SOMALI RELIEF AND RECOVERY PROGRM-SRRP

Somaliland, Puntland, Galmudug and Jubbaland States of Somalia

Endline Assessment Report

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1 Introduction

Due to repeated climate shocks, continued conflict, and protracted displacement mean that Somalia remains one of the most prolonged humanitarian crises in the world. Over 4.2 million people, including 2.5 million children are estimated to need humanitarian assistance and protection in 2019. Significant displacement and destitution driven by the 2016/17 drought and protracted conflict have left more than 1.5 million people across Somalia facing acute food insecurity through June 2019 with 903,100 children under the age of five are likely to be malnourished in 2019 including 138,200 who are likely to be severely malnourished[1].

Women and children like in many other instances of conflicts represented the majority of the 2.6 million people displaced across the country; including over 1 million who were displaced in 2018 alone. Discrimination and exclusion of women, girls, and socially marginalized groups persist; worsened the level of acute humanitarian needs. An estimated 525,000 people in Somaliland, Puntland and Galmudug regions are in IPC Phases 3 and 4. Displaced women and girls, in particular, are at risk of domestic violence as well as rape and sexual abuse by armed civilians, government forces, and militia members.

As a result, the call for humanitarian assistance to drought-affected communities by the Somaliland, Puntland and Galmudug administrations between February and April 2019 bore some fruits. In response to the said needs and based on key needs identified by CARE assessments and corroborated by reports from other agencies, the Somalia Relief and Recovery Program (SRRP) came in place.

The Somalia Relief and Recovery Project-SRRP main goal was to address the most urgent and basic needs of drought affected communities in Bari, Galgaduud, Lower Juba, Mudug, Sanaag, Hiraan, and Sool regions that have been severely affected by the recurrent drought crisis. In particular, the project aimed to improve access to safe water and hygiene to drought-affected communities, provide temporary employment opportunities, and delivered treatment services for acutely malnourished children and pregnant and lactating women, provide basic health services, and protection services. The project also aimed at improving coordination through Somalia NGO consortium to concert and coordinate efforts to adequately address the recurrent humanitarian challenges in Somalia.

The SRRP 12-month project was built on the achievements of the 2018 – 2019 USAID/OFDA-funded program. The project specifically targeted IDPs, pastoralists, returnees and vulnerable groups of host communities prioritizing women-headed households, persons living with disability, the elderly, and adolescent girls. USAID/OFDA-funded activities were complemented with funding from USAID/FFP, GAC, UNOCHA, WFP and UNICEF in the program areas.

At the inception of the program, a baseline study was carried out to establish the baseline indicators for measurement across the project period and at closure. The baseline findings and the recommendations (we believe) established benchmarks against which we can track shifts in program indicators as a result of the various project activities implemented by the program over the last one year. The purpose of the endline evaluation is therefore to check how the indicators measured at baseline have evolved over the last year, due to impact of programming and its activities.

Project Goal and objectives

The project aimed at improving the humanitarian situation in Bari, Galgaduud, Lower Juba, Mudug, Sool, and Sanaag regions by meeting key priority needs including livelihood support, improving access to quality WaSH, Nutrition, Health, and Protection services.
Specific objectives of the project included:

[1] 2018 Somalia Post Deyr Seasonal Food Security and Nutrition Assessment Key Findings – FSNAU-FEWSNET, February 2019

Objective 1: **ERMS**
•To increase income for disaster-affected households to meet basic needs
Objective 2: **Health**
•To improve health status amongst children under 5 and pregnant and lactating women through provision of quality health services and contribute to the reduction of maternal and childhood morbidity and mortality .
Objective 3: **Coordination**
•The Somalia NGO Consortium (SNC) plays an increasingly effective role in coordination for humanitarian aid actors
Objective 4: **Nutrition**
•To improve the nutritional status and prevent malnutrition- related morbidity and mortality of vulnerable children under five years and pregnant and lactating woman
Objective 5: **Protection**
•To enhance the prevention and mitigation of protection risks and improve quality of care offered to GBV survivors
Objective 6: **WASH**
•To increase equitable access to safe and affordable drinking water and hygiene services for all and prevent waterborne-related diseases

Endline Assessment Objectives

SRRP project was successfully implemented and closed by the end of the project period hence the need for an external endline evaluation of this program. The endline evaluation goal and objectives included;

Evaluation objective

- The overall objective of the evaluation is to assess the performance of the project against its targets and find out the key best practices documented or learnt over the course of the implementation.

Specific objectives

- Assess relevance, effectiveness, efficiency, sustainability, and identify and document lessons learned, best practices, gaps and recommendations.
- Establish areas of synergy between the SRRP with other projects funded by USAID and other donors in those sectors in view of consolidating SRRP humanitarian portfolio.

Through measurement and comparison with baseline data on the key variables of interest in the specific focus areas on health, WaSH, economic recovery and market systems, nutrition, protection and humanitarian coordination and information management, this endline evaluation will identify key best practices learnt from the SRRP project for better future programming and scaleup.

Scope of work

The endline evaluation involved carrying out literature reviews, conducting household interviews, key informant interviews (KIIs) as well as focus group discussions (FGDs) with project beneficiaries and stakeholders in the program regions of Bari, Galgaduud, Sool, Sanaag, Bay, Banadir, Mudug and Lower Juba regions.

2 Endline Methodology

The endline evaluation utilized a multipronged approach combining desk-review, qualitative and quantitative methods to collect and analyze the data. Specifically, the study relied on qualitative approach, which utilized Key Informant Interviews (KIIs) and Focus Group Discussions (FGDs) and quantitative approach whose data was collected using individual face-to-face interviews and whose data was triangulated to write this endline findings report. The data collection was carried out using face-to-face household interviews with project beneficiaries, project staff and project stakeholders (partner NGOs, implementing partners, Village Relief Committees (VRCs), water management agencies, NGO consortium, relevant ministry representatives) from the seven project regions of Bari, Galgaduud, Lower Juba, Mudug, Sool, and Sanaag. The survey data was then analysed thematically to highlight the findings for reporting.

Desk review

A review of relevant project documents was carried out to inform the design of data collection tools and analysis. To provide an overview of the project, relevant literature was collected, organized and synthesized for this endline assessment. The reviewed literature additionally, provided a basis and background for analysis thus allowing for triangulation of the evaluation methodologies. The programme documents included project quarterly reports, the project logframe, baseline survey report and related previous studies. CARE provided these project documents while other related documents were accessed online from credible websites.

Qualitative data collection

For the qualitative approach, KIIs and FGDs were carried out across the project districts with project beneficiaries, project staff and stakeholders. Qualitative data collection involves collective descriptive information that can be analyzed to give a detailed discussion with regard to the subject matter. This process was carried out using discussion guides to guide the entire process. The discussion guides were developed after a thorough desk review to ensure that all evaluation parameters were captured. The qualitative method was used to access the beneficiaries' and stakeholders' experience, involvement, awareness and utilisation of the project services.

Key Informant Interviews and Focus Group Discussions

Sampling for the qualitative (FGDs, and KIIs) respondents was done using purposive sampling method where respondents are identified based on their standing in the target communities, understanding of the project and community needs and local context so as to provide the best information.

The KIIs selected respondents included SRRP project staff, partners, Village Relief Committees (VRCs), Government officials. FGDs on the other hand, were administered with project beneficiaries to capture wide range information on the different project sectors. Discussions during these FGD's touched on the needs of the community regarding access to health, access to food, access to safe water, access protection services and income opportunities before, during and after the SRRP project. Participants of FGDs were purposively selected from target beneficiary populations and the sessions composed of 8-12 respondents and lasted a maximum of 90 minutes. The KIIs and FGDs data was captured using digital recording devices as well as comprehensive notes taken for use in transcripts development, analysis and reporting.

Quantitative Data Collection

Household Survey method and Sampling

The quantitative data collection for this endline evaluation was administered to project beneficiaries. The sample size for the beneficiaries was determined using Yamane formula (1967:886) n=M/1+M(e)2 where 95% confidence interval and P=.5 were assumed, in the formular *n* is the sample size, *M* is the population

size and e is the level of precision. The total sample per sector were distributed in proportion to population per target district from which villages were sampled.

Qualitative Sampling

The qualitative respondents for the qualitative approach were identified using purposive method of selection and were distributed to the two methods as shown below. A total of 24 KIIs and 20 FGDs with the target respondents were conducted. The sample distribution for these components were as shown below.

KII Sampled respondents

Description	Number
SRRP Project team	3
NGO Consortium	1
Partners/CSOs	2
Relevant stakeholders (Government Ministries, VRCs, WASH) committees	18
Total	**24**

FGDs Sampled respondents

Description	Number
Health	3
Nutrition &Mothers and Care givers of U5	3
WASH	7
Protection	3
ERMS	4
Total	**20**

Quantitative Sampling procedure and respondent selection

A multistage sampling method was used to select beneficiary household for the endline data collection. In the first stage, regions were grouped based on implemented project, next villages were purposively selected with support from project staff and within each village specific number of households were chosen randomly and interviewed. Households were selected using random walks and only respondents who agreed to participate in the survey voluntarily after understanding survey objectives were interviewed. A total sample of 1821 (as shown below) respondents was drawn for the quantitative survey and it targeted both male and female respondents and considered all sectors of the society including refugees, internally displaced persons (IDPs) and host communities. Data was collected using smartphones/tablets and submitted through Online Data Kit (ODK-ONA).

Table 1: Quantitative Sample Distribution

Region	District	n	ERMS	Health	Nutrition	Protection	WASH
Sool	Laascanood	224	**	101	50	72	51
	Caynabo	187	**	97	47	60	30
Sanaag	Erigavo	155	**	73	41	51	30

	Elafwayn	124	**	60	19	39	25
	Badhan	70	**	70	30	25	40
	Bosaso	290	**		97	134	91
	Qardho	99	55	**	**	**	45
Bari	Iskushuban	93	74	**	**	**	25
Mudug	Jariiban	131	131	**	**	**	
	Abudwak	71	61	**	**	**	30
Galguduud	Dhusamareeb	119	69	**	**	**	50
Hiraan	Beletweyn	150	**	**	**	**	150
Lower Juba	Afmadow	108	**	**	109		
	Total	1821	**390**	**401**	**393**	**381**	**567**

** Districts and sectors not targeted by CARE project

A summary of the overall approach is described in the table below;

Table 2. Sampling methodology Summary

Sample Size	**25 KIIs, 20 FGDs & 1821 Individual Quant Interviews**
Sampling Methodology	Purposive/random selection of respondents who fit into the selection criteria provided
Population Universe	Adults aged 18+ (project beneficiaries - women, youth, minority groups -IDPs and refugees), stakeholders, partners and implementing partners from the thirteen districts
Data Collection Methodology	Individual quantitative interviews, Key Informant Interviews and Focus Group Discussions
Areas of Study	Laascanood, Caynabo, Erigavo, Elafwayn, Badhan, Bosaso, Qardho, Iskushuban, Jariiban, Abudwak, Dhusamareeb, Balatwayn and Afmadow
Interview Language	Somali and English (some project staff)

Questionnaire Scripting and Translation

The household questionnaire was programmed into an online server (ONA) KOBO Collect; data was collected using Open Data Kit (ODK) software which allowed for data collection offline. The questionnaire was translated into Somali for ease of administration and understanding. Enumerators who speak the local Somali language administered the questionnaire with the selected respondents. The teams were supervised by consultants and the assigned field supervisor.

Training

The teams were supervised closely by the consultant and assigned field supervisors. In each team, the enumerators were taken through a 2-day training session prior to starting data collection. All the trainings adhered to the COVID-19 protocols by observing social distance and wearing of facemasks. During the training, enumerators were given a detailed review of the data collection tools, survey objectives, approach and the standard fieldwork procedures, which were to be implemented during fieldwork. After the training, the enumerators were taken through a pre-test/piloting session. The aim was to test for accuracy and the coherence of the tool, the logic programming, proper translation of the

tools, the timing for tool administration and completion, clarity of the questions and understanding for beneficiaries. During the pilot exercise, the consultant and assigned field supervisors assessed their level of understanding of the survey tool, and any other issues that may hamper effective administration of the interviews using the survey questionnaire. The pilot exercise also provided an opportunity for the field enumerators to familiarise and internalise the study tools for ease of administration. After the pilot, a de-brief session was held where the field teams provided feedback on the pilot, any insights, challenges or questions that might have been raised by pilot respondents. Feedback provided by the enumerators allowed for tools review and finalisation for the main data collection. All tools used in the evaluation was approved and signed off for use by the CARE evaluation team.

Data Collection

Once all tools were signed off, the enumerators were deployed for data collection. Given the mixed-method approach for this endline, the data collection for both qualitative and quantitative methods was carried out concurrently and individually by our trained and seasoned enumerators and moderators. The enumeration team comprised CARE's roster enumerators and staff who well understood the evaluation locations and beneficiaries. The data collection exercise took a duration of two weeks after the target sample was achieved.

The quantitative interviews were carried out using questionnaires scripted onto the mobile platform while the qualitative KIIs and FGDs were carried out using discussion guides. For qualitative interviews, moderators asked the questions and probed for further information in instances when clarifications were needed. This ensured that the data collected was detailed enough, relevant and that no information was left out (Quantitative questionnaire, KIIs and FGDs discussion guides are annexed in this report).

Data analysis

Once the qualitative data was collected, the audio recordings were transcribed in verbatim and summaries of each transcript created for use in writing the report. The evaluation primarily adopted the OECD DAC criteria, which evaluates humanitarian and development work based on five key parameters to measure results. This endline evaluation therefore assessed this project against their quality, relevance and effectiveness. On the other hand, once the quantitative data was collected, they were cleaned, processed and analyzed to provide descriptive analysis in forms of frequency tables, percentages and cross-tabulation of variables disaggregated by gender, age, social status and by region. The quantitative and qualitative data were analysed using SPSS and content analysis respectively to write this finding report.

In drawing correlation between the data from the three approaches (desk review, quantitative and qualitative methods), triangulation of data was done and a detailed thematic analysis of the project has been given in this report and additional input has been made on the quality component to measure community perspectives, based on Chianca[2]. Additionally, under relevance and effectiveness criteria the investment has been assessed in terms of the stated project objectives. Quality of responsiveness and adaptability of the interventions, considering the cultural and contextual challenges was reviewed alongside stakeholder participation in programme activities. In addition to the relevance component, the assessment set out to measure programme alignment with community priorities, and consistency with overall goals and objectives and prospects for sustainability of the interventions. The endline evaluation analysis has been done systematically and thematically focusing on the project goals and objectives.

The analyses of the endline findings were guided by the following research questions;

Guiding Research Questions

[2] * Chianca, T. 2008. The OECD/DAC Criteria for International Development Evaluations: An Assessment and Ideas for Improvement. Journal of Multidisciplinary Evaluation, Volume 5, Number 9

Quality

1) To what extent was the project fully responsive and adaptive in the face of challenges?
2) To what extent did all relevant sub-groups have the appropriate opportunity to participate in programme decisions and activities (dialogue, decision-making and management)?
3) To what extent did the project activities reflect conflict sensitivity?

Relevance

1) To what extent were the programme objectives aligned with the priorities of community?
2) To what extent was the investment consistent with the overall goal and objectives (alignment with strategy and logframe objectives)?

Effectiveness

1) To what extent did the project achieve its intended objectives and reaches the proposed target beneficiaries?
2) To what extent is the project fully sustainable (including high level of community ownership, clear long-term planning and buy-in, continued resources to sustain itself)?
3) Overall, what were the major factors influencing success and major challenges to achieving the project's objectives?

Ethical Considerations

The endline assessment adhered to a specific set of codes of conduct for the researchers as well as ethical obligations to assessment respondents in relation to data collection, data management, storage and usage. Strategies that were deployed in this regard included:

- Survey respondents were assured of the confidentiality of all data collected from them and further that the data will be used exclusively for the assessment process. Their participation was on voluntary basis, no personal information was collected to ensure anonymity. These were clearly stated in the consent and information section of all tools and were clearly read to the survey respondents.
- Further, the assessment tools did not contain fields that capture personal data that could be used to identify respondents.
- Respondent participation in assessment was purely voluntary and based on their consent to participate without coercion. Participants who did not want to be interviewed were given opt out options.
- Participation was based on informed consent, which entailed providing survey respondents with full information about the assessment and its approach, their role in the assessment and attendant personal benefits, both directly and indirectly.
- The interactions between the researchers and the respondents as well as among the survey respondents themselves were based on mutual respect and trust.
- All data protection principles for CARE were adhered to throughout this assessment.
- Safeguards to ensure confidentiality during data processing did entail not making or implying precise references to survey respondents or statements made by particular survey respondents. Further, data from KIIs and FGDs has been processed as a whole and in the absence of personal information to ensure anonymity of information gathered.
- In summary, a shared responsibility with regard to ethical conduct amongst the evaluators and the survey respondents was of essence to ensure high quality work guided by professional standards and ethical and moral principles to be achieved. Ethical obligations of the evaluators included independence thus free of bias; impartiality at all stages of the assessment; credibility thus based on reliable data and observations; avoidance of conflict of interest to ensure that the credibility of the assessment process and output is not undermined, honesty and integrity and accountability.
- Obligations to the respondents included respect for dignity and diversity, acknowledgement of rights of respondents, confidentiality and avoidance of harm.
- Lastly, during data processing and reporting, the obligations of the evaluators included ensuring accuracy, completeness and reliability of the data processed as well as the assessment reports and presentations; transparency as far as all the assessment processes are concerned; ensuring accessibility of the assessment report to all formal parties; and reporting of any omissions, wrongdoing and unethical conduct.
- **Do No Harm principle**: During the endline assessment, the team obeyed and adhered to Do No Harm policy and other operational policies in the project target districts. All field enumerators and supervisors are required to conduct data collection in an ethical manner to avoid inadvertent harm to respondents.
- Due to the COVID-19 pandemic, the research team exercised all the WHO requirements to ensure their safety and that of the study population. These included;

- Social distancing during interviews,
- Handwashing points installed at the entry of the FGD rooms/venues,
- Provision of hand sanitizers to the survey teams as well as the FGD respondents,
- Wearing of protective masks at all times,
- Limiting the number of respondents held in an FGD per session,
- Ensuring that all the rooms/venues utilised for interviews were properly aerated (open windows)

Limitations of the Endline Evaluation

- Some respondents were unavailable/refused to participate in the survey and the survey team had to conduct respondents' call-backs and some respondent replacements as well as additional respondents to cover for dropouts;
- A qualitative method has limitations due to its design. Findings are merely opinions and could be subjective due to different situations under which they are discussed. They should therefore be interpreted with caution and especially where they are grossly over-stated.
- The COVID-9 pandemic and the social distancing protocols as per WHO regulations limited the number of respondents that could be held in a room during FGDs as well as the number of sessions conducted.

3 Endline evaluation findings

The success of humanitarian and development projects is determined by their relevance, efficiency, fulfilment and alignment of its objectives to community needs as well as structures put in place to ensure sustainability. This endline evaluation of the CARE Somalia Relief and Recovery Program (SRRP) Project was therefore carried out to assess its outcomes, successes and lessons learned for scale up and/or for future programming. This report therefore presents a detailed analysis of evaluation findings at intervention level and has been organized thematically detailing the project's key components including quality, relevance and effectiveness of the programme.

This analysis report of the SRRP project has been developed based on data from both qualitative and quantitative sources, which have been analysed and triangulated based on generated themes to write this endline evaluation report. The quantitative data has been analysed using descriptive statistics while the data from KIIs and FGDs have been analysed thematically. The findings have further been presented as per the sectors and regions of the study that were covered by the SRRP project. Detailed findings including respondents' demographic information, findings on key themes as quality, relevance, effectiveness, lessons learned as well as conclusions and proposed recommendations. The endline evaluation tools are presented in annex section of this report.

3.1 Demographic Information

The endline evaluation indicates that a total of 1821 respondents were sampled and successfully interviewed for the quantitative method in this survey. The surveyed respondents included 38% IDPs, 55% host community and 5% being returnees. In terms of gender of the respondents, a majority of respondents interviewed were females (68%) and were mostly heads of households (59%), as compared to their males (32%) counterparts. A larger proportion of survey participants were aged between 18-40 years (73%): 18-24 (16%), 25-30 (26%), 31-35 (16%) and 36-40 (15%) representing the productive age group in the community within these regions focused on to evaluate the impact of the implemented project.

