



# SOMALIA

INDEPENDENT COUNTRY PROGRAMME EVALUATION  
2011-2015



**This report was prepared by Vision Quest Consultants.**



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## ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ASRH	Adolescent Sexual Reproductive Health
AWPs	Annual Work Plans
CARMMA	Campaign on Accelerated Reduction of Maternal Mortality in Africa
CID	Criminal Investigation Department
CO	Country Office
COARs	Country Office Annual Reports
CPAP	Country Programme Action Plan
CPD	Country Programme Document
CPE	Country Programme Evaluation
EQ	Evaluation Question
FGD	Focus Group Discussion
FGM/C	Female Genital Mutilation/ Cutting
FP	Family Planning
GBV	Gender-Based Violence
GBV WG	Gender Based Violence Working Group
GDP	Gross Domestic Product
HIV	Human Immuno-Deficiency Virus
HMIS	Health Management Information System
HSSP	Health Sector Strategic Plan
ICPD	International Conference on Population and Development
IPs	Implementing Partners
IRF	Integrated Results Framework
ISF	Integrated Strategic Framework
KII	Key Informant Interview
MCH	Maternal Child Health
MDSR	Maternal Death Surveillance and Response
MICS	Multiple Indicator Cluster Survey
MISP	Minimum Initial Service Package
MoLSA	Ministry of Labour and Social Affairs – Somaliland
MOLYS	Ministry of Labour Youth and Sports
MoPIC	Ministry of Planning and International Cooperation
MoWDAFA	Ministry of Women Development and Family Affairs
MSF	Médecins sans Frontières
MW&HR	Ministry of Women and Human Rights
OSPAD	Organisation for Somali Protection and Development
P&D	Population and Development
PESS	Population Estimation Survey for Somalia
PC	Protection Cluster
PL	Puntland
QA	Quality Assurance
RH	Reproductive Health
RHCS	Reproductive Health Commodity Security
RHR	Reproductive Health and Rights

SAMA	Salama Medical Agency
SCZ	South and Central Zone of Somalia
SIS	Strategic Information System
SL	Somaliland
SRH	Sexual Reproductive Health
SSW&C	Save Somali Women and Children
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
UNCT	United Nations Country Team
UNDP	United Nations Development Programme
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nation Children Fund
UNMPTF	United Nations Multi-Partner Trust Fund
UNSAS	United Nations Somalia Assistance Strategy
WARDI	WARDI Relief Development Initiative
WHO	World Health Organisation

# MAP OF SOMALIA





# SOMALIA KEY FACTS

Indicator	Data Value <sup>1234</sup>	Year of Estimate
<b>Population</b>	12,316,895	2014
<b>Sex Ratio</b>	1.01 (Males/Female)	2014
<b>Population Growth rate</b>	1.75	2014
<b>Birth Rate</b>	40.87 (births/1,000 population)	2014
<b>Death rate</b>	13.91 (deaths/1000 population)	2014
<i>Socio-economic Indicators</i>		
<b>Human Development Index</b>	0.285 (165/170 countries)	2012
<b>Human Development Index rank by gender</b>	0.773	2012
<b>Poverty rate</b>	73percent	2012
<b>Life Expectancy at birth</b>	51.58 (years)	2014
<b>Infant Mortality Rate</b>	89 (per 1000 live-births)	2013
<b>Maternal Mortality Rate</b>	732 (per 100,000 live-births)	2015
<b>Proportion of births attended by skilled health personnel</b>	33.1	2013
<b>Under-five mortality rate</b>	145.6 (deaths of children per 1,000 births)	2013
<b>Total Fertility Rate</b>	6.08 (children born per woman)	2014
<b>Contraceptive Prevalence Rate</b>	24 (percentage of women aged 15- 49, using any method of contraception)	2015 <sup>5</sup>
<b>Contraceptive Prevalence Rate</b>	6 (percentage of women using Modern methods of Family planning)	2015
<b>Unmet Need for Family Planning</b>	24.5 (percentage of women aged 15- 49, with unmet need for family planning)	2013
<b>HIV Prevalence Rate (among the general population)</b>	0.5percent	2012

<sup>1</sup> [http://en.worldstat.info/Africa/Somalia/Vital\\_statistics](http://en.worldstat.info/Africa/Somalia/Vital_statistics) accessed on 01/10/2015

<sup>2</sup> accessed on 01/10/2015

<sup>3</sup> Somalia 2012 Human Development Report

<sup>4</sup> Population Estimation Survey of Somalia (2014)

<sup>5</sup> <http://www.unfpa.org/world-population-dashboard>

# EXECUTIVE SUMMARY

This report presents the results of the final evaluation of the UNFPA Somalia 2nd Country Programme for 2011-2015.

The Somalia programme had a total budget of 74.87 million USD, with funds mobilised from both regular (21.42 million USD) and other (53.45 million USD) sources to finance programme activities. The programme covered the three programme components namely reproductive health and rights (a total expenditure of 35.37 million USD); population and development (expenditure of 10.11 million USD) and gender equality (expenditure of 10.05 million USD). The 2nd Country Programme sought to improve the overall quality of life of the Somali people and was developed to contribute to the outcomes of the United Nations Somalia Assistance Strategy (UNSAS).

## Purpose and Objectives of the Country Programme Evaluation

The purpose of this evaluation was to demonstrate accountability to stakeholders on performance in achieving results at country level. It was also to ensure accountability of invested resources, support evidence-based decision making, and contribute important lessons learned to the existing knowledge-base on how to accelerate implementation and better design the next cycle of the country programme for Somalia.

The specific objectives of the CPE are to:

- 1) Provide an independent assessment of the progress achieved towards the expected outputs and outcomes in the results framework of the 2nd country programme, and the contribution towards the realisation of the national outcomes with special focus on relevance, effectiveness, efficiency sustainability, added value and coordination;

- 2) Review the overall coordination and partnership approach adopted during programme implementation;
- 3) Identify innovative approaches towards programme implementation and lessons learnt or best practices identified including the extent to which UNFPA programmes integrated gender and rights-based approaches;
- 4) Identify any challenges and impending threats the programme is facing, as well as opportunities; and
- 5) Draw key lessons from past and current implementation arrangements to provide a set of clear and forward looking options leading to strategic and actionable recommendations for the next country programme cycle.

The CP evaluation covered the period from 1st January, 2011 to 30th September, 2015 and was conducted to cover all the three zones in (SCZ, Puntland, and Somaliland) where UNFPA interventions are implemented. The evaluation also looked at the three technical areas of the UNFPA programme (Population and Development, Gender, Sexual Reproductive Health, Adolescents Youth plus HIV and AIDS), in addition to cross cutting aspects such as gender mainstreaming, coordination and partnerships for each thematic area.

## Methodology

The design of the evaluation was guided by the objectives and criteria of relevance, effectiveness, efficiency, sustainability, added value and coordination. These criteria were used to assess the various programme components. Data and information for the evaluation were gathered from both primary and secondary sources. Sampling of respondents was purposive and comprised of the UNFPA's implementing partners, staff of UN agencies, beneficiaries and other development

partners. Methods of data collection included review of documents, key informant interviews (KIIs), in-depth interviews (IDIs), focus group discussions (FGDs) and observations. The consultants routinely validated data at the end of each data collection day through debriefing sessions with the evaluation team. Data analysis took the form of content analysis and secondary data obtained through document reviews complemented primary data, obtained through interviews and focus groups. Data collected from multiple sources were triangulated to support and validate the evaluation findings. Additionally, the evaluation team sought to validate the data through regular exchanges with the CO programme managers, technical officers at national and field levels and the evaluation manager.

### **Main Findings**

The country programme design and implementation was well adapted to the needs of the Somalis, and was based on assessments, consultations and country strategic plans. It was also responsive to the emerging needs during the period of coverage.

#### **In the area of reproductive health and rights, UNFPA supported interventions have contributed to improved access and utilisation of maternal health, including the Somali IDPs.**

The programme has contributed to improved access to reproductive health services through supporting enhanced reproductive health-care service delivery processes, including midwifery training and establishing midwifery training institutions, supporting increased family planning service uptake and increasing RH commodity security, obstetric fistula prevention and management, strengthened capacities of zonal authorities, community-based and non-governmental organisations, and the most-at-risk youth. However, service delivery and awareness raising in the rural areas are still inadequate. Cultural challenges have also affected access to family planning services and RH services by the youth.

**In the area of population and development, UNFPA has contributed to availability of population-based data** through implementation of PESS, and built the capacity of the government including revival and strengthening of statistical units both at national and sub-national levels to enhance the use and dissemination of data.

**In the area of gender equality, UNFPA contributed to** the promotion of gender equality and women's dignity through its leading coordination role and technical and financial support to GBV actors and national machineries in areas such as gender based violence prevention and promotion of women's human rights treaties/legal frameworks. UNFPA provided lead support, in collaboration with UNDP and the GBV sub cluster, on the ongoing legislative process of sexual offences and zero tolerance FGM bills. Together with UNICEF, FGM/C policies across the country are being drafted and implemented (in Puntland). The Convention on the Status of Women (CEDAW) is at advanced stages of ratification, with over 20 government directors and parliamentarians trained to understand the convention. The component led the government and GBV sub cluster to strengthen GBV response/service provision to survivors, which saw through the establishment of 12 GBV one stop centres, 2 protection shelters (safe homes) and three family centres, providing comprehensive clinical management of rape, legal aid, psychosocial support, livelihood and referrals for other services. Technical trainings and coaching were conducted for over 45 GBV coordinators with leading coordination functions in the field. In as much as GBV prevention was weak within the Protection Cluster (PC) response agenda, UNFPA made gains in engaging the government and NGOs to intensify communication engagement that has enhanced community response in declarations to end FGM and also mobilising GBV survivors to utilise services. The component interventions were challenged by the strong social-cultural, including strong religious perceptions, which the programme has

managed to deal by developing a GBV working group strategy that was endorsed by both the humanitarian and United Nations country teams. This gave an opportunity to engage local authorities and policy makers systematically to address religious and socio-cultural issues that are critical to promoting the dignity and rights of women and girls.

**UNFPA programme efficiency in service delivery had mixed results.** UNFPA had qualified technical staff, who managed and coordinated the activities with the stakeholders, providing effective guidance for quality service delivery. Coordination and the joint approach to implementation of activities, including M&E, was cost-effective in delivering services. Operational costs were hampered by insecurity. The programme M&E was largely functional where key actions and strategies were adopted during the period. Insecurity, emergency nature of the implementation context and inadequate staff capacity however limited monitoring activities by technical staff to all the project sites.

**On sustainability, the contributions of UNFPA to policies and strategies, development of guidelines, manuals, protocols and capacity strengthening are likely to contribute to sustenance in standardising operations and improving quality of service delivery.** The programme promoted community ownership in its processes and this made it easy for the activities to be accepted and supported by the community. However, there is high level of dependency on the programme's operations by the government due to its inability to mobilise own resources and limited capacity. Unstable context also hinders sustainability.

UNFPA had technical and comparative advantage in all its programme components that it supported or coordinated. It also contributed to the functional coordination within the UN system in Somalia through its participation in and leading some, several thematic and working groups.

## **Main Conclusions**

The country programme is adapted to the population needs in the areas of reproductive health, gender equality, particularly in the areas of GBV and promoting the dignity of women and girls plus population and development and continues to be relevant both at the national and international levels. UNFPA focuses on both development and humanitarian priority areas.

**The level of efficiency in service delivery was mixed, often due to factors that were not in the control of the programme.** UNFPA had qualified technical staff who managed and coordinated the activities with the stakeholders, providing effective guidance for quality service delivery. Coordination and the joint approach to implementation of activities, including M&E, was cost-effective in delivering services.

**The design of the programme took into consideration sustainability of interventions through capacity strengthening and development of protocols, guidelines and manuals for utilisation in standardising operations and improving quality of service delivery.** However, there is high level of dependency on the programme's operations by the government due to its inability to raise funds via tax revenues, and further due to limited capacity. The context of humanitarian intervention also hinders achievement of sustainability as the causes of the humanitarian crisis still exist and therefore require sustained response from the humanitarian actors.

The UNFPA Somalia programme made use of its comparative advantage across the three components; SRH, P&D and Gender Equality. It was also resourceful with human and financial capitals in expertise and funding. Its contribution within the UN system is highly valuable and played a central role in achieving the targeted UN inter-agency results.

**UNFPA facilitated and participated in coordination mechanisms within the UNCT and**

**was effective in providing technical support and guidance in joint programmes with the UN partners;** enhancing synergy among stakeholders in service provision and building the capacity of implementing partners.

**The UNFPA's RHR component was effectively implemented, achieving most of the intended results within the life of the programme cycle.** Access to skilled birth attendance improved with staff and health facility capacity strengthened to provide better and quality RH services. Development of manuals and service delivery protocols effectively guided quality and standardisation of delivery of RH services. Integrating youth activities with the RHR increased awareness among the youth on reproductive health, including access to services.

However, the youth faced some stigma accessing RHR services at the youth-friendly service centres. Discussing sex issues openly in Somalia is not acceptable especially among youth and adolescents, and this affects delivery of ASRH among the target groups.

**UNFPA's humanitarian interventions effectively responded to the needs and provided timely services to the vulnerable IDPs and refugees.** The unit was responsive and addressed real needs, including prepositioning commodities for emergency cases arising during the period, which was in compliance with the minimum initial service package. The maternity waiting homes played a significant role in improving access to maternal health services by those in displacement, including referral services.

**UNFPA contributed significantly to the provision of data to guide policy formulation and planning** through financing and technical guidance in the implementation of the Population Estimation Survey of Somalia (PESS).

**Partnerships between UNFPA, government and NGOs facilitated GBV response across the**

**country.** The programme provided essential added value to the area of GBV response in Somalia through the development of bills to improve legal framework, training, awareness raising and supporting coordination activities on GBV in the country. Strong socio-cultural factors, traditional justice system and religious perceptions influence achievement of gender equality and limited the utilisation of the available services by the programme component.

### Recommendations

1. UNFPA should continue the practice of focusing its programme interventions and support on results of studies, needs assessments, strategic plans, stakeholder consultations and feedback, and implementing partner plans and being responsive to arising needs for effective service provision and coverage.
2. To enhance sustainability, UNFPA needs to support capacity strengthening initiatives of the government institutions and civil societies, including strengthening their capacities on resource mobilisation; and embed in its design measures to integrate sustainability strategies, including focus on mitigating the possible threats to sustainability in the partnership
3. In the next programme cycle, the programme needs to prioritise rural areas with integrated RH services after conducting assessments, including establishing contextual applicable strategies;
4. UNFPA should make provisions for timely disbursement of funds, annual planning should be done earlier and once the annual work plans are signed, they should be implemented as such;
5. UNFPA should strengthen its M&E staff capacity and those of the IPs and ensure

that there is clear linkage between results and indicators in the programme design; and use its technical expertise to support the CO in guiding operation research so that even the M&E processes can be enhanced;

6. UNFPA should continue supporting production of qualified midwives, as there is still a huge gap for midwifery within the country to cover the needs of the existing population, through training, supporting infrastructure and regulation of the profession, as well as advocating to the government to ensure that the trained midwives go back to their communities and their work well supervised and supported with home delivery kits to perform their work;
7. UNFPA needs to increase engagement of the MoH and other stakeholders to provide routine obstetric fistula repair services to maximise on the demand that is created through mobilisation; and allocate more

funds for innovative methods of prevention like prevention-with-positives (PwP);

8. UNFPA need to support capacity strengthening of government institution including expanding into supporting analysis of population dynamics data and its utilisation for policy development, programming and impact assessment
9. UNFPA should continue to support the legal framework and law enforcement efforts to reduce incidences of GBV and promoting gender equity and intensify engagement and involvement of religious leaders in advocacy and raising awareness on FGM;
10. There is need to support coordination and capacity strengthening of local level structures, including religious leadership, and community-based organisations, traditional and community leaders to form sustainable local movements to end GBV through public education and locally based support services for survivors.

# 1.0 INTRODUCTION

The UNFPA Somalia country office commissioned this evaluation of its 2<sup>nd</sup> Cycle Country Programme (2011 – 2015). The purpose and objectives of this Country Programme Evaluation (CPE) are defined in the Terms of Reference (ToR).<sup>6</sup> The scope and the main evaluation questions were developed along the criteria of relevance, effectiveness, efficiency, sustainability and added value of the programme. This section details the evaluation process, methodology and questions, describes a valid sampling technique and limitations encountered.

## 1.1 The Purpose and Objectives of the Country Programme Evaluation

The purpose of this evaluation is to demonstrate accountability to stakeholders on performance in achieving results at country level. It is also to ensure accountability of invested resources, support evidence-based decision making, and contribute important lessons learned to the existing knowledge-base on how to accelerate implementation and better design the next cycle of the country programme for Somalia. The specific objectives of the CPE are:

- a. Provide an independent assessment of the progress achieved towards the expected outputs and outcomes set forth in the results framework of the 2nd country programme, and the contribution towards the realisation of the national outcomes, with special focus on:
  - Determining whether planned activities were carried out as planned (effectiveness) and assess program performance (extent to which targets were achieved or not)

- Examining programme implementation efficiency in achieving expected results
  - Assessing the relevance and sustainability of the 2nd Cycle CP
- b. Review the overall co-ordination and partnership approach adopted during programme implementation
  - c. Identify innovative approaches towards programme implementation and lessons learnt or best practices identified including the extent to which UNFPA programmes integrated gender and rights-based approaches
  - d. Identify any challenges and impending threats the programme is facing and opportunities
  - e. Draw key lessons from past and current implementation arrangements to provide a set of clear and forward looking options leading to strategic and actionable recommendations for the next country programme cycle.

## 1.2 Scope of the Evaluation

The CP evaluation covered the period from 1st January, 2011 to 30<sup>th</sup> September, 2015 and includes all three Somalia Zones (SCZ, Puntland, and Somaliland) where UNFPA interventions are implemented. The evaluation also looked at the three technical areas of the UNFPA programme (Population and Development, Gender, Sexual Reproductive Health and Adolescents Youth, HIV/AIDS). Additionally, the evaluation covers cross-cutting aspects such as gender mainstreaming, coordination and partnerships for each thematic area.

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<sup>6</sup> See Somalia Country Programme Evaluation Terms of Reference.

### 1.3 Evaluation Criteria and Questions

The evaluation design was informed by the UNFPA Evaluation Handbook on how to design and conduct a CPE and follows four OECD-DAC criteria of Relevance, Effectiveness, Efficiency and Sustainability as well as those on strategic positioning of UNFPA within the UNCT of Coordination and Added Value.

The main questions answered by the evaluation were suggested in the Terms of Reference as shown in the table on the following page.



EVALUATION CRITERIA	CPE QUESTION AS PER THE TOR
<b>RELEVANCE</b>	<p>Q1: To what extent were the programme interventions consistent with the needs of the beneficiary populations and to what extent was it aligned with government priorities as well as with policies and strategies of UNFPA?</p> <p>Q2: How well was the CPAP aligned with the ICPD actions and MDGs as well as with the UNFPA Strategic Plans?</p>
<b>EFFECTIVENESS</b>	<p>Q3: To what extent did the interventions supported by UNFPA in the field of reproductive health and rights contribute to (i) Improved access and utilisation of high quality maternal health and family planning services, including populations affected by humanitarian crisis (ii) Increased national and sub-national capacity to deliver integrated sexual and reproductive health services (iii) Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes?</p> <p>Q4: To what extent have the interventions supported by UNFPA in the field of population and development contributed to (i) increased availability and use of data on emerging population issues at national and sub-national levels (ii) Strengthened national and sub-national capacity for production and dissemination of quality disaggregated data on population and development issues.</p> <p>Q5 To what extent have the interventions supported by UNFPA in the field of gender contributed to: (i) Strengthened national and sub-national protection systems for advancing reproductive rights, promoting gender equality and non-discrimination and addressing gender-based violence; (ii) Increased capacity to prevent gender-based violence and harmful practices and enable the delivery of multisectoral services, including in humanitarian settings?</p> <p>Q6: To what extent was the programme coverage (geographic; beneficiaries) reached as planned?</p>
<b>EFFICIENCY</b>	<p>Q7: Was the programme implementation approach (funds, expertise, time, administrative costs.) the most efficient way of achieving results?</p>
<b>SUSTAINABILITY</b>	<p>Q8: To what extent are the development gains made under the UNFPA supported interventions in Somalia sustainable in terms of continuity in service provisions and partnerships integration of CP activities into the regular country and counterparts' programming?</p>
<b>ADDED VALUE</b>	<p>Q9: What has been the comparative strength of the UNFPA CO response to the Somalia context of protracted crisis and particularly in the areas of reproductive health, gender-based violence and population and development?</p>
<b>COORDINATION</b>	<p>Q10: To what extent has the UNFPA CO contributed to good coordination among UN agencies in the country, particularly in view of avoiding potential overlaps?</p>

Each of the evaluation questions has been translated into information needs, displayed in the Evaluation Matrix (Annex 3), which linked evaluation questions with corresponding assumptions that were tested, sources of information and methods and tools for the data collection.

## 1.4 Process and Methodology

### 1.4.1 The Evaluation Process

The evaluation process had five phases:

- I. **The Preparatory Phase** involved drafting of the terms of reference by Somalia CO, followed by selection of the evaluation team.
- II. **The Design Phase** entailed structuring the evaluation, including briefing the evaluation team and preparation of the design report by the evaluation team in consultation with the evaluation manager and other stakeholders.
- III. **The Field Phase** consisted of field trips to programme sites in Somaliland (Hargeisa), Puntland (Garowe) and South Central (Mogadishu). Due to unavailability of staff from ministries of planning across the country, the team had to travel to meet them in Entebbe where they were holding a training meeting on further analysis and PESS report writing. Respondents who were not based in the visited areas were contacted virtually. The evaluation team also met the UNFPA CO based in Nairobi among other selected partners. Selected CO staff were initially interviewed before field phase to elicit an understanding of the programme

and identification of the contacts for the selected partners and field staff. There were follow-up interviews to the actual programme managers, repeat appointments, and review documents conducted.

- IV. **The Reporting Phase** entailed further analysis and drafting of the evaluation report, including review and feedback by UNFPA.
- V. **The Dissemination Phase** will be at the point where the main recommendations of the final evaluation report will be circulated to the relevant units who will in turn be invited to submit a response.

### 1.4.2 Methods for Data Collection and Analysis

The CP evaluation made use of mixed methods to collect primary and secondary data, and to analyse the data by evaluation question as relevant from each source. Secondary data sources consisted primarily of programme documents and other relevant reports, whereas primary data were collected during the field phase from program stakeholders through semi-structured interviews, focus group discussions and site visits/observations.

#### Data collection Processes

- **A comprehensive desk literature review and content analysis** were carried out to allow for an in-depth understanding of the CP design, implementation and management processes, including structural issues of the programme. Some of the documents include UNFPA and Somali government policy and strategy documents, Country Programme documents, CP progress reports and implementation plans

(CPAPs; AWP), monitoring and assessment reports and relevant secondary data. Other sources such as thematic evaluation reports and findings of assessments conducted by other donors and international organisations were reviewed.

- **Semi-structured Interviews (SSI)** were conducted for sampled key informants. These included CP Implementing Partners, relevant government ministry staff (sampled from all the three administrative zones), relevant UN agencies, NGOs and UNFPA staff, (refer to the Annex 4 for complete list of respondents). The interview guides were developed along the UNFPA thematic areas of SRH, P and D, and Gender and rights; and the questions were aligned to answer the evaluation questions as per the evaluation criteria.
- **Focus group discussion (FGD)** were designed to target programme beneficiaries. The discussion guide was designed to obtain the beneficiaries' perspectives on the performance of the programme based on its intended results and further help establish gaps and needs in each of the CP outputs. The rationale of including this instrument is its strength in providing rich qualitative data and ability to provide further insights into data obtained from other categories of respondents.
- **Site Visits/Observations:** Considering the resources and security constraints in Somalia, the evaluation team purposively selected sites visited in Somalia and conducted a site visit to selected number of facilities and institutions that benefitted from UNFPA programme support. The site

visits helped observe and assess utilisation of the assistance. A checklist was developed to structure observations and key aspects to look at during the visits. Informal interviews were also conducted with both users and in-charges.

#### **1.4.3 Selection of the Sample of Stakeholders**

A complete sampling frame including all the CP stakeholders at different levels was constituted. Considering the large number of stakeholders, the selection of the sample was based on a set of criteria, including but not limited to the programme components which they implement; the level of programme investment (and interventions) by UNFPA, based on the AWP and length of engagement with UNFPA as an IP to be able to provide an opinion on the performance of the programme. Considering the sensitivities in Somalia, geographic location of stakeholders was another criterion for selection in order to ensure balance among the 3 zones. For those away from the visited places, they were contacted virtually. The respective programme staff advised on stakeholder selection for SSI.

Selection of FGD participants targeted the incidental beneficiaries of the programme. The criteria selection depended on kind of interventions involved and the depth of understanding, especially on the effectiveness of the programme. These included midwifery students, health workers, health facility staff and youth (peer educators).

The data collection tools primarily consisted of semi structured and focus group discussion guides. These guides contained evaluation questions for each of the thematic areas including i) Sexual and Reproductive Health, HIV/AIDS and Youth, ii) Gender, iii) Population

and Development (see Annex 2). Interview questions were clustered according to the evaluation criteria and relevant questions to facilitate data collection and later analysis. Each data collection tool was pilot tested with selected IPs not in the final sample selected for the main evaluation.

**Table: Interviews and Focus Group Discussions**

	RH			Gender			PD			Total
	S L	P L	SC Z	S L	P L	SC Z	S L	P L	SC Z	
# of SSI										
UNFPA staff <sup>7</sup>	3	3	3	2	1	1	3			16
Ministries	3	6	4	2	3	2	2	3	4	29
Other IPs	3	2	5	3	1	1				15
Other UN agencies				2			1			3
# of FGDs										
Beneficiaries	2	2	2		2	1	1	1	1	12

#### 1.4.4 Data Validation Mechanism and Analysis

The consultants routinely validated data at the end of every data collection day through debriefing sessions with the evaluation team. Data analysis took the form of content analysis. Secondary data obtained through documentary review complemented primary data obtained through interviews and focus groups and to the extent that it was possible, data collected from multiple sources were triangulated to support and validate the evaluation findings. Additionally, the validation of data was sought through regular exchanges with the CO programme managers, technical officers at national and field levels and the evaluation manager.

<sup>7</sup> Includes the Head of Sub-Offices who oversee all the programme activities and the Technical Specialists who are not affiliated to any Sub-Office

#### 1.4.5 Limitations of the Evaluation and Mitigation Measures

I. *Missing Baseline data*: Most of the baseline data were missing in the CP documents; particularly in the Country Programme Document, making it difficult to assess the level of achievement of CP results based on the organisational targets. Further, the major component of the analysis for this evaluation report was based on qualitative information from interviews and desk review and depended on the programme documents for the quantitative achievements.

II. *Insecurity*: Insecurity in some parts of South Central Somalia did not allow the lead consultant to conduct site visits and interview the various respondents at their work place. Instead, the UNFPA field office arranged for interviews of all the selected respondents at a central point. Only one respondent could not make it to Mogadishu and was interviewed virtually. The national consultants visited the sites and met with beneficiaries, including conducting FGDs in the midwifery training schools, one-stop centres, MWH and other health facilities.

#### 1.4.6 Structure of the Evaluation Report

The Evaluation Report is structured in line with UNFPA Evaluation Handbook requirements. It begins with the Executive Summary and Key Facts Table. These are then followed by Chapter One, which introduces the evaluation covering the purpose and objectives, scope and methodology. Chapter Two addresses the country context, development challenges and national strategies, and covers the role of

external assistance. Chapter Three provides an overview of the UN and UNFPA response and the current UNFPA Country Programme, including the financial structure of the current CP which covers the costs according to the three programme components and that of management. Chapter Four provides the evaluation findings and analysis for each programme component according to the evaluation criteria of relevance, effectiveness,

efficiency, sustainability, added value and coordination. Chapter Five provides conclusions from the evaluation covered under the strategic and programmatic. Chapter Six covers the recommendations for consideration in on-going programme interventions and in the development of the 3rd CP derived from findings and the conclusions. The Annexes section includes the Terms of Reference, the evaluation matrix, and list of respondents.

## 2.0 COUNTRY CONTEXT

### 2.1 Development Challenges and National Strategies

Somalia, situated in the Horn of Africa, lies along the Gulf of Aden and the Indian Ocean. It is bordered by Djibouti in the northwest, Ethiopia in the west, and Kenya in the southwest. The population of Somalia is estimated at 12,316,895<sup>8</sup>. Data from UNHCR indicates that the refugees of Somali origin in the Horn of African countries are 973,029.<sup>9</sup> The vast majority of the republic's population is Somali; they speak a Cushitic language and are Sunni Muslims. They are divided into five principal clans and many sub-clans. Islam is the state religion. Although Somali is the national tongue, Arabic, Italian, and English are used officially. There are Bantu-speaking ethnic groups in the southwest and numerous Arabs in the coastal towns.<sup>10</sup>

The Federal Republic of Somalia is faced with the challenge of rebuilding state institutions in the midst of recurrent and protracted conflict. Since the collapse of the Siad Barre government in 1991, Somalia has experienced cycles of conflict that fragmented the country, destroyed legitimate institutions and created widespread vulnerability. The south central region has experienced years of fighting and lawlessness, while the north-east (Puntland) and north-west (Somaliland) have achieved a fragile semblance

of peace and stability.<sup>11</sup> Following the collapse, armed factions began competing for influence in the power vacuum that followed, bringing years of violence and insecurity to large parts of the country. It represents one of the modern world's most protracted cases of statelessness.<sup>12</sup>

Persistent cases of conflicts, drought and floods have disrupted livelihoods with repeated failure of crops, diminishing water resources and water quality, depleted livestock, rising food prices and deteriorating purchasing power, thus degrading coping mechanisms. According to the Human Development Index, Somalia is among the five least developed countries. The pre-eminence of customary clan-based systems inhibit social cohesion and pervasive traditional practices such as polygamy, early and forced marriage, exclusion of women from education and employment opportunities, result in some of the worst gender equality indicators in the world.<sup>13</sup>

There has been registered suffering and violation of human rights for more than two decades. The protection of civilians in the context of armed conflict, combined with impunity and lack of accountability, is of major concern. Somalia crisis is among the largest and most complex humanitarian emergencies in the world with an estimation of about 2.9 million

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<sup>8</sup><http://countryoffice.unfpa.org/somalia/drive/Population-Estimation-Survey-of-Somalia-PESS-2013-2014.pdf>

<sup>9</sup>According to data as at 31<sup>st</sup> October 2015, accessed from <http://data.unhcr.org/horn-of-africa/regional.php>

<sup>10</sup> See <http://www.infoplease.com/encyclopedia/world/somalia-land-people.html>

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<sup>11</sup> Somaliland seceded from Somalia and declared independence in 1991, while Puntland became an autonomous state within the Somalia federal structure in 1998. These two regions have established some stability through bottom-up conflict transformation with a sustained focus on resolving issues at the community level. They each have a fully-structured government. For the purposes of this report, they are treated as zonal authorities within Somalia.

<sup>12</sup> See <http://www.worldbank.org/en/country/somalia/overview>

<sup>13</sup> Somalia Human Development Report (2012)

people reported to be in need of humanitarian assistance including an estimated 1.1 million people are internally displaced by recurrent droughts, floods and conflict.<sup>14</sup>

Somalia's economy has been shaped and sustained by conflict. It has a gross domestic product (GDP) per capita of \$284 which together with its human development outcomes are among the lowest in the world. Poverty incidence is 73 percent (61 percent in urban centres and 80 percent in rural areas).<sup>15</sup> Livestock is the mainstay of the economy with 60 percent of the population deriving a livelihood from pastoralism-based livestock production. The export of livestock and meat generates 80 percent of foreign currency. Most Somalis live in rural areas where traditional coping mechanisms, clan affiliations and pastoral mobility have been undermined by conflict. Only 7 percent of the rural population enjoys access to improved water sources, compared to 66 percent of people living in urban areas. Somalia is heavily dependent on aid and remittances. In the absence of a formal commercial banking sector, remittance companies have enabled the diaspora to remit around \$1.3 billion annually to families in Somalia; in addition to approximately \$1 billion in foreign aid.<sup>16</sup>

Somalia faces some of the worst health indicators in the world; only 30 per cent of people have access to health services and one in five children die before their fifth birthdays<sup>17</sup>. Although some estimates indicate that Somalia has made visible progress decreasing the under-

five mortality rate, it still hosts the worst infant, child, and maternal mortality rates in the world. The leading causes of death and disability for Somali women of reproductive age are complication during pregnancy and childbirth, lack of access to skilled birth attendants, narrowly spaced births, and early adolescent marriages. Maternal mortality in Somalia, already extremely high and on the rise, is significantly higher than that of other Least Developed Countries (LDCs) globally.<sup>18</sup> The percentage of current contraception use among married women of reproductive age in Somalia is just under 15 percent. In addition, use of modern contraception methods is even much lower (1.2 percent). These low contraceptive prevalence rates result most likely from cultural and religious factors as well as low education and literacy rates among women, resulting in minimal knowledge about contraception methods.

Available survey data indicate that Somalia has multiple HIV epidemics. In the North West zone, HIV prevalence is generalized, with HIV prevalence among women attending antenatal care of 1.4 percent and 1.3 percent in 2004 and 2007, respectively, with those in Somaliland at the rate of 0.67 percent in 2015. HIV infection among sex workers is 5.2 percent. The North East and South Central zones have concentrated or low level epidemics. HIV among women attending antenatal care is 0.5 percent in the North East, while in the South Central zone the rate is 0.5 percent. The HIV and sexually transmitted infections programme still faces a number of challenges in Somalia including stigma, the weakness of community-based groups in supporting antiretroviral therapy

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<sup>14</sup> See IDMC estimates as of 09 October 2014 (rounded figures) <http://www.internal-displacement.org/global-figures>

<sup>15</sup> UNDP (2012): Human Development Report

<sup>16</sup> See

<http://www.worldbank.org/en/country/somalia/overview#1>

<sup>17</sup> WHO: Somalia Health Update - May – June 2014

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<sup>18</sup>

<http://www.undp.org/content/somalia/en/home/mdgoverview/overview/mdg5.html> accessed on 2/10/2015

services and the low service uptake of TB/HIV co-infection patients, including children.<sup>19</sup>

With more than 70 percent of the population under the age of 30, Somalia is a young country with enormous development needs. Among the more urgent is food security which, together with displacement of a large share of the population, has led to a continuing humanitarian crisis that has spilled over into the wider region. According to the UNDP in its 2012 Human Development Report, The future of Somalia and the well-being of its people rests significantly on empowering its large youth population.<sup>20</sup>

Somalia is still characterized by a severe lack of basic economic and social statistics for development and policy formulation. Most of the data on the country statistics are estimates from different sources and are not consistently updated. The situation has been exacerbated by the two-decade conflict and the resulting collapse of the country's institutions. The existence of de facto spatial and political entities results in complex economic realities and complicates the issue of data reliability and consistency for Somalia as a whole.<sup>21</sup> Inadequate capacity of the government to develop statistical systems to help in collection and analysis remains problematic. Further, there is no central point of reference for information access and dissemination on the aspects of development and departments/sectors (ministries) still depend on their data for referencing as the statistical system is very weak. As a result, it is almost impossible to undertake planning and

programming work, or to monitor economic and social developments.

Gender inequality in Somalia is alarmingly high at 0.776 on a scale of 0 to 1 (complete inequality), the fourth worst position globally on the Gender Inequality Index (GII). Women suffer severe exclusion and inequality in health, employment and labour market participation.<sup>22</sup> Even though statistics are of mixed quality and poorly maintained, Somali women continue to face extremely high maternal mortality, rape, female genital mutilation (FGM), child marriage rates, and violence against women and girls. Despite all stakeholders including the Federal Government of Somalia, local authorities, and the international community acknowledging that gender-based violence (GBV) is persistent throughout Somalia, widespread discrimination and abuse against Somali women continues and services to survivors are only available in very limited areas and criminal prosecutions frequency is negligible.<sup>23</sup> FGM afflicts an estimated 98 percent of Somali women and girls.<sup>25</sup> Young women end up greatly disadvantaged in all spheres of life, a reality that hinders their rights and development, and perpetuates intergenerational cycles of gender inequality and the feminization of poverty.<sup>26</sup>

Traditional laws, used in lieu of a state judiciary, are highly discriminatory against women as the traditional Somali society does not openly discuss issues such as domestic violence and rape, which further hampers women's access to justice.

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<sup>19</sup>See <http://www.emro.who.int/som/programmes/hiv-sti.html>

<sup>20</sup> UNDP (2012): Somalia Human Development Report

<sup>21</sup> African Development Bank (2013): Somalia Country Brief 2013 - 2015

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<sup>22</sup> UNDP (2012): Somalia Human Development Report

<sup>23</sup> Somalia Gender-Based Violence Working groups Strategy 2014 - 2016

<sup>24</sup> United Nations Human Rights Council

<sup>25</sup> [http://www.unicef.org/cbsc/files/UNICEF\\_FGM\\_report\\_July\\_2013\\_Hi\\_res.pdf](http://www.unicef.org/cbsc/files/UNICEF_FGM_report_July_2013_Hi_res.pdf)

<sup>26</sup> UNDP (2012): Somalia Human Development Report



Efforts of Somali women to rise above oppression have been isolated and short lived, and they have yet to achieve the critical mass in decision-making required to effect wider change. Even though their participation and role in politics and decision-making spheres remains limited, data indicates that since the civil war, women in Somalia have increased economic involvement and decision-making power within the household.<sup>27</sup>

## 2.2 Role of External Assistance

Somalia has been among the top 10 recipients of humanitarian assistance in seven of the last 10 years. Humanitarian assistance peaked at US\$1.1 billion in 2011, when it was the second largest recipient of humanitarian assistance. Between 2003 and 2012 Somalia received US\$5.4 billion in official development assistance (ODA), making it the 43rd largest recipient. In the same 10-year period the proportion of ODA given as humanitarian assistance averaged 68 percent, ranging from 49 percent in 2010 to 77 percent in 2011. Somalia received the equivalent of 15 percent of its gross national income (GNI) as aid (ODA) in 2012. The United States (US\$181 million) was the largest donor of humanitarian assistance to Somalia in 2012, followed by the EU institutions (US\$83 million) and the United Kingdom (US\$82million). The US provided 18 percent (US\$678 million) of all humanitarian assistance to the country between 2003 and 2012. In 2013, Somalia had only 51 percent of the required US\$ 1.2 billion through the UN-coordinated appeal met; while as of November 2014, the country's Strategic Response Plan requested US\$933 million for

2014.<sup>28</sup> While a majority of aid has been directed toward humanitarian assistance in the past, an increasing proportion of ODA is being directed toward longer-term development in Somalia under the New Deal.

The United Nations (UN) Resident and Humanitarian Coordinator oversees and coordinates the work of the different UN agencies working in Somalia. All the UN agencies operate within the United Nations Somali Assistance Strategy (UNSAS), an overarching five-year plan for UN agencies. The UNSAS covers the UN's humanitarian, recovery and development priorities in Somalia from 2010 until 2015, and defines how assistance should contribute to the national priorities identified by the Somali authorities themselves in their own Reconstruction and Development Programme (RDP). There are 19 UN agencies active in Somalia; WFP, FAO, WHO, UNFPA, UN OCHA, UNICEF, UNMAS, UNSOM, UNSAS, UNV, UNIDO, UNHCR, UNDP, IOM, UNOPS, UNCDF, UNODC, World Bank and UN Women.

