THE MHPSS COLLABORATIVE
FOR CHILDREN & FAMILIES IN ADVERSITY

EVALUATION REPORT

Improving psychosocial support and mental health care for conflict-affected youth in Somalia: a socially inclusive integrated approach for peacebuilding

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1. Acknowledgements

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2. List of Acronyms

Acronym	**Full form**
AAP	Accountability to affected populations
AMISOM	African Union Mission in Somalia
AMHRTF	Africa Mental Health Research and Training Foundation
CCCM	Camp coordination and camp management
CHW	Community health worker
CMHC	Community mental health center
CMR	Clinical management of rape
EPHS	Essential package for health services
FGD	Focus group discussions
GBV	Gender based violence
IASC	Inter-Agency Standing Committee
IDP	Internally displaced people
IOM	International Organization for Migration
KAP	Knowledge, attitudes, and practices
KII	Key informant interviews
M&E	Monitoring and evaluation
MH	Mental health
mhGAP	Mental Health Gap Action Programme
MHPSS	Mental health and psychosocial support

MoH	Ministry of Health
NCE	No cost extension
NGO	Non-governmental organizations
NIAG	National Islamic Advisory Group
OCHA	Office for the Coordination of Humanitarian Affairs
PBF	Peacebuilding Fund
PBSO	Peace Building Support Office
PESS	Population Estimation Survey for Somalia
PSS	Psychosocial support
PTSD	Post-traumatic stress disorder
SIHR	Somali Institute for Health Research
SNU	Somali National University
ToR	Terms of reference
ToT	Training of trainers
UHC	Universal Health Coverage
UN	United Nations
UNDP	United Nations Development Programme
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
VoT	Victims of trafficking
WHO	World Health Organization

3. Working Definitions of Key Terms

Terms	**Definitions**
Internally displaced people	IDPs are persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of, or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognized state border.(1)
Mental Health and Psychosocial Support	Mental health and psychosocial support is a composite term that describes any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder.(2)

Psychosocial	Psychosocial is defined as "close interrelationship and interlinking between psychological aspects of experience (thoughts, emotions, behavior) and wider social experience (relationships, traditions, norms, and culture).(3) Psychosocial work can be described as "existing social and community processes, as well as formal programs and projects, no matter their content, that aim to improve the psychosocial well-being".(4)
Peacebuilding	Peacebuilding aims to reduce the risk of lapsing or relapsing into conflict by strengthening national capacities at all levels for conflict management, and to lay the foundation for sustainable peace and development. It is a complex, long term process of creating the necessary conditions for sustainable peace. Peacebuilding measures address core issues that affect the functioning of society and the State, and seek to enhance the capacity of the State to effectively and legitimately carry out its core functions.(5)

4. Executive Summary

Somalia today experiences large scale displacement of individuals within and outside of its borders on account of multiple and intersecting factors including armed conflict, political instability, and recurrent droughts. To date, parts of Somalia continue to experience violence and insecurity, and decades of ineffective governance and collapse of public institutions have worsened access to healthcare, livelihoods, and employment opportunities. These circumstances have compromised the well-being of Somalia's youth, who form the bulk of Somalia's population and are well positioned to contribute to their country's transition from conflict to sustainable peace. The project under evaluation was set up in response to the growing and unaddressed need for MHPSS amongst the young people in Somalia, with the understanding that healing from the harms of violence, instability, and displacement is key to reducing harmful coping behaviors and achieving sustainable peace. It aimed to strengthen institutional and community-based MHPSS supports for conflict-affected youth in Somalia alongside awareness and sensitization activities to reduce stigma in the selected project sites (Baidoa, Dolow, and Kismayo) against mental health and substance use problems. In addition, it included a multi-methods research study on the interlinkages between MHPSS and peacebuilding in the Somalian context. This evaluation included a desk review, a review of the relevant project documents, consultations with community stakeholders from the implementation sites and key informants from the implementing organizations, as well as a survey conducted with youth who received support under the project.

Given the widespread nature of mental health problems and substance use amongst youth in the selected project sites, there was a unanimous agreement amongst the community stakeholders about the need for increasing MHPSS services in their communities. For many of the community stakeholders consulted during the evaluation, this was the first project in their community that focused on mental health and substance use problems amongst youth. However, given that their communities struggled with meeting the most basic needs, health-based supports on their own were seen as insufficient for improving the well-being of youth, reducing substance use, and promoting sustainable peace. Health-based supports were desired not in isolation but in conjunction with supports that can improve the living environments of youth, through for e.g., creation of livelihood opportunities. Family environment emerged as a factor linked to mental health problems and substance use issues amongst young people, which suggests that training/inclusion of caregivers was

a missed opportunity. Although the project involved consultations with community stakeholders (including youth) – particularly in the initial stages of the project – some youth leaders expressed the desire to have been involved to a greater extent and in greater numbers in the implementation of the project, given their immersion in the context and understanding of the issues that affect their peers.

The COVID-19 pandemic posed many challenges to the implementation of the project, especially in the first 6 months, when delays related to baseline assessment, training and awareness activities were experienced despite transition to remote work via virtual platforms. Post a no cost extension (NCE) that extended the original project duration by 6 months, many of the project targets were met. The biggest impact of the implementation challenges was that the baseline assessments could not be completed before project implementation, making it impossible to conduct pre- and post-comparisons for understanding the project's impact. Coordination across stakeholders was largely smooth, but a review of the project documents suggested that some of the delays might have been avoided through more regular meetings, more engaged teams, stronger project management structure, and stricter timelines. The collaboration with SNU was fruitful in receiving support on training, workshops, and supervisions. The collaboration with MoH faced communication challenges in the initial stages, which were smoothened out over the course of project through regular calls and written communication to foster trust and cooperation.

Whilst the majority of project targets were met after a NCE of 6 months, a few were only partially met. This included identification and referral of fewer GBV survivors than planned (91 against a target of 288), fewer counselling sessions than planned (426 against a target of 3600), and partial progress on community mobilization sessions organized by trained youth for their peers. Training of health and community workers seems to have positively contributed to an increase in their knowledge, confidence, social esteem, and affected a shift from the previously held beliefs that mental illness cannot be addressed and/or people with severe mental illness are dangerous. At the same time, there was a clear desire amongst the community stakeholders for longer and ongoing training and supervision that can train more people like them to meet the vast needs for MHPSS in their communities. There were also some practical constraints faced in accessing and implementing the training, for e.g., lack of access to transportation to distant implementation areas and to transfer patients to health centres. In terms of the effectiveness of the awareness activities, majority of youth surveyed linked substance abuse to compromised well-being and increased chances of conflict. However, those implementing the project reported low levels of awareness about the objectives and scope of the project in the wider community, and expectations of other forms of support (financial or other supports such as food) that were not available within the project. Repeated visits and engagement with the wider community were to some extent useful in cultivating trust in the project and creating openness for seeking mental health supports available under 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. The project also built some momentum for identification of cases and support seeking within the selected IDP sites, alongside promoting a greater

dialogue about the challenges faced by people with mental health problems. Although the majority of young people surveyed reported perceiving an increase in mental health supports and mental well-being, the survey results on perceived changes in substance use and engagement in conflict by youth were mixed. Importantly, about half of the youth surveyed reported the need for employment support to reduce their involvement in conflict and just under one-fifth of them (18%) chose mental health and psychosocial support.

At the time of this evaluation, 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. However, in the absence of any remuneration, such efforts were largely dependent on individual motivation/initiative and were challenging to scale up. Systematic and large-scale community-wide initiatives were not operational, but low-intensity community-level supports including counselling and referrals (where possible) seem to be operational across the project sites. Importantly, clinical services have been compromised across sites as medicines are largely unavailable and access to health facilities varies depending upon their distance from the villages of those seeking support. An unintended negative impact of the project was that the reduction of supports after the project ended made the wider community feel that the promises made to them by community and health workers (those providing support under the project) were not kept. If this issue remains unaddressed, it can compromise social cohesion, mutual trust, and engagement with future projects. Although the project was envisaged to be financially/programmatically catalytic, no new funding had materialized at the time of evaluation. However, the project catalyzed greater integration of mental health into WHO's work, with at least 3 project proposals in the pipeline that contain mental health activities.

5. The Somalian Context

This evaluation report begins with an analysis of the political, social, and environmental milieu of Somalia, with the understanding that context is of central importance in understanding the mental health and psychosocial impacts of conflict and making efforts towards reconstructing societies emerging from conflict. At the end of 2021, 776,700 individuals from Somalia[1] were displaced across borders(6), and about 1 in every 5 individuals was displaced internally[2], with a majority of those internally displaced being less than 25 years old.(7, 8) Although startling, these figures likely underrepresent the scale of challenges in Somalia as they do not include individuals more widely affected by displacement such as returnees, members of the host communities, and individuals who are left behind.

Centuries ago, Somalian cities were described as affluent and powerful trade centres by Arab and Portuguese explorers.(9) Large scale displacement of individuals seen within and outside Somalia today can be understood in context of its long and turbulent history of colonization, political instability, civil war, environmental degradation, and development projects causing major changes to

[1] Throughout this report, "Somalia" refers to the territory of the internationally recognized Federal Republic of Somalia including the Republic of Somaliland that proclaimed independence from Somalia in 1991 and has been a self-governed administration since then.

[2] Approximately 3 million individuals from Somalia were displaced internally, and 2 million of them are estimated to be under 25 years of age.

land use and ownership.(10-12) Internalist explanations that attribute conflict and displacement to "tribalism" and Islamic fundamentalism are reductive, as they disregard the complexity of influences that have historically shaped Somalia.(12) During the so called "scramble for Africa" in the 19th century, the strategic location of Somalia on the Gulf of Eden and the Indian Ocean stimulated colonial expansion that fragmented it into five distinct colonial units.[3](12, 13) Although two of the colonized parts, namely British Somaliland and Somalia Italiana, became liberated and joined together as the Republic of Somalia[4] in 1960, democratic governance and stability lasted only for a decade before Major General Mohammed Siad Barre seized power in a 1969 military coup.(14) The 22 years of Barre's dictatorship was marked by political repression, clan based divisions, and human rights violations, even as some advances were made towards promoting gender equality.(14) The Barre government collapsed in 1991 and plunged Somalia into a civil war that was mired in deep clan-based divisions and left the country vulnerable to exploitation of its land and marine resources by warlords and foreign fishing fleets, respectively.(15)

Over time, political conflict transformed into clan-based and communal violence that was perpetrated by and towards ordinary citizens of Somalia, and the situation progressively turned into a severe humanitarian crisis.(14) Peace processes sought to establish new governments on multiple occasions, but their effectiveness was compromised by internal political divisions, and their legitimacy was rejected by several factions that emerged during the crisis.(14) In the absence of effective governance, killings, lootings, sexual violence, and property destruction led to large scale displacement of individuals both within and outside the Somalian borders.(14) Recruitment of children in conflict and targeted attacks on civilians were carried out (and continue to the present day) by Al-Shabaab, a violent militant group in Somalia.(16) Military operations against Al-Shabaab – led by Somali government forces, foreign actors, and troops from the African Union Mission in Somalia (AMISOM) – also contributed to civilian deaths, injuries, and displacements.(16, 17)

Alongside decades of conflict, Somalia has also been experiencing an increasing frequency of ecological disasters (e.g., droughts and floods) on account of climate change.(18) In the year 2021 alone, Somalia witnessed an estimated 271,000 internal displacements[5] due to ecological disasters.(7) Disasters such as droughts and floods pose profound challenges for Somalia, where many people practice pastoralism – a way of life that is very well suited to the dry lands of the Horn of Africa – and depend on land and livestock for sustenance.(19) According to the 20 May 2022 report from the

[3] (i) British Somaliland (colonized by Great Britain), (ii) Somalia Italiana (colonized by Italy), (iii) Côte Française des Somalis (colonized by France and is today the Republic of Djibouti), (iv) the Ogaden (conquered by Ethiopia), and (v) the Northern Frontier District (colonized by the British as the northeastern corner of Kenya's Crown Colony).

[4] French Somalia gained independence in 1977 and became Djibouti. The Ogaden remained an integral part of the Ethiopian empire. After Kenya's liberation in 1963, the new government in Nairobi refused the local Somali demand of detachment of the Norther Frontier District from the new state and reunion with the Somali Republic.

[5] An "internal displacement" refers to each new forced movement of persons within the borders of their country recorded during the year. Note that these figures are likely to be underestimates because of access or security constraints that limit the ability to conduct assessments or verify data on short-term movements. Also, triggers of displacement can overlap, and it remains difficult to ascertain which movements are caused by conflict/disaster and which are caused by a mix of triggers.

United Nations (UN) Office for the Coordination of Humanitarian Affairs (OCHA), an estimated 6.1 million people have been affected by the drought emergency in Somalia.(20) A fourth consecutive failed rainy season in Somalia has created a heightened risk of famine in six areas, and the emergency is expected to worsen with the next rainy season projected to be below average.(20) It has been estimated that approximately 7.1 million people will be affected by drought by the end of this year (2022), with 1.4 million children facing acute malnutrition, and 330,000 likely to become severely malnourished.(20) The crisis in Ukraine – particularly its impact on prices of food, oil, and fertilizers – is also expected to intensify the drought-related devastation in the Horn of Africa.(21)

Ecological disasters and conflict are interlinked(22), as conflict can result from competition over scarce resources (e.g., water, pasture, trees), and hunger, deprivation and insecurity can motivate allegiance to armed groups promising protection, money, and food.(23, 24) Large scale migration to urban regions in search for food and water also heightens pressure on already stretched urban infrastructures and resources.(25) On the other hand, conflict – especially prolonged conflict – deters environmental governance needed to keep emissions and unsustainable practices in check whilst also giving rise to new and significant sources of greenhouse gas emissions.[6](26)

In the absence of effective governance, legal and institutional reforms in Somalia have stagnated,[7] once prosperous Somalian cities have been reduced to rubble by years of conflict, and experiences of violence, abuse and displacement have taken a heavy toll on civilians.(16) Children have faced serious abuses, including maiming, killings, attacks on schools, and recruitment and use in armed conflict.(16) They have also experienced arrests, detention, abuse, and due process violations for alleged ties to armed groups.(16, 27) Displacement has altered the social and demographic composition in Somalia through a reorganization of social groups,(28) and caused separation from family and community – these are factors that pose immense challenges in any context, but are especially harmful for the Somali society, which is traditionally collectivist and has the clan system as its organizing principle.(14) Although the bulk of support to people in Somalia comes from multilateral bilateral donors and non-governmental organizations (NGOs), it is limited in coverage, and most people depend on informal supports in times of need, which includes reciprocal support between neighbors, circulation of livestock and other assets, among other things.(24) As such, safety nets in Somalia exist largely along kinship and clan lines, which can be stretched thin by repeated shocks and become inaccessible for people displaced and separated from their families and communities.(24)

The current situation in Somalia can be described as a state of 'delicate stability', with a relatively stable but rapidly shifting political situation combined with ongoing instances of violence and insecurity.(9) As the political environment stabilizes and the economy shows the first signs of recovery, there has been an increase in returnees from the Somali diaspora who – after staying in countries with markedly different cultures, resources, and law and order situation – face challenges in adapting to their new lives.(24) At the same time, their comparative advantage on the job market – stemming

[6] Emissions can result from targeting of oil production, storage and transportation resulting in oil fires and spills, attacks on vegetation and loss of forest cover, damaged infrastructure, etc.

[7] According to a 2021 report by Human Rights Watch, there had been no movement on the passing of federal legislation on sexual offences and key child rights' legislation. The government in power at the time had also failed to establish a national human rights commission, with the appointment of commissioners pending since 2018. https://www.hrw.org/world-report/2022/country-chapters/somalia

from fluency in English, ownership of international visas, and exposure to greater opportunities for quality education and employment – make the local youth feel economically threatened and resentful.(24)

The present-day Somalia can thus be characterized not by isolated events of conflict and natural disasters, but by a social context with deeply embedded cycles of deprivation, violence, humiliation, and a disrupted sense of belongingness, place, and community. Such circumstances create alienation, undermine resilience, encourage reliance on self-destructive coping behaviors, and damage well-being.[8] Given the widespread nature of conflict, displacement, disasters and compromised living conditions in Somalia, many individuals can be expected to experience psychological distress. However, distress is not necessarily indicative of mental disorders, and most people experiencing extreme events and circumstances cope well and do not develop a mental disorder. Although there is no reliable and comprehensive data available on the current nationwide prevalence of mental health problems,[9] a 2010 WHO report suggested that about one in every three people in Somalia experiences a mental health problem.(29) A recently conducted research by the World Health Organization (WHO) Country Office for Somalia and the Africa Mental Health Research and Training Foundation (AMHRTF) in internally displaced people (IDP) sites of Baidoa, Kismayo and Dolow found a high burden of mental health disorders across the three sites, with the most common disorders affecting more than 1 in every 3 people included in the study (top 3 disorders were panic disorder without agoraphobia, post-traumatic stress disorder (PTSD), generalized anxiety disorder).[10] The study also found high comorbidity between mental and substance use disorders.

Despite high mortality from civil war and famine, the Somalian population is growing, and has nearly doubled in the last twenty years. (24, 30) The growing population puts a strain on the already stretched healthcare and social services.(31) According to the Universal Health Coverage (UHC) Partnership[11] backed by WHO and others, only 25% of the population in Somalia have access to essential health services.(32) In 2017, Somalia had only 0.5 beds per 100,000 people for mental health in general hospitals compared to a global average of 24.(31) As per a 2020 report, there were only 3 psychiatrists and 25 trained nurses in Somalia involved in mental health care.(29) Even when support is available, it needs to be perceived as relevant and useful by the people it is meant to serve – purely western approaches can be inconsistent with the local conceptualizations and explanations of distress and mental illness and supports that undermine traditional ways of thinking are unlikely to be welcomed.(33)[12]

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[8] Broadly defined in social, material, psychological, environmental, cultural, and spiritual terms

[9] This is because of the limited research capacity and routine data collection in health centres in Somalia and the challenges of obtaining accurate prevalence figures across cultural and linguistic boundaries.

[10] This research study was one of the components of the project under evaluation.

[11] UHC Partnership is a platform for international cooperation on universal health coverage and primary health care.

