PBF PROJECT PROGRESS REPORT

COUNTRY: Somalia
TYPE OF REPORT: FINAL
YEAR OF REPORT: 2022

Project Title: Improving psychosocial support and mental health care for conflict affected youth in Somalia: a socially inclusive integrated approach for peace building
Project Number from MPTF-O Gateway: please select 118835

If funding is disbursed into a national or regional trust fund:
☐ Country Trust Fund
☐ Regional Trust Fund

Name of Recipient Fund:

Type and name of recipient organizations:

RUNO **WHO (Convening Agency)**
~~please select~~ **IOM**
~~please select~~ **UNICEF**
please select
please select

Date of first transfer: 26th November 2019
Project end date: 31 August 2021
Is the current project end date within 6 months? Yes

Check if the project falls under one or more PBF priority windows:
☐ Gender promotion initiative
☒ Youth promotion initiative
☐ Transition from UN or regional peacekeeping or special political missions
☐ Cross-border or regional project

Total PBF approved project budget (by recipient organization):

Recipient Organization	Amount
WHO	$770,400
UNICEF	$254,948
IOM	$474,652
Total:	**$1,500,000**

Approximate implementation rate as percentage of **TOTAL** project budget: 100%
ATTACH PROJECT EXCEL BUDGET SHOWING CURRENT APPROXIMATE EXPENDITURE

Gender-responsive Budgeting:

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: $430,556.45

Project Gender Marker: GM2
Project Risk Marker: Medium
Project PBF focus area: 3.2 Equitable access to social services

Report preparation:
Project report prepared by: Saeed Ahmed, WHO
Project report approved by: Dr. Marina Madeo, WHO
Did PBF Secretariat review the report: please select

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 held a training of trainers (TOTs) and cascade trainings alongside Somalia National University (SNU), and federal and state ministries of health using the mhGAP intervention guide; undertook on-the-job supervision, field visits and two refresher workshops during 2021 in each project site; finalized the research study (report attached); launched the project website health4peacesomalia.org; and completed the end-of-project evaluation (conducted by a team of national/international experts), for which the final report is attached.
IOM trained 60 health workers including 25 females on community based MHPSS skills in Dollow, Kismayo, Baidoa districts, which helped with increased active case finding, outreach activities and referrals to health facilities. Individual counselling, home visits, and follow-up sessions were provided to 6,524 persons. 24 youth-aged groups were formed. 30 youth animators, 45 youth-aged and 15 non-youth aged counsellors received technical orientation on community-based MHPSS skills and formed mobile teams. GBV actors were engaged to identify key MHPSS services and strengthen existing referral pathways; 91 IDP GBV survivors were referred for PSS and protection services.
UNICEF helped to create mass awareness on issues related to mental health connecting people with available services which involved a combination of community level intervention and media engagement. A human centric design interviewing and service mapping was conducted to generate evidence and better understand youths, their families and peers. Service mapping was conducted in Jubaland and Gedo to identify MHPSS service provision gaps and referrals. Radio spots were broadcast by selected radio stations. In cooperation with the Somali Poets Council (SOPCO), radio programs aired messages on substance abuse and harmful coping mechanisms. To ensure adherences to religious and cultural sensitivities, scholars in the National Islamic Advisory Group (NIAG) helped develop messages with quotes from religious scriptures for the awareness campaign.

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: The project officially ended on 31 August 2021 but was extended exceptionally until 28 February 2022. The research study and the endline evaluation were completed after this date. An event meant to share the experience and to disseminate the outcomes of these two exercises is foreseen, to be organized with project partners and PBF during 2022 (in Mogadishu), whereby donors and other relevant stakeholders would be invited to engage.

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 knowledge of health care workers on mental health (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: Deployment of community health workers (CHWs) and clinicians has helped improve the identification and service provision for persons needing MHPSS service through (i) individual counselling services provided by clinical teams and community-based mobile teams (ii) youth group discussions on relevant social or health-related issues, (iii) increased access to MHPSS services for people in need of support through facility-based and decentralized actions and (iv) increased community leaders' awareness on the referral pathways.
-**UNICEF**: A qualitative study within the framework of human-centric design research was carried out in four (4) IDP camps in Baidoa, Dollow, Bossaso and Garowe – two (2) of which happened to be outside the project areas. Key findings included: (i) Correlation between last ten years' experience and current addiction among youths in IDP camps is not conclusive, (ii) idle time in the absence of work or education often encourages youths to take drugs, (iii) feeling of isolation, lack of self-worth and fear of rejection from families and society are the most crucial factors for addicted youths to return to a healthy life. The evidence compiled will be critical in designing future MHPSS interventions for youth with an ecological approach as a basis for individual solutions.