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<sup>27</sup> <http://genderindex.org/country/somalia>

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<sup>28</sup> See <http://www.globalhumanitarianassistance.org/countryprofile/somalia>

## 3.0 UN/UNFPA RESPONSE AND PROGRAMME STRATEGIES

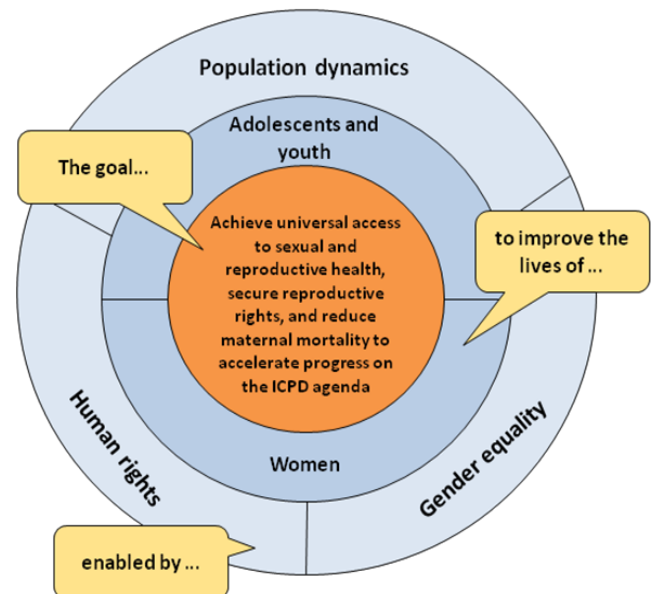
### 3.1 UN and UNFPA Response

The United Nations (UN) has been involved in Somalia since independence in 1960, carrying out activities that help alleviate poverty and suffering, encourage development, support peace-building and security and mitigate the effects of the conflict on the Somali people. The UN response in Somalia is coordinated under the UN Country Team, led by a resident coordinator. Currently, the UN’s work is guided by the New Deal<sup>29</sup>, which emphasises Somali-owned and Somali-led development and effective aid management and delivery that mirrors development needs among other principles. It also helps in strengthening its partnership in Somalia.

### 3.2 UNFPA Response through the Programme

UNFPA promotes the right of every woman, man and child to enjoy a life of health and equal opportunity. It supports countries in using population data for policies and programmes to reduce poverty and to ensure that every pregnancy is wanted, every birth is safe, every young person is free of HIV&AIDS, and every girl and woman is treated with dignity and respect as espoused in the UNFPA motto - *because everyone counts*. The UNFPA Global Strategic plan 2014 – 2017<sup>30</sup> has a main goal characterized as the “bull’s eye”: the achievement of universal access to sexual and

reproductive health, the realisation of reproductive rights, and the reduction in maternal mortality. The work of the organisation is centred on attaining this goal, particularly through an enhanced focus on family planning, maternal health, and HIV/AIDS.



**Figure 1: The “Bull’s Eye” as UNFPA Global Strategic Goal**

The Strategic Plan revolves around four outcomes, achieved through 15 outputs and developed to achieve the “bull’s eye” goal. These are:

- Outcome 1: Increased availability and use of integrated sexual and reproductive health services (including family planning, maternal health and HIV) that are gender-responsive and meet human rights standards for quality of care and equity in access

<sup>29</sup><http://www.undp.org/content/unct/somalia/en/home/what-we-do/new-deal-for-somalia.html>

<sup>30</sup><http://www.unfpa.org/sites/default/files/resource-pdf/Strategic%20Plan%202014-2017.pdf>

- Outcome 2: Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education and sexual and reproductive health services
- Outcome 3: Advanced gender equality, women's and girls' empowerment, and reproductive rights, including for the most vulnerable and marginalized women, adolescents and youth
- Outcome 4: Strengthened national policies and international development agendas through integration of evidence-based analysis on population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality

### **3.2.1 Brief description of UNFPA previous cycle strategy, goals and achievements**

The first UNFPA Somalia country programme 2008-2009, was extended through 2010. The programme was based on priorities identified in the United Nations Transition Plan for Somalia, 2008-2010. Achievements in the area of reproductive health included the development of a reproductive health strategy for Somaliland and Puntland, strengthened capacity of service providers to increase skilled birth attendance, provision of family planning services in selected institutions, including health facilities serving internally displaced people in Mogadishu, and implementation of the fistula management campaign. The programme also supported the establishment of the Youth Peer Education Network (Y-PEER) and youth advisory panels.

The programme's population and development focus was on strengthening the institutional capacity of the government to respond to population and development needs in emergency, recovery and development situations. In the area of gender equality, UNFPA supported and facilitated the work of coordinating bodies to prevent and respond to gender-based violence. UNFPA provided commodities and training support to local partners working with the survivors of gender-based violence. Lessons learnt from the first cycle of assistance included the need for flexible planning that considers the political context and the differing stages of development in the three zones, and the feasibility of delivering essential services through partnerships between non-governmental organisations and governmental organisations in situations where government capacity is weak.

### **3.2.2 Current UNFPA Country Programme**

The 2nd Somalia Country Programme seeks to improve the overall quality of life of the Somali people. It was developed based on national priorities identified in the Somalia Reconstruction and Development Programme, 2008-2012, and the United Nations Somalia Assistance Strategy (UNSAS), 2011-2015<sup>31</sup>, which focuses on three areas: (a) emergency response, (b) the transition from conflict to peace and from crisis to recovery, and (c) longer-term development. The programme is aimed at contributing to the three outcomes of the United Nations Somalia Assistance Strategy (UNSAS): (a) Somali people have equitable access to basic services in health, education, shelter, water and sanitation, (b) Somali people

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<sup>31</sup> UN programmes were under the UNSAS umbrella up to 2014. UN Somalia developed an Integrated Strategic Framework for 2014-2016, which is aligned to the New Deal/Somalia Compact

benefit from poverty reduction through equitable economic development and decent work, and (c) Somali people live in a stable environment where the rule of law is respected and rights-based and gender-sensitive development is pursued. For the special situation in Somalia, the United Nations Country Team (UNCT) decided to use the UNSAS as the framework for assistance and to use the Country Programme Action Plan (CPAP) as an internal document to guide implementation. The 2nd Country Programme (CP) was approved by the UNFPA Executive Board for the period 2011-2015.

The current CP was extended for one operational year, ending 2016. This was done in 2014 with the United Nations Integrated Strategic Framework (ISF) for Somalia (2014 - 2016), which is aligned to the New Deal/Somali Compact. After the signing of the Somalia Compact in the presence of the President of Somalia and the Secretary-General of the United Nations in October 2014, the UN team in Somalia initiated the design and supporting implementation of programmes that respond to the priorities and principles of the ISF, which details planning frameworks for each Peace state building goals (PSG) for 2015-2016. Through the arrangement, the funding mechanisms were detailed and a funding mechanism was established (the UN Multi-Partner Trust Fund (UNMPTF)) to allocate funding to UN agencies. Given the developments and the national commitments to change, peace and state building goals and coordination, there was common consensus among the UN agencies, through the UNCT to extend their respective country programmes to fully align with the national development framework (ISF) and cycle. UNFPA was eligible to receive funding through the UNMPTF

mechanism through the UN stream, and it was through this that UNFPA had to be fully engaged in the new thinking jointly with other UN Agencies and Donors that the country programme was extended. The extension was approved by the UNFPA Executive Board.

In order to ensure that UNFPA Somalia strategies are in line with the global UNFPA strategic plan 2014-2017, the CP contributes directly to the goals and interventions are focuses on the following priorities

- (a) Decreasing maternal mortality
- (b) Managing population growth and the “youth bulge” and
- (c) Improving humanitarian preparedness and response.

The above priorities are addressed through the three programme components. It mainstreams the needs of youth and focuses on the empowerment of young women. Table 3.1 demonstrates the alignment of the UNFPA Somalia Country Programme with the UNFPA Strategic Plan.

**Table 3.1 Alignment of Somalia Country Programme with UNFPA Strategic Plan<sup>32</sup>**

<b>UNFPA SP 2014 - 2017 Outputs</b>	<b>UNFPA Somalia 2<sup>nd</sup> CPAP 2011 – 2016 Outputs</b>
<p><b>SP Outcome 1:</b> Increased availability and use of integrated sexual and reproductive health services (including family planning, maternal health and HIV) that meet human rights standards for quality of care and equity in access</p> <p><b>SP Output 3:</b> Increased national capacity to deliver comprehensive maternal health care services.</p>	<p><b>CP Output 1:</b> Improved health-care delivery to reduce maternal and neonatal mortality and related morbidity</p>
<p><b>SP Outcome 1:</b> Increased availability and use of integrated sexual and reproductive health services (including family planning, maternal health and HIV) that meet human rights standards for quality of care and equity in access</p> <p><b>SP Output 1:</b> Increased national capacity to deliver integrated sexual and reproductive health services.</p>	<p><b>CP Output 2:</b> Increased capacity of government, community-based and non-governmental organisations to offer high-quality, comprehensive sexual and reproductive health services, education and information for young people, with a focus on young people who are most at risk</p>
<p><b>SP Outcome 3:</b> Advanced gender equality, women’s and girls’ empowerment, and reproductive rights, including for the most vulnerable and marginalized women, adolescents and youth.</p> <p><b>SP Output 10:</b> Strengthened capacity to prevent gender-based violence and harmful practices and enable the delivery of multi-sectoral services, including in humanitarian settings.</p>	<p><b>CP Output 3:</b> Increased advocacy and community engagement to promote the reproductive health and rights of women and adolescent girls and to eliminate harmful practices affecting maternal health</p>
<p><b>SP Outcome 3:</b> Advanced gender equality, women’s and girls’ empowerment, and reproductive rights, including for the most vulnerable and marginalized women, adolescents and youth.</p> <p><b>SP Output 9:</b> Strengthened international and national protection systems for advancing reproductive rights, promoting gender equality and non-discrimination and addressing gender-based violence</p>	<p><b>CP Output 4:</b> Enhanced systems and mechanisms to prevent and protect against all forms of gender-based violence, using a human rights perspective, including in emergency and post-conflict situations</p>
<p><b>SP Outcome 4:</b> Strengthened national policies and international development agendas through integration of evidence-based analysis on population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality.</p> <p><b>SP Output 12:</b> Strengthened national capacity for production and dissemination of quality disaggregated data on population and development issues that allows for</p>	<p><b>CP Output 5:</b> Strengthened capacity of selected sectoral ministries and partner organisations to collect, analyse, disseminate and utilise disaggregated population data for planning and delivering humanitarian, recovery and development assistance</p>

<sup>32</sup> UNFPA Somalia to the UNFPA Global Strategic Plan, 2014-2017 Aligning Document

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mapping of demographic disparities and socio-economic inequalities, and for programming in humanitarian settings

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**SP Outcome 4:** Strengthened national policies and international development agendas through integration of evidence-based analysis on population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality.

**SP Output 15:** Strengthened national capacity for using data and evidence to monitor and evaluate national policies and programmes in the areas of population dynamics, sexual and reproductive health and reproductive rights, HIV, adolescents and youth and gender equality, including in humanitarian settings

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**CP Output 6:** Improved systems for generating, analysing and disseminating disaggregated population and related data, with a focus on improving the monitoring of maternal health at zonal and sub-zonal levels in order to inform interventions in this area

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Programme Coordination and Assistance (PCA)

**SP Output 1:** Enhanced programme effectiveness by improving quality assurance, monitoring, and evaluation;

**SP Output 2:** Improved mobilisation, management and alignment of resources through an increased focus on value for money and systematic risk management;

**SP Output 3:** Increased adaptability through innovation, partnership and communications

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### 3.2.3 The Somalia CP Intervention Logic

The outcome of the Reproductive Health and Rights (RHR) component of this programme is the demand for, access to and utilisation of equitable and improved reproductive health services are increased in all three zones, including in settlements for internally displaced people. The component emphasizes maternal health services delivery through partnership and capacity strengthening to facilitate provision of basic and comprehensive emergency obstetric care as well as prevention and management of obstetric fistula, Family planning and RH commodity and security strengthening, HIV prevention, youth, and adolescent sexual and reproductive health. It uses a rights-based, gender-sensitive and culturally sensitive approach and adopts behaviour change strategies expected to increase access to, and the utilisation of,

services by young people, women and men, especially in the fight against HIV and AIDS, and family planning uptake. It has two distinct outputs, which are: **Output 1:** Improved health-care delivery to reduce maternal and neonatal mortality and related morbidity; and **Output 2:** Increased capacity of government, community-based and non-governmental organisations to offer high-quality, comprehensive sexual and reproductive health services, education and information for young people, with a focus on those who are most at risk.

According to the programme design, UNFPA aims to achieve the first output of the component through developing, monitoring and coordinating the implementation of the road map for reducing maternal mortality, building the capacity of skilled birth attendants, strengthening midwifery at the community level to improve maternal health, strengthening the

capacity of selected health facilities to provide basic and comprehensive emergency obstetric care as well as obstetric fistula repair, strengthening referral systems for emergency obstetric care, strengthening reproductive health commodity security, including the provision of emergency delivery kits, increasing and consolidating partnerships to address reproductive health needs within the context of humanitarian crises and emergency situations, and supporting the production and implementation of training on standard reproductive health service protocols.

The second output of this component was designed to include adolescent sexual and reproductive health and HIV prevention in the national youth strategy. It includes increasing the access to and use of integrated HIV/AIDS and reproductive health services, supporting community-based interventions with selected line ministries and the National AIDS Commissions, building the capacity of youth groups and networks to disseminate knowledge and information on reproductive health, helping line ministries and civil society organisations to design and establish youth-friendly health facilities, supporting the development of behaviour change communication interventions to reduce high-risk behaviour, and strengthening partnerships with organisations, groups and networks that address the needs of those populations who are most at risk, including young people affected by the conflict.

The **Population and Development (P&D)** component of the programme was developed to build the capacity of the government to collect, analyse and use data. In the CPAP, the P&D component has one outcome and two outputs. The outcome is the availability of reliable demographic and related data is

ensured, along with institutional capacity and systems for planning, delivering and monitoring humanitarian, recovery and development policies and programmes, especially at zonal and sub-zonal levels. The **first** output aims to ensure improved systems for generating, analysing and disseminating disaggregated population and related data, with a focus on improving the monitoring of maternal health at zonal and sub-zonal levels in order to inform interventions in this area. The **second** one aims to ensure a strengthened capacity of selected sectoral ministries and partner organisations to collect, analyse, disseminate and utilise disaggregated population data for planning and delivering humanitarian, recovery and development assistance.

The strategies and interventions for attainment of the first output of the component include; Data collection and analysis of data related to reproductive health and gender, support on-the-job basic statistics capacity strengthening for line ministries' data compilers, recruitment and placement of statistical experts in Ministries of Planning; Formulation of population or statistics policies; in collaboration with Ministry of Planning, Health and Women Affairs UNFPA support the development and maintenance of the Health Management Information System and a gender disaggregated database respectively; Technical assistance and capacity strengthening for data production activities and preparation of reports by each zone on progress towards achievement of the ICPD Goals and Millennium Development Goals 4 and 5; Building the capacity and providing technical assistance to government and other partners to integrate maternal mortality and morbidity into emergency preparedness and response; and Formulation of population or statistics policy. On the other hand, output two

is to be achieved through the provision of technical support, capacity strengthening for better planning and monitoring of humanitarian assistance and recovery.

The outcome of the **Gender Component** of the programme is to ensure an improved socio-cultural environment to advance gender equality, reproductive health and women's and girls' empowerment, including for the most vulnerable and marginalized women, adolescents and youth. Implemented in an integrated manner throughout the programme, the component has **two outputs**: (1) an increased capacity for advocacy and community engagement in the reproductive health and right of women and adolescent girls and the elimination of harmful practices affecting maternal health; and (2) creation of enhanced systems and mechanisms for prevention and of protection from all forms of gender-based violence, using human rights perspective, including emergency and post-conflict situations.

The strategies and activities implemented towards the first output included:

- raising awareness of the effects of female genital mutilation/cutting and early marriage on maternal mortality and morbidity
- advocating the implementation of laws prohibiting female genital mutilation/cutting
- enhancing community-based efforts to address the harmful effects of early marriage and female genital mutilation/cutting
- strengthening community-based initiatives to increase the retention of girls in formal and non-formal education

- and targeting community and religious leaders, young men and boys with awareness campaigns on early marriage and female genital mutilation/cutting.

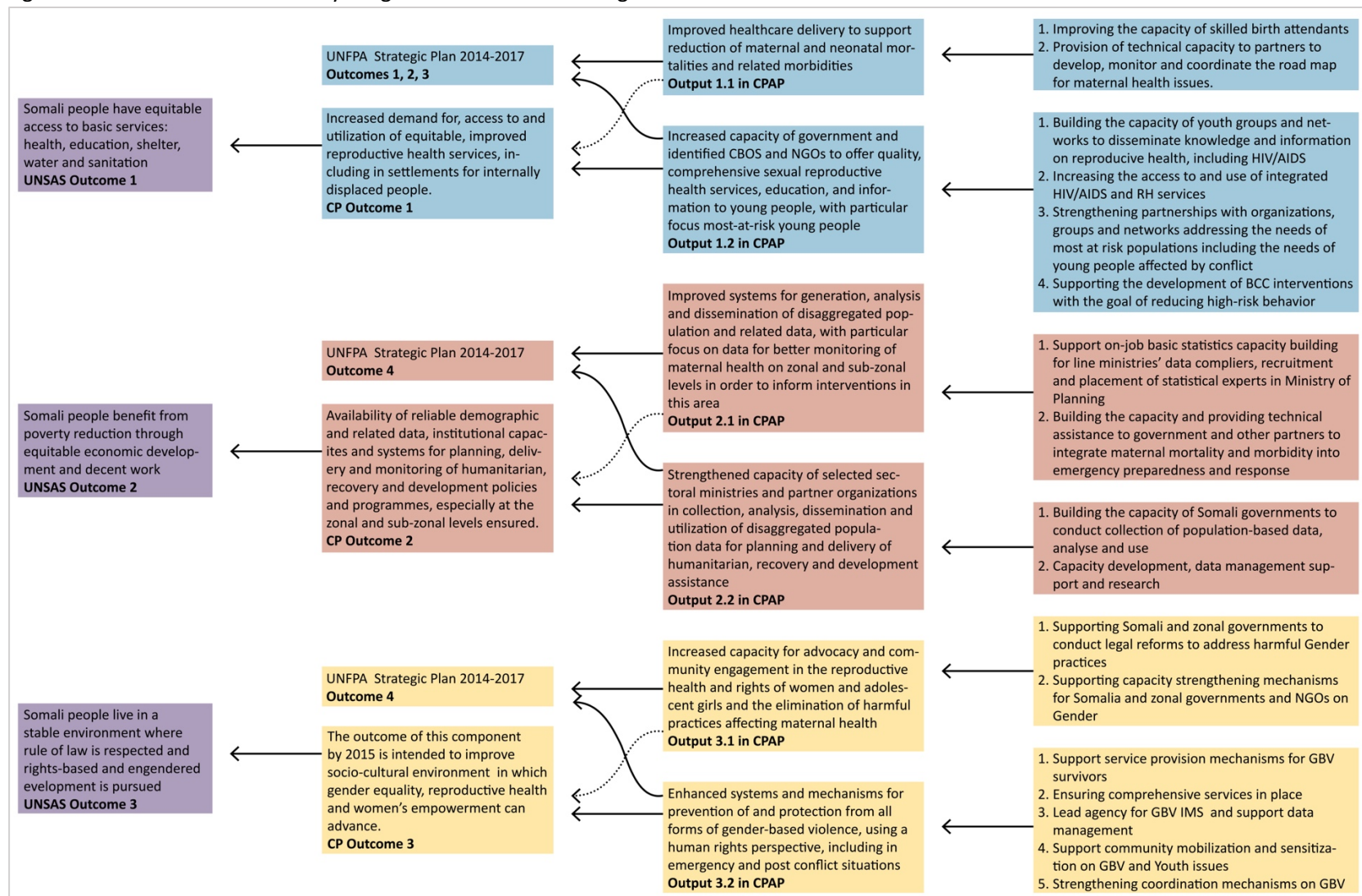
Strategies to ensure achievement of the second output included:

- strengthening the capacity of selected non-governmental and community-based organisations to provide health and psychosocial support to survivors of sexual and gender-based violence, including support to address the complications of female genital mutilation/cutting
- supporting the institutionalization of modules to prevent sexual and gender-based violence in a training-of-trainers curriculum for health-care providers
- strengthening community-level 'safety nets' for survivors of sexual and gender-based violence; promoting the involvement of men, boys and community leaders in preventing sexual and gender-based violence
- and addressing sexual and gender-based violence as part of humanitarian response efforts and as per the minimum initial services package.

The programme logic in Figure 3.1 gives an overview of the flow of results, from the activities to the intended results, including how they contribute to the UNFPA global results and those of the UN country level.



Figure 3.1 UNFPA Somalia Country Programme Intervention Logic<sup>33</sup>



<sup>33</sup> It should be noted that the Compact Deal's Integrated Strategic Framework (ISF) replaced the 2011-2015 UN Somali Assistance Strategy (UNSAS) in 2013. The UNFPA CP was therefore updated to align to the Compact. See further <https://unsom.unmissions.org/Portals/UNSOM/Somalia%20ISF%202014-2016%20FINAL%20signed.pdf>

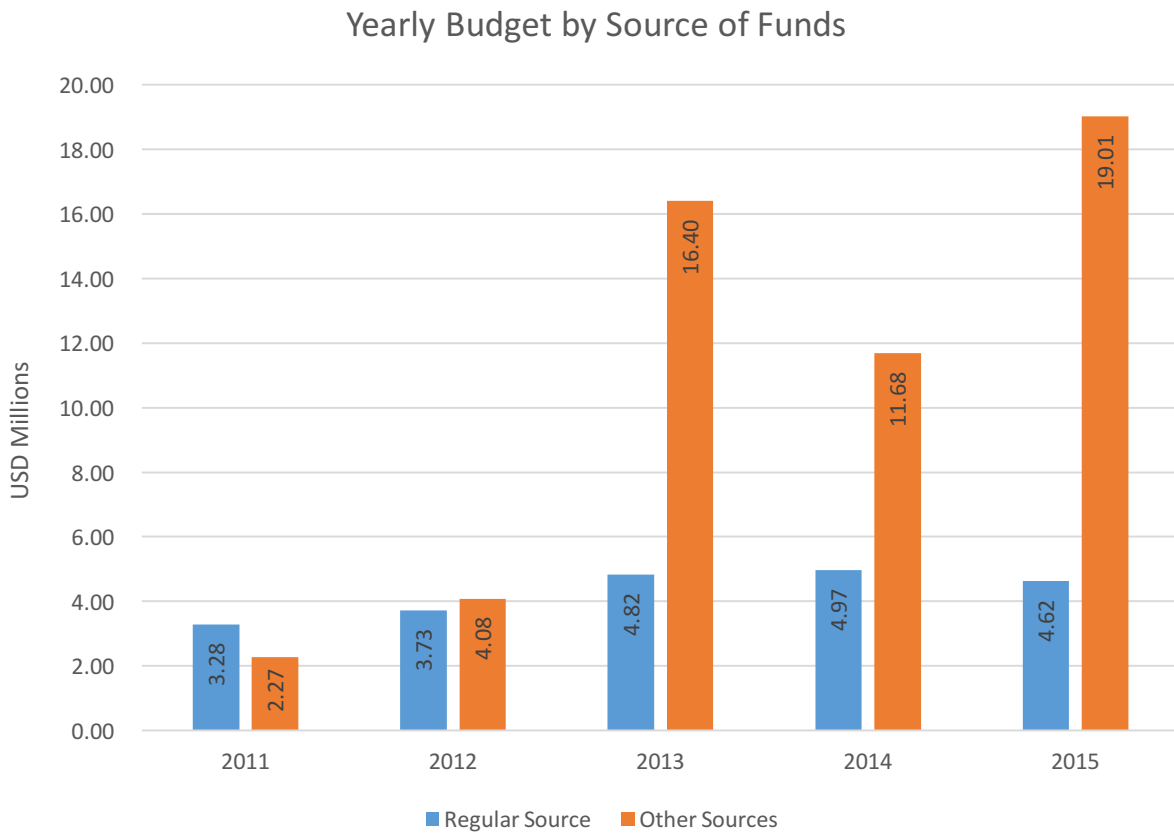
### 3.2.4 The Financial Structure of the Programme

The CPD had proposed indicative UNFPA assistance of US\$ 27.2 million. Out of the US\$ 27.2 million, US\$ 12.7 million was to be from regular sources and US\$ 14.5 million through co-financing modalities and/or other, including regular resources, for a five-year period. Of the US\$ 27.2 million, US\$ 14.0 million was allocated to reproductive health and rights, US\$ 6.0 million for population and development, US\$

6.5 million for gender equality and US\$ 0.7 million for programme coordination assistance.

During the period of evaluation, the programme surpassed the proposed indicative budget, reaching a total of budget of US\$ 74,871,837.38, and a total expenditure of US\$ 65,860,659.82. Figure 3.2 shows the distribution of the yearly budget by source.

**Figure 3.2: Yearly Budget by Source of Funds**



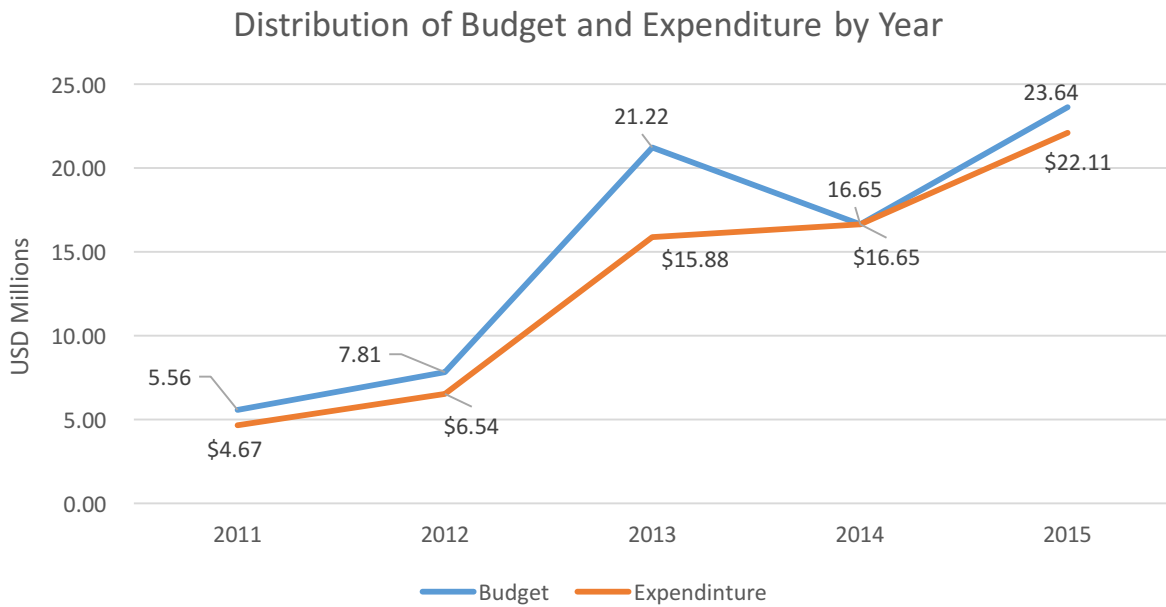
**Source:** UNFPA CO<sup>34</sup>

<sup>34</sup> Financial data was provided by the UNFPA CO in Nairobi

The programme budget gradually increased from 2011, with the highest increase registered in 2014 where the budgeted amount was almost triple (US\$ 21,224,361.18) the amount of the year 2012 (US\$ 7,806,395.72), showing the responsiveness of the country programme

to the needs of the Somali people and the ability of the CO to fundraise. There was a sharp decrease in budget in 2014, but this increased again in 2015. Figure 3.3 shows the distribution of programme budget and expenditure by year.

**Figure 3.3: Distribution of Budget and Expenditure by Year**

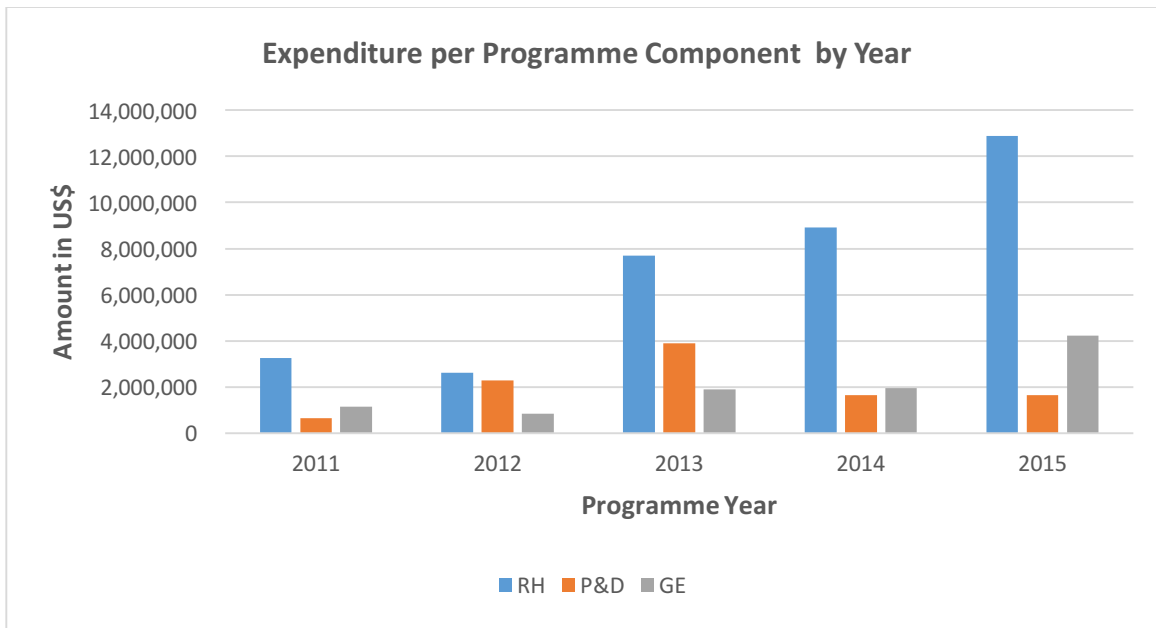


**Source:** UNFPA CO

The RHR component has the highest share of the budget and disbursement followed by the P&D component, the Gender Equality component, and then management, respectively. Further, on expenditure, RHR had the highest amount spent, nearly half the total

budget, then both P&D and GE spent almost the same amounts. Figure 3.4 shows the distribution of the programme expenditure over the period of evaluation per component by year.

**Figure 3.4 Expenditure Amount per Programme Component by Year**



**Source:** UNFPA CO

## 4.0 EVALUATION FINDINGS

### 4.1 Introduction

This section presents the findings of the evaluation based on the three programme components. The first section is the findings on the reproductive health and rights component. Second is population and development, and third is the gender component. The analysis of the performance on each component follows the evaluation criteria of relevance, effectiveness, efficiency and sustainability. The findings and analysis based on the UNFPA-specific criteria of coordination and value added is made separately for the whole CP at the end of this section. The extent to which the results have been realised is described in the text with a section summary at the end of every component covering the evaluation questions and UNFPA-specific criteria of assessment.

### 4.2 Reproductive Health & Rights Component

#### 4.2.1 Relevance

**EQ 1:** To what extent were the programme interventions consistent with the needs of the beneficiary populations and to what extent was it aligned with government priorities as well as with policies and strategies of UNFPA?

**EQ 2:** How well was the CPAP aligned with the ICPD actions and MDGs as well as with the UNFPA Strategic Plans?

In establishing the extent to which the programme is relevant, the evaluators considered the programme interventions, their relevance to identified country needs, how they addressed the government priorities and development plans, and

relevance to the UNSAS and UNFPA priorities and mandate. The evaluation also sought to establish how the target beneficiaries involved in determining the kinds of activities being implemented or supported through the CP.

The UNFPA's Somalia Country Programme Document (CPD) was developed to address the gaps identified from the previous programme cycle based on the lessons learnt. The programme's reproductive health and rights (RHR) component was implemented and was in line with the Somalia health sector strategic plan (HSSP, 2013 – 2016) results areas 2 (*Increase the health workforce, improve their skill balance and strengthen their capacity*), 3 (*Roll out the provision of equitable health services and functional health facilities in all regions*) and 5 (*Ensure provision of appropriate and sufficient medical products and technologies*).<sup>35</sup> However, the 2<sup>nd</sup> Country Programme only contributed to the strategic plan as the HSSP results areas were too broad, as well as ambitious for achievement within the time frame covered. Through the same component, the programme led and supported the development of the Youth Policy<sup>36</sup>, whose objective is to create a framework that will enable youth in Somalia to address issues that are unique to them and their communities through dialogue. HIV and AIDS activities were also supported during the life of the CP. UNFPA contributes to RHR mainly through the Ministries of Health (MoH), Ministry of Youth and Sports (MoYS), and the National AIDS Commissions across the three zones.

<sup>35</sup> Somalia Health Sector Strategic Plan January 2013 – December 2016

<sup>36</sup> Key informant interviews with staff of Ministry of Labour, Youth and Sports in Garowe; Ministry of Youth and Sports in Mogadishu; UNFPA Staff and 2015 COAR

The RHR component is relevant as it addressed identified and existing needs in Somalia<sup>37</sup>. At the time of the design, Somalia had some of the worst health indicators in the world. The child and maternal mortality rates were among the highest, with one in every ten children dying before seeing their first birthday; while on the other hand, one out of twelve women dying due to pregnancy related causes. Further, only nine percent of the births were attended by skilled staff, among the lowest rates of access to skilled maternal services. Somalia is still characterized with high fertility rates, putting the women at a high risk of mortalities and morbidities around child birth especially with the low access to basic health services, including family planning. There was also low status of women and high rates of female genital mutilation (FGM/C). The programme addressed identified barriers to accessing reproductive healthcare through raising awareness on benefits; supporting logistical means to reach the underserved nomadic and rural communities; supporting improved quality of RH services; and continued support on commodity supplies which were intermittent.

As stated in the previous chapter, Somalia has high maternal mortality rates and infant mortality making it imperative to address the needs through improved access to and uptake of basic emergency obstetric and neonatal care (BEmONC). Delays in seeking care and poor quality care on arrival at facilities have been the most significant of the three delays<sup>38</sup> in access to effective emergency care. Through the 2nd CP, UNFPA is responding by strengthening capacity for EmONC and equipment of the health facilities across the country. The programme is highly relevant and contributes to the

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<sup>37</sup> Key informant Interviews in Hargeisa, Garowe and Mogadishu; CP Documents and UNFPA Annual reports

<sup>38</sup> There are three types of delays contributing to maternal mortality, which are; 1. Delay in making decision to seek care; 2. Delay in arrival at a health facility; and 3. Delay in receiving adequate treatment. – See <http://www.ncbi.nlm.nih.gov/pubmed/8042057/> for further reading.

country's health priorities and population needs with its focus on improving the quality of care, increasing demand and service uptake, and improving quality, collection, analysis and use of data to assess programme performance. These approaches align with the Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA)<sup>39</sup>.

The activities and design of the CP are relevant to the Somalia context. It is during the period that saw the development of the Health Sector Strategic Plan (HSSP), the youth policy and other related guidelines that promote standardized and quality implementations of the interventions as targeted and within the RHR framework. The UNFPA programme supported the development of family planning and clinical management of rape guidelines, which are applied and continue to guide service delivery processes, thereby providing strengthening of RHR.

The UNFPA Somalia contributions in the 2<sup>nd</sup> CP's were fully aligned to the UNFPA Strategic Plan and the United Nation's Integrated Strategic Framework (ISF) as stated in the alignment documents.<sup>40</sup> The alignment of the CP to the UNFPA Strategic Plan and ISF, including UNSAS was implicit from the CPAP and even though there were no changes made to the CPD, the programme was refocused, laying more emphasis on key strategic areas, enhancing RHR results and integration of programme interventions and further strengthening the national execution modality. There is consistency of the CPAP with the UNSAS outcome 1 (which states that *Somali people have equitable access to basic services which include health, education, shelter, water and sanitation*) as presented in the intervention logic (as in *Figure 3.1*)

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<sup>39</sup> [http://countryoffice.unfpa.org/somalia/2014/12/02/11059/puntland\\_launches\\_carmma/](http://countryoffice.unfpa.org/somalia/2014/12/02/11059/puntland_launches_carmma/)

<sup>40</sup> UNFPA Somalia Aligning To The Strategic Plan, 2014-2017

of the country programme. The CP also contributed to the achievement of the Somalia response to the Millennium Development Goals (MDGs) 3 (promote gender equality and empower women, 4 (reduced child mortality), 5 (improve maternal health) and 6 (on combating HIV&AIDS, TB, malaria and other infectious diseases). UNFPA also upheld the spirit of partnership to build on synergy to enhance achievement of its results. This was seen through employing a collaborative approach to work with various stakeholders to ensure that services reached the target populations<sup>41</sup>.

Somali Joint Health Nutrition Programme (JHNP 2012 -2016) is an effort of UNICEF (the United Nations Children's Fund), WHO (World Health Organisation), UNFPA, the Somali health authorities and donors to improve the health of mothers and children and to strengthen the Somalia Health Care System<sup>42</sup>. In particular, JHNP aims to support sustained and improved reproductive, maternal, new-born and child health (RMNCH) and nutrition outcomes for Somali women, girls, children and their communities, while strengthening the systems that support improved quality and access to health care. UNFPA implemented its RHR component in the umbrella of JHNP and this was effective in delivering its maternal health services through a complementary manner.

The JHNP supports critical elements of the New Deal initiative 'the Somali Compact', the Somali 'Six pillar' policy for peace building & state-building and more specifically implementation of the in-country developed Health and Nutrition Policies, Health Sector Strategic Plans (HSSPs), aligned strategies and relevant United Nations cooperation strategies. Its implementation also considers the specific

context of Somaliland, Puntland and South Central and on-going health sector reform initiatives. UNFPA's participation in this programme in Somalia makes it highly relevant given the extent of unmet needs and prevailing health needs.

The evaluation established the involvement of the target populations in determining the kind of interventions that they require. It was evident from assessments conducted by the various stakeholders, documenting gaps and capturing the needs of the affected<sup>43</sup>. These needs formed part of planned activities supported through UNFPA CP support. UNFPA would also make decisions to recommit resources to identified areas of gaps arising from the programme review and planning meetings facilitated and coordinated by its implementing partners and beneficiaries<sup>44</sup>. It was notable when UNFPA expanded its support to MoH-managed health facilities in Marka, Baidoa and Kismayo, in areas that were previously supported by Médecins Sans Frontières (MSF) before closing its programmes in Somalia<sup>45</sup>. All these among other service provision exhibit the relevance of the UNFPA country programme.

The family planning (FP) component is also highly relevant in as maternal mortality rates are high among the Somali women. UNFPA CP continues to strengthen reproductive health commodity security (RHCS). UNFPA also supported the government in

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<sup>41</sup> Key informant interviews with IPs in Garowe, Hargeisa and Mogadishu; UN Partners; and UNFPA Staff and Reports

<sup>42</sup> See more about the programme from <http://jhnp.org/about-jhnp/> [Accessed on 10/12/2015]

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<sup>43</sup> Interviews with IPs; AWP

Community-led discussions documented on GBV and FGM, facilitated by IRADA in Gebiley and Marodi Jeeh regions in Somaliland informed the projects and interventions that UNFPA funded on GBV and FGM; KAP Surveys on HIV&AIDS conducted among the youth by Y-Peer Network informed interventions funded by UNFPA in Puntland; UNFPA staff interviews

<sup>44</sup> Interviews with IPs in Hargeisa, Mogadishu and Garowe; review of AWP

<sup>45</sup> <https://www.humanitarianresponse.info/system/files/documents/files/Healthpercent20Clusterpercent20Bulletin-Sept-Octpercent202013.pdf>

Somalia Situation Report; Interviews with UNFPA RH Technical Advisor and MoH staff in Mogadishu

developing family planning guidelines (referred to as *birth spacing* for contextualization). Government Staff were also trained on the techniques for provision of the family planning services.