[12] For a detailed review of local conceptualisations of mental health in Somalia, please refer to: Cavallera, V, Reggi, M., Abdi, S., Jinnah, Z., Kivelenge, J., Warsame, A.M., Yusuf, A.M., Ventevogel, P. (2016). Culture, context, and mental health of Somali refugees: a primer for staff working in mental health and psychosocial support programmes. Geneva, United Nations High Commissioner for Refugees

In the absence of appropriate and effective support,[13] abusive practices such as chaining and protracted confinement of individuals believed to be experiencing mental health challenges have been recorded both inside households and health facilities (34, 35) alongside high levels of stigma and discrimination.(36) Family members have limited access to information about mental health and community-based supports such as outpatient medical services and counselling services and rely either on traditional Islamic leaders or over the counter treatments from unregulated pharmacies.(35) In response to the widening gap between mental health needs and available supports, private centres claiming to offer mental health services have also grown in the absence of appropriate legal frameworks, regulation, and oversight.(35) Mental health stands as an isolated sector in Somalia that needs to be integrated within primary health care, as well as other sectors including education, gender, livelihoods, protection, and human rights programs.(34) As Somalia rebuilds itself, it is encouraging that the Federal Government has recently collaborated with WHO to develop a mental health strategy for 2019-22 and is also in the process of finalizing a mental health policy.(37)

Somalia has just experienced a relatively peaceful political transition, and there is currently some hope and momentum for enlarging civil spaces for change, strengthening public institutions, and supporting legal, institutional, and ecological reforms in the country. In its journey towards reconciliation and rebuilding, Somalia's predominantly young population can make invaluable contributions if it's supported with opportunities for growth and empowerment. Internationally, the role of youth in promoting peacebuilding and driving change is increasingly gaining recognition, with the understanding that a failure to invest in youth will perpetuate intergenerational poverty and conflict.(24) This momentum has also translated into the launch of a National Youth Policy (2017-2021) in Somalia to promote youth participation in development.(38, 39) Increasing youth participation in the social, economic and political spheres has also been the focus of local and international NGOs and youth groups operating in Somalia.(24)

6. Interlinkages between MHPSS and Peacebuilding work

Armed conflict not only causes loss of life and property, but also disrupts social cohesion and harmony by creating mistrust and resentment between people who were previously family members, friends, and neighbors.(40) In additional to psychological harm, it also destroys *"ways of life, social institutions, norms, sense of belonging and systems of meaning."*(41) Significant suffering results from armed conflict, not just from exposures to violence, but also from ongoing stressors, such as separation from family, loss of social supports, challenges in meeting basic needs, and living in constant fear of trafficking, gender-based violence (GBV), and recruitment into armed forces and groups.(42) Poverty and deprivation that are rife in conflict and post-conflict settings can not only reduce well-being but also mediate the development of psychological disorders such as post-traumatic stress disorder (PTSD).(42, 43) Even in settings that are ostensibly "post conflict", people often identify fear of attacks, insecurity, and concerns about the well-being of one's family as their main sources of distress.(40)

Extensive evidence indicates that children affected by war face a higher risk of mental health problems,(44) and this association is mediated by a range of ongoing stressors experienced within the context of conflict and the wider disruptions that are caused to the social, political, economic environments.(45-47) Armed conflict exposes young people to multiple violations of their rights, including recruitment into armed groups, abductions, maiming and killings, sexual violence, and

[13] Please refer to annex X for the recorded number of mental health facilities and human resources in Somalia.

attacks on schools and hospitals.(48) Conflict, uncertainty and instability also discourage youth from investing in their future, increase reliance on self-destructive coping behaviors, and undermine their resilience to cope.(49) Crucially, mental health impacts of conflict can also reduce the openness of youth to reconciliation and heighten feelings of revenge.(50)

Although peacebuilding and mental health and psychosocial support (MHPSS) have developed as two independent fields, they are fundamentally interlinked in their objectives and interdependent in their outcomes. Peace cannot emerge or be sustained between groups with unresolved social and emotional wounds of war, and conversely, ongoing conflict and insecurity worsen mental health and psychosocial well-being and deprive individuals of social supports and cohesion.(40) Injustices and humiliations experienced during conflict can create a sense of victimization that takes root into people's collective narratives and social identities and set into motion patterns of intergenerational thinking that lead to repeated cycles of violence.(40) It has been estimated that in the last three decades, about 80% of countries emerging from conflict globally have experienced repeat violence.(51)

Social contexts marred by poor governance, unaddressed structural violence, violation of rights, and deprivation of basic necessities can cause protests, conflict, and compromise well-being.(52) Peacebuilding and MHPSS should operate in an integrative fashion to change the underlying causes of harm and transform contexts in which violence and human rights violations occur.(41, 53) Failure to link MHPSS and peacebuilding can limit the impact of each, with evidence indicating that conflict-affected civilians suffering from emotional anguish or psychological disorders are less likely to support peacebuilding efforts(54) and MHPSS issues such as stigma against ex-combatants deter reintegration.(55-57) Conversely, justice processes including truth telling and reparations also have better outcomes when they integrate MHPSS work.(40) Lack of integration of MHPSS into peacebuilding processes of transitional justice might also lead to unintended harm.(40) For instance, in the absence of appropriate MHPSS considerations and support, truth telling processes can increase psychological suffering and vulnerability.(58) Conversely, if MHPSS work fails to integrate peacebuilding considerations, it might lead to unintended harms by worsening social divisions.(40)

In spite of these interdependencies, MHPSS and peacebuilding have largely operated in silos(51, 59) and historically evolved with distinct disciplinary roots, theories, methods, and problems of focus.(40) The evidence base for outcomes and impact of integrative work on MHPSS and peacebuilding is also limited.(51) However, in response to the increases in armed conflict around the world, and the need for effective peacebuilding approaches, explicit and structural incorporation of MHPSS into peacebuilding efforts has started receiving increased attention and endorsement from the international community.(60, 61)

7. About the Project

Based on a 2014 population estimation survey for Somalia, just under half of the Somalian population is less than 15 years old and three-fourth of the population is less than 30 years old.(62) Many young people have been directly or indirectly impacted by the violence, natural disasters, instability, and deprivation affecting Somalia for decades. This project was set up in response to the growing and unaddressed need for MHPSS amongst the young people in Somalia, with the understanding that healing from the harms of violence, instability, and displacement is key to reducing harmful coping behaviors and achieving sustainable peace. It was implemented in Kismayo (Jubaland), Dolow (Gedo

region), and Baidoa (South West State)[14,15] through a partnership between three UN agencies (WHO; International Organisation for Migration or IOM;[16] and United Nations Children's Fund or UNICEF), Somali National University (SNU), and Ministry of Health in Somalia.

- **Baidoa (*Baydhabo* in Somali):** Baidoa is the largest city of the South West state of Somalia. At the start of the project, it was reportedly hosting one of the country's largest IDP populations (over 300,000 individuals). Between 2016 and 2018, the number of IDP camps rose by 72 new sites, and from 2018, Baidoa continued to receive high numbers of IDPs and refugee returnees, creating pressures that led to water shortages, increased environmental impact, and challenges in hygiene and sanitation provision. In August 2020, approximately 60,000 displaced families were living in 514 settlements in and around Baidoa, and the numbers were expected to grow because of conflict and natural disasters. Most of the settlements are built on private land, with tenants living under the constant threat of eviction. Barwaaqo resettlement site (both old and new) was the main site for most of the activities under this project.
- **Kismayo (*Kismaayo* in Somali):** Kismayo is a port city in the Lower Juba region of Somalia and is the commercial capital of Jubaland. At the start of the project, Kismayo town was relatively more peaceful compared to the surrounding districts. It had IDP arrivals mainly from Lower Juba region and returnees from the Dadaab refugee camp in Kenya. IOM has been present in Kismayo from 2006. The activities of this project focused on Gulwade and Dalxiiska with Bulagudud as the secondary site. Dalxiiska is the site with the biggest IDP population in Kismayo and is located closer to the town. Bulagudud is located 30 kms from the town and is the farthest among the three sites.
- **Dolow (*Dooloow* in Somali):** Dolow is a town in the Dolow district, which is one of the 7 districts of the Gedo region of Somalia. The urban center of Dolow is relatively more peaceful compared to other nearby districts and hosts many IDPs affected by droughts and road restrictions by Al Shabab around Garbaharey and Bardhere districts, from where pastoral communities had to migrate to more urban locations for food, water, and other necessities. IOM has an office in Dolow, which was set up in 2018 and has been supporting the basic needs of IDPs in settlements and affected host communities through camp management, shelter reinforcement, and water and sanitation provision. It is also conducting community stabilization work in the wider Gedo region that includes rehabilitation of schools and district administration offices. The IDP sites selected for this project included Qanxaley and Kabasa

[14] As per the donor agreement, these sites were identified as priority areas based on an in-depth context analysis.

[15] In Baidoa, Kismayo, and Dolow, service provision, awareness-raising, and cascade training took place. Additional sites included: a) Mogadishu, where ToTs took place, and b) Galkayo, where awareness raising activities took place. Mogadishu is a host to the largest IDP population in the country and has experienced the greatest frequency and concentration of armed attacks in Somalia since 2012. Galkayo has one of the highest protection severities resulting from clan violence, drought, migration, and displacement.

[16] Before the project started, IOM was working in all three sites to support the basic needs of IDPs in settlements and affected host communities through camp management, shelter reinforcement, and water and sanitation provision. It was also implementing primary health services through health facilities and conducting outreach programs in collaboration with the regional, state, and district level MoH.

IDP camps. Qanxaley is the most populated site in Dolow and is located near the Ethiopian border town of Dollo Ado. During the psychosocial needs assessment conducted by IOM, there was ongoing conflict in a town 40 kilometres from the Dolow town and there was influx of new arrivals to the Qanxaley IDP site.

The project sought to strengthen support for mental health and psychosocial needs of conflict-affected young men and women in Somalia to advance peacebuilding and reconciliation in the country. Specifically, it aimed to:

- **Develop an institutional response to the mental health needs of conflict-affected youth in Somalia:** This involved integration of care and treatment of mental illness into primary health services delivered at health facilities, which included development of a youth-centered and gender aware MHPSS module for health workers and professional training of clinical staff at health facilities in the targeted IDP settlements. The training also had components on clinical management of rape (CMR) and care for Victims of Trafficking (VoT), which are particularly relevant for the Somalian context.
- **Strengthen community-based supports for addressing the mental health and psychosocial needs:** Community-based psychosocial support structures were established using the local health facilities as entry points. This included: (a) formation of support groups; (b) provision of counselling (youth peer-to-peer counselling and problem management plus counselling); (c) training of community leaders and health workers in psychological first aid; (d) activation and facilitation of gender based violence referral pathways; (e) mobilization of communities by their youth for social/traditional/recreational activities to strengthen social cohesion and enhance community bonds; (f) and establishment of MHPSS youth resource centres connected to the health facility. These centres were meant to provide a space for psychosocial support services, positive empowerment activities and community dialogues between youth, community leaders, and local authorities on conflict and peacebuilding. As such, a combination of community psychosocial support (PSS) structures and activities were utilized to mobilize, train, and empower youth to offer PSS to their peers and communities.
- **Improve awareness and reduce stigma in the community against youth with mental health problems and substance abuse:** Youth were supported to raise awareness in their communities about mental health, substance abuse, and harmful coping behaviors that contribute to conflict and stigmatization of mental health problems. Contextualized messaging was developed and disseminated (through radio spots and community mobilization sessions) in partnership with the community stakeholders on mental health, gender-based violence (including female genital mutilation), child marriage, and child recruitment.
- **Advance understanding about the interlinkages between mental health and peacebuilding in the Somalian context with focus on youth and gender dynamics:** Towards this end, a multi-methods research study was conducted by the AMHRTF in collaboration with the WHO Country Office for Somalia, SNU and Ministry of Health Somalia.[17] The study was intended to

[17] Qualitative and quantitative data was collected from 713 participants under 35 years of age between 25th October to 15th November 2021 in three districts of South and Central Somalia, namely, Dolow (Gedo region), Kismayo (Lower Juba region), and Baidoa (Bay region).

create a knowledge base about the interplay between MHPSS and conflict drivers in Somalia, to inform subsequent evidence-informed approaches and interventions and help contextualize results and analysis from the other project components.

7.1. Scope of the Evaluation

This evaluation was conducted jointly by the MHPSS Collaborative and the Somali Institute for Health Research (SIHR) between May to September 2022. The purpose of this evaluation was to document the impact of the project in the three implementation sites – specifically, it intended to learn about the extent to which the provision of youth- and gender-sensitive MHPSS services and awareness activities enabled conflict-affected youth to reduce harmful coping behaviors and feel empowered and engaged in contributing to social cohesion and peacebuilding in their communities. It also aimed to analyse the project's strengths and identify areas of improvement with a view to make recommendations for future work. Importantly, it documented the lessons learned throughout the project cycle, especially considering the many pandemic-related restrictions and challenges faced during the roll out and implementation of the project.

7.2. Methodology

In the interest of a comprehensive and well-rounded evaluation of the program, data was collected and triangulated across multiple sources:

- **Desk review of academic and grey literature:** The desk review aimed to understand the Somalian context and its unique challenges in depth, explore the interlinkages between MHPSS and peacebuilding work, and situate insights emerging from project documents and primary data into the broader body of knowledge that exists on MHPSS and peacebuilding work in conflict and post-conflict settings. To be comprehensive, many different sources were searched for the desk review including:
    - Google and Google Scholar for academic and grey literature using search terms such as "mental health Somalia", "Somalia", "conflict in Somalia"
    - Relief Web, a humanitarian information service provided by UN OCHA
    - MHPSS and Peacebuilding Community of Practice hosted by MHPSS.net
    - Assessment, Monitoring, Evaluation and Research Group hosted by MHPSS.net
    - Inter-Agency standing committee (IASC) MHPSS Reference Group's Consultancy by Michael Wessells and Raksha Sule
    - Guidance note commissioned by United Nations Development Programme (UNDP) on the integration of MHPSS and peacebuilding
    - UNHCR, the UN Refugee Agency, for statistics on displacement in Somalia
    - Snowballing from reference lists of key papers, articles, and reports identified from the previously listed sources
    - Relevant national documents, e.g., Somalia National Youth Policy
    - Relevant reports and articles published by rights organizations including Human Rights Watch and Amnesty International
- **Desk review of the project documents shared by the implementing partners:** These documents not only provided important contextual information about the challenges and needs in Somalia that shaped the project, but crucial information on the project's evolution through its design and implementation stages, progress documented across the different

components and stages of the project, and learnings from the management of the challenges encountered through the implementation of the project (including the pandemic-related challenges).
    - Donor agreement/proposal
    - IOM's psychosocial needs assessment report
    - Donor reports
    - Monitoring and Evaluation Framework
    - Report from the research study on "the interlinkages between youth mental health and peacebuilding in Somalia"
    - Minutes of the steering committee meetings
    - SNU supervision reports
    - Mental Health Gap Action Programme (mhGAP) training document for Somalia
    - No cost extension (NCE) request
    - Workplan
- **Consultations with community stakeholders and key informants and quantitative survey with youth who received the intervention:** Consultations comprised 12 focus group discussions (FGDs) with community stakeholders including health workers, community health workers, youth leaders, and community leaders from the project implementation sites (please refer to table 1 below to see the distribution of FGDs across project sites and stakeholder groups). Each FGD included 6 participants, and while efforts were made to secure an equal representation of male and female participants, this could not be achieved across groups.[18] In addition, 4 key informant interviews (KIIs) were conducted, one each with stakeholders from WHO, MoH, UNICEF, and SNU, to understand their perspective about the project based on their specific project roles. Finally, a quantitative survey was conducted with 60 youth (across three project sites) to get feedback on the project from their perspective and assess the project's impact on young people in Somalia. From each project site, 20 youth were selected through non-probability sampling, which implies that the data from the survey might not be representative of the entire population of youth who received support under the project in the selected project sites. As mentioned before, in the absence of baseline data, pre- and post-comparison was not possible. Therefore, the quantitative survey focused on understanding the youth's perception of changes in key outcomes (conflict, substance use, mental health supports) from the time before the project started to the time of evaluation.

Table 1: Distribution of FGDs across project sites and stakeholder groups

	Dolow	**Baidoa**	**Kismayo**	**Total**
Health workers	1 FGD	1 FGD	1 FGD	3 FGDs
Community health workers	1 FGD	1 FGD	1 FGD	3 FGDs
Youth leaders	1 FGD	1 FGD	1 FGD	3 FGDs

[18] Across the 12 FGDs, a total of 72 community stakeholders were consulted. Out of these 72 participants, 48 were males and 24 were females.

Community leaders	1 FGD	1 FGD	1 FGD	3 FGDs
Total	4 FGDs	4 FGDs	4 FGDs	12 FGDs

All the fieldwork was conducted using a set of tools developed by the evaluation team at the MHPSS Collaborative and informed by the project monitoring and evaluation framework and evaluation questions from the project inception report. Please refer to appendix A-F for the full set of tools including the informed consent forms. The tools were prepared in English and later translated in Somali by the SIHR team. Participants were interviewed in Somali in Kismayo and Dolow and in the *"Maay"* dialect in Baidoa. The tools were uploaded on Kobo Collect and administered by trained and experienced research assistants. All the fieldwork was conducted in person/face-to-face. The questions across tools were geared towards understanding the:

- Relevance of the project in meeting the needs and priorities of the community stakeholders
- Effectiveness of the project in meeting its objectives, ensuring high quality of implementation, using an appropriate targeting strategy, and leveraging data to inform programming
- Efficiency of the project in making the best use of resources, delivering outputs in a timely fashion, successfully adapting to implementation challenges, and complementing and coordinating with the work of other actors in the selected sites
- Impact of the project on the selected settlements, including the positive and negative impacts, intended and unintended impacts, and the impact of addressing key drivers of conflict
- Sustainability of the project results post completion, inclusion of appropriate sustainability and exit strategy, and an increased commitment and ownership of the project amongst the community, local authorities, and the government
- Catalytic value of the project in scaling up other peacebuilding work and creating broader platforms for peacebuilding
- Use of novel approaches and lessons learned for future projects

Qualitative data from consultations with the community stakeholders and key informants from the implementing organizations were coded by two individuals from the evaluation teams at the MHPSS Collaborative and SIHR using MAXQDA 22.2.1 and NVivo, respectively. The coding of data was largely deductive, using the information categories/themes agreed in advance for the evaluation. After coding, the coded segments were retrieved and analyzed with respect to the research questions agreed in the inception report. The retrieved segments were synthesized through descriptive analysis conducted across cases,[19] which included an analysis of the patterns and variations in data for each information category/theme. Quantitative data was analyzed by the evaluation team at SIHR using STATA 17.0.

[19] Each case represents a single FGD or interview.

