff interview). UNFPA also increased potential for triggering early warning or early action through provision of data (Interviews with CO staff). It is however not clear to what extent this information was used to reduce disaster effects during the 3rd CP.

Involvement of young people in humanitarian settings, especially implementation of the Youth Compact, was not so pronounced in the 3rd CP interventions, but integrated in other SRH, GBV and youth activities,

[126] UNFPA ensured that the One-Stop centres provided Dignity kits to the survivors, psychosocial support, clinical management of rape (CMR), legal aid, and functional referral mechanism for services not available at the centres.

including youth involvement in peace-building. The National Youth Policy SRH, in addition to other deliberate cases to target the youth in IDP and marginalized populations. For example, the young IDPs, especially vulnerable women and girls were targeted and trained on life skills, including numeracy, literacy and vocational skills; and citizenship education and facilitated their coping mechanisms to the challenges of growing up in a post-conflict setting (Document reviews, Interviews with IPs and CO staff and FGD with beneficiaries), particularly; avoiding negative cultural practices; learning about their rights and responsibilities and the rights of others as citizens.

While UNFPA has made huge contributions to the humanitarian response in the country, in addition to immense contributions to the humanitarian-development nexus, there is still room for improvement in a number of ways to enhance changes. there is still a need for multi-stakeholder involvement in advocacy, especially for funding. Since there the current implementation thinking in Somalia is slowly shifting from humanitarian to development to enhance long-term results, UNFPA's advocacy would benefit more by joining the newly established Nexus WG, where the humanitarian partners and donors are currently meeting to make decisions and strategize. There is also need to think of some long-term engagement for durable solutions on IDPs access to SRH services.

4.3.6 Gender and Human rights-based approaches integration into the 3rd Country Programme

Integration of gender and human rights-based approaches into the implementation of the 3rd country programme is inherent, to a varied extent by component of the programme. There was a gender and human rights lens in the delivery of the programme. The programme design and implementation is generally founded on gender mainstreaming and rights-based approaches, especially in strengthening policy frameworks and engagement that enhance rights of the marginalized, vulnerable populations to express their rights in addition to non-discriminatory access to services, in addition to eradication of harmful practices. UNFPA ensured this through supporting needs assessments, training, conducting advocacy sessions with religious and community leaders, Islamic scholars, government and law enforcement agencies, enhancing targeting of the moralized and development of protocols and policies. Targeting criteria for the youth centre vocational skills training gave equal opportunities for GBV survivors, people living with disabilities, IDPs, among other vulnerable women and girls (Interviews with youth IPs). There was also no evidence of an assessment being carried out or a specific programme targeting people living with disabilities. The extent of effectiveness of the right-based approach and integration of gender is however inhibited by the context-related challenges that require further advocacy, with high level participation of rights holders.

During the 3rd CP, UNFPA supported revision of existing guidelines to incorporate human rights in delivery of services. The revision of the Family Planning guidelines (Birth Spacing) saw inclusion of a section on ensuring human rights in the provision of family planning counselling and services, with 298 health workers from over 68% health facilities in the country trained on integration of human rights approach to services, aimed at ensuring fulfilment of the rights of women and girls, and families to freely access quality FP and reproductive health services and information. Further, the costed Supply Chain Master Plan incorporated rights-based contraceptive delivery as per UNFPA/WHO implementation guide (document review and Interview with CO staff). In 2020, UNFPA technically and financially supported the review of Midwifery curriculum and integrated rights-based approach to maternity and reproductive health care in line with ICM/WHO midwifery education standards (Interviews with CO staff and document review).

UNFPA Gender Equality and Women's Empowerment (GEWE) component supported different advocacy mechanisms on the roadmap endorsement for policies and declarations that aim to ensure accountability on human rights of marginalized groups, gender equality, women's reproductive rights issues and gender-based violence prevention and response in Somalia. In 2018, for example, UNFPA supported training of religious and community leaders with indigenous platforms and mobilized a select section of them to conduct discussions on FGM abandonment, with the aim of advancing gender equality and reproductive rights within the context (Interviews with IPs and CO staff and document review). In 2019, UNFPA advocated for the implementation and enactment of sexual offences bills and zero tolerance FGM bills and policies by the government and CSOs, with the passing of the Sexual Offences Bill (SOB) draft by the cabinet of the Federal Government and being forwarded for debate and approval by the Parliament. There are however challenges of implementation of these results, especially lack of consensus of some key religious leaders on provisions around the age of marriage and FGM as a violation of the rights of women and girls; and inadequate political will of government at regional levels to enact and implement zero tolerance FGM bills. Misconceptions also exist among the communities and may take time to address (interviews with IPs and CO staff). Save for Puntland[127], the country has not developed comprehensive action plans to address core rights of women and girls (document review).

The 3rd CP also supported implementation of strategies that addressed marginalization and discrimination based on social and harmful practices in the country, including the needs of people living with disabilities. UNFPA made deliberate efforts through partnerships with stakeholders to reach the hard-to-reach locations, in addition to supporting inclusion and participation of adolescents, youth, IDPs, vulnerable women and girls in access to services, dialogues and education sessions aimed at changing discriminatory gender norms, especially in relation to abandonment of FGM and participation in discourses on implementing their reproductive rights. There were also support for training IPs on gender issues, establishment of women and girls' safe spaces, early child marriage awareness (Interviews with IPs and CO staff and document review). UNFPA also partnered with Somali Women Journalists' Rights Association and Ifrah Foundation[128] and 2 FM radio talk shows on FGM and other harmful practices, to reach the masses, and with a local understanding (Document review).

UNFPA supported equal age and sex representation of the adolescents and youth to participate in the formulation and development of national policies. For example, Somali Youth Advisory Board (SYAB) consists of 50% males and 50% females to ensure the gender balance as well as that all target groups from different age groups are represented in the development process in Somalia (Interviews and document review). The beneficiaries of the UNFPA-UN-Habitat joint programme on youth had between 40% – 60% female beneficiaries including targeting (Interviews). There were however experiences of rigidity in some locations where men were preferred by the local administrators, like in the hiring of Somali Experts out of eight, only one was a woman. UNFPA enhanced participation of young men and women on governance and peacebuilding processes in Baidoa, Kismayo, Dollow and Mogadishu through establishment District Youth Councils, Youth Forum,inter generational dialogues Youth Voices in digital platforms (interviews with UN-Habitat and CO staff and document review).

UNFPA participated in dialogues sessions through SRH, GEWE, and adolescents and youth components on issues of human rights. In addition, UNFPA Somalia is part of RMNCAH regional and global strategy engaging on international human rights mechanism and focused on reporting and follow up to human rights mechanisms (document review).

[127] Puntland has developed an action plan for the implementation of the Sexual Offences legislations which is currently being implemented.

[128] Ifrah Foundation is a prominent advocacy entity in the UK and Somalia

Key populations were targeted during the 3rd CP, exhibiting focus on enhancing human rights approaches. During the period of consideration, the FGS enacted the National Disability Agency Act in 2018, aimed at protection and promotion of participation of people living with disability (PWDs) in development (interviews and document review). While conducting the SHDS, a module was included to give a profile on the prevalence of disability, with a Situation Analysis on the rights of persons with disability available. UNFPA also supported 450 marginalized adolescent girls from displaced population, those with disability and those orphaned, received both soft life skills education and livelihood skills on tailoring, henna and beauty, and culinary art courses, with the aim of building the resilience of vulnerable girls in the communities (Annual report). Further, UNFPA used advocacy mechanisms through social media platforms to amplify the voices of the youth and the need for youth inclusion in the political process, while giving consideration to young women and people with disabilities into the decision-making process. There was however no deliberate project targeting PWDs, in addition to any of the programme reports reporting the number of PWDs supported.

Review of programme reports revealed sex and age disaggregated data among the beneficiaries of the programme. The reporting tools (SIS) however do not give provision for disaggregating the data into age, sex or diversity, unless it is a component indicator. During the conduct of the SHDS, more women enumerators were hired to collect data from women of reproductive age and children under-5 years. UNFPA also contributed to production of facts and figures disaggregated by sex and capture gender issues (CO staff Interview) which are key in identifying gender and human-rights related needs for interventions.

During the 3rd CP, UNFPA technically and financially supported the Somali authorities in the development of ICPD@25 report, including advocating on advancement of human rights on issues such as elimination of child marriage, abandonment of FGM/C, access to and individual choices on family planning services and reproductive health. The ICPD events culminating into the participation of the authorities in the ICPD Nairobi Summit let to the commitment of the country into the ICPD PoA, which is central to advancing rights-based approaches to services (interviews with CO staff and document review). In addition, UNFPA supported vulnerable women in the humanitarian settings and GBV survivors with dignity kits (Interviews with IPs and CO staff).

4.4 Efficiency

EQ 6: To what extent has UNFPA used available financial and human resources, its technical expertise, as well as funding, operations and commodity supply systems, mechanisms and policies in an adequate manner to achieve the intended results of its Country Programme in the most efficient way?

Summary of Findings

UNFPA efficiently utilized its human, financial, logistics and technical resources at the CO level to achieve the desired and intended results. The CO has skilled and technical staff in all the programme and operation areas, and in addition to clear and robust internal systems. There were however notable staff gaps in GEWE and M&E where there were inadequacies, leading to overstretching in the existing teams. UNFPA has presence in Somalia, in addition to field offices able to support programme implementation processes and effectively support the IPs. The CO surpassed the indicative resources mobilized for the 3rd CP by over 64%. UNFPA partnership and technical assistance approach enabled coverage for the areas of need and strengthening capacities of implementing partners, and government. Training and provision of guidelines and operating manuals enabled compliance and enhanced quality of achievements. The integration approach to implementation of the CP component themes enabled achievement of the planned results in the CP for implementation, despite funding gaps and inadequacy of staff. There were marked delays in the disbursements of funds to the CO which also affected implementation activities by the implementing partners. The CP had a robust monitoring and evaluation systems enhancing quality and compliance in the planning, implementation, monitoring and evaluation activities. Limitations included; high turnover among partner staff, especially the government, inadequate capacity and commitment of the government in monitoring and weaknesses in design of the CP in results areas.

4.4.1 Human Resources and Operations Management

UNFPA made good use of financial and human resources to deliver the programme. UNFPA Somalia had five offices, with three being fully operational offices (Mogadishu, Hargeisa and Garowe) with staff covering both programme and operational decisions, while two other offices in Baidoa and Nairobi. Nairobi has the M&E Specialist and Communications Specialist with frequent visits to the field support programmes; while in Baidoa office is meant for liaison with the South-West State partner ministries and implementing partners in the locations. Unlike during the 2nd Country Programme, the UNFPA Somalia Mission transitioned from Nairobi to Mogadishu in 2019. This has made it easier for the mission to discharge its operations effectively, saving time, enhancing quality of supervision and support to national staff, reinforcing presence in the country and politically became more credible earning political goodwill from the country leadership. Further, engagement with the implementing partners, especially those in the southern part of Somalia, has become easier and they are able to meet face-to-face in addition to improved close supervision, unlike before when meetings would be organized including the logistics involved in panning wasting a lot of time (Document review and Interviews with IPs and CO staff). Interviews with the CO staff indicated that the CP had skilled staff in their areas of expertise facilitating delivery of programme and operational functions. The skill sets were generally relevant to the implementation framework, including the partnership arrangement.

The UNFPA sub-offices in Hargeisa and Garowe in Somaliland and Puntland, respectively, and the liaison office in Baidoa were reported by IPs to be very instrumental in improving efficiency in programme delivery. These also enable close working with the government authorities including coordination of the activities with the IPs in the various locations. The staff in the locations also contributed immensely to the identification of priorities for the 3rd CP, including implementation. They also facilitated improved level of liaison between IPs and the Mogadishu office, in addition to being locally recruited staff (CO and IPs interviews). While these improvements in the office typology worked and favoured implementation of the CP interventions, the federal system of governance is taking shape in Somalia, and the need to have presence in every state to enable liaison, as needs also vary by the states given the levels in development. The plan to have presence in four more FMS is welcome as these are where the humanitarian situation is severe to ensure that the work on the nexus is possible and will enhance

efficiency in delivery, in addition to strengthening working relationship and local coordination. (Interviews with CO and Partners).

IPs interviewed reported that UNFPA had the right capacities and skills set, and was passionate to deliver in their various roles, ensuring delivery of the CP interventions and support. All the component leads had had the relevant qualifications in their areas of delivery, with required technical skills and experience. The CO leadership, in addition to regional capacity was recognized as a facilitating factor for UNFPA performance in the mandate.

The field offices also had respective component staff to represent and coordinate related interventions in the locations. There were however notable gaps in GEWE and M&E where there were inadequacies, leading to overstretching in the teams. In Somaliland, the GBV IMS specialist handles everything in the GEWE components, while in Puntland, the GEWE-handling staff is 'borrowed' from the SRH component. On the other hand, M&E did not have any staff in the field with the programme staff being made focal points, again stretching the staff in delivering on their assigned tasks (CO Interviews). There was however no occasion reported that there were areas not handled because staff were overstretched.

Interviews with the CO staff and document reviews indicated that the CO managed to mobilize resources more than the indicative budget for the programme by USD 20 million. This indicates the ability of the team to mobilize resources, with a level of reliability to the donors. While in the financial documents it shows that the programme was able to mobilize USD 20million more than the indicated amount, interviews with the CO confirmed that by the time of the CPE, the CO had only received about USD 7 million more, as the reflection was based on commitments of the donors, but had not been disbursed. With the additional funds, UNFPA was able to expand programmes interventions, especially in the SRHR component, including responding to emerging needs (Interviews with CO). It was however not possible from the interviews or records to show the specific achievements based on the extra amount. GEWE component and humanitarian response programme had a lot of budget insufficiencies, with GEWE having to cut down on some activities, impacting achievement of targets. Interviews with GEWE staff and document reviews indicated that in 2018, the component did not receive funds from the Joint Global Programme on FGM/C, in addition to missing on some promising project proposals, creating a gap in funding availability for service provision. Integration of activities covered the gaps, however, there is still need for more core resources to cover the arising gaps.

The flow of the funds to the CO kitty from donors was based on tranches, and this affected the level of planning for interventions. Interviews with both the CO and IP staff indicated that while the AWPs were based on yearly plans, UNFPA would disburse funds to IPs based on existing amounts at the beginning of the year and amend the AWP when they get more funds, and this worked to main the operations of the of the component activities. Interviews with IPs and CO staff acknowledged delays in funds transfer, leading to effects on some activities. There were however ways that the IPs worked through the delays to ensure that the interventions were implemented. UNFPA is a member of the Multi-Partner Trust Fund (MPTF), through which it received more funding. In this arrangement, all UN agencies in Somalia received funds from a pool of donors, with reporting also done by a team of agencies. Interviews with stakeholders revealed that this channel of funding is favourable since it does not earmark funding, enabling decision-making on channels of CP interventions, in addition to offering more transparency among donors and accountability among UN agencies. However, interviews also reported that it was too bureaucratic, leading to some delays. UNFPA also receives funds through UNDP, and this had its share of challenges, especially delays within the UNDP systems, which also delayed disbursements to the IPs. This was even worsened during COVID-19, where a lot of delays were experienced and some activities had to be rescheduled (CO Interviews). More engagement needs to be conducted to ensure hastened processes.

There was a high level of integration of programmes across the 3rd CP components and teamwork among the staff. This facilitated efficiency in delivering on various aspects of the programme. This also enhanced internal coordination of activities among the staff. This was manifested in the staff management mechanisms where some staff could handle the component activities, and effectively deliver in the area (CO interviews). IPs interviewed also reported that there was harmonized communication among UNFPA staff, with no conflicts or overlaps in the interventions implemented. It could also be seen that most of the IPs, save for the government ministries, handled more than one component interventions. This enhanced coverage and efficiency in delivery with little (IP and CO interviews). The frequency of CO team meetings was reported not to be regular, but there were confirmations that there were constant communications among the teams, in addition to frequent field visits by the component leads and the CO leadership (CO interviews). Feedback from the UN colleagues and other stakeholders indicated that UNFPA was able to protect, articulate and deliver in the areas of mandate (GBV and SRHR), in addition to a high level of implementation and covered Somalia well.

Interviews with CO staff revealed that UNFPA has good financial and administrative policies ensuring checks and balances in the internal controls, thereby minimizing risks. UNFPA has an online reporting system (both narrative and financial) that was used by the IPs to report on, minimising delays. IPs also confirmed that the systems were user-friendly. However, there were concerns of high turnover among partner staff, especially the government, prompting some delays in learning the processes (Interviews).

UNFPA also made some strategies that ensured achievements of results with less. The UNFPA-supported midwifery schools were strategically positioned in health facilities, providing clinical exposure to the students with technical supervision offered. In addition, locating one-stop centres in health facilities also enhanced access to nearly all the services to GBV survivors in one place SHDS undertaking had its efficient delivery through the strategy of using pre-war regional boundaries limited conflicts, ensured ownership by all the Somali communities and saved time in consultations or negotiations (Interviews with CO). The use of South-South Cooperation through the support of the Rwanda Institute of Statistics; mobilization of *pro-bono* technical expertise from WHO, UNICEF, UNDP, World Bank, peer reviewers (UKONS, Statistics Sweden and Statistics Norway); UNICEF also supported with weight measurement and tools; UNSOS support with the satellite imagery for use in developing the sample when UNFPA could not procure in time. There were also mechanisms put in place during implementation making the implementation of the activity more efficient i.e. development manuals, training, task forces and steering committees that ensured speedy redress of any challenges that emanated during the period (Interviews with CO and IP staff). Conducting ToT/ Master trainers for FP and SHDS also made it efficient in cascading the transfer of technical skills to deliver in their areas of focus. Enumerators used during the SHDS were employees of the government and were not paid, but only given stipends (Interviews with CO). Coordination also ensured leveraging of resources, facilitating wider reach of beneficiaries and maximizing use of resources through planning. Strengthening the capacities of the partners enabled delivery of efficient services. Provision of technical guidelines and SOPs to stakeholders also ensured harmonized and quality delivery (Interviews with CO).

Selection and capacity strengthening of the IPs

Selection of IPs was done in three different levels namely; Government (line ministries) where it was automatic to be selected; and NGOs had two different levels, either through open calls or direct negotiations. For open calls, which is done in a span of 3-4 years, UNFPA hired PricewaterhouseCoopers (PWC) to conduct the assessments and vet the NGOs and select based on laid down criteria. On the other hand, direct negotiations are dependent on the assessed capacity and the need in the support (CO interviews). Based on the comprehensive review from the assessments, recommendations are arrived at, and selection made (CO Interviews). UNFPA, conducted yearly audit, which also provided feedback on

the performance and compliance by the selected IP, minimising risks (CO Interviews). There was evidence of capacity building processes to the IPs in their areas of weakness, ensuring that they complied with the CP delivery processes, in addition to ensuring quality and efficient management processes. Guidelines were also provided to the IPs for compliance and guidance purposes, ensuring guided and quality delivery (IPs and CO interviews). Since UNFPA had no choice in selection of the government line ministries, with the low level of capacities in delivery, there were challenges ensuring that there was compliance. There were however reports of improvement in internal controls, that show improvement in capacity, for efficient delivery. UNFPA minimized risks in dealing with various internal capacities of the IPs. Most of the modes of engagement were based on advanced methods, others were based on reimbursement basis, while in other cases UNFPA would pay directly for particular activities. Further, a joint technical assessment for each partner was independently carried out by an external company through collaboration between UN agencies (UNDP, UNICEF and UNFPA), leading to reduced cost and time invested in the process and uncompromised decision. The assessment is risk-based and it focuses on internal controls, procurement, audits and financial systems. Low risk IPs received fewer spot checks whilst high risk IPs receive more spot checks minimising possibilities of risks in delivery processes (CO Interviews).

4.4.2 Partnership and Technical Assistance

UNFPA utilized partnerships and technical assistance to scale the impact of the country programme to achieve various results across the country (Interviews and document review). UNFPA 3rd CP was implemented through partnerships with various stakeholders ranging from development partners, international and local NGOs and government in the implementation of its programme, thus working both with duty-bearers in government and rights-holders in civil society in the country. The selection of partners was informed by various consultative processes and was found to be strategic and suitable for efficient implementation of the programme, evident by the high programme implementation rates (CO Interviews and reports). The partnership enabled the programme to reach the hard-to-reach and areas, targeting the vulnerable populations with much-needed services on SRHR, Adolescent and youth, and gender equality and women empowerment.

UNFPA fostered partnerships with national government ministries both at national and the federal state levels. The partnership approach between UNFPA and government was reported to have contributed to a lot of achievements of the programme milestones through consultations and joint planning mechanisms, in addition to ensuring national ownership of the programme interventions. Partnerships with the government also contributed to advancing advocacy mechanisms especially on development, ratification and implementation of various policy documents and guidelines (interviews and document review). UNFPA also played an important role in fostering coordination among government departments facilitating consolidation of resources and coordinated responses. For example, during implementation of the SHDS, UNFPA brought together Ministries of health and planning across the country, from national to the federal state level, where the ministries of health contributed in the technical health content of the questionnaires in addition to facilitating recruitment of enumerators who were health facility staff; while the ministries of planning contributed the technical aspects of the development and implementation of the interventions, facilitating efficiency in delivery of the activity (Interviews with IPs and CO staff and document review). Through implementation of an integrated approach to delivery of the various programme components, UNFPA ensured delivery of programme results with less through leveraged resources (CO Interviews).

UNFPA partnership with local institutions also facilitated efficient implementation of the 3rd CP interventions through providing local understanding of the contextual dynamics, including cultural

structures, enhancing local solutions to the various challenges. Local organizations also enhanced the reach of the UNFPA programmes to the marginalized communities, especially in the hard-to reach locations, facilitating access to services by the vulnerable populations, enhancing their rights (interviews and document review). Partnership with the local organizations also ensured acceptance from the communities targeted. These particularly played a role in the discussions on the elimination of harmful practices like FGM, Child marriage and discrimination of women and girls in access to services.

There was evidence on partner contributions in the delivery of CP interventions. For example, some of the SRH services were delivered in existing health facilities, therefore the CP only had to contribute to the operations or support staff stipends (Interviews with CO and IPs). In most occasions (as reported by the IPs and CO interviews), there existed cost-sharing arrangements, ensuring that UNFPA did not incur all the costs involved in delivering the CP services as the partners engaged had other sources of income from other donors. The partnership arrangement was also vital in resources utilization, UNFPA could have required massive financial capacity to implement the country programme directly as a result of its staff remuneration and allowances (Interviews with IP and CO staff).

Partnership mechanisms also brought with it capacity strengthening for the local organization and the communities, at large. UNFPA in its selection of the partners took into consideration experience and availability of technical expertise in the thematic areas of the programme. This facilitated ease of understanding on the thematic areas and ensured quality and timely delivery of the programme services, adhering to standards (Interviews and document reviews). There was evidence of flexibility in reporting to priorities deliberated and identified at the semi-annual and annual review sessions, with contributions of the partners based on their implementation experiences, ensuring relevance of the interventions supported by the CP (IP and CO interviews).

UNFPA's active role in coordination with partners ensured standardization of delivery of services. Through the RHWG, GBV sub-cluster, Fistula Steering Committee, anti-medicalization of FGM, CMR and MDSR taskforces, technical guidelines were developed from a multi-stakeholder contributions and disseminated through the coordination platforms facilitating a wider reach. (Document review and Interviews with IPs and CO staff). The coordination platforms also served as training grounds for partners, with participants sharing experiences and strengthening synergies (Interviews with partners and CO). Interviews with the CO and IP staff reported that the existing coordination mechanisms enabled sharing of harmonized advocacy messages, in addition to messages in the IEC materials, e.g. harmonized messages on birth spacing, COVID-19, FGM among others, ensuring a harmonized response and delivery of messages. UNFPA also made successful endeavours through coordinating activities with various stakeholders to ensure that legislative and policy frameworks were influenced and implemented by the duty bearers. In addition, the GBV cluster collaboration has also provided an opportunity to leverage GBV responsive humanitarian interventions in the IDP camps, through mainstreaming GBV across health, nutrition, food, shelter and WASH by introducing GBV mitigation measures (Interviews and Annual Reports). Greater focus was paid to enhancing the systems to prevent and protect women and girls against all forms of gender based violence using human rights perspectives, including in emergency and post conflict situations (Interviews). Partnerships in the GBV response enabled GBV survivors to access services in an effective manner through referrals, promoting reproductive health rights of women and girls (Interviews).

Through UNFPA support of inter-ministerial collaboration with the Ministry of Health, Women Ministries, Justice Ministries and Humanitarian affairs has also enabled the anchoring of sound mechanisms for quick, confidential and sensitive responses. This is evidenced by the development and implementation of clinical guidelines for the management of rape, integration of GBV within the protection clusters in humanitarian settings, emergence of more empowered and GBV sensitive law enforcement actors as well

as development and implementation of GBV IMS system as a sustainable mechanism for GBV data collection to amplify and inform interventions.

In the implementation of the SHDS, UNFPA partnered with Rwanda Institute of Statistics in a South-South Cooperation, and provided training to the Somali Statistics staff and government on the technical aspects of the survey, given their previous experience. I addition, partnerships were nurtured between UNFPA and various international institutions and experts, including UKONS, Statistics Sweden, Statistics Norway and Sampling experts to support in validating the methodology and report and ensuring that it met international quality standards through peer reviews (Interviews with IP and CO staff and document review).

There was evidence of UNFPA hiring technical experts to provide technical expertise, with some seconded to various ministries on a consultancy basis. For example, UNFPA hired consultants who helped develop the Somaliland NDP and development of Humanitarian Strategic Plan, among other guidelines and policies, and ensured that the documents or deliverables met high level expertise to serve their purpose and compliance (Interviews with government IPs and CO staff). Further, some national consultants were brought on board were seconded to various ministries to provide technical support to the ministries with clear ToRs, majorly based on on-job technical capacity building (Interviews).

Partnerships with other UN agencies were also used to strengthen programme delivery. Partnership with UN Habitat resulted in successful implementation of the peace-building project in Jubaland and South-West State as well as the development of a road map for youth engagement building on comparative advantages of each of the agencies. UNFPA also utilized partnership with UNICEF and WHO to develop SOPs for clinical management of rape and anti-medicalization of FGM Through partnership process UNFPA developed resilience framework for the ministry of humanitarian affairs and disaster management by engaging consultant to provide expertise services.

The partnership with midwifery schools fostered knowledge and skills enhancements, while at the same time contributing to the infrastructural development for the institutions, capacities enhancement during development and implementation of training modules ensuring compliance with quality, and producing skilled staff into the medical fraternity (interviews and document review). The arrangement also enabled the creation of employment opportunities for the various graduates and other cadre of people involved in the process.

Key training provided included Result based monitoring and evaluation, peer to peer engagements and report writing that greatly enhanced robust programme activities implementation within the required timelines and sufficiently reduced the amount of time spent on follow ups while ensuring the quality of services to the programme participants. KIIs with some of the implementing partners identified that partner capacity building were adequate during the start of the programme but dwindled from the year 2019, with some partners stating that they were not getting adequate training as they would have wanted to sufficiently deliver the implementation of the country programme.

Implementing partners from all outcome areas widely reported strong and effective technical assistance from the CO team (interviews with IP), with evaluation participants reporting that CO programme staff placed high priority on ensuring rapid feedback to request. They were also flexible to respond to changing requirements[129] and viewed as having an open door policy, which created easy communication and enhanced the partnership. Relationships between the players in the 3rd CP (IPs & CO) were noted to be effective, proficient, flexible and cooperative. IPs acknowledge the high technical competences of their

[129] KI interviews, Document Reviews

respective programme officers. Thus, the CO appeared to have an established competent staff to address the needs of the CP.

4.4.3 Monitoring and Evaluation

The third UNFPA Somalia Country Programme has been anchored on effective and varied processes for ensuring that the programme interventions are planned, implemented, monitored and reported upon, and appraised, capturing quality results in a timely manner. From the document review and interviews with both CO staff and IPs, UNFPA put in place mechanisms to ensure that the programme performance mechanisms were in place to inform decision-making.

At inception, the Country Programme developed a results and resources framework (RRF) to guide on the planning, implementation, monitoring and evaluation of the programme interventions. Developed in consultation with a wide range of stakeholders, the RRF reflects alignment with the UNFPA Global Strategic Plan, national development plan and UNSF result areas with clear resource allocations. It is imperative that M&E is an integral part of the CP management process (document review). UNFPA Somalia uses the global Strategic Information System (SIS) for planning, monitoring and reporting and was reported to be effective and efficient in ensuring tracking of CP performance and reporting progress towards the outcomes, outputs and indicators. The system is also easy to understand and follow by the various users involved (Interviews and document reviews). Evidence of monitoring and reporting done both at activity and output levels, and the milestones (progress on achievements) made used to inform planning processes (Interviews and document reviews).

The various monitoring and evaluation (M&E) mechanisms embedded in the programme as confirmed from the documentary reviews and interviews with staff and IPs can be categorised in four distinct phases, namely; planning, monitoring, reporting and evaluation. Table 4.5 below lists the M&E actions / activities during each phase and the respective frequencies of implementation during the CP period. The interviews further confirmed a fairly robust M&E system in place and ensured the programme was effectively managed and feedback used to support decision-making during the period of implementation (Interviews and document reviews).

Table 4.5 CP M&E activities and frequency of implementation130

M&E Activity per phase	Frequency of Implementation
Planning:	
● CPD and results and resources framework	● 2017 (for current CP) and 2020 (for next CP)
● Work Plan with IPs	● Annually
● M&E Planning for CP	● Annually
Monitoring:	
● CP review	● Annually
● CP progress reporting	● Quarterly (milestones) and Annually
● ASRO Review	● Quarterly
● Review with IPs	● Semi-annually
● Internal review of milestones	● Semi-annually
● IP Annual work plan monitoring	● Quarterly
● IP Progress narrative reports	● Quarterly
● IP Financial Reports (FACE forms)	● Quarterly
● Spot checks	● Routine

[130] Documentary review and KIIs

• IP Audits • Field monitoring by UNFPA staff • External audit of CO • Joint Monitoring of CP activities • Joint Audits (UNICEF in the first 2 years, and UNDP in the last year) • HQ-led audit	• Annually • Routine • After every 2-3 years • Routine, depending on the activity • Annually • Done in 2020
Reporting: • Country Office Annual Reports • IP AWP progress reports (both narrative and financial reports) • Donor reports • UNSF Progress Reports	 • Annually • Quarterly • Varied, depending on donor agreements (range from quarterly to annually) • Quarterly and Annually
Evaluation: • Country Programme Evaluation	 • Commissioned in the last year of the CP

The CP M&E functions are coordinated by a Monitoring and Evaluation Specialist based in Nairobi, and supported by focal points in the various field offices in Somalia. Before the recruitment of the M&E Specialist in June 2019, the functions were handled by the Deputy Country Representative, who is also the head of programmes. The presence of a dedicated specialist enabled streamlining of M&E functions in the CP management ensuring efficiency in delivery CP, including enhancing results-based management (RBM), including reporting through training, development of the CP monitoring and reporting plan, refocusing of the reporting on indicators rather than activities, and development of the CP theory of change (ToC) (Interviews and document reviews). All UNFPA CO staff, especially the programme teams, and the IPs were trained on RBM and this improved the tracking of the programme performance based on results (Interviews and document reviews).

The CP planning and monitoring processes contributed immensely to the efficiency in delivering the CP results. Interviews with both CO staff and IPs reported that the annual planning and semi-annual reviews with IPs enabled them to review the programme performance and prioritize areas with highest needs and based on evidence. It is also during these planning and review sessions that gaps are identified and prioritized in the subsequent AWPs, for example, SRH service gaps were identified in Baidoa Referral Hospital necessitated UNFPA to identify a partner in Save the Children and supported then to provide the services at the facility, a move that has made a big difference in access to quality maternal, child and neonatal health services in the facility by the local populations (Interview with CO). These ensured alignments of the AWPs with the CP M&E framework ensuring collective efforts on the CP performance in the targeted areas. Monitoring activities through reports and field visits also enabled the planning process effective in setting targets, and defining milestones to be achieved in a particular programme area. The tracking of activity progress through the GPS, enabled the performance measurement at output level as defined in the programme results framework. The GPS also served as the monitoring tool for the AWPs with the IPs, including budget (Interviews and document reviews).

As stated in Table 4.5, there were various reporting mechanisms within the CP, ensuring effective communication on the performance of the CP, based on the various achievements reported. Documentary reviews and interviews with IPs and CO staff revealed that the process within the programme were effectively facilitated through the SIS and GPS, and use of FACE forms for financial reporting. The IPs, during interview sessions, reported an effective system of reporting as it allowed them to focus on the planned activities as contained in the AWPs, with specific indicators, guiding effective

reporting on a quarterly basis, and based on the targets. Interviews with the CO staff also revealed that the reporting by the IPs was compliant with the UNFPA requirements, guided by the existing systems and tools provided by the CO. Interviews revealed an existing system of review of reports and eventual approvals of the IP reports the CO ensures that there is effectiveness in capturing evidence-based, quality and standardized reports. In addition, the programme staff conduct field visits to the IPs for quality assurance and support on the implementation processes. While there was reported efficiency in the reporting processes, the IPs' capacity still needs strengthening as the documentary reviews and interviews revealed some varied levels of quality, timeliness and capacity gaps among them. Some reports tended to focus more on activity achievements with generalized achievement rather than on the results from the actions, with UNFPA reports reflecting the same activity levels, limiting accountability and understanding of the level of achievement of results from the financial support (Interviews with a donor).

All the IPs reported being trained on the operation of the GPS and understood its operation, with no IP reporting having challenges with using it. Training on the use of the CP operations, including M&E tools was reported to be effective by the IPs. The CO however reported challenges of frequent staff changes in the ministries, especially those with responsibilities in the use of the tools, affecting the smooth operation of the CP. The CO however, put in place mechanisms to ensure that there were no gaps in the use of the CP planning, monitoring and reporting systems through targeted training. During field visits, the field staff also provided frequent on-the-job training to the IPs in any identified areas of weakness contributing to efficiency in delivering the CP (Co Interviews).

During the CP period, there was no evaluation conducted by the CO, save for the evaluation of the joint youth programme, implemented with and led by UN Habitat. There was also documentary evidence that the lessons learnt during the previous programme cycle were used to inform the development and implementation of the current programme. Further, documentary reviews, there was evidence of integration of age, gender, diversity and vulnerability status of the programme stakeholders, including beneficiaries. Population-based reports were disaggregated by age, sex and diversity of the stakeholder composition.

Despite the effectiveness in the M&E System, there were gaps in the design of the RRF, with some indicators being weak, lacking representation of the CP performance. For example, Outcome 2 indicator '*Percentage of young women and men aged 15-24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission (female/male)'* tended to limit measurement of the CP Adolescents and Youth component on increased knowledge and attitude change on HIV. While this may be part of the CP performance, in the Somalia context, HIV is not much of a concern, with current prevalence rate being at less than one percent. The CP made great achievements under the youth component, especially on increasing their participation in governance processes, increased access to ASRH and improved perceptions in GBV prevention and response, and reduction of harmful practices in the community. With the outcome indicator description, it limits the measurement contribution of the programme. Similarly, the GEWE component's results chain could have been well defined to ensure a more encompassing indicator at the outcome level. This was also the case in Some SRHR output, and PD outcome and output which assumed that the existence of statistical reports, plans and systems is enough to inform performance, but does not go beyond the existence to assess utilization and role in making a difference. Further, there were weaknesses inherent in the ToC, with the causal relationships and results not well defined across the intervention logic, limiting understanding on the expected changes and results due to the CP interventions.

From programme analysis and interviews, the capacity to deliver M&E functions in the programme appear limited and structurally inadequate. With only one international staff dedicated to M&E, there is possibility of overstretching in his oversight to the programme management and quality, and this may also limit the

scope of support provided. In addition, the staff is based in Nairobi, which may limit frequent interaction with the CP subjects, especially the IPs. While there were field staff supporting M&E functions, they were not dedicated M&E staff and are likely to perform the roles with little focus and commitment on priorities. For example, in Somaliland, the M&E focal point is the Youth Programme Associate, in Puntland, it is done by the SRH Specialist, while in Mogadishu the SRH Specialist supports. There is need for consideration of a dedicated M&E staff in each of the field offices dedicated for the responsibilities, with support from the specialist. Further, the interviews revealed varied levels of capacity among the programme team, and this may also limit the level of quality delivery of the CP. In addition, the M&E capacity among the IPs was noted to be weak during report reviews and interviews, in addition to some not having dedicated staff on M&E, and require improvement, especially the government. Generally, there is continuous need for strengthening of the IP capacities especially on reporting processes, including M&E tools in place to ensure their proficiency and efficiency in delivering the CP, in addition to quality of deliverables.

4.5 Sustainability

EQ 7: To what extent has UNFPA been able to support its partners and the beneficiaries in developing capacities and establishing mechanisms to ensure ownership and the durability of effects?

Summary of Findings

The 3rd CP implementation was through the support of government line ministries as both strategic and implementing partners. The activities were mainly implemented through government institutions, departments at national and regional state level and government agencies such National AIDS commission among others. The activities of the programme were majorly introduced through government consultations as key stakeholders in programme implementation. Interviews with staff from the various line ministries at national and regional state level stated that the programme directly contributed to the priorities of the country thereby giving them a comprehensive platform for delivering their own mandate as a government and as such gave them a strong sense of ownership for the programme. Through the 3rd CP, UNFPA utilized capacity building as one of it modes of engagement and strengthened the capacities of its national partners aimed at ensuring sustainability of the programme results. With strengthened capacity among the national stakeholders, the benefits realized from the programme should be sustained within the constraints.

