

**PBF PROJECT PROGRESS REPORT**  
**COUNTRY: Somalia**  
**TYPE OF REPORT: SEMI-ANNUAL, ANNUAL OR FINAL: SEMI-ANNUAL**  
**YEAR OF REPORT: 2021**



<b>Project Title:</b> Improving psychosocial support and mental health care for conflict affected youth in Somalia: a socially inclusive integrated approach for peace building											
<b>Project Number from MPTF-O Gateway:</b> please select <b>118835</b>											
<b>If funding is disbursed into a national or regional trust fund:</b> <input type="checkbox"/> Country Trust Fund <input type="checkbox"/> Regional Trust Fund  <b>Name of Recipient Fund:</b>	<b>Type and name of recipient organizations:</b>  <table border="0"> <tr> <td><b>RUNO</b></td> <td><b>WHO (Convening Agency)</b></td> </tr> <tr> <td>please select</td> <td><b>IOM</b></td> </tr> <tr> <td>please select</td> <td><b>UNICEF</b></td> </tr> <tr> <td>please select</td> <td></td> </tr> <tr> <td>please select</td> <td></td> </tr> </table>	<b>RUNO</b>	<b>WHO (Convening Agency)</b>	please select	<b>IOM</b>	please select	<b>UNICEF</b>	please select		please select	
<b>RUNO</b>	<b>WHO (Convening Agency)</b>										
please select	<b>IOM</b>										
please select	<b>UNICEF</b>										
please select											
please select											
<b>Date of first transfer:</b> 26 <sup>th</sup> November 2019 <b>Project end date:</b> 31 August 2021 <b>Is the current project end date within 6 months?</b> Yes											
<b>Check if the project falls under one or more PBF priority windows:</b> <input type="checkbox"/> Gender promotion initiative <input checked="" type="checkbox"/> Youth promotion initiative <input type="checkbox"/> Transition from UN or regional peacekeeping or special political missions <input type="checkbox"/> Cross-border or regional project											
<b>Total PBF approved project budget (by recipient organization):</b>											
<b>Recipient Organization</b>	<b>Amount</b>										
WHO	\$770,400										
UNICEF	\$254,948										
IOM	\$474,652										
<b>Total:</b>	<b>\$1,500,000</b>										
Approximate implementation rate as percentage of total project budget: 56% *ATTACH PROJECT EXCEL BUDGET SHOWING CURRENT APPROXIMATE EXPENDITURE*											
<b>Gender-responsive Budgeting:</b>											
Indicate dollar amount from the project document to be allocated to activities focussed on gender equality or women's empowerment:											
-WHO: \$333,305											
-IOM: \$309,403/88											
-UNICEF: \$157,384.6											
TOTAL: \$800,093.48											
Amount expended to date on activities focussed on gender equality or women's empowerment: \$452,363.07											

<b>Project Gender Marker:</b> GM2
<b>Project Risk Marker:</b> Medium
<b>Project PBF focus area:</b> 3.2 Equitable access to social services
<b>Report preparation:</b>
Project report prepared by: Clara Bruhman, WHO
Project report approved by: Dr. Humuyan Rizwan, WHO
Did PBF Secretariat review the report: Yes. Fadumo Mumin, M&E Specialist and Maurits Rade, Conflict Analysis Officer

#### **NOTES FOR COMPLETING THE REPORT:**

- *Avoid acronyms and UN jargon, use general /common language.*
- *Report on what has been achieved in the reporting period, not what the project aims to do.*
- *Be as concrete as possible. Avoid theoretical, vague or conceptual discourse.*
- *Ensure the analysis and project progress assessment is gender and age sensitive.*
- *Please include any COVID-19 related considerations, adjustments and results and respond to section IV.*

#### **PART 1: OVERALL PROJECT PROGRESS**

Briefly outline the **status of the project** in terms of implementation cycle, including whether preliminary/preparatory activities have been completed (i.e. contracting of partners, staff recruitment, etc.) (1500 character limit):

**-WHO:** After developing the curriculum using the mhGap intervention guide, WHO held a training of trainers (TOTs) and cascade trainings, in collaboration with Somalia National University (SNU). WHO published an open call and selected a firm to undertake the research. The M&E framework was finalized and qualitative data for the baseline is being compiled (the report on facilities assessment will be available soon). The project website is final. WHO contracted a consultant to update the Mental Health (MH) situation analysis and prepare a draft action plan for Somalia, to help expand MH services and mobilize additional funds.