7.3. Limitations

Considerations of the shortcomings of the research process, while important for all research, are also crucial for program evaluation. This is because program evaluation does not happen in a vacuum and depending upon the way it is carried out, can in and of itself impede or contribute to peacebuilding.(58)

- Evaluation of this project was delayed by a year[20] and this is likely to have affected participants' recall of their experiences during the project as well as their estimations of the immediate project impacts. To mitigate the impacts of this delay and tackle the issue of compromised recall, a brief description of the project and its components was provided to the participants before initiating the discussion.
- Time constraints also compromised the breadth and depth of our engagement with the all stakeholders, including the community stakeholders at the project implementation sites. Regretfully, it was not feasible to conduct a participatory evaluation, which improves the scientific validity of evaluation results, produces richer and more accurate data, creates active support for the process of inquiry, greater commitment for change, as well as greater likelihood that the results of the evaluation would be meaningfully applied by the community towards addressing its challenges.(63)
- Given the short amount of time available for planning and mobilizing resources for evaluation, the participation of vulnerable sub-groups (e.g., youth with disabilities, youth with severe mental illness, youth previously associated with armed groups and armed forces) was not explicitly sought out and planned for. It is unclear if the gender representation in the evaluation was diverse as religious and cultural considerations did not permit the evaluation team to ask probing questions on gender identity and sexual orientation of the participants.
- Although it is best practice to seek ethical approval for an evaluation like this, it was not secured due to time constraints, but efforts were taken to uphold ethical standards in alignment with key documents and guidance materials for conducting research with children, adolescents, and others in fragile and emergency settings.[21] This included discussions and deliberations on ethical considerations with the national partner (SIHR) on, for e.g., the best ways of seeking informed consent, securing a referral pathway to respond to any protection cases, etc.
- Although each participating UN agency had planned to conduct its own baseline,[22] baseline data was only available from WHO (background information about selected the implementation sites) and IOM (psychosocial needs assessment). A knowledge, attitudes, and practices (KAP) survey and focus groups with youth was planned by UNICEF to understand baseline levels of knowledge, attitudes, and practices relevant to the project outcomes, but it could not be completed at the beginning of the project on account of pandemic-related

[20] While the project implementation ended in August 2021, the fieldwork for the evaluation started a year later (July 2021).

[21] Resources consulted include: (a) "Using focus group discussions with children and adolescents" by Terre des hommes; and (b) "Program evaluation: why process matters" by Michael Wessells (2015)

[22] Source: Minutes of the steering committee meeting on 29th May 2020.

restrictions and other challenges at the field level. As such, pre and post comparisons were not possible to assess the changes in knowledge, attitudes and practices associated with the project. Results from IOM's qualitative psychosocial needs assessment conducted by IOM[23] were used extensively to understand the relevance of the project to the community stakeholders, but some parts of the needs assessments overlapped with the project implementation. It is possible that the needs at baseline were greater or lower than the assessment results suggest.

- The survey participants were not selected randomly, owing to which it cannot be ensured that they were representative of the population that received the intervention. A related issue is that many different projects tend to operate in IDP settlements at any given time, because of which it is not feasible to causally link any changes in the community to the project components. To address this issue to some extent, the quantitative survey with youth participants focused on their perception of change caused by the project on the relevant project outcomes.

8. Evaluation Findings

8.1. Relevance

Was the project relevant to the needs and priorities of the target communities? To what extent did the project design address and respond to "mental health and psychosocial support services in the context of peacebuilding"?

Across the community stakeholder groups consulted during the evaluation, there was unanimous agreement about the need for improving MHPSS services in the selected IDP sites. Mental health and substance use problems were considered widespread amongst youth, and there was a severe shortage of supports available to effectively manage them, with clinical services either completely missing or inaccessible. This finding was triangulated by IOM's needs assessment, which also found that there were very limited services providing psychiatric treatment and psychosocial support in the selected IDP sites.

Community stakeholders consulted during this evaluation recognized the interdependencies between mental health problems, substance use, violence, and conflict. However, given that their communities struggled with meeting even the most basic of their needs, MHPSS services were on their own considered insufficient for ensuring the well-being of youth and cultivating sustainable peace. For context, the IOM needs assessment found that even though many people living in the selected IDP sites had experienced extremely distressing events, they described their current distress primarily in relation to the extraordinary challenges of living in camps and settlements, difficulty in meeting basic needs, lack of social support, early marriages with multiple births, and exposure to communal, inter-clan, and domestic violence. They reported experiencing grave uncertainty about their future, ongoing

[23] IOM's needs assessment was conducted between March and September 2020 (initiated in March 2020, halted because of the pandemic, and resumed from June to September 2020). Some parts of the assessment such as mapping services continued until January 2021.

fear about violence erupting both inside and outside the site,[24] despondency related to their compromised life circumstances, and a profound sense of loss of place, possessions, connections, identity, self-esteem, and status.

Consultations with the community stakeholders included in the evaluation revealed that amongst young people, unemployment was the most significant contributor to mental health problems and substance use, with other factors including hunger, displacement, violence, and loss of family and friends. For young women, lacking a voice within the family and community and gender-based violence were considered important contributory factors. As such, health-based supports were desired not in isolation but in conjunction with supports that can improve the living environments of youth, through for e.g., creation of livelihood opportunities.

> *"In most of Jubaland, drug addiction is high. You see small boys using drugs and others who are homeless. Their families are dependent on them, and they have no other sources of income apart from shoe cleaning and car cleaning. They buy khat and hashish, and these lead to addiction problems and issues with their thinking. There are many people who, when they use these drugs, commit harmful actions such as rape because their minds are not stable at that time. When a person is mentally stable, they can make better judgement"- **Youth leader, Kismayo***
>
> *"Stress can result not only from being insane but also being unemployed. It can come from the household. When parents treat their children unfairly, then they can have behavioral issues"- **Youth leader, Kismayo***
>
> *"Supporting Somali youths, whether they are street children or those who are addicted to drugs, is surely very welcome. I think the long-lasting solution to this problem is to solve the root causes including unemployment, recurrent droughts, and lack of functional mental health centres"- **Youth leader, Baidoa***
>
> *"There are many people who are mentally ill, but when they are given medication, they become okay. There are others who have stress, which is caused by poor economy, they have been treated but the poor economy is still there."- **Youth leader, Baidoa***

The wider body of literature also shows that lack of access to livelihood opportunities and education are the most pressing concerns of young people in Somalia. The latest estimates indicate that around one in every two young people of working age in Somalia (20-35 years) is economically inactive, and IDP camps and urban centres tend to have the highest unemployment rates in the country.(24) Also, a 2016 IOM Somalia study found that only a third of the youth (14-30 years) surveyed (33.7%) reported

[24] Although the IDP site was generally perceived to be relatively safer compared to its neighbouring areas, there was still uncertainty about the security situation within the site, which the participants felt was liable to change with changes in the external security situation.

having a job, and they were usually in a state of underemployment – nearly half of them (42%) had at least two occupations, and over a third (35%) were engaged in part-time/occasional jobs.(64)

Young people in Somalia believe that education is a crucial source of opportunities and knowledge needed for cultivating peace in their country,(11) but many of them do not have access to education opportunities[25] or face challenges to entering the labor force because of lack of skills, limited capital for investment, or other vulnerabilities imposed by conflict and displacement.(64) The research study conducted as part of this project to understand the interlinkages between MHPSS and peacebuilding in the selected project centres (Baidoa, Dolow and Kismayo) also found that about 4 out of every 10 of the study participants[26] could not read or write.

What was the level of youth engagement during the design and implementation of the project? In giving feedback throughout? What was the engagement of other stakeholders? Were both men and women included in this process?

A review of the project documentation suggests that consultations with community stakeholders primarily occurred in the initial stages of the project. This included a round of consultations prior to the submission of the project proposal to the Peace Building Support office (PBSO) with a diverse group of stakeholders in the UN, government, academia, and community.[27,28] The exact representation of youth and gender in these consultations is unclear. In addition, IOM conducted a needs assessment, including both men and women above 18 years of age,[29] to understand the MHPSS needs from the perspective of the community stakeholders in the relevant IDP sites. UNICEF also conducted consultations with young people and opinion leaders to develop awareness messaging that is culturally appropriate and tailored to community and youth needs.

While the project was being implemented, health workers reported being consulted for their feedback on the MHPSS training that they received under the project. Also, informal engagements with the community during project implementation led to the adaptation of some of the awareness activities

[25] Somalia has one of the highest illiteracy rates in the world (62.2%) https://www.indexmundi.com/somalia/literacy.html

[26] The sample included 713 participants, majority of whom were community-based, under 35 years of age, and did not stay in an IDP site.

[27] The first round took place before initial submission of the summary proposal and second round took place after the initial approval.

[28] A project development team (including technical officers from all three implementing UN agencies) consulted with the local peacebuilding fund (PBF) coordination team, Ministry of Health (MoH), local stakeholders, and youth leaders from two target IDP settlements, and the feedback from these stakeholders was included in the proposal.

[29] The needs assessment exercise from IOM included 14 qualitative individual interviews and 24 group discussions with participants aged over 18 years who were key informants, youth, and community stakeholders in all three sites. The groups included community members (men, women, elderly men, people with disabilities), community and religious leaders and key actors in the community including people working for the government, NGOs, CBOs dealing with youth-related activities, and school officials. Across the interviews and groups, a total of 107 females and 99 males participated.

by UNICEF.[30] Also, a range of community stakeholder groups (health workers, CHWs, youth, and community leaders) were trained to directly implement the project through delivery of MHPSS services and awareness generation activities. Community leaders were also engaged in the selection and recruitment of community based MHPSS teams that provided support under the project.

> *"The target community was part of the implementation, and they were also partly involved in planning. That's one of the reasons why we used media, particularly radio, which was not in our plan earlier. While talking with the community, we found that they understand messages better at an interpersonal level, but they often have more trust on electronic media."* - ***Key informant, UNICEF***

Majority of the youth surveyed[31] during the evaluation felt that they were consulted for their "inputs/feedback during the project" (86%), their "inputs/feedback were taken seriously" (85%) and that "the support provided during the project was suitable to the needs of the young people" in their community (84%) (please refer to table 2 below). Interestingly across these parameters, fewer youth from Kismayo were in strong agreement/agreement compared to youths consulted in Baidoa and Dolow. Consultations with youth leaders from Kismayo revealed their desire to have played a greater role in the planning and implementation of the project, given their expertise and immersion in the context and their ability to connect and manage interactions with their peers experiencing problems with mental health and substance use and/or involved in crime. This issue was raised only in Kismayo possibly because Kismayo District Youth Council has already been active in awareness activities through mental health/substance use projects run by NGOs operating in their region (this is discussed in more detail in section 8.9 on innovation). It was also felt that more extensive engagement of youth in project implementation could have helped them more directly by creating income opportunities, even if they were short-term.

> *"The project could have been better if the youth leaders were leading it because they are involved in the situation more than the Ministry of Health and (other) political leaders. They know about what youth in their area are experiencing, such as drug issues and crime. They know how to face these challenges, and how to deal with people involved in substance abuse and crime. If they were leading the project, they would have benefited more, it would have given them chances of employment and (led to) a reduction in drug use "* ***- Youth leader, Kismayo***

[30] It was found that electronic media were considered credible by the community, and consequently, radio spots were utilized to sensitize the community about mental health problems and substance use.

[31] The survey included data from 60 participants (selected through non-probability sampling) living in IDP camps in Baidoa, Dolow, and Kismayo.

Table 2: Relevance of the project for youth (source: survey with youth participants)

Statements	**Proportion of youth who either strongly agreed or agreed - N(%)**			
	Overall	*Dolow*	*Baidoa*	*Kismayo*
I was consulted for my inputs/feedback during the project.	52 (86)	20 (100)	19 (95)	13 (65)
I feel that my inputs/feedback were taken seriously.	51 (85)	20 (100)	20 (100)	11 (55)
The support provided during the project was suitable to the needs of the young people in my community.	50 (84)	20 (100)	20 (100)	10 (50)

8.2. Efficiency

How efficient was the project implementation overall?

Given that the project implementation required coordination across multiple implementing partners within and outside Somalia, the COVID-19 pandemic posed significant challenges in running the project smoothly and efficiently, especially in the first 6 months after the date of the first transfer of funds (i.e., 26th November 2019). From a review of the project documents and consultations with the key informants, it was found that the implementation picked up after the delays experienced in the first 6 months, and many project targets were achieved before the project ended. In the youth participant survey, majority (80%) either strongly agreed or agreed that "the project was implemented well despite the COVID-19 pandemic related disruptions". Possibly the biggest impact of the implementation challenges was that the baseline assessments could not be completed before interventions were rolled out, making it impossible to conduct pre- and post-comparisons for understanding the project's impact. From the consultation with the key informant from UNICEF, it was found that the delay in UNICEF's baseline evaluation might be attributable not only to the pandemic-related challenges, but also to the lack of budgeting for the baseline evaluation at the project planning stage.

The research study on interlinkages between MHPSS and peacebuilding in Somalia was also delayed, because the initial engagement of WHO with a group of academics was unfruitful due to communication challenges and disagreements over budget. Post this, an open call was posted by WHO to solicit proposals, but by this time, the study was significantly behind the deadline. Staff turnover at all three participating UN agencies was another concern raised in relation to the implementation delay. WHO, as the coordinating agency, also expressed concerns about delays in the receipt of progress reports from partner agencies, which further caused a delay in securing funding for the remaining project components. The present evaluation of the project has been delayed by approximately a year, and this was attributed in the donor reports to the time taken by the clearance process for drafting the terms of reference (ToR) for the evaluation consultant.

> *"When the project was designed, we did not have any research component, only the demand generation component. That's why the research was never planned or budgeted for. We had to do it using our own resources and staff time. This is problematic because for research to be robust and intensive, it needs staff time." -* ***Key informant, UNICEF***

"Some of the agencies were fast in terms of implementing their components. We struggled somehow with the other components. Because of COVID-19, our two partners in the UN were unable to collect baseline data on time, which had some impact on implementation. But overall, despite the circumstances and challenges posed by COVID-19, the experience was good." - ***Key informant, WHO***

How efficiently, timely, and successfully did the project adapt to challenges resulting from the COVID-19 pandemic? Were the project outputs delivered promptly/in line with the proposed timelines?

In response to the physical distancing measures and travel restrictions introduced to manage the pandemic, there was a transition to remote work via virtual platforms for meetings and trainings. Pandemic-related delays were also caused by the shift in priorities and redirection of resources on the ground to focus on activities related to the pandemic. Specifically, all the three implementing UN agencies (WHO, IOM, and UNICEF) diverted their resources towards the management of the pandemic as a part of their health programming in Somalia. At the same time, the MoH also shifted its focus from development work to emergency preparedness and response.

Ultimately, there were delays in the development of the MHPSS training module, completion of baseline evaluations before project implementation,[32] and implementation of training and awareness activities on the ground.[33] A no cost extension (NCE) was secured to make up for the time lost, and it extended the initial project duration by 6 months. One of the positive outcomes of this experience was that, as part of the NCE, the scope of the MHPSS training curriculum was extended to include a section on emergency situations and public health emergencies, with focus on addressing psychosocial distress that stems from exposure to extreme stressors.

"Since COVID-19 coincided with the project implementation period, it was difficult for the partners to have face-to-face meetings and most of the coordination meetings were

[32] There was a delay in rolling out the health facility assessment (part of IOM's baseline evaluation) on account of administrative issues and challenges caused by the pandemic such as the rotation schedule of the field staff. A KAP survey and focus groups planned as a part of UNICEF's baseline evaluation were also delayed because of lengthy negotiations with universities and community workers on its modality and foreseeable limitations stemming from COVID-19 prevention and response measures. Later, UNICEF collaborated with a New York based organization to conduct the evaluation which was completed in the last few months of the project.

[33] All of UNICEF's staff working on the project had to depart Mogadishu in mid-March 2020, which combined with physical distancing requirements, made it challenging to organize awareness raising activities in the selected project sites. SADA, which was a youth group engaged by UNICEF for awareness raising activities, was also deterred in its work by the need to adapt to new implementing modalities because of COVID-19. To address this challenge, cooperation was sought from existing institutional collaboration and social mobilizers to fill gaps in resources available for the awareness generation activities. Training of youth by UNICEF had to be postponed because of political uncertainty and were postponed to February 2021. Trainings on ground by IOM were also delayed due to the pandemic-related restrictions and rescheduled to the first week of May 2021.

conducted virtually. More regular face-to-face meetings would have been useful for the smooth functioning of the project." - ***Key informant, MoH***

To what extent did the project complement work, avoid duplication, ensure coordination among different entities, especially with other UN actors, other government institutions and alignment with other PBF projects?

Coordination between implementing partners (the 3 UN agencies, MoH, and SNU) had both strengths and challenges. Interviews with the key informants suggested that the strengths of the coordination and implementation process included: (a) clearly defined roles of each implementing partner based on their areas of specialisation and expertise; (b) establishment of a steering committee that regularly met, provided oversight, and brainstormed solutions for implementation challenges; and (c) transparent documentation and communication regarding the task distribution and responsibilities. On the other hand, a review of the project documents suggested that some of the delays could have been avoided through more regular meetings, stronger project management structure, and stricter timelines.[34]

"We were focusing more on the demand generation part and the other partners were focused on the services component, so we had our specialization. There were routine meetings amongst the partners, documents were shared widely and transparently, everybody could see what others are doing, and everything was very specific and clear cut." - ***Key informant, UNICEF***

Collaboration between WHO and national partners (including MoH and SNU) was instrumental in the training of local health workers and integration of mental health supports in primary health services at the selected project sites. Key informants from SNU and MoH reported a fruitful collaboration, with consistent technical support from the WHO team. However, a review of the project documents suggested that the UN agencies implementing the project found coordination with MoH suboptimal in the initial stages, and this was attributed to the change in the key point person for the project at the ministry as well as to communication challenges. This issue was reportedly resolved through regular and open telephone calls and written communication to foster trust and cooperation. Crucially, MoH's leadership and ownership was believed to have strengthened over the course of the project, and this was partly attributed to the presence of a dedicated MHPSS focal point in the Ministry whose work was supported by incentives. On the other hand, cooperation with SNU was reported to be excellent throughout the project.