4.5.1 National Ownership and Policy Framework

UNFPA, through the 3rd CP contributed to strengthening reproductive health commodities security strategy, logistics management information systems (LMIS) which is able to forecast supplies and quantification of consumption. The tools for reporting and forecasting are also in place and the MoH staff trained on their use. UNFPA provided technical support in the development of the system, in collaboration with UNICEF, but the process was led and owned by the government. On the other hand, the extent of implementation of this is limited and currently challenging as the means of transportation and distribution of the commodities is expensive and riddled with poor infrastructure and insecurity challenges. The government's ownership of the systems, in addition to not fully utilizing the LMIS tools, is also limited due to constrained resource base. Decentralization of the system at the regional level is also limited, and the most of the FMS still depend on Mogadishu to supply the commodities.

Interviews with MoH indicated that the government of Puntland had allocated budget to the operation of the Forensic bureau laboratory, in addition to having engaged other donors to support the facility. During the 3rd CP, UNFPA continued to support the country through training, to facilitate testing of the COVID-19, and recognized by the government as one of the centres providing results on the same. The use of the forensic results from the facility in conducting investigations by the justice system in the country to provide forensic evidence on GBV perpetrators was also reported during the interviews. This indicates ownership by the government and are likely to continue operating it even after UNFPA support ceases.

There was evidence through interviews that the government authorities participated directly in all the processes involved in the UNFPA-supported midwifery training programme, starting from recruitment, up to the time they graduate, with the government advocating for their employment in their facilities, including assessing them and providing guidance. The trainings were also conducted in most of the government health facilities, and this showed support by the government.

In the period of coverage, interview and review of documents indicate that UNFPA strengthened the policy framework through technically and financially supporting development of policies and technical guidelines in the SRHR, adolescent and youth, GBV components. The government IPs reported the relevant contributions made by UNFPA through the 3rd CO in development of guidelines and policies to shape the quality of service delivery. The development of family planning guidelines, midwifery training curriculum, review of the midwifery curriculum, development of BEmONC and CEmONC training and service provision guidelines, and Guidelines, One-Stop Centre, Safety audit among other SOPs, Initiation of the Anti-medicalization of FGM policy and the Draft Sexual Offenses Bill, Training Manual on Life skills, TVET Curriculum development, COVOID-19 Guideline, training guidelines, among other were some of the key initiatives recognized by the government as likely to contribute immensely to policy and technical guidance in provision of services and protection of the vulnerable populations in the country, especially women, girls and IDPs in the country. Some results have been realized as highlighted in the EQ 4, including declarations by the communities and religious leaders towards abandonment of FGM, defeat of *fwatwas*, among others. Policy and legislative implementation framework in Somalia is still weak with inadequate monitoring and supervision, in addition to deeply-rooted cultural norms that require time to change. Despite ownership by the government institutions, there is still also to support their enforcement, and institutionalization. Inadequacy of resource mobilization capacity to implement the same, without the support of UNFPA among other stakeholders is also low.

UNFPA made considerable contribution to the development of strategies which directly fed into the work of the government, either with their full participation and at their request. There is evidence from IP and CO interviews that UNFPA supported development of government development plans for both FGS and Somaliland, in addition to writing CP-related sections in the plans, ensuring that they are properly captured. These are government owned documents and implementation is dependent on the government. UNFPA, in collaboration with other partners supported development of RMNCH Strategy in addition to developing a cost implementation plan, National Humanitarian Strategic Plan, GBV strategy, reviews and development of the HSSP for both Somaliland and FGS. These strategies were confirmed to be domiciled in the respective ministries and implementations directly contributed to the ministry strategies and deliverables, confirming ownership (Interviews with CO and IP staff). Interview with the FGS Ministry of Humanitarian Affairs and Disaster Management also confirmed using the humanitarian strategic plan for fundraising to respond to the humanitarian situation in the country.

Interviews with IPs and CO staff confirmed participation of the government agencies in the coordination activities, enhancing their delivery of services. There was also confirmation of the government's participating and contributing to the semi-annual reviews and annual planning sessions organized by UNFPA (Interviews with CO and IP staff). UNFPA and government ministries also conducted joint

monitoring activities of some of the interventions together, indicating shared interest in the activities and are likely to sustain them when UNFPA support ceases. UNFPA strategically invested in partnerships with the local organizations to provide services in their areas of existence showed strengthened local ownership in the delivery of services in the various locations, enhancing The Grand Bargain (Interviews with IPs and CO staff).

Interviews with the Ministries of Sports and Youth Affairs across the three governments of Puntland, Somaliland and FGS, confirmed ownership of the UNFPA-supported Youth Centres where they contributed in donating land on which the centres are built, electricity and water, in addition to participating in the running of the same. In Somaliland, for example, the Ministry of Youth and Sports directly supervises the operation of the youth centres in Gabiley and Hargeisa and attach their own staff to work at the facilities to provide expertise services. The youth participants also confirmed working with and getting operational support from the ministries. Reports also confirmed direct support of the President of the SW state in acceptance of the participation of the youth in governance and peace processes, in addition to allocating them offices to work in while learning and contributing to the various department deliverables. In Mogadishu, for example, the youth centre is planning to establish a cafeteria which will form a training ground for the youth training on catering at the centres, while at the same time providing restaurant services with the proceeds being ploughed back to run the centre. The life skills training curriculum used to train the youth in the centres were developed by the ministry of education, with support of UNFPA, are used in other government facilities to provide similar services (Interviews with the ministry IPs).

UNFPA supported the final completion of the National Youth Policy and National Youth Strategy with contribution through consultations and endorsement in FGS by the Council of Cabinet but yet to be go to the President for assent. There are however legislative challenges in Puntland since they already have their policy and aligning it is a challenge; while in Somaliland, it is not needed as the NDP covers youth development needs. There is confirmed ownership by the government departments in the use of the strategy to guide their implementations, and contributing to their direct performance in their plans, in addition to formulation of the department interventions (Interviews with the IPs). Further, there was increased participation and ownership of the peacebuilding programme by FGS, leading to their development and publishing of a roadmap to ‘One Youth’ engagement that is crucial in highlighting the needs and challenges of youth participation in peace, state building and leadership in the country. Implemented, it is hoped that they will contribute to addressing the needs of the youth and likely lead to sustainable results.

Establishment and operations of the one-stop centres in government facilities like Maatokaal GBV centre in Garowe General Hospital and the Borama General Hospital-based centre, and using the government facilities and staff for service indicated government ownership. In addition, the training of the justice-related institutions and government healthcare workers, counsellors, and lawyers, in the pursuit of enhancing access to justice for the GBV survivors is a manifestation of the ownership by the government (Interviews with CO and IPs). There was also confirmed handover of management of safe spaces to NAGAD and WABO in Somaliland (Interviews with GEWE staff)

Delivery of the BEmONC and CEmONC services were conducted in government owned health facilities, with the support of the government, with data from the efforts of UNFPA support contributing to the government performance. The period also saw the transition of the previously referred to as Maternity waiting homes to be fully BEmONC facilities with more services, including on the FP and EPHS, with the government participating in their operations, especially in recruitment of staff and reports from the facilities. The government was very instrumental in the transition process, establishing them as

permanent structures with year-round operation, unlike before when they depended on intermittent operation based on availability of funding.

There is enough evidence to show government commitment and local ownership of the interventions supported by the 3rd CP. In most cases, the contributions are more about human resources and facility space donation, in addition to donating their time in the interventions. A number of those however require resource investments for them to continue with the delivery of the services they are meant for. From the interviews, there is very limited indication that the government can be able to manage the facilities or implementation of the strategies or interventions in place, left alone. Somalia is also a challenging framework to support legislative changes with different cultural and social norms that hinder implementation of some of the policy documents developed. In addition, there are a lot of contextual variations in the stability of the various government institutions, with some having systems in place while the others are at their initial stages of establishment.

Throughout the implementation of the PD component, there was deliberate efforts put in place to ensure that the Somali authorities participated and led in the interventions in the country. The PD component appropriately utilized the 3rd CP modes of engagements to ensure that there was ownership of the programme interventions. During interviews with all the respective IPs identified the critical role and turnaround made in the production of data and statistics by UNFPA during the 3rd CP. UNFPA leveraged resources and strengthened systems for long tern benefits to the country's authorities.

The relevance of the programme in many ways contributed to the national and local teams own the 3rd CP results and will continue to be used for local benefit. The data from the SHDS report contributed to the data that was used by the Somali authorities in planning, reporting and decision-making. There was evidence from interviews and review of reports that the data produced was used to set baselines and targets for national development plans and SDGs. It was also for the first time that Somalia developed the Addis Ababa Declaration on Population and Development (AADPD), highlighting progress made with regards to ICPD PoA because there was data brought about by SHDS through UNFPA support. The data generated were also used to inform policy documents guiding development planning in the country, like the Health Sector Strategic Plan (HSSP), supported by UNFPA and owned by the government authorities.

UNFPA played a key role in the establishment of the National Bureau of Statistics (NBS). This was enacted into law by the FGS Parliament, and will contribute immensely to amplifying data collection and use in development planning and policy. There was also evidence on the government contributing more than 60% to the cost of the trip of the Parliamentary Committee on Planning Unit in charge of the drafting of the NBS Bill, manifesting their ownership to the bill. Documentation of technical manuals, guidelines and Standard Operating Procedures (SOPs) will remain in the units to be used by the statistics teams to promote data production for planning and policy development.

4.5.2 Capacity Building

Capacity development of healthcare workers on various SRHR aspects, including technical guidelines increased the competency of the staff to deliver quality health services. Training of the Healthcare workers including midwives, medical officers and nurses on the FP curriculum and training on the guidelines, CMR guidelines, and service delivery guidelines like BEmONC and CEmONC guidelines enabled transfer of skills and knowledge and were able to provide the services effectively. There was evidence of trained ToTs on FP and other SRHR areas delivering their training effectively from national to regional levels. Staff were also able to administer a range of FP methods without the need for support. All these as a result of UNFPA support (Interviews with CO and IPs). UNFPA also trained surgeons on fistula surgery and management and were successfully able to conduct surgeries of 425 fistula cases,

manifesting skills transfer. These are likely to stay even after UNFPA support ceases (Interviews with IP and CO). There is still need to increase the number of surgeons able to undertake fistula repairs, in addition to decentralizing the services as they are still being conducted in selected hospitals with lead to a lasting contribution to improved SRHR services, especially in the hard-to-reach and less-resourced locations IP and CO interviews).

UNFPA invested in the training of GBV actors in the government and stakeholders on the GBV prevention and response, with the government currently taking the leadership role in advocating against GBV practices. With the targeting of local actors, like women groups, youth groups and religious leaders, community members in the fight against FGM and GBV, with confirmed evidence of their participation in the advocacy campaigns, there is likelihood of continuation of the activities without the support of UNFPA, due to the capacities gained. Engagement of former circumcisers and the active participation of the community FGM Champions after training without incentives is an open evidence that the campaigns are likely to continue without UNFPA.

UNFPA strengthened the capacities of the local NGOs to deliver on areas of programme management and access local funding from SHF and CERF. For example, UNFPA technically strengthened the capacity of SEDHURO and was successfully funded by SHF. The areas of capacities built included on proposal and report writing, programme management, funds compliance aspects, among others to assure stability and capacity to deliver. In addition to being given platforms to participate in the national priority determination, the exposure and skills will continue to remain with them.

Supporting the government on policy development and implementation of guidelines in the various areas of response enabled them to provide quality and standardized service delivery. Training of FP strategy, for example, increased the demand for FP services, training on CMR guidelines to the healthcare workers as discussed earlier was important in strengthening the capacity, training of technical government staff on implementation of the guidelines were crucial and will go a long way in contributing to increased access to services in the country. turnover in the government ministries was a concern during the implementation of the 3rd CP, limiting strengthening and utilization of the skills to make a difference in the various areas.

It is hoped that the advocacy to abandon harmful practices like child marriages, GBV and FGM/C through the enactment of the proposed Sexual Offences Bill will result in a more positive legal environment in the country especially for women and girls who are exposed to these acts. It however remains essential to continue engaging and working with community members, leaders and health care providers to keep the campaigns against the practices. There is long term benefit of the developed National Youth Policy, which highlights the rights of the adolescents and youth to access SRH services and Rights. These efforts, in addition to the campaigns to enhance knowledge and attitude change on the practices should contribute to a sustained increase in SRHR knowledge among adolescent girls and boys, and youth to access the services.

UNFPA facilitated access to marketable and employable technical and vocational skills by the vulnerable youth from the various centres. Interviews with the youth beneficiaries and implementing partners adequately revealed that the targeted youth beneficiaries were able to secure employment, in addition to some of them establishing their own businesses. UNFPA also contributed immensely to preparing the youth for employment, giving them the skills to be able to add value to their background. Life skills trainings, in addition to the skills in computers gave the youth more advantage in handling interviews for employment (Interviews with IPs and FGDs with youth beneficiaries).

During FGDs session youth beneficiaries' shared an overwhelming level of satisfaction and use of the attained knowledge and skills to better their lives and contribute to effecting changes in their community. Most of those who benefitted from tailoring courses for example stated that they have sought the support

of the family members to buy a sewing machine and started community work of providing free tailoring services to the community members so that they sufficiently utilize an otherwise strained household income to acquire basic household needs. The evaluation team, however established challenges among some of the youth beneficiaries' who were unable to work with the attained skills due to lack of capital to buy the required equipment to start their own businesses. It was also a great achievement of the Adolescent and Youth component of securing funding from European Union (EU) to support business start-ups by the youth. This will contribute a lot in strengthening access to income for the youth in addition to reducing idleness among the youth and the risk of being recruited by the armed groups in the country, and hence enhancing peacebuilding.

There was a high level of increased awareness among the targeted interest groups on SRHR, GBV and HIV and other harmful practices. The registered changes among community leaders and members, religious leaders and government policy-makers should likely contribute to sustainability. The adolescent and youth, particularly, exuded self-awareness with improved self-esteem, in addition to participating actively through various media channels in sensitizing their peers on their reproduction rights. UNFPA ensured that information being shared were current and addressed various myths and misconceptions around SRHR/GBV/HIV and other harmful practices in the country. The establishment of youth centres and support for training of healthcare workers on youth friendly services accelerated access to services by the youth (Interviews and FGDs). There were also confirmed utilization of the gained skills by the young people in advancing them in their respective communities, including promotion of girls' rights in access to education. While there was no assessment conducted to establish the extent of knowledge and change in attitude, there were indications from the interactive social media used by the various UNFPA-supported youth groups. On the other hand, harmful practices such as early marriages, FGM and GBV are highly embedded in the social and cultural norms of the Somali community and would take considerable time to change, especially in the rural and peri-urban areas where even discussions on sexual and reproductive health is considered a taboo. In some instances, the policy makers expected to advocate for implementation of laws or legislations prohibiting the harmful vices are themselves the perpetrators, limiting the collective levels of identifying this as a common problem requiring redress.

UNFPA, in the joint programme with UN Habitat made considerable progress in enhancing participation of the youth in peacebuilding and governance in the country, especially in Jubbaland and South-West States through establishment of youth structures, influencing the policy makers and showcasing the need for inclusion of the youth in leadership. The capacity building injections were instrumental in equipping the youth with necessary skills and empowered them to foster changes in their communities through representing their voices to the governments and other stakeholders. The election of 17% and 45% of the youth under 35 years of age in Jubbaland and South-West Federal State parliamentary respectively, in 2019 elections contributed to laying the foundation for inclusive politics which are representative of the society (Interviews and document reviews). The role of youth in peacebuilding is more pronounced due to this programme, and they are currently being engaged, with clear roles and the dialogue can continue going on using the youth-led platforms like Youth Councils and blogs (https://youthvoices4peace.org/).

The existence of the infrastructural support to the Somali governments and communities added to the capacity of the country to deliver various services even after the cessations of external service. UNFPA contributed to development and improvement of health facility infrastructure including equipment support and technical skills training. These are likely to continue to provide services or present the foundation for service provision. The ongoing establishment of the Blood Bank in Mogadishu will contribute to the saving lives of women of reproductive age and children during birth, in addition to contributing to saving lives during emergencies occasioned by frequent bomb blasts in the city (Interviews). There is though need to put in place proper structures and systems for its operation and sustainability, including having in place proper equipment, supply and refill systems, and technical skills developed.

Putting in place systems that are likely to institutionalize service delivery was a great achievement of this programme. UNFPA contributed to the development of the Commodity supply chain LMIS and development of related tools which is likely to provide a solution to the management of supplies in the country. UNFPA also conducted training for the national stakeholders on the use of the LMIS tools. There was evidence of utilization of the tools in reporting however there were not effectively used to inform quantification of the commodities and supplies. More will need to be done to ensure that this is learnt by the government team and mechanisms of addressing some of the contextual challenges, especially on poor and expensive infrastructure. Further, UNFPA initiated the need to include Commodity Supplies Security into Hargeisa University curriculum, but did not succeed due to institutional challenges in the university. This may need to be explored further to ensure actualization as it will contribute to efficiency in supplies management. Existence of the school youth clubs with champions for youth participation in and promotion of eradication of FGM in schools.

UNFPA's support to midwifery training, contributing to skilled birth attendance has been lauded as making a huge difference in the country's health human resource strengthening. The graduating students were reported to get employment both by the government and private sector, including NGOs and UN agencies, which is further contributing to income generation for the midwives. There is a possible long term benefit in the development of the Midwives Deployment and Retention strategy currently being developed in collaboration with the government, as it has an issue in the deployment and retention of the midwives graduating, with some not being able to serve from their gained skills. In addition, UNFPA contributed to the review and implementation of the midwifery training curriculum in accordance with ICM-WHO standards, in addition to training the instructors on it ensuring standardization of delivery. The inclusion of FP and Fistula modules in the Midwifery training curriculum will also ensure production of skilled personnel able to address existing contextual health challenges.

The implementation of population dynamics component of the 3rd led to strengthening the capacities of the country statistics units on data generation and production through developing a sampling frame for data collection development. For the first time, a sampling frame has been developed through spatial analysis using the most recent high resolution satellite imagery covering the urban and rural strata across the 18 regions in a very fragile security context, with geofiles and landmarks and will remain to be relevant for institutional use in generation of data, including census (Document review and interviews with IP and CO staff). During the period of evaluation, the sample frame had been used for the Labour Force Survey in the whole country (Interviews with IPs).

The national respondents confirmed gaining skills on designing and implementation of survey methodology, data cleaning, coding and tabulation, in-depth analysis and reporting. These were also confirmed with the CO staff interviews, where the national statistics teams led in the analysis of data and production of the regional reports, with technical guidance of UNFPA. The national teams confirmed gaining knowledge on the use of configuration of the computer-assisted personal interview (CAPI) technology in data management, use of high resolution satellite images to define the sample frame, programme skills using (CSPro) system, data hosting for surveys, and data analysis such as SPSS, Open Data Kit (ODK), SAS. This knowledge and skills gained are likely to enhance sustainability of the CP areas of focus. Embedding on-job-training by UNFPA encouraged hands-on learning for practical experience, with the national statistics teams being able to produce State Level reports for Puntland and Banadir (Document review and interviews with IP and CO staff), which will enable planning for development at the lower level of governance.

While a lot of progress has been made by UNFPA's 3rd CP on strengthening the capacity of the national statistics units on data processing and production in Somalia, there is still huge need for data production

in various sectors through updates based on current on current statistics, which still needs support from other development workers, UNFPA included. In addition, there is still a need for advocacy and sensitization on the importance of data. Inadequacy of resource by the government is also a limitation in implementing surveys or data collection endeavours. Retention of staff by the government is another challenge as the staff, after getting experience, get attracted to the private sector and international organizations, including UN entities and NGOs.

4.6 Coordination

EQ8: To what extent has the UNFPA country office contributed to the functioning and consolidation of existing United Nations system-wide coordination mechanisms for both development assistance and humanitarian action?

Summary Findings

UNFPA is actively involved and contributes significantly to the functioning of the Somalia UNCT coordination mechanisms stemming from the triple mandate of coordination, accountability and capacity building, and contributes to the implementation of the United Nation Strategic Framework (UNSF). Under the leadership of an independent and delinked UN Resident Coordinator (RC), UNCT coordination has been enhanced among the UN agencies and is functioning. Interviews with UN Staff also confirmed strong linkages and synergies among the UNCT partners, with UNFPA's contribution highly recognized and valued.

UNFPA is an active participant in the two main UNCT coordination mechanisms, the programme management and operation management teams, attended respectively by the Country Representative and the Operations and Finance Manager, or their respective designates on a quarterly basis. UNFPA co-chaired the Programme Management Team (PMT), and an active member of the United Nations Country Team (UNCT), Security Management Team (SMT), Humanitarian Country Team (HCT) and being a member of the Protection cluster (Interviews with CO and UN staff). The decisions made by these teams were implemented by the agencies individually or collectively based on thematic strength, and directly contribute to interests of the UN in the country, and with the guidance of the UN RC. The Country Office through its operations, programme and coordination in Somalia has consistently participated in and contribution to the Somalia Risk Management Team. It is also at these mechanisms that the UN agencies exchange information for coordination and response to the ministry requests. UNFPA collaborates with WHO and UNICEF in the area of health; and UN Women in the areas of Gender (interviews with CO and UN staff). The CO actively participated in the Risk Management Unit and HACT working group meetings (Document review).

In the Somalia UNCT, UNFPA directly contributes to the Strategic Framework priorities in all the component areas of Sexual and Reproductive Health, Youth, Gender-based Violence and population dynamics and monthly reports submitted to the RC. In addition, UNFPA is the Chair of the RH and Fistula Working Groups respectively, Chair of the Statistical coordination group, and Co-Chair of the GBV coordination sub-cluster. Under the youth, UNFPA chairs the UN inter-agency Working Group on Adolescent and Youth, co-chairs the Joint UN Team on AIDS (JUNTA), and represents the UN constituency at the Global Fund (GF) Steering Committee where key decisions on funding for HIV, monitoring the GF programme and reports are made. UNFPA was also an active lead in the

establishment of the Somali Youth Advisory Board. UNFPA also participated in the cross-cutting themes of M&E and Communication, in the spirit of Delivering as One (Interview with UN and CO staff).

UNFPA is also a key member of the UN Humanitarian Coordination Team (UNHCT) and participates actively in the Prevention of Sexual Exploitation and Abuse (PSEA) Task Force, led by UNICEF (Interview). Under the Gender Technical Working Group (GTG) led by the UN Women, UNFPA contributed to ensuring that gender is mainstreamed across the UN agencies, and contributed directly to the Gender strategy for UNCT and development of Annual Work Plan for the GTG approved by the RC. ensuring mainstreaming of gender (Interviews with CO and UN Staff). Under the UN DaO, UNFPA, together with UNICEF, UN Women, UNDP, among others, actively participated, in addition to leading, the development of knowledge products to ensure advocacy on FGM, Gender and GBV. UNFPA, together with the UN Women also contributed to the development of the NDP, articulating how gender was to be mainstreamed in the document, actively contributes to the Somalia Gender Profile report which highlights key aspects of gender in Somalia, and various studies on gender. When many delegates were not able to travel to Beijing due to COVID-19, UNFPA and UN Women coordinated and provided key information and analysis to contribute to the Beijing+25 Report (Interviews with CO and UN staff).

As the Co-Chair of the GBV sub-cluster, UNFPA partnered with UN Women and UNICEF, in collaboration with other stakeholders, including donors, to draft Sexual Offences Bill, and advocating so that Parliament can initiate a discussion with stakeholders on the Bill through development of advocacy policy briefs on the same. All the partners in Somalia, including UN agencies rely on the UNFPA-managed GBV information management system (GBV-IMS) (Interviews with CO and UN Staff). Interviews with UN partners revealed that UNFPA's role in the GBV cluster was crucial for the improvement of the checklist for camp coordination and camp management (CCCM) cluster. UNICEF also shared the draft GBV Case Management SOP for review by UNFPA and eventual validation, enhancing collaboration (Interviews with CO and UN Staff).

Through these mechanisms, the UNCT operations have minimised overlaps in programme and at the same time increased coverage. For example, UNIDO had a project targeting youth in Benadir with technical and vocational skills, and had to agree with UNFPA so that they targeted youth above 24 years, in addition to targeting different districts with the programme, enhancing reach. In addition, they have contributed to efficient operations (Interviews with CO and UN Staff). For example, UNFPA coordinates with UNICEF and UNDP to conduct audits for the respective implementing partners through the Harmonized Approach for Cash Transfers (HACT). Coordination among the UN agencies in Somalia is further enhanced by the funding arrangement through the MPTF, which has ensured alignment of programme activities of the agencies to their mandates, systemised the reporting processes which pass through an online gateway and minimised overlaps (Interviews with CO and UN Staff).

UNFPA participates and contributes to the UNCT Statistical Coordination group as the co-chair of the secretariat. UNFPA is the only recognized UN agency for provision of data and evidence-based information generation for planning and reference. Through the SHDS, UNFPA contributed in provision of data for the Agenda 2030's Leave No One Behind indicators on the SDG and the Country Context Report for 2018 and 2019. UNFPA was also provided data for use in the new Country Cooperation Framework (CCF) indicators for the entire country and covering the different states, in addition to updating the UN Country Cooperation Assessment (CCA) based on the new information. Further, based on the SHDS published results on the prevalence of FGM, UNICEF was able to hire a consultant to review the FGM strategy, with high level of consultation with UNFPA (Interviews with CO and UN agency staff). The SHDS sampling frame for urban and rural areas was shared to complement UN Habitat and local governments' property databases.

During implementation of the SHDS, UNFPA leveraged resources through coordinating the technical teams within the UNCT to contribute to the process. WHO and UNICEF participated and took an active role in the methodology preparation, training, questionnaires development, manual and also provided the indicators needed alongside SDGs and NDPs. UNICEF also supported the child-related data through a project that supported the statistics system (Interviews with CO and UN Staff).

UNFPA implements a joint programme with UNICEF, in collaboration with MoH, on the management of procurement and distribution of medical commodities in the country, funded by the DfID. In this arrangement, UNICEF is responsible for procurement of commodities because they have a larger warehouse, while UNFPA is in charge of preparing the distribution and procurement plan. While this was at the request of the donor, interviews with IPs, CO staff and other stakeholders revealed that this had challenges and was not working well, as the commodities did not go to the right locations, with some excesses registered and disruption in the distribution of the commodities due to inadequate systems, including vehicles to transport them. Further, UNFPA conducted training on commodity security in Somaliland, covering four regions, except Sool and Sanaag; however, when UNICEF started conducting the similar training, they did not build from where UNFPA left, exhibiting aspects of inadequate coordination and synergy (Interviews).

UNFPA was instrumental in development of various strategies in collaboration with the UN agencies. The UN Inter-Agency Working Group, chaired by UNFPA, developed the UN Somalia Youth Strategy to articulate and advocate for youth issues in Somalia (Interviews). UNFPA coordinated with WHO in the development of the guideline of Clinical Management of Rape (CMR) which was instrumental in the management of risks of rape (Interviews with IPs, CO and WHO staff).

Under the leadership of UNICEF, UNFPA actively contributed to the development of the safety audit checklist in the One-Stop Centres through the GBV sub-cluster co-chaired by UNFPA. UNFPA also collaborates with UNICEF and UN Women on development of gender-related guidelines to provide direction on implementation and quality.

During the 3rd CP, UNFPA implemented a joint programme with UN-Habitat on youth inclusion on politics and peacebuilding where UNFPA handled the communication component while UN-Habitat handled the governance component (Interviews with CO and UN-Habitat staff). UNFPA and UNICEF continued to implement a joint programme on FGM, where they coordinated activities leading to abandonment of FGM/C, in addition to having common messaging on the same for advocacy (Interviews with CO and UNICEF staff). There were also unsuccessful joint endeavours where WHO, UNICEF and UNFPA submitted a proposal for funding; and UNSOM and UNFPA partnered to secure Peacebuilding Funds (Interviews with CO and UN Women staff).

In the humanitarian settings, UNFPA is depended on by the UNCT to provide mapping data on IDP influx in Baidoa and flooding in Beletweyn to estimate those affected using satellite images in collaboration with UNSOS. In addition, in COVID-19 response, UNFPA is currently providing data to the HCT for planning through production of maps and indicators for the various areas and addressing various needs for different areas (Document review and Interviews with CO and UN staff). UNFPA, UNICEF, UNDP and UN Women collaborated and developed key messages on FGM and GBV linked with COVID-19, shared with UNCT and broadcasted through the local radio stations. In the procurement for personal protection equipment (PPE) for COVID-19 pandemic, a common procurement plan was developed and shared with UNOPS as the agency to make the purchase (Interviews with CO and UN staff). To enhance coordination, there are joint working humanitarian coordination meetings in SL, chaired by UNOCHA, with UNFPA coordinating GBV WG, UNICEF child protection working group (CPWG), UNHCR Protection WG, while WHO Health WG (Interviews with CO and UN staff).

UNFPA collaborated with WHO and UNOPS to help set up the blood bank in Mogadishu, on request from the government. WHO contributed to the technical aspects of establishing the blood bank, on request from the government (CO and UN Staff interview)[131].

In commemoration of international days, the UN agencies conducted activities together, including sharing the same message using different communication mechanisms. During the 2020 International Youth Day, UN agencies, under leadership of UNFPA, worked together on a plan for the activities, including pulling resources, in addition to organizing a panel discussion of youth issues in Somalia and providing solutions. The Un agencies made a common statement on International Women's day.

UNFPA in collaboration with WHO and UNICEF worked on developing FP Guidelines, BEMONC of training guidelines, FGM guideline, RMNCH Guidelines and Advocacy strategy, Training guidelines, and reviewed the health sector strategic plan (HSSP), in addition to its work plan. They also collaborated to capacity build the MoH is delivery of Health services (interviews with CO and UN staff).

4.7 Coverage

EQ 9: To what extent has the UNFPA humanitarian response reached those most in need and vulnerable in crisis situations both geographically and demographically?

Summary of Findings

UNFPA humanitarian programme contributed to addressing the needs of the vulnerable in many ways, though limited by resources allocation. In the programme design, humanitarian programming is not clearly designated, but mostly integrated in the other programme components. The budget allocation for the component was quite little given the humanitarian needs in the implementation context.

While the evaluation was limited and did not reach the ultimate beneficiaries, there are mechanisms in place to show that the UNFPA 3rd CP reached the IDPs, vulnerable women and girls, and marginalized communities through integrated SRH and GBV services. Through supporting the establishment and operation of the Humanitarian Coordination Forum bringing all humanitarian actors together, in addition to the development of the National Humanitarian Strategy, UNFPA contributed to leveraging of resources and coordination for effective response and coverage of the humanitarian gaps (document review and interviews with IPs and CO staff). The advocacy by the GBV sub-cluster, under the leadership of UNFPA, for more coverage of GBV in the HRP (Interviews with the CO staff), in addition to availability of a dashboard on GBV accessible to donors on the achievement and the existing gaps enabled more resources being channelled to support response in the humanitarian settings, increasing coverage.

UNFPA contributed immensely to development of the capacity of the humanitarian actors on the various areas, enhancing quality of response and coverage. Development of response guidelines, enhancing quality RH service through training actors on MISP, emergency preparedness training, and support in distribution of supplies and availability of services points like BEmONC and One-Stop centres provided wider coverage by UNFPA programme in the affected areas (Document review and Interviews with IPs and CO staff). In addition, advocacy for humanitarian support elicited the interests of actors, including donors to allocate funding for various humanitarian activities in the country (Interviews with IPs and CO staff).

[131] The Blood Bank had not been finalized at the time of the CPE

Interviews with IPs and CO staff indicated that UNFPA's humanitarian programme is implemented on a need basis, and is depended upon by stakeholders on humanitarian response. Through the integrated outreach services, UNFPA shifted focus to support locations with needs. Notable from the IPs was the flexibility by UNFPA enabling adaptation to changing situations, reprogramme and contextualizing response to suit the situation including putting a response plan. In the period of evaluation, Somalia experienced some of the worst humanitarian crisis from cyclones and severe and prolonged drought in Somaliland and Puntland, floods in South-Central locations and Qardo in Puntland, locust invasion and COVID-19. UNFPA contributed in gathering information on the effect of the drought and mobilized secured funding out of the CPD from Humanitarian Central Emergency Response Fund (CERF) to respond to the drought situation in Puntland and Somaliland effectively providing integrated SRH and GBV services to the affected. The data collected also enabled other stakeholders to respond in other areas of response based on the gaps established (Document review and Interviews with IPs and CO staff). UNFPA's support for the establishment of a blood bank in Mogadishu will contribute enormously in addressing key emergency health service needs, especially for CeMONC services in the humanitarian context (Interviews with IPs, CO and Partners staff), however with limited coverage due to poor infrastructure.

As a member of the HCT, UNFPA is part of the prioritization and allocation of resources based on vulnerability and those at risk like IDPs, pregnant women, children, girls, people living with disabilities and the elderly to access services within the resource constraints. Interviews with IPs, UN agencies and CO staff confirmed inter-cluster agency rapid assessments conducted to identify the needs for response, and there existed coordination mechanisms among WHO, UNFPA and UNICEF to ensure that there was no gap in response. With evidence of consultations with IDPs, leaders, government and host communities on the needs and response (Document review, Interviews with IPs, UN agencies and CO staff).

As the youth programme implementation progresses, youth friendly centres were also adapted to additionally provide clinical services of sexual and reproductive health issues among the targeted youth of. UNFPA youth friendly centre in Mogadishu was for example equipped with clinical facilities which provided STI testing services including HIV&AIDS testing, psychosocial cancelling services and family planning services. Referrals were made to other supported UNFPA facilities if additional support is required by the target beneficiaries. Awareness raising on GBV and early marriages were also provided to complete the vocational skills training obtained by the target beneficiaries'.

At the time of reporting, there was no clear information on the extent to which the needs of those affected and vulnerable in crisis situations were met but there is evidence from documents and interviews with various stakeholder that the efforts by UNFPA yielded positive results in alleviating suffering and lowering risks for those affected in crisis, especially for IDPs, women and girls, and other vulnerable populations in the hard-to-reach locations. Efforts by UNFPA to advocate for and resource the humanitarian programme in Somalia was also noted during the evaluation period, with a recent successful funding by Global Affairs Canada (GAC) advancing 1 million Canadian dollars and 1 million Euros from Finnish Government for COVID-19 response (Interviews with CO staff). Somalia is however a humanitarian context, with exponential needs amid scarce resources. This has been exacerbated by the onset of the COVID-19 pandemic with more needs arising making the response more complex. There is therefore a need for adapting responses tailored to COVID-19. UNFPA humanitarian response for the youth was also limited, though reported to be integrated with the adolescent and youth component of the programme. Feedback from the IPs and CO staff, and analysis of financial documents also indicated that UNFPA's allocation for humanitarian response was low, in addition to no adequate plan for the same in the AWPs. With the emerging focus on shifting the programme focus from humanitarian to development, it is highly recommended that UNFPA join the Nexus Working Group.

4.8 Connectedness

EQ10: To what extent does UNFPA humanitarian action and plan for longer-term development goals articulated in the results and resources framework of the 2018-2020 Country Programme and contribute to resilience building?

Summary of Findings

UNFPA, through the 3rd CP, enhanced mechanism to ensure that short term actions contribute to longer term effects in Somalia. UNFPA contributed to this through strengthening capacities of the actors, development of strategies, guidelines and policies to guide implementation, coordination and promoting integration of programmes and national ownership of interventions and results. The 3rd CP also contributed directly to the NDP-9 which was developed incorporating resilience as the framework of implementation.

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During the 3rd CP, UNFPA used all the modes of engagement as defined by the global strategic plan, Somalia being classified as a 'red country'[132], strengthening systems in the country. UNFPA strategically partnered and implemented the programme with the contribution of the government structures in addition to channelling funding of activities directly through Somali government systems, ensuring that they were part of the results achievement (Document review and interviews). The 3rd CP financed the development of the LMIS for the FGS, and capacity built them on it, enhancing ownership in management of service delivery. Through advocacy mechanisms, has ensured national ownership of the programme interventions in addition to the results. While progress has been made in ensuring national ownership, the capacity of state institutions, particularly at the local level, remain very weak and varied across the federal member states limiting the likelihood of sustenance. In addition, the government's resource mobilization capacity is still low with high dependence of foreign aid (Document review and interviews).

During the period in consideration, UNFPA initiated incorporation of resilience programme in the Somalia context through hiring a Resilience Specialist, who facilitated establishment of a roadmap to resilience programme in Somalia through development of a strategic plan on resilience, in addition to setting baselines to guide implementation and performance management. In addition to building the capacity of the UNFPA CO team on resilience, the Specialist also worked with the UNFPA's National Humanitarian Specialist to build the capacities of the government and NGOs and other actors on the same (Document review and interviews with IP and CO staff). UNFPA HQ also deployed the regional advisor in Somalia who conducted an assessment on resilience. In addition, there was also support in December 2019 from

[132] The UNFPA SP (2018 – 2021) classifies Somalia as in the red quadrant with modes of engagement being advocacy and policy dialogue, knowledge management, capacity development, and service delivery.

the RH technical Advisor who supported the establishment of the resilience baseline on SRH (Interview with CO staff). Implementation of these have been impeded by the onset of COVID-19. However, from the efforts, there is indication that UNFPA put in measures to ensure long-term benefits of the programme beyond humanitarian response.