**-IOM:** Following the rapid Mental Health and Psychosocial Support (MHPSS) needs assessment, IOM trained 54 health workers (22 females, 32 males) in community-based MHPSS skills (Dollow, Kismayo, Baidoa). 142 persons were assisted through individual counselling, home visits and follow-up sessions. 12 youth-aged groups were formed and 98 members are participating in small group discussions. 30 youth-aged counsellors, 15 non-youth aged counsellors and 30 youth animators have formed mobile MHPSS teams, after receiving technical orientation on community-based MHPSS skills.

**-UNICEF** consulted with 42 youth (24 male and 18 female) (Baidoa, Galkayo) to develop contextualised messages on MHPSS and aired radio messages (~200,000 people reached). The package of key messages currently awaits endorsement by the MOH's MHPSS focal point. Consultations with youth in Kismayo and Dollow are still ongoing. Social workers mobilised peer-to-peer youth groups and sensitised communities on stigma, substance use prevention, child marriage and Gender-Based Violence (GBV) referral mechanisms (Baidoa, Galkayo, Kismayo). 35 religious leaders were oriented on similar themes by youth mobilisers and social workers from the Ministries of Justice and of Women and Human Rights. Billboards with key MHPSS messages are pending authorisation by local authorities.

Please indicate any significant project-related events anticipated in the next six months, i.e. national dialogues, youth congresses, film screenings, etc. (1000 character limit):

**-WHO** will (i) contract the firm and roll out the research evidencing the link between MH and peacebuilding in upcoming weeks, (ii) sub-contract an evaluation firm, for the final evaluation report, (iii) roll out refresher and mentoring trainings for participants of cascade trainings and (iv) launch the project website.

**-IOM** with the support of trainers trained as part of the TOTs, will hold a refresher training on community-based MHPSS skills (53 health workers) to increase active case finding, outreach activities at home level and referrals. IOM will conduct (i) a meeting with GBV actors to identify key MHPSS services and update the service mapping in existing referral pathways and (ii) a workshop for community leaders to map out ways of supporting youth in their communities

-**UNICEF** will expand its peer-to-peer awareness activities to reach remote communities (Kismayo, Galkayo). Billboards and murals will be set up. Community mobilisers will work with (i) religious leaders, to extract religious texts supporting initiatives to prevent substance abuse, stigma, GBV and negative coping mechanisms, and (ii) universities, to conduct a Knowledge, Attitude and Practices (KAP) survey.

FOR PROJECTS WITHIN SIX MONTHS OF COMPLETION: summarize **the main structural, institutional or societal level change the project has contributed to**. This is not anecdotal evidence or a list of individual outputs, but a description of progress made toward the main purpose of the project. (1500 character limit):

-**WHO**: Reports from trainings and subsequent consistent exchanges between trainees and trainers have shown (i) an increase in health care workers' knowledge on MH and (ii) a change in attitude among service providers and affected communities, suggesting that a long-term structural change could take place in MH service provision in Somalia (cf. training reports in annex). The MH curriculum will help harmonize training of MH care providers throughout Somalia, formalizing a structural/institutional change with the potential for long-term positive consequences.

-**IOM**: The deployment of community health workers (CHWs) and clinicians has helped improve the identification of persons needing MHPSS service and has improved the provision of community-based MHPSS services. People's wellbeing has increased through (i) individual counselling services provided by clinical teams and community-based mobile teams (comprised of youth and non-youth aged counsellors) that help reduce daily stressors in life, (ii) youth group discussions on relevant social or health-related issues, organised jointly by youth animators, clinical and mobile teams of counsellors and (iii) increased access (including geographically) to MHPSS services for people in need of support through the combination of facility-based and decentralised actions

-**UNICEF**: Youth and social workers leading community awareness-raising have noted an increased knowledge on child protection, GBV, MHPSS and dangers of substance abuse. Youth are aware of MHPSS services in their communities and have created peer support groups to conduct effective and timely referrals. Consultations with the youth as part of the process of development of key messages increased their self-awareness, empowerment and confidence as agents of change in the communities.