The CP also supported underserved areas in Somalia through outreach activities, implemented by the ministries of health, which was applauded by the staff as very appropriate for increasing access to services by the populations<sup>46</sup>. The humanitarian assistance programme of the CP contributed immensely in improving access to skilled birth attendance by the IDPs through establishing maternity waiting homes (MWH)<sup>47</sup> in IDP settlements<sup>48</sup>. UNFPA provided technical and financial support in the running of the activities in the MWH. Staff salaries and supplies in these set-ups were financed by UNFPA. In designing the programme plan, UNFPA employed a minimum initial service package for lifesaving interventions related to RHR and Family planning for those affected by disasters and emergencies. The programme supported the Somali returnees from Yemen and Yemeni refugees. It also effectively responded during the 2013 cyclone in Eyle in Puntland as those affected were supported with MISP for emergency<sup>49</sup>. Even though this was appropriate in most situations, there were instances in Mogadishu where it was felt that some of the MWHs were not necessary as they were established

closer to MoH facilities where patients could visit directly; a case in point is where a MWH is supported near Benadir Hospital which is also supported by UNFPA, through Swisso Kalmo<sup>50</sup>. However, the centre complements the services provided by the hospital which is a CEmONC centre given the population in Mogadishu far outweighs the capacity of the hospitals available, and to have all women giving birth in CEmONC centres would be much less cost effective than having lower level centres as standard<sup>51</sup>. There was also a gap in coordination between UNFPA's humanitarian assistance unit and the MoH in South Central as the ministry is not involved in monitoring of the related activities.<sup>52</sup>

Given the unmet needs in maternal health, UNFPA supports the Somalia MoHs to implement and strengthen access to family planning (FP). Notable during the period of evaluation is the revision of the National RH strategy through working with the policy makers, supporting the development of FP guidelines and training of trainers (ToT) on FP to reach more health workers across the country. Further, UNFPA supported in contraceptive supply and related commodity procurement to meet the needs of the women of reproductive age including for young people. These are highly relevant activities to address unmet needs within the country.

### **Adolescent and Youth Sexual Reproductive Health**

The adolescent and youth sexual reproductive health (ASRH) was not initially a priority programme in the initial stages but later given prominent focus during alignment to the UNFPA Strategic Plan. The alignment focuses on Outputs 6, 7 and 8 of the Strategic plan under Outcome 2 which seeks to increase priority on adolescents, especially on very

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<sup>46</sup> Interviews with MoH staff in Puntland, Somaliland and FGS  
[http://countryoffice.unfpa.org/somalia/2015/06/29/12360/reaching\\_out\\_to\\_the\\_underserved\\_in\\_somalia/](http://countryoffice.unfpa.org/somalia/2015/06/29/12360/reaching_out_to_the_underserved_in_somalia/);

[http://countryoffice.unfpa.org/somalia/2015/08/31/12716/more\\_reproductive\\_health\\_services\\_for\\_the\\_underserved\\_in\\_somalia/](http://countryoffice.unfpa.org/somalia/2015/08/31/12716/more_reproductive_health_services_for_the_underserved_in_somalia/)

<sup>47</sup> The name of maternity waiting homes was previously reviewed and recognised to be misleading, as they are maternity centres offering clinical services rather than waiting homes purely for awaiting labour. For the purpose of this evaluation report, Maternity Waiting home is used but the role is recognized.

<sup>48</sup> Interviews with IPs in Mogadishu and Garowe; FGDs at Jowley MWH in Garowe and Hodan district in Mogadishu with beneficiaries; End of Project Evaluation report on MWHs in Somalia  
<https://www.humanitarianresponse.info/system/files/documents/files/Healthpercent20Clusterpercent20Bulletin-Sept-Octpercent202013.pdf>

<sup>49</sup> Interviews with MoH staff in Garowe

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<sup>50</sup> Key Informant Interviews Mogadishu

<sup>51</sup> Feedback from UNFPA

<sup>52</sup> Ibid



young adolescent girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education and sexual and reproductive health. The programme's design was also responding to a gap realised from the previous country programme, which was found not to sufficiently address the needs of the Somali youth.

Development, humanitarian assistance and peace-building, can be more responsive by mobilizing and empowering Somalia youth as positive agents of change<sup>53</sup>. The UNFPA Somalia programme integrated the ASRH interventions across all the three programme components as a cross-cutting theme. They were mainly involved in advocacy on issues affecting them and the general community. The approach was used on UN System-Wide Action Plan (SWAP) which seeks to enhance the coherence and synergy of United Nations' system-wide activities in key areas related to youth development<sup>54</sup>. To address this, UNFPA implemented the activities through its brain-child youth programme, Y-PEER Network. The approach included the use of evidence-based advocacy; capacity development for ASRH services; and supporting the Life Skills, Sexuality, HIV and AIDS Education; and promoting youth leadership programmes. All these are highly relevant to the Somalia situation, as ASRH have not been sufficiently addressed to date<sup>55</sup>. The GBV programme also benefitted the youth as most of the survivors are young, in addition to involving them to carry out the campaigns.

Integration of the youth programming into the mainstream CP service delivery results was relevant given the socio-cultural challenges where they felt

<sup>53</sup> UNDP 2012. Somalia Human Development Report

<sup>54</sup> <http://unyouthswap.org/thematic-areas/employment-and-entrepreneurship> [accessed on 14 Dec 2015]

<sup>55</sup> Interviews with IPs and FGDs with youth in Hargeisa, Garowe and Mogadishu; and UNFPA staff; Somalia National Youth Policy

stigmatised whenever they sought youth-friendly services as the RH services mostly perceived to associate with those who are married or suffering from certain ailments like HIV and other sexually transmitted infections. UNFPA further enhanced the youth programming by creating a unit within the RH component, equipping it with staff who are also youthful to drive the youth agenda. This integration was also relevant since the Somali youth consist of 70 percent of the population and given that most of the RH service seekers or targets were the youth. This is also given the fact that there is a very high rate of early marriage<sup>56</sup>, which contributes to poor obstetric outcome. UNFPA also integrated the youth issues through the training of the midwives where those selected to participate in the training were between the ages of 19 and 20 years old. After graduation, this also contributed to the employment of the youth to earn a living.

Somalia's HIV prevalence among the adult population is estimated to be between 0.5 percent - 0.7 percent and is said to be on the rise<sup>57</sup>. The rise in infections is being blamed on ignorance, cultural barriers and fear of stigmatization which hampers many people from finding out their HIV status<sup>58</sup>. Other factors include the impact of the conflict and an ensuing increase in sexual assaults<sup>59</sup>. The programme is highly relevant as it targets prevention activities across the country, including in the IDP settlement. Integration of HIV and AIDS with the youth programming is a step in the right direction as they are considered the most vulnerable groups in Somalia [<sup>60</sup>][<sup>61</sup>]. Relevance of the CP's focus on the Somali youth and HIV&AIDS is

<sup>56</sup> <http://www.girlsnotbrides.org/child-marriage/somalia/>

<sup>57</sup> <http://amisom-au.org/so/2014/12/hiv-infections-on-the-rise-in-somalia/>

<sup>58</sup> Ibid

<sup>59</sup> <http://www.so.undp.org/content/somalia/en/home/mdgoverview/overview/mdg6.html>

<sup>60</sup> IOM (2012), Youth Behavioural Survey Report: Somalia

<sup>61</sup> See further in <http://amisom-au.org/2014/12/hiv-infections-on-the-rise-in-somalia/>

not to the extent that it should, as the focus is not given emphasis despite the appreciation that the population of Somalia is mainly youth which comes with different challenges. Various adolescent sexual reproductive health (ASRH) interventions are discussed further under effectiveness, as well as complementary discussion under HIV prevention.

#### 4.2.2 Effectiveness

**EQ 3:** To what extent did the interventions supported by UNFPA in the field of reproductive health and rights contribute to (i) Improved access and utilisation of high quality maternal health and family planning services, including populations affected by humanitarian crisis (ii) Increased national and sub-national capacity to deliver integrated sexual and reproductive health services (iii) Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes?

**EQ 6:** To what extent was the programme coverage (geographic; beneficiaries) reached as planned?

In assessing the effectiveness of the country programme, the evaluation considered the achievements made towards realizing the targeted results in the CPAP, the activities implemented and the extent to which they contributed to realisation of the intended design objectives. The assessment was guided by the evaluation question which sought to establish the extent with which the interventions supported by UNFPA in the field of reproductive health and rights contribute to improved access and utilisation of high quality maternal health and family planning services, including populations affected by humanitarian crisis; increased national and sub-national capacity to deliver integrated sexual and reproductive health services; and increased priority on adolescents,

especially on very young adolescent girls, in national development policies and programmes.

The performance of the CP in the RHR component is summarised in Annex 2<sup>62</sup>. Implementation of the UNFPA RHR component was built from the previously developed country programme. Implementation approach was however different since the previous one was implemented on a spontaneous manner due to the fragile context. It is built around the UNFPA global approach which revolves around the life of a woman, on the premise that no woman should die due to pregnancy-related causes. Its mandate is to ensure availability of service and is developed along three pillars:

- Supply, where it delivers services to the target groups
- Demand, where the programme works with communities to create demand through information, availing the services through interventions, including commodities; and
- Policy, where the programme seeks to make the environment favourable for access and utilisation of the services through policy influence

The Somalia UNFPA RHR component was mainly implemented through the joint health and nutrition programme (JHNP) across the country among other projects implemented by UNFPA. There is high level of effectiveness of RHR component<sup>63</sup> programming in meeting the results of the targeted objectives by the time of the evaluation, despite the contextual influence on implementation processes and design<sup>64</sup>. The RHR component was implemented

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<sup>62</sup> The Performance Framework is summarised considering the baseline and the targets in the RHR component that were to be achieved by 2015; and the achievement at the time of the evaluation, and based on the CPAP.

<sup>63</sup> Key Informant Interviews

<sup>64</sup> The Humanitarian access in Somalia still faces a lot of challenges. The coverage and quality of basic social services in Somalia is extremely

within the Somalia health sector strategic plan (HSSP) which further led to the programme directly contributing to the country's development on health issues.

### Community Midwifery

In response to the low access to skilled birth attendance by the Somali women, UNFPA supported implementation of various interventions to increase availability and access to quality RH service delivery to the target groups. This entailed contextualizing the responses based on the needs of the targeted regions. Some of the key achievements through the programme are the elimination of delay two and three<sup>65</sup> which were initially issues towards accessing of maternal services; improved skills of the health staff.

**“Maternal mortality rates are going down, not because we have magic, but because the women are coming on time, services are there, including caesarean-sections, and they are not charged.”**

—Key Informant in Somaliland

Training of midwives is an area that UNFPA performed so well in eliminating obstacles to access to maternal health care at the community level<sup>66</sup>, especially targeting the hard-to-reach communities. In collaboration with the Somalia MoH, professional associations, private health providers, communities and training institutions, UNFPA strengthened the

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low, mainly due to the absence or low capacity of existing government structures. The healthcare system in Somalia remains weak, poorly resourced and inequitably distributed. See more in <https://docs.unocha.org/sites/dms/Somalia/Somaliapercent202015percent20Humanitarianpercent20Needspercent20Overviewpercent20-percent20FINAL.pdf>

<sup>65</sup> According to *Thaddeus S and Maine D (1994)*, There are three types of delays contributing to maternal mortality, which are; delay in making decision to seek care; delay in arrival at a health facility; and delay in receiving adequate treatment, and names them as first, second, and third delay respectively – See <http://www.ncbi.nlm.nih.gov/pubmed/8042057/> for further reading.

<sup>66</sup> Interviews with IPs in Garowe, Hargeisa and Mogadishu

capacity of the health facilities to provide skilled birth attendance through supporting recruitment, training and equipping of trained midwives. To ensure effectiveness in utilisation of the services of the midwives after graduation, a clear guideline was developed, further facilitating accountability among the involved stakeholders. UNFPA also supported establishment of nurses and midwifery associations in both Somaliland and Puntland<sup>67</sup> to support on quality assurance for the midwifery training, including curriculum implementation, supervision and recruitment of students for the midwifery training.

With the support of UNFPA, training of the midwives has been a successful endeavour, with a total of 388 having graduated and a further 448<sup>68</sup> being in class at the time of the evaluation. This will surpass the target which was revised upwards to 400. However, there are gaps that have not been addressed for effective delivery of maternal health services at the community level. Deployment of the graduate midwives from their targeted communities and their retention in those communities is a bit of a challenge as some do not go back or stay in their communities to offer the services for which they are trained for. This is attributed to lack of proper framework by the government for their engagement to return to their communities where they are recruited from.<sup>69</sup> As part of the agreement, the government is to ensure their deployment and they are to work on a voluntary basis but this is not actually happening to a certain extent, as the graduate midwives retreat to town to look for paying jobs in cities or NGOs that offer to pay them salaries, unlike the volunteerism in their agreement of engagement

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<sup>67</sup> Somaliland Nursing and Midwifery Association, and Puntland Nursing and Midwifery Association in Somaliland and Puntland, respectively.

<sup>68</sup> Interviews; Programme reports

<sup>69</sup> Interviews and FGDs in Garowe and Hargeisa

with the MoH.<sup>70</sup> In some instances, though, the midwives have been employed by NGOs in their locality, thereby delivering services within their targeted communities. There is also a gap in ensuring consistent supervision of the midwives at the community level and equipment of the facilities that they work in; functions that are supposed to be performed by the government. They also need to be consistently supplied with delivery kits to be able to deliver in their assignments. UNFPA has however realised these gaps and is seeking to focus on strengthening these with the government during the programme extension period. Even though UNFPA has contributed immensely to the skilled birth attendance in Somalia through training and equipment of midwives, there still remains a huge gap of midwives within the country going by the WHO minimum standards of 2.3 full time skilled birth attendant per 1000 population<sup>71</sup>.

### **Strengthened Basic and Comprehensive Emergency Obstetric Care Service Delivery and Fistula Repair**

UNFPA effectively supported building the capacities of the health staff, in addition to equipping health facilities, to provide both basic and comprehensive emergency obstetric and neonatal care, and to conduct obstetric fistula repair<sup>72</sup>. Due to the high maternal deaths in Somalia, the programme

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<sup>70</sup> [http://countryoffice.unfpa.org/somalia/2013/05/20/6908/voices\\_from\\_the\\_field%20i%20am%20ready%20to%20work%20even%20without%20salary%20or%20compensation%20in%20order%20to%20save%20mothers%20and%20babies%20in%20my%20village%20rdg%20uo/](http://countryoffice.unfpa.org/somalia/2013/05/20/6908/voices_from_the_field%20i%20am%20ready%20to%20work%20even%20without%20salary%20or%20compensation%20in%20order%20to%20save%20mothers%20and%20babies%20in%20my%20village%20rdg%20uo/)

<sup>71</sup> In 2015 the estimated population in Somalia was 12.8 million, which means that 29,440 skilled birth attendants are needed to cover the whole population as per the WHO minimum standard (2.3 full time skilled birth attendants per 1,000 population). In accordance with midwives providing 87 percent of reproductive health care, Somalia needs 23,618 more midwives to be trained to be able to cover the population of 2015. At the current rate of training this can only be achieved in 24 years. This demonstrates the huge gap that still exists, and the importance of on-going and increasing investment.

<sup>72</sup> Interviews with IPs, FGDs at Maternity Waiting Homes and Programme reports

supported training of nurses and doctors to provide basic emergency obstetric care and neonatal care (BEmONC) and comprehensive emergency obstetric and neonatal care (CEmONC). UNFPA also supported the zonal authorities with ambulances in selected facilities to facilitate referrals from communities, including maternity waiting homes, to health facilities for CEmONC, in case of emergencies. There are also instances that, through coordination, NGOs have bridged the gap in facilitating referrals. These efforts yielded commendable results given the RH situations at the beginning of the programme. For example, in Puntland, there have been drastic changes in terms of access to maternal health services over the period of programme coverage, and the maternal mortality ratio (MMR) decline from 1044 to 732 per 100,000 live births and increase skilled birth attendance, and preventive services can be attributed to better access to the related services including comprehensive emergency obstetric care and referral supported by UNFPA<sup>73</sup>. In addition, UNFPA facilitated opening of six midwifery schools in Puntland over the same period and currently operating; continuing to train midwives.

To enhance effectiveness in the delivery of RH services across Somalia, UNFPA supported the government and continue to strengthen in establishment of Reproductive Health Unit under Primary Health Care Department of the MoH across the Somali zones (Puntland, Somaliland and South Central); including equipping the unit with staff and office equipment. This facilitated coordination and quality control through support supervision and overseeing implementation of guidelines, including operationalizing them<sup>74</sup>.

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<sup>73</sup> Interviews and programme reports

<sup>74</sup> Interviews and programme reports

**“I suffered for 31 years for something that took a few hours to repair. I can now smile after the 31 years of lost dignity. When I heard that there are women providing the services is when I decided to come. I could not share my situation with a male service provider.”**

**—Fistula repair beneficiary in Somaliland**

Somalia has one of the highest obstetric fistula cases in the world<sup>75</sup>. In response, UNFPA made concerted efforts to support both case management and prevention of obstetric fistula among women. Even though this was not covered through the core resources, UNFPA mobilised funds from Maternal Health Trust Fund, through its Global campaign to end Obstetric Fistula. The programme trained medical doctors on fistula repairs. There was also secondment of specialists in health facilities, through UNFPA support, to repair cases. Initially in Puntland, UNFPA supported Galkayo Medical Foundation to offer fistula and this benefited affected women in Puntland, including those from the South Central zone. The programme further collaborated with an NGO which conducted fistula repair campaigns in Bossaso during the same period of evaluation.<sup>76</sup> In Somaliland, UNFPA collaborated with MoH and supported the National Fistula Hospital in Borama, where the programme covered operation costs and transport of the patients to the hospital, in addition to conducting fistula campaigns<sup>[77]</sup><sup>[78]</sup>. Other repairs were handled through partnering with NGOs, both local and international to provide the services.

UNFPA also supported in equipping health facilities and trained doctors in UNFPA-supported facilities to manage fistula cases on a routine basis. Currently,

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<sup>75</sup> <https://www.fistulafoundation.org/countries-we-help/somalia/>

<sup>76</sup> Interview and programme reports

<sup>77</sup> Programme report and Interviews with IPs in Hargeisa

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[http://countryoffice.unfpa.org/somalia/2012/01/20/4468/unfpa\\_conti\\_nues\\_fistula\\_campaign/](http://countryoffice.unfpa.org/somalia/2012/01/20/4468/unfpa_conti_nues_fistula_campaign/)

in Puntland, there is however a gap as the obstetric and gynaecologist who was hired through UNFPA support, in partnership with Comitato Collaborazione Medica (CCM) for skills transfer in obstetric and gynaecological cases, including surgeries does not perform obstetric fistula repair due to inadequate skills in the field. The staff has been instrumental in transfer of skills immensely supporting in providing maternal health services at the Garowe General hospital. At the time of the evaluation, CCM was seeking funds to hire a fistula surgeon to be based at the health facility. In Mogadishu, Physicians Across Continents (PAC), the only UNFPA partner providing CEmONC services in South and Central Somalia, is providing routine fistula repair, further providing relief to the affected mothers. This is unlike in the past where campaigns would be conducted and cases registered and repairs scheduled. This would delay restoration of dignity to the targeted women. In addition to inadequate funds for fistula case management, this outcome still faces challenges within the Somali community.

Women with obstetric fistula usually feel shamed or disgraced and this hinders them from expressing themselves, including seeking for the repair services, to some extent<sup>79</sup>, though not in large scale. Further, there is inadequate information, especially in the rural areas, on availability of the services, inadequate equipment and staff capacity to manage cases. Efforts have however been made through the government to ensure that there is continued information of the communities to prevent cases of fistula. Since 2013, UNFPA funded marking of International Day to End Obstetric Fistula, an event through which increased awareness on the fistula has been marked, with illustrative testimonials of survivors who have benefited from the services offered in health

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<sup>79</sup> Interview and FGD in Hargeisa

facilities. Health facility staff and the youth have also participated in community outreaches to sensitise masses on the causes and availability of the fistula repair services at particular health facilities.

The JHNP only covered nine regions (three per zone) while the other nine regions were not covered (total pre-war regions are 18). This limited access to maternal health services by the left-out regions. UNFPA however realised this and, in 2015, in collaboration with the Ministry of Health, organised integrated outreach campaign programmes<sup>80</sup> and plans to organise more to ensure that underserved areas are covered, within resource and security constraints. UNFPA also mobilised funds from other sources to finance existing gaps through the work plans, further partnering with NGOs to cover the gaps.

### **Reproductive Health Commodity Security**

In compliance with Programme of Action adopted at the 1994 ICPD in Cairo, to improve to RH services in Somalia, UNFPA support the health facilities with RH commodities, which are delivered freely to the facilities. UNFPA further supported establishment of warehouses for storing the commodities before they are supplied to the various health facilities. Management of the warehouse is by the MoH and any requests for replenishment of facilities is done through the ministry, further ensuring control and contribution to the national ownership.

Further, UNFPA has endeavoured to improve commodity security through strengthening the Logistics Management Information System (LMIS) for all the three zones, a case that was found weaker during the Mid-Term Review<sup>81</sup>. This strengthening continues to enable the three zones

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<sup>80</sup> Interviews in Garowe and Outreach activity reports

<sup>81</sup> UNFPA Somalia 2<sup>nd</sup> Country Programme 2011-2015 (2013), Mid-Term Review Report

to manage better logistics data and stocks associated with reproductive health life-saving drugs and family planning commodities. The governments, through respective MoH, have signed validation letters for the implementation of the newly revised LMIS Forms which will reinforce the logistics systems across the zones and foster logistics data collection and reporting. It is anticipated that this will effectively eliminate breakdown in supply chains. A total of 85 service providers have been trained in supply chain management at the national level and this was done in collaboration with respective UN agencies and all the zones in Somalia. They were trained on using the stock card, FP daily activity register and stock status report and order form; and donors have agreed to fund production and supply of some of the forms, while the production of the summary activity forms will be funded by UNFPA<sup>82</sup>.

### **Family Planning**

Somalia's fertility rate is 6.6, one of the highest in the world.<sup>83</sup> Due to poor basic education and lack of sexuality education in schools, levels of information on risks related to pregnancy and childbirth are low, and are mostly derived from traditional beliefs than from informed health staff. Awareness of beneficial effects of preventive health services like birth spacing is poor and many misconceptions prevail. In its mission to ensure that every pregnancy is wanted, UNFPA, through the programme, embarked on supporting efforts to increase uptake of family planning services (referred to as birth-spacing<sup>84</sup> for clarity of purpose) by the Somali women of reproductive age. However, there still exist gaps hindering FP service uptake<sup>85</sup>. Misconceptions still thrive among the majority of

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<sup>82</sup> Interview with UNFPA Staff in Nairobi

<sup>83</sup> <http://data.worldbank.org/indicator/SP.DYN.TFRT.IN/>

<sup>84</sup> [http://countryoffice.unfpa.org/somalia/2013/07/08/7266/religious\\_leaders\\_in\\_puntland\\_raised\\_their\\_voice\\_in\\_support\\_of\\_birth\\_spacing\\_and\\_addressing\\_gbv\\_including\\_abandonment\\_of\\_fgm\\_c/](http://countryoffice.unfpa.org/somalia/2013/07/08/7266/religious_leaders_in_puntland_raised_their_voice_in_support_of_birth_spacing_and_addressing_gbv_including_abandonment_of_fgm_c/)

<sup>85</sup> Interviews in Hargeisa, Mogadishu and Garowe, and FGDs

the populations, especially at the community levels; resistance from religious leaders, home deliveries also hamper access to the services<sup>86</sup> due to inadequate access to information on FP and services<sup>87</sup>; inadequate participation of the male in the process and inadequate staff capacity to provide the services.

UNFPA supports training of health care providers, including midwives, doctors, and nurses; referred as core team, to provide FP services within Somalia. To support operationalisation in the implementation of the services, the programme supported development of guidelines, facilitation of support supervision, and equipment of health facilities to provide FP services. In collaboration with the policy makers across the country, the National RH strategy was revised to incorporate FP service provision. Further, UNFPA trained trainers of trainers (ToTs) to reach out to more health workers. Coordination of ToTs is ensured and motivated through incentives. Progress has been made in increasing uptake of the service with a total of 54,441 clients served by 2015, recording an increase of 7,132 from 2014<sup>88</sup>; with expansion of the services, including use of implants and IUCDs; increased demand for the services among the women of reproductive age; and increased number of health facilities administering more than one method of FP<sup>[89][90]</sup>. Currently, there is preference for injections and one-off methods, particularly implants as opposed to the oral ones<sup>91</sup>, although the FP results from UNFPA show that oral contraceptives still remain

the most popular contraceptive methods<sup>92</sup>. Culture, religious beliefs and misconceptions play a critical role in influencing the uptake of family planning contraceptives. Another issue that was cited as affecting effectiveness of FP service uptake is male involvement<sup>93</sup>. Currently, for any client to be given any family planning method by any service provider she has to have consent from her husband, and when this is not provided, then the client will not be served. However, UNFPA is currently working with policy makers and religious leaders to advocate for a policy that will allow women to freely consent for all reproductive health procedures without their husbands' involvement<sup>94</sup>.

It is worth noting that UNFPA currently is conducting a lot of demand creation activities through the Integrated Community Reproductive Health project using Community's own resource persons (CORPS) who are mainly men and include religious leaders, village elders, chiefs, women group leaders, youth group leaders and also community health workers. More efforts are however required for multi-stakeholder involvement and commitment on the use of mass media for promotion of FP services; religious and community leaders to make reference in their daily religious teachings and to encourage men's involvement and support for women in the use of the services to increase uptake and thereby increase quality of life of the Somali women.

UNFPA has helped in the creation of FP taskforce within the RH working group, guided by the global UNFPA Family Planning 2020 taskforce. Through integrated community RH outreach project, community own resource persons (CORPs) have been trained with the aim of 'taking RH services to the people'.

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<sup>86</sup> Access to maternal health services is low with 44 and 38 per cent of births in Somaliland and Puntland being attended by skilled birth attendants. See more in [http://www.unicef.org/somalia/health\\_53.html](http://www.unicef.org/somalia/health_53.html)

<sup>87</sup> <http://www.panafrican-med-journal.com/content/article/20/10/full/#.Vu0bzuj97IU>

<sup>88</sup> Somalia COAR 2015 and Interviews

<sup>89</sup> [http://countryoffice.unfpa.org/somalia/drive/UNFPA\\_in\\_Somalia\\_-\\_From\\_Relief\\_to\\_Development.pdf](http://countryoffice.unfpa.org/somalia/drive/UNFPA_in_Somalia_-_From_Relief_to_Development.pdf)

<sup>90</sup> Somalia COAR 2015

<sup>91</sup> Interviews with MoH staff and FGDs in Hargeisa

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<sup>92</sup> UNFPA Staff

<sup>93</sup> Ibid

<sup>94</sup> Ibid

To address resistance emanating from religious beliefs, UNFPA facilitated a visit to Cairo by 30 Islamic leaders in 2015 to sensitise and help them understand the Islamic perspective of FP. It is currently acceptable to talk about FP, contrary to an initially held position before sensitisation activities were conducted across Somalia<sup>95</sup>. Women, however cannot, in most cases, talk about FP without the participation of men, a challenge that needs to be addressed. FP supplies to the health facilities have been intensified through training of health staff on RH commodity security. To ensure quality control, the roll-out of FP services has been done according to assessed level of appropriateness, where implants are only administered at the national health facility levels (Garowe, Hargeisa and Mogadishu for Puntland, Somaliland and SCZ purposes), injections at district health facility levels and orals at the primary level. The process is strict and ensures that supplies are only distributed depending on the level and qualification of the staff. A five to seven days mentorship trainings have also been employed to increase the skills of the staff on administration of FP services<sup>96</sup>. Even though this was a strong deliverable, there is currently no strategic plan to guide provision of RH commodity services in Somalia.

### **Humanitarian Assistance in Somalia**

Although the general context of implementation within Somalia is defined within the tenets of humanitarian response, UNFPA Somalia made deliberate efforts to specifically address gaps in emergency preparedness and response to child birth complications at the IDP settlements which are particularly vulnerable, exacerbated by the conditions they are living in. The programme also targeted people in hard to reach rural areas within

Somalia<sup>97</sup>. This component of the programme was implemented based on the needs as defined through zoning of the country according to security levels according to UN security department. With this, both South-Central zone and Puntland were targeted, with Somaliland being excluded at the initial stages of the programme, mainly due to limited financial support, much as needs to respond were there. Somaliland was however included in 2015 during deteriorating situation as a result of conflict in Yemen which led to return of Somalis living there and Yemeni refugees.

Across the target regions in Somalia, UNFPA supported establishment of maternity waiting homes (MWHs) – model facilities designed and supported by UNFPA to ensure improved access to and provision of basic and life-saving maternal health services to people in displacement. Through UNFPA CP support, these homes are supported on delivery kits and trained midwives who conduct deliveries. They were also supported with equipment, which included fixtures and contributing to paying salaries of staff in the facilities; and carry out all the requisite services to the mothers and their children. Predominantly located in displacement settlements, these facilities offer essential care to expectant mothers at all stages of pregnancy, providing a range of health services. To ensure effective care and observation of skilled birth attendants, expectant mothers are invited to stay in the waiting homes in their last month of pregnancy. The MWHs in Somalia IDP settlements, run by local NGOs, with support from UNFPA and the MoH provide timely referrals of complicated cases to hospitals while non-complicated cases are handled at the waiting homes. Scale-up of the MWHs concept was informed by the findings and recommendations of an evaluation commissioned by UNFPA on the

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<sup>95</sup> Interviews with IPs and UNFPA staff

<sup>96</sup> Interviews with UNFPA staff and reports

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<sup>97</sup> Interviews with MoH and UNFPA staff



same, which elicited evidence on the relevance and effectiveness in increasing access to skilled birth attendance by expectant mothers in emergency set-ups.<sup>98</sup> As at the time of evaluation, UNFPA supported establishment and operationalisation of over 36 MWHs<sup>99</sup>. The MWHs also provide health consultations for the IDPs and the host communities, thereby filling the gap in health service access and delivery to the deserving populace.

The MWHs have been successful in reducing cases of maternal deaths in Somalia because of the services that are provided. This information was also corroborate by feedback provided by a religious leader stating a reduction in the number of funerals he administered after an MWH was established in his settlement<sup>100</sup>. Further, the facilities filled a critical gap in the health system of the country where health facilities available are not able to accommodate the needs of all women. As at the time of evaluation, a total of 16,724<sup>101</sup> pregnant women delivered and over 1,300 pregnancy and childbirth complications were identified and referred for further management and care. Through the MWHs, the CP was able to scale up quality RH services among expectant women and girls as well as providing outreach services in the target IDP settlements, increasing chances of survival of the mothers. Apart from serving as emergency delivery centres, the concept of MWHs has also facilitated access to other RH services like the family planning by the populations in displacement<sup>102</sup>.

The humanitarian assistance aspects of the CP were effectively covered through the MWHs<sup>103</sup>. Supervision of these homes by the ministry of health was well coordinated among stakeholders within Somalia, including reporting on service deliveries. To further ensure contribution to the national performance, monthly performance meetings were held and supported by UNFPA to be able to assess the level of performance and quality control. Implementing partners attended these meetings and in addition, submitted monthly service reports to the government. The level of effective coordination and supervision was reported to be stronger in Puntland, while in South-Central region the coordination needs to be strengthened further, especially on selection of partners where it was reported that UNFPA engages the partners directly<sup>104</sup>.

Through the humanitarian assistance programme, the CO contributed to the emergency preparedness plan strategy through the practice of contingency planning to respond in emergency situations as they occur, ensuring minimum preparedness. This commitment ensures that gaps in emergency are addressed through provision of minimum initial service package for lifesaving interventions for those affected by disasters and emergencies. The programme supported the Somali returnees from Yemen and Yemeni refugees. It also effectively responded during the 2013 cyclone in Eyle in Puntland as those affected were supported with MISIP for emergency<sup>105</sup>.

### **Support for ASRH, Youth and HIV Prevention**

Adolescents and youth constitute more than 70 percent of the Somali population<sup>106</sup> and the decision to target them is highly lauded by the

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<sup>98</sup> UNFPA (2014) An Evaluation Report of Maternity Waiting Homes Experiences in South Central Somalia.

<sup>99</sup> UNFPA 2015 Annual Report - Somalia

<sup>100</sup> See <http://www.unfpa.org/news/safe-haven-pregnant-women-somalia> [accessed on 10 December 2015]

<sup>101</sup> Ibid

<sup>102</sup> Interviews with MoH, UNFPA staff, FGDs at MWHs and MWH Evaluation report

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<sup>103</sup> Interviews with IPs and UNFPA Staff

<sup>104</sup> Interview with MoH staff in Mogadishu

<sup>105</sup> Interview with UNFPA and IPs

<sup>106</sup> <http://www.unfpa.org/news/young-leaders-make-case-peace-somalia>

respondents. Fulfilling the strategies to realise the CP's second output, UNFPA implemented a number of activities aimed at meaningfully involving the youth on issues affecting them, including building their capacities to increase their level of resourcefulness in Somalia. The CP involved the youth strategically in ensuring that they were effectively useful agents in the socio-economic change process. This is however broad based within different CP component and integrated in the RH outcome.

During the period of review, UNFPA supported the Somali zonal authorities (Somaliland and Puntland) partially in the development of Youth Policy and is currently supporting the FGS in developing the same; set up youth centres; and provided scholarship for vulnerable girls for school-based education targeting entrepreneurship. UNFPA also supported strengthening of life-skills and HIV prevention among the youth using different techniques. Through the youth policy development, other UN agencies and INGOs have been able to contractively engage (in a guided framework) in addressing the youth issues. The youth centres also served as multi-purpose centres, including meeting points for youth groups<sup>107</sup>.

Youth activities were integrated in the whole programme intervention. To start with, the RH programme in the quest to increase human resource for skilled birth attendance, recruited young women aged between 19 and 20 years old. After graduation, some of them land in paid jobs, in addition to being in an empowered socially through the role. Though not specifically deliberate, the MoH staff in the RH Unit (supported by UNFPA) are mostly young people. UNFPA also sponsored vulnerable adolescent girls to pursue vocational

skills after which they were supported with business start-up kits worth \$700<sup>108</sup>.

For the first time in Somalia, a Youth Forum was established through the support of UNFPA aimed at facilitating meaningful role of the youth in key aspects of the Somali society<sup>109</sup>. This forum aimed at bringing together the line youth ministries to ensure coordination among themselves. The Youth Forum is chaired by the Ministry of Youth and Sports across the Somalia zonal authorities and co-chaired by UNFPA further showing the interest that UNFPA has put on coordinating the interests of the youth. In Puntland for example, UNFPA supported establishment of Puntland Youth Association Network (PYAN), bringing together youth umbrella bodies from all the Puntland regions, to coordinate youth issues in the zone. The UNFPA's Y-PEER Network was also actively engaged by the government in meaningful roles, including national institutions focusing on youth issues and involving the youth in peace-building as stipulated in the Compact New Deal<sup>110</sup>. This success brought to the fore the need for youth-interest groups like NGOs, State networks and private sector to work together and build state networks.

Towards empowerment of the youth, UNFPA, in collaboration of the governments, recruited and trained mostly youth who participated in the PESS activities in data collection, entry and analysis. In addition to building their technical capacity, they were also retained as employees by the government, while at the same time others were getting employment elsewhere because of the skills gained during the PESS process.

UNFPA actively involved the youth on campaign activities targeting awareness raising on GBV,

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<sup>107</sup> Interviews with IPs and UNFPA staff and FGDs with youth

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<sup>108</sup> Interviews with IPs and UNFPA staff

<sup>109</sup> Ibid

<sup>110</sup> Interviews with Y-Peer Network members and UNFPA staff

FGM/C, HIV&AIDS and Adolescent Sexual Reproductive Health (ASRH) issues. They have been trained and mobilised as agents of change using peer-to-peer education in the community focusing mainly on the raising awareness on the harmful traditional practices. They used mass media, radio and TV spots, theatre performances, sports and social media to increase advocacy activities on the above themes. In addition to using peer-to-peer approaches through school clubs, UNFPA funded implementation of sports tournaments across Somalia where key messages were shared and youth participated actively. These were disseminated through the mainstream media.

UNFPA implemented HIV and AIDS prevention activities mainly targeting and involving the Somali youth. The HIV and AIDS activities implemented by UNFPA broadly included youth peer education, conducting HIV and AIDS workshops with religious leaders targeting awareness raising on stigma reduction, and supporting development of social behaviour change strategic plan. The efforts have contributed to high level of awareness among the youth as confirmed by the respondents<sup>111</sup>. Involvement of the religious leaders in advocacy activities have also borne fruits as stigma toward people living with HIV and AIDS (PLWHA) has also reduced<sup>112</sup> as it is currently acceptable to relate to them, unlike before when it was not possible to be near one.

Prevention services like voluntary counselling and testing (VCT) have been integrated into the health facilities for access and uptake is increasing<sup>113</sup>. These gains have, however, been registered in the urban centres and there is need to target the rural areas. Cultural and religious challenges are also

cited as contributing factors<sup>114</sup>. HIV prevention activity like condom distribution is regarded to be promoting promiscuity among the populace. In fact, condom distribution is banned in Somaliland<sup>115</sup>. Investment in HIV and AIDS activities in Somalia is lower, even with statistics showing that HIV prevalence is on the rise<sup>116</sup>. There is also inadequate data on HIV and AIDS, which limits the level of understanding on the possible effect on the pandemic.<sup>117</sup>

Y-Peer networks effectively facilitated<sup>118</sup> sessions including training, debates and peer education among the youth. During debates, they have invited religious leaders, elders and experienced youth to clarify issues of discussion, especially to demystify socio-cultural issues affecting the youth. In addition, this was also to help facilitate listening to the youth issues by the opinion leaders to target change in perception towards the youth. Youth were incorporated in the constitution-making process in Somalia, something that could not happen before they were involved in the CP interventions. Efforts were also made to ensure that the RH services were accessed by the youth, with staff being trained by UNFPA to further understand the youth. However, the youth interviewed found it is better to go for integrated RH services due to stigma associated with RH-specific services. Young people face challenges in accessing services as most of the issues are culturally sensitive. Young, unmarried women face challenges accessing to RH services where they will be asked to bring their husbands as RH services like family planning are meant for those who are married in the cultural and religious

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<sup>111</sup> Interview with SoLNAC in Hargeisa and FGDs with Youth

<sup>112</sup> Ibid

<sup>113</sup> Interviews with IPs, UNFPA and FGDs with Youth

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<sup>114</sup> Ibid

<sup>115</sup> Interview with Youth

<sup>116</sup> <http://amisom-au.org/so/2014/12/hiv-infections-on-the-rise-in-somalia/>

<sup>117</sup> <http://www.so.undp.org/content/somalia/en/home/mdgoverview/overview/mdg6.html>

<sup>118</sup> Interview with the Youth and UNFPA Staff

context<sup>119</sup>. Community advocacy activities can also not be effectively addressed by the young people, especially on HIV and AIDS as it involves sexual behaviours, which is not only a taboo to talk about in public, but being young even makes it more demeaning<sup>120</sup>. UNFPA Somalia however continues to lobby with government authorities and religious leaders through various strategies to accept and has further undertaken translation of family planning book in the legacy of Islam, with the hope of boosting ASRH among the young people. Even though integration of youth activities yielded notable results, the budget allocation for the activities in the current CP were cited to be inadequate given that the youth account for 70 percent of the country's population<sup>121</sup>.

