



World Health
Organization

Evaluation of WHO contribution in Somalia 2020-2025

Executive summary

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Cover photo: National Immunization Days campaign in Somalia @WHO / Abdirahman Caaylawe

Executive summary

Introduction

This independent evaluation of the contribution of the World Health Organization (WHO) in Somalia during the period 2020–2025 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). It documents WHO’s key contributions, achievements and strategic approaches to improving health outcomes in Somalia, and also identifies success factors, gaps and lessons learned. The evaluation is framed by the Thirteenth General Programme of Work of WHO (GPW 13, 2019–2025) and the Fourteenth General Programme of Work of WHO (GPW 14, 2025–2028), which set WHO’s strategic priorities during and beyond the evaluation period. The purpose of the evaluation is to inform the strategic direction of the WHO Country Office (WCO), including the next Country Cooperation Strategy cycle. As part of WHO’s biennial evaluation workplan for 2024–2025, the evaluation exercise underscores the Organization’s commitment to evidence-based decision-making, transparency and accountability to national governments, implementing partners, donors and Member States. The evaluation was jointly commissioned by the WHO Evaluation Office, the Regional Office for the Eastern Mediterranean and the WHO Country Office in Somalia and was conducted in accordance with the revised WHO Evaluation Policy (2025).

1.1 Context

Somalia is classified as both a least developed country and a fragile state. The country remains in a protracted post-conflict recovery situation and faces chronic food insecurity and recurrent droughts and floods. Since 2007, it has been included in the World Bank list of fragile and conflict-affected countries since 2009 [\(1\)](#), and the security situation remains precarious, with Mogadishu classified at level 5 under the United Nations (UN) security level system [\(2\)](#). In 2022, WHO declared a grade 3 health emergency in Somalia – the highest emergency level recognized by the Organization [\(3\)](#). Decades of large-scale humanitarian assistance have sustained lives, but have also entrenched parallel service delivery systems, leading to systemic post-delivery aid diversion and prompting high-level reforms [\(4\)](#). The population, estimated at 18.7 million in 2023, is exceptionally young (median age 15.5 years), with 54% living below the poverty line [\(5\)](#). A compounding crisis of conflict and climate shocks continues to drive disease outbreaks, with flooding linked to recurrent acute watery diarrhoea and cholera outbreaks [\(6\)](#). Somalia’s health system is severely constrained by fragmented governance, workforce shortages, chronic underfunding and unreliable data, and recent humanitarian funding cuts have forced health facility closures [\(7\)](#). These challenges undermine progress towards health equity and the WHO GPW 13 goal of “one billion more people with better health and well-being”.

1.2 Object

The object of the evaluation is WHO's portfolio of work at country level in Somalia from 2020-2025. The WHO Country Cooperation Strategy (CCS) for Somalia (2021–2025) provides the strategic framework guiding WHO's work in the country (8). It is aligned with the national health and development agenda, the UNSDCF (2021–2025), GPW 13 and, prospectively, GPW 14. Developed through extensive consultations with federal and state health authorities and partners, the CCS articulates WHO's mission to promote health, and serve the vulnerable, translating global priorities into country-specific actions. It focuses on four strategic priorities: advancing universal health coverage (UHC) through strengthened primary health care; enhancing health security by improving emergency preparedness and response; promoting healthier populations through multisectoral approaches; and strengthening health governance and partnerships. These priorities are pursued through a mix of direct implementation, technical assistance and policy advocacy, supported by defined progress indicators. Since 2020, WHO Somalia has mobilized about US\$ 343 million in awarded funds, of which over US\$ 304 million had been utilized by June 2025. Overall, WCO financing remains heavily dependent on emergency-driven resources, underscoring Somalia's continued reliance on humanitarian funding to sustain health service delivery.

1.3 Purpose, objectives and scope

The purpose of this evaluation is to support organizational learning and accountability for results among external and internal WHO stakeholders. While the CCS results framework provided the principal reference, the evaluation also encompassed WHO's response to emergent needs, including the COVID-19 pandemic, outbreaks and humanitarian health emergencies such as floods, droughts and population displacements. 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's work during the period 2020–2025. Primary users of the evaluation include WHO (WCO Somalia, the WHO Regional Office for the Eastern Mediterranean, WHO headquarters), the Government of Somalia, the United Nations country team (UNCT), donors and the populations served.