In a few sentences, explain whether the project has had a positive **human impact**. May include anecdotal stories about the project's positive effect on the people's lives. Include direct quotes where possible or weblinks to strategic communications pieces. (2000 character limit):

-**WHO**: As already mentioned, the unified curriculum (that uses the mhGAP intervention guide) combined with the trainings has had positive human impact both on service providers who are able to provide better and more appropriate services, and on patients and beneficiaries who are in turn receiving enhanced services.

-**IOM**: The involvement of youth-aged health workers and community-based MHPSS workers (counsellors and animators) as service providers, have increased their knowledge and awareness of the importance of promoting well-being among their fellow youth. This initiative has also allowed them to be more proactive in identifying people who may need support and to provide relevant support within their own capacities, as a result of the capacity building trainings they received. Despite limitations imposed on social gatherings, communities are able to access basic

information on how to better care for their wellbeing during the pandemic, through targeted key messaging social activities.

**-UNICEF:** In total, 42 youth (18 female and 24 male) youth participating in community mobilisation have been empowered as change agents to trigger social norm change in their communities. There is also increased awareness of the dangers of substance abuse, child marriage, GBV, and MHPSS, evidenced by the increased use of child protection service points.

## **PART II: RESULT PROGRESS BY PROJECT OUTCOME**

*Describe overall progress under each Outcome made during the reporting period (for June reports: January-June; for November reports: January-November; for final reports: full project duration). Do not list individual activities. If the project is starting to make/has made a difference at the outcome level, provide specific evidence for the progress (quantitative and qualitative) and explain how it impacts the broader political and peacebuilding context.*

- *“On track” refers to the timely completion of outputs as indicated in the workplan.*
- *“On track with peacebuilding results” refers to higher-level changes in the conflict or peace factors that the project is meant to contribute to. These effects are more likely in mature projects than in newer ones.*

*If your project has more than four outcomes, contact PBSO for template modification.*

**Outcome 1:** Somali youth in conflict-prone displacement settings are less likely to resort to negative practices that contribute to conflict, and instead are more likely to actively engage in activities that promote peacebuilding and social cohesion— achieved through increased access to youth-friendly mental health care, community-based psychosocial support activities and services, and tailored information dissemination.

**Rate the current status of the outcome progress: On track**

**Progress summary:** (3000 character limit)

**-WHO:** As mentioned above, after finalizing the development of the MH curriculum, using the mhGAP intervention guide, WHO implemented as planned the TOTs (24 participants, Dec. 2020) and cascade trainings (60 participants, Feb. 2021), in collaboration with SNU. So far, only the research study remains to be implemented. In this regard, WHO has already selected the firm which will conduct the research study (Africa Mental Health Research and Training Foundation) and is now discussing with it to finalize the last details of the contract (e.g. ensuring the presence of a gender expert as part of the team, discussing the budget, etc.). The research study is expected to be delivered before the due date for final report. With regards to the visibility of the project, WHO finalized the website.

**-IOM** has activated the provision of socially inclusive MHPSS services in selected health facilities in Dollow (Qanxaley, Kabasa), Kismayo (Dalxiiska, Gulwade, Bulagudud) and Baidoa (Barwaqo resettlement sites) to receive youth-aged persons in need of specialized MH care. Clinical teams (clinicians, qualified nurses and CHWs) are working in health facilities and through community outreach sessions, along with community based MHPSS counsellors. 142 persons have been assisted by MHPSS mobile teams in IDP sites, through active case identification, initial needs assessments, individual and family counselling (426 counselling sessions provided), and follow-up visits both at health facilities and at their homes. 23 persons were found in need of further referral for specialized MH care and were referred, in

coordination with the MOH. 98 youth-aged persons are also actively involved in youth groups discussing issues and solutions to promote their wellbeing at individual, family and community-levels. Engagement with GBV actors in Kismayo, Baidoa and Dollow was also activated and preparations have started for a workshop with GBV/MHPSS actors to identify key MHPSS services and update the service mapping in existing GBV referral pathways. Lastly, community leaders were engaged during the selection and recruitment of the MHPSS community-based teams. To capitalize on this, IOM is planning a workshop for community leaders in July 2021, aimed at undertaking a mapping exercise on various ways for them to support the youth in their communities.