"The collaboration with WHO was excellent, we were dealing more with them, especially with them providing us technical support whenever new things happened. Although there

[34] Sources: "Lessons learned" section from the annexure to the final donor report

were some challenges when delays happened due to COVID-19, but they worked with us a lot and put more effort into the work (for) it to continue." - ***Key informant, MoH***

"Collaboration with a reputable organization like WHO was a great experience. I was always receiving proper guidance about project implementation from the WHO consultant on this project." - ***Key informant, SNU***

At the field level, coordination of work between some actors was at times suboptimal with individual actors focused primarily on their roles in the project. One of the key informants interviewed for this evaluation suggested that the lack of engagement between some implementing partners (i.e., SNU's engagement with UNICEF and IOM; and MoH's engagement with UNICEF) at the field level might have been due to the restrictions imposed by the pandemic. Consultation with the key informant from MoH suggested that the ministry was not always informed about the progress of UNICEF's awareness and sensitization work. From the MoH's perspective, the awareness activities were not implemented efficiently – specifically, the community was not sufficiently aware about the nature and purpose of the project, which led to false expectations of financial support or in-kind support through food and ration instead of MHPSS services. This made it necessary for health workers to engage in community sensitization themselves and possibly led to low service uptake. FGDs with community stakeholders also revealed that health workers and community health workers spent a substantial amount of time explaining the project and persuading the community about the value of the mental health and psychosocial support available under the project. After multiple visits and interactions, the community reportedly became more welcoming of the support offered by the project.

"We had a little problem with UNICEF because their replies were slow. There were not like WHO that had more staff on board. At UNICEF, there were two staff and one of them died due to COVID-19. The staff that came in after that was not responsive. The awareness of the community towards MHPSS activities was low, which affected service utilization. It was difficult to coordinate awareness activities implemented by UNICEF in different regions. Awareness raising took the time of health workers although awareness should not have been the priority for them" - ***Key informant, MoH***

"The fact that the community you work for is unfamiliar with the project is one of the difficulties. We have to gradually raise people's awareness and comprehension." - ***Health worker, Baidoa***

"I hardly ever communicated with project partners such as UNICEF, IOM, and peacebuilding. So, I was not well informed about what they were doing in the field. IOM and UNICEF were implementing the same project on the same sites as us, but we never met each other in the field. I believe this was because of COVID-19." - ***Key informant, SNU***

In terms of coordination with external actors doing similar work in the project sites, the key informants consulted for this evaluation suggested that there were unlikely to be any other actors working at the intersection of mental health and peacebuilding in the selected project sites. This finding was triangulated by feedback from the community stakeholders that this project was the first of its kind in

their community, except for non-governmental organizations called GRT and *Kalsan* that have projects focusing on mental health and substance use in Kismayo.

> *"The only UN agencies that contribute to the health agenda are WHO, UNICEF on the advocacy and mobilization side, and IOM dealing with the health of the displaced populations. Only other UN agency that gets involved in health but was not involved in this project is UNHCR. It deals with refugees and here we mostly have IDPs. So, I can confidently say that there were no other UN partners that were implementing similar programs in the target area."* - ***Key informant, WHO***

8.3. Effectiveness

How effective was the project in meeting its objectives? To what extent were the targets met? How effective were the strategies and tools?

A review of the project documentation revealed that many of project outputs were delivered successfully after a NCE of 6 months. This included the completion of the following targets:

- Hiring of a MHPSS consultant who developed an MHPSS training curriculum (with a module on gender- and youth-sensitive MHPSS) post 3 consultation meetings with the key stakeholders
- ToTs and cascade trainings conducted for a total of 84 health workers[35] (against a target of 80) across Baidoa, Dolow, and Kismayo[36]
- Training of 60 health workers and community stakeholders[37] (against a target of 60) in community based MHPSS skills (including PFA, CMR, GBV management, stigma reduction, and PSS)
- Training of 45 community-based counsellors (against a target of 30), including 30 youth-aged and 15 non-youth aged counsellors
- Formation of 24 support groups[38] (against a target of 20 groups) with 192 participants[39] (against a target of 100 participants)
- Identification and furnishing of 3 MHPSS resource centres (against a target of 3) in the selected sites[40]
- Training of 30 youth-aged animators (against a target of 30) actively mobilizing community activities towards improved social cohesion and peacebuilding

[35] Including 24 ToTs and cascade training of 60 frontline health workers (20 each in Kismayo, Dolow, and Baidoa). This was followed by 8 days of supervision and 4 days of mentoring workshops.

[36] Post cascade training, 15 health facilities initiated MHPSS services

[37] 25 females and 35 males

[38] Divided into male and female groups and into two age groups - 18 to 25 years old and 26 to 35 years old

[39] 102 females and 90 males

[40] These centres were identified jointly with camp coordination and camp management (CCCM) and community leaders in the respective locations.

- Development of contextualized messaging with support from scholars from the National Islamic Advisory Group (NIAG) and dissemination through FM radio stations and interpersonal communication channels
- Engagement with 10 radio stations to broadcast 3 radio spots 5 times a day for 30 days
- Completion of a research study on the interlinkages between MHPSS and peacebuilding in Somalia

Despite the implementation challenges, the project was also extended to include certain tasks/activities that were not a part of the initial plan. This includes mentoring/refresher workshops for health workers post training and development of an additional training module on support during emergency situations/public health emergencies. At the same time, the following projects targets were only partially achieved:

- **Identification and referral[41] of 91 GBV survivors against a target of 288:** a review of the project documents suggested that the reporting of GBV cases to health facilities (and further to specialized GBV services) might have been low on account of the reluctance of the community to report GBV. MHPSS teams started working with GBV actors from June 2021 to increase the referral of GBV survivors to MHPSS services.
- **Completion of 426 counselling sessions against a target of 3600:[42]** a review of the project documents suggested that the number of counselling sessions were limited by COVID-19 precautionary measures. The sessions that were completed included the observance of COVID-19 prevention measures such as social distancing, hand washing, and mandatory use of face masks.
- **Partial progress on community mobilization sessions organized by trained youth for their peers on substance abuse, stigma, and negative coping mechanisms:** Social workers mobilized peer to peer youth groups consisting of 42 youth (18 female and 24 male) and conducted 29 mobilization 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.

Pre-and post-training assessments recorded improvements in the knowledge levels of trainees about mental, neurological, and substance use disorders using a 16-item questionnaire. Consultations with trained health and community workers revealed that the training might have played a role in changing their own attitudes and beliefs about mental health. Specifically, there was a palpable shift from the previously held beliefs that severe mental illness cannot be addressed and/or people with severe mental illness are dangerous. Community stakeholders who received training under the project reported feeling more confident and empowered to engage with and support those in their community experiencing mental health and substance use problems.

[41] To PSS, medical, and protection services

[42] 23 individuals in need of referral were referred to specialized mental health services in coordination with MoH.

"Previously, I believed that people with mental illness cannot be treated. I learned that many people who are suffering from mental illness can be treated easily." - ***Health worker, Dolow***

"I used to believe that mentally ill persons should be chained, or they will harm others, but after the training, I have a better understanding." - ***Health worker, Baidoa***

"Before this, if somebody had a mental health problem, we used to bring him home and isolate him, but now we sit with those patients, give awareness, and work on how to calm them down." - ***CHW, Dolow***

At the same time, some felt that the training was not inclusive in the sense that it did not prepare the trainees to address the mental health needs of young people with disability. Health workers, CHWs, and youth leaders also expressed a need for more intensive and ongoing training and supervision so that the capacity of people supporting those in their communities can be strengthened. Some CHWs expressed a desire for training conducted at a national level in multicultural teams, probably because it could serve as a pathway for greater exposure and career growth. It was also felt that the trainings conducted under the project should have been expanded to train more people so that the vast needs in the communities can be adequately met.

"The quality of training was good, but we were provided very basic skills. The training was not continuous, it was only 3 to 4 times. Supervisors were visiting us during our work, but I can say that complete support was not there." - ***CHW, Kismayo***

"In my opinion, the training was no sufficient because the work was vast. The training was short and concise, and the workers were few. I believe the training, as well as the number of people working needs to be increased." - ***Health worker, Kismayo***

In terms of the effectiveness of the awareness activities, most of the youth who received support from the project and participated in the survey agreed[43] that "drug/substance use can negatively impact mental health" (77%) and "drug/substance use can lead to acts of aggression and increase chances of conflict" (77%) (please refer to table 3 below for details). Majority of them also displayed positive attitudes towards help seeking in case of substance use dependence or depression (77%, 80%, and 80% agreed that they would seek help from family, community elders/spiritual leaders, and psychologist/counsellor, respectively).[44] However, please note that because of the delay in conducting

[43] On a 3-point Likert scale with the following response choices: agree, disagree, and neither agree nor disagree

[44] Note that there were substantial centre wise differences, with youth in Kismayo responding with lower levels of awareness against all the measures.

the evaluation, the recall of the project might have suffered, and this might have led to the participants providing extremely consistent responses across the different statements in table 3 (and other tables in the document with data from the quantitative survey).

Table 3: Awareness of youth about the impacts of substance use on mental health and attitudes towards help seeking

Statements	**Proportion of youth who agreed - N(%)**			
	Overall	*Dolow*	*Baidoa*	*Kismayo*
Mental health is affected by stressful events that people experience in their lives, such as loss of a loved one, witnessing violence, loss of a job, etc.	60 (100)	20 (100)	20 (100)	20 (100)
Drug/substance use can negatively impact mental health.	46 (77)	20 (100)	20 (100)	6 (30)
Drug/substance use can lead to acts of aggression and increase chances of conflict.	46 (77)	20 (100)	20 (100)	6 (30)
If I feel depressed, get very stressed or become highly dependent on drugs/substances, I will seek support from family.	46 (77)	20 (100)	19 (95)	7 (35)
If I feel depressed, get very stressed or become highly dependent on drugs/substances, I will seek support from my community elders and spiritual leaders.	48 (80)	20 (100)	20 (100)	8 (40)
If I feel depressed, get very stressed or become highly dependent on drugs/substances, I will seek support at a health facility/from a psychologist or a counsellor.	48 (80)	20 (100)	19 (95)	9 (45)

At the same time, consultations with stakeholders working closely with their communities (health workers, CHWs, youth leaders, and community leaders) revealed that the wider community was not well informed about the objectives and scope of the project. Health and community workers faced substantial resistance from the community that impeded their ability to offer support and limited the uptake of services. Existing deprivations of basic needs in the targeted communities created expectations of other forms of support (financial or other supports such as food) that were not available within the project. Stigma in the community against mental health problems also prevented people from seeking and accepting support, especially in the initial stages of the intervention rollout. Towards the end of the project, there were signs of reduction in stigma in the wider community and improvement in support seeking for mental health and substance use problems. However, youth who received support under the program and participated in the survey reported high levels of stigma persisting in their communities, with most of them agreeing that people in their community "discriminate against those with mental illness/disorder and treat them unfairly" (70%). Unfortunately, majority of them (62%) themselves thought that "people with mental illness/disorder are violent and dangerous."

Encouragingly, the community stakeholders implementing the project reported that repeated visits and attempts to engage were helpful in sensitizing the community about mental health problems, cultivating trust in the project, mitigating stigma against mental health, and creating openness to seeking support for mental health and substance use problems. This suggests that a longer project

duration could have been helpful in securing a buy-in from the community and ensuring alignment with their expectations.

> *"Previously, the awareness of the community was low. It was hard for them to understand the project and acknowledge that it is beneficial. It is very hard for a person to understand when you come up with a new thing. It will take them time to digest it and react to it. The other issue is time…when the community understood the project and people from nearby villages also started coming to seek support, that's when the project ended."* - ***CHW, Kismayo***
>
> *"If you visit them in their houses, they will think that you will give them food and they will tell you: would you give food to someone who is starving? They will tell you that someone who is hungry cannot be healthy. You will encounter difficulties while you work with these communities."* - ***Health worker, Baidoa***
>
> *"As we are in the middle of severe droughts that have hit the country, many people are asking you to support them with something, i.e., food or money to use in their daily lives. If not, they will likely not give any attention to your awareness. They will most likely tell you that hunger is one of the factors that cause mental health problems."* ***- Community leader, Baidoa***

The communities' own beliefs about mental health problems – i.e., mental health problems are caused and can be resolved only by a higher power/*Allah* – were also reported to limit their engagement with the project. The awareness/sensitization activities under the project seem to have overlooked the importance of engaging with the communities' own beliefs about mental health problems. Such engagement is critical to ensure that the interventions are culturally grounded and not rejected by the communities that they are meant to serve.

> *If you go to the community, they will tell you that what you are talking about (the project) is nonsense, only Allah can give us health. It will take time for them to understand what you are talking about."* - ***Health worker, Baidoa***
>
> *"You meet someone who has mental health problems, you try to support him, but he will tell you that Allah has a reason for making him sick. Some of them will say that they only trust in Allah for both their illness and health, and health centres cannot do anything for such people."* - ***Health worker, Baidoa***

What were the overall strengths, weaknesses, opportunities, and threats of the project's implementation process?

A key strength of the project was its use of a combination of community-based and clinical approaches to tackle mental health problems, involving the expertise of diverse global, national, and local implementing partners across the UN, government, and academia. Community stakeholders who participated in this evaluation believed that the inclusion of peer-led interventions/activities alongside

clinical supports was a source of solidarity and engagement within the community. Creation of community-based supports was considered particularly relevant in their context given the limited availability of clinical services. Engagement of knowledgeable and experienced trainers was considered instrumental in improving local competencies of managing and approaching mental health and substance problems.

> *"A strength was that we were able to draw on the expertise of three UN agencies, IOM specializes in dealing with migration and UNICEF has a specialty in advocacy and communication. These two organizations have a field presence, and they were directly involved at the implementation level. WHO with its expertise in capacity building was responsible for delivering on the capacity component with MoH and SNU."* - ***Key informant, WHO***
>
> *"Yes, we support them (community) as we are the ones who have taken the training and have experience. It's not a problem if the funding has stopped, we are the ones who took the training, and our contribution is needed. Last week, I successfully helped two people who were stressed."* - ***CHW, Kismayo***
>
> *"We were sitting on the same mat when we were going to the camps. We were working for them in the best possible way. A boy said to me "success has come as you are working with the community in a great way.""* - ***CHW, Kismayo***

At the same time, family environment also emerged as a factor linked to mental health problems and substance use issues amongst young people, which suggests that training/inclusion of caregivers was a missed opportunity. Additionally, unemployment was considered interlinked with mental health problems, substance use, gender-based violence, aggression, and criminality. This suggests the project could have benefited from the inclusion of a livelihoods component that focused on skills building and job creation alongside improving MHPSS services.

> *"We start with the family because it is the basics, and the person needs to think about the health of their family before the community. I advise everyone to listen to each other because when I start talking if someone says keep silent, you're nothing, I'll think why the person is saying this. Being mentally ill starts from there, so I started with my family"* - ***CHW, Kismayo***

Community stakeholders consulted for this evaluation voiced the need for: (a) improvement in the provision of clinical services; (b) greater awareness and mobilization activities; (c) buy-in from the wider community during the initial stages of the project; and (d) continuation of the project over a much longer duration (5-6 years was suggested as the minimum). The short period of intervention rollout was considered insufficient to train enough health and community workers to meet the vast mental health needs of their communities and/or transform deep seated beliefs and attitudes about mental health problems. Also, consultations with the community stakeholders and a review of the supervision reports revealed that medications were not consistently available across the project sites.

Supervision reports from Dolow and Kismayo record absence of medication at health centres and interviews with health workers across centres also highlighted challenges of access to medication and health centres.

> *"Personally, I do not give them anything, and it's because at this health center, we do not have any treatment options or medication to treat patients with mental illness. I see that there are counselling services which are given to patients, but they are below standard as there is no medication to accompany them."* - ***Health worker, Dolow***
>
> *"The project is now only about awareness. The other services such as health centres, treatment, and care centres are still missing. The community does not only need awareness, it needs action. Awareness alone won't be sufficient for a person who is ill"* – ***Community leader, Kismayo***

Aside from the previously discussed challenges of working within communities with deeply entrenched stigma about mental health problems, there were also other practical issues faced by community stakeholders implementing the project, such as the inaccessibility of transportation to travel to the implementation sites or transfer of patients from their homes to the health center. Some CHWs reported that the remuneration provided under the project was insufficient in view of the challenges involved in implementing the project. CHWs in Kismayo felt that the training was not easy to access as the training center was far from their location, transportation was unavailable, and water logging due to rain restricted access via some roads. Health workers in Dolow expressed challenges of treating patients with severe mental health problems alongside others and stressed the need for calm and private spaces.

> *"The places were going to were distant and transportation was difficult. Also, the time was short, and the needs were vast."* - ***Health worker, Kismayo***
>
> *"The challenge is how to transport the patient to the mental health center. We should either have money for transport or a motorcycle, but we don't have either. Some of the patients ask you to pay their transport fees. There is no hospital car that brings the patient to the health center and if you do not pay, they refuse to go. As a health worker, you cannot just leave them in that situation, it is hard."* - ***CHW, Baidoa***

How appropriate and clear was the project's targeting strategy in terms of geographic and beneficiary targeting?

A review of the project documents revealed that the selection of priority areas for the project was based on multiple factors including the size of the IDP population; number and density of IDP settlements and communities; political context; conflict dynamics and severity; and relative accessibility and security of towns. The selected sites were also known to be severely affected by droughts and the pre-famine circumstances prevalent in Somalia at the time of project planning. Although it is unclear if the selected sites had the highest levels of unaddressed MHPSS and

peacebuilding needs across Somalia, IOM's needs assessment highlighted many challenging circumstances and experiences of people living in the selected IDP sites. Consultations with the community stakeholders in the selected project sites corroborated the high need for MHPSS services in their communities, but they were also indications that the project's geographical coverage was insufficient. This was particularly true in Kismayo, where the project was seen to primarily serve urban communities with the rural communities largely left out. This is probably because all 5 health facilities in Kismayo (where the project was implemented) were in the city, and consultations with health and community workers revealed accessibility challenges and lack of transportation. On the other hand, in Dolow, 5 health facilities in Dolow were in IDP sites; and in Baidoa, one health facility was in the IDP settlements, with others in the city.

> *"Kismayo has villages which also have youth. These villages should be reached as well so that the program is not limited only to cities." -* ***Youth leader, Kismayo***

The project was designed to focus on youth, who form half of Somalia's population[45] and can play a crucial role in the country's recovery. It recognized the marginalization and disenfranchisement of youth as a key driver of conflict. Conflict analysis conducted prior to project conceptualization found that mass disruption and displacement have damaged the social capital of Somalia's young people. Decades of civil war, conflict and displacement have compromised the participation of youth in the political process, reduced access to education and livelihood opportunities, and heightened vulnerability to violence, substance abuse, disempowerment, and exclusion from governance and peacebuilding processes.(24) Also, culturally, decision making in Somalia tends to rest with clan elders, leading to disfranchisement and marginalization amongst youth.(24)

In the context of deprivation and unrelenting and overlapping stressors, some of the youth consulted during IOM's needs assessment expressed feeling high levels of pressure to be the principal source of support both within their families and communities. Young men articulated feelings of overwhelm emerging from the high pressures of expectations from men to provide support to their families and communities, whilst navigating their own challenges. The pressures on youth are complicated by the fact that as soon as boy reaches adolescence (10 to 12 years of age), he is expected to take on the responsibilities of an adult man.

