WHO contribution in Somalia 2020-2025

Evaluation brief

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Background

This independent evaluation of the World Health Organization's (WHO) contribution in Somalia has been jointly commissioned by the WHO Evaluation Office (EVL), the Regional Office for the Eastern Mediterranean (EMRO), and the WHO Somalia Country Office, and conducted in accordance with the revised WHO Evaluation Policy (2025).

It documents WHO's key contributions, achievements, success factors, gaps, lessons learned and strategic approaches to improving health outcomes in Somalia. The evaluation is framed by WHO's Thirteenth General Programme of Work (GPW13, 2019–2025) and the Fourteenth General Programme of Work (GPW14, 2025–2028), which set WHO's strategic priorities during and beyond the evaluation period.

Purpose and scope

The purpose of this evaluation is to support organizational learning and accountability for results among external and internal WHO stakeholders. The evaluation assesses country-level results against national priorities in alignment with WHO's global and regional agendas and the United Nations Sustainable Development Cooperation Framework (UNSDCF). Its aims to inform the strategic direction of the WHO Country Office, including the next Country Cooperation Strategy (CCS) cycle. The evaluation covered WHO interventions across all regions of Somalia, including urban, rural and hard-to-reach areas, and reviewed the full portfolio of WHO Somalia work from 2020-2025.

Methods

The evaluation used a non-experimental, mixed-methods, utilization-focused, and theory-based approach to assess how and why WHO's interventions contributed to health outcomes in Somalia. A reconstructed Theory of Change (ToC) guided the analysis of causal pathways and enabling factors. Data collection included a desk review, quantitative analysis, and extensive qualitative inquiry – 78 key informant interviews, seven focus group discussions, a participatory workshop with nine state health directors, and a perception survey of 47 WHO and partner staff. The assessment applied adapted OECD-DAC criteria for humanitarian contexts –relevance, coherence, effectiveness, efficiency, and sustainability/connectedness, integrating gender, human rights, equity and disability inclusion throughout.

Key findings

Relevance

Between 2020 and 2025, WHO's strategies in Somalia were well aligned with national and local health priorities. The Organization served as a key normative anchor, providing technical guidance and coordination while demonstrating flexibility in responding to crises such as COVID-19, droughts, and recurrent outbreaks. The ToC was conceptually rigorous and relevant but limited by weak contingency planning and partial misalignment with operational realities. Somalia's protracted crisis context led WHO's portfolio to focus heavily on emergency response and health security, constraining progress in areas like maternal health and community accountability. National-level alignment did not always translate to subnational relevance, and persistent gaps remain in addressing the needs of marginalized and hard-to-reach populations.

Coherence

There was moderate technical and operational coherence, with strong alignment in vertical programmes such as polio and immunization across WHO's three levels. Coherence was weaker in emergency response, UHC, and health systems strengthening due to funding constraints, communication gaps, and the absence of a CCS mid-term review. While WHO was recognized as a technical lead and coordination convener, fragmentation, donor-driven priorities, and parallel systems limited harmonization with partners and internal programme integration. WHO's strong field presence enhanced coordination and credibility, though persistent challenges such as duplication and limited subnational ownership underscored the need to strengthen the emerging Area-Based Coordination (ABC) model to improve alignment and accountability.

Effectiveness

WHO demonstrated strong effectiveness in immunization, surveillance, and emergency response, achieving improvements such as higher Penta-3 coverage (70% in 2024), stronger cold-chain systems, and reduced cholera fatality rates (0.06%). Its support to Integrated disease surveillance and response (IDSR) and laboratory systems enhanced outbreak detection and response timeliness, though recurrent epidemics highlight ongoing fragility. WHO's convening power advanced key frameworks such as such as the Essential Package of Health Services (EPHS) 2020, and Reproductive, Maternal, Neonatal, Child and Adolescent Health (RMNCAH) strategies, but measurement gaps and misalignment between outputs and outcome indicators obscure the full extent of its contributions. Overall, WHO's technical authority and policy influence were evident, yet effectiveness was constrained by funding dependence, insecurity, and limited institutional capacity.

Efficiency

WHO Somalia's portfolio showed low efficiency, constrained by reliance on emergency and vertical funding, persistent Base-Strategic Priority financing gaps, and high operational costs that limited strategic resource allocation. The absence of an integrated performance framework and reliance on upward global reporting weakened adaptive management, obscured value-for-money, and skewed delivery toward short-term emergency priorities. Nonetheless, emerging practices, such as pooled UN logistics, shared security services, and harmonized health information systems, offer a potential pathway to greater efficiency if institutionalized.