**-UNICEF:** Information on mental health and substance use, GBV, stigma and negative coping mechanisms contributing to sustaining conflict was broadcasted across various radio stations using radio clips (aired 5 times/day, 10 radio stations for 30 days). Messages were developed through a consultative process with the youth and elders. An estimated 200,000 people in Baidoa and Galkayo were reached through those radio broadcasts and are now informed and aware of the dangers of substance use and negative coping mechanisms. Young people have also been empowered as social change agents and are now participating actively as drivers of change in their communities. Similarly, 35 religious leaders (all men) are now empowered to prevent substance use and refer protection cases to specialised services.

**Indicate any additional analysis on how Gender Equality and Women’s Empowerment and/or Youth Inclusion and Responsiveness has been ensured under this Outcome:**

*(1000 character limit)*

**WHO:** A specific gender lens has been included as part of the MHPSS curriculum and a gender balance was sought amongst project participants in TOTs and cascade trainings: out of 24 trainers and 60 health care providers trained, 38 were female. Data is systematically being disaggregated by gender and a gender expert will be included in the research team. Specific indicators have been included in the M&E framework.

**IOM:** 97 team members are involved in the delivery of MHPSS services, of which: 22 health workers (all youth, 6 female, 16 male) and 75 CHWs (60 youth, 21 female, 44 male), allowing beneficiaries to choose whom they feel most comfortable working with. 68% of assisted people and 100% participants in youth groups are youth aged. Males and females were equally included in group activities

**UNICEF:** Community mobilisation and information dissemination sessions were conducted with a gender lens. Out of 42 social workers mobilised to support peer to peer youth groups, 18 were female and 24 male. At least 52% of people receiving radio broadcasts are female.

**PART III: CROSS-CUTTING ISSUES**

<p><b>Monitoring:</b> Please list monitoring activities undertaken in the reporting period (1000 character limit)</p> <p>The M&amp;E framework was finalized by WHO-contracted consultants and includes inputs from all project partners. The framework is based on the project’s</p>	<p>Do outcome indicators have baselines?</p> <p>Yes. Moreover, these baselines are meant to be reviewed more in-depth by the M&amp;E and research teams, which will help ensure they are relevant and sound enough for subsequent data analysis with respect to monitoring of results as well as the research study.</p>
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<p>result framework, albeit in a refined manner. Regular steering committee meetings were held between project partners to monitor progress and update each other on plans for future implementation.</p>	<p>There were no baselines for outcome indicator 1.2 as this is a pilot project. The target indicators that will be achieved at the end of the project will also serve as a baseline for future related projects. The report on facilities assessment will be shared soon.</p> <p>The baseline finding report is still being consolidated and is in its final drafting stages. IOM will also combine the results of the capacity building assessments which have started late, due to administrative issues. There were delays for the roll-out of the health facilities' assessment, including due to the rotation schedule of the field staff. Although the KAP survey activity was not budgeted for, UNICEF accepted to lead the activity, using community workers. Delays in the KAP survey were mostly due to the long negotiations with universities and community workers on its modality and foreseeable limitations associated with the COVID-19 prevention and response measures. However, UNICEF hopes to complete this by the end of July 2021. Indeed, although the initially collected data as part of the KAP survey could not be used, UNICEF changed its strategy: a Human Centric Research, in collaboration with a New York-based research organization (Necleus) is now being undertaken. Data collection started in June 2021, and the final report will be published by the end of July 2021.</p> <p>Has the project launched perception surveys or other community-based data collection?</p> <p>Yes. A series of focus group discussions and key informant interviews were undertaken to collect qualitative information on: 1) assessing people's psychosocial well-being in a family and community setting in a participatory way; 2) mapping the provision of pre-existing and emergency tailored services and capacities to respond to the needs of the affected population; 3) identifying the most urgent areas of intervention; and 4) planning interventions aimed at addressing needs that are not covered by existing services, in thematic areas where the intervention is most needed.</p> <p>The initial information collected information as part of the KAP survey was however incomplete and could not be used. UNICEF therefore opted for a Human Centric Research in collaboration with a New York-based research organization, Necleus to conduct the KAP survey. Data collectors have been provided with a four-day training (end of May) with hands-on demonstration on qualitative data collection. Data collection is scheduled to take place in Dollow, Baidoa and Kismayo by the end of June 2021.</p>
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	Currently, this research is awaiting clearance from the Federal Ministry of Health
<p><b>Evaluation:</b> Has an evaluation been conducted during the reporting period?</p> <p>No. An evaluation has not yet been carried out but will be at the end of the project. However, baseline information has been collected from the intervention site. UNICEF and its implementing partners have conducted focus group discussions with youth groups, the analysis of which could not be completed due to missing data sets. Instead, new data is being collected and a final report will be shared by the end of July 2021.</p>	<p>Evaluation budget (response required): USD \$30,000</p> <p>If project will end in next six months, describe the evaluation preparations (<i>1500 character limit</i>):</p> <p>WHO plans to launch the tendering process for the recruitment of the evaluation team in coming weeks. TORs are currently being drafted, which will be shared with project partners for their inputs and endorsed by the WHO regional office. The recruitment process is expected to take approximately four weeks and the selected firm should be operational by the end of the project.</p>
<p><b>Catalytic effects (financial):</b> Indicate name of funding agent and amount of additional non-PBF funding support that has been leveraged by the project.</p>	<p>Name of funder:      Amount:</p>
<p><b>Other:</b> Are there any other issues concerning project implementation that you want to share, including any capacity needs of the recipient organizations? (<i>1500 character limit</i>)</p>	<p>Despite the COVID-19 pandemic, project implementation has advanced, including thanks to the six-month no-cost extension granted by PBF. In addition, two other issues slightly impeded implementation during this reporting period.</p> <p>The first concerns the recruitment process for the research proposal. WHO underwent this process however this has been slow due to administrative hurdles. These have been however overcome and WHO expects the research firm to be on board within the upcoming weeks.</p> <p>Second and as already mentioned for UNICEF, the KAP survey was delayed partly due to COVID-19 restrictions and delays in reaching an agreement with partners (universities and community mobilizers) on the modality of conducting the survey. However, UNICEF has now agreed with Communication for Development (C4D) community workers attached to three universities to conduct the survey.</p> <p>As already mentioned, there have been delays in the roll-out of the health facilities' assessment, due to administrative issues as well as technicalities caused by COVID-19, including rotation schedule of the field staff.</p>