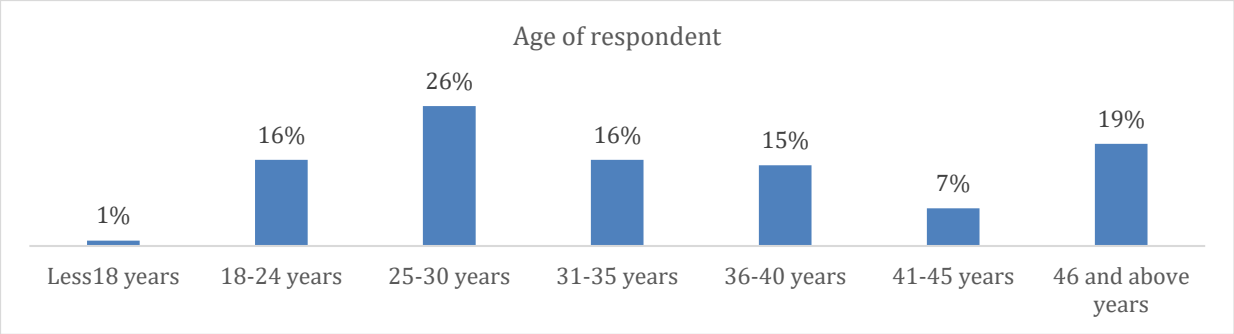


Figure 1: Respondents' information

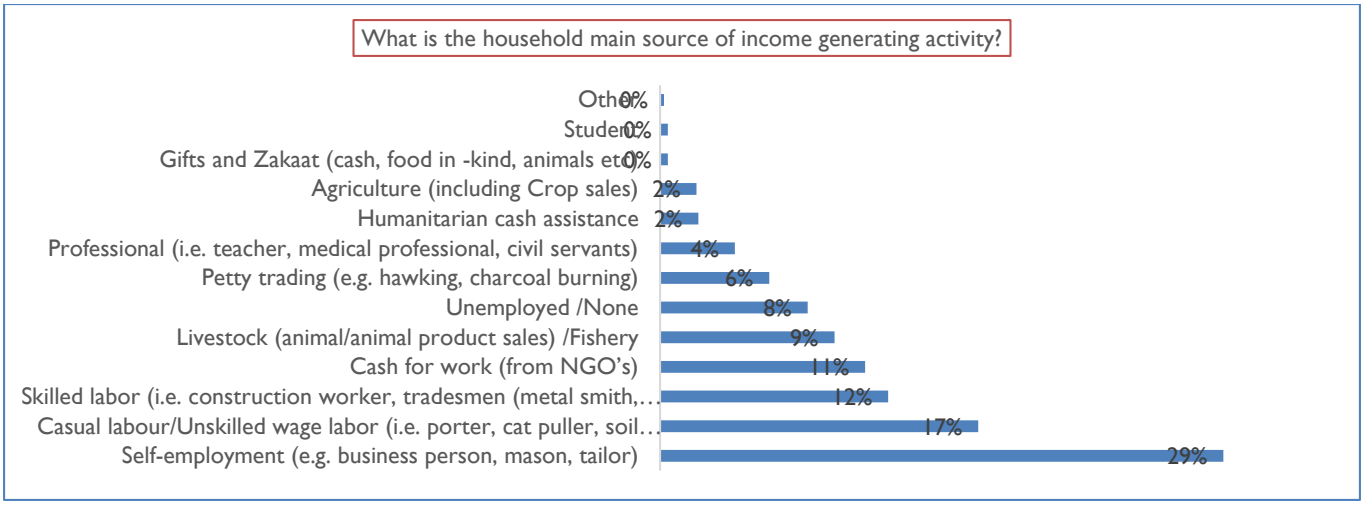
Household Information

At the household level, a majority of respondents interviewed were females (68%) who were mostly heads of their households (59%), the rest of respondents interviewed were males 32%. Of the respondents interviewed who were not heads of households were mostly spouses (70%) while the rest were children of the household heads (6%), parent (17%) sibling (3%) or a relative (4%) of household head. In terms of education levels, it emerged from the endline findings that across the examined regions, a majority of the respondents had no education (52%) while those who had attended any schooling many had been to madrassa (29%) compared to those who had primary education (12%), secondary education (6%) or tertiary education (1%). A similar distribution of proportion was observed between male and females interviewed where overall majority had no education and many with education had attended madrassa, and those with primary education were more than those with secondary education or tertiary education.

On average, and similar to the SDHS report (2020) as well as the World Bank estimates[3], every family had 6 family members (with a standard difference of -/+3). The common livelihood engagement across the surveyed locations was self-employment (29%). The endline findings indicate an increase in self-employment as compared to the baseline (23%). Although the endline findings also indicate that other common but not so regular sources of livelihoods were casual labour (17%), skilled labour (12%), cash for work (11%) and livestock/fishery keeping (9%) there is a decrease in engagement in these activities as compared to baseline; cash for work (baseline (22%): endline (11%), skilled labour baseline (16%): endline (12%). Unemployment rate among the respondents was low (8%).

Figure 2: Main source of income generating activity

[3] Directorate of National Statistics, Federal Government of Somalia. The Somali Health and Demographic Survey 2020



3.2 Relevance of SRRP Programme

Alignment to community needs and priorities and Consistency with SRRP's overall goal and objectives

- The project adopted an integrated approach in its design thus very relevant in addressing the various needs of the community members. The ERMS sector design was thus relevant to community needs and priorities. The Cash for Work (CfW) intervention supported the communities' needs in terms of their household income and strengthening their resilience to future shocks and prevent relapse.
- The protection activities provided safe spaces for survivors of rape and GBV;
- It is evident that there was an increase in knowledge and understanding of protection issues;
- The programme team was fully aware of community needs and priorities and this was attributed to the stakeholder participation, engagement and constant consultations.
- The programme strongly consistent with the SRRP project overall goal and objectives.

3.2.1 Alignment to community priorities and consistency with the project goal

The SRRP project was a continuation of the Drought Response and Recovery Project-DRPS that was implemented in September 2018 to August 2019. This project was built on the success gained through it's indicative that people felt safe than before, understood the referral pathways and could easily seek help and redress if faced by incidences that violated their rights that project which mainly targeted the internally displaced persons (IDPs) and the host communities in the targeted regions and districts.

The endline findings indicate that the project aligned with communities' needs, gaps and priorities and that they were engaged right from the design and inception stages of the project. Qualitative results indicate that a community needs assessment was conducted by CARE in addition to other joint assessments and other reports conducted. The needs assessment alongside the FSNAU data[4] established that there was severe food shortage in the targeted areas, particularly Mudug and Galgaduud regions thus targeting them for the ERMS components.

> *"…so we can say the design of the project was actually from the community consultations…the gaps were identified by the community…," Project Team, KII*

It was further alluded that a needs assessment was also done on the water infrastructures in the different areas in consultation with the relevant government authorities in Somaliland, Puntland and in Galmudug. The assessment found out that there was a critical need to rehabilitate water points so as to enable people and animals access enough water.

[4] Post Deyr 2018 Technical Release-FSNAU-FEWSNET, February 2019

Additionally, the project identified gaps in the nutrition and health services sectors based on findings from other previous projects. The project further established that a significant number of non-governmental organisations (NGOs) had withdrawn their services in certain areas and that there were very high malnutrition rates among pregnant women and lactating women and children under five (U5). The SRRP project also utilised the service delivery approach as opposed to just awareness creation on protection services. This was further informed by the reality at the time that there was a sharp increase in protection issues in the targeted locations [5]. The project managed clinical cases of rape, referrals as well as provision of incentives for gender-based violence (GBV) survivors.

> *"…..we selected the most critical areas that needed critical support at the time," Partner, KII*

> *"…this project is most relevant for the community priority needs in terms nutrition foods, nutrition messaging including breast feeding, child spacing and immunization of children as well health facility has been provided all basic necessary services," Mother/caregiver for U5 FGD respondent, Sanaag*

In terms of stakeholder participation, the SRRP project consulted with the community and relevant government authorities to discuss what critical areas of support in the sectors of water, health, nutrition and protection.

> *"……the project was based on a needs assessment carried out in various homes and targeting different areas and in response to the needs on the ground, we have actually designed the project," Partner, KII*
>
> *"…The project had different components but I am more informed about the protection sector. The project wasn't a long-term intervention, just started I think around Sept 2019, but it had a bigger impact in terms of protection of human rights during the times of emergency, protecting the vulnerable from all forms of violations. It is much needed," Government -MESAF KII, Sanaag*

In terms of complementarity, it emerged from the endline findings that the different sectors of the SRRP project as well as other related projects implemented by CARE complemented each other. The ERMS sector improved the income levels and purchasing power of households thus being able to access other needs such as health services, proper nutrition, clean water that is safe for drinking and handwashing among others. The rehabilitation of water boreholes benefited the entire community, as improved access to clean water means safe drinking and cooking water as well as the WaSH component of hygiene promotion that was conducted by hygiene volunteers.

The implemented project was relevant (87%) to many of the respondents needs (relevant 66% & slightly relevant 21% combined). Similar findings were also depicted by a majority of the qualitative respondents who also felt that the project was very relevant to the community's needs.

> *"….this project is most relevant for the community priorities needs in terms nutrition foods, nutrition messaging including breast feeding child spacing and immunization of children. As well as health facility has been provided all basic necessary services," Mother/caregiver for U5 Female FGD respondents, Carmale, Sanaag*

Further, a significant proportion (10%) deemed the interventions implemented not to be relevant to them. This could be attributed to the fact that some of the respondents were volunteer health workers who mentioned inadequate work spaces as well as basic facilities such as toilets/latrines. Other needs that were mentioned to be very critical and that should have been addressed in the project is access to some locations which were said to still face challenges in accessing healthcare services.

> *"…I am one of the health workers but we are still working as voluntary base together with another lady. We do give awareness about the children/infants' health. We do not have good working space. There is no toilets and fence around this place. Now we have water in the tank," FGD respondents, Erigavo, Somaliland.*

> *"…what we really want you to do for us is to help us get an Ambulance to support patients from far areas," FGD respondents, Erigavo, Somaliland.*

Table 3:To what extent were the interventions relevant to your needs and priorities

[5] Ibid

To what extent were the interventions relevant to your needs and priorities?	Sool (n=411)	Sanaag (n=349)	Bari (n=482)	Mudug (n=131)	Galgaduud (n=190)	Hiraan (n=150)	Lower Juba (n=108)	Overall (n=1821)
Not relevant at all	3%	9%	7%	74%	0.5%			10%
Slightly relevant	39%	12%	21.8%	22.1%		19.3%	9.3%	20.7%
Relevant	55%	69.1%	69.3%	2.3%	99.5%	74.0%	90.7%	66.1%
don't know	2%	10.0%	1.7%	1.5%		6.7%		3.5%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

A majority 88% (slightly met – 27% & met 61% combined) of the respondents felt the implemented intervention had met their expectations especially /given that they were the project beneficiaries.

Table 4: To what extent did the intervention(s) meet your expectations as a beneficiary?

To what extent did the intervention(s) meet your expectations as a beneficiary?	Sool (n=411)	Sanaag (n=349)	Bari (n=482)	Mudug (n=131)	Galgaduud (n=190)	Hiraan (n=150)	Lower Juba (n=108)	Overall (n=1821)
Not met at all	6%	6%	8%	59%	0.5%	2%		9%
Slightly met	38%	15%	36%	36%	0.5%	27%	17%	27%
Met	55%	69%	54%	2%	97%	69%	83%	61%
don't know	1%	10%	2%	3%	2%	2%		3%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Across all the regions 90% (39% very satisfied and 51% satisfied) of the respondents expressed being satisfied with the service provided by the program so far.

Table 5: To what extent were you satisfied with the way the services were provided to you?

To what extent were you satisfied with the way the services were provided to you?	Sool (n=411)	Sanaag (n=349)	Bari (n=482)	Mudug (n=131)	Galguduud (n=190)	Hiraan (n=150)	Lower Juba (n=108)	Overall (n=1821)
Very Satisfied	48%	43%	23%	70%	55%	1%	44%	39%
Satisfied	46%	42%	59%	28%	45%	90%	50%	51%
Somewhat satisfied	5%	7%	17%	1%		7%	6%	8%
Not satisfied	1%	8%	2%	2%		2%		2%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

The SRRP project team on the other hand played a coordination role where they complemented other CARE projects through their integrated approach as well as coordinated other projects in the target areas alongside other agencies who implemented related projects. Additionally, other than partnering with other sectors and clusters for better coordination and better results in their respective projects, the project also collaborated with the Ministry of Health. The project therefore supported government health facilities in delivering services to the people through partnerships, technical support as well as secondment of CARE staff to government health facilities.

It was further added that the SRRP project was in line with the project goal and objectives as well as the overall goal of CARE global and CARE country office priorities. At global level, the Emergency Project is a key area that focussed on health, WaSH and nutrition sectors which are actually global goals for CARE. At country level, and considering that Somalia is a fragile country where frequent crises are experienced frequently, conflict crises and the emergency programmes are the priority areas for CARE in Somalia. CARE therefore responds to survivors of conflicts of other forms of crises to offer support and reprieve to allow them cope during such tough situations. The CARE Somalia country office strategy

for the emergency program has six sectors *(water, health, nutrition, protection and economic recovery/market systems)* out of which five of the sectors are also addressed by the SRRP project.

> *…….one of the positive things for this project was that it brings all the services to these people affected by the crisis in one place.," Project team, KII*

3.3 Effectiveness of Program Interventions

3.3.1 Sector 1: Economic Recovery and Market systems-ERMS

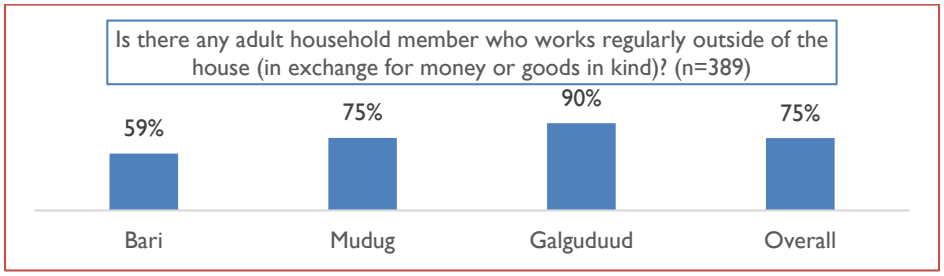
Objective: To increase income for disaster-affected households to meet basic needs

Attainment of Objectives:

- Findings indicate a strong achievement of the ERMS objective;
- The cash-based interventions led to significant improvement in income and communities' purchasing power, longer-term recovery and livelihood restoration, as well as protect complete depletion of household assets was achieved.

The Economic Recovery and Market Systems (ERMS) sector set out to increase income for disaster-affected households to meet basic needs in the target locations by providing temporary employment as one of the cash-based interventions to improve income and communities' purchasing power temporarily, support longer-term recovery and livelihood restoration, and protect complete depletion of household assets i.e., selling of assets and livestock[6]. This endline assessment targeted 3 regions of Bari, Mudug and Galgaduud. In these regions 75% of the households had an adult family member who regularly engaged in paying jobs outside of the house. Galgaduud (90%) recorded the highest number of adults who worked regularly outside of the house in exchange for money or goods as compared to Mudug (75%) and Bari (59%). The average income of the surveyed household in the past 6 months had been 194.64 USD (standard deviation 150.7 USD). This thus indicates an increase in household income in the last 12 months as compared to the baseline where the household average income was US$30 per month. The increase most probably alluded to be as a result of the increase in self-employment (29%) as compared to the baseline (23%).

Figure 3: Any adult household member who works regularly outside of the house



To ensure that community members participated in the programme design and implementation stages, the SRRP project identified project beneficiaries who benefitted from the various ERMS activities. Qualitative findings indicate that the cash assistance program was implemented at the most opportune time when the communities were in dire need of help so as to meet their daily basic needs especially food.

> *"….this has actually came in a time when people were in dire need to get it, it really impacted really improved the food security levels of the household and even the nutritional status in general." Project staff, KII*

[6] CARE SSRP Baseline report-Jan2020

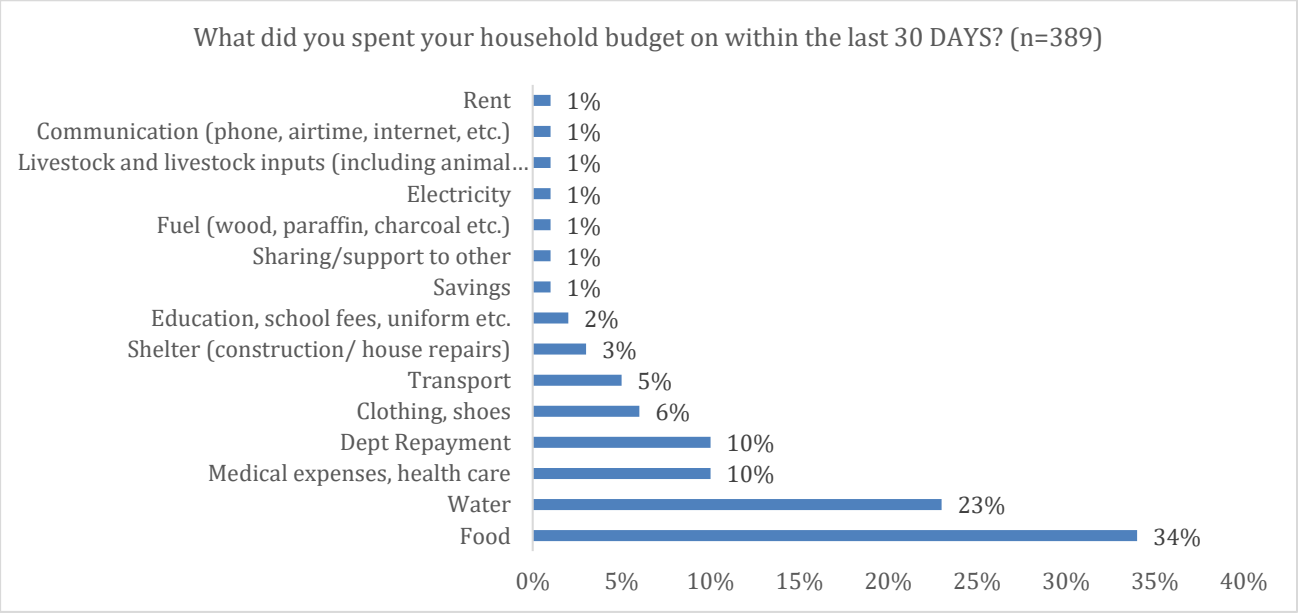
This finding is also alluded to by the quantitative respondents whom a majority (89%) of the household in the regions surveyed affirmed to be aware and had engaged in Cash Assistance Program (Bari 85%, Mudug 99% and Galgaduud 83%) in the past 12 months. When asked how long they had been in the Cash Assisted Program (21%) reported to have engaged in the program for 8 months, majority had been in the program for 3 months (70%). By regions, respondents had on average engaged in Cash Assisted Program in Bari for 4.6 months, Mudug for 47.1 months and Galgaduud for 3 months and received their pay per month which on average was 62.9 USD (Bari $72.84, Mudug $37.02 and Galgaduud $84). While these figures were quoted by the SRRP endline respondents as their monthly pay, and compared to the project reports and documents[7], there is a disparity in the figures. This could easily point to other similar cash programs implemented by other agencies other than CARE thus a possible mix-up on average monthly income.

Table 6: Household member engaged in Cash Assistance Program in the last 12 months

Have you/ anyone in your household engaged in Cash Assistance Program in the last 12 months?	Bari (n=128)	Mudug (n=131)	Galgaduud(n =130)	Overall (n=389)
Yes (n=347)	85%	99%	83%	89%
No	15%	1%	17%	11%
Total	**100%**	**100%**	**100%**	**100%**

Additionally, the findings indicate that the surveyed households had in the past one month heavily spent on food (34%) and water (23%). Some household expenditures were high in proportion in specific regions: Medical expenses/healthcare in Bari (15%) and debt repayment in Galgaduud (19%). Baseline findings indicate that a majority of households indicated that they spent 60% of their income on food. The endline therefore shows an increase in household spending on food. This could possibly indicate increased food prices, additional household members or changes in household food consumption habits or patterns as well as the impact of COVID-19 on the economy. The overall budget of households spending in the last 30 days was as shown in the figure below.

Figure 4: Household budget spending within the last 30 days

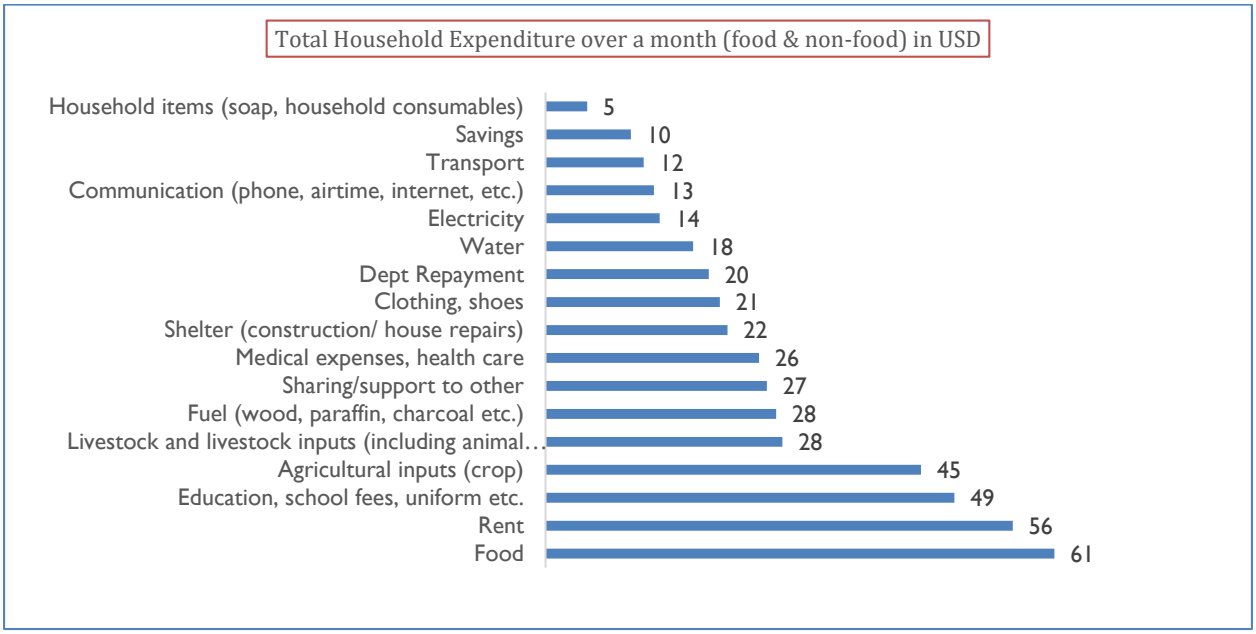


[7] SRRP technical narrative and project proposal indicate the following monthly earnings per regions: Sanaag $77, Sool $70, Mudug $79.8, Galgaduud $84 and Bari $77. This thus indicates a huge disparity in the figures from the endline.