#### 4.2.3 Efficiency

**EQ 7:** Was the programme implementation approach (funds, expertise, time, administrative costs, etc.) the most efficient way of achieving results?

The 2<sup>nd</sup> UNFPA Country's RHR component was reported to be very efficient in the interventions it supported. To begin with, UNFPA has technical staff qualified and provided appropriate guidance both in design and delivery of services in the key areas of RH, including humanitarian assistance. Across the country, the staff had competent and relevant staff in all the programme component areas and from respondents' feedback<sup>122</sup>, they supported delivery of services in a professional manner, including supervision and design of manuals and guidelines. Availability of the technical specialists based in Nairobi and supporting during field visits was cited as a challenge but it was not so pronounced to be

an impediment in provision of technical support and services<sup>123</sup>. There is always coordination and mechanisms to consult, including with field staff. The maternity waiting homes were also run in a more cost-effective manner in comparison to the CEmONC centres while providing maternal health services especially in the humanitarian set-up.

Supporting establishment of the RH unit facilitated efficiency in monitoring and quality assurance towards delivery of RH services in various government and other health facilities. The unit also acted as a launch-pad or custodian for the manuals, protocols, records and guidelines for RH services enabling coordination and effective provision of the service. Measuring performance of the government systems on RH service delivery was also possible through this unit. It was however reported that this unit did not have enough resources to go about its functions as expected, more-so on supervision and coordination of the work of the midwives. Even though UNFPA invested a lot in building the capacity of the government staff to manage delivery of RH services, it was reported that the capacity of the staff is still inadequate for effective delivery of their functions<sup>124</sup>.

The national approach to delivery of services utilised already existing government structures enabling provision of services within a properly constituted structure making the operation costs less with more focus in delivery of services. Disbursement of funds was mentioned to take time, especially after approval of annual work plans for implementation affecting implementation processes. Given that UNFPA had signed working MoUs with the government, when delays were imminent, the government would fund activities with funds allocated for other functions (that are

<sup>119</sup> Interview and FGDs with youth

<sup>120</sup> Interview and FGDs with the youth and UNFPA COAR 2015.

<sup>121</sup> Interview with UNFPA Staff and Youth IPs

<sup>122</sup> Interviews with IPs

<sup>123</sup> Interviews with IPs in Mogadishu

<sup>124</sup> Interview with MoH staff

not immediate) from other sources then replenish when programme money is wired<sup>125</sup>. Some factors were cited to be responsible for delays in funding as bureaucracy within the UN system, late planning of activities, compliance issues by the IPs<sup>126</sup>.

UNFPA programmes were implemented through annual work plans, where implementing partners would be required to plan their activities well in advance, discussed and approved before funds are disbursed making them support only interventions that had been agreed upon as efficient. In addition, there are mechanisms in place to monitor implementation of activities through financial reports that are also based on AWP, enabling efficient management of funds. This also ensures compliance with the financial management procedures of the organisation.

Implementation of the programme interventions through a joint programmes enhanced synergy in delivery of services to the targeted areas. JHNP helped the programme in surpassing the targets. This enables division of labour and shared responsibility with clarity of roles. Partnership also made it possible for target population to access services without UNFPA having to spend on staff and infrastructure to implement. For example, the MWH were run with NGOs which had funding from elsewhere and not just from UNFPA, making its contribution complementary; PAC also had a lot of contribution to make in its programmes, especially on treatment of obstetric fistula on a regular basis, as opposed to waiting for outreaches; and other organisations running programmes in various localities within Somalia had shared costs as they did not just depend on UNFPA for operation and logistics costs like SAMA transported commodities from Mogadishu to Baidoa. Training of midwives

through partnership with the established training schools enable efficiency in churning out graduates at a lower operation costs.

UNFPA supported capacity strengthening endeavours including supporting different technical positions in offices in the line ministries to facilitate capacity development in coordination and delivery of the RH services. The supported positions were crucial for the ministries as they also enabled on-the-job training of other staff in the ministries. This contributed immensely to enhancing and speeding up of service provision to the targeted beneficiaries, further enhancing efficiency and effectiveness in delivery of results.

On efficiency with regard to timely delivery of services to the affected, UNFPA's model of MWH facilitated access to skilled and quality maternity care services by pregnant women in the IDP camps. Further, during the influx of IDPs, Somali returnees and refugees from Yemen, UNFPA strategically responded by supporting medical teams in settlements to provide emergency maternal health and services to SGBV survivors, with some being referred to the MWHs available. Notable is that, all these happened outside the UNFPA AWP with the partners but were effectively delivered within budget constraints.

#### 4.2.4 Sustainability

**EQ 8:** To what extent are the development gains made under the UNFPA supported interventions in Somalia sustainable in terms of continuity in service provisions and partnerships integration of CP activities into the regular country and counterparts' programming?

<sup>125</sup> Interviews with MoH Staff and UNFPA Staff

<sup>126</sup> Interviews with IPs

It is evident that UNFPA made considerations to ensure implementation of interventions continued beyond the programme period. From the design, UNFPA recognised the need to ensure that the programmes be country-led, through working with relevant line ministries. It was also evident when implementations were embedded on policy frameworks. Community participation was also promoted, especially in supporting recruitment of the midwifery trainee-candidates. Ownership by the community was also manifested in the partnership that existed between communities, MoH and UNFPA to support in referrals during emergency deliveries. In Puntland, for example, the community contributed a plot of land to construct maternal and neonatal health centre next to the Garowe General Hospital, in addition to flattening and levelling the ground and further constructing the walls.

UNFPA fostered partnerships among the development partners within Somalia increase synergy in service delivery and thereby enhancing sustainability through capacity strengthening and coordination among partners. UNFPA had a unique collaboration between the health and environment sector through a tripartite arrangement and coordination; where UNFPA, UNDP and MoH in Puntland in securing solar power stations in Garowe and Galkayo. These stations will provide uninterrupted power supply, solving the issue of frequent power cuts, in addition to being cost-effective by providing power with no costs incurred, unlike before when the facilities paid US\$ 6,000 and US\$ 15,000 per month respectively for Garowe General Hospital and Galkayo Hospital.<sup>127</sup>

During the period of evaluation, UNFPA elaborately supported policy, strategy, guideline and training

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<sup>127</sup> See further [http://countryoffice.unfpa.org/somalia/2015/01/29/11339/a\\_solar\\_powered\\_maternal\\_and\\_neonatal\\_health\\_centre\\_for\\_somalia/](http://countryoffice.unfpa.org/somalia/2015/01/29/11339/a_solar_powered_maternal_and_neonatal_health_centre_for_somalia/) [Accessed on 10/12/2015]

development, which should strengthen RHR orientation and capacity development, and promote integration in the long term in Somalia. UNFPA support to build health system capacity through training, facility construction, rehabilitation and equipment; procurement of commodities, and community demand generation may also have some lasting impact. Maintenance of the equipment could also be funded by the MoH through the cost-sharing modality. Currently, UNFPA provides RH commodities and this poses a sustainability issue. Another issue is about the South-Central region service providers most of which are privately owned affecting sustainability in access to the maternal health services, especially on implementation of guidelines and standards<sup>128</sup>.

There is mixed feedback on the extent to which the interventions will remain to advance the targeted health outcomes in the long term as they are dependent on a number of factors. Strengthening of the health system capacity through training of health staff to provide lasting results depend on a number of factors spanning; the quality of training; the extent to which trained health providers utilise their new skills and knowledge, and how this is cascaded to the other staff after training, especially for the ToTs and even the selected few who get trained in different areas. Another critical factor within Somalia is also on the ability of the government to retain the trained staff in order to utilise their skills in provision of services to the general.

Increasing the capacity of the government to offer skilled birth attendance in the hard-to-reach populations through training and deployment of the midwives still faces a major challenge and this threatens their retention by the government in their places of deployment. Their recruitment for

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<sup>128</sup> UNFPA Staff

training is highly participatory with the local authorities; however, there are reported cases where they do not go back to the rural areas to offer the intended service. Currently, there is no formal framework to keep the trained midwives at their designated places of work after training.

Coordination of quality health service delivery in Somalia has been improved over time through facilitated support supervision and establishment of structures within facilities and ministries further assuring sustainability. Technical capacity has also been enhanced in the ministries, which UNFPA supporting salaries of various staff and financing periodic coordination meetings among stakeholders. The capacity of the government to mobilise funds to fill the existing gaps in the reproductive health needs is still low.

### **Summary of Findings**

Overall, the RHR component of the programme was well designed and responded to the needs of the Somali population. The interventions in the CPAP addressed development needs within the country and were consistent with the government priorities in their areas of focus. It was also well aligned to contribute to the UNFPA Strategic plan and MDG 5, where the MMR reduced from 1044 to 732 per 100,000 births during the period of evaluation. Joint programmes enhanced programme coverage but this was limited to only three regions per zone, with some needy rural areas not being reached.

The programme has contributed to improved access to reproductive health services through supporting enhanced reproductive health-care service delivery processes, including midwifery training and establishing midwifery training institutions, supporting increased family planning service uptake and increasing RH commodity security, obstetric fistula prevention and management, strengthened capacities of zonal authorities, community-based

and non-governmental organisations, and the most-at-risk youth. The targets in the RHR component are likely to be achieved, with some already surpassed during the period of implementation (Refer to Annex 2). However, service delivery and awareness raising in the rural areas are still inadequate. Cultural challenges have also affected access to family planning services and RH services by the youth. Youth targeting was limited at the beginning of the programme but later scaled up during alignment with the UNFPA strategic plan. Further, even though UNFPA made a significant contribution in improving skilled birth attendance through training and equipping of midwives, there still exists a huge gap in the discipline given the WHO minimum standards of 2.3 skilled birth attendants per 1000 population and considering the 2015 data on 12.8 million as the population of Somalia.

The programme component was found to be efficient in delivery of the RHR services throughout the period of evaluation. Availability of technical staff, established RH unit to coordinate activities and guide quality provision of RH services; and working through the government units made facilitated efficient provision of the service within the component. Security constraints however affected field monitoring of activities by the technical international staff, including those based in Nairobi. Sustainability is embedded in the design and implementation processes. The programme component built the capacity of government structures, developed quality protocols, establishment and equipped health facilities and promoted ownership of the project intervention, assuring sustainability. However, Somalia is still faced with low capacity, cultural inhibitors and conflicts which take a toll on sustainability. Further, in the South-Central Somalia, the maternal health provision is mostly by privately owned health facilities which hinders sustainability, especially on implementation of standards and guidelines.

## 4.3 Population and Development

### 4.3.1 Relevance

**EQ 1:** To what extent were the programme interventions consistent with the needs of the beneficiary populations and to what extent was it aligned with government priorities as well as with policies and strategies of UNFPA?

**EQ 2:** How well was the CPAP aligned with the ICPD actions and MDGs as well as with the UNFPA Strategic Plans?

UNFPA Somalia's P&D component has had a far-reaching relevance to the planning and policy formulation for the development outcomes within the country. The component was developed to address the inadequate and weak capacity of government staff to develop statistical systems, collect, process, archive and analyse data; unavailability of crucial statistical data such as population size and distribution to support planning and policy formulation; limited statistical equipment and unreliable channels for data dissemination; unavailability of policy framework to guide the production and dissemination of statistical information<sup>129</sup>.

The most glaring product from this component during the period of evaluation is the Population Estimation Survey of Somalia (PESS)<sup>130</sup>. Its objective was to provide evidence based, technically sound, reliable, estimates of population of Somalia including IDPs and nomads. This was a collaborative effort, under the leadership of UNFPA, of UN agencies - UNICEF, UNDP, WHO, WFP, UNHCR and FAO; operating under a Technical Support Unit

(TSU); and three zonal taskforces created for the PESS at the Planning Ministries of the Federal Government of Somalia in Mogadishu, in Puntland and in Somaliland.<sup>131</sup>

From the targeted design, the first output strategies were; supporting the establishment, strengthening and periodic updating of an integrated population database on selected issues at zonal and sub-zonal levels; developing a framework and support for evidence-informed advocacy to improve maternal health; supporting the collection, analysis and use of data on maternal mortality and morbidity; strengthening the capacity to monitor and report on International Conference on Population and Development (ICPD) and Millennium Development Goal targets; and building the capacity of government and other partners to integrate maternal mortality and morbidity into emergency preparedness and response efforts. On the other hand, those for the second output were; improving the capacity of selected sectoral ministries and partner organisations in data collection and analysis; providing technical support to improve the planning and monitoring of humanitarian assistance and recovery efforts; and operationalising inter-linkages between humanitarian, recovery and development assistance. These make the programme component highly relevant as it centred on addressing the development gaps within the country<sup>132</sup>.

The demographic data in Somalia has been incomplete and scanty for close to four decades. Attempts have been made to collect and compile data on key areas such as number of settlements, population, household income and expenditure, prices of essential commodities, agriculture,

<sup>129</sup> Somalia CPD and CPAP

<sup>130</sup> For further reading about the report, <http://countryoffice.unfpa.org/somalia/drive/Population-Estimation-Survey-of-Somalia-PESS-2013-2014.pdf> [Accessed on 12/12/2015]

<sup>131</sup> For further information on the role of each member partner, refer to [http://countryoffice.unfpa.org/somalia/2013/03/12/6401/population\\_pest/](http://countryoffice.unfpa.org/somalia/2013/03/12/6401/population_pest/) [Accessed on 02/01/2016]

<sup>132</sup> CP Document and Interviews



education and health in areas that could be reached. The first census carried out in 1975 was not published, and only an analytical report based on the census results was brought out in 1984<sup>133</sup>. A national demographic survey was carried out in 1980-81, but the data were not processed, barring a few hand-tabulations<sup>134</sup>. Another census was carried out in 1985-86, and was contested due to doubts about its accuracy, and was therefore not published. Several international NGOs engaged in humanitarian activities in Somalia collect data pertaining to the areas of their interest, particularly on food security, WASH, education, health and other social aspects, thereby limiting the level of information on the demographic, social and economic characteristics to inform decision-making. The Population Estimation Survey of Somalia (PESS), conducted under the leadership and support of UNFPA in collaboration with UN agencies and other partners, provides a remedy to the data needs on the people of Somalia, based on facts<sup>135</sup>.

Given the low capacity of the Somalia governments in resource mobilisation and even availability, UNFPA played a leading role in mobilising and managing financial resources for the conduct of PESS. UNFPA was actively involved in guiding, monitoring and coordinating the activities of the PESS exercise including mapping and mitigation of problems that arose during the process. The support was also in logistics and operational. UNFPA also supported the post-estimation survey to train selected staff and various stakeholders including university staff on data analysis and report writing.

The decision by UNFPA to bring on board participants drawn from the various parts of

Somalia to deliberate on how to go about the PESS, demonstrated the commitment that it had in addressing the local needs of the people of Somalia<sup>136</sup>. All the decisions made, processes taken in defining the PESS process was as a result of consultation among the various authorities. UNFPA, through a High-level task force to oversee implementation of the process was composed of each zone stakeholders. Each of the three taskforces were staffed by a Survey Director and Deputy Survey Director and funded by UNFPA. This ensured that work plans executed addressed the needs of the three zonal authorities, with their contribution. It is notable that the decision to conduct PESS came as a request from the authorities during a meeting where the three Somalia authorities were involved.

The collapse of the government led to wiping away of existing statistical infrastructure and systems and systems crumbled, implementation of PESS provided an opportunity for bridging the gap in enhancing statistical capacities in Somalia. It provides soundly accurate, reliable, credible and accepted indicators for more specific follow-up surveys; further enhancing the capacity of the Somalis to be able to have a framework for conducting further data collection activities<sup>137</sup>. Capacity strengthening interventions were conducted in close collaboration and partnerships with the government staff, including Somali universities, ensuring that the capacities of the Somalis was enhanced and technically sound to implement similar processes<sup>138</sup>.

In preparation for the planned census, the results of the PESS provide a basis for baseline information. It further provides a platform for putting systems in place to facilitate nation-wide data collection

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<sup>133</sup> See <http://www.somali-jna.org/downloads/ACFA9.pdf>

<sup>134</sup> Ibid

<sup>135</sup> Interviews with Planning Ministry and UNFPA Staff; and Programme Report

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<sup>136</sup> Interviews with UNFPA and Planning Ministries' Staff

<sup>137</sup> Ibid

<sup>138</sup> Interviews and programme reports

processes. With the challenges of access due to insecurity and financial constraints within Somalia, PESS provided an opportunity for bridging the gap in providing institutional capacity and specialised skills in preparation for the planned census exercise; and within a scale that required a more manageable cost than census<sup>139</sup>.

The evaluation also established that the programme was aligned to the UNFPA Strategic Plan 2014 – 2017, in compliance to the ICPD. In the aligned document from the country programme, the outputs 5 and 6 directly contribute to SP outputs 12 and 15 for the achievement of outcome 4, as contained in the integrated results framework (IRF)<sup>140</sup>. The targeted interventions implemented accordingly and are well defined and measured through capturing of performance indicators, clearly defined. The CP component's outcome 3 also contributed to the achievement of the UNSAS Outcome 3 as presented in the intervention logic (Figure 3.1). Further, the programme interventions directly contributed to the priority areas in the Compact Deal's IRF.

The relevance of the P&D component was evidenced when it strategically targeted mostly young people in training them as enumerators during the PESS process<sup>141</sup>. In addition to building their capacity, possibility of continuity is ensured through the programme and employability of the participants.

The P&D component, in design of the methodology of PESS took into consideration the local context to ensure that all the aspects of interest were captured. In recognizing that part of the population is nomadic, they were targeted, including when and

where to get them using water-points. Soaring temperatures in places like Bossaso and Berbera port towns were recognized and planning made to suit the circumstances, including scheduling at a favourable time<sup>142</sup>.

Once the PESS analytical reports are completed and validated, they will be available to be used in informing the national and sub-national development plans. This will also make it possible to better monitor progress on health indicators, especially maternal health across the national and sub-national levels.

#### 4.3.2 Effectiveness

**EQ 4:** To what extent have the interventions supported by UNFPA in the field of population and development contributed to (i) increased availability and use of data on emerging population issues at national and sub-national levels (ii) Strengthened national and sub-national capacity for production and dissemination of quality disaggregated data on population and development issues.

**EQ 6:** To what extent was the programme coverage (geographic; beneficiaries) reached as planned?

The UNFPA Somalia CP's P&D component was initially designed to operate as a programme on its own, but was later integrated across the country programme. The component is implemented in partnership with the ministries of National Planning and Development in Somaliland, Planning and International Cooperation (MoPIC) in Puntland, and department of Planning in the Ministry of Finance and National Planning for The Federal Republic of Somalia in South-Central Zone. Through the component, UNFPA provides both technical and financial support to facilitate the operationalisation of population and development processes<sup>143</sup>. The

<sup>139</sup> Interviews with Planning Ministry Staff across Somalia

<sup>140</sup> UNFPA Somalia document for Alignment to the Strategic Plan 2014 – 2017 and Interviews with UNFPA Staff

<sup>141</sup> Interview with UNFPA staff and FGDs with the enumerators

<sup>142</sup> Interviews and PESS Report

<sup>143</sup> Interviews and CPD

implementation process of the population estimation survey of Somalia (PESS) involved high level of consultations among various stakeholders emanating from the zonal governments of Somalia, UN agencies and other development partners, including donors. The processes of implementation of activities also entailed involvement of a number of stakeholders drawn from the government. The performance of the CP in the Population and Development component is summarised in Annex 2<sup>144</sup>.

The use of pre-war regions and boundaries to conduct PESS facilitated successful engagement of the three Somalia authorities<sup>145</sup>. The extent that the various zonal authorities were involved in mobilisation of their citizens enabled their buy-in to the process. This was done through the high level task force teams that were formed in each zone. This process even led to acceptance of the results by all the zonal governments. From the results and achievements through the component, it is evident that UNFPA effectively played its roles of mobilisation of resource, including coordination and provision of technical assistance in the processes<sup>146</sup>. The collaboration and partnership between UNFPA and Somali authorities and technical experts, communities and other UN entities, donors and partners ensured the survey was conducted in line with international standards in all 18 pre-war regions<sup>147</sup>.

The results of the PESS enabled the Federal government to develop a two-year development plan based on the data, which could not happen before<sup>148</sup>. Initially, the data that was there was so

scanty and unreliable and did not capture accurate details about Somalis, including age, gender, and other characteristics such as education, employment, as well as information on birth and death. The survey also estimated the regional data which enabled effective planning by the government. The results were accepted across the Somalia zones on a technical basis. However local politics played in the way the results were disseminated by UNFPA. Puntland initially contested the results based on the boundaries covered between them and Somaliland (Sanaag region has always been contested between the two). The methodology used was however not in contention. UNFPA further consulted the high level team to sensitise the people on the elements involved. Somaliland disowned the results, based on political reasons because of the decision taken to release the results in Mogadishu, as its government felt that it is no longer part of Somalia. This was also addressed by UNFPA and a way forward was arrived at to launch the results in all the zones<sup>149</sup>. Ideally, it would have been more acceptable for the governments if the results had been launched simultaneously across the three zones. UNFPA recognized this shortcoming and also took it as a learning point for future launching of the remaining PESS (analysed) results and the planned census data<sup>150</sup>. The initial contestation of the results of PESS by the Puntland government was a manifestation of the value that they had in the information.

The methodology used to produce the PESS was lauded as the most reliable with the availability of technical team to support on quality issues<sup>151</sup>. There were also checks and balances in place to ensure that processes were within standards. The level of

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<sup>144</sup> The Performance Framework is summarised considering the baseline and the targets in Population and Development component that were to be achieved by 2015; and the achievement at the time of the evaluation, and based on the CPAP

<sup>145</sup> Interview with Planning Ministry and UNFPA Staff

<sup>146</sup> Ibid

<sup>147</sup> Interviews with UNFPA Staff and Programme Report

<sup>148</sup> Interviews with Planning ministry Staff in Mogadishu

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<sup>149</sup> Interview with Planning Ministry and UNFPA Staff; and UN Coordination staff

<sup>150</sup> Interview with UNFPA Staff

<sup>151</sup> Ibid

consultation from national level to the community level ensured that it was part of the Somalis. Piloting was also done in selected areas, with verification techniques involving the authorities.

**“This is the first time the Somalis are taking part in such an exercise of such magnitude. Those previously conducted have been done by experts who are outsiders but they have also not captured this level of detail that PESS covered.”**

**– Government respondent in reference to the level of detail in PESS and its acceptance by the authorities**

With the collapse of statistical institutions and systems for data collection, UNFPA enabled capacity development and establishment of structures, including frameworks that could be used as frameworks for conducting data collection. The sample frame that was used for PESS can be used for large scale surveys, including evaluations<sup>152</sup>. Country Programme contributed to addressing these capacity challenges by building capacity in population and development integration, and provided support in population surveys and general research.

In order to address issues of capacity on population and development, UNFPA embedded capacity strengthening in PESS and ensured that the staff involved were from relevant ministries. UNFPA supported a statistics working group coordinated by the Director-Generals from the three partner ministries from each zone. This was not only limited to the planning ministries, but also staff from different ministries, especially those in the planning department to participate in the training processes due to their relevance in the use of data for the policy formulation<sup>153</sup>. UNFPA facilitated capacity strengthening processes by networking with other agencies such as WHO, UNFAO and African

Development Bank to build the capacities of the staff involved.

UNFPA trained over 4,500 enumerators who participated in the PESS process, most of whom were youth from universities<sup>154</sup>. The beneficiaries confirmed that they had the capacity to implement a similar process<sup>155</sup>. To ensure that there was systematic transfer of statistical knowledge, training of trainers (ToTs) was conducted. The ToTs were those from the regional government authorities who in turn trained those within their jurisdiction either as supervisors or enumerators. At the time of the evaluation, it was confirmed that the ToTs had trained staff from other ministries especially on data collection, analysis and utilisation of the information<sup>156</sup>. In Puntland a statistical forum was developed from users who were from line ministries and this is supportive on the use of statistical data and information, informing planning and decision-making<sup>157</sup>. Again, in Puntland, the MOPIC data entry personnel trained by PESS project provided support to producing the Multi-Cluster/Sector Initial Rapid Assessment Report (MIRA) in the aftermath of the tropical cyclone in Puntland in 2013, demonstrating that national staff trained through the PESS project can also support other types of surveys and assessments<sup>158</sup>.

Partnership and involvement of technical experts enabled the success of the PESS process<sup>159</sup>. Staff from UNFAO, Norway Statistics and UN agencies seconded expert staff to participate and lead the PESS activities. UNFAO seconded a Geographic Information Systems (GIS) expert to support of creation of geo-files for storing data. Norway

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<sup>154</sup> Interview with UNFPA Staff and Planning-related Ministry staff

<sup>155</sup> Interviews with Ministry of Planning Staff across Somalia

<sup>156</sup> Ibid

<sup>157</sup> Interview with MoPIC Staff in Garowe, Puntland

<sup>158</sup> Interviews with MoPIC and UNFPA staff

<sup>159</sup> Interviews with UNFPA and Ministry of Planning Staff across Somalia

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<sup>152</sup> Interviews with UNFPA and Ministry of Planning Staff across Somalia

<sup>153</sup> Interviews with UNFPA and Ministry of Planning Staff across Somalia

Statistics seconded a data expert to guide the team on generating and handling the data. UNFPA's Arab States Regional Office seconded staff to advice on the PESS methodology. Other stakeholders also participated and contributed towards the success of the activities, for example a sampling expert was seconded from Tunisia to support on sampling of the nomadic communities. The expertise used in the whole process composed of experts in the fields of survey design, implementation, sampling and analysis, as well as demographers, data processors, cartographic and GIS, translators, and three national survey directors and other key support staff.

The role of UNFPA of providing technical and financial support led to enormous benefits<sup>160</sup>, including ensuring quality control and adherence and in enhancing the capacity of the Somalia authorities on population and development issues. UNFPA also recruited consultants and seconded them to planning ministries to build the capacity of the staff and strengthen statistics system within the ministries; leading to enhanced capacity<sup>161</sup>. In addition to seconding staff, UNFPA paid salaries to some staff based in the ministries in order to ensure facilitation of the activities between the ministries and UNFPA. The offices were also equipped through the financial support of UNFPA.

At the time of the evaluation, the P&D team was training selected staff to further analyse the data to capture district level data and write report on the lower level analysis, including socio-economic characteristics of the Somali people. To enhance the capacity of the planning ministry staff, they produced the reports, with the guidance of the UNFPA technical team. In addition, a high level taskforce on population has been established to

spearhead the preparations for planned population census, demographic health surveys, conduct situational analysis, vital analysis and improving the statistical skills of the staff.

### 4.3.3 Efficiency

**EQ 7:** Was the programme implementation approach (funds, expertise, time, administrative costs, etc.) the most efficient way of achieving results?

Assessing how efficient the implementation process of P&D component of the CP to achieve the desired goals entailed looking at the interventions implemented, how they were implemented and the circumstances and modalities of implementation.

During the evaluation, the government stakeholders interviewed confirmed that the national execution modality employed by UNFPA was efficient in ensuring that the targeted results were achieved within the financial constraints<sup>162</sup>. The availability of the staff seconded from the various ministries to take part in the PESS process made it easier for implementation as they were on salaries and no additional costs were involved in having to discharge their services in the process, save for those who were seconded to the various ministries to facilitate the processes<sup>163</sup>. UNFPA therefore reduced operation costs that would have been involved in assembling a team to conduct the survey.

Partnership between UNFPA and other UN agencies and other experts who participated in the process also made it easier to get the required expertise from within, instead of hiring them. These occurred as results were being realised and learning

<sup>160</sup> Interviews with UNFPA and Ministry of Planning Staff across Somalia

<sup>161</sup> Interviews with Ministry of Planning Staff across Somalia

<sup>162</sup> Interviews with Ministry of Planning Staff across Somalia

<sup>163</sup> Interviews with UNFPA Staff and Planning Ministry Staff

processes taking place to facilitate achievement of the intended targets<sup>164</sup>.

The use of staff from ministries enabled the capacity strengthening of the programme participants. This allowed for effectiveness in capacity strengthening the staff while at the same time filling the capacity gaps in various expertise in population and development issues that was associated with Somalia workforce. From this process, structures were created that facilitated cascading of learning processes where some results were achieved across the country with the involvement of the existing ministry staff. For example, from the feedback from respondents, it was evident that the ToTs initially trained by UNFPA's team of experts were able to train others within the team, imparting knowledge that enabled successful implementation of the component activities<sup>165</sup>.

Delay in disbursement of funds to the implementing partners was registered during the implementation of the component activities. However, there weren't cases where it was reported that there were lags in implementation of activities or realisation of low targets. Because there was an understanding between the government and UNFPA, they could implement activities supporting with funds from other sources and replenish when UNFPA disbursed the funds. Some factors were cited to be responsible for delays in funding as bureaucracy within the UN system, to which UNFPA subscribes, late planning of activities, contractual compliance issues by the IPs. Disbursement of CP funds from UNFPA was variously cited as a major source of inefficiency in the programme cycle, including during the MTR<sup>166</sup>.

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<sup>164</sup> Ibid

<sup>165</sup> Interviews with UNFPA staff and IPs' Staff

<sup>166</sup> Interviews with IPs and UNFPA Somalia CP 2011 – 2015 Mid-Term Review Report

PESS implementation across the country was delayed among the nomadic community and this was due to the sampling methodology, which employed targeting them at the water points and this had to happen during dry seasons. On the contrary, the timing did not coincide as long rains were experienced and the CP had to wait till there was drought to target the communities<sup>167</sup>. To mitigate this issue, UNFPA went ahead and collected data from the other communities, rural and urban, and also went ahead to continue training the targeted enumerators, especially to retain them. This stretched the financial commitment in the process and UNFPA successfully secured funding from Swedish government and its own bridged funding<sup>168</sup>.

As common in Somalia during the CP period, insecurity took a toll on the PESS implementation process and this affected access issues across the country, especially in the South Central regions which were deemed to be in control of the militant groups. UNFPA however used satellite imagery methods for estimation of populations in the rural areas and access information according to the sampling methodology. The evaluation did not however assess the cost implications, using satellite versus physically accessing the areas. This was supported and contributed by UNSOA (UN Support Office for Somalia)<sup>169</sup>.

Logistics across Somalia made it challenging for implementation of the activities, especially on meetings that required high level consultation. UNFPA used venues outside Somalia, which involved additional costs especially visa,

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<sup>167</sup> Interviews with UNFPA and Planning Ministry Staff

<sup>168</sup> Interview with UNFPA Staff

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[http://countryoffice.unfpa.org/somalia/2013/03/12/6401/population\\_pest/](http://countryoffice.unfpa.org/somalia/2013/03/12/6401/population_pest/) [Accessed on 02/01/2016]

accommodation and flights. It was however felt that meeting outside Somalia was convenient for achieving consensus among the different Somalia zonal government authorities. It was also efficient as in-country meetings would have led to distractions as some staff may have wanted to focus on their jobs. It was also one of the ways to mitigate against insecurity, especially for the facilitators whose work would have been affected, in terms of conducive environment<sup>170</sup>.

#### 4.3.4 Sustainability

**EQ 8:** To what extent are the development gains made under the UNFPA supported interventions in Somalia sustainable in terms of continuity in service provisions and partnerships integration of CP activities into the regular country and counterparts' programming?

From the design and implementation of the P&D component of the CP, it was evident that aspects that were supportive of sustainability while others were not. The consultative approaches and the modality of execution provided a platform for ensuring entrenched sustainability by creating a sense of ownership of the programme from the wide array of governmental and non-governmental stakeholders involved. The involvement of the same stakeholders at every stage of the programme also ensured sustained interest and continuous creation of awareness on PD issues<sup>171</sup>.

Capacity strengthening was an in-built aspect of the programme component and it is one aspect that the respondent were proud to have gained in addition to producing, PESS, the product. This also led to strengthening of the statistical capacity of the Somali authorities at various levels from the design

to implementation of extensive surveys<sup>172</sup>. Further structures created by UNFPA across the zones enabled the Somali authorities to implement PESS on their own. During the trainings, a toolkit was developed by the taskforces and made available to the ToTs and could be used to guide training. At the time of the evaluation each zonal ToT had training other ministry staff on data collection, management and processing, including utilisation, a confirmation that the capacity was effectively enhanced and could be applied even after the project ends<sup>173</sup>. There is need to institutionalize capacity strengthening through the use of universities or building specialised units within the government to provide statistical technical support.

The strategy of working with staff seconded from the authorities will enable retention of staff even after the PESS process ends and would be able to use the skills within for the benefit of the government<sup>174</sup>. There were however cases where concerns were raised on the government retaining the trained staff as they were attracted by other institutions that were offering them better pay<sup>175</sup>. This was not in a large scale however.

PESS enabled establishment of structures that will guide the conduct of future surveys. In addition to setting up 'sample frames', or tools to make data collection in Somalia easier in the future, the survey has spent months training personnel in relevant institutions, including ministries of planning and concerned line ministries to collect, process and analyse disaggregated population data – a crucial ingredient for effective policy formulation, including humanitarian and development programmes.

<sup>170</sup> Interviews with Planning Ministry and UNFPA Staff

<sup>171</sup> Ibid

<sup>172</sup> Ibid

<sup>173</sup> Interviews with Planning Ministry and UNFPA Staff, FGD with participating data analysts and report writers and observation

<sup>174</sup> Interviews with UNFPA and Planning Ministry staff

<sup>175</sup> Interview with Planning Ministry Staff

### Summary of Findings

The CP component of Population and Development was well aligned to the national policies and addressed the needs of the Somali people and government priorities. Implementation and completion of the Population Estimate Survey of Somalia (PESS) was and continues to be relevant to a wide range of stakeholders including government and development partners. Once completed, it will increase availability and use of data on emerging population issues at national and sub-national levels. Through implementation of PESS, the CP effectively built the capacity of the government staff who were involved in all the processes. This will lead to improved decision-making and policy formulation, including data management, monitoring and strategic planning. Through the component, the programme has led to revival and strengthening of statistical units both at national and sub-national levels to enhance the use and dissemination of data. The use of pre-war regions of Somalia, the need for data for informed decision-making and high level coordination of activities of the programme interventions ensured success in the component delivery. Working directly with the

government also enhanced the capacity and facilitated ownership by the locals.

The programme utilised available resources effectively to produce results as per the design. However, insecurity and issues of consensus-building demanded that workshops be held out of Somalia. The methodology was effective. However, it was affected by rains leading to delays in estimating the number of the pastoralist communities as water points were to be used to access them. This also delayed implementation of the PESS activity, but UNFPA was able to mobilise further resources to ensure that this was done.

Building capacity of the government and establishment of coordinating mechanisms facilitated transfer of skills and practical application of knowledge gained, manifesting learning and enhanced capacity. Further, direct engagement of the government planning ministries facilitated ownership which also assures sustainability. There are however data needs and low capacity for effective management of emerging population issues.



## 4.4 Gender Component

### 4.4.1 Relevance

**EQ 1:** To what extent were the programme interventions consistent with the needs of the beneficiary populations and to what extent was it aligned with government priorities as well as with policies and strategies of UNFPA?

**EQ 2:** How well was the CPAP aligned with the ICPD actions and MDGs as well as with the UNFPA Strategic Plans?

In establishing the extent to which the programme is relevant, the evaluation process considered the interventions implemented that contributed to the component objectives, their relevance to identified country needs, how they addressed the government priorities and development plans, and to the UNSAS (up to 2014; and ISF for 2014-2016) and UNFPA priorities and mandate. Further, evidence of corroborating information to the assertions of the assessment was also a contributing factor.

The programme is relevant based on Somali's commitment to promoting gender equality through, which is being translated by the gender policies developed across the entire country, commitment made in the London communique of May 2013 with the UN on ending sexual violence in conflict. The provision of zero tolerance FGM in the 2012 Constitution of the Federal Government of Somalia among others. The need to strengthen capacity strengthening and coordination efforts by both national and international actors and stakeholders to prevent, mitigate and respond to GBV in both Humanitarian and development situations .UNFPA, through the programme component provided both financial and technical support towards the current ratification process of CEDAW, training of government officials to understand the convention

and their expectations towards its full implementation, accession, Ratification and reporting. UNFPA supported government on drafting and enactment process of the sexual offenses bill, FGM/C bill and the development of the FGM policy. One all these legal and policy frame works are finalised and fully implemented/reported, these will provide a platform which will support access to justice and contribute to the promotion of gender equality<sup>176</sup>. All these are geared towards improving the legal framework and as gathered from the respondents, the bills and policies address the needs of the Somali people<sup>177</sup>.

Gender-Based Violence (GBV) remains a serious concern, particularly for women and girls in Somalia. It remains pervasive, with increased risks of violations, yet there are limited prevention programmes or medical, psychosocial or legal services in place for the survivors. The protection environment remains weak for the Internally Displaced Persons (IDPs) and civilians affected by the clan conflicts, regions where the military offensives by the AMISOM and Somali National Army against the Al Shabaab took place, regions affected by the floods, forced evictions and where life-saving services are either limited or facing closure due to funding constraints. Reporting of violation cases by survivors is also a challenge due to stigma and ineffective response from the judicial system<sup>178</sup>. In addition to limited educational opportunities for girls, early marriages and associated physical and psychological damage severally continue to erode girls' rights. Like any other humanitarian context, Somalia faces myriad of challenges in bridging the gap in both basic services, such as post-rape care or psychosocial

<sup>176</sup> Interviews with Gender IPs and UNFPA staff; programme reports and updates

<sup>177</sup> Interviews with Gender IPs and UNFPA Staff

<sup>178</sup> UNOCHA (2014), Somalia Humanitarian Needs Overview for 2015

support, and in comprehensive, high-quality survivor-centred care, including case management. UNFPA's programme on GBV response and prevention was highly relevant in the context as the aim was to improve access to services by the survivors, ensure safety of the affected and increase community awareness targeting behaviour change and elimination of harmful social practices<sup>179</sup>.

Insufficient and unreliability of GBV data is limiting response and access to GBV services by the survivors in Somalia. Currently, the data that is available or depended on are those that have been reported incidences to service providers. Even in situations where some data is available, these figures represent only a small proportion of the actual number of incidents due to the stigma often associated with reporting GBV and/or the lack of available services. This unreliability of data further limits the understanding of trends and patterns in GBV incidents to improve prevention and response programming. The focus of UNFPA in strengthening the capacity of stakeholders in GBV information management systems (GBVIMS) through training, research, harmonization or data collection tools; presents an opportunity to improve impact of inter-agency coordination mechanisms, enhances advocacy efforts, and thereby promotes evidence-based fundraising to address existing gaps<sup>180</sup>.

UNFPA's approach of implementation through national execution directly contributed to the performance of the governments through the various Somalia zone-based strategic plans, as stipulated for Somaliland<sup>181</sup> and Puntland<sup>182</sup>, and corroborated by the ministry staff for Federal Government of Somalia during interviews. The UNFPA programme team consulted widely with the

stakeholders and implementation was done, with the government ministries taking charge, while the programme supporting technically and financially. The outcome of the component, directly contributed to the achievement of Outcome 3 of the UNFPA global strategic plan 2014 – 2017<sup>183</sup>. It also contributed to Outcome 3 the UNSAS (ISF 2014 – 2016). Even through the gender components cuts across all the MDGs, it directly contributes to MDG 3 which aims to promote gender equality and empowerment. All these efforts make the programme component highly relevant<sup>184</sup>.

#### 4.4.2 Effectiveness

**EQ 5:** To what extent have the interventions supported by UNFPA in the field of gender contributed to: (i) Strengthened national and sub-national protection systems for advancing reproductive rights, promoting gender equality and non-discrimination and addressing gender-based violence; (ii) Increased capacity to prevent gender-based violence and harmful practices and enable the delivery of multi-sectoral services, including in humanitarian settings?