	<p>However, following a lessons-learned process, IOM is now combining the results of the capacity building assessments</p> <p>In comparison with the previous reporting period, it is however notable that the relationship with the MOH has considerably improved and now includes regular and open telephone calls, as well as written communications. The MOH is now effectively ensuring ownership and leadership for this project. This improvement can probably be explained by the presence of a dedicated focal point for MHPSS within the Ministry, whose work is also supported by incentives – a good practice to be replicated in the future.</p>
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**PART IV: COVID-19**

*Please respond to these questions if the project underwent any monetary or non-monetary adjustments due to the COVID-19 pandemic.*

- 1) Monetary adjustments: Please indicate the total amount in USD of adjustments due to COVID-19:

\$0

*Please note:* WHO’s budget for this project was not used for COVID-19 response. However, the health workers who were trained on mhGAP in Kismayo, Dollow and Baidoa have been involved in COVID-19 response activities in their areas of work. MHPSS has been one of the thematic pillars in COVID-19 response as outlined in the Somalia National Preparedness and Response Plan and this team have proven to be a useful resource in supporting the implementation of activities under the MHPSS pillar.

- 2) Non-monetary adjustments: Please indicate any adjustments to the project which did not have any financial implications:

As a consequence of the pandemic, a specific section was included in the MH training curriculum related to emergency situations such as floods and public health emergencies in the case of COVID-19, with key messages on stress reduction and addressing psychosocial distress associated with extreme stressors.

As partners’ resources and time were diverted in March 2020 to focus on fighting the pandemic in Somalia, project implementation faced significant delays during the first reporting period. Project implementation is now however back on track, with activities unfolding as planned as per the adjusted workplan and calendar reflected in the six-month no-cost extension.

3) Please select all categories which describe the adjustments made to the project (*and include details in general sections of this report*):

- Reinforce crisis management capacities and communications
- Ensure inclusive and equitable response and recovery
- Strengthen inter-community social cohesion and border management
- Counter hate speech and stigmatization and address trauma
  
- Support the SG's call for a global ceasefire
- Other (please describe): Adjustments were made based on the impact of COVID-19 on project implementation. For instance, instead of focus group discussions, distance discussions were held as a precautionary measure. For all project activities, participants observed social distancing, hand washing and wearing of masks.