UNFPA strengthened the capacities of the humanitarian actors through development of guidelines and tools to enhance quality service delivery in the health sector. UNFPA, together with WHO, UNICEF and national counterparts contributed to development of RMNCH guidelines to enhance advocacy that influence health-service delivery and RMNCH outcomes in the country enhancing service access. UNFPA also led the development of guidelines on FP, BeMONC, and CeMONC, which are aimed at ensuring services delivery meeting standards and in a coordinated manner (Document reviews and interviews). Further, UNFPA contributed to the development of the country 's health sector strategic plans guiding planning for resources, including possibilities for resource mobilization. In the same period, UNFPA financed and technically supported review of the midwifery curriculum with a chapter added on family planning, in addition to development of Midwifery Employment and Retention Strategy which will address the issues of midwives' deployment and availability of skilled birth attendance in the health facilities (Document reviews and interviews). These documents provide structures for response and will guide service delivery adhering to standards thereby improving the performance indicators. While these guidelines and policies are developed, with the contribution of the government and expectation of national ownership and implementation, there are still gaps in their implementation and require further advocacy and strengthening supervision and legislation (Interviews with IPs and Partners).

In the period under review, UNFPA engaged a consultant to develop a roadmap towards meaningful and inclusive participation of youth people in peacebuilding and governance, and built capacity of the FGS government on the same for implementation. While the implementation of this has been hampered by the COVID-19 pandemic, it is hoped that empowering Somali youth provides a chance to advance peace and socio-economic transformation. UNFPA also contributed to the establishment and strengthening of the Youth Advisory Board which directly contributes to political processes and peacebuilding initiatives (Interviews with IPs and CO staff). The integration of the adolescent and youth component of the programme also provided an opportunity, though to a limited extent, the youth from marginalized populations in Somalia (Interviews with the IP and CO staff). While the resource allocation for the youth programme was lowest, at the time of evaluation, UNFPA had secured a new funding from European Union valued at 8.5 Million Euros to capacity build the youth on leadership, skills development for social enterprise building and increase their financial literacy. These are aimed at increasing involvement of the youth in governance and peacebuilding (Interviews with CO staff) and will contribute to the linkage between humanitarian, peacebuilding and development efforts.

UNFPA strengthened the gender policy and legislative reforms, guidelines and coordination in Somalia aimed at preventing and mitigating GBV in addition to elimination of harmful practices. Awareness and advocacy at the community levels also improved during the period through various community level engagement to stop FGM and child marriage, and prevent GBV, strengthening resilience of the communities. During the period, UNFPA, among other partners facilitated response through development of the One-Stop centre SOP and initiation of the FGM anti-medicalization policy strengthens response. UNFPA technically and financially supported the operation of GBV sub-cluster and the FGM, GBVIMS and the CMR Task Forces at the national and sub-national levels in line with the HRP ensures GBV-related issues are prioritized and dealt with in a timely manner and strengthening accountability among stakeholders. UNFPA also enhanced capacity building mechanisms in the area of gender through strengthening integration of GBV prevention and mitigation mechanisms, enhancing early recovery. Somalia is still plagued with limited response, negative social norms, and poor conditions in the IDP

camps propagating GBV. Inadequacy of rights awareness, weak local governance, legal and legislative capacity continue to hinder response and may take a long time to realize change.

This period saw the transition of the maternity waiting homes to health centres providing BEmONC services while at the same time providing CMR and FP services to ensure long-term operations with the support and oversight of the government. One-Stop Centres are also integrated into the government health facilities and overseen by the government. Partnerships with local organizations in the hard-to-reach locations strengthened service delivery and strengthened their capacity to deliver similar services. As one of the five modes of engagement in the country, UNFPA made deliberate efforts to build the capacities of the various national stakeholders on quality SRH service provision, GBV response and on data generation and service mapping of the vulnerable populations including IDPs, women, girls and marginalized population, skills that will continue to remain with the beneficiaries, enhancing resilience. Through the PD component of the 3rd CP, enhanced access to data in humanitarian settings which can trigger early warning and early action to avert the recurrent shocks from disasters.

4.9 Lessons learnt

The following lessons can be learnt from the Somalia 3rd CP

- Promoting an integrated programme approach to CP components enhanced achievement of results, in addition to ensuring efficiency in utilization of resources and covered some of the budget deficits, e.g. advocacy on FGM/C continued despite inadequacy of resource allocation in 2018 because it was integrated into GBV, SRHR and Adolescent and youth issues.
- Supplementary Sexual and Reproductive Health (SRH) outreach campaigns activities increased access of rural communities to skilled health services, strengthened referrals for complicated maternal cases to CeMONC facilities and human rights approaches in the programme.
- Structured youth engagement platforms promote their levels of participation, creates spaces and able to express themselves and contribute meaningfully to the civil and development discourse
- The CO's Youth programme requires refocus to address the priority needs in the country. The outcome indicator for the component was on HIV&AIDS, which is not among the core priorities for the youth in the Somalia context. Acquisition of marketable technical vocational skills education is core
- Youth Centres can self-sustain if equipped and the capacity of the youth is enhanced to engage in income generating activities are the centres
- UNFPA GBV team in Somalia has noticed the critical and importance of engaging new partners to build alliance for zero tolerance of GBV and FGM. To this end the Ministry of Religion and Justice, women religious scholars, young adolescent girl's platforms etc. This is considered a good practice by UNFPA - to bring those new partners to be on board, which strengthened the policy and strategy advocacy in Somalia. The multi-sectoral and multi-ministerial collaborations were found to successfully scale up the visibility of the GBV and FGM. Additionally, the inter and intra cluster identification and dissemination of focal points improved referrals and enabled women and girl's survivors of GBV to access timely and confidential services.
- Investments in changing social cultural norms and cultures that drive GBV are critical. They however require to be accompanied by a rapid response strategy in the event of backlash.
- The scaling up of GBV response and integration in humanitarian settings was observed is a good practice that requires more scaling up. The needs are grave and require holistic GBV responses accompanied with other development and humanitarian assistance. Beyond the dignity kits, there is need for psychosocial support including trauma counselling, training for IDP teams on protections against sexual assaults and transactional sex for protection.

- The male engagement component as champions for abandonment of FGM/C is a good practice. As a patriarchal society, male influence and where male elders are custodians of culture, this investment of transforming their perceptions is a sound basis for attaining gender equality and women empowerment
- Implementation of the SHDS contributed to strengthening the capacity of the national statistical teams in addition to enhanced ownership of the programme results
- Establishment of management and coordination structures provided platforms for engagement and resolution of arising issues during implementation of the SHDS
- Flexibility in the PD team by being responsive to the emerging needs during design, training and implementation of the SHDS facilities smooth process to its successful completion. The team used the 18 pre-war regions, but had to include Somaliland regions on request of the government, which were not as defined during the pre-war session.

CHAPTER 5: CONCLUSIONS

5.1 Introduction

The generation of conclusion complies with the UNFPA CPE Handbook, presented with both strategic and programmatic focus, and logically flows from the findings presented in Chapter four. They are presented at strategic level (covering relevance, efficiency, sustainability, coverage, connectedness and coordination), and programmatic level covering the CP component area.

5.2 Strategic Level

Conclusion 1: The Somalia 3rd Country Programme is strategically aligned and relevant. The programme effectively responded to the national priorities and needs of the populations, especially the marginalized in addition to the changing context, strengthening partnerships and capacities of national partners, as well as cutting a strong niche in the areas of mandate among a wide range of stakeholders in the country. There were however inherent weaknesses in the design, especially on definition of indicators contextually and operationally.

The 3rd Somalia Country programme (3rd CP) was strategically aligned to the international normative frameworks, policies and standards, in addition to the UNFPA global Strategic Plan 2018 – 2021, as well as strongly contributing to the Somalia UNSF priority areas. There is evidence of design and implementation of the programme in consultative manner with the participation of the government, advancing national ownership and capacity building. There was further evidence of application of lessons learnt during the previous 2nd CP to inform the current programme; and systematic application of assessments to inform planning for the programme interventions and strategies in the context. The 3rd CP also responded effectively to the emerging needs during the period of implementation such as responding to the drought and people affected by the Cyclone in Puntland and Somaliland and floods in the central part of Somalia. During the programme implementation, the CO exhibited strength in the areas of responsibility in advancing access to SRHR by women, girls and youth; strengthening advocacy and policy framework towards GBV prevention and response, and abandonment and elimination of harmful practices; and in improving existing capacities, evidence-based planning and development in the country. While the programme was strategically aligned, including implementation and targeting, the design was inherently weak in the measurement of performance.

Associated Recommendation: 1

Origin: EQ 1, EQ 3, EQ 6 **Priority**: High

Conclusion 2: The CO surpassed its indicative resources mobilized for the implementation of the Country Programme, with most of it received through the UN pooled funding basket of MPTF, showing a strong capacity and trust among donor community and government. The utilization was not however smooth as there were concerns from the CO and IPs on delays in disbursement of funds affecting implementation of intervention and achievement of targets. Further, earmarking of funds and prioritization of intervention areas limited implementation of some of the intervention areas.

The 3rd UNFPA Somalia Country Office showed strength in resource mobilization and earned donor trust on the capacity to deliver, in addition to good coverage of the country in the areas of responsibility, building on some of the global partnerships and networks to mobilize resources. The feedback however showed that some of the results could not effectively be achieved as implementation of programme interventions was affected due by late disbursement of funds from the donors, which affects the CO's utilization rate and further delay by the CO to the IPs. FGM, RH supplies, FP commodities and interventions, were limited by funding opportunities in the period of coverage and affected some of the planned achievement of results, including abandoning some of the activities. Making contingency plans with allocations, especially from core sources of resources, for planned activities would reduce the delays and enhance effectiveness and efficiency in achievement of programme results. With the MPTF as a source of funding calls the need for strong results-based planning and reporting to ensure that there is high level of accountability in the use of the resources accessed.

Associated Recommendation: 2

Origin: **Origin**: EQ1, EQ3, EQ7, EQ9, EQ10 **Priority**: High

Conclusion 3: The 3rd CP had strong and robust monitoring and evaluation (M&E) systems in place for programme monitoring, reviews, compliance and quality assurance. However, there were inherent weaknesses in the design and use of M&E learning and quality assurance.

As explained in Chapter 4, UNFPA had a robust system in place for measuring the 3rd CP performance. Feedback from reviews and interviews indicated that the systems were mostly utilized by the various CO teams, and were effective and efficient in informing decision-making programmatically and operationally. Design issues, limited staffing and resource allocation however affected effectiveness in the application of M&E functions in quality assurance. Reporting was mostly activity-based, limiting the focus of the CP in achievement of the results across the results chain, in addition to inadequate accountability to the funding systems. While planning is an important activity in the delivery of the CP, there practice is limiting results achievement as the activity ends by March, and contracting engagement is always done by year. Coupled with lateness in disbursing of funds, the results are bound to be affected further.

There were inherent weaknesses in the design of the CP ToC across the results chain. The causal links, for example, between the output and corresponding indicators, and the outcome and corresponding indicator for the adolescent and youth component do not correspond well. In addition, the overall indicator

for the component is not contextually strong and relevant and should be redefined to reflect the reality from the interventions. The performance metrics, like the indicators for the PD component makes assumptions that existence of reports or strengthened statistical offices will translate into use of data in the reports to inform planning and policy decisions, which is not entirely the case, especially in the Somalia context where turnover is also high in government.

Associated Recommendation: 3

Origin: **Origin**: **Origin**: EQ1, EQ3, EQ6 **Priority**: High

Conclusion 4: UNFPA realized great achievements in most of the output result, and are likely to effectively contribute to the planned outcome results. The performance is largely attributed to the strong partnership nurtured between the CO and organizations and government ministries and agencies across the country, capacity building and promotion of national ownership; integration, coordination, technical and responsiveness to the needs in the country implementation framework, both in development and humanitarian. The commitment and capacity of the government, as well as inadequate support systems may affect sustainability of the programme results.

UNFPA achieved most of the output targets in the M&E results framework, as per the design in all the four thematic areas. Adolescent and Youth component however had changes in the indicators and could not be assessed perfectly, but there were great achievements from the component. At outcome levels, there were a lot of indications that the achievement at the output results are likely to contribute to their realization, though some at a minimum extent, especially given the context and nature of the results expected. Integration contributed a lot to the achievement of the results, despite limitation in funding for some of the programme components.

There is a lot of capacity built and promotion of national ownership among the national stakeholders through leveraged resources, development of guidelines, training curricula and policies, advocacy and coordination. The strategic selection of partners, especially the local organizations enhanced targeting of the marginalized populations, particularly women, girls and youth, and community level of engagement on programme themes. Development of guidelines and manuals to guide service provision was a great achievement, however monitoring and support supervision is key to ensure compliance and delivery. There is also a great need to strengthen evidence-based programmes so as to know the levels of achievement, especially the promotional interventions targeting social change. There is also a need for a coordination mechanism between the governments in service delivery and response to increase accountability and to strengthen capacities in addition to learning, especially for the newly formed federal states.

Associated Recommendation: 4&5

Origin: EQ1, EQ2, EQ3, EQ4, EQ5, EQ6, EQ7, EQ8, EQ9 and EQ10 **Priority**: High

Conclusion 5: UNFPA made considerable efforts to strengthen roadmaps for policy and legislative frameworks through technical and financial support to advocacy at higher and lower levels of engagement to address the development challenges, particularly in empowerment of women, girls and youth, and elimination of harmful practices. It is however evident that inadequate and disjointed legislative processes slowed down the gains and changes are likely to take time be accepted or operationalized.

UNFPA made a lot of progress in strengthening advocacy mechanisms to improve policy formulation and development frameworks. UNFPA provided technical expertise, financing, capacity building, development of tools, guidelines for implementation of advocacy strategies. UNFPA also enhanced levels of engagement, both at policy and community levels, engaging the government, religious leaders and key interest groups in the country, with a lot of progress made in strengthening the processes. Deeply rooted cultural beliefs, and inadequate and disjointed legislative frameworks are hindering implementation of the gained results in the policy formulation and implementation. Further, given the nature of issues being addressed by UNFPA's efforts in policy and advocacy, the changes are slow and take time to realize.

Associated Recommendation: 6

Origin: EQ1, EQ3, EQ4, EQ 7, EQ 9 and EQ 10 **Priority**: High

Conclusion 6: UNFPA is a highly valued partner and demonstrated strong commitment in the functioning of the UNCT, with its areas of mandate well reflected in the UN Somalia Strategic Framework. UNFPA also effectively contributed to UNCT coordination, engaged in effective joint programming, using comparative advantage in its thematic areas, as well as addressing areas of potential overlap. There were however cases of inadequate coordination in the field, especially health.

UNFPA contributed significantly to the functioning of the UNCT coordination mechanisms and has strong commitment to the implementation and achievement of the joint UNSF result priority areas individually or collectively in the areas of mandate. UNFPA was an active member of the United Nations Country Team (UNCT), Security Management Team (SMT), Humanitarian Country Team (HCT) and Programme Management Team (PMT), among other coordination mechanisms. UNFPA collaborated with the other UN agencies for coordination and response, and standardized delivery of services in the country, in addition to implementing joint programmes. The CO actively participated in the Risk Management Unit and HACT working group meetings (Document review). UNFPA is the Chair SRH working groups and taskforces, Statistical coordination group, and Co-Chair of the GBV coordination sub-cluster; UN inter-agency Working Group on Adolescent and Youth, co-chairs the Joint UN Team on AIDS (JUNTA), and represents the UN constituency at the Global Fund (GF) Steering Committee. UNFPA implemented two joint programmes under the A&Y and GEWE components respectively with UN Habitat and UNICEF. UNFPA also participated in the cross-cutting themes of M&E and Communication, in the spirit of Delivering as One. There were however areas of potential overlap or inadequate coordination that requires strengthening.

Associated Recommendation: 7

Origin: EQ1, EQ3, EQ4, EQ 6, EQ7, EQ8 **Priority**: High

Conclusion 7: UNFPA demonstrated comparative strength in population dynamics during the 3rd CP, making it possible in the context and history of Somalia to produce the Somali Health and Demographic Survey (SHDS) providing reliable data for evidence-based development and policy formulation, monitoring and reporting for the NDPs, ICPD PoA, SDGs, among other national and frameworks; as well as strengthening the national statistics capacities in production and dissemination of high-quality disaggregated data on population, development and sexual and reproductive health issues.

UNFPA stood out as an authority and was depended upon among development and humanitarian stakeholders to generate reliable population data for evidence-based programmes, as well as establishing and strengthening lasting systems to facilitate data access. UNFPA, through the successful design, implementation and dissemination of the SHDS made a big difference in the history of Somalia. The developed sampling frame, digital geo-referencing systems and capacities strengthened were instrumental during the 3rd CP in informing development decisions based on production of reliable quality and internationally comparable data. The leveraging of resources, utilization of South – South Cooperation and international networks, contextualizing the delivery process and technical expertise enable the success of the activity. Using a national ownership approach and building on the PD team's understanding of the context provided resulted into strengthening the capacities of the teams involved. UNFPA was also instrumental in providing data for humanitarian response during the period, utilizing the structures already laid down for data generation in the country. The results of the SHDS enabled Somali authorities to design results-based development plans, report progress on ICPD PoA, SDGs, AADPD, among other decisions made due to availability of data, including being invited to participate in international conferences.

Associated Recommendation: 8

Origin: EQ1, EQ3, EQ4, EQ 7, EQ 9 and EQ 10 **Priority**: High

Conclusion 8: UNFPA contributed to strengthening humanitarian response capacities in the country through financing development of response strategic plan, provision evidence-based information for quick response, coordination and complementarity, training and integrated support services in the disaster and conflict affected locations and IDP settlements improving their access to quality services. However, inadequate funding limited the extent of targeting and implementation of humanitarian interventions to the most vulnerable groups.

UNFPA contributed immensely to the humanitarian response in the country through technical financing and supporting the national humanitarian affairs ministry to develop a humanitarian response strategy for the country. In addition, UNFPA financially supported initiatives to support the marginalized populations and vulnerable communities to receive integrated SRHR, essential health services, dignity kits support, and capacity building on standardized preparedness and response. UNFPA also successfully advocated for revision of the Somalia Humanitarian Response Plan to include all components of SRHR such as Family Planning, STI and HIV prevention, Basic and Comprehensive EmONC services and Clinical Management of Rape, enhancing financing for the intervention areas. Towards ensuring lasting

humanitarian capacities, UNFPA initiated a resilience programme and trained the CO and Ministry staff guiding programme approaches. There was however inadequate information on the level of implementation and coverage of humanitarian response. Targeting of the youth in IDP settlement was also limited and there was no specific deliberate targeting.

UNFPA was also responsive to the changes in the humanitarian response context, supporting drought and cyclone-affected populations in Puntland and Somaliland, new influx in Baidoa and flood affected populations of the central parts of Somalia. In addition, UNFPA provided needs-based integrated health services targeting highly populated and marginalized populations in hard-to-reach locations across the country. further UNFPA was depended upon to provide data on people affected by floods and influxes, supporting evidence-based response. During the COVID-19 pandemic, UNFPA supported the country through managing the testing and treatment centre in Mogadishu, testing centre in Garowe, and support to the healthcare workers with PPE. In addition to providing mapping information on high-risk locations for response. Inadequacy of funding and human resource hampered response, with increasing humanitarian needs.

Associated Recommendation: 9

Origin: EQ1, EQ2, EQ3, EQ4, EQ5, EQ 7, EQ 9 and EQ 10 **Priority**: High

5.3 Programmatic Level

5.3.1 Sexual and Reproductive Health

Conclusion 9: UNFPA in the 3rd CP strengthened efforts of reducing maternal and neonatal mortality and morbidity in Somalia through development of RMNCH advocacy strategy, healthcare workers training, development of guidelines and policies, and strengthened integration and coordination for SRHR, FP and GBV service provision in the country, including humanitarian settings.

UNFPA contributed immensely to increase and strengthen access to quality and standardized integrated SRHR, FP and GBV service delivery by the Somali populations through supporting strong BEmONC and CEmONC service delivery facilities for lifesaving, including financially and technically supporting commodity distribution, equipment support, operational costs and staff salaries. These were provided in the facilities throughout the year. To enhance quality service delivery, UNFPA supported development of guidelines and training healthcare staff on the same to enhance infection prevention and management, as well as providing support mechanisms to deliver services through coordination. UNFPA also strengthened referral mechanisms for the marginalized communities to allow them access to emergency skilled birth attendance. In addition, FP and GBV services are integrated in the RH service provision. These enhanced access to skilled service and standardized service delivery to women, adolescents and young people and other vulnerable, marginalised groups. Further, UNFPA strengthened national ownership through fostering partnerships with national line ministries and local organizations, in addition to strengthening their capacities to supervise and oversee delivery. Monitoring and supervision systems to ensure compliance and delivery were however reported to be low among the implementing partners and the national counterparts.

UNFPA enhanced service delivery through coordination of the RH related Working groups and taskforces, including RH working group, fistula steering committee, MDSR taskforce, FGM anti-medicalization and CMR taskforce. In addition, UNFPA contributed to the policy framework through development of FP training and advocacy curriculum in the Islamic context for BCC and advocacy messages, integrated complementary outreach service, supporting yet-to-be completed development of midwifery deployment and retention guideline, CMR guideline, LMIS system and tools, and improving FP method mix. There is also need to strengthen support for the special needs groups, like people with disabilities and enhanced gender mainstreaming including capturing them in the reports to know the extent of support.

Associated Recommendation: 10

Origin: EQ1, EQ3, EQ4, EQ 7, EQ 9 and EQ 10 **Priority**: High

Conclusion 10: The 3rd CP contributed to increasing FP demand in the country through employing a mix of contextual strategies, in addition to strengthening administration systems through capacity building and development guidelines and tools, and supporting commodities commodity supplies. Training on FP was effectively conducted, but was affected by funding cuts during the period. Inadequate male involvement, supply breaks and inadequate information on FP method preference, coupled with strong myths and perceptions are still hindrances in the uptake of the services.

Through concerted efforts of UNFPA and other stakeholders, the demand creation for FP services have been increased. UNFPA led the efforts to ensure that FP was integrated in the SRHR service delivery through development of context-specific training curriculum incorporating Islamic-sensitive BCC and advocacy strategy on FP, promoting FP method mix including introduction of subcutaneous injectable method and approved by the FGS MoH. UNFPA enhanced training by creating a national FP curriculum and thereby facilitated training cascade through the use of Trained Trainers (ToTs) to the lowest facility level, equipping healthcare workers with skills to administer the services. Supply breaks experienced during the period, inadequacy of information on FP preferences, inadequate male involvement in the BCC context affect the extent of uptake. UNFPA partnered with PSI in Somaliland to target peer-to-peer engagement of use of FP methods and male involvement, but this did not take off. FP training was also affected because of budget cuts during the period.

Associated Recommendation: 11

Origin: EQ1, EQ3, EQ4, EQ 7, EQ 9 and EQ 10 **Priority**: High

Conclusion 11: The 3rd CP has contributed to improving the SRHR, FP, MNCH indicators of the Country. There is still a huge need for skilled birth attendance, in addition to strengthening deployment and retention of the midwives.

During the period of implementation, UNFPA made efforts in improving service delivery in the area of SRHR, particularly in strengthening skilled birth attendance through supporting midwifery training producing skilled healthcare workers to provide services. Review and development of the Midwifery training curriculum, integrating FP and complying with the ICM/WHO standards, and training of school

tutors ensures production of a comprehensive skills base. While much has been done to support production of the midwives, there has been no structured way of deploying and retaining them to be able to contribute to the providing skilled services. UNFPA in collaboration with the Ministry of Health developed a Midwives Deployment and retention strategy, and is yet to be approved. Implemented, this strategy will increase availability of healthcare workers in the health workforce, hence increasing access to skilled service delivery, especially for the marginalized populations. In the same period, UNFPA stepped up the fistula case identification and treatment conducted by specialized surgeons, in addition to enhancing social integration for the treated cases. Fistula funding reduced, limiting the results achieved in the period, especially in 2019.

Associated Recommendation: 12

Origin: EQ4, EQ 7 **Priority**: High

Conclusion 12: The 3rd CP supported Supply Chain System Strengthening through development of a functional electronic Logistics Management Information System (LMIS) including tools and strengthening capacity of human resources, and was used for qualification, forecasting and monitoring of utilization of RH commodities. In addition, UNFPA supported a costed supply chain master plan, incorporating rights-based contraceptive delivery.

UNFPA supported the development of the LMIS to enable quantification of movement and consumption of RH commodities in the country. This is in the right step in developing health systems and increasing access to services. Despite training being conducted for supply chain staff from across the country to manage the process, the feedback was that the tools were not applied well, especially by the government. There were inconsistencies in the supply systems with little coordination of supply and consumption information. Frequent stock-outs also contributed to the dysfunctionality in the commodity supply chain systems and required redress and concerted capacity building of the staff in charge of using the system. The infrastructural challenges were also inherent in affecting distribution systems for the RH commodities.

Associated Recommendation: 13

Origin: EQ4, EQ5, EQ7 **Priority**: High

5.3.2 Adolescent and Youth Component

Conclusion 13: UNFPA strengthened adolescent and youth access to integrated SRHR and GBV services through increased policy development and implementation, improved targeting strategies, capacity building and increasing access to access to youth-friendly services particularly by young women and adolescent girls. Inadequacy in identification of youth needs, limited funding and conflicting mandate focus and the context limit results achievement.

UNFPA 3rd CP strengthened youth and adolescents access to youth-friendly SRHR services, particularly their reproduction rights. Establishment of youth-friendly centres and training of medical staff to provide

the services facilitated increased access to the services in various facilities in the country. Youth participation in advocacy and awareness raising on HIV&AIDS, GBV, child marriage and FGM issues school boys and girls, and youth in the targeted locations contributed to addressing barriers to service access by the young people. The youth were also able to discuss issues affecting them and coming up with solutions to them through intergenerational dialogue. UNFPA strengthened partnerships with Youth networks to reach adolescents and young people in and out of school through use of peer to peer approaches, enabling increase in knowledge and demand for the SRHR services and information uptake, including contraception. While the context is conservative on discussing sex issues by the young people, UNFPA trained healthcare workers to be able to deliver these services to the adolescent and youth upholding client confidentiality and this encourages demand for the services. UNFPA also enhanced dignity of the vulnerable and poor girls through supporting them on menstrual health management kits, in addition to distribution of reusable sanitary pads to young women in the IDP settlements.

There was high level of integration of youth services, including among the youth IPs being able to provide services on FGM, GBV, Health and HIV, in addition to counselling services. There were interlinkages of activities and services, especially in the youth centres where youth could access contraceptives to prevent unwanted pregnancies. Youth beneficiaries' who benefitted from life skills training established a high level of satisfaction with the impact of acquiring skills, most of those who graduate stated that they were able to access job opportunities especially in hospitality sectors. Majority of those who were trained on tailoring reported to have established self-employment with some indicating they have voluntarily taken up community work by providing free tailoring services in the community. Adolescent and youth component interventions were underfunded compared to the needs of the youth in the country. There is also inadequacy of identification of the needs of young people to strengthen strategic evidence-based interventions aligned to the context. Further, there is limited information on monitoring progress, especially for the advocacy mechanisms targeting social behaviours change among the youth. The intergenerational dialogues have got limited institutionalisation to ensure continuity without the support of implementing partners.

Associated Recommendation: 14

Origin: EQ1, EQ3, EQ4, EQ 7, EQ 9 and EQ 10 **Priority**: High

Conclusion 14: 3rd CP reinforced opportunities for youth-targeted interventions through strengthening policy and strategic frameworks for engagement, and mainstreaming of youth development interventions in all sectors at national and regional levels.

UNFPA contributed to providing a roadmap for meaningful engagement of the youth in the sectors of the economy through development of policy and strategic framework highlighting the youth needs and priority areas of support. The development of the National Youth strategy and policy, with support from UNFPA was critical in addressing youth needs in the country, in addition to establishment of a coordinated framework for tracking youth development in the country. The frameworks provide an opportunity for the stakeholders to coordinate resource allocation to address the key priorities for the youth in the country. While the strategy and policy is comprehensive and covers a wide spectrum of issues, the concept of 'youth' in Somalia is more inclined to male youth and the target interventions may not highlight the specific needs of female youth, in addition to the needs of the youth in marginalized locations and IDP settlements. There will be a need to systematise the youth programme through evidence-based programming.

Associated Recommendation: 15

Origin: EQ1, EQ3, EQ4, EQ 7, EQ 9 and EQ 10 **Priority**: High

Conclusion 15: Structured engagement of the Somali Youth is critical for their participation and contribution in governance and peacebuilding initiatives. There are however many youth platforms that may derail youth engagement processes in the country.

The joint programme between UNFPA and UN Habitat exemplified the potential in the Somali youth through structured engagement and provided a roadmap to youth participation in political processes and other important discourses in the country. The advocacy mechanisms put in place were able to yield positive results with a considerable number of youth being elected into parliamentary political positions, most of whom were beneficiaries of the programme. Training and opening spaces for participation enabled them to meaningfully contribute to the peacebuilding and government processes. There are however gaps in coordinating youth issues in the country as there exist a number of youth advocacy group. There is a need for building strong networks of youth so as to ensure one voice of engagement.

Associated Recommendation: 16

Origin: EQ1, EQ3, EQ4, EQ 7, EQ 9 and EQ 10 **Priority**: High

5.3.3 Gender Equality and Women's Empowerment

Conclusion 16: The Somalia 3rd CP significantly contributed to strengthening GBV issues comprehensively through capacity building, coordination, advocacy for strengthening legislative and policy framework, awareness raising and engagement with duty bearers and rights holders, and support to the GBV survivors and vulnerable women and girls, including in the humanitarian setting.

There has been enhanced quality and comprehensive service provision for GBV survivors as well as community empowerment for behaviour change, which is critical for GBV prevention, particularly in emergencies. A variety of gender knowledge products that have lasting impact have been developed such as the GBVIMS, Clinical management for rape guidelines, GBV service directory as well as the harmonised GBV messages. UNFPA Effectively contributed to humanitarian assistance by leading advocacy and coordination for prevention of GBV in emergencies. In addition, capacities for key duty bearers within the relevant line Ministries and the justice sectors. The coordination of IPs and establishment of One Stop GBV Centres and the Women and girl's friendly spaces has triggered demand for comprehensive survivor centred services.

Associated Recommendation: 17

Origin: EQ1, EQ3, EQ4, EQ 7, EQ 9 and EQ 10 **Priority**: High

Conclusion 17: The progressive interventions by UNFPA have made significant contribution to the policy and legal framework reforms in Somalia aimed at ensuring accountability for human rights for marginalised populations, especially women and girls.

The partnerships with other UN agencies and bilateral partners has successfully led to reforms of laws and policies. For the first time in Puntland, a conviction of a perpetrator was made under the Sexual Offences law. At the same time the Joint Somali Women's Charter was developed with specific calls of actions for the Prime Minister and Parliament around gender equality and women's empowerment. Towards the ratification process of CEDAW consultations with different key actors have been convened. In addition, the Sexual Offences Bill and FGM bills will enhance capacity to demand protection of the survivor's rights. There are also advanced plans to operationalise the National Human Rights Commission having passed the law in 2015. This will be an accountability mechanism towards strengthening human rights monitoring and enforcement.

Associated Recommendation: 18

Origin: EQ1, EQ3, EQ4, EQ7 **Priority**: High

Conclusion 18: UNFPA has strengthened its community responsiveness gender equality and women's empowerment through implementation of integrated, multiple and targeted approaches to engagement.

The gender equality and women empowerment component was able to deliver on most planned interventions, specifically around advocacy, coordination and capacity building on GBV response and management and abandonment of FGM/C. The approach of identifying community needs through participatory sources contributed to UNFPA's interventions receiving higher uptake and support. Through encouraging community participation at grassroots levels, and interactions with women affected by crisis, women at risk, UNPFA was able to ensure target response and based on needs. Integration of programme interventions also enhanced the campaigns targeting changes in harmful social norms in the communities targeted. Strongly rooted misconceptions and social norms take time to change.

Associated Recommendation: 19

Origin: EQ1, EQ3, EQ4, EQ5, EQ 7, EQ 9 and EQ 10 **Priority**: High

5.3.4 Population Dynamics

Conclusion 19: The 3rd CP exceeded expectations in strengthening national capacities production of high quality disaggregated data on Somali population, development and SRH issues, institutionalization of data generation and use is still weak and need strengthening.

UNFPA immensely contributed to the development of capacities of the national statistics systems in generation of data to inform evidence-based development planning and policy formulation, monitoring and evaluation. UNFPA used a highly participatory process to ensure national ownership and capacity building of the various teams involved. The implementation of national-led SHDS gave a milestone in the

history of Somalia, ranging from development of data systems and frameworks, skills development of the participating staff and availability of data informing development status in the country. through the SHDS, Somalia was able to report on ICPD PoA, SDG, among other international normative frameworks. The reports gave distinct development challenges for the nomads, urban and rural populations, making it easier to prioritize service delivery. The gained skills were already used by the teams in conducting surveys and interrogating the quality and validity of information generated in the country. There are however low data utilization policy frameworks that still need to be strengthened. Thematic reports being produced for the federal member states will enhance planning and advocacy for planning. The data were also used to enhance advocacy on use of population data for development planning. Even though data was available through the CP activities, institutionalising evidence-generation to inform programme effectiveness remains weak. While the SHDS produced a disability thematic report, there was little to show about targeting the segment of the populations with the programme.

Associated Recommendation: 20

Origin: EQ1, EQ3, EQ4, EQ5, EQ 7, EQ 9 and EQ 10 **Priority**: High

Conclusion 20: SHDS has provided roadmap for conducting larger surveys, like housing and population census survey in Somalia, in addition to ensuring more accountability on data, through strengthened integration of population dynamics into development planning.

The implementation of SHDS created important structures and capacities for designing, planning and execution of data production in the country, and led to a momentum and recognition of population dynamics as an important aspect for national planning and decision-making. The information gathered from the report was used in several strategic documents, including informing development status in various sectors of the economy, exemplifying the importance of data in a country's development framework. The UNFPA has effectively built awareness and increased capacity for generating and analysing disaggregated population data, forecasting population dynamics and assessing demographic development linkages. Systems are however still weak to effect integration of population dynamics utilization. Inadequacy of resources to strengthen development planning may limit use of data. In addition, there is a need for interdepartmental engagement on planning issues to increase integration of population dynamics into development planning. UNFPA was able to create a sample frame with enumeration units enabling sampling. The various capacities have also been developed in the country to be able to utilize for supporting the process. Systems for planning are also in existence to support implementation of large surveys like household and population census. This however requires strengthening the framework. There is also a need to strengthen CRVS for more accountability.

Associated Recommendation: 21

Origin: EQ1, EQ3, EQ4, EQ5, EQ 7, EQ 9 and EQ 10 **Priority**: High

CHAPTER 6: RECOMMENDATIONS

6.1 Introduction

This chapter presents the recommendations of the Country Programme Evaluation (CPE) along strategic and programmatic considerations based on the findings, conclusions and feedback from the CP stakeholders.

The recommendations are classified into high and medium priority. High priority refers to implementation within a 1-2-year period whilst medium priority refers to implementation within a 3-4-year period. Implementation of the recommendations would also require increased resource allocation to strengthen the role of the CO to provide technical support, as well as avail additional funding to IPs.

6.2 Strategic Level

Recommendation 1: UNFPA should continue to strategically align the CP to Somalia's national development and humanitarian priorities, as well as to the international and regional normative frameworks to respond to the country's needs and priorities, in addition to strengthening national and international partnerships in the development and humanitarian framework for effective delivery. The design should also be contextualized for maximum realization of results.

Origin: EQ1, EQ3, EQ7, EQ9, EQ10

Associated Conclusion: 1 **Priority**: High

Implications: UNFPA should continue wide consultations and widen participation of government agencies, CSOs and other development and humanitarian actors for evidence-based and relevant response and support in the national, regional and international development and humanitarian frameworks. There is also need for continuous needs assessments and consultations of the national development strategies, as well as ensuring enhanced coordination with the UN agencies for strategic alignment and assure sustainability of the CP results.

Recommendation 2: UNFPA should maintain current trust and relationships with the existing donor organization, in addition to expanding resource base to cover for arising deficits, particularly on Family planning, FGM, Adolescent and youth, and RH commodities. UNFPA needs to strengthen financial planning mechanisms to ensure that there are no lapses in programmatic and financial support, especially to the implementing partners. The CO should also strengthen accountability mechanisms in the utilization of resources to facilitate delivery of results.

Origin: EQ1, EQ3,

Associated Conclusion: 2 **Priority**: High

Implications: Strengthening financial planning at CO level to reduce episodes of delays in the disbursement of funds thereby facilitating smooth programme implementation and realization of better results. On the other hand, strengthening the capacities of IPs on results-based programme and reporting with increase accountability in the utilization of funds to donors, and will strengthen their trust.

Recommendation 3: UNFPA needs to strengthen the theory of change across the results chain to ensure that the causal relationships between results are clearly defined and contextually relevant for ease of measuring performance. The planning in the results framework could also enhance results-based targets for more accountability and to inform learning. M&E functions also need to be strengthened at the field to ensure quality assurance in the delivery of the programme.

Origin: **Origin**: EQ1, EQ3, EQ6

Associated Conclusion: 3 **Priority**: High

Implications: UNFPA needs to review the current results chain to ensure that the theory of change is clearly defined to enhance accountability in performance measurement. Results indicator for measuring results should be results-based and not process-based to limit ambiguity, i.e. CO should avoid targets such as (Yes or No). The indicators should also be well aligned with the interventions being implemented and relevant to the planned results. The CO should increase human resources for M&E at the field to increase learning and quality assurance.

Recommendation 4: Expand and strengthen partnerships and capacities in all the programme components (SRHR, A&Y, GEWE, PD and Humanitarian Response) for increased effectiveness in programming, enhance efficiency, and assure sustainability.