**EQ 6:** To what extent was the programme coverage (geographic; beneficiaries) reached as planned?

In assessing the effectiveness of the gender equality component of the Somalia 2<sup>nd</sup> UNFPA CP, the evaluation considered analysing the degree of achievement of outputs, the extent to which the outputs contributed to the achievement of the outcomes and the unintended effects of the interventions implemented. The programme strategies were focused on legislative and policy framework, capacity strengthening and coordination, community mobilisation and participation and the creation of partnerships to respond to gender-related issues, including service

<sup>179</sup> Interviews with Gender IPs, UNFPA Staff and Programme report

<sup>180</sup> Interviews with UNFPA Staff and Gender IPs

<sup>181</sup> Somaliland National Development Plan (NDP) 2012-2016

<sup>182</sup> Puntland Second Five-Year Development Plan 2014 - 2018

<sup>183</sup> UNFPA Strategic Plan 2014 – 2017 and Interview with UNFPA Staff

<sup>184</sup> Interviews with UNFPA Staff and Gender IPs; Programme reports and updates

delivery for GBV survivors and harmonization of tools such Clinical Management of Rape protocol, GBV harmonised messages, referral pathway among others. This component was mainly implemented in partnership with the ministry of women and human rights in South Central Zone, ministry of women development and family affairs (MOWDAFA) in Puntland and Ministry of labour and social affairs (MOLSA) in Somaliland and selected NGOs within Somalia. The programme component maintains a special focus on protection, promoting of women's rights, with a specific focus on the fulfilment of reproductive rights, and prevention and response to gender based violence (GBV).

Even though this component was a component on its own, UNFPA integrated most of its activities, especially the RHR component, including humanitarian assistance with the activities of this one, yielding greater results<sup>185</sup>. The interventions implemented in this component were in the main pillars, which were; the legislative framework and policy development, provision of GBV services, Community engagement for GBV prevention, GBV data management and coordination/capacity strengthening of GBV Actors and stakeholders. In order to strengthen the work of the stakeholders involved in gender equality and empowerment, UNFPA supported coordination activities through working groups and taskforces. The support has been both in financial and technical expertise.

Discussions with stakeholders and beneficiaries indicate that support of UNFPA through its gender equality component was effective. Documentation accessed from UNFPA and its partners show that the interventions were delivered as planned and the overall feedback suggest that the component is likely to have made, or to make a significant

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<sup>185</sup> Interviews with UNFPA Staff, Implementing Partners and beneficiaries; and review of programme reports

contribution to the intended results. During the period of evaluation, the respondents confirmed receiving services in time and that most of the planned activities were on track<sup>186</sup>. Due to the nature of the interventions and areas of focus by the organisation, it is evident that considerable strides were made towards realizing the expected results as shown in Annex 2 for performance framework<sup>187</sup>, although a few socio-cultural and economic challenges still existed in addressing gender issues as analysed within the section of this evaluation criteria.

### **Prevention and Protection against all forms of GBV**

Gender-based violence (GBV) is a major challenge in Somalia. The environment makes it difficult for access to legal aid services for the GBV survivors. In addition to the security challenges, there are also enormous social, cultural and religious barriers in reporting GBV cases and the survivors are often reluctant to pursue prosecution or civil cases against the perpetrator due to the social stigma associated with rape. The problem is further aggravated by the traditional and customary laws such as the *Xeer* system, which are used to resolve majority of the cases and they are rarely survivor-centred. In some areas, particularly in the South Central Somalia, survivors, lawyers, witnesses, journalists and family members have been threatened, harassed and arrested for reporting GBV offences.<sup>188</sup> These further make the survivors hesitant to report GBV cases<sup>189</sup>.

In order to improve the legal framework to address prevention and protection against all forms GBV,

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<sup>186</sup> Interviews with Gender IPs and FGDs with beneficiaries; and IP AWP

<sup>187</sup> The performance Framework is summarised considering the baseline and the targets in Gender component that were to be achieved by 2015; and the achievement at the time of the evaluation, and based on the CPAP.

<sup>188</sup> Interviews with IP staff

<sup>189</sup> Legal Action Worldwide (2014): Legal Aid Providers Supporting Survivors of Gender Based Violence in Somalia – A report commissioned by UNDP and UNFPA.

UNFPA provided both technical and financial support in drafting of bills, policies and ratification of internationally-accredited processes. During the period, UNFPA, together with UNDP and UNHCR technically and financially supported drafting of Sexual Offenses Bills (SOBs) across the country and at the time of the evaluation, they were at different stages of legislation. In Somaliland, it was submitted for discussion to the Parliament, in Puntland, it was approved by the Cabinet and awaiting approval by the Parliament while for the Federal Government, the bill was expected to be finalized by the Cabinet and submitted to Parliament for approval before the end of the year 2015. These SOBs are the first of their kind in Somalia<sup>190</sup> and have made significant progress in ensuring that sexual offences are prosecuted under the new sexual offences legislation<sup>191</sup>.

Through UNFPA's support, Somalia made strides in the ratification of the Convention on the Elimination of all forms of Discrimination against Women (CEDAW). Training and sensitisation of the policy makers on the process was conducted during the period, with the Director-Generals from ministries, ministers and members of Parliament (MPs) targeted. CEDAW Technical Advocacy Committee, composed of DGs, chaired by the Deputy Minister of Women and Human Rights Development and co-chaired by Ministry of Information was set up, with the ratification roadmap and implementation plan put in place<sup>192</sup>. Initially, there was perception that the CEDAW was against the cultural and religious beliefs but through trainings, the people have been sensitised on the need to embrace the convention and even the constitution of the Federal government has been reviewed and aligned to the

tenets of the convention<sup>193</sup>. It is worth noting that UNFPA collaborates with related UN organisations, and partnership with task forces, working groups, line ministries across Somalia in development of the protocols, bills and policies.

A pilot project between UNDP and UNFPA to address Gender Based Violence (GBV) through community policing in Puntland was initiated. This involved training female police volunteers, who used their skills to help break down barriers between the community and the police, making it easier for women to approach the police for protection and justice services. It led to increased community involvement and public confidence in the justice systems to address GBV cases, including increased cases reported<sup>194</sup>. In Puntland for example, more than 20 rape cases have been submitted to the courts for legal redress, making considerable strides in justice for survivors. There was historic milestone made in Puntland where a rape perpetrator was convicted for 20 years through the legal support of *Maato Kaal*, a one-stop centre based at Garowe general hospital,<sup>195</sup> supported by UNFPA. Further in Puntland, highlight the documented fact that UNFPA and UN partners already addressed the issue of "Xeer" system where the sexual perpetrators are convicted through the courts with the support of the trained police and under the Sexual Offenses Act<sup>196</sup>.

### Female Genital Mutilation/ Cutting

During the period, a number of developments took place towards eradicating Female Genital Mutilation/Cutting (FGM/C), including its health

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<sup>193</sup> Interviews with MW&HR in Mogadishu

<sup>194</sup> See

[http://countryoffice.unfpa.org/somalia/2015/03/23/11737/finding\\_justice\\_for\\_survivors\\_of\\_gender\\_based\\_violence\\_in\\_somalia/](http://countryoffice.unfpa.org/somalia/2015/03/23/11737/finding_justice_for_survivors_of_gender_based_violence_in_somalia/) [Accessed on 5/01/2016]

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[http://countryoffice.unfpa.org/somalia/2015/03/23/11737/finding\\_justice\\_for\\_survivors\\_of\\_gender\\_based\\_violence\\_in\\_somalia/](http://countryoffice.unfpa.org/somalia/2015/03/23/11737/finding_justice_for_survivors_of_gender_based_violence_in_somalia/)

<sup>196</sup> Interview with UNFPA and UNDP Staff

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<sup>190</sup> Somalia GBV Sub-Cluster 2015 Annual Report

<sup>191</sup> Interview with UNFPA, UNDP and Gender IP Staff

<sup>192</sup> Interviews with Ministry of Women and Human Rights (MW&HR) and UNFPA Staff in Mogadishu and Nairobi

effects, through the support of UNFPA. The FGM/C bill and FGM/C Policy, which advocate for zero tolerance to FGM/C, was drafted across Somalia. The Federal Government had made a first draft, with the help of UNFPA, in Puntland, the FGM/C Policy<sup>197</sup>, outlawing the practice had been approved, and in Somaliland the bill is still being discussed at the government level<sup>198</sup>. The Somali Constitution enacted in 2012 outlaws FGM/C. The programme period saw strides made towards abandonment of FGM/C. The programme employed a multi-stakeholder involvement in the eradication of the practice in Somalia. The high level of government commitment, engagement of communities, youth peer groups, religious and traditional leaders, health associations, women groups, FGM/C practitioners and child protection groups provided an enabling environment for FGM/C abandonment<sup>199</sup>.

Challenges still continue to affect the fight against the FGM/C practice. These include reaching a common position by the religious leaders on total abandonment of all forms of FGM/C, reaching the remote rural areas and medicalization<sup>200</sup> of FGM/C<sup>201</sup>. UNFPA has however managed to involve key religious stakeholders, including religious ministries across the governments and Muslim Scholars to clarify the beliefs. UNFPA ASRO, in partnership with Al-Azhar University in Cairo held a workshop for Somali religious leaders on FGM in Djibouti in December 2015. Participants included representatives from line ministries, prominent Sheikhs, civil society representatives, UNFPA staff

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<http://countryoffice.unfpa.org/somalia/drive/GoodPracticeonFGMinSomalia.pdf>

<sup>198</sup> Interview with UNFPA and Gender IP staff; and programme reports and updates

<sup>199</sup> Interview with Gender IPs and UNFPA staff; and UNFPA-UNICEF FGM/C Joint Programme Report

<sup>200</sup> Medicalization of FGM/C refers to a case where a medical practitioner conducts the FGM/C, which is identified to be legitimizing the act, despite its long term negative effects.

<sup>201</sup> Review of programme reports and Interviews

and scholars from the Al-Azhar University. At the end of the workshop, the religious leaders issued a declaration condemning FGM practice. Further, religious leaders in Puntland issued Islamic decree (*Fatwa*) outlawing all forms of FGM/C and communities making public declarations on total abandonment of FGM/C. Other efforts include criminalization in Somaliland of FGM/C by professional health workers associations; and formation of Regional Religious Network against FGM with participants from Somalia, Djibouti, Egypt and Sudan, notably prominent sheikhs and two Coptic religious leaders to provide a platform that aims at facilitating experience and knowledge sharing among faith-based entities in the region through the organisation of ASRO<sup>202</sup>. UNFPA has made progress in addressing FGM/C amid socio-cultural and religious challenges. The gains made, especially in Puntland with religious leaders, and other regions of the country can form learning points for cascading and can be utilised to address this in the other areas including rural communities.

Constant changes in the government have also affected development and enactment of the Bill in both the South Central Somalia and Puntland, but UNFPA worked closely with the DGs of the gender-related ministries to overcome challenges. Wider consultations bore fruits for the legislative framework, especially with the opinion leaders, including religious leaders, as this led to the approval of the bills. Continuous engagement of the policy-makers, discussing their concerns also built trust between them and UNFPA, thereby promoting ownership of the processes and decisions by the national governments.

### **GBV Response and Service Provision**

GBV response and service provision was also integrated in the RH and Humanitarian Assistance

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<sup>202</sup> Interviews with UNFPA and CP Reports

interventions, a process which realised a lot of relief to the survivors. In partnership with local and international NGOs, UNFPA supported establishment of One-Stop Centres for GBV survivors. These centres provide a range of services in one facility. The GBV service delivery interventions included; psychosocial support and counselling, post rape treatment and other medical care, legal assistance and community based GBV prevention<sup>203</sup>. To reduce stigma, these centres are located within health facilities, which can also conveniently facilitate referral for further clinical management, especially for rape cases. A total of 11 centres (2 in Puntland and 9 in South Central) were established and supported to provide these services. In addition, UNFPA supported and facilitated establishment of 3 family centres in Daynile, Hodan, and Dharkenley districts of Banadir region providing multi-sectoral services for GBV survivors, including clinical management, psychosocial, legal, dignity kits and material assistance<sup>204</sup>. UNFPA also facilitated development of a comprehensive Manual on Clinical Management of Rape Survivors, which was finalized and validated with the leadership of MOH and technical support of the Clinical Management of Rape (CMR) taskforce; and was endorsed by all the Ministries of Health from the authorities of Somalia. It is being rolled out.

Currently, there are challenges of rape cases, especially for those seeking legal services, where cases are dropped because of lack of laboratory for collecting and analysing forensic evidence<sup>205</sup>. UNFPA has realised this and with support of SIDA, launched a pilot project on establishing a forensic system in Puntland. This project involves setting up forensic lab, training of lab technicians and other

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<sup>203</sup> Interview with UNFPA and Gender IP staff; and programme reports and updates

<sup>204</sup> Ibid

<sup>205</sup> Interview with Gender IPs in Garowe and Mogadishu; UNFPA Staff and FGDs with beneficiaries in Garowe

health staff, adoption of forensic evidence generation protocols and guidelines, sensitisation/awareness raising, to support in investigations on rape cases<sup>206</sup>. In efforts to curb the threats that some GBV survivors undergo, UNFPA established 3 safe homes in the South Central zone and a GBV resource centre operational in Hargeisa and at the time of the evaluation, there were plans to establish more in Lower Shabelle region to provide relief to the survivors<sup>207</sup>. It is hoped that these homes are therapeutic to the survivors as they felt better protected where safe houses are established, particularly in South Central Somalia and get to recover from trauma associated with GBV<sup>208</sup>. In recognition of the security challenges involved for those involved in the fight against GBV, UNFPA financially supported the development of draft Security and Safety Protocol for lawyers, clients and witnesses.<sup>209</sup>

The programme also supported stakeholders in mapping of GBV service providers across Somalia and to ensure that quality and standardising procedures was enhanced, supported development of standard operating procedures (SOPs). The Midwifery curriculum was also revised to integrate FGM/C issues<sup>210</sup>. Access to services is still hampered by insecurity issues in Somalia, thereby some locations missing out on the services. The programme has however reached the areas through RH outreach campaigns where integrated services have been provided. Even though UNFPA has tried in supporting of partners to provide survivors with livelihoods and economic empowerment services, it is still in small scale<sup>211</sup>.

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<sup>206</sup> Interview with UNFPA Staff

<sup>207</sup> Interview with UNFPA and IPs

<sup>208</sup> Interview with UNFPA Staff and Gender IPs

<sup>209</sup> Ibid

<sup>210</sup> Interview with UNFPA Staff

<sup>211</sup> Interview with UNFPA Staff and Gender IPs

<sup>211</sup> Interview with UNFPA Staff

## GBV Advocacy

Given the challenging environment addressing gender issues in Somalia, UNFPA continues to enhance multi-stakeholder involvement and capacity strengthening mechanisms to ensure effectiveness in combating GBV. The programme supported implementing partners (IPs), including regional authorities across Somalia to build capacity of community leaders, religious leaders, opinion leaders, young girls, women, boys and men and to enable them to create awareness on issues related to gender equality, including sexual and gender-based violence (SGBV) in the target areas<sup>212</sup>. UNFPA was successful in its programme through the efforts in engaging the regional states, including involving them in decision-making, further making the processes more inclusive and consultative.<sup>213</sup>

UNFPA targeted raising awareness on GBV and FGM/C through enhancing community mobilisation and sensitisation using different media. The youth peer (Y-Peer) networks were capacitated to reach out to the young people with messages that aimed at addressing behaviour change, social norms, practices and utilisation of available services. They participated in sensitisation events on early marriage, girls' education and rights<sup>214</sup>. NGOs and other stakeholders were involved in reaching out to the communities using messages that had been harmonized through the coordination efforts of UNFPA to promote consistent communications. Radio messages were aired on GBV prevention, and workshops held to train various participants on GBV messages<sup>215</sup>. The use of former circumcisers as champions for abandonment of FGM/C also yielded positive results<sup>216</sup>. There is however likelihood of

the women reverting to the practice as it acted as a source of their livelihood. Male involvement in GBV prevention would be an effective way in fighting gender discrimination. This was inadequately embraced by the programme<sup>217</sup>. The GBV working groups however identifies the role of the Male and Youth networks in prevention of GBV and are increasingly targeting their involvement.<sup>218</sup>

A strong inter-ministerial working relationship that has been fostered by UNFPA has helped yield good results in the efforts to improve gender equality and empowerment in Somalia, especially on development of bills and in the advocacy efforts. This could be seen in the CEDAW committee composed of several ministry DGs, FGM/C task force which is led by the ministry of women and human rights and co-chaired by the MoH. Community engagement on total abandonment of GBV in the 3 zones is ongoing and has seen lots of commitment from the stakeholders, including policy-makers<sup>219</sup>. Anti-FGM/C clubs were formed in Somaliland universities and colleges with members being activists, religious leaders, mothers and girls reached through small group discussions, billboards, public events and theatre performance on FGM/C<sup>220</sup>. There still exist misconceptions on FGM/C requirement by the Islamic religion and as much as progress is being made in awareness raising, total abandonment of the practice faces a challenge of whether the religion accepts the *sunni*-type of FGM/C.<sup>221</sup>

To further increase advocacy, UNFPA supported commemoration of International Day for Zero-Tolerance to FGM/C and International Women's

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<sup>212</sup> Interview with UNFPA and Gender IPs Staff and programme report

<sup>213</sup> Interview with UNFPA Staff and Gender IPs

<sup>214</sup> [http://countryoffice.unfpa.org/somalia/2015/10/29/12996/using\\_performance\\_and\\_poetry\\_to\\_break\\_the\\_silence\\_in\\_somalia/](http://countryoffice.unfpa.org/somalia/2015/10/29/12996/using_performance_and_poetry_to_break_the_silence_in_somalia/)

<sup>215</sup> Interviews with UNFPA and IP Staff; FGDs with Youth and programme reports

<sup>216</sup> Interview with UNFPA staff in Nairobi and Mogadishu

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<sup>217</sup> Interview with IPs

<sup>218</sup> [https://unsom.unmissions.org/Portals/UNSOM/GBV%percent20WG%20Strategy%20final%20Jan%2029%202014\\_new.pdf](https://unsom.unmissions.org/Portals/UNSOM/GBV%percent20WG%20Strategy%20final%20Jan%2029%202014_new.pdf)

<sup>219</sup> Interviews with UNFPA and Gender Ministries across Somalia

<sup>220</sup> Interviews with UNFPA and IP staff, FGDs with youth and Observations

<sup>221</sup> Interviews with UNFPA Staff; 2015 Somalia GBV Sub Cluster report; and UNFPA – UNICEF Joint programme Report

Days across the country. 16 days of gender activism were also marked through the support of UNFPA. It is also during these occasions that further sensitisations to the masses were conducted including raising awareness on the importance of upholding the rights of women through empowering them. Specific messages are designed through radios, talk shows, theatre and public events during these days to emphasize the need to increase the campaigns to abandon harmful practices.<sup>222</sup>

### **Capacity Strengthening for the GBV Response**

UNFPA contributed enormously towards enhancing the capacities existing in Somalia towards the response in addressing gender issues. A number of capacity strengthening training were conducted for service providers on case management, GBVIMS, GBV guiding principles, GBV referral pathways, and GBV case investigation and prosecution training for police and Criminal Investigation Department (CID)<sup>223</sup>. The programme in collaboration with selected implementing partners strengthened various stakeholder capacities in the implementation of gender-related bills and policies. The programme also built the capacities of key actors on GBV including related ministries. With funding from the Office of the United States Foreign Disaster Assistance (OFDA)/USAID, Humanitarian financing such as Somalia Humanitarian Fund, Central Emergency Fund, and also Swedish embassy, UNFPA is strengthening the technical capacity of the GBV Working groups across Somalia. The programme supported training on GBV coordination and programming for 45<sup>224</sup> chairs, co-chairs and focal points for the working groups from the three regions of Somalia. GBV working group chairs/co-chairs/focal points were trained on human rights based approach, results-based

management, advocacy, networking, communications, resource mobilisation, and harmonized tools (reporting, service mapping and standard operating procedures) were developed.<sup>225</sup>

UNFPA leads in the coordination of GBV interventions as the Chair of the national GBV Sub Cluster, national FGM/C Taskforce, GBVIMS Taskforce and Clinical Management of Rape (CMR) Task Force and strengthened field based GBV Sub-Clusters in Puntland (Garowe, Bossaso and Galkayo), South Central (Mogadishu, Baidoa, Middle Shabelle, Dollow, Hiran, Dhobley, Kismayo and Galgaduud), and Somaliland (Hargeisa).<sup>226</sup> UNFPA also supported the coordination capacity through recruitment of Regional Gender-Based Violence Coordinators and posted in the field by UNFPA. These coordinators have provided technical support to the functions of the sub-cluster within the respective regions with monthly coordination meetings held and action points followed and implemented.<sup>227</sup>

To get comprehensive data on GBV is difficult to come by in Somalia. This hampers evidence-based programming and advocacy. To respond to this, UNFPA enhanced capacity of the actors on GBV Information Management System (GBV-IMS). The GBV-IMS enables humanitarian actors who are responding to GBV to safely collect, store and analyse reported GBV incident data, and facilitate the safe and ethical sharing of reported GBV incident data<sup>228</sup>. This was done through training of stakeholders on data collection techniques, harmonization of data collection tools, training on utilisation of the system and supporting development of a User Guide. UNFPA is the lead agency on GBV-IMS and chairs the IMS task force. UNFPA further partnered with UNICEF and UN

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<sup>222</sup> Ibid

<sup>223</sup> Interviews with UNFPA, UNDP and IPs and Programme reports

<sup>224</sup> Interview of UNFPA staff and Programme reports

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<sup>225</sup> Ibid

<sup>226</sup> Interviews with UNFPA Staff

<sup>227</sup> Ibid

<sup>228</sup> Ibid



Women to conduct GBV survey. This will provide key data to inform programming. There are still gaps on FGM/C data and other forms of GBV, due to inadequate capacity and other social and cultural issues that hinder reporting<sup>229</sup>. Inadequacy in reporting of GBV cases hinders assessment of the extent to which they occur. There is limited coverage of UNFPA support in the rural areas. Integrated RH outreach programme tends to address this to the extent of resource constraints.<sup>230</sup>

UNFPA Somalia programme has endeavoured to strengthen its staff capacity to be able to respond to the needs within the country. The gender unit is however still understaffed limiting the capacity of the programme activities to be effectively monitored and evaluated. At the moment, the component only has one focal-point staff in all the three Somalia zones, while in Somaliland and South Central zones, the staff double up as the focal points for the programme's youth interventions. Integration of the component interventions into the RHR component interventions bridges this gap, but not effectively<sup>231</sup>. It is also notable though that the programme implements through IPs, and that notwithstanding, some deliverables from the staff in the component demand more time. From the evaluation, it came out that apart from coordination with the IPs, staff time to monitor the interventions was lacking as the available staff have more workload.<sup>232</sup>

#### 4.4.3 Efficiency

**EQ 7:** Was the programme implementation approach (funds, expertise, time, administrative costs, etc.) the most efficient way of achieving results?

<sup>229</sup> Interviews with UNFPA Staff and IPs; FGDs and programme report

<sup>230</sup> Interviews, FGDs and Outreach activity report

<sup>231</sup> Interview with field UNFPA staff

<sup>232</sup> *ibid*

As one of the evaluation criteria, efficiency examined the extent to which the costs of the CP and implementing partners could be justified by its results/ the value for money, taking alternatives into account.

The consultative coordination forums were strategic in ensuring that UNFPA worked as a team with the relevant stakeholders in an integrated manner. However, in terms of efficient programme implementation, there was a problem of lack of skills and low educational levels of the involved partners on gender issues. This means there was a huge need for capacity strengthening to ensure that human rights and gender equality were recognised by everyone. There was also the need for qualified personnel to implement the gender promotion programmes. By focusing on technical assistance and capacity strengthening UNFPA was therefore providing a most required resource.<sup>233</sup>

UNFPA work plans were in line with government priorities and there was collaboration and team work in implementation with the line ministries across the country. Implementing partners commended the excellent working relationship with UNFPA on gender issues. This could be attributed to the improved coordinating fora where joint planning, reporting and response of programmes were done with implementing partners through the working groups and taskforces supported by UNFPA.<sup>234</sup>

Integration of gender services within the RH component facilitated efficient provision of services to the affected in an effective manner. Positioning of the post-rape kits at the referral points and major hospitals ensured that the services were accessed

<sup>233</sup> Interviews and programme reports

<sup>234</sup> Interviews

at the time of referral. These were also availed to the IPs. One-stop centres promoted efficiency in the kind of services accessed by the GBV survivors. The provision of the minimum initial service package (MISP) enabled access to services in an efficient manner by the survivors during emergencies<sup>235</sup>.

The strategic target of the influential community and religious leaders facilitated country-level advocacy mechanisms in prevention of GBV. The involvement of the religious leaders in exchange programmes in Egypt and scholars enabled them to make public decrees and declarations against some practices like FGM/C, due to the messages and learning<sup>236</sup>. The involvement of circumcisers as agents of change in advocacy against FGM/C showed efficiency in delivery especially their messages on zero tolerance to FGM/C<sup>237</sup>.

#### 4.4.4 Sustainability

**EQ 8:** To what extent are the development gains made under the UNFPA supported interventions in Somalia sustainable in terms of continuity in service provisions and partnerships integration of CP activities into the regular country and counterparts' programming?

From the evaluation feedback from the targeted respondents, it was evident that the programme addressed the aspects of sustainability within Somalia<sup>238</sup>. These were through ensuring national and community ownership, capacity strengthening, implementation mechanisms and addressing relevant aspects that affect the community.

From analysis of documents and feedback, it was evident that the programme intervened on strategic

needs of the target communities and national governments across the country<sup>239</sup>. The respondents reached, identified with the UNFPA interventions and could identify with the achievements that the programme component had yielded<sup>240</sup>. The government especially identified the contribution that the gender component made in improving the legislative frameworks through policies, bills and the conventions. It was evident this contributed directly to their strategic plans, thereby enhancing national ownership<sup>241</sup>. The approach to implementing the intervention through the government structures also enhanced the ownership aspects thereby building their capacity to ensure that they are able to implement the laws or enforce mechanisms even after the end of the programme period. The utilisation of local IPs also made the communities identify with the interventions of the CP component<sup>242</sup>. Perceptions and conflicts of opinions, especially on the FGM/C and gender empowerment bills still exist and this needs to be addressed to ensure that there is effectiveness in realisation of the intended results. To the extent that the community structures, including religious groups and the governments have not sufficiently supported GBV programming, there are serious challenges for sustainability of the programme.

The likelihood of sustainability was also inherent in some of the interventions such as development of protocols for clinical management of rape, capacity-building the partners on GBV prevention and response coordination, harmonization of messages on GBV and establishment of taskforces and working groups which were in turn co-chaired by the local NGOs and government line ministries<sup>243</sup>. Strengthening the curriculum of RH to include

<sup>235</sup> *ibid*

<sup>236</sup> Interviews with UNFPA staff

<sup>237</sup> Interviews with UNFPA Staff and IPs

<sup>238</sup> Interviews with IPs

<sup>239</sup> Interviews with UNFPA IPs and Programme reports

<sup>240</sup> Interviews with IPs

<sup>241</sup> Interviews with Government (gender) staff

<sup>242</sup> Interview with UNFPA and Government (gender) Staff

<sup>243</sup> Interview with UNFPA staff

FGM/C will also ensure sustainability by setting standards to be adhered to even when the programme comes to an end<sup>244</sup>. Partnerships and networking endeavours initiated by UNFPA to develop strategies, establish one-stop and family centres, safe homes were also implemented with a sustainability lens. Resource mobilisation capacity is still insufficient among the government ministries and other stakeholders in the gender programming in Somalia. As the legal and clinical frameworks continue to be strengthened, the services would require support.

The magnitude of contribution that UNFPA made towards development of technical guidelines including the standard operating procedures (SOPs) in GBV response and prevention was given a great acknowledgement by the respondents<sup>245</sup>. The financial support to the gender empowerment processes and technical support provided by the UNFPA gender experts came in handy in ensuring that change was realised towards ensuring gender equality. Due to inadequate capacity to implement effectively among the local NGOs and the government<sup>246</sup>, the quality of services will be compromised.

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<sup>244</sup> Interviews with UNFPA Staff and Programme report

<sup>245</sup> Interviews with IPs

<sup>246</sup> Interviews with UNFPA Staff and IPs

### Summary of Findings

The interventions of Gender Equality were adequately designed and adapted to achieve the targeted outputs which addressed the needs of the target populations and government priorities. Achievement of the component outputs were on course, and in some cases targets were surpassed as reviewed during alignment of the programme to the UNFPA Strategic Plan 2014 – 2017. The programme interventions covered the country, but at regional levels. The programme contributed to improvement of the legal framework to addressing GBV through supporting development of gender Bill, FGM/C policy, and enactment of Sexual Offences Bill. There was also improved prevention of and response to GBV through improved advocacy effort and support to GBV survivors, including mechanisms aimed at ensuring zero tolerance to FGM/C. The programme interventions were highly integrated with those of the RHR component to ensure comprehensive service delivery. However the main challenges affecting implementation of the GE component were the strong social-cultural, including strong religious perceptions, which the programme has managed to deal with during the course of the programme. The achievement of results is attributed to the close working relationships built through partnerships, thematic taskforces and working groups and enhanced coordination mechanisms established and spearheaded by the programme across the country and at Nairobi level. These facilitated efficiency in delivery of the programme services, in addition to the technical support provided by the programme gender specialists and resource mobilisation. Increased advocacy and capacity strengthening for ease of mobilisation and sensitisation against the harmful societal norms affecting Somali women and girls has been realised (refer Annex 2 for the component performance against the set target in the CPAP).

The programme component incorporated sustainable measure to ensure lasting solutions to the harmful practices in Somalia. Development of bills, policies and ratification of CEDAW facilitated sustainability, capacity strengthening, partnerships and establishment of coordination mechanisms also ensured meaningful participation and thereby strengthening sustainability. Low capacity and strong socio-cultural and religious beliefs, unless more actively addressed can affect the gains made towards ensuring gender equality in Somalia.

## 4.5 Management and Coordination

### 4.5.1 Management

The UNFPA Somalia CO management is one of the UN agencies responding to the Somalia humanitarian crisis under the United Nations Coordination Team (UNCT). The country programme is coordinated by a team in Nairobi and implementation is mainly done by the field staff, who operate at zonal level, led by a Head of Sub-Office (HSO). The technical team based at the Country Office level guide implementation, including supporting the field staff in all the related programme components. The programme unit has got experienced technical staff in RH including RH Specialist, RH Commodities and Humanitarian Assistance; Gender and GBV; and Population and development and effectively contribute to the programme's efficiency and effectiveness. Further contribution of these staff is discussed under the thematic programme component. Insecurity limits staff, especially the international specialists, movement particularly in the South-Central zone and this hinders their effective visit programme sites<sup>247</sup>.

The UNFPA's programme support unit of finance, procurement and administration was reported to be moderately effective, but with incidences of delays in delivery of services, caused by the bureaucratic and rigidity in the UN system, as reported by most IP respondents. However, given the identified gaps in capacity of the IP staff, the slow process in disbursement of funds at the CO level, though affected service delivery and execution of the plan, was to ensure that there was compliance and accountability based on agreements between the involved parties.

Responsibility for programme management, as agreed in CPAP, rests mainly with respective government ministries and their assigned focal staff, using the Annual Work plans (AWPs) modality, developed with UNFPA assistance by implementing partners within the framework of CPAP, as a means of coordinating and monitoring programme implementation. The CP was mainly implemented following the National Execution (NEX) modality in both Somaliland and Puntland, while in the South-Central zone; the modality was both NEX and Direct Execution (DEX). This is due to the development nature of interventions and relative stability in both Puntland and Somaliland which favours NEX, while in SCZ the humanitarian response favoured the DEX modality<sup>248</sup>. NEX proved more effective, especially in building the capacity of the national government, made it possible for audit for the first time in 20 years, enabled effective coordination role of the governments, eliminated bureaucracy, quality control, brought about consolidation and response to the government needs and achievements, and ensured compliance with the ICPD which does not advocate for creation of a parallel system<sup>249</sup>. Even though DEX modality was favoured in most humanitarian response, particularly in the South Central Zone, there is need to coordinate with the national government, especially on recruitment of IPs and service provision, to further ensure that gaps are effectively addressed and achievements captured.

### 4.5.2 Coordination

**EQ 10:** To what extent has the UNFPA CO contributed to good coordination among UN agencies in the country, particularly in view of avoiding potential overlaps?

<sup>247</sup> Interview with UNFPA staff and IPs; and programme reports

<sup>248</sup> Interview with UNFPA Staff

<sup>249</sup> Interviews with UNFPA, Somali regional Government, UNDP and UN Coordination office staff; and programme reports

Coordination as a function is embedded in the design of the programme and UNFPA played a great role in supporting coordination mechanisms across the country in the thematic components of the programme<sup>250</sup>. In addition, the programme coordinated its activities with the national government to ensure that gaps were effectively addressed. Within the UN, the CP was implemented under the umbrella of UNCT which made deliveries of services more coordinated<sup>251</sup>.

The RH component was implemented in close consultation with the ministry of health. The programme also closely coordinated with Youth-related ministries on youth activities in the RH component. The Population and development was mainly implemented in coordination with the Ministry of National Planning and development in Somaliland, Ministry of Planning and International Cooperation for Puntland and the Federal government of Somalia; while on the other hand, Gender component was implemented in collaboration with MoLSA in Somaliland, MoWDFAFA in Puntland and Ministry of Women Affairs and Human Rights in the Federal Government of Somalia.

UNFPA supported coordination through leading task forces and working groups in the programme component thematic areas. UNFPA chairs the GBV working group in Somalia and co-chaired by Somali Save Women and Children (SSWC). Currently, there are 12 GBV working groups (one in Somaliland, three in Puntland and eight in South-Central zones) in Somalia and UNFPA has trained co-chairs, including mentoring and coaching them. Within the Somalia Protection Cluster, the GBV sub-cluster continues to serve as the primary body for humanitarian coordination of GBV deliverables,

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<sup>250</sup> Interviews with UNFPA and Gender IPs Staff

<sup>251</sup> Interviews with UNFPA, Somali regional Government, UNDP and UN Coordination office staff; and programme reports

providing technical advice and oversight of GBV prevention and response activities in Somalia<sup>252</sup>. Through UNFPA programme leadership and support, the GBV sub-cluster members developed and implemented the activities within the Strategic Response Plan and the GBV Sub Cluster Strategy, in coordination with the government and other stakeholders in order to integrate GBV in the multi-sectoral response<sup>253</sup>. Improved coordination of the GBV sub clusters is a tangible milestone for UNFPA Somalia as this has greatly enhanced the services offered to survivors and at the same time promoted the visibility of the GBV sub cluster<sup>254</sup>. In addition, the country programme facilitated coordination of RH through establishment of RH unit and RH working groups in each zone to coordinate RH, and strengthening of the midwifery associations.

UNFPA also chairs FGM/C, IMS and Clinical Management of Rape Task Forces and has technically supported their operation, including financially supporting their operations. These have improved responses due to service provider mapping and standardisation of operating procedures (SOPs), including harmonization of advocacy messages, realised through coordination<sup>255</sup>.

Key informant interviews confirmed efforts to minimize overlaps, however there were reported cases that still existed requiring strengthening of coordination mechanisms<sup>256</sup>. There was also reported limitation in reporting due to insecurity in some operating areas<sup>257</sup>. Further, due to increased players in GBV issues, monitoring and reporting could be a challenge when coordination and

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<sup>252</sup> Interview with UNFPA Staff across Somalia and Gender IPs; Somalia 2015 GBV Sub-Cluster Annual Report

<sup>253</sup> Somalia GBV Sub-Cluster Annual Report

<sup>254</sup> Interviews with UNFPA and Gender IPs Staff

<sup>255</sup> Ibid

<sup>256</sup> Ibid

<sup>257</sup> Ibid

advocacy among stakeholders is not strong, thereby affecting response<sup>258</sup>.

UNFPA supported establishment of the RH unit and this facilitated efficiency in monitoring and quality assurance towards delivery of RH services in various government and other health facilities<sup>259</sup>. The unit, which also acted as a launch-pad or custodian for the manuals, protocols, records and guidelines for RH services enabled coordination and effective provision of the service<sup>260</sup>. The other coordination mechanisms led by UNFPA included RH Working Groups, National Maternal Death Surveillance and Response (MDSR) task forces, Reproductive Health Commodities and Security (RHCS) & Youth coordination fora at Nairobi level; Youth Forum in the zones co-chaired by UNFPA (established in September 2015)<sup>261</sup>.

Interviews confirmed UNFPA has a high standing among the UN partner agencies<sup>262</sup>. UNFPA played a key role with the UNCT during the period of evaluation. Towards realisation of access to skilled birth attendance by the pregnant women, UNFPA worked closely with World Food Programme (WFP), which provided incentives to women who delivered in the health facilities. It is notable that this cooperation was lauded to have contributed to mothers visiting health facilities for delivery services<sup>263</sup>. UNFPA, together with UN HABITAT led UN Inter Agencies Stakeholders Forum in Nairobi, which facilitated consultations towards development of the Somali National Youth Policy upon request from the Federal Government of Somalia, a product which is aimed at creating a framework that will enable youth in Somalia to

address issues that are unique to them and their communities through dialogue. UNFPA is coordinating research together with UNICEF on the Joint FGM Programme. This will enable evidence-based response of GBV, including FGM/C that is currently an area with limited prevalence data<sup>264</sup>.

UNFPA collaborates with UNDP in the UN Joint Rule of Law Programme towards contributing to the achievement of the Somalia Compact Deal. In Puntland, UNFPA coordinated with UNDP to provide Solar-powered electricity supply to the Garowe general and Galkayo hospitals<sup>265</sup>. UNFPA partners with UNICEF and WHO in the JHNP also actively participate in one cluster meetings with them. In Somaliland, there were however cases of overlaps in the health ministry on the roles of the partners in JHNP, causing confusion<sup>266</sup>. Further, this arrangement in JHNP at times led to delay in decision-making and some of the decisions depended on the other partners, who at times would delay, thereby leading to delayed implementation<sup>267</sup>. The success of PESS was as a result of UNFPA's role in coordination of resources within the Somalia UNCT, with UNFPA having brought on board different expertise within the UN and other stakeholders to support the process to its successful design and implementation. PESS was also conducted through coordination with the High Level task Force established with membership across the country<sup>268</sup>.

Internally, harmonization or coordination of activities among the programme component units is not strong<sup>269</sup>. Integration of programme

<sup>258</sup> Interviews with UNFPA and RH IP staff

<sup>259</sup> Ibid

<sup>260</sup> Ibid

<sup>261</sup> UNFPA Staff Interviews

<sup>262</sup> Interviews with UNDP and UN Coordinating Office staff

<sup>263</sup> Interviews with UNFPA and Government MoH staff

<sup>264</sup> Interviews with UNFPA and Government MoH staff

<sup>265</sup> [http://countryoffice.unfpa.org/somalia/2015/01/29/11339/a\\_solar\\_powered\\_maternal\\_and\\_neonatal\\_health\\_centre\\_for\\_somalia/](http://countryoffice.unfpa.org/somalia/2015/01/29/11339/a_solar_powered_maternal_and_neonatal_health_centre_for_somalia/)

<sup>266</sup> Interview with UNFPA and Government MoH staff

<sup>267</sup> Interview with UNFPA and Health IPs

<sup>268</sup> Interviews with UNFPA, Government, UN Coordination office Staff; and programme reports

<sup>269</sup> Interviews with UNFPA Staff

components' activities, especially with the RHR component, is strong, however the Gender and humanitarian response unit coordination was cited not to be strong<sup>270</sup>. Even though the target populations are the same, with the almost the same partners implementing activities in similar areas joint planning sessions are rarely embraced<sup>271</sup>.

established by the programme during implementation period supported achievement of results in the country framework.