If relevant, please share a COVID-19 success story of this project (*i.e. how adjustments of this project made a difference and contributed to a positive response to the pandemic/prevented tensions or violence related to the pandemic etc.*)

**PART V: INDICATOR BASED PERFORMANCE ASSESSMENT**

Using the **Project Results Framework as per the approved project document or any amendments**- provide an update on the achievement of **key indicators** at both the outcome and output level in the table below (if your project has more indicators than provided in the table, select the most relevant ones with most relevant progress to highlight). Where it has not been possible to collect data on indicators, state this and provide any explanation. Provide gender and age disaggregated data. (300 characters max per entry)

	<b>Performance Indicators</b>	<b>Indicator Baseline</b>	<b>End of project Indicator Target</b>	<b>Indicator Milestone</b>	<b>Current indicator progress</b>	<b>Reasons for Variance/ Delay (if any)</b>
<b>Outcome 1</b> Somali youth in conflict-prone displacement settings are less likely to resort to negative practices that contribute to conflict, and instead are more likely to actively engage in activities that promote peacebuilding and social cohesion—achieved through increased access to youth-friendly	Indicator 1.1 Youth awareness and practice of negative coping mechanisms contributing to conflict (e.g. substance abuse, self-harm GBV), and participation in positive activities contributing to peacebuilding and social cohesion in their communities.	Significant improvement between baseline and endline KAP surveys	Significant improvement between baseline and endline KAP surveys		<b>No progress</b>	As mentioned in the last report, some delays were reported in project implementation (including for the KAP survey), due to a major part to the current COVID-19 pandemic. As a result of these setbacks, partners applied for a no-cost extension for the project.  Project implementation is now back on track.  With regards to the KAP survey, considering that the data initially collected as part of the KAP survey could not be used, a change in strategy was adopted whereby a Human Centric Research, in collaboration with a New York-based research organization (Nucleus), will be undertaken. Data collection started in June 2021, and the final report will be published by the end of July 2021.  IOM: As mentioned previously, assessments started late due to COVID-19 and administrative issues.
	Indicator 1.2 Perceptions and views of IDP community leaders and health	Significant change in perception between	Significant change in perception between		<b>No progress</b>	Same as above

	Performance Indicators	Indicator Baseline	End of project Indicator Target	Indicator Milestone	Current indicator progress	Reasons for Variance/ Delay (if any)
mental health care, community-based psychosocial support activities and services, and tailored information dissemination	workers about whether they feel empowered with avenues to support their local youth who have mental illness or face context-driven psychosocial problems.	baseline and endline Baseline is 0. At this point, we are unable to measure change in perceptions. However, improved knowledge on MHPSS and child protection issues (social norms, child marriage, GBV, FGM) has been seen. Use of child protection service points and referrals increased, and peer to peer support among youth was also witnessed.	baseline and endline			

Commented [FM1]: If the baseline for this is indeed 0, state it so. Also explain why you've found this to be the case in a few lines below the number.

	<b>Performance Indicators</b>	<b>Indicator Baseline</b>	<b>End of project Indicator Target</b>	<b>Indicator Milestone</b>	<b>Current indicator progress</b>	<b>Reasons for Variance/ Delay (if any)</b>
	Indicator 1.3					
Output 1.1 Health professionals and community health workers in select conflict-affected IDP communities gain professional-level capacity to deliver youth-centered and gender-sensitive MHPSS services, towards reducing stigma, and alleviating gender-driven psychosocial barriers faced by Somali youth, while building Somalia's long-term institutional capacity to	Indicator 1.1.1 # of consultants that support SNU to develop specialized youth MHPSS training	<b>0</b>	<b>1</b>		<b>1</b> The MHPSS consultant was hired and successfully developed the MH curriculum, using the mhGap intervention guide. Training modules include parts on psychosocial stressors related to extreme stress in the context of natural and man-made disasters	
	Indicator 1.1.2	<b>0</b>	<b>3</b>		<b>3</b>	

	<b>Performance Indicators</b>	<b>Indicator Baseline</b>	<b>End of project Indicator Target</b>	<b>Indicator Milestone</b>	<b>Current indicator progress</b>	<b>Reasons for Variance/ Delay (if any)</b>
systematically address a key enabler of youth-driven conflict.	# consultation meetings among key stakeholders conducted for development of MHPSS training module				Despite delays due to COVID-19, 2 consultation meetings took place and the curriculum was successfully developed.	
	Indicator 1.2.3 # of gender-sensitive and youth-oriented MHPSS training module developed, endorsed and published in Somali and English.	<b>0</b>	<b>1</b>		<b>1</b> The curriculum has successfully been developed and includes a gender sensitive and youth orientated module. Sections of the curriculum will be translated	