1.4 Methods

The evaluation employed a non-experimental design and blended mixed-method, utilization-focused and theory-based methodological approaches to assess how and why WHO's interventions in Somalia contributed, or failed to contribute, to expected health outcomes. A reconstructed theory of change (ToC) guided the exercise, providing a framework for examining underlying mechanisms, enabling conditions and results pathways. Data collection combined an extensive desk review and secondary quantitative analysis with primary qualitative methods, including 78 in-depth interviews with key informants, seven focus group discussions with frontline health workers and state-level public health officers, a participatory workshop with nine state-level health directors and a perception survey of 47 WHO and partner staff. Primary data were collected through both in-person and remote (online) modalities. Stakeholders were purposively sampled to capture diverse perspectives, including those of federal and state health authorities and representatives of United

Nations (UN) agencies, donors, non-governmental organizations (NGOs), the private sector, academia and persons with disabilities. The assessment utilized the evaluation criteria of the Development Assistance Committee of the Organisation for Economic Co-operation and Development, adapting them for the evaluation of humanitarian action [\(9\)](#). It covered relevance, coherence and coordination, effectiveness, efficiency and sustainability/connectedness, while also integrating cross-cutting dimensions of gender equality, human rights, equity and disability inclusion.

1.5 Findings

Relevance

Between 2020 and 2025, WHO's strategies and interventions in Somalia were broadly aligned with national and local health priorities, policies and needs. WHO played a central role in providing normative guidance, technical support and thought leadership, acting as a key normative anchor that connected global health objectives with Somali strategies. The Organization also demonstrated notable flexibility in responding to evolving humanitarian crises, such as the COVID-19 pandemic, droughts, floods and recurrent outbreaks, by adapting operations, strengthening coordination with partners and prioritizing vulnerable groups. The ToC is relevant, conceptually rigorous and logically sound, although its robustness and practical credibility were somewhat restricted by limited articulation of contingency strategies and partial misalignment between ambitions and operational realities.

Somalia's protracted crisis context drew WHO's portfolio heavily towards emergency response and health security, which, while appropriate to the context, limited progress in other areas, such as maternal health and community accountability. Alignment at the national level did not always translate into relevance at state and district levels, with stakeholders citing insufficient subnational consultation and tailored interventions. Moreover, WHO's adaptations were largely operational rather than programmatic, with limited recalibration of frameworks such as the CCS to reflect the protracted emergency dimension. Persistent gaps remain in systematically addressing the needs of minorities, marginalized groups, persons with disabilities and populations in hard-to-reach areas.

Coherence

WHO's interventions in Somalia during 2020–2025 demonstrated moderate technical and operational coherence with external partners, particularly in vertical programmes such as those on polio and immunization, which also showed strong alignment across WHO's three levels. However, coherence was less consistent in emergency response, UHC and health system strengthening, where funding constraints, communication gaps and the absence of a CCS mid-term review limited strategic integration. While WHO is widely recognized as a technical lead and coordination convener, fragmentation, parallel systems and donor-driven priorities hindered fuller harmonization with partner agendas, and internal coherence across programmes remained uneven.

At the same time, WHO made substantive contributions to both UN system-wide and health sector coordination, providing technical leadership for policy development, strategy formulation and

outbreak response. Its strong field presence enabled state-level coordination and reinforced its reputation as a reliable technical authority among stakeholders and donors. Nevertheless, coordination challenges persist, including duplication of effort and limited government leadership at subnational levels. The ongoing transition to area-based coordination offers an opportunity to address these structural and operational gaps.

Effectiveness

WHO demonstrated its strongest effectiveness in the areas of immunization, surveillance and emergency response, where outputs were closely tied to service delivery. Notable achievements include increased coverage of the third dose of the pentavalent vaccine (Penta-3) (70% in 2024), strengthened cold chain and Expanded Programme on Immunization (EPI) systems, and vaccination campaigns that contributed to a modest decline in under-5 child mortality (from 117 to 114 per 1000). In the area of health security, WHO's support for integrated disease surveillance and response, laboratory systems and rapid response teams improved outbreak detection and timeliness of response (from 51.7% to 68.3%), with reduced cholera case fatality rates (0.06%), illustrating the impact of enhanced epidemic preparedness. However, recurrent epidemics underscore the fragility and inequity of prevention measures.