Additionally, quantifying household expenditure by funds in USD, food was still the most spent on item where households had spent approximately **$61** out of the $194.6 average monthly income in the past one month to feed. The other household expense that took most of the funds were rent (56 USD), Education (49 USD) and Agricultural inputs (45 USD). Although most households had budgeted for water, funds directed towards water fell behind other household expenses such as rent, education, medical expenses and many other, this might be attributed to water scarcity in some areas where the SRRP project did not cover the water infrastructure components and hence need to budget for water for the household use. Generally, compared to the average household income of $194.6, the average total expenditure of the sampled household in Bari was 131.83 USD, in Mudug 84.13 USD and in Galgaduud 81 USD. In each month households received on average $62.9 cash assistance similar findings supported by Qualitative respondents who also indicated to having receive between $60 -70 USD per month. *"….They gave us some money every month so that we can buy foods to sustain our lives. They used to send us a cash payment of $60usd a month or $70 sometimes," ERMS FGD respondents, Bari.*

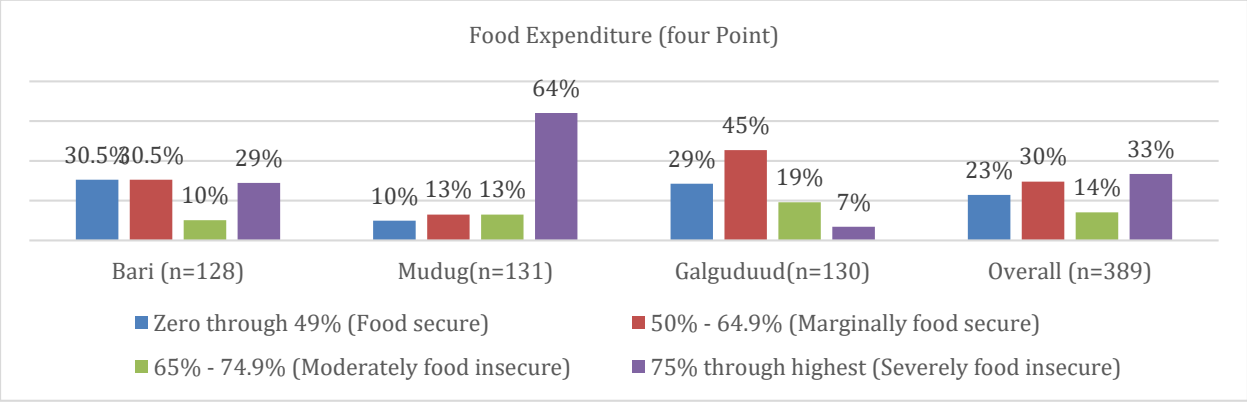
Baseline findings indicate 0$ amount of cash transferred to beneficiaries as CfW payments as compared to endline which indicates $62.9 per month.

Figure 5:Total Household Expenditure over a month (food & non-food) in USD



In terms of food security, and as compared to the baseline (52%) findings, (53%) (*food secure and marginally food secure combined)* of endline households indicated being food secure. This thus indicates a slight (1%) improvement in food security. Of the households that indicated that they were food insecure, most of those who were severely food insecure resided in Mudug (64%) region; an indication of increased food insecurity as compared to baseline (54%). In Bari region participant households were food secure (61%) (food secure (31%) & marginally food secure (31%) combined) as compared to baseline (43%). Additionally, most participant households in Galgaduud were marginally food secure (45%) as compared to baseline where 54% of the households were food insecure. Although Mudug indicates a worsened food insecurity at endline (64%) as compared to endline (54%), there is a general demonstration of an improvement in food security for a majority of the target regions.

Figure 6: Food expenditure



All the regions surveyed had observed an increase in household expenditure in the last one month, majority being in Mudug (98%) and Galgaduud (92 %) region, as for respondents in Bari region a third of the households had experienced no change in their expenditure while 23% had experienced a decrease in their household expenditure.

Table 7:Changes in Expenditure in the past one month

How has your household expenditure changed in the past one months?	Region			
	Bari	Mudug	Galgaduud	Total
Increased	46%	98%	92%	79%
Remained the same	31%	1%	8%	13%
Decreased	23%	1%		8%
Total	**100%**	**100%**	**100%**	**100%**

Food consumption score and Household Diet Diversity Score[8]

Approximately half of the households had acceptable food consumption score (49%) while 41% exhibited acceptable food consumption score. On the other hand, 10% of the households had poor food consumption score, most of them in Bari region (23%). A significant proportion of qualitative FGD respondents also supported these finding with data indicating that households took up to three meals per day while poor households only survived on one meal per day. Those that were mainly affected were the pastoralist communities who lost their livelihoods to drought in the past 12 months. *"….We are pastoralist community that depend on livestock for livelihood and during the droughts there are no pastures to feed thus leading to poor productivity , owners also experience food shortage because they used to feed on these animals for milk and meat," ERMS FGD respondents, Bari*

"…90% of the people get 2 meal or less per day. Some people sleep without eating food," ERMS FGD respondents, Puntland

Figure 7: Food consumption Score

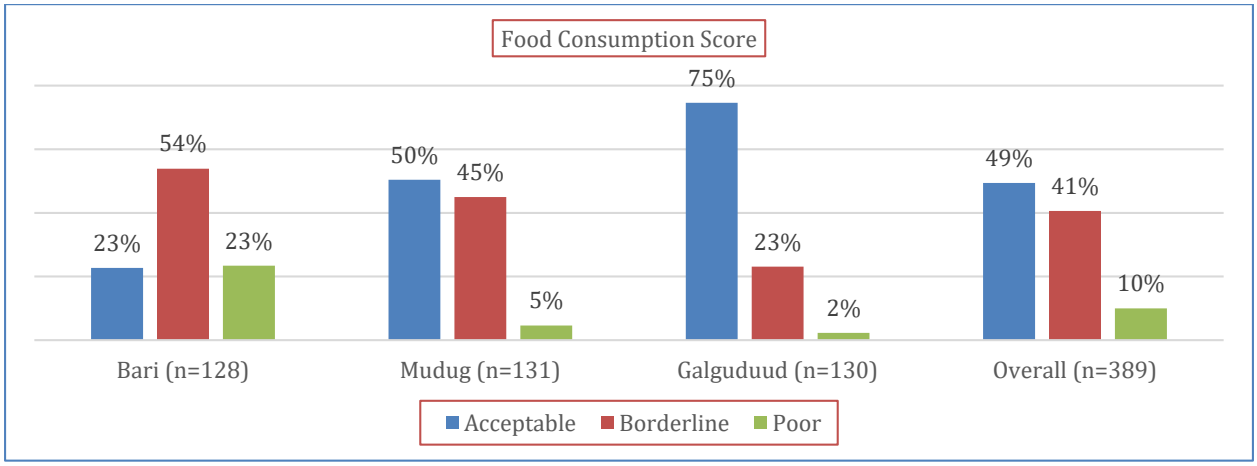
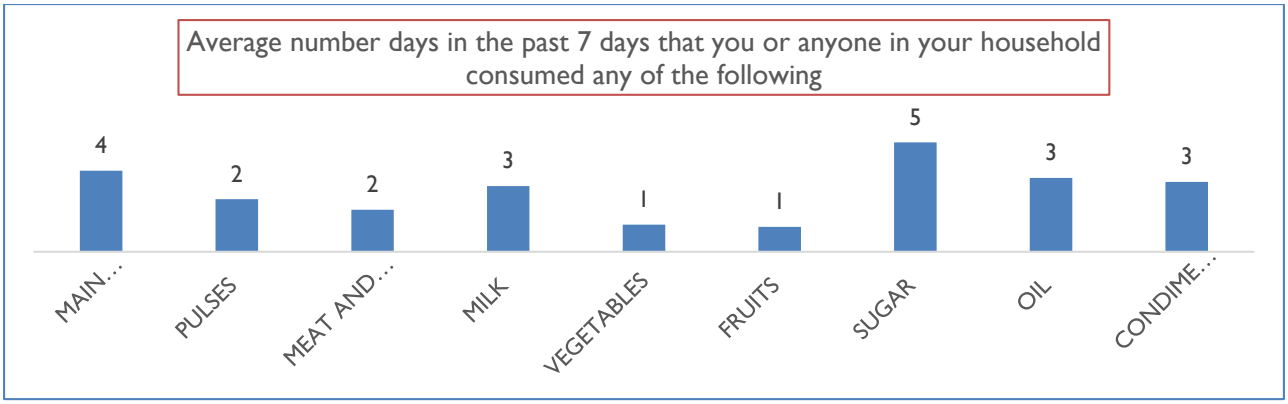


Figure 8: Specific food consumed in the last 7 days in your household

[8] MAIN STAPLES (Any millet, sorghum, bread, rice, or foods made from cereals (maize, rice, bur (injera, sabayad, rooti), sorghum, pasta) manioc or foods made from tubers and roots)
PULSES (Any food made with Legumes/Nuts, beans, lentils, cowpeas, peanuts, pigeon pea)
MEAT AND FISH (Any beef, lamb, goat, chicken, other birds, liver, kidney, heart or any organ meats, eggs or fish)
MILK (Any milk or milk products - Quantity must be more than half a cup per person, small quantity added to tea/coffee should not be counted)
VEGETABLES (Any vegetables and leaves – Spinach, cabbage, lettuce)
FRUITS (Any fruits - Mangoes, ripe bananas, apples, oranges, guava)
SUGAR (Any sugar or honey, cake, cookies, jam or other sugary drinks)
OIL (Any foods made with oil, fat or butter)
CONDIMENTS (Any other foods such as spices, tea or coffee)



There is significant relationship between food consumption score and household size ($X^2(28, N=389) =47.24$, $p=0.013$), region ($X^2(4, N=389) =85.93$, $p<0.001$) and household status ($X^2(6, N=389) =69.41$, $p<0.001$), demonstrating that larger household sizes depending on region were likely to exhibit lower FCS score hence poor FCS, also the vulnerable household (IDPS, returnees) were likely to exhibit lower FCS score than host community. Meanwhile, there is no significant relationship between sex of the household head and FCS.

Household Dietary Diversity Score

Surveyed households indicated that a majority of the regions scored a medium HDDS (55%) with about a third (32%) scoring high HDDS and 13% scoring low HDDS. Almost half of the surveyed households in Bari 47%) mostly could access varied diets as indicated by the high proportion of households with high Dietary Diversity Score, this was a different scenario in Galgaduud where access to food variety were at medium score (93%). In Mudug region surveyed households weighed heavily between high scores (45%) and medium scores (50 %) in being able to access diverse diet. The mean HDDS in Bari were 1.73, in Mudug 2.05 and in Galgaduud 2.88.

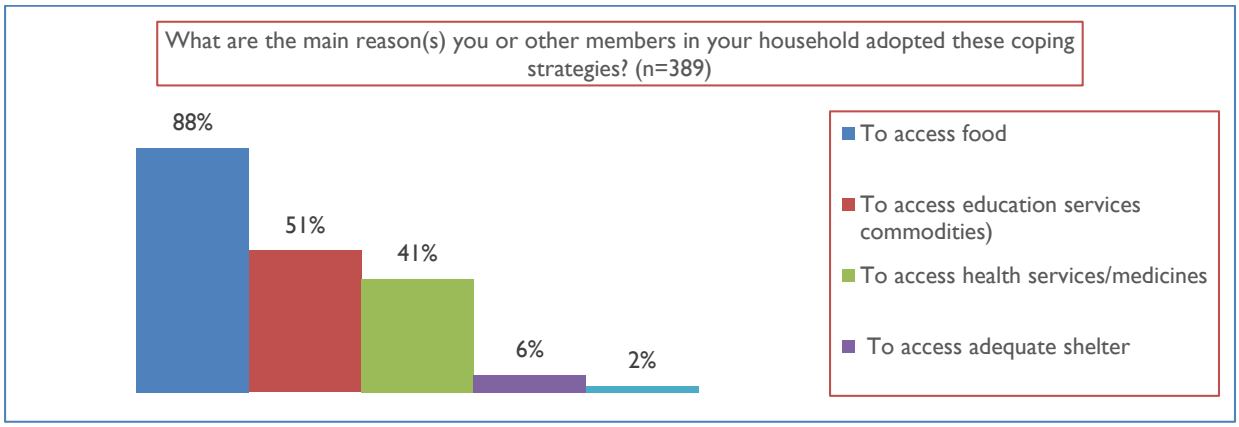
Table 8: Household Dietary Diversity Score

Household Dietary Diversity Score	Bari (n=128)	Mudug (n=131)	Galgaduud (n=130)	Overall (n=389)
High	47%	45%	5%	32%
Low	34%	5%	2%	13%
Medium	19%	50%	93%	55%
Total	**100%**	**100%**	**100%**	**100%**

Livelihood coping score

Livelihood coping strategy for households differed across the surveyed regions with more than half (55%) reporting a neutral score while another 17% and 15% scoring emergency and crisis LCS respectively. While households in Mudug (70%) and Galgaduud (89%) regions were mostly at a neutral level with regard to livelihood coping strategies, most households in Bari were scored in crisis coping strategies (44%). Whereas most of the strategies adopted by households were mostly used as a mechanism to access food (88%), quite a number adopted coping strategies for education (51.1%) and health services/medicine (41%) purpose.

Figure 9: Reason household adopted the coping strategies

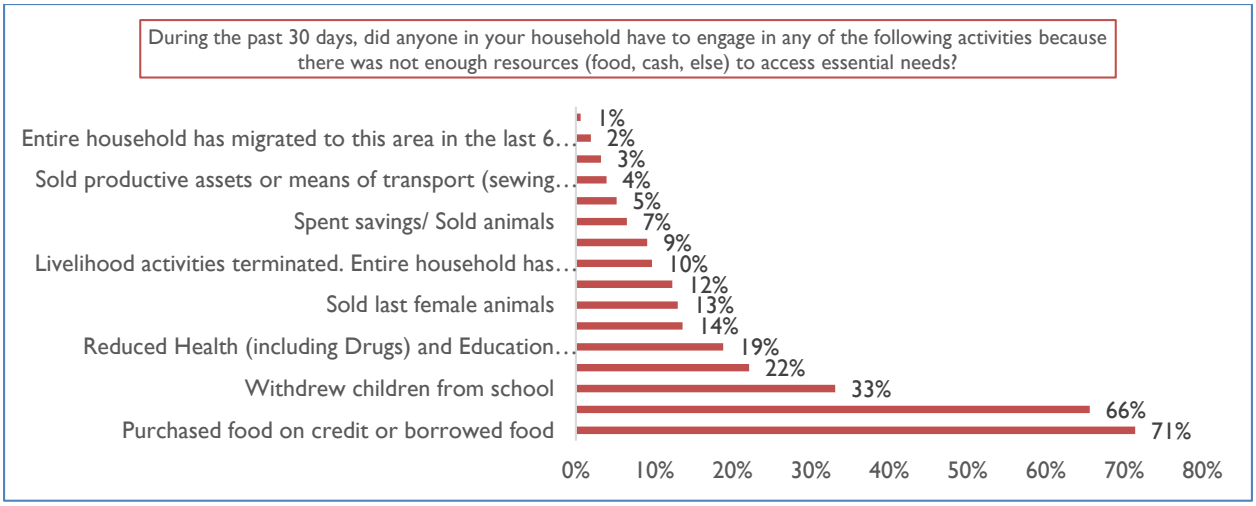


There is evidence of relationship between LCS and region ($X^2(6, N=389) = 236.7$, $p<0.001$), household size ($X^2(42, N=389) = 85.5$, $p<0^9.001$) and household status ($X^2(9, N=389) = 24.6$, $p=0.003$), implying for household size that the larger the household size the higher the need were to engage in copying strategies, and the vulnerable households (IDPs and returnees) were more likely to engage in copying strategies too.

Just as the baseline report shows that a majority of the surveyed households purchased water and food on credit thus increasing their debt levels, endline findings also paint a similar picture. A majority (71%) purchased food on credit or borrowed, some borrowed money (65%), another withdrew children from school (33%), and while others either sold land or last female livestock among others. While it is important to note that building the purchasing power and food security among the target beneficiaries was one of the key objectives to be addressed by the SRRP project, it is almost obvious to conclude that the project met the water needs of about a third of the target communities. This finding was also reported among qualitative FGD respondents who indicated that a number of coping mechanisms were adopted by community members including reduction of the number of meals in a data as well as selling of livestock which was also said to not accrue any profits. *"…The strategies adapted are to reduce number of meals eaten per day. If you used to eat three times a day, you lower it to twice a day. There are some people who eat only once a day. It depends on what you get," ERMS FGD respondents, Bari*. This therefore points to the need for scale-up or continuation of the intervention in the locations so as to ensure every targeted beneficiary's needs are met. The various coping strategies adopted by households are shown in the figure below.

Figure 10: Coping strategies adopted by households

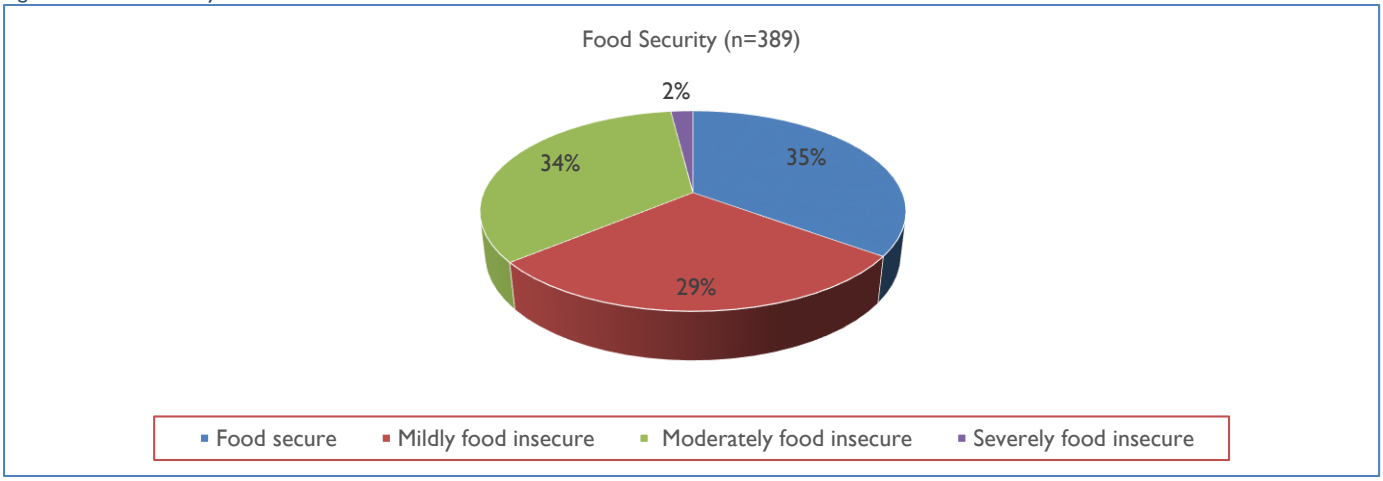
[9] (X2 (degrees of freedom, N = sample size) = chi-square statistic value, p = p value)



Respondents were asked how many days in the past one month their household had lacked food or any member of their family had gone hungry either at night or the whole day, rarely did such situation arise indicating that most households were food secure. The proportion of households that experienced severe food insecurity were 2%, greatly cutting back on meals often. This further indicates an improvement in food security in households as compared to baseline where 52% of the households had reported having experienced food shortage during the previous 12 months. These quantitative findings were also corroborated by the qualitative data where it was indicated the food security programme had resulted in improved food security levels of the household as well as the nutritional status in general.

> *"…..so this component has really impacted on the people although it was 3 months' time but it has helped," Project staff, KII*

Figure 11: Food security



Household Hunger Scale

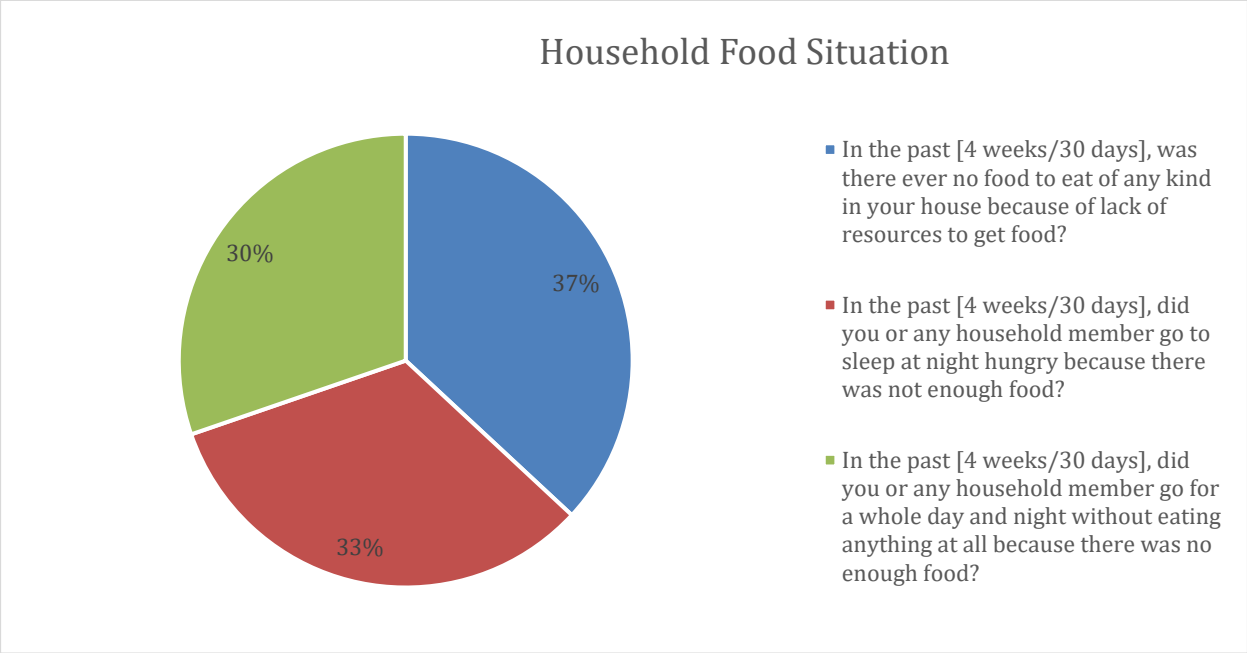
surveyed respondents were asked about their food sources. The endline findings indicated that food consumed in respondents' households were mostly purchased (76%) with other common means of getting food being borrowing (28%), producing their own (27%) or accessing NGOs food aid (16%). Galgaduud region had the highest number of households who purchased (78%) food as compared to Bari (37%) and Mudug (31%). Evidently, Bari (22%) and Mudug (22%) had a significant proportion of those who produced food on their own comparatively.