	<b>Performance Indicators</b>	<b>Indicator Baseline</b>	<b>End of project Indicator Target</b>	<b>Indicator Milestone</b>	<b>Current indicator progress</b>	<b>Reasons for Variance/ Delay (if any)</b>
					into Somali dialects for the purpose of health awareness campaign.	
	Indicator 1.1.4: # health care providers trained in the MHPSS Training of Trainers to enable decentralization of MHPSS in the health system (sex and age disaggregated)	<b>0</b>	<b>20</b>		24 Despite the delay due to COVID, we successfully trained 24 ToTs which are more than the target of 20 ToTs in Dec, 2020	
	Output Indicator 1.1.5: % of health workers trainers providing MHPSS services in target health facilities (after the cascade trainings), which may contribute to positive peacebuilding outcomes. (sex and age disaggregated)	<b>0</b>	<b>90%</b>	<b>80</b>	84 Delays due to COVID pushed to cascade training to February, 2021 but successfully trained 60 frontline healthworker	

	<b>Performance Indicators</b>	<b>Indicator Baseline</b>	<b>End of project Indicator Target</b>	<b>Indicator Milestone</b>	<b>Current indicator progress</b>	<b>Reasons for Variance/ Delay (if any)</b>
					s in Kismayo (20), Dollow (20) and Baidoa (20) in addition to the 24 ToTs for a total of 84	
	Indicator 1.1.6: # of studies conducted on inter-linkages between youth, MHPSS and peace building in Somalia published and disseminated in a forum with key policymakers, relevant donor and government representatives, and influencers within the MHPSS sectors.	N/A	1		No progress	Difficulties with engagement with the initial team of researcher, due mainly to problems of communication and disagreement over budget, led to initial delays in the recruitment and the development of a research proposal. To overcome this, WHO launched an open call to recruit a team of researchers. Some of the researchers initially considered applied and WHO received many good-quality proposals. One firm has been selected and WHO is currently in the process of negotiating with them. The firm is expected to be ready in upcoming weeks and the research study should be done by the end of the project.
Output 1.2 Youth with mental health and psychosocial issues in conflict-vulnerable IDP communities are provided with socially	Indicator 1.2.1 # of health workers and community stakeholders trained in PFA, CMR, GBV management, stigma reduction, Psychosocial Support (PSS) skills (disaggregated by age, gender, type/cadre of participant)		60	<b>54 health workers in Dollow (2 females; 5 males), Kismayo (6 females; 15 males) and Baidoa (14 females; 12 males)</b>	<b>54</b>	

	Performance Indicators	Indicator Baseline	End of project Indicator Target	Indicator Milestone	Current indicator progress	Reasons for Variance/ Delay (if any)
inclusive MHPSS services through community-based PSS activities integrated in health service delivery, consequently improving individual well-being, building emotional resilience, raising aspiration, and strengthening community social cohesion towards mitigation of conflict drivers and empowerment of youth as peace builders (change agents).	Indicator 1.2.2 # of GBV survivors from 3 IDP settlements/ facilities identified and referred for PSS and/or medical and / or protection services disaggregated by youth versus non-youth; gender; types of services referred for; point of identification		288	5	5	During the meetings with GBV actors (April and May 2021), there was high underreporting of GBV cases in health facilities and slower referrals to GBV specialized services. Upcoming workshop will be organized with GBV/PSS actors in June 2021 to ensure that MHPSS resources are carefully mapped and included in the referral pathways of each service sector. The MHPSS teams will start working with GBV actors on June 2021 to increase the inter-referral of GBV survivors to MHPSS services in Baidoa, Dollow, Kismayo.
	Indicator 1.2.3: # of community-based counsellors trained, and # of counselling sessions conducted disaggregated by Youth versus Non-Youth; Age; Gender; and facility-based versus community based	# of counsellors trained: 0 # of counselling sessions: 0	# of counsellors trained: 30 # of counselling sessions: 3,600	<b>45 trained counsellors (30 youth aged and 15 non-youth aged 426 counselling sessions)</b>	<b>150%</b>  <b>426</b> 12 female counsellors and 33 male counsellors 142 persons received x 3 counselling sessions. The number of sessions was limited by COVID-19	