IOM's needs assessment also found that the many challenges that pervade life in Somalia, combined with the lack of appropriate and effective mental health and psychosocial support, force young people to rely on harmful coping strategies such as self-medication and substance abuse, which can worsen mental health, reinforce stigma and discrimination from the community, and increase their disenfranchisement and alienation. Youth can be appropriately involved and empowered as

[45] According to the 2014 Population Estimate Survey for Somalia (PESS), about half of the country comprises adolescents and youth (50.8%). PESS defined adolescents and youth as individuals who were 10-35 years of age. The definition of youth can vary across societies. Some societies use biological markers to define youth (e.g., period between puberty and parenthood), while other may use cultural or religious markers. The UN considers individuals between 15-24 years of age as youth. The National Youth Policy of the Federal Government of Somalia refers to people between 15 to 40 years as youth.

changemakers within their communities, as they are widely acknowledged in the selected IDP sites as the "backbone" and the most productive members of the community. It was found that they tend to regularly organize in groups to mobilize support and are uniquely positioned to offer help on account of attributes – such as high physical ability, energy, and access to opportunities (e.g., education) – that others in the community might not be able to match. Youth themselves are keen to support Somalia's journey towards sustainability, a learning that has emerged clearly from a recent study on youth and peacebuilding that was conducted jointly by the UN and World Bank Group.(11)

How well did the project collect and use data to inform programming and monitor results? (Use of responsive M&E practices/systems)

A review of the project documents suggested that implementation challenges discussed in the previous section compromised the establishment of a responsive monitoring system. At the time of planning, it was decided that all three implementing UN agencies will utilize the monitoring and evaluation plan to collect data throughout the project and produce regular reports to monitor progress.[46] Although the plan at the proposal stage included monthly updates and reporting from each implementing UN agency as per the M&E plan, the M&E framework was not finalized until February 2021, 6 months before the end of the extended deadline.[47]

Consultations with key informants and health workers involved in the evaluation revealed that during the implementation period, there was routine collection of data at health facilities. Although there was no indication that this data was used to tailor the project in a significant way, the consultation with a key informant from WHO revealed that it was instrumental in securing missing medical supplies at health facilities.

> *"There was plenty of data collected in terms of the prevalence of mental health problems, the treatments that were given. We were constantly using this data to make sure that the project was on course. The clinical data was used to inform the MoH about the medications that are required in the field. We didn't change the course of the project because of the data, but we made minor adjustments like procuring medical supplies to support the rolling out of medical services for mental health." -* ***Key informant, WHO***
>
> *"There was data that was collected from us, but we haven't seen any change or improvement that it has made to the project." -* ***Health worker, Dolow***

8.4. Impact

What are the perceived impacts of the project? To what extent did the project generate or is expected to generate significant positive or negative, intended, or unintended, higher-level peacebuilding results by addressing key drivers of conflict? To what extent does it support the theory of change?

[46] Source: Minutes of the steering committee meeting on 29th May 2020.

[47] Source: Minutes of the steering committee meeting on 8th February 2021.

Consultations with community stakeholders implementing the project revealed that the project likely had some positive impacts for some individuals, but community-wide impacts were limited. Community stakeholders directly involved in the project implementation (including youth) reported experiencing a heightened sense of purpose, improved confidence in engaging with other community members, and improved social esteem, credibility, and influence within their communities. Consultations with key informants suggested that the project indirectly contributed to an increased focus on MHPSS in Somalia. Specifically, with support from WHO, the MoH in Somalia revised it's the essential package for health services (EPHS) to ensure that mental health services are included in the basic health package available at the primary health facilities. MHPSS was also prioritized in the government's National Contingency Plan for Preparedness and Response to COVID-19 and the joint UN Somalia Country Preparedness and Response Plan for COVID-19. It also indirectly contributed to the implementation of guidelines released on COVID-19 by international organizations, including WHO Emergency Response Plan for COVID-19 in Somalia, Inter-agency Standing Committee (IASC) guidelines on Operational Considerations for Multisectoral Mental Health and Psychosocial Support Programmes During the COVID-19 Pandemic. In addition, key informants believed that the project improved the understanding of mental health in Somalia amongst donors and implementation partners, which can have cascading impact for future programming in Somalia.

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*"We understood from this project that mental health services need to be integrated into primary health services and they cannot stand on their own. The project showed us that mental health should be a part of every response."- **Key informant, MoH***

*"The training boosted my confidence and made me proud as I am someone who works for their community in the field of mental health. I always get the attention of people as they have not heard of someone working in mental health." - **CHW, Kismayo***

*"I got to know how to give advice to people, how to interview them, and I can proudly say that I benefited a lot. But, on the other hand, the project did not achieve much at the community level because of its short duration and the limited number of people trained under the project." - **Youth leader, Kismayo***

*"This project has benefited us more than it has benefited the youth." - **Health worker, Baidoa***

By engaging with the communities and establishing referral pathways, the project built some momentum for identification of cases and support seeking in the selected IDP sites. It also seems to have created greater sensitization and dialogue about the challenges faced by people with mental health problems, with some reports of less stigma and discrimination faced by those with mental health problems. Encouragingly, there were also some instances of improvement in mental well-being and reduction/prevention of substance use. On the other hand, there were also instances where the support offered by the project was considered insufficient.

"I do not see what it has contributed to youth. Due to unemployment, youth become mentally ill. It is easy to become mentally ill as there are droughts and wars going on. They are using drugs and the project did not change this much. If more jobs were created, then youth would have been too busy to use drugs. The drugs that they were using have become more popular in the city, so I do not think there is a change." - ***Health worker, Dolow***

"People took our advice and included people with mental illness in the community by unchaining them, cutting their nails, bathing them, and doing other things." - ***Health workers, Dolow***

"This awareness program was much needed. Some patients were unchained when awareness reached their families, and they gained knowledge about how to care for mentally ill people. The project also increased the bond between the community." - ***Community leader, Dolow***

"Previously, mentally ill people were chained and imprisoned in their homes. They were not taken to health centres; they were treated with Quranic recitation. Now, they get Quranic recitation but are also taken to the health centre. Many people got well although there are still others who are not well. " - ***Youth leaders, Baidoa***

"I would say no because the project was only an awareness project, not a practical project which contributed something to these people. The truth is that the reality was not touched. It is not enough, it is necessary to create mental health centres for these people, and after their minds are calm, there should be job opportunities." - ***Youth leaders, Kismayo***

"The communities are more aware about the linkage between mental health and peace, and we get reports that people who were chained for 10 to 15 years were unchained and taken to the health facilities, but in terms of measuring metrics for peace, I am not sure we have data that have captured that aspect." - ***Key informant, WHO***

Results from the youth survey (survey with youth who received support from the project) suggest that most of the youth participating in the survey perceived[48] an increase in the availability of mental health support for youth in their community from the time before the project started to the time of evaluation (approximately a year after the project ended) (please refer to table 4 below). Majority of them also perceived an improvement in their own well-being or the well-being of others like them, except in Kismayo where less than half of the youth participating in the survey (40%) felt so. It is possible that the impact was weaker in Kismayo because all the health facilities where the project was

[48] Please note that because baseline data was not available for pre- and post-comparisons, the survey could record only "perceived" changes.

implemented were in the city and might have been hard to access (unlike Baidoa and Dolow where 1 and 5 facilities were in IDP settlements, respectively).[49].

Table 4: Perceived project-related changes in MHPSS and well-being (from the youth's perspective)

Statement	**Proportion of youth who strongly agreed or agreed - N(%)**			
	Overall	*Dolow*	*Baidoa*	*Kismayo*
The project improved the availability of mental health support for youth in my community.	57 (95)	20 (100)	20 (100)	17 (85)
The project led to an improvement in my well-being, or the well-being of others like me.	48 (80)	20 (100)	20 (100)	8 (40)

The survey results on the perceived changes in substance use and engagement in conflict by youth were less promising. 40% of youth felt that substance use by youth in their community increased from the time the project started to the time of evaluation (the proportions were higher in Baidoa and Kismayo, at 55% and 50%, respectively) (please refer to table 5 below). Also, many of the youth surveyed (43%) perceived an increase in the engagement of youth in conflict from the time before the project started to the time of evaluation (please refer to table 6 below).

When youth were asked about how they should be supported to reduce their engagement in conflict, half of them expressed the need for promoting youth employment (50%), and just under one-fifth of them (18%) chose mental health and psychosocial support. One-tenth of them (10%) chose education and over one-fifth of them (22%) believed that their exclusion from their family, community and society should be addressed. Consultations with the community stakeholders also suggested that the project's impact on substance use and conflict might have been limited because underlying issues and contextual factors relevant to mental health problems and substance use (for e.g., unemployment, accessibility of drugs, regulation for drug control, etc.) were not addressed by the project. Additionally, changes in the security and drought situation over the last two years might have also affected substance use and engagement in conflict by youth in the selected communities.

Table 5: Perceived changes in substance use amongst youth from the time before the project started to the time of evaluation (from the youth's perspective)

Compared to the time before the project started (March 2020), do you think there has been a change in the use of drugs/substances (e.g., khat, cigarettes, alcohol, cocaine, marijuana, tramadol, heroin, etc.) by youth in this community?	**Proportion of youth who agreed - N(%)**			
	Overall	*Dolow*	*Baidoa*	*Kismayo*
Yes, I think there has been an increase in the use of drugs/substances by youth in this community	24 (40)	3 (15)	11 (55)	10 (50)

[49] Note that because the sample for each centre was small (n = 20 for each centre) and participants were not selected randomly, these centre differences might not represent real differences between centres.

Yes, I think there has been a decrease in the use of drugs/substances by youth in this community	31 (52)	17 (85)	6 (30)	8 (40)
No, I think there has been no change in the use of drugs/substances by youth in this community	5 (8)	0 (0)	3 (15)	2 (10)

Table 6: Perceived changes in the engagement of youth in conflict from the time before the project started to the time of evaluation (from the youth's perspective)

Compared to the time before the project started (March 2020), do you think there has been a change in the engagement of youth (from this community) in conflict?	**Proportion of youth who agreed - N(%)**			
	Overall	*Dolow*	*Baidoa*	*Kismayo*
Yes, I think the engagement of youth in conflict has increased	26 (43)	4 (20)	13 (65)	9 (45)
Yes, I think the engagement of youth in conflict has decreased	32 (53)	15 (75)	6 (30)	11 (55)
No, I think there has been no change in the engagement of youth in conflict	2 (3)	1 (5)	1 (5)	0 (0)

Post the discontinuation of the project, awareness activities, counselling, and referral supports continued to some extent on a voluntary basis, but accessibility to medication and health centres reduced even further/completely stopped. Feedback received from community stakeholders working closely with the community suggests that the discontinuation of supports have made the community feel that promises made by community and health workers to their fellow community members were not kept. This issue needs to be addressed immediately as it can compromise social cohesion, mutual trust, and engagement with future projects.

"Yes, this project has caused us harm such as (from) seeing someone who is mentally ill and locked up. When you visit their home, they may throw things at you. Other thing is when you write down their case, the person expects to be given something. Later, when his family sees you in the streets, they will ask you why you have not done something for them."- ***CHW, Kismayo***

"The negative impact it had on me was the expectation that the community had of us and the short duration of the project. People always see us and ask for medications. When they see us, they are always expecting something from us."- ***Health worker, Kismayo***

"One of the harms was that people were saying where are the things that you have been given to deliver to us other than awareness and treatment? You are the ones that took what was given to us and now you're tiring us with this senseless talk. They said you only came here for a talk, and you took the rest."- ***Health worker, Dolow***

"When it was going very well and the community was working with us, the project ended. We are now hiding our faces from those parents because they are asking us where are the thieves? Why did you tell us a lie?" - ***CHW, Kismayo***

8.5. Sustainability and Ownership

Did the intervention design include appropriate sustainability and exit strategy (including promoting national/local ownership, use of national capacity, etc.) to support positive changes in peacebuilding after the end of the project?

A review of the project documentation and consultations with key informants revealed that, at the planning stage, a range of provisions and strategies were considered to sustain the supports initiated by the project beyond its termination. These included:

(a) integration of MHPSS into existing primary health care services by training existing health staff and community workers in the selected IDP settlements
(b) creation of opportunities and structures (i.e., MHPSS Resource Centres) for community engagement and mobilisation
(c) collaboration with MoH to ensure retention of trained staff and on-the-job training of other staff in the target sites
(d) integration of the MHPSS training modules developed under project with the relevant curricula at SNU so that future cadres of clinicians can be trained
(e) storing data from health facilities providing MHPSS services into a data repository at SNU that can serve as a source for analysis

MHPSS training was conducted with health and community workers in the primary health care settings in the selected IDP settlements, but access to health facilities varied depending upon their distance from those seeking support. MHPSS Resource Centres were furnished in all three project sites, but consultations with young people suggested that they might not have been in active and consistent use at the time of evaluation and/or during the project implementation. For instance, youth consulted in Dolow mentioned that in the absence of a designated and comfortable meeting place for peer counselling and mobilisation, the peer sessions were conducted in open spaces.

> *"They (youth leaders) used to come and do counselling for us. They welcomed us very well. Since we did not have a special meeting place, they used to educate and inform us under trees. The places where we used to meet were not good enough."* - ***Youth, Dolow***

Although it was envisaged that the extensive collaboration with MoH would facilitate training of additional health staff post the termination of the project, this had not materialised at the time of the evaluation. Consultations with key informants suggested that training was rolled out in a district called Hudur as a part of the exit strategy, but the total number of health and community workers trained under the project was still too low to effectively meet the vast mental health and psychosocial support needs in Somalia. The integration of the MHPSS modules developed during the project into the relevant training curricula at SNU was reported to be underway at the time of evaluation. On the other hand, there was no indication of ongoing data collection at SNU for continued assessment of mental health psychosocial needs in the target sites.

> *"The project timeline was short, and it was not sustainable. You will see that some villages have no nearby health centres. There are many needs that are not solved, and the project*

ended while the needs were still there. When the project ends, the number of people (seeking help) increases because someone who you have treated when the project was running would inform others to seek care. So, the demand increases but the project is no longer there." - ***Health worker, Baidoa***

"What I feel was a missed opportunity is that we did not establish a network hub of health workers. Such a network would have been a platform for knowledge exchange and would have allowed service delivery to continue even after the project ended" - ***Key informant, SNU***

To what extent are the project results likely to be sustained after the completion of this project?

At the time of this evaluation, 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. However, in the absence of any remuneration, such efforts were largely dependent on individual motivation/initiative and were challenging to scale up. Systematic and large-scale community-wide initiatives were not operational, but low-intensity community-level supports including counselling and referrals (where possible) seem to be operational across the project sites. Importantly, clinical services have been compromised across sites as medicines are largely unavailable and access to health facilities varies depending upon their distance from the villages of those seeking support.

Other challenges that seemed to have disrupted MHPSS services – particularly community level supports – include pandemic related restrictions, worsening economy, and worsening drought and starvation. Discontinuation or reduction of MHPSS services is likely to not only directly impact people experiencing mental health disorders, but they have evidently also led to some tensions between health & community workers and others in the community who expected supports to continue.

"What we disliked about the project was that when it was running very well and the community had started working with us, the project ended. We are now hiding our faces from those parents because they are asking us why did you tell us a lie? Where are the treatments and doctors, we were expecting from you? - ***Community health worker, Kismayo***

"Many people have been trained and continue to provide services even though the project has ended. There are some challenges like the absence of mental health centres in Dolow, another challenge is the lack of medication. Some people were expecting psychotropic medication at the health facilities, and they discouraged when they couldn't them. This could have a negative impact on the project's continuity." ***- Key informant, MoH***

"No, the project does not exist because people cannot afford hospital transport. They cannot even get food, forget about medicine and transport. We need to get the project started again, and I do not think it can work without government support." - ***Community leader, Baidoa***

"I don't have the capacity to take care of my sick nephew and he is in my home; I cannot give him anything other than food. We need programs that have the capacity to build houses for mentally ill people and take care of them there." - ***Community leader, Baidoa***

To what extent did the government, local authorities and the community's participation in the project foster increased commitment and ownership of the project results for sustainability beyond the project period?

The training provided under the project[50] seems to have been instrumental in building knowledge and confidence levels of health and community workers and enabling the continuation of low intensity supports. Although the survey of youth participants found that most of them (75%) either strongly agreed or agreed that "the support initiated during the project" was still ongoing, analysis from group discussions revealed that the supports that were continuing (low intensity psychosocial supports, case findings and referral) were considered insufficient to meet the needs of the community. Although the collaboration with the government and a national academic institution could have been a helpful route towards the project's sustainability, the project does not seem to have catalysed further investment from MoH and/or donors in capacity building. However, with support from WHO, the MoH in Somalia has revised its essential package for health services (EPHS) to include mental health services in the basic health package available at the primary health facilities.

"There are young people who used to come to us all the time and spend a lot of time with us. Now, it is not like before. They come 3 or 4 times a month and that is because they are working voluntarily." - ***Youth participant, Dolow***

"Yes, there are activities that are ongoing and being done by the Kismayo district youth council. We are volunteering to hold discussions related to drugs and their effect on society. As young people we organize for free and will continue to create awareness to educate the community about the effects of drugs and how to prevent their use." - ***Youth leader, Kismayo***

"The project has increased my confidence, but I cannot do anything on my own. Like Somalis say: a single hand cannot wash the entire face." - ***Youth leader, Baidoa***

8.6. Catalytic

Was the project financially and/or programmatically catalytic?

This project was envisaged as a pilot and catalytic project integrating MHPSS and peacebuilding components. At the planning and early implementation stages, measures taken to make the project financially/programmatically catalytic were:

[50] Both at the community and health facility level

(a) inclusion of a research study on the interlinkages between mental health and peacebuilding in Somalia to catalyze funding from other donors for project continuation
(b) project visibility throughout the project, with the view to potentially attract future donors (this included the launch of a project website in August 2021)
(c) proactively reaching out to donors for funding beyond the project
(d) contracting a consultant to conduct a situational analysis to inform the project proposal that can be used for fundraising

Key informants suggested that the project improved the understanding of mental health in Somalia amongst donors and implementation partners, which can have cascading impact for future programming in Somalia. Consultations with key informants and a review of the project documents suggested that the project catalyzed greater integration of mental health into WHO's work, with at least 3 project proposals in the pipeline that contain mental health activities. However, no new funding had materialized at the time of evaluation. A review of the project documents revealed that three donors were engaged to seek additional funding, but at the time of evaluation, there was no indication that these engagements led to any additional funding. This was attributed (in the final donor report) to limited funding available at the time due to the COVID-19 pandemic. A proposal was submitted in response to a PBF call in 2021, but it was not selected for funding.