In the area of governance, WHO effectively used its convening power to drive coordination frameworks and policies (such as the Essential Package of Health Services 2020 and reproductive, maternal, neonatal, child and adolescent health strategies) and the integration of health into social protection, but measurement of WHO's contribution in this area relied heavily on binary indicators that obscured quality considerations and downstream effects. A structural misalignment persists between WHO's outputs and CCS strategic priority outcome indicators. On the one hand, outcome metrics are often high-level (e.g., maternal mortality, availability of essential medicines) and are influenced by multiple external factors; on the other, WHO's outputs are mainly related to its normative and system-enabling role. This disconnect risks underestimating WHO's contributions, except in areas such as immunization and health security where outputs and outcomes are closely linked.

Overall, WHO's technical authority, national presence and ability to mobilize resources have enabled significant achievements in policy influence, system strengthening and emergency response. Yet, sustainability and equity remain limited by insecurity, funding dependence and weak government ownership. While WHO has normatively embraced cross-cutting commitments to equity, gender, human rights and disability inclusion, operational mainstreaming of these commitments remains weak, with uneven implementation at subnational levels.

Efficiency

WHO Somalia's portfolio demonstrates low efficiency. It has been sustained largely through emergency and vertical funding, and persistent base strategic priority financing gaps and high operational and security costs have limited the Organization's capacity to allocate resources strategically or ensure balanced portfolio delivery. The lack of an integrated, programme-level

performance architecture has further reduced efficiency, as monitoring data are primarily structured for upward global reporting rather than for real-time operational use. This has curtailed the ability to link outputs to outcomes, track equity dimensions and undertake timely course corrections. As a result, adaptive management is weakened, value-for-money is obscured and delivery is skewed towards short-term emergency responses at the expense of longer-term, system-strengthening and equity-focused priorities. Despite these constraints, good practices are emerging, including proposals for pooled UN logistics and procurement, cost-sharing for security services and efforts to harmonize health information systems. These initiatives, if institutionalized, point to a pathway towards greater efficiency.

Sustainability

WHO's contribution to sustainability in Somalia has been mixed. Financial sustainability is low, as reliance on earmarked, emergency funding has left base strategic priorities underfunded and gains fragile, with little government financing to ensure continuity. The country's health system remains vulnerable to external shocks, with health workforce sustainability at risk as a result of continued reliance on donor rather than government financing. Institutional sustainability is moderate, with the Federal Ministry of Health showing ownership of the CCS; but fragmentation, weak integration of reproductive, maternal, neonatal, child and adolescent health (RMNCAH) services and the absence of a coherent national care model have made it difficult to consolidate the gains made. Technical sustainability is relatively strong in surveillance, early warning and laboratory systems, which are increasingly embedded in government structures, but weaker in primary health care (PHC) delivery and equity-oriented outreach, which remain dependent on parallel mechanisms and external financing. Persistent monitoring and evaluation (M&E) weaknesses further limit adaptive use of data to sustain improvements.

1.6 Conclusions

WHO's country programme in Somalia (2020–2025) was broadly relevant and adaptive, with strong alignment with 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 diminished 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 with regard to surveillance and laboratories show durability, but financial and institutional sustainability are weak due to dependence on donors, fragmentation and limited domestic financing. In particular, the absence of a coherent national

service delivery model and limited integration of RMNCAH services hinder 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 solid progress towards resilient, inclusive and sustainable health systems.



*WHO field visit to Dolow General hospital in Somalia. A little boy has his chest examined by a doctor..
August 2023
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1.7 Recommendations

Overall, when planning the next CCS, WHO Somalia should reinforce its role as the health normative convener and systems anchor, focusing on areas where it adds value (standards, regulation, coordination, data and equity), rather than duplicating service delivery. The strategic plan should explicitly balance emergency response capacity with investments in PHC, regulation of the mixed, public–private partnership (PPP) system and sustainable financing, ensuring that WHO’s support contributes to durable, equity-focused health system strengthening.

The recommendations, which have been validated through consultations with stakeholder consultations and the Evaluation Reference Group, are summarized below and further elaborated in the main report, with examples from other countries provided to demonstrate how some operations have implemented specific actions. The recommendations are organized by implementation horizon and level of responsibility, and priorities for the short term (within six months) and medium term (within one year) are identified.