	Performance Indicators	Indicator Baseline	End of project Indicator Target	Indicator Milestone	Current indicator progress	Reasons for Variance/ Delay (if any)
					precautionary measures. The sessions completed were implemented in observance of strict COVID-19 preventive measures such as social distancing, hand washing and wearing of masks.	
	Indicator 1.2.4: # of youth support groups newly formed or re-activated, # of support group participants	0 support groups 0 support groups participants	20 groups 100 group participants	<b>12 groups</b> (divided into male and female groups and into two age groups of 18 to 25 years old and 26 to 35 years old)	12 98	

	<b>Performance Indicators</b>	<b>Indicator Baseline</b>	<b>End of project Indicator Target</b>	<b>Indicator Milestone</b>	<b>Current indicator progress</b>	<b>Reasons for Variance/ Delay (if any)</b>
				<b>98 participants</b> (54 females and 44 males)		
	Indicator 1.2.5: # of MHPSS Resource Centres established within target health facilities and offering youth-focused activities towards strengthening social cohesion and PSS services	<b>0</b>	3	<b>0</b>	0 Spaces in the 3 health facilities are identified and will be scheduled for renovation in July 2021 (as the facilities were recently renovated last September 2020 through other funds). Together with CCCM and community leaders, the	

	Performance Indicators	Indicator Baseline	End of project Indicator Target	Indicator Milestone	Current indicator progress	Reasons for Variance/ Delay (if any)
					team has identified spaces within 3 community centers for counselling spaces or improvements of communal activities, also due for renovation in July 2021.	
	Indicator 1.2.6: # of youth-aged activity animators mobilizers trained and actively mobilizing community activities towards improved social cohesion and peacebuilding	0	30	30	30 All youth animators were recruited and received technical orientation during the reporting period. A refresher course and review will be	

	<b>Performance Indicators</b>	<b>Indicator Baseline</b>	<b>End of project Indicator Target</b>	<b>Indicator Milestone</b>	<b>Current indicator progress</b>	<b>Reasons for Variance/ Delay (if any)</b>
					conducted in June 2021.	
Output 1.3 Awareness among youth of mental health/substance abuse, stigmatization, harmful behaviors and negative coping mechanisms that drive conflict is increased, with youth empowered to effect positive change through peer sensitization / education.	Indicator 1.3.1 # of packages of locally contextualized and validated messages are developed on substance abuse, stigma, conflict-associated negative coping mechanisms, and the power of youth to be positive change agents for their communities.	<b>0</b>	<b>1</b>	<b>1</b>	<b>1</b> A consultation with 42 youth (18 female and 24 male) to contextualize mental health and substance abuse messages was completed. The package of key messages currently awaits endorsement by the MOH's MHPSS focal point. Consultations with	

	Performance Indicators	Indicator Baseline	End of project Indicator Target	Indicator Milestone	Current indicator progress	Reasons for Variance/ Delay (if any)
					youth in Kismayo and Dollow are still ongoing	
	Indicator 1.3.2 # of radio programmes developed, together with youth, to create awareness of substance abuse and negative coping behaviours that contribute to sustaining conflict.	0	1		1 Radio clips and programmes on substance abuse awareness and negative coping behaviours that contribute to sustaining conflict were aired in Galkayo, Baidoa and Kismayo. Two radio spots were	

	<b>Performance Indicators</b>	<b>Indicator Baseline</b>	<b>End of project Indicator Target</b>	<b>Indicator Milestone</b>	<b>Current indicator progress</b>	<b>Reasons for Variance/ Delay (if any)</b>
					broadcasted five times a day in ten radio stations for 30 days (1500 broadcasts made)	
	Indicator 1.3.3: # of community mobilization sessions organized by trained youth for their peers on substance abuse, stigma, and negative coping mechanisms	<b>0</b>	<b>50</b>		29	COVID-19 precautionary measures slowed down progress against this indicator. Social workers mobilised peer to peer youth groups consisting of 42 youth (18 female and 24 male) and conducted 29 mobilisation sessions on MHPSS, substances abuse, child protection referrals and prevention of negative coping mechanism in Baidoa, Galkayo and Kismayo, reaching an estimated 1,500 people. Youth were empowered as change agents in their communities. All activities were implemented by observing COVID-19 precautionary measures such as social distancing, hand washing and wearing of masks.