Origin: EQ1, EQ2, EQ3, EQ4, EQ5, EQ6, EQ7, EQ9 and EQ 10

Associated Conclusion: 4 **Priority**: High

Implications: The CO should increase investment in evidence-based programme through constant engagement of stakeholders, conducting barrier analysis, especially for GBV, FGM, FP, and reproductive rights to address social norms that perpetuate behaviours and attitudes. Further, enhance both upstream and downstream advocacy strategies to strengthen legislative and policy framework for national ownership and capacity building. Strengthen institutionalization of response through strategic partnerships and innovative approaches to assure effectiveness and sustainability. Strengthen monitoring and evaluation processes in the next CP cycle for informed programme decision-making

Recommendation 5: Continue strengthening programme integration and capacity building through strong leadership in areas of mandate at national and regional levels.

Origin: EQ1, EQ3, EQ4, EQ5, EQ 7, EQ 9 and EQ 10

Associated Conclusion 4: **Priority**: High

Implications: There was great achievement in results through adoption of integrated approach to programme on SRHR, FP, GBV, FGM and Adolescent and Youth issues. Strengthen operational capacities of the service providers and advocate for integration of programmes for maximum results, while at the same time standardizing services for quality delivery.

Recommendation 6: The UNFPA CO should enhance the level of policy dialogue, partnerships and coordination for improvement on the legislative and policy frameworks in the country.

Origin: EQ1, EQ3, EQ4, EQ5, EQ 7, EQ 9 and EQ 10

Associated Conclusion 5: **Priority**: Medium

Implications: The UNFPA CO should intensify advocacy efforts in the programme areas in the national agenda to improve integration of population dynamics in programme in the country, especially targeting the marginalized and vulnerable populations. TheContinue advocating with the government and national actors to highlight gender issues through upstream and downstream advocacy, coordination and consultation among stakeholders, enhancing accountability in the advancement of gender and human rights in programme

Recommendation 7: It is recommended that the CO continues to build and strengthen partnerships with the UN agencies in the spirit of Delivering as One for pooled resources to support joint interventions within the UNCT. In addition, there is need for enhanced coordination among UN partners for elimination of overlaps and complementarity in response.

Origin: EQ1, EQ3, EQ4, EQ5, EQ 7, EQ 9 and EQ 10

Associated Conclusion 6: **Priority**: High

Implications: Under the DaO, UNFPA CO should utilize its comparative advantages to enhance evidence-based integrated programme while mainstreaming gender and human rights, while in coordination, UNFPA CO should build strong partnerships and networks within the UNCT for joint programme and high level advocacy. Continue contributing to the functioning of the UNCT

Recommendation 8: UNFPA Somalia should continue strengthening of statistical capacities in data generation and evidence-based programming, while at the same time increasing advocacy for data use of credible sources of information to inform development and humanitarian planning. In addition, encourage strengthening of institutional capacity building and policy formulation to enhance sustainability.

Origin: EQ1, EQ3, EQ4, EQ5, EQ 7, EQ 9 and EQ 10

Associated Conclusion: 7 **Priority**: High

Implications: Somalia has made great strides in laying foundation for strengthening evidence-based development planning and management, amid constrained resource base. UNFPA should continue to mobilize resources to strengthen the national capacities to generate data for national development. Increased capacity in evidence-based programmes will improve integration of development dynamics in to SRH, GBV, FP, and Youth, thereby contributing to ICPD PoA results. And assure effectiveness and sustainability.

Recommendation 9: There is high need for strengthening resilience programming in the Somalia context to bridge the humanitarian-development nexus. Programming emphasis should include evidence-based interventions that promote strengthening the capacities of local and national actors to identify and deal with associated risks, vulnerabilities and their underlying causes. UNFPA need to focus on strengthening early warning mechanisms, including contribution to peacebuilding systems in the country to avert conflicts and disasters in the country. UNFPA should also advocate for ensuring that most vulnerable populations are identified and mapped, and their needs prioritized, with increased allocations for humanitarian funding and human resource to increase coverage for the areas of mandate in the humanitarian context.

Origin: EQ1, EQ3, EQ4, EQ5, EQ 7, EQ 9 and EQ 10
Associated Conclusion: 8 **Priority**: High

There is need to strengthen the humanitarian-development nexus in Somalia to build capacities of the actors and the affected so as to strengthen their resilience capacities to be able to reduce the effects of shocks emanating from the perennial natural and man-made calamities. Early warning and peacebuilding interventions will contribute to addressing the humanitarian preparedness and reduce suffering during humanitarian situations. UNFPA needs to strengthen its human resource capacity and allocate more financial resources for the CO preparedness and response during humanitarian situations, including COVID-19 context of programme. There is also a need for capacity building of the actors, especially in enhancing coordination between development and humanitarian, data collection and analysis to support the resilience programme shift for effective delivery.

6.3 Programmatic Level

6.3.1 Sexual and Reproductive Health

Recommendation 10: UNFPA should continue to strengthen technical and financial support for integrated services in the areas of its mandate, in addition to strengthening capacity building, development of guidelines, supervision, mentorship, quality assurance, sensitisation, and coordination. In addition, strengthen scale up of family planning through partnership, capacity building, demand creation through evidence-based response, increased male involvement, enhancing FP commodity supplies, supervision and quality assurance and mentorship.

Origin: EQ1, EQ3, EQ4, EQ5, EQ 7, EQ 9 and EQ 10

Associated Conclusion: 9 and 10 **Priority**: High

Implications: More resources would be required to maintain or expand service delivery, in addition to capacity building within the CO and partners to be able to integrate services. Resource mobilization to increase to enhance evidence-based response and availability of commodities in the health facilities, and

continue integration of FP into SRHR, GBV and other service delivery options, including outreaches. There is also need to strengthen community level engagement on the benefits of FP, including strategies to increase male involvement in FP uptake, and increased partnerships and coordinated service delivery

Recommendation 11: Advocate for increased investment on RMNCH.

Origin: EQ1, EQ3, EQ4, EQ5, EQ 7, EQ 9 and EQ 10

Associated Conclusion: 11 **Priority**: High

Implications: The UNFPA CO should continue supporting midwifery education, and strengthening a strategic framework on deployment and retention of the graduating midwives in the health system, especially in the hard-to-reach populations; and facilitate necessary support supervision and quality assurance for enhanced standardization of service delivery. There is also need for ensuring support services and integration of RMNCH service delivery, and expand fistula identification, repair and reintegration in routine SRHR service provision, in addition to strengthen capacities of surgeons to conduct repairs

Recommendation 12: Strengthen the national capacities, partnerships and coordination to facilitate functionality of the LMIS and tools being effectively used the supply chain teams across the country.

Origin: EQ1, EQ3, EQ4, EQ5, EQ 7, EQ 9 and EQ 10

Associated Conclusion: 12 **Priority**: High

Implications: The UNFPA CO should continue strengthening the capacities of the health personnel handling LMIS for its functionary. Resources need to be mobilized to support training, in addition to managing the logistical challenges, and decentralise supplies and commodities security.

6.3.2 Programmatic Recommendation: Adolescent and Youth

Recommendation 13: UNFPA to continue strengthening partnerships and coordination to enhance capacities to increase integration of youth- and adolescent friendly SRH services and reproduction rights, and policy development.

Origin: EQ1, EQ4, EQ5,

Associated Conclusion: 13 **Priority**: Medium

Implications: Strengthen advocacy mechanism to increase integration of youth and adolescent friendly services; Enhance awareness mechanisms at the community level and strengthening enabling environment; and Strengthen partnerships and capacities of service providers and strengthen social change at the community for sustainable change

Recommendation 14: UNFPA should strengthen mechanisms aimed at engagement and mainstreaming of youth development interventions in all sectors at national and regional levels; in addition to strengthening of implementation of the Youth Strategy and Youth Policy.

Origin: EQ1, EQ4, EQ5,

Associated Conclusion: 14 **Priority**: Medium

Implications: Increase resource allocation for youth economic empowerment to address the high levels of youth unemployment in the country; Enhance evidence-based response on youth issues as there is currently inadequate information specific youth needs and Mobilize resources for systems enabling monitoring of the youth strategy and policy implementation framework

Recommendation 15: Enhance consolidation and coordination of youth-targeted interventions while advocating for youth participation in the humanitarian and sustainable development.

Origin: EQ1, EQ4, EQ5,

Associated Conclusion: 15 **Priority**: Medium

Implications: UNFPA CO needs to advocate and use their comparative advantage to consolidate youth advocacy mechanisms and enhance coordination for harmonized targeting and response and need for resource mobilization for more support to advocacy mechanism on participation of youth

6.3.3 Gender Equality and Women's Empowerment

Recommendation 16: Sustain community level engagement and strengthening response systems, including incorporating evidence-based planning and response.

Origin: EQ1, EQ3, EQ4, EQ 7, EQ 9 and EQ 10

Associated Conclusion: 16 **Priority:** High

Implication: Increased support for community level engagement for sustained social behaviour change among community members through addressing myths and misconceptions on cultural religious and practices; and increased funding for evidence-based response, including strengthen GBV IMS to capture wide range of information, including harmonizing information

Recommendation 17: Sustain and strengthen lead role of GBV sub cluster as well as capacity strengthening of key actors in GBV and FGM/C and child marriage.

Origin: EQ1, EQ4, EQ5,

Associated Conclusion: 17 **Priority**: Medium

Implications: UNFPA's to scale up its technical capacity and systems strengthening of GBV prevention and response; Support expansion of establishment of one-stop GBV centres in the hard-to-reach areas;

and Strengthen referral systems, especially access to the justice system by the GBV survivors through enhanced capacity strengthening and coordination among the police, prosecutors and lawyers.

Recommendation 18: Scale up legislative and policy reforms to ensure accountability for human rights of marginalised groups, attaining gender equality and women empowerment.

Origin: EQ1, EQ4, EQ5,

Associated Conclusion: 18 **Priority**: High

Building on results of the 3CP, there is a need to strengthen the legal framework to support the implementation of the gender equality and women empowerment constitutional principles. Somalia requires a strong national legal framework to protect women's rights. [133] There is also need to increase access to justice by capacity building, awareness creation on the formal justice system so that survivors of GBV get redress and perpetrators do not go unpunished. There is also need to have continuous engagement and advocacy with religious leaders to support the zero tolerance of FGM, UNFPA campaign. To this end, the recommendation to have a strategic advisory group of religious leaders is highly recommended. This will facilitate a sustained advocacy on the subject matter.

6.3.4 Populations Dynamics

Recommendation 19: There is need to broaden strategies for statistical systems capacity for evidence-based development planning and policy formulation, including hastening institutionalized approach to capacity building in addition to enhancing stakeholder engagement in thematic analysis of data and strengthen data quality.

Origin: EQ1, EQ4, EQ5, EQ7

Associated Conclusion: 19 **Priority**: High

Implication: Sustain establishment of statistics bodies, like the bureau in Mogadishu to sustainable implementation of statistics functions in the federal member states; Broaden national planning departments in various ministries to be part of the capacity building strategies data generation, analysis and dissemination; and Establish partnerships with institutions of higher learning to strengthen the capacities delivery of statistics courses for sustainable development.

Recommendation 20: UNFPA should engage in advocacy efforts to ensure that the needs of people with disabilities, marginalized and other vulnerable populations are deliberately targeted and are adequately addressed.

Origin: EQ1, EQ4, EQ5, EQ7

Associated Conclusion: 20 **Priority**: High

[133] Universal Periodic Review reporting/Somalia Voluntarily Committee to ratify CEDAW-see Universal Periodic Review HR Bodies/UPR/Pages/Soindex.aspx

Implication: Advocate for more resources to be allocated to address the needs of different marginalized and vulnerable populations; Engage in studies to establish priorities for the various populations' needs in development and strengthen legislation on policy and legislative framework on use and protection of data

Recommendation 21: The UNFPA CO should focus on building from experiences in the SHDS to strengthen data generation of a periodic basis based on needs and advocate adequacy of resource allocation for evidence-based development.

Origin: EQ1, EQ4, EQ5, EQ7

Associated Conclusion: 21 **Priority**: High

Implications: UNFPA should advocate for resource mobilization and allocation for population information generation by the government and development partners, and further advocate for support in production of the periodic data, like CRVS to strengthen estimation of population statistics

SOMALIA COUNTRY PROGRAMME EVALUATION

3RD COUNTRY PROGRAMME 2018 – 2020

PART 2: ANNEXES

AUGUST 2020

Table of Content

Abbreviations and Acronyms

AIDS	Acquired Immuno-Deficiency Syndrome
ASRO	Arab States Regional Office
ART	Antiretroviral Therapy
AWP	Annual Work Plan
CO	Country Office
CP	Country Programme
CPD	Country Programme Document
CPE	Country Programme Evaluation
DAC	Development Assistance Committee
DaO	Delivering as One
EM	Evaluation Manager
EO	Evaluation Office at HQ
ERG	Evaluation Reference Group
EQA	Evaluation Quality Assessment
FGM	Female Genital Mutilation
FGM/C	Female Genital Mutilation/Circumcision
FGS	Federal Government of Somalia
GBV	Gender-based Violence
GEWE	Gender Equality and Women Empowerment
GPS	Global Positioning system
HCT	Humanitarian Country Team
HIV	Human Immuno-Deficiency Virus
HR	Human Rights
HRP	Humanitarian Response Plan
HQ	UNFPA Head Quarter at New York
ICPD	International Conference on Population and Development
IDPs	Internally Displaced Persons
ILO	International Labour Organisation
IPs	Implementing Partners
KII	Key Informant Interview
KPIs	Key Performance Indicators
M&E	Monitoring and Evaluation
MoH	Ministry of Health
MoNP&ND	Ministry of National Planning and National Development
MoPIC	Ministry of Planning and International Cooperation - Puntland
MOPIED	Ministry of Planning, Investment and Economic Development
MPTF	Multi Partner Trust Fund
NBS	National Bureau of Statistics
NDP	National Development Plan
NGO	Non-Governmental Organization
NRC	Norwegian Refugee Council
ODA	Official Development Assistance
OECD	Organization for Economic Cooperation and Development
PD	Population Dynamics
SDGs	Sustainable development Goals
SHDS	Somalia Health and Demographic Survey
SOLO	Somali Lifeline Organization
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
ToC	Theory of Change

ToR	Terms of Reference
UN	United Nations
UNCT	United Nations Country Team
UNDP	United Nations Development Programme
UNEG	United Nations Evaluation Group
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNSF	United Nations Strategic Framework
UN HABITAT	United Nations Human Settlements Programme

Annex 1: Terms of Reference

COUNTRY PROGRAM EVALUATION OF THE 3RD COUNTRY PROGRAMME OF COOPERATION (2018-2020)UNITED NATIONS POPULATION FUND SOMALIA COUNTRY OFFICE

Terms of Reference

December 2019

Introduction

As part of its commitment of measuring the impact and results of its implemented interventions and activities, the UNFPA Somalia Country Office (CO) is planning to undertake its 3rd Country Programmecycle (2018-2020) final independent country programme evaluation (CPE). The 2019 UNFPA Evaluation Policy requires country Programmes to be evaluated at least once every two cycles. The UNFPA Evaluation Policy, along with the 2019 version of the Handbook on How to Design and Conduct Country Programme Evaluations at UNFPA will guide the evaluation exercise. The CPE willfollow the evaluation criteria defined by the Organization for Economic Cooperation and Development (OECD) / Development Assistance Committee (DAC) and uphold the United Nations Evaluation Group (UNEG) standards, norms and principles in the implementation and management of the evaluation process. The purpose of the CPE is two-fold: i) Enhancing the accountability of the UNFPA CO towardsits stakeholders, donors and partners by demonstrating its performance in terms of achieving the envisaged results at the country level; and ii) Supporting the evidence-based decision-making process at country level through generating high quality evidence-based information and data, which will serveas a basis for the planning and design of the next country programme. In addition the CPE seeks to examine to what extent the CO has contributed to the response to the on-going humanitarian crises, as well as assess its contribution to the national resilience and recovery process based on the development-humanitarian-peace nexus.

By addressing these two overarching purposes, the CPE will analyse the country programme's contribution to the Somali national development goals and priorities, global commitments such as the implementation of the Programme of Action of the International Conference on Population and Development (ICPD), particularly in the context of Sexual Reproductive Health and Rights (SRHR), and progress towards the achievement of the SDGs and the objectives of the UNFPA Strategic Plan 2018-2021.

The CPE will be conducted as a participatory, independent, transparent and accountable exercise among UNFPA CO, Government counterparts, UN sister agencies, stakeholders and other relevant entities and organizations. It will also seek to illustrate UNFPA CO's contribution to the Somalia national agenda and development plan, needs and priorities. Additionally, it will seek to provide information regarding the contribution to the United Nations Country Team's (UNCT) efforts and coordination agenda.

Having the CPE conducted will allow UNFPA to inform different levels of users and target audiences such as decision-makers at UNFPA CO, regional and global levels as well as the UNFPA Executive Board, in addition to government counterparts, implementing partners, the UNCT and other development and humanitarian partners operating in Somalia. The evaluation results will be disseminated to these users and audiences in an appropriate format.

2. Country Context

2.1 Somalia Context

Somalia is a country with an area around 637,657 square kilometres located in Africa, mainly in the Horn of Africa, on the eastern coast, which has the Gulf of Aden and the Indian Ocean on its northern and eastern shores, respectively. The country is a federal-based system called the Federal Republic of Somalia. Based on latest estimations, its population reached 15.6 million in 2019, compared to 10 million in 2013[1]. The population in Somalia increases rapidly as the population growth rate is 3% alongwith a total fertility rate 6.27[2] children per women, which means that Somalia is the 4th highest total fertility rate in the world. Somalia's population ranks 73rd globally[3].

Figure 1: Map of Somalia 2019[4]

The boundaries on this map do not imply any official endorsement or acceptance by the United Nations Population Fund.

Somalia is a complex political, security and development environment, and much of its recent past has been marked by poverty, famine and recurring violence. However, in 2012, with the establishment of permanent political institutions and important military offensives, Somalia entered into a new period; a period where longer term peace seems possible. After decades of conflict and instability, a federal government was established, built through national dialogue and consensus. The Constitution of the Federal Republic of Somalia was a ground-breaking achievement. It put in place an overarching, nationally endorsed legal framework to guide Somalia's efforts to rebuild the nation in accordance with the rule of law. When this Federal Government was formed, Somalia was divided and with no clear path to reconciliation and unification. Somalia faced the significant challenge of simultaneously building frameworks and institutions, whilst needing to immediately deliver tangible benefits to the Somali people. Accordingly, the challenges that Somalia faces are complex, multifaceted and differ according to various political, social and regional contexts. The government's national plans recognize this fact.

The socio-economic situation of the country is very poor. Poverty cuts across sectors, location, group and gender, and its forms and causes vary. An understanding of Somalia geography, recent trends in its economy and consequences of the civil strife is important to determining the nature and extent of its poverty. Approximately 69% of Somalia population lives below the poverty line. Poverty in Somalia is more pronounced in the internally displaced persons (IDP) camps. IDPs have the largest family size in Somalia (more than 7 persons compared to the average size of 5.3 persons per household) and an estimated 88% of the IDP population lives below the poverty line, followed by rural areas with 75% and urban areas with 67%.[5]

[1] World Population, Somalia dashboard, UNFPA 2019.
[2] Somalia Population Estimation Survey (PESS), 2014.
[3] World Population review, Somalia 2019.
[4] National Development Plan (NDP) 2017-2019, Ministry of Planning and International Cooperation (MoPIC)

At regional level, two specific regions of Somalia, namely Somaliland, located in the North-West and Puntland, located in the North East, experience more stability with regard to socio economic conditions. Stability in the two areas may have contributed to some improvement in poverty reduction. On the contrary, the Southern part of Somalia is comparatively poorer and suffers from unstable economic conditions and fragile security conditions. The southern part of Somalia, where conflict and instability are common, is subjected to food shortages and suffers from lack of proper infrastructure.
The poor socio-economic conditions and extreme poverty in Somalia can be attributed to a number of factors. The prominent ones being absence of an active and strong central government, civil disputes, and natural disasters such as floods and droughts. Somalia witnessed many inhibiting factors including the downfall of the government, and outbreak of civil war, which further aggravated the problem of poverty.

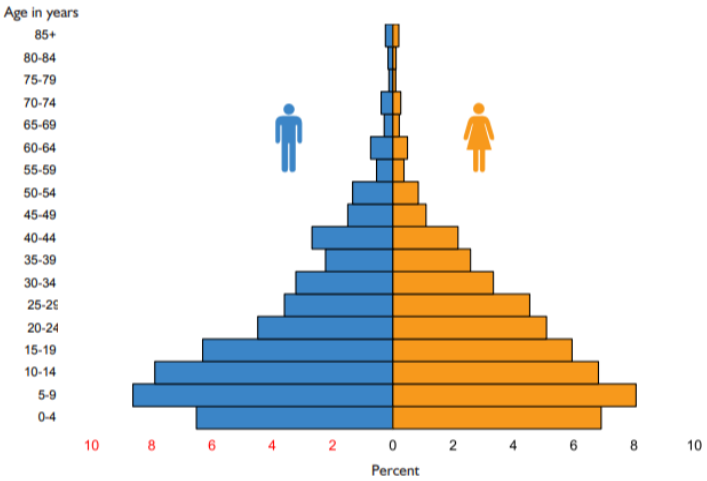
Another key aspect linked to the poverty is that Somalia demographic profile shows a pronounced youth bulge. According to the 2017 World Bank High Frequency Survey results, Somalia has a very young population. Approximately 50% of the population is below the age of 15 years. This situation is unlikely to change in the near future due to a high fertility rate.

The major structural drivers underlying youth engagement in violent conflict in Somalia are high youth unemployment and lack of livelihood opportunities. It is estimated that two thirds of youth are unemployed in the country, which is one of the highest rates of youth unemployment in the world[6]. In addition, there are other causes including insufficient, unequal and inappropriate education and skills, combined with poor governance and weak political participation, and a legacy of past violence. All of these factors combined contribute to youth joining violent groups. Immediate triggers include political events, abuses by security forces, sudden economic crisis, and personal loss.

According to last population estimations, the Somalia population pyramid still has the very wide base youthful structure that declines when age group increases. As mentioned above, this can be either an economic opportunity (in terms of a demographic dividend) or a core challenge to Somalia's stabilization and poverty reduction.

[5] Federal Government of Somalia (FGS), National Development Plan 2017-2019, December 2016, p. 1.
[6] World Bank High Frequency Survey results, 2017.

Figure 2: Somalia Population Pyramid 2014



Source: UNFPA, 2014 Somalia Population Estimation Survey (PESS).

A 51% against 49% the population distribution between female and male respectively with around 99.55 males per 100 females.

As far as health and demographic aspects of Somalia are concerned, the country has a very high maternal mortality ratio of 732 deaths per 100,000 live births according to 2016 estimations and statistics, compared to 1,080 deaths per 100,000 live births in 2000[7]. Despite significant progress made, it remains one of the highest in the world. In 2016, the adolescent fertility rate was 103 births per 1,000 women aged 15-19 years, with 45.3 per cent of all women aged 20-24 years in 2006 reporting being married or in union before the age of 18. Somalia also faces high levels of obstetric fistula, which is widespread and available evidence points to high prevalence of female genital mutilation, child marriage and early pregnancy as some of the contributing factors, along with low contraceptive prevalence rate, to the high maternal mortality rate.

Despite this, there has been a gradual increase in midwife-attended and/or facility-based births, from less than 10 per cent in 2011 to 36 per cent in 2016, and an increase in birth spacing/family planning, with the contraceptive prevalence rate more than doubling from less than 3 per cent in 2011 to 6 per cent in 2016[8].

Based on Somalia's situation over decades of instability and security deterioration, gender inequality, discrimination against women, and gender-based violence in all its various forms exist. According to the State of the World's Mothers 2015 report by Save the Children, Somalia is one of the worst places in the world to be a mother. This poses a challenge in addressing human rights issues including gender equality and women's empowerment in a systemic manner. The prevalence of female genital mutilation is one of the highest in the world, at an estimated 98 percent[9]. Child marriage is a culturally accepted harmful practice.

The large number of young people could spur economic growth if harnessed well as a dividend, or could result in tensions and unrest if young people are left unemployed and disenfranchised. The needs of young people cannot be fully addressed without ensuring that the new generations are healthy and able to make informed decisions. It is estimated that only about 30,000 adolescents (10-19 years of age) receive SRHR services each year out of an estimated adolescent population of 3.3 million in 2014[10].

[7] Maternal Mortality Interagency Working Group 2015.
[8] UNFPA Somalia CPD 2018-2020.
[9] UNFPA Somalia CPD 2018-2020.

At the end of 2018, over 2.6 million Somalis were internally displaced, of which an estimated 650,000 had been displaced since January 2015[11]. The inability to provide adequately for internally displaced people has led to disparities and exclusion, which have only further weakened community resilience. The Somali statistical system collapsed in the late 1980s and the country has seen a data vacuum since then. Until recently, most population estimates were based on the 1975 census. The largest recent data collection effort, covering the entire country, was the 2014 Population Estimation Survey, carried out by the Somali authorities with technical and financial support from UNFPA and other partners and donors.

National priorities, as articulated in the National Development Plan 2017-2019 have a strong focus on tackling poverty. The implementation of the plan will be underpinned by activities that will help create an environment necessary for sustainable development. This will entail making robust yet sustained improvements to the political, security, governance, social and economic conditions of the country. In terms of strategic opportunities, UNFPA is well positioned to contribute to Somalia's social and human development, particularly in the national plan areas of health, youth, gender and resilience capacity building.

Among the key achievements of the past UNFPA country programme of cooperation, Somalia has realized improved access to reproductive health services through enhanced reproductive health-care service delivery processes, increased family planning service uptake and increased reproductive health commodity security, obstetric fistula prevention and management, and strengthened capacities of national and local authorities. The number of midwifes trained according to international standards rose from about 250 in 2011 to about 1,223 in mid-2019.[12]

The number of obstetric fistula cases successfully repaired at supported sites increased from an estimated few cases in 2011 to almost 1,010 in mid-2019. The number of regions and communities that declared the abandonment of female genital mutilation went from zero in 2011 to around 300 in mid- 2019[13]. UNFPA contributed significantly to the provision of data to guide policy formulation and planning. UNFPA, with the financial support from different donors, conducted the Somalia Demographic and Health survey 2017 (SDHS) as well as undertakes Somalia population projections and estimations on an annual basis.

Among the lessons learned in the past country programme, partnerships between UNFPA, Government and NGOs proved to be instrumental in several areas, particularly for gender-based violence response across the country. Coordination and capacity strengthening of local level structures, including religious leadership, community-based organizations, traditional and community leaders was a key success factor of the programme.

[10] UNFPA Somalia CPD 2018-2020.
[11] Internal Displaced Monitoring Centre, 2019.
[12] UNFPA Somalia CPD 2018-2020.
[13] UNFPA Somalia Country Programme 2018-2020 progress reports.

2.2. UNFPA 3rd Cycle Programme 2018-2020

The UNFPA Somalia country office implemented two country programme cycles before the current one. UNFPA and the Government of Somalia have worked jointly to address and contribute to the national development priorities as well as to support the improvement and advancement of thematic areas under the UNFPA mandate, in particular SRHR. This joint work is aligned with the Somalia National Development Plan 2017-2019, the 2030 Agenda for Sustainable Development Goals (SDGs) and the United Nations Integrated Strategic Framework (UNSF) 2017-2020.

UNFPA Somalia's current Country Programme 2018-2020 has four thematic areas of programming, which are structured according to the four outcomes in the UNFPA Strategic Plan 2018-2021 (except Outcome 1):

1. Sexual and reproductive health and rights: **Outcome 1: Increased availability and use of integrated sexual and reproductive health services (including family planning, maternalhealth and HIV) that are gender-responsive and meet human rights standards for qualityof care and equity in access.** This outcome is addressed through the following two output(s) Output 1: Increased national capacity to deliver comprehensive maternal health services,including in humanitarian settings; and Output 2: Increased national capacity to provide sexual and reproductive health services,including in humanitarian settings.

2. Adolescents and youth: **Outcome 2: Every adolescent and youth, in particular adolescent girls, is empowered to have access to sexual and reproductive health and reproductive rights, in all contexts.** This outcome is addressed through the following output: **Output 1:** Increased capacity of partners to design and implement comprehensive programmesto reach marginalized youth, including adolescent girls at risk of child marriage.

3. Gender equality and women's empowerment: **Outcome 3: Gender equality, the empowerment of all women and girls, and reproductive rights are advanced in development and humanitarian settings**. This outcome is addressed through the following output: Output 1: Increased capacity of partners to provide services to survivors of gender-based violence, to prevent gender-based violence and harmful practices, and to promote reproductive rights and women's empowerment, including in humanitarian settings.

4. Population Dynamics: **Outcome 4: Everyone, everywhere, is counted, and accounted for, in the pursuit of sustainable development.** This outcome is addressed through the followingoutput: Output 1: Strengthened national capacity for production, dissemination, and use of high-qualitydisaggregated data on population, development, and sexual and reproductive health issues thatallows for mapping of demographic disparities and socio-economic inequalities, and for programming in humanitarian settings.

2.2.1.Sexual and reproductive health and rights

The SRHR programme component consists of two different elements. First, it focuses on the strengthening of national capacity to deliver comprehensive maternal health services, including in humanitarian settings. This will be addressed by supporting the expansion of midwifery training and capacity building to ensure women have access to skilled attendance at birth; expansion of quality preventive care as well as life-saving services for the management of complications during pregnancy and childbirth. Improving access to skilled health care and referrals to lower the rates of obstetric fistula and strengthening social reintegration services; and to support and promote advocacy and dialogue for elimination of harmful practices in the country.

Second, the SRHR component supports provision of reproductive health and birth spacing counselling

services at health centres and mobile clinics. Increasing accessibility of target and vulnerable populations including by engaging men; ensuring continuous availability of quality, essential life- saving maternal/reproductive health medicines/commodities, including contraceptives; supporting the outreach services targeting areas with poor access to health services, and areas affected by humanitariancrises; and finally prepositioning of emergency reproductive health supplies. The combination of these interventions targets hard-to-reach populations.

2.2.2.Adolescents and youth

The adolescents and youth component of the country programme is integrated within the SRHR component and aims at increasing the capacity of partners to design and implement comprehensive programmes to reach marginalized adolescents and youth, including adolescent girls at risk of child marriage. This country programme prioritizes the implementation of the Somali Youth Strategy, with a specific focus on integrating young people in national sexual and reproductive health development policies and programmes, incorporating empowerment and age-appropriate service delivery. Promoting youth-led interventions by engaging adolescents and youth in the assessment, design, implementation, and evaluation of programmes, with young people as decision-makers, equal partners, and agents of social change; strengthening national capacity to conduct evidence-based advocacy for incorporating human rights/needs of young people in laws and policies; and developing and enhancing youth-friendly health services.

2.2.3.Gender equality and women's empowerment

The gender equality and women's empowerment component focuses on enhancing the capacity of partners to provide services to survivors of gender-based violence, and activities to prevent gender- based violence and harmful practices, and to promote reproductive rights and women's empowerment, including in humanitarian settings. In its function as lead of the gender-based violence sub-cluster within the humanitarian response architecture in Somalia, UNFPA coordinates activities to strengthen gender-based violence prevention and the delivery of services among a multitude of stakeholders, including Government institutions, and national and international non-governmental organizations.

The following interventions have been implemented under this thematic area: supporting the government in policy and legislative reforms that aim to ensure accountability on human rights of marginalized groups, gender equality, women's reproductive rights issues and gender-based violence prevention and response. Promoting advocacy efforts with Government and national partners, and community-based organizations to develop, enact and implement gender-based violence-related legal frameworks. Supporting the continuous operation of family centres/one-stop centres, which provide medical, psychosocial and legal support to gender-based violence survivors. Additionally, temporary shelters/safe homes for gender-based violence survivors; and promoting social norm and behaviour change, particularly focusing on total abandonment of female genital mutilation and child/forced/early marriage by extensive community-led engagement, dialogues, sensitization and mobilization at variouslevels.

2.2.4.Population dynamics

The main focus of the population dynamics programme component lies on strengthening national capacity for production, dissemination, and use of high-quality, disaggregated data on population, development, and sexual and reproductive health issues that enables the mapping of demographic disparities and socio-economic inequalities, and can inform programming in humanitarian settings. Accordingly, UNFPA Somalia mainly works with the government to strengthen the capacity of the Somali statistical system at federal and state levels to generate, disseminate, and analyse quality statistical information by: providing technical support for the development of tools, manuals and guidelines for the generation of population data to inform policy and programmes, including through South-South cooperation. Providing technical assistance in conducting a population census as part of the 2020 census round. In addition to strengthening the civil registration and vital statistics systems; providing capacity development support to

national institutions to enhance the tracking of progress towards the SDGs and national- and state-level development plans; and finally promoting the use of evidence for decision-making to improve public accountability.

In addition, UNFPA coordinates with the UNCT under the umbrella of the UN Resident and Humanitarian Coordinator through Somalia's UNSF 2017-2020, with the aim to facilitate the achievement of the SDGs at the national and global levels. The UNSF has the following strategic priorities:

1. Deepening federalism and state-building, supporting conflict resolution and reconciliation, and preparing for universal elections.
2. Supporting institutions to improve peace, security, justice, the rule of law and safety in Somalia.
3. Strengthening accountability and supporting institutions that protect human rights.
4. Strengthening resilience of Somali institutions, society and population.
5. Supporting socioeconomic opportunities for Somalis leading to meaningful poverty reduction, access to basic social services and sustainable, inclusive and equitable development.

Through these 5 strategic priorities, the UNCT works jointly on the institutional systems strengthening, national capacity development to promote accountability, transparency, good governance, human rights, gender equality and women's empowerment, peace and security, as well as federalization and decentralization.

3. Objectives and Scope of the Evaluation

3.1. Overall Objectives and Specific Objectives

The CPE's **overall objective**s are:

a) To enhance the accountability of UNFPA for the relevance and performance of the Somalia country programme.
b) To generate robust evidence to inform decision-making and enable evidence-based programming by the UNFPA Somalia CO.
c) To draw key lessons and success stories from past and current country programme interventions and provide a set of forward-looking and actionable recommendations to improve the design, implementation and monitoring of the next country programme cycle.

While the CPE's **specific objectives** are:

a. To provide an independent and objective assessment of the relevance, effectiveness, efficiency and sustainability of UNFPA support and progress towards the expected outputs and outcomes articulated in the results and resources framework of the Somalia country programme 2018- 2020.
b. To examine the role played by the UNFPA Somalia CO in the coordination mechanisms of the United Nations Country Team with a view to enhancing the United Nations contribution to national development results.
c. To analyse the contribution of the country programme to the humanitarian-development-peace nexus, with a particular focus on the establishment of linkages between development and humanitarian interventions, resilience building and capacity development of national partners and stakeholders.

2.2 Scope of the Evaluation:

Time period: The CPE will cover the interventions and activities implemented within the period of the current UNFPA Somalia country programme cycle (1 January 2018 – 31 December 2020).

Geographic coverage: This evaluation exercise will cover all sites where the UNFPA Somalia CO and its implementing partners have implemented projects and programmes within the current cooperation cycle, including the Federal Members States.

Thematic areas of programming: The CPE will assess all thematic areas of programming that are covered by the 4 outcomes and 5 associated outputs, as stated in the results and resources framework of the 2018-2020 country programme (e.g. SRHR, population dynamics, adolescents and youth, and gender equality and women's empowerment). In addition, it will focus on the linkages between development, humanitarian action and peacebuilding, including resilience-building components of the country programme.

4. Evaluation Criteria and Preliminary Evaluation Questions

The evaluation will be informed by the 2019 Handbook on How to Design and Conduct Country Programme Evaluations at UNFPA as well as the UNEG standards, norms and principles.

4.1 Evaluation Criteria

The CPE will examine the following four OECD/DAC evaluation criteria: Relevance, Effectiveness, Efficiency and Sustainability. It will also assess the strategic positioning of UNFPA within the UNCT by using coordination as evaluation criterion. Given the humanitarian crises in Somalia, the evaluation will pay particular attention to how well UNFPA support bridges the humanitarian-peace-development nexus and contributes to enhancing resilience by examining the criterion of connectedness.

Evaluation criteria	Definition
Relevance	The extent to which the objectives of the UNFPA country programme correspond to population needs at country level (inparticular those of vulnerable groups) and were aligned throughout the programme period with Government priorities and with strategies of UNFPA.
Effectiveness	The extent to which country programme outputs have been achieved,and the extent to which these outputs have contributed to the achievement of the country programme outcomes.
Efficiency	The extent to which country programme outputs and outcomes havebeen achieved with the appropriate amount of resources (funds, expertise, time, administrative costs, etc.).
Sustainability	The continuation of benefits from a UNFPA-financed interventionafter its termination, linked, in particular, to their continued resilience to risks.
Coordination	The extent to which UNFPA has been an active member of, and contributor to, the existing coordination mechanisms of the UNCT.
Connectedness	The extent to which activities of a short-term emergency nature arecarried out in a context that takes longer-term and interconnected problems into account.

4.2 Evaluation Questions

The evaluation team is expected to formulate a final set of evaluation questions (limited to a maximum of

10) - to be approved by the Evaluation Manager, in consultation with the Evaluation Reference Group(ERG) - drawing on the preliminary evaluation questions presented below. When finalizing the evaluation questions, the evaluation team should refer to the sample evaluation questions that are presented in the UNFPA evaluation handbook for the individual evaluation criteria.

Relevance:

1. To what extent has the country programme addressed national priorities and needs of the population vis-à-vis the UNFPA mandate?
2. To what extent has the country office been able to respond to changes in the national development context and in relation to the humanitarian crisis in Somalia?
3. To what extent have UNFPA-supported interventions been aligned with the UNFPA Strategic Plan 2018-2021, national development plans and priorities, and international policy and normative frameworks related to development and humanitarian action?
4. To what extent has UNFPA ensured that the needs of young people have been considered in the planning and implementation of UNFPA-supported interventions under the country programme?