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**: A unified curriculum (using the mhGAP intervention guide), combined with the trainings and supportive supervision workshops, has had positive human impact both on service providers who are able to provide better and more appropriate services, as well as on patients and beneficiaries who are in turn receiving enhanced services, as 15 health facilities initiated MHPSS services since the cascade training was completed.
-IOM: The involvement of youth, health workers and community based MHPSS workers (counsellors and animators) as service providers and the training of youth on basic PSS skills and Psychological First Aid (PFA) helped increase their knowledge and awareness on importance of promoting well-being among fellow youth and enabled them to be more proactive in identifying people who may need support and in providing this support. As a result of the recruitment and training of 45 community-based counsellors, 6,524 counselling sessions were conducted for youth and non-youth groups in IDPs (respecting COVID-19 preventive measures) thereby improving the general perceptions of the community about MHPSS related issues. Hence, despite limitations imposed on social gatherings due to COVID-19, communities are now able to access basic information on how to better care for their wellbeing during the pandemic, through targeted key messaging during social activities.
-UNICEF: Youth were empowered with knowledge to prevent substance abuse, GBV and mitigate the impact of traumatic experiences on their mental health through peer-to-peer

activities targeting IDPs and host communities. Youth participated in bringing about change in their communities by conducting awareness campaigns on mental health, prevention of GBV and marginalisation, prevention of child marriage, child recruitment and FGM. Support received from local leaders, Imams and opinion leaders through consultation on appropriate messaging indicated strong community ownership and sustainability of the activity beyond the project's timeframe.

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: **Completed**

Progress summary: *(3000-character limit)*
-WHO: 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 to 60 participants in Feburary 2021, in collaboration with SNU. WHO also carried out supportive supervision, field visits and refresher workshops, for all TOT and cascade trainings participants. The research study was conducted by the Africa Mental Health Research and Training Foundation in partnership with SNU using primary and secondary data collection for analysis, elaboration, and final reporting. WHO's technical team provided oversight for the process and reviewed and cleared the final research report. The endline project evaluation was conducted by the MHPSS Collaborative (specialized knowledge hub) in collaboration with the Somali Institute for Health Research. WHO provided all background information, documents, contacts and links. WHO did not interfere during the process to allow for an independent evaluation. With regards to the visibility of the project, and as a mean for knowledge sharing, WHO finalized the project specific health4peacesomalia.org website, in addition to having developed a brochure and ensured to mention the project and PBF's support during various meetings, events and other relevant fora.
-IOM: Activated the provision of socially inclusive MHPSS services in facilities in Dollow (Qanxaley, Kabasa), Kismayo (Dalxiiska, Gulwade, Bulagudud), and Baidoa (Barwaqo resettlement sites) and identified and trained (i) 22 clinical staff (clinicians, qualified nurses and CHWs) to provide health counselling and community outreach sessions and (ii) community-based MHPSS counsellors on receiving youth-aged persons in need of specialized MH care. 142 persons were assisted by MHPSS mobile teams in IDP sites, through active case

identification, initial needs assessments, individual and family counselling and follow-up visits both at health facilities and at their homes. 23 persons were referred for specialized MH care in coordination with the MOH. 192 youth-aged persons were also actively involved in youth groups discussions on issues and solutions to promote their wellbeing. Engagement with GBV actors in Kismayo, Baidoa, and Dollow was also activated, and several meetings were organised to identify key MHPSS services and map services in existing GBV referral pathways. 91 GBV survivors from 3 IDP settlements/facilities were identified and referred for PSS and medical services. Lastly, community leaders were engaged during the selection and recruitment of the MHPSS community-based teams.
-UNICEF: All planned interventions have been completed. UNICEF successfully conducted a human centric study with youth to understand perceptions on MHPSS, substance abuse and marginalisation. Contextualised messaging on MHPSS and substance abuse were developed in close consultation with youth and support from the National Islamic Advisory Group (NIAG). The messages were disseminated through radio broadcast in ten radio stations covering the targeted community. 42 community mobilisation sessions by social workers targeted peer groups helped reach over 1500 vulnerable people.

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 was included as part of the MHPSS curriculum, and a gender balance was sought amongst project participants in TOTs, cascade trainings and supportive supervision trainings: out of 24 trainers and 60 health care providers trained, 39 were female. Data is systematically being disaggregated by gender. Gender is also being considered as part of the research study and specific indicators have been included in the M&E framework.
IOM: Gender was considered in team selections, training and as well in the composition of the youth group and gender equity was a key guiding principle for implementation of activities. 97 team members were involved in the delivery of MHPSS services, of which: 5 clinical health workers (2 females),17 CHWs (5 females), 30 youth counsellors (10 females), 30 youth animators (12 females) and 15 Non youth counsellors (5 females), thereby 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: UNICEF systematically ensured gender needs were considered during awareness raising or community mobilisation on MHPSS and the prevention of substance abuse and marginalisation. 18 girls played a strong leadership role as peer leaders in all stages of the project, with support from seven female social workers.

PART III: CROSS-CUTTING ISSUES

Monitoring: *Please list monitoring activities undertaken in the reporting period (1000-character limit)* The M&E framework was finalized by WHO-contracted consultants and includes inputs from all project partners. The	***Do outcome indicators have baselines?*** • Yes, some baselines were available, and they were reviewed by the M&E and research teams, which helped ensure the relevance for subsequent data analysis with respect to monitoring of results as well as the research study. • There were no baselines for outcome indicator 1.2 as this was a pilot project. The targets achieved at the end of the

framework is based on the project's 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.	project will serve as a baseline for future related projects. • IOM conducted a needs assessment with the aim to obtain information on (i) psychosocial needs and resources, affected or vulnerable groups in the designated IDP sites and host communities, (ii) identify socio-cultural expressions of distress, local concepts of mental health, community sources of support, attitudes towards people with mental illness, care practices and help-seeking patterns; (iii) existing technical resources at site and state levels that could be mobilized to respond to identified needs; (iv) coordination mechanisms and resources available at site and state levels and (v) culturally appropriate psychosocial interventions that can be implemented to support the affected population. • 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 COVID-19 prevention and response measures. Nevertheless, human centric research, in collaboration with a New York-based research organization (Necleus) was successfully undertaken and finalised by the end of the project. **Has the project launched perception surveys or other community-based data collection?** • 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. • The initial information collected as part of the KAP survey was however incomplete and could not be used. UNICEF therefore opted for human centric research in collaboration with a New York-based research organization, Necleus. Data collectors were provided with a four-day training (end of May 2021) with hands-on demonstration on qualitative data collection. Data

	collection, analysis and reporting were successfully completed. IOM SOM MHPSS Assessment 2020[20 • *IOM conducted a* needs assessment. Recommendations included (i) establishing a minimum package of mental health services in health facilities; (ii) the need for continuous MHPSS support for targeted beneficiaries; (iii) population mobility from IDP sites to host communities is an opportunity to strengthen community based programming; (iv) the need for delivery of different packages of trainings for different targeted groups and follow-up on the effectiveness of the training; (v) the need for coordination among MHPSS actors and linkages with other sectors such as livelihoods (vi) the limited number of MH specialists in the project locations, limited clinical trainings and limited resources to deliver services.
<u>Evaluation:</u> Has an evaluation been conducted during the reporting period? The project evaluation has been conducted after the end of the project. This exercise suffered a substantial delay, due to lengthy process to agree on the ToRs, unsuccessful initial call for solicitation of applications, selection of an international highly qualified knowledge hub, increased resource requirements and eventually the contracting process. Finally, the task was carried out by the MHPSS Collaborative—a specialized international consultancy--in coordination with the Somali Institute for Health Research (SIHR) and resulted in a quality evaluation of the process, settings, achievements and limitations of the project and lessons learned to help enrich any future endeavour. This work made use of the limited baseline information from the intervention sites, including the outcomes of focus group discussions conducted by UNICEF and its implementing partners and a needs assessment conducted by IOM.	***Evaluation budget*** *(response required): USD $20,000* **If project will end in next six months, describe the evaluation preparations** *(1500-character limit)*: • WHO drafted TORs for an evaluation consultant which were commented upon and reviewed by PBF. The TORs were published but no candidate succeeded in the competitive process. WHO therefore considered a shortlist of international firms and collaborating centres provided by its headquarters, from which it selected the most qualified firm, the MHPSS Collaborative based in Denmark. This firm partnered with the Somali Institute for Health Research for in-country data collection. • Due to the demanding ToR – requiring international expertise in additional to the national institute – the cost of the evaluation resulted higher than the $20,000 originally allocated to it in the project budget. In addition, the delay in the process had extended beyond the project implementation period. Therefore, the evaluation was funded by WHO internal resources instead.
<u>Catalytic effects (financial)</u>: Indicate name of funding agent and amount of additional non-PBF funding support that has been leveraged by the project. (Please	Name of funder: AICS Amount: approx. $200,000 The Italian Agency for Development Cooperation (AICS) has provided funding to WHO for mental health

only report on NEW funding since last reporting cycle)	activities in Hudur and Dusramreb hospitals as part of a larger health systems strengthening project.
Other: Are there any other issues concerning project implementation that you want to share, including any capacity needs of the recipient organizations? *(1500-character limit)*	Despite onset of the COVID-19 pandemic, project implementation advanced with some hiccups. Due to prevailing restrictions imposed during the pandemic, a six-month no-cost extension was agreed with the PBF. In addition, the below issues impeded implementation during this reporting period. • First, although administrative hurdles significantly delayed the recruitment of the research firm, the researchers finally were onboarded, completed the data collection with support of the SNU, ran a throughout analysis and submitted the draft report. After a number of iterations and in-depth analysis of data, the final report was reviewed and cleared by WHO experts. • Second, the clearance process for the drafting of TORs for the evaluation consultant took much longer than expected, which contributed to the delay in the evaluation exercise. Funds for the endline evaluation were committed but could not be spent during the project's implementation period. Moreover, the evaluation required a larger financial effort than what had originally been planned. The evaluation was finally conducted beyond the agreed extended period and WHO funded it from its internal resources. • Third, data collection on the ground by UNICEF was delayed by COVID-19 precautionary measures, slowing movement, supervision and training of data collectors. • Fourth, as mentioned in the lessons learned document various implementation issues were identified, including communication. The document has listed the possible alternatives to address such issue in any future project. **Future direction and opportunities for project** WHO will leverage from this PBF-supported project to organize some roundtable dialogues to disseminate project outcomes, raise the profile of MH needs in Somalia, discuss ways forward and give visibility to both agencies. WHO foresees doing one event in Mogadishu during 2022 (with PBF and possibly the Netherlands), followed by

	another in 2023, perhaps at the WHA in cooperation with the Lancet-SIGHT Commission and Carter Center, whereby PBF would also be invited to participate. WHO also foresees the possibility to build on this current project by expanding it to include a youth employment component (ideally led by ILO) and a technical and vocational training component (ideally led by UNESCO), which may help to complement any MH services being provided. WHO will, indeed, explore this as a possible, future joint programme for PBF or other support.

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. (Please only report on NEW expenditure since last reporting cycle)***

1) **Monetary adjustments: Please indicate the total amount in USD of adjustments due to COVID-19: 0$**

WHO's budget for this project was not used for COVID-19 response. It would have been a complex process and it was not necessary to make monetary adjustments, as some slight adjustments in the activities contributed to the to the COVID-19 response

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

A specific section was included in the MH training curriculum related to emergency situations such as floods and epidemic prone diseases including COVID-19, with key messages on stress reduction and addressing psychosocial distress associated with extreme stressors.
In fact, 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 (SNPRP) and this team have proven to be a useful resource in supporting the implementation of activities under the MHPSS pillar.

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. The project was implemented on time, except for the research study, completed by May 2022, and endline evaluation, conducted and completed between June and September 2022.

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.*)

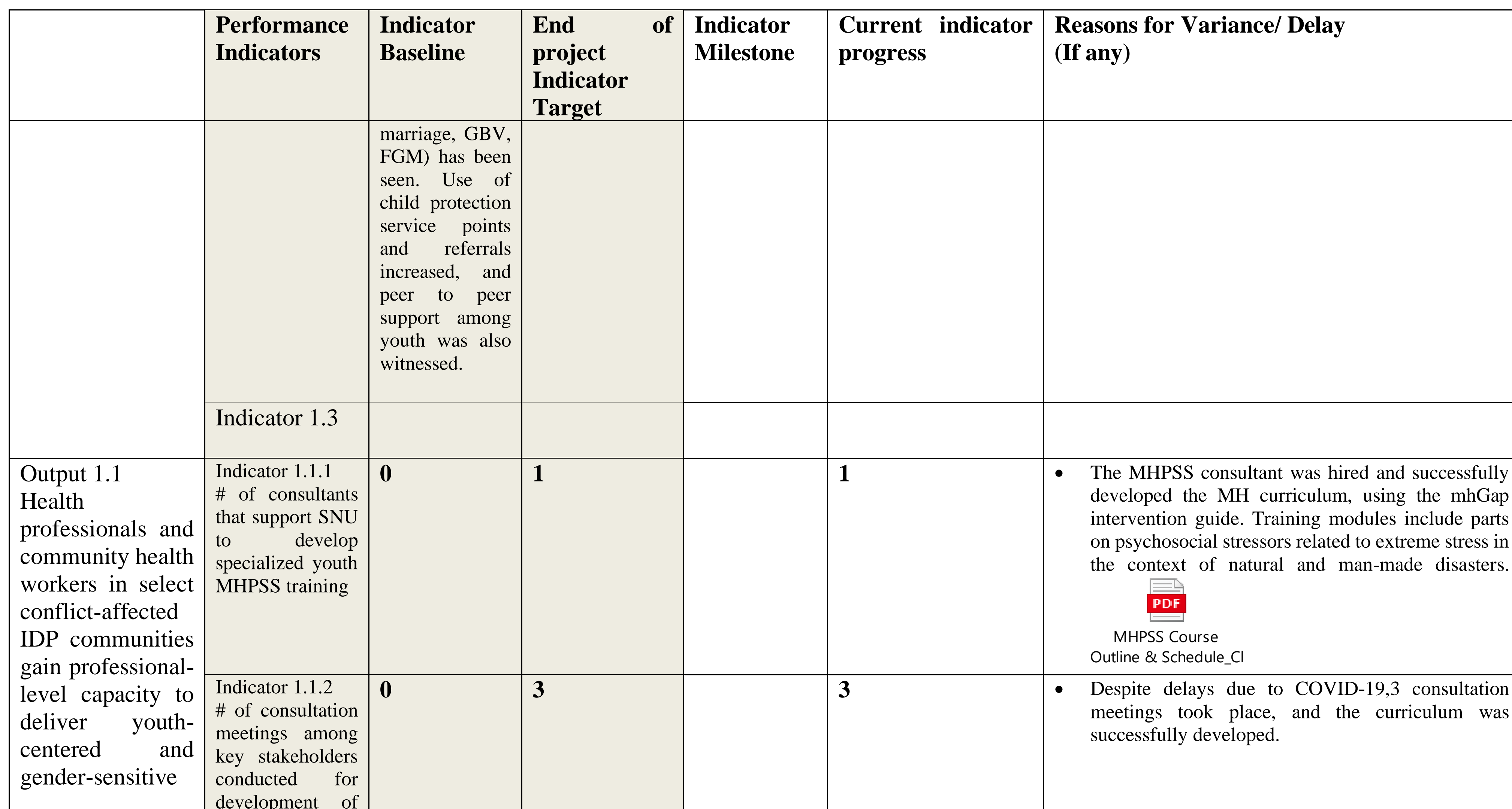
Avalable at < *http://www.emro.who.int/somalia/news/somalia-implements-ground-breaking-project-aimed-at-improving-psychosocial-support-and-mental-health-care-for-young-people-affected-by-conflict-through-a-socially-inclusive-integrated-app.html* >

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)

	Performance Indicators	**Indicator Baseline**	**End of project Indicator Target**	**Indicator Milestone**	**Current indicator progress**	**Reasons for Variance/ Delay (If any)**
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	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			• Amongst the positive impacts of the project were the increase in knowledge, confidence, and social esteem of the community stakeholders (including youth) directly involved in the project implementation. • Increased focus of MoH in Somalia on MHPSS; and improved understanding of mental health in Somalia amongst donors and implementation partners, which might have a cascading impact on future programming in Somalia. There were also indications that the engagement of female health and community workers in project implementation elevated their credibility, voice, and influence within their families and communities. • As mentioned in the previous 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.

	Performance Indicators	Indicator Baseline	End of project Indicator Target	Indicator Milestone	Current indicator progress	Reasons for Variance/ Delay (If any)
to youth-friendly mental health care, community-based psychosocial support activities and services, and tailored information dissemination						• The project ended up being implemented on time and only the research study and evaluation reports were completed beyond the project timeline . • Despite earlier hurdles UNICEF completed a KAP survey using a human centric research approach, in collaboration with a New York-based research organization (Necleus). IOM conducted a needs assessment that can be used to inform future programming.
	Indicator 1.2 Perceptions and views of IDP community leaders and health workers about whether they feel empowered with avenues to support their local youth who have mental illness or face context-driven psychosocial problems.	Significant change in perception between 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	Significant change in perception between baseline and endline			• Community stakeholders (including health workers, CHWs, youth and community leaders) expressed high levels of motivation and commitment to continue the supports initiated during the project. • Amongst the positive impacts of the project were the increase in knowledge, confidence, and social esteem of the community stakeholders (including youth) directly involved in the project implementation. • Increased focus of MoH in Somalia on MHPSS; and • Improved understanding of mental health in Somalia amongst donors and implementation partners, which might have a cascading impact on future programming in Somalia. • There were also indications that the engagement of female health and community workers in project implementation elevated their credibility, voice, and influence within their families and communities.



	Performance Indicators	**Indicator Baseline**	**End of project Indicator Target**	**Indicator Milestone**	**Current indicator progress**	**Reasons for Variance/ Delay (If any)**
		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.				
	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	Indicator 1.1.1 # of consultants that support SNU to develop specialized youth MHPSS training	**0**	**1**		**1**	• 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. PDF MHPSS Course Outline & Schedule_CI
	Indicator 1.1.2 # of consultation meetings among key stakeholders conducted for development of	**0**	**3**		**3**	• Despite delays due to COVID-19,3 consultation meetings took place, and the curriculum was successfully developed.

	Performance Indicators	**Indicator Baseline**	**End of project Indicator Target**	**Indicator Milestone**	**Current indicator progress**	**Reasons for Variance/ Delay (If any)**
MHPSS services, towards reducing stigma, and alleviating gender-driven psychosocial barriers faced by Somali youth, while building Somalia's long-term institutional capacity to systematically address a key enabler of youth-driven conflict.	MHPSS training module					
	Indicator 1.2.3 # of gender-sensitive and youth-oriented MHPSS training module developed, endorsed and published in Somali and English.	**0**	**1**	**1**	**1**	• The curriculum has successfully been developed and includes a gender sensitive and youth orientated module. Sections of the curriculum will be translated 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)	**0**	**20**	**20**	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	**0**	**90%**	**80**	84	• Delays due to COVID pushed to cascade training to February 2021 but successfully trained 60 frontline health workers in Kismayo (20), Dollow (20) and Baidoa (20) in addition to the 24 ToTs for a total of 84.

	Performance Indicators	Indicator Baseline	End of project Indicator Target	Indicator Milestone	Current indicator progress	Reasons for Variance/ Delay (If any)
	health facilities (after the cascade trainings), which may contribute to positive peacebuilding outcomes. (Sex and age disaggregated)					• These HCWs also followed 8 days of supervision trainings as well as 4 days of mentoring
	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**	**1**	Research study completed. Project endline evaluation completed.	• There were issues with commissioning and initiations of the research study mainly due to problems of communication and disagreement over the allocated budget for this activity. • This led to initial delays in the recruitment and the development of a research proposal. To overcome this, WHO took the lead to recruit a firm through open bidding process. One firm was selected and carried out the research, with support from SNU.
Output 1.2 Youth with mental health and psychosocial issues in conflict-vulnerable	Indicator 1.2.1 # of health workers and community stakeholders trained in PFA, CMR, GBV management, stigma reduction, Psychosocial Support (PSS)		60	**60 – 25**	**60 – 25 females; 35 males**	

	Performance Indicators	Indicator Baseline	End of project Indicator Target	Indicator Milestone	Current indicator progress	Reasons for Variance/ Delay (If any)
IDP communities are provided with socially 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	skills (disaggregated by age, gender, type/cadre of participant)					
	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	**91**	**91**	• Due to cultural and social sensitivities, gross under reporting was identified as a common place. Usually, community elders tend to settle among themselves any GBV cases reported from within the communities.

	Performance Indicators	Indicator Baseline	End of project Indicator Target	Indicator Milestone	Current indicator progress	Reasons for Variance/ Delay (If any)
youth as peace builders (Change agents).						
	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	**45 trained counsellors (30 youth aged and 15 non-youth aged** **426 counselling sessions**	**150%** **426**	• The number of sessions were cut down due to COVID-19 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. However, community stakeholders (including health workers, CHWs, youth and community leaders) expressed high levels of motivation and commitment to continue the supports initiated during the project.
	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	**24 groups** (divided into male and female groups and into two age groups of 18 to 25 years old and 26 to 35 years old) **192 participants** (102 females and 90 males)	24 192	
	Indicator 1.2.5: # of MHPSS Resource Centres established within target health	**0**	3	**3**	3	• MHPSS centers identified jointly with CCCM and community leaders in the respective locations and furnished. Currently being used by youth group for

	Performance Indicators	Indicator Baseline	End of project Indicator Target	Indicator Milestone	Current indicator progress	Reasons for Variance/ Delay (If any)
	facilities and offering youth-focused activities towards strengthening social cohesion and PSS services					meetings and other social cohesion and recreational activities.
	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**	
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	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.	**Baseline data was not available**	**NA**	**Achieved**	**Completed**	• Contextualized messages were developed based on local knowledge and with the support of scholars from the National Islamic Advisory Group (NIAG). These messages were disseminated through FM radio stations and interpersonal communication channels.
	Indicator 1.3.2 # of radio programmes developed, together with youth, to create awareness of	**Baseline data was not available**	**NA**	**Achieved**	**Completed**	• 10 radio stations were engaged and broadcasted: 3 radio spots 5 times a day for 30 days.

	Performance Indicators	Indicator Baseline	End of project Indicator Target	Indicator Milestone	Current indicator progress	Reasons for Variance/ Delay (If any)
to effect positive change through peer sensitization / education.	substance abuse and negative coping behaviours that contribute to sustaining conflict.					
	Indicator 1.3.3: # of community mobilization sessions organized by trained youth for their peers on substance abuse, stigma, and negative coping mechanisms	**Baseline data was not available**	**NA**	**Achieved**	Completed	• 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.
Output 1.4	Indicator 1.4.1					
	Indicator 1.4.2					
Outcome 2	Indicator 2.1					
	Indicator 2.2					
	Indicator 2.3					

	Performance Indicators	**Indicator Baseline**	**End of project Indicator Target**	**Indicator Milestone**	**Current indicator progress**	**Reasons for Variance/ Delay (If any)**
Output 2.1	Indicator 2.1.1					
	Indicator 2.1.2					
Output 2.2	Indicator 2.2.1					
	Indicator 2.2.2					
Output 2.3	Indicator 2.3.1					
	Indicator 2.3.2					
Output 2.4	Indicator 2.4.1					
	Indicator 2.4.2					
Outcome 3	Indicator 3.1					

	Performance Indicators	**Indicator Baseline**	**End of project Indicator Target**	**Indicator Milestone**	**Current indicator progress**	**Reasons for Variance/ Delay (If any)**
	Indicator 3.2					
	Indicator 3.3					
Output 3.1	Indicator 3.1.1					
	Indicator 3.1.2					
Output 3.2	Indicator 3.2.1					
	Indicator 3.2.2					
Output 3.3	Indicator 3.3.1					
	Indicator 3.3.2					
Output 3.4	Indicator 3.4.1					
	Indicator 3.4.2					
Outcome 4	Indicator 4.1					
	Indicator 4.2					

	Performance Indicators	**Indicator Baseline**	**End of project Indicator Target**	**Indicator Milestone**	**Current indicator progress**	**Reasons for Variance/ Delay (If any)**
	Indicator 4.3					
Output 4.1	Indicator 4.1.1					
	Indicator 4.1.2					
Output 4.2	Indicator 4.2.1					
	Indicator 4.2.2					
Output 4.3	Indicator 4.3.1					
	Indicator 4.3.2					
Output 4.4	Indicator 4.4.1					

Annexes

1- Project Management, Roles and Responsibilities and Visibility file (enclosed as separate file)
2- Project Evaluation Report (enclosed as separate file)
3- Research Report (enclosed as separate file)