Table 9: Household hunger scale

The source of food consumed in the	Bari	Mudug	Galgaduud	Overall

/this household				
Produce own food	22%	22%	4%	27%
Purchase food	37%	31%	78%	76%
Borrowed	26%	22%	1%	28%
NGO food aid	8%	8%	17%	16%
Government food aid	0%	3%	0%	1%
Charity	0%	5%	0%	2%
Begging	0%	10%	0%	3%
Food for work	6%	0%	1%	5%

In assessing the household hunger scale (HHS), In the 4 weeks prior to the survey 37% of the households indicated there were situations where there was no food of any kind to eat in their household due to lack of resources, 33% of the households indicated that a household member had slept hungry because there was not enough to eat and 30% indicated that a household member had spent the whole day and night without meals because food was not enough. Overall, majority of the households were experiencing moderate level of hunger scale (99%) while 1% experienced severe hunger scale.



ERMS Key Takeout

- There was an increase in average household income at endline ($194.64 per month - (*standard deviation 150.7 USD)* in the past 6 months as compared to the baseline where the household average income was US$30 per month.
- Baseline findings indicate 0$ amount of cash transferred to beneficiaries as CfW payments as compared to endline which indicates $194.6 per month. These endline figures therefore shows that significant cash/in-kind voucher assistance was effected.
- In Bari region participant households were food secure (61%) as compared to baseline (43%) while in Galgaduud most participant households were marginally food secure (45%) as compared to baseline where 54% of the households were food insecure.

- The proportion of households that experienced severe food insecurity were 2%, greatly cutting back on meals often. This further indicates an improvement in food security in households as compared to baseline where 52% of the households had reported having experienced food shortage during the previous 12 months.

3.3.2 Sector 2. Health

Overall objective: To improve health status amongst children under 5 and pregnant and lactating women through provision of quality health services and contribute to the reduction of maternal and childhood morbidity and mortality

Attainment of Objectives

- Findings indicate a strong achievement of the health sector objective;
- Improved access to health services was recorded;
- Respondents received health messaging which impacted on their lives;
- There was a general feeling that child mortality and morbidity rates had reduced significantly.

According to the Somalia Humanitarian Response Plan 2019, 3 million people are in need of emergency health interventions in the country[10]. The ratio of primary healthcare facilities in Somalia to the population is quite low in Sool and Sanaag regions with 0.89 and 0.41 facilities /10,000[11] respectively, making health service availability scattered and fragmented. Compared to the national average, access to healthcare in Sool and Sanaag is very poor due to inadequate capacity of existing facilities and lack of basic medical supplies as well poor partner coverage. These factors have therefore resulted in poor service delivery to the people. Government health financing in Somalia is similarly low with most health facilities supported by NGOs. The SRRP project under the health component therefore stepped up to support communities access healthcare services especially children U5 and pregnant and lactating women. Its activity areas therefore were aligned to the specific health needs of the target categories.

In the past 12 months, more than four fifth of households in Sanaag and Sool have visited a health center in their region and when asked to rate the service they received, a majority perceived them to be excellent (62%) and good (34%). Very few households (5%) expressed dissatisfaction with quality of service they received from the health centers and this dissatisfaction was because the health facilities had lacked medical equipment, drugs, qualified staff and health staff attitude towards them. A similar finding was also established in an assessment carried out by CARE in February 2019 which found that poor functioning of health facilities (incompetent staff and unavailability of medical supplies and equipment), were a hindrance to accessing health services[12].

Table 10:Have you/member of your household visited a health center in the past 12 months?

Have you/member of your household visited a health center in the past 12 months?	Sool (n=198)	Sanaag (n=203)	Overall (n=401)
Yes	99.0%	84%	92%
No	1.0%	16%	8%
Total	**100%**	**100%**	**100%**

According to qualitative findings, an improvement in access to healthcare was reported among community members especially children U5 and pregnant and lactating mothers in the project target locations. This was said to be attributed to the SRRP project where the project took up support on critical roles in health facilities including management and direct service delivery such as general health,

[10] Somalia Humanitarian Response Plan 2019, OCHA Somalia
[11] Somalia Service Availability and Readiness Assessment (SARA) Survey 2016." World Health Organization (WHO), 2016. https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/somali_country_report_final_draft_30dec2016-.pdf
[12] [12] CARE Rapid Needs Assessment Report-Somaliland, Puntland, and Galmudug States, 6th- 28th February 2019

general consultation, outpatient health, maternal (post-natal and ante-natal services) as well as immunizations.

> *"…. people living in those areas have improved their health status in the various health domains. All these domains have therefore increased dramatically," Partner, KII*

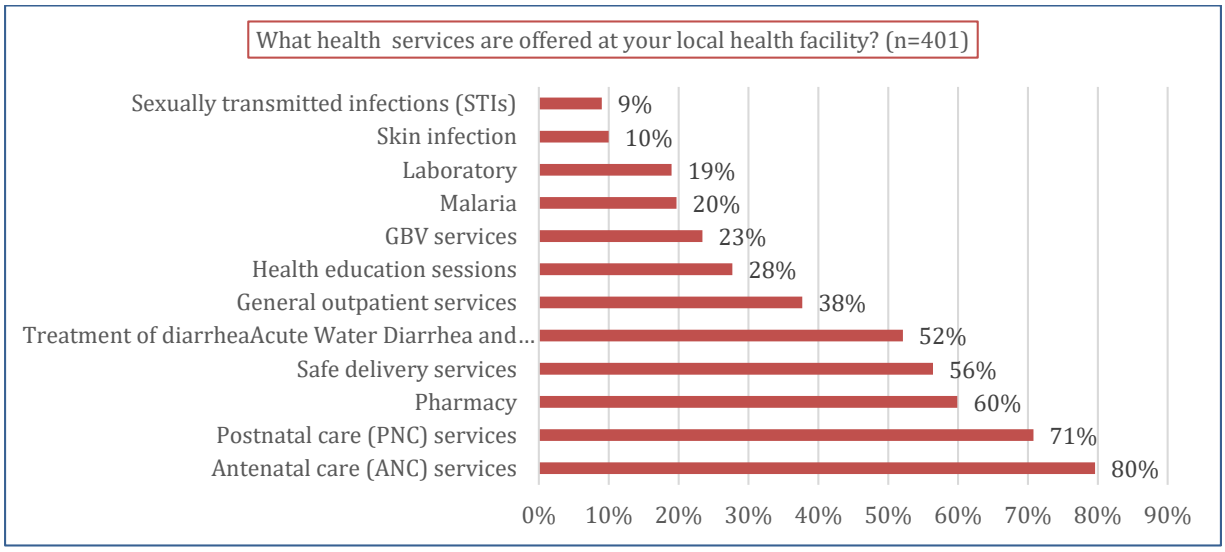
Table 11: In your view how was/would you rate the services provision at the health facility?

In your view how was/would you rate the services provision at the health facility?	Sool (n=198)	Sanaag (n=203)	Overall (n=401)
Excellent	70%	54%	61%
Good	29%	37%	34%
Poor/below average	1%	3%	2%
Very poor		6%	3%
Total	**100%**	**100%**	**100%**

In terms of healthcare services offered at the respective local health facilities, a majority of respondents cited ANC services (80%), PNC (71%), pharmacy (60%), safe delivery (56%) and treatment of acute water diarrhoea and pneumonia (52%) among others. It also emerged from the qualitative respondents that ANC and PNC were the key top services offered at the health facilities in their localities. Other services listed included medication, nutrition supplements and plumpy nut. The project further provided hospital equipment and some medical supplies thus improving the availability of health services in a timely manner.

> *"…..As well as they said, we get motivations towards importance of immunization and child exclusive breast feeding especially for the six months," Mother/caregiver of U5 FGD, Sanaag*
>
> *"….we get medicines, plumpy nuts for our children, vaccination and other drugs/medicines," FGD respondents, Somaliland*

Figure 12: What health services are offered at your local health facility



Health facilities were in operation on different timelines; some operated 24-hour services, particularly in Sool region (64%), others were operated for a half a day: 7am-2pm, 7-12am, or form 2-7 pm. Respondents stated that they were aware of health facilities that were in operation for 10 hours, 12 hours and 18 hours in their regions. The working hours of the health facilities in the two regions were convenient to a majority of the respondents (93%) to access services. The few respondents who found health facility working hours inconvenient did so because they resided far away from the facility or the facility in their area closed early.

Table 12:What are the working/opening hours for the health facility?

What are the working/opening hours for the	Sool (n=198)	Sanaag (n=203)	Overall (n=401)

health facility?			
7am-2pm	31%	74%	52%
2-7pm		6%	3%
24hours	64%	10%	37%
Others (specify)	5%	10%	8%
Total	**100%**	**100%**	**100%**

The findings further indicate that while a majority of the respondents resided 30 minutes' walk away from health facilities (78%) and that only 22% lived far away from MCH (over 30 minutes' walk combined), most (90%) of them found it easy to access the health facility from their homes.

Table 13:How long does it take you to walk to the nearest health facility for services

How long does it take you to walk to the nearest health facility for services	Sool (n=198)	Sanaag (n=203)	Overall (n=401)
Less than 30 Minutes	74%	82%	78%
30 minutes to hour	24%	9%	17%
Over hour walk	2%	9%	5%
Total	**100%**	**100%**	**100%**

The health facilities in the Sool and Sanaag were well stocked with drugs and medical supplies which had been accessed by 94% of respondents during their last visit at the facility. Similarly, qualitative focus group respondents indicated that most of them accessed drugs and medical supplies without any challenges in Sool and Sanaag.

> *"…. the facility existed before the organization came. CARE supported us with equipment, medications and salary for the workers. It was constructed by the community," Health FGD respondents, Sanaag*
>
> *"…we have never seen it under stocked except addition of more supplies," FGD respondents, Somaliland.*

Table 14: your last visit at the heath facilities were you/your household able to get drugs and other medical supplies at the facility

During your last visit at the heath facilities were you/your household able to get drugs and other medical supplies at the facility?	Sool (n=198)	Sanaag (n=203)	Overall (n=401)
Yes	99%	89%	94%
No	1%	11%	6%
Total	**100%**	**100%**	**100%**

Although CARE through the SRRP project have recorded great results in other surveyed regions, the situation in Jidale, Arigavo in Somaliland was said to still need some critical equipment and medical supplies as they are not sufficient. Qualitative FGD respondents indicated that machines for running tests, screening as well as for scanning were unavailable.

> *"…some equipment is missing which is used for scanning and testing. No enough wards, there are enough beds for patients, workers are not enough and toilets. They are many. It cannot be summarized," FGD respondents, Somaliland*
>
> *"…The major things that we urgently need now are Ambulance…. They are many things required. Needs are unlimited. Computer (Scanning machines) for mothers during pregnancy," FGD respondents, Sanaag*

Antenatal Care

Somalia's maternal mortality ratio is the highest in the world at 732 per 100,000[13] primarily due to complications that arise during late pregnancy and childbirth (hemorrhage, prolonged and obstructed labor, eclampsia and infection). Low access to maternal health services is experienced on a daily basis with approximately only one-third of births attended by skilled birth attendants[14]. The unmet need for child spacing carries greater risk of infant, neonatal deaths, low birth weight and malnutrition. In Sool and Sanaag regions, only 32% and 46% [15]of the health facilities offer antenatal care (ANC) services making difficult for mothers with pregnancy complications to be identified and referred for treatment.

[13] The State of The World's Children, UNICEF 2017
[14] Situation Analysis of Children in Somalia 2016." United Nations Children's Fund (UNICEF), 2016.
[15] Ibid

Across the surveyed region for the health component, expectant family members were on average 0.98, proportionwise only 44% of surveyed households had a family member who had been pregnant in the last 12 months. All the expectant mothers, according to both qualitative and quantitative respondents had attended an antenatal visit with majority having attended so far 3, 4 or more antenatal care sessions. During ANC visits, the key things were said to be checked by the medical practitioners included expectant mothers' blood pressure (74%) and most of all given iron supplements (81%). Other supplements that were provided for during ANC were folic acid and vitamin A.

Table 15:Services household member receives during antenatal visit

What services did you/household member receive during your/their antenatal visit?	Sool (n=97)	Sanaag (n=63)	Overall (n=160)
Iron supplements tablets	59%	42%	81%
Blood pressure measurement taken	62%	38%	74%
Folic acid	53%	47%	66%
Vitamin A supplements	64%	36%	63%
Counselling	60%	41%	46%
Blood sample taken	70%	30%	35%
Urine sample taken	30%	70%	14%

Subsequently, the endline respondents indicate that a majority of pregnant women in the last 12 months had delivered at health facilities (66% public and 19% private). One of the key reasons cited for this high percentage of health facility deliveries was the free delivery (54%) services at both the public and private health facilities. Additionally, proximity to the health facility (16%) as well as the sense/feeling of security and safety (30%) encouraged mothers to deliver at the health facilities resulting in very few women delivering at home (14%: 32% Sanaag, 3% Sool). Additionally, qualitative respondents shared similar views that pregnant women preferred to deliver at the health facilities.

> *"….. they prefer coming here. They are connected here. Here, they love the care and they do not pay for anything…," Health FGD respondents, Sanaag*

While a majority of pregnant mother preferred delivering in the health facilities, it emerged from some qualitative respondents that some regions such as Erigavo in Somaliland still face a challenge of insufficient facilities in terms of space. This was said to force women to deliver at home although with the help of the doctors, nurses and midwives. While this was the reality in these areas, the findings point out that there was an improvement in women who seek the assistance of a qualified midwife as opposed to a traditional birth attendant (TBAs).

> *"…..when mothers go into labor pain, they are taken to their houses, we send doctor/nurses to them. They could have delivered here but there is no space and toilets," FGD respondents, Somaliland.*

Table 16: Where did you deliver the baby at?

Where did you deliver the baby at?	Sool (n=97)	Sanaag (n=63)	Overall (n=160)
Health facility-Public	75%	51%	66%
Health facility-Private	22%	14%	19%
Home	3%	32%	14%
Others (specify)		3%	1%
Total	**100%**	**100%**	**100%**

In terms of baby delivery assistance, a majority of mothers had been assisted by midwife(s) (82%: 93% Sool and 67% Sanaag). Other personnel who had assisted mother's during delivery were doctors, nurses, other trained health personnel and traditional birth attendants. Interestingly 2% mothers had managed to delivered live babies on their own. It is evident from both qualitative and quantitative findings that a midwife plays a core role in Somalia during baby deliveries. According to a majority of respondents, pregnant women acknowledged that a midwife is very important in all their stages of their pregnancies and thus sought their services. *"…now, that tradition of delivering at home is long gone, they have now realized that they cannot stay without midwife," Health FGD respondents, Sanaag*

Table 17:Who assisted with the delivery of your/household member's last live birth

Who assisted with the delivery of your/household member's last live birth?	Sool (n=97)	Sanaag (n=63)	Overall (n=160)
Doctor/Medical assistance	2%	14%	7%
Midwife	93%	67%	82%
Nurse	2%		1%
Other trained health personnel	.	2%	1%
Traditional birth attendant	2%	14%	7%
No one helped	1%	3%	2%
Total	**100%**	**100%**	**100%**

Postnatal Care Service

The endline findings indicate that a majority of respondents in the surveyed regions had accessed postnatal care services (81%), whom half of them had visited a health facility immediately after delivery (50%). Another considerable percentage had not visited any health center after delivery citing lack of time, health facility being far away, lack of trust in doctors and medicine as major factors for not attending PNC service after child birth.

Table 18:Had Postnatal care service

Did you visit health center or get visited by health care provider such as nurse, CHW etc. after delivery?	Sool (n=189)	Sanaag (n=176)	Overall (n=365)
Yes	86%	76%	81%
No	14%	24%	19%
Total	**100%**	**100%**	**100%**

More than half (59% - more than 3 times combined) of the respondents indicated having visited a health facility for PNC after delivery. A similar scenario was also painted by FGD respondents who also indicated that they had attended PNC services after delivery of the children. Most of the respondents indicated to have visited the health facility for PNC immediately after delivery (50%), while another smaller proportion visited at the end of the first week after delivery (28%).

Table 19: When did this visit take place?

When did this visit take place?	Sool (n=163)	Sanaag (n=134)	Overall (n=297)
Immediately after delivery	51%	49%	50%
3 days after delivery	10%	10%	10%
End of the first week after delivery	35%	18%	28%
Others (Specify)	3%	14%	8%
Never	1%	9%	4%
Total	**100%**	**100%**	**100%**

Both qualitative and quantitative respondents alluded that postnatal visits allowed their children to be vaccinated (68%). It was also widely mentioned that other services acquired during PNC included counselling, provision of Vitamin A supplements as well as advice on child spacing. The table below shows the various services offered during PNC services.

> *"…if they find that the blood level is very low, they give out some drugs to boost the blood level like vitamins and they are also given advice," FGD respondents, Somaliland*
>
> *"…yes they come… they normally track their post-natal care and they finish the vaccination for their infants," Health FGD respondents, Sanaag.*

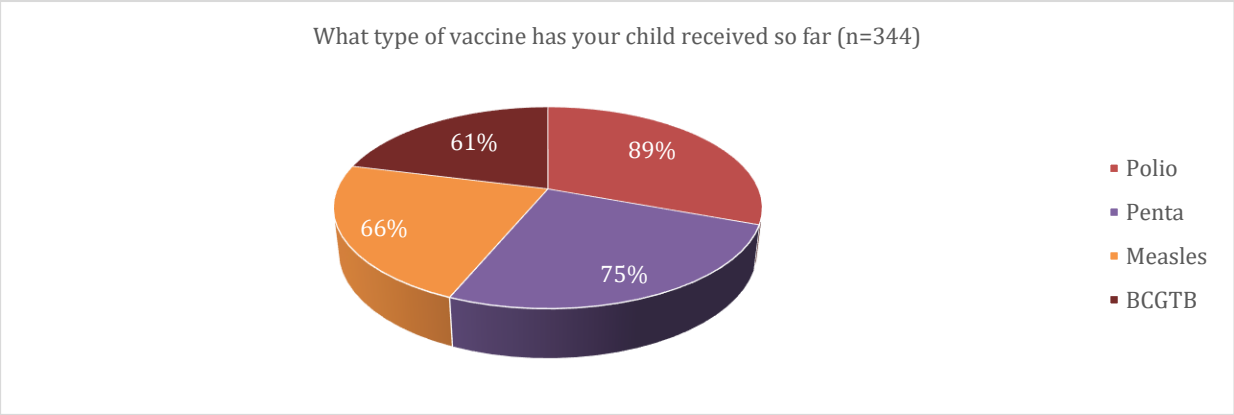
Table 20: Drug or services provided for during PNC

What drug or service were you/your child provided for postnatal care?	Sool (n=163)	Sanaag (n=134)	Overall (n=297)
Immunization	54%	85%	68%
Counselling	28%	6%	18%

Vitamin A	18%	5%	12%
Health spacing of children	.	1%	1%
Others (specify)	.	3%	1%
Total	**100%**	**100%**	**100%**

During postnatal visit, more than half of the respondents had their children vaccinated (68%). As at the time of this endline assessment, (94%) had accessed routine immunization for their children at health facilities. Of the few who said to have missed the routine immunization, they cited unavailability of the vaccine at the health facility. The routine vaccines listed by the respondents that were administered to children were BCG, Penta, Polio and Measles with the coverage rate being more than (50%) for each vaccination among the sampled households.

Figure 13: What type of vaccine has your child received so far



Health messages

The project sent or provided health information to the target community members so as to build their knowledge and understanding on health matters. The messages were shared with the community members during health facility visits, groups sessions and discussions, door to door sensitization by community health workers and the media among others. Similar to most of the qualitative FGD respondents, majority (85%) of the quantitative respondents indicated to have received or heard health educational messages in the last 12 months on diseases, prevention, treatment and health seeking behavior. Their main sources of the health messaging included community health workers (77%), health facilities (78%) and mass media (4%).