Effectiveness:

1. To what extent has the country programme contributed to improving access and use of affordable quality reproductive health (RH) services, particularly maternal health services related to child delivery and management of complications prior, during and after pregnancy (including the surgical repair of obstetric fistula)?
2. To what extent have UNFPA-supported interventions contributed to a sustained increase in theuse of demographic and socio-economic information and data by national authorities and external stakeholders in the development and implementation of plans, programs and policies to improve access to RH services, including in areas associated with gender equality, populationdynamics and HIV/AIDS.
3. Has the UNFPA support in the area of gender equality contributed to the empowerment of women and girls and the prevention and response to gender-based violence and harmful practices, especially in crisis-affected settings?

4. To what extent have UNFPA-supported interventions contributed to increasing access of adolescents and youth to affordable quality SRHR services (incl. rights-based family planning services) and comprehensive sexuality education?

Efficiency:

1. To what extent has UNFPA used available financial and human resources as well as its technical expertise in an efficient manner to achieve the intended results of its country programme?
2. To what extent did the intervention mechanisms (financing instruments, human resource policies, rules and procedures, administrative regulatory framework, and timing) foster or hinder the achievement of the programme outputs?

Sustainability:

1. To what extent has UNFPA been able to support its partners and the beneficiaries in developingcapacities and establishing mechanisms to ensure ownership and the durability of effects?

Coordination:

1. To what extent were programme coordination mechanisms effective to boost the programme implementation and achieve better results?
2. To what extent did UNFPA contribute to the functioning and consolidation of existing United Nations system-wide coordination mechanisms for both development and humanitarian actionin Somalia?

Connectedness:

1. To what extent does UNFPA response to humanitarian crises in Somalia support and plan for longer-term development goals articulated in the results and resources framework of the 2018-2020 country programme?
2. To what extent has UNFPA contributed to developing the capacity of civil society (incl. youth and women's organizations), government partners (in particular health facilities) and communities to better prepare, respond to and recover from humanitarian crisis?

The final set of evaluation questions will be presented in the Inception/Design Report.

5. Evaluation Approach and Methodology

5.1 Evaluation Approach

The evaluation approach will adhere to the standards and principles of evaluation at UNFPA, particularly transparency, inclusiveness, participation and human rights and gender responsiveness. Furthermore, the CPE will adopt a mixed method approach and use qualitative and quantitative data collection, processing and analysis methods.

This CPE approach will be in line with the 2019 UNFPA Evaluation Policy along with its 2019 Handbook on How to Design and Conduct Country Programme Evaluations at UNFPA. It will also be aligned with UNEG standards, norms and principles, in addition to OECD/DAC criteria. Moreover, theCPE will abide by the UNEG Ethical Guidelines and Code of Conduct, in particular it will rely on the "UNEG Handbook on Integrating Human Rights and Gender Equality in Evaluation - Towards UNEGGuidance".

Theory-based Approach

The CPE will rely on a theory-based approach that illustrates how and why UNFPA contributed to the expected results of the country programme in the context of Somalia. At the centre of the theory-based approach is the analysis of the theory of change (ToC) underlying the country programme (see Annex 1) to determine whether and to what extent UNFPA activities contributed to changes at output and outcome levels that ultimately support the achievement of impact. Evaluators will review and, in a second step, test the ToC by collecting evidence on observed results, causal pathways and contextual factors to verify whether the expected chain of results manifested and whether assumptions of why the results were expected to occur hold true. This approach therefore will facilitate understanding of the performance of the UNFPA Somalia country programme 2018-2020. In addition, using the ToC as guidance for the evaluation will strengthen the robustness of the CPE results and provide a clear picture of what works, does not and why.

Participatory Approach

The CPE will ensure a participatory and inclusive process by establishing an Evaluation Reference Group (ERG), which will include stakeholders and partners who will follow the evaluation process from the beginning to the end.

The Evaluation Team will consider the participation of partners and stakeholders in the evaluation process. This includes direct and indirect partners such as national federal and member states government(s), international and national NGOs, and the programme beneficiaries at national and sub-national levels. The evaluation will ensure that women, girls and young people are part of the evaluation process and that their perspectives and opinions are collected. This inclusive approach is important to generate diverse views on the programme performance and achievement of expected outcomes.

Mixed-methods Approach

The evaluation will primarily use qualitative methods for data collection, including document review, interviews, group discussions and observations through field visits, as appropriate. The qualitative data will be complemented with quantitative data to minimize bias. Quantitative data will be compiled through desk review of documents, websites and online databases to obtain relevant financial data and data on key indicators that measure change at output and outcome levels.

These complementary approaches described above will be used to ensure that the evaluation: (i) responds to the information needs of users and the intended use of the evaluation results; (ii) upholds gender and human rights principles throughout the evaluation process, including, to the extent possible, participation and consultation of key stakeholders (rights holders and duty-bearers); and (iii) provides credible information about the benefits for recipients and beneficiaries (women and adolescents and youth) of UNFPA support through triangulation of collected data.

5.2 Evaluation Methodology

The evaluation team will develop the evaluation methodology in line with the evaluation approach and design data collection and analysis tools as a foundation to provide answers to the evaluation questions and to assess the overall performance of the UNFPA Somalia country programme 2018-2020. The methodological design will include a ToC, a strategy for collecting and analysing data (incl. a sampling strategy), specific data collection instruments (interview and focus group tools and protocols etc.), an evaluation matrix, and a detailed work plan.

As a first step in the CPE, the evaluation team will undertake a literature and desk review that will give the evaluators a comprehensive initial picture of the country programme and the country context. The literature review will help the evaluators' review of the existing ToC of the country programme to validate the pathway of change that it describes. The information and insights gained from the literature review will also provide the basis for the definition and the development of the CPE methodological design, including the development of the evaluation matrix and all required data collection instruments (interview and focus group protocols and tools etc.), the stakeholders map and sampling strategy, as well as the agenda for the field phase (data collection).

The evaluation approach and methodology will be presented in the Inception/Design Report and will be reviewed by the evaluation manager and the ERG, with final approval by the evaluation manager.

Data Collection

The evaluation will consider both secondary and primary sources for data collection.

As for the primary sources, semi-structured interviews with key informants at national and state levels, as well as focus group discussions with beneficiaries (women, adolescent girls and young people) and service providers, along with field visit observations shall be conducted as appropriate and needed. As part of data collection planning, the evaluation team will define a well-designed sampling frame for the data collection exercise, providing a rationale for the selected respondents and locations.

Secondary sources will be sought through desk review, primarily focusing on annual and mid-year reviews of the country programme, progress and monitoring frameworks/reports as well as any records/registries of partners, such as health centres, safe spaces, and youth centres, and any available documentation on population and housing census data. Particular attention will be paid to compiling reports documenting data for some thematic key performance indicators (KPIs) that were supported by UNFPA during the time frame of the 2018-2020 country programme, such as the Somalia Health and Demographic Survey (SHDS) 2018. Furthermore, thematic evaluation reports and findings of assessments conducted during the country programme shall also be considered.

The evaluation team will ensure that all available or collected data and information will be disaggregated by age group, sex, displacement/migration status, disability, and location to the extent possible, as the geographic scope of the CPE exercise covers all levels of programme implementation of the UNFPA Somalia 2018-2020 country programme (i.e. national, sub-national and local level). Additionally, the evaluation team will be responsible for linking all the data collection methods with the scope of work of the evaluation, in particular with the evaluation criteria and standards. The utilization of an Evaluation Matrix template will assist the evaluation team in putting all components together and in ensuring an integrated process is in place.

Data Analysis

The evaluation team will be responsible for generating robust evidence and for identifying findings and conclusions during the data analysis. Information on results along the results chain described by the ToC, especially outputs and outcomes, will be subject to in-depth analysis to identify what the actual changes are to which the country programme has contributed, and to provide a robust evidence base for the final Evaluation Report. Using the set of KPIs in the results and resources framework of the 2018- 2020 country programme will be helpful to assess the changes that have happened during the cycle of the country programme.

The evaluation matrix will be the major framework for analyzing data. Once all data will have been entered into the evaluation matrix for each evaluation question, the evaluators will identify common themes, patterns and relationships in the data, as well as areas that should be further explored to answer the evaluation questions. The evaluation team will utilize a mix of data analysis methods and techniques to triangulate and process the data, relying on different types of qualitative and quantitative data and information.

Data Validation Mechanisms

The evaluation team should have in its methodology the most appropriate validation protocols and mechanisms that will support its work on data validation and reliability. No results will be accepted without demonstrating the underpinning evidence and supporting information. The evaluation team may utilize innovative data validation mechanisms that will work along with the regular systematic data andinformation triangulation mechanism. Furthermore, the evaluation team will communicate all of its findings along with the evidence to the ERG and UNFPA evaluation manager, and any other relevant stakeholders, aiming at enhancing the validity and reliability of the data and information used.

Evaluation Process

The country programme process can be broken down into the following phases which include a number of key steps that are outlined below:

Preparatory Phase:

- Sending official letter to the respective governmental partners' coordinator (Ministry of Planningand International Cooperation, MoPIC) to inform them about the CPE.
- Drafting of CPE Terms of Reference in close collaboration with the M&E Adviser at the UNFPAArab States Regional Office (ASRO) and approval of UNFPA Evaluation Office (EO) at HQ.
- Selecting potential evaluators in close collaboration with ASRO M&E Adviser and UNFPA Evaluation Office at HQ for pre-qualification.
- Establishing an ERG.
- Stakeholder mapping of the main relevant partners and stakeholders.
- Compiling list of initial background information and documents regarding country context aswell as the UNFPA Somalia country programme 2018-2020.
- Compilation of list of Atlas GPS projects, interventions and annual work plans.
- Develop an Evaluation Communications Plan for effective sharing of the final Evaluation Reportand the evaluation brief.

Design Phase:

- Review the theory of change underlying the country programm and adapt is, as needed.
- Review documents and draft the Inception Report/Design Report.
- Develop the proposed evaluation methodology, finalize evaluation questions, prepareevaluation matrix and select data collection methods and tools.
- Share the Inception Report/Design Report with the UNFPA CO and ERG for feedback.
- Revise and finalize the Inception Report/Design Report based on feedback received.
- Develop a detailed Evaluation Plan, including the sampling framework with stakeholders andpartners in close coordination with Evaluation manager/CO.

Field Phase:

- Undertake the first meeting with UNFPA CO staff, including senior management and Programme Officers.
- Conduct field work and data collection, including planned interviews and focus group discussions in selected areas inside and outside of Mogadishu (this includes the data analysis process).
- Present the preliminary findings and analysis to Evaluation Manager/ERG for feedback and comments (this includes providing some initial recommendations).

Reporting Phase:

- Draft the Evaluation Report.
- Submit the draft Evaluation Report to UNFPA Somalia CO and ERG for review.
- Conduct first Evaluation Quality Assurance (EQA) of draft Evaluation Report (UNFPA internal review in close collaboration with ASRO M&E Adviser).
- Review the draft Evaluation Report based on the consolidated comments and feedback provided by evaluation manager/ERG/ASRO M&E Adviser) and develop the final draft Evaluation Report.
- EQA of final Evaluation Report by evaluation manager in close collaboration with ASRO M&E Adviser and ERG.
- Final EQA by the UNFPA Evaluation Office.

Facilitation of Use and Dissemination Phase:

- Organise and conduct a validation workshop/meeting with all relevant parties to validate and endorse the CPE final report.
- Develop Evaluation Summary Brief document that includes key findings, conclusions and recommendations of the evaluation.
- CPE report distributed to relevant stakeholders, partners and audience through CO, ASRO, ERG and UNFPA HQ.
- Prepare and finalize Management Response to the CPE Report recommendations, including the feedback and comments from UNFPA units at ASRO and HQ.
- CPE report, final EQA and management response published on CO website and UNFPA evaluation database.

6. Expected Deliverables

UNFPA Somalia CO expects to receive the following deliverables from the evaluation team within the CPE exercise timeframe:

- **Inception Report/Design Report** (a maximum of 30-40 pages) prior to the evaluation exercise per se. The report should include the ToC of the country programme, a stakeholders map and sampling stratgy, the evaluation matrix with evaluation questions along with related Key Performance Indicators (KPIs) and a proposed schedule of tasks, activities and deliverables, as well as the overall evaluation approach and methodology. This report is intended to reflect how each evaluation question will be answered by way of: proposed methods, sources of data, and data collection protocols and methods, and data analysis and interpretation. The report should specify the division of labor among the evaluation team members describing each member's roles, responsibilities and related level of efforts and working days.
- **Powerpoint presentation of the Inception Report/Design Report** and the detailed evaluation work plan. This will be delivered at a specific event to elaborate the inception/design report contents and structure, intended operational and action plans for the UNFPA CO team,

the evaluation manager, ERG and any other relevant stakeholders.

- **Debriefing meeting at the end of the field phase** and data analysis work with all UNFPA CO staff, in particular the programme managers and officers as well as the evaluation manager. This meeting will include a discussion of all main preliminary findings and emerging conclusions and recommendations.
- **Draft final Evaluation Report** to be delivered to UNFPA CO and ERG for their review, feedbackand inputs, which will be taken in consideration by the evaluation team.
- **Power point presentation on final evaluation findings, conclusions and recommendations** thatwill be delivered during the validation workshop, which also provides an opportunity to disseminatethe final results of the CPE.
- **Final Evaluation Report** that includes all the feedback, inputs and comments that were received during the validation and dissemination workshop as well as from the ERG and UNFPA CO staff. This report will include a full set of forward-looking and actionable recommendations based on the CPE findings, best practices, lessons learnt and challenges identified, which will be taken in consideration during the development of the new CP cycle.
- **Evaluation Summary Brief** document that includes key findings, conclusions and recommendations of the evaluation. It should be a short and concise documents that provides key highlights of the evaluation in an easily understandable manner, similar to the evaluation briefs of centralized evaluations produced by the UNFPA Evaluation Office.

7. Work Plan and Indicative Schedule of Deliverables

Phase	Tasks	Timeline	Deliverables	Expected Working days
Preparation	Send official letter to the respective governmental partners' coordinator (MopIC) to inform them regarding the CPE	Aug 2019	Government approval granted	N/A (UNFPA internal work and arrangements)
	Drafting of CPE ToR in close collaboration with ASRO M&E Adviser, and approval by UNFPA EO	Sep-Nov 2019	Endorsed and approved CPEToR	
	Establishment of an Evaluation Reference Group (ERG)	Oct-Nov 2019	ERG is in place	
	Selection of potential evaluatorsin close collaboration with ASRO M&E Adviser, submission of recommended selection to UNFPA EO for pre-qualification, and recruitment of evaluation team	Nov-Dec 2019	Signed contract with all evaluation team members	
	Compilation of initial background information and	Nov-Dec 2019	Documents and all needed	
	documents regarding country context as well as UNFPA country programme and preparation of list of Atlas GPS projects		background information provided to evaluation team	

	Development of a stakeholder map	Nov-Dec 2019	Stakeholder map is in place	
Design	Development of the evaluation approach and methodology, validation of the existing ToC, finalization of evaluation questions per evaluation criteria,selection of data collection methods and tools and samplingframework, as well as articulation of evaluation matrix	Jan-Feb 2020	Draft Inception Report/Design Report is available and draft CPE work plan, including all requirements in place	21 working days
	Submission of the draft Inception Report/Design Report to Evaluation Manager and ERG for feedback and comments	Jan-Feb 2020		
	Present draft Inception Report/Design Report to ERG for feedback and comments, including evaluation matrix, datacollection methods and tools, sampling framework and CPE work plan	Jan-Feb 2020	Power point presentation ofthe Inception Report/Design Report and the detailed CPE work plan	
	Submission and approval of final Inception Report/Design Report	Feb 2020	Final Inception Report/Design Report is available, including CPEwork plan	
	Develop Evaluation Communications Plan	Jan-Feb 2020	Communications plan is in place	N/A (UNFPA internal work and arrangements)
Field	Meeting of evaluation team with UNFPA Somalia CO staff and presentation of programming by relevant Programme Officers	March 2020	Kick-off meeting withall UNFPA Somalia CO staff	21 working days
			(individual meetings with relevant Programme Officers as required)	

	Conduct 3-weeks field work including data collection and planned interviews in selected areas inside of Somalia (this includes the data analysis process)	March 2020	Data collection (key information interviews, focus group discussions, site visits in and outside Mogadishu)	
	Present the preliminary findings and analysis to Evaluation Manager/ERG for feedback and inputs (this includes providing some initial recommendations)	Last week of March 2020	Debriefing meeting with UNFPA Somalia CO staff and ERG (PowerPoint presentation on preliminaryfindings and emerging conclusions and recommendations)	
Reporting	Draft final evaluation report to be shared with ERG and UNFPA Somalia CO, as well as ASRO M&E Adviser	April 2020	Draft final Evaluation Report is available	14 working days
	Submission of the zero draft final evaluation report for feedback and comments by UNFPA Somalia CO, ERG, and ASRO M&E Adviser	May 2020		
	Conduct validation meeting with stakeholders, ERG and UNFPA Somalia CO to validate the CPE findings, conclusions and recommendations	Last week of May 2020	Stakeholders validation meeting (PowerPoint presentation on final evaluation findings, conclusions and recommendations)	2 working days
	Preparation of Evaluation Quality Assurance (EQA) by Evaluation Manager and ASRO M & E Adviser	June 2020	EQA Matrix isin place	N/A (UNFPA internal work)

	Drafting final evaluation report based on comments and feedback received at validation meeting and quality assurance reviews	June 2020	Final Evaluation Report is available	14 working days
	Conduct of the Evaluation Quality Assessment (EQA) by EO	June 2020	EQA by EO isin place	N/A (UNFPA internal work)
Facilitation of use and dissemination	Develop draft Evaluation Brief and submit to Evaluation Manager and ASRO M&E Adviser for review and preparefinal version based on feedbackand comments	July 2020	Draft EvaluationBrief is available Final EvaluationBrief is available	5 working days
	Dissemination and launch of the final Evaluation Report: Distribute the final evaluation report to all relevant audiences and stakeholders via UNFPA Somalia CO, ASRO, ERG and UNFPA HQ for their responses and recommendations that will be included in the CPE final management response	July 2020	Final Evaluation Report and Evaluation Brief disseminatedand launchedand all evaluation-related products publicly available on UNFPA website and repositories	N/A (UNFPA internal work)
	Final Evaluation Report, Evaluation Brief, EQA and management response uploaded and published on CO website and UNFPA evaluation database	July 2020		
	Share the final Evaluation Report with UNFPA Executive Board	Early Aug 2020		

8. Composition of the Evaluation Team

The CPE exercise is expected to count on a professional and qualified evaluation team that will undertake a robust assessment. The expected composition of the team will be:

- A Team Leader (international), with overall responsibility for carrying out the evaluation exercise.
- Three Thematic Consultants (national), who will provide the expertise in the core subject areas of the evaluation, and be responsible for supporting the evaluation exercise.

All members of the evaluation team must have considerable knowledge of and experience in conducting evaluations of complex interventions in developing countries, including strong regional experience, and preferably having worked on evaluations in the Arab region and/or sub-Saharan Africa or in Somalia specifically. The team should have experience of similar exercises in conflict and/or post-conflict settings and in humanitarian environments.

Team members should have technical expertise on one or more UNFPA mandate areas (SRHR, population and development, adolescents and youth and/or gender equality) and be committed to respecting deadlines and delivering outputs within the agreed timeframes. All team members should be knowledgeable about issues pertaining to gender equality and must be able to work in a multidisciplinary team and a multicultural environment.

All the members of the evaluation team should be independent from any organizations that have been involved in designing, executing or advising on any aspect of the UNFPA country programme in Somalia.

The Team Leader (international consultant)

The Team Leader is tasked with managing and ensuring the quality of the work conducted by the evaluation team members and has ultimate responsibility for delivering results – s/he will be responsiblefor the quality and timeliness of all deliverables and for guiding and supervising the other consultants. The Team Leader is also expected to cover one of the thematic areas of programming of the country programme.

Qualifications and experience of Team Leader

- Minimum of Master's Degree in public health, demographics, social sciences, development studies or a related field.
- Minimum of 10 years professional experience in conducting/managing programme evaluations in the field of international development and/or humanitarian action.
- Extensive previous experience in leading and conducting complex evaluations, especially evaluations commissioned by international organizations or development agencies.
- Thematic expertise in one of the UNFPA mandate areas (SRHR, population and development,adolescents and youth or gender equality).
- Excellent analytical, writing and communication skills.
- Leadership and good management skills.
- Experience in gender mainstreaming and management of cross-cutting themes.
- Familiarity with the UNFPA work will be an added advantage.
- Experience of similar exercises in conflict and/or post-conflict settings and in humanitarian crisis situations.

- Previous experience in conducting evaluations of UNFPA country programmes will be considered an asset.
- Development sector background.
- Ability to work with a multi-cultural and multi-disciplinary team of experts.
- Excellent problem identification and solving skills.
- Excellent written and spoken English.

Roles and responsibilities of the Team Leader

- Provide overall leadership and methodological guidance to the evaluation team in all phases of the evaluation.
- Provide the inputs for quality aspects of the overall process.
- Cover a thematic component of the CPE (e.g. SRHR, population and development, adolescentsand youth or gender equality).
- Compile the design report with the inputs from national consultants.
- Compile draft and final Evaluation Reports and deliver them on time, in line with quality requirements, including his/her inputs in his/her assigned thematic area of expertise. The Team Leader will have primary responsibility for the timely completion of a high-quality EvaluationReport that meets all the requirements and specifications outlined in this ToR.
- Responsible for debriefing the evaluation findings.
- Liaison with Evaluation Manager at UNFPA Somalia CO.

Qualifications and experience of Thematic Consultants (national consultants)

- Minimum of Master's Degree in public health, demographics, social sciences, development studies or a related field.
- Minimum of 7 years of experience in programming on SRHR, in particular on reproductive and maternal health (including family planning, emergency obstetric and new-born care), population and development, adolescents and youth or gender equality.
- At least 3 years of experience in conducting evaluations in the fields of SRHR, population and development, youth and adolescents or gender equality.
- Previous experience in research, data collection and analysis in the fields of SRHR,population and development, youth and adolescents or gender equality.
- Excellent knowledge of the national development context, as well as challenges andopportunities for sustainable development in the country.
- Excellent analytical, writing and communication skills.
- Ability to work with a multi-cultural and multi-disciplinary team of experts.
- Excellent problem identification and solving skills.
- Should be able to provide deliverables on time.
- Excellent written and spoken English and Somali.

Roles and responsibilities of the Thematic Consultants

- Contribute to the preparation of the design report in line with UNFPA and UNEG standards and requirements.
- Evaluate each thematic section of the country programme.
- Take part in the data collection during the design and field phases, as well as data analysis atthe end of the field phase.
- Be involved in the debriefing to the CO.

- Deliver quality inputs on the assigned thematic areas of expertise on time.
- Responsible for drafting key parts of the Design Report and of the final Evaluation Report.

9. Remuneration and Duration of Contract

Repartition of workdays among the evaluation team will be the following:

- 77 workdays for the Team Leader.

- 55 working days each for the three Thematic Consultants.CPE Evaluation Team timeline by working days

Working days per CPE Phases	Team Leader	Thematic Consultant(s)
Preparation	0	0
Design	21	14
Field	21	21
Reporting	30	20
Dissemination and Facilitation of Use	5	0

Payment of fees will be based on the delivery of outputs, as follows:

- Upon satisfactory completion of the Inception Report/Design Report: 20%
- Upon satisfactory completion of the draft final Evaluation Report: 40%
- Upon satisfactory completion of the final Evaluation Report: 30%
- Upon satisfactory completion of the Evaluation Brief: 10%

In addition to the professional fees, Team members will receive a Daily Subsistence Allowance (DSA) to be paid per night spent at the place of the mission following UN Daily Subsistence Allowance standard rates. DSA does not apply for days spent at place of residence. Travel costs will be settled separately from the consultancy fees and will be covered by UNFPA.

9. Management of the Eva valuation

Evaluation Manager

The UNFPA Somalia CO M&E Specialist will act as the evaluation manager for this CPE and oversee the entire process of the CPE. He will receive technical support and guidance from the CO Representative, Deputy Representative and ASRO Regional M&E Adviser to:

- Prepare the Terms of Reference (ToR) for the evaluation.
- Identify potential evaluators and submit the recommended selection to the Evaluation Officefor pre-qualification.
- Compile a preliminary list of background information and documentation on both the country context and the UNFPA country programme.
- Constitute an evaluation reference group.

- Prepare a first stakeholders mapping of the main partners relevant for the CPE and the Atlas project list.
- Develop a communications plan to guide dissemination of the Evaluation Report andEvaluation Brief.
- Conduct a quality assurance assessment for the CPE draft report and the final report.
- Coordinate the feedback and inputs that will be made by ERG, the ASRO M&E Adviser andEO at HQ.
- Submit the final Evaluation Report and the evaluation quality assessment to the ASRO M&E Adviser and EO at HQ.
- Lead and participate in the preparation of the CPE management response.

Evaluation Reference Group

As per the UNFPA evaluation handbook, an ERG will be put in place and tasked to provide guidance and constructive feedback on different products of the evaluation, hence contributing to both the quality and credibility of the exercise. Throughout the process of the evaluation, the ERG will be regularly invited to discuss and comment on notes and reports produced by the evaluation team.

Members of the ERG are also expected to facilitate the evaluation team's access to sources of information and documentation on the activities under evaluation. They will specifically:

- Provide inputs to the ToR, including the preliminary evaluation questions.
- Contribute to the selection of the final evaluation questions.
- Provide comments and feedback on the design report.
- Facilitate the evaluation team's access to sources of information (documents and interviewees)to support data collection and to ensure relevant key informants and stakeholders are consulted.
- Provide comments from a technical perspective on the main deliverables of the evaluation, including the draft and final Evaluation Reports.
- Advise on the quality of the work conducted by the evaluation team.
- Ensure that the final evaluation draft adheres to UNFPA and UNEG quality standards.
- Contribute to disseminating the findings, conclusions and recommendations of the evaluationand play a key role in learning and knowledge sharing based on the evaluation.

M&E Adviser at the UNFPA Regional Office for Arab States

The M&E Adviser of ASRO will closely work with the Evaluation Manager at CO level in providing technical inputs to the drafting of the ToR and the recruitment of evaluators, providing comments on the Inception Report/Design Report, the draft and final Evaluation Reports and the Evaluation Summary Brief, preparing the evaluation quality assessment (EQA) for the final CPE report, the CPE managementresponse, and supporting the CO in the dissemination of the CPE results.

The UNFPA Evaluation Office in New York will be involved in the CPE ToR approval, pre- qualification of the evaluation team, and quality assessment of the final Evaluation Report. The EO willpublish the CPE report, evaluation brief and accompanying independent EQA grid, as well as the management response in the UNFPA Evaluation Database
(available at: https://web2.unfpa.org/public/about/oversight/evaluations/documentList.unfpa).

10. Evaluation Quality Assurance

The evaluation team leader will undertake the first level of quality assurance of all evaluationdeliverables prior to submitting the deliverables to the CO evaluation manager. The EQA process involves: (a) a quality assessment of the draft final Evaluation Report by the CO Evaluation Manager; a quality assurance by the Regional M&E Adviser at ASRO; (c) a final independent quality assessment by the EO at HQ.

The Quality Assurance will include the following level as per each role of CO evaluation manager, ASRO M&E Adviser and EO at HQ:

Evaluation Manager at Country Office:

(b) Conduct a comprehensive quality assurance of the draft Inception Report/Design Report covering all chapters.
(c) Review and double-check the selection of the interviewees and information sources.
(d) Provide preliminary feedback on the validity of hypotheses/preliminary answers toevaluation questions.
(e) Review with evaluation team leader the data collection plan along with its methods and protocols.
(f) Review quality of draft Evaluation Report against the EQA grid and explanatory note.
(g) Share the report with the Regional M&E Adviser for quality assurance (using EQA grid).
(h) Finalize the quality assurance of the final Evaluation Report.
(i) Submit the final report to EO at HQ for quality assessment.

M&E Adviser at UNFPA Arab States Regional Office:

(a) Review the CPE ToR and ensure it is according to the UNFPA CPE ToR as per UNFPAEvaluation Handbook 2019.
(b) Review and provide quality assessment for the potential evaluation team.
(c) Review the draft Inception Report/Design Report covering all chapters.
(d) Review jointly with CO evaluation manager the data collection methods and protocols.
(e) Provide quality assessment for the hypotheses/preliminary answers to evaluation questions.
(f) Review quality of draft Evaluation Report against the EQA grid and explanatory note.

Evaluation Reference Group:

(a) Provide feedback on the draft Inception Report/Design Report covering all chapters.
(b) Provide feedback on the selected interviewees and information sources.
(c) Provide feedback and review the quality of the draft final Evaluation Report.

UNFPA Evaluation Office:

(a) Review and provide feedback regarding the CPE ToR to ensure it is according to UNFPAEvaluation Handbook 2019.
(b) Provide quality assessment and feedback on the draft Inception Report/Design Reportcovering all chapters (if possible).
(c) Provide quality assessment for the hypotheses/preliminary answers to evaluation questions.
(d) Review quality of draft Evaluation Report against the EQA grid and explanatory note.
(e) Conduct the final evaluation quality assessment for CPE final report.

12. Bibliography[14]

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2. Somalia UNFPA CPD 2018-2020.
3. Somalia United Nations Strategic Framework (UNSF) 2017-2020.
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5. UNFPA Strategic Positioning Note-UNFPA's programme priorities in Somalia 2017-2020.
6. UNFPA Somalia National Youth Policy 2019.
7. Somalia Population Analytical Report 2016.
8. Puntland State Health Sector Strategic Plan Phase II 2017-2021.
9. UNFPA Somalia Annual Progress Reports 2018-2019.
10. UNDP Arab States Human Development Reports 2017-2019.
11. UN Somalia Gender Equality Strategy 2018-2020.
12. UNFPA Somalia Annual Work Plans 2018-2019.
13. SIS Annual Reports.
14. UNFPA Somalia Independent Country Programme Evaluation 2011-2015.
15. UNFPA Strategic Plan 2018-2021.
16. Grand Bargain.
17. New Way of Working.
18. Joint Evaluation of the UNFPA-UNICEF Joint Programme on the Abandonment of Female Genital Mutilation: Accelerating Change Phase I and II (2008-2017).
19. Joint Evaluation of the UNFPA-UNICEF Global Programme to Accelerate Action to End Child Marriage.
20. Corporate Evaluation of UNFPA Support to the Prevention, Response and Elimination of Gender-based Violence and Harmful Practices (2012-2017).
21. UNFPA Evaluation Office Meta-analysis of the Engagement of UNFPA in Highly Vulnerable Contexts.
22. *Forthcoming:* Evaluation of UNFPA Capacity in Humanitarian Action (incl. desk review of Somalia).

[14] All links for these documents will be provided to the awarded evaluation team.

14. Annexes

Annex 1:	UNFPA Somalia Country Programme of Cooperation 2018-2020 Theory of Change
Annex 2:	UNEG Code of Conduct of Evaluation in the UN System
Annex 3:	UNEG Guidance Document on Integrating Human Rights and Gender in Evaluation
Annex 4:	UNEG Norms and Standards
Annex 5:	ALNAP Guide on “Evaluating Humanitarian Action Using the OECD-DAC Criteria” (providing specific guidance on how to assess humanitarian-specific criteria)
Annex 6:	List of Atlas Projects
Annex 7:	Design Report Template
Annex 8:	Evaluation Matrix Template
Annex 9:	Evaluation Report Template
Annex 10:	Evaluation Quality Assessment Grid
Annex 11:	Management Response Template
Annex 12:	UNFPA Evaluation Handbook 2019

Annex 2: List of Participants Interviewed

	Name of the Respondent	Designation	Agency
1.	Mohamed Bashir Mohamed	Chief Filed office	ANNPPCAN - Puntland
2.	Mohamed Osman Mumin	RH Project Officer	ANNPPCAN - Puntland
3.	Kaltun Ismail	Admin and Finance	ANNPPCAN - Puntland
4.	Amina Hussein Muse	Midwife - Jowle maternity home	ANNPPCAN - Puntland
5.	Nimco Abdullahi	Community Mobilzier	ANNPPCAN - Puntland
6.	Nimo Omar	Pharmacist	ANNPPCAN - Puntland
7.	Asma Hussein	Nurse	ANNPPCAN - Puntland
8.	Deko Hassan	Y-PEER Coordinator	FGS - Y-PEER
9.	Mohamed Hassan	Y-PEER Officer	FGS - Y-PEER
10.	Karita Laisi	Head of Cooperation for Somalia	Finland Government - Donor
11.	Abdirahman Nunow	Programme Manager	INTERSOS
12.	Falastin Omar	Program Management Officer – Human Settlement	Joint Programme with UNFPA – Youth
13.	Adan Mohammed	Director General	MEFSA
14.	Luul Adan	Gender Officer	MEFSA
15.	Abdullahi Ali Alasow	Tailoring	Mercy USA – TVET Beneficiary
16.	Bishara Sheikh Said	Tailoring	Mercy USA – TVET Beneficiary
17.	Fahad Mohamud Hussein	Computer Science	Mercy USA – TVET Beneficiary
18.	Mustapha Haji	Computer Science	Mercy USA – TVET Beneficiary
19.	Raho Mohamed	Salon	Mercy USA – TVET Beneficiary
20.	Sabirin Abdi Mohamed	Salon	Mercy USA – TVET Beneficiary
21.	Awes Abdullahi	Tailoring	Mercy USA – TVET Beneficiary
22.	Farhiya Abdi Mohamed	Traditional artefact	Mercy USA – TVET Beneficiary
23.	Mohamed Ali Jellow	Senior Program Manager	MERCY USA - YOUTH (2019)
24.	Amatarahman Isse Omar	Youth Project Coordinator	MERCY USA - YOUTH (2019)
25.	Subane	Monitoring and Evaluation Officer	MERCY USA - YOUTH (2019)
26.	Abdullahi Ismail	Monitoring and Evaluation Manager	Ministry of Health - FGS
27.	Dr. Mohamed Derow	Child Health	Ministry of Health - FGS
28.	Dr. Nur Ali Mohamed	Director of Planning	Ministry of Health - FGS
29.	Ibrahim Mohamed Nuur	Human Resource Director - MoH	Ministry of Health - FGS
30.	Deqa Mohamed Nur	Adolescent Sexual Rep RH Officer	Ministry of Health - Mogadishu
31.	Sirat Hassan Ali	Monitoring and Evaluation Officer	Ministry of Health - Mogadishu

	Name of the Respondent	Designation	Agency
32.	Mubarik Abdi	Directorate of Community Health Services	Ministry of Health Somaliland
33.	Mustafa Ahmed	Director – Directorate	Ministry of Health Somaliland
34.	Dr. Mohamed Hergeye	DG MoH	Ministry of Health Somaliland
35.	Mohamed Abuk-	Director of Humanitarian Affairs Department	Ministry of Humanitarian Affairs and Disaster Management - FGS
36.	Mahdi Ali Osman	Gender Coordinator	Ministry of Justice, Religious Affairs and Rehabilitation-Puntland
37.	Abdi Mahamud Ali	Senior Advisor – Statistician	Ministry of planning - Puntland
38.	Osman Warsame	National Coordinator	Ministry of Planning and National Development
39.	Nur Weheliye	National SHDS Coordinator	Ministry of Planning, Investment and Economic Development - FGS
40.	Said Abdulahi	Technical Lead in the SHDS	Ministry of Planning, Investment and Economic Development - FGS
41.	Abdishakur	Director of Planning	Ministry of Women's Development and Family Affairs – FGS
42.	Sadia Mohammed	Director of Gender	Ministry of Women's Development and Family Affairs – FGS
43.	Abidwali Hirad Mohamed	RH and Gender Adviser	Ministry of Women's Development and Family Affairs - Puntland
44.	Mohamed Ali	Coordinator / Youth Specialist	Ministry of Youth - Puntland
45.	Mohamed Hassan	Director of Youth	Ministry of Youth and Sports - Somaliland
46.	Mohamed Abdirizak Hared	Executive Director	Puntland – Y-PEER
47.	Abdikadir Ahmed Dooy	Programme Manager	Puntland – Y-PEER
48.	Falis Ali Jama	Member	Puntland Girls Basketball team
49.	Farxiyo Hassan Duale	Member	Puntland Girls Basketball team
50.	Nado Muktar Hersi	Member	Puntland Girls Basketball team
51.	Nasteho Ibrahim Ali	Member	Puntland Girls Basketball team
52.	Dahran Abdinur Ali	Member	Puntland Girls Basketball team
53.	Najmo Mohamed Adan	Member	Puntland Girls Basketball team
54.	Kowsar Abdi Omar	Member	Puntland Girls Basketball team
55.	Bosteero Ahmed Muse	Member	Puntland Girls Basketball team
56.	Fatxi Buluc Shoohiro	Member	Puntland Girls Basketball team
57.	Faith Thuku	Programme Manager	Relief International
58.	Hassan Ali	Area Manager	Relief International