### Summary of Findings

Management and delivery of the UNFPA Country programme was within the UNCT coordination mechanisms. The programme was initially developed to contribute to the UNSAS outcomes and later changed to the UN's ISF in compliance with the contribution to the Somalia Compact. UNFPA is an active member of the UN coordinating mechanism within Somalia. UNFPA leads through chairing sub-clusters and coordinating working groups (GBV and RH) and participating in various cluster meetings led and coordinated within the UN. It further implemented joint programmes with other UN agencies like UNDP on access to justice by GBV survivors; UNICEF on FGM; and UNICEF and WHO on JHNP, and included joint planning which eliminated possibilities of overlaps in targeting and services provided by the joint membership. The role played by UNFPA in the P&D component in coordinating expertise within the UN to ensure successful design and implementation of the PESS was also an achievement worth noting. There was high level of complementarity in the joint programmes. Joint programming however affected the programme especially where the other members were not able to implement their programmes as planned. The programme employed NEX modality of implementation and this managed to facilitate further coordination of interventions and capacity strengthening of the government structure. Coordination and partnerships

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<sup>270</sup> Ibid

<sup>271</sup> Ibid



## 4.6 Added Value

**EQ 9:** What has been the comparative strength of the UNFPA CO response to the Somalia context of protracted crisis and particularly in the areas of reproductive health, gender-based violence and population and development?

In assessing if UNFPA added value through its programming, the evaluation guided by the evaluation question sought to establish the comparative strength of the UNFPA CO response to the Somalia context of protracted crisis and particularly in the areas of reproductive health, gender-based violence and population and development. Overall, the evaluation results have shown that UNFPA added value to the governments' goals of improving the quality of life of the target segment of the population. The respondents, both NGO and government IPs identified UNFPA as having technical and comparative advantage in all the key components that it supported or coordinated. The financial support that UNFPA provided was strategic in contributing directly to filling existing gaps in the components.

UNFPA had notable comparative strengths during implementation of the country programme. One of the notable strengths was its ability to gather a team of technical experts drawn both from the UN and international spheres to plan and implement the population estimate survey of Somalia (PESS). The methodology used in this exercise benefited from numerous contributions from different experts, ranging from the design to analysis of the data. This immensely contributed to the success of the activity, including building the capacity of the Somalia government staff<sup>272</sup>.

Somalia is a country divided under a number of regional authorities with a lot of notable differences in political ideologies and perspectives with regard to legitimacy. While conducting the PESS, UNFPA was able to bring together all the three zonal authorities of Somaliland, Puntland and the Federal Republic of Somalia to accept the use of the pre-war regions of Somalia as the sampling boundaries. This brought the comparative advantage to UNFPA by succeeding where it seemed impossible among other development partners within Somalia<sup>273</sup>.

The level of consultation that UNFPA nurtured with its partners and stakeholders was highly distinguishable among the respondents and this made it stand out in cooperating with its stakeholders. The working relationship that the leadership of the UNFPA Somalia CO nurtured was lauded as very positive and identified as one which facilitated a lot of successes achieved within the country<sup>274</sup>. It was recognized as one of the UN agencies that spearheaded adoption and readily aligned its programmes to the Somalia Compact New Deal, aimed at contributing to a lasting peace in Somalia<sup>275</sup>. The method of execution by UNFPA (NEX) directly contributes to the national performance, thereby contributing to the UN's result framework<sup>276</sup>.

The programme focus also gave UNFPA a comparative advantage among development stakeholders in Somalia. It was the lead in the areas of reproductive health, population and development and played a lead role, including coordination of GBV prevention, response and management. By focusing on health, specifically reproductive health endeared the programme to its partners and beneficiaries. Improving the quality of

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<sup>272</sup> UNFPA and IP staff interviews

<sup>273</sup> UNFPA, IP and UN Coordination office staff interviews; Programme reports

<sup>274</sup> Interviews with IPs

<sup>275</sup> Interviews with Government and Alignment Documents

<sup>276</sup> Ibid

life and aiming at saving the lives of women and their children makes it a key partner that addresses the needs that affect every household in Somalia. On population and development, UNFPA played a key role in building the capacities of the zonal governments in generating data through financing and supporting implementation of PESS which provides evidence to inform and improve policy formulation and implementation. Further it had a niche in coordination of gender programming across the country. The implementing partners and the beneficiaries lauded the contribution of UNFPA and could easily identify the role played by UNFPA in its mandate, including a close and cordial working relationship<sup>277</sup>. Assessment of UNFPA by the beneficiaries was also positive<sup>278</sup>. There was also value addition in the role of UNFPA in humanitarian coordination at Nairobi and zonal levels as well as JHNP central and zonal steering committees, where the programme participated actively<sup>279</sup>.

The role that UNFPA played in supporting the zonal authorities' units in salary payments and top-ups across the country contributed immensely to the achievement of results in thematic performance. In the Ministry of Health, UNFPA supported the salaries of those in the RH unit, including supporting activities of the units to perform its duties. Statistics functions in the planning-related ministries across the country were also supported by UNFPA, including seconding experts into the units to guide and build the capacity of the ministry staff on various technical areas<sup>280</sup>. On the other hand, to enhance coordination of GBV activities across the country, UNFPA facilitated employment and payment of salaries of regional coordinators. Notable were staff in ministries recruited and seconded by UNFPA to coordinate implementation

of programme activities with the government. For example, the youth ministries across the authorities have had a staff each recruited and seconded by UNFPA to coordinate the youth activities in collaboration with the ministry staff. Further, UNFPA supported salaries of staff in hospitals providing CEmONC services by the government through NGOs. For example in Burco Regional Hospital had 24 out of 50 Health Poverty Action (HPA) staff salary paid by UNFPA, in addition to topping up salaries of the rest of the staff within the hospital at an agreed percentages<sup>281</sup>.

UNFPA contributed immensely on information management within the related line ministries through supporting data collection in research; training on IMS both for management of RH commodities and GBV; implementation of PESS; and supporting of coordination mechanisms in task forces (FGM/C, Clinical management of Rape, RHCS, RH, MDSR and GBV IMS) and Working groups in Somalia. Establishment of technical coordination units like the RHU and Statistics Units in the Ministries of Health and Planning respectively added a lot of value in operationalisation of technical procedures, including overseeing implementation of guidelines and SOPs.

Integration of programming enabled realisation of key results across the country in the thematic areas of the CP. Integrating gender interventions within the RH component contributed to increased access to services, especially by the GBV survivors and integration of FGM/C issues in the revised midwifery training curriculum. Use of RH outreach campaigns to reach the hard-to-reach areas also facilitated access to maternal health services. Involvement of the youth to conduct community mobilisation and sensitisation on HIV and AIDS, FGM/C, GBV and Family Planning made it easier for

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<sup>277</sup> Interview with UNFPA IPs and FGDs with beneficiaries

<sup>278</sup> Ibid

<sup>279</sup> UNFPA and IP Staff interviews

<sup>280</sup> Interview with UNFPA IPs and programme reports

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<sup>281</sup> Interview with UNFPA IPs' staff

increased access to information on the same<sup>282</sup>. UNFPA also made a strategic targeting of the youth for employment to participate in PESS as enumerators and serving in other roles, thereby building their capacity and creating employment opportunities for them<sup>283</sup>.

### **Summary of Findings**

The respondents during the evaluation identified UNFPA as having technical and comparative advantage in all its programme components that it supported or coordinated. The programme exhibited strength in the area of RHR through development of protocols and manuals to guide quality provision of maternal services. It also exhibited technical expertise on gender issues and contributed immensely to addressing the gender issues within Somalia. Another notable strength was its ability to gather a team of technical experts drawn both from the UN and international spheres to plan and implement the population estimate survey of Somalia (PESS). The financial support that UNFPA provided was strategic in contributing directly to filling existing gaps in the components. The national execution (NEX) modality directly contributed to enhancing the capacity of the government to deliver in its strategic needs. Its coordination role of sub-clusters within the health (RH Sub-cluster) and Protection (GBV sub-cluster) gave it a comparative advantage in the areas.

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<sup>282</sup> Interviews with UNFPA and IPs' staff

<sup>283</sup> Interviews with UNFPA Staff

## 4.7 Monitoring and Evaluation

From the design of the UNFPA programme, M&E was given prominence in the CPAP towards measurement of the performance of the Country Office in its mandate. The programme indicators were supposed to be measured on a yearly basis and consolidated as the programme progressed during the period of implementation. The CPE assessed this function of the programme based on the levels at which this was done. It also looked at the actions taken during the processes, based on the results. The evaluation looked at the routine M&E activities implemented in the course of the programme.

The Country Office uses M&E System of reporting that is results-based Strategic Information System (SIS) and electronic in format. However, at the field level, the CO monitors and reports accomplishment of activities by IPs through quarterly work plan progress report which informs achievement of milestones. The system used by for reporting its achievements is led by UNFPA. However other system such as health management information system (HMIS) is government led. The system is also clear on the roles of various users. The Programme and operation staff report on achievement of results on quarterly basis. The quality assurance (QA) is provided by the M&E person and the results approved the country office deputy representative or the Representative. UNFPA also provides appropriate templates for reporting.

The Country Office has a full time M&E Specialist, based in Nairobi. His functions are complemented by the field component staff, with the leadership of the Heads of Sub-Offices. Each of the three field offices have an M&E focal point responsible for supporting M&E functions, however these focal

points hold RH positions, limiting their level of support and delivery in the M&E functions in the various offices<sup>284</sup>. The field staff mainly coordinate the programme activities, including monitoring with the partners to ensure that activities are effectively implemented. The component technical specialists also provide guidance on effective implementation of programme interventions, including providing standard tools for reporting on programme progress.

From respondent feedback, the capacity of the CO M&E Unit is low in comparison to the workload that is expected from the unit and results<sup>285</sup>. There is separate budget for M&E in the programme. However the budget is not sufficient for implementation of the planned M&E activities<sup>286</sup>. Currently, the programme activities are implemented by components, and the M&E unit is able to utilise these plans to minimize on resources, which ensures cost-effectiveness.

According to the CPAP, the role of M&E function during the CP is clearly stated. It also explains the responsibilities of each stakeholder, but most importantly, it is evident that it is a function jointly involving UNFPA, the governments of the Somalia zones and other implementing partners. The UNFPA country office M&E unit on the other hand is to support all the related processes, including participating in joint M&E activities with the CO staff, other UN agencies and other stakeholders within the country. There were mixed feedback on this function from the evaluation interviews and analysis of the feedback. Overall, the programme conducted planned M&E activities; however the scope was too broad and wide for the CO unit's capacity to effectively capture the intended and targeted results<sup>287</sup>.

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<sup>284</sup> Ibid

<sup>285</sup> Ibid

<sup>286</sup> Ibid

<sup>287</sup> Interview with UNFPA staff

Monitoring and supervision of the activities by the government entities was limited due to inadequate capacity, both financial and technical. There has been capacity strengthening for government partners and civil society during biannual reviews, though it was cited as inadequate for the IPs to effectively implement M&E activities<sup>288</sup>. Human resource capacity within the government was also limited as reported by some respondents<sup>289</sup>. There were however no major problems with regard to compliance monitoring; staff and partners have been trained in the use of results-based M&E and tools<sup>290</sup>. There were however structural weaknesses with regard to the collection of information in the country in general given the weaknesses in the system, including HMIS<sup>291</sup>. Further, the implementing partners have very little funds allocated to M&E and related activities<sup>292</sup>.

The UNFPA 2<sup>nd</sup> Cycle CP has an M&E calendar across the years stating the activities that were to be implemented each year and these were categorized under thematic areas depending on where the activity fell. UNFPA programme staff participated in the planned monitoring activities, including joint activities, however most of the planned survey activities could not take off as planned due to resource constraints<sup>293</sup>. Insecurity and implementation context within Somalia also hindered on-site and frequency of monitoring activities, including field visits by the technical staff<sup>294</sup>.

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<sup>288</sup> Feedback from M&E Unit

<sup>289</sup> Interviews with IPs and UNFPA staff

<sup>290</sup> Interviews with UNFPA Staff

<sup>291</sup> Interviews with UNFPA Staff

<sup>292</sup> Ibid

<sup>293</sup> Interviews with UNFPA staff and analysis of records and reports

<sup>294</sup> Interviews with UNFPA Staff

All the evaluation activities planned for during the period were conducted and this CPE concludes the list of evaluation activities for the CP cycle. Application of recommendation from the 1<sup>st</sup> cycle CPE was used in designing of the second cycle CP. The 2<sup>nd</sup> cycle CP MTR conducted informed review of the programme indicators and informed the CPE design<sup>295</sup>.

During the period CP cycle, the CO developed Annual Reports (COARs) for the years of existence. These were in compliance with the M&E of the country programme management. The CO also used the Annual Work plans to assess the performance of the partners who were awarded the grantees and had to comply through reports to ensure that the feedback mechanisms on the programme progress and achievements by each partners were reported. UNFPA also conducted partner-focused review of the AWP, which in addition built the capacity of the partners<sup>296</sup>. The constant programme review also contributed in identification of gaps both programming and strategic position which were effectively planned for and supported<sup>297</sup>. There was no evidence-based regular feedback with regard to government partners within the framework of the M&E system of the CPAP, as feedback is given to implementing partners during biannual and annual reviews and on visits to IP office. The CO have developed a template for providing feedback to IP.

According to the CPAP, the CP was to be evaluated under the overall framework of UNSAS, and later UN's IRF. UNFPA participated in Joint M&E activities conducted among the UN agencies, together with the government ministries, including Joint reviews and monitoring activities within the UNCT framework. UNFPA was also

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<sup>295</sup> Ibid

<sup>296</sup> Review of Partner reports and interviews with UNFPA and IPs

<sup>297</sup> Interviews with UNFPA and IP staff

involved in joint data collection with other partners e.g. participating in the UNICEF-led MICS and those of GBV, including data on FGM/C<sup>298</sup>. These further facilitated coordination and enhanced evidence-based planning and targeting. These efforts further enhanced accountability and ensured efficient use of resources.

In order to monitor progress of the programme, UNFPA supported annual reviews, with the partners and to further make decisions, including changes for effective programme delivery<sup>299</sup>. Further, mid-term review of the programme was to be conducted the third year of the programme cycle. All these activities were implemented during the period of evaluation and confirmations are there to address the identified impediments to effectiveness in service delivery<sup>300</sup>. UNFPA supported these meetings, both financially and technically. The government departments however led in facilitations and presenting performance and discussing the gaps together as stakeholders, which also included NGOs in the same thematic areas of interventions. It is notable that during mid-term review, weaknesses in RH commodity management, break-outs in the supply pipelines, among other areas requiring support, were identified. UNFPA responded by training partners involved, including reporting to manage the stock effectively<sup>301</sup>. The MTR also identified weaknesses in the description of the indicators and UNFPA made efforts to review some of them during alignment and extension for the current programme as discussed in the paragraph that follow.

During the programme alignment to the SP IRF 2014 - 2017, the programme indicators were

reviewed to reflect on the measurable deliverables. Initially, the CP had a total of 22 indicators (16 Output and 6 Outcome) but remained the same after alignment, though with drastic but contextualized description. Recommendations to review indicators were also contained in the MTR<sup>302</sup> for the programme. These indicators were reported on the COAR for 2015<sup>303</sup>. MTR recommendations were channelled into management decision-making processes and further informed work plans development for 2014 and 2016<sup>304</sup>. The M&E system exhibited inherent systemic weaknesses towards ensuring effective monitoring of results. Formulation of indicators and outputs in turn led to mismatch between indicators, output and outcomes<sup>305</sup>. This led to a weak linkage in the results chain of the programme. The level of conducting action research to inform programming was also not so prominent during the period of implementation. This would have informed learning processes, further providing evidence-based programme planning and implementation. Further, it could be seen in the CPAP planning and tracking tool that there is no baseline for measuring most of the indicators, which limits the level of performance measurement.

### Summary of Findings

The overall performance of the Programme on M&E was largely functional where key actions and strategies were adopted during the period. There were joint monitoring activities within UN partners and the government partners, periodic review meeting supported by the programme, support supervision by the technical staff in the areas of gender and RHR. The programme also used the Country Office Annual Reporting and Annual Work

<sup>298</sup> Ibid

<sup>299</sup> Interviews with UNFPA staff, CPAP and Partner Reports

<sup>300</sup> UNFPA and IP Staff interviews

<sup>301</sup> Ibid

<sup>302</sup> UNFPA CP 2011 - 2015 Mid-Term review Report

<sup>303</sup> 2015 Somalia Country Office Annual Report

<sup>304</sup> Interview with UNFPA Staff

<sup>305</sup> From analysis of the M&E and programme documents provided

Planning to report on its performance. There was also enhanced coordination of programme activities with the partners which ensured frequent monitoring of results. Field visits by the CO and field staff contributed to monitoring of the programme activities. Insecurity, emergency nature of the implementation context and inadequate staff capacity however limited monitoring activities by

technical staff to all the project sites. Limited capacity of the government also hindered continuous monitoring and supervision. All the planned evaluations were conducted. Inherently though, the M&E function had weak linkages between the indicators, outputs and outcomes, which affected effective measurement of the results of the programme.

## 5.0 CONCLUSIONS

This chapter presents the conclusions derived from the findings in the previous chapter. In compliance with the UNFPA CPE Handbook, the section is presented in subsections with both strategic and programmatic perspective. The conclusions made in this report are guided by the evaluation questions and criteria, where the strategic conclusions refer to the overall Somalia Country Programme performance and have been structured around relevance, efficiency, sustainability, added value, coordination. Programmatic conclusions refer to UNFPA's programmatic areas and are largely based on the effectiveness criterion.

### 5.1 Strategic Level

**CONCLUSION 1:** The country programme was found to be well adapted to the population needs in the areas of reproductive health, gender equality and population and development and continues to be relevant both at the national and international levels. It was also responsive to the emerging needs across the country.

- **Origin: EQ 1 and EQ 2**
- **Associated Recommendations: 1 & 2**

The UNFPA Somalia CP interventions were implemented according to the New Compact, contributing to the Integrated Strategic Framework (ISF), contributes to the achievement of the MDGs and is aligned to the UNFPA 2014 – 2017 Strategic Plan. UNFPA was found to work through the government; aligning its programme support within the established development framework and the national strategic plan of the government, including regional priorities. The interventions were relevant to a wide range of stakeholders including the

government, non-governmental actors and beneficiaries. The CP's thematic components; i.e. the RHR component addressed the health priorities as contained in the Health Sector Strategic Plan; the P&D component addressed the data and information needs to guide the governments on policy formulation and planning, bridging the data needs that has been in existence for the past three decades; and the gender component's effectiveness in addressing gender issues along the priority areas of the line ministries (zonal authorities) was of high repute.

The capacity gaps that the programme filled during the period of evaluation was also noted and the contributions that this made towards achievement of the development and humanitarian response in Somalia. The CP was aligned to the UNFPA Global strategic plan (2014 -2017) in compliance with the ICPD. It also contributed to the implementation of the MDGs and ratification of the CEDAW. It also upheld the South-South cooperation especially during the conduct of PESS.

UNFPA, through its humanitarian response unit ensured emergency preparedness and responded to the needs IDPs and arising emergencies as per the Minimum Initial Services Package (MISP) standards. The programme responded to arising emergencies through supporting IDP crisis as a result of the 2011 - 2012 drought throughout Somalia, 2013 cyclone effect in Puntland, and in 2015 during the return of Somali returnees and refugees from Yemen in Bossaso and Berbera towns in Puntland and Somaliland respectively. It also responded to arising needs, especially in providing support to cover up for gaps that arose during the period.



**CONCLUSION 2:** The design and implementation of the programme took into consideration factors of promoting sustainability of the programme interventions and results. However, the humanitarian nature of the context in most parts of Somalia, highly religious and cultural-sensitive perceptions and inadequate capacity of the government entities affected the extent to which sustainability could be realised.

- **Origin: EQ 3, EQ 4, EQ 5, and EQ 8**
- **Associated Recommendation: 4**

The programme invested heavily in capacity strengthening and development of protocols, guidelines and manuals for utilisation in standardising operations and improving quality of service delivery; and promoted community ownership in its process and this made it easy for the interventions to be accepted and supported by the community.

In GBV prevention and response, the programme advocated for development of protocols, policies and bills that aim to enhance legal frameworks to clarify management of GBV cases and prohibit some harmful practices and behaviours. In RHR, the development of RH guidelines, and establishment of RH unit for coordination will ensure continuation of application of skills and standards accordingly.

There were however a number of aspects of the programme that, even though strategic in enhancing service delivery, are not sustainable in the long-run. Provision of standardized services may also be limited by the fact that in the South-Central zone, most facilities are privately owned, hindering sustainability. The high level of dependency on the programme's operations by the government; for example payment of salaries and salary top-ups by

UNFPA cannot be sustained. The humanitarian nature of context also hinders achievement of sustainability as the causes of humanitarian crisis still exist and require response from the development stakeholders. Given the efforts of the programme in capacity enhancement of the staff on various thematic CP components, assessing the capacity and ability of the staff to achieve the intended deliverables would concretize sustainability mechanisms. Further, given the sensitivity and perceptions on the programme interventions with regard to culture and religion, including inadequate commitment of some of the related institutions; with UNFPA still involved in advocacy activities to address the barriers; sustainability may be a challenge in actualizing.

**CONCLUSION 3:** There were measures in place to ensure that the programme was implemented in a high level of efficiency, ensuring achievement of intended results in a cost-effective manner. However, there were cases of inefficiency especially in operations; some of which were necessary given the context, while some were not in control of the programme.

- **Origin EQ 7**
- **Associated Recommendation: 6**

UNFPA programme had qualified technical staff who managed and coordinated the activities with the stakeholders, further providing effective guidance for quality service delivery. Coordination and joint approach to implementation of activities, including M&E was cost-effective in delivery of services. M&E functions were integrated in the components which improved the efficiency in delivery amid inadequate staff and financial capacity. Joint reviews and monitoring contributed

a lot in assessing the performance of the programme through an efficient manner.

The UNFPA's programme support unit of finance, procurement and administration was reported to be moderately effective, but with incidences of delays in delivery of services caused by the bureaucratic and rigidity in the UN system, as reported by most IP respondents. Late planning of activities and verification (scrutiny) of documents for contractual compliance by the IPs also led to delays in fund disbursement to the IPs and decision-making.

Operation costs were also reported to be higher given the security situation which hinders the CO from being based in Somalia, which ideally would be in Mogadishu but cannot due to the existing insecurity situations. Crucial meetings bringing together the staff from various zonal governments were also held outside again due to insecurity in Somalia and political reasons.

**CONCLUSION 4:** UNFPA Somalia Programme has made use of its comparative advantage and added value across its three components; SRH, P&D and Gender Equality; and was resourceful with both expertise and funding. Its approach to implementation through the national execution modality, partnership building and use of context sensitive approaches enhanced its niche within the country among stakeholders in the country.

- **Origin: EQ 3, EQ4, EQ 5, & EQ 10**
- **Associated Recommendation: 3**

The government and other stakeholders within Somalia appreciate the value added and the level of contribution that UNFPA has nurtured over time, including the good working relationship with the

staff, and their context-sensitive programming approaches and making tangible changes to the lives of Somalis. Its contribution within the UN system is very valuable and played a great role in contributing to the achievement of the targeted UN inter-agency results. The UNFPA's NEX modality enhanced the capacity of the government to meet its needs in the strategic plans.

**CONCLUSION 5:** UNFPA facilitated and participated in coordination mechanisms within the UNCT and was effective providing technical support and guidance in joint programmes with the UN partners; enhancing synergy among stakeholders in service provision; and building the capacity of implementing partners.

- **Origin: EQ 3, EQ4, EQ 5, EQ 9**
- **Associated Recommendation: 4**

UNFPA Somalia participates in, supports and leads different coordination mechanisms within the UN system, national and regional structures and institutions within the country. The programme nurtured collaborative approach between the programme and the zonal governments, supported coordination mechanisms within the country, and also closely coordinated with the other UN organisations to bring about synergies in provision of services to the affected.

The programme's facilitation of development of terms of reference for various taskforces and working groups facilitate clear roles and execution of responsibilities, thereby eliminating duplication and overlap and enhancing complementarity in service provision and support. It also supported and participated in joint programming, resource mobilisation, joint planning and advocacy within the UN system. Some isolated elements of confusion still exist, especially on clear mandates of WHO,

UNICEF and UNFPA in the JHNP, where some respondents could not effectively differentiate the limits of each partner. The programme also harmonized its programmes to contribute effectively within the Somalia Compact Deal,

**CONCLUSION 6:** The UNFPA Programme embedded M&E functions in its implementation processes. The planned evaluation activities were accomplished during the programme period. On the other hand, monitoring activities were implemented, to a greater extent, but were however affected by insecure context, inadequate IP and UNFPA staff capacity. Further, there was inadequate operation research to continuously inform programme design and implementation; and inadequate baseline data and consistent targeting by indicators

further eliciting its role in coordination within the UNCT. Weak capacities of the government ministries and other implementing partners however affect the strength of coordination mechanisms.

- **Origin: M&E Assessment**
- **Associated Recommendations 5 & 6**

Joint reviews and monitoring contributed a lot in assessing the performance of the programme. Coordination among partners through task forces and working groups also facilitate the monitoring mechanisms of the programme interventions, including data collection. All planned evaluation activities were implemented. The M&E function of the programme was however weak in operation research to guide implementation and updating of the implementation framework. Staffing capacity of unit is limited in the field. Insecurity also affects and limits field visits by the technical expatriate staff. Formulation of the initial indicators was too

ambitious and ambiguous in some circumstances, thereby limiting measurement of performance of the programme. These were however reviewed to include a mix of qualitative and quantitative indicators.

## 5.2 Programmatic Level

Overall, analysis of the results of the evaluation, the evaluation team concludes that the UNFPA programme has been effective. This has been manifested in capacity strengthening; development of guidelines and protocols, including SOPs; coordination and partnerships for enhanced synergy and service delivery. Working through the government structures ensured ownership and support of the programme interventions, training of qualified midwives, lobbying and advocacy for legislation on zero tolerance to FGM/C, including religious decrees (*fuatwa*) and public declarations in Puntland were key highlights of the programme.

**CONCLUSION 7:** UNFPA has contributed to improved access to reproductive health services through supporting enhanced maternal health-care service delivery processes, including training of qualified midwives and establishment of training and coordination institutions, strengthened capacities of zonal authorities, community-based and non- governmental organisations, and the most-at-risk youth. However, service delivery and awareness raising in the rural areas are still inadequate, including limited coverage of the component interventions, which through JHNP reached only 9 out of the possible 18 regions. Cultural challenges are also affecting access to family planning and RH services by the youth. Further, the targeting of the youth issues was inadequate, in proportion to their population in the country.

- **Origin: EQ 3 and EQ 6**
- **Associated Recommendations: 7, 8, 9, & 10**

Improved access to skilled birth attendance was enhanced through supporting training of midwives and facilitating establishment of midwifery schools, staff and health facility capacity to provide better and quality services improved, coordination unit and task force for reproductive health established across the country and enhanced partnership with the ministries of health and the midwifery training institutions. Deployment of the trained midwives to the designated rural communities is inadequately addressed in the current arrangement. Further, the gaps of midwives in the country is still exist and this requires more funding support. Development of manuals and service delivery protocols effectively guided quality and standardisation of delivery of RH services.

Joint programming through the JHNP enhanced achievement of the programme outputs in the RH component. The coverage was also effective in the targeted areas; however this was limited to only 9 regions across the country. Even though this was shared equally between the zonal governments, it was not proportionate for the South Central zone which has a total of ten (10) regions and with a larger population distribution. Further, given that this was a partnership involving complementarities, some deliverables were affected by the other partners not being effective in delivering services. It also affected decision-making, leading to delays, as some decisions had to be made jointly among the partners.

Access to BEmONC and CEmONC services improved during the period of evaluation, courtesy of UNFPA efforts, however, the services were not integrated in all the health facilities. Neonatal services were also not fully integrated in the package for service

delivery. Blood banks for the CEmONC services were inadequate in the facilities and hindered timely provision of the services. Availability of ambulances for emergency referral to health facilities were not effective, especially in the rural areas.

Increased access to family planning services was registered during the period of coverage due to UNFPA's advocacy expertise in engaging the highly cultural and religious society to support the idea of family planning. The uptake of the services still face challenges of strong cultural and religious barriers.

Integration of interventions of the programme components with those of the RHR component was strategic and contributed to enhanced achievement of results. Integrating youth activities with the RHR effectively ensured increased awareness among the youth on their reproductive health, including access to services. Discussing sex issues openly in Somalia is not acceptable especially among the youth and adolescents and this significantly affect delivery of ASRH. The review and development of the National Youth Policy helped in focused targeting of the youth issues across the country. The youth needs require deliberate efforts and measures to be addressed, given their high percentage in relation to the country's population.

The CP's response on HIV and AIDS prevention was effectively integrated in the RHR component of the programme, particularly on prevention of mother to child transmission (PMTCT) services with the maternal health made access to the services effective. The youth actively participated in sensitizing the communities leading to increased awareness; however they faced challenges of speaking about sex-related transmission, given the conservative nature of the Somali community. There is also inadequate data on HIV prevalence,

making response ineffective in terms of achievement.

UNFPA's Humanitarian response effectively responded to the needs and provided timely services to the vulnerable IDPs and refugees. The unit was responsive and addressed the needs, including prepositioning commodities for emergency cases arising during the period in compliance with minimum initial service package. The maternity waiting homes played a great role of improving access to maternal health services by those in displacement, including referral services. These facilities also facilitated access to GBV by the survivors.

**CONCLUSION 8:** UNFPA made a commendable step towards availing data to guide policy formulation and planning through financing and technically supporting implementation of the Population Estimation Survey of Somalia (PESS). It also enhanced the capacity of the government ministries on data management and utilisation, which will further enable effective planning and monitoring of development interventions, including performance measurement.

- **Origin EQ 4, EQ 8, EQ 9**
- **Associated Recommendations 11 & 12**

The process of design and accomplishment of PESS enabled creation of enumeration areas that form a basis on which the population census can be conducted. The success of the PESS was due to the 'hunger' for data by all the governments, community participation, financial and technical support available through the coordination of UNFPA, and having the right people (done by Somalis) to participate in the process.

UNFPA supported revival of statistical and built the government's capacity to effectively implement similar endeavours, including on the use of data for decision-making. UNFPA which had collapsed with the government of Siad Bare. The strategy used by UNFPA to build the capacity of the staff through recruiting and seconding of consultants or other related technical UN agency staff to support the government in various areas, through training made a difference. The governments' capacity may however be hindered since they have little resources to retain the trained staff to provide services and they get hired by NGOs or the private sector who can afford to pay them well.

**CONCLUSION 9:** Interventions of the UNFPA's Gender Equity component were relevant and contributed immensely for the response and prevention of the gender-related violence and inequalities in Somalia. The programme provided essential added value to the area of GBV response in Somalia through development of bills to improve legal framework, training, awareness raising and supporting coordination activities on GBV in the country. Strong socio-cultural factors, traditional justice system and religious perceptions influence achievement of gender equality and limited the utilisation of the available services by the programme component.

Statistics lacks in key sectors of the economy and these will need further data collection to tell the level of occurrence. Civil registration and vital statistics is lacking (a concept note developed for this and submitted), demographic health surveys and need for refinement of the strategic plans to reflect on the reality. There is also no data policy existing to guide on use and management of data.

- **Origin EQ 1, EQ 5, EQ 8, EQ 10**

➤ **Associated Recommendations 13, 14, & 15**

The component interventions are relevant and were effectively implemented during the period of evaluation. The programme contributed to improving the legal framework for GBV response supported development of laws, conventions, policies and bills aimed at improving the legal framework for handling gender-related cases. The bills were however not enacted except in Puntland where the Sexual Offences Bill was enacted into law. Ratification of the CEDAW was done by the Federal government and the roadmap to implementation developed. Socio-cultural factors, including religious beliefs and perceptions however contributed to influencing most aspects of this component.

UNFPA is effectively enhancing collaboration and partnership between the government, NGOs and other stakeholders and this has led to sustained response among partners. However, inadequate support from the government, particularly on capacity especially on enactment of the gender-related bills and response to other GBV issues is limiting the gains and effectiveness in the collaboration. Partnership between UNFPA and NGOs facilitated GBV response across the country. Establishment of one-stop centres and family centres ensured access to services by the survivors. Reporting of GBV cases improved due to availability

of services and awareness levels created about existence of services like the access to justice project between UNDP and UNFPA which has facilitated training of female police officers and deploying them at the gender help desks, giving the survivors the confidence to report. However, access to justice by the survivors is still an issue given the strong traditional *Xeer* system where the survivors never get justice and at times forced to be married by the perpetrator. Further, culture, fear of reporting, perceptions, and community norms are still impediments to realisation effective response to GBV. This also applies to zero tolerance to FGM/C.

The CP contributed to coordination and improved GBV response through the establishment of the task forces and working groups; and availability and training of the stakeholders on the GBV IMS, data management led to improved response. However, the programme is weak in prevention due to the humanitarian context that is more focused on response. Somalia is still riddled with conflicts and there is continued violence against women and children heightening GBV cases, limiting the level of effectiveness in response. Changes in results from GBV response take time and with limited level of documentation, it is difficult to see immediate changes.

## 6.0 RECOMMENDATIONS

This section addresses the areas that were found to be either working well for replication or not effectively addressed for improvement in the subsequent programme cycle. The recommendations are categorized for consideration both strategically and programmatically, and are informed by the lessons learnt, the strategies yielding better results, areas of weaknesses and underlying contextual issues that need to be addressed for maximization of the strengths exhibited and opportunities presented.

### 6.1 Strategic Recommendations

From the results of the evaluation, UNFPA Somalia programme is strategically placed and addressing felt needs. The programme is also responsive. To maximize on this and enhance realisation of the more impact in its programme, the evaluation recommends the following;

1. UNFPA should continue the good practice of focusing its programme interventions and support on results of studies, needs assessments, strategic plans, stakeholder consultations and feedback, and implementing partner plans and being responsive to arising needs for effective service provision and coverage by UNFPA. Further, given the magnitude of the youth needs in Somalia and towards aligning the programme with the UNFPA 2014 – 2017, the next programme cycle should create a new programmatic component for the adolescents and youth and allocate funds to the component.
2. The evaluation results showed that the performance of the programme in the regional areas of coverage is exemplary and that huge gaps still exist, especially in the rural and hard-to-reach areas of Somalia. It is therefore recommended that in the next programme cycle, the programme need to prioritise rural areas, after conducting assessments, including establishing contextual applicable strategies. The concept of maternity waiting homes can be escalated to increase access to maternal services in the under-served locations
3. Joint programming, coordination and integration of interventions facilitated enhanced achievement of the UNFPA programme outputs and eliminated overlaps in targeting and services delivery. The evaluation recommends replication of this approach but also suggests that the reasons for delays by other joint partners affecting delivery of service should be assessed and addressed effectively, including joint planning and partner capacity enhancement.
4. Even though Somalia is still full of capacity gaps, while at the same time lacks adequate financial capacity, UNFPA should focus on strengthening capacities of government institutions and civil societies, including in the area of resource mobilisation. UNFPA should also embed in its design; measures to integrate sustainability strategies, including focus on mitigating the possible threats to sustainability in the partnership
5. The M&E capacities among the implementing partners were found to be limited and were not effective in their responsibilities. The evaluation recommends enhanced capacity strengthening of the IPs on M&E. There is also need for the M&E unit of the CO to ensure that there is clear linkage between results and indicators in the programme design; and conduct a baseline at the beginning of the next programme cycle for

effective targeting and measurement of results. Further, the M&E staff capacity should be assessed against the workload and increased accordingly for improved efficiency and continued tracking of performance. UNFPA should also use its technical expertise to support the CO in guiding operation research so that even the M&E processes can be enhanced.

6. In planning for the 3<sup>rd</sup> CP it would be prudent to emphasise on conducting baseline survey where there is no data and to emphasise data capture by IPs to facilitate realistic target setting and trend analysis at both MTR and CPE. This would enhance impact measurement. Further, best practices of the programme should be documented and shared to ensure enhancement of knowledge management and more effective south-south collaboration. In addition, UNFPA should continue to build government capacities; and should identify ways to reduce direct service delivery, thus also reducing dependence and contributing to sustainability.

## 6.2 Programme Level

### Reproductive Health

7. UNFPA should continue supporting production of qualified midwives as there is still a huge gap for midwifery within the country to cover the needs of the existing population. This should be through training, supporting infrastructure and regulation of the profession. Deployment of trained midwives was found not to be effective as a number of the trained midwives did not go back to their communities of recruitment either due to non-engagement by the government or lack of support from the government. Supervision of those in the communities was also reported to be low. There is further need for UNFPA and the government to engage, reassess the arrangement and ensure that the

trained midwives go back their communities and their work well supervised and supported with home delivery kits to perform their work.

8. UNFPA should strengthen its assistance in streamlining the Supply Chain System through the development of a National RHCS Strategic Plan.
9. There is need for more engagement of the MoH and other stakeholders to provide routine obstetric fistula repair services to maximise on the demand that is created through mobilisation; and allocate more funds for innovative methods of prevention like prevention-with-positives (PwP), including giving women special focus.
10. Uptake of family planning services improved during the period and the implants were reported to be preferred by the beneficiaries for convenience. There were also some respondents reporting resistance by the religious leaders towards family planning. Due to these feedback, the evaluation recommends the following;
  - a. That UNFPA build on the gains made to intensify further advocacy measures including more religious leaders to get their buy-in to the importance of family planning towards improving the health of the mother and baby;
  - b. The newly installed LMIS system should be managed to ensure that implants are stocked in warehouses and supplied to the health facilities on a timely basis to ensure that there are no stock-outs and expiry of those supplies that are not currently used by the clients



- c. Male involvement in family planning activities need to be intensified and strengthened to ensure that men support their wives in seeking and accessing family planning services

## **Population and Development**

11. Implementation of PESS has revived the interest in data for policy formulation and planning by the Somalia governments. To enhance sustainability, UNFPA need to support capacity strengthening of government institution including expanding into supporting analysis of population dynamics data and its utilisation for policy development, programming and impact assessment. UNFPA should provide support through the following key activities; Population research
  - a. The demographic health survey
  - b. Population and housing census; and
  - c. Operational research
12. The need for effective institutions and systems of statistics and planning to drive the population and development agenda cannot be overstated. It is therefore imperative that these institutions are strengthened through a comprehensive capacity development that includes, short and long-term trainings, deployment of experts in various relevant fields and South-South cooperation. Twinning arrangements between the statistical and planning units in Somalia with those from other countries in Africa should be explored. Capacity development should aim at integrating population, Reproductive Health, youth and

gender issues into development policies and plans.

## **Gender Equity**

13. Through the CP, the efforts were made to improve the legal framework to address Gender based violence. These were however not completed during the period and still a lot of advocacy and lobbying is required for the pending gender-related bills and policies to be passed or enacted as law and operational. UNFPA needs to use its relationship with the government to lead and support this course.
14. Enactment of Gender Policy was found to be contentious and perceived to be sensitive to the cultural and religious values. Given the sensitivity of the issue, UNFPA should intensify further consultations and sensitisation of the content of the Policy to clear misunderstanding on its intentions and what it stands for to address the misconceptions leading to resistance. UNFPA should also capitalize on the gains made in the area of FGM and engage the religious leaders, especially in the rural areas, including engaging Muslim Scholars to effectively address the FGM
15. Coordination and collaborative efforts between UNFPA and its partners facilitated effective response to GBV especially through the task forces and working groups. Capacity of the partners was however identified to be low for effectiveness. There is need to continue strengthening both the capacities of the partners and the coordination between them and the communities; and support coordination with them to form sustainable local movements to end GBV through public education and locally based support services for survivors.