Short-term priorities (next 6 months): These address the most needed adaptive and operational improvements identified by the evaluation, particularly in planning, coordination and data systems.

- 1. Strengthen strategic planning and adaptation** (*tri-level: WHO headquarters – Regional Office – Country Office*)
 - Institutionalize participatory priority-setting at all levels, ensuring the inclusion of minorities, nomadic groups, women and persons with disabilities.
 - Update the ToC to include explicit risk/contingency scenarios (e.g. insecurity, funding shocks) with decision triggers. This will ensure that WHO’s portfolio can be adapted without abandoning longer-term health system strengthening goals.
 - Operationalize equity and human rights through a funded, monitorable plan co-developed with UN and civil society partners.
- 2. Improve subnational coordination and accountability** (*Country Office-led*)
 - Institutionalize area-based coordination platforms to reduce parallel systems and align partners around district priorities. In its role as Health Cluster lead agency, WHO should advocate for a review of the terms of reference for area-based coordination in order to clearly define roles, responsibilities and linkages with existing cluster coordination mechanisms, ensuring complementarity rather than competition.
 - Embed Community accountability mechanisms (e.g. hotlines, scorecards, radio forums) across programmes.
 - Set up national mechanisms to ensure accountability to affected populations (AAP) and receive complaints and feedback.
- 3. Strengthen M&E and equity-disaggregated data** (*Country Office-led, with technical support from the Regional Office*)

- Develop an integrated monitoring framework linking CCS outputs and outcomes to GPW 13/14 indicators, with equity disaggregation.
- Improve the roll-out of health information systems with District Health Information System 2 (DHIS2)¹ dashboards and routine data reviews at subnational levels. This will bring analysis and problem-solving closer to the point of care.
- Strengthen other essential components of the health information system, such as the civil registration and vital statistics system, including cause of death data.
- Conduct a CCS mid-term review and publish an annual *State of Health Equity in Somalia* report to inform course correction and donor targeting.

Medium-term priorities (next 12 months): These priorities will require deeper structural, financing and institutional engagement to improve sustainability and coherence across WHO levels and the national system.

4. Improve resilience and sustainability of the health system (*Country Office-led, in partnership with Government and UN agencies*)

- Co-develop a Somali PHC roadmap integrating the Essential Package Of Health Services, RMNCAH and outbreak preparedness into a unified primary healthcare model. This will reduce vertical silos and improve continuity of care.
- Support a human resource for health strategy, with equitable deployment of health personnel, 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 “PHC+” service delivery sites that combine RMNCAH, nutrition and outbreak readiness, with independent evaluation for scale-up. Such demonstrations could reduce risk and create an evidence-based playbook for extending the PHC+ model beyond the pilot areas. The essential health services package, as the service delivery framework, already describes RMNCAH healthcare interventions, but outbreak preparedness should be better integrated.

5. Strengthen tri-level WHO coherence and resource mobilization (*Tri-level: WHO headquarters – Regional Office – Country Office*)

- Hold biannual strategic consultations of staff from WHO headquarters, the Regional Office and the Country Office, with action logs (e.g. on emergencies, health system strengthening, financing). This will reduce transaction costs and facilitate follow-through on technical missions.
- Publish an annual Somalia funds flow statement to improve transparency; leverage pooled and flexible funding aligned with the integrated monitoring framework to reduce overhead and competition; and establish a Somalia-specific budget line in the Regional Office budget for technical follow-up and accountability.

¹ DHIS2 is an open source, web-based platform for health information management. More information may be found at <https://dhis2.org>.

6. Develop a comprehensive advocacy strategy for resource mobilization (*Tri-level, coordinated by the Country Office and the Regional Office*)

- 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. technical leadership, Health Cluster coordination, emergency response and normative guidance).
- Align advocacy with national priorities; institutionalize a resource mobilization team within WCO Somalia; and leverage regional and global platforms to elevate Somalia's case for sustained, predictable investment.



WHO's response to the drought crisis in Baidoa, Somalia (November 2022): In August 2022, WHO supported displaced communities in Baidoa as severe drought affected 7.8 million people nationwide. The crisis drove mass displacement, acute food insecurity and high levels of child malnutrition amid ongoing conflict and limited access to health care. © WHO / Ismail Taxta

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