	Name of the Respondent	Designation	Agency
59.	Abdullahi Ali Mohamed	Programme Coordinator	Rural Education and Agriculture Development Organization (READO)
60.	Mukhtar Mohamed Hassan	Programme Coordinator	Salama Medical Agency (SAMA)
61.	Mohamed Jama	Programme Manager	SEDHURO
62.	Hinda Abdi	Programme Manager	Somali Birth Attendants and Cooperative Organization (SBACO)
63.	Hussein Kulmiye	Executive Director	Somali Lifeline Organization (SOLO)
64.	Abdishakur Mumin	Executive Director	Somaliland National AIDS Commission (SOLNAC)
65.	Abdifatah Dahir	Project Manager	Somaliland National AIDS Commission (SOLNAC)
66.	Fouzia Ismail	Executive Director	Somaliland Nursing and Midwifery Association
67.	Hamda Ali Abdulai	Programme Coordinator (Focal point for Midwifery	Somaliland Nursing and Midwifery Association
68.	Farh Mohamed	Programme Manager	Somaliland Nursing and Midwifery Association
69.	Filsan Hussein Yussuf	SGBV Focal Point	Somaliland Nursing and Midwifery Association
70.	Asma Saed	Finance Assistant	Somaliland Nursing and Midwifery Association
71.	Hassan Nour Abdullahi	Finance Manager	Somaliland Nursing and Midwifery Association
72.	Mohamed Mahad Dama	Executive Director	Somaliland Y-PEER
73.	Abdiaziz Hersi Warsame	Chairman	Somaliland Y-PEER
74.	Daniel Magnusson	Programme Manager- Health –SHR portfolio	Swedish Government
75.	Gulled Osman	Director	Talowadag Coalition
76.	Anisa Mohamoud	Gender and PCoord	TIDES
77.	Abdi Ibrahim Hassan	Executive Director	TIDES
78.	Julius Otim	Policy Specialist, Women Peace & Security	UN Women
79.	Walter Mendonça Filho	Deputy Country Representative	UNFPA Somalia
80.	Pedro Roballo	Operation Manager [HR, Finance and Logistics and Security	UNFPA Somalia
81.	Kamlesh Giri	Chief of Health	UNFPA Somalia
82.	Dr. Ahmed Aweis	RH Specialist-Mogadishu	UNFPA Somalia
83.	Hawa Abdullahi Elmi	Midwifery Specialist- Mogadishu	UNFPA Somalia

	Name of the Respondent	Designation	Agency
84.	Jihan Salad	Puntland Maternal and Reproductive Health Programme Specialist	UNFPA Somalia
85.	Dr. Jama Warsame	RH Consultant – Somaliland – SRH and Maternal and Child health	UNFPA Somalia
86.	Juliana Nzau	Integrated Community RH - Family Planning	UNFPA Somalia
87.	Ibnou Diallo	Commodity Securities Technical Advisor	UNFPA Somalia
88.	Mariam Alwi	PD Team Leader	UNFPA Somalia
89.	Richard Ngetich	PD GIS and Statistical Specialist	UNFPA Somalia
90.	Ahmed Mihile	Population Specialist – Somaliland	UNFPA Somalia
91.	Amina Omar	GIS Assistant	UNFPA Somalia
92.	Felix Mulama	Demographer	UNFPA Somalia
93.	Jusline Gikunda	GIS Specialist	UNFPA Somalia
94.	Kamala Ahmen	Advocacy Support Consult	UNFPA Somalia
95.	Samwel Andati	Data Management	UNFPA Somalia
96.	Haider Rasheed	Monitoring and Evaluation Specialist	UNFPA Somalia
97.	Abdiaziz Farah	Programme Associate Youth -SL	UNFPA Somalia
98.	Mohamed Mursal Abdi	GBV and Youth Specialist – Mogadishu	UNFPA Somalia
99.	Abdihakim Abdulahi	UNV – Youth Specialist - Garowe	UNFPA Somalia
100.	Fatuma Muhumed	Youth Team Leader and Programme Officer	UNFPA Somalia
101.	Fatuma Abass	Program Assistant – Nairobi	UNFPA Somalia
102.	Bahsan Said	Gender/Youth Programme Specialist-PL	UNFPA Somalia
103.	Ridwan Abdi	Humanitarian Specialist	UNFPA Somalia
104.	Abdirizak Ali	GBV IMS Coordinator	UNFPA Somalia
105.	Osman Mohamed	National GBV IMS Coordinator	UNFPA Somalia
106.	Kamal Abdikadir –	Gender and Youth PO – Zonal GBV	UNFPA Somalia
107.	Nkiru Igbelina-Igbokwe	Head of Gender team and GBV Specialist	UNFPA Somalia
108.	Dr. Hussein Ali Mohamed	Health and Nutrition PM	WARDI Relief
109.	Hamayun Rizwan	Programme Management Officer	World Health Organization
110.	Mohamed Hussein Hared	Finance and Director	Y-PEER – Mogadishu
111.	Deka Hassan	Youth Centre Beneficiary	Y-PEER – Mogadishu
112.	Elizah Mohamed	Youth Centre Beneficiary	Y-PEER – Mogadishu

	Name of the Respondent	Designation	Agency
113.	Salima Issack	Youth Centre Beneficiary	Y-PEER – Mogadishu
114.	Ahmed Mohamed	Youth Centre Beneficiary	Y-PEER – Mogadishu
115.	Abdirahman Ali	Youth Centre Beneficiary	Y-PEER – Mogadishu

Annex 3: Documents Consulted

1. Africa Union: Addis Ababa Declaration on Population and Development in Africa beyond 2014
2. Chiwara, et al. Youth Employment Somalia Mid-term Evaluation Report. (2018).
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Annex 4: Atlas Projects

Year 2020								
	Fund type	**IA Group**	**Implementing agency**	**Activity description**	**Geographic location**	**Atlas budget**	**Expense [1]**	**Implementation Rate[2]**
GENDER EQUALITY								
Strategic plan Outcome 3: Gender equality, the empowerment of all women and girls, and reproductive rights are advanced in development and humanitarian settings								
Country Programme Output 1: Increased capacity of partners to provide services to survivors of gender-based violence, to prevent gender-based violence, harmful practices, and to promote reproductive rights and women's empowerment, including in humanitarian settings								
Annual work plan *(UNFPA 2020)*								
Activity 1	UDC46	PGSO02	Ministry of Labor and Social Affairs - SL	Capacity building and service delivery for GBV survivors, including for FGM and harmful practices	All Somaliland regions	126,212	77,600	67.3%
Activity 2	UDC46	PGSO04	Ministry of Women's Development and Family Affairs (MoWDFA) - PL	Support to One Stop GBV centres and safe shelters in Puntland	Boame, Sool region Jariban, Mudug region Burtinle, Nugaal region Badhan, Sanaag region Dhahar, Sanaag region	257,462	170,962	66.41%
Activity 3	UDC46	PGSO12	Ministry of Women and Human Rights	Support to National GBV Working Group strategy	All the regions of Somalia (Federal	570,000	366,000	64.2%

[1] For Year 2020, all figures are until end of quarter 2/2020 only; the activities still are on-going until 31 December 2020.
[2] Same to above in footnote 1.

			Development (MoWHRD) - FGS	and to support SGBV services delivery to SGBV survivors	Government and Federal Member States)			
Activity 4	UDC46	PGSO15	Ministry of Justice and Religious Affairs (MoJRA) - PL	To support Sexual Offenses Bill (SOB) capacity building To support production of SOB booklet and Media and outreach activities	All Puntland regions	95,500	85,700	74.39%
…	ZZJ29			Support training, conferences and workshops		19,700		
Activity 5	UDC46	PGSO19	Ministry of Endowment and Islamic Affairs (MoEIA) - SL	To support capacity building of religious women on FGM and Fatwa revision activities	All Somaliland regions	77,440	69,850	73.96%
…	ZZJ29			Support capacity building for harmful practices elimination		17,000		
Activity 6	FPA90	PN6323	INTERSOS	Support to GBV prevention and psychosocial first aid and capacity building of community leaders.	Jowhar, Hirshabelle Region Hudur, Bakool	25,000	333,712	40.93%
…	UDC46			Support preventive and curative services in health facilities such Jowhar regional hospital including skilled birth attendance,		790,228		

				cesarean sections and pregnancy-related complications management				
Activity 7	UDC46	PN6803	Action Aid International	Support Safe Spaces for GBV and harmful practices survivors	Erigavo Garadag Ainaba Lasanod	58,420	26,842	45.95%
Activity 8	UDC46	PN7014	Socio Economic Development and Human Rights Organization (SEDHURO)	Support services delivery to Sexual Assault survivors and strengthening the capacities of the GBV-Sub cluster members as well as support the community sensitization on FGM	Beled-hawo Bardere Dhusamareb	333,581	290,300	74.26%
…	ZZJ29			Support mobilization of FGM champions for outreach, home discussions and sensitization on FGM and to support media campaigns on FGM		78,000		
Activity 9	UDC46	PN7161	Relief International Somalia (RI-SOM)	Support GBV services and SRH rights through the WGSS for GBV survivors	Banadir Hiiran	141,040	126,668	89.81%
Activity 10	UDC46	PN7390	Action in Semi-Arid Lands (ASAL)	Support GBV one stop centres with COVID 19 arrangements for GBV workers and survivors'	Dhahar Qardho, Puntland	39,400	0.00	0.00%

				protection				
Activity 11	UDC46	PN7427	Ifrah Foundation	Support FGM prevention and awareness strategy across Somalia	All FMS regions	41,691	39,000	93.55%
Annual work plan *(UNFPA 2019)*								
Activity 1	UDC46	PGSO02	Ministry of Labor and Social Affairs - SL	Support to FGM Task Force coordination, training and capacity building and GBV services including Prevention of Sexual Exploitation and Abuse (PSEA), FGM and GBVIMS training	All Somaliland regions	148,200	204,060	100%
…	ZZJ29			Support International Women's Day and FGM champions and FGM mobilization in communities		55,860		
Activity 2	UDC46	PGSO04	MoWDAFA - PL	Support to One Stop GBV centres and W/G Safe shelters in Puntland	Boame, Sool region Jariban, Mudug region Burtinle, Nugaal region Badhan, Sanaag region Dhahar, Sanaag region	275,035	292,594	100%
…	FPA90			Support procurement of dignity kits for affected communities by cyclone and floods		17,559		
Activity 3	UDC46	PGSO12	MoWHRD - FGS	Support to National GBV Working Group strategy and to support SGBV	Nationwide. All the regions of Somalia (Federal Government	710,757	586,356	82.50%

				services delivery to assault survivors and to strengthen the capacity of GBV sub-cluster on psychosocial support (PSS) first aid	and Federal Member States)			
Activity 4	UDC46	PGSO15	Ministry of Justice and Religious Affairs (MoJRA) - PL	To support SOB capacity building for justice actors and to support the implementation of SOB law	All Puntland regions	76,250	111,250	100%
…	ZZJ29			Support training, conference, meetings, dialogues and workshops on GBV and FGM bill content		35,000		
Activity 5	UDC46	PGSO19	Ministry of Endowment and Islamic Affairs (MoEIA) - SL	To support regional and community dialogues among religious leaders for FGM abandonment and establishment of SAG	All Somaliland regions	46,100	54,230	96.67%
…	ZZJ29			Support community discussions and dialogues and media campaigns on harmful practices including FGM		10,000		
Activity 6	UDC46	PN6323	INTERSOS	Support to GBV prevention and psychosocial first aid and	Jowhar, Hirshabelle Region	197,548	650,233	95.91%

				capacity building of community leaders.	Hudur, Bakool			
…	UOH11			Support to GBV and harmful practices prevention as well as for monitoring and supervision Support to interim care centres to provide referral for sexual violence cases		450,421		
…	ZZJ29			Support communication and FGM champions		29,998		
Activity 7	UDC46	PN6803	Action Aid International	Support Safe Spaces including establishment of a new safe house in Awdal for GBV and harmful practices survivors and capacity building to community volunteers	Erigavo Garadag Ainaba Lasanod	170,975	158,928	92.95%
Activity 8	UDC46	PN7014	Socio Economic Development and human Rights Organization (SEDHURO)	Support services delivery to Sexual Assault survivors and strengthening the capacities of the GBV actors as well as support the community sensitization on FGM and GBVIMS capacity building and skills	Beled-hawo Bardere Dhusamareb	181,000	378,608	98.71%

…	ZZJ29			Support mobilization of FGM champions and community dialogues		15,000		
…	FPA90			Support capacity building on case management skills		50,000		
…	UOH11			Support to deployment of health, social and PSS workers and technical staff to deliver one on one counselling and group counselling		137,548		
Activity 9	UDC46	PN7161	Relief International Somalia (RI-SOM)	To enhance GBV services provision for GBV survivors through WGSS programming including capacity building in PSS, case management and community mobilization and communication	Banadir Hiiran	190,352	161,279	84.73%
Activity 10	UDC46	PN6998	TIDES	Support capacity building, FGM/C champions' mobilization and establishment new WGSSs in PL locations and regions	Galkayo	212,683	266,033	98.55%
…	ZZJ29			Support FGM declaration and abandonment and FGM champions mobilization as well as for		57,263		

				dignity kits costs				
Activity 11	UDC46	PN6204	Action for Relief and Development (ARD)	Support to BEmONC centre and referral services through GBV one stop centre in the maternity waiting homes	Bal'ad, Lower Shabelle Luuq, Gedo region	84,220	84,220	100%
Annual work plan *(UNFPA 2018)*								
Activity 1	UDC46	PGSO02	Ministry of Labor and Social Affairs - SL	Strengthen the national capacity to provide needed services to the GBV survivors and to support GBVWG, FGM Task Force coordination, training and capacity building and GBV services including PSEA, FGM and to support the SOB implementation plan	All Somaliland regions	49,500	73,480	88.02%
…	SEA89					33,980		
Activity 2	UDC46	PGSO04	MoWDAFA - PL	Strengthen the national capacity to provide needed services to the GBV survivors through the support to Forensic Centre and One Stop GBV centres and safe shelters in Puntland	Boame, Sool region Jariban, Mudug region Burtinle, Nugaal region Badhan, Sanaag region Dhahar, Sanaag region	387,800	528,614	93.68%
…	3006E					48,400		
…	SEA89					128,100		
Activity 3	UDC46	PGSO12	MoWHRD - FGS	Support to National GBV Working Group strategy and to support SGBV services delivery to	Nationwide. All the regions of Somalia (Federal Government and Federal Member	620,200	783,941	90.09%
…	FIA21					183,996		

…	FPA90			assault survivors and to strengthen the capacity of GBV sub-cluster on PSS first aid and to support community leaders for GBV prevention as well as to increase the advocacy for GBV issues	States)	66,003		
Activity 4	UDC46	PGSO15	Ministry of Justice and Religious Affairs (MoJRA) - PL	To support SOB capacity building for justice actors and to support the implementation of SOB law Support training, conference, meetings, dialogues and workshops on GBV and FGM bill content	All Puntland regions	109,420	157,394	96.15%
…	ITA35					12,000		
…	SEA89					35,974		
Activity 5	FPA90	PN6152	Human Development Concern	Strengthen the capacity to support the prevention of GBV and harmful practices, including the PSS first aid To support GBV WG strategy and community leaders' empowerment on GBV issues	Galmudug	35,329	35,329	100%
Activity 6	3006E	PN6323	INTERSOS	Support to GBV prevention and psychosocial first aid and capacity building of community leaders.	Jowhar, Hirshabelle region Hudur, Bakool	24,503	229,426	95.80%
…	ITA35					12,422		

…	SEA89			Support to GBV WG strategy		194,537		
Activity7	UDC46	PN6998	TIDES	Support advocacy for faith based organizations on elimination harmful practices. And support the capacity building focusing on leadership and youth entrepreneurship skills	Galkayo	68,040	68,040	100%
Activity 8	SEA89	PGSO18	Ministry of Humanitarian and Disaster Management (MoHDM) - FGS	Support to Humanitarian forum, coordination and MoHDM strategy and Gender assessment within the crisis context	Nationwide. All the regions of Somalia (Federal Government and Federal Member States)	18,000	18,000	100%
Activity 9	SEA89	PN6182	Initiative for Research and Development Agency (IRADA)	Increased national capacity to provide services to GBV survivors including FGM/C and increase the awareness of the communities on the FGM/C risks	All Somaliland regions	62,455	74,045	99.76%
	UDC46					11,770		
Activity10	FPA90	PN6324	Danish Refugee Council (DRC)	Increase advocacy on GBV and harmful practices among women and girls and connect to SRH services and prevention	Hargeisa, Somaliland	70,296	70,296	100%
POPULATION DYNAMICS								
Strategic plan Outcome 4: Everyone, everywhere is counted, and accounted for, in the pursuit of sustainable development								

Country Programme Output 1: Strengthened national capacity for production and dissemination of high-quality disaggregated data on population, development and sexual and reproductive health issues that allow for mapping of demographic disparities and socio-economic and health inequalities, and for programming in humanitarian settings								
Annual work plan *(UNFPA 2020)*								
Activity 1	UDC46	PGSO03	Ministry of Planning and International Cooperation - PL	Support the SHDS data producing coordination and COVID-19 impact assessment. Support to SHDS survey in Sool, Sanaag, and Mudug locations	All regions of Puntland	92,720	73,720	72.47%
…	UKB09			Support SHDS national project staff incentives		9,000		
Activity 2	UDC46	PGSO05	Ministry of Planning and National Development - SL	Support to SHDS nomadic survey national project staff	All regions of Somaliland	25,000	25,000	100%
Activity 3	UDC46	PGSO08	Ministry of Planning, Investment and Economic Development (MoPIED)	Support to strengthen the national capacity to produce and disseminate a high quality of SHDS disaggregated data	Nationwide. All the regions of Somalia (Federal Government and Federal Member States)	303,068	131,950	39.65%
…	UKB09			Support SHDS national project staff		29,700		
Annual work plan *(UNFPA 2019)*								

Activity 1	UDC46	PGSO03	Ministry of Planning and International Cooperation - PL	Support the SHDS project staff capacity and statistics Working Group coordination	All regions of Puntland	259,404	246,394	80.41%
…	UKB09			Support SHDS national project staff incentives		27,000		
…	FPA90			Support ICPD+25 sensitization		20,000		
Activity 2	UDC46	PGSO05	Ministry of National Planning and National Development - SL	Support to SHDS human resources, capacity building, nomadic methodology and advocacy for Parliament and Somaliland Government cabinet	All regions of Somaliland	63,590	63,590	100%
Activity 3	UDC46	PGSO08	Ministry of Planning, Investment and Economic Development (MoPIED)	Support to strengthen the national capacity to produce and disseminate a high quality of SHDS disaggregated data	Nationwide. All the regions of Somalia (Federal Government and Federal Member States)	626,581	635,597	92.13%
…	UKB09			Support SHDs national project staff		63,300		
Annual work plan *(UNFPA 2018)*								
Activity 1	UDC46	PGSO03	Ministry of Planning and International Cooperation - PL	Support to strengthen the national capacity in the statistical areas including data production and	All regions of Puntland	70,155	268,468	97.32%

…	UKB09			dissemination with a focus on the statistics WG including in the humanitarian settings and context		36,000		
…	SEA89					169,703		
Activity 2	UDC46	PGSO05	Ministry of National Planning and National Development - SL	Support to SHDS human resources, capacity building for the statistical system, nomadic data methodologies and approaches	All regions of Somaliland	34,100	141,016	94.01%
…	SEA89					53,400		
…	UKB09					62,500		
Activity 3	UDC46	PGSO08	Ministry of Planning, Investment and Economic Development (MoPIED)	Support to strengthen the national capacity to produce and disseminate a high quality of SHDS disaggregated data. Support SHDS national project staff incentives. In addition to support data production for demographic and SDGs measurements	Nationwide. All the regions of Somalia (Federal Government and Federal Member States)	606,769	905,221	95.61%
…	UKB09					63,300		
…	SEA89					278,736		
REPRODUCTIVE HEALTH								
Strategic plan Outcome 1: Every woman, adolescent and youth everywhere, especially those furthest behind, has utilized integrated sexual and reproductive health services and exercised reproductive rights, free of coercion, discrimination and violence								
Country Programme Output 1: Increased national capacity to deliver comprehensive maternal health services including in humanitarian settings								
Annual work plan *(UNFPA 2020)*								
Activity 1	UDC46	PGSO01	Ministry of Health -	Support to Maternal Health facilities and	Garowe, Galkayo, Badhan, Qardho, Eyl,	1,192,745	812,838	67.30

			PL	Midwifery strategy	Jiriban			
…	ZZJ29			Support to FGM de-medicalization		15,000		
Activity 3	UDC46	PGSO11	Ministry of Health and Development (MoHD) - SL	Support to BEmONC and CEmONC activities and services	Hargeisa, Borama, Baligubadleh Gabiley, Lughaya, Zeila, Berbera, Sheikh, Buroa, Oodweyne, Buhodle, Lasanod, Huddun, El-Afwein, Erigavo, Badhan, Dhahar, Taleh, Sallahley	973,899	639,098	60.37%
…	UKB09			Support capacity building, conferences and training workshops activities		84,661		
Activity 4	UDC46	PGSO18	Ministry of Humanitarian and Disaster Management (MoHDM) - FGS	Support to Humanitarian forum and Gender unit at the Ministry	All the regions of Somalia (Federal Government and Federal Member States)	250,000	128,500	51.40%
Activity 5	UDC46	PN6002	Somaliland Nursing and Midwifery Association (SLNMA)	To support Midwifery schools in Somaliland	Hargeisa, Borama, Lasanod, Erigavo, Gabiley, Buroa	406,692	360,175	81.35%
…	ZZJ29			Support FGM de-medicalization and health engagement in FGM issues		36,068		
Activity 6	UDC46	PN6147	Salama Medical Agency	To support Bayhawa CEmONC facility in Baidoa	Baidoa, Bay region Hudur and Wajid, Bakool region	17,999	86,949	98.81%

…	ZZT07			To support maternal health services and GBV response through maternity waiting houses and one stop GBV centres, including response to COVID-19		70,000		
Activity 7	UDC46	PN6148	WARDI Relief and Development Initiative	Supporting Beletweyne CEmONCfFacility	Hodon, Mogadishu Afgoi Corridor and Wanlaweyne, Lower Shabelle region Beletweyne, Hiran region	130,000	59,999	46.15%
Activity 8	UDC46	PN6152	Human Development Concern	To support Baravo CEmONC facility in South West State including the prevention of GBV and harmful practices	Baardheere, Gedo region Bulo-huubay, Wadajir District, Mogadishu Galmudug	130,000	88,596	68.13%
Activity 9	UDC46	PN6204	Action for Relief and Development (ARD)	Support maternal and neonatal health in humanitarian settings and GBV and harmful practices response services through one stop GBV centre	Bal'ad, Lower Shabelle Luuq, Gedo region Lower Shabelle	59,999	58,675	97.79%
Activity 10	UDC46	PN6217	Somali Birth Attendance and Cooperative Organization (SBACO)	Support BEmONC services and referrals	North and South Galkayo, Mudug region	15,000	74,306	99.08%
…	ZZT07			Support establishment of maternity waiting homes and increase the capacity of workers to address the		60,000		

				maternal death and harmful practices preventive services				
Activity 11	UDC46	PN6305	Organization for Somali Protection and Development (OSPAD)	Support BEmONC and operational management of OSPAD	Hodon, Mogadishu Barawe, Wanlaweyne and Afgoi, Lower Shabelle region	15,000	108,860	98.96%
…	ZZT07			Support maternal, neonatal and GBV services in humanitarian settings in Galmaduud regions		95,000		
Activity 12	UDC46	PN6748	African Network for Prevention and Protection Against Child Abuse and Neglect (ANPPACAN)	Support to maintain safe delivery services to 3 maternity homes in Tawakul, Hayyat and Bahnaano.	Garowe Galkayo Bosaso Talex Laasqoray	90,000	86,850	96.50%
Activity 13	UDC46	PN7013	Physicians Across Continent (PAC)	Support to BEmONC, CEmONC and maternity homes and youth life skills training including in the humanitarian settings	Wadajir and Daynile, Mogadishu Bandiradlay, Mudug region	1,589,753	1,201,895	60.22%
…	CAB10			Support quality midwifery schools' education in Baidoa, Mogadishu, Gal-Gaduud and Kismayo		350,425		
Activity 14	UDC46	PN7148	Rural Education and Agriculture Development Organization	Support Maternal health and CMR-GBV services in Baidoa and Bakool including B/CEmONC	Bay and Bakool regions of Southwest State	130,000	109,613	56.21%

			(READO)	facilities				
…	ZZT07			Support GBV one stop centre services within the BEmONC facilities		65,000		
Activity 15	UDC46	PN7276	Terre Solidali Onlus	Support to De Martino Hospital including SRH and GBV services	Mogadishu, FGS	52,915	25,000	47.25%
Activity 16	UDC46	PN7304	Cooperazione Internazionale	Support to De Martino Hospital	Mogadishu- FGS	89,120	84,142	94.41%
Activity 17	UDC46	PN7315	Save the Children	Support to Kismayo general hospital to enhance the accessibility to SRH services in Jubba region and Jubbaland State	Kismayo Lower Jubba region, Jubbaland	131,273	4,347	3.31%
Activity 18	UDC46	PN7328	New Ways Organization	Support to Guricel CEmONC in Galmudug State and Baravo CEmONC in South West State	Galmudug State South West State	260,000	260,000	100%
Activity 19	CAB10	PN7340	Canadian Association of Midwives	Support to SRH/R for women through strengthen the capacity of the midwifery schools and enrolled students in these schools	FMS and Somaliland	278,377	112,375	40.37%
Activity 20	UDC46	PU0031	UNOPS Somalia	Support to medical equipment for Banadir	FGS-Banadir	2,669,506	2,669,506	100%

				Hospital in Mogadishu and COVID-19 PPE Procurement for national distribution	Nationwide (for PPE)			
Annual work plan *(UNFPA 2019)*								
Activity 1	UDC46	PGSO01	Ministry of Health - PL	Support maternal health services and capacity in Puntland including capacity building and coordination for GBV one stop centres	Garowe, Galkayo, Badhan, Qardho, Eyl, Jiriban	1,369,288	1,402,288	99.15%
…	ZZJ29			Support FGM training for health care professionals on FGM		12,000		
…	ZZT06			Support to fistula awareness and reintegration and support Puntland Midwifery Association capacity building		33,000		
Activity 2	UDC46	PGSO09	Ministry of Health and Human Services (MoHS) - FGS	Support SRH services, capacity building, commodity security and SRH youth-friendly skills and services and GBV mainstreaming	All the regions of Somalia (Federal Government and Federal Member States) Emergency Obstetric and Neonatal Care Centers (EmONCs): Beletweyne, Hiran region	2,169,740	2,940,287	125.29%
…	UQA70			Support workshops, conferences and meetings		3,500		

…	ZZT06			Support development of regulatory systems and midwives' capacity building	Wanlaweyn and Barawe, Lower Shabelle Bardhere, Gedo region Daynile and Wadajir, Mogadishu Dhusomareeb, Galgaduud region Bandiredley, Mudug region <u>Midwifery Schools:</u> Baidoa, Bay region Dhusomareeb, Galgaduud region Kismayo, Lower Jubba region Abdiaziz, Mogadishu	160,561		
Activity 3	UDC46	PGSO11	Ministry of Health and Development (MoHD) - SL	Support BEmONC facilities, MDSR and Fistula coordination, SHDS awareness campaigns, medical fair and conference	Hargeisa, Borama, Baligubadleh Gabiley, Lughaya, Zeila, Berbera, Sheikh, Buroa, Oodweyne, Buhodle, Lasanod, Huddun, El-Afwein, Erigavo, Badhan, Dhahar, Taleh, Sallahley	1,252,637	1,203,125	96.05%
Activity 4	UDC46	PGSO18	Ministry of Humanitarian Affairs and Disaster Management (MoHDM) -FGS	Support to Humanitarian forum and neonatal and maternal health through the health care delivery capacity building and advocacy for community engagement to promote SRH/R for women and	All the regions of Somalia (Federal Government and Federal Member States)	100,000	100,000	100%

				adolescent girls in Somalia				
Activity 5	UDC46	PN6323	INTERSOS[3]	Support preventive and curative services in health facilities such Jowhar hospital including skilled birth attendance, cesarean sections and pregnancy-related complications management	Jowhar, Hirshabelle Region Hudur, Bakool	180,711	153,446	84.91%
Activity 6	UDC46	PN6002	Somaliland Nursing and Midwifery Association (SLNMA)	To support Midwifery schools in Somaliland and support enrolled students	Hargeisa, Borama, Lasanod, Erigavo, Gabiley, Buroa	441,817	660,731	98.79%
…	ZZJ29			Support FGM complication management through capacity building		20,000		
…	ZZT06			Support to Media and advocacy on FGM and EmONC capacity		16,000		
…	UOG85			Support to CEmONC facilities for integrated SRH services including CMR		191,023		
Activity 7	UDC46	PN6147	Salama Medical	To support BEmONC	Baidoa, Bay region	35,938	153,700	99.99%

[3] This IP's RH component budget is estimated out of the total budget allocated for all its 2019 AWP.

			Agency	facilities	Hudur and Wajid, Bakool region			
…	UOH11			To support maternal health services and outreach campaigns including GBV response through maternity waiting houses and Bayhawa hospital		117,762		
Activity 8	UDC46	PN6217	Somali Birth Attendance and Cooperative Organization (SBACO)	Support Maternal Health and mortality in humanitarian settings including maintain the maternity waiting homes in the FGS regions and states	North and South Galkayo, Mudug region	142,139.50	140,500.64	98.85%
Activity 9	UDC46	PN6204	Action for Relief and Development (ARD)	Support to BEmONC centre and referral services through GBV one stop centre in the MWHs	Bal'ad, Lower Shabelle Luuq, Gedo region	16,738	93,567	100%
…	UOH11			Support B/CEmONC facilities and outreach		76,829		
Activity 10	UDC46	PN6305	Organization for Somali Protection and Development (OSPAD)	Support maternal and neonatal health services and GBV response in humanitarian settings	Hodon, Mogadishu Barawe, Wanlaweyne and Afgoi, Lower Shabelle region	20,938	168,640	100%
…	UOH11					140,702+7,000 RR		
Activity 11	UDC46	PN6748	African Network for Prevention and Protection Against Child Abuse and Neglect	Support to RH outreach and services through B/CEmONC facilities	Garowe Galkayo Bosaso Talex	65,716	216,591	98.67%
…	UOG85					153,784		

			(ANPPACAN)		Laasqoray			
Activity 12	UDC46	PN6994	Somali Institute for Development and Research Analysis	Support to advocacy and conferences on Women in Global Health in Somalia	Garowe, Puntland	11,795	11,795	100%
Activity 13	UDC46	PN7013	Physicians Across Continent (PAC)	Support to BEmONC, CEmONC and maternity homes and outreach services including support to fistula and GBV one stop centres	Wadajir and Daynile, Mogadishu Bandiradlay, Mudug region	916,813	1,129,593	98.91%
…	ITA35					72,500		
…	UOH11					97,702		
…	ZZT06					55,000		
Activity 14	UOH11	PN7148	Rural Education and Agriculture Development Organization (READO)	Support Maternal and Neonatal health through B/CEmONC facilities and outreach campaigns	Bay and Bakool regions of Southwest State	153,784	153,754	99.99%
Annual work plan *(UNFPA 2018)*								
Activity 1	UDC46	PGSO01	Ministry of Health - PL	Support to national capacity strengthening to deliver and provide comprehensive SRH services including in the humanitarian settings with a focus on the maternal and neonatal services as well as BCC activities and advocacy and the midwifery schools in Puntland	Garowe, Galkayo, Badhan, Qardho, Eyl, Jiriban	498,400	1,345,312	97.59%
…	JPA60					42,785		
…	ZZT06					33,000		
…	ITA35					536,750		
…	SEA89					223,846		
…	UKB20					50,000		

Activity 2	UDC46	PGSO09	Ministry of Health and Human Services (MoHS) - FGS	Support to maternal health services including Maternal Death Surveillance and Response (MDSR) system and to strengthen the national capacity to provide and deliver comprehensive SRH services including youth friendly services and to strengthen the Reproductive Health Working Group coordination	Government and Federal Member States) Emergency Obstetric and Neonatal Care Centers (EmONCs): Beletweyne, Hiran region Wanlaweyn and Barawe, Lower Shabelle Bardhere, Gedo region Daynile and Wadajir, Mogadishu Dhusomareeb, Galgaduud region Bandiredley, Mudug region Midwifery Schools: Baidoa, Bay region Dhusomareeb, Galgaduud region Kismayo, Lower Jubba region Abdiaziz, Mogadishu	1,146,010	2,103,161	78%
…	JPA60					46,058		
…	ZZT06					97,224		
…	UKB20					45,000		
…	ITA35					1,322,301		
Activity 3	UDC46	PGSO11	Ministry of Health and Development (MoHD) - SL	Strengthen the national capacity to deliver and provided comprehensive SRH services including to support the CEmONC facilities, MDSR Task Force, Midwifery strategy development and Maternal and Child Health (MCH) and Clinical Management of Rape	Hargeisa, Borama, Baligubadleh Gabiley, Lughaya, Zeila, Berbera, Sheikh, Buroa, Oodweyne, Buhodle, Lasanod, Huddun, El-Afwein, Erigavo, Badhan, Dhahar, Taleh, Sallahley	817,230	1,299,068	84.90%
…	ITA35					440,088		
…	UKB20					94,250		
…	SEA89					178,550		

				(CMR) services				
Activity 4	UDC46	PN6002	Somaliland Nursing and Midwifery Association (SLNMA)	To support Midwifery schools in Somaliland and support the commodity security institutionalization at universities Support establishment of GBV one stop centres to address and provide services to GBV survivors	Hargeisa, Borama, Lasanod, Erigavo, Gabiley, Buroa	160,613	830,139	98.94%
…	ITA35					168,381		
…	ZZT06					21,030		
…	UOG49					200,782		
…	3006E					48,472		
…	UKB20					50,300		
…	JPA60					43,000		
…	SEA89					146,478		
Activity 5	SEA89	PN6147	Salama Medical Agency	To support maternal and neonatal health services and outreach campaigns including GBV response through maternity waiting homes and GBV stop centre	Baidoa, Bay region Hudur and Wajid, Bakool region	61,987	60,677	97.89%
Activity 6	SEA89	PN6217	Somali Birth Attendance and Cooperative Organization (SBACO)	Support Maternal Health and mortality in humanitarian settings including maintain the maternity waiting homes in the FGS regions and states	North and South Galkayo, Mudug region	59,987	100,419	98.81%
…	UOG49					40,423		

Activity 7	SEA89	PN6204	Action for Relief and Development	Support to maternal and neonatal health services through maternal waiting homes (MWHs)	Bal'ad, Lower Shabelle Luuq, Gedo region	59,987	59,987	100%
Activity 8	SEA89	PN6305	Organization for Somali Protection and Development (OSPAD)	Support maternal and neonatal health services and GBV response through MWHs	Hodon, Mogadishu Barawe, Wanlaweyne and Afgoi, Lower Shabelle region	59,987	59,987	100%
Activity 9	UDC46	PN6748	African Network for Prevention and Protection Against Child Abuse and Neglect (ANPPCAN)	Support to RH safe delivery services through 3 MWHs in PL	Garowe Galkayo Bosaso Talex Laasqoray	155,720	195,100	99.61%
…	UOG49					40,233.88		
Activity 10	UDC46	PN6994	Somali Institute for Development and Research Analysis	Support to advocacy and conferences on Women in Global Health in Somalia	Garowe, Puntland	58,700	58,700	100%
Activity 11	UDC46	PN7013	Physicians Across Continent (PAC)	Support to maternal and neonatal health through maternity homes and outreach services including support to GBV WG strategy and GBV survivors	Wadajir and Daynile, Mogadishu Bandiradlay, Mudug region	412,625	593,430	86.93%
…	ITA35					270,000		
Activity 12	UDC46	PN6148	WARDI Relief and Development Initiative	Support Maternal and Neonatal health through BEmONC facilities and GBV WG strategy as well as provide GBV services	Hodon, Mogadishu Afgoi Corridor and Wanlaweyne, Lower Shabelle region Beletweyne, Hiran	90,000	531,164	98.27%
…	3006E					25,338		
…	ITA35					206,915		

…	SEA89			through health facilities	Region	218,235		
Activity 13	UDC46	PN6751	Somali Red Crescent Society	Support to SRH outreach and referral campaigns in harsh to reach areas in Puntland	Jalam Dangoroyo Halaboqad Goldogob Rako Ufayn	54,022	130,137	99.80%
	UOG49					76,380		
Adolescents and Youth								
Strategic plan Outcome 2: Every youth and adolescents are empowered to realize their SRHR and participate in sustainable development, humanitarian action and sustaining peace								
Country Programme Output: Increased capacity of partners to design and implement comprehensive programmes to reach marginalized youth, especially adolescent girls, including those at risk of child marriage								
Annual work plan *(UNFPA 2020)*								
Activity 1	UDC46	PGSO07	Ministry of Youth - PL	Support to youth-friendly centres and technical staff incentives	All Puntland regions	126,948	78,400	61.76%
Activity 2	UDC46	PGSO10	Somaliland National AIDS Commission (SOLNAC)	Support to strengthen the national capacity at institutional and religious leaders' levels	All Somaliland regions	41,800	17,000	40.67%
Activity 3	UDC46	PGSO13	Ministry of Youth and Sports (MoYS) - FGS	Support to awareness raising of youth and adolescents on harmful practices. To support life skills and capacity building	All the regions of Somalia (Federal Government and Federal Member States)	171,500	127,500	74.34%

				for marginalized youth				
Activity 4	UDC46	PGSO14	Ministry of Youth and Sports (MOYS) - SL	Support events and international youth commemoration days. Support to coordination mechanisms. Support 8 youth centres through youth skills development, including for IDPs ones	All Somaliland regions	133,560	109,960	82.33%
Activity 5	UDC46	PGSO20	South Central AIDS Commission - FGS	Support to HIV/AIDS sensitization at community level	All the regions of Somalia (Federal Government and Federal Member States)	64,000	64,000	100%
Activity 6	UDC46	PN6181	Somaliland Y-PEER Network	Support to communication for behavior change and HIV awareness increasing and prevention including in IDPs' locations	All Somaliland regions	200,764	128,397	59.27%
…	UQA72			Enhance behavior change communication on HIV prevention		7,471		
…	ZZJ29			FGM Media campaign abandonment		8,400		
Activity 7	UDC46	PN6754	Y-PEER Puntland	Support to Y-PEER Puntland for public forums to address FGM zero tolerance	All Puntland regions	306,647	249,418	75.05%