> *"This was meant to be a catalytic project. There was a call for proposal in 2021, we submitted the proposal, but they selected several partners to implement another component that was not related to mental health and peacebuilding. So, as far as I am aware, there has been no additional funding from PBF to support more work on mental health and peacebuilding."* - ***Key informant, WHO***

> *"Apart from the MHPSS activities covered in this project, I don't have any other activities supported by PBF, but we hope that PBF will implement more projects to scale up peacebuilding as well as extend this project to contribute more to the community."* - ***Key informant, MoH***

8.7. Gender/Youth Responsiveness

Did the project consider the different challenges, opportunities, constraints and capacities of women, men, girls, and boys in the project design (including within the conflict analysis, outcome statements and results frameworks) and implementation?

The consequences of conflict and displacement vary for individuals depending upon their intersecting identities of gender, age, and clan membership, among other factors. In the deeply patriarchal Somalian society, women do not enjoy the same social, economic, and political rights as men, have reduced opportunities for education and employment, and can experience violations such as female genital mutilation, forced early marriages, and limited decision-making power related to child bearing.(39)

The civil war in Somalia imposed enormous costs on women by increasing their exposure to many forms of GBV,(16) but it also created circumstances that challenged traditional gender norms, as many men participating in the war lost their lives, became disabled, or were otherwise unable to provide for

their families because of widespread unemployment.(65) These changes enabled many women to become household heads and primary caretakers of their children and opened avenues for social, economic and political enterprise and activism.(65) As such, women were both victims of war as well as active agents fighting state collapse and shaping the societal response to conflict.(65) Similarly, men were not just perpetrators of violence and war in Somalia, but also its victims. In IOM's needs assessment, men expressed that they felt pressured to financially support and take responsibility for their families, and not doing so led to feelings of worthlessness and increased conflict between family members. Equally, women separated from their husbands because of displacement, violence, or divorce also struggled to singlehandedly take care of their children and provide the resources needed by their family.

The conflict analysis highlighted that traditional gender and societal norms, and practices exacerbate the psychosocial vulnerability of young people in Somalia. Accordingly, the project plan envisaged:

- gender-balance amongst health facilities staff trained and deployed in project activities,
- collection and analysis of all project data with gender disaggregation,
- 50% female representation in community health committees,
- emphasis on female and youth-led organizations in capacity building of institutions on mental health and peacebuilding

GBV survivors were listed as one of the "direct beneficiaries" in the proposal, with plans to provide support and appropriate referral linkages to the needed services (medical, legal, protection, shelter, and security) for male and female GBV survivors. The outcome statement emphasized youth friendly MHPSS, and IOM's psychosocial needs assessment included consultations with both female and male youth groups and key informants.[51]

Were the commitments made in the project proposal to gender-responsive peacebuilding realized throughout implementation?

Although USD 800,093 (approximately half of the total project budget) was allocated towards gender equality and women empowerment,[52] the actual amount used was USD 430,556.

However, the following commitments made at the project planning stage were realized during the project implementation:

[51] The needs assessment exercise from IOM included 14 qualitative individual interviews and 24 group discussions with participants aged over 18 years who were key informants, youth, and community stakeholders in all three sites. The groups included community members (men, women, elderly men, people with disabilities), community and religious leaders and key actors in the community including people working for the government, NGOs, CBOs dealing with youth-related activities, and school officials. Across the interviews and groups, a total of 107 females and 99 males participated.

[52] The project gender marker score was 2, which is for projects that have gender equality as a significant objective and allocate at least 30% of the total project budget to gender equality and women's empowerment. Score 3 and score 1 are for projects allocating at least 80% and less than 30% of the total project budget, respectively.

- Development of a module in the MHPSS curriculum for providing gender-sensitive and youth-oriented MHPSS
- Gender balance among project participants in ToTs and cascade trainings: 38 out of 80 trainees (20 ToTs and 60 cascade trainees) were female
- Gender balance in the social worker team mobilized to support peer to peer youth groups: 18 out of 42 of these social workers were female
- Gender balance in the people reached by radio broadcasts: over half (52%) of them were female
- Inclusion of a gender expert in the research team and disaggregation of data by gender
- Specific indicators for gender were included in the M&E framework
- Inclusion of 100% youth participants in youth groups with equal gender representation.

At the same time, there were challenges experienced in realizing some of the other commitments:

- IOM collaborated with its GBV partners in the selected implementation sites to support the inclusion of MHPSS services in GBV work. This included orientation and planning sessions with GBV actors (service providers and community stakeholders) on updating the existing referral pathways with MHPSS resources. However, few GBV cases were reported on account of fear of reporting GBV cases.
- A total of 97 team members were involved in the delivery of community based MHPSS services: this included 22 health workers out of which all were youth and 6 were female; 75 community health workers out of which 60 were youth and 21 were female. Out of all the people assisted through these services, 68% were youth.

Consultations with community stakeholders revealed that the female health workers, female CHWs, and female youth leaders directly involved in the project implementation experienced an increase in self-confidence in addressing the needs of their communities. There were also indications that their visibility and association with the project elevated their credibility, voice, and influence within their families and communities. Importantly, the project seems to have also served as a space for women to look closely at the stressors present within their own family and community environments along with the confidence to work on them through dialogue and cooperation.

> *"I got a lot of experience and motivation when I was working on this project. People looked for me and said where is that health worker woman? There is someone who is sick, take us to the hospital or give us a referral letter. I can say that my name became popular" -* ***Female CHW, Baidoa***
>
> *"This program has changed by thinking; I can now help young people in the neighborhood and assist them if they have a problem. This program has added to my experience of how to help someone who is in trouble."* ***- Female youth leader, Kismayo***

Another dimension of gender and youth responsiveness of the project was the use of community-level messaging to address the specific issues affecting young men and women in the community, such as, discrimination and stigma faced by young girls on account of pregnancies resulting from rape as well as substance use and self-harm/suicide that disproportionately affect the young people in the

community. There were a few mentions of increase in help seeking by GBV survivors because of the sensitization activities conducted under the project. However, this is unlikely to have happened at a large scale as project documents recorded low reporting of GBV cases to health facilities even towards the end of the project. During the consultations with community stakeholders, the lack of designated facilities/areas for the treatment of GBV survivors was mentioned as an issue that might be preventing uptake of health services.

The youth participant survey found that majority of the youth included in the survey either agreed or strongly agreed that the project had improved the availability of mental health support that was suitable for young girls and other vulnerable groups in their community (88% and 84%, respectively) (please refer to table 7 below). However, it is also important to acknowledge that the privileges and supports accessible to people result from a range of intersecting factors including not only age and gender, but also others like disability and homelessness -- factors that are particularly relevant to consider for interventions targeted at conflict-affected settings. The project did not explicitly partner with or address the specific concerns of young people with disability and young people experiencing homelessness. Concerns about exclusion of people with disability and homelessness were raised by both youth and community leaders consulted during this evaluation.

Table 7: Perceived project-related increase in the availability of mental health support suitable for young girls and other vulnerable young people in the community (from the youth's perspective)

Statement	**Proportion of youth who strongly agreed or agreed - N(%)**			
	Overall	*Dolow*	*Baidoa*	*Kismayo*
The project improved the availability of mental health support that was suitable for the unique challenges and needs of young girls in my community.	53 (88)	20 (100)	20 (100)	13 (65)
The project improved the availability of mental health support for other vulnerable young people in my community (e.g., youth who have experienced gender-based violence, youth with disability, and youth with severe mental illness).	50 (84)	20 (100)	20 (100)	10 (50)

"When you are doing awareness, you encounter many things that you were not expecting. You see a child who is mentally ill and unable to walk. We could not find a solution for this child as we could not support him with a walking aid like a wheelchair" - ***Health worker, Baidoa***

"Most of the people who have benefited from this program are the ones who are non-disabled. This is because the participation of disabled people was low as they could not come to health centres and could not receive counselling. It would have been good for those people to have taken part in the awareness (activities) and to have been helped with wheelchairs." ***- Youth leader, Dolow***

8.8. Risk Tolerance

Were the risks adequately monitored and mitigated?

Community stakeholders and key informants consulted during the evaluation did not report being aware of any systematic monitoring of risks and harms posed to people receiving the intervention. However, consultants for this evaluation revealed a range of harms that should have been monitored and mitigated. For instance, health workers recalled situations in which they anticipated possible harms posed to those receiving the support (i.e., distress caused by recall of disturbing events from the past), but there was no indication of systematic monitoring of such harms caused to the community through the project related engagements. There were also concerns related to the risks that those delivering MHPSS services might themselves be exposed to while engaging with the wider community or people with severe mental illness.

> *"Sometimes the people we worked for were sick, and when we visited them, they would recall something that had happened previously, which would aggravate their illness. As health workers, we would calm that person and change their mood."* **- Health worker from Kismayo**

> *"When you visit someone who is mentally ill, you can encounter many things like insults and physical harm."* **- Health worker from Kismayo**

Other sources of potential harm to the community were the research study and the possibility of an increased exposure to COVID-19 through the project activities. Consultations with key informants revealed that to minimize the risks that participation in the research can cause to the community, ethical approval was secured by the Somali National University Ethical Review Board. To safeguard against the risk of increased coronavirus transmission, key informants reported adherence to COVID-19 protocols during implementation of all project-related activities. To capture and incorporate community feedback into program implementation throughout the project cycle, the project plan envisaged the inclusion of mechanisms for Accountability to Affected Populations (AAP), such as phone hotline and written complaints boxes. However, these mechanisms were reportedly not established on account of disruptions related to COVID-19.[53]

> *"To minimize the risk of the pandemic to the young people, we followed the COVID-19 prevention measures during implementation of all the activities. Similarly, ethical consideration of research is always important, we strictly followed all ethical procedures, and the research tools were ethically approved."* - **Key informant, SNU**

8.9. Innovation

How novel or innovative was the project approach?

[53] Source: Email correspondence of the evaluation team with Dr. James Ndithia (WHO) on 31st May, 2022

Key informants consulted for this evaluation cited the project's integrative focus on MHPSS and peacebuilding as its most differentiating aspect. Other innovative aspects mentioned were the partnership amongst diverse stakeholders (including 3 UN agencies, federal and state MoH, and an academic partner in Somalia), engagement with youth, as well as inclusion of a research study one of the project components (on the interlinkages between MHPSS and peacebuilding in the Somalian context), with a view to plug the existing evidence gaps and catalyze funding for the continuation of the project.

> *"This was a pilot project to study the linkages between peacebuilding and mental health. So, it was a unique project in a way, and therefore it brought onboard all the stakeholders that we talked about. I know that there are agencies that work in the field of mental health, but not necessarily on peacebuilding. This was meant to be a pilot project and meant to lay the foundation for further programming for mental health. It is not usual that you find two or three UN agencies working on a particular field and engagement with government and youth as well."* - ***Key informant, WHO***

For many of the community stakeholders consulted during the evaluation, this was the first project in their community that focused on mental health and substance use problems amongst youth. Majority of the youth participants surveyed for this evaluation either agreed or strongly agreed (83%) that "the project was innovative in its approach towards mental health." The agreement was stronger in Dolow (100% participants strongly agreed) compared to Baidoa (25% strongly agreed and 40% agreed) and Kismayo (30% strongly agreed and 45% agreed). In FGDs, youth leaders from Kismayo, who reported a mental health project run by an NGO called GRT in partnership with the mental health department of Ministry of Health in Somalia. They also discussed a program run by an organization called *Kalsan*, which strives to bring different stakeholders together (including the police) to reduce substance use amongst youth.

Overall, from the perspective of the community stakeholders, innovative features of the project were the provision of on-the-job training for health workers, training on clinical management of mental illness with medication and counselling, focus on substance use problems amongst youth, extensive work at the community level, and engagement of a broad range of stakeholders (including community and religious leaders).

> *"The staff were trained for this project, and they were not based in a center, but they were doing household visits and going to the patients themselves. We were deeply connected with the community."* - ***Health worker, Kismayo***

> *"Many projects implemented in this area have not focused on mental health. This was the first project targeting those with mental illness, and we need it to be expanded."* - ***Health worker, Dolow***

> *"There are no other projects in which all parts of the community, such as clan elders, religious leaders, and others have participated, and they have been sponsored by NGOs or the government."* - ***Community leader, Kismayo***

"There is a project run by GRT agency in partnership with the MoH, especially in the mental health department. I have received training from it as well. It has stopped now, but it was going on for 7 months." - ***Youth leader, Kismayo***

8.10. Lessons Learned for Future Projects

Can lessons be drawn to inform similar approaches elsewhere?

Armed conflict not only destroys life, but also ways of life, social and cultural assets, and public institutions. They typically fester in contexts rife with social problems – such as poverty, unemployment, lack of education, gender violence – which are in turn made worse because of conflict. These problems not only exacerbate psychosocial impacts of armed conflict, but also have psychological ramifications of their own. This evaluation shows that even though health-based supports are helpful in promoting well-being to some extent, they cannot on their own reduce drivers of conflict such as substance abuse and lead to sustainable peace. Community stakeholders consulted during this evaluation underscored the need for holistic approaches that not only improve health based supports available to young people, but also address other needs/issues that are seen to drive substance use and mental health problems in youth (e.g., lack of livelihood opportunities), and engage all the relevant stakeholders (e.g., including pharmacists for preventing the sale of substances, advocating/engaging with governments to ensure lower supply of substances, etc.). Family environment was seen to play an important role in ensuring the well-being of young people of Somalia, and future work should consider directly engaging with caregivers for cultivating family environments that are amenable to the well-being of the young people in Somalia. GBV reporting at health facilities was low at the end of the project, even though many survivors need healthcare services. On this issue, it is important to work with the community in increasing help seeking in response to GBV, strengthen healthcare services available for GBV (including capacity strengthening for primary health centres for providing services such as CMR), build local capacities to promote GBV reporting and action, and create strong referral points.[54]

Feedback from community stakeholders showed that many in the communities sought support for their immediate needs (e.g., hunger) and upon the satisfaction of those needs, they might have been keener to engage with the project. Before the interventions are rolled out, it critical to secure the community buy-in on the project as well as set clear expectations about the supports available under the project, and the roles played by the different community stakeholders engaged in implementing the project. Also, awareness and sensitization efforts should not take the form of one-way knowledge transfer but should engage with communities in a dialogue about local understandings of the causes of mental health problems and local preferences and priorities for treating mental health problems. Importantly, sensitization work should be followed up with improved and continued accessibility to MHPSS services. Also, to ensure training and interventions are accessible and inclusive, additional measures should be considered based on the contextual challenges and needs, for e.g., access to transport to access hard to reach places and to transfer patients to health centres; access to assistive technology to facilitate inclusion of people with disabilities.

[54] Source: annexure to the final donor report

Post the termination of the project, low intensity psychosocial support has continued, but clinical services seem to have almost stopped and sustainability is an issue. To ensure the financial sustainability of the project, the final donor report underscored the need for securing longer term funding and the need for future projects to build on the work already done. In terms of lessons learned for smoother project implementation, consultations with key informants revealed that measures taken to prevent high staff turnover rate can be helpful in preventing implementation delays and discontinuity. Engaging teams of people rather than a single contact point at each implementing agency could help in offsetting the challenges associated with staff turnover in the middle of the project. For better collaboration between partnering agencies, the final donor report highlighted the need for more engaged teams, more regular meetings, stronger project management structure, and stricter deadlines. The collaboration with SNU was reported to be excellent, and future work in Somalia might benefit from engaging with SNU for trainings, workshops, mentorships, and field supervision at a large scale. MoH's leadership and ownership was believed to have strengthened over the course of the project, and this was partly attributed to the presence of a dedicated MHPSS focal point in the Ministry whose work was supported by incentives.

9. RECOMMENDATIONS

1. Invest in understanding how the selected communities conceptualize MHPSS services in times of extreme deprivation. Work alongside the community, youth leaders, and community leaders to adopt cross-cutting and multi-sectoral MHPSS services so that MHPSS is integrated and delivered with other services including WASH, nutrition, etc. Livelihood and education opportunities are particularly important for the well-being of youth and should be integrated with all MHPSS programming for youth in Somalia.
2. Engage in a dialogue with the selected communities to understand the local conceptualizations of mental health and the best ways to address stigma and discrimination against people experiencing mental health problems, substance use, and gender-based violence.
3. Strengthen healthcare services available for GBV, including MHPSS services, and train and supervise all healthcare staff in offering MHPSS to childhood survivors of GBV. Women's protection programming should integrate psychological interventions with trauma informed care, advocacy, and linkages with other services (on the lines of the Nguvu intervention, which was a psychosocial and protection intervention developed in Nyarugusu refugee camp in Tanzania for survivors of intimate partner violence).
4. Secure long-term funding to ensure that the supports promised under the project are available until institutional capacities and resources can be sufficiently built to ensure project sustainability. Continue and leverage on the existing partnerships with SNU and MoH to further strengthen Somalia's institutional capacities for promoting its youth's well-being.
5. Secure long-term funding that allows ongoing and supportive supervision for trained staff for addressing the challenges they face in extending MHPSS to their communities, in keeping with the integrated model for supervision for MHPSS.
6. In the project plan and budget, account for provisions that can make project interventions more accessible and inclusive, for e.g., provisioning for transport to and from health and community centers, provisioning for assistive technology to make the project more inclusive of people with disabilities, etc.

10. ANNEXURES

Annex A: Discussion guide – FGDs with Community Health Workers

Expected duration: approximately 1 hour

Protocol: Before starting, please ensure that all participants have consented to participate in the discussion. For face-to-face discussions, please do not proceed if the venue, or the way to the venue is not safe from physical dangers or otherwise unsuitable for open dialogue and sharing. If possible, allow a break of about 5 minutes after the first 30 minutes of discussion. Please prompt as required but never ask leading questions. As much as possible, please encourage everyone to participate in the discussion. Where it is observed that few individuals dominate the discussion, please note down why this might be happening. If possible, please use local expressions/idioms for terms such as mental illness, stress/distress, and gender-based violence. All notes to the facilitator are in *italics*.