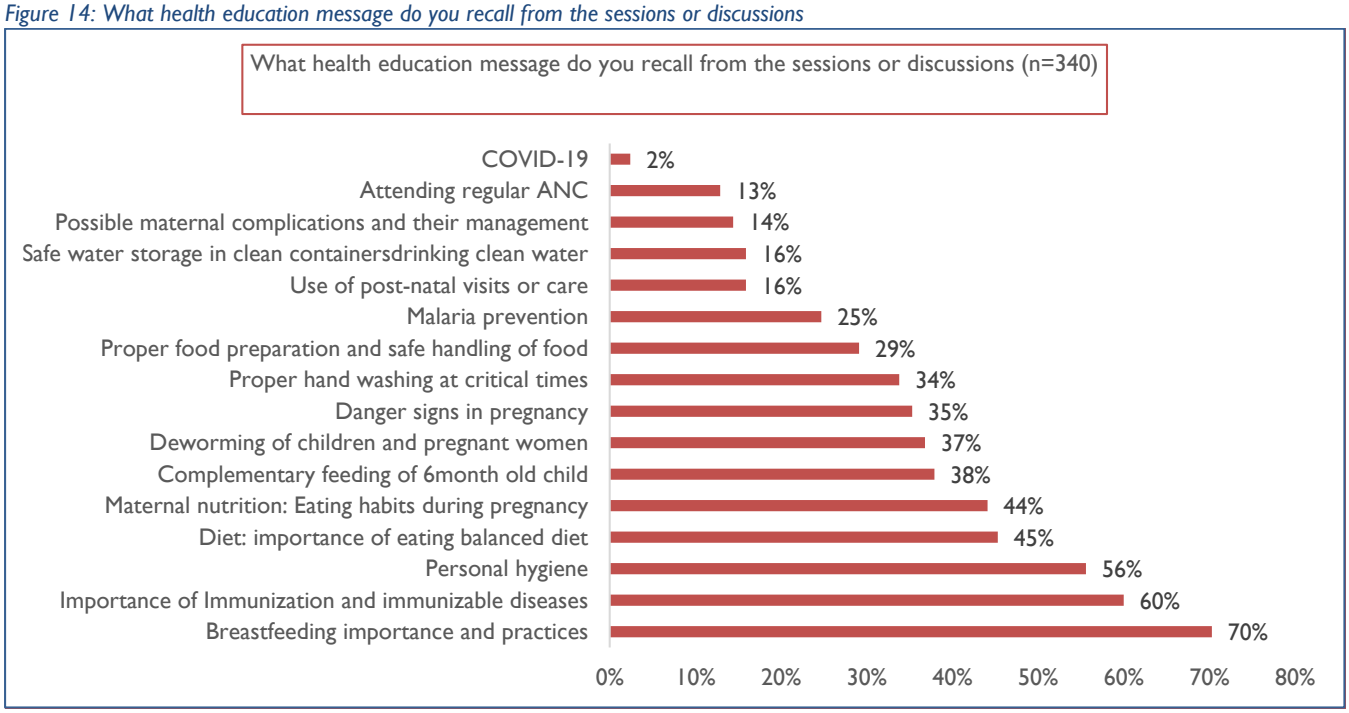
Table 21:Have you received health education message in the last 12 months

Have you heard or received any health education message information about specific disease, prevention, treatment or health seeking behavior in your community within the last 12 months?	**Sool (n=198)**	**Sanaag (203)**	**Overall (n=401)**
Yes	84%	85%	85%
No	16%	15%	15%
Total	**100%**	**100%**	**100%**

Of the various health messages received by the respondents, majority of them recalled the messages presented in the figure below. The messages recalled by more than half of the respondents were importance and practices of breastfeeding (70%), importance of immunization and immunizable diseases

(60%) and personal hygiene (56%) messages. Health education keeping with current events, COVID-19 prevention and protection practices, had also been conveyed to participants.

Figure 14: What health education message do you recall from the sessions or discussions



The findings further indicate that the health educational messages had greatly improved most of the household health status (96%). This was said to have resulted in healthier children at the household level (76%), less sickness and illnesses related to malnutrition (55%) at the community level as mothers and caregivers' health was improved as community members were more enlightened on health issues. (52%) of the respondents mentioned that they often practised what they had learnt on health in within their household. (1%) had completely disregarded the health messages they had heard/learnt and did not practice any. Although worrying, it was a very small proportion compared to respondents who practiced what they had learnt all the time (31%). Qualitative respondents weighed in into this finding citing that the reason for the improvement in household health status especially among children and pregnant and lactating mothers was as a result of breastfeeding practices as well as proper feeding of both mother and child.

Table 22: Benefit of health education messages

Benefit of health education messages	Sool (n=167)	Sanaag (n=173)	Overall (n=340)
Children are now healthier	48%	52%	76%
Reduction in sickness and illnesses like malnutrition	46%	55%	55%
Improved well-being health of the mother/care giver	54%	46%	58%
Improved knowledge on health issues	58%	42%	52%

Key to note, although health and nutrition services were received free of charge by 99% of the respondents 3% respondents in Sanaag region had paid on average 82.8 USD (min 2USD max 150 USD) for such services. According to some FGD respondents, some services that were not available in MCH could only be access in private hospitals thus forcing them to pay for such services. Indicatively, there were more gains for the respondents in terms of health services and despite the few challenges cited in some instances, a majority of the respondents were satisfied with service they received at the health facility (94%: 52% very satisfied, 42% satisfied).

Table 23: How satisfied were you with the service offered in the health facility?

How satisfied were you with the service offered in the health facility?	Sool (n=198)	Sanaag (n=203)	Overall (n=401)

Very Satisfied	56%	48%	52%
Satisfied	43%	40%	42%
Somewhat satisfied	1%	7%	4%
Not satisfied	.	5%	2%
Total	**100%**	**100%**	**100%**

Health - Key Takeout

- There was an overwhelming satisfaction with the health services received by the respondents of Sool and Sanaag;
- The health messaging impacted on the lives of the respondents; a majority recalled the messaging received as well as practised what they learnt from the SRRP project;
- Exclusive breastfeeding was overwhelmingly embraced by the respondents and community members in general as an important component to ensure better health and wellbeing of children;
- In addition to high levels of attendance to ANC and PNC services, it is evident that the target respondents preferred to deliver their babies in a health facility as opposed to home;
- It is obvious that there is an ease in access to health services as a majority of the respondents were 30 minutes' walk away from the health facilities;

3.3.3 Sector 3 -Humanitarian Coordination and Information Management

Overall objective: The Somalia NGO Consortium (SNC) plays an increasingly effective role in coordination for humanitarian aid actors

Attainment of Objectives

- Findings indicate a strong achievement of the Coordination sector objective;
- Improved coordination at programme and cluster levels was reported;

The complex, inter-linked and multi-dimensional humanitarian challenges in Somalia requires concerted and coordinated efforts in ensuring underlying causes of recurrent humanitarian crisis in Somalia are adequately addressed and assistance is focused towards building and strengthening resilience of Somali communities[16]. The need for synergy and complementarity among development agencies and partners is critical for high scale development results to be achieved. This would encourage efforts to manage bureaucratic impediments and other challenges experienced by NGOs and partners in delivering on their mandate. The coordination aspect of the SRRP project was implemented in form of clusters where the organizations came together to coordinate programs.

Qualitative findings indicate that the humanitarian sector coordination is multiple-fold and varied in the Somaliland and the Federal government (FGS). The two governments demand different approaches in terms of coordination of humanitarian work. It emerged that there are several levels of coordination which for Somalia include four coordination structures: sector coordination meetings comprising government institutions, NGOs, UN agencies and other development companies or partners, inter-sectoral coordination meeting comprising sector chairs, the government line ministries, co-chairs and UN only. The third level coordination structure, which is known as the National Aid Coordination Forum led by the Ministry of Planning. This level is also attended by the National Planning Commission and civil society actors while the fourth level is the High-Level Aid Coordination Forum also led by

[16] SRRP Project_Technical Narrative,2019

Ministry of National Planning and co-chaired by one of the donors and hosts development partners and the civil society. Somaliland on the other hand has two levels of coordination that include sector coordination led by the Ministry of National Planning and a government-led coordination and cluster meeting which is donor driven. The interplay in these coordination structures was cited to be a challenge on several occasions when competing interest are at stake.

CARE played a critical role in coordination and they were sector leads in the various clusters. The project ensured there was complementarity and synergy at program, cluster, organisational and inter-agency levels so as to avoid overlapping and duplication of programmes and activities in specific target locations. *"..that system of coordination was there and we are part of the coordination structures and in most of them we are the lead…the government is also there," Program staff KII*

Evidently, to ensure achievement of coordination objectives, regular meetings and information sharing sessions were organised. Such fora were said to create an environment for organisations to understand each other's areas of work as well as the specific areas of focus. *"…monthly cluster meetings are conducted by the cluster leads where information is shared so that we share what gap exists in village X, what resources is available, what organization is implementing and where," Partner KII*

It was also observed that the governments are also partners in the coordination efforts and that the platform had provided a platform for great working relationships between government and NGOs. *"… Some time they work together with government agencies. Just recently, a week ago, the ministry of Planning (Galmudug state) conducted a meeting to all agencies about the effect of the "Tipple Shocks" and how to continue addressing especially COVID-19," Partner KII*

While a general observation indicates that while success in humanitarian coordination was achieved in partnership with government and other players, the sector was said to be faced a number of challenges including the competing interests by government especially for Somaliland in the quest to have control over humanitarian affairs. The lack of synergy between the government and the humanitarian players was said to undermine the donor goodwill especially during funding allocations thus resulting in underfunding or no funding at all for some projects. *"…the original plan was for the two levels sector and the cluster to complement one another. The Somaliland government however does not want to integrate the two coordination structures because they are saying as long as it is donor driven, there is always a political issue behind it and the agenda of Somaliland is not there," Humanitarian coordination, KII.* The competition to manage NADFOR by the line ministries was also said to bring confusion between NADFOR, the humanitarian response institutions and the rest of the organizations.

CARE was mentioned as one of the key players in coordination efforts. Some of the activities that were cited to be done by CARE included research, assessments and studies regarding the crises situation in the region, sharing of challenges as well as the funding trends and opportunities in the sector. It was therefore evident without second-guessing that the coordination efforts had provided the humanitarian organizations with a platform to weigh in their voice on humanitarian issues.

> *"….In the cluster meetings for example, they meet every end month to discuss issues related to program implementation, focus areas and lesson learnt," Partner KII*
>
> *"… CARE is one of the frontline organizations when it comes to response and am sure now for the consortium wise, CARE is very active and you see the coverage is bigger than other organizations so the response is very swift," Humanitarian coordination, KII*

Coordination platform was said to be an important component in programming as it is used to understand the exact figures or data on humanitarian activities in the region as well as help to understand the strengths and weakness of the agencies and also to find out existing gaps and opportunities. Additionally, the platform provides the actors with a platform to have one voice to push for agenda that would benefit all including the new actors in the humanitarian field.

Key Takeout

- CARE played a critical role in coordinating activities with other agencies;
- The coordination platform was said to have provided an opportunity for organisations to share available opportunities;
- Humanitarian coordination is a complete interplay between the different actors as competing interests carry the day in some occasions;
- The need for coordination and synergy is inevitable if development and achievement of development objectives have to be realised;
- Coordination helped avoid duplication and build complementarity and synergy.

3.3.4 Sector 4: Nutrition

Overall objective: To improve the nutritional status and prevent malnutrition- related morbidity and mortality of vulnerable children under five years and pregnant and lactating woman

Attainment of Objectives

- Findings indicate a strong achievement of the nutrition objective;
- Training on nutrition was conducted and a majority of the respondents indicated to have attended and benefitted from them;
- A majority of the women/mothers of U5 recalled and practised the IYCF messages;
- Improved levels of infant nutritional wellbeing were reported.

Effective infant and young child feeding (IYCF) intervention is one of the available key prevention services that prevents childhood morbidity and mortality available. The baseline findings of the SRRP project indicate that some of the factors that undermine the achievement of the IYCF results are poor practices amongst community members[17]. The SRRP target communities include IDPs, refugees, pastoralists and host communities who adopt poor IYCF practices. Factors resulting in these include high food prices, competing childcare priorities, poor food consumption, limited access to livelihoods, poor child spacing, low literacy rates of mothers and low awareness.

The endline assessment for the Nutrition sector was carried out in 4 regions including Sool, Sanaag, Bari and Lower Juba, that had been recipient of nutrition programs by CARE and affiliate partners. The endline findings demonstrate that many residents in these regions had in the last 12 months received training and messages on nutrition (84%). This indicates an increase in participation in training and messages on nutrition as compared to baseline where only 52% had participated.

The nutrition messages had been conveyed to them mostly by community health workers (83%). Other persons who got to pass on the nutrition educational messages were nurses (36%), midwives (16%), mother to mother support group (12%) and family members (5%). Qualitative findings further agree to this finding with some FGD respondents also indicating that they had received the nutrition messages.

"….When visiting the MCH, we are given messages on proper nutrition," FGD Respondent, Somaliland

Table 24:Training attended or message received in the last 12 months

Have you attended any training and or received any message on nutrition education in the last 12 months in the area?	Sool (n=97)	Sanaag (n=90)	Bari (n=97)	Lower Juba (109)	Overall (n=393)

[17] SRRP_Baseline report-Jan2020

Yes	72%	67%	95%	100%	84%
No	28%	33%	5%		16%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

The different nutritional messages respondents could recall are shown in the table below. Recalling nutritional messages translated to respondents practicing what they entailed the most recalled message and practiced by respondents were the message on breastfeeding practices (91% recall and 88% practice) while quite a large proportion recalled and/or practiced complementary feeding (68% recalled and 55% practiced) very few (22% recalled, 22% practiced) remembered the frequency, quantity and quality to feed the child on. Message on safe handling of food (46%) and food preparation practice (34%) were recalled by less than a half of respondents and similarly half of the respondents practiced such message (41.5% safe handling of food, 29% preparation of food).

Table 25: Nutritional education message currently used/practiced

Which nutritional education message are you currently using or practicing	Sool (n=70)	Sanaag (n=60)	Bari (n=92)	Lower Juba (n=108)	Overall (n=330)
Breastfeeding practices	84%	95%	85%	88%	88%
Complementary feeding practices	70%	62%	46%	50%	55%
Safe handling of food	59%	32%	47%	32%	42%
Preparation of food	53%	28%	27%	17%	29%
Frequency of feeding, quantity and quality	31%	10%	12%	30%	22%
Others	1%	2%	0%	0%	1%

According to the quantitative data, the nutritional education messages had been effective to majority of the respondents and their households (96%: 46% extremely useful & 50% very useful) with majority (99%) being of the opinion that the nutritional messages had improved their household health status additionally their children were healthier (81%). Other benefits of the nutritional message are as shown in the table below.

Table 26: In what ways has the nutritional educational message been beneficial to you and your household?

In what ways has the nutritional educational message been beneficial to you and your household?	Sool (n=70)	Sanaag (n=60)	Bari (n=92)	Lower Juba (n=108)	Overall (n=330)
Children are healthier	77%	80%	90%	76%	81%
Reduction in sickness among the family members	44%	62%	65%	32%	49%
More healthier food variety for family	50%	52%	46%	12%	37%
Improved knowledge on food handling	63%	43%	23%	33%	39%
Improved knowledge on food preparation methods	53%	27%	8%	16%	23%
Improved knowledge on feeding practices for infants	36%	7%	9%	57%	30%
Others(specify)	1%				0%

Table 27: How useful has the nutrition education message been to you and your household?

How useful has the nutrition education message been to you and your household?	Sool (n=70)	Sanaag (n=60)	Bari (n=92)	Lower Juba (n=108)	Overall (n=330)
Extremely useful	77%	65%	36%	24%	46%
Very useful	21%	35%	55%	73%	50%
Slightly useful	2%		8%	3%	3%
Not at all useful			1%		1%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Of the respondents who had received nutritional messages in the last 12 months, 60% were able to implement what they had learnt with ease, the rest of the respondents (40%) indicated that high food prices and social norm of breastmilk hindered them from implementing nutritional message they had learnt. Evidently, inadequate household income was cited a limiting factor to mothers in accessing a variety of foods hence making the messages impractical without cash support. This therefore highlights

the need to support nutrition beneficiaries with cash so as to allow them follow through the messaging by practising them.

Table 28: Do you face any challenge implementing what you learnt?

Do you face any challenge implementing what you learnt?	Sool (n=70)	Sanaag (n=60)	Bari (n=92)	Lower Juba (n=108)	Overall (n=330)
Yes	17%	17%	71%	43%	40%
No	83%	83%	29%	57%	60%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table 29: What challenges did you face in implementing what you learnt from the training?

What challenges did you face in implementing what you learnt from the training?	Sool (n=12)	Sanaag (n=10)	Bari (n=65)	Lower Juba (n=46)	Overall (n=133)
High food prices	75%	100%	85%	65%	78%
Social beliefs that breastmilk is not enough	33%	60%	63%	94%	71%
Poor child spacing	58%	10%	26%	17%	25%
Become ill and started mixed feeding	33%	10%	23%	9%	18%
Others	0%	0%	2%	0%	1%

According to the qualitative findings the SRRP project under the nutrition component realized an increase in nutritional status of households. It was reported that the nutrition treatment programme through the project activities that included provision of OTP and TSFP services for children and pregnant and lactating mothers achieved commendable results as a majority of the beneficiaries recovered from malnutrition thus making it an effective service. This was therefore reported to have impacted on lives of the people in the target locations.

> *"…..sometimes we used to deliver particularly the health and nutrition services to the general or the main referral hospitals in the main areas we were working," Project Staff, KII*

> *"…the nutrition programs supported mothers and their children in terms of the food delivery, nutrition messaging, child breast feeding and child spacing/ family planning," Mother/caregiver for U5 FGD respondents, Sanaag*

Similar, sentiments shared by the quantitative respondents who reported that a majority of them (94%) were able to access OTP/TSFP treatment and were in approval of how the programs on nutrition had been implemented in their community. On the other hand, the few respondents (1%) who were unable to access OTP/TSFP treatment cited inability to afford transport to the health facilities as well as sanitation materials as key constraints. Some Focus groups respondents across all the surveyed regions also indicated that they received OTP/TSFP treatment courtesy of the project.

> *"….they came to my house, my children were malnourished and I had never taken them to any facility, they told me to take them to MCH and then gave me a paper," FGD Respondent, Puntland*
>
> *"….While we don't know where to go and where to take our children to then CARE intervene and open MCH that provides nutrition for the infants," FGD Respondent, Somaliland*

Table 30: Was the OTP/TSFP treatment program accessible to all of the community members?

Was the OTP/TSFP treatment program accessible to all of the community members?	Sool (n=97)	Sanaag (n=90)	Bari (n=97)	Lower Juba (n=108)	Overall (n=392)
Yes	97%	81%	98%	100%	94%
No	1%		2%		1%
Don't Know	2%	19%			5%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

According to quantitative (94%) and a majority of qualitative respondents, the project design met the communities needs and the nutrition component improved the general wellbeing of their children's nutritional status. *"….Yes, it was needed because that time whatever I nourish with my infants was not enough and their strength used to deteriorate day in day out but when I started feeding them with CARE medication then their soundness and strength rebound," FGD Respondent, Bossaso.*

To corroborate this finding, project reports and program performance indicators show the recovery rate was very high (97%). The high recovery rate (97%) is therefore indicative of good adherence to the

treatment protocol and quality service. The table below shows a table from the Semi-Annual SRP Report for Nutrition, April – September 2020.

Figure 15: TSFP beneficiary's exits by category[18]

Performance indicators	Discharge Category (no. of beneficiaries)	Percentage %
Recovery rate	**6,102**	**97%**
Default rate	**134**	**2%**
Death rate	**5**	**0%**
Non-response rate	**84**	**1%**
Total	**6,325**	**100%**

Table 31: Was the design of the project appropriate for the community?

Was the design of the project appropriate for the community?	Sool (n=97)	Sanaag (n=90)	Bari (n=97)	Lower Juba (n=108)	Overall (n=392)
Yes	95%	82%	97%	100%	94%
No	4%		3%		2%
Don't Know	1%	18%			4%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

The quantitative findings further indicate that out of the surveyed households, (73%) had a child below 23 months of age, of which 97% had been breastfed within the first hour of their lives as indicated by all the respondents in Sool, Bari and Lower Juba. The 3% respondents who had not been able to breastfeed their child within the first hour of life failed to do so because the baby or mother had been ill. Inability of the baby to suckle, refused to suckle or inadequate breastmilk for the child were some of the other reasons for failing to breastfed the child in first hour of life.

When the respondents were asked what the child had been fed on the previous day before the survey, a majority (75%) of them reported that the children had been breastfed. Additionally, for those who had fed their children on other feeds, the common foods the child had been given the previous day included cow/goat/Camel milk (35%) and plain water (14%). There were very high rates of children breastfed on the previous day in Sool (96%) as compared to other regions of Bari (81%), Sanaag (78%) and Lower Juba (57%). Subsequently, the data further indicated very high proportions of breastfeeding practise (97%) as well as those who breastfed their infants within the first hour of birth were (97 %). The other feeds are shown in the table below.

Table 32:During day and night yesterday, what did you give to your child?