# ANNEXES

Annex 1: Terms of Reference

## **COUNTRY PROGRAMME EVALUATION**

### **TERMS OF REFERENCE**

Draft version

February 2015

## **1.0 THE BACKGROUND**

Somalia has been in conflict for almost three decades since the collapse of Siad Bare administration. The country has been divided essentially into three semi-autonomous zones namely Somaliland, Puntland and South Central Somalia. Somaliland and Puntland territories enjoy relative stability compared to lawless South Central Zone.

Because of the conflict, Somalia is among the largest and most complex humanitarian crisis in the world. It is estimated that About 2.9 million people are in need of humanitarian assistance including an estimated 1.1 million people are internally displaced by recurrent droughts, floods and conflict. The maternal mortality rate for Somalia is amongst the highest in the world; one out of every 12 women dies due to pregnancy related causes. Poor and inadequate basic social services continue to undermine the resilience of the people in the country.

## **2.0 2nd Programme Cycle for Somalia**

UNFPA assistance to Somalia began in the 1970s and continued until 1991, when the civil war led to a suspension of development programming. From 2003 to 2006, UNFPA resumed support on comprehensive reproductive health service delivery, focusing on training and the provision of medical supplies for internally displaced persons in Somaliland and Puntland. The first programme of assistance 2008-2009, was extended through 2010. The programme was based on priorities identified in the United Nations Transition Plan for Somalia, 2008-2010. The 2nd Country Programme (CP) was approved by the UNFPA Executive Board for the period 2011-2015. The CP is based on national priorities identified in the Somalia Reconstruction and Development Programme, 2008-2012, and the United Nations Somalia Assistance Strategy, 2011-2015, which focuses on three areas: (a) emergency response; (b) the transition from conflict to peace and from crisis to recovery; and (c) longer-term development.

The 2nd Country Programme seeks to improve the overall quality of life of the Somali people. The programme is aimed at contributing to the three outcomes of the United Nations Somalia Assistance Strategy (UNSAS): (a) Somali people have equitable access to basic services in health, education, shelter, water and sanitation; (b) Somali people benefit from poverty reduction through equitable economic development and decent work; and (c) Somali people live in a stable environment, where the rule of law is respected and rights-based and gender-sensitive development is pursued. For the special situation in Somalia, the United Nations Country Team (UNCT) decided to use the UNSAS as the framework for assistance and to use the Country Programme Action Plan (CPAP) as an internal document to guide implementation and not to go through the whole process.

The CP is composed of eight outputs, which were designed to contribute to the UNFPA Strategic Plan (2008-2011) responding to the three programme components: Population and Development (PD), Reproductive Health and Rights, and Gender Equality. In 2012, the Country Programme was re-aligned to contribute to the UNFPA Strategic Plan (2012-2013), which abolished the programme components and brought to the fore a more integrated country programme. It is directly executed under the overall coordination of the Ministry of International Cooperation in each Somalia Zone, namely the Transitional Federal Government, Somaliland and Puntland Governments.

## 2.1. Re-alignment of UNFPA Somalia Programme to UNFPA Global Strategy 2014-2017 and Somalia's compact deal

The UNFPA strategic plan, 2014-2017, focuses squarely on addressing the unfinished agenda of the Cairo ICPD declaration of 1994, with a particular concentration on sexual and reproductive health (SRH) and reproductive rights. In order to ensure that UNFPA Somalia strategies are in tandem with the global UNFPA strategic plan 2014-2017 and also responding to Somalia's compact deal 2014-2016, the document identifies five approaches to support alignment.

The country programme focuses on the following priorities: (a) decreasing maternal mortality; (b) managing population growth and the 'youth bulge'; and (c) improving humanitarian preparedness and response. These priorities are addressed under three programme components: (a) reproductive health; (b) population and development; and (c) gender equality. It mainstreams the needs of youth and focuses on the empowerment of young women.

## 3.0 PURPOSE OF THE EVALUATION

### 3.1. Purpose of the CPE

The purpose of the Country Program Evaluation is to (a) demonstrate accountability to stakeholders on performance in achieving results at country level and on invested resources; (b) support evidence-based decision making and (c) contribute important lessons learned to the existing knowledge-base on how to accelerate implementation and better redesign the next cycle of the country programme for Somalia among other uses.

### 3.2 The specific objectives of the CPE

The specific objectives will be to:

- a) Provide an independent assessment of the progress achieved towards the expected outputs and outcomes set forth in the results framework of the 2nd country programme, and the contribution towards the realisation of the national outcomes, with special focus on:-
  - Determining whether planned activities were carried out as planned (effectiveness) and assess program performance (extent to which targets were achieved or not)
  - Examining programme implementation efficiency in achieving expected results
  - Assessing the relevancy and sustainability of the 2nd Cycle CP
- b) Review the overall co-ordination and partnership approach adopted during programme implementation.
- c) Identify innovative approaches towards programme implementation and lessons learnt or best practices identified including the extent to which UNFPA programmes integrated gender and rights-based approaches.
- d) Identify any challenges and impending threats the programme is facing and opportunities.
- e) Draw key lessons from past and current implementation arrangements to provide a set of clear and forward looking options leading to strategic and actionable recommendations for the next country programme cycle.

## 4.0 SCOPE OF THE EVALUATION

- **Time period:** The CP evaluation will cover the period from 1st January 2011 to 30th April 2015.
- **Geographical coverage:** The evaluation will cover all the three Zones where UNFPA-funded programmes are implemented (SCZ, Puntland, and Somaliland).

- **Programme aspects:** The evaluation will look at the three technical areas of the UNFPA programme (Population and Development, Gender, Sexual Reproductive Health and Adolescents Youth, HIV/AIDS) in the three zones of Somalia. In addition for each thematic area, the evaluation will look at cross cutting aspects such as gender mainstreaming, coordination and partnerships.
- **Evaluation criteria:** The evaluation will be based on four OECD/DAC criteria: Relevance, Effectiveness, Efficiency and Sustainability as well as on questions related to strategic positioning: Coordination with UNCT and Added Value.

#### 4.1 Evaluation questions

The evaluation team is asked to put together a list of evaluation questions (to be approved by the Evaluation Manager, in consultation with the ERG) addressing the following topics/issues:

Relevance:

1. To what extent were the programme interventions consistent with the needs of the beneficiary populations and to what extent was it aligned with government priorities as well as with policies and strategies of UNFPA?
2. How well was the CPAP aligned with the ICPD actions and MDGs as well as with the UNFPA Strategic Plans?

Effectiveness:

3. To what extent did the interventions supported by UNFPA in the field of reproductive health and rights contribute to (i) Improved access and utilisation of high quality maternal health and family planning services, including populations affected by humanitarian crisis (ii) Increased national and sub-national capacity to deliver integrated sexual and reproductive health services (iii) Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes
4. To what extent have the interventions supported by UNFPA in the field of population and development contributed to (i) increased availability and use of data on emerging population issues at national and sub-national levels (ii) Strengthened national and sub-national capacity for production and dissemination of quality disaggregated data on population and development issues.
5. To what extent have the interventions supported by UNFPA in the field of gender contributed to: (i) Strengthened national and sub-national protection systems for advancing reproductive rights, promoting gender equality and non-discrimination and addressing gender-based violence; (ii) Increased capacity to prevent gender-based violence and harmful practices and enable the delivery of multisectoral services, including in humanitarian settings?
6. To what extent was the programme coverage (geographic; beneficiaries) reached as planned?

Efficiency:

7. Was the programme implementation approach (funds, expertise, time, administrative costs, etc.) the most efficient way of achieving results?

Sustainability:

8. To what extent are the development gains made under the UNFPA supported interventions in Somalia sustainable in terms of continuity in service provisions and partnerships integration of CP activities into the regular country and counterparts' programming?

Added value:

9. What has been the comparative strength of the UNFPA CO response to the Somalia context of protracted crisis and particularly in the areas of reproductive health, gender-based violence and population and development?

Coordination:

10. To what extent has the UNFPA CO contributed to good coordination among UN agencies in the country, particularly in view of avoiding potential overlaps?

#### 4.2 Evaluation ethics

The CPE is to be conducted legally, ethically and with due regard for the welfare of those involved in evaluation, especially women, children, and members of other vulnerable and disadvantaged groups, and in accordance with the United Nations Evaluation Group ethical guidelines for evaluation, available at [www.unevaluation.org/ethicalguidelines](http://www.unevaluation.org/ethicalguidelines).

#### 5.0 The Evaluation process and Indicative Timeframe

The Somalia country programme evaluation will unfold in five phases: preparatory phase, design phase, field phase, reporting phase, and management response, dissemination and follow-up phase.

Following the signing of a contract, the consultants should complete the assignment and produce the first draft of the report to the evaluation manager in accordance to the timelines above. The evaluation manager will coordinate the reviews by partners and Arab States Regional Office (ASRO) team. Comprehensive comments will be shared with the team of consultants after 10 working days following the submission. The final report should be received by the evaluation manager not later than 10 working days following submission of comments to the consultants. The report may be considered final depending on the satisfaction of the Evaluation Reference Group, or another round of comments could be submitted to the consultants.

#### 6.0 METHODOLOGY

The consultants are expected to use a mix of qualitative and quantitative methods and work with primary and secondary data sources.

##### 6.1 Desk review:

- Analysis of available data sources such as midterm evaluation report, needs assessment documents, audit report, progress reports, country office annual reports (COARs) monitoring template available at the country office and field offices and any other materials that the evaluator considers useful for this evidence-based assessment
- Review of project documents such as Country Programme document, UNSAS, New Deal, including financial records available in the UN Nairobi Office
- Review of policy documents and strategies at the CO level

##### 6.2 Field Data collection

- Interviews with relevant UNFPA programme staff at country office and field offices
- Interviews with relevant implementing partners and project partner organisations (see Annex 1)
- Interviews and focus group discussions with project beneficiaries and where possible; non-beneficiary population in target areas
- Observations and informal interviews

The detailed methodological approach will be designed by the selected evaluator and included in the inception report taking into consideration the following:

- The CP evaluation design
- Size and structure of targeted entities to be interviewed
- The sampling method
- Data collection tools and procedures
- Data management and analysis
- Selection of sites to host data collection

Methods may vary by project but should reflect the precise nature of the aspects under examination and the personal expertise. Apart from a preference for triangulation, the evaluators could consider existing data and published research.

It is highly possible that the Somali local language may be needed during data collection in cases where the targeted respondents do not have adequate English proficiency. If such a risk becomes a reality, then in order to standardize the formulation of the questions and avoid adhoc interpretation, the data collection tools will be translated into Somali.

## 5.2 Stakeholder involvement

An inclusive approach, involving a broad range of stakeholders, should be taken. The evaluation will have a process of stakeholder mapping that would identify both UNFPA's direct partners as well as stakeholders who do not work directly with UNFPA, but play a key role in a relevant outcome or thematic area in a national context. Relevant stakeholders should be involved at the different stage of the CPE including design, data collection, data analysis, reporting especially at the recommendation formulation process, debriefing, and dissemination (stakeholder workshop) as appropriate. The final evaluation report should describe the efforts made to include stakeholders in these processes and the positive consequences of these efforts.

## 7.0 THE EVALUATION TEAM

The evaluation will preferably be conducted by an independent evaluation consultancy firm or, alternatively, by a team of independent evaluators if, for any reason, a firm cannot be identified. The selected firm should be legally registered, have past experience in carrying out similar evaluations, and have stable financial records for the last three years. In any case, the team will comprise of three consultants (three team members must have expertise to cover one of the thematic areas): a technical expert for each thematic programme area – reproductive health and adolescent and youth, population and development, and gender. The team members must appoint one of the members with broad evaluation expertise as the team leader. It should be ensured that interviews and focus group discussions will be possible both for men and women (especially when consulting beneficiaries) therefore gender balance among consultants should be taken care of as much as possible. In addition one of the team members must be fluent in spoken and written Somali language with extensive experience in conducting evaluations in Somalia. The data collection tools shall be translated into Somali Language before commencement of the data collection exercise.

Considering the language challenges in Somalia, it will be possible that the key evaluation team hires local research assistants speaking Somali and with good experience in qualitative data collection, particularly FGDs facilitation and/or note taking.

#### 7.1 Competencies for the thematic consultants

1. Excellent analytical, writing and communication skills
2. Ability to work with a multi-disciplinary team of experts
3. Excellent problem identification and solving skills
4. Excellent written and spoken English Language skills. Knowledge of Somali an asset\*.
5. Experience of operations and response to humanitarian/crisis an advantage
6. Familiarity with UN and/or UNFPA mandate an asset
7. Should be able to provide deliverables on time

#### 7.2 Qualifications and experience of thematic consultants

1. Specialization and/or demonstrated knowledge on either reproductive health, population and development, or gender field
2. Minimum of five years of experience in conducting evaluations in reproductive health, population and development, or gender sectors

#### 7.3 Roles and responsibilities of the thematic consultants

1. Contribute to the development of the design report as per UNFPA standards
2. Take charge of Evaluation components related to his thematic section of the country programme as relevant
3. Member of the evaluation team and as such, abides by the requirements and work plan validated by the team
4. Deliver timely quality reports related to his theme as relevant

#### 7.4 Competencies for the Team Leader

In addition to competencies for the thematic roles above the team leader must possess the following competencies:

1. Development sector background
2. Excellent analytical, writing and communication skills
3. Leadership and good management skills
4. Ability to work with a multi-disciplinary team of experts
5. Excellent problem identification and solving skills
6. Excellent written and spoken English Language skills.

#### 7.5 Qualifications and experience of Team Leader

1. Minimum of 10 years' experience in conducting/managing program evaluations
2. Experience in mainstreaming and management of cross cutting themes
3. Familiarity with the UNFPA work will be an added advantage
4. Experience in evaluating programmes/projects in fragile context
5. Proven knowledge of the country settings and priorities
6. Experience of operations and response to humanitarian/crisis an advantage



## 7.6 Roles and responsibilities of the Team Leader

The team leader will have primary responsibility for the timely completion of a high-quality evaluation that addresses all the items required in this TOR. He will specifically

1. Provide overall coordination and leadership to the evaluation team
2. Responsible of the assessment of one thematic programme area
3. Provide the inputs for quality aspects of the overall process
4. Compile the design report with the inputs from national consultants
5. Compile draft and final reports and deliver them on time, considering the quality aspects.
6. Responsible for debriefing the findings when required
7. Liaise with Evaluation Manager

## 8.0 Indicative Timeframe

The number of working days required for the successful completion of this assignment is 90 days spread over a period of 4-6 months.

Phases/deliverables	Dates
Phase 1: preparatory phase Finalization of the ToR and recruitment of experts	June 2014 – April 2015
Phase 2. Design phase Preparation, review of documents leading to submission of the design report, including travel days and expected start date	April 2015
Phase 3. Field Phase	May 2015
Phase 4. Reporting phase - 1st draft final report - Stakeholders workshop - Final report	June - September 2015 July 2015 August - 2015 September-2015
Phase 5: Management response, dissemination phase	October 2015

## 9.0 Duration of contract and Remuneration

The 90 working days required for the successful completion of this assignment will be indicatively spread over among the evaluation team members as follows:

Deliverables	Technical Experts			
	Reproductive adolescent and youth	Health	Population & Development	Genre & GBV
Design report	4		3	3
Field phase	15		10	10
Data analysis and draft report	10		8	8
Final report and annexes	2		2	2

Dissemination workshop	1	1	1
Total	32	24	24

In addition to the number of days required for its technical thematic area, 10 days will be added to the team leader to allow proper coordination of the team of evaluators, ensure quality and finalisation and submission of all deliverables.

The allocation of days in the table above is indicative and as such, final repartition should be done by the team of consultants following the development of the design report. However, the total number of days should not exceed 90.

#### 10.0 EVALUATION MANAGEMENT

A management structure will be established and will include:

- An Evaluation Reference Group (ERG)
- Evaluation Manager

The specific roles and functions of the ERG as provided by the UNFPA Policies and Procedure Manual is to provide guidance and constructive feedback on the products of the evaluation, hence contributing to both the quality and utility of the exercise. Throughout the process of the evaluation, the ERG will regularly meet from planning phase to implementation phase. They will be expected to discuss and comment on notes and reports produced by the evaluation team. Members of the ERG are also expected to facilitate the evaluation team's access to information sources and documentation on the activities under evaluation. Specific roles include;

- Provides input to the TOR and to the selection of the team of evaluators
- Contributes to the formulation of the evaluation questions
- Provides comments on the design report
- Contribute to the selection of the evaluation team
- As much as possible, facilitates access of evaluation team to information sources (documents and interviewees) to support data collection
- Provides timely comments on the draft
- Ensure the final draft meets the UNFPA quality standards
- Present final document to the UNFPA Somalia CO Evaluation Manager

The ERG membership will include members drawn from Ministries (FGS, Somaliland and Puntland) to be appointed by Authorities, UNFPA Somalia Country Office staff Members appointed by the Country

Representative, Representatives of other UN agency working closely with UNFPA Somalia in delivery of services, Representatives from the leading Partner(INGO/LNGO's) in Somalia and Representative of UNFPA Arab States Regional Office. Under the overall guidance of the UNFPA Representative, the Monitoring and Evaluation Analyst will act as the Evaluation Manager. The ERG and the Evaluation Manager will provide oversight to the evaluation. Supported by the Evaluation Manager, the ERG will regularly meet as needed to undertake the main oversight activities such provide technical support, monitor progress and quality of evaluation activities, and review and comment on drafts documents.

The UNFPA Somalia country office, with the support of implementing partners, will provide the logistical support for the overall evaluation process.

#### 11.0 DELIVERABLES

The selected consultant team will submit the following deliverables:

##### 11.1. Evaluation Deliverables:

The Consultant will prepare an evaluation draft design report and a final evaluation design report that will describe the evaluation and include evaluator's findings and recommendations to the best approaches of conducting the evaluation. The evaluation team will be asked to make an oral presentation of the design report to UNFPA and its stakeholders (through a teleconference or a local team). The Evaluation Manager will coordinate the review of the inception report, compile and summarize comments from the ERG members, the Regional M&E adviser and the Evaluation Office. He will provide the comprehensive written comments on the design report to the team within 30 days (please see annex 3 for design report outline). UNFPA's approval of the design report is required before any field work can be initiated.

DELIVERABLE	CONTENT	TIMING	RESPONSIBILITIES
Inception Report	Evaluator provides clarifications on methodology, tools, work schedule	April 2015	Evaluator
Debriefing workshop	Initial Findings	June 2015	Evaluator needs to carry out a validation session for UNFPA Somalia's partners and Programme staff immediately after the field data collection and before leaving the country.
Draft of the Final Report <sup>306</sup>	Full report	August 2015	Evaluator sends the draft of the final report to the UNFPA Somalia. The Evaluation Manager shares the draft report with the Evaluation Reference

<sup>306</sup> the evaluation report **should not** be shared outside of UNFPA before it is **final**

			Group for comments.
Final Report	Revised report	September 2015	The Evaluator submits a final report incorporating UNFPA staff and implementing partners comments
Power point presentation summarizing the key findings, conclusions and recommendations	Not more than 20 slides, to be submitted together with the final report and to be used for dissemination workshop.	October 2015	

These deliverables are to be:

- Prepared in English
- Submitted to UNFPA Somalia electronically via e-mail
- Submitted in official hard copy format (2 copies)

Payment modalities and specifications

Percentage	Milestones
10percent	Following the submission and approval of the inception report to UNFPA and ERG
40percent	After the 1 <sup>st</sup> comprehensive draft of the final evaluation report has been submitted and approved by UNFPA Somalia and the ERG
50percent	After the final version of the final evaluation report has been submitted and approved by UNFPA Somalia and the ERG

#### Evaluation Implementation Arrangements

UNFPA Somalia shall provide prior arrangements of relevant implementing partner, stakeholders, concerned government officials or beneficiaries for interviews. However the evaluator must inform UNFPA Somalia and the implementing partners in a timely manner when s/he intends to collect information from the respondents at field and office level.

#### Application Process

Applicants are requested to send their applications by email to [recruit.unfpasom@unfpa.org](mailto:recruit.unfpasom@unfpa.org)

Applicants are requested to submit their: 1) CV highlighting their experiences and academic qualifications. UNFPA SOMALIA applies a transparent selection process that will take into account competencies and experience of the applicants as well as their financial offers.

#### 12.0 DISSEMINATION AND USE OF EVALUATION RESULTS

As for the dissemination of the final evaluation report, the following should be considered:

- Upload to UNFPA docushare.
- The evaluation report to be printed and the hardcopy with a snapshot of findings and recommendations will be distributed among relevant stakeholders.

- The report including key findings and recommendations will be shared electronically among the stakeholders and the report will be uploaded to the UNFPA Somalia website.
- Dissemination meetings will be conducted at national level and, when appropriate, at individual level.

Management responses will be prepared for each of the recommendations using the standard UNFPA management response tool and they should be uploaded into central document repository within one month of accepting the final report of an evaluation.

Recommendations will be added collaboratively with relevant stakeholders. The Evaluation Manager and UNFPA Representative drafts the management response, circulates the response together with the evaluation report to the relevant partner(s) and convenes a meeting to discuss and agree on the management response. (The required approval will be obtained from the key stakeholders and partners before finalizing). UNFPA Somalia country office will prepare a management response monitoring checklist progress of implementing CPE recommendations.

## 13.0 ANNEXES

### Annex 1: Documents to be consulted

The following documents will be shared as part of the desk review:

- United Nations Somalia Assistance Strategy (UNSAS) including monitoring and evaluation framework
- Reproductive Health Strategy
- Second Country Programme Document (CPD)
- Second Country Programme Action Plan (CPAP)
- Annual Work Plans
- Country Office Annual Reports (COAR) 2011-2014
- Realignment Strategy Document
- Midterm Review Document
- Evaluation Report on Humanitarian Response Project
- AWP progress reports
- Audit reports
- Financial expenditure reports (face forms)
- UNFPA Evaluation Guidelines
- Norms and Standards for Evaluation in the UN System
- UNEG Code of Conduct for Evaluation in the UN System
- UNEG Ethical Guidelines for Evaluation

### Annex 2: Reporting guideline

UNFPA evaluation report should use the following template:

EXECUTIVE SUMMARY	2-4 pages max
CHAPTER 1: Introduction	5-7 pages max
1.1 Purpose and objectives of the Country Programme Evaluation	
1.2 Scope of the evaluation	
1.3 Methodology and process	
CHAPTER 2: Country context	5-7 pages max
2.1 Development challenges and national strategies	
2.2 The role of external assistance	
CHAPTER 3: UN / UNFPA response and programme strategies	5-7 pages max
3.1 UN and UNFPA response	
3.2 UNFPA response through the country programme	
3.2.1 Brief description of UNFPA previous cycle strategy, goals and achievements	
3.2.2 Current UNFPA country programme	
3.2.3 The financial structure of the programme	
CHAPTER 4: Analysis of the programmatic areas	20-30 pages max
4.1 Reproductive Health and Adolescent and Youth	
4.1.1 Relevance	
4.1.2 Effectiveness	

4.1.3	Efficiency	
4.1.4	Sustainability	
4.2	Population and Development	
4.2.1	Relevance	
4.2.2	Effectiveness	
4.2.3	Efficiency	
4.2.4	Sustainability	
4.3	Gender	
4.3.1	Relevance	
4.3.2	Effectiveness	
4.3.3	Efficiency	
4.3.4	Sustainability	
CHAPTER 5: Strategic positioning		5-10 pages max
5.1	Corporate strategic alignment	
5.2	Strategic alignment	
5.3	Responsiveness	
5.4	Added value	
CHAPTER 6: Assessment of the Monitoring & Evaluation system		4- 8 pages max
6.1	The Country Office Monitoring and Evaluation (M&E) system	
6.2	Support to national partners' capacity in terms of M&E systems	
CHAPTER 7 Conclusions and recommendations		10–15 pages max
7.1	Main conclusions	
7.1.1	Strategic level	
7.1.2	Programmatic level	
7.1.3	Transversal aspects	
7.2	Main recommendations	
7.2.1	Strategic level	
7.2.2	Programmatic level	
7.2.3	Transversal aspects	
(Total number of pages) 60 – 90 pages		
ANNEXES		
Annex 1 Terms of Reference		
Annex 2 List of persons / institutions met		
Annex 3 List of documents consulted		
Annex 4 The evaluation questions		
Annex 5 The evaluation Matrix		

## Annex 2: Summary of Findings of UNFPA Somalia 2nd CP Implementation Results (2011-2015)

Component Result	Indicator	Baseline and Target by 2015	Achievement by December 2015	Comments
<b>Reproductive Health</b>				
<b>Outcome 1:</b> Increased demand for, access to and utilisation of equitable, improved reproductive health services, including in settlements for internally displaced people				
<b>Output 1:</b> Improved health-care delivery to reduce maternal and neonatal mortality and related morbidity	Number of obstetric fistula cases successfully repaired at supported sites	<b>Baseline</b> N/A <b>Target</b> 400	534 cases repaired	Target adjusted from 300 to 400 cases and it was surpassed by the end of the year.
	Number of midwives trained according to ICM-WHO standards	<b>Baseline</b> 250 <b>Target</b> 400	388 midwives completed training and graduated	442 are in class by the time of evaluation. Target will be surpassed.
	EmONC needs assessment in place to develop a costed national action plan to scale up maternal and new-born health services	<b>Baseline</b> 0 <b>Target</b> 3	Yes	A costed national action plan developed in January 2015 to scale up maternal and new-born and approved.
	Functional Logistics management information systems in Somaliland, Puntland and South-Central Zone for forecasting and monitoring RH Commodities	<b>Baseline</b> 0 <b>Target</b> 1	Yes	UNFPA technically assisted in development of the LMIS tools, approved by all the three MoHs and partners trained on the tools. UNICEF and WHO have also agreed to harmonize the tools with their data collection tools and supported by other stakeholders. Implementation to begin in Q1 2016.



Component Result	Indicator	Baseline and Target by 2015	Achievement by December 2015	Comments
<b>Output 2:</b> Increased capacity of government, community-based and non-governmental organisations to offer high-quality, comprehensive sexual and reproductive health services, education and information for young people, with a focus on young people who are most at risk	Existence of guidelines, protocols and standards for health care workers for the delivery of quality SRH services for adolescents and youth	<b>Baseline</b> 0 <b>Target</b> 1	Yes	Guidelines, protocols and standards for health care workers for the delivery of quality sexual and reproductive health services for adolescents and youth developed and exist in Somalia
	Existence of integrated national SRH action plan	<b>Baseline</b> 0 <b>Target</b> 1		The Somalia SRH Strategic Action plan 2011 – 2015 exists and guides implementation of the CP's RH component
	Number of outlets providing youth-friendly services	<b>Baseline</b> 0 <b>Target</b> 3	3	Target adjusted from 5 to 3 during alignment.  Target achieved.

### Population and Development

**CP Outcome 2:** Population dynamics Strengthened national policies and international development agendas through integration of evidence-based analysis on population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality

Output 1: Strengthened capacities of selected sectoral ministries and partner organisations to collect, analyse, disseminate and utilise disaggregated population data for planning and delivering humanitarian, recovery and	Population Estimation Survey completed with the subsequent data dissemination and use	<b>Baseline</b> 0 <b>Target</b>  <b>Yes</b>	Yes	The PESS completed and launched by the Federal Government of Somalia. At the time of the evaluation further analysis was still being done for various parameters of importance
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Component Result	Indicator	Baseline and Target by 2015	Achievement by December 2015	Comments
development assistance				
	Existence of databases in three zones with population-based data accessible by users through web-based platforms facilitating mapping of socio-economic and demographic inequalities	<b>Baseline</b> <b>0</b> <b>Target</b> <b>3</b>	Ongoing	This is on course once the PESS data analysis and disaggregated by regions is completed
	Evidence of UNFPA supported technical assistance on the use of population-related data and support for assessments including during emergencies	<b>Baseline</b> <b>0</b> <b>Target</b> <b>3</b>	Ongoing	UNFPA has trained government staff on population-based data and continues to support them in strengthening their statistical capacity to be able to apply in assessment.
Output 2: Improved systems for generating, analysing and disseminating disaggregated population and related data, with a focus on improving the monitoring of maternal health at zonal and sub-zonal levels in order to	Existence of scientifically sound monitoring and evaluation procedures in support of sexual and reproductive health, and adolescents and youth programmatic interventions	<b>Baseline</b> <b>1</b> <b>Target</b> <b>3</b>	Done <sup>307</sup>	

<sup>307</sup> Somalia COAR 2015

Component Result	Indicator	Baseline and Target by 2015	Achievement by December 2015	Comments
inform interventions in this area.				
	Number of high-quality reports on utilizing data to measure the attainment of country programme outputs and to monitor maternal mortality and morbidity	<b>Baseline 0</b> <b>Target 3</b>	7	Seven volumes of the national Analytical reports have been drafted. Consolidated reports for Somaliland, Puntland and Banadir have also been prepared.

### Gender Equality

**Outcome 3:** Advanced gender equality, women's and girls' empowerment, and reproductive rights, including for the most vulnerable and marginalized women, adolescents and youth

Output 1: Increased advocacy and community engagement to promote the reproductive health and rights of women and adolescent girls and to eliminate harmful practices affecting maternal health	Existence of a functioning inter-agency gender-based violence coordination body as a result of UNFPA guidance and leadership	<b>Baseline 0</b> <b>Target Yes</b>	Yes	UNFPA has facilitated establishment of 12 inter-agency GBV working groups (3 in Puntland, 8 in South Central and 1 in Somaliland zones)
	Number of regions and communities supported by UNFPA Somalia that declare the abandonment of female	<b>Baseline 0</b> <b>Target 300</b>	240	UNFPA has made progress in addressing FGM/C amid socio-cultural and religious challenges. The gains made, especially in Puntland with religious leaders, and other regions of the country can form learning points for cascading and can be utilised to address this in the other areas including rural

Component Result	Indicator	Baseline and Target by 2015	Achievement by December 2015	Comments
	genital mutilation/cutting (FGM/C);			communities
	Gender-based violence prevention, protection and response integrated into SRH programmes	<b>Baseline</b> <b>N/A</b> <b>Target</b> <b>Yes</b>	Yes	SRH programme integrated GBV prevention, protection and response through revision of the Midwives training curriculum to include FGM/C, and provision of minimum initial service package (MISP) under SRH interventions during emergencies
Output 2: Enhanced systems and mechanisms to prevent and protect against all forms of gender-based violence, using a human rights perspective, including in emergency and post-conflict situations	Existence of functioning tracking and reporting system to follow up on the realisation of reproductive rights and addressing gender-based violence	<b>Baseline</b> <b>N/A</b> <b>Target</b> <b>Yes</b>	Yes	UNFPA has supported establishment of GBVIMS reporting system in Somalia and partners trained on utilisation of the system and are currently using it on a monthly basis both at Zonal and National levels.
	Number of institutions (one-stop centres) providing services to survivors of gender-based violence	<b>Baseline</b> <b>0</b> <b>Target</b> <b>6</b>	11	11 one-stop centres established in Somalia (2 in Puntland and 9 in South Central Zones)

### Annex 3: CP Evaluation Matrix

RELEVANCE			
Evaluation Question (EQ) 1a: To what extent were the Reproductive Health interventions consistent with the needs of the beneficiary populations and to what extent was it aligned with government priorities as well as with policies and strategies of UNFPA?			
Assumption to be assessed	Indicators	Sources of Information	Methods and Tools of Data Collection
<p>The RH (MNCH, FP, ASRH) interventions addressed the needs of the targeted beneficiaries</p> <p>The CP design was aligned with the government priorities and UNFPA Policies and strategies</p>	<ul style="list-style-type: none"> <li>The existence and evidence of wide consultations during needs assessments, studies, evaluations that identified needs and lessons learned prior to programming and during the CP, updated periodically to guide the programme, including design</li> <li>Separate components are integrated in planning with cross cutting aspects such as gender and equity</li> <li>The choice of target groups for UNFPA-supported RH interventions is consistent with identified and evolving needs as well as national priorities</li> <li>Extent to which the RH interventions supported by UNFPA targeted most</li> </ul>	<ul style="list-style-type: none"> <li>CPD, CPAP, AWP</li> <li>Needs assessment reports and Evaluations</li> <li>Specific Government strategies (for identified priorities)</li> <li>Key Informants from Government and Partners</li> <li>Beneficiaries</li> <li>UNSAS and ISF</li> </ul>	<ul style="list-style-type: none"> <li>Interview with UNFPA staff</li> <li>Literature review</li> <li>Interview with MoH staff</li> <li>FGDs with beneficiaries</li> <li>Site visits to the programme areas</li> </ul>

	<p>vulnerable as needed (Youth, Women of Reproductive age and Lactating mothers)</p> <ul style="list-style-type: none"> <li>• Extent to which the targeted people were consulted in relation to programme design and activities throughout the programme</li> </ul>		
<p>Evaluation Question (EQ) 1b: To what extent were the Population and Development interventions consistent with the needs of the beneficiary populations and to what extent was it aligned with government priorities as well as with policies and strategies of UNFPA?</p>			
Assumption to be assessed	Indicators	Sources of Information	Methods and Tools of Data Collection
<p>The Population and Development interventions addressed the needs of the targeted beneficiaries</p> <p>The CP design was aligned with the government priorities and UNFPA Policies and strategies</p>	<ul style="list-style-type: none"> <li>• The existence and evidence of wide consultations during needs assessments, studies, evaluations that identified needs and lessons learned prior to programming and during the CP, updated periodically to guide the programme, including design</li> <li>• Separate components are integrated in planning with cross cutting aspects such as gender and equity</li> <li>• Extent to which the PD interventions supported by UNFPA targeted most</li> </ul>	<ul style="list-style-type: none"> <li>• CPAP, CPAP AWP</li> <li>• Consultative reports</li> <li>• Training reports</li> <li>• PESS report</li> <li>• Government strategies (for identified priorities)</li> <li>• Key Informants from Government</li> <li>• UNSAS and ISF</li> </ul>	<ul style="list-style-type: none"> <li>• Interview with UNFPA staff</li> <li>• Literature review</li> <li>• Interview with Government staff</li> </ul>

	<p>vulnerable as needed (People of Concern)</p> <ul style="list-style-type: none"> <li>• Extent to which the targeted people were consulted in relation to programme design and activities throughout the programme</li> </ul>		
<p>Evaluation Question (EQ) 1c: To what extent were the Gender interventions consistent with the needs of the beneficiary populations and to what extent was it aligned with government priorities as well as with policies and strategies of UNFPA?</p>			
Assumption to be assessed	Indicators	Sources of Information	Methods and Tools of Data Collection
<p>The CP's Gender component interventions addressed the needs of the targeted beneficiaries</p> <p>The CP design was aligned with the government priorities and UNFPA Policies and strategies</p>	<ul style="list-style-type: none"> <li>• The existence and evidence of wide consultations during needs assessments, studies, evaluations where needs and lessons learned prior to programming and during the CP to guide the programme, including design</li> <li>• Separate components are integrated in planning with cross cutting aspects such as gender and equity</li> <li>• The choice of target groups for UNFPA-supported interventions is consistent with identified and evolving needs as well as national</li> </ul>	<ul style="list-style-type: none"> <li>• CPD, CPAP AWPs</li> <li>• COARS</li> <li>• Needs assessment reports and Evaluations</li> <li>• Government strategies (for identified priorities)</li> <li>• Key Informants from Government and Partners</li> <li>• Beneficiaries</li> <li>• UNSAS and ISF</li> </ul>	<ul style="list-style-type: none"> <li>• Interview with UNFPA staff</li> <li>• Literature review</li> <li>• Interview with implementing partners, including government</li> <li>• FGDs with beneficiaries</li> <li>• Site visits to the programme areas</li> </ul>

	<p>priorities</p> <ul style="list-style-type: none"> <li>• Extent to which the interventions supported by UNFPA targeted most vulnerable as needed</li> <li>• Extent to which the targeted people were consulted in relation to programme design and activities throughout the programme</li> </ul>		
<b>EFFECTIVENESS</b>			
<b>EQ 2: How well is the CPD aligned to the ICPD actions as well as with the UNFPA Strategic Plans and how well is the CPAP delivering the CPD?</b>			
<b>Assumption to be assessed</b>	<b>Indicators</b>	<b>Sources of Information</b>	<b>Methods and Tools of Data Collection</b>
<p>The CPAP is delivering the CPD (reflection of the CPD)</p> <p>The CPD is aligned to the UNFPA Strategy (ICPD actions)</p>	<ul style="list-style-type: none"> <li>• ICPD goals are reflected in the CPAP and component activities</li> <li>• The CPAP sets out relevant goals, objectives and activities to develop national capacities</li> <li>• Plans are executed as planned</li> <li>• Extent to which South-South (Especially for the PESS, Gender equality) cooperation has been mainstreamed in the country programme</li> </ul>	<ul style="list-style-type: none"> <li>• CPD</li> <li>• CPAP</li> <li>• AWP</li> <li>• UNFPA Strategic Plans 2011-2015; 2014 – 2017</li> <li>• Joint and collaborative programme documents</li> </ul>	<ul style="list-style-type: none"> <li>• Literature review</li> <li>• Interview with UNFPA staff</li> <li>• Interview with government staff</li> <li>• Interview with other UN staff</li> </ul>



	<ul style="list-style-type: none"> <li>• Extent to which gender equality and women’s empowerment have been mainstreamed</li> <li>• Extent to which specific attention has been paid to youth in the programme</li> <li>• Extent to which plans are executed within the</li> </ul>		
<b>EFFECTIVENESS</b>			
EQ 3: To what extent did the interventions supported by UNFPA in the field of reproductive health and rights contribute to (i) Improved access and utilisation of high quality maternal health and family planning services, including populations affected by humanitarian crisis (ii) Increased national and sub-national capacity to deliver integrated sexual and reproductive health services (iii) Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes			
Assumption to be assessed	Indicators	Sources of Information	Methods and Tools of Data Collection
The UNFPA-supported interventions in RH and Rights contributed to improved access and utilisation of high quality maternal health and family planning services, including populations affected by humanitarian crisis	<ul style="list-style-type: none"> <li>• Timeliness of the CO response to the emergency situations especially during displacements</li> <li>• Evidence of availability of RH service in health facilities</li> <li>• Evidence of capacity strengthening of RH program management</li> <li>• Reproductive health emergency preparedness and response plan have been developed in consultation with concerned national and international partners</li> <li>• CO capacity to adjust the</li> </ul>	<ul style="list-style-type: none"> <li>• COARs</li> <li>• AWP</li> <li>• CPAP</li> <li>• Evaluation reports</li> <li>• Assessments</li> <li>• Government RH policies and strategies/ plans.</li> <li>• Training modules and reports.</li> <li>• Field visits to health facilities</li> <li>• Monitoring reports</li> <li>• Training workshop</li> </ul>	<ul style="list-style-type: none"> <li>• Literature review, including financial documents</li> <li>• Interview with IPs</li> <li>• Interview with UNFPA staff</li> <li>• Interview with government staff</li> <li>• Field visits</li> </ul>

	<p>objectives of the CPAP and the AWP</p> <ul style="list-style-type: none"> <li>• Integration of Essential reproductive health services package (including Emergency obstetric and neonatal care, and post unsafe abortion care) health care services.</li> <li>• Extent to which the response was adapted to emerging needs, demands and national priorities</li> <li>• Extent to which the reallocation of funds towards new activities (in particular humanitarian) is justified</li> <li>• Extent to which the CO has managed to ensure continuity in the pursuit of CPAP objectives while responding to emerging needs and demands</li> </ul>	<p>reports and training materials</p>	
<p>The UNFPA-supported interventions in RH and Rights increased national and sub-national capacity to deliver integrated sexual and reproductive health services</p>	<ul style="list-style-type: none"> <li>• Evidence of capacity strengthening on the government services providers on RH</li> <li>• Evidence of integrated of RH in Government Health Plans</li> <li>• Evidence on availability of SRH services in health facilities</li> <li>• Strengthening and standardisation of the logistics management information system</li> </ul>	<ul style="list-style-type: none"> <li>• Government RH plans</li> <li>• Site visits to health facilities</li> <li>• Training reports on RHCS and LMIS</li> </ul>	<p>Site visits Interviews with beneficiaries</p>