Script: "My name is _____ and I work for _____ (organization). Thank you very much for taking the time to join this discussion. As you may be aware, recently a project on "improving psychosocial support and mental health care for youth" was implemented in this community by the WHO Country Office in Somalia and its partners including IOM, UNICEF, Somali National University and Ministry of Health. The project aimed to strengthen mental health support for youth in Somalia by improving access to mental health treatment within primary health centres, cultivating different forms of mental health supports within the community, and reducing stigma against youth with mental health problems. We want to understand your perceptions and experiences related to this project. We also want to understand the extent to which you, as community health workers, feel empowered with avenues to provide mental health support to youth and others in your community. There are no right or wrong answers to the questions that we ask, and everyone's perspective is important to us. The information that you provide to us would be collated in a report that will be used to learn if the project was successful in meeting its objectives and the areas in which it could have worked better. We will treat all the information that you share with us with utmost confidentiality and your name will not appear in any of our reports. The discussion will be recorded, and this is only so that we do not miss out on anything that you share with us. All data will only be utilized for the purpose of this project, will be stored without identifying you, and will not be passed on to anyone outside the project."

"Please note that you are free to withdraw your participation at any time by simply communicating your desire to leave without giving any explanations. If a question is uncomfortable to answer, you are free to remain silent. We expect the discussion to last for about an hour. I strongly encourage you to express yourself in ways that best represent how you think and not what you think we might want to hear. Before we proceed, I want to present some ground rules for the discussion and check if you are willing to go ahead with them: a) there are no right or wrong answers, you are welcome to both agree or disagree with each other in respectful ways, b) you are encouraged to not only interact with me, but also with each other, c) as much as possible, please try not to speak over each other and allow everyone time to participate in the discussion, d) you do not need to raise your hand if you wish to say something. At this point, do you have any questions? If not, do I have your permission to begin the discussion?" *Facilitator can begin the discussion if everyone in the group is okay to proceed.*

Questions:

1) Could you tell us what you like about your role as a community health worker?
2) Are you currently providing any support to youth or other people with mental health problems in your community? If yes, how? If no, what are the reasons? *Probe to understand support for youth*

with mental illness, youth who are stressed/distressed, youth who are using substances/drugs, and youth who have experienced gender-based violence.

3) Overall, what do you think about the project on "improving psychosocial support and mental health care for youth"? Please allow for spontaneous responses first, and then probe for both likes and dislikes/positive and negative experiences related to the project.
   a) If not already mentioned, probe to understand any challenges related to implementing the project at the community level
4) Did the project make any difference to the way in which youth and others with mental health problems in your community are supported? If yes, in what ways? If no, what are the reasons? *Probe for any impact on:*
   a) Identification of youth with mental health problems
   b) Access to basic psychosocial support within the community
   c) Availability of referral pathways
   d) Capacity building for health workers
5) What best describes the most significant change that has resulted from <u>your involvement</u> in this project? Why has this experience been significant for you? Please feel free to mention both positive and negative effects.
6) Has the project made any difference in your capacity and confidence to support youth in your community with mental health problems? If yes, how? If no, why not?
7) What has been your experience with the training that you received as a part of the project? *Probe for:*
   a) Any issues faced in accessing the training
   b) Any issues regarding the quality of training received
   c) Any issues regarding supervision/support after training ended
   d) Any other issues in applying the training in practice
8) Was the training <u>appropriate</u> to support the mental health needs of the youth in your community? Was it <u>sufficient</u>? Please explain.
9) *Probe for the suitability of training for vulnerable groups* (*e.g., females, youth who have experienced gender-based violence, youth with severe mental illness, youth with disabilities, children associated with armed forces and armed groups, etc.)*
10) Is there anything that can be done to better support youth in your community? What is that?
11) Did you feel that the project was duplicating work done by other actors in your area? If yes, why? If no, why?
12) Although projects are designed to support people, they can sometimes cause unintended harms and risks. Did you notice any unintended harm or risks that the project might have caused to youth that it was trying to support? What was it, and how was it addressed?
13) Imagine that the project is to be started again and you are completely in charge, what sort of activities would you include in the project for improving mental health, and reducing substance abuse and conflict in this community? Is there anything that you would do differently? What is that?

Thank you very much for your participation.

Annex B: Discussion guide – FGDs with Community Leaders

Expected duration: approximately 1 hour

Protocol: Before starting, please ensure that all participants have consented to participate in the discussion. For face-to-face discussions, please do not proceed if the venue, or the way to the venue is not safe from physical dangers or otherwise unsuitable for open dialogue and sharing. If possible, allow a break of about 5 minutes after the first 30 minutes of discussion. Prompt as required but never ask leading questions. As much as possible, please encourage everyone to participate in the discussion. Where it is observed that few individuals dominate the discussion, please note down why this might be happening. If possible, please use local expressions/idioms for terms such as mental illness, stress/distress, and gender-based violence. All notes to the facilitator are in *italics*.

Script: "My name is _____ and I work for _____ (organisation). Thank you very much for taking the time to join this discussion. As you may be aware, recently a project on "improving psychosocial support and mental health care for youth" was implemented in this community by the WHO Country Office in Somalia and its partners including IOM, UNICEF, Somali National University and Ministry of Health. The project aimed to strengthen mental health support for youth in Somalia by improving access to mental health treatment within primary health centres, cultivating different forms of mental health supports within the community, and reducing stigma against youth with mental health problems. We want to understand your perceptions and experiences related to this project. We also want to understand the extent to which you, as community health workers, feel empowered with avenues to provide mental health support to youth and others in your community. There are no right or wrong answers to the questions that we ask, and everyone's perspective is important to us. The information that you provide to us would be collated in a report that will be used to learn if the project was successful in meeting its objectives and the areas in which it could have worked better. We will treat all the information that you share with us with utmost confidentiality and your name will not appear in any of our reports. The discussion will be recorded, and this is only so that we do not miss out on anything that you share with us. All data will only be utilized for the purpose of this project, will be stored without identifying you, and will not be passed on to anyone outside the project."

"Please note that you are free to withdraw your participation at any time by simply communicating your desire to leave without giving any explanations. If a question is uncomfortable to answer, you are free to remain silent. We expect the discussion to last for about an hour. I strongly encourage you to express yourself in ways that best represent how you think and not what you think we might want to hear. Before we proceed, I want to present some ground rules for the discussion and check if you are willing to go ahead with them: a) there are no right or wrong answers, you are welcome to both agree or disagree with each other in respectful ways, b) you are encouraged to not only interact with me, but also with each other, c) as much as possible, please try to not speak over each other and allow everyone time to participate in the discussion, d) you do not need to raise your hand if you wish to say something. At this point, do you have any questions? If not, do I have your permission to begin the discussion?" *Facilitator can begin the discussion if everyone in the group is okay to proceed.*

Questions:

1. Could you tell us what you like about your work as a community leader?
2. Are you currently supporting youth and other people in your community experiencing mental health problems? If yes, in what way? *Probe to understand support for youth with mental illness, youth who are stressed/distressed, youth who are using substances/drugs, and youth who have experienced gender-based violence.*
3. Overall, what do you think about the project on "improving psychosocial support and mental health care for youth"? *(Please get spontaneous responses here without any probing. Also stress that there are*

no right or wrong answers and encourage the participants to feel free in expressing themselves.) If not already mentioned, please ask:

   a. Were there any challenges that you encountered while participating in the activities under the project?
   b. What do you think needs to be done better to more effectively support the mental health of youth in your community?

4. From your perspective, was the project suitable to address the mental health support needs of youth and others in your community? If yes, why? If no, why not?
5. Who do you think the project was most helpful for? Who do you think this project was least helpful for? Why? *Facilitator to probe to understand if there were any groups that were left out (e.g., females, youth who have experienced gender-based violence, youth with severe mental illness, youth with disabilities, children associated with armed forces and armed groups, etc.)*
6. Were you consulted at the different stages of this project? *Please allow spontaneous responses first and then probe:*
   a. When were you consulted? What was it like for you?
   b. Were both men and women consulted?
   c. Did you observe any changes to the project based on your feedback? What were these changes?
7. What best describes the most significant change that has resulted from your involvement in the project? Why has this experience been significant for you?
   Please feel free to mention both positive and negative effects. *Please probe:*
   a. Has the project improved the relationship of youth with their families, and other people in the community? *Check for improved trust, increased participation of youth in social activities, etc.*
   b. Do you think the project might have/has already had any impact on youth's well-being, involvement with violence, and involvement with substance abuse?
   c. Has this project made any difference in your capacity and confidence to support youth in your community with mental health problems? If yes, how? If no, why not?
8. Have there been any other projects in your community/camp that are similar to this project that we have been discussing? *If not, please proceed to Q10. Otherwise, please ask:* Were there any differences between this project and the other projects? If yes, what were the differences?
9. Are there any activities from the project that are still taking place in your community? If yes, what are they? If no, what are the reasons? Do you think they are likely to continue in future as well?
10. Imagine that the project is to be started again and you are completely in charge, what sort of activities would you include in the project for improving mental health, and reducing substance abuse and conflict in your community? Is there anything that you would do differently? What is that?

Thank you very much for your participation.

Annex C: Discussion guide – FGDs with Health Workers

Expected duration: approximately 1 hour

Protocol: Before starting, please ensure that all participants have consented to participate in the discussion. For face-to-face discussions, please do not proceed if the venue, or the way to the venue is not safe from physical dangers or otherwise unsuitable for open dialogue and sharing. If possible, allow a break of about 5 minutes after the first 30 minutes of discussion. Please prompt as required but never ask leading questions. As much as possible, please encourage everyone to participate in the discussion. Where it is observed that few individuals dominate the discussion, please note down why this might be happening. If possible, please use local expressions/idioms for terms such as mental illness, stress/distress, and gender-based violence. All notes to the facilitator are in *italics*.

Script: "My name is _____ and I work for _____ (organisation). Thank you very much for taking the time to join this discussion. As you may be aware, recently a project on "improving psychosocial support and mental health care for youth" was implemented in this community by the WHO Country Office in Somalia and its partners including IOM, UNICEF, Somali National University and Ministry of Health. The project aimed to strengthen mental health support for youth in Somalia by improving access to mental health treatment within primary health centres, cultivating different forms of mental health supports within the community, and reducing stigma against youth with mental health problems. We want to understand your perceptions and experiences related to this project. We also want to understand the extent to which you, as community health workers, feel empowered with avenues to provide mental health support to youth and others in your community. There are no right or wrong answers to the questions that we ask, and everyone's perspective is important to us. The information that you provide to us would be collated in a report that will be used to learn if the project was successful in meeting its objectives and the areas in which it could have worked better. We will treat all the information that you share with us with utmost confidentiality and your name will not appear in any of our reports. The discussion will be recorded, and this is only so that we do not miss out on anything that you share with us. All data will only be utilized for the purpose of this project, will be stored without identifying you, and will not be passed on to anyone outside the project."

"Please note that you are free to withdraw your participation at any time by simply communicating your desire to leave without giving any explanations. If a question is uncomfortable to answer, you are free to remain silent. We expect the discussion to last for about an hour. I strongly encourage you to express yourself in ways that best represent how you think and not what you think we might want to hear. Before we proceed, I want to present some ground rules for the discussion and check if you are willing to go ahead with them: a) there are no right or wrong answers, you are welcome to both agree or disagree with each other in respectful ways, b) you are encouraged to not only interact with me, but also with each other, c) as much as possible, please try to not speak over each other and allow everyone time to participate in the discussion, d) you do not need to raise your hand if you wish to say something. At this point, do you have any questions? If not, do I have your permission to begin the discussion?" *Facilitator can begin the discussion if everyone in the group is okay to proceed.*

Questions:

1. Could you tell us what you like about your role as a health worker?
2. Are you currently providing any support to youth and others with mental health problems in your health facility/community? If yes, how? If no, what are the reasons? *Probe to understand support for youth with mental illness, youth who are stressed/distressed, youth who are using substances/drugs, and youth who have experienced gender-based violence.*
3. Overall, what do you think about the project on "improving psychosocial support and mental health care for youth"? *If not already mentioned, ask:*
    a. What did you like about the project? What did you dislike?
    b. Do you think that this project was innovative?
    c. Were there any challenges in Implementation? Were COVID-19-related disruptions handled well?
    d. Was the selection of target sites and participants appropriate?
4. Do you think that the training you received as a part of project was <u>appropriate</u> and <u>sufficient</u> for supporting the needs of the youth in your health facility/community? If yes, why? If no, why not?

    a. Was the training appropriate and sufficient to provide support to vulnerable groups (e.g., females, youth who have experienced gender-based violence, youth with severe mental illness, youth with disabilities, children associated with armed forces and armed groups, etc.)?
    b. *If it was not considered suitable/helpful, ask:* What could have been done better to help you support youth in your health facility/community?
5. Did you face any challenges in receiving or applying the training that was provided to you under the project? *Allow spontaneous response, and if not already mentioned, ask:*
    a. Were they any issues faced in accessing the training?
    b. Were there any issues regarding the quality of training received?
    c. Are there any time or resource constraints because of which you are not able to support youth and others with mental health problems?
6. Did you feel that the project was duplicating work done by other actors in your area? If yes, how?
7. Were you consulted at the different stages of this project? *Please allow spontaneous responses first and then probe:*
    a. When were you consulted? What was it like for you?
    b. Were both men and women consulted?
    c. Did you observe any changes to the project based on your feedback? What were these changes?
8. What best describes the most significant change that has resulted from <u>your involvement</u> in the project? Why has this experience been significant for you? Please feel free to mention both positive and negative effects.
    a. *If not already mentioned, then ask:* Has this project made any difference in your capacity and confidence to support youth in your health facility/community with mental health problems? If yes, how? If no, why not?
    b. Did the project make any difference to the way in which youth with mental health problems in your community are supported? If yes, in what ways? If no, what are the reasons? *Probe for any impact on:*
        i. *Identification of youth with mental health problems*
        ii. *Access to basic psychosocial support*
        iii. *Availability of referral pathways*
        iv. *Capacity building of health workers*
9. Are you aware of any data collected in your area to monitor the progress of the project? Were there any changes/adaptations made to the project based on this data? If yes, what were they and were they useful?
10. Although projects are designed to support people, they can sometimes cause unintended harms and risks. Was there anything done to monitor if the project is posing any kind of harm/risk to the young people receiving support? If yes, what was it and was it helpful?
11. Imagine that the project is to be started again and you are completely in charge, what sort of activities would you include in the project for improving mental health, and reducing substance abuse and conflict in this community? Is there anything that you would do differently? What is that?

Thank you very much for your participation.

Annex D: Discussion guide – FGDs with Youth Leaders

Expected duration: approximately 1 hour

Protocol: Before starting, please ensure that all the participants have consented to participate in the discussion. For face-to-face discussions, please do not proceed if the venue, or the way to the venue is not safe from physical dangers or otherwise unsuitable for open dialogue and sharing. If possible,

allow a break of about 5 minutes after the first 30 minutes of discussion. Prompt as required but never ask leading questions. As much as possible, please encourage everyone to participate in the discussion. Where it is observed that few individuals dominate the discussion, please note down why this might be happening. If possible, please use local expressions/idioms for terms such as mental illness, stress/distress, and gender-based violence. All notes to the facilitator are in *italics*.

Script: "My name is _____ and I work for _____ (organisation). Thank you very much for taking the time to join this discussion. As you may be aware, recently a project on "improving psychosocial support and mental health care for youth" was implemented in this community by the WHO Country Office in Somalia and its partners including IOM, UNICEF, Somali National University and Ministry of Health. The project aimed to strengthen mental health support for youth in Somalia by improving access to mental health treatment within primary health centres, cultivating different forms of mental health supports within the community, and reducing stigma against youth with mental health problems. We want to understand your perceptions and experiences related to this project. We also want to understand the extent to which you, as community health workers, feel empowered with avenues to provide mental health support to youth and others in your community. There are no right or wrong answers to the questions that we ask, and everyone's perspective is important to us. The information that you provide to us would be collated in a report that will be used to learn if the project was successful in meeting its objectives and the areas in which it could have worked better. We will treat all the information that you share with us with utmost confidentiality and your name will not appear in any of our reports. The discussion will be recorded, and this is only so that we do not miss out on anything that you share with us. All data will only be utilized for the purpose of this project, will be stored without identifying you, and will not be passed on to anyone outside the project."

"Please note that you are free to withdraw your participation at any time by simply communicating your desire to leave without giving any explanations. If a question is uncomfortable to answer, you are free to remain silent. We expect the discussion to last for about an hour. I strongly encourage you to express yourself in ways that best represent how you think and not what you think we might want to hear. Before we proceed, I want to present some ground rules for the discussion and check if you are willing to go ahead with them: a) there are no right or wrong answers, you are welcome to both agree or disagree with each other in respectful ways, b) you are encouraged to not only interact with me, but also with each other, c) as much as possible, please try to not speak over each other and allow everyone time to participate in the discussion, d) you do not need to raise your hand if you wish to say something. At this point, do you have any questions? If not, do I have your permission to begin the discussion?" *Facilitator can begin the discussion if everyone in the group is okay to proceed.*

Questions:

1. There are times when people become emotionally upset or distressed and they may even find it difficult to function properly. If a young person in your community is experiencing distress and/or a mental illness, where could he/she go for support? How do you think he/she would be supported there?
    a. *If not already mentioned:* Is this support sufficient? If no, what is missing?
2. In general, what are some of the things that youth in this community do to cope with their mental health problems? *If not mentioned, probe about the use of drugs/substance abuse and violence/aggression.*
3. Overall, what do you think about the project on "improving psychosocial support and mental health care for youth"? *(Ensure spontaneous responses first without any leading questions. Also stress that there are no right or wrong answers and encourage them to feel free in expressing themselves. Please probe what they liked and disliked about the project.)*

4. Who do you think this project was most helpful for? Who do you think this project was least helpful for? Why? *Facilitator to probe to understand if there were any groups that were left out (e.g., females, youth who have experienced gender-based violence, youth using drugs/substances, youth with severe mental illness, youth with disabilities, children associated with armed forces and armed groups, etc.)*
5. Was the training that you received during the project suitable to support the mental health needs of your peers? Why? *Probe to also understand if the training was suitable for vulnerable groups listed in the previous question.*
6. Were you consulted at the different stages of this project? *Please allow spontaneous responses first and then probe:*
    a. At which stages were you consulted? What was your experience like?
    b. Were both males and females consulted?
    c. Did you observe any changes to the project based on your feedback? What were these changes?
7. Overall, has this project affected or changed your life or the lives of those around you in any way? Please feel free to mention both positive and negative changes. *If not already mentioned, please probe for perceived changes in:*
    a. awareness levels and stigma surrounding mental health problems
    b. mental health and well-being of peers
    c. making youth feel more empowered
    d. making youth feel like a part of their family and community
    e. support available to vulnerable groups, include females, youth who have experienced gender-based violence, etc.
    f. changes in behaviours discussed earlier that young people might use to cope with their mental health problems, including substance abuse, violence/conflict
8. From your experience, what best describes the most significant change that has resulted from <u>your involvement</u> in the project? Why has this experience been significant for you? *If not already mentioned, please probe:*
    a. Has the project made any difference to your capacity to provide support to your peers with mental health problems?
9. Are there any activities from the project that are still taking place in your community? If yes, what are they? If no, what are the reasons? Do you think they are likely to continue in future as well?
10. Have there been any other projects in your community/camp that are similar to this project that we have been discussing? *If not, please proceed to Q11. Otherwise, please ask:* Were there any differences between this project and the other projects? If yes, what were the differences?
11. Did you notice any changes in the project because of the pandemic? Is there anything that could have been done differently?
12. Imagine that the project is to be started again and you are completely in charge, what sort of activities would you include in the project for improving mental health, and reducing substance abuse and conflict in your community? Is there anything that you would do differently? What is that?