…	UBRAFSOM			Support HIV prevention for youth through behavioral change communication		6,000		
…	ZZJ29			Support youth engagement in FGM prevention and awareness raising through training and conferences		19,700		
Activity 8	UDC46	PN6852	Somali Youth Peer Education Network	Support access to Behavioral Change Communication (BCC) to increase HIV awareness and prevention	All the regions of Somalia (Federal Government and Federal Member States)	122,684	124,679	92.59%
…	UQA70			Support access to BCC to increase HIV awareness and prevention		1,860		
…	UQA72			Enhance BCC on HIV prevention		10,000		
Activity 9	UDC46	PN6998	Timely Integrated Development Services (TIDES)	Support Media campaign on FGM and community declaration on FGM abandonment	Mudug region Galmudug (Galkayo)	46,373	40,326	62.91%
…	ZZJ29			Support FGM champions mobilization and media champions on FGM		17,730		
Activity 10	ZZJ29	PN7076	TALOWADAG	Support BCC on HIV through drama and	Somaliland. Hargeisa,	15,825	15,816	99.95

			Coalition	theatre services	Talowadag safe house			
Activity 11	UDC46	PN7077	Somali Life Line Organization (SOLO)	Support Social BCC through media outlets and community awareness on FGM and child and forced marriage	Kismayo Banadir	94,991	92,162	97.02%
Activity 12	UDC46	PN7140	Mercy USA for Aid and Development	Support building the youth holistic health and economic assets through youth centres including SRH information and services	Banadir Hiiran	231,012	146,935	63.61%
Activity 13	UQA72	PN7303	IRISE Hub Foundation	To sensitize youth, health workers, journalist and social media bloggers and influencers on COVID-19 and HIV	Jubaland Banadir South West Hirshabelle	27,454	21,454	78.15%
Activity 14	UDC46	PN7389	Laakarin Sosiaalinen Vastuu ry (Physicians for Social Responsibility)	Support capacity building and awareness raising on COVID-19	All regions of Somaliland	210,433	12,395	5.89%
Annual work plan *(UNFPA 2019)*								
Activity 1	UDC46	PGSO07	Ministry of Youth - PL	Support to comprehensive youth friendly centres establishment and youth	All Puntland regions	231,338	234,838	100%

				empowerment interventions				
…	UQA70			Support youth behavioral survey validation workshop		3,500		
Activity 2	UDC46	PGSO10	Somaliland National AIDS Commission (SOLNAC)	Support to strengthen the national capacity to design and implement comprehensive programmes to reach youth, in particular marginalized ones including adolescent girls at risk of child marriage	All Somaliland regions	83,200	96,540	100%
…	UQA70			Support HIV prevention advocacy through mass-media		13,340		
Activity 3	UDC46	PGSO13	Ministry of Youth and Sports (MoYS) - FGS	Support to youth and adolescents' comprehensive programmes through youth centres, including young people at risk and marginalized youth	All the regions of Somalia (Federal Government and Federal Member States)	250,000	250,000	100%
Activity 4	UDC46	PGSO14	Ministry of Youth and Sports (MOYS) - SL	Support to national capacity to implement youth comprehensive programmes including adolescent girls at risk through youth centres	All Somaliland regions	189,900	155,270	79.26%

…	SEA89			Support the commemoration of Somaliland national youth day		6,000		
Activity 5	UDC46	PGSO20	South Central AIDS Commission - FGS	Support to HIV/AIDS sensitization at community level to address youth awareness and knowledge in HIV/AIDS and high quality SRH/R services and information	Federal Government and Federal Member States	90,000	90,000	100%
Activity 6	UDC46	PN6181	Somaliland Y-PEER Network	Support to communication for behavior change and HIV awareness increasing and prevention including in IDP locations and promote youth health and SRH rights	All Somaliland regions	78,704	85,009	99.20%
…	UQA70					6,994		
Activity 7	UDC46	PN6754	Y-PEER Puntland	Enhance behavior change communication on HIV prevention and schools' health education	All Puntland regions	338,691	345,526	100%
…	UQA70					6,853		
Activity 8	UDC46	PN6852	Somali Youth Peer Education Network	Support to communication and advocacy campaigns on young people civic participation and involvement in the decision-making process	All the regions of Somalia (Federal Government and Federal Member States)	118,934	341,459	99.7%
…	UQA70					7,208		
…	UJA56					216,762		
Activity 9	UDC46	PN7076	TALOWADAG Coalition	Support schools on SRH and HIV prevention and increase their awareness	Somaliland	85,135	85,059	99.91%

				and knowledge				
Activity 10	UDC46	PN7077	Somali Life Line Organization (SOLO)	Support Social BCC through Media outlets and community awareness on FGM and child and force marriage	Kismayo Banadir	111,091	110,419	99.39%
Activity 11	UDC46	PN7140	Mercy USA for Aid and Development	Support building the youth holistic health and economic assets through youth centres including SRH information and services	Beletweyne Mogadishu	237,886	222,154	93.39%
Annual work plan *(UNFPA 2018)*								
Activity 1	UDC46	PGSO07	Ministry of Youth - PL	Support to comprehensive youth-friendly centres establishment and youth empowerment interventions Support youth entrepreneurship and the integration between SRH and youth awareness on HIV prevention	All Puntland regions	134,394	148,896	75.64%
…	SEA89					62,458		
Activity 2	UDC46	PGSO10	Somaliland National AIDS Commission (SOLNAC)	Support to strengthen the national capacity to design and implement comprehensive programmes to reach youth, in particular marginalized ones	All Somaliland regions	36,730	55,530	100%
…	SEA89					18,800		

				including adolescent girls at risk of child marriage and support HIV prevention advocacy and response through mass-media for youth				
Activity 3	UDC46	PGSO13	Ministry of Youth and Sports (MoYS) - FGS	Support to youth and adolescents' comprehensive programmes and response to harmful practices including FGM and forced and child marriage	All the regions of Somalia (Federal Government and Federal Member States)	147,200	194,222	97.98%
…	SEA89					28,429		
…	UJA56					20,000		
Activity 4	UDC46	PGSO14	Ministry of Youth and Sports (MOYS) - SL	Support to national capacity to implement youth comprehensive programmes including adolescents' girls at risk through youth centres in SL through development of youth policy, sensitization on SRH/HIV issues and establishment of youth centres	All Somaliland regions	63,400	172,903	100%
…	SEA89					82,588		
…	ITA35					26,915		
Activity 5	UDC46	PN6181	Somaliland Y-PEER Network	Support to communication for behavior change and HIV/family planning awareness raising and to increase GBV awareness among young people and communities	All Somaliland regions	21,840	76,174	99.67%
…	ITA35					28,986		
…	SEA89					22,000		
…	UQA68					3,600		

Activity 6	ITA35	PN6754	Y-PEER Puntland	Support to youth programmes through sensitization and awareness raising on SRH issues including family planning. Support to capacity building for youth centres	All Puntland regions	55,062	141,702	100%
…	UDC46					70,956		
…	UQA68					3,600		
…	SEA891					12,084		
Activity 7	UDC46	PN6852	Somali Youth Peer Education Network	Support to communication and advocacy campaigns on young people civic participation and involvement in the decision-making process	All the regions of Somalia (Federal Government and Federal Member States)	30,000	224,706	80.45%
…	UQA68					3,600		
…	UJA56					240,710		
…	SEA89					5,000		
ADMINISTRATION								
Annual work plan *(UNFPA 2020)*								
Activity 1	All funds including FPA90	PU0074	UNFPA	Support to UNFPA Somalia CO AWP 2020 and related OEE activities and operations costs, including direct implementation of projects, programmes and procurement of health commodities and medical equipment	All Somalia	10,109,597	5,670,616	56.09%
Annual work plan *(UNFPA 2019)*								

Activity 1	All funds including FPA90	PU0074	UNFPA	Support to UNFPA Somalia CO AWP 2019 and related OEE activities and operations costs, including direct implementation of projects, programmes and procurement of health commodities and medical equipment	All Somalia	14,261,502	9,967,374	69.89%
Annual work plan *(UNFPA 2018)*								
Activity 1	All funds including FPA90	PU0074	UNFPA	Support to UNFPA Somalia CO AWP 2018 and related OEE activities and operations costs, including direct implementation of projects, programmes and procurement of health commodities and medical equipment	All Somalia	11,698,275	8,795,173	75.18%

Annex 5. Evaluation Matrix.

Relevance			
EQ1: To what extent has the Country Programme addressed national priorities and needs of the population, in particular vulnerable groups, vis-à-vis the UNFPA mandate? **EQ2:** To what extent has the UNFPA Country Office been able to respond to changes in priorities and needs of the population over time, including those of vulnerable groups, especially in response to shifts caused by new or evolving humanitarian crises? **EQ3:** To what extent have UNFPA-supported interventions been aligned to the UNFPA Strategic Plan 2018-2021 and international normative frameworks, policies and standards related to development and humanitarian action?			
Assumption to be assessed	**Indicators**	**Source of Information**	**Methods for data collection**
Assumption 1: The country programme addressed national priorities and needs of the population, vis-à-vis the UNFPA mandate	● Evidence of an exhaustive and accurate needs assessment conducted by UNFPA and/or implementing partners, identifying the varied needs of diverse stakeholder groups prior to the programming of the SRHR, A&Y, P&D and gender components of the CPD ● Evidence of systematic use of findings from needs assessments in programme planning and design and the selection of target groups for UNFPA-supported interventions in the four thematic areas of programming in line with identified needs (as detailed in the needs assessments) as well as priorities in the CPD and AWPs. ● Extent to which the targeted populations were consulted in relation to programme design and activities throughout the programme	● UNFPA CO M&E Framework ● Strategic Information System (SIS) annual reports. ● National policy/strategy documents. ● Needs assessment studies (incl. Humanitarian Needs Overviews) ● Evaluations – Evaluation of the 2nd Country Programme and other UN agencies in the same thematic areas of focus. ● Key Informants from Government, CSOs and UNFPA CO ● Direct and indirect beneficiaries.	● Document review ● KI interviews ● Focus groups with beneficiaries and communities in targeted sites ● Focus groups with direct and indirect beneficiaries and communities in targeted sites
Assumption 2: The UNFPA Country Office responded to changes in priorities and needs of the population over time, including those of vulnerable groups in the national development context and in	● Evidence of repeated needs assessments conducted by UNFPA and/or implementing partners, identifying the varied needs of diverse groups and lessons learned during programming in the four thematic areas of programming ● Extent to which development and humanitarian interventions in the four thematic areas of programming	● UNFPA CO M&E Framework ● Strategic Information System (SIS) annual reports. ● Emergency Preparedness and Response Plans (EPRPs). ● National policy/strategy documents.	● Document review ● KI interviews ● Focus groups with beneficiaries and communities in targeted sites

relation to the humanitarian crisis in Somalia	were adapted to emerging needs, demands and priorities of the population, in particular the most vulnerable, disadvantaged, marginalized and excluded population groups (as detailed in the needs assessments). ● Evidence of UNFPA conducting needs assessments and/or contributing to joint needs assessments in the four thematic areas of programming at the onset of humanitarian crises	● Needs assessment studies (incl Humanitarian Needs Overviews). ● Key Informants from Government, CSOs and UNFPA CO ● Direct and indirect beneficiaries	
Assumption 3.1: UNFPA-supported interventions are aligned with the national development plans and priorities, in the areas of SRH, A&Y, GEEW and P&D.	● The extent to which UNFPA-supported interventions have appropriately taken into account the priorities of the Federal Government of Somalia, Federal Member States and key stakeholders. ● Extent to which the objectives and strategies of the Country Programme and Annual Plan(s) have been discussed and agreed upon with a wide array of national stakeholders at federal and state levels	● UNFPA Strategic Plan 2018-2020 CPD SIS, UNSF 2017 – 2020 and review ● FGS/UNFPA 2nd CPE, Needs Assessment Report ● National policies/ strategy documents (e.g. National Population Policy, National Gender Policy, National Adolescent Sexual and Reproductive Health Policy, National Youth Policy) ● CSO and government staff ● UNFPA CO staff ● Beneficiaries	● Document review ● Interviews with UNFPA Country Office staff ● Interviews with other United Nations agencies ● Interview with government officials ● Interviews with implementing partners ● Interviews with other development actors (i.e., NGOs/groups working in the areas in which UNFPA works, but that do not partner with UNFPA)
Assumption 3.2: UNFPA-supported interventions are aligned with the UNFPA Strategic Plan 2018-2021 and international normative frameworks, policies and standards related to development assistance.	● Extent to which the CPD, CPAP(s) and AWPs are in line with the SDGs and the UNFPA Strategic Plan 2018-2021. ● Proportion of needs assessments and proposals that are aligned with the SDGs and the UNFPA Strategic Plan 2018-2021. ● Extent to which the interventions implemented on the ground are in line with the SDGs and the UNFPA Strategic Plan 2018-2021. ● The expected results, targets and implementation strategies outlined in the CPD, CPAP(s) and the AWPs are in line with the priorities, results and targets of the	● UNFPA Strategic Plan 2018-2021 and annexes ● CPD 3rd UNFPA Somalia CP (2018-2020) ● UNSF 2017-2020 and annexes ● Government officials at federal and state levels ● Needs assessments ● Proposals ● CPAP ● AWPs	● Document review ● Interviews with UNFPA Country Office staff ● Interviews with other United Nations agencies ● Interview with government officials ● Interviews with implementing partners ● Interviews with other development actors (i.e.,

	United Nations Strategic Framework (UNSF) 2017-2020 for Somalia.		NGOs/groups working in the areas in which UNFPA works, but that do not partner with UNFPA)
Assumption 3.3: UNFPA humanitarian assistance is aligned with successive Humanitarian Response Plans and international normative frameworks, policies and standards related to humanitarian assistance.	• Extent to which the design, implementation and monitoring of UNFPA humanitarian assistance is aligned with the Somalia Humanitarian Response Plans for the period 2018 to 2020. • Extent to which the design and implementation and monitoring of UNFPA humanitarian assistance is aligned with the New Way of Working, the commitments of the Grand Bargain, and the five key actions of the Global Compact for Young People in Humanitarian Action. • Extent to which the design, implementation and monitoring of UNFPA humanitarian assistance is aligned with the United Nations Security Council Resolution 1325 on Women, Peace and Security and the Security Council Resolution 2250 on Young People, Peace and Security. • Extent to which the design, implementation and monitoring of UNFPA humanitarian assistance is aligned with external minimum standards for humanitarian action, in particular Sphere, MISP and GBV Area of Responsibility standards.	• Humanitarian Response Plans • Humanitarian programming documents • UNFPA CO staff • HCT members • Implementing partners	• Document review • Interviews with UNFPA Country Office staff • Interviews with other United Nations agencies • Interview with government officials • Interviews with implementing partners • Interviews with other development actors (i.e., NGOs/groups working in the areas in which UNFPA works, but that do not partner with UNFPA)
Effectiveness			
EQ 4: To what extent have the 3rd CP outputs been achieved, and to what extent have these outputs contributed to the achievement of the expected outcomes? **EQ 5: To what extent has the program integrated the cross-cutting issues of gender and human rights based approaches?**			
Assumption to be assessed	**Indicators**	**Source of Information**	**Methods for data collection**
Assumption 4.1: The 3rd CP planned outputs were	• Degree of completion of outputs planned in the M&E Framework against indicators	• The Global Programming System (GPS) AWP and annual reports	• Documentary review • Review of recent

successfully or are likely to be achieved, and contributed to the achievement of the expected outcomes	● Evidence that completed outputs contributed to planned outcomes ● Extent to which M&E of programme achievements indicate timely meeting of outputs. ● Extent to which the response was adapted to emerging needs, demands and national priorities during the period of implementation	(SIS) ● Annual Review and Planning reports ● Review reports and other related documents ● IPs (government, NGOs, and Academia) ● UNFPA CO staff ● CP Results Framework ● CP Theory of Change ● IP Progress reports ● Beneficiary groups / communities ● Quarterly and annual implementation progress reports ● Relevant evaluation reports ● UNCT reports ● Relevant programme, project and institutional reports of stakeholders	relevant ministry policies and strategies ● Interviews with Line Ministry project coordinators and other IP and non-IP staff ● Group meeting with UNFPA staff ● Focus Group Discussion with beneficiaries ● Field visit to project sites, and beneficiaries at the locations
Assumption 4.2: The CP results effectively responded to achieve targeted results within the constraints of the context	● The speed and timeliness of response (response capacity) ● Adequacy of the response (quality of the response) ● Evidence of changes in programme design or interventions reflecting context and influencing factors i.e. change in population needs and government priorities.	● GPS AWPs ● APRs/SIS ● CO staff ● Government and key partners	● Document review ● KI interviews
Assumption 5.1: The programme integrated the cross-cutting issues of gender and human rights based approaches	● Extent to which a gender-responsive and human rights-based approach was integrated in situation assessment and analysis, planning and design, implementation and monitoring and evaluation of UNFPA-supported interventions in the four thematic areas of programming ● Evidence of increased incorporation of a gender-responsive and human rights-based approach in Government policies, strategies and plans at federal and state levels during the period of the Country Programme	● AWPs and SISs/APRs ● CO staff ● Government and key stakeholders ● CP documents ● Government and key partners ● Key government policies, strategies and plans at national and county levels ● IP progress reports	● Document review ● KI interviews ● FGDs with beneficiaries

	● Evidence of inclusive and participatory mechanisms to systematically seek input from target populations in the design, implementation and monitoring of UNFPA-supported interventions in the four thematic areas of programming ● Presence of accountability mechanisms for populations affected by humanitarian crisis, such as complaints mechanisms to report sexual exploitation and abuse by UNFPA staff and/or implementing partners	● Beneficiaries	
Efficiency			
EQ 6: To what extent has UNFPA used available financial and human resources, its technical expertise, as well as funding, operations and commodity supply systems, mechanisms and policies in an adequate manner to achieve the intended results of its Country Programme in the most efficient way?			
Assumptions to be assessed	**Indicators**	**Sources of information**	**Methods and tools for the data collection**
Assumption 6.1: Implementing partners received UNFPA financial and technical support as planned and in a timely manner, and UNFPA was able to mobilize appropriate resources in a timely manner to support the implementation of the Country Programme.	● Evidence that implementing partners received the planned resources to the foreseen level in AWPs ● Evidence that implementing partners received resources in a timely manner ● Evidence of coordination and complementarity among the programme components of UNFPA ● Evidence of progress towards the delivery of multi-year, predictable, core funding to implementing partners ● Percentage of annual humanitarian funding requirements met	● AWPs and APRs/SIS and IP, government reports ● UNFPA CO financial reports ● UNFPA CO staff ● Government officials ● Implementing partners ● Resource mobilization strategy	● Document review ● KI interviews ● Group interviews
Assumption 6.2: The UNFPA main and sub-offices were appropriately staffed (the right number of people with the right competencies and skills in the	● Evidence that UNFPA personnel (all types of contracts) have adequate expertise and experience to deliver development and humanitarian assistance ● Evidence that CO staffing structure is appropriate for timely and effective implementation, including in	● UNFPA CO Staff interviews ● HR structure	● Documentary review ● Key Informant and group interviews

right positions)	humanitarian settings ● Extent to which existing human resource management policies, rules and procedures enable the timely and effective implementation, including in humanitarian settings		
Assumption 6.3: Program strategic approaches, administrative, procurement and financial procedures as well as the mix of implementation modalities led to efficient achievement of programme outputs	● The planned inputs and resources were received as set out in the AWPs and agreements with partners. ● The resources were received in a timely manner according to project time lines and plans ● Budgeted funds were disbursed in a timely manner ● Quality technical assistance to build capacity was available to the level planned ● Evidence that technical assistance increased capacity among recipient stakeholders ● Inefficiencies were corrected as soon as possible	● AWPs and APRs/SIS and IP, government reports ● UNFPA CO financial reports ● UNFPA CO, government and IP staff	● Document review ● KI interviews ● Group interviews
Assumption 6.4: Programme strategic approaches, administrative, procurement and financial procedures as well as the mix of implementation modalities led to the efficient achievement of programme outputs.	● The planned inputs and resources were received by IPs as agreed up on with partners. ● Budget utilization rates per year ● Quality technical assistance to build capacity was available to the level planned ● Evidence that technical assistance increased capacity among implementing partners ● Evidence that efforts were made to identify inefficiencies in the four thematic area of programing and to correct them ● Evidence that qualified implementing partners with adequate capacity were selected for implementation of interventions in the four thematic areas of programming ● Extent to which administrative, procurement and financial policies, rules and procedures are appropriate for timely and effective implementation, including in humanitarian	● AWPs and APRs/SIS and IP, government reports ● UNFPA CO financial reports ● UNFPA CO staff ● Government officials ● Implementing partners	● Document review ● KI interviews ● Group interviews

	settings ● Number of days/weeks for the procurement and distribution of dignity kits and reproductive health kits to crisis-affected populations in hard-to-reach areas		
Assumption 6.5: The M&E system was efficient and effective in producing timely and disaggregated data to track progress at output and outcome levels and guiding future implementation	● Proportion of output indicators for which data has been systematically collected and comprehensive, timely and accurate data that is disaggregated at least by sex and age is available ● Proportion of outcome indicators for which data has been systematically collected and comprehensive, timely and accurate data that is disaggregated at least by sex and age is available ● Quality of the indicator in the M&E framework of the Country Programme ● Extent to which monitoring responsibilities are clearly assigned to UNFPA CO staff ● Extent to which the M&E system contributes to developing local capacity for data collection in all four thematic areas of programming ● Extent to which implementing partners are able to provide required data for M&E ● Proportion of output and outcome indicators for which baseline data is available ● Assumptions and risks were identified and updated in response to changes in the national context and data on assumptions and risks regularly collected ● Evidence that monitoring data is used to adapt programing and make course corrections in the four thematic areas of programming	● AWPs ● APRs/SISs ● UNFPA CO staff (incl., but not limited to, the M&E Officer) ● Implementing partners' interviews ● Country Programme Results Framework	● Document review ● Key Informant / group Interviews
Sustainability			
EQ 7: To what extent has UNFPA been able to support its partners and the beneficiaries in developing capacities and establishing mechanisms to ensure ownership and the durability of effects?			

Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
Assumption 7.1: The benefits of the Country Programme are likely to continue beyond the life of the programme and UNFPA has been able to support its partners and the beneficiaries in developing systems, mechanisms and capacities that ensure the durability of outputs, and eventually outcomes	• Extent of ownership of each project by implementing partners • Extent to which Government and implementing partners at national and sub-national levels have allocated adequate budget for continued implementation of interventions and safeguarding the gains that have been made in the four thematic areas of programming. • Extent to which UNFPA has taken any mitigating steps to strengthen areas with gaps hindering sustainability • Evidence of the development of exit strategies in the four thematic areas of programming to hand over UNFPA-supported interventions to Government and/or implementing partners at national and sub-national levels • Evidence for enhanced capacity of the Government and implementing partners at national and sub-national levels to implement interventions in the four thematic areas of programming without the technical support of UNFPA • Extent to which programmes in the four thematic areas of programming were developed and implemented in a participatory multi-stakeholder process to promote ownership	• Beneficiary groups • Government Ministries/Departments • Implementing partners • UNFPA Country Office staff • AWPs • Previous evaluations • Projects and Interventions exit strategies • Government Ministries Policies and budget documents • Training reports • NGOs and Academia	• Document review • KI and Group Interviews • Focus groups with beneficiaries
Coordination			
EQ8: To what extent has the UNFPA country office contributed to the functioning and consolidation of existing United Nations system-wide coordination mechanisms for both development assistance and humanitarian action?			
Assumptions to be assessed	**Indicators**	**Sources of information**	**Methods and tools for the data collection**

Assumption 8.1: UNFPA effectively led or supported system-wide development coordination mechanisms to reinforce programme implementation and achieve better results by preventing overlap and duplication and promoting synergies.	● Evidence of UNFPA actively contributing and taking initiative in UNCT meetings ● Evidence of UNFPA playing a leading role in thematic working groups of the UNCT relevant to the UNFPA mandate ● Extent to which UNFPA participates in the Somalia Development and Reconstruction Facility and/or relevant pillar working groups ● Extent to which UNFPA applied the Delivering as One (DAO) approach in its interventions ● Evidence that synergies have been actively sought in the design, implementation and monitoring and evaluation of the UNFPA Country Programme and programmes and interventions of other UNCT members ● Extent to which the comparative advantages and technical expertise of UNFPA in the four thematic areas of programming added value to the UNCT support for sustainable development	● Joint initiatives. ● Monitoring / evaluation reports of joint initiatives. ● Staff of relevant United Nations agencies ● Coordination modalities with UN, federal and state stakeholders. ● UNCT meeting reports or minutes ● Implementing partners	● Documentary review ● Interviews with UNFPA CO staff ● Interviews with other UN agencies relevant staff
Assumption 8.2: UNFPA effectively led or supported system-wide humanitarian coordination mechanisms to reinforce programme implementation and achieve better results by preventing overlap and duplication and promoting synergies.	● Evidence of UNFPA actively contributing and taking initiative in the inter-cluster coordination group meetings ● Evidence of UNFPA actively contributing and taking initiative in the logistics cluster meetings ● Evidence that integrated and interoperable information and knowledge management as well as monitoring systems were created ● Extent to which UNFPA has played an active role in informally coordinating humanitarian action targeted at adolescents and youth ● Evidence that synergies have been actively sought in the design, implementation and monitoring and evaluation of UNFPA humanitarian assistance and support provided by other humanitarian actors ● Extent to which the comparative advantages and technical expertise of UNFPA in the four thematic areas of programming added value to the humanitarian	● Joint initiatives. ● Monitoring / evaluation reports of joint initiatives. ● Staff of relevant United Nations agencies ● Coordination modalities with UN, federal and state stakeholders. ● Implementing partners	● Documentary review ● Interviews with UNFPA CO staff ● Interviews with other UN agencies relevant staff

	preparedness, response and recovery activities of the HCT		
Coverage			
EQ 9: To what extent has the UNFPA humanitarian response reached those most in need and vulnerable in crisis situations both geographically and demographically?			
Assumption 9.1: The UNFPA humanitarian support systematically reaches all geographic areas in which women, adolescents and youth are in need, as well as the geographic areas that are most at risk and vulnerable to humanitarian crises.	• Evidence of needs assessment conducted by UNFPA and/or implementing partners, identifying the varied needs of vulnerable populations in various geographical areas in the country prior to the programming of the SRH, A&Y, P&D and gender components of the CPD • Evidence of systematic use of findings from needs assessments in programme planning and design and the selection of target groups for UNFPA-supported interventions in the four thematic areas of programming in line with identified needs (as detailed in the needs assessments) as well as priorities in the CPD and AWPs. • Extent to which the planned interventions in the four thematic areas of programming, as described in the AWPs, were targeted at the most at risk groups in a prioritized manner. • Extent to which the actual interventions implemented on the ground met the needs of the most at risk groups. • Extent to which the most at risk groups were consulted in relation to programme design and activities throughout the programme	• UNFPA CO M&E Framework • Strategic Information System (SIS) annual reports. • Needs assessment studies (incl. Humanitarian Needs Overviews) • Evaluations – Evaluation of the 2nd Country Programme and other UN agencies in the same thematic areas of focus. • Key Informants from Government, CSOs and UNFPA CO • Direct and indirect beneficiaries.	• Document review • KI interviews • Focus groups with beneficiaries and communities in targeted sites • Focus groups with direct and indirect beneficiaries and communities in targeted sites
Assumption 9.2: The UNFPA humanitarian support systematically reaches demographic populations of vulnerability and marginalization (i.e. women, girls, and youth with disabilities;	• Evidence of UNFPA responding to protection needs of the affected population in the country • Evidence of UNFPA response targets vulnerable and marginalized in Somalia • Evidence of UNFPA programme supporting creation of humanitarian space to reach the vulnerable populations in	• UNFPA CO M&E Framework • Strategic Information System (SIS) annual reports. • Needs assessment studies (incl. Humanitarian Needs Overviews) • Evaluations – Evaluation of the 2nd Country Programme and other	• Document review • KI interviews • Focus groups with beneficiaries and communities in targeted sites • Focus groups with direct

displaced women, adolescents and youth within and outside camps; the elderly; female-headed households; women and adolescents and youth from minority clans, etc.).	Somalia ● Extent to which the planned UNFPA interventions in the four thematic areas of programming, as described in the AWPs, were targeted at the most vulnerable, disadvantaged, marginalized and excluded population groups in a prioritized manner. ● Extent to which the actual interventions implemented on the ground met the needs of the most vulnerable, disadvantaged, marginalized and excluded population groups. ● Extent to which the vulnerable and marginalized were consulted in relation to programme design and activities throughout the programme	UN agencies in the same thematic areas of focus. ● Key Informants from Government, CSOs and UNFPA CO ● Direct and indirect beneficiaries.	and indirect beneficiaries and communities in targeted sites
Connectedness			
EQ10: To what extent does UNFPA humanitarian action and plan for longer-term development goals articulated in the results and resources framework of the 2018-2020 Country Programme and contribute to resilience building?			
Assumptions to be assessed	**Indicators**	**Sources of information**	**Methods and tools for the data collection**
Assumption 10.1: UNFPA response to humanitarian crises supports and plans for longer-term development goals articulated in the results and resources framework of the 2018-2020 Country Programme and contributes to building resilience by enhancing capacities at individual, community and systems level and bridging the development-humanitarian-peace nexus.	● Evidence of the existence of an exit strategy with timelines, allocation of responsibility ● Evidence of details of a handover process from UNFPA to the government departments and/or development agencies ● Evidence of allocation or plan for resource allocation post-response ● Evidence that affected communities are mapped and targeted with interventions ● Evidence of the existence of a transition strategy from humanitarian action to development, which specifies timelines, allocation of budget and roles and responsibilities ● Extent to which the capacity of individuals, in particular	● Results and resources Framework ● UNFPA Staff ● Government staff ● NGO/IP Staff Programme reports	● Document review ● Interviews with staff ● Group Interviews

	women, adolescents and youth, has been increased to reduce vulnerability to and adapt to humanitarian crises, as well as transform livelihoods to successfully cope with humanitarian crisis ● Extent to which the capacity of communities to prepare for, mitigate the impact of, and recover from humanitarian crisis has been enhanced ● Extent to which the preparedness of the health and social protection systems at federal and state levels and the capacity to deliver services in the mandate areas of UNFPA has been increased ● Extent to which UNFPA humanitarian assistance was linked specifically to peacebuilding initiatives		

Annex 6. Data collection tools.

Programme Component 1: Sexual Reproductive Health

Key Informant / Group Interviews with UNFPA Staff

Introduction:

a. Introduce yourself and the purpose of the Interview: the objective of assessing experience and learning of the current program cycle with the view of proposing recommendations for the next CP cycle.

b. Assure participants of the confidentiality of information exchange, which will serve only for the purpose of analysis.

1. **Rationale for the project and activities undertaken (needs assessments, value added, targeting of the most vulnerable, extent of consultation with targeted people, ability and resources to carry out the work, gender sensitivity)**

- How did you decide to undertake this work, what were the indications that it would be effective and would reach the target population?
- Who was consulted regarding the design? To what extent were they consulted?
- What other actors have been involved, how does this activity contribute to that of others?

2. **Relevance of the project/activities to the UN priorities, government policies, local structures, to changes in the political and institutional situation**

- How well does the activity/work support the government's priorities and work within the national structures that are in place? How well does it work within private structures?
- How well is the work designed to achieve the outcomes/results in the M&E Framework? (to increase physician assisted deliveries, to increase demand by women for SRHR services, to reduce disparities in fertility and maternal mortality/morbidity, to improve SRHR knowledge of youth)
- Were the objectives and strategies of the Country Programme M&E Framework discussed and agreed with national partners? [Probe]
- Has UNFPA adapted the programme and activities to respond to changes in the institutional environment (e.g. dynamism in the government, restructuring of the Ministry of Health; and other IPs, including CSOs?
- Were there any SRRH needs or priorities of the implementing partners that the country program did not address adequately or at all? If Yes, what were these needs and Priorities
- To what extent has UNFPA responded to SRHR emerging issues in the IDP Settlements or calamities? What were the factors that facilitated UNFPA response to such SRHR emerging issues? What were the factors that hindered the UNFPA response to such SRHR emerging issues?

3. **Effectiveness of the approaches/activities/projects used to improve access to high quality SRHR services and for the most vulnerable.**

- What are the indications that the approach is working or making progress toward goals established to be achieved in 2020 - end of CP - (e.g. anecdotes which provide illustrations of positive, negative or unintended effects, or quantitative and qualitative evidence) ; (numbers being reached, products produced/purchased and the extent of impact, evidence of usage of knowledge, increasing networks, etc.)
- Were UNFPA interventions implemented at adequate scale to reach intended outcomes?

- What else should be done to make the programmes more effective?
- How effective was the training on adolescent and youth sexual and SRHR in addressing the adolescent and youth health?
- What are the barriers/challenges to increasing demand and access to services, and how are they being addressed?

4. Sustainability

- Are the capacities in place among stakeholders to be able to carry out the activities/project without support from UNFPA?
- Are financial resources available?
- Will the results of the project last after the CP is completed?
- Is there an exit strategy?

5. Efficiency of use of UNFPA resources (partners, staff, money, global experience)

- Did your work receive the needed support from UNFPA in terms of advice, staff inputs, money or technical assistance, what were the strengths and weaknesses?
- Did you receive any other donor support in connection with the UNFPA work? Did UNFPA promote greater connections and resources from the government or national actors?

6. Functioning Coordination mechanisms

- Do you work with other UN agencies and/or can you say how well the activities are coordinated, overlapping?
- Are there gaps in the population needs, which would not have been identified by the UN system, collectively?
- How big of a difference is UNFPA making in SRHR in Somalia, what contributes to its effect, what detracts?
- Can UNFPA input be improved or strengthened?

7. Coverage

- How does UNFPA CP respond to humanitarian needs in Somalia? In which locations? Who were the target groups?
- How does UNFPA programme identify those at risk or vulnerable
- To what extent does UNFPA programme target the vulnerable and those in displacement in Somalia?
- To what extent has UNFPA responded to SRH on the humanitarian and emerging needs in the IDP Settlements or calamities?
- What were the factors that facilitated UNFPA response to such adolescent and youth humanitarian and emerging issues?
- What were the factors that hindered the UNFPA response to such humanitarian and emerging issues?
- To what extent does the UNFPA CP interventions address the needs of populations at risk and vulnerable?
- Budget allocation for humanitarian programme interventions

8. Connectedness

- To what extent has UNFPA built the capacities of local partners during the current CP? What are the indications that the capacity building efforts are working?
- How has UNFPA built partnerships with local organizations or institutions in the areas of SRHR in Somalia?

- How adequate have the resources allocated to addressing emergency response been to ensure recovery and resilience
- How has UNFPA ensured that long-term plans are put in place to address the existing SRHR
- Have the facilities supported by UNFPA to respond to emergency been handed over to the local government or local communities?

9. Interviewee Recommendations

- Programmatic
- Strategic

Key Informant Interview Guide for Implementing Partners

Introduction:

a. Introduce yourself and the purpose of the Interview: the objective of assessing experience and learning of the current program cycle with the view of proposing recommendations for the next CP cycle.

b. Assure participants of the confidentiality of information exchange which will serve only for the purpose of analysis.

1. Which activities in your institution (department/ministry) were supported by the 3rd Country Programme?

2. Relevance (Usefulness and value to stakeholders)

- Do the objectives for programme interventions supported by the 3rd Country Programme; address the needs of your organization, the needs of the institutions and users you serve?
- How has the programme supported the organization (ministry) to address the needs of your clients (users of population and other data)? If not, what issues still need to be addressed? Are the data used in planning? Examples
- To what extent are the results and benefits from the sixth Country Programme 2018 - 2020 useful to users of population data?
- How are UNFPA interventions integrated/ into related government programmes?
- Is UNFPA responsive to government needs in the context of Somalia?

3 . Efficiency (Organisational and programmatic efficiency)

- How appropriately and adequately are the available resources (funding and resources) used to carry out activities for the achievement of the outputs?
- To what extent were the activities managed in a manner to ensure delivery of high quality outputs and best value for money?
- Were agreed outputs delivered?
- Was the programme approach, partner and stakeholder engagement appropriate for results delivery?
- Which partnerships were more strategic in bringing about results and value-for money?
- Were institutions adequately equipped to deliver on results-based management/ M& E for the CP?

4. Effectiveness (Degree of achievements of outputs and outcomes)

- To what extent did the UNFPA CP contribute to the stated outcome?
- Are the outcomes a result of/attributable to CP interventions?
- Were UNFPA interventions implemented at adequate scale to reach intended outcomes?
- To what extent did the programme address the needs of the beneficiaries?
- Were strategic information outputs and other research reports used to inform policy/planning?

- Are relevant population reports and demographic data used for planning?
- What else should be done to make the programmes more effective?

5. Sustainability (Continuity of benefits after 3rd Country Programme)

- Were UNFPA interventions integrated into departmental plans?
- What are plans for sustainability within your organisation?
- Does your institution have capacity to continue programme interventions without UNFPA or any donor support? If not, what kind of assistance will be required?
- To what extent have the capacities been strengthened?

6. Coverage

- How did UNFPA CP respond to humanitarian needs in Somalia? In which locations? Who were the target groups?
- How did UNFPA programme identify those at risk or vulnerable
- To what extent did UNFPA programme target the vulnerable and those in displacement in Somalia?
- To what extent did the UNFPA CP interventions address the needs of populations at risk and vulnerable? Ask for adolescents, girls, women, youth, IDPs and marginalized populations (minority clans).