<p>The UNFPA-supported interventions in RH and Rights increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes</p>	<ul style="list-style-type: none"> <li>• Extent to which specific attention has been paid to the youth in the programme</li> <li>• Sexual and reproductive health and rights outreach services tailored to the needs of special population groups are provided by 2015</li> <li>• Evidence of usage of the hygiene kits and RH information by the IDPs in settlements</li> <li>• Evidence that the training materials and training sessions for health workers have contributed to increased demand for RH services</li> </ul>	<ul style="list-style-type: none"> <li>• COARs</li> <li>• CPAP</li> <li>• Monitoring reports</li> <li>• Health records</li> <li>• RH strategic plans by the governments</li> </ul>	<ul style="list-style-type: none"> <li>• Literature review</li> <li>• Data analysis</li> <li>• FGDs with beneficiaries, including Y-PEER members</li> <li>• Interviews with the health service providers in facilities</li> <li>• Interview with UNFPA staff</li> <li>• Visit to health facilities</li> </ul>
<p>EQ 4: To what extent have the interventions supported by UNFPA in the field of population and development contributed to (i) increased availability and use of data on emerging population issues at national and sub-national levels (ii) Strengthened national and sub-national capacity for production and dissemination of quality disaggregated data on population and development issues.</p>			
Assumption to be assessed	Indicators	Sources of Information	Methods and Tools of Data Collection
<p>UNFPA's population and development interventions contributed to increased availability and use of data on emerging population issues at national and sub-national levels</p>	<ul style="list-style-type: none"> <li>• Policy frameworks and protocols for production and integration of population dynamics, reproductive health and gender in development planning are in place and operational.</li> <li>• Extent of implementation of</li> </ul>	<ul style="list-style-type: none"> <li>• AWP</li> <li>• COARs</li> <li>• Sectoral Plans</li> <li>• Annual reports from NPC and CBS</li> <li>• Need assessment, evaluation and monitoring reports</li> <li>• Planning Staff and Publications</li> </ul>	<p>Literature review</p> <p>Interview with government staff</p> <p>Other agencies involved in development interventions in Somalia</p>

	<p>plan for capacity strengthening on population and policy issues;</p> <ul style="list-style-type: none"> <li>• Formulation and operationalisation of Policies for Development of Statistics at national and regional levels;</li> <li>• Difference in contributions of professionals and units trained to apply integration methods and tools;</li> <li>• Gender disaggregated data produced, analysed and utilised at national and sectorial levels;</li> <li>• In-depth, policy-oriented studies released</li> <li>• Number of national and sectorial plans incorporating population, reproductive health and gender issues;</li> <li>• Inter-linkages between data producers and data users operational</li> </ul>	<ul style="list-style-type: none"> <li>• Relevant Stakeholders</li> </ul>	
<p>UNFPA's population and development interventions contributed to strengthened national and sub-national</p>	<ul style="list-style-type: none"> <li>• Large-scale population surveys conducted, disseminated and results utilised for planning;</li> </ul>	<ul style="list-style-type: none"> <li>• COARs</li> <li>• AWP's</li> <li>• Monitoring reports</li> <li>• Sector plans and reports</li> </ul>	<ul style="list-style-type: none"> <li>• Interviews with policy makers (government and professional bodies, where applicable)</li> <li>• Interview with other UN</li> </ul>

<p>capacity for production and dissemination of quality disaggregated data on population and development issues.</p>	<ul style="list-style-type: none"> <li>• Database for planning and monitoring established at national and state levels;</li> <li>• Government staff and other Professionals trained to apply integration methods and tools;</li> <li>• Statistics units set up and strengthened at government ministries</li> </ul>	<ul style="list-style-type: none"> <li>• Site visits</li> <li>• Governments staff and professional bodies</li> </ul>	<p>agencies and NGOs</p> <ul style="list-style-type: none"> <li>• Literature review</li> </ul>
<p>EQ 5: To what extent have the interventions supported by UNFPA in the field of gender contributed to: (i) Strengthened national and sub-national protection systems for advancing reproductive rights, promoting gender equality and non-discrimination and addressing gender-based violence; (ii) Increased capacity to prevent gender-based violence and harmful practices and enable the delivery of multi-sectoral services, including in humanitarian settings?</p>			
Assumption to be assessed	Indicators	Sources of Information	Methods and Tools of Data Collection
<p>UNFPA's gender interventions have contributed to strengthened national and sub-national protection systems for advancing reproductive rights, promoting gender equality and non-discrimination and addressing gender-based violence</p>	<ul style="list-style-type: none"> <li>• Evidence of Gender policies</li> <li>• Evidence of capacity strengthening of various stakeholders by UNFPA</li> <li>• Establishment of task forces to oversee implementation of gender-based violence cases</li> <li>• Establishment of monitoring systems for GBV cases</li> <li>• Percentage of responsible parties identified in the</li> </ul>	<ul style="list-style-type: none"> <li>• Agencies in various gender task forces in Somalia (FGM and GBV)</li> <li>• Gender policies</li> <li>• Government gender plans</li> <li>• COARs</li> <li>• Monitoring reports</li> <li>• Training reports</li> <li>• Minutes of task forces</li> </ul>	<ul style="list-style-type: none"> <li>• Interviews with agencies in various gender task forces and working groups in Somalia (FGM and GBV)</li> <li>• Interviews with religious leaders</li> <li>• Interviews with government staff</li> <li>• Interview with UNFPA staff</li> <li>• Literature review</li> </ul>

	national action place who report their GBV prevention activities (CPAP indicator)		
UNFPA's gender interventions have contributed to increased capacity to prevent gender-based violence and harmful practices and enable the delivery of multi-sectoral services, including in humanitarian settings	<ul style="list-style-type: none"> <li>Evidence of increased national and local level dialogue and activities aimed at improving the protection of women from violence</li> <li>Evidence of capacity development of CSOs to partner with national and regional government on advancement of women and to combat GBV</li> <li>Training programmes for service providers within the government and NGOs to combat GBV</li> <li>Existence of programmes involving men and young people for combating GBV</li> <li>Evidence of effective monitoring of the cases on GBV</li> </ul>	<ul style="list-style-type: none"> <li>CPAP and Strategic Plans</li> <li>AWPs</li> <li>National policy/strategy documents</li> <li>Needs assessment studies</li> <li>Evaluations</li> <li>Implementing Partners in Government, Women's and Youth NGOs</li> <li>Training reports</li> <li>Gender policies and GBV reduction Plans</li> </ul>	<ul style="list-style-type: none"> <li>Literature review</li> <li>Interviews with UNFPA staff</li> <li>Interviews with implementing partners</li> <li>Interviews/Focus groups with beneficiaries</li> <li>Field visit to GBV centres and meeting with service providers</li> <li>Field visit to women centres in selected IDP settlements and groups interviews with beneficiaries</li> <li>Interview and group discussion with trainers and partner NGOs</li> <li>Group discussion with GBV support group</li> </ul>
EQ 6: To what extent was the programme coverage (geographic; beneficiaries) reached as planned?			
Assumption to be assessed	Indicators	Sources of Information	Methods and Tools of Data Collection

<p>The programme reached or is likely to reach its targeted outputs for each component (geographic; beneficiaries) as planned</p>	<ul style="list-style-type: none"> <li>• Achievements for each of the six outputs</li> <li>• Facilitating factors/reasons to the achievement and/or non-achievement of the results</li> </ul>	<ul style="list-style-type: none"> <li>• AWP</li> <li>• CP reports (RH, Gender and PESS)</li> <li>• CPAP</li> <li>• COARs</li> <li>• Performance monitoring plans</li> </ul>	<ul style="list-style-type: none"> <li>• Document review and analysis</li> <li>• Interviews with UNFPA staff</li> <li>• Interview with partners</li> </ul>
<p>EFFICIENCY</p>			
<p>EQ 7: Was the programme implementation approach (funds, expertise, time and administrative costs) the most efficient way of achieving results?</p>			
Assumption to be assessed	Indicators	Sources of Information	Methods and Tools of Data Collection
<p>The Programme Implementation Approach was the most efficient way of achieving results</p> <p>The monitoring, evaluation, reporting and accountability systems adequate to enable UNFPA to demonstrate programme results</p>	<ul style="list-style-type: none"> <li>• The planned inputs and resources were received as set out in the AWP and agreements with partners or a regular basis</li> <li>• The resources were received in a timely manner according to project time lines and plans</li> <li>• Budgeted funds were disbursed in a timely manner</li> <li>• Inefficiencies were corrected as soon as possible (programme monitoring and evaluation decisions)</li> <li>• Evidence that the resources provided by UNFPA triggered</li> </ul>	<ul style="list-style-type: none"> <li>• UNFPA staff (including finance/administrative departments)</li> <li>• Partners (implementers and direct beneficiaries)</li> <li>• Monitoring reports</li> <li>• Audit reports</li> <li>• CP reports (Progress reports)</li> <li>• Review reports</li> </ul>	<ul style="list-style-type: none"> <li>• Review of financial documents</li> <li>• Interviews with UNFPA Staff</li> <li>• Interviews with government staff/health facilities</li> <li>• FGDs with beneficiaries of funding (including NGOs)</li> </ul>

	<p>the provision of additional resources from the government levels and from communities</p> <ul style="list-style-type: none"> <li>Leveraged resources appropriate to planned program outputs</li> </ul>		
<b>SUSTAINABILITY</b>			
EQ 8a: To what extent are the development gains made under the UNFPA supported interventions in Somalia sustainable in terms of continuity in service provisions and partnerships integration of CP activities into the regular country and counterparts programming?			
Assumption to be assessed	Indicators	Sources of Information	Methods and Tools of Data Collection
UNFPA has been able to support its partners in developing their capacities and establishing mechanisms to ensure ownership and the durability of effects in the areas of Gender Equality, RH and PD	<ul style="list-style-type: none"> <li>Evidence of addressing sustainability at the planning phase.</li> <li>Capacity strengthening covered broad spectrum of partners' needs.</li> <li>RH care providers acquired necessary competencies to deliver quality services.</li> <li>Evidence of commitment of the implementing partners in support of UNFPA supported interventions</li> <li>Allocation of funds from national sources to maintain equipment, and continue</li> </ul>	<ul style="list-style-type: none"> <li>COARs</li> <li>AWPs</li> <li>CPAP</li> <li>CPD</li> <li>Programme Progress reports</li> <li>Financial reports</li> <li>Key Informants from Government and NGOs</li> <li>Training reports</li> <li></li> </ul>	<ul style="list-style-type: none"> <li>Interviews with implementing partners</li> <li>Interviews with health care providers</li> <li>Interview with ministry staff</li> <li>Interviews/Focus groups with beneficiaries</li> <li>Site visits</li> </ul>



	<p>updating information.</p> <ul style="list-style-type: none"> <li>• Commitment of government for application of laws policies and strategies related to GBV.</li> <li>• Extent of ownership of NGOs and partners for UNFPA programme related results</li> <li>• Evidence for capacities of NGOs and partners to continue training and engagement with communities addressing gender equality and GBV issues.</li> <li>• Program monitoring systems in place and functional.</li> <li>• Program coordination mechanisms with UN agencies, government and partners are established and functional.</li> </ul>		
EQ 8b. To What extent is UNFPA CP potential to contribute to the MDGs?			
Assumption to be assessed	Indicators	Sources of Information	Methods of Data Collection
The CP Intervention are likely to contribute to the MDGs	<ul style="list-style-type: none"> <li>• Data related to the related MDGs are in place</li> <li>• There is progress made in the MDGs from the inception to</li> </ul>	<ul style="list-style-type: none"> <li>• Programme M&amp;E reports</li> <li>• Programme progress report</li> <li>• CPAP</li> <li>• CPD</li> </ul>	<ul style="list-style-type: none"> <li>• Document review</li> <li>• UNFPA staff interview</li> <li>• Government interview</li> <li>• FGDs with Beneficiaries</li> </ul>

	<p>the time of evaluation</p> <ul style="list-style-type: none"> <li>• Program monitoring systems in place and functional.</li> <li>• Program coordination mechanisms</li> </ul>	<ul style="list-style-type: none"> <li>• Somalia MDG report</li> </ul>	
<b>VALUE ADDITION</b>			
EQ 9: What has been the comparative strength of the UNFPA CO response to the Somalia context of protracted crisis and particularly in the areas of reproductive health, gender-based violence and population and development?			
Assumption to be assessed	Indicators	Sources of Information	Methods and Tools of Data Collection
UNFPA had comparative strengths in response to the Somalia context of protracted crisis and in the areas of RH, Gender and PD.	<ul style="list-style-type: none"> <li>• Comparative strengths of UNFPA, both corporate and in-country, particularly in comparison to other UN agencies, have been identified and built upon</li> <li>• The results observed in programmatic areas that have been achieved with UNFPA's contribution are described.</li> <li>• The perceptions of national stakeholders in regard to UNFPA's added value have been collected and used for future programming</li> <li>• Perception by the stakeholders of the comparative strengths of</li> </ul>	<ul style="list-style-type: none"> <li>• CPAP and COARs</li> <li>• Reports from partners and other agencies</li> <li>• UNFPA strategies</li> <li>• Government partners</li> <li>• UN agencies</li> </ul>	<ul style="list-style-type: none"> <li>• Interviews with UNFPA staff</li> <li>• FGD with government beneficiaries</li> <li>• Literature review and analysis</li> <li>• Interviews with other UN agencies</li> <li>• Interviews with government partners</li> </ul>

	<p>UNFPA</p> <ul style="list-style-type: none"> <li>Evidence that UNFPA comparative strengths are reflected in its cooperation with other development partners</li> </ul>		
<b>COORDINATION</b>			
EQ 10: To what extent has the UNFPA CO contributed to good coordination among UN agencies in the country, particularly in view of avoiding potential overlaps?			
Assumption to be assessed	Indicators	Sources of Information	Methods and Tools of Data Collection
The UNFPA CO contributed to good coordination among UN agencies in the country, particularly in view of avoiding potential overlaps	<ul style="list-style-type: none"> <li>Evidence of active participation in UN working groups</li> <li>Evidence of the leading role played by UNFPA in the working groups and/or joint initiatives corresponding to its mandate areas</li> <li>Evidence of exchanges of information between UN agencies</li> <li>Evidence of joint programming initiatives (planning)</li> <li>Evidence of joint implementation of Programmes</li> <li>Evidence of overlaps and/or</li> </ul>	<ul style="list-style-type: none"> <li>CPAP</li> <li>UN Agencies</li> <li>UNFPA Country Office</li> <li>Monitoring/Evaluation reports of joint programmes and projects</li> <li>Minutes of working groups</li> <li>Programming documents regarding UN joint initiatives</li> </ul>	<ul style="list-style-type: none"> <li>Document review</li> <li>Interview with UN agencies having joint programmes with UNFPA and NGOs intervening on emergency response</li> <li>Interview with UNFPA Staff</li> <li>Interview with implementing partners</li> </ul>

	<p>absence of overlaps between UNFPA interventions and those of other agencies</p> <ul style="list-style-type: none"><li>• Evidence that synergies have been actively sought in the implementation of the respective programmes of UN agencies</li></ul>		
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#### Annex 4: List of Persons Interviewed

<b>Name of Respondent</b>	<b>Organisation/ Institution</b>	<b>Title</b>
Abdirisak Yousuf	Admas University	Student (Y-PEER Beneficiary)
Samira Mohamed Ahmed	Admas University	Student (Y-PEER Beneficiary)
Mohamed Bashir	ANPPCAN – Jowle MWH	Head of Office
Ahmed Hassan	CCM, Puntland	Programme Officer
Nikolai	CCM, Puntland	Programme Coordinator
Dr. Asif	CCM, Puntland	Programme Officer
Dr Edna Adan	Edna Adan University hospital	Director
Dr. Jesus Ganzalez	Edna Adan University hospital	Visiting Obstetrician and Gynaecologist
Abdisamal Ahmed Jama	Garowe General Hospital	Director
Tedesse Kassaye Woldetsadik	Health Poverty Action	Africa Programme Director
Khadar Abdilahi Mohamed	Health Poverty Action	Programme Manager
Ridiwan Mohamed	IRADA	Director
Ahmed Yassin	IRADA	Research and Com. Manager
Ahmed Celabe	IRADA	Admin & Finance Officer
Timira Abdirahman Sheikh	Maato Kaal One Stop Centre	Coordinator
Aniso Abdulfatah Mohamoud	Maato Kaal One Stop Centre	Case Manager
Saad Mohamed Jama	Maato Kaal One Stop Centre	Psychosocial Counsellor
Fadumo Mohamed Faliye	Maato Kaal One Stop Centre	Case Worker
Faisal Mahdi Ali	Maato Kaal One Stop Centre	Legal Aid Support
Juweria Jama Geele	Maato Kaal One Stop Centre	Case Worker
Ahmed Abdallah Tigana	Ministry of Labour, Youth & Sports - Puntland	DG – Youth and Sports
Mohamed Abdullah Hassan	Ministry of Labour, Youth & Sports - Puntland	UNFPA Focal Point
Dr. Osman Hussein Warsame	Ministry of National Planning and Development – Somaliland	Post-PESS Coordinator
Ahmed Elmi Muhumad	Ministry of Planning - Federal Government of Somalia	Director General of National Statistics
Hussein Elmi Gure	Ministry of Planning - Federal Government of Somalia	Deputy DG
	Ministry of Youth and Sports	Director of Finance and Admin (Acting DG)

Name of Respondent	Organisation/ Institution	Title
Omer Ali Abdi	Ministry of Youth, Sports and Tourism - Somalia	Director of Youth Dept.
Habibo Mohamed Warsame	Mogadishu Midwifery Training Institute	Student: Qualified nurse midwife training
Hodan Farah Ismail	Mogadishu Midwifery Training Institute	Student: Qualified nurse midwife training
Sadiyo Mohamed Hassan	Mogadishu Midwifery Training Institute	Student: Qualified nurse midwife training
Luul Ahmed Warsame	Mogadishu Midwifery Training Institute	Student: post-basic nurse midwife training
Maryan Mohamed Abdi	Mogadishu Midwifery Training Institute	Student: post-basic nurse midwife training
Zahra Mohamed Abdi	Mogadishu Midwifery Training Institute	Student: post-basic nurse midwife training
Halimo Mohamed Ali	Mogadishu Midwifery Training Institute	Midwifery Teacher
Ardo Adan Mohamed	Mogadishu Midwifery Training Institute	Midwifery Teacher
Dr. Abdirizack Yusuf Ahmed	MoH - Federal Government of Somalia	Deputy DG (Ag. DG)
Dr. Abdikadir Welil Afra	MoH - Federal Government of Somalia	RH Advisor
Abdinasir Elmi	MoH, Puntland	EHS Manager
Idris Abdullahi	MoH, Puntland	RH Manager
Abdirizak Abshir	MoH, Puntland	Director of PHC (Ag. DG)
Dr. Ali Sheikh Omar	MoH, Somaliland	Director of Family Health
Dr. Idris Noor Mohamed	MoH, Somaliland	Child Health Section
Dr. Abdullahi	Hargeisa Group of Hospitals	Ag. Director
Ahmed Dahir	Hargeisa Group of Hospitals	Administrator
Mohamed Bashir	Jowle Maternity Centre	Officer-In-Charge
Hamdi Noor	Jowle Maternity Centre	Nurse-In-Charge
Awale Mohamed	MoLSA - Somaliland	Director of Planning
Abdifatah Alinoor Naimo	Haji Abdi School of Nursing	Vice Principal
Ardo Siid Mohamed	Haji Abdi School of Nursing	Director of School
Yussuf Noor	Haji Abdi School of Nursing	Tutor
Amina Osman Ali	Haji Abdi School of Nursing	Student



<b>Name of Respondent</b>	<b>Organisation/ Institution</b>	<b>Title</b>
Fauma Mohamed Ahmed	Puntland Midwifery Association (PAM)	Secretary General
Abdishakur Adam	MoLSA – Somaliland	Head of Gender
Ahmed Abdullah Tigana	MOLYS - Puntland	DG, Youth and Sports
Mohamed Abdullah Hassan	UNFPA - Puntland	UNFPA Focal Point
Hashim Sheikh Abdinoor	MoPIC – Fed Gov't of Somalia	PC – National Statistics
Mohamed Abdinoor M.	MoPIC – Fed Gov't of Somalia	Regional Coordinator
Nur Ahmed Wehliye	MoPIC – Federal Government of Somalia	PESS Coordinator
Dr. Abdi Mohamoud Ali	MoPIC – Puntland	Snr. Statistics Advisor
Abdinasir Ali Dahir	MoPIC – Puntland	Director of Statistics
Khadar Mohamed Gahayr	MoPND - Somaliland	Demographer Consultant
Abdirizack Nouh M. Isse	MoWDAFA – Puntland	Director General
Abdijabal Bashir	MoWDAFA – Puntland	Admin and Finance Officer
Abdirizack Hassan Farah	MoWDAFA – Puntland	UNFPA Finance Focal Point
Kemal Abdijabar Rashid	MoWDAFA - Puntland	UNFPA Gender Consultant Focal Point
Saadia Mohamed Nur	MW&HR – Federal Government of Somalia	Director - Gender
Mohamed Omar Nur	MW&HR – Somalia Federal Government	Director General
Gavin Roy	Office of UN Resident Coordinator	Resident Coordination Advisor
Abdinoor Osman Wehliye	OSPAD	Executive Director
Dr Ahmed Aways	PAC	CEmONC Prog. Coordinator
Dr. Mohamed Abdirahman	PAC	Health and Nutrition Coord.
Halima Mohamed	PESS	Team Leader [Data Entry and Analysis]
Ahmed Abdurizack	PESS	ToT / Data Entry/ Data Analysis
Mohamed Ali Ibar	PESS	Mappinf Supervisor/ ToT
Mukhtar Mohamed Hassan	SAMA	Programme Manager
Hassan Noor	SLNMA	Ag. Programme Manager
Prof. Abdi Ali Jama	SOLNAC	Executive Director
Mama Amina Haji Elmi	SSW&C	Director
Habiba Abass	SSW&C	GBV Training Specialist

<b>Name of Respondent</b>	<b>Organisation/ Institution</b>	<b>Title</b>
Dr. Abdullahi Mohamed Nur	SWISS Kalmo	Programme Manager
Saynab Jama Ismail	SWISS Kalmo MWH	Nurse midwife
Nuurto Moallin Isse	SWISS Kalmo MWH	Nurse midwife
Hamilimo Hassan Abdi	SWISS Kalmo MWH	Ward in charge
Dr. Nafiso Abdirahman Sheikh	SWISS Kalmo MWH	Obstetrician & Gynaecologist
Dr. Ikran Abdullahi Hashi	SWISS Kalmo MWH	Obstetrician & Gynaecologist
Dr. Abdullahi Mohamed	SWISS Kalmo MWH	Program Manager
Victoria Nwogu	UNDP	Gender Specialist
Judith Otieno	UNDP	GBV Officer
Mohamed Mursal Abdi	UNFPA	GBV Coordinator – SCZ
Dr. Salad Hussein Duale	UNFPA	RH Specialist – SCZ
Bakhtior Kadirov	UNFPA	Head of Puntland Sub-Office
Mr Anas	UNFPA	Head of Somaliland Sub-Office
Jihan Salad	UNFPA	Reproductive and Maternal Health Programme Specialist - Puntland
Dr. Achu Lodfred	UNFPA	RHR Technical Specialist
Fatuma Muhumed	UNFPA	Adolescent, Youth and HIV Analyst
Eri Taniguchi	UNFPA	GBV Specialist
Mariam Alwi	UNFPA	P&D Focal Point
Felix Mulama	UNFPA	Technical Team
Richard Chirchir	UNFPA	Statistician
Dr. Samia Hassan	UNFPA	PM – Humanitarian Response
Grace Kyeyune	UNFPA	Deputy Country Rep.
Mr. Ibnou Diallo	UNFPA	Chief Technical Advisor, Reproductive Health Commodity Security (RHCS)
Ahmed Abdi Jama	UNFPA	Youth and Gender Specialist
Bahsan Ahmed Siciid	UNFPA	Gender and Youth Specialist
Sulaika Abdi Ibrahim	University of Hargeisa	Student (Y-PEER Beneficiary)
Hibo Abdikarin Aden	University of Hargeisa	Student (Y-PEER Beneficiary)

<b>Name of Respondent</b>	<b>Organisation/ Institution</b>	<b>Title</b>
Dr. Hussein Ali Mohamed	WARDI	Health and Nutrition Officer
Mohamed A. Ibrahim	Y-PEER Network	Executive Director
Abdiweli Ali Abdule	Y-PEER Network – Puntland	Executive Director
Hassan Ahmed Aideed	Y-PEER Network – Puntland	PM – Youth Alternatives
Mohamed Abdullah	Y-PEER Network – Puntland	Finance Assistant
Abdiaziz Hersi	Y-PEER Network, Somaliland	Chairperson
Abdirahman Mohamed	Y-PEER Network, Somaliland	Project Officer

## Annex 5: Evaluation Data Collection Tools

### Interview Guide – Reproductive Health Thematic Area

**(Target: UNFPA Staff, Ministry, Training Institutions, Youth Networks, IPs and Service Points)**

#### RH Interview Guide

Target: UNFPA Staff, IPs and Service Providers

Name of

Interviewee: .....

Position: .....

Institution/Organisation: .....

Interviewee: .....

Stakeholder

Introduction:

- a. Introduce yourself and the purpose of the Interview: the objective of assessing experience and learning of the current program cycle with the view of proposing recommendations for the next CP cycle.
- b. Assure participants of the confidentiality of information exchange which will serve only for the purpose of analysis.

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

Questions:

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

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

Questions:

- a. How well does the activity/work support the government's priorities and work within the national structures that are in place? How well does it work within private structures?
  - b. How well is the work designed to achieve the outcomes/results in the CPAP? (to increase physician assisted deliveries, to increase demand by women for RH services, to reduce disparities in fertility and maternal mortality/morbidity, to improve RH knowledge of youth)
  - c. Has UNFPA adapted the programme and activities to respond to changes in the institutional environment (e.g. dynamism in the government, restructuring of the Ministry of Health)?
  - d. Were there any RH needs or priorities of the implementing partners that the country program did not address adequately or at all? If Yes, What were these needs and Priorities
  - e. To what extent has UNFPA responded to RH emerging issues in the IDP Settlements or calamities? What were the factors that facilitated UNFPA response to such RH emerging issues? What were the factors that hindered the UNFPA response to such RH emerging issues?
3. Effectiveness of the approaches/activities/projects used to improve access to high quality RH and FP services and for the most vulnerable.

Questions:

- a. What are the indications that the approach is working or making progress toward goals established to be achieved in 2015 - end of CP - (e.g. anecdotes which provide illustrations of positive, negative or unintended effects, or quantitative and qualitative evidence) ; (numbers being reached, products produced/purchased and the extent of impact, evidence of usage of knowledge, increasing networks, etc.)
- b. Were UNFPA interventions implemented at adequate scale to reach intended outcomes?
- c. What else should be done to make the programmes more effective?
- d. How effective was the training on adolescent and youth sexual and RH in addressing the adolescent and youth health?
- e. What are the barriers/challenges to increasing demand and access to services, and how are they being addressed?

4. Sustainability

Questions

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

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

Questions:

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

## 6. Functioning Coordination mechanisms

### Questions:

- a. Do you work with other UN agencies and/or can you say how well the activities are coordinated, overlapping?
- b. Are there gaps in the population needs which would not have been identified by the UN system, collectively?

## 7. The value of UNFPA work to national development

### Questions:

- a. How big of a difference is UNFPA making in RH in Somalia, what contributes to its effect, what detracts?
- b. Can UNFPA input be improved or strengthened?

## 8. Interviewee Recommendations

- a. Programmatic
- b. Strategic

## Focus Group Interview for Y-Peer Members and Youth (ASRH)

- a. Introduce yourself and the purpose of the Interview: the objective of assessing experience and learning of the current program cycle with the view of proposing recommendations for the next CP cycle.
- b. Assure participants of the confidentiality of information exchange which will serve only for the purpose of analysis.
- c. Write the names of all the Participants

## 1. Rationale for the project and activities undertaken

### Possible questions:

- Please describe the groups you are trying to reach through your participation in the activities and why you think it is important for RH?

## 2. Relevance of the project/activities to the UN priorities, government policies and local structures

### Questions:

- How well does the activity/work fit in with the youth and Y-Peer activities across Somalia?

- What effect do you think the work should have, with which groups?

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

Questions:

- Can you provide examples of success of the approach/activity (e.g. box game, peer counselling) both long term and short term?
- How useful are these activities to communicate the RH messages?
- Can the youth network carry on the work without UNFPA? What will help the youth network to carry on the RH work on its own?

4. Efficiency in the use of UNFPA resources (partners, staff, money, global experience)

Questions:

- Did your work receive the needed support from UNFPA?
- Did the youth network receive any other support in connection with the UNFPA work and who provided this support?

5. Functioning of coordination mechanisms

Questions:

- Do you work with other UN agencies and/or can you say how well the activities are coordinated, overlapping or gaps identified?

6. Value Added

Questions:

- How big of a difference is UNFPA making in RH in Somalia, what contributes to its effect, what detracts?
- Can UNFPA input be improved or strengthened?

7. Interviewee recommendations

## Focus Group Discussions with IDPs (RH)

### Introduction:

- a. Introduce yourself and the purpose of the Interview: the objective of assessing experience and learning of the current program cycle with the view of proposing recommendations for the next CP cycle.
- b. Assure participants of the confidentiality of information exchange which will serve only for the purpose of analysis.
- c. Write the names of all the Participants

### 1. Rationale for the project and activities undertaken

#### Questions:

- What were, and are your priority needs?
- How well have you been consulted about your needs?

### 2. Relevance of the project/activities to the UN priorities, government policies and local structures

#### Questions:

- Did you help plan the services you have received?
- What effect do you think the work should have, with which groups?

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

#### Questions:

- Can you provide examples of success of the services or activities?
- How do you think the activities can be improved?
- What was helpful for you regarding your health (psychosocial support, learning, access to contraceptives, birth spacing)?
- Will the activities/services be useful in the future?

### 4. Efficiency in the use of UNFPA resources (partners, staff, money, global experience)

#### Questions:

- Did you receive the service when you needed them? Where there delay? Did you receive what you expected? Were you consulted afterwards about your use of the items and services?

### 5. Functioning of Coordination Mechanisms

#### Questions:

- Do you receive assistance from other agencies or individuals? Do they work together?

### 6. Value Added

#### Questions:



- How big of a difference has this work made in the lives of your families?
- Can UNFPA input be improved or strengthened?

**GENDER EQUALITY COMPONENT**

Target: UNFPA Programme Specialists and IP Programme Staff.

Name of

Interviewee: .....

Position: .....

Institution/Organisation: .....

Interviewee: .....

Stakeholder

Introduction:

- Introduce yourself and the purpose of the Interview: the objective of assessing experience and learning of the current program cycle with the view of proposing recommendations for the next CP cycle.
- Assure participants of the confidentiality of information exchange which will serve only for the purpose of analysis.

1. Degree and Quality of involvement in the Programme

Questions:

- How long have you been involved in this programme / project?
- In which stages have you taken part? (Design, implementation, etc.)
- What do you think about the pursued objectives / target groups?
- Could you describe the activities undertaken and your role within the implementation process?

2. Relevance of the programme

Questions:

- How did you decide to undertake this work, what were the indications that it would be effective and would reach the target population?
- How well does the activity/work support the government’s priorities and work within the national structures that are in place? How well does it work within private structures?
- What can you say about the gender sensitivity of the programme activities?

3. Coordination and relations with UNFPA, donors, other implementing partners (from public, private sector, NGOs) and beneficiaries

Questions:

- What other actors have been involved, how does this activity contribute to that of others?
- How would you describe your relations with UNFPA and the support provided by them?
- How would you describe your relations with other implementing partners?
- How would you describe your relations with the beneficiaries of the project?
- Do you think the channels of dialogue with other partners and beneficiaries are sufficient? In what ways could they be improved?
- Do you work with other UN agencies and/or can you say how well the activities are coordinated, overlapping?
- Are there gaps in the population needs which would not have been identified by the UN system, collectively?

#### 4. Sustainability, ownership and capacity strengthening within the framework of the particular Programme

Questions:

- What are the particular gains your institution has provided from this project?
- What do you think about the sustainability of the project?
- What are the main factors affecting sustainability?
- Are the capacities in place among stakeholders to be able to carry out the activities/project without support from UNFPA?

#### 5. Effectiveness of the approaches/activities/projects

Questions:

- What are the indications that the approach is working or making progress toward goals established for 2015?
- What are the main strengths and weaknesses of this programme? In what ways could the weaknesses be addressed?

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

Questions:

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

7. Perceived difficulties / challenges for the smooth implementation of the Programme/project (including the impacts of changing development context, changing national priorities, institutional structures, etc.)

Questions:

- Have you experienced any particular difficulties/obstacles in project implementation?
- Have they been resolved effectively? What were the main factors leading to their resolution?
- Have your activities been affected by recent changes in legal/administrative context?

8. The value of UNFPA work to national development

Questions:

- How big of a difference is UNFPA making in gender equality in Somalia, what contributes to its effect, what detracts?
- Can UNFPA input be improved or strengthened?
- What are the strengths and weaknesses of UNFPA
- How can you compare UNFPA with other major international funding organisations?

9. Interviewee Recommendations

## Gender Questions for Policy Level Interviews

Name of

Interviewee: .....

Position: .....

Institution/Organisation: .....

Interviewee: .....

Stakeholder

Introduction:

- a. Introduce yourself and the purpose of the Interview: the objective of assessing experience and learning of the current program cycle with the view of proposing recommendations for the next CP cycle.
- b. Assure participants of the confidentiality of information exchange which will serve only for the purpose of analysis.

Relevance:

Questions:

- In your view, how appropriate is the GE programme within Somalia's efforts to advance gender equality and ending GBV or Violence against Women?
- To what extent do you think that the programme is aligned to national priorities and policies on GBV? Where possible, please indicate the policies you have in mind as you respond.
- In your view, to what extent is the UNFPA Gender programme dealing with prevention and service provision for survivors necessary and sufficient?
- What else could the Gender programme take on board to increase its relevance?

Effectiveness:

Questions:

- Has UNFPA's Gender programme contributed towards Somalia's efforts to advance gender equality and end GBV? To the extent possible, please provide the evidence to demonstrate this point.
- To what extent has UNFPA contributed towards profiling or raising GBV as a national issue?
- In your view are there any unintended impacts of this programme? If any please share your thoughts on what those are and who has been affected positively and negatively by them.

Efficiency:

Questions:

- Has UNFPA delivered GBV programming in a cost effective manner?

- Could the same quality of programming and results have been achieved with less investment of resources? Please qualify your answers where possible.

Sustainability:

Questions:

- To what extent are UNFPA supported programmes owned by the targeted communities?
- Are the UNFPA resource allocations both technical and financial sufficient to support meaningful community initiatives and results?

Value Addition:

- In your view could Somalia have made the same advances in promoting Gender Equality and ending GBV without UNFPA intervention?
- What is UNFPA's added value in the GE sector, especially GBV?

Coordination:

Questions:

- What other actors have been involved, how does this activity contribute to that of others?
- How would you describe your relations with UNFPA and the support provided by them?
- How would you describe your relations with other implementing partners?
- How would you describe your relations with the beneficiaries of the project?
- Do you think the channels of dialogue with other partners and beneficiaries are sufficient? In what ways could they be improved?
- Do you work with other UN agencies and/or can you say how well the activities are coordinated, overlapping?
- Are there gaps in the population needs which would not have been identified by the UN system, collectively?

Interviewee recommendation:

What are your recommendations to the CO as the strategic focus on GE and GBV for the next programme cycle?

GENDER COMPONENT

KII: Beneficiary

Name of

Interviewee: .....

Position: .....

Name of Interviewee Department: .....

Stakeholder Type: .....

Introduction:

- a. Introduce yourself and the purpose of the Interview: the objective of assessing experience and learning of the current program cycle with the view of proposing recommendations for the next CP cycle.
- b. Assure participants of the confidentiality of information exchange which will serve only for the purpose of analysis.

1. Relevance of the programme / project objectives for targeted groups,

Questions:

- How and how long have you been involved in this programme / project?
- How were you reached to take part in this programme /project?
- What do you think about the activities undertaken?

2. Relations with UNFPA and implementing partners (from public, private sector, NGOs)

Questions:

- Can you describe your relations with UNFPA? What is the extent of support, guidance, assistance provided by the agency?
- What do you think about the communication channels with UNFPA and other partners (if relevant)

3. Importance of the service provided

Questions:

- How would you describe the gains provided by this programme?
- Can you talk about the concrete impacts of these gains in your life? What kind of impacts?
- Do you face any difficulties / obstacles in benefiting from these gains? In what ways can they be improved

#### 4. Value Added

Question:

- What do you think about the role of UNFPA in this project? What are its strengths and weaknesses?

#### 5. Interviewee recommendations

### **POPULATION AND DEVELOPMENT**

Policy-Makers & Ministry Directors

Name of

Interviewee: .....

Position: .....

Name of Interviewee Department: .....

Stakeholder Type: .....

Introduction:

- a. Introduce yourself and the purpose of the Interview: the objective of assessing experience and learning of the current program cycle with the view of proposing recommendations for the next CP cycle.
- b. Assure participants of the confidentiality of information exchange which will serve only for the purpose of analysis.

1. Which activities in your institution (department/ministry) were supported by 2<sup>nd</sup> Country Programme?

- *PROBE*: Statistics Unit: data & report production
- *PROBE*: At Ministry: Population policy, integrating population and development

Relevance (Usefulness and value to stakeholders)

2. Do the objectives for programme interventions supported by the 2<sup>nd</sup> Country Programme:

- Address the needs of your organisation?
- The needs of the institutions and users you serve?

3. How has the programme supported the organisation (ministry) to address the needs of your clients (users of population and other data)?

- If not, what issues still need to be addressed?
- Are the data used in planning? Examples

4. To what extent are the results and benefits from the 2<sup>nd</sup> Country Programme 2011-2015 useful to users of population data?

5. How are UNFPA interventions integrated/ into related government programmes?

6. Is UNFPA responsive to government needs in the context of Somalia as a developing country?

Efficiency (Organisational and programmatic efficiency)

7. How appropriately and adequately are the available resources (funding and resources) used to carry out activities for the achievement of the outputs?
8. To what extent were the activities managed in a manner to ensure delivery of high quality outputs and best value for money?
9. Were agreed outputs delivered?
10. Was the programme approach, partner and stakeholder engagement appropriate for results delivery?
11. Which partnerships were more strategic in bringing about results and value-for money?
12. Were institutions adequately equipped to deliver on results-based management/ M& E for the CP?

Effectiveness (Degree of achievements of outputs and outcomes)

13. To what extent did the UNFPA CP contribute to the stated outcomes?
14. Are the outcomes a result of/attribution to CP interventions?
15. Were UNFPA interventions implemented at adequate scale to reach intended outcomes?
16. To what extent did the programme address the needs of the beneficiaries?
17. Were strategic information outputs such as Census Reports and other research reports used to inform policy/planning?
18. Are relevant population reports and demographic data used for planning?
19. What else should be done to make the programmes more effective?

Sustainability (Continuity of benefits after 2nd Country Programme)

20. Are UNFPA interventions integrated into departmental plans?
21. What are plans for sustainability within your organisation?
22. Does your institution have capacity to continue programme interventions without UNFPA or any donor support? If not, what kind of assistance will be required?
25. To what extent have the capacities been strengthened?

Interviewee Recommendations

26. Any recommendations on improving data use?

Thank you for your time and information