During day and night yesterday, what did you give to your child	Sool (n=72)	Sanaag (n=45)	Bari (n=63)	Lower Juba (n=105)	Overall (n=285)
Breast milk	96%	78%	81%	57%	75%
Milk from cows/camel/goats Porridge	11%	22%	5%	74%	35%
Plain water	8%	16%	30%	7%	14%
Infant formula (e.g., milk powder)		13%	2%	25%	12%
Tea infusion		2%		16%	6%
Fruit juice	3%		11%	6%	5%
Sugar, salt water solution	1%		13%		3%
Sugar or glucose water	0%		10%		2%
Other		4%	3%		1%
Honey		4%		1%	1%

It was evident from the findings that breastfeeding practice was widespread among the respondents since a majority (97%) had breastfed their last-born child even on colostrum (99%). Much as not all respondents had practiced exclusive breastfeeding on their infants, there was a strong belief that

[18] Sourced from - Semi-Annual SRP Report for Nutrition, April – September 2020

exclusive breastfeeding infants improved their general health and thus a majority of the respondents highly recommended it thus showing a shift in perceptions on breastfeeding as compared to the baseline. These findings are further supported by project reports including CARE IYCF KAP survey report, September, 2020[19] which also indicate that majority of children had been breastfed (exclusively) a widespread practical knowledge among mothers in Sool and Sanaag with belief that it was important for the child's growth. *"…The infants that has been exclusively breastfeed are healthier and more stable than those without exclusively breastfeed," FGD respondents, Bossaso.* Additionally, it was observed that breastfeeding practice had widely been embraced by a significant proportion of community members and according to some KII respondents, breastfeeding had greatly improved based on a report from a study done by the UNFPA[20] as well as the CARE IYCF KAP survey report, September, 2020. *"…you can see how the rate of breastfeeding is going up," CARE project staff, KII.*

Inclusion of fathers in the breastfeeding journey was also cited as one of the reasons of improved breastfeeding practices. The program reached out to fathers with health and breastfeeding messages to sensitize them on the possibility of not only exclusive breastfeeding but also breastfeeding a child even when the mother is pregnant. The CARE IYCF KAP report further indicate that fathers understood their role in supporting mothers to ensure that they breastfeed their infants as required with a majority of them indicating that their role was to support the mothers by providing for them nutritious foods for adequate milk production as well as encouraging them to breastfeed the infants. *"…Usually when you meet with the fathers some of them had a negative perception on continued breastfeeding but now when you give more information and message related to breastfeeding and give practical scenarios, it makes sense to take the role of the father," CARE Project staff, KII*

Similar sentiments were also shared by FGD respondents who stated that colostrum was had very high nutritional values to an infant and thus important to breastfeed them soon after birth. *"…..Colostrum is good milk and it's the first nutritional product the baby receives, good for mental and physical development. It is good for the mother's uterus and helps against many diseases, gives the body immunity," FGD respondents, Somaliland*

On average, the youngest child had been breastfed for 8.8 months (min 1, max 24 months). Mothers who had failed to breastfeed their lastborn children pointed out reasons as the child had either refused to suckle, had been unable to suckle or had fallen ill or the mother had lacked adequate breastmilk or had fallen ill or just refused to breastfeed their infants. *"….The challenges with exclusive breastfeeding may include sickness or mother's malnourished state.," FGD respondents, Somaliland.* Interestingly, some qualitative respondents alluded that in the past and even now mothers or girls did not breastfeed their children for fear of their breast sagging[21] as well as to prepare to conceive another baby.

The specific reason for not giving the child colostrum were that the mother considered the milk to be dirty, insufficient, unsatisfying or basically that the mother needed to rest.

[19] CARE IYCF KAP Survey in Sool And Sanaag Region, September 2020

[20] The Somali Health and Demographic Survey [Oct 2020], UNFPA

21 Similar findings as those in the CARE IYCF KAP Survey in Sool And Sanaag Region, September 2020

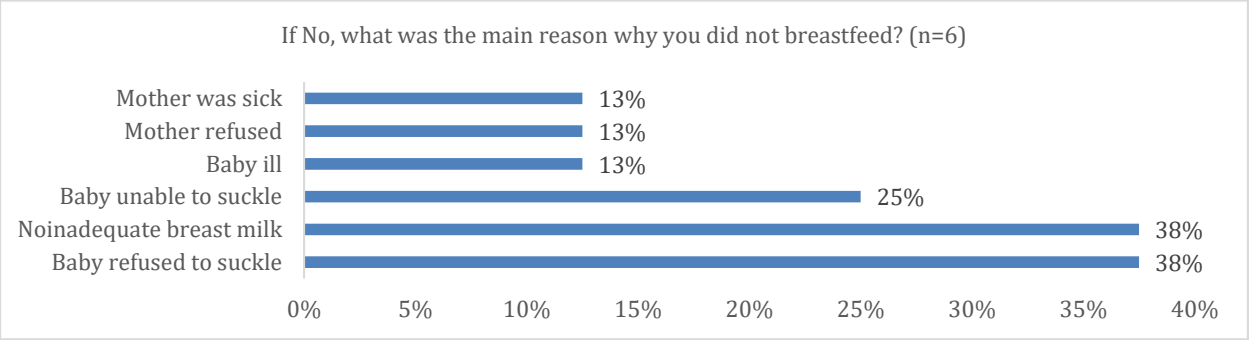


Figure 16:What were the main reasons why you did not breastfeed?

Subsequently, it emerged that (84%) of the respondents had in the last 12 months attended an IYCF, nutrition and health counselling/promotion session which had proven to be beneficial (90%) to them (88% very useful, 3% useful combined). Further, almost all (99%) the respondents indicated that they were very likely to continue practicing what they had learnt (very probably (55%) and probably (45%) combined. These findings were also corroborated by a majority of the qualitative respondents who indicated that they attended the IYCF sessions on a weekly basis and that the knowledge they received from the sessions were extremely beneficial to them and their children's wellbeing.

Table 33: If yes, how likely are you to practice what you learnt from IYCF counselling or training?

If yes, how likely are you to practice what you learnt from IYCF counselling or training?	Sool (n=88)	Sanaag (n=40)	Bari (n=59)	Lower Juba (n=102)	Overall (n=289)
Very probably	65%	60%	51%	46%	55%
Probably	35%	40%	46%	54%	44%
Probably not			3%		1%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

High levels of awareness among quantitative (82%) and a majority of qualitative participants on the existence of mother-to-mother support group in the areas of study among the survey respondents were also recorded. *"….people have gotten awareness, there is mother-to-mother support groups that provide advice," FGD respondents, Bossaso.*

Almost all those who were aware indicated that the mother-to-mother support groups were very important (98%) to households with expectant members or breastfeeding mothers (53% very important and 45% important).

Table 34: How important have such group been to you/your household during pregnancy or breastfeeding period?

If yes, how important have such group been to you/your household during pregnancy or breastfeeding period?	Sool (n=84)	Sanaag (n=41)	Bari (n=91)	Lower Juba (n=104)	Overall (320)
Very important	73%	49%	40%	50%	53%
Important	24%	51%	56%	49%	45%
Moderately important	3%		4%	1%	2%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

The reach of the malnutrition treatment was reported to be tremendously huge with almost all (99%) the quantitative respondents as well as most of the qualitative respondents indicating that pregnant and lactating mothers across the 4 surveyed regions in the past 12 months had accessed the treatment. The 1% who were of the view that pregnant and lactating mothers had yet to receive malnutrition treatment in the past 12 months mentioned that there were no health services in their vicinity or didn't know anyone who had received such services. *"…Mothers with acute malnutrition (AM) cases get biscuits and plumpy nuts and are advised to take water, juices," FGD respondents, Somaliland*

Table 35: Have pregnant and lactating mothers in the area been able to receive treatment for malnutrition in the last 12 months?

In your view, have pregnant and lactating mothers in the area been able to receive treatment for malnutrition in the last 12 months?	Sool (n=97)	Sanaag (n=90)	Bari (n=97)	Lower Juba (n=108)	Overall (n=392)
Yes	100%	96%	100%	100%	99%
No		4%			1%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

At the surveyed regions 94% (55% effective, 39% very effective) of the respondents thought the nutrition program had been effective in treating their children malnutrition, very few (4%) considered the program ineffective in treating malnourished children. According to qualitative participants also the nutrition program had improved the health of their children as they were provided with nutrition

information and well as treatment services. CARE was said to have raised a lot of awareness and mothers have now understood the benefits of exclusive breastfeeding.

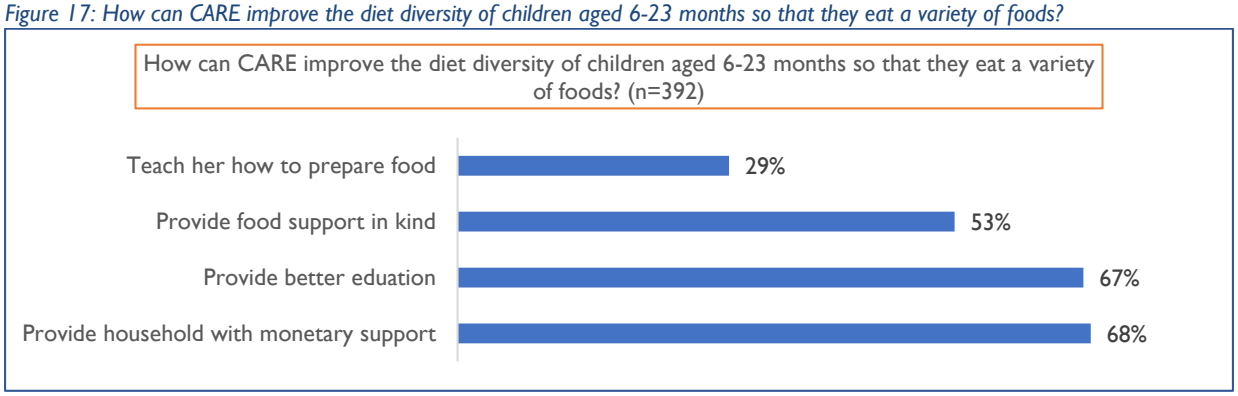
> *"…While was at home and I didn't know anything about MCH. Nutrition officers came to my house and weighed my infants then took me to the MCH and they prescribed for me how to feed them with OTP. I followed the procedure over and over again till my child became healthy, next they re-directed me to a process of getting 30 biscuits per month at the MCH," FGD respondents, Bossaso.*
>
> *"…My daughter was severely malnourished and got support, she is now better," FGD respondents, Somaliland*
>
> *"…we have seen health changes in our children. We have not encountered any problems with our infants, before we used to come back after every week to the OTP but now, we don't come back," ," FGD respondents, Bossaso.*
>
> *"…So the awareness has really benefited the mothers and really practice the exclusive breastfeeding, soft food and vitamins will be started for the baby as from 7 months," Camp leader KII, Bari*

Table 36: How effective were the nutrition programs targeting children with malnutrition in terms of treating them?

How effective were the nutrition programs targeting children with malnutrition in terms of treating them?	Sool (n=97)	Sanaag (n=90)	Bari (n=97)	Lower Juba (n=108)	Overall (n=392)
Not effective, it doesn't work	3%	5%	10%		4%
Effective, it worked	40%	64%	61%	56%	55%
Very effective	56%	23%	29%	44%	39%
I don't know	1%	8%			2%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

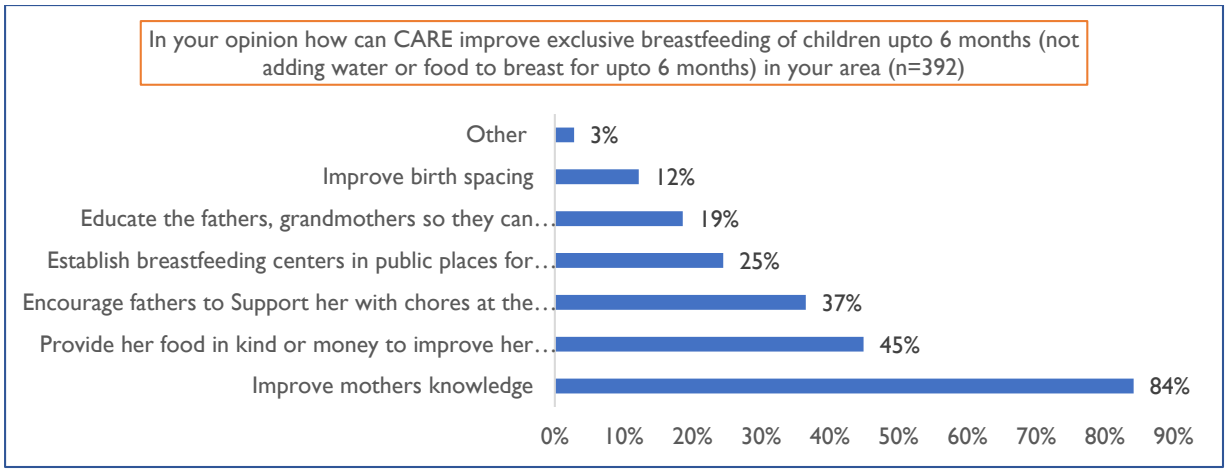
When asked how CARE could improve the diet diversity of 6-23 months old to include variety of foods, three top suggestions made included supporting the households financially (68%), providing education/training (67%) aa well as providing food support (53%). Teaching mothers on how to prepare their children feeds was also mentioned by (29%) of the respondents.

Figure 17: How can CARE improve the diet diversity of children aged 6-23 months so that they eat a variety of foods?



On improving exclusive breastfeeding of children to upto 6 months, it was suggested by by a majority of both qualitative and quantitative respeondents that there was need to improve mothers' knowledge on breastfeeding. Additionally, financial support and food items to mothers as well as encouraging fathers to support them with household chores so as to have enough time to breastfeed were also suggested. The various points of view on improving excusive breastfeeding for upto six months are shown in the figure below. In terms of counselling services received by the respondents from the programme, a majority of them were happy with it and indicated that the timing was appropriate.

Figure 18: In your opinion how can CARE improve exclusive breastfeeding of children upto 6 months (not adding water or food to breast for upto 6 months) in your area



Nutrition – Key Takeout

- Training on nutrition was conducted and a majority of the respondents indicated to have attended and benefitted from them;
- A majority of the women/mothers of U5 recalled and practised the IYCF messages;
- There was a strong indication that the respondents were willing to continue practising what they had learnt from the training and counselling;
- There was a commendable improvement in the health of infants as a result of the nutrition services;
- There was a strong belief that exclusive breastfeeding was critical for an infant's health;
- Inadequate household income was cited a limiting factor to mothers in accessing a variety of foods hence making the messages impractical without cash support. This therefore highlights the need to support nutrition beneficiaries improve their dietary diversity through cash, educations and in-kind support;
- The project design met the community's needs;
- There were high levels of awareness of mother-to-mother support groups and were recognised as very important to both pregnant and lactating mothers as they offered advice to each other.

3.3.5 Sector 5 - Protection

Overall objective: To enhance the prevention and mitigation of protection risks and improve quality of care offered to GBV survivors

Attainment of Objectives

- Findings indicate a strong achievement of the protection sector objective;
- Improved access to GBV and protection support services was reported;
- There was improved access to PSS services for GBV survivors;

According to UNDP[22], there were over 7,200 reported cases of GBV in 2016. In 2018, UNICEF and partner agencies supported some 10,956 survivors (3,640 girls, 5,396 women, and 1,920 boys), indicating a 52% increase in the number of incidents reported and supported in 2016. Focus Group Discussions conducted by CARE's protection team reported that the women in displacement settlements in Las Caanood district (Sool region), feel unsafe to go out of the informal IDP settlements, due to fear of sexual exploitation and abuse[23].

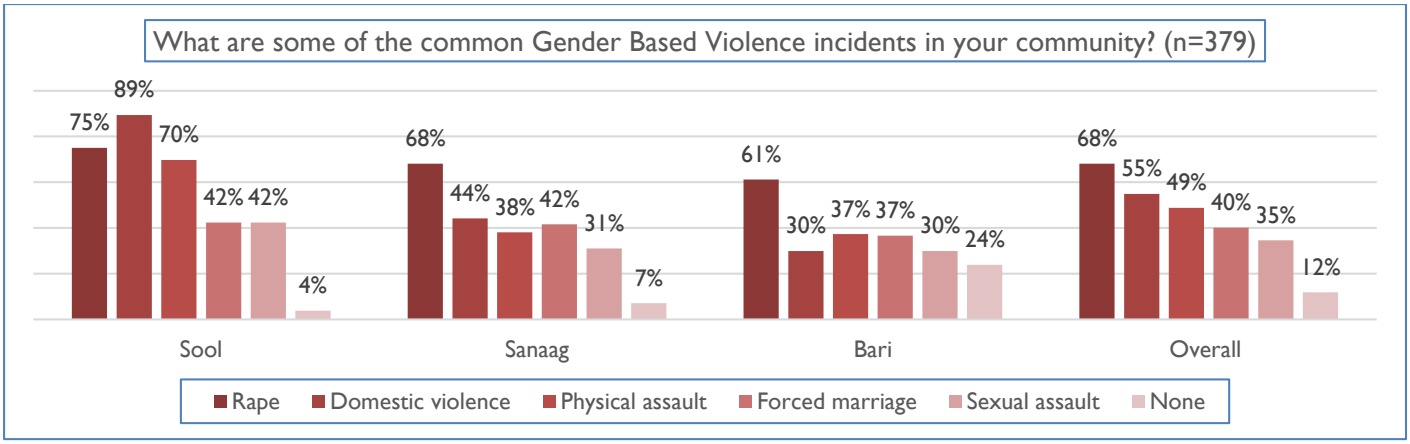
The protection sector of the SRRP project surveyed Sool, Sanaag and Bari regions. In this region, qualitative and quantitative respondents were asked to list some of the common gender-based violence (GBV) incidents present in their community and distribution of findings are as shown in figure below. The most prevalent GBV incidence was rape (68%) which had a proportion higher than 50% across all the regions. Within the regions, the proportion of GBV incidences varied, In Sool rape, domestic violence and physical assaults had been witnessed by more than half of the residing respondents which in Sanaag and Bari region only rape cases were more than 50%, the other GBV incidences in these regions were below 50%. Overcrowding dwellings in the IDP camps, many members of the households sleeping in one room, insecure dwellings, water problems and squalor conditions in IDP camps as well as female headed households were cited as factors leading to GBV cases. *"…we are aware of various forms of GBV including rape, physical assault, forced marriage, FGM," Female FGD respondents, Las Canood.*

On the other hand, although very few (12%) respondents stated to have not witnessed any GBV incidence in their community, qualitative findings indicate that the GBV question is still not talked of openly. This could therefore mean that while a small proportion said to have not witnessed GBV, it does not outrightly mean that it doesn't exist. The most at risk of GBV were said to include the elderly, people living with disability (PLWDs), young boys and girls, minority groups, widows and neglected children.

> *"….We have never seen such things and Allah never brought it to us. It has never happened in our area…. Someone may not say this happened to me…," Male FGD respondents, Somaliland*
>
> *"…The most common types in this community including rape, forced marriage, early marriage, discrimination and marginalization," Female FGD respondents, Caynabo*

Figure 19:What are some of the common Gender Based Violence incidents in your community?

[22] https://www.so.undp.org/content/somalia/en/home/blog1/2017/11/27/Ending-Gender-Based-Violence-in-Somalia-.html
[23] CARE_SRRP Project_Technical Narrative 2019



GBV services were reported to be highly accessible across the 3 regions given the high proportion of both qualitative and quantitative respondents with knowledge of where to access such services (88%) and the high proportion who responded to having accessed protection support services (81%). Overall, similar to a majority if the qualitative FGD respondents, a total of 307 respondents (78% in Sool, 76% in Sanaag and 87% in Bari) had accessed Protection support services. These services were accessed from counsellors and/or GBV focal points. Baseline findings indicate that the community members/target communities had no access (0%) to GBV services[24]. The endline findings therefore indicate increased access to the services with a majority (81%) of the respondents indicating high access to GBV services.

Table 37: Have you ever received Protection Support Services-PSS from counsellor or GBV focal points?

Have you ever received Protection Support Services-PSS from counsellor or GBV focal points?	Sool (n=132)	Sanaag (n=115)	Bari (n=134)	Overall (n=381)
Yes (n=307)	78%	76%	87%	81%
No	22%	24%	13%	19%
Total	**100%**	**100%**	**100%**	**100%**

Subsequently, in addition to improved access to protection support, most of the respondents were more than half of the respondents were confident (95%) very confident (60%) and somewhat confident 36% combined) with the service offered to them at Protection support service 4.6% were not confident. The findings further allude that the respondents were likely (90%) {very likely 52% and somewhat likely (37%) combined} to seek such services in future. A small proportion (4%) of the respondents lacked confidence in the PSS and were likely not to seek these services (8% not likely, 2% definitely not) in the future. The SRRP project evidently provided critical services that were so sought after by survivors of GBV. In addition to counselling, the project offered psychosocial and rehabilitation support to the survivors of GBV.

> *"…in the protection sector, we deal with the GBV survivors, giving support of counselling sessions, psychosocial rehabilitation and also dignity kits and referral of cases to other service providers," Project staff, KII*

Table 38:How confident did you feel when dealing with PSS counsellors/GBV focal points?

How confident did you feel when dealing with PSS counsellors/GBV focal points?	Sool (n=103)	Sanaag (n=87)	Bari (n=117)	Overall (n=307)
Very confident	54%	82%	49%	60%
Somewhat confident	42%	16%	44%	36%
Not confidence	4%	2%	6%	4%
Not at all confident	.	.	1%	0%
Total	**100%**	**100%**	**100%**	**100%**

[24] CARE_SRRP_Baseline Report_Jan2020

Protection services provided across the 3 regions were more effective as noted by respondent who majority rated the efficacy of PSS as excellent (51%) and good (41%). Similar sentiments were echoed by FGD and KII respondents who also rated PSS services provided by the SRRP protection sector while indicating them to be very effective to the survivors. Additionally, it also emerged that CARE played a key role in ensuring the GBV victims were accorded the necessary support whenever an incident such as sexual violence occurred.

"…they did a lot of follow-ups, particularly the GBV focal points work. CARE worked together with them to ensure speedy health checks for victims whenever there is a delay." Coordinator- Ministry of Employment, Social Affairs and Family, KII

Table 39:How would you rate the efficiency of the protection support service in the area?

How would you rate the efficiency of the protection support service in the area?	Sool (n=103)	Sanaag (n=87)	Bari (n=117)	Overall (n=307)
Excellent	54%	48%	50%	51%
Good	34%	44%	45%	41%
Average	11%	7%	5%	8%
Below average	1%			0%
Poor		1%		0%
Total	**100%**	**100%**	**100%**	**100%**

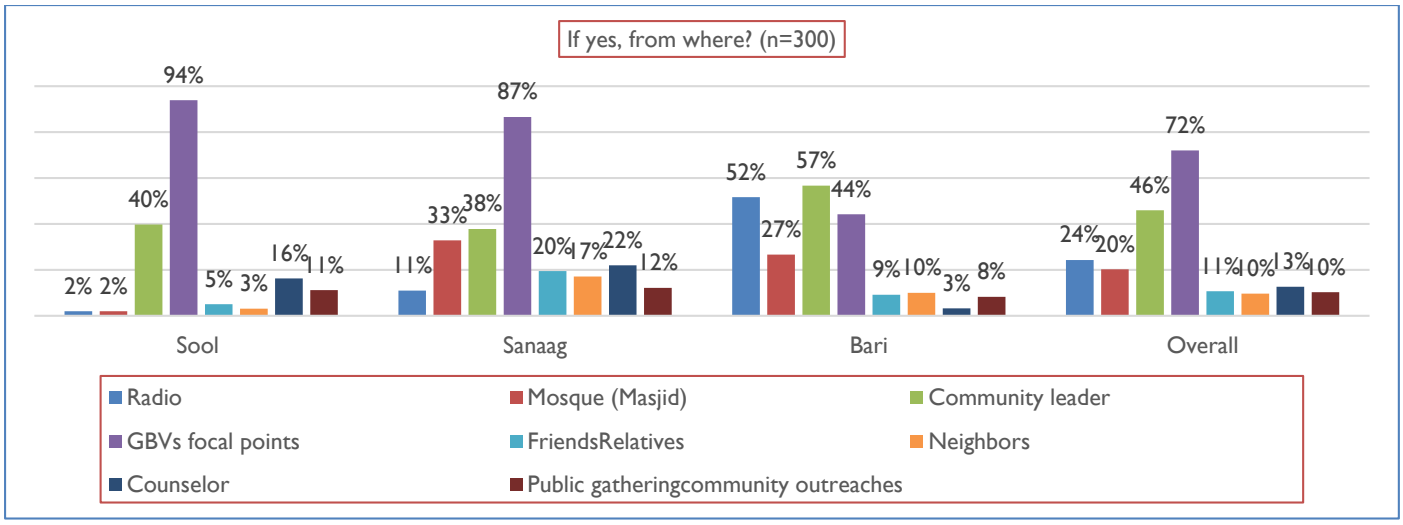
Compared to the baseline (73%%) findings, endline results indicated increased (79%) access to information or training on GBV prevention and risk mitigation were reported in the last 12 months. There was also a drop in the proportion (21%) of respondents who were yet to receive such information/training as compared to baseline which indicated (27%) had not received such information or training.

Table 40: Have you received any information or training on Gender Based Violence prevention/risk mitigation in the last 12 months?

Have you received any information or training on Gender Based Violence prevention/risk mitigation in the last 12 months?	Sool (n=132)	Sanaag (n=115)	Bari (n=134)	Overall (n=381)
Yes	74%	71%	90%	79%
No	26%	29%	10%	21%
Total	**100%**	**100%**	**100%**	**100%**

According to those who reported receiving information, the common source was the GBVs focal points (72%) with less than half of the respondent having accessed the information from radio, counsellor, mosque, friends/relatives, public gathering, neighbours and community leaders.

Figure 20: Sources of information



When respondents were asked about the possibility of reporting GBV incident if they witnessed it, (97%) stated they would report such incidences comfortably. This shows an increase in levels of reporting of GBV incidences as compared to baseline where 64% had indicated that they would report a GBV incident. A small proportion (3%) however wouldn't report a GBV happening in either their household or community. This could be attributed to the stigma that survivors or witnesses would suffer in the community should they be known to have reported. While most respondents showed high willingness to report cases of GBV as a result of information shared, there is need to continue with awareness creation and information sharing on prevention and reporting of GBV incidents.

"…sincerely speaking… our place here is much behind…… People are much shy… unless someone comes with his/her old person, there is no one that comes and report such incident," FGD respondents, Somaliland

Table 41:Would you report any Gender Based Violence if it happens in your household/community?

Would you report any Gender Based Violence if it happens in your household/community?	Sool (n=132)	Sanaag (n=115)	Bari (n=134)	Overall (n=381)
Yes	99%	98%	95%	97%
No	1%	2%	5%	3%
Total	**100%**	**100%**	**100%**	**100%**

Among the places that respondents indicated they would report GBV incidences many indicated that they were comfortable reporting GBV incidences at the police station (82%), community leaders (53%), health facility/hospital 43%), chief's office (24%) and at the masjid (9%). While this was overwhelmingly indicated by most respondents, there was however some level of displeasure among the respondents from all regions; that the perpetrators of GBV are mostly men and that such cases were resolved by a council of elders using customary laws (xeer) to resolve rape cases as communal crimes as well as blood compensation (*diya*) to settle cases. This was said to make young men commit more acts, as they faced no criminal charges or convictions for their actions, and are protected by the customary laws. Some of the FGD respondents shared the sentiments below;

"…Cases sometimes reach the government courts but due to communal understanding are withdrawn and resolved as resolved using civil xeer procedures. There a few cases of people sentenced for years," FGD respondents, Las Canood

"…The most perpetrators including youth in particularly from 18-40 age groups and drug dealers," FGD respondents, Caynabo

Table 42:Where would you report Gender Based Violence case?

Where would you report Gender Based Violence case?	Sool (n=130)	Sanaag (n=113)	Bari (n=127)	Overall (n=370)
Police	86%	90%	70%	82%
Community leaders	59%	43%	56%	53%

Chief	25%	35%	13%	24%
Masjid/Sheikh	6%	12%	9%	9%
Health Facility/Hospitals	60%	50%	18%	43%
Others(specify).	0%	2%	2%	1%

Sanaag region in particular recorded a significant reduction in GBV cases (40%) in the last 12 months. The respondents attributed this to the training and awareness creation around GBV in the community. On the other hand, although most FGD respondents indicated a decrease in GBV cases in Sool region, quantitative respondents had a contrary opinion saying they had not experienced a change in GBV cases (77%).

> *"…after project being implemented the situation has been getting better in term of the Gender based violence," FGD respondents, Caynabo*
>
> *"….The situation is good now, GBV cases has decreased, there was lack of knowledge in the past and people have now received awareness .Where there is community the GBV cases is always there and cannot be eradicated at completely but compared to the past the cases have reduced tremendously," Camp leader, Bari*

In Bari region respondent's opinion on GBV increase, decrease or being constant were roughly of the same proportion. Overall, a significant proportion (almost half) of the respondents stated that GBV cases had remained the same (49%) in their area.

Table 43: In the last 12 months have SGBV related cases increased/remained the same or decreased?

In the last 12 months have SGBV related cases increased/remained the same or decreased?	Sool (n=132)	Sanaag (n=115)	Bari (n=134)	Overall (n=381)
Increased	2%	26%	30%	19%
Remained the same	77%	34%	33%	49%
Decreased	21%	40%	37%	32%
Total	**100%**	**100%**	**100%**	**100%**

With the objective of protecting and supporting GBV survivors, the endline respondents made a number of suggestions for improvement. Awareness creation on reporting mechanisms for GBV (73%) and enforcing laws against GBV perpetrators (73%) were the topmost opinions on protection that could be afforded GBV survivors. Creation of safe spaces for GBV survivors was also proposed by more than half of the respondents in Sool (62%) and Bari (62%). Community education on penalties for GBV was highly proposed by Sool respondents (69.7%).

It was also observed that most of the propositions for protecting GBV survivors were supported by Sool respondents; a region that also reported high rates of GBV incidences.

Table 44: What can be done to protect SGBV survivors?

What can be done to protect SGBV survivors?	Sool (n=132)	Sanaag (n=115)	Bari (n=134)	Overall (n=381)
Enforcing country laws against GBV perpetrators	67%	87%	66%	73%
Creating safe spaces for GBV survivors	62%	39%	62%	55%
Creating awareness on GBV helpline and report mechanisms	78%	62%	77%	73%
Educating the community on penalties associated with GBV	70%	42%	27%	46%
Others (specify)	1%	5%	0%	2%

Protection- Key Takeout

- A significant reduction in GBV cases (40%) in Sanaag region in the last 12 months;
- The main source of GBV information was GBVs focal points (72%);
- The most at risk are PLWDs, elders, neglected children, young boys and girls, women;
- Factors leading to GBV included squalor conditions in the IDP camps, overcrowded households, lack of water such that women have to trek long distances to fetch water, insecure dwellings as well as female headed households who lack a male figure;
- There was increased access to GBV services with at endline (81%) as compared to baseline (0%);

- There was increased willingness to report GBV incidences with a majority preferring to report to the police station (82%),
- There was increased (79%) access to information or training on GBV prevention and risk mitigation at endline results as compared to baseline (73%%).

3.3.6 Sector 6 - Water, Sanitation and Hygiene (WaSH)

Overall objective: To increase equitable access to safe and affordable drinking water and hygiene services for all and prevent waterborne-related diseases.

Attainment of Objectives

- Findings indicate a strong achievement of the WaSH sector objective;
- Improved access to improved water services and other hygiene facilities like latrines was evident with OFDA funding;
- Water use committees were created and trained by the SRRP project;
- High levels of hygiene promotion were reported among respondents;
- A majority of respondents received WaSH NFIs and were satisfied with the contents.

The WaSH sector assessment was carried out in five regions of Sool, Sanaag, Bari, Galgaduud and Hiraan; areas that the WaSH project was implemented. On any typical day, each household in the regions on average utilized 86.4 litres (SD 70) of which averagely 21.1 litres were from the rehabilitated water source in the community. Water sources for households were mostly piped into households, boreholes/wells and protected springs.

"…we get water from the well and borehole," FGD respondents, Somaliland

"…No there is a big well-constructed by Save the children after CARE where they connected taps, people use those taps and also the Barkat constructed by CARE.," FGD respondents, Bari

Table 45:What Is the main source of water for your household use?

What Is the main source of water for your household use?	Sool (n=81)	Sanaag (n=95)	Bari (n=161)	Galgaduud (n=80)	Hiraan (n=150)	Overall (n=567)
Piped water	44%	3%	33%	10%	41%	29%
Borehole/wells	25%	29%	35%	90%	29%	38%
Protected springs	11%	37%	15%		6%	14%
Protected Rain water collection system		1%	11%			3%
River		4%			19%	6%
Water vendors	15%	18%	1%			5%
Others(specify)	5%	8%	5%		5%	5%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

When asked whether they treated their drinking water, most quantitative (80%) households as well as the qualitative respondents in all the survey regions indicated that they treated their drinking water. The proportions in the regions included a high level in Sanaag (60%), Bari (91%), Galgaduud (100%) and Hiraan (93%) region but less in Sool (40%) region. While the DRPS evaluation indicated (37%) of the surveyed households reported treating their water, the baseline study noted that a vast majority of households did not treat their water as reported. There is therefore an increase in water treatment practice at endline comparatively. Drinking water treatment methods were said to include boiling and adding of chlorine, which was practiced by most of the respondents (64% and 61% respectively) across the 4 regions. Other uncommonly used methods were filtering using clay (17%), cloth strainer (7%) and letting drinking water stand and settle (4%).

Table 46:Does your household treat drink water?

Does your household treat drink water?	Sool (n=81)	Sanaag (n=95)	Bari (n=161)	Galguduud (n=80)	Hiraan (n=150)	Overall (n=567)
Yes	39%	60%	91%	100%	93%	80%
No	61%	40%	9%		7%	20%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

A small proportion (20%) of household respondents indicated that they did not treat their drinking water. Some of their reasons for not treating their drinking water included lack of treatment chemicals (38%), some thought the water was already clean (22%) while another proportion cited lack of time (22%). Another smaller percentage (10%) of respondents lacked knowledge on how to treat their drinking water at home.

Water storage is a key component in ensuring safe water for drinking and household use. The endline findings indicate that the most common containers for drinking water storage were jerrycans (61%). The drinking water storage containers were cleaned on different occasions either daily, weekly or on every other day. Interestingly, a smaller proportion admitted to never cleaning their drinking water storage containers (4%: 6% Sanaag and 10% Bari), or only cleaned them on monthly basis (3%: 15% Sanaag and 3% Bari). It was also mentioned that most of these drinking water storage containers had lids (88 %).

"…We just store them in drums and cover them to protect from insects," VRC member KII, Somaliland

"…we store in jerrycans, underground tanks (Berkad) and we sometimes use drums…," FGD respondents, Somaliland

Table 47: Where do you store your water for drinking at home?

Where do you store your water for drinking at home?	Sool (n=81)	Sanaag (n=95)	Bari (n=161)	Galgaduud (n=80)	Hiraan (n=150)	Overall (567)
Jerry cans	75%	59%	60%	89%	41%	61%
Drum	20%	31%	12%	6%	58%	27%
Bucket	5%	6%	26%	5%		10%
clay pot (Ashun)	.	2%	1%		1%	1%
Other [Specify]	.	2%	1%			1%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Hygiene promotion:

More than three quarters (78%) of the endline respondents stated that they had been trained on safe water treatment and storage practices. They had been trained by organisations such as CARE Organization (51%) or local NGO such as WASDA.DBG or WARDI (47%) or by government agents (1%). The was an indication from the respondents that the training had come in very handy and was helpful (95%); (42% extremely helpful and 53% very helpful combined) to the respondents whom a majority stated that they were practicing what they had been taught.

"…They were 8 people who were trained," FGD respondents, Somaliland

*"…CARE built for us this pool /Barkat when there was a time, we faced water shortages, the kids would fetch water long distance with cracked jericans that can't hold water and bring the jerican half empty and also the poor hygiene in the camp. After building the Barkat they trained a team to do hygiene promotion awareness, CARE did a lot for us and we really appreciate," FGD respondents, B**ari***

Table 48: Have you/your household been trained on safe drinking water storage practice?

Have you/your household been trained on safe drinking water storage practice?	Sool (n=81)	Sanaag (n=95)	Bari (n=161)	Galgaduud (n=80)	Hiraan (n=150)	Overall (n=567)
Yes	57%	61%	86%	100%	81%	78%
No	43%	39%	14%		19%	22%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

It was evident that more than 90% (Once in a while 16%, Every so often 43% & all the time 31% combined) practised what they had been taught.

Table 49: How often are you able to practice what you learnt?

How often are you able to practice what you learnt?	Sool (n=81)	Sanaag (n=95)	Bari (n=161)	Galgaduud (n=80)	Hiraan (n=150)	Overall (n=567)
Once in a while	18%	22%	22%	11%	7%	16%
Every so often	25%	43%	47%	85%	26%	43%
All the time	27%	18%	28%	4%	58%	31%
Not at all	30%	17%	3%		9%	10%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Endline respondents indicated high levels of awareness of water committees present among both qualitative and quantitative respondents in the surveyed regions. A slightly higher proportion of awareness of the committees was observed in Sool (84%), Bari (86%), Galgaduud (100%) and Hiraan (95%) as compared to awareness levels in Sanaag (58%). A general outlook on WaSH implemented program in the target regions indicated a significant impact to a majority of households in all the 5 regions (92%).

> *"…yes we are aware of the committees and they are trained….. it is CARE who trained them. Their work is awareness creation on hygiene related issues in the towns," FGD respondents, Somaliland*
>
> *"..There is a committee made of men and women of 7 in number. Those 7 people also gave it to one responsible man who looks after the pool/Barkat and he lives close to the pool/Barket like the husband and wife," FGD respondents, Bari*

Table 50: Are you aware of existence of water management committees in your area?

Are you aware of existence of water management committees in your area?	Sool (n=81)	Sanaag (n=95)	Bari (n=161)	Galgaduud (n=80)	Hiraan (n=150)	Overall (n=567)
Yes	84%	58%	86%	100%	95%	85%
No	16%	42%	14%		5%	15%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Sanitation

Sampled households with clean latrines constituted of 86% of which 61% stated that they shared such latrines with other households. On average, 5 households shared a latrine, and only 39% had latrines only for their household use. The 14% households that lacked latrines defecated in the street/open area/bush or riverbanks. Households (3%) that lacked latrine defecated in the streets/open area or bushes (84%) river bunks were from Bari. *"..Yes we have latrines, but not all people do. They are still people lacking latrines/ toilets in the IDPS therefore due to insufficient latrines 3 families use one toilet," VRC member KII, Somaliland*

Table 51: Do you/your household have access to clean latrine?

Do you/your household have access to clean latrine?	Sool (n=81)	Sanaag (n=95)	Bari (n=161)	Galgaduud (n=80)	Hiraan (n=150)	Overall (n=567)
Yes	57%	75%	88%	100%	99%	86%
No	43%	25%	12%		1%	14%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

High levels of awareness on critical hand washing times were observed among both qualitative and quantitative respondents. A majority of them stated before eating (89%), a response that was similarly high in proportion at baseline survey (93%). Across all the surveyed regions, most respondents were able to identify the critical times for handwashing. The respondents further indicated they had access to water and soap for handwashing purposes (84%) within their households. Compared to the baseline findings (70%), endline data indicate that only 31% participants were able to recall 3 critical times for washing hands thus showing a significant drop in awareness levels. Another small proportion (2%) did not know the critical times to wash hands. Other occasions identified by respondents as critical for handwashing are shown in table below. While the overall score shows a low proportion, who were

aware of the three critical times to wash hands, the qualitative KII and FGD respondents were very aware and also confident that the community members were aware of the critical hand washing times with a majority of them indicating that the levels of awareness received by the beneficiaries was very high. *"…they have a very positive perception. Especially washing hands before and after meals and also washing hands after use of toilet facility," VRC member KII, Somaliland.*

"….after using the toilets, after cleaning the baby or removed diaper, even after you wake up from sleep, after cleaning the house and before preparing food," Male and female FGD, Carmale, Somaliland

Table 52: What are the critical times to wash hands?

What are the critical times to wash hands?	Sool	Sanaag	Bari	Galgaduud	Hiraan	Overall (n=567)
Before eating,	100%	85%	84%	96%	88%	89%
Before cooking or preparing food,	79%	59%	73%	81%	67%	71%
After cleaning a child defecated or changing nappies,	77%	59%	57%	41%	70%	61%
After cleaning toilet or potty,	74%	56%	39%	36%	81%	58%
After defecation,	88%	59%	36%	71%	29%	50%
Before breastfeeding or feeding a child	56%	17%	21%	26%	53%	35%
Don't know	0%	3%	3%	0%	3%	2%

On hygiene promotion, the most communicated hygiene promotional information/training by CARE directly or by affiliate organizations was said to be critical handwashing times (82%), water cleaning/purification methods (72%), personal hygiene (68%) and latrine usage (68%) as recalled by 81% of respondents who had received such information. Other Hygiene promotional messages received by respondents were on Garbage collection (31%) and animal faeces (4%). *"…They formed teams that will clean the environment every Friday. We formed 3 groups of ladies who work voluntarily every Friday and clean the environment. They also taught us how to dispose children's waste to latrines and washing hands with soaps regularly after visiting the toilets. So, they've done a lot on the side of hygiene and sanitation," FGD respondents, Bari*

Table 53: Have you or your household received any promotional information or training on hygiene from CARE or any other organization supported by CARE?

Have you or your household received any promotional information or training on hygiene from CARE or any other organization supported by CARE?	Sool (n=81)	Sanaag (n=95)	Bari (n=161)	Galgaduud (n=80)	Hiraan (n=150)	Overall (n=567)
Yes	62%	64%	84%	100%	87%	81%
No	38%	36%	16%		13%	19%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

If yes, what were the promotional about?	Sool (n=50)	Sanaag (n=61)	Bari (n=135)	Galgaduud (n=80)	Hiraan (n=131)	Overall (n=457)
Personal hygiene	98%	89%	87%	26%	53%	68%
Critical handwashing	94%	74%	70%	84%	94%	82%
Water cleaning/purification	78%	74%	62%	71%	79%	72%
Use of latrines	76%	59%	53%	80%	77%	68%
Garbage collection	64%	28%	43%	14%	19%	31%
Animal faeces	4%	5%	5%	0%	3%	4%

The hygiene promotional information/training had been useful to households across the surveyed regions given that 41% and 51% households stated the message had been extremely useful and very

useful respectively. A majority of the qualitative respondents indicated that the hygiene promotion and access to clean water had reduced cases of waterborne diseases as they were trained on safe water handling, and treatment.

"…We really practice what we were trained by CARE. Before we used to face waterborne diseases like diarrhea but now, we are very careful, the condition of the water is very good," FGD respondents, Bari

"..The impact of the project is felt a mong community especially the Sanitation program due to the people observing the guidelines provided by the Project implemented agency, VRC member KII, Somaliland

Table 54: How has the promotion message been useful to you and your household?

How has the promotion message been useful to you and your household?	Sool (n=50)	Sanaag (n=61)	Bari (n=135)	Galgaduud (n=80)	Hiraan (n=131)	Overall (n=457)
Extremely useful,	76%	51%	49%	51%	9%	41%
Very useful,	18%	47%	40%	49%	78%	51%
Slightly useful,	6%	2%	10%		13%	7%
Not at all useful	.		1%			1%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

WASH NFIs

63.8% of the surveyed households had received WaSH non-food items (NFIs) assistance of whom a majority were residents of Hiraan (92%) and Bari (68%) regions. A quarter of respondents in Galgaduud had also received WaSH NFIs assistance; a low proportion as compared to other regions. The rest of the regions of Sool and Sanaag each had 51% and 56 % respectively of respondents who had received WASH NFIs.

The contents of the WaSH NFIs consisted mostly of Jerrycans (87%), sanitary pads (62%), wash basin (56%), laundry soap (54%), water jug (53%) and aqua tabs (46%). Other goods that the respondents had received as part of WaSH NFIs were a torch, a bucket and a cash voucher.

"…The package had basic household items like laundry soap," FGD respondents, Somaliland

On the contrary however, while most of the respondents indicated to have received the NFIs, a significant proportion of both qualitative and quantitative respondents had not received any NFIs. Of those who received the NFIs, a majority of the respondents indicated high levels of satisfaction with the quality, quantity and contents of the WaSH NFIs they received.

Table 55: what was the content items of the hygiene kit your household received

If yes, what was the content items of the hygiene kit your household received	Sool (n=41)	Sanaag (n=53)	Bari (n=110)	Galgaduud (n=20)	Hiraan (n=138)	Overall (n=362)
Jerry cans	100%	83%	66%	100%	99%	87%
Sanitary pads	56%	45%	41%		97%	62%
Wash basin	37%	26%	34%		99%	56%
Laundry soap	17%	55%	22%		98%	54%
Torch	7%	40%	15%		1%	11%
Water jug	68%	49%	26%	10%	78%	53%
Bucket	29%	30%	16%		4%	14%
Water purification tablets (Aqua tabs)	34%	19%	9%		96%	46%
Cash or voucher	5%	2%				1%

Key-Takeout

- Improved access to clean water and other hygiene facilities like latrines was evident;
- WaSH messaging was useful to the beneficiaries;
- Main sources of water were wells and boreholes;
- High levels of awareness on critical hand washing times were demonstrated;

- The beneficiaries were trained on safe drinking water storage practice;
- Jerricans were the common water storage items;
- Boiling and adding chlorine to water was the common practice of water treatment among the respondents.

3.4 Feedback Mechanisms

Most of the respondents (82%) were well informed about the CARE SRRP project being implemented in their regions and especially the services the project was going to provide (56%). Generally, there was insufficient information on how long the project was going to last (5%) or who the donors were (11%) or even how to get feedback on the project (5%) that had been communicated to respondents.

Table 56: What specific information were you given?

What specific information were you given?	Sool (n=411)	Sanaag (n=349)	Bari (n=482)	Mudug (n=131)	Galgaduud (n=190)	Hiraan (n=150)	Lower Juba (n=108)	Overall (1821)
The services the project will provide	68%	61%	54%	90%	31%	1%	82%	56%
Donor who funded the project	0%	16%	18%	7%	29%			11%
The duration of the project	1%	7%	8%	1%	5%	4%		5%
Feedback and information sharing mechanisms	2%	6%	13%	1%				5%
Community committees working the project at the community level	29%	10%	7%	1%	35%	95%	18%	23%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Different regions had been informed about the project by different stakeholders, and although a majority of respondents had received information from CARE staff (60%) this proportion was high only in 4 regions: Sool (86%), Sanaag (77%), Bari (76%) and Mudug (83%), the other 3 regions (Galgaduud 99%, Hiraan 81% and lower juba 100%) had mostly been informed about the project by either WASDA or DBG or WARDI. Additionally, government officials (2%), community committees (9%) and other community members (4%) had been instrumental in communicating about project information though at a small scale.

Table 57: Who provided this information?

Who provided this information?	Sool (n=411)	Sanaag (n=349)	Bari (n=482)	Mudug (n=131)	Galgaduud (n=190)	Hiraan (n=150)	Lower Juba (n=108)	Overall (1821)
CARE Staff	86%	77%	76%	83%				60%
Partner (WASDA, DBG, WARDI)	.	1%	6%	11%	99%	81%	100%	25%
Government officials		1%	6%	5%				2%
Community committees	7%	16%	11%	1%	1%	11%		9%
Other community members	7%	5%	1%			8%		4%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Respondents at Hiraan (81%) region were mostly unaware of how they could report any grievances, issues or concerns about project and /or programs by CARE. This was a complete contrary scenario in other regions where more than half (majority)of respondents were aware of the reporting mechanism for CARE implemented projects. This was however attributed to the newness of the location to CARE programming although the partner agency in the area had been trained by CARE team on the setting up

and maintaining effective feedback mechanism. Overall, most of the qualitative and quantitative (69%) respondents were aware of how they could report an issue about the CARE program. As at the endline assessment, about a third (39%) had reported an issue and many had used either toll free line (34%) or reporting through community leader (41%). A bigger proportion of the 15% respondents who had reported their concern/issue directly to CARE staff or project partner were residents of Sool region (46%). The rest (10%) of the respondents had visited CARE or partner offices to raise their concerns.

"..yes are aware of the feedback channel. We were given the number to call for any complaints. The contact is 301, you dial it if you've any complains," FGD respondents, Bari

Table 58: Are you aware of existing reporting mechanism for your grievances, issues or concern on the project and/or programs implemented by CARE

Are you aware of existing reporting mechanism for your grievances, issues or concern on the project and/or programs implemented by CARE?	Sool (n=411)	Sanaag (n=349)	Bari (n=482)	Mudug (n=131)	Galgaduud (n=190)	Hiraan (n=150)	Lower Juba (n=108)	Overall (n=1821)
Yes	60%	70%	74%	85%	84%	19%	99%	69%
No	40%	30%	26%	15%	16%	81%	1%	31%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Table 59: What channel did you use to share your concern with CARE/partner

If yes, what channel did you use to share your concern with CARE/partner?	Sool (n=57)	Sanaag (n=105)	Bari (n=265)	Mudug (n=47)	Galgaduud (n=120)	Hiraan (n=9)	Lower Juba (n=104)	Overall (n=707)
Toll free line	49%	71%	40%	66%	3%	11%		34%
Report through community leader	5%	7%	32%	30%	68%	67%	87%	41%
Visit CARE/partner offices	.	3%	22%	2%	3%	22%	2%	10%
Tell CARE/partner staff member about the issue/concern	46%	19%	6%	2%	26%		11%	15%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

CARE staff and project partner staff were deemed to be responsive to concerns raised (85%) by many of the respondents across all the 7 regions. The respondents also expressed very high satisfaction levels (97%: 39% very satisfied and 59% satisfied combined) with the response received. On the contrary, although level of response to concerns raised was rated highly in 6 regions (Sanaag 73%, Bari 93%, Mudug 85%, Galgaduud 95%, Hiraan 78% and lower juba 100%), Sool's rating on CARE staff for non-responsiveness to concerns raised was very high (75%).

Table 60:Did you get response/feedback from CARE/partner regarding your issue/concern

Did you get response/feedback from CARE/partner regarding your issue/concern?	Sool (n=57)	Sanaag (n=105)	Bari (n=265)	Mudug (n=47)	Galguduud (n=120)	Hiraan (n=9)	Lower Juba (n=104)	Overall (n=707)
Yes	25%	73%	93%	85%	95%	78%	100%	85%
No	75%	27%	7%	15%	5%	22%		15%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

In terms of feedback, respondents observed that they received feedback from CARE or partner staff mostly within a day or in a day (66%: 36% within a day, 30% a day), on very few occasions (3%). On some occasions, feedback or response was received within 2 days (15%) or a Week (13%).

Table 61:how long did it take to receive this feedback/response

If yes, how long did it take to receive this feedback/response?	Sool (n=14)	Sanaag (n=77)	Bari (n=247)	Mudug (n=40)	Galguduud (n=114)	Hiraan (n=7)	Lower Juba	Overall (n=603)

							(n=104)	
Within a day	7%	28%	32%	63%	29%	43%	49%	36%
Day	57%	17%	47%	33%	12%	57%	13%	30%
2 days	22%	12%	7%	2%	52%		4%	15%
Week	14%	17%	8%	2%	7%		33%	13%
Month	.	5%	5%				1%	3%
Others (specify)	.	21%	1%					3%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

3.5 Sustainability

To what extent was the project fully sustainable (including high level of community ownership, clear long-term planning and buy-in, and continued resources to sustain itself)?

The SRRP project created community ownership by working with the community structures to ensure that services would continue even after project closure. The project established the water management committees for each borehole they rehabilitated where the respective boreholes were handed over to the committees to manage them. The water management committees were also trained on water source management for continuous supply in the long run. This therefore means that the communities have the responsibility to manage the water for a long time since the committees were identified from and by the community members. The committee members identified were deemed to have the knowledge and the capacity to handle water issues. *"…Yes, we going to continue, the community awareness and sensitization, the training we received and inherited will make us continue, we will continue carrying out the community awareness and sensitization," Camp leader KII, Bari*

The knowledge gained during counselling sessions, the establishment of mother-mother support groups, were great structures that could continue even after project closure. It emerged that some volunteer mothers who advise their fellow mothers existed in the project and could continue with the sensitization on IYCF.

For the health and Nutrition sectors, the project trained, equipped health facilities and seconded staff from the ministry of health Puntland and Somaliland so that they can still continue to run the services within these facilities. The training therefore has given the staff long term skills to run the project activities in the Wash sector.

"…for instance, for the WASH we have actually handed over to the relevant ministries, we have also set up water management committees at the community level who will have the ultimate ownership to sustain the project and do minor rehabilitation," Project staff KII

The water management committees were trained on basic repair skills and if there is actually a system failure at some point, the minor rehabilitation can be handled by them.

The community members were also involved right from the design and implementation stages of the project and played a critical role by their involvement in needs assessment that was carried out before the project begun. The needs assessment identified community needs and thus the SRRP project was needs oriented. This thus ensured community ownership and buy in thus ensuring that the different project sector activities will continue even after closure. Similarly, there are community structures established in all sectors, so as to ensure service continuation. *"…from the assessment level, the community become the owners and ensure services continue long after the end of the project," Partner KII*

It was widely mentioned by FGD respondents the project was sustainable since the skills and knowledge acquired from the SRRP project was already being practised. *"…whatever we learnt from CARE will continue even if they leave and there is nothing we will abandon or forget," FGD respondents, Bari*

The government also partnered in the project and played a critical role from the design, inception and implementation of the project through its line ministry. The government is also involved in coordination, where it supports the health facilities that are managed by the ministries of health of Puntland and Somaliland, the MOH staff as well. This therefore means that when the project ends, the communities alongside the government will be able to run the health services independently.

Subsequently, the project design is sustainable in itself since its main sectors are sustainable and core to the community members and government. The project engaged all community level structures right from the grassroots levels to national levels. Through the ERMS sector, the project rehabilitated roads as well as degraded land; activities that are sustainable for a long term. *"..People will still continue to access these roads as well as use the rehabilitated land for their use as there is reduction in erosion,"*

The project further, as part of its exit strategy will carry out a detailed handover as well as organise and support the relevant authorities with the technical skills should they need.

It was also observed that sustainability of the project is assured as an extension of the project was given. The project staff therefore mentioned that the project would continue to discharge its services in the areas where they are working currently. There was also a mention of possible considerations of more target areas especially health and nutrition facilities.

3.6 Contributing factors

Contributing factors include the major factors influencing success and major challenges to achieving the project's objectives. It emerged from the endline findings that CARE's long-term presence in Somalia allowed them to understand the context of the project areas as well as implement project activities based on the real community needs as opposed to assumptions. Its presence has also allowed the organisation to build a great working with these communities for a long time thus experiencing community buy in on the project. *"..Engagement of the community enabled the success of the project in that we get the right assessment from them," Project staff KII*

Subsequently, well-qualified and experienced staff also contributed to the project success. Their technical knowhow enabled the project to run seamlessly while adhering to all the project implementation protocols thus achieving the set objectives.

The project activities and services offered by the SRRP project were relevant to the context and needs of the community at the time. The project activities were designed and implemented together with the community members thus more targeted. *"… the cash for work activity was implemented at the right time people needed it, the rehabilitation of the water the same, which means the assessment and the needs, were from the community," Implementing agency, KII*

Coordination, complementarity and integration of the project activities was also cited as another critical factor in the SRRP project success. In addition, the coordination and partnership with the government ensured their support to the project thus ensuring success.

Some of the challenges experienced during the project implementation included natural calamities such as locust invasions, floods, COVID-19 pandemic, conflicts and surge in beneficiary numbers. Such challenges could lead to delays in delivering the project activities as planned and worse off could lead to change in the project design so as to address the crises that arises from such. *"..I remember [due to the floods] in Beletweyne, we made modifications to the project budget in order to deliver some support to the communities," Project staff, KII*

While these challenges were mentioned, the project teams were able to mitigate them and still achieved the project objectives as per the planned timelines and budget lines.

3.7 Adaptability and Flexibility

The project was said to be highly flexible and adaptable in the face of challenges. When faced with conflicts between community members, the project team adapted to the situation by integrating CARE's security strategy to act as a guideline to the team to ensure implementation of the project while at the same time ensuring their safety and security.

During the COVID-19 outbreak, CARE developed the country office strategy, which spells out guidelines on project implementation which included standard operating procedures (SOPs) and compliance with all the global and national health requirements. These guidelines were said to have been very effective as project implementation continued without interruption at the field levels. The CfW activities for instance were changed to unconditional cash transfer to avoid the spread of the COVID-19 to the community during the rehabilitation and implementation of cash for work activities. Additionally, mobile money transfer was adopted in move to stop the spread of COVID-19 through thumbprints and signing of cash receipts.

When faced with the challenge of floods, and with the approval of the donor, the project modified its budget to accommodate support to the people affected by floods in Beletweyne.

3.8 Similar Interventions

Endline findings indicate similar interventions being implemented within CARE. According to the project team, most of the projects implemented at by CARE complement each other in different components so as to ensure synergy and achievement of high scale results. Some of the projects complementing each other at CARE were said to include EFSP, HBCC, JC, DRPS and SRRP. These projects worked in such a way that if one of them misses out on one sector, the other project could come in to address that gap/need. Additionally, CARE's role in coordinating other humanitarian organisations through the clusters has allowed synergy and complementarity between the organisations thus avoiding duplication and overlapping of programmes. Other agencies therefore were said to implement complementary projects although there was no mention of the names.

3.9 Efficiency

There was maximum utilization of resources according to the SRRP project team. The use of the BVA (budget variance analysis) enabled the project to balance between project activities alongside the costs thus allowing them to implement all the activities while at the same time saving some cash. The savings made by the project were then reallocated to more target beneficiaries in different areas thus enabling the project to surpass its original targets. CARE human resource was also well utilised where the project leveraged on facilities such as vehicles and project staff of other already existing projects.

Internal utilization of human resource, particularly the MEAL and technical staff in carrying out assessments and studies enabled the project save some money that would have otherwise been paid to an external consultant to carry out the assignment.

3.10 Value for Money

The SRRP project ensured efficient use of small resources while delivering the best quality of services to the beneficiaries with the lowest cost, which was done some saving from some budget lines. The water kiosks and water tanks were rehabilitated according to the required standards and the materials were on used were of high quality. That could therefore mean that more money can be saved and used it to rehabilitate more boreholes and reach more beneficiaries. Additionally, the project carries out a

monthly budget monitoring together with the technical team who recommend the materials to use in each activity. The procurement guidelines have been very efficient thus ensuring the achievement of project objectives within the required timelines and budgets.

3.11 Innovation

The SRRP project realised key innovations to improve its service delivery to the beneficiaries. Some of the projects that adopted innovation include the Voice ID project; a biometric beneficiary identification system, that was used during disbursement. The system is used to identify beneficiaries through their voices whenever they are due to receive their disbursements.

The project also currently uses biometric registration system to register project beneficiaries for easy identification and avoidance of duplication of names. The project also used mobile money transfer services in place of cash money. In addition to the commodity tracking systems pilot project; a system that will help in tracking the stock flow within the health facilities, the project is also in the process of developing a digital app for maternal health that will be used to record personal information of pregnant mothers and improve ante-natal coverage and health facility deliveries while at the same time linking the community health workers to these women for support services.

4 Cross-cutting Issues

The SRRP project addressed crosscutting issues including protection; a sector that was fully mainstreamed to all the sectors in the project. All community members were involved in identification of beneficiaries, CfW activities and establishment of the beneficiary registration committees. The project was also keen in ensuring that the minority groups including PLWDs are included in the project. A selection criterion was developed and used in the establishment of the committees so as to ensure that 60% of them are women. The project also mainstreamed protection to WASH where the rehabilitation management committees were also a part of the hygiene awareness committees. Most of them were women who did awareness campaigns. CARE also implemented its gender guidelines and also trained its FSL, WASH and Nutrition staff, on how to mainstream protection to other sectors. *"…all sectors of the project were therefore fully mainstreamed into the protection," Project staff, KII*

5 Lessons learnt

What worked well

- Community engagement in the project ensured successful implementation often project activities within the set timelines;
- The coordination and networking with the government line ministries and other actors enhanced CARE's success in the project;
- The need-based approach adopted by the project enhanced its success and community buy in thus realising high results;
- The project adaptability and flexibility allowed it to surpass its target objectives;
- The adoption of BVA allowed the project team to manage the project resources well.

6 Conclusions and recommendations

6.1 Conclusions

The SRRP project endline assessment was conducted to establish the impact of the investment by measuring change after the project implementation in the target areas and locations as well as measure the project performance by evaluating the project outputs and outcomes alongside the provided

timelines. Based on the specific objectives examined in the study, the following conclusions and recommendations can be drawn;

General observations

It is evident that the project was relevant to the needs and priorities of the community members. Both male and female respondents participated in this assessment.

ERMS

Many adults were engaged in an income generating activity and at household level many households had engaged in cash assisted program to boost their income, this income was mostly spent on food. Food consumed by household comprised of diet that were at an acceptable range on FCS. In terms of security, although few households were categorized as being severely food insecure only 35% were food secure.

Nutrition

Nutrition messages had a wide coverage with a large percentage of respondents being able to recall at least two messages. Although most of them recalled the messages, the proportion of those practising the nutrition messages was low. The nutrition messages were perceived to be useful, effective and beneficial to respondents' households and although they faced challenges in implementing the messages most of respondents were able to fully implement what they had learnt. This was mainly as a result of inadequate income for households thus limiting mothers from accessing a variety of food to allow them produce sufficient milk for their infants. Child breastfeeding was widely practised across the regions with reasons for not breastfeeding being high food prices, social norms, poor child spacing and mothers ill forcing child to be mixed fed. Mother-to-mother support groups were very visible in Sool, Bari and Lower Juba region and had proven to be very important to households with expectant members or breastfeeding mothers. Suggestion on how CARE could improve diet diversity for children included provision of monetary support while education for mothers was recommended for 6 months exclusive breastfeeding.

Health

Health facilities provided good variety of services that were rated by most participant as excellent. The facilities' operation hours though convenient to many, some respondents could not access services at the facility because the facility closed early. On very few occasions did respondents miss any drug or medical supply at the facility. Expectant mothers had accessed ANC and PNC services and at different frequency at the health facility. Deliveries were free at both public and private health facility rationale that can be attributed to many deliveries that had occurred at the health facility. Most children had been routinely vaccinated. Health messages including on COVID-19 prevention and practices had been communicated to participants and these messages had resulted in healthier children, reduction in sickness and improved wellbeing plus knowledge on health issues.

Protection

GBV incidences in Sool were high compared to the other surveyed regions which unfortunately 77% stated that in the last 12 months it had remained the same. Just like in all the other regions, most respondents from Sool also stated that they would report any GBV incident if they came across it either to the police, community leader, chief, masjid/sheikh or at the hospital. There was high awareness on how and where to access GBV services in the surveyed regions. A majority were confident with the services they had received from GBV focal points and stated their likelihood to revisit for services in future.

WaSH

In many households drinking water was treated either by boiling, adding aqua tabs, clay filters, cloth strainers or just letting the water settle then stored in a container that most likely had a lid. CARE and other local NGOs had trained (78%) of the participant households on safe drinking water storage practices which the households stated to mostly practice every so often. WaSH implemented program had impacted (92%) of participant households and members. Many households had a latrine that they shared with other households. Promotional messages which had been extremely useful to many participants were sent by CARE and affiliate organizations. WaSH NFIs had been distributed to more than half of the participants, who expressed satisfaction with the contents, quantity and quality of the items received.

Feedback

Generally, CARE staff were responsive to issues raised by the community in most of the regions with exception to Sool where (75%) of issues were so far unanswered. A majority of the respondents were aware of the toll-free line for reporting any concerns.

6.2 Recommendations

- **ERMS:**
  - Although few households were categorized as being severely food insecure only 35% were food secure. This therefore means that there was a larger proportion of households who were neither here nor there. There is therefore need for follow-up programmes that will support households to achieve food security.
- **Nutrition:**
  - While high results were achieved in this sector with a majority of households achieving its recommended nutritional status, there is need to improve diet diversity for children by providing monetary support and education on 6 months exclusive breastfeeding to mothers. There is need to support nutrition beneficiaries with cash so as to allow them follow through the messaging by practising them.
- **Health:**
  - With the health sector achieving its objective of enhancing access to healthcare services to pregnant and lactating mothers and children U5, there is need to consider scale up of the health sector in the regions where some respondents indicated lack of access to health services due to long distance to the facility or inconvenient operation hours.
- **Protection:**
  - while the project has achieved commendable scores in addressing protection issues in the survey regions, some regions like Sool still recorded high numbers of GBV cases. \there is therefore need for scaleup and follow-up on these locations so as to continue with the intervention so as to reduce the numbers. A change of approach; community-centered approach might be critical for better results.
- **WaSH:**
  - The WaSH component achieved great success in ensuring that beneficiary households have access to clean water as well as hygiene and sanitation information. While this is an indication of success, there is need to continue with community sensitization on drinking water treatment and water storage.
  - Additionally, a majority of the respondents indicated that they buy water for domestic use; a majority of qualitative respondents cited this a big challenge to most households. There is

need to come up with projects that could cushion such households of such costs that they may not be able to afford.

7 Annexes

7.1 Tools

FINAL HHS QUESTIONNAIRE_CARE SRRP-4th n

CARE_FDG_mother-U5_Revised -3.docx

CARE_FGD_Direct Beneficiaries_Revised-3

CARE_KII_Implementing Agency_Revised-3.

CARE_KII_Partners_NGO&Gov_Revised-3.doc

CARE_KII_VRCs_Revised-3.doc