Sustainability

WHO's contribution to sustainability in Somalia is mixed. Financial sustainability remains low due to reliance on earmarked emergency funding and limited government financing, leaving health gains fragile and the workforce dependent on donor support. Institutional sustainability is moderate, with Federal Ministry of Health ownership of the CCS, but fragmentation, weak RMNCAH integration, and the absence of a coherent national care model hinder consolidation. Technical sustainability is stronger in surveillance and laboratory systems but weaker in primary health care (PHC) and equity-focused outreach, while persistent monitoring and evaluation (M&E) gaps constrain the use of data for adaptive improvement.

Conclusions

WHO's country programme in Somalia (2020–2025) was broadly relevant and adaptive, with strong alignment to national priorities and clear effectiveness in immunization, surveillance, and emergency response, where outputs were closely linked to outcomes. Its normative leadership and convening power positioned WHO as a policy anchor, though fragmented funding, weak M&E, the absence of a clearly articulated risk management approach and limited subnational ownership reduced coherence and accountability.

Efficiency was constrained by heavy reliance on emergency and vertical funding, high operational costs, and non-integrated monitoring systems, skewing delivery away from equity and health system-strengthening priorities. The predominance of short-term humanitarian financing and the limited integration of programmatic and financial planning reduced WHO's ability to optimize resources and achieve balanced results across strategic priorities.

Sustainability remains mixed: technical gains in surveillance and laboratories show durability, but financial and institutional sustainability are weak due to donor dependency, fragmentation, and limited domestic financing. In particular, the absence of a coherent national service delivery model and limited integration of RMNCAH services constrain the institutionalization and sustainability of core health system functions. Future impact will depend on diversifying funding, embedding equity and accountability, and consolidating government ownership to ensure that emergency-driven gains translate into resilient, inclusive, and sustainable health systems.

Recommendations

Validated through stakeholder consultations and the Evaluation Reference Group, the following recommendations are presented:

Recommendation 1: Strengthen strategic planning and adaptation *(Tri-level: HQ – EMRO - CO)*
Institutionalize participatory priority-setting at all levels, ensuring inclusion of minorities, nomadic groups, women, and persons with disabilities. Update the ToC to include explicit risk/contingency scenarios to the ToC (e.g., insecurity, access, funding shocks) with decision triggers. Operationalize equity and human rights through a funded, monitorable plan co-developed with UN and Civil Society Organization (CSO) partners.

Recommendation 2: Institutionalize Area-Based Coordination (ABC) platforms to reduce parallel systems and align partners around district priorities *(CO-led)* In its role as Cluster Lead Agency, WHO should advocate for a review of the ABC Terms of Reference ensuring complementarity rather than competition. Embed community accountability mechanisms (SMS hotlines, scorecards, radio forums) across programmes and systematically adopt national Accountability to Affected Population (AAP) and Complaint/Feedback Mechanism frameworks.

Recommendation 3: Strengthen M&E and equity-disaggregated data *(CO-led, with EMRO technical support)*
Develop an integrated monitoring framework linking CCS outputs and outcomes to GPW13/14+ indicators with equity disaggregation. Improve the roll out of Health Information System (HIS) with district-level DHIS2 dashboards and routine data reviews at sub-national levels. Conduct a CCS mid-term review and publish an annual State of Health Equity in Somalia report to inform course correction and donor targeting.

Recommendation 4: Improve resilience and sustainability of the health system *(CO-led, in partnership with Government and UN agencies)* Co-develop a Somali PHC Roadmap integrating EPHS, RMNCAH, and outbreak preparedness into a unified primary healthcare model. Support a Human resources for health (HRH) strategy with equitable deployment, incentives, and task-shifting; strengthen regulatory capacity for the mixed system; and enhance WHO– United Nations Population Fund (UNFPA) coordination through joint standard operating procedures and results frameworks. Pilot integrated service-delivery "PHC+" sites that combine RMNCAH, nutrition, and outbreak readiness, with independent evaluation for scale-up.

Recommendation 5: Strengthen tri-level WHO coherence and resource mobilization *(Tri-level: HQ – EMRO - CO)*
Hold biannual HQ–EMRO–WCO strategic consultations with action logs (emergencies, HSS, financing). Publish an annual Somalia funds flow statement to improve transparency; leverage pooled and flexible funding aligned to the integrated monitoring framework to reduce overhead and competition; and establish a Somalia-specific EMRO budget line for technical follow-up and accountability.

Recommendation 6: Develop a comprehensive advocacy strategy for resource mobilization *(Tri-level, coordinated by CO and EMRO)*
Articulate value propositions - develop evidence-based outcome narratives, investment cases and value-for-money briefs, highlighting WHO's comparative advantage in fragile settings (e.g., health cluster coordination, and normative guidance). Align advocacy with national priorities, institutionalize a resource mobilization team within the WCO, and leverage regional and global platforms to elevate Somalia's case for sustained, predictable investment.

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WHO/DGO/EVL/2025.135