7. Connectedness

- To what extent has UNFPA built the capacities of local partners during the current CP? What are the indications that the capacity building efforts are working?
- How has UNFPA built partnerships with local organizations or institutions in the areas of SRH in Somalia?
- How adequate have the resources allocated to addressing emergency response been to ensure recovery and resilience
- How has UNFPA ensured that long-term plans are put in place to address the existing SRH challenges?
- Have the facilities supported by UNFPA to respond to emergency been handed over to the local government or local communities?

8. Interviewee Recommendations

a. Any recommendations on improving data use?

Programme Component 2: Adolescents and Youth

Interview Guide with UNFPA Component Staff

Introduction

a. Introduce yourself and the purpose of the Interview: the objective of assessing experience and learning of the current program cycle with the view of proposing recommendations for the next CP cycle.
b. Assure participants of the confidentiality of information exchange, which will serve only for the purpose of analysis.
c. Write the names of all the Participants

1. Rationale for the project and activities undertaken

- Please describe the groups you are trying to reach through your participation in the activities and why you think it is important for the adolescents and youth?

2. Relevance

- How well does the activity/work support the government's priorities and work within the national structures that are in place? How well does it work within private structures?

- How well is the work designed to achieve the outcomes/results in the M&E Framework? (to improve SRHR knowledge of adolescent and youth)
- Were the objectives and strategies of the Country Programme M&E Framework discussed and agreed with national partners? [Probe]
- Has UNFPA adapted the programme and activities to respond to changes in the institutional environment (e.g. dynamism in the government, restructuring of the Ministry of Youth Affairs; and other IPs, including CSOs?
- Were there any adolescent and youth needs or priorities of the implementing partners that the country program did not address adequately or at all? If Yes, what were these needs and Priorities

3. Effectiveness of the approaches/activities/projects used to improve access to high quality SRHR services and for the most vulnerable.

- What are the indications that the approach is working or making progress toward goals established to be achieved in 2020 - end of CP - (e.g. anecdotes which provide illustrations of positive, negative or unintended effects, or quantitative and qualitative evidence) ; (numbers being reached, products produced/purchased and the extent of impact, evidence of usage of knowledge, increasing networks, etc.)
- Were UNFPA interventions implemented at adequate scale to reach intended outcomes?
- What else should be done to make the programmes more effective?
- How effective was the training on adolescent and youth sexual and SRHR in addressing the adolescent and youth health?
- What are the barriers/challenges to increasing demand and access to services, and how are they being addressed?

4. Sustainability

8. Are the capacities in place among stakeholders to be able to carry out the activities/project without support from UNFPA?
9. Are financial resources available?
10. Will the results of the project last after the CP is completed?
11. Is there an exit strategy? (***for UNFPA***)

5. Efficiency of use of UNFPA resources (partners, staff, money, global experience)

- Did your work receive the needed support from UNFPA in terms of advice, staff inputs, money or technical assistance, what were the strengths and weaknesses?
- Did you receive any other donor support in connection with the UNFPA work? Did UNFPA promote greater connections and resources from the government or national actors?

6. Functioning Coordination mechanisms

- Do you work with other UN agencies and/or can you say how well the activities are coordinated, overlapping?
- Are there gaps in the population needs, which would not have been identified by the UN system, collectively?
- How big of a difference is UNFPA making in SRHR in Somalia, what contributes to its effect, what detracts?
- Can UNFPA input be improved or strengthened?

7. Coverage

- How does UNFPA CP respond to humanitarian needs in Somalia? In which locations? Who were the target groups?

- How does UNFPA programme identify those at risk or vulnerable
- To what extent does UNFPA programme target the vulnerable and those in displacement in Somalia?
- To what extent has UNFPA responded to adolescents and youth in the humanitarian and emerging needs in the IDP Settlements or calamities?
- What were the factors that facilitated UNFPA response to such adolescent and youth humanitarian and emerging issues?
- What were the factors that hindered the UNFPA response to such humanitarian and emerging issues?
- To what extent does the UNFPA CP interventions address the needs of populations at risk and vulnerable?
- What was the budget allocation for adolescent and youth in the humanitarian set-up?

8. Connectedness

- To what extent has UNFPA built the capacities of local partners during the current CP? What are the indications that the capacity building efforts are working?
- How has UNFPA built partnerships with local organizations or institutions in the areas of SRHR in Somalia?
- How adequate have the resources allocated to addressing emergency response been to ensure recovery and resilience
- How has UNFPA ensured that long-term plans are put in place to address the existing SRHR
- Have the facilities supported by UNFPA to respond to emergency been handed over to the local government or local communities?

9. Interviewee Recommendations

a. Programmatic
b. Strategic

Interview Guide for Adolescent and Youth Implementing Partners

Introduction

- Introduce yourself and the purpose of the Interview: the objective of assessing experience and learning of the current program cycle with the view of proposing recommendations for the next CP cycle.
- Assure participants of the confidentiality of information exchange, which will serve only for the purpose of analysis.
- Write the names of all the Participants

1. Rationale for the project and activities undertaken

- Please describe the groups you are trying to reach through your participation in the activities and why you think it is important for the adolescents and youth?

2. Relevance of the project/activities to the UN priorities, government policies and local structures

- Were the objectives and strategies of the Country Programme M&E Framework discussed and agreed with national partners? [Probe]
- How well does the activity/work with UNFPA fit in with the youth and adolescent activities across Somalia?
- What effect do you think the work should have, with which groups?

3. Effectiveness of the approaches/activities/projects used to improve access to high quality ASRH and FP services and for the most vulnerable.

- Can you provide examples of success of the approach/activities used during the programmes both long term and short term?
- How useful are these activities to communicate the ASRH messages?

- Can the youth network carry on the work without UNFPA? What will help the youth network to carry on the ASRH work on its own?
- Are there factors affecting successful implementation of the 3rd CP?
- What factors have facilitated effective implementation of the 3rd CP?

4. Efficiency in the use of UNFPA resources (partners, staff, money, global experience)

- Did your work receive the needed support from UNFPA?
- Did the youth network receive any other support in connection with the UNFPA work and who provided this support?

5. Functioning of coordination mechanisms

- Do you work with other UN agencies and/or can you say how well the activities are coordinated, overlapping or gaps identified?
- How big of a difference is UNFPA making in ASRH in Somalia, what contributes to its effect, what detracts?
- How can UNFPA input be improved or strengthened?

6. Sustainability

- To what extent are the benefits likely to go beyond the programme completion?
- What measures are in place at the end of the programme cycle for the various programmes to continue?
- What are the plans for sustainability of the programmes?
- Does your institution have the capacity to continue the programme interventions without any donor support?
- **Coverage**
- How does UNFPA CP respond to humanitarian needs in Somalia? In which locations? Who were the target groups?
- How does UNFPA programme identify those at risk or vulnerable
- To what extent does UNFPA programme target the vulnerable and those in displacement in Somalia?
- To what extent has UNFPA responded to adolescents and youth in the humanitarian and emerging needs in the IDP Settlements or calamities?
- What were the factors that facilitated UNFPA response to such adolescent and youth humanitarian and emerging issues?
- What were the factors that hindered the UNFPA response to such humanitarian and emerging issues?
- To what extent does the UNFPA CP interventions address the needs of populations at risk and vulnerable?

7. Interviewee recommendations

Programme Component 3: Gender Equality and Women Empowerment

Key Informant Interview Guide for UNFPA Staff

Introduction:

- Introduce yourself and the purpose of the Interview: the objective of assessing experience and learning of the current program cycle with the view of proposing recommendations for the next CP cycle.
- Assure participants of the confidentiality of information exchange which will serve only for the purpose of analysis.

Describe the UNFPA 3rd Country Programme component in which you are involved in

1. **Relevance**

- How is the gender equality and women empowerment component of the 3rd Country Programme (CP) consistent with the a) national needs and priorities in Somalia such as articulated in the national and sectoral policies b) Partners and beneficiaries needs? c) UNFPA Strategic Priorities and strategic plan? d) International frameworks, policies and strategies on gender equality and human rights? **(probe for the needs first)**
- What aspects of the national and sectoral policies are covered in the 3rd CP?
- Were the objectives and strategies of the Country Programme M&E Framework discussed and agreed with national partners? [Probe]
- How did you identify the needs prior to the programming of the Gender Equality and women's empowerment (GEWE) including GE/GBV/HR components?
- Who was consulted regarding the design? What other actors have been involved, how does this activity contribute to that of others?
- In your view, does UNFPA have the right strategic partnerships? Mutual benefit, critical to achieving shared vision
- Were there any changes in national needs and global priorities during the implementation period? How did UNFPA Country Office (CO) respond to these?

2. **Effectiveness**

- What types of new gender knowledge and skills have you attained through this programme
- What are the barriers/challenges to increasing demand and access to services, and how are they being addressed?
- What are the indications that the approach is working or making progress toward goals established for the CP (e.g. anecdotes which provide illustrations of positive, negative or unintended effects, or quantitative and qualitative evidence) (types of gender equality and women empowerment tools developed/supported; numbers being reached, and the extent of impact, evidence of changes in social norms and practices due to new GEWE knowledge, increasing networks enabling a multi-sectoral response for GEWE etc.)?
- Are there factors affecting successful implementation of the 3rd CP?
- What factors have facilitated effective implementation of the 3rd CP?
- Overall, what are the achievements of the 3rd CP in respect of the GEWE component area? [evidence in]
    a. Legal and policy framework
    b. Services (public/private) for whom (survivors of violence)
    c. Capacity for implementation enhancement
    d. Thought leadership
    e. Social and cultural change
- What challenges were encountered during implementation of the 3rd CP as far as your programme area is concerned?
- What do you consider to be the best practices from the 3rd CP?
- To what extent do you see UNFPA as having helped foster inclusion of gender based violence in national level dialogue and processes? - Within national programmes and policy
- Extent to which internal communication strategies on GEWE facilitate transformation of gender stereotypes for improved SRH outcomes in terms of funding, personnel, administrative arrangements, time and other inputs contributed to, or hindered achievement of results.

Note: Remember to ask for documents if not already shared

3. **Efficiency**

- Were all the planned activities of the CP implemented and completed – what where the facilitating/hindering factors
- Explain the resources management process of your programme area?
- How many staff are in your unit? Qualified with appropriate skills?

- Do you think your staff strength and capacity are enough for the 3rd CP implementation and achievement of results?
- How many consultants have worked on the 3rd CP since inception? International consultants? National consultants?
- What was/is their output? How useful is the output in the implementation of the 3rd CP?
- Describe UNFPA CO administrative and financial procedures in the 3rd CP?
- Do you think UNFPA CO administration and financial procedures are appropriate for the 3rd CP implementation? Explain
- How timely were resources for interventions disbursed for implementation? Were there any delays? If yes, why? And how did you solve the problem?
- Are there occasions when the budget was not enough or you overspent?
- Are there any programmes cancelled or postponed? Why?
- Have the programme finances been audited?
- Any additional funding from the Government of Somalia and other partners?
- What lessons has your Unit learnt in implementing the 3rd CP?

4. Sustainability

- What are the benefits of the programme interventions?
- How do you assess the level of ownership of programme inputs and are there efforts to integrate/retain them within IP work plans, strategies?
- To what extent are the benefits likely to go beyond the programme completion?
- Are the strategies, plans, protocols and practices developed within the programme anchored on IPs institutional arrangements
- What measures are in place at the end of the programme cycle for the various programmes to continue?
- What are the plans for sustainability of the programmes?
- Do you believe that there is political will and national ownership behind GEWE interventions, and is this changing? Have programmes been integrated in institutional government plans?

5. UNCT Coordination

- Is there any Inter-Agency Technical Working Group on this 3rd CP, involving other UN Country Team?
- What is the role of UNFPA CO in the United Nations Country Team coordination in Somalia? What partnerships exist? Any specific contributions to the achievement of results? Any Challenges?
- Can you say how well the activities are coordinated, overlapping and how is this handled?
- How could these challenges be overcome?
- What role has UNFPA played in the UNCT joint programs? Any specific contributions? Any lessons learned? Any challenges?
- Is UNFPA playing an active coordination or leadership role around GEWE in the UN system?
- What are the special strengths of UNFPA when compared to other UN agencies and development partners?
- How do implementing and national partners perceive UNFPA?

6. Connectedness

- To what extent has UNFPA built the capacities of local partners during the current CP? What are the indications that the capacity building efforts are working?
- How has UNFPA built partnerships with local organizations or institutions in the areas of GEWE in Somalia?
- How adequate have the resources allocated to addressing emergency response been to ensure recovery and resilience
- How has UNFPA ensured that long-term plans are put in place to address the existing GEWE challenges?
- Have the facilities supported by UNFPA to respond to emergency been handed over to the local government or local communities?

7. **Coverage**

- How does UNFPA CP respond to humanitarian needs in Somalia? In which locations? Who were the target groups?
- How does UNFPA programme identify those at risk or vulnerable to GEWE issues
- To what extent does UNFPA programme target the vulnerable and those in displacement in Somalia?
- To what extent has UNFPA responded to adolescents and youth in the humanitarian and emerging needs in the IDP Settlements or calamities?
- What were the factors that facilitated UNFPA response to such GEWE humanitarian and emerging issues?
- What were the factors that hindered the UNFPA response to such humanitarian and emerging issues?
- To what extent does the UNFPA CP interventions address the needs of populations at risk and vulnerable?
- Budget allocation for humanitarian programme interventions

Key Informant Interview Guide for Implementing Partners

National Stakeholders: Government Departments, CSO and NGOs

Introduction:

- Introduce yourself and the purpose of the Interview: the objective of assessing experience and learning of the current program cycle with the view of proposing recommendations for the next CP cycle.
- Assure participants of the confidentiality of information exchange which will serve only for the purpose of analysis.

Describe the UNFPA Country Programme and your involvement in it.

1. Relevance

- To what extent is the gender equality and women empowerment component of the 3rd Country Programme (CP) aligned to the a) national needs and priorities in Somalia such as those articulated in the national and sectoral policies; b) International frameworks, policies and strategies on gender equality and human rights
- What aspects of the national and sectoral policies do you consider are covered in the 3rd CP?
- Were the objectives and strategies of the Country Programme M&E Framework discussed and agreed with national partners? [Probe]
- How does the GEWE programme intervention interface/merge with your institutional programmatic objectives and strategies
- How were needs of your institution identified prior to the programming of the Gender Equality and Women's Empowerment (GE) including GE/GBV/HR components?
- Do you see the work of UNFPA and its implementing partners as supporting the right things to address GE/GBV/HR, harmful practices and discrimination against women and girls?
- Are these the most relevant issues for UNFPA to focus on given national priorities and what other agencies are doing?

2. Effectiveness

- Looking at the implementation so far, to what extent has 3rd CP reached the intended beneficiaries?
- Are the planned outputs/targets achieved?

- To what extent is there support to relevant groups including survivors of GBV, adolescents and youth, boys and men?
- Are there factors affecting successful implementation of the 3rd CP?
- What factors have facilitated effective implementation of the 3rd CP?
- Is UNFPA's work coordinated with other partners , and has it led to more groups supporting action to address violence against women and girl? Promote gender equality and women's empowerment?
- Has UNFPA support to GEWE/GBV/HR been sufficiently sustained over time?
- Do you consider that your institution has embedded sufficient political will and official ownership on the GEWE agenda including elimination of GBV and promotion of human rights? If any changes have been witnessed due to this programme what have they been?
- Has UNFPA support to GE/GBV/HR been sufficiently sustained over time?
- In your experience, what factors most help or hinder achieving improvements in gender equality and women's empowerment; reductions in GBV including harmful traditional practices?
- Has there been evidence of expected or unexpected results from work on GEWE/GBV/HR that has been supported by UNFPA?
    - Legal and policy framework
    - Services (public/private) for whom
    - Capacity for implementation
    - Thought leadership
    - Social and cultural change

3. Efficiency

- Explain the resources management process of the programme
- How many staff in your unit are responsible for the implementation of this program? Qualified with appropriate skills?
- Do you think UNFPA CO administration and financial procedures are appropriate for the 3rd CP implementation?
- How about the programme approach, partner and stakeholder engagement, was it appropriate for CP implementation and achievement of results?
- How timely did the resources for this particular intervention come to your office?
- Were there any delays? If yes, why? And how did you solve the problem?
- Any new activities added to the current programme activities?
- Are there occasions when the budget was not enough or you overspent?
- Are there any programmes cancelled or postponed? Why?
- Any additional funding from the Government of Somalia and other partners?
- Do you think that the UNFPA project targeted all civil society organizations in your state and elsewhere that can play an active role in the promotion of gender sensitive policies, services as well as education of subject communities?

4. Sustainability

- What are the benefits of the programme interventions?
- To what extent are the benefits likely to go beyond the programme completion?
- What measures are in place at the end of the programme cycle for the various programmes to continue within your own interventions?
- What are the plans for sustainability of the programmes?
- Have programmes been integrated in institutional government plans?
- Does your institution have the capacity to continue the programme interventions without any donor support?

5. UNCT Coordination

- What are the special strengths of UNFPA when compared to other UN agencies and development partners?

- What are the comparative strengths of UNFPA in the country and does it add value to the work of other entities?
- How is UNFPA perceived by implementing and national partners?

6. **Coverage**

- How does UNFPA CP respond to humanitarian needs in Somalia? In which locations? Who were the target groups?
- How does UNFPA programme identify those at risk or vulnerable
- To what extent does UNFPA programme target the vulnerable and those in displacement in Somalia?
- To what extent has UNFPA responded to GEWE issues in the humanitarian and emerging needs in the IDP Settlements or calamities?
- What were the factors that facilitated UNFPA response to such GEWE in humanitarian and emerging issues?
- What were the factors that hindered the UNFPA response to such humanitarian and emerging issues?
- To what extent does the UNFPA CP interventions address the needs of populations at risk and vulnerable?
- Budget allocation for humanitarian programme interventions

Connectedness

- To what extent has UNFPA built the capacities of local partners during the current CP? What are the indications that the capacity building efforts are working?
- How has UNFPA built partnerships with local organizations or institutions in the areas of GEWE in Somalia?
- How adequate have the resources allocated to addressing emergency response been to ensure recovery and resilience
- How has UNFPA ensured that long-term plans are put in place to address the existing GEWE challenges?
- Have the facilities supported by UNFPA to respond to emergency been handed over to the local government or local communities?

Key Informant/ Focus group Interview Guide for GEWE Beneficiaries

Introduction:

a. Introduce yourself and the purpose of the Interview: the objective of assessing experience and learning of the current program cycle with the view of proposing recommendations for the next CP cycle.
b. Assure participants of the confidentiality of information exchange which will serve only for the purpose of analysis.

I would like to know the type of support did you received from (UNFPA implementing partner)

1. **Relevance**

- What are the national needs and priorities in Somalia/in your community in terms of the development agenda? How important is the work supported by (UNFPA implementing partner) to these needs and priorities at district, provincial and national levels?
- Does the (UNFPA implementing partner)'s work address the needs in Gender Equality and Women's Empowerment (GEWE) including GBV/ FGM?
- How important is the work supported by (UNFPA implementing partner) to these needs and priorities at district, provincial and national levels?

2. **Effectiveness**

- To what extent has UNFPA (Implementing Partner) support reached the intended beneficiaries?
- Are different beneficiaries appreciating the benefits of the UNFPA interventions? For example,
- What are the specific indicators of success in your programme?
- How are gender relations and human rights being influenced by the activities undertaken by the programme Are there ways to sustain the positive changes?
- What do you think has worked best? What has not worked well
- What factors contributed to the effectiveness or otherwise?

3. **Sustainability**

- What are the benefits of the programme interventions?
- To what extent are the benefits likely to go beyond the programme completion?
- What measures are in place at the end of the programme cycle for the various programmes to continue?
- Have programmes been integrated in institutional/government plans?
- How does the UNFPA CO/ (Implementing partner) ensure ownership and durability of its programmes?

4. Connectedness

- To what extent has UNFPA built the capacities of local partners during the current CP? What are the indications that the capacity building efforts are working?
- How has UNFPA built partnerships with local organizations or institutions in the areas of GEWE in Somalia?
- How adequate have the resources allocated to addressing emergency response been to ensure recovery and resilience

5. Coverage

- Would you say that UNFPA support is reaching the vulnerable and at risk groups with the GEWE interventions in Somalia? How or why?
- To what extent does the UNFPA CP interventions address the needs of populations at risk and vulnerable?
- How does UNFPA CP respond to humanitarian needs in Somalia? In which locations? Who were the target groups?
- How does UNFPA programme identify those at risk or vulnerable
- To what extent does UNFPA programme target the vulnerable and those in displacement in Somalia?
- To what extent has UNFPA responded to GEWE in the humanitarian and emerging needs in the IDP Settlements or calamities?
- What were the factors that facilitated UNFPA response to such adolescent and youth humanitarian and emerging issues?
- What were the factors that hindered the UNFPA response to such humanitarian and emerging issues?

6. Interviewee Recommendations

- If you were to recommend changes or ways to improve the interventions what changes would you make or like to see

Programme Component: Population Dynamics

Informants: **UNFPA PD Staff**

Introduction:

a. Introduce yourself and the purpose of the Interview: the objective of assessing experience and learning of the current program cycle with the view of proposing recommendations for the next CP cycle.
b. Assure participants of the confidentiality of information exchange which will serve only for the purpose of analysis.

1. **Rationale for the project and activities undertaken**

- How did you decide to undertake this work, what were the indications that it would be effective and would reach the target population?
- Have you conducted a problem analysis, needs assessment? Who was consulted regarding the design?
- What other actors have been involved, how does this activity contribute to that of others?

2. **Relevance of the project/activities to the UN priorities, government policies, local structures**

- How well does the activity/work support the government's priorities and work within the national structures that are in place? How well does it mobilise and work with NGOs, universities and private structures?
- How well is the work designed to achieve the outcomes/results in the M&E Framework?
- How well were UNFPA supported activities responding the contextual changes in the implementing environment? (such as ICPD)

3. **Effectiveness of the approaches/activities/projects used** to make available data on population dynamics, gender equality, young people, sexual and reproductive health and HIV/AIDS available, analysed and such data are used at national and sub-national levels to develop and monitor policies and programme implementation.

    - Overall, what are the main results / achievements of activities undertaken?
    - What are the indications that the approach is working or making progress toward goals established for 2030?
    - What are the barriers/challenges to increasing demand and access to services, and how are they being addressed?
    - What are the strengths and weaknesses of the approaches to achieve the desired results?

4. **Efficiency of use of UNFPA resources (partners, staff, money, global experience)**
    - Have adequate resources of UNFPA been mobilized to implement the programmes - staff inputs, money or technical assistance, etc. what were the strengths and weaknesses?
    - Has UNFPA mobilized the resources of other partners and stakeholders?
    - What are the contributions of other partners or stakeholders – donors, in kind-contribution, etc in connection with the UNFPA work? (Such as the universities, NGOs and the government institutions).
    - Have the activities been implemented in accordance with the AWP?
    - Have the activities been monitored and followed up within the AWP?

5. **Sustainability**:
    - Are there capacities in place among stakeholders to be able to carry out the activities/project without support from UNFPA?
    - How sustainable are the outcomes of this work, who will carry it on with or without UNFPA?
    - What will improve or inhibit sustainability?

6. **Functioning of coordination mechanisms**

- How have you worked with other UNFPA component staff on issues that would relate to PD as well?
- What are the cooperation areas and means of cooperation? How well the activities are coordinated particularly if there are overlapping fields? Have synergies been created?
- What are the comparative strengths of UNFPA in the UN system and does it add value to the work of other entities?
- What is the role of UNFPA CO in the United Nations Country Team coordination in Somalia? What partnerships exist? Any specific contributions to the achievement of results? Any Challenges?
- Can you say how well the activities are coordinated, overlapping and how is this handled?
- How could these challenges be overcome?
- What role has UNFPA played in the UNCT joint programmes? Any specific contributions? Any lessons learned? Any challenges?
- Is UNFPA playing an active coordination or leadership role around PD in the UN system?
- What are the special strengths of UNFPA when compared to other UN agencies and development partners?

7. **Coverage**

- How does the PD component contribute to availing data to identify humanitarian needs in Somalia? In which locations? Who were the target groups?
- How does UNFPA programme identify those at risk or vulnerable
- What were the factors that facilitated availability of information for UNFPA response to humanitarian and emerging issues?
- What were the factors that hindered the UNFPA response to such humanitarian and emerging issues?
- To what extent does the UNFPA CP interventions address the needs of populations at risk and vulnerable?
- Budget allocation for humanitarian programme interventions in PD

8. Connectedness

- To what extent has UNFPA built the capacities of local partners during the current CP? What are the indications that the capacity building efforts are working?
- How has UNFPA built partnerships with local organizations or institutions in the areas of PD in Somalia?
- How adequate have the resources allocated to addressing emergency response been to ensure recovery and resilience
- How has UNFPA ensured that long-term plans are put in place to address the existing PD challenges?
- Have the facilities supported by UNFPA to respond to emergency been handed over to the local government or local communities?

Policy-Makers & Ministry Directors [Adapted for all Components)

Introduction:

a. Introduce yourself and the purpose of the Interview: the objective of assessing experience and learning of the current program cycle with the view of proposing recommendations for the next CP cycle.

b. Assure participants of the confidentiality of information exchange which will serve only for the purpose of analysis.

1. Which activities in your institution (department/ministry) were supported by the 3rd Country Programme?

2. Relevance (Usefulness and value to stakeholders)

- Do the objectives for programme interventions supported by the 3rd Country Programme; address the needs of your organization, the needs of the institutions and users you serve?
- How has the programme supported the organization (ministry) to address the needs of your clients (users of population and other data)? If not, what issues still need to be addressed? Are the data used in planning? Examples
- To what extent are the results and benefits from the 3rd Country Programme 2018-2020 useful to users of population data?
- How are UNFPA interventions integrated/ into related government programmes?
- Is UNFPA responsive to government needs in the context of Somalia?

3. Efficiency (Organisational and programmatic efficiency)

- How appropriately and adequately are the available resources (funding and resources) used to carry out activities for the achievement of the outputs?
- To what extent were the activities managed in a manner to ensure the delivery of high quality outputs and best value for money?
- Were agreed outputs delivered?
- Was the programme approach, partner and stakeholder engagement appropriate for results delivery?
- Which partnerships were more strategic in bringing about results and value-for money?
- Were institutions adequately equipped to deliver on results-based management/ M&E for the CP?

4. Effectiveness (Degree of achievements of outputs and outcomes)

- To what extent did the UNFPA CP contribute to the stated outcome?
- Are the outcomes a result of/attributable to CP interventions?
- Were UNFPA interventions implemented at adequate scale to reach intended outcomes?
- To what extent did the programme address the needs of the beneficiaries?
- Were strategic information outputs such as Census Reports and other research reports used to inform policy/planning?
- Are relevant population reports and demographic data used for planning?
- What else should be done to make the programmes more effective?

5. Sustainability (Continuity of benefits after 3rd Country Programme)

1. Were UNFPA interventions integrated into departmental plans?
2. What are plans for sustainability within your organisation?
3. Does your institution have capacity to continue programme interventions without UNFPA or any donor support? If not, what kind of assistance will be required?
4. To what extent have the capacities been strengthened?
5. How functional are the youth-serving NGOs? What are the results of capacity building interventions implemented by these organizations?

Interviewee Recommendations

- Any recommendations on improving UNFPA work in the area of focus?

Key Informant Guide

UN, Donors, and Organizations that are not implementing the programme but are key players in the sector

a. Introduce yourself and the purpose of the Interview: the objective of assessing experience and learning of the current program cycle with the view of proposing recommendations for the next CP cycle.

b. Assure participants of the confidentiality of information exchange which will serve only for the purpose of analysis.

1. **Rationale for the project and activities undertaken**
   - Please could you explain a little bit about your role in relation to UNFPA's work in Somalia?
   - How relevant do you perceive UNFPA's work to be in regard to national objectives and priorities?
   - How well does the activity/work support the national structures that are in place? How well does it work within private structures?

2. **Relevance of the project/activities to the UN priorities, local structures**
   - How well is the work designed to achieve the outcomes/results in the UNSF?
   - Has UNFPA adapted the programme and activities to respond to changes in the institutional environment and assistance environment

3. **Effectiveness of the approaches/activities/projects used to improve access to high quality UNFPA Component services and for the most vulnerable.**

- What are the indications that the approach is working or making progress toward goals established for 2030 (e.g. anecdotes which provide illustrations of positive, negative or unintended effects, or quantitative and qualitative evidence)?
- What are the barriers/challenges to increasing demand and access to services, and how are they being addressed?
- Are the capacities in place among stakeholders to be able to carry out the activities/project without support from UNFPA and other external actors?
- Are financial resources available?
- Will the results of the external assistance last after is it over?
- Does your organization have an exit strategy?
- Coverage of SRH, A&Y, GEWE and PD in the humanitarian context

4. **Efficiency of use of UNFPA resources (partners, staff, money, global experience)**

   - Can you comment on the quality of UNFPA's contribution in terms of advice, staff inputs, money or technical assistance, what were the strengths and weaknesses?
   - Can you comment on whether UNFPA's efforts have helped to bring in any other support from the government, other stakeholders, such as universities and donors?

5. **Functioning of coordination mechanisms**

   - Are you participating in any coordination mechanism with UN Agencies? Cluster or thematic group on the national level? On the state level? How often do you meet?
   - What is your view of UNFPA's strategic positioning regarding GE/GBV/FGM and how should it position itself in the future?
   - Do you work with other UN agencies and/or can you say how well the UN agency activities are coordinated, overlapping?
   - What are the comparative strengths of UNFPA in the UN system and does it add value to the work of other entities?

- Are there gaps in the population needs which would not have been identified by the UN system, collectively?
- Can the UNFPA inputs be improved or strengthened?

6. Interviewee **recommendations**

Annex 7: Stakeholder Map

Donor	**Implementing Agencies**	**Other Partners**	**Beneficiaries**
SEXUAL AND REPRODUCTIVE HEALTH			
Strategic Plan Outcome: Increased availability and use of integrated sexual and reproductive health services (including family planning, maternal health and HIV) that are gender-responsive and meet human rights standards for quality of care and equity in access			
CP Output 1: Increased national capacity to deliver comprehensive maternal health services including in humanitarian settings			
CP Output 2: Increased national capacity to provide sexual and reproductive health services, including in humanitarian settings			
Sweden, Finland, Italy, Switzerland	Ministry of Health of Puntland	UNICEF, Save the children, World Vision, ANPPCAN, SRCS	Women of reproductive age, Pregnant and lactating women, and GBV survivors,
Sweden, Finland, Italy, Switzerland	Ministry of Health Somaliland-SL		Women of reproductive age (including Pregnant & lactating women), women & girls at risk and/or survivors of GBV
Sweden, Finland & Italy	Ministry of Health and Human Services-FGS	State Ministries of Health	CEMONC, MIDWIVERY, RHSC & FAMILY PLANNING
Sweden, Finland & Italy	Ministry of Humanitarian Affairs and Disaster Management-FGS	Somalia Humanitarian Partners including UN, NGOs and National Institutions	Somali Population
Sweden, Finland & Italy	Action for Relief and Development		Basic Emergency Obstetric and Newborn Care
Sweden, Finland & Italy	Somali Birth Attendance and Cooperative Organization		Basic Emergency Obstetric and Newborn Care
Sweden, Finland & Italy	Organization for Somali Protection and Development		Basic Emergency Obstetric and Newborn Care
Sweden, Finland, Italy	INTERSOS Somalia		Comprehensive Emergency Obstetric and

Donor	Implementing Agencies	Other Partners	Beneficiaries
			Newborn Care (CEmONC)
Sweden, Finland, Italy, Switzerland	ANPPCAN	UNICEF, Save the children, World Vision, ANPPCAN, SRCS, MOH	Women of reproductive age, Pregnant and lactating women, and GBV survivors,
Sweden, Finland, Italy, Switzerland	Somali Red Crescent Societies-FGS	UNICEF, Save the children, World Vision, ANPPCAN, SRCS, MOH	Women of reproductive age, Pregnant and lactating women, and GBV survivors,
Sweden, Finland, Italy, Switzerland	Somaliland Nursing and Midwifery Association		Women of reproductive age (including Pregnant & lactating women), women & girls at risk and/or survivors of GBV
Sweden, Finland, Italy	Physicians Across Continents-FGS	UNICEF	Emergency Obstetric and Newborn Care
ADOLESCENT AND YOUTH			
Strategic Plan Outcome: Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education and sexual and reproductive health services			
CP Output: Increased capacity of partners to design and implement comprehensive programmes to reach marginalized youth, especially adolescent girls, including those at risk of child marriage			
Sweden, Finland, Italy, Switzerland	Ministry of Youth and Sport-FGS	UNHABITAT	Young men and Women
Sweden, Finland, Italy, Switzerland	Ministry of Youth and Sports-SL		Young men and Women
Sweden, Finland, Italy, Switzerland	National HIV/AIDS Commission-SL		Somali Population
Sweden, Finland, Italy, Switzerland	Ministry of Labour, Youth and Sports PL	UNICEF, Mercy Corps	Youth
Sweden, Finland, Italy, Switzerland	South Central AIDS Commission		Young men and Women
Sweden, Finland, Italy, Switzerland	Somaliland Y-Peer Network-SL		Young men and Women
Sweden, Finland, Italy, Switzerland	Puntland Youth Peer Network-PL	UNICEF, MERCY Corps	Women of reproductive age, Pregnant and lactating women, and GBV survivors, youth
Sweden, Finland, Italy, Switzerland and Peace building Fund	Somali Youth Peer Network-FGS	UNHABITAT	Youth
Sweden, Finland, Italy, Switzerland	Timely Integrated Service-FGS	UNICEF, UNDP, Save the Children Muslim Aid, IRC, GECPD	GBV survivors, Women, and Girls
Sweden, Finland, Italy, Switzerland	Talowadag-SL		

Donor	Implementing Agencies	Other Partners	Beneficiaries
Sweden, Finland, Italy, Switzerland	Somali Lifeline Organization-FGS		Youth
Sweden, Finland, Italy, Switzerland	Mercy USA for Aid and Development-FGS		Youth
GENDER EQUALITY AND WOMEN'S EMPOWERMENT			
Strategic Plan Outcome: Advanced gender equality, women's and girls' empowerment, and reproductive rights, including for the most vulnerable and marginalized women, adolescents and youth			
CP Output: Increased capacity of partners to provide services to survivors of gender-based violence, to prevent gender based violence, harmful practices, and to promote reproductive rights and women's empowerment, including in humanitarian settings			
CERF Funds	Rural Education and Agriculture Development Organization-FGS	None	Women of reproductive age, Pregnant and lactating women, and GBV survivors,
Sweden, Finland, Italy, Switzerland	Socio Economic Development and Human Rights Organization-FGS	None	GBV survivors, Women, and Girls
Sweden, Finland, Italy, Switzerland	Action Aid International-SL	MESAF, Nagaad, and WAAPO	Women and girls those are at risk for GBV
Sweden, Finland, Italy, Switzerland	Relief International-FGS	None	GBV survivors, Women, and Girls
Sweden, Finland & Italy	Salama Medical Agency	None	GBV survivors, Women, and Girls
Sweden, Finland & Italy	WARDI Relief and Development Initiative-FGS	None	GBV survivors, Women, and Girls
Sweden, Finland, Italy, Switzerland	Ministry of Justice, Religious Affairs and Rehabilitation - PL	UNICEF, UNDP, UN WOMEN, IDLO	Women, girls, GBV survivors, police, prosecutors, Judges
Sweden, Finland, Italy, Switzerland	Ministry of Endowment and Islamic Affairs-SL	World vision	Women and girls those are at risk of GBV
Sweden, Finland, Italy, Switzerland	Initiative for Research	None	Women and girls those are at risk of GBV
Sweden, Finland, Italy, Switzerland	Ministry of Women and Human Rights Development-FGS	None	Women of reproductive age, Pregnant and lactating women, Youth and GBV survivors,
Sweden, Finland, Italy, Switzerland	Ministry of Labour and Social Affairs- Somaliland	UNICEF, ActionAid, Nagaad, and WAAPO	Women and girls those are at risk for GBV
Sweden, Finland, Italy, Switzerland	Ministry of Women's Development and Family Affairs -PL	CARE, UNICEF, UN WOMEN, UNDP, IRC, Save the Children, GRT, and UNHCR	Women, girls, GBV survivors
Sweden, Finland, Italy, Switzerland and Peace building Fund	Somali Institute for Development and Research-PL	None	Women of reproductive age, Pregnant and lactating women, and GBV survivors,

Donor	Implementing Agencies	Other Partners	Beneficiaries
POPULATION DYNAMICS			
Strategic Plan Outcome: Strengthened national policies and international development agendas through integration of evidence-based analysis on population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality			
CP Output: Strengthened national capacity for production and dissemination of high-quality disaggregated data on population, development and sexual and reproductive health issues that allow for mapping of demographic disparities and socio-economic and health inequalities, and for programming in humanitarian settings			
Sweden, Finland, Italy, Switzerland, and UK	Ministry of Planning and Development-SL	WHO, MoH, MoWomen	Somali population, mainly Women and girls
Sweden, Finland, Italy, Switzerland, and UK	Ministry of Planning of Puntland	UNICEF, UNDP	Women of reproductive age, Pregnant and lactating women, Youth and GBV survivors,
Sweden, Finland, Italy, Switzerland, and UK	Ministry of Finance and Planning-MOPIED_FGS	WHO, MoH, MoWomen Affairs	Somali population, mainly Women and girls

United Nations Population Fund
Somalia Country Office

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