Thank you very much for your participation.

Annex E: Discussion guide – KIIs

Expected duration: approximately 1 hour

Protocol: This is a general guide for KIIs with key management/technical leadership and partners on the project (i.e., WHO, IOM, UNICEF, SNU, researchers, MOH, UN Peacebuilding Fund, and the steering committee members). Please ensure that questions asked during the interview are informed by the profile and role of each interviewee. Please do not use the long list of questions provided below, but instead refer to the shorter list of questions adapted for each interviewee. Although it is ideal to record

the interviews (video recording where possible), in the unlikely event that recording is not feasible, please ensure the presence of a notetaker in addition to the facilitator.

Script: "Thank you for very much for taking the time to join this discussion. My name is _____, and I am a part of an independent evaluation team for the project implemented by the WHO Country Office in Somalia and partner organisations on "improving psychosocial support and mental health care for youth" in Somalia. The evaluation is being conducted by the Somali Institute for Health Research and the MHPSS Collaborative, which is a global research and advocacy organisation hosted by Save the Children Denmark. The purpose of this discussion is to understand your perspectives about the project from the standpoint of the unique role that you played within the project. As you are likely aware, the information that you provide to us would be collated in a report that will be used to learn how the project performed and how similar projects can be improved in future. We will treat all the information that you share with us with utmost confidentiality, and your name will not appear in any of our reports. The discussion will be recorded, and this is only so that we do not miss out on anything that you share with us today. All the data will only be utilized for the purpose of this project, will be stored without identifying you, and will not be passed on to anyone outside the project. I expect the discussion to last for about an hour. At this point, do you have any questions for me? If not, do I have your permission to proceed with the interview?" *Facilitator can begin the interview if the interviewee is okay to proceed.*

Questions

Introduction and context setting:

1. Could you please tell me a bit about your involvement and role in the project on "improving psychosocial support and mental health care for youth"?

Overall strategy and coordination:

2. How were the project target sites and participants selected? How did you know that the adopted project approach will be appropriate for the targeted sites in Somalia?
3. How did the project integrate peacebuilding components with MHPSS?
4. Are you aware of any other projects involving MHPSS work in peacebuilding contexts? If yes, how is this project similar or different from them? How novel or innovative was this project?
5. How did the project ensure coordination and alignment with the different entities operating in the target locations, including other UN actors, private institutions, government institutions where applicable, and other Peace Building Fund projects? Were there any measures taken to complement and not duplicate other work? What were they and were they effective?
6. Has PBF funding been used to scale-up other peacebuilding work and/or has it helped to create broader platforms for peacebuilding?

Engagement with stakeholders, relevance, and inclusivity

7. How was it ensured that the project is relevant to the needs and priorities of the communities in the target locations?
8. How were youth from the target communities involved in the planning and implementation of the project? *If not already mentioned, probe for:*
    a. Stages of involvement (planning, implementation)
    b. Type of input invited
    c. Composition of the youth group, based on age, gender and any other diversity considerations (individuals with mental health problems, individuals with disabilities, individuals who have experienced GBV, etc.)

    d. Key learnings from this exercise
9. How were other stakeholders (such as health workers, private institutions providing services, government institutions where applicable, national university, community leaders, etc.) involved through the course of the project?
    a. Stages of involvement (planning, implementation)
    b. Type of input invited
    c. Key learnings from this exercise
10. Given that the challenges and constraints faced by girls/women differ, were there any measures introduced to ensure that the project can support girls/women equally effectively?
11. What about other vulnerable groups such as youth who have experienced gender-based violence, youth with disabilities, youth with severe mental illness, children associated with armed forces and armed groups?

Implementation

12. In terms of implementation, what went well? What were the reasons for this?
13. What do you think were the main implementation challenges, and how were they handled?
    a. *If not already mentioned probe to understand the pandemic-related adaptations and their success*
14. Overall, how successfully did the project adhere to the timeline? What contributed to this?
15. Are you aware of any data collected to monitor the progress of the project? Were there any changes/adaptations made to the project based on this data? If yes, what were they and were they useful?
16. Although projects are designed to support people, they can sometimes cause unintended harms and risks. Was there anything done to monitor if the project is posing any kind of harm/risk to the young people receiving support? If yes, what was it and was it helpful?

Impact and sustainability

17. According to you, what were the main objectives of the project? Do you think the project was effective in meeting these objectives? Why? Why not?
18. What do you expect has been/will be overall impact of the project? *Probe for:*
    a. Positive and negative impacts
    b. Intended and unintended impacts
    c. Impact on peacebuilding
19. What was the exit strategy of the project? Do you think it was appropriate? To what extent do you think it is likely to be successful in ensuring sustainability? Why/why not?
    a. *If not already mentioned, please probe:* Do you think the participation of government, local authorities, a national university, etc. will make the project more sustainable? In what ways?
    b. Are there any additional measures being taken to ensure the project's sustainability?

Lessons learned

20. What were the key lessons learned from this project to inform similar projects elsewhere?
21. If the project runs again, what are the things that you would do differently?

Thank you very much for your participation.

Annex E: Survey with youth participants

Protocol: Before starting the interview, please ensure that the interviewee has consented to participate. For face-to-face interviews, please do not proceed if the venue (or the way to the venue)

where the interview is being held is not safe from physical dangers or otherwise unsuitable for open dialogue and sharing.

Project centre: _____

IDP camp/settlement: _____

Name of the interviewer: _____

Date: _____

Time: _____

Script: "Thank you for very much for taking the time to join me for this interview. As you may be aware, recently a project on "improving psychosocial support and mental health care for youth" was implemented in this community from March 2020 to August 2021. This project was implemented by the WHO Country Office in Somalia and its partners including IOM, UNICEF, Somali National University, and Ministry of Health. It aimed to strengthen mental health support for youth in Somalia by improving access to mental health treatment within primary health centres, cultivating different forms of mental health supports within the community, and reducing stigma against youth with mental health problems. In this survey, we are talking to youth to understand their perceptions and experiences related to the project, their experiences with conflict, substance abuse, and the extent to which they feel supported by their families and community. The information that you provide to us would be collated in a report that will be used to learn if and how the project was successful in meeting its objectives. Importantly, we want to learn how future projects/work with your community can be improved. We will treat all the information that you share with us with utmost confidentiality and your name will not appear in any of our reports. All the data would only be utilized for the purpose of this project, will be stored without identifying you, and will not be passed on to anyone outside the project."

"Please note that you are free to withdraw your participation at any time by simply communicating your desire to leave without giving any explanations. If a question is uncomfortable to answer, you are free to remain silent. We expect the interview to last for about 30 minutes. At this point, do you have any questions? If not, do I have your permission to begin the interview?" *Interviewer can begin the interview if the interviewee is comfortable to proceed.*

Demographics

1. What is your age?
   a. Less than 15 years [ ]
   b. 15 - 16 years [ ]
   c. 17 - 18 years [ ]
   d. 19 - 20 years [ ]
   e. 21 - 22 years [ ]
   f. 23 - 24 years [ ]
   g. Above 24 years [ ]

2. What is your preferred gender identity?
   a. Male [ ]
   b. Female [ ]
   c. Other/not mentioned above [ ]
   d. Prefer not to say [ ]

3. What is your highest level of education?
   a. No education [ ]
   b. Koranic school/Madrassa [ ]
   c. Preschool [ ]
   d. Primary school [ ]
   e. Secondary school [ ]
   f. Tertiary school [ ]
   g. Prefer not to say [ ]
   h. Not listed above, please mention [ ] _____

4. How long have you lived in this IDP camp/settlement?
   a. Less than 6 months [ ]
   b. 6 months to 1 year [ ]
   c. 2 to 3 years [ ]
   d. 4 to 5 years [ ]
   e. More than 5 years [ ]
   f. Prefer not to say [ ]

Family and Community Support

5a. Compared to the time before the project started (March 2020), do you think the level of support available to you from your family (e.g., in your day-to-day life, education or career) has changed in any way?

   a. Yes, support from my family has increased [ ]
   b. Yes, support from my family has decreased [ ]
   c. No, the support from my family has stayed the same as before [ ]

5b. <u>TO BE ASKED ONLY IF a. OR b. HAVE BEEN SELECTED IN Q5a:</u> In what ways has the support from your family increased or decreased (compared to the time before the project started)?

_____

_____

_____

6a. Compared to the time before the project started (March 2020), do you think the level of support available to you from your community (e.g., in your day-to-day life, education or career) has changed in any way? (*Community includes those outside your immediate family such as distant relatives, neighbours, community leaders, religious leaders, friends, etc.*)

   a. Yes, support from my community has increased [ ]
   b. Yes, support from my community has decreased [ ]
   c. No, support from my community has stayed the same as before [ ]

6b. TO BE ASKED ONLY IF a. OR b. HAVE BEEN SELECTED IN Q6a: In what ways has the support from your community increased or decreased (compared to the time before the project started)?

_____

_____

_____

7. Compared to the time before the project started (March 2020), has your sense of belonging to your family changed in any way?

a. Yes, my sense of belonging to my family has increased [ ]
b. Yes, my sense of belonging to my family has decreased [ ]
c. No, there is no change in my sense of belonging to my family [ ]

8. Compared to the time before the project started (March 2020), has your sense of belonging to your community changed in any way?

a. Yes, my sense of belonging to my community has increased [ ]
b. Yes, my sense of belonging to my community has decreased [ ]
c. No, there is no change in my sense of belonging to my community [ ]

9. Compared to the time before the project started (March 2020), has your participation in community-level activities (e.g., community meetings, activities aimed at promoting peace, discussions with community elders, etc.) changed in any way?

a. Yes, my participation in community-level activities has increased [ ]
b. Yes, my participation in community-level activities has decreased [ ]
c. No, there has been no change in my participation in community-level activities [ ]

Conflict

10. Compared to the time before the project started (March 2020), do you think there has been any change in the engagement of youth (from this community) in conflict?

a. Yes, I think the engagement of youth in conflict has increased [ ]
b. Yes, I think the engagement of youth in conflict has decreased [ ]
c. No, I think there has been no change in the engagement of youth in conflict [ ]

11. What do you think should be done to help youth not engage in conflict?

a. Support their education [ ]

b. Promote youth employment [ ]

c. Address their exclusion from their families, communities, and societies [ ]

d. Provide mental health and psychosocial support to them [ ]

e. Any other suggestion, please mention [ ]_____

Drug Use/Substance Abuse

12. Compared to the time before the project started (March 2020), do you think there has been any change in the use of drugs/substances (e.g., khat, alcohol, cocaine, marijuana, heroin, etc.) by youth in this community?

a. Yes, I think there has been an increase in the use of drugs/substances by youth in this community [ ]
b. Yes, I think there has been a decrease in the use of drugs/substances by youth in this community [ ]
c. No, I think there has been no change in the use of drugs/substances by youth in this community [ ]

Mental Health and Wellbeing

13. Have you heard about mental health?

a. Yes [ ]

b. No [ ]

14. TO BE ASKED ONLY IF a. HAS BEEN SELECTED IN Q13: If yes, do you agree or disagree with the following statements about mental health?

	Statement	Agree (1)	Neither agree nor disagree (2)	Disagree (3)
1	As a young person, it is important to learn about mental health.			
2	Mental health is affected by stressful events that people experience in their lives, such as loss of a loved one, witnessing violence, loss of a job, etc.			
3	Drug/substance abuse can negatively impact mental health.			
4	Drug/substance abuse can lead to acts of aggression and increase chances of conflict.			
5	If I feel depressed, get very stressed or become highly dependent on drugs/substances, I will seek support from my family members (parents, siblings, relatives) or friends.			
6	If I feel depressed, get very stressed or become highly dependent on drugs/substances, I will seek support from my community elders and spiritual leaders.			
7	If I feel depressed, get very stressed or become highly dependent on drugs/substances, I will seek support at a health facility/from a psychologist or a counsellor.			

8	I think that people with mental illness/disorder are violent and dangerous.			
9	I think people in my community discriminate against those with mental illness/disorder and treat them unfairly.			

Perceptions about the Project Implemented by WHO and Partner Organisations

15. Now I have some statements about the project on "improving psychosocial support and mental health care for youth". Please read each statement carefully and decide to what extent you agree or disagree with it.

	Statements	Strongly agree (1)	Agree (2)	Neither agree nor disagree (3)	Disagree (4)	Strongly disagree (5)
1	The project improved the availability of mental health support for youth in my community.					
2	The project improved the availability of mental health support that was suitable for the unique challenges and needs of young girls in my community.					
3	The project improved the availability of mental health support for other vulnerable young people in my community (e.g., youth who have experienced gender-based violence, youth with disability, and youth with severe mental illness).					
4	The support provided during the project was suitable to the needs of the young people in my community.					
5	The project has led to an improvement in my well-being, or the well-being of others like me.					
6	The project empowered me to actively contribute to reduce violence and promote peace in my community.					
7	The project empowered me to provide support to my peers who might be experiencing mental health problems.					
8	I was consulted for my inputs/feedback during the project.					

9	I feel that my inputs/feedback were taken seriously.					
10	The project was implemented well despite the COVID-19 pandemic related disruptions.					
11	The support initiated during the project is still ongoing.					
12	The project was innovative in its approach towards mental health.					

Thank you very much for your participation.

Annex F: Informed consent form

After you have read the information sheet or listened to an explanation about the research, please sign the consent form at the end of this document if you are willing to participate.

Title of the study: Improving psychosocial support and mental health care for youth

Name of the researcher: _____

Contact details of the researcher: _____

1. **Invitation**
   I would like to invite you to participate in a study that aims to evaluate a recently concluded project on improving psychosocial support and mental health care for youth in your community. Before you decide to participate, I would like to provide information about the study and convey what your participation would involve. Please take the time to go through the information below and feel free to ask questions about anything that is not clear or requires more explanation. You are entitled to consent or decline participation.

2. **Project background**
   This study evaluates a project that was jointly implemented by the WHO Country Office in Somalia and other partners including IOM, UNICEF, Somali National University (SNU), and the Ministry of Health. The project aimed to strengthen mental health support for youth in Somalia by improving access to mental health treatment within primary health centres, cultivating different forms of mental health support within the community, and reducing stigma against youth with mental health problems. It targeted urban centres of Kismayo and Dolow in Jubaland state and Baidoa in South West state.

   This study is being carried out to gain feedback about the project from different groups of people in the centres that were a part of the study. We want to understand if and to what extent the project has been able to achieve its objectives. In this study, we expect to involve health workers like you, community leaders, youth from the target communities as well as individuals involved in designing,

planning, and implementing the project from the WHO Country Office in Somalia and its partner organisations.

3. Procedure

If you agree to participate in this study, you would be asked to sign a consent form provided at the end of this information sheet. You would also be requested to confirm your availability for a group discussion that will last for approximately one hour. The group would involve 5 other health workers like you and would take place at _____ (location) on _____ (date) at _____ (time). The discussion would be recorded, and this is only so that we do not miss out on anything that you share with us. We might also contact you again in the coming 2-3 months to invite you to a meeting in which we would like to share the study findings with you. However, your participation in the follow-up meeting would be completely voluntary, and you are entitled to either accept or decline our invitation.

4. Benefits

This study will help provide an understanding about the strengths and weaknesses of the project, which can guide the planning and implementation of similar initiatives in Somalia and elsewhere. It might also contribute to an improved understanding about the mental health support needs of youth in this IDP camp/settlement, which can improve the effectiveness of future projects with this community. The findings from this study would be shared with you and other members of your community, so that any lessons that emerge from this study can be utilised by you for the benefit of your community.

5. Risks

Although you are the best judge of the risk that your participation might pose to you, we have identified some of the risks that we are able to foresee. Given the nature of the project, this study may involve discussions about mental health, substance abuse, and conflict. Such discussions can sometimes cause discomfort and trigger unpleasant feelings. In the unlikely event that this happens, we will connect you with the relevant referral services that can offer you appropriate psychological support to address any issues that might arise from the discussion.

6. Voluntary participation

Your participation in this study is completely voluntary. Please be assured that refusal to participate will not have any negative consequences for you. For instance, this will not have any impact with respect to your employment at the health facility. If you consent to participate, you will retain the right to withdraw your consent any time during the study. During the discussion, if there is a question that is uncomfortable to answer, or that you otherwise do not wish to answer, you have the right to remain silent.

7. Confidentiality

Any information that you share with us throughout the study, including your name and any other personal details, will be treated with utmost confidentiality. Your information will not be shared with anyone outside the project, and you would not be identified in any of the reports and publications arising from this project. Confidentiality will be maintained as far as possible, unless during the discussion you say something that makes the facilitator worried that you or someone else might be in danger of harm. In such a case, the facilitator will need to contact the relevant authorities in your area to seek the necessary support and action.

8. Compensation

You will not be paid to participate in this study.

9. Additional information

In case you have any complaints or questions during the study, please contact the project lead (name) at (telephone) or (email). Your personal data will be processed only for the purposes outlined in this notice. You consent to the use of your personal data in this project by completing and signing the consent form at the end of this information sheet.

Thank you reading this information sheet and for considering taking part in this research study.

Participant consent form:

I, _____, have the read the information sheet or the information sheet has been read to me by _____ on the evaluation study conducted by the WHO Country Office in Somalia in collaboration with the Somali Institute of Health Research (SIHR) and the MHPSS Collaborative. This study aims to understand my feedback on a project recently implemented to strengthen psychosocial support and mental health care for youth in this community. I understand that my personal data will be processed only for the purposes of the study. I confirm that I was given time to ask any questions and when I had questions, they were answered satisfactorily. Therefore, I agree to participate in the study. I reserve the right to withdraw from the study whenever I want to.

Signature of the respondent: _____

Date: _____

Witnessed by - Person Obtaining Consent

Name: _____

Signature of the witness: _____

